Torbay and South Devon NHS Foundation Trust
Public Board of Directors

The Boardroom, Hengrave House/MS Teams
24 November 2021 11:30 - 24 November 2021 14:30

AGENDA

#	Description	Owner	Time
1	**Welcome and Introductions** Note	Ch	11:30-11:35
2	**Preliminary Matters**	Ch	11:35-11:40
2.1	**Apologies for Absence and Quoracy** Note	Ch	
2.2	**Declaration of Interests** Note	Ch	
2.3	**Board Corporate Objectives** Information 📄 2.03 Board Corporate Objectives.pdf 　　　　9	Ch	
3	**User Experience Story** Receive and Note	CNO	11:40 - 12:10
4	**Consent Agenda (Pre Notified Questions)**		
4.1	**Committee Reports**		12:10 - 12:20
4.1.1	**Finance, Performance and Digital Committee Chairs Report - 25 October 2021** Receive and Note 📄 4.01.01 Finance Performance and Digital Committe... 　　11	P Richards	
4.1.2	**People Committee - 25 October 2021** Receive and Note 📄 4.01.02 People Committee - 25 October 2021.pdf 　　15	C Balch	
4.1.3	**Building a Brighter Future Committee Chairs Report - 17 November 2021** Receive and Note 📄 4.01.03 Building a Brighter Future Committee Chair... 　　17	C Balch	

#	Description	Owner	Time
4.2	Reports from Executive Directors (for noting)		12:20 - 12:25
4.2.1	Chief Operating Officer's Report - November 2021 Receive and Note 📄 4.02.01 Chief Operating Officer's Report 2021.pdf 19	COO	
4.2.2	Estates Performance and Compliance Group Report Receive and Note 📄 4.02.02 Estates Performance and Compliance Grou... 33	CFO	
5	For Approval		12:25 - 12:30
5.1	Unconfirmed Minutes of the Meeting held on the 27 October 2021 and Outstanding Actions Approve 📄 5.01 Minutes of the Meeting held on the 27 October... 39	Ch	
6	For Noting		12:30 - 12:45
6.1	Report of the Chairman Verbal	Ch	
6.2	Chief Executive's Report Receive and Note 📄 6.02 Chief Excutives Report.pdf 53	CE	
7	Safe Quality Care and Best Experience		12:45 - 13:15
7.1	Integrated Performance Report (IPR): Month 7 2021/22 (October 2021 data) Receive and Note 📄 7.01 Integrated Performance Report Month 7 Octob... 65	HCSD	
7.2	Winter Planning Arrangements Approve 📄 7.02 Winter Planning Arrangements.pdf 129	COO	

#	Description	Owner	Time
7.3	**November 2021 Mortality Safety Scorecard** Receive and Note 📄 7.03 November 2021 Mortality Score Card.pdf 135	MD	
7.4	**Annual Incidents Report 2020/21** Receive and Note 📄 7.04 Annual Incidents Report 2020 21.pdf 155	CN	
7.5	**Care Quality Commission (CQC) NHS Patient Experience Surveys 2020 Reports** Receive and Note 📄 7.05 Care Quality Commission NHS Patient Experi... 175	CN	
7.6	**Feedback, Complaints and Patient Advice and Liaison (PALS) Policy** Approve 📄 7.06 Feedback, Complaints and Patient Advice and... 279	CN	
7.7	**7.07 Smokefree 2030 - the All Party Parliamentary Group on Smoking and Health** Approve 📄 7.07 Smokefree 2030 - the All Party Parliamentary... 297	HCSD	
8	Valuing our Workforce		13:15 - 13:30
8.1	**Freedom to Speak Up Guardian Six Monthly Report** Receive and Note 📄 8.01 Freedom to Speak Up Guardian Six Monthly R... 311	CPO	
9	Improved Well-Being Through Partnerships		13:30 -13:45
9.1	**Research and Development Annual Report 2020/21** Receive and Note 📄 9.01 Research and Development Annual Report 20... 315	MD	
10	Well-Led		13:45 - 14:15

#	Description	Owner	Time
10.1	**Single Oversight Framework - exit criteria** Approve 📄 10.01 Single Oversight Framework – exit criteria.pd... 361	CFO	
10.2	**Building a Brighter Future Programme Update** Receive and Note 📄 10.02 Building a Brighter Future Programme update... 371	DTP	
10.3	**2021 NHSE CCG external assessment of the Trust against EPRR responsibilities and national standards** Receive and Note 📄 10.03 2021 NHSE CCG external assessment of the... 375	COO	
11	Compliance Issues		
12	**Any Other Business Notified in Advance** Note	Ch	
13	**Date and Time of Next Meeting - 11.30 am, Wednesday 26 January 2022** Note	Ch	

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BOARD CORPORATE OBJECTIVES

Corporate Objective:

1. Safe, quality care and best experience

2. Improved wellbeing through partnership

3. Valuing our workforce

4. Well led

Corporate Risk / Theme

1. Available capital resources are insufficient to fund high risk / high priority infrastructure / equipment requirements / IT Infrastructure and IT systems.

2. Failure to achieve key performance / quality standards.

3. Inability to recruit / retain staff in sufficient number / quality to maintain service provision.

4. Lack of available Care Home / Domiciliary Care capacity of the right specification / quality.

5. Failure to achieve financial plan.

6. Care Quality Commission's rating of 'good' and the ability to maintain sufficient progress to retain 'good' and achieve 'outstanding'.

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

Committee meeting date:	25 October 2021
Report author + date:	Paul Richards, Non-Executive Director 18 November 2021
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐

Key issues to highlight to the Board

Risk management

The Committee reviewed the risks within its scope, namely BAF risks 2, 3, 5, 6 and 7. A wide-ranging discussion was held, highlighting the importance of articulating step-wise risk mitigations which will have a positive impact in advance of the New Hospital Programme investment. It was highlighted that a number of the Trust's strategic risks would require some alignment with system risks, given some Trust risks will not be mitigated without significant collaboration and service redesign across Devon.

Strategy & long-term planning

The committee received an update on the digital business case. Significant progress was noted, but it was highlighted that sources of funding remained uncertain and that this could have a bearing on the alignment of the NHP and digital business cases. The strategic importance of the digital case was emphasised and agreed.

Medium-term planning

The committee received a report and recommendation on the future of the Dawlish PFI contract. A preferred way forward was identified, based on strategic tests against the Trust's clinical model, and financial tests such as the net present value (NPV) of different options. The committee commended work, undertaken within a complex and highly regulated framework.

The committee also received a report on the draft budget for H2 (October 2021-March 2022). The Trust is required to deliver an operating surplus of £1.8m for H2, after the allocation of £1.8m of winter support funding. The committee that there was a gross risk of around £8.3m risk within the plan, chiefly driven by the current CIP position, the ongoing OPEL 4 escalation position and the associated financial consequences

associated with that. A discussion was held around the approach to mitigating the gross risk of £8.3m, and it was felt that reasonable mitigations were in place to balance the plan.

It was noted that an expenditure review / cost containment process was being established within the Devon ICS. Under this process, any revenue investment above £150k would require ICS scrutiny. The Trust is engaging fully with this exercise.

The committee accepted the draft financial plan for H2, welcoming the clarity but cautioning the very difficult choices ahead. The fine balance at play was brought into sharp focus through discussion of the follow up actions subsequent to the Sirius report into the HIS function. These recommendations have not made progress owing to financial constraints, and as such the Trust holds significant residual risk.

Performance

The committee received the M6 Integrated Performance Report, noting:

Operationally

- Significant escalation continued, with the Trust being at "Opel 4" for most of the month. The Trust was seeing increasing demand and acuity, particularly for emergency care.
- Waiting times are increasing including long waits and follow ups, owing to disruption to care pathways
- Cancer performance is challenged, particularly in urology and lower GI – recovery plans are in place
- Challenges within the out of hospital market were noted, in particular regarding workforce availability
- Further opportunities for improvement were being pursued through the Best Week initiative and new funding available through the Targeted Investment Fund

Financially, the Trust delivered a £1.3m deficit in month, but achieved the required financial performance for H1 of a breakeven position. The cash position remained acceptable, but CIP remained challenging in terms of outlook.

The committee received an update on **Capital Expenditure and Cash**. The committee noted the year to date position and the spend of just over £7m against a plan of £9.3m. Steps to accelerate spending were outlined, as well as four specific risks namely i) the BBF programme seed funding, ii) the Wave 3 funding applied for through the TIF process which had not been successful, iii) approval of capital support for Torbay Pharmaceuticals and iv) emerging supply chain issues regarding medical equipment.

The committee also reviewed the quarterly Treasury performance report, with no areas of concern noted.

Items for escalation

From its discussion, the committee seeks to highlight:

- The IPR report and in particular the very challenged performance position

- The Risk Register, given the significant number of high (and possibly deteriorating) risks
- The overarching financial position and lack of progress with the delivery of CIP
- The digital risk, and the consequences the Trust faces as a result of not being able to invest in line with external recommendations

Key decision(s)/recommendations made by the Committee

Approved:

- Preferred option for Dawlish PFI
- H2 draft financial plan
- Insurance renewals

People Committee
Chair's Report to the Board of Directors

Meeting date:	25th October 2021
Report by:	Chris Balch, NED
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 (October 2021):

1. The Committee received a presentation on the long-term workforce planning work which has started as part of the Building a Brighter Future (BBF) Programme. The Committee were assured that there is a clear programme of activities to establish the long-term workforce needs of the Trust when the BBF Programme is fully implemented. Work is underway with education and training providers to identify potential future suppliers of the necessary skills. The Committee noted that the Trust is currently facing significant workforce pressures because of sustained levels of retirement which reflects the age profile of its workforce. In the short-term international recruitment is expected to help replace lost staff. However the challenge of balancing short term staffing imperatives with longer term workforce planning was noted.

2. The Committee received the Workforce Information Report which highlighted increasing staff sickness levels linked to operational pressures. The rate of achievement review has fallen back a little and remains below target. However mandatory training targets are being met. The Committee subsequently received a report on mandatory training which revealed that in a number of key areas targets are not being met, in part due to the suspension of activities due to the pandemic. While these areas are being prioritised, this remains an area of concern particularly in relation to CQC 'must do' actions.

3. The Committee received a deep dive report on the 'belonging' pillar of the People Plan.
A number of areas of progress were noted, particularly in the establishment of forums and networks and seeking greater diversity through the recruitment process. The Committee agreed that promoting equality and diversity in terms of race and disability remains an important priority for action.

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

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

Meeting date:	17th November 2021
Report by:	Chris Balch
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 (November 2021):

1. The Committee were updated on the risks to the delivery of the Building a Brighter Future (BBF) Programme covering both infrastructure and digital elements. These remain as previously advised and are being actively managed.

2. The Committee considered proposed changes to the Board Assurance Framework for Objective 11 – to develop and implement the New Hospital Plan (Building a Brighter Future) ensuring that it meets the needs of the local population and the Peninsula System. It was agreed that the strength of assurance should be downgraded from green to amber. This reflects slippage in the anticipated timetable for Strategic Outline Case approval and notification of the release of seed funding for the Outline Business Case (OBC). While this is outside our control it introduces uncertainty into our ability to develop our plans at pace and the project timetable is currently adversely affected by this delay. A further review of timetables will take place in January alongside the impact on risk and assurance.

3. The Committee received a 'deep dive' report on managing the risks associated with developing a workforce plan to support the BBF programme and enabling mobile digital working. The Committee were assured that there is a clear process in place for creating a deliverable workforce plan. Work is underway to establish the baseline' position onto which demand and capacity and service line transformation will be modelled. A series of iterations are envisaged taking into account financial implications. Early discussions are underway with education and training providers to maximise the potential for local recruitment.

4. The Committee recognised the opportunities and challenges of enabling a mobile workforce through digital investment. It was agreed to explore the opportunity of working with partners to ensure that the infrastructure was in place (mobile communication and broadband) to support a digital first approach to the delivery of healthcare. The need to ensure that this was reflected in Information Technology infrastructure in the Trust's new Health and Well Being Centres was noted.

5. The Committee received an update on the Digital OBC which is now at draft stage. Further work is underway to refine the economic case with a preferred option emerging. The Committee agreed that work needs to continue at pace to enable approval of the OBC, subject finalisation of funding sources.

6. The Committee received a report from Mr Michael Green, the Trust's Chief Clinical Information Officer, on the lessons emerging from the implementation of the Royal Devon and Exeter NHS Foundation Trust's electronic patient record (EPR) system one year on. This highlighted significant potential benefits in staff satisfaction, clinical efficiency, quality and safety particularly when the EPR is deployed as an integrated system. Success is dependent of a significant amount of preparatory work to redesign workflow and 'win hearts and minds'. This requires deep engagement with clinicians to support state of the art healthcare delivery.

7. The Committee received its regular finance report which confirmed that as at the end of November the seed funding allocated to progress the SOC is largely exhausted. The Trust continues to press for approval of the next tranche of funding. In its absence the Trust is at financial risk in maintaining the BBF Programme team.

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors		
Report title: Chief Operating Officer's Report 2021		**Meeting date:** 24th November 2021
Report sponsor	Chief Operating Officer	
Report author	System Directors	
Report provenance	Contents reflect latest updates from management leads across all Integrated Service Units (ISUs) and Children and Family Health Devon (CFHD)	
Purpose of the report and key issues for consideration/decision	To provide an operational update to complement the Integrated Performance Report (IPR) monthly reports including performance metrics. The report explains the key activities, risks and operational responses to support delivery of services now and into winter including efforts to increase delivery of high priority elective services. The report also provides information and greater visibility for a number of important areas of Trust business not fully covered in the IPR. In particular this month provides a greater insight into the adult social care agenda. Other issues for consideration include the impact of securing the beds for high priority surgery and the ongoing hospital flow and workforce challenges. Ongoing risks in regards to delivering Dermatology capacity are also outlined including the subsequent cancer wait impacts. The Winter plan for the Trust and the wider system is being finalised and will reflect the improvements identified in the Best week. Some notable areas for celebration include the Helping Overcome Problems Effectively Programme (HOPE) roll out to some very vulnerable and important groups supporting men's mental health, anxiety and depression.	

Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board are asked to receive and note the Chief Operating Officer'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		**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: 24th November 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 organisation has continued to experience significant pressure on flow and has seen an increase in Covid-19 patient admissions. Despite this pressure the ring-fenced use of a surgical ward - Ella Rowcroft has been achieved to enable an increase in high priority planned care delivery.

Workforce insufficiency across the organisation has remained a challenge including continued pressure in the independent sector although there is evidence of small improvements in length of stay driven in part by a reduction of the number of patients in beds waiting for community care support.

Learning from the tests of change during the Best Weeks have continued to be developed and are incorporated into the winter plan.

Detailed planning and preparation has been focused on the additional grant funding and winter planning in adult social care, alongside governance and reporting changes.

Financial planning sessions to optimise cost improvement delivery across the service delivery units for the second half of the year have taken place. Budget spending and investment protocols have been introduced to support operational and clinical teams.

3. Emergency Preparedness Resilience and Response (EPRR)

The EPRR team over the last month have been working on the EPRR Assurance Action Plan in line with the related Board report elsewhere on the Board agenda. The EPRR focus for November is supporting the operational demand with capacity and planning assumptions for winter as well as recertifying the Trust's decontamination volunteers ensuring the Trust is able to maintain its response to a CBRN[1] Incident.

4. COVID -19

October into November has seen a rise in Covid-19 presentations to the emergency department and subsequent inpatients.

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[1] Chemical, Biological, Radiological and Nuclear

5.   Children and Family Health Devon (CFHD)

5.1 Performance
There is a continued focus on improving waiting times across services. Referral to treatment (RTT) time is 100% in children's community nursing services and the learning disability service. The autistic spectrum disability (ASD) assessment service is delivering an improvement plan with the use of CFHD non-recurrent funding aided by significant efficiency improvements which have increased assessment output by almost 100% per wte clinician. RTT remains low but is now improving and the mean wait time has been reduced by 6 weeks from the start of the project in April. There are currently 1,818 children on the waiting list, a reduction of around 900 from April, with 1,400 assessments undertaken since April.

Physiotherapy, occupational therapy (OT) and the specialist developmental assessment centre are improving RTT times (although had a slight drop in September). Challenges delivering access times remain with the Child and Adolescent Mental Health Service (CAMHS) and speech and language therapy (SALT). There is an intensive focus on productivity in CAMHS in order to optimise clinical capacity in the context of a high rate of vacancies.

Additional non-recurrent Covid related funding has been granted by Devon County Council (DCC) to reduce OT and SALT waits.

Overall RTT (Incomplete Pathway)

Service	Mean Wait	% waiting ≤ 18 weeks	% RTT ≤ 18 weeks compared to last month	% RTT ≤ 18 weeks over the last 12 months
Community Children's Nursing (CFH Devon)	4.6	100.0%	→	
Learning Disability (CFH Devon)	5.3	100.0%	↑	
Mental Health and Wellbeing (CFHD)	19.4	52.0%	↓	
Occupational Therapy (CFH Devon)	16.3	58.7%	↓	
Palliative Care (CFH Devon)	0.0	100.0%	↑	
Physiotherapy (CFH Devon)	11.3	78.5%	↓	
Special School Nursing (CFH Devon)	5.7	100.0%	→	
Specialist Autism Spectrum Assessment Team (CFHD)	54.9	12.1%	↑	
Specialist Children's Assessment Centre (CFHD)	25.4	40.0%	↓	
Speech & Language Therapy (CFH Devon)	28.9	32.6%	↓	

5.2 Demand
In the learning disability service there is a notable increase of children and young people placed on the dynamic support register or escalated to care, education and treatment reviews (CETR) who are at risk of requiring admissions to specialist units.

In the physiotherapy service, there has been a significant increase in demand for paediatric respiratory physiotherapy as a result of COVID and RSV infections. There has been increased referrals since Covid with a 13% increase of children on the caseload.

In the SALT service RTT has continued to be impacted due to suspension of service during Covid and lower treatment activity during lockdowns and reduced face to face activity. Post Covid wave 1 there has been a 28% increase in demand.

In the ASD service, the accepted referral rate has reduced from 155 pre covid to 77 per month. The reduction in the referral numbers may be a sign of the early support offer becoming more embedded across the system.

In the CAMHS service, overall referrals have increased by 9% since Covid this is lower than the increase seen nationally.

5.3 Workforce
Staff turnover is an issue for some services; some of this is likely to be influenced by the on-going uncertainty regarding the service transformation. A number of initiatives are being implemented including 'Stay interviews' and a plan to gather feedback from new starters after two months in the service. Our CFHD People plan, which is in development, will address retention, recruitment, training and development including leadership development.

5.4 Transformation Programme
Final internal check and challenge is being undertaken with regard to the workforce re-design. The move to an agreed percentage of our clinical work being delivered face to face is in place and the service is working with staff to establish the optimal balance of remote and clinic-based working. This should also enable CFHD to rationalise the estate.

During the remainder of November, the financial modelling is being undertaken on the transformation plan. The proposed new service model will be presented to Partnership Board in December.

5.5 Corporate Level Risks
Corporate level risks relate to inadequate pharmacy and medicine optimisation capacity, waits across a number of services, workforce vacancies in CAMHS and insufficient nursing capacity in the Children In Care team. All risks have active mitigation plans.

6.   Coastal ISU: Elective / Planned Care

Despite continued urgent care pressures the surgical ward Ella Rowcroft has been retained for elective use. This has enabled an average of 16 orthopaedic inpatients and a further 59-day case patients to be treated per week across 12 specialties. As a result, the list of priority category 2 patients has stopped increasing and a reduction in the overall number waiting has been achieved.

There is an expectation that no patients will be waiting over 104 weeks by the end of March 2022; many of these patients are awaiting surgery and therefore with the with Coastal ISU, with more than 50% are in orthopaedics. The team is focusing on out patients to ensure that by the end of November all patients have a treatment plan. The team continue to use Mount Stuart hospital for appropriate patients and insourcing continues, primarily around day cases at weekends. The plan to utilise the Nightingale Hospital in Exeter from January 22 for orthopaedics is in place and Ella Rowcroft will continue for those patients too complex to be treated elsewhere.

A dashboard of performance and forecasting is now in place and is highlighting particular challenges with urology and UGI, if additional insourcing capacity is secured this will help to close these gaps.

The H2, second half of the financial year, Elective Recovery Fund (ERF) plans have been resubmitted and final approval expected in November. Talks with insourcing companies in readiness for approval are imminent being organised.

7.   Paignton and Brixham ISU: – cancer and diagnostics update

7.1 Cancer Performance

Cancer Annual Reports   cancer_site (All)   fy_year (Multiple values)

Two Week Wait (2ww) Referrals

Total number of 2ww referrals received. This will be slightly different to the Cancer Wait Times (CWT) position, as for CWT purpose the referral is counted when the patient is first seen, rather than when the referral was made.

Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Grand To..
1,345	1,454	1,192	1,246	1,215	1,142	1,559	1,507	1,454	1,586	1,595	1,466	1,822	1,562	25,593

Sept 2021 – >1,800 referrals, the highest number of referrals received by the Trust.
- ◦ High in most sites
- ◦ Significant rises in Breast, LGI + Skin
- ◦ Breast – current two celebrity diagnosis raising awareness
- ◦ Skin continued referrals at a high level throughout the summer.

The significance of this rise in cancer referrals will flow through the specialities and consequent impact on chemotherapy and radiotherapy services.

Dermatology 2ww first appointments are being booked at 6 weeks which is impacting on the 28-day trust standard.

A recovery action plan as previously noted is in place for dermatology. A south east and north Devon (SEND) stakeholder engagement meeting is planned for November facilitated by the Trust Executive Director of Transformation.

In advance of the Integrated Care System (ICS) long-term sustainable model for dermatology services discussions are underway between the operational teams and clinical leads:

- RD&E currently scoping potential Consultants internationally to come and work in the Region to support rising demand in suspected skin cancer referrals
- 2WW super clinics with RD&E and TSDFT 1-2 clinics per month (in week or weekend) potentially utilising TSDFT accommodation, RD&E Consultants and joint nursing provision.

- Potential joint appointment with RD&E following end of clinical fellow contract at RD&E – July 2022
- CESR (Certificate of Eligibility for Specialist Registration) appointments – build own workforce collaboratively across SEND. Potential trainees, but lack of national training posts. CESR training takes 4 years (full time); up to 7/8 years (part time).
- Teledermatology – success and future use.

7.2 Diagnostics

CT

Whilst a large number of patients await their CT scan the increase in referrals has slowed a little over the last month. Priority continues to be given to the ED, inpatients and 2ww demand. Difficulty is being experienced recruiting suitably trained CT radiographic staff and this continues to hamper recovery. The risk is in part mitigated by use of the Nightingale hospital in Exeter (NHE) scanner and continued use of InHealth mobile scanning. However, both these solutions have their limitations. Patients are reluctant to travel to the NHE facility and a mobile scanner is restrictive in the range of scans it can provide. Despite the challenge's plans are progressing to increase the capacity available at the NHE scanner for the Trusts patients from 2 to 4 sessions/week.

There has been a recent insourcing staffing solution presented to Radiology which is currently being worked through. This would be designed to staff the third CT scanner.

MRI

As with CT there are a large number of patients waiting for an MRI scan. Similarly, the number of referrals has slowed in the last month. There has been a considerable increase in inpatient demand which has had a negative impact upon elective capacity. Mitigation incudes the outsourcing to InHealth mobile scanning. More scans could be outsourced but the lack of sufficient locations to site a mobile scanner is an obstacle. In addition, the NHE will be offering MRI scanning which is due to come online in December 2021.

Ultra Sound

Waiting lists for an ultrasound scan have been reducing. However, the last 2 weeks has seen a considerable increase in referrals from primary care. This will be closely monitored to better understand the longer-term impact.

7.3 Mortuary

As reported last month the Trust's mortuary capacity continues to be severely tested. Careful management by the lead Mortuary Technician is a significant factor in maintaining flow so that capacity is not totally exhausted.

A recent criminal case in Kent has put a spotlight upon mortuary services nationwide, particularly around appropriate systems to ensure only staff with a legitimate right have access to the premises. At the request of the Human Tissue Authority all mortuary and body storage facilities have had to undertake a review of their safeguarding systems. The service at the Trust can demonstrate that there are

systems and processes in place, supported by appropriate audits, to prevent unauthorised access to the facility

8. Newton Abbot ISU: - Urgent & Emergency Care

The pressure across the health service continues to impact on bed occupancy and the resulting delays in transfers out of the emergency department. This is the main contributing factor to delays for both ambulance handover times and waits for walk in patients.

Emergency care continues to provide escalation areas at times of peak demand and enable patients to be cared for safely. Where possible, patients with an urgent care need are being redirected to the Urgent Treatment Centre (UTC) at Newton Abbot Hospital.

The UTC continues to provide an expanded footprint on a temporary basis while a new waiting area layout is being procured and installed.
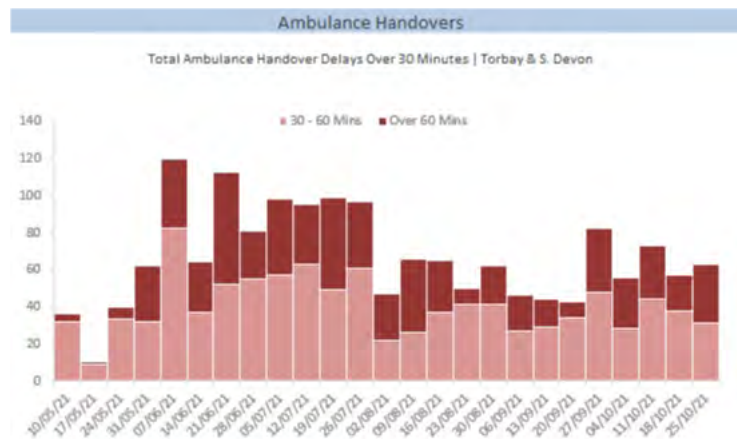
9. Torquay ISU: Child Health /Paediatrics

Louisa Cary Ward have achieved Gold accreditation for excellence in care following a recent visit by the Lead Nurse, who fed back "it was an absolute pleasure, excellent care, documentation with knowledgeable and kind staff".

The waiting list for new general outpatient appointments has reduced by 10% in the last month with up to a 4 month wait. However, the waiting list for new community appointments is the departments primary concern. Children / Young People (CYP) are waiting for up to 12 months to be seen. Plans to tackle this waiting list include the extended pilot of the first steps programme, whereby CYP are seen in a joint clinic with a paediatrician and appropriate therapists and clinicians from the CFHD team. These appointments take a little longer, but evidence from the first pilot suggests 90+% CYP are discharge on first appointment, compared to 22% in traditional clinics. Reducing the follow ups creates more capacity for new patients to be seen.

There is a plan to have more registrar clinics to support training and development of these medics and reduce the waiting list.

Currently there are a number of vacancies in Child Health for both Nursing and 2 Consultant posts.

10.   Torbay System: - Community Services and Independent Sector

10.1 COVID-19 and Workforce
There are 4 Department of Health and Social Care funding streams coming into the Council to support the care market as follows:

Infection Protection and Control	£987,387
Rapid Testing	£519,770
Vaccine Support	£97,801
Workforce Recruitment and Retention (NEW)	£561,017
Total	**£2,165,975**

The first three grants run from 1st October 2021 to 31st March 2022, whilst the Workforce Recruitment & Retention monies run from 21st October 2021 to 31st March 2022.

All four grants will be paid in two tranches – tranche 1 is 60% paid in November 2021 and tranche 2 is 40% paid in January 2022 conditional on submission of a return to DHSC by 14th January 2022.

The workforce and retention funding of £561,071 is intended to be spent between now and March 31st 2022.

All funding must be used to deliver measures that address local workforce capacity pressures through recruitment and retention activity. Examples of this include, but are not limited to:

- supporting payments to boost the hours provided by the existing workforce – including childcare costs, overtime payments
- investment in measures to support staff and boost retention of staff within social care – including occupational health, wellbeing measures, incentive and retention payments
- the creation and maintenance of measures to secure additional or redeployed capacity from current care workers – for example shared staff banks, redeploying local authority staff, emergency support measures, overtime payments
- local recruitment initiatives
- activities to support hospital discharge or to prevent or address delays as a result of workforce capacity shortages (distinct from enhanced guidance on finance and contracting arrangements for H2 2021 to 2022 discharge funding agreed in H2 2021 to 2022 settlement)
- activities which support the recruitment of local authority employed social care staff, or which enhance or retain the capacity of existing local authority employed social care staff
- local authorities and, where funding has been passported, providers to use the grant to cover reasonable administrative and/or set up costs they incur for new measures that deliver additional staffing capacity through recruitment and retention activity

If local authorities, or where funding has been passported, providers are already using such approaches, the funding can be used to increase the scale of activity.

DHSC expect local authorities to work closely with providers to determine how funding should best be spent, including passporting funding directly to providers where appropriate. This will be managed through the scheduled domiciliary care and residential care engagement meetings to evidence spending governance.

Local authorities are encouraged to look at other local authorities' strategies and replicate their approaches to successfully delivering additional staffing capacity through recruitment and retention activity (The team will connect this with both DCC and Plymouth City Council).

The grant may be used to fund alternative approaches not specified above on condition such measures generate additional adult social care workforce capacity through recruitment and retention activity. Funding must be spent only on time-limited activity during the 21 October 2021 to 31 March 2022 period.

Subject to the grant conditions being satisfied, local authorities can choose to pass some or all of their funding to care providers within the local authority's geographical area to meet unprecedented levels of pressure on staff capacity due to winter pressures. If the local authority chooses to make payments to providers financed by this grant they must ensure that providers will use the funding to support genuinely new expenditure that delivers additional staffing capacity through recruitment and retention activity and has not already been funded by other sources of public funding. This means the grant cannot be used on expenditure which does not produce new capacity.

In addition to the grant funding Torbay council have provided a non-recurrent incentive scheme for winter 2021 / 2022.

10.2 Safeguarding
During October a Learning disability home in Torquay closed following a CQC report and large-scale safeguarding enquiry. The safeguarding concerns were first raised in response to CQC inspection and care reviews undertaken by health and social care staff. These identified that the service failed to escalate health and social care needs to appropriate services in a timely manner and in some cases health and social care staff were given inaccurate accounts of people's needs and actions taken by the service.

The people who were residing in the home have all been found appropriate alternative placements. This was as a result of exceptional effort by the Trusts teams in particular the service manager and their team from Hollacombe. The team focused on ensuring the human rights of the people were front and centre to provide wellbeing, choice, and meaningful lives.

A learning event is planned including a focus on how placing authorities were monitoring the well-being needs of residents and what if anything could have been done differently via placement monitoring / quality assurance systems and processes. This will include a reflection on the application of professional curiosity within these processes.

10.3 Emergency Duty Service (EDS)
The EDS is responsible for all statutory activity during the evening, weekends and Bank Holidays. Activity is provided by skilled practitioners and is functioning well, raising no concerns regarding productivity or service safety. The team continue to provide an excellent service which in recent months has managed some very complex childcare related referrals. Work on behalf of the Adult Social Care teams remains consistent at between 80 to 100 cases per month.

The EDS has seen a significant peak in their Mental Health Act activity which has also proven to be highly variable. There are further challenges as recent Covid-19 pressures on clinical environments has meant assessment timescales are being closely monitored with significant pressure to complete assessment in a timely manner. EDS have also been challenged relating to the emergency housing function they hold as the lack of emergency housing became more apparent as Covid-19 restrictions lifted and Torbay's tourism footfall increased. This reduced the amount of hotel stock that would usually be available for the temporary accommodation of vulnerable people.

10.4 Adult social care governance
The ASC Performance Committee and the ASC Transformation Board will merge. This change in the governance reporting arrangements will occur in line with a paper submitted to the ASCIB in August 2021 and will provide additional detail within the reporting framework. The performance process will remain the same with each Community Service Manager (CSM) submitting a monthly report.

The Adult Social Care Outcomes Framework (ASCOF) remains subject to revision and it is understood is about to be ratified by ADASS. Once the new ASCOF have

been released they will be incorporated into the Performance Committee's reporting framework. The iPMO are engaged with the discussions about the proposed new ASCOF measures and these will, where possible be featured throughout the developing ASCiP. As a result, Torbay will be in a good position to evidence compliance with the Care Act and strength-based focused KPIs.

10.5 Transitions Team
The team have built strong networks with their children service colleagues and continue to work hard to address the limitations identified via a recent Local Government Association (LGA) Peer review. Low sickness and good levels of training and supervision have all supported a positive team working which has brought benefits to this cohort of young people. Transitions has recently become an ASCiP workstream to help maintain the momentum that has built.

10.6 Drug and Alcohol Service (DAS)
New digital resource Silver Cloud is now taking referrals. This is wider than just addictions and covers support for people suffering depression, anxiety, stress, sleep, financial worries and chronic pain. This is now due to be widely marketed as a resource than can be utilised as self-help or supported by suitably trained staff within the DAS. Trauma informed training has been commissioned and the DAS service have been allocated with 50 places of 250 across Torbay. This is an exciting opportunity for staff and the service to be skilled and trained up in recognising and supporting clients who have been experienced trauma. Adopting trauma informed practices can potentially improve patient engagement, treatment adherence and overall health outcomes for the individual.

10.7 Children's 0-19 Service
The Service has experienced an increase in demand partly due to the current increases in birth-rates. Work is being undertaken with families to understand barriers to engagement and understanding of non-attendees. Another project looking at creating resources to support schools and school aged children, parents and carers is in development. The service is developing its digital capacity e.g. the school entry (for all reception children) screening questionnaire is being completed electronically for the first time this year, there is also a virtual school nurse drop in available and currently being widely promoted.

The National Childhood Measurement Programme is due to start this month, all reception and year 6 Children are weighed and measured by a small team from the 0-19 service. This is a nationally mandated public health programme which provides the data for the child excess weight indicators in the Public Health Outcomes Framework, and is part of the government's approach to tackling child obesity.

10.8 Personalisation / Hope
The number of facilitators to deliver the Hope programme is increasing with a total of 98 active facilitators, with 33 training in the past 6 months. There are a wide range of Hope programmes being delivered both virtually and face to face – areas include including men's mental health, anxiety and depression, health and social care staff, parental wellbeing and rheumatology.

10.9 Nutrition and Dietetics
The Hydration in Care and Nursing Homes project is well underway with some very positive feedback from the staff and homes who are actively engaged. The project includes training delivered as part of the project which increases care homes staff knowledge and awareness of hydration. This has a direct impact on the quality of people's lives and empowering care home staff to make a difference through increased hydration, which should reduce the number of urinary tract infections and falls within homes and ultimately reduce the number of admissions to hospital as a result of increased hydration.

11.   South Devon System:

The GP contract to provide medical cover to Dart Ward at Totnes ceased on 1st November. An interim plan is in place to provide GP cover from local GP's working on the bank with some remote telephone support from the Health Care of the Older Person (HOP) team. The plan will provide cover for up to 3 months whilst we put in place a more permanent solution supported by the CCG.

Intermediate Care (IC) and Community Nursing teams remain under pressure due to backfilling domiciliary care (IC) and vacancies (community nursing).

Structure is being put in place to support the operationalising of winter plans across southern Devon and Torbay community via weekly community meetings.

12.   Conclusion

As winter approaches the current pressures in the system are significantly heightened. Efforts to optimise recruitment strategies and focus on the ability to respond to the evolving and challenging picture are in progress. Clear and authentic communication, understanding and recognition of the current state is crucial during this period to provide support to all sectors of the workforce and stakeholders.

13.   Recommendation

The board are asked to note the contents of this report.

Report to the Trust Board of Directors

Report title: Estates Performance and Compliance Group Report	**Meeting date:** 24 November 2021

Report appendix	
Report sponsor	Deputy CEO & Chief Finance Officer
Report author	Director of Environment
Report provenance	Estates Performance and Compliance Group EFM Senior Management Team Meeting
Purpose of the report and key issues for consideration/decision	The purpose of this report is to brief the Trust Board on EFM key issues, performance and compliance for September and October 2021

Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐

Recommendation	To note the current performance of Estates and Facilities Operations and headline summary of key work areas underway within the Division.

Summary of key elements				

Strategic objectives supported by this report				
	Safe, quality care and best experience		**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**	25
	Risk Register	2179	**Risk score**	16

BAF Objective 5: To provide and maintain a fit for purpose estate infrastructure ensuring service continuity at all times

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

Legal, financial and reputational implications of the consequence of any regulator enforcement notices/action.

Report title: Estates Performance and Compliance Group Report	**Meeting date: 24 November 2021**
Report sponsor	Deputy CEO & Chief Finance Officer
Report author	Interim Director of Environment

1. Introduction

This report summarises Estates and Facilities performance and compliance for September and October 2021 and provides a headline summary of the key work areas underway within the directorate.

2. Headline Summary

2.1 Winter Planning

A range of options have been developed in collaboration with clinical and operational colleagues to strengthen the estate in preparation for winter. In particular, a business case for the creation of an Ambulance Pod at the Emergency Department entrance has been prepared ready for consideration. In addition, a business case to fast-track the creation of additional inpatient bed facilities in Midgley and Simpson Wards is underway. While design work is advanced, the operational aspects of mobilising at pace are still being worked through.

2.2 Dawlish PFI Expiry

On October 27th, Trust Board approved the recommendation to purchase the property leases at PFI contract expiry in 2024. The PFI representative has been notified of this decision and negotiations around the ultimate cost (capped to £1.6m), together with formalising arrangements for monitoring and handing back will progress later this month and into the new year. We continue to work closely with NHSE/I colleagues and are now working collaboratively to develop national guidance to support other NHS Trusts facing the similar considerations of imminent expiry.

2.3 Corporate Health & Safety

As of 1st October, the Safety element of the SSEP team (now known as Corporate Health & Safety) transferred to the EFM Division. Following the transfer, recruitment is taking place to formalise the appointment of a Band 7 Safety Manager and a Band 5 Safety Advisor. Short-term, this team is being supplemented by a temporary health and safety advisor who will join the organisation in December 2021.

University Hospitals Plymouth continue to support the Trust on a twice weekly basis with general fire safety advice.

In November, a new initiative known as Ward Walkarounds was launched. This initiative involves a representative from the Division carrying out an audit of the physical environment in clinical areas and formulating an action plan to address

issues identified. This includes seeking feedback from clinicians and should satisfy some of the recommendations of the most recent CQC report.

2.4   Dartmouth Hospital Disposal

Weekly meetings have been established with Town Council representatives and the Director of Environment to provide a discussion point and to support the Town Council in developing a community bid for the former cottage hospital site. Together, we are now asking for the views of local people on what they would like to see on the site in future. As a first step, we are launching an online and printed survey, independently run by Healthwatch.

2.5   Acute Medical Unit

During September and October, Kier Construction have progressed with foundation and oversite works in preparation to accept the pre-constructed lift housings and the structural steel which has been craned onto site and is being erected during November/December.

A contract programme has been agreed with Kier identifying the completion date of 30th September 2022. The programme allows for Trust access for fitting out from 30th August 2022.

Unfortunately, operational services do continue to be experience periods of noise disruption, which given the ongoing steel-frame works is inevitable. Weekly briefing meetings continue as does close liaison with those departments most impacted to minimise the exposure where possible and agree stoppage time for clinical critical activities.

2.6   Urology Services

The feasibility study has concluded and has identified a fixed design utilising the Elizabeth Ward in Level 7 of the old hospital block. Earlier fire safety concerns have been considered and a misting system has been agreed as the preferred mitigation.

With a draft cost plan of circa £2.5m, a business case is being prepared for FPDC and Trust Board consideration of funding from the 2022/23 capital allocation.

2.7   Dartmouth Health & Wellbeing Centre

Building work continues to cost and programme at the site in Townstal, Dartmouth to create the Health & Wellbeing Centre development. Legal agreements are nearing conclusion with the proposed occupants – the GP practice and voluntary sector services. A tender exercise has concluded to identify a preferred supplier for the pharmacy retail outlet with contract award due later this month.

2.8 Teignmouth Health & Wellbeing Centre

Discussions continue with Teignbridge Council to identify a solution to the Planning application.

The Secretary of State for Health and Social Care has requested that the Independent Reconfiguration Panel (IRP) undertake an initial assessment of the referral by Devon County Council's Health and Adult Care Scrutiny Committee regarding the future of Teignmouth Community Hospital.

The IRP will offer advice to the Secretary of State on what further action should be taken. The Secretary of State will then consider the Panel's advice. Next steps include seeking further advice or announcing a decision that may detail any action he would like to see taken.

The Secretary of State has directed the IRP to report their initial findings by mid-December 2021.

2.9 Critical Infrastructure Update

With significant design work undertaken during the early months of the year, the six infrastructure projects (chilled water, additional stand-by generator, fire hydrant main, steam infrastructure, hot water and heating systems and building management system controls) are now either at tender stage or about to start on site. As part of the 46-scheme estate portfolio of capital projects underway, the Team structure has been supplemented by both short-term and permanent recruitment of experienced project managers to oversee the delivery of the programme this year.

3. Compliance Overview

The EFM Operations team routinely assess 129 metrics of productivity and compliance, of which 44 key compliance indicators are measured against an expected performance standard. A summary of the in-month achievement of compliance indicators is included in Table 1 below.

Table 1 has been assessed against the following standards criterion.

Tier 1 - Implementation	Evidence of Planned Preventative Maintenance Delivery, Defect Logs and External Contractor management
Tier 2 - Assets and Infrastructure	Evidence of specific asset groups and condition management
Tier 3 - Management Systems	Evidence of Policies and Management Plans, Roles and Responsibilities, Training, Risk Assessments and Committees / Management Groups.
Key	Green = good; Yellow = requirements minimal improvement; Amber = requires significant improvement; red = inadequate

Table 1: Compliance Summary

Compliance Item	Tier 1 - Implementation	Tier 2 - Assets & Infrastructure	Tier 3 - Management Systems	Total	Trend
Water	85.00	86.00	74.00	81.67	☐
Fire	67.50	60.00	71.00	66.17	☐
Medical Gases	87.00	80.00	86.50	84.50	☐
Electrical Power / Resilience	86.00	86.00	87.50	86.50	☐
Critical Ventilation	76.67	70.00	70.00	72.22	☐
Lifts / LOLER	85.00	80.00	68.00	77.67	☐
Pressure Systems	86.67	72.50	67.00	75.39	☐
Asbestos	82.50	85.00	83.00	83.50	☐
Cleaning	87.50	86.00	86.00	86.50	☐
Waste	77.50	66.00	77.00	73.50	☐
Catering	85.00	86.00	87.00	86.00	☐

3.1 Exception Reports

Fire Safety: Planned maintenance regimes are largely up to date and complete, however, due to the significant higher levels of remedial actions required relating to the current levels of backlog maintenance, moving to a fully compliant position is challenging given the condition of the estate.

The Director and Deputy Director of Environment has met with Trust Matrons to identify a means by which clinical engagement relative to fire safety can be enhanced. Following this initial meeting, a series of individual meetings with Matrons is being established to take this important work forward.

Water: As an update to the last report, Pseudomonas risk assessments are now fully completed. There were no significant issues identified and the report was broadly positive about the Trust's approach to water management.

Dr Nick Hill (chairman of a national water safety group) has conducted a review of the estate's management aspects of hydrotherapy pool oversight and maintenance. An action plan is currently being formulated to address findings and a training programme for all relevant stakeholders will take place in the New Year.

3.2 Performance Improvements

The in-month performance dashboard was reviewed by the Estates Performance and Compliance Group (EPCG) on 28 October 2021 and an action log has been updated and will continue to be used by the EFM Operations Leads to take forward measures of improvement, with a review of progress reported to EPCG meeting. Performance standards of the two PFI Contractors operating at Dawlish

and Newton Abbot Hospitals and of the Community sites maintenance contractor have been similarly reviewed, with the in-month metrics incorporated into Table 1.

4. EFM Workforce Headlines

- Sickness absence, decreased in month and for the rolling 12-month period. Mental Health remains the most significant reason for absence.

- Achievement Reviews for the Division are below the required compliance level, with 10 teams RAG rated red. Weekly progress checks have been initiated to ensure this trend is reversed.

- Mandatory Training – overall compliance is RAG rated green, although Information Governance training remains low across the Directorate and needs to be addressed. There are six teams that are not achieving the overall average rate for all mandatory training.

- Turnover for the Directorate is within the acceptable range.

- Fatigue Indicator – there are currently no teams that have triggered three of the four indicators

5. Finance Overview Month 07 2021/22

The overall position for EFM at the end of M07 was £7,210k, reported as a favourable variance to budget of (£382k), while net expenditure in M07 was (£226k) lower than M06. Forecast outturn of £12,479k set for the year is forecast to be (£232k) lower than the full year budget of £12,712k.

6. Torbay Pharmaceuticals – Estates Performance & Compliance

From February 2022, Torbay Pharmaceuticals estates and performance and compliance information will be reported to FPDC/Board as part of the EPCG report that will move to a quarterly reporting frequency.

7. Conclusion

The Board is asked to note the current performance and key headlines of the Estates and Facilities Management Division.

NHS
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 27TH OCTOBER 2021**

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	* Professor C Balch	Non-Executive Director
	* Mr P Richards	Non-Executive Director
	* Mrs S Taylor	Non-Executive Director
	* Dr S Wollaston	Non-Executive Director
	* Mrs J Lyttle	Non-Executive Director
	Ms L Davenport	Chief Executive
	* Mr I Currie	Medical Director
	* Ms A Jones	Director of Transformation and Partnerships
	* Mr D Stacey	Chief Finance Officer

In attendance:	Mrs S Byrne	Board Secretary
	* Dr J Harris	Associate Director of Communications Partnerships
	* Mr D Armitage	Associate Director of People
	* Mrs J Phare	Associate Director of Nursing and Professional Practice, Torbay
	* Mrs S Boyne	Associate Director of Nursing and Professional Practice, Coastal (Part)
	* Ms R Beeny	Senior Nurse, Hutching Ward (Part)
	* Mr A Cooper	Interim Director of Environment (Part)

* via Microsoft Teams

		ACTION
189/10/21	**User Experience Story** Jacquie Phare, System Director of Nursing and Professional Practice welcomed Rachel Beeny, Unit Manager and Senior Nurse on Hutchings Day Unit and Sharon Boyne, Associate Director of Nursing and Professional Practice, Coastal. They had been asked by a patient of the Trust, Joanne Bishop, a recovering alcoholic of two years, to present her story to the Board. Joanne had been awaiting a liver transplant, further to a diagnosis of alcoholic liver disease, which had caused severe jaundice, weight loss, internal bleeding, and vulnerability to infections and confusion. There was a strict criteria for patient to remain on the liver transplant waiting list, Joanne was	

required to maintain. The disease was brought on by her reliance on alcohol during the breakdown of her marriage and the death of her sister and she used alcohol as her coping mechanism for six years. In the time she had received intervention from the clinical psychology team but acknowledged the need for her to be ready to admit her dependence on alcohol and was now under the care of Hutchings Day Unit, University Hospital Plymouth and King's Hospital, London.

During Covid Joanne valued the virtual appointments with Plymouth Tertiary Centre; there is now no need for Joanne to travel outside of the area for her appointments as they could be conducted virtually.

Rachel Beeny, Senior Nurse, explained Joanne's story was not uncommon in Torbay and South Devon, there was a high prevalence of alcohol misuse in the Trust's footprint and the Trust took a multi-disciplinary team approach to support patients. The team had been recently been awarded funding to develop the inpatient alcohol team service.

The Chairman asked how the Team managed to be non-judgmental yet discourage use. Rachael explained that the team were always mindful patients were not drinking for pleasure and they treated every patient contact as an 'opportunity'.

Adel Jones, Director or Transformation and Partnerships, asked if there was anything Trust could do to support the service, Sharon Boyne explained that it was in the patient's interest to be sign posted to the appropriate pathway immediately to ensure they are detoxed rapidly and safely she explained this was difficult as quite often people with alcohol issues presented to the Emergency Department with a different problem. When patients attend for routine operations they are asked to complete a lifestyle questionnaire and those perceived to be in the harmful drinking category are offered preventative measures support. The Board were asked to note the research indicated that there would be a 13.5% increase in alcoholic liver disease post covid.

Jacqui Lyttle, Non-Executive Director, reflected on the powerful patient story that was presented and how the data from patients who die from drug and alcohol abuse had been presented to the Quality and Assurance Committee in September. She felt the population benefited from the Trust being an ICO with integrated services across hospital and community services.

Sarah Wollaston, Non-Executive Director, commented on the additional funds and asked where the Alcohol Team would concentrate the resource from the additional funds, Sharon Boyne confirmed the Team would focus on both early stages of alcoholism and those significantly at risk of death due to alcoholism. There would also be training for staff to ensure they signpost patients to the appropriate pathway.

Liz Davenport, Chief Executive Officer, explained how the funding was an acknowledgement of the alcohol issues faced with the Trust's footprint and the wider issues that can be caused by alcohol abuse.

Chris Balch, Non-Executive Director, asked what the Trust were doing to support alcohol dependent staff. Sharon Boyne explained often people who

are alcohol dependent are high performing and therefore, it is difficult to identify within the workplace.

Robin Sutton, Non-Executive Director, asked whether the Trust had a robust alcohol intervention and prevention pathway. Sharon Boyne confirmed the Trust used every opportunity to ensure patients alcohol consumption is checked and provided brief education.

The Chairman on behalf of the Board thanked the Hutchings Day Unit Team.

Preliminary Matters

190/10/21 Welcome and Introductions

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

191/10/21 Board Corporate Objectives

The Trust Board's Corporate Objectives were noted.

The Board received and noted the Board Corporate Objectives.

192/10/21 Apologies for Absence

The Board noted apologies of absence from Deborah Kelly, Chief Nurse; Joanne Watson, Health and Care Strategy Director; Judy Falcao, Chief People Officer; and Vikki Matthews, Non-Executive Director

The Board noted Mrs Jacquie Phare's attendance on behalf of the Chief Nurse; and Mr Darran Armitage's attendance on behalf of the Chief People Officer.

193/10/21 Declaration of Interests

There were no declarations of interest.

Consent Agenda (Pre-notified questions)

Reports from Board Committees

194/10/21 South East North Devon (SEND) Chairs Report – 5th October 2021

The Board received the Chair's Report of the South East North Devon Alliance meeting held on 5th October 2021.

The Board received and noted the Chair's report of the South East North Devon Alliance.

195/10/21 Finance, Performance and Digital Committee – 27th September 2021

The Board received the Chair's Report of the Finance, Performance and Digital Committee meeting held on 27th September 2021.

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

196/10/21 Quality Assurance Committee - 27th September 2021

The Board received the Chair's Report of the Quality Assurance Committee held on 27th September 2021.

The Board received and noted the Chairs report of the Quality Assurance Committee.

197/10/21 Building a Brighter Future Committee Chairs Report – 20th October 2021

The Board received the Chair's Report of the Building a Brighter Future Committee held on 20th October 2021.

The Board received and noted the Chairs report of the Building a Brighter Future Committee.

Reports from Executive Directors

198/10/21 Chief Operating Officer's Report October 2021

The Board received the Chief Operating Officers Report for October 2021.

Chris Balch, Non-Executive Director, noted the Trust had limited MRI scanning capacity which had impacted the Trust's elective activity and the report also suggested the loss of day surgery capacity had impacted elective activity. He asked for assurance the Trust had addressed maintaining elective capacity in a comprehensive way; and whether the Trust had identified suitable locations for additional mobile scanners.

John Harrison, Chief Operating Office, acknowledged the restricted MRI capacity and confirmed Adrien Cooper, Interim Director of Environment had worked closely with the Operations teams to secure a suitable site for a portable MRI scanner. He explained elective MRI capacity had reported an improved position with additional capacity sourced from Nightingale, Exeter and Mount Stuart but, patients preferred to have their MRI's within the Trust, close to where they live.

The Board were informed clinical teams were being operationalised to undertake additional orthopaedic day surgery activity at the Nightingale.

	The Board received and noted the Chief Operating Officers Report.	
199/10/21	**Directorate of Transformation and Partnerships Quarterly Report – October 2021** The Board received the Directorate of Transformation and Partnerships Quarterly Report.	
	The Board received and noted the Directorate of Transformation and Partnerships Quarterly Report.	
	For Approval	
200/10/21	**Minutes of the Meeting held on 29th September 2021** The Board approved the minutes of the meeting held on 29th September 2021. Darran Armitage, Associate Director of People updated the Board in respect of action 177/09/21. He confirmed the People Committee had been commissioned to undertake a review to establish safer staffing ratios including permanent and bank and agency staff ratios. The findings would be presented to the Board. The Board agreed the action was to be closed.	
	The Board approved the minutes of the meeting held on 29th September 2021	
201/10/21	**Annual Members Meeting held on 22nd September 2021** The Chairman explained to the Board the Annual Members Meeting was held on 22nd September 2021 via Microsoft Teams. He asked the Board to consider and approve the minutes of the Annual Members Meeting.	
	The Board approved the minutes of the meeting held on 22nd September 2021	
	For Noting	
202/10/21	**Report of the Chairman** The Chairman briefed the Board on the following key events:	

- The Flu and COVID Booster vaccination programmes had commenced.
- In support of Black History Month, a virtual event, 'Proud To Be…an evening with Michael Caines MBE, Alexandra Ankrah and Dr Habib Naqvi MBE' would be hosted by the Trust at 7pm on 27th October 2021.
- The Chairman had been privileged to attend presentation on 11th October 2021 of two new paediatric ventilators from Torbay Hospital League of

Friends; and offered sincere thanks and gratitude to all the Leagues of Friends who supported the Trust.
- Staff were thanked for the significant effort that was put in to ensure Building Effective Solutions Together (BEST) week enabled the Trust to operate more efficiently for the benefit of the Trust's patients.
- The Annual Governor election process had commenced. He explained the role of the Governors was vital to deliver the best care to those the Trust served.

203/10/21   **Report of the Chief Executive**

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

- Due to a number of pressures, the Trust were working with system partners to ensure the people we serve had access to the care they required over the winter period.
- The Trust's flu and covid booster vaccination was underway which would offer resilience to the workforce over the winter period.
- Further to the Government guidance for staff working in care homes from 11th November 2021, the Trust was working closely with Care Homes and had plans to mitigate the risk of the loss of care home staff who were not vaccinated against covid19.
- The pressures the staff were working under was acknowledged and the importance of providing support to staff so that the Trust provided the best quality care and kept patients safe.
- Progress had been seen within the Trust following the implementation of (BEST) week, it had enabled Teams to consider what worked, test new ways of working and demonstrate the positive learning.
- There was an ongoing programme of engagement within Dartmouth and Kingswear, and a sense of optimism as to how the Trust alongside the community could reach a way forward on the Health and Wellbeing Centre and the future of the Hospital site.
- The Clinical Services and the Research Team had successfully initiated a trial in respect of the early detection of cancers.
- The Devon Integrated Care System and the Local Care Partnerships Board was working towards the Integrated Care System regulatory framework but, it was important to note currently, no Chair had been appointed.

Adel Jones, Director of Transformation and Partnerships, reflected on the benefits of the BEST week, she explained how powerful it had been to listen to staff and for staff to feel acknowledged and heard. There was benefit to more senior clinicians rostered to work over weekend to enable admission avoidance and support people to be cared for at home. Further consideration needed to be given to the discharge to assess process.

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

Safe Quality Care and Best Experience

Integrated Performance Report – Month 6, 2021/22

John Harrison, Chief Operating Officer presented the Integrated Performance Report for month 6, 2021/22 and drew the following to the Board's attention:

Quality and Safety

*   69% of stroke patients were being cared for on the stroke ward which was an improved position compared to August when 56% of patients were being treated on the stroke ward but, it was acknowledged the Trust remained below the 90% target.
*   Venous thromboembolism performance had reduced, assurance was provided that training and support for the Junior Doctor rotation was in place.
*   Maternity births were reported as high; with a challenged staffing position but mitigation plans were in place to maintain safety.

Workforce

*   Sickness absence rate was reported unseasonably high at 5.36% and spoke to the tiredness of staff.

Trust Performance

*   Services across the Trust had been impacted due to an increase in the number of patients admitted with COVID-19.
*   Activity levels with the Emergency Department were at pre-pandemic levels but there was pressure on the service due to the need two deliver blue and green pathways.
*   Ambulance handovers delays remained high, in September over 72 patients experienced over an hour delay once arriving to the Emergency Department for handover.
*   The number of patients waiting for over 18, 52, 104 weeks for treatment had continued to increase.
*   Day Surgery Unit remained partially closed; capacity had been re-directed to support the Medical Receiving Unit to ensure there was sufficient capacity for urgent care patients. As an interim measure, Ainslie Ward and Ella Ward had been re-classified as surgical wards, to try and recover the Day Surgery position and implement elective orthopaedic activity.
*   The Cancer two week wait and 62 day pathways remained challenged due to capacity, particularly in dermatology.

John Harrison, confirmed the focus for half two of the financial year was for all additional capacity: Mount Stuart, the Nightingale and insourcing to be utilised to reduce the wait lists for the benefit of the people the Trust served.

System Performance

*   Workforce shortages across every sector had impacted flow; currently there were 608 hours of outstanding packages of care and an increase in community referrals and intermediate care placements which had impacted the system.

Finance

- The Trust reported a £1.6m deficit which was adverse to plan due to a significant increase in bank and agency spend because of the increased pressure on the Trust due to the higher prevalence of COVID; the year to date position showed a small surplus against a break even plan.
- The half 2 financial position would be challenged, with a reported gross risk of £8m due to the continued escalation response and Cost Improvement Plan (CIP) requirements.

Robin Sutton, Non-Executive Director, clarification of patient facing meetings that could be converted to virtual meetings to support the challenged elective care position and asked the Board to consider the importance of this medium in half 2 of the financial year to the Trusts recovery

Paul Richards, Non-Executive Director, asked if there was local and national modelling available in respect of elective activity to support the Trust; and what business plans were in place to secure funding to support the challenged diagnostic position.

A successful of £1m bid had been made to the Targeted Improvement Fund to support the Trust's challenged Urgent and Emergency Care position the resource would be used to support the plans to re-open the Day Surgery Unit.

Liz Davenport, Chief Executive, explained to the Board, Suzanne Tracey, Chief Executive of Royal Devon and Exeter and North Devon Foundation Trust, was chairing the Devon System Planned Care Group, the focus of the group was to give consideration to the optimisation of capacity across the ICS footprint, to ensure there was equality of access to services across the Devon system.

Sarah Wollaston, Non-Executive Director, asked what was happening to ensure the Trust are keeping the sickest patients as safe as possible.

John Harrison described how patient presentation and risk would determine the environment where the patient would be cared for; with substantive experienced staff being carefully selected to support patient care.

Chris Balch, Non-Executive Director, brought to the Boards attention a concern raised at People Committee, in respect of high staff turnover, and concern that experienced nursing staff were choosing to retire and recruitment including international recruitment not totally addressing the gap. He also asked to be updated on the Trust's mandatory training position.

Jacquie Phare, System Director of Nursing and Professional Practice, Torbay, acknowledged there were areas of concern in achieving some mandated training targets but she explained she was sighted on the training positions and plans were in place to ensure the Trust met all mandatory training targets and there was a robust mandatory training data base which allowed teams to identify the training their staff required.

Ian Currie, Medical Director, reported the Trust's care planning summary having had a high completion rate which was a significant positive quality between secondary and primary care.

Jacquie Phare, highlighted the need for a 'deep dive' into paediatric mandatory training, as there were nuances within the service which presented a risk. Dave Stacey, Chief Finance Officer, proposed the Board undertook a development session with Sam Riley, Head of Improvement Analytics for NHSEI, with the aim of the Trust's mandatory training reporting to account of nuances.

CFO

Jacquie Phare, System Director of Nursing and Professional Practice, Torbay, explained 'Stay Interviews' had been convened to establish any changes that could be made to encourage people to stay, she acknowledged the loss of knowledge as Nurses retired but reflected that international nurses would bring their qualities to the Trust.

Darran Armitage, Associate Director of People, explained a recruitment and resourcing drive was in place to attract people to work in Devon. The Trust had also focused on the progression of the People Plan, stay interviews, flexible working, flexing the pension scheme and supporting staff to remain employed by the Trust.

Sarah Wollaston, Non-Executive Director asked whether by not meeting the virtual appointment target the Trust had missed out on recovery funding, and sought clarification on why the Trust were struggling to meet the virtual appointment target.

John Harrison, Chief Operating Officer, acknowledged the need for the system to have a 25% aggregate for virtual appointments to obtain funding. He explained the low uptake of virtual appointment was multifaceted but, he reflected on the reluctance of the Trust's clinical teams to engage and the need for some patients to be seen face to face, however, there would be a focus on virtual appointments for the second half of the financial year.

Adel Jones, Director of Transformation and Partnerships, acknowledged virtual appointments had not received enough focus. She explained virtual appointment support was varied among Teams for various reasons and this would be an of focus for the planned care offer, with an allocated programme manager to support virtual appointment agenda.

It was agreed an insight report into the virtual appointment data would be provided to the November Board by John Harrison, Chief Operating Officer and Adel Jones, Director of Transformation and Partnerships.

COO/ DTP

Liz Davenport, asked the Board to note the patient safety measures in place for the people the Trust cared for in the community. She explained a significant amount of work had been undertaken to support Domiciliary Care and this had been of benefit to the Trust.

The Board received and noted the Integrated Performance Report – Month 6, 2021/22.

205/10/21   **Maternity Governance and Safety Report 1 July – 30 September 2021**

Jacquie Phare, System Director of Nursing and Professional Practice, Torbay, presented the quarterly maternity governance and safety report. She confirmed the focus of the maternity department aligned to the national priorities and were compliant with the ten CNST Incentive Scheme safety actions. There was a robust governance process in place which had been supported at Board level by Deborah Kelly, Chief Nurse and Sally Taylor, Non-Executive Director.

Five incidents were highlighted to the Board two cases had been referred to HSIB for investigation; two still births at 23 and 25 weeks, both were under review and the families were being supported by the bereavement midwife. The Trust had continued on its improvement trajectory and reduced still births by two thirds.

A HSIB investigation had been published and had made six recommendations, Rachel Glasson, Head of Maternity had met with HSIB and the family had asked to be part of the improvement process.

There was high prevalence of COVID19 in pregnant women and the maternity department had ensured their pathways functioned safely; assurance was provided that the Trust were promoting the vaccination to all pregnant women.

The funding had been secured to recruit additional midwifes into the maternity service and recruitment was being undertaken.

Sally Taylor, Non-Executive Director, highlighted to the Board following listening events with staff, one team within maternity department had developed and were trialling a new set of shift patterns. Rachel Glasson, Head of Midwifery confirmed once the feedback had been received from the trial consideration of different shift patterns would be given to implementation across the maternity department.

Liz Davenport, Chief Executive, announced Rachel Glasson, Head of Maternity had been successfully appointed to the post of Regional Deputy Chief Midwife and thanked her for her service to the Trust.

The Chairman acknowledged how Rachel Glasson had led the Maternity Department through a difficult period and delivered improvements for the benefit of the people the Trust served and the staff who worked in the service.

The Board received and noted the Maternity Governance and Safety Report 1 July – 30 September 2021

Valuing our Workforce

206/10/21	**Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training**	
	Ian Currie, Medical Director, reported a low number of exception reports and with soft intelligence the reason for low reporting had been triangulated. He explained Junior Doctors were supported by their educational supervisors and standard practice was for Junior Doctor's to take time in lieu.	
	The Board were asked to note how Trust Grade Doctors during periods of escalation have felt less protected as they are more likely to be re-deployed, he proposed the appointment of a Tutor for the fifty Trust Grade Doctors.	
	Senior grade Doctors had raised concern over a reduction in elective work and the impact for Doctors in Training.	
	The Chairman, reflected historically, exception reporting had been low, subjectively he felt the balance was correct and for spikes in data were closely monitored.	
	Sarah Wollaston, Non-Executive Director, asked if under reporting could provide false assurance. Ian Currie, confirmed he had triangulated the exception reporting data with rota arrangements and the exception reports submitted followed the degree of acuity and pressure of the departments. It was agreed Ian Currie would review and keep the Board updated on addressing cultural barriers to reporting.	MD
	Jacqui Lyttle, asked what was in place to support the Junior Doctors whose elective surgery training would be compromised. Ian Currie confirmed the Deanery was aware of the reduction in elective surgery and training opportunities provided to the Junior Doctors and acknowledged, training for the Junior Doctor's would need to extended.	
	The Board received and noted Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training	
	Well Led	
207/10/21	**Engagement and Communications Strategy**	
	Jane Harris, Associate Director of Communications and Partnerships presented the Engagement and Communications Strategy to the Board, she explained this was a significant step change for the Trust, Governors and the people the Trust served, as the Trust proposed to move from a 'broadcast' to 'conversation' approach, which spoke to the core values and beliefs of the Trust. Feedback received had confirmed people appreciated the realistic but caring and supportive tone of recent communications.	
	Jane Harris explained the communications team cannot undertake this alone and it would be for the communications team to offer support to the Board and the teams within the Trust.	

The Chairman asked the Board to acknowledge and commit to the change in the Trusts engagement and communications strategy.

Sarah Wollaston, Non-Executive Director, raised that two way conversations with community could cause misinformation. Jane Harris explained the ICS were working to national guidance in respect of misinformation.

If the Board approved the Communications and Engagement Strategy it was felt it would be appropriate to ensure the Governors were fully sighted on the strategy and it would be an enabler for conversations in respect of how to utilise them most effectively.

Adel Jones, Director of Transformation and Partnerships, highlighted the importance of the engagement strategy as it would underpin the Trust strategic intent with community partnerships, enabling people and providing an opportunity to co-produce plans with the population by working in partnership.

The Board approved the Engagement and Communications Strategy

208/10/21 **Sustainability Position and Green Plan Development**

Dave Stacey, Chief Finance Officer and Deputy Chief Executive, explained that in line with the Green NHS Framework there was the need to develop a green plan for the Trust by the end of the financial year. Therefore, he asked the Board to approve:

- The nomination of a Senior Responsible Officer (SRO) to act as Net Zero Carbon (NZC) Lead, Deputy Chief Executive.
- The use of some Board Development time to agree our definition of social value
- The development of a three-year Green Plan which aligns to *Greener NHS* guidance
- Approve the formation of a Sustainability & Wellbeing Group to provide appropriate governance

Jacqui Lyttle, Non-Executive Director, had worked alongside Adrien Cooper, Interim Director of Environment and Dave Stacey to develop the future objectives to comply with national NHSEI sustainability targets.

Robin Sutton, Non-Executive Director, suggested consideration be given to working alongside a University Intern.

Chris Balch, Non-Executive Director, highlighted the plan had a strong focus on hardware and energy of buildings and proposed the paper considered people, as behaviour change was vital for the sustainability plan. Adrien Cooper, agreed there needed to be cultural changes to achieve the sustainability ambition.

The Chairman reflected, the Building a Brighter Future plan touched on sustainability and the Green NHS Framework therefore the proposal was timely and valuable.

The Board approved:

- **The nomination of Deputy Chief Executive Officer Senior Responsible Officer (SRO) to act as NZC Lead**
- **The use of some Board Development time to agree our definition of social value**
- **The development of a three-year Green Plan which aligns to *Greener NHS* guidance**
- **The formation of a Sustainability & Wellbeing Group to provide appropriate governance**

209/10/21 **Compliance Issues**

There were no compliance issues reported.

210/10/21 **Any Other Business Notified in Advance**

There was no any other business raised for discussion.

211/10/21 **Date and Time of Next Meeting:**

11.30 am, Wednesday 24th November 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)

No	Issue	Lead	Progress since last meeting	Matter Arising From
177/09/21	The People Committee undertake a deep dive into optimal ratios for substantive staff and bank and agency staff within larger cohorts of the workforce.	JF	Darran Armitage, Associate Director of People updated the Board in respect of action 177/09/21. He confirmed the People Committee had been commissioned to undertake a review to establish safer staffing ratios including permanent and bank and agency staff ratios. The findings would be presented to the Board. The Board agreed the action was to be closed.	
204/10/21	Dave Stacey, Chief Finance Officer, proposed the Board undertook a development session with Sam Riley, Head of Improvement Analytics for NHSEI, with the aim of the Trust's mandatory training reporting to account of nuances.	CFO		
204/10/21	It was agreed an insight report into the virtual appointment data would be provided to the November Board by John Harrison, Chief Operating Officer and Adel Jones, Director of Transformation and Partnerships.	COO/DTP	Insight report presented to FPDC on 22.11.2021 and an update will be covered in the FPDC escalation report.	
206/10/21	Ian Currie would review and keep the Board updated on addressing cultural barriers to reporting.	MD		

Report to the Trust Board of Directors			
Report title: Chief Executive's Report		**Meeting date**: 24 November 2021	
Report appendix	Board assurance framework summary		
Report sponsor	Chief Executive		
Report author	Associate Director of Communications and Partnerships		
Report provenance	Reviewed by Executive Directors 16 November 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	Various
	Risk Register	X	Risk score	Various
	- 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: 24 November 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 27 October 2021 are as follows:

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

Redevelopment of former site of Dartmouth and Kingswear community hospital

Community engagement is now underway in Dartmouth and the surrounding villages as part of our work with Dartmouth Town Council to explore whether the community can buy the former hospital site and whether its redevelopment could include uses specifically to benefit people in and around Dartmouth. The community engagement focuses on hearing from local people about what new facilities they would like to see on the site.

The survey is being run by the independent health and social care champion,, Healthwatch to make sure that results are independently collated and reported. The survey is live now and runs until 08 December. People can access the survey online **https://surveymonkey.co.uk/r/DartmouthHospital** or pick up a printed copy of the survey from a range of local venues which can be returned via Freepost to Healthwatch.

Printed copies of the survey are available at post offices in Kingswear, Townstal (BP garage) and Dittisham, Blackawton Community Shop, Stoke Fleming Village

Hall, Townstal Spar, Dartmouth Town Council offices, Dartmouth Medical Practice, Dartmouth Clinic.

Healthwatch will collate all responses into an independent report to share with Dartmouth Town Council and ourselves in early 2022.

Flu vaccination programme for health and care staff
Our flu vaccination programme continues and to date we have vaccinated over 4,200 of our people – well over half of our workforce. While the majority of vaccinations are given at our Torbay Hospital site, we are also delivering flu clinics for staff at our community sites.

COVID-19 booster vaccinations
Our COVID-19 booster vaccination programme continues and to date we have vaccinated more than 4,300 of our people with the booster. Staff are being encouraged to book in for their booster as soon as they become eligible (26 weeks after they received their second dose of the original COVID-19 vaccination).

Mandatory COVID-19 vaccinations for frontline health and care staff
On 09 November 2021 the Health Secretary, Mr Sajid Javid, announced that following a consultation, frontline NHS staff in England will have to be fully vaccinated against COVID-19, to protect patients, colleagues and the NHS itself.

A deadline has been set for 01 April next year to give unvaccinated colleagues time to get both jabs.

We are working in partnership with staffside, to review and update our mandatory Coronavirus Vaccinations policy which was originally developed to ensure full compliance with the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 (the Regulations) which were made on 22 July 2021, come into force on 11 November 2021.

The Regulations require all persons working in or deployed into a CQC registered care home (which provides accommodation together with nursing or personal care) in England to be fully vaccinated against COVID-19.

National terrorism threat level raised
Following the Remembrance Sunday incident, the national threat level from terrorism has been raised from substantial to severe (an attack is highly likely). Our Security and Emergency Planning Team have reviewed our security arrangements and we have reissued guidance to staff across all our services on staying safe and remaining vigilant.

3.2 Excellent experience receiving and providing care

Current pressures
Like most trusts across the country, we have been and continue to be under significant pressure with more people needing emergency treatment and an increase in prevalence of COVID-19 in our communities, our hospitals and our staff.

This has had an impact across our whole healthcare system with fewer beds available in our hospitals and in care homes and fewer care staff to support people at home.

Our hospital infrastructure is out-dated and inflexible, with low side room capacity, which hinders patient flow, admissions and discharges. In addition, emergency attendances are up 5% on the same period last year; like many others, we are experiencing major staff shortages across hospital and community services; and getting people home quickly and safely remains an ongoing challenge.

Staff are working incredibly hard to look after the people in our care and additional measures we are putting in place include working with our care providers to improve our discharge position and building a new Acute Medicine Unit to double our capacity and reduce overcrowding in the Emergency Department.

All these factors are currently making it difficult to discharge people from hospital into the community or back home, and mean that sometimes patients being admitted to hospital from our Emergency Department wait longer than four hours before we can find a ward bed for them. We are an outlier in performance on four hour waits and our performance in this area has significantly declined compared to this time last year. Our performance on ambulance handover times has also declined and we are experiencing significant challenges in this area.

Every person waiting for care is important to us, and our dedicated staff will always prioritise the sickest patients first. Sadly, in the current environment, this means difficult decisions often have to be made and some people experience a longer wait and a poorer overall experience than we would like.

The team in our Emergency Department work closely with the ambulance team to ensure patients waiting are assessed and care is escalated and prioritised where there are clinical concerns about individual patients.

In terms of planned care, we continue to be able to deliver a limited amount of operations and procedures where we can safely do so but we recognise that waiting lists are continuing to grow and that people are waiting a very long time for care. We are working with system partners to prioritise those who are most in need and those who have been waiting longest.

The Exeter Nightingale has been repurposed and will provide a range of ophthalmology, orthopaedic, rheumatology and diagnostic testing services which will be available to people on our waiting lists. We strongly encourage anyone who is offered treatment, operations or scans at the Exeter Nightingale to accept it – the services offered are of high quality and free parking is available on site.

Ward accreditations
During November five more of our wards were assessed under the Pathways to Excellence scheme.

Allerton ward achieved a bronze award on their first accreditation.

Midgley ward and Turner ward both achieved a silver award on their first accreditation which is a wonderful achievement.

Teign ward and Templar ward both achieved a gold award, showcasing the progress they have made since their silver awards earlier this year.

DAISY awards

In September our DAISY award winner was the Minors team, a group of nurses and allied health professionals who are an integral part of the wider Emergency Department team. The nomination highlighted:

"The team demonstrate extraordinary nursing and AHP leadership in providing evidence-based nursing practices and embody a "can do attitude". I have personally witnessed and benefitted as a patient from their expertise and clinical wisdom. The Minors team are not just a good team, they are outstanding. They can see anything up 100 patients per day while keeping patient safety and quality at the forefront of their minds which is embedded into their everyday practice . . .the Minors team truly demonstrate why Devon nursing is so very special and in a particular they work in a challenging environment where they encounter violence and aggression . . . they respect patients' time . . . they involve patients in their treatment decisions and choices and they are sensitive to the needs of others."

Remembrance Day and Sunday

We marked Remembrance Day by joining in the national two-minute silence across all our services. At Torbay Hospital those of us who were able to do so, gathered outside the main entrance and our chaplains gave two short readings before we fell silent at 11am.

On Remembrance Sunday our chaplains held a remembrance service in the Rose Garden at Torbay Hospital.

Veterans aware hospital accreditation

We are proudly committed to the Armed Forces Covenant, which is a promise by the nation ensuring that those who serve or who have served in the UK Armed Forces, and their families, are treated fairly.

Veteran aware hospitals are exemplars of the best care for veterans in the NHS. They are accredited by the Veterans Covenant Hospital Alliance (VCHA), in line with the Armed Forces Covenant.

It is our ambition to achieve this accreditation and we are establishing a working group to support us to take this forward.

CONNECTPlus app wins national award

On 30 October 2021, our CONNECTPlus app won a national Building Better Healthcare Award for best patient-centred healthcare software.

Our CONNECTPlus app, developed with Health and Care Innovations, helps people to manage multiple health conditions from their own phone or device, day or night, wherever they are. It provides 24/7 access to a range of features including symptom trackers, medication management and appointment

reminders, as well as accredited information and content provided by their own doctors and other healthcare professionals.

Our CONNECTPlus app is also a finalist in the Health Service Journal Awards 2021 in the driving efficiency through technology category. The winner will be announced on 18 November 2021.

Successful collaboration for Valneva vaccine study
The collaboration between our research team and University Hospitals Plymouth's research team has delivered the highest UK recruitment into the national Valneva (VLA2001) COVID-19 vaccine study, surpassing our target and giving 268 local residents the chance to be involved in this crucial study which has found Valneva to be a safe and effective vaccine.

Participants had an overwhelmingly positive research experience and out of 148 participants, feedback collected by the NHS 'Friends and Family test' reported that 147 classed their experience as 'very good', and 1 classed it as 'good'. People commented on the professionalism and knowledge of the team and how enjoyable the research experience was.

The collaboration with another trust made this study possible, and it gave valuable research and leadership experience to nurses and doctors. Feedback from individual team members is that this was a really enjoyable and worthwhile project which helped develop skills clinically and in teamwork. It paves the way for future collaborations with University Hospitals Plymouth on research studies.

3.3   Excellent value and sustainability

Single Oversight Framework segment
As part of the new NHS System Oversight Framework (SOF) for Integrated Care Systems (ICSs), each system and each provider is awarded a segment ranging from 1 (the best) to 4 (intensive support). It has been recently confirmed that the Devon system has been placed in segment 4 due to longstanding financial issues. This means support under the new Recovery Support Programme will span all member organisations of the ICS, including the CCG and all providers.

We have now been formally notified that as an organisation we have been placed into SOF segment 3 and will receive mandated support. We have been placed in segment 3 due to our long-term financial performance and we welcome the support that we will receive.

We recognise the challenges we face in Devon both as a system and as a provider, particularly around our financial performance.

Throughout the pandemic, our dedicated staff have all worked hard to identify opportunities to improve our productivity, our efficiency and the care we provide.

We are committed to working with our staff to address those issues which are within our control while we work closely with our partners to address issues at a system level.

We are truly proud of, and grateful for, our staff's continued commitment to care for the people who need us and for looking after each other while also looking to find solutions to our problems and making things better for everyone in Torbay and South Devon.

Teignmouth Hospital
The Secretary of State for Health and Social Care has asked the Independent Reconfiguration Panel (IRP) to undertake an initial assessment of the referral by Devon County Council's Health and Adult Care Scrutiny Committee regarding the future of Teignmouth Community Hospital.

NHS Devon Clinical Commissioning Group was informed of the Secretary of State's request this week and is now providing the IRP with the information they need to complete the initial assessment.

The IRP is the independent expert on NHS service change. It offers advice to the Secretary of State on proposals for health service change in England that are being contested. The Panel members have wide-ranging expertise in clinical healthcare, NHS management, patient involvement and representing the public.

In coming weeks, the IRP will offer advice to the Secretary of State on what further action should be taken. The Secretary of State will then consider the Panel's advice. Next steps include seeking further advice or announcing a decision that may detail any action he would like to see taken.

The Secretary of State has directed the IRP to report their initial findings by mid-December 2021.

MRCP PACES exam run successfully at Torbay Hospital
Our Medical Education team ran the prestigious Royal College of Physicians PACES at the Horizon Centre, Torbay Hospital. 26 doctors from all over the UK were examined over a two-day period earlier this month, by a team of five of our consultants, two visiting examiners and four virtual examiners via MS Teams.

The MRCP PACES clinical exam is a national exam that all doctors have to pass. It is an important milestone for physicians and essential for career progression. By hosting the exam at Torbay and South Devon, we are developing our Consultant Physicians of the future.

Celebrating Diwali
We celebrated Diwali, the festival of lights, with a special menu in our Bayview Restaurant at Torbay Hospital. I'd like to formally recognise the commitment of our catering teams to marking special events and significant celebrations through the provision of special menus. They also created some wonderful menus for staff and visitors to enjoy during last month's Black History Month celebrations.

Black History Month
We celebrated and embraced Black History Month in October with lots of wonderful events and activities. We ran a series of poetry events run by our very own HeArTs+minds group and the Devon Wide BAME Network. This included hosting an evening of poetry with Totnes based performance poet, Harula Ladd

and a poetry writing workshop with performance poet, Angela 'Poppy Seed' Harvey.

Tanya White, one of our Physician Associates, talked to us about micro-aggressions, a term used to describe daily occurrences, whether intentional or not, that contribute to negative attitudes, false stigmas and ultimately discrimination towards ethnic minority groups, and advised how to avoid them. Other colleagues told us what Proud to be and Black History Month meant to them, and we had a list of Black Lives Matter reading courtesy of the library. Our LGBTQIA+ network highlighted that LGBTQIA+ liberation and equality had been led by black people such as Marsha P Johnson, and invited us to celebrate their contributions, and the contributions that black LGBTQIA+ organisations are making throughout the world.

We ended a month-long of activities with our Proud to be…An evening with Celebrity Chef Michael Caines MBE, Alexandra Ankrah from Health Education England, Dr Habib Naqvi, Director of the NHS Race and Health Observatory, and Tanya White, Physician Associate. The event, hosted by Sir Richard Ibbotson and I, saw esteemed guests sharing their stories and reflections on the theme of Proud to be with a Q&A session following afterwards. The recording of the event is available here.

Grange Lea care home award celebration
One of our care home partners, Grange Lea in Paignton, has won the regional Academic Health Science Network Care Home Health and Wellbeing Award.

A video has been produced which highlights why they were recognised and the great work they did during the most challenging period in the sector's history. Congratulations to the team and residents who made this happen.

This success is just a snapshot of the extraordinary things that many of our partners have achieved during the pandemic, and we are delighted to continue to work together as we develop our local response to the national Enhanced Health in Care Homes framework.

4.   **Chief Executive engagement November**
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.

During this month I have taken a fortnight's annual leave.

Internal	External
• Vlog sessions • Black History Month, Proud to be… an evening with Celebrity Chef Michael Caines MBE,	• Chief Executive, Devon Integrated Care System • Chief Nurse, Devon Integrated Care System

Alexandra Ankrah from Health Education England, Dr Habib Naqvi, Director of the NHS Race and Health Observatory, and Tanya White, Physician Associate • Staff side	• Director of Long-Term Plan, Devon Clinical Commissioning Group • Chief Officer for Adult Care and Health, Devon County Council • Chief Executive, Devon Partnership NHS Trust • Locality Director, South & West, Devon Clinical Commissioning Group • Chief Executive, Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust • Devon Children and Families Partnership • Anthony Mangnall MP for Totnes • Devon NHS Chief Executives Meeting • Assistant Director, South West, NHS Confederation

5.   Local health and care economy developments

5.1   Partner and partnership updates

5.1.1 Devon integrated care system and local care partnerships

Chair and Chief Executive for Devon's Integrated Care Board
We are very proud that our Non-Executive Director, Dr Sarah Wollaston has been appointed chair of the Integrated Care System for Devon (ICSD) for the next 12 months, starting in post on 01 December 2021.

Unfortunately, this does mean that Sarah will be leaving her role as a Non-Executive Director with us at the end of November. While we will miss Sarah's insight and expertise on our Board of Directors, her appointment as Chair will make Devon a stronger health and care system, benefitting not only us and our partner organisations but most importantly, the people of Devon.

Sarah succeeds Dame Suzi Leather, who has chaired the Devon health and care system since 2018. We thank Dame Suzi for her leadership, dedication and commitment to improving health and care services in Devon.

Jane Milligan has been formally appointed to the role of Chief Executive Officer for the new Integrated Care System for Devon (ICSD), when it officially comes into being from 01 April 2022.

Following a rigorous national process for all new ICS Chief Executive Officer posts, NHS England has now approved Jane in this role. Jane joined the Devon system in April 2021, having previously worked in north east London.

5.1.2 Association of Ambulance Chief Executives report
The Association of Ambulance Chief Executives (AACE) published a report earlier this month following a structured clinical review of handover delays at hospital emergency departments across England. The review focuses on the

extent of potential harm caused to patients by waiting in the back of ambulances or in corridors before being accepted into the care of their local hospital.

The review found that the proportion of patients who could be experiencing unacceptable levels of preventable harm is significant. Over eight in ten of those whose 'handover' (from ambulance clinician to hospital clinician) was delayed beyond 60 minutes were assessed as having potentially experienced some level of harm; 53% low harm, 23% moderate harm and 9% (one patient in ten) could have been said to have experienced severe harm.

The impact assessment was coordinated by AACE and was undertaken in all ten English NHS ambulance services who reviewed a sample of cases from one single day in January 2021, where handovers exceeded one hour. As the report recognises improvements and learning are required at a national and a system level to identify and support an improved situation for the future.

As outlined in 3.2 we are experiencing challenges in offloading ambulances as quickly as we would wish and at times there are a queue of ambulances being held outside our Emergency Department. We are working with South Western Ambulance Service NHS Foundation Trust to make sure all patients waiting in ambulances are robustly assessed and care is escalated and prioritised appropriately. We are also exploring all opportunities to reduce ambulance handover delays.

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.

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

Recent key media releases and responses:

- New cancer study – release issued marking the opening of a trial we are participating in which examines a new multi-cancer early detection blood test
- Bus strike – release issued advising the public on the potential impact of the planned Stagecoach bus driver strike and the effect this would have on people travelling to appointments
- Help us help you – regional release provided an update on the current pressures, the impacts on the system and outlining what people can do to help their local health services
- Dartmouth Hospital site update – statement issued jointly with Dartmouth Town Council on working together to prepare for a new future for the site and our support for a community bid if possible
- Spillage at Torbay Hospital - following a spill of chemicals outside of our theatres, a media enquiry was received and a pre-prepared response was issued outlining that no one was harmed and disruption was minimal

- Minor Injuries Units update – response issued to enquiries about the reopening of our MIUs, reaffirming our commitment but outlining the difficulties in recruiting
- Wave 3 capital funding project – addressed enquiry around the current status of our wave 3 capital funding project and the most recent updates

Recent engagement on our social media channels includes:
- Allied Health Professions Day – celebrated our fantastic AHP colleagues and shared some stories from our podiatrists and speech and language therapists on Twitter
- Diarrhoea and vomiting visiting warning – urging the public to not visit our sites if they have symptoms of diarrhoea and vomiting in order to protect our patients and staff
- World Mental Health Day – promoted the five ways to wellbeing as a way of encouraging people to take time for themselves on WMHD
- Urgent Treatment Centre promotion – during a busy period for our Emergency Department, highlighting the services and urgent care our UTC at Newton Abbot Community Hospital can provide
- League of Friends donation – celebrating the fantastic news that Torbay Hospital League of Friends has funded two paediatric ventilators for our Emergency Department
- Help us help you – letting the public know what they can do to support their local healthcare services, including collecting relatives ready to be discharged and using the 111 service
- Black History Month – promoting our event celebrating Black History Month for all health and social care staff in Devon
- COVID-19 reminders – highlighting the rise in hospital cases and what people can do to keep infection rates down
- Crocus planting – the Rotary Club of Torbay Sunrise planted more than a thousand crocuses at Torbay Hospital's Lowes Bridge entrance as part of their End Polio Now campaign
- Bank promotion – promoting our staff bank, the roles available and how to join

Development of our social media channels:

Channel	End of year target	As of 31 March 2021	As of 30 October 2021
LinkedIn	5,000 followers	2,878	3,411 ⬆ 533 followers
Facebook	15,000 likes	12,141	12,558 ⬆ 417 followers
	15,000 followers	12,499	12,948 ⬆ 449 followers
Twitter	8,000 followers	6,801	7,091 ⬆ 290 followers

7 Recommendation

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

BOARD ASSURANCE FRAMEWORK SUMMARY

Q3 2020/21 v15

NHS Torbay and South Devon NHS Foundation Trust

Ref	Executive Owner	Corporate Objective	Current risk	Target risk	Strength of Controls	Strength of assurance	Changes
1	Liz Davenport Chief Executive	To develop and implement the Long Term Plan with partners and local stakeholders to support the delivery of the Trust's strategy	20	16	Amber	Amber	
2	John Harrison Chief Operating Officer	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	20	16	Amber	Red	
3	Dave Stacey Chief Finance Officer	To achieve financial sustainability, enabling appropriate investment in the delivery of outstanding care	16	16	Amber	Amber	
4	Deborah Kelly Chief Nurse	To provide safe, quality patient care and achieve best patient experience, responding to the new paradigm of harm and safety as a result of of COVID-19	20	16	Amber	Amber/Red	
5	Dave Stacey Chief Finance Officer	To provide and maintain a fit for purpose estate infrastructure ensuring service continuity at all times	25	16	Amber	Amber	
6	Adel Jones Director of Transformation & Partnerships	To provide and maintain a fit for purpose digital infrastructure ensuring service continuity at all times	25	25	Red	Red	
7	Adel Jones Director of Transformation and Partnerships	To implement the Trust plans to transform services, using digital as an enabler, to meet the needs of our local population	16	12	Amber	Red	
8	Judy Falcao Chief People Officer	To implement and continuously review the Trust People Plan, ensuring the Trust is a 'great place to work'	12	8	Amber	Amber	
9	Judy Falcao Chief People Officer	To ensure management practice, leadership capacity and capability to deliver high-quality, sustainable care for the local population	12	8	Amber	Amber	
10	Liz Davenport Chief Executive	To actively manage the potential for negative publicity, public perception or uncontrollable events that may impact on	9	9	Amber	Amber	
11	Adel Jones Director of Transformation & Partnerships	To develop and implement the New Hospital Plan (Building a Brighter Future) ensuring that it meets the nees of the local population and the Peninsula System	12	12	Amber	Amber	November 21 - strength of assurance moved from Green to Amber
12	Deborah Kelly/Ian Currie Chief Nurse/Medical Director	To mitigate the long term impact of Covid-19 on the quality and safety of services for the local population	20	6	Amber	Amber	Risk merged with no 4 as prevalence of Covid-19 continues

Report to the Trust Board of Directors

Report title: Integrated Performance Report (IPR): Month 7 2021/22 (October 2021 data)		Meeting date: 24 November 2021
Report appendix	M7 2021/22 IPR focus report M7 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: 17 November 2021 Integrated Governance Group: 17/18 November 2021 Finance, Performance, and Digital Committee: 22 November 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 on progress in meeting 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**	X	**Valuing our workforce**	X
	Improved wellbeing through partnership		**Well-led**	X
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework**	X	**Risk score**	20
	Risk Register	X	**Risk score**	25

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

This report reflects the following corporate risks:

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

Report title: Integrated Performance Report (IPR): Month 7 2021/22 (October 2021 data)		**Meeting date:** 24 November 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:

There has been one reported severe incident related to delay in treatment following an assessment and no intervention at the time, breast screening and delay in diagnosis and treatment.

There has been one death which is a learning disability death related to delay in diagnosis and cancer treatment. This has been reported to safeguarding and will form part of a LeDer investigation

Stroke:

The percentage of stroke patients spending 90% of time on the stroke ward remained below the 90% target. The position for October was 35.9% compared to 69.2% in September. This underperformance was driven by:

1. The sustained escalated position of the Trust;
2. Restricted access to the stroke ward due to outbreaks of covid and norovirus; and
3. Delayed swabbing in the Emergency Department.

The following measures are in place to maintain patient safety at this time:

- The control room continue to monitor the stroke beds and allocate to them when available
- There is a stroke specialist nurse allocated to ED every day, to review and progress the treatment and transfer to a stroke bed. If patients are delayed getting to the stroke unit these nurses will help oversee their care.
- The stroke team (nurses and therapists) outreach to see stroke patients on other wards.
- Covid swabbing delays – the stroke co-ordinators should order swabs themselves to facilitate speed.

It is to note that the flow of patients throughout the hospital due to a number of variables that include availability of rapid response and care homes, increase in demand in the Emergency department has impacted on the ability to move our stroke patients to a stroke ward.

VTE performance remains below the required 95% standard: In September and October 2021, the compliance achieved has slight reduced from 94.4% in July and August to 91.9%. In analysis of the data it has been recognised that a variable to the data is the changes of bed base across the Trust with fluctuating escalation beds.

The improvements to date have included:
- VTE is a mandatory field within the CPS since 8 July 2021
- The weekly report distribution has been reviewed and updated to ensure those recipients hold accountability for achieving this requirement.
- All junior doctors joining the Trust undertake VTE training within the Trust education platform the HIVE and this is monitored by medical education.

An area of focus will be identifying the gaps and understanding further the associated elements for non-compliance.

Once the VTE prevention group is fully operational, with its first meeting in November they will integrate this work into their workplan and drive forward continuous improvement of VTE assessment within 24 hours.

IPC: For October the number of C.Diff cases was 1 with no lapses of care, however the patient had moved wards several times. The number of bed closures due to infection exceeded 460 in October due to norovirus, diarrhoea no cause and covid infection

Maternity: During October 2021, the number of births were 194 births in month.
- Sadly, there was one woman who attended the maternity services whose baby was stillborn at 25 weeks gestation. We also admitted a term baby who required 'cooling' treatment and therefore met the criteria for referral to HSIB in October.
- The staffing challenges have continued throughout October and a number of actions have been taken to mitigate the risk, however it is an improving picture

CQC compliance: October saw the completion of the Executive peer review exercise with internal audit and ward visits to triangulate improvement priorities around must do's and should dos. There are a number of improvements recommended to strengthen the existing evidence and a detailed report will be submitted to the Board in January.

2. <u>Workforce Headlines</u>

The annual rolling sickness absence rate was 4.50% to end of October 2021; this is against the target rate for sickness of 4%. The monthly sickness figure for October was 5.82% which is the highest ever sickness in a single month since ESR was implemented in 2005. As part of an ICS review of sickness the Trust is completing a deep dive into sickness absence.

The Achievement Review rate for the end of October 2021 was 77.86% a reduction from the 79.69 % as at the end of September
The Trust's turnover rate now stands at 11.57% for the year to October 2021 and is within the target range of between 10%-14%. A Devon ICS retention project has just been initiated to support staff to work longer for specifically identified hotspots focussed on staff aged 50 and above.

The current overall mandatory training rate is 89.02% for October 2021 against a target of 85% and this is an increase from the 88.95% in September. Overall training

compliance has stayed reasonably stable and not been impacted as much by the continuing pressure on the system however many of the subjects with multiple levels still need addressing.

As at Month 07 the Trust Agency spend was £1.231m giving Financial YTD figure of £7.476m (£3.2m above plan as at the end of month 6 with second half of year forecast to be confirmed).

3. Performance Headlines

Details of specific national performance indicators are contained in the IPR focus report.

Operational headlines

Covid: The Trust continues to care for a number of Covid patients averaging 17 to 20 daily in hospital beds in October; with up to 3 patients being cared for in the intensive care unit. Current trajectories show the number of covid patients in hospital staying within the existing covid ward bed capacity without further escalation, this is under continuous review.

Accident and Emergency: Demand for urgent and emergency services with ongoing high bed occupancy and delays to ambulance handover continues to be a challenge. Access to inpatient beds remains the primary contribution to the length of time patients are spending in the Emergency Department. In October there were 753 people who spent 12-hours or more in the Emergency Department with ambulance handover delays remaining high with over 125 patients experiencing over an hour delay once arriving to the Emergency Department.

People waiting for care: The number of patients waiting over 18-weeks, 52-weeks, and 104-weeks for treatment continues to increase. Based on activity plans the overall forecast is not showing any reduction in waiting times in the short term. Capacity within the independent sector remains important in supporting delivery of routine elective care for orthopaedics, upper GI, urology, and gynae along with insourcing capacity at weekends for Endoscopy and Ophthalmology day cases. Patient initiated follow up (PIFU) and video/telephone appointments will release capacity to reduce the waiting time for some patients. Recovery plans, specific to delivery of cancer targets, are focusing across the three most challenged areas of Dermatology (2-week-wait), Urology, and Lower GI pathways and are being escalated with executive oversight. In January 2022 the Trust will begin accessing capacity at the Nightingale Hospital Exeter for orthopaedic day case and will support the reduction of longest waits over 104 weeks. The ongoing need to escalate bed capacity to maintain patient flow continues to see the Day Surgery Unit re-designated as the Medical Receiving Unit to allow Forrest ward (25 beds) to be opened as general acute medical inpatient beds. This has restricted the capacity for planned elective surgery with elective admission prioritising cancer treatments and the most urgent patients. Routine elective orthopaedic surgery has continued having restarted during the September Best Week releasing the orthopaedic ward to focus on elective care.

Cancer care: An increase in referrals and reduction in capacity for certain specialties has led to a deterioration in the cancer 2-week-wait at 50.5% and the lowest performance for 13 months. Meeting the 28-day cancer diagnosis target has also been a challenge with the second month of decreasing performance.

Diagnostic waiting times: for Endoscopy, CT, and MRI remain a risk to the timely treatment of cancer and urgent patients. The use of a mobile scanner, insourcing at weekends, and the use of the Nightingale Hospital facilities will increase capacity over the coming months.

Patients in hospital: There remains a number of staffing challenges for the independent sector providers to support timely discharge from hospital. In October the number of long lengths of stay 21- day and 7-day length of stay patients has remained significantly higher than normal levels with an average of 44 patients over 21 days in hospital compared to 17 last October. To date November has seen a moderate improvement in these long lengths of stay.

There remains a significant number of patients who are medically fit with no 'criteria to reside' and require ongoing support and care in community settings. It is noted that there is a relative shift in the proportion of patients in hospital requiring additional care needs on discharge as measured through the discharge pathways being recorded and reflects the acuity of patients coming in to hospital. With a significant number of discharges being delayed this remains one of the most significant challenges to patient flow and patient experience.

Community and social care: The levels of unfilled packages of care has continued to increase. Urgent care team capacity continues to be diverted to ensure packages of care for the most at-risk patients are maintained. Staffing across many community teams are below desired levels. Some impact from the vaccination status ruling for staff working in care homes has been felt across the system with some staff transferring to Dom care – it is noted that in April the same rules will apply to domiciliary care, voluntary sector, and front-line NHS staff.

4.   Finance headlines

For the month of October (M7) and year to date, the Trust is reporting a £0.2m surplus, which is in line with plan.

Total income for the year to date is £2.6m favourable to plan. Key drivers are as follows: in-year COVID related income e.g. Council funding stream which was not initially budgeted in H1 (£3.6m favourable) and ASC client contribution income (£0.4m matched by cost) offset by: lower ERF income owing to the changes in funding threshold alongside increasing cancellation of elective surgery (£1.4m adverse), reclassification of renal transport income and audit income from patient care income to other income and pass through drugs within block contract income (£0.4m adverse).

Operating expenditure and financing cost in the year to date is £2.4m adverse to plan. Key drivers are as follows: COVID related costs including those council funding stream not initially budgeted in H1 (matched by income), increase in Agency (£3.6m adverse) and Bank spend (£2.6m adverse), undelivered CIP (£0.3m adverse), increased clinical supplies cost (£0.4m adverse), net increase in operating cost (£1.2m adverse due to: IT equipment purchase £0.5m, STP resourcing contribution £0.3m, consultancy £0.2m, leases and transport £0.2m) offset by under one-off mitigations of reserves (£5.0m favourable), and lower than planned spend on depreciation (£0.3m favourable).

The cash position remains strong with a month end balance of £33.6m. To date the Trust has spent c. £9.6m on capital schemes, an increase of c. £2.5m from Month 6.

The M7 CIP plan is £1.17m with actual delivery of £0.83m, a shortfall of £0.34m. Year to date, CIP delivery in H2 is £0.8m.

The Trust has prepared a forecast out-turn for the year, based on current levels of expenditure and likely impacts over the winter period, which suggests a gross risk of overspend at £5.9m before mitigations. The deficit is largely driven by the projected shortfall in delivery of CIP, between £3.6m-£4.1m, a weakening of the trading outlook for Torbay Pharmaceuticals and on-going pressures within the hospital due to non-elective surge exacerbated by the current Covid situation. The Trust has identified non-recurrent, non-cash mitigations which will cover the current risk identified above.

With regard to ERF the threshold % has been amended from 95% of SUS submitted activity to 89% of RTT stop clock activity. The STP has reviewed this position and asked each provider to calculate their view of ERF income to enable a comparison. This will confirm the STP risk to progressing with ERF schemes. There is a chance that some of these schemes might be covered by a potential new funding source and this is being investigated.

Liberty protection safeguard standards are due to be implemented from 1st April 2022 however we are still awaiting further guidance. Staffing costs and associated training/setup costs will need to be incurred from Q4 of 2021/22 and are included in the H2 request (with an anticipated income offset) for the Torquay ISU but no known funding arrangements have yet been confirmed with costs set to increase further when the act becomes live in 2022/23.

Looking ahead, the National planning guidance for H2 and the budget envelope was issued on 30th September, requiring the Devon system to submit high level plans by 16th November (now moved back to 18th November) and a more detailed submission of the Trust's organisational budget will be submitted on 25th November.

A planned submission has been prepared by the Trust in accordance with the guidance, which has been incorporated into the Devon system plan. This requires a break-even position after taking account of CIP achievement of £7.2m. Should the Trust achieve the break-even plan it will also receive from the CCG £1.8m cash only Provider Incentive payment (i.e. a requirement of planned surplus at £1.8m, dependent on achieving a break-even position before the incentive payment).

November 2021: Reporting period October 2021 (Month 7)

	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:
There has been one reported severe incident related to delay in treatment following an assessment and no intervention at the time.
There has been one death which is a learning disability death related to delay in diagnosis and cancer treatment.

Stroke: The percentage of stroke patients spending 90% of time on a stroke ward remains below the 90% target dramatically reduced at 35.9%.
A number of measures are in place to improve compliance.
The impact of unprecedented attendances to ED and number of closed beds due to infection have contributed to this position:
- Drivers behind the under-performance are capacity predominantly and length of stay in ED as opposed to outlier across other wards.
- 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 helping oversee their care.
- Covid-19 swabbing delays.

VTE performance remains below the required 95% standard:
In September 2021 the compliance achieved had a slight reduction to 91.9%. One variable which is a challenge has been the changes in bed base across the Trust with fluctuating escalation beds. These key elements have included:
- VTE is a mandatory field within the CPS since 8 July 2021.
- The weekly report distribution has been reviewed and updated to ensure those recipients hold accountability for achieving this requirement.
- All junior doctors joining the Trust undertake VTE training within the Trust education platform the HIVE and this is monitored by medical education.
- The VTE prevention group has been reinstated and will meet monthly from November 2021.
Once the VTE Prevention Group is fully operational this work will be a function of this group and report to the Quality Improvement Group.

Infection, Prevention, and Control: For October the number of C.Diff cases was one, no lapses of care, however the patient had moved wards several times. The number of bed closure due to infection exceed 460 in October due to norovirus, diarrhoea (no known cause), and covid infection.

Maternity: During October 2021, the number of births were 194 births in month.
- Sadly there was one women who attended the maternity services whose baby was stillborn at 25 weeks gestation. We also admitted a term baby who required 'cooling' treatment and therefore met the criteria for referral to HSIB in October.
- The staffing challenges have continued throughout October and a number of actions have been taken to mitigate the risk, however it is an improving picture.

CQC compliance: October saw the completion of the executive evidence validation with internal audit and ward visits to triangulate the evidence. There are a number of improvements recommended to strengthen the existing evidence.

CQC update

The 28 Requirement Notices (Must Dos) and the 43 Should Do Improvements in TSDFT's CQC Inspection Report published on 2 July 2020 is monitored through the CQC and Compliance Assurance Group (CQCCAG). An Improvement Plan is in place to address these requirement notices.

During October the executives undertook a review of all the evidence from the Must Do and Should Do improvements. The ward visits by the Executives and team are also being scheduled, with three having been completed. These triangulated with the presentation the areas gave and the evidence put forth for Must DO and Should DO improvement plan closure.

Internal Audit were invited to our executive evidence reviews to provide some challenge regarding our processes and question whether we have sufficient evidence to close our must do and should do improvement actions.
Internal audit have provided some detailed actions for us to consider these have been distributed to the areas. We will work with the core service leads to manage this action plan alongside the CQCs Must DO Should Do improvement plan.

Following a review of the process to date, a number of the Must Do actions that have been deemed closed by the CQCCAG group, may have their status change to ongoing action required. The Must Do actions are:
- Mandatory Training MCA, Resus.   Whilst the Trust has achieved a clear and current Training Needs Analysis more clarity is required on competition trajectories and the possible modularization on the Mental Capacity training to aid completion
- Paediatric Waiting Area – Phase 2 build delayed until Spring 2022
- Annual Appraisals – the requirement to disaggregate the Medics from the reporting numbers due to their Covid dispensation
- Clearer processes on the Medical Replacement Programme

Table 1: The status of Must Dos and Should Dos per CQC core service at 30th October 2021.

CQC Compliance Actions Status										
CQC Core Service	No. of Actions		Completed		On track		Risks overdue		Overdue / Concern	
	Must	Should	Must	Should	Must	Should	Must	Should	Must	Should
Trustwide	1	0	1	n/a	0	n/a	0	n/a	0	n/a
Urgent and Emergency	8	6	8	6	0	0	0	0	0	0
Medical Care	9	12	9	9	0	0	0	0	0	3
Surgery	4	5	3	1	0	0	0	0	1	4
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	27	36	0	0	0	0	1	7

Quality and Safety Quadrant

🟢 Achieved

Never Events

Formal complaints - Number received

Hand hygiene

Reported Incidents – Severe

Medication errors resulting in moderate harm

Avoidable New Pressure Ulcers - Category 3 + (reported 1 month in arrears)

Strategic Executive Information System (STEIS)

🟡 Under Achieved

Safer Staffing - ICO – Daytime

QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams

🔴 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

Fracture Neck Of Femur - Time to Theatre <36

Infection Control - Bed Closures - (Acute)

Safer Staffing - ICO – Night time

⚫ No target set

Medication errors - Total reported incidents

Data not currently available

Hospital Standardised Mortality Rate (HSMR) – not yet available from Telstra Health UK

Number of Clostridium Difficile cases

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Acute	4	2	2	1	1	4	1	3	2	4	7	2	1
Community	0	0	1	0	0	1	1	2	0	1	1	0	0

The number of C.Diff cases have dramatically reduced in October seeing 1 case.
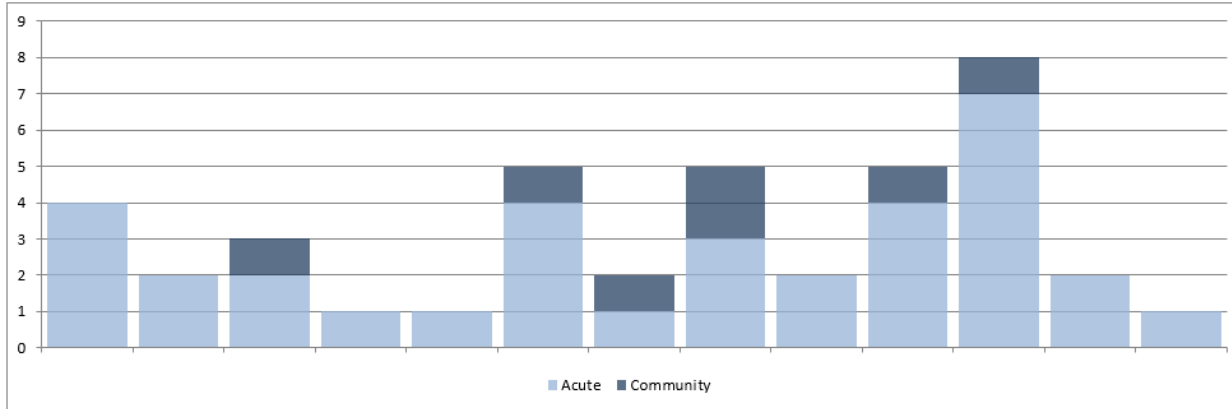
Upon review of this case there has been no lapses in care noted. However the patient had a significant number of ward moves.

Infection control - Bed closures (Acute)

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Bed closures	23	0	30	6	0	23	24	42	381	24	8	42	476

October has seen an unprecedented number of bed closures from the 48 in September to 476 in October.
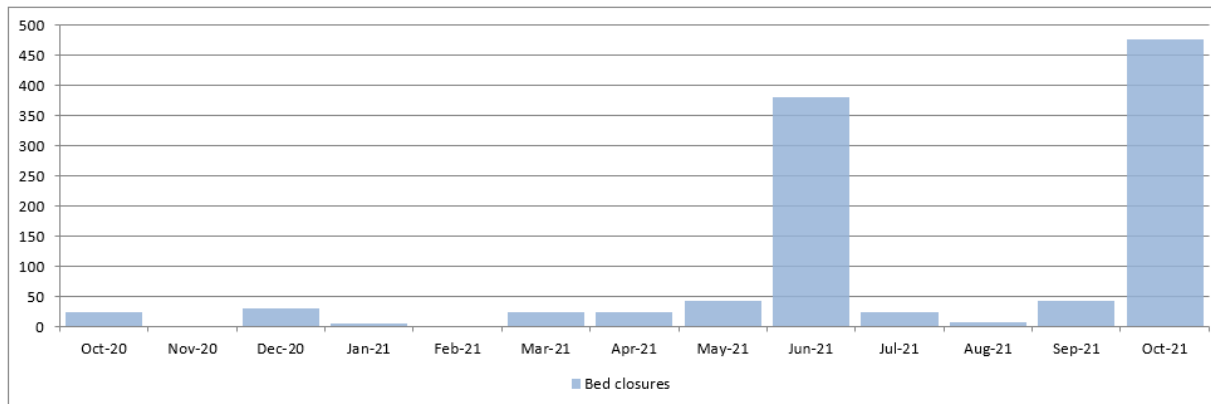
The reason for these closures have included:
- Norovirus
- Diarrhoea no known cause
- Covid positive

Management of these have followed IPC guidelines including Public Health England guidance. We have therefore increased levels of cleaning.

Quality and Safety- Incident reporting and complaints

Reported Incidents - Severe and Death

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Severe	0	1	2	1	1	4	0	2	4	2	2	0	1
Death	1	0	1	3	1	2	0	2	1	2	0	0	1
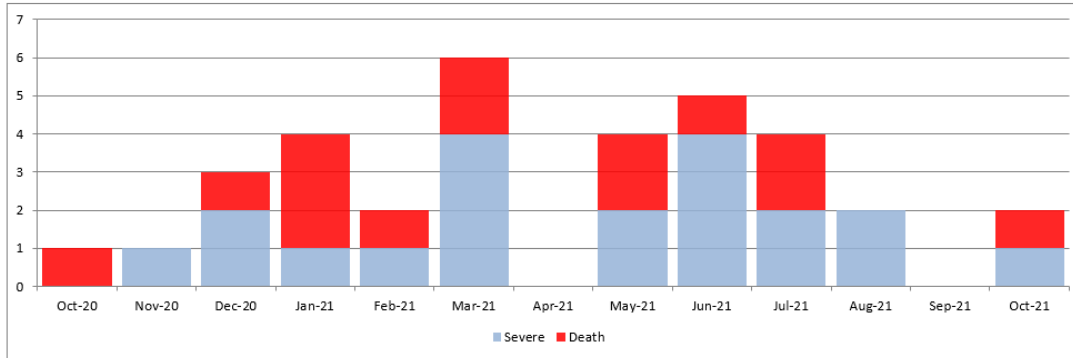
There has been one reported severe incident related to delay in treatment following an assessment and no intervention at the time

There has been one death which is a learning disability death related to delay in diagnosis and cancer treatment

Formal complaints

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Formal complaints	19	20	14	7	13	17	10	9	15	18	17	11	11
Target	60	60	60	60	60	60	60	60	60	60	60	60	60
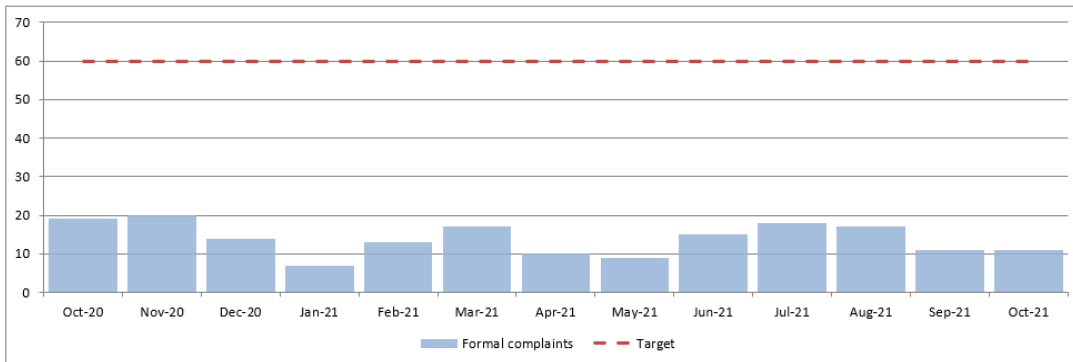
In October 2021, the Trust received 11 formal complaints, this is consistent with September (11).

Themes of complaints included:
- Treatment
- Assessment
- Care

There is no theme relating to a specific service therefore has not highlighted an area of concern.

Stroke

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
90+% of time on stroke ward	73.2%	82.2%	80.4%	69.4%	51.6%	77.5%	84.1%	65.9%	66.1%	51.4%	56.3%	69.2%	35.9%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

Stroke: The percentage of stroke patients spending 90% of time on a stroke ward remains below the 90% target dramatically reduced at 35.9 %. A number of measures are in place to improve compliance.

The impact of unprecedented attendances to ED and number of closed beds due to infection have contributed to this position:

- Drivers behind the under-performance are capacity predominantly and length of stay in ED as opposed to outlier across other wards.
- 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 helping oversee their care.
- Covid swabbing delays

Follow ups 6 weeks past to be seen by date

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
6+ weeks past TBS date	17519	17229	17837	17489	16986	16950	17118	16713	16323	16967	17651	17789	18231
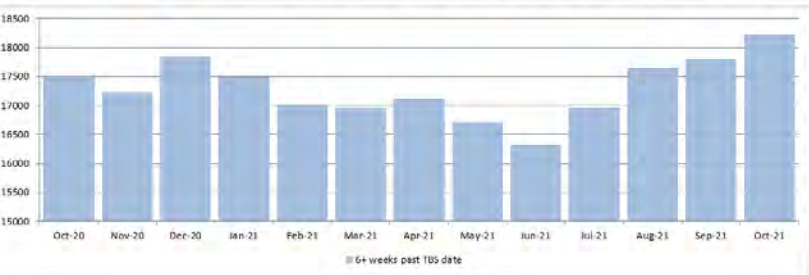
Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' has increased from 17789 in September to 18231 in October.

- Supporting teams to implement Patient Initiated Follow Up (PIFU) to reduce number of follow up appointments required.
- Harm Review meetings are being progressed and thematic reviews being conducted against our longest waiting patients.
- The main area is ophthalmology six-weeks beyond their to be seen by date.

ICO VTE risk assessment on admission

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
VTE Numerator	5066	4837	4903	4705	4457	5307	5491	5400	5518	5685	4962	5188	5058
VTE Denominator	5423	5209	5423	5091	4831	5775	5938	5851	6228	6024	5344	5643	5508
VTE Performance (Acute)	93.4%	92.9%	90.4%	92.4%	92.3%	91.9%	92.5%	92.3%	88.6%	94.4%	92.9%	91.9%	91.8%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

VTE assessment

October 2021 the compliance achieved had a slight reduction to 91.9%. One variable which is a challenge has been the changes in bed base across the Trust with fluctuating escalation beds.

These key elements have included:

- VTE is a mandatory field within the CPS since 8 July 2021
- The weekly report distribution has been reviewed and updated to ensure those recipients hold accountability for achieving this requirement.
- All junior doctors joining the Trust undertake VTE training within the Trust education platform the HIVE and this is monitored by medical education.

Once the VTE prevention group is fully operational, with its first meeting is in November they will integrate this work into their workplan and drive forward continuous improvement of VTE assessment within 24 hours.

7.01 Integrated Performance Report Month 7 October 2021.pdf

Quality and Safety- Perinatal Clinical Quality Surveillance

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	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	YTD
% of Caesarean sections	25-30%	34.9%	26.7%	28.7%	24.3%	29.5%	34.0%	31.4%	36.2%	40.2%	37.8%	34.1%	28.4%	32.2%
Breast feeding rates	>75%	69.8%	82.2%	78.1%	75.7%	81.8%	73.5%	76.2%	75.3%	74.4%	76.4%	78.1%	71%	76.1%
% of women booked for 'Continuity of carer' model	>35%	63.3%	60.1%	61.7%	62.3%	67.9%	57.0%	64.2%	64.3%	64.9%	59.7%	65.3%	69.5%	63.4%
No. of stillbirths	0	0	1	1	1	0	0	0	0	0	0	2	1	6

- During October 2021, the maternity service the number of births were maintained, with 194 births in month. November and December 2021 are still projected to be busy months, with over 200 births projected.

- The service has continued to see high 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. However in month there was a reduction in both the Caesarean section and induction of labour rate. The team continue to see women presenting to maternity services who are positive for COVID-19.

- Sadly there was one women who attended the maternity services whose baby was stillborn at 25 weeks gestation. We also admitted a term baby who required 'cooling' treatment and therefore met the criteria for referral to HSIB in October.

- The staffing challenges have continued throughout October. This has been from a midwifery and obstetric perspective. We are beginning to see a small improvement as colleagues are beginning to return from periods of long-term absence. A number of actions have been taken to mitigate the risk, including managerial and specialist midwives undertaking clinical shifts and use of agency staff, and medical staff 'acting down'. Recruitment is underway to increase the midwifery establishment following agreement at the September Trust Board.

Performance exceptions and actions

Staff sickness/absence: RED for 12 months and RED for current month

The annual rolling sickness absence rate was 4.50% to end of October 2021; this is against the target rate for sickness of 4%. The monthly sickness figure for October was 5.82% which is the highest ever sickness in a single month since ESR was implemented in 2005. This continues the exceptionally high sickness seen over the last few months especially when compared to long-term seasonal averages. The total estimated cost for all sickness in October was just over £1m with mental health accounting for 32% of October's sickness absence which is in the region of 4200 calendar days for 225 individuals. 11% of October's absence (370 staff and 1400 days) was for cold/flu which has started to increase as we move into the historical high months for cold/flu. A deep dive into sickness absence has been initiated as part of an ICS review.

Appraisal rate: Red

The Achievement Review rate for the end of October 2021 was 77.86% a reduction from the 79.69 % as at the end of September. Continuing high sickness absence and system pressures are drivers for this being the fifth month in a row the appraisal rate has reduced from the high of 86.61% in May. Improvement in these figures will be a challenge in the current climate with approximately 1200 staff who are required to have an achievement review meeting now overdue.

Turnover (excluding Junior Doctors): GREEN

The Trust's turnover rate now stands at 11.57% for the year to October 2021 and is within the target range of between 10%-14%. A Devon ICS retention project has just been initiated to support staff to work longer for specifically identified hotspots focussed on staff aged 50 and above. Delivery of the People Promise will ensure improved staff experience and also positively impact on retention.

Mandatory Training rate: GREEN

The current overall rate is 89.02% for October 2021 against a target of 85% and this is an increase from the 88.95% in September. Information Governance continues to be the subject with the lowest compliance against target standing at 82.75% against a target of 95%. Infection Control and Manual Handling are both below the overall target figure but the subjects with multiple levels of training are not as compliant as they are required to be. Safeguarding Children has 2 out of 3 levels non-compliant, Safeguarding Adults 4 out of 6 levels non compliant, Life support training has only 1 out of 8 levels compliant and MCA all 8 levels are non- compliant, however, this subject has only recently be systemised. Training is also being impacted heavily by system pressures and the inability to prioritise training over other activities.

Agency Expenditure: As at Month 07 the Trust Agency spend was £1.231m giving Financial YTD figure of £7.476m (£3.2m above plan as at the end of month 6 with second half of year forecast to be confirmed). Increased recruitment of overseas Nursing in the coming months and especially into the new calendar year should start to reduce the need for agency upon those staff being in place and contributing fully. Continuing high sickness rates will be a significant factor in the on-going high overall agency expenditure.

Vacancy Rate: The Trust has not yet submitted the plan for the second half (H2) of FY 2021/22 and therefore there is no current vacancy data. The Trust plan will be submitted to NHSE/I on 25th November 2021.

November 2021 Update of Progress Against Our People Plan

Our People Plan

As we approach the end of Year One of Our People Promise and Plan, we are reviewing progress against our baseline measures, achievements and areas we will need to focus on further, to inform Year 2 priorities. We have reviewed our organisational values in light of the review of our organisational strategy, researched best practice and collated views from our people via an online short survey. We have had preliminary agreement to focus specifically on embedding and delivering Our People Promise, which reflect our organisational values. These were created using national evidence and engagement as well as local engagement, using words of our people.

Reflecting on the KPIs reviewed above, the plans in place to address improvements are built into our strategic People Plan; progress against the five pillars is described below.

1. Growing for Our Future

- Positive feedback from Best Week activity and introducing some as part of Resourcing Hub service levels to continue to improve and support service users.
- New approach to developing generic job descriptions progressing and priority will be given to those roles with high numbers of vacancies to make the biggest impact to the service.
- Increased priority on progressing our attraction activity and the Digital Communications Assistant is now driving this task and finish group, expending to include marketing material more general to support attraction activity.
- A pilot of introducing Inclusivity Reps onto selection panels is underway, progressing drive for inclusive recruitment approaches.
- First cohort of *new to care* Health Care Support Workers (HCSW) apprentices have been recruited to start in December 2021 and planning underway for a further cohort to start in January 2022.
- New attraction material now being released, HCA bank worker video received positive feedback and all involved in the production has an immense sense of pride.
- Resourcing event group making great progress with contributions from across directorates and starting to attend events such as local schools' careers evenings and planning for recruitment events.
- Implementation of new volunteering database stated, the new system will support the recruitment and retention of our NHS volunteers.

2. Looking After Our People

- Wellbeing buddy training continues with additional trainers being identified to support the roll out
- We are now in BEST Week 3 and are providing wellbeing packs to Pharmacy, HSDU, ED, Transport, Radiology, Estates, Theatres, PAC, CFHD and Torbay Pharmaceuticals – leads in the areas will be asked to feedback at the end of the week to the wellbeing team.
- Feedback is being provided to the BEST Week 1 areas on what heard and progress

- A group is being set up to look at the new national Health and Wellbeing Framework and plan for its role out– this will help support our People Plan and People Promise to identify areas of good practice and areas we need to focus on. The graphic below shows the 7 health and wellbeing domains which form the basis of the framework.

Introducing the NHS health and wellbeing model

Many factors influence the health and wellbeing of our diverse NHS people and teams. Some of these, such as physical and mental health, are well understood. However, there are other factors such relationships, management skills and the environment that are fundamental to support our diverse NHS people in providing world class health care to our patients. This model underpins the set of resources that form this Health and Wellbeing Framework. There are seven health and wellbeing domains containing sixteen elements, these elements incorporating supporting evidence, case studies and critical questions for our organisations.

The proactive interventions and services that empower our NHS people to manage their own health and wellbeing. Section's cover:
– mental and emotional wellbeing
– physical wellbeing
– healthy lifestyle

The teams and services, like occupational health, who are available to support organisations and our NHS people's health and wellbeing. Section's cover:
– support services and partners
– organisation design and policy
– interventions overview

The ways our teams work together with care and compassion. Section's cover:
– working together
– supporting each other

Our approach to understanding our health and wellbeing needs and then measuring our effectiveness in supporting them

How our work at the NHS inspires our NHS people and how we support their growth and passion. Section's cover:
– bringing your whole self to work
– life balance
– purpose, potential and recognition

Physical work spaces and the facilities available for our people to rest, recover and succeed

How our leaders and managers across all levels of the NHS provide health and wellbeing support as part of their role. Section's cover:
– senior manager responsibilities
– healthy leadership behaviours
– skilled managers

CREATING HEALTH AND WELLBEING CULTURE

- Improving personal health and wellbeing
- Professional wellbeing support
- Relationships
- Data insights
- Fulfilment at work
- Environment
- Managers and leaders

Our people, our patients

- Plans are being put in place to deliver our Moral Distress support session, initially to 3 identified teams. From this we will be able to identify any themes coming from teams and review appropriate support for our teams.

3. New Ways of Working and Delivering Care

- The Medical Directors and Heads of Medical workforce across the SEND Network have met to discuss and agree a consistent approach to the BMA local agreements for SAS doctors transferring to the new National 2021 SAS Contract. A joint agreement has been reached across the SEND network that will now be negotiated at individual Trust JLNCs.
- SEND Medical Directors have requested this approach is used to address future issues which impact medical staffing across Devon to allow equitable and consistency agreements. Heads of Medical Workforce will consider how this approach maybe used in the future.
- Medical Workforce continue to support the Medical Director on reviewing payment for additional clinical work undertaken by medics, with one approach being to align Torbay with RD&E rates to provide equity with cross working. Further financial modelling is now required due to UHP and RD&E recently increasing their payments for this work.
- Medical Workforce are taking the lead in the ICS for a medical recruitment campaign; an agreement has been made to fund two key projects. The first project is a 6-month contract with Liaison Workforce for a new digital marketing support programme for the Southwest Peninsula NHS Bank, which went live on the 1st November. The second project is to create a medical recruitment landing page to advertise all of the medical vacancies in Devon as well as provide vital information about relocating to Devon.
- The ICS is leading on developing an ICS approach to workforce planning which will align to the awaited ICS Workforce Strategy.
- The interim workforce plan for H2 has been submitted to the ICS ready for the national submission on 16 November 2021. The submission includes the additional WTE required as a result of ERF and TIF funding.
- Discussions are underway with BBF to further develop the workforce planning process and associated tools to support the development of workforce plans for 2022-25 which also provide the information required for BBF. This work continues to be supported by the People Business Partners, working with the ISUs.
- Work is underway to achieve greater alignment between finance and ESR data to ensure consistency and therefore providing 'one version of the truth'.
- Work in ongoing to develop career pathways, initially within the nursing profession. A staff council for Professional Practice is being established which will also support this work.

4. Belonging

- In response to the year on year increase in bullying and harassment reported through the staff survey and subsequently through the WRES and WDES it is clear that a different response is required to address this. When seeking to understand with the specific experiences of our people in and beyond our Equality and Diversity networks it is apparent that we need to build a framework of education starting with mandatory training. This month has seen the first draft of developing a contextualised and meaningful mandatory training package using digital technologies to enhance and bring to life our individual contributions to the experiences of others. It is the intention that this product will be available for use in February 2022.
- In addition, to support the shift from a re-active response to a proactive approach when addressing conflict and relationship issues in the workplace, a further cohort of potential 11 mediators are attending training this week.

5. Creating the Conditions to Enable Transformation

- Just and Learning culture – more mediators are being trained in November which will bring the total from 4 to 11. The Disciplinary policy and Achievement Review are in the process of ratification.
- Increasing Skills and Confidence in Improvement - Quality Improvement Group reviewed the 'Building Capability Framework and Improvement and Innovation Prospectus' document, shared for feedback. QI Hub - Design Council met to discuss/design the Hub, collated feedback of what was wanted from a Hub. Creating 'Our ICO Way', our own approach to Transformation. A large amount of work will come from our Drum Beat meetings and will need trained people to deliver it – resource still an issue. Supporting Design Leaders in QI. Re-launching 4 Day QI programme.
- Cultural Framework and Manager's Essentials - IManage launch on HIVE is currently scheduled for December. Resource limitations impacting on ability to populate more than the 12 prioritised modules before December. Currently circa 75% complete to date.

Workforce – KPI's (New Ways of Working - Growing for the Future)

Indicator	Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Performance
Month Sickness %	4%	4.33%	4.27%	4.20%	4.14%	4.04%	3.98%	4.12%	4.63%	4.75%	5.06%	5.41%	5.82%	
Mental Health Days % of Sickness	N/A	32.42%	35.08%	30.45%	35.10%	33.97%	33.29%	32.03%	32.37%	35.70%	37.03%	33.84%	33.44%	
12 Mth Rolling Sickness %	4%	4.92%	4.10%	4.11%	3.92%	3.78%	3.57%	3.98%	4.04%	4.13%	4.24%	4.36%	4.50%	
Achievement Rate %	90%	78.88%	80.38%	78.78%	78.45%	82.37%	85.95%	86.61%	84.73%	81.26%	80.56%	79.69%	77.86%	
Labour Turnover Rate	10-14%	10.67%	10.48%	10.17%	10.18%	10.00%	10.83%	11.03%	11.28%	10.95%	11.73%	11.32%	11.57%	
Overall Training %	85%	89.56%	89.62%	89.75%	89.51%	89.58%	90.06%	90.10%	90.51%	89.53%	89.36%	88.95%	89.02%	
FTE Vacancy	N/A	253	230	228	178	151	183	196	183	257	117	208	tbc	
Vacancy Factor	<10%	4.05%	3.88%	3.83%	2.99%	2.53%	3.06%	3.28%	3.05%	4.25%	1.93%	3.41%	tbc	
Monthly Agency Spend	£511K	£662	£741	£667	£572	£1,053	£756	£827	£1,096	£1,284	£1,090	£1,090	£1,231	
Nuring Staff Average % Day Fill Rate- Nurses		90%	90%	90%	86%	83%	89%	92%	87%	90%	87%	82%	86%	
Nuring Staff Average % Night Fill Rate- Nurses		85%	89%	89%	88%	85%	90%	90%	89%	93%	88%	75%	81%	
Safer Staffing- Overal CHPPD		8.53	8.90	8.52	8.46	8.39	8.39	8.08	7.71	7.73	7.75	7.55	7.56	

Workforce – WTE (New Ways of Working - Growing for the Future)

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

NHSI Staff Group	2021/03	2021/04	2021/05	2021/06	2021/07	2021/08	2021/09	2021/10	Change since March 2021	% Change
Allied Health Professionals	524.97	527.08	528.95	524.64	519.16	524.63	538.34	536.58	11.61	2.21%
Health Care Scientists	94.17	95.17	93.71	93.71	93.71	94.39	92.69	92.70	-1.47	-1.56%
Medical and Dental	531.34	527.82	524.87	527.65	556.82	557.43	561.16	561.56	30.22	5.69%
NHS Infrastructure Support	1122.74	1120.22	1121.66	1126.62	1123.82	1121.33	1122.71	1124.58	1.84	0.16%
Other Scientific, Therapeutic and Technical Staff	341.40	342.77	343.99	341.63	348.60	346.41	345.03	346.02	4.62	1.35%
Qualified Ambulance Service Staff	10.72	9.52	9.52	9.33	10.33	10.53	10.53	10.53	-0.19	-1.74%
Registered Nursing, Midwifery and HV staff	1241.94	1237.33	1239.03	1237.77	1248.15	1254.04	1267.34	1266.85	24.91	2.01%
Support to clinical staff	1906.40	1880.31	1889.59	1902.13	1898.32	1901.54	1904.65	1899.35	-7.04	-0.37%
Grand Total	5773.68	5740.22	5751.33	5763.49	5798.91	5810.30	5842.46	5838.17	64.50	1.12%

Pay Report Summary for the final 3 months of 2020-21 and YTD 2021-2022

Cost	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT
	£	£	£	£	£	£	£	£	£	£
Substantive	£24,645,064	£21,483,866	£31,299,992	£21,340,031	£21,422,432	£21,269,748	£21,100,577	£21,485,466	£25,412,838	£22,212,036
Bank	£1,052,959	£1,074,886	£1,253,501	£1,058,626	£1,040,420	£991,252	£1,098,843	£997,363	£1,177,818	£1,105,903
Agency	£666,436	£572,475	£1,053,038	£755,150	£827,832	£1,095,792	£1,284,092	£1,090,236	£1,191,740	£1,231,573
Total Cost £	£26,364,459	£23,131,226	£33,606,531	£23,153,807	£23,290,684	£23,356,792	£23,483,512	£23,573,065	£27,782,396	£24,549,512
WTE Worked	WTE	WTE	WTE	WTE	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	5,750.55	5,848.93	5,887.22	5,868.32
Bank	248.71	331.21	301.34	328.09	269.23	317.11	336.05	247.74	313.21	272.84
Agency	116.38	102.39	160.15	115.40	116.45	161.63	151.10	143.60	174.75	174.59
Total Worked WTE	6,076.21	6,249.88	6,305.86	6,281.92	6,142.94	6,240.99	6,237.70	6,240.27	6,375.18	6,315.75

All the key staff groups are starting to see increased staff in post FTE based on the increased investment in clinical staffing groups. N&M increasing by 25 FTE and Medical and Dental by 30 FTE since March.

The increased Agency costs are a consequence of increased Consultant usage in October however the overall Agency FTE usage is similar to the September figure. Bank costs and FTE usage are both reduced from the September figures with a reduction of 37 FTE usage in support staff being the significant change.

Workforce – Agency (New Ways of Working - Growing for the Future)

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.

October showed another significant increase in agency and the total being the second highest of this financial year to date.

The negative agency spend against health care assistants is due to finance corrections against forecasted usage.

The Trust plan will be submitted to NHSE/I on 25th November and the plan variance information will be included in M8 report.

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	Jul	Aug	Sep	Oct	Total
Registered Nurses	310	289	316	3012	356	348	468	584	520	599	557	3432
Scientific, Therapeutic and Technical	12	14	32	504	43	99	142	122	110	112	162	790
of which Allied Health Professionals	6	1	25	336	31	45	63	58	65	47	65	374
of which Other Scientific, Therapeutic and Technical Staff	6	13	7	168	12	54	79	64	45	65	96	415
Support to clinical staff (HCA)	31	56	45	214	-1	-10	-3	7	-8	2	15	2
Total Non-Medical - Clinical Staff Agency	353	359	393	3730	398	437	607	713	622	713	734	4224
Medical and Dental Agency	193	47	442	2704	243	262	353	455	328	317	322	2281
Consultants	178	141	310	1961	213	203	281	344	178	171	212	1603
Trainee Grades	15	-94	132	743	30	59	72	111	150	146	110	678
Non Medical - Non-Clinical Staff Agency	121	166	218	1196	114	128	136	116	140	162	174	970
Total Pay Bill Agency and Contract	667	572	1053	7630	755	827	1096	1284	1090	1192	1231	7476

Ward	Day RN / RM Total Monthly Planned hours	Day RN / RM Total Monthly Actual hours	Day Nursing Associates Total Monthly Planned hours	Day Nursing Associates Total Monthly Actual hours	Day Care Staff Total Monthly Planned hours	Day Care Staff Total Monthly Actual hours	Night RN / RM Total Monthly Planned hours	Night RN / RM Total Monthly Actual hours	Night Nursing Associates Total Monthly Planned hours	Night Nursing Associates Total Monthly Actual hours	Night Care Staff Total Monthly Planned hours	Night Care Staff Total Monthly Actual hours	Total Patients	Day Average fill rate - registered nurses/midwives (%)	Day Average fill rate - nursing associates (%)	Day Average fill rate - care staff (%)	Night Average fill rate - registered nurses/midwives (%)	Night Average fill rate - nursing associates (%)	Night Average fill rate - care staff (%)
Ainslie	1783	1226	0	0	1783	2016	1426	999	0	0	1070	1173	787	68.8%	0.0%	113.1%	70.1%	0.0%	109.7%
Allerton	2895	1593	0	0	1070	2003	1426	1070	0	0	1070	1198	892	55.0%	0.0%	187.3%	75.0%	0.0%	112.0%
Cheetham Hill	1426	1824	357	0	2139	2469	1070	1139	0	0	1426	2011	838	127.9%	0.0%	115.4%	106.5%	0.0%	141.0%
Coronary Care	1426	1528	0	0	0	8	1070	1046	0	0	0	12	401	107.1%	0.0%	0.0%	97.8%	0.0%	0.0%
Cromie	1668	1390	0	0	891	1092	1070	1082	0	0	713	720	726	83.4%	0.0%	122.5%	101.2%	0.0%	101.0%
Dunlop	1426	1231	0	0	1248	1542	1070	725	0	0	1070	1024	694	86.3%	0.0%	123.6%	67.7%	0.0%	95.7%
Forrest - Summer Escalation	1783	1479	713	0	1426	1198	1783	1523	713	0	1426	923	777	82.9%	0.0%	84.0%	85.4%	0.0%	64.7%
EAU4	1783	1386	0	0	1426	632	1783	1265	0	0	1426	574	510	77.7%	0.0%	44.3%	71.0%	0.0%	40.2%
Ella Rowcroft	1070	946	0	0	1426	981	1012	794	0	0	713	598	331	88.5%	0.0%	68.8%	78.4%	0.0%	83.9%
Warrington	1070	1016	0	0	713	1219	713	713	0	0	713	828	513	95.0%	0.0%	170.9%	100.0%	0.0%	116.1%
George Earle	1426	1769	357	0	2139	2166	1070	1070	0	0	1426	1897	778	124.1%	0.0%	101.2%	100.0%	0.0%	133.0%
ICU	3565	2423	0	0	0	391	3209	2323	0	0	0	0	156	68.0%	0.0%	0.0%	72.4%	0.0%	0.0%
Louisa Cary	2139	1702	0	0	713	976	2139	1530	0	0	713	725	524	79.6%	0.0%	136.9%	71.5%	0.0%	101.6%
John Macpherson	1070	1069	0	0	564	612	713	615	0	0	713	674	345	100.0%	0.0%	108.6%	86.2%	0.0%	94.5%
Midgley	1783	1605	0	0	1783	2178	1783	1218	0	0	1426	1418	882	90.0%	0.0%	122.2%	68.3%	0.0%	99.4%
SCBU	1070	1039	0	0	357	201	1070	794	0	0	357	299	218	97.1%	0.0%	56.2%	74.2%	0.0%	83.9%
Simpson	1426	1870	357	0	1783	2247	1070	1056	0	0	1070	1599	868	131.2%	0.0%	126.0%	98.7%	0.0%	149.5%
Turner	1070	1263	0	0	1783	1917	713	736	0	0	1426	1154	458	118.1%	0.0%	107.5%	103.2%	0.0%	80.9%
Total (Acute)	*29874*	*26358*	*1782.5*	*0*	*21241*	*23845*	*24185*	*19694*	*713*	*0*	*16756*	*16823*	*10698*	*88.2%*	*0.0%*	*112.3%*	*81.4%*	*0.0%*	*100.4%*
Brixham	868	759	434	0	1302	1461	1023	726	0	0	682	862	613	87.4%	0.0%	112.2%	71.0%	0.0%	126.3%
Dawlish	868	831	0	0	1085	1143	744	795	0	0	682	685	532	95.7%	0.0%	105.3%	106.8%	0.0%	100.4%
Newton Abbot - Teign Ward	1953	1265	0	0	1953	1841	1023	682	0	0	1023	1111	925	64.7%	0.0%	94.3%	66.7%	0.0%	108.6%
Newton Abbot - Templar Ward	1736	1177	0	0	2198	1927	1023	672	0	0	1116	1138	863	67.8%	0.0%	87.7%	65.7%	0.0%	102.0%
Totnes	868	764	0	0	1302	1241	744	683	0	0	682	709	539	88.0%	0.0%	95.3%	91.8%	0.0%	104.0%
Organisational Summary	36167	31152	2217	0	29081	31456	28742	23252	713	0	20941	21327	14170	86.1%	0.0%	108.2%	80.9%	0.0%	101.8%

- The Registered Nurse (RN) average fill rate for day has increased to 86.1 % for days from 81.9% and night has increased to 80.9% from 74.6%.
- The increased in fill rates is reflective of the increase in the international nurse recruitment of 15 nurses arriving in October and the increased fill rates from our temporary workforce team.
- Ainslie fill rate of 68.8% for RN days and 70.1% for nights is due to the challenges due to sickness, maternity and vacancies; there is an increase fill rate for health care assistants (HCA) in order to backfill and provide safe patient care. Fill rate for HCA's is 113.1% for days and 109.7% at night.
- Allerton fill rate of 55.5% for days and 75.0% for nights has increased since this month, due to sickness, maternity, and vacancies and the ward continues to backfill with HCA's. The HCA fill rate for days was 187.3% and 112% at nights. As well as backfilling the RN shifts some of the HCA shifts are the International nurses in training. Simpson ward have seen a higher than average RN fill rate during the day due to a patient with complex health needs requiring an RMN.
- Wards at Newton Abbot have recorded a reduced fill rate for RN's due to sickness and vacancies but staff have been redeployed throughout the hospital dependant upon patient needs.
- The vacancy position is reflective of the safer staffing uplift

Controls:
- Twice daily staffing meetings continue to be lead by the Matrons to ensure wards are risk assessed on every shift and staff redeployed appropriately to ensure safety across the Trust

Safer Staffing – Care hours per patient day (CHPPD) and planned versus actual
(New Ways of Working - Growing for the Future)

Ward	Planned Total CHPPD	Planned RN / RM CHPPD	Planned NA CHPPD	Planned HCA / MCA CHPPD	Actual Mean Monthly Total CHPPD	Actual Mean Monthly RN / RM CHPPD	Actual Mean Monthly NA CHPPD	Actual Mean Monthly HCA / MCA CHPPD	Total CHPPD days not met in month	RN / RM CHPPD days not met in month	NA CHPPD days not met in month	HCA/MCA CHPPD days not met in month	Total CHPPD % days not met in month	RN / RM CHPPD % days not met in month	NA CHPPD % days not met in month	HCA/MCA CHPPD % days not met in month	Carter Median CHPPD All (September 2016)	Carter Median CHPPD RN (September 2016)	Carter Median CHPPD NA (September 2016)	Carter Median CHPPD HCA (September 2016)
Ainslie	7.52	3.98	0.00	3.54	6.90	2.80	0.00	4.10	27	31	0	4	87.1%	100.0%	0.0%	12.9%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	6.60	3.00	0.00	3.60	26	31	0	1	83.9%	100.0%	0.0%	3.2%	7.74	4.74	0	2.91
Cheetham Hill	7.39	2.88	0.41	4.11	8.90	3.50	0.00	5.30	1	2	31	2	3.2%	9.7%	100.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.50	6.40	0.00	0.00	2	2	0	0	6.5%	6.5%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.53	3.54	0.00	1.99	5.90	3.40	0.00	2.50	10	19	0	7	32.3%	61.3%	0.0%	22.6%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.50	2.80	0.00	3.70	12	25	0	4	38.7%	80.6%	0.0%	12.9%	7.74	4.74	0	2.91
Forrest - Summer Escalation	10.12	4.60	1.84	3.68	6.60	3.90	0.00	2.70	31	29	31	26	100.0%	93.5%	100.0%	83.9%	7.74	4.74	0	2.91
EAU4	7.96	4.42	0.00	3.54	7.60	5.20	0.00	2.40	18	5	0	28	58.1%	16.1%	0.0%	90.3%	7.74	4.74	0	2.91
Ella Rowcroft	6.57	3.29	0.00	3.29	10.00	5.30	0.00	4.80	1	1	0	2	3.2%	3.2%	0.0%	6.5%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	7.40	3.40	0.00	4.00	4	9	0	1	12.9%	29.0%	0.0%	3.2%	7.74	4.74	0	2.91
George Earle	7.39	2.88	0.41	4.11	8.90	3.60	0.00	5.20	2	0	31	2	6.5%	0.0%	100.0%	6.5%	7.74	4.74	0	2.91
ICU	24.28	24.28	0.00	0.00	32.90	30.40	0.00	2.50	1	2	0	0	3.2%	6.5%	0.0%	0.0%	7.74	4.74	0	2.91
Louisa Cary	7.36	5.52	0.00	1.84	9.40	6.20	0.00	3.20	1	9	0	0	0.0%	29.0%	0.0%	0.0%	7.74	4.74	0	2.91
John Macpherson	5.18	2.88	0.00	2.30	8.60	4.90	0.00	3.70	0	1	0	1	0.0%	3.2%	0.0%	3.2%	7.74	4.74	0	2.91
Midgley	7.53	3.97	0.00	3.57	7.30	3.20	0.00	4.10	18	30	0	6	58.1%	96.8%	0.0%	19.4%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	10.70	8.40	0.00	2.30	10	10	0	15	32.3%	32.3%	0.0%	48.4%	7.74	4.74	0	2.91
Simpson	6.57	2.88	0.41	3.29	7.80	3.40	0.00	4.40	1	3	31	0	3.2%	9.7%	100.0%	0.0%	7.74	4.74	0	2.91
Turner	10.73	3.83	0.00	6.90	11.10	4.40	0.00	6.70	11	6	0	17	35.5%	19.4%	0.0%	54.8%	7.74	4.74	0	2.91
Brixham	6.95	3.05	0.70	3.20	6.20	2.40	0.00	3.80	28	30	31	0	90.3%	96.8%	100.0%	0.0%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	6.50	3.10	0.00	3.40	18	19	0	22	58.1%	61.3%	0.0%	71.0%	7.74	4.74	0	2.91
NA - Teign Ward	6.40	3.20	0.00	3.20	5.30	2.10	0.00	3.20	31	31	0	17	100.0%	100.0%	0.0%	54.8%	7.74	4.74	0	2.91
NA - Templar Ward	6.50	2.97	0.00	3.53	5.70	2.10	0.00	3.60	28	30	0	13	90.3%	96.8%	0.0%	41.9%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	6.30	2.70	0.00	3.60	18	22	0	8	58.1%	71.0%	0.0%	25.8%	7.74	4.74	0	2.91

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
	7.40	4.07	0.18	3.14	7.56	3.84	0.00	3.72
Total Planned Beds / Day	514							
Days in month	31							

- October 21 the overall CHPPD for Registered Nurse and HCA combined is 7.56 which is a slight increase from last month's combined CHPPD of 7.45 and the Carter median.
- The Trust has continued to see a high demand for acute and emergency services and have declared OPEL 4 during this month hence the total number of care hours required being above the planned in some areas.
- Of the ward areas above, 52% were resourced above the planned total care hours due to additional demand driven by increased care needs and the opening of escalation areas/beds. This increase in staffing requirements is achieved through the use of bank and agency staffing.
- Operationally, the continued need for unfunded beds ultimately reduces the overall CHPPD as nursing teams provide care to more patients.
- The committee should note the uplift to nurse staffing has now been built into the roster templates and therefore a gap has emerged with planned and actual CHPPD in some areas. Targeted recruitment work is currently underway to address this gap.
- Where there are days when the CHPPD is not met the staffing risk framework is enacted at the twice daily Matron staffing meeting to ensure staff deployment is safe and effective and patients care needs are met.

Community and Social Care Quadrant

🟢 Achieved

Carers Assessments Completed year to date

Safeguarding Adults - % of high risk concerns where immediate action was taken

Intermediate Care - No. urgent referrals

Percentage of Adults with learning disabilities in settled accommodation (ASCOF)

Proportion of carers receiving self-directed support (ASCOF)

Proportion of clients receiving self-directed support (ASCOF)

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

🟡 Under Achieved

Percentage of Adults with learning disabilities in employment (ASCOF)

🔴 Not Achieved

Proportion of clients receiving direct payments (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)

Number of Delayed Discharges (Community)
- national return suspended

Number of Delayed Transfer of Care (Acute)
- national return suspended

Data not currently available

Percentage of reablement episodes not followed by long term SC support (ASCOF)

Under 65 Mental Health Residential Review
The team is continuing to successfully address the issue of over use of residential placements. An example of improving independence has been demonstrated over the last month as an individual has moved from a 6-year residential placement to a supported living arrangement.

Adult Social Care Improvement Plan was presented to Torbay Council's Overview and Scrutiny Committee on 13 October. Steve Honeywill, Torbay Council - Head of Commissioning, and Steve Holman , TSDFT - Associate Director of ASC Operations for Torbay presented on the following topics:
- To review the effectiveness of the Adult Social Care Improvement Plan to ensure that the changes underway are being delivered as proposed and are meeting the needs of Torbay's residents.
- To track patients from discharge from hospital to the care they receive in the community to ensure that it is fit for purpose

Current savings: In Year 1 (2021/22) current savings are £1.7m, 86% of the year 1 target.

Social Care and Public Health performance metrics - Torbay

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

Social Care Performance Report

2021/22 Performance Scorecard to 31 October 2021

Torbay Social Care KPIs	2021/22 full year target	2021/22 YTD target	Outturn YTD	Comment
% clients receiving self-directed support	94%	94%	100.0%	On target.
% clients receiving direct payments	28%	28%	19.4%	Not meeting target (317 / 1638). 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	17.7	A low outturn signifies better performance. Not meeting target (13 admissions compared to target of 10)
Permanent admissions (65+) to care homes per 100k population (BCF) (rolling 12 month)	450.0	450.0	422.7	A low outturn signifies better performance. On target.
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. Resolution in progress.
% carers receiving self directed support	85%	85%	100.0%	On target.
% Adults with learning disabilities in paid employment	7.0%	7.0%	6.8%	Not meeting target (32 / 470).
% Adults with learning disabilities in settled accommodation	80%	80%	80.6%	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	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Year to date 2021/22
PUBLIC HEALTH SERVICES															
% of face to face new birth visits within 14 days *	95.0%		95.7%	88.7%	88.0%	90.0%	80.2%	91.9%	92.5%	86.6%	80.4%	74.4%	81.0%	72.9%	82.0%	81.0%
Children with a child protection plan *			214	221	223	223	207	223	234							234
4 week smoking quitters (Quarterly) **	200				199			334			117					117
Opiate users - % successful completions of treatment (Quarterly) **	Var				4.4%			3.7%			4.3%					4.3%

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	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Year to date 2021/22
COMMUNITY BASED SERVICES																
Nursing activity (F2F)			7,819	7,858	7,697	7,165	7,031	8,064	7,608	7,431	7,771	7,615	7,080	7,611	7,295	52,411
Therapy activity	65,415		3,609	2,708	2,638	2,783	3,016	3,593	3,756	3,338	3,492	3,226	4,014	4,236	3,762	25,824
No. intermediate care urgent referrals	0		200	207	235	175	146	155	165	155	129	158	191	241	219	1,258
No. intermediate care placements			11	20	19	13	14	42	39	39	39	41	46	30	35	269
Intermediate Care - placement average LoS			16.8	28.8	28.7	37.4	34.1	21.0	27.6	17.8	25.6	28.3	23.9	30.1	23.6	25.5

The Community Hospital Dashboard should be reviewed in the context of the significant changes in services and service demand from the COVID-19 response. The ICO model of care seeks to optimise use of intermediate care referrals and placements as an alternative to attendance to emergency departments and assessments and reduce the length of stay in hospital.

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

	Act. 20/21 Outturn	Aug-21	Sep-21	Oct-21	Total
Admissions / Discharges					
Total Admissions (General)	2,677	201	196	213	1,594
Direct Admissions (General)	186	13	7	19	97
Transfer Admissions (General)	2,491	188	189	194	1,497
Stroke Admissions	220	17	19	17	146
Transfers from CH to DGH	179	22	21	20	181
Beds					
Bed Occupancy [1]	84.5%	98.5%	98.8%	97.6%	97.3%
Bed Days Lost to Bed Closure	244	0	2	9	21
Length of Stay					
Delayed Discharges		30	60	59	230
Average Length of Stay - Overall (General)	10.4	11.9	12.7	14.1	12.4
Average Length of Stay - Direct Admissions	8	8.8	9.4	11.2	9.4
Average Length of Stay - Transfer Admissions	10.5	12.1	13.0	14.3	12.6
Average Length of Stay - Stroke	14.4	19.8	22.2	24.1	19.9
Long LoS (>30 days)	246	16	21	26	104
MIUs					
Total MIU Activity	22,487	3,505	3,162	2,859	22,070
New MIU Attendances	20,310	3,218	2,885	2,587	20,174
All Follow Up Attendances	2,177	287	277	272	1,896
Planned Follow Up Attendances	1,650	185	190	195	1,353
Unplanned Follow Up Attendances	527	102	87	77	543
MIU Four Hour Breaches	1	3	8	0	13
Average Waiting Time (Mins) - 95th Pctile	43	77	92	95	71

Community Hospitals

Community hospital admissions have risen above pre-covid levels. Bed occupancy remains high at 97.6%.

Average length of stay has risen to 14.1 days compared with the 13.1 days pre covid in 2019/20. Discharges from community hospitals continue to be impacted by the availability of domiciliary care and access to residential nursing home beds.

Minor Injury Unit activity records 2,859 attendances in October with zero four-hour breaches and an increase in average waiting time to 95 minutes.

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.

7.01 Integrated Performance Report Month 7 October 2021.pdf

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. 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.

Hours of care given

Domiciliary Hours by Week (Health & Social Care)
Updated to w/c 04/10/21

1) Standard domiciliary care delivered and outstanding:
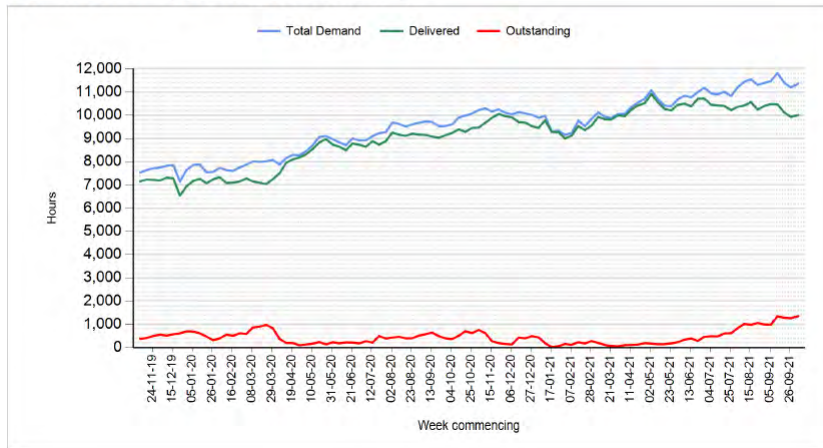
Unmet packages of care

The chart 'Hours of care given' shows the latest data available for total commissioned domiciliary hours by week for Torbay. The Chart "Unmet packages of care" shows the number of unmet packages of care for South Devon (orange) and Torbay (Green) and where provided by diverting other NHS community provision (Blue) . The increase in unfilled packages of care since June is one of the key factors in the increased number of patients having discharge delays once medically fit for discharge. Across the sector there are significant workforce recruitment and retention challenges so increasing capacity is very difficult at this time. However, increasing the capacity in the domestic care sector will be critical if we are to support the flow of patients from an acute setting where a new or changed package of care is needed.

Criteria To Reside

The criteria to reside tool was developed in March 2020 with the Academy of Medical Royal Colleges and has since been reviewed with the collaboration of the British Geriatric Society. The tool equips clinical teams to have discussions and make decisions whether a person needs to stay in an acute bed to receive care, a 'Criteria to Reside'. This should then lead to a plan concerning the resources and services required to support a safe and timely discharge of that person if they no longer need the support and services of an acute hospital.

The Trust records a patient's Criteria to Reside daily. The Graph below is for whole ICO bed base acute and community hospital beds:

No Criteria to Reside - patient daily average (weekday)

Month	Number of patients
Jul-21	45.4
Aug-21	57.8
Sep-21	55.6
Oct-21	61.7
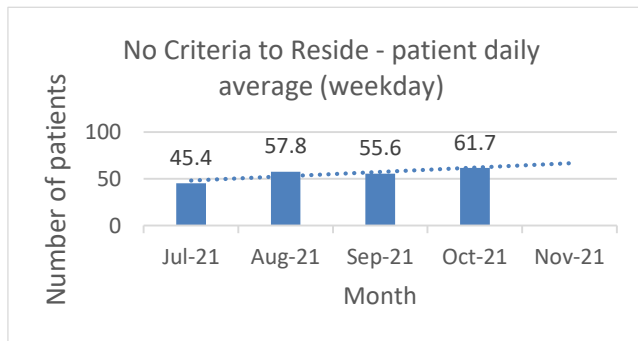
The average number of patients with no criteria to reside is increasing. There is a strong correlation to the increase in unfilled packages of care.

The graphs opposite show the split of patient per day by discharge pathway; there is a recent increase in the number of patients on more complex discharge pathways.

Pathway 0 = Simple discharge - no additional support
Pathway 1 = Home / usual residence with support
Pathway 2 = Short term placement - rehab/reablement in a temporary bedded setting
Pathway 3 = Long term placement - complex support package / long term placement

Pathway 0 (simple discharge) - Total — Best week

Pathway 1 (Home with Support) - Total

Pathway 2 (Short Term Placement) - Total

Pathway 3 (Long Term Placement) - Total
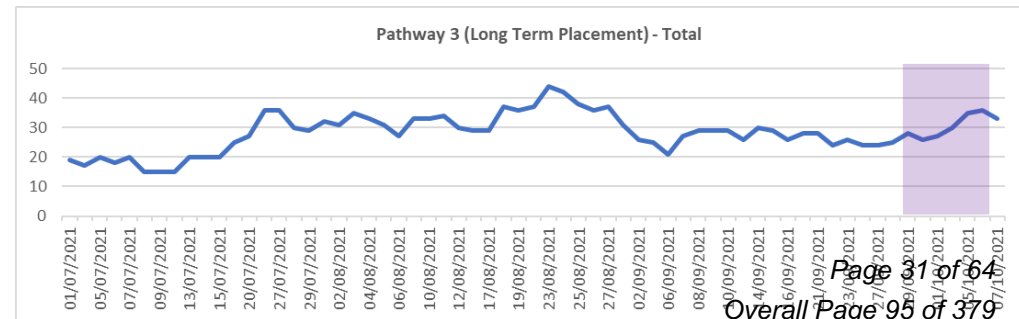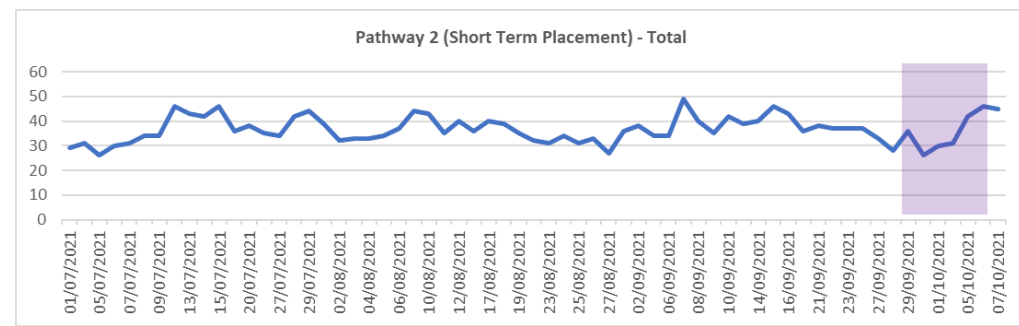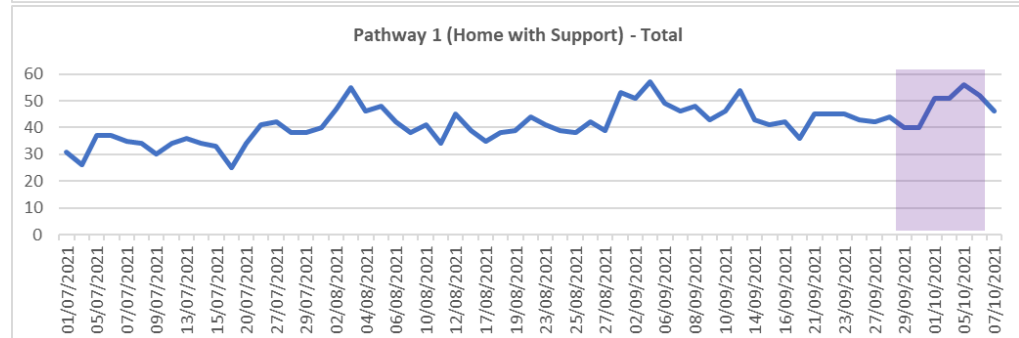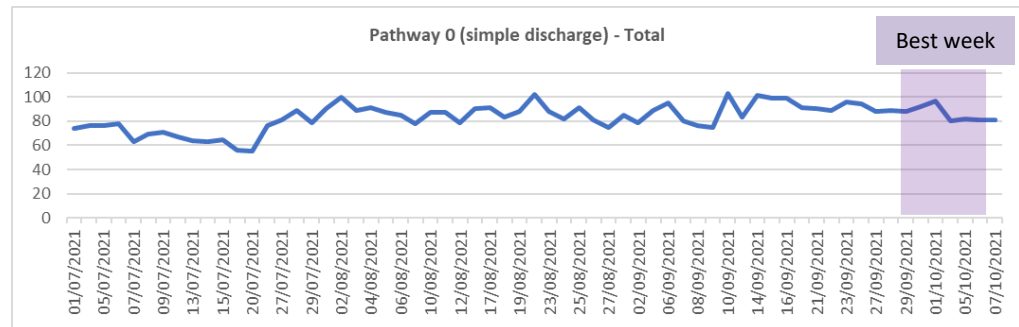
Operational performance summary: Chief Operating Officer

Covid: The Trust continues to care for a number of Covid patients averaging 17 to 20 daily in hospital beds in October; with up to 3 patients being cared for in the intensive care unit. Current trajectories show the number of covid patients in hospital staying within the existing covid ward bed capacity without further escalation, this is under continuous review.

Accident and Emergency: Demand for urgent and emergency services with ongoing high bed occupancy and delays to ambulance handover continues to be a challenge. Access to inpatient beds remains the primary contribution to the length of time patients are spending in the Emergency Department. In October there were 753 people who spent 12-hours or more in the Emergency Department with ambulance handover delays remaining high with over 125 patients experiencing over an hour delay once arriving to the Emergency Department .

People waiting for care: The number of patients waiting over 18-weeks, 52-weeks, and 104-weeks for treatment continues to increase. Based on activity plans the overall forecast is not showing any reduction in waiting times in the short term. Capacity within the independent sector remains important in supporting delivery of routine elective care for orthopaedics, upper GI, urology, and gynae along with insourcing capacity at weekends for Endoscopy and Ophthalmology day cases. Patient initiated follow up (PIFU) and video/telephone appointments will release capacity to reduce the waiting time for some patients. Recovery plans, specific to delivery of cancer targets, are focusing across the three most challenged areas of Dermatology (2-week-wait), Urology, and Lower GI pathways and are being escalated with executive oversight. In January 2022 the Trust will begin accessing capacity at the Nightingale Hospital Exeter for orthopaedic day case and will support the reduction of longest waits over 104 weeks.

The ongoing need to escalate bed capacity to maintain patient flow continues to see the Day Surgery Unit re-designated as the Medical Receiving Unit to allow Forrest ward (25 beds) to be opened as general acute medical inpatient beds. This has restricted the capacity for planned elective surgery with elective admission prioritising cancer treatments and the most urgent patients. Routine elective orthopaedic surgery has continued having restarted during the September Best Week releasing the orthopaedic ward to focus on elective care.

Cancer care: An increase in referrals and reduction in capacity for certain specialties has led to a deterioration in the cancer 2-week-wait at 50.5% and the lowest performance for 13 months. Meeting the 28-day cancer diagnosis target has also been a challenge with the second month of decreasing performance.

Diagnostic waiting times: for Endoscopy, CT, and MRI remain a risk to the timely treatment of cancer and urgent patients. The use of a mobile scanner, insourcing at weekends, and the use of the Nightingale Hospital facilities will increase capacity over the coming months.

Patients in hospital: There remains a number of staffing challenges for the independent sector providers to support timely discharge from hospital. In October the number of long lengths of stay 21- day and 7-day length of stay patients has remained significantly higher than normal levels with an average of 44 patients over 21 days in hospital compared to 17 last October. To date November has seen a moderate improvement in these long lengths of stay. There remains a significant number of patients who are medically fit with no 'criteria to reside' and require ongoing support and care in community settings. It is noted that there is a relative shift in the proportion of patients in hospital requiring additional care needs on discharge as measured through the discharge pathways being recorded and reflects the acuity of patients coming in to hospital. With a significant number of discharges being delayed this remains one of the most significant challenges to patient flow and patient experience.

Community and social care: The levels of unfilled packages of care has continued to increase. Urgent care team capacity continues to be diverted to ensure packages of care for the most at risk patients are maintained. Staffing across many community teams are below desired levels. Some impact from the vaccination status ruling for staff working in care homes has been felt across the system with some staff transferring to Dom care – it is noted that in April the same rules will apply to domiciliary care, voluntary sector, and front line NHS staff.

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 - Two week wait from referral to date 1st seen - symptomatic breast patients
Clinic letters timeliness - % specialties within 4 working days
Cancer - 31-day wait for second or subsequent treatment – Surgery
A&E - patients recorded as > 60 min corridor care
Number of Clostridium Difficile cases reported

🟡 Under Achieved
Cancelled patients not treated within 28 days of cancellation
Cancer - Patient waiting longer than 104 days from 2 week wait

⚫ No target set

🔴 Not Achieved
Cancer - Two week wait from referral to date 1st seen
A&E - patients seen within 4 hours (NHSI)
Ambulance handover delays > 30 minutes
Ambulance handover delays > 60 minutes
Cancer - 28 day faster diagnosis standard
Cancer - 62-day wait for first treatment - 2ww referral (NHSI)
Cancer – 62-day wait for first treatment – screening
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 – Weekend
Care Planning Summaries % completed within 24 hours of discharge – Weekday
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)
Number of extended stay patients >21 days (daily average)
Number of patients >7 days LoS (daily average)
On the day cancellations for elective operations

Covid - Hospitalisations

Devon ICS
(as at 10 November 2021)
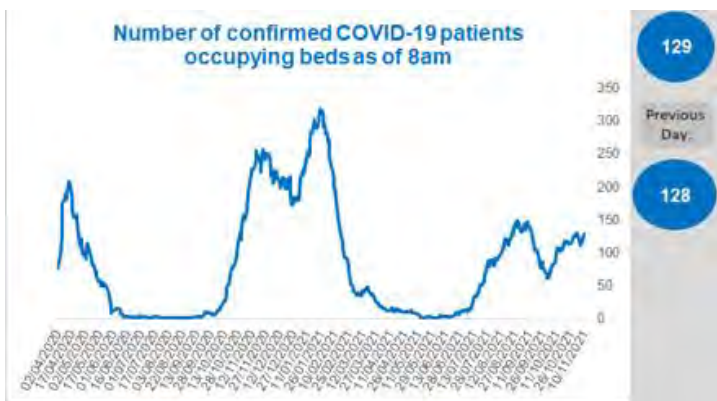
Torbay and South Devon NHS FT
(as at 10 November 2021)
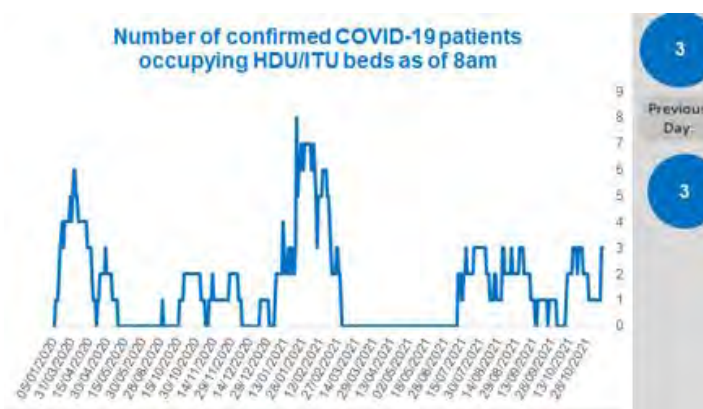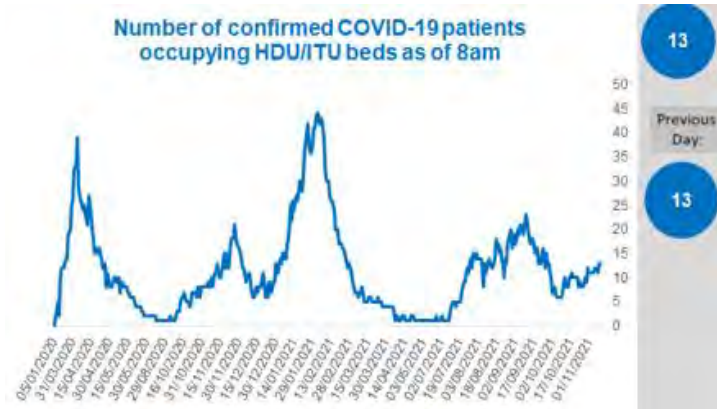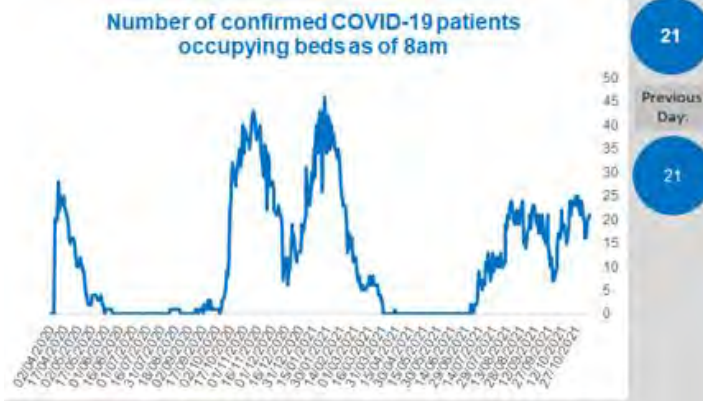
Latest modelling: hospitalisations are more closely aligned to the best case scenario. This remains steady for the time being and modelling suggests covid hospitalisations are at the forecast peak and should begin to fall, however, will continue throughout the winter and under weekly review.

As winter approaches it is recognised that the normal winter virus and flu hospitalisations will start to increase. This will place further pressure on inpatient beds and challenges on patient flow.

To date infection, prevention, and control procedures remain robust with little or no cross-infection being reported.

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Patients seen within 4 hours in A&E	**Performance M7**	Demand for Urgent and Emergency service remains at a significant high level; access to inpatient beds continues to contribute to delays. Acuity of patients arriving remains high. All Trusts across the region are experiencing high levels of A&E demand. In October, 753 patients experiencing a 12-hour stay in the department comparing to 16 in October 2020. The length of stay on assessment units has also increased with patients routinely having to stay overnight in assessment areas and emergency department. Ambulance handover delays have increased impacting on emergency response times and quality of patient care	To improve access to beds the scaling back of elective inpatient programme and re-purposing of the Day Surgery Unit has continued. Winter plan initiatives include: 1.Additional senior decision-making roles (including GPs) to provide alternatives to admission. 2.Additional resource into the rapid response and intermediate care teams. 3. Increase in the provision of reablement support workers. Funding secured through the Transformation investment fund (TIF)	
	62.5%			
	Performance M6			
	65.1%			
	Target			
	95%			
	Risk level			
	HIGH			
Patients waiting longer that 18 weeks from Referral to Treatment	**Performance M7**	The total number of people waiting for treatment has increased by 352 from last month. 565 patients are waiting longer that 78 weeks and 117 patients waiting longer than 104 weeks. All over-52- week waits have been validated by the Performance Team. 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. A limited inpatient Orthopaedic programme continues, with long wait patients now being admitted. 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 Elective Recovery Fund funding.	
	56.95%			
	Performance M6			
	57.4%			
	Target			
	92%			
	Risk level			
	HIGH			

Activity variance vs 2019/20 baseline	M6	M7
Op new	-3.7%	-19.4%
OP Follow up	-6.0%	-19.1%
Day Case	-6.5%	-20.7%
Inpatient	-25.6%	-25.8%

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NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Cancer 62 day wait for 1st treatment from 2-week wait referral	**Performance M7**	Performance against the 62-day referral to treatment standard remains below target (85%) in October. Increasing backlogs for certain tests including prostate biopsies colonoscopy and Dermatology 2-week-wait initial consultations remains a concern and is delaying diagnosis and treatment on these pathways. Whilst urgent cancer pathways continue to be prioritised, the ongoing escalation to manage covid-19 and urgent care pressures is a risk to delivering procedures that require access to theatres and beds.	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. Dermatology 2-week-waits are improving due to additional locum sessions. There is a trial of GPs sending photographs of lesions to support timely access to treatment. Upper GI and Urology recovery plans are in progress and will be monitored through the Risk and Assurance Group.	
	70.5%			
	Performance M6			
	73.3%			
	Target			
	85%			
	Risk level			
	HIGH			
Diagnostic tests longer than 6 weeks	**Performance M7**	Diagnostic waiting times for Endoscopy CT and 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 Sickness, training, and recruitment remain critical factors in the current staffing pressures and to fully utilise fixed CT and MRI capacity. The removal of historical overtime incentives will limit the number of sessions offered as overtime	Using of insourcing and mobile scanner units continue to support in house capacity. Radiology (CT and MRI) are using capacity at the Nightingale hospital Exeter and this will increase in November. An increase in endoscopy insourcing lists from two to three weekends per month has been agreed. Proactive recruitment and training initiatives continue to support teams that are operating with vacancies to minimise locum and bank staff.	
	33.8%			
	Performance M6			
	32.6%			
	Target			
	1%			
	Risk level			
	HIGH			

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Dementia Find	Performance M7	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.	
	94.4%			
	Performance M6			
	92.7%			
	Target			
	90%			
	Risk level			
	LOW			

Services with greater than 100 patients waiting over 18 weeks

OCTOBER 2021 Incomplete 92% Table - National Specialty

Row Labels	Incomplete IPDC	Incomplete OP	Grand Total	%<18wk
	>126			
Vascular Surgery	35	96	285	54.04%
Pain Management	58	167	476	52.73%
Endocrinology		233	565	58.76%
Respiratory Medicine		384	1097	65.00%
Neurology	6	422	902	52.55%
Gynaecology	222	243	1632	71.51%
Gastroenterology	338	209	1918	71.48%
Colorectal Surgery	128	540	1316	49.24%
Dermatology	1	668	2184	69.37%
Cardiology	43	686	2280	68.03%
Paediatrics	9	762	1552	50.32%
Oral Surgery	258	553	1892	57.14%
Upper Gastrointestinal Surgery	453	432	1491	40.64%
ENT	184	772	2302	58.47%
Urology	348	1121	2604	43.59%
Trauma & Orthopaedics	1230	604	2805	34.62%
Ophthalmology	354	1546	4218	54.95%
Grand Total	3700	9984	31787	56.95%

Referral to Treatment – incomplete pathways

Legend: % seen within 4 hours — National target — Local trajectory
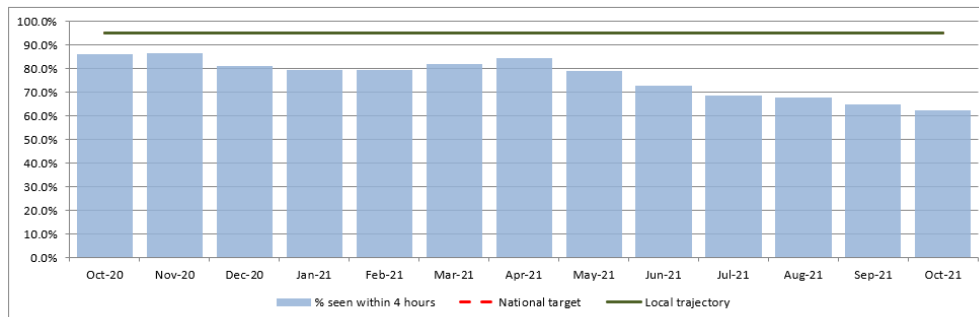
Referral to Treatment: RTT performance in October has deteriorated with the proportion of people waiting less than 18 weeks at 56.95%; this is behind the Operational Plan trajectory of 82% and national standard of 92%. We have continued to see an increase in the total number of incomplete pathways (waiting for treatment) to 31,787 from 31,435 an increase of 352 from the September position.

52 week waits: For October 2,093 people will be reported as waiting over 52 weeks and is an increase from 1,943, and is due to the change in referral numbers 12 months ago as the Trust came out of the first wave of Covid. Overall long waits are increasing, but patients waiting longer than 78 weeks have decreased to 565 in September from 641, with 104 weeks waits continuing to increase to 117 from 101 in September. The loss of elective activity from emergency pressures on beds continues to be seen. Teams are being asked to review plans to maximise every opportunity to return activity levels to pre-COVID levels.

Recovery planning: Teams are being asked to increase the utilisation of Mount Stuart Hospital capacity for T&O, UPGI, Urology, Colorectal and Gynae. Plans remain on track for 24 orthopaedic inpatient / day cases per month to be treated through the recommissioned Nightingale Hospital Exeter that will be coming online January 2022. Further insourcing and outsourcing capacity is being sought through the Elective Recovery Fund (ERF) application to invite insourcing companies to use theatres on site at weekends for Urology, Upper GI, and T&O as well as looking at options to bolster overall Anaesthetic provision.
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 the percentage of non-face-to-face delivered outpatients being below national and local peers.
A target to reduce the number of 104 week waits to zero has now been confirmed in the planning guidance, and meetings are now in place with the CCG and NHSE/I Region to monitor performance, all options are being considered by the CCG - including securing IS capacity out of area. The waiting time forecast however is showing that there will remain between 100 – 200 104 week waits on our lists at 31st March. 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).

NHSI Performance – Follow ups

The table below shows the specialties with the highest backlog for follow-up appointments. The number of overdue follow ups in the 6 - 12 category has decreased in October, but there have been increases in the 12-18 and 18 plus week categories with an increase in the overall total.

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 04.10.2021				Specialtities with highest Follow-Up Backlog Passed TBS as at 01.11.2021				Variance		
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +	Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	850	1302	5064	Ophthalmology	803	1299	5116	-47	-3	52
Rheumatology	227	416	1019	Rheumatology	264	423	1077	37	7	58
Ear Nose Throat	204	250	808	Ear Nose Throat	190	272	830	-14	22	22
Paediatrics	228	264	509	Paediatrics	280	259	481	52	-5	-28
Neurology	145	213	560	Neurology	120	209	634	-25	-4	74
Orthoptist	157	220	325	Orthoptist	138	221	352	-19	1	27
Urology	65	107	453	Urology	39	56	387	-26	-51	-66
Gynaecology	60	85	210	Gynaecology	62	76	229	2	-9	19
Respiratory Medicine (Chest)	55	79	184	Respiratory Medicine (Chest)	78	74	153	23	-5	-31
Orthodontics	42	48	258	Orthodontics	36	55	246	-6	7	-12
Colorectal Surgery	57	88	358	Colorectal Surgery	47	70	343	-10	-18	-15
Orthopaedics	58	53	143	Orthopaedics	66	68	129	8	15	-14
Dermatology	207	175	120	Dermatology	177	277	167	-30	102	47
Geriatric Medicine	23	42	143	Geriatric Medicine	13	34	120	-10	-8	-23
Cardiac Testing	73	34	10	Cardiac Testing	93	33	11	20	-1	1
Gastro-Enterology	162	196	79	Gastro-Enterology	135	219	115	-27	23	36
Breast Surgery	29	39	238	Breast Surgery	26	38	256	-3	-1	18
Cardiology	89	81	68	Cardiology	107	87	58	18	6	-10
Pain Management	78	62	45	Pain Management	46	91	47	-32	29	2
Oral Surgery	56	52	27	Oral Surgery	74	77	40	18	25	13
Plastic Surgery	32	46	62	Plastic Surgery	47	42	64	15	-4	2
Diabetic	56	43	20	Diabetic	42	60	37	-14	17	17
Upper Gastrointestinal Surg	19	25	73	Upper Gastrointestinal Surg	16	20	72	-3	-5	-1
Respiratory Technician	17	16	16	Respiratory Technician	26	15	90	9	-1	74
Endocrinology	31	23	1	Endocrinology	26	40	24	-5	17	23
Grand Total	3032	4053	10886	Grand Total	2979	4143	11109	-53	90	223

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

A&E and MIU patients seen within 4 hours

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Patients	6777	5844	6227	5436	5365	7118	7947	8802	9622	9536	9072	8738	8415
4 hour breaches	934	787	1171	1118	1103	1268	1238	1860	2636	2990	2935	3052	3155
% seen within 4 hours	86.2%	86.5%	81.2%	79.4%	79.4%	82.2%	84.4%	78.9%	72.6%	68.6%	67.6%	65.1%	62.5%
National 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%
Local trajectory	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%

Legend: % seen within 4 hours — National target — Local trajectory
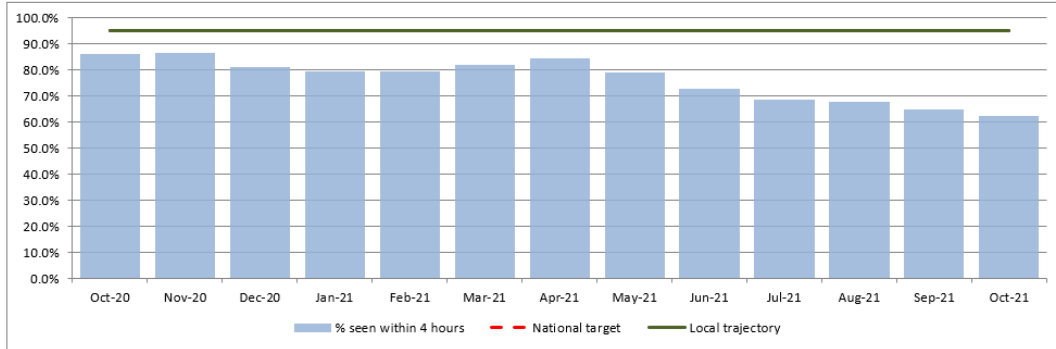
Performance 4 hour standard: Performance has deteriorated in October to 62.5%. Access to suitable inpatients beds has contributed to delays at peak times. The levels of escalation as recorded by the Daily OPEL score reflect the increased levels of escalation with 27 days at OPEL 4.

12 hour Trolley wait: 130 patients are reported as having a 12-hour trolley wait from decision to admit to admission to an inpatient bed.

Ambulance Handovers: 125 ambulance delays over 60 minutes; delays of over 30 minutes increased from 219 to 285.

Patients with a greater than 12-hour visit time pathway: 753 patients had a greater than 12-hour visit time.

Corridor Care: No patients recorded as receiving corridor care.

Operational delivery:

The Trusts level of escalation has remained high at OPEL 4 for the majority of the month and this is significantly higher than the previous year. This has caused increased delays in the ability to move patients that require admission out of the emergency department. The affect of these delays has increased both the waiting times of patients to be seen and the ability to offload ambulances.

Acuity of patients presenting to the emergency department continues to be high and the department continues to manage an escalation area for the covid positive patient pathway.

During these times safety remains the biggest priority and the Trust is continually monitoring the patients both in the department and waiting for treatment.

Escalation status

Opel status	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Opel 1	2	0	1	0	0	1	3	2	0	0	0	0	0
Opel 2	8	14	16	4	0	23	26	16	1	0	0	0	0
Opel 3	21	17	14	26	28	7	1	13	21	7	7	5	3
Opel 4	0	0	0	1	0	0	0	0	8	24	24	25	28
4-hour Performance (ICO)	86.2%	86.5%	81.2%	74%	79%	82%	84%	79%	73%	69%	69%	65%	62%
Bed Occupancy (Acute)	88%	85%	83%	89%	89%	85%	87%	92%	95%	95%	95%	94%	93%
Ambulance handover delays >1 hour	14	1	19	15	20	32	19	26	173	165	120	72	125
Dom Care - hours outstanding	620	150	490	58	174	51	189	235	467	613	994	1,261	1,357
No Criteria To Reside - daily average (weekday)										45	58	56	62

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Oct-20

Mo	Tu	We	Th	Fr	Sa	Su
				1	2	3	4
			2	2	1	1
5	6	7	8	9	10	11
3	3	3	3	2	2	2
12	13	14	15	16	17	18
2	2	2	3	3	3	3
19	20	21	22	23	24	25
3	3	3	3	3	3	3
26	27	28	29	30	31	
3	3	3	3	3	3	

Oct-21

Mo	Tu	We	Th	Fr	Sa	Su
				1	2	3
				4	4	4
4	5	6	7	8	9	10
4	4	4	4	4	4	4
11	12	13	14	15	16	17
4	4	4	4	4	4	4
18	19	20	21	22	23	24
4	4	4	4	4	3	3
25	26	27	28	29	30	31
4	4	4	4	4	4	3

Cancer treatment and cancer access standards

	2021											
	Q3								Q4			
	August				September				October			
target_type	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf
14 day - 2ww Referral	748.0	619.0	1,367.0	54.7%	856.0	675.0	1,531.0	55.9%	750.0	725.0	1,475.0	50.8%
14 day - Breast Symptomatic Referral	56.0	16.0	72.0	77.8%	73.0	6.0	79.0	92.4%	77.0	4.0	81.0	95.1%
28 day - Faster Diagnosis Standard	1,034.0	304.0	1,338.0	77.3%	880.0	557.0	1,437.0	61.2%	729.0	519.0	1,248.0	58.4%
31 day - 1st Treatment	167.0	2.0	169.0	98.8%	167.0	1.0	168.0	99.4%	158.0	3.0	161.0	98.1%
31 day - Subsequent Treatment - Drug	88.0	0.0	88.0	100.0%	93.0	0.0	93.0	100.0%	81.0	0.0	81.0	100.0%
31 day - Subsequent Treatment - Radiotherapy	52.0	2.0	54.0	96.3%	71.0	1.0	72.0	98.6%	60.0	1.0	61.0	98.4%
31 day - Subsequent Treatment - Surgery	36.0	1.0	37.0	97.3%	23.0	0.0	23.0	100.0%	19.0	0.0	19.0	100.0%
31 day - Subsequent Treatment - Other	19.0	0.0	19.0	100.0%	24.0	0.0	24.0	100.0%	15.0	0.0	15.0	100.0%
62 day - 2ww referral	75.0	26.0	101.0	74.3%	78.5	27.5	106.0	74.1%	72.0	29.5	101.5	70.9%
62 day - Screening Referral	12.0	1.0	13.0	92.3%	4.0	2.0	6.0	66.7%	7.0	1.0	8.0	87.5%
62 day - Consultant Upgrade					1.0	0.0	1.0	100.0%	0.0	2.0	2.0	0.0%

Cancer standards The table above shows the position for October 2021 (as at 12th November 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: 50.8% (unvalidated) is below the standard of 93%. We continue to see skin breaches increase from a loss of clinical capacity along with a continued high level of referrals back to or exceeding pre-covid levels. We are also seeing increased levels of Breast referrals 150-200% above normal levels which will impact in November. The most challenged pathways are Skin (6.0%) 410 breaches, Lower GI (58.0%) 120 breaches, H&N (54%) 70 breaches and Urology (52%) 56 breaches

28 days From Referral to Diagnosis: Performance in September is 58.6% (unvalidated) against the target of 75% and is the second consecutive month where we will not be compliant against this standard since September 2020 and reflects the impact of the high number of breaches for Skin (244) and LGI (137)

NHSI monitored Cancer 62 day standard: The 62-day referral to treatment standard continues to plateau in October at 70.2% against the target of 85% (unvalidated) with 72 patient being seen within 62 days, however, 30.5 patients falling outside the target time; Urology account for 12 breaches, Skin 6.5 breaches and LGI 6 breaches being (80%) of all breaches.

104-day wait: Currently there are 19 (unvalidated) patients with a greater than 104- day wait in October, 13 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 16 patients waiting longer than 104 days, 11 with confirmed cancers.

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.

The target required to meet Elective Recovery Fund (ERF) system gateway is to deliver a minimum of 25% non face-to- face outpatient appointments across new and follow ups in reported activity.
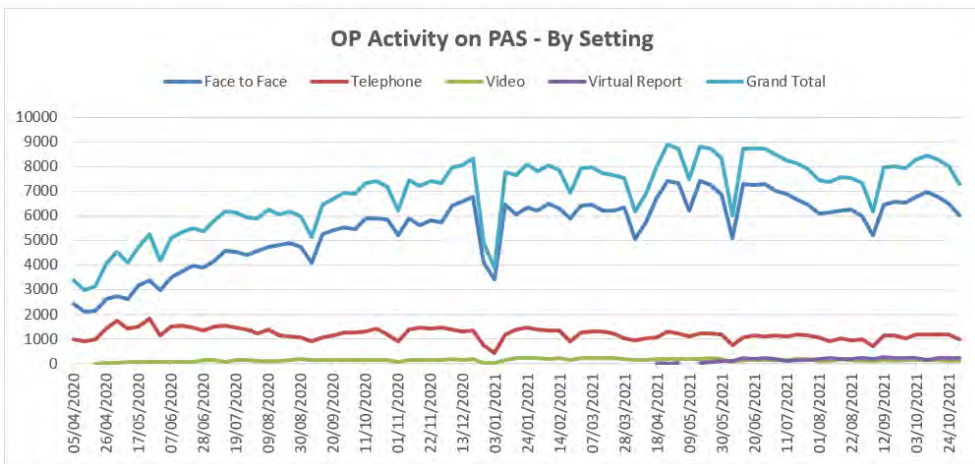
The actual performance for non face-to-face is:

	July	August	Sept	October
New	14%	15%	9%	14%
Follow Up	22%	21%	21%	21%
Combined	**20%**	**19%**	**18%**	**19.5%**

October performance is below the Nationally set aim of 25%. The programme of in-depth specialty reviews with clinical and operational teams is progressing. Opportunities are being identified as well as increased awareness of outpatient utilisation and productivity. A number of activities recorded on other systems (InfoFlex) are being identified where non-face-to-face clinical activity is captured and needs be reported in our national returns.

Actions

The following actions are being taken to improve Trust performance:
- Shared learning with North Devon services that are achieving higher non-face-to-face rates;
- Sharing good practice from one service to another wherever possible/appropriate;
- Providing service and clinic level performance reports highlighting where there are areas for improvement;
- Improving the functionality of the Patient Administration System (PAS) including mandatory fields to record if appointments are telephone/video/ or face-to-face and 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.
- Sharing Tableau reports with operational teams to review performance and forecasts.
- Programme of validation and data mapping required to ensure all activity is reported in national returns.

Numbers On CT Waiting List Over Time

- No. waiting 0-1 wks
- No. waiting 1-5 wks
- No. waiting 6-12 wks
- No. waiting 13+ weeks
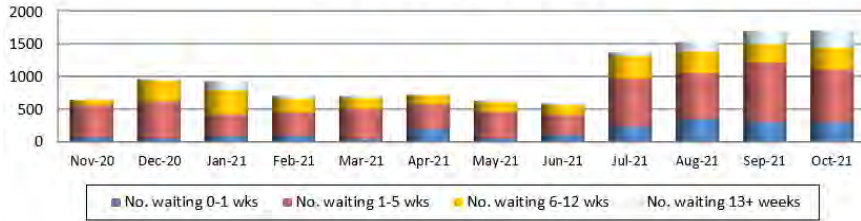
Numbers On MRI Waiting List Over Time

- No. waiting 0-1 wks
- No. waiting 1-5 wks
- No. waiting 6-12 wks
- No. waiting 13+ weeks
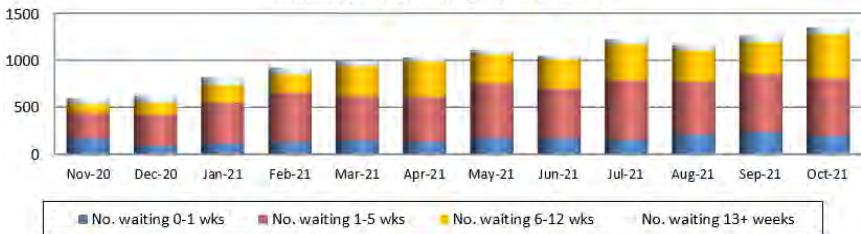
Numbers On Colonoscopy Waiting List Over Time
Includes Planned Patients Over Their To Be Seen Date from Nov 20

- No. waiting 0-1 wks
- No. waiting 1-5 wks
- No. waiting 6-12 wks
- No. waiting 13+ weeks
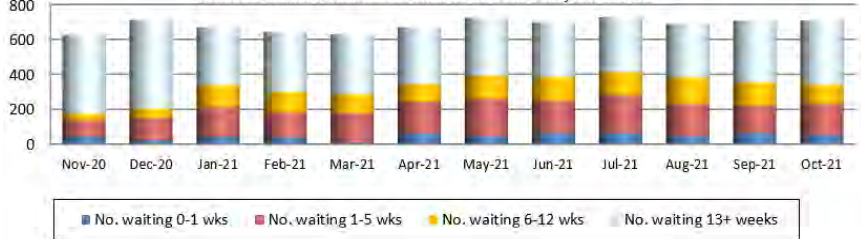
Numbers On Cardiology (Echocardiography) Waiting List Over Time

- No. waiting 0-1 wks
- No. waiting 1-5 wks
- No. waiting 6-12 wks
- No. waiting 13+ weeks
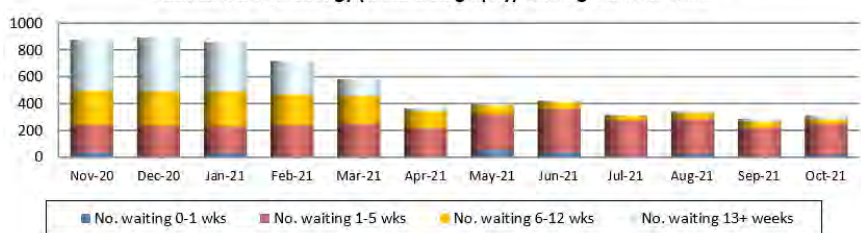
Diagnostic tests longer than the 6 week standard

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Patients	3810	4624	4989	5013	4934	4957	4876	4909	4702	5682	5655	5542	5591
Waiting longer than 6 weeks	1312	1957	2389	2462	1992	1892	1768	1478	1516	1799	1821	1808	1888
% over 6 weeks	34.4%	42.3%	47.9%	49.1%	40.4%	38.2%	36.3%	30.1%	32.2%	31.7%	32.2%	32.6%	33.8%
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%

- % over 6 weeks
- National target
- Local trajectory
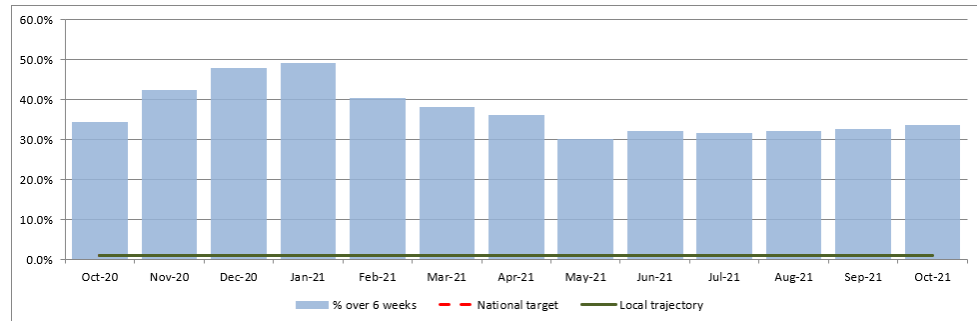
All modalities are continuing to see patients with urgent need with appropriate Infection, Prevention and Control precautions.

CT numbers waiting and waiting times for routine tests have continued to increase in October. There are increasing staffing pressures to maintain capacity for in-house scans, reporting and vetting of referrals. Additional capacity at the Nightingale Hospital Exeter will come on line in November 2021.

Colonoscopy numbers and routine waiting times remain high. Loss of lists at the Independent Sector from October will be partly offset by additional weekend insourcing now agree. Overall capacity however remains insufficient to bring waits back to plan without continued significant insourcing support and investment. Urgent cancer pathways are being prioritised.

MRI waits and total numbers on the list continue to be a concern. This reflects the continued high demand and capacity pressures. Access for mobile scanning units to increase capacity is limited as only one mobile pad available and needed for mobile CT.

Access to diagnostics, and in particular radiology, is critical for maintaining timely cancer diagnosis and supporting treatment pathways. Whilst teams continue to prioritise urgent referrals it does mean that overall some patients will wait longer for routine diagnostic tests.

long length of stay acute beds

- Number of patients >7 days LoS (daily average)
- Number of extended stay patients >21 days (daily average)
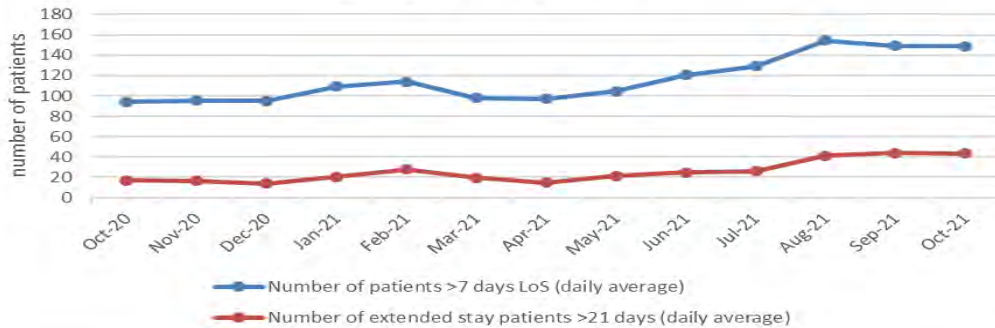
Long Length of Stay (LOS)

In October the average number of patients counted as having long length of stay greater than 7 and 21 days as measured in a daily census has remained high. The number of patients experiencing long LOS is a critical measure as the Trust is challenged to maintain the flow of urgent patients requiring hospital care and treatment following emergency presentation. Many of these patient are waiting for support in at alternative home or care setting; this may be a package of care or nursing home placement.

Care Plan Summaries completed within 24 hours of discharge - Weekday

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Discharges	1324	1176	1436	1157	1049	1282	1434	1484	1474	1341	1286	1424	1263
CPS completed within 24 hours	913	754	950	774	650	828	866	883	848	812	953	1101	941
% CPS completed <24 hours	69.0%	64.1%	66.2%	66.9%	62.0%	64.6%	60.4%	59.5%	57.5%	60.6%	74.1%	77.3%	74.5%
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%

% CPS completed <24 hours — Target

Care Planning Summaries (CPS)

Hospital discharge summaries serve as the primary documents communicating a patient's care plan to the post-hospital care team.

CPS completion (within 24 hours of discharge) has deteriorated from last month across weekday and weekend CPS completion.

5.9% (96) of patient discharges in October had no CPS completed within 72 hours of discharge.
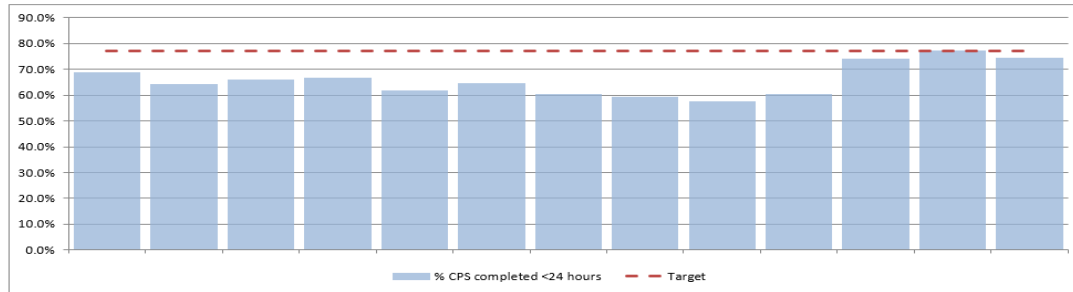
On the day cancellations for elective operations

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Cancellations	20	26	35	29	71	71	48	9	40	51	14	14	34
Elective spells	2742	2835	2835	2550	2400	2904	2922	2760	3276	2933	2602	2994	2830
% of on the day cancellations	0.7%	0.9%	1.2%	1.1%	3.0%	2.4%	1.6%	0.3%	1.2%	1.7%	0.5%	0.5%	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

34 patients (1.2%) were cancelled on the day of an elective operation.

% of on the day cancellations — Target
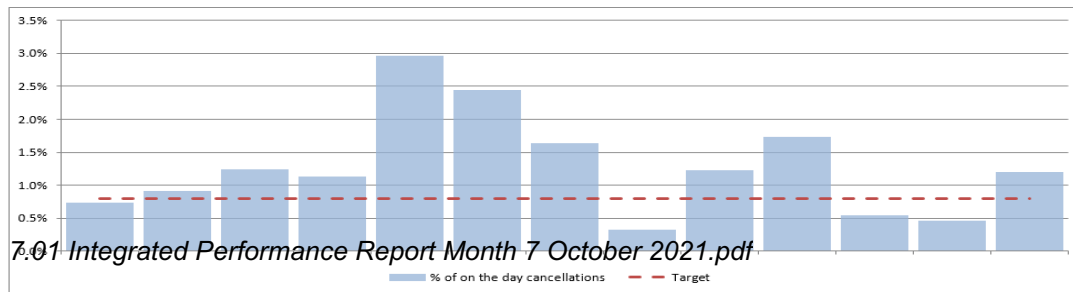
Headline acute activity comparisons 2019/20 v 2020/21

Elective Day Case

Emergency admissions (not CDU)

Elective Inpatient

Outpatients - New
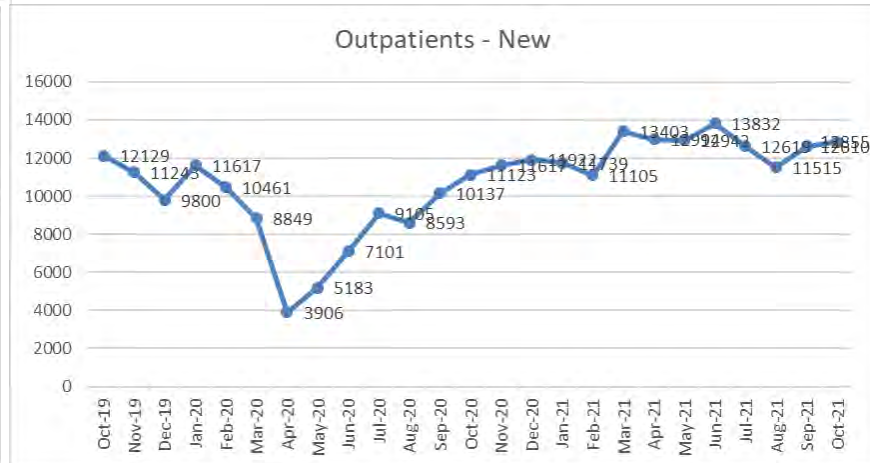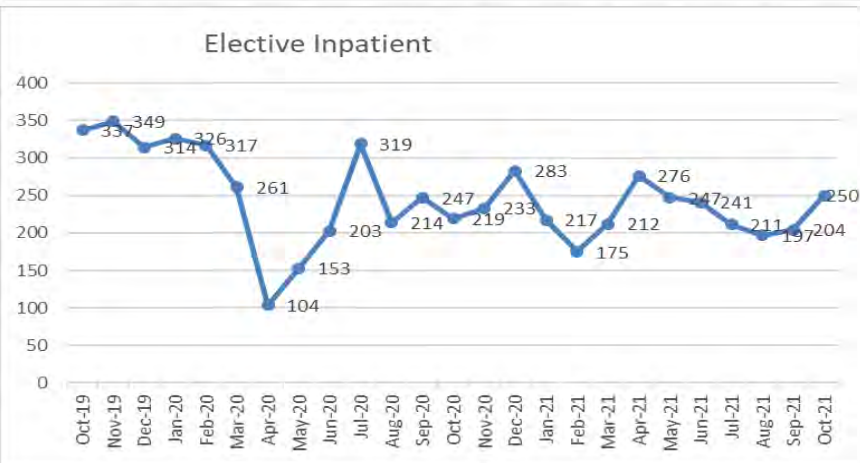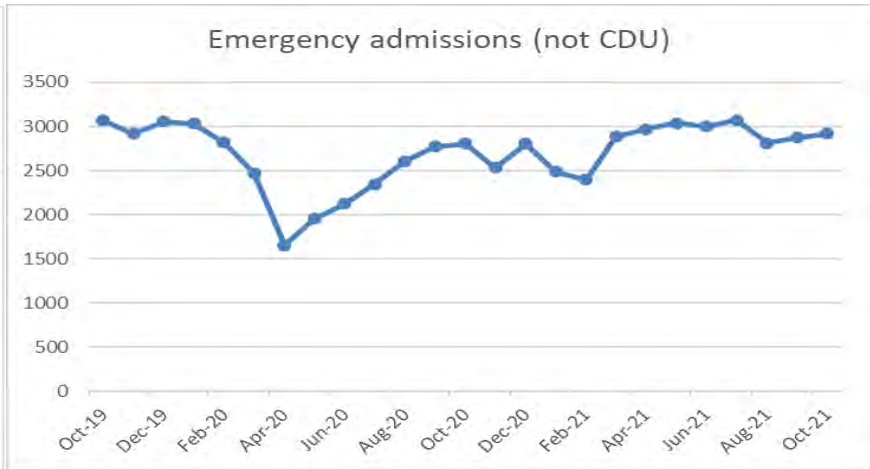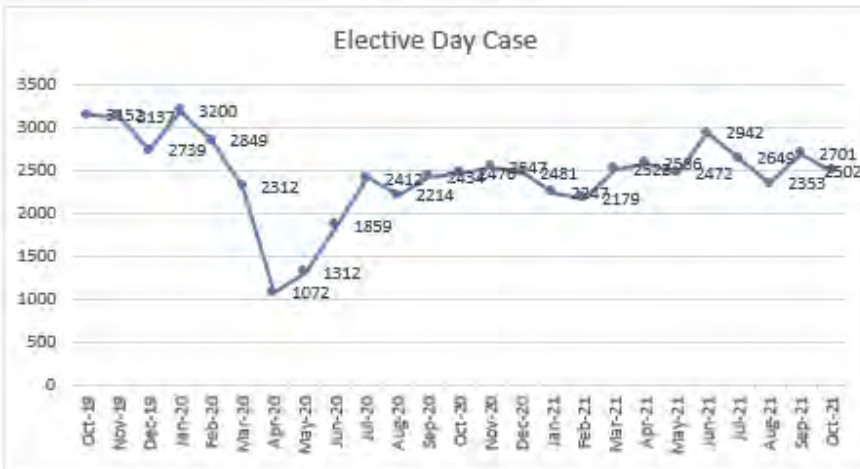
The charts above show the monthly activity run rate of reported contract activity to end of October 2021.

A steady increase in activity levels since first wave of pandemic is seen. Levels of elective activity have now plateaued. In October we have seen an increase in elective inpatient activity with the re-opening of the elective orthopaedic ward for IP procedures as well as supporting day case pathway through main theatres.

The Day Surgery Unit remains partially closed to elective surgery to respond to emergency pressures with the hosting of the Medical Receiving Unit allowing 25 inpatient beds to be returned for general acute care.

Teams continue to seek opportunities working with the Chief Operating Officer and Interim Head of Elective Care to further increase activity to utilise the Elective Recovery Fund (ERF) where this is operationally possible and working with system partners to optimise these opportunities.

In January we will benefit from capacity at the Nightingale Hospital Exeter now recommissioned with operating theatres to support orthopaedic surgery.

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

CAMHS
- The CAMHS Service remains under pressure due to staff vacancy and recent increased levels of demand. A deep dive was conducted by Devon Partnership Trust reported at the September Integrated Governance Group and reviewed in the October meeting There are multiple challenges that are being addressed and actions monitored.
- Additional monies for crisis, easting disorder, and mental health in schools has been awarded and the service model developed; recruitment is under way.
- There remains a high level of demand for the acute and out of hours service, significant new investment from NHS England has been announced, model developed, and recruitment progressing.
- Estates work being undertaken to model the estate capacity for both clinical and administration functions.

Integrated therapies and nursing
- Recovery plans for Autistic Spectrum Disorder (ASD) waiting times have been implemented and due to recruitment issues, these will be extended until the end of March 2022. Progress is positive with a sustained downward trend evident. Regular reporting to NHS England and the Clinical Commissioning Group (CCG) fortnightly.
- Referral to Treatment (RTT) performance has improved in Learning Disability and Physio services. ASD and Speech and Language Therapy (SLT) have the greatest challenge on reducing waiting times for treatment. Plans are being monitored with the CCG and IGG.

	Number of children waiting over 52 weeks for first definitive treatment		Percentage of routine referrals for CYP who are on an incomplete pathway within 18 weeks		Total number on caseload	
	FY 2021 October	FY 2022 October	FY 2021 October	FY 2022 October	FY 2021 October	FY 2022 October
Community Children's Nursing (CFH Devon)	0	0	100.0%	100.0%	282	284
Learning Disability (CFH Devon)	0	0	97.1%	81.8%	296	229
Mental Health and Wellbeing	3	42	79.7%	49.4%	3960	4397
Occupational Therapy (CFH Devon)	1	0	58.5%	59.3%	1211	1137
Palliative Care (CFH Devon)	0	0	NA	NA	40	41
Physiotherapy (CFH Devon)	0	0	93.0%	82.6%	497	490
Special School Nursing (CFH Devon)	0	0	NA	NA	481	520
Specialist Autism Spectrum Assessment Team (CFHD)	1190	1364	18.1%	14.3%	3189	3177
Specialist Children's Assessment Centre (CFHD)	14	35	47.3%	35.5%	683	981
Speech & Language Therapy (CFH Devon)	130	321	50.7%	34.8%	4353	5116

Financial Performance – Month 7 (October)
FY 2021 / 22

Financial Overview – Month 7, October 2021

High Level Summary

For Period ended - 31 October 2021, Month 7			
	Plan £m	Actual £m	Variance £m
Total Operating Income	333.44	336.01	2.57
Total Operating Expenditure and Financing Cost	(333.74)	(336.14)	(2.40)
Surplus/(Deficit)	(0.30)	(0.13)	0.17
Add back: NHSE/I Adjustments	0.47	0.31	(0.16)
Adjusted Surplus/(Deficit)	0.17	0.18	0.01
Capital	21.89	9.56	(12.34)
Cash & Cash Equivalents		33.56	

Adjusted Surplus / (Deficit)
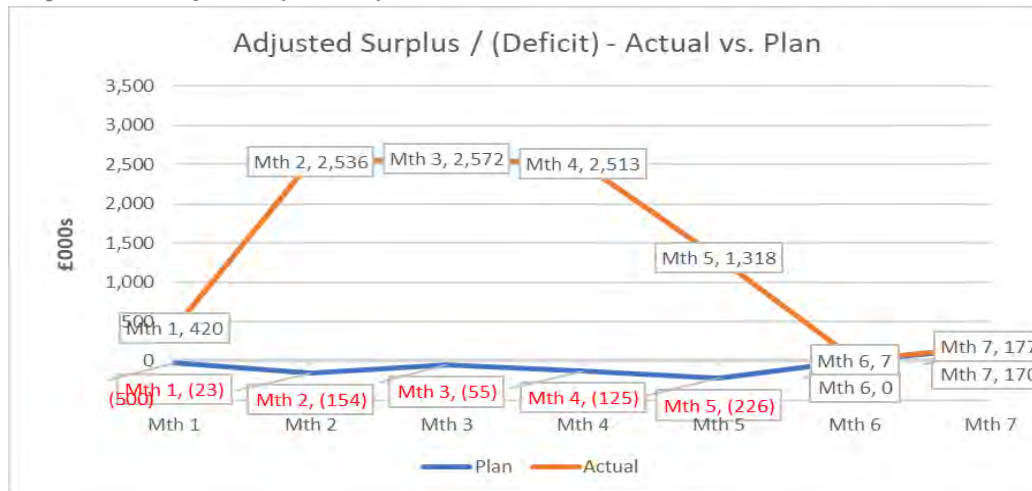
Operating Income
Operating income for the year to date totals £336.0m, within which income for patient care activities totals £307.4m. Total income for the year to date is £2.6m favourable to plan. Key drivers are as follows: in-year COVID related income e.g. Council funding stream which was not initially budgeted in H1 (£3.6m favourable) and ASC client contribution income (£0.4m matched by cost) offset by: lower ERF income owing to the changes in funding threshold alongside increasing cancellation of elective surgery (£1.4m adverse), reclassification of renal transport income and audit income from patient care income to other income and pass through drugs within block contract income (£0.4m adverse).

Operating Expenditure
Total operating expenditure and financing cost of £336.1m, which includes £169.2m of staff costs. Operating expenditure and financing cost in the year to date is £2.4m adverse to plan. Key drivers are as follows: COVID related costs including those council funding stream not initially budgeted in H1 (matched by income), increase in Agency (£3.6m adverse) and Bank spend (£2.6m adverse), undelivered CIP (£0.3m adverse), increased clinical supplies cost (£0.4m adverse), net increase in operating cost (£1.2m adverse due to: IT equipment purchase £0.5m, STP resourcing contribution £0.3m, consultancy £0.2m, leases and transport £0.2m) offset by under one-off mitigations of reserves (£5.0m favourable), and lower than planned spend on depreciation (£0.3m favourable).

Adjusted Surplus / (Deficit)
At month 7 the Trust is recording a surplus of £0.18m against plan of £0.17m.

Cash
The Trust is showing a healthy cash position at the end of Month 7, with £33.6m held in cash and cash equivalents. A planned cash position was not required as part of the H1 and H2 submission.

Capital
To date the Trust has spent c. £9.6m on capital schemes. A separate capital report has been prepared for the Trust's FPDC.

I&E Position – Month 7, October 2021

Income & Expenditure – Performance versus Plan

£m	M7 - In Month			M7 - YTD		
	Budget	Actual	Variance	Budget	Actual	Variance
Patient Income - Block	32.40	32.23	(0.16)	229.38	228.65	(0.72)
Patient Income - Variable	3.91	4.00	0.09	26.72	26.36	(0.36)
ERF Funding	0.00	0.00	0.00	3.41	2.04	(1.37)
ASC Income - Council	4.59	4.59	0.00	32.09	32.11	0.02
Other ASC Income - Contribution	1.00	1.27	0.27	6.94	7.30	0.36
Torbay Pharmaceutical Sales	1.83	1.64	(0.19)	12.20	12.22	0.02
Other Income	6.90	4.09	(2.81)	19.97	20.95	0.98
Covid19 - Top up & Variable income	0.41	0.59	0.19	2.74	6.38	3.65
Total (A)	**51.03**	**48.41**	**(2.62)**	**333.44**	**336.01**	**2.57**
Pay - Substantive	(27.52)	(23.31)	4.21	(164.04)	(161.71)	2.33
Pay - Agency	(0.85)	(1.24)	(0.39)	(3.86)	(7.48)	(3.62)
Non-Pay - Other	(11.51)	(12.80)	(1.29)	(90.30)	(87.10)	3.20
Non- Pay - ASC/CHC	(8.88)	(8.68)	0.20	(60.44)	(65.05)	(4.61)
Financing & Other Costs	(2.16)	(2.20)	(0.04)	(15.10)	(14.80)	0.30
Total (B)	**(50.92)**	**(48.23)**	**2.69**	**(333.74)**	**(336.14)**	**(2.40)**
Surplus/(Deficit) pre Top up/Donated Items and Impairment (A+B=C)	**0.11**	**0.18**	**0.07**	**(0.30)**	**(0.13)**	**0.17**
NHSE/I Adjustments - Donated Items / Impairment / Gain on Asset disposal	0.06	(0.01)	(0.07)	0.47	0.31	(0.16)
Adjusted Financial performance - Surplus / (Deficit)	**0.17**	**0.17**	**(0.00)**	**0.17**	**0.18**	**0.01**

In Month 7 and year to date the Trust recorded a surplus of £0.2m which is in line with plan.

In Month Position:

Income
The key variances are below:
- Patient income block – lower income in month (£0.16m) due to reclassification of renal and audit income from patient care block income to other income.

- ASC Client contribution income is £0.27m higher in month (matched by cost).

- Torbay Pharmaceutical sales were £0.19m lower than planned due to NHS sales.

- Other income is £2.81m lower than plan primarily due to technical timing difference for H1 pay award income budgeted in retrospect (£3.63m) offset by additional income received in month from various sources: e.g. Education & Training (£0.26m), R&D (£0.20m), non-patient care services (£0.18m) and miscellaneous income (£0.18m).

- COVID income is £0.19m higher in month due to labs testing (matched by cost).

- Included within the income position is £0.3m of provider incentive payment.

Pay
- In Substantive pay there is a net favourable variance in month (£4.21m). This is primarily due to the technical timing difference for H1 pay award costs budgeted in retrospect.

- Agency cost is £0.39m higher than budget across the various staff groups: Ancillary £0.16m (COVID and TP production requirement), Nursing and HCA (£0.10m) due to clinical activity and other Clinical staff (£0.13m) due to vacancies.

Non-pay
- The main driver of the adverse non-pay other position (£1.29m) is undelivered CIP (£0.74m), increased cost of COVID lab testing (£0.19m matched by income), purchase of lab and various clinical supplies (£0.18m) and consultancy and other costs (£0.18m).

- The £0.20m favourable position for ASC/CHC costs is due to: Placed People underspend by £0.38m due to FNC/CHC/Adult IPP lower costs than anticipated offset by ASC overspend of £0.16m.due to increased hours on domiciliary care and slightly higher COVID cost (£0.02m).

H2 Plan and Risks and Mitigations

H2 Plan

The National planning guidance for H2 and the budget envelope was issued on 30th September, requiring the Devon system to submit high level plans by 16th November (now moved back to 18th November) and a more detailed submission of the Trust's organisational budget will be submitted on 25th November.

A planned submission has been prepared by the Trust in accordance with the guidance, which has been incorporated into the Devon system plan. This requires a break-even position after taking account of CIP achievement of £7.2m. Should the Trust achieve the break-even plan it will also receive from the CCG £1.8m cash only Provider Incentive payment (i.e. a requirement of planned surplus at £1.8m, dependent on achieving a break-even position before the incentive payment).

Risks and Mitigations

As noted above, the plan for the second half of the year requires delivery of a break-even position, after CIP of £7.2m. Should the Trust achieve that financial target it will receive £1.8m of cash only provider incentive payment.

The Trust has prepared a forecast out-turn for the year, based on current levels of expenditure and likely impacts over the winter period, which suggests a gross risk of overspend at £5.9m before mitigations. The deficit is largely driven by the projected shortfall in delivery of CIP, between £3.6m-£4.1m, a weakening of the trading outlook for Torbay Pharmaceuticals and on-going pressures within the hospital due to non-elective surge exacerbated by the current Covid situation. The Trust has identified non-recurrent, non-cash mitigations which will cover the current risk identified above.

With regard to ERF the threshold % has been amended from 95% of SUS submitted activity to 89% of RTT stop clock activity. The STP has reviewed this position and asked each provider to calculate their view of ERF income to enable a comparison. This will confirm the STP risk to progressing with ERF schemes. There is a chance that some of these schemes might be covered by a potential new funding source and this is being investigated.

Liberty protection safeguard standards are due to be implemented from 1st April 2022 however we are still awaiting further guidance. Staffing costs and associated training/setup costs will need to be incurred from Q4 of 2021/22 and are included in the H2 request (with an anticipated income offset) for the Torquay ISU but no known funding arrangements have yet been confirmed with costs set to increase further when the act becomes live in 2022/23.

Monthly Run rate Income – £000
(M6 Value excludes £3.6m Pay award)

Monthly run-rate: Pay costs (£000)
(M6 Value excludes £3.6m Pay award)

Monthly run-rate: Non-pay costs (£000)

Change in Activity Performance – Month 6 to Month 7

		Plan	Sep-21	Oct-21	Change	% Change	Oct-20	% change
Activity Drivers	A&E Attendances		8,960	8,604	-356	-4%	6,933	24%
	Elective Spells	2,784	2,905	2,752	-153	-5%	2,672	3%
	Non Elective Spells		3,158	3,177	19	1%	3,114	2%
	Outpatient Attendances	29,607	28,857	27,718	-1,139	-4%	27,815	0%
	Adult CC Bed Days		246	201	-45	-18%	173	16%
	SCBU Bed Days		121	152	31	26%	150	1%
Bed Utilisation	Occupied beds DGH		9,881	10,067	186	2%	8,508	18%
	Available beds DGH		10,534	10,812	278	3%	9,988	8%
	Occupancy		94%	93%	-1%	-1%	85%	8%
Resource Consumption	Medical Staff Costs - £000's	5,757	5,782	5,526	-256	-4%	4,833	14%
	Nursing Staff Costs - £000's	6,991	6,671	5,628	-1,044	-16%	5,143	9%
	Temp Agency Costs - £000's	855	1,192	1,232	40	3%	675	83%
	Total Pay Costs - £000's	28,375	27,782	24,549	-3,233	-12%	22,425	9%

Elective and Non Elective (Spells) and A&E Attendances

Outpatient Activity (Attendances)
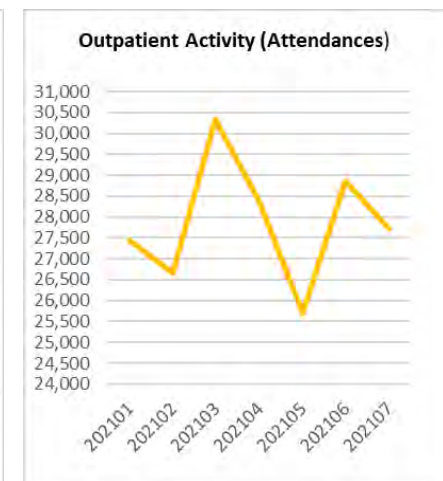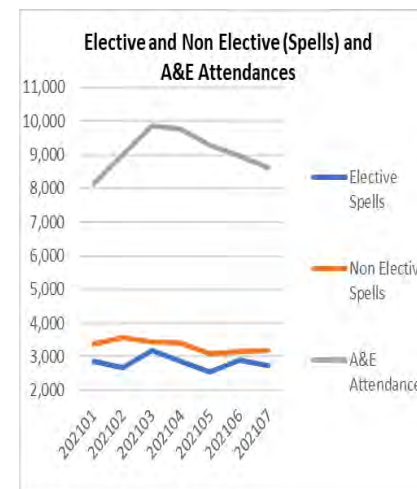
Activity Drivers

- 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 from the centre.

- Overall, elective activity levels is below plan at Month 7 and below that of 2019/20, which is the comparator year for NHSE/I purposes. At least part of the reason for this is because elective activity was cancelled in October as a result of both NEL pressures and the impact on staffing because of COVID.

- 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 H2 guidance has now been issued and the Trust recently submitted an activity plan to the STP. As a result of the new guidance and change in requirements, providers have submitted ERF plans to the STP for review. ERF Schemes have now been included in Providers' Activity and Finance plans and will be monitored on a monthly basis, from M8. The Trust included increased activity assuming full access to SDU/Ella from the 1st December and made clear with the STP on the assumptions this inclusion was based.

Bed utilisation

- In October, overall bed occupancy at 93% remains above required levels to support patient flow to avoid emergency care delays and reduced elective capacity.

- Access to beds for medical and surgical emergencies has continued to be a major operational constraint. There continues to be long waits in the Emergency department and a high number of hours lost due to delayed Ambulance handovers. Trust being in OPEL 4 escalation for most of the month.

- The ongoing need to escalate bed capacity to maintain patient flow continues to see the Day Surgery Unit re-designated as the Medical receiving Unit to allow Forrest ward (25 beds) to be opened as general Acute medical inpatient beds. This has restricted the capacity for planned elective surgery with elective admission prioritising Cancer treatments and the most urgent patients. Routine elective orthopaedic surgery has restarted during the Best Week 29th September releasing the orthopaedic ward to focus on elective care, however maintaining this position is high risk.

Pay Expenditure – Month 7, October 2021

Pay - Total Expenditure Run Rates

M12 20/21 value excludes £11.5m NHS Pension cost
M10 - M12 2020/21 excludes additional Annual Leave accrual and Flowers case
M6 21/22 value excludes £3.6m Pay award

- Budget 2021/22
- Actual Expenditure 2021/22
- Actual Expenditure 2020/21

Pay - Agency Run Rates

- Budget 2021/22
- Actual Expenditure 2021/22
- Actual Expenditure 2020/21
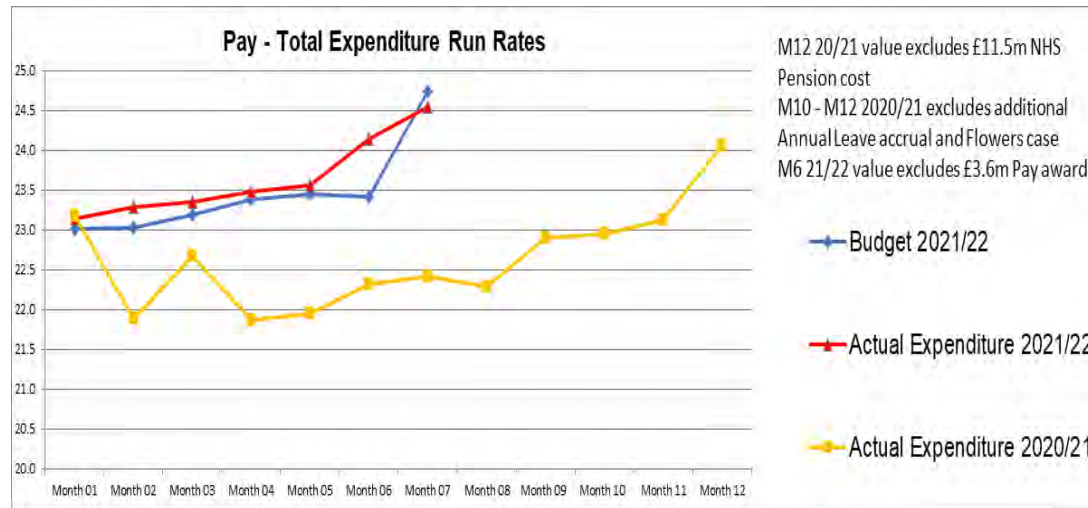
Note the Month 7 and H2 pay budget also include estimated Targeted Investment Fund (TIF) for Elective recovery and winter pressure costs currently budgeted centrally before formal approval.

In Month 7 the total pay expenditure is £24.55m, which is £3.23m lower compared to Month 6 (£27.78m). In M6 there was pay award of £3.63m (backdated from April).

Further details are provided below:

- Substantive pay decreased by £3.20m across the various staff group mainly due to the pay award as described above.

- Bank pay decreased by £0.07m primarily within HCA's.

- Agency costs were £0.04m higher than Month 6 across various staff groups.

- The Agency costs as at M7 totals £7.48m which is just £0.15m below the FY 2020/21 full year spend of £7.63m. The Agency use this financial year is particularly high due to operational pressures along with COVID, sickness absence and difficulty in recruiting.

- Of the year to date pay costs, those associated with COVID account for £3.88m, comprised of:
  o Sick pay - £1.71m,
  o vaccination - £0.22m
  o additional shifts of existing workforce – £1.71m, and
  o testing – £0.24m

- The Apprentice levy balance at Month 7 is £2.21m (£2.18m in M6). The Trust's apprenticeship strategy is reviewed regularly and actions are being taken.
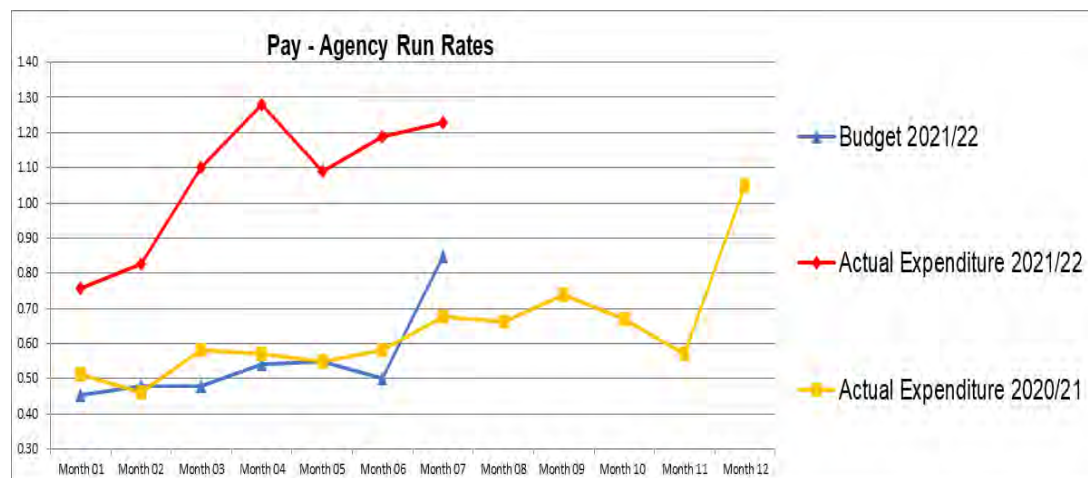
Non-Pay Expenditure – Month 7, October 2021
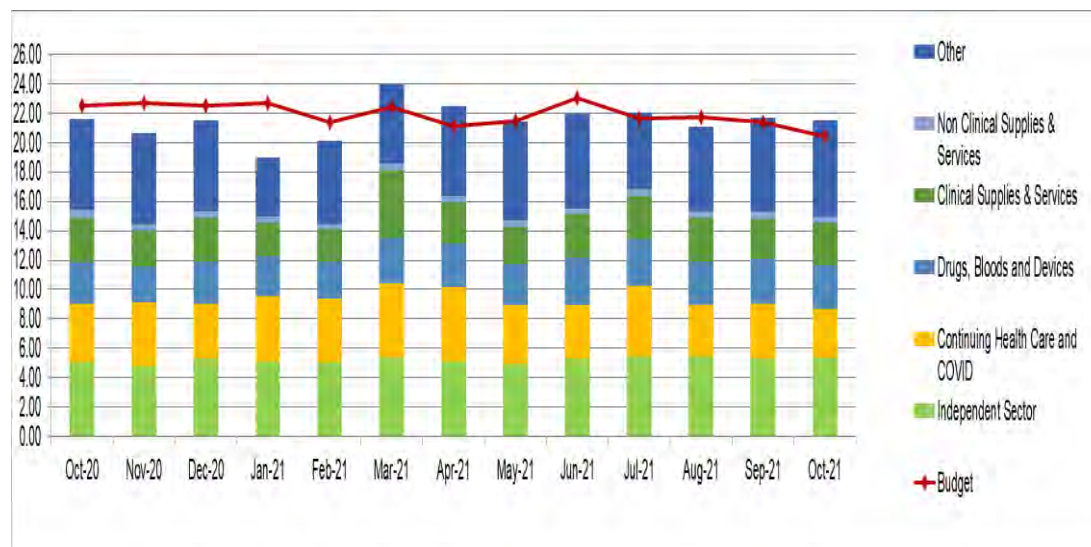
The total non-pay run rate in Month 7 (£21.48m) is £0.22m lower in comparison to previous month (£21.70m), key details are provided below:

- Decreases in:
  - Placed People - £0.50m primarily driven by Continuing Health Care (CHC) across both localities where costs arising from anticipated FNC reviews, converting to CHC have been lower in October than September.
  - Drugs costs – £0.11m lower primarily in Healthcare at Home drugs (£0.06m) and Cancer drugs (£0.05m).
  - Non-clinical supplies – decreased by £0.04m due to domestic cleaning materials (£0.07m) offset by increase in accreditation cost (£0.03m); offset by:

- Increases in:
  - Net Operating expenditure – £0.14m relates mainly to increase in Consultancy (£0.08m) and CFHD alliance (£0.06m) costs.
  - Independent Sector – £0.11m higher. This relates to there being one day more in October than there is in September combined with higher levels of Domiciliary Care costs.
  - Clinical supplies – £0.11m, primarily increased spend on medical and surgical supplies, and
  - COVID £0.07m increase in COVID related funding (hospital discharge, testing, infection prevention and control) matched by income.

COVID Cost Analysis – Month 7, October 2021

COVID Expenditure	Inside Envelope Actual 31/10/2021 YTD £'000	Outside Envelope Actual 31/10/2021 YTD £'000	Total Actual 31/10/2021 YTD £'000
Staff and executive directors costs	3,415	461	3,876
Supplies and services – clinical (excluding drugs costs)	122	1,604	1,726
Supplies and services - general	155	1	156
Drugs	149		149
Establishment	55		55
Purchase of social care	1		1
Premises - other	148	11	159
Lease expenditure	16	0	16
Transport	42	0	42
Other	97		97
Total operating expenditure	**4,200**	**2,077**	**6,277**

Hospital Discharge, Rapid Testing and Infection Control COVID	Total Cost Actual 31/10/2021 YTD £'000	CCG Income Actual 31/10/2021 YTD £'000	Council Income Actual 31/10/2021 YTD £'000	Provider Refunds Actual 31/10/2021 YTD £'000
Hospital Discharge Programme (HDP) Scheme 2	1,818	(1,818)		
Rapid Testing & Infection Prevention & Control	2,622		(2,458)	(164)
General & Sustainability Fund	133		(47)	(106)
Total	**4,573**	**(1,818)**	**(2,505)**	**(269)**

As highlighted above, within the Trust's pay position at Month 7 COVID costs account for £3.88m.

Within non-pay COVID costs account for £2.40m, comprised of:
- o Testing - £1.61m, and
- o Segregation of patient pathways - £0.74m
- o Patient transport and other - £0.05m

Hospital Discharge and other COVID Costs
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 £4.6m, with a contribution of £2.5m received from Torbay Council towards this.

- Rapid Testing and Infection Control grants (Q1 & Q2 2021/22) have been fully passported to providers within Torbay in line with grant conditions. H2 grants have been allocated and Torbay Council will receive £1.6m in two tranches. Funding will be fully passported to the trust and paid to providers in line with grant conditions. The first tranche of just £1.0m has just been received by the Council and intention is to get this passported to providers late November.

- Hospital discharge costs (year to date £1.8m) being reclaimed through Devon CCG. Discharge criteria saw clients entitlement drop from six to four weeks from the 1st July. National funding for Hospital Discharge will continue for H2 and Trust will work with Devon CCG who have a capped allocation to work within for the county.

- Outside of the above, Torbay Council have provided two tranches of additional funding for market sustainability which will be jointly managed by the Trust / Torbay Council, but administered through the Trust.
  -£0.3m funding specifically for Domiciliary Care providers (Living well at Home). This is specific and targeted funding focusing on workforce Incentive / retention schemes.

  -£1.0m of general funding to support providers experiencing short term financial difficulties as a result of the pandemic. Funding will be used for elements such as insurance, staffing and voids and is administered through weekly panel, being jointly chaired by Head of ASC Commissioning (Torbay Council) and Joint Associate Director of Operations for ISU Torquay.

- Recently Torbay Council has received notification that it will receive further new grant funding of £0.6m for workforce recruitment and retention. Guidance is currently being worked through but intention is that like other grants received to date, this will be managed though the weekly sustainability panel and administered through the Trust.

Key Drivers of System Positions – Month 7, October 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 M7 is £0.19m lower than plan primarily due to lower NHS sales; year to date is in line with plan.
Corporate	EFM	Underspend has reduced to £170k in M7 mainly due to an increase in the non pay overspend to £214k & slight reduction in pay underspend. Overspend on non-pay arising mainly from increased spend on utilities and repairs and maintenance. Income remains overachieved by £172k mainly from visitor car parking & some backdated income.
	Exec. Directors	Underspend has reduced to £274k in M7 mainly due to a reduction in the pay underspend to £361k as vacancies are filled. Non pay is overspent by £239k mainly due to a provision of £322k for STP resourcing costs & legal fees and £123k for HIS Nerve Centre & Windows 10 business cases – offset by various underspends. Income is over achieved by £190k largely due to secondment income across directorates plus overseas nursing income.
	Financing Costs	Excluding items outside the NHSE/I control total, costs are £0.3m favourable to plan. There are no noteworthy components.
	Other	Reserves includes plan adjustments, contingency accrual, & provision for Sharepoint CALS, FNC backlog & Independent Sector inflation, legal fees & miscellaneous other small provisions.
South System	Coastal	Underspent at M7 against budget with £1.3m being non pay £0.3m, pay £0.2m, pass through £0.7m, other income £0.3m offset by under delivery of CIP £0.2m. Continued reduction in elective activity due to the ongoing response to Covid and green surge, delays in recruitment, reduced spend in theatre supplies, income higher than planned for which most offsets expenditure. Run rates in the coming months are expected to increase as capacity becomes available and activity increases. Approval awaited for revised H2 ERF bids.
	Newton Abbot	Overspent against M7 YTD budget by £1.7m, of which £130k is the H2 Savings Target not achieved, mainly due to continued cost pressures in response to the green and Covid Patient surge in ED and Acute Medicine. This is reflected by high Medical Locum and Bank and Nursing Agency and Bank spend: ED areas were overspent £1.5m and Acute Medicine (including all Gen Med Junior Doctors) by £650k. These cost pressures are expected to continue due to autumn and winter demand but are offset by underspends in UTC/MIUs of £200k and ICU of £120k (a budget setting issue). The balance of all other underspends is c£260k, mainly due to vacancies - some of these underspends will be matched with the Savings Target non-recurringly, but are not yet transacted.
	Moor to Sea	Overspent against M7 YTD budget by £235k, of which £70k is the H2 Savings Target not achieved. This is mainly due to the continued cost pressures on the four Wards (£340k) to cover Patient activity, staff absence and also specialist security for a Patient. Intermediate Care Beds are overspent by £265k but this will reduce considerably when the DCC contribution has been agreed. All other net variances are £375k underspent. - some of these underspends will be matched with the Savings Target non-recurringly, but are not yet transacted.

	Shared Operations	Underspent against M7 YTD budget by £95k, which is mainly due to vacant posts in the SSEP and Outpatients Teams of £110k combined, less the H2 Savings Target of £18k not achieved. There are many other offsetting variances of < £30k and some of the underspends will be matched with this non-recurringly, but are not yet transacted.
Torbay System	Independent Sector	ISU is circa £0.1m underspent against a YTD budget envelope of £54.2m. Non Pay cost is £4.7m higher than budget but this is primarily due to COVID related spend (£4.3m) which has no budget (Hospital Discharge 'H1', Rapid Testing and Infection Control). Additional pressures in ASC (Domiciliary Care volume) have adversely impacted non pay cost. Offsetting the adverse non-pay cost there is £4.3m of additional Covid related funding and £0.5m of ASC client contributions.
	Torquay	ISU has a circa YTD £0.35m overspend against a YTD budget envelope of circa £23.6m. The main area of risk to be noted is around Ward Staffing with ongoing staffing pressures on Child Health and Maternity Wards reflecting a range of issues including filling vacancies, sickness levels, staff isolating and high patient acuity.
	Paignton and Brixham	ISU has a circa YTD £0.2m overspend against a YTD budget envelope of circa £50.0m. Underlying this the main areas to note is a material £1.0 pay / non-pay underspend (Labs Medicine) but this is offset by £1.2m under recovery of income. Other Labs Medicine income (£0.6m) forms part of this under recovery with the balance within Income from patient activities (Long Term Conditions).
Contract Income	Patient Income	The Trust has received the following income: 1) £2.0m of Elective Recovery Funding (ERF) at M7 from the CCG. 2) C. £1.8m additional income via the CCG relating to the Hospital Discharge Programme (HDP). There is a corresponding cost to offset this. 3) An additional c. £2.5m 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.

CIP – Month 7, October 2021

Monthly CIP Plan profile (£000)
(M7 to M12 (H2) Value)
Identified   Unidentified

	202107	202108	202109	202110	202111	202112
Total	1,166	1,171	1,192	1,207	1,216	1,275
Unidentified	780	780	779	780	780	779
Identified	386	391	413	427	436	496

H2 CIP Plan and Actual

- Planned CIP 2021/22
- Actual CIP Delivered 2021/22
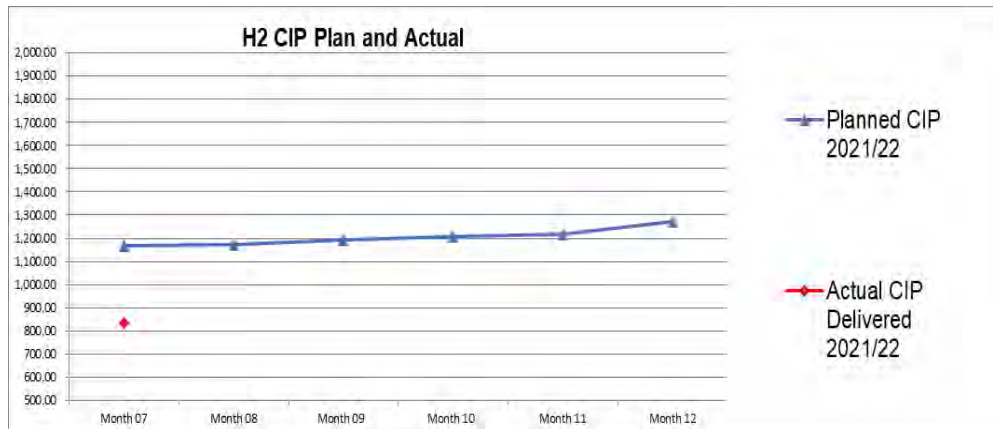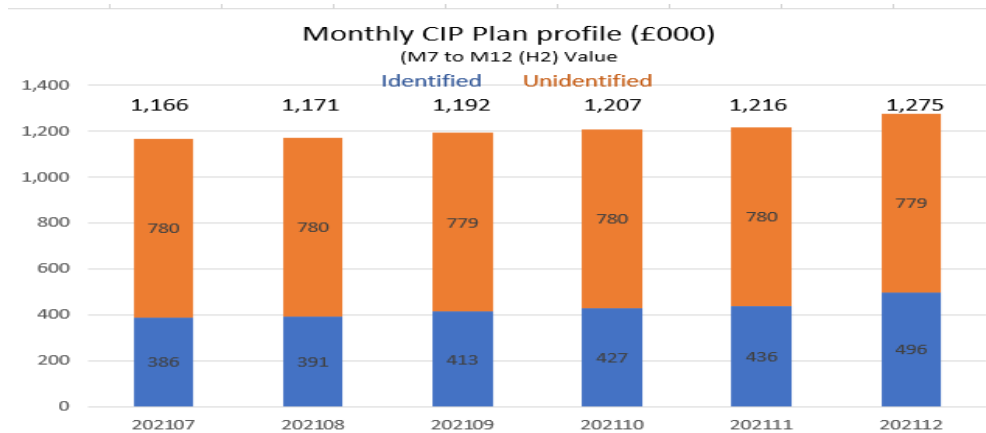
CIP H2 Plan and M7 Actual

H2 Plan

The target CIP requirement for H2 is £7.23m. CIP plans identified to date total £2.76m (unidentified therefore £4.47m).

There are some non-recurrent central mitigations included in the YTD position however this is not sustainable, new recurrent saving schemes must be identified. CIP review meetings are being held during November to identify additional schemes and mitigating actions, which will be reflected in the Month 8 Report.

M7 Actual and year to date

The M7 CIP plan is £1.17m with actual delivery of £0.83m, a shortfall of £0.34m.

Year to date, CIP delivery in H2 is £0.8m

Please note: The planned CIP for H1 was £0.77m, against which £1.02m was delivered as at M6.

Cash Position – Month 7, October 2021

	YTD at M07 £m
Opening cash balance	**45.45**
Capital Expenditure (accruals basis)	(9.55)
Capital loan/PDC drawdown	2.01
Capital loan repayment	(2.40)
Proceeds on disposal of assets	0.00
Movement in capital creditor	(8.99)
Other capital-related elements	(0.89)
Sub-total - capital-related elements	**(19.82)**
Cash Generated From Operations	14.43
Working Capital movements - debtors	(9.45)
Working Capital movements - creditors	8.26
Net Interest	(1.69)
PDC Dividend paid	(2.88)
Other Cashflow Movements	(0.74)
Sub-total - other elements	**7.94**
Closing cash balance	**33.56**

Better Payment Practice Code	Paid year to date	Paid within target	% Paid within target
Non-NHS - number of bills	83,734	73,527	87.8%
Non-NHS - value of bills (£k)	157,743	134,130	85.0%
NHS - number of bills	1,214	891	73.4%
NHS - value of bills (£k)	12,197	9,114	74.7%
Total - number of bills	84,948	74,418	87.6%
Total - value of bills (£k)	169,940	143,244	84.3%

Key points of note:

- A 2021/22 cashflow plan has not been required by NHSE/I. The Trust is planning that its cash balance will decrease over the year from the exceptionally high March 2021 level of £45m, to circa £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 £11.9m. This was principally due to the paying down of capital creditors (£9.0m) and an increase in debtors (£9.5m) from the unusually low year end level, partly offset by an increase in revenue creditors of £8.3m. 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 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 and implemented.

Statement of Financial Position (SoFP) – Month 7, October 2021

	Month 7		
	Position 31 March 2021 **£m**	**Position 31 Oct 2021** **£m**	**Movement** **£m**
Non-Current Assets			
Intangible Assets	10.09	11.69	1.60
Property, Plant & Equipment	202.37	200.75	(1.62)
On-Balance Sheet PFI	17.11	16.85	(0.26)
Other	2.04	2.02	(0.02)
Total	**231.61**	**231.31**	**(0.30)**
Current Assets			
Cash & Cash Equivalents	45.45	33.56	(11.88)
Other Current Assets	33.20	42.79	9.59
Total	**78.64**	**76.35**	**(2.29)**
Total Assets	**310.25**	**307.66**	**(2.59)**
Current Liabilities			
Loan - DHSC ITFF	(4.80)	(4.80)	0.00
PFI / LIFT Leases	(1.17)	(1.25)	(0.09)
Trade and Other Payables	(61.81)	(55.66)	6.16
Other Current Liabilities	(10.44)	(16.44)	(5.99)
Total	**(78.23)**	**(78.15)**	**0.08**
Net Current assets/(liabilities)	**0.41**	**(1.80)**	**(2.21)**
Non-Current Liabilities			
Loan - DHSC ITFF	(29.08)	(26.67)	2.40
PFI / LIFT Leases	(16.60)	(15.78)	0.82
Other Non-Current Liabilities	(15.88)	(14.72)	1.16
Total	**(61.55)**	**(57.17)**	**4.38**
Total Assets Employed	**170.47**	**172.34**	**1.87**
Reserves			
Public Dividend Capital	130.76	132.76	2.01
Revaluation	49.15	49.15	0.00
Income and Expenditure	(9.44)	(9.57)	(0.14)
Total	**170.47**	**172.34**	**1.87**

Key points of note:

- Non-current assets have reduced by £0.3m during the year to date, principally as depreciation (£9.8m) has exceeded capital expenditure (£9.5m).

- Cash has reduced by £11.9m, as explained in the commentary to the cashflow statement.

- Other current assets have increased from the unusually low year-end level by £9.6m, principally due to increased accrued income (e.g. CCG ERF £1.4m, CCG Covid £2.8m, DHSC Covid reimbursement £1.2m), invoiced HEE funding £4.5m and insurance / rates prepayments £1.5m.

- Trade and other payables have reduced by £6.2m, principally due to the paying down of the capital creditor £9.0m and agreed repayment of 2020/21 CCG funding £4.0m, partly offset by increased PDC Dividend creditor £0.4m and increased general payables.

- Other current liabilities have increased by £6.0m, due to increased deferred income (e.g. HEE £4.9m).

- Non-current liabilities have reduced by £4.4m, principally due to scheduled loan / lease repayments.

	ISU	Target	13 month trend	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		0	1	2	1	1	4	0	2	4	2	2	0	1	11
Reported Incidents - Death	Trustwide	<1		1	0	1	3	1	2	0	2	1	2	0	0	1	6
Medication errors resulting in moderate harm	Trustwide	<1		0	0	0	0	2	0	0	1	1	0	0	0	0	2
Medication errors - Total reported incidents	Trustwide	N/A		53	53	34	41	51	54	50	64	57	47	38	47	58	361
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		3	0	0	0	1	1	0	1	0	2	0	0		3
Never Events	Trustwide	<1		1	0	0	0	0	1	0	0	0	0	0	0	0	3
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		5	2	3	7	6	6	5	7	11	8	8	6	1	30
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	0	0	0	0	0	0	0	0	2	1	3
Formal complaints - Number received	Trustwide	<60		19	20	14	7	13	17	10	9	15	18	17	11	11	91
VTE - Risk Assessment on Admission	Trustwide	>95%		93.4%	92.9%	90.4%	92.4%	92.3%	91.9%	92.5%	92.3%	88.6%	94.4%	92.9%	91.9%	91.8%	92.0%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		94.4	101.2	85	92.8	85.3	85.1	76.4	88.9	85.8					86.4
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		86.5%	90.1%	89.7%	90.3%	85.8%	82.5%	89.0%	90.2%	87.1%	89.5%	87.0%	81.9%	81.9%	86.6%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		89.4%	84.8%	88.5%	88.6%	88.3%	85.4%	90.3%	88.5%	89.4%	93.4%	88.0%	74.6%	74.6%	85.2%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		23	0	30	6	0	23	24	42	381	24	8	42	476	997
Hand Hygiene	Trustwide	>95%		96.9%	97.8%	97.0%	98.3%	95.3%	92.8%	96.0%	94.8%	97.6%	98.9%	97.1%	96.5%	98.5%	98.1%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		74.5%	75.7%	75.6%	85.3%	94.4%	78.8%	73.2%	90.3%	84.8%	91.2%	82.1%	81.0%	82.1%	84.9%
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		73.2%	82.2%	80.4%	69.4%	51.6%	77.5%	84.1%	65.9%	66.1%	51.4%	56.3%	69.2%	35.9%	55.6%
Follow ups 6 weeks past to be seen date	Trustwide	6400		17519	17229	17837	17489	16986	16950	17118	16713	16323	16967	17651	17789	18231	18231
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		4.3%	4.3%	4.3%	4.2%	4.1%	4.0%	4.0%	4.0%	4.1%	4.1%	4.2%	4.4%		4.1%
Appraisal Completeness	Trustwide	>90%		78.4%	78.9%	80.4%	78.8%	78.4%	82.4%	85.9%	86.6%	84.7%	81.3%	80.6%	79.7%	77.9%	82.4%
Mandatory Training Compliance	Trustwide	>85%		89.7%	89.6%	89.6%	89.7%	89.5%	89.6%	90.1%	90.1%	90.5%	89.5%	89.4%	89.0%	89.0%	89.6%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.5%	10.7%	10.5%	10.2%	10.2%	10.0%	10.8%	11.0%	11.3%	11.0%	11.7%	11.3%	11.6%	

	ISU	Target	13 month trend	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Carers Assessments Completed year to date	Trustwide	40% (Year end)		94.8%	95.5%	95.8%	98.0%	96.3%	96.3%	93.3%	97.5%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%
Children with a Child Protection Plan (one month in arrears)	Trustwide	NONE SET		214	221	223	223	207		234							234
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET					199					117					117
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET					4.4%					4.3%					4.3%
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		576	599	658	617	615	616	0	608	629	631	564	546	604	604
Intermediate Care - No. urgent referrals	Trustwide	113		200	207	235	175	146	155	165	155	129	158	191	241	219	1258
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		274	193	242	249	205	255	282	294	292	297	233	229	243	1870
ADULT SOCIAL CARE TORBAY KPIs																	
Proportion of clients receiving self directed support	Trustwide			79.8%	77.6%	76.4%	75.1%	73.8%	74.0%	72.9%	71.9%	71.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Proportion of carers receiving self directed support	Trustwide			94.8%	95.5%	95.8%	98.0%	96.3%	96.3%	93.3%	97.5%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%
% Adults with learning disabilities in employment	Trustwide			8.5%	8.5%	8.2%	8.1%	8.3%	8.3%	7.5%	7.4%	7.4%	7.4%	7.1%	7.1%	6.8%	6.8%
% Adults with learning disabilities in settled accommodation	Trustwide			80.2%	80.6%	80.5%	80.4%	80.6%	81.8%	82.6%	82.3%	81.7%	81.3%	81.0%	80.6%	80.6%	80.6%
Permanent admissions (18-64) to care homes per 100k population	Trustwide			20.2	14.8	18.9	14.8	17.5	16.2	17.5	20.2	23.1	17.7	19.0	17.7	17.7	17.7
Permanent admissions (65+) to care homes per 100k population	Trustwide			565.4	573.6	579.0	587.2	540.8	464.3	499.8	510.8	487.3	498.1	511.5	449.6	422.7	422.7
Proportion of clients receiving direct payments	Trustwide			23.6%	22.6%	22.4%	21.7%	21.2%	21.1%	20.1%	19.8%	19.5%	19.6%	19.5%	19.0%	19.4%	19.4%
% reablement episodes not followed by long term SC support	Trustwide			84.6%	85.2%	85.5%	85.4%	85.7%	85.8%								..

	ISU	Target	13 month trend	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Year to date
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		86.2%	86.5%	81.2%	79.4%	79.4%	82.2%	84.4%	78.9%	72.6%	68.6%	67.6%	65.1%	62.5%	71.2%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		62.3%	64.2%	64.3%	61.8%	61.4%	61.4%	62.7%	63.9%	64.4%	61.7%	59.4%	57.4%	57.0%	60.8%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		67.9%	77.0%	78.9%	73.8%	80.9%	64.8%	71.8%	77.9%	68.8%	67.8%	75.0%	73.3%	70.5%	72.0%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		34.4%	42.3%	47.9%	49.1%	40.4%	38.2%	36.3%	30.1%	32.2%	31.7%	32.2%	32.6%	33.8%	32.7%
Dementia - Find - monthly report	Trustwide	>90%		96.6%	94.4%	97.7%	94.8%	98.0%	95.0%	96.7%	96.9%	97.4%	97.8%	97.2%	92.7%	94.4%	96.2%
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3		4	2	3	1	1	5	2	5	2	5	8	2	1	25
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		74.8%	83.6%	78.9%	77.1%	89.6%	85.1%	67.7%	83.9%	83.0%	71.3%	54.6%	55.6%	50.5%	66.9%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		97.8%	86.6%	94.0%	75.0%	96.3%	95.2%	61.9%	54.1%	56.7%	91.0%	77.8%	92.4%	95.1%	74.3%
Cancer - 28 day faster diagnosis standard	Trustwide			72.7%	75.3%	75.9%	72.2%	77.3%	75.0%	75.6%	75.6%	76.0%	76.4%	77.4%	60.6%	58.8%	71.8%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		97.7%	99.0%	97.5%	97.5%	98.8%	99.0%	97.4%	96.7%	98.5%	97.5%	98.8%	99.4%	98.2%	98.0%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		100.0%	100.0%	100.0%	98.8%	100.0%	100.0%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		100.0%	98.0%	96.0%	100.0%	100.0%	100.0%	98.5%	100.0%	97.0%	98.3%	96.4%	98.6%	98.4%	98.1%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		93.3%	96.3%	93.3%	96.4%	97.0%	84.8%	100.0%	96.7%	97.7%	100.0%	97.3%	100.0%	100.0%	98.6%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		60.0%	75.0%	66.7%	77.8%	83.3%	100.0%	75.0%	73.3%	85.7%	78.6%	92.3%	71.4%	87.5%	80.9%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			8	13	14	11	6	15	15	17	10	10	13	15	29	29
RTT 52 week wait incomplete pathway	Trustwide	0		1141	1277	1435	1570	1823	2041	1895	1596	1562	1648	1799	1943	2093	2093
On the day cancellations for elective operations	Trustwide	<0.8%		0.7%	0.9%	1.2%	1.1%	3.0%	2.4%	1.6%	0.3%	1.2%	1.7%	0.5%	0.5%	1.2%	1.3%
Cancelled patients not treated within 28 days of cancellation *	Trustwide	0		4	1	1	5	6	8	6	11	3	10	17	5	3	90
Bed Occupancy	Overall System	80.0%		82.4%	90.5%	89.8%	94.4%	93.4%	99.5%	94.2%	96.1%	98.0%	97.4%	98.5%	98.8%	97.6%	97.3%
No Criteria to Reside - daily average - weekday (ICO)	Trustwide	No target											45	58	56	62	
Number of patients >7 days LoS (daily average)	Trustwide			94.0	95.4	95.1	109.5	114.2	98.2	97.0	104.5	120.5	129.4	154.4	149.1	148.4	106.8
Number of extended stay patients >21 days (daily average)	Trustwide			17.1	16.7	14.0	20.8	27.8	19.9	15.2	21.3	25.0	26.3	41.5	43.9	43.6	20.3

	ISU	Target	13 month trend	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Year to date
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		73	38	138	75	82	94	90	128	380	421	266	219	285	1789
Ambulance handover delays > 60 minutes	Trustwide	0		14	1	19	15	20	32	19	26	173	165	120	72	125	700
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			16	4	18	18	27	28	14	46	246	438	534	491	753	2522
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		1	0	1	2	3	5	2	3	32	157	188	69	130	581
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		4	2	2	1	1	4	1	3	2	4	7	2	1	20
Number of Clostridium Difficile cases - (Community)	Trustwide	0		0	0	1	0	0	1	1	2	0	1	1	0	0	5
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		69.0%	64.1%	66.2%	66.9%	62.0%	64.6%	60.4%	59.5%	57.5%	60.6%	74.1%	77.3%	74.5%	66.0%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		41.4%	41.6%	32.4%	47.4%	30.9%	41.0%	25.5%	33.1%	32.4%	34.2%	46.6%	46.4%	45.5%	37.5%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		100.0%	90.9%	86.4%	81.8%	95.5%	81.8%	86.4%	90.9%	100.0%	95.5%	100.0%	90.9%	95.5%	94.2%

	ISU	Target	13 month trend	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-23	1420	2378	3635	937	3180		2623	2551	2438	1240	-367	-327	
Agency - Variance to NHSI cap	Trustwide			-0.10%	-0.20%	-0.20%	-0.20%	-0.20%	-0.25%		-1.40%	-1.80%	-2.10%	-2.10%	-2.10%	-2.10%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide															-332	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			1686	5147	6653	9748	11822	2305		2004	3206	4292	5275	9080	12336	
Distance from NHSI Control total (£'000's)	Trustwide			112	1493	1858	3993	1179	655		2690	2621	2638	1539	7	8	
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			-5.6%	4.5%	-0.9%	-21.7%	-14.0%	26.8%	-5.3%	-15.9%	0.6%	-20.4%	-14.4%	-4.8%	-19.4%	-11.7%
Outpatients - Follow ups	Trustwide			-23.8%	-18.5%	-8.5%	-25.3%	-17.0%	16.8%	-7.6%	-12.9%	-0.9%	-13.1%	-10.2%	-5.9%	-19.1%	-10.2%
Daycase	Trustwide			-21.9%	-18.9%	-9.4%	-29.8%	-23.5%	9.1%	-8.9%	-20.5%	5.1%	-12.2%	-18.4%	-4.5%	-20.7%	-11.8%
Inpatients	Trustwide			-37.7%	-33.8%	-9.9%	-33.4%	-44.8%	-18.8%	1.8%	-19.8%	-15.4%	-33.1%	-35.2%	-24.4%	-25.8%	-22.2%
Non elective	Trustwide			-9.7%	-15.4%	-13.3%	-20.2%	-16.5%	18.0%	4.5%	3.8%	8.1%	3.9%	-5.3%	-0.8%	-7.9%	0.8%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			425	423	494	473	464	502	590	564	574	539	0	0	0	
Intermediate Care GP Referrals	Trustwide			90	83	106	106	98	95	94	79	81	77	74	76	63	
Average length of Intermediate Care episode	Trustwide			14.744	10.846	11.798	12.237	12.336	12.498	11.735	12.593	12.42	16.107	0	0	0	
Total Bed Days Used (Over 70s)	Trustwide			8677	8211	8796	9271	8636	9898	9713	8593	4035		0	0	0	
- Emergency Acute Hospital	Trustwide			5566	5202	5522	5575	5561	6021	5257	4953			0	0	0	
- Community Hospital	Trustwide			2943	2606	2844	3172	2461	3353	3268	2981	3240		0	0	0	
- Intermediate Care	Trustwide			168	403	430	524	614	524	1188	659	795		0	0	0	

NHS Torbay and South Devon
NHS Foundation Trust

Report to Torbay & South Devon NHS Foundation Trust Board			
Report title: Winter Planning Arrangements – Torbay and South Devon Foundation Trust/South Local Care Partnership		**Meeting Date**: 24th November 2021	
Report appendix			
Report sponsor	Chief Operating Officer		
Report author	Locality Director (South & West) – Local Care Partnership/Integrated Care System		
Report provenance	Local Care Partnership		
Purpose of the report and key issues for consideration/decision	Present the latest version of the arrangements developed in support of the winter period along with the risk and issues which still exist and the mechanics for further evolving, implementing and overseeing the delivery of agreed plans.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board are asked to review and approve the winter planning arrangements subject to on-going development.		

Summary of key elements				
Strategic objectives supported by this report	Safe, quality care and best experience	X	Valuing our workforce	
	Improved wellbeing through partnership		Well-led	X
Is this on the Trust's Board Assurance Framework and/or Risk Register	Board Assurance Framework	X	Risk score	
	Risk Register		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		Terms of Authorisation	
	NHS Improvement		Legislation	
	NHS England	X	National policy/guidance	X

Report title: Winter Planning Arrangements	Meeting date: 24.11.2021
Report sponsor	Chief Operating Officer
Report author	Locality Director (South & West)/Chief Operating Officer

1. Introduction and context

The purpose of this document is to describe how the Trust and its local system partners are planning to manage the anticipated continuation of operational pressures for the winter period from November 2021 to March 2022. Additionally, the document will outline the risks that the system is facing and describe the extent to which these will be addressed and mitigated in seeking to provide assurance to the Board and system partners.

This document summarises the key actions from individual organisational plans to provide a local system overview, owned by the Local Care Partnership (LCP). All individual plans are being taken through respective internal governance processes. It should also be recognised that, due to its nature, this is an iterative document that will need to respond to changing operational circumstances.

2. Current System Pressures

The local system has experienced significant and sustained pressure across all sectors over the last few months, with demand [volumes and acuity] increasing set against a backdrop of reduced capacity due to a continuation of Infection Prevention and Control (IPC) / social distancing requirements and workforce challenges. This at the same time as some aspects of normal life/society behaviour meaning that the number of people meeting and gathering and the impact and potential for spread is heightened.

We are seeing care providers in the local system with significant challenges because of staffing shortfalls and additionally organisations are experiencing high levels of both COVID-19 and non COVID19 related absence with all sectors under pressure the entire system is extremely fragile. The Trust continues to operate beyond its planned level of COVID-19 response and is working through the LCP and Integrated Care System (ICS) to seek the support needed in order to reduce the number of COVID-19 patients to the original modelled maximum of 8 upon which these plans place reliance.

The local system escalation level at the time of writing is OPEL 4, which has largely been the position for several months with local primary care, ambulance and 111 services also experiencing significant challenge. The impact is felt across the entire system from domiciliary care to community teams, wards and of course the Emergency Department where the impact on ambulance handover times is perhaps the most visible manifestation of the challenges.

Daily escalation calls have been taking place for several months now between providers with ICS colleagues, this ensures a detailed, patient-focussed discussion takes place. Whilst all partners are fully engaged in this it is evident that all the challenges being faced mean solutions are often challenging to find.

3. Planning for Winter

The trust and local system have been working to increase the level of preparedness in response to the current period of sustained challenge. All partners have worked to refresh their organisational surge and escalation plans and these have been incorporated into the updated ICS for Devon Escalation Framework and as part of the Devon Winter Plan. This framework is structured into three sections which cover: -

- Detailed instructions regarding the escalation and de-escalation response from business as usual through to gold command.
- In hours response from all system partners.
- On call and out of hours arrangements.

All system partners have been working on refreshing and further developing their detailed winter plans to reflect the learning from last winter and recognise the sustained pressure that the system is currently under.

4. Summary Plan

The following sections provide summarised information from organisational plans and include key points to note with the detailed documents available separately as part of the core winter planning arrangements for the local system.

The plan is set in the context of there being no realistic proposition for a significant increase in bed capacity in the short-term and the approach to managing the level of COVID patients anticipated from the ICS modelling.

The aim of the plan is to support all parts of the system in dealing with increased demand over the winter period through increasing same day urgent care access, proactively managing patients in the community, improving flow within the hospital, and enhancing discharge support.

It provides the framework for enhanced resilience over the winter period and demonstrates system-wide engagement, partnership working and compliance with national requirements. The plan is broadly constructed into four areas:

a) Acute Urgent Care (In Hospital):

All Trusts are facing the same issues with challenging elective recovery programmes in place to address the growing waiting lists and long waiters that have emerged during the pandemic. However, the known challenges in relation to the age of the Trust estate results in significant restriction to the ability to flex or increase ward areas, creating a disproportionate challenge for the Trust. Significant risks around workforce availability due to sickness, annual leave and self-isolation as described previously in this document, all impact on the ability to deliver safe hospital care and maintain both planned and unplanned care pathways.

During the winter months there is an expectation that seasonal pressures such as outbreaks of Norovirus, flu and respiratory illness will increase and impact on hospital bed capacity, leading to potential stand down of elective activity, but resulting in a reduced bed base across the system.

The Trust will deliver a number of initiatives both workforce and non-workforce related to improve resilience and maintain as much capacity as possible to facilitate flexible deployment. These are all described in the detailed plans, examples of these are as follows:

- Establish ICS Blue Pathway to maintain only 8 patients locally which requires system agreement and support. To the extent this is not facilitated, further development of short-stay capacity proposals as a winter contingency plan to create sufficient medical bed capacity.
- Expansion of Same Day Emergency Care (SDEC).
- Optimisation of Ward support to promote releasing time back to care
- Ensuring that timely discharges are taking place to release bed capacity and maintain system flow including hub co-ordination.

  b) Care at Home/In the Community:

The local system is supported by Trust activity and community and local authority providers to enable patients to be cared for in the community supporting both hospital admission avoidance and safe and effective discharge from hospital with packages of care. Partners have worked together to create additional bed capacity by block booking beds for both COVID-19 and non-COVID-19 patients for step-up and step-down care, following a period extensive analysis to determine the required capacity, despite significant pressures particularly relating to market stability and workforce.

There are several actions and initiatives being taken to address this very challenging position:

- Strengthened MDT across health, social care, with significantly increased reablement capacity targeted at people with complex needs
- Community frailty services including comprehensive assessment and personalised care planning.
- Agreed additional domiciliary care and bed capacity arrangements to ensure flow is supported at times of surge and escalation.
- IPC training and a range of additional support measures for care homes, including in reach, sustainability support and additional agency staff/recruitment.
- Expansion of two-hour crisis response service to avoid inappropriate admissions to hospital, hospice or care home.

  c) Workforce & Wellbeing:

- Continuing to recruit to both bank and substantive posts ahead of winter and investing in recruitment personnel to maximise coverage.
- Redesign and refocus or recruitment approach to support interest in health and care roles.
- Investment in incentive schemes to encourage staff to work additional shifts.
- Aim to achieve increased uptake of COVID-19 vaccinations, commencement the COVID-19 Vaccination Booster programme and improved uptake of Flu Vaccinations for all staff.

  d) Wider local system with partners:

    Providers of urgent and emergency care including ambulance services, 111 and GP Out of Hours Services have highlighted several areas of risk in their plans. The

overriding concern is that the demand for these services will exceed the capacity to see and treat patients in a timely manner, thus increasing waiting times and impacting on the next stage of the patient journey.

To manage the expected rise in demand over winter 2021/22 there are several initiatives being deployed and we will have visibility of these through the local care partnership approach described including that for Primary care and mental health in support of the approach being taken with partners in the local system.

5. Governance Arrangements

Further development and oversight of the implementation and delivery against this plan will be through a combination of robust internal workstream/cell arrangements. This culminates in a weekly Executive review session focusing on the actions and learning facilitated through a PDSA style approach to ensure progress.
The Local Care Partnership will also have in place a weekly 'Delivery Huddle' to promote visibility and action for the broader range of local system actions with representation form all partners and will hold accountability for delivery.

6. Communication

Work is in place to help support work to address current and anticipated system winter pressures. The intention is to promote informed access to the breadth of NHS and community health and care services available, with the aim of helping people get the care they need in the most efficient and effective way both for themselves and the health and care system.

We are taking a coherent approach with colleagues across the system attempting to align our activities such that we don't push people from one part of the system to another. The communications team regularly feeds into meetings, and engagement will continue to be delivered through existing networks. Specific activities worthy of note are as follows:

- Promote the NHS App / HandiApp for children
- Encourage use of NHS111 and NHS111 online
- Promote 'Pharmacy First' and self-care options
- Protect emergency care services and facilities for life and limb threatening occurrences
- Provide clear sign posting to services

7. Next Steps

The Trust has worked with system partners to collectively develop the arrangements which support the Winter Plan for 2021/2. The detailed plans are being robustly scrutinised and challenged and taken through internal Trust Executives and through ICS/LCP Executive and Delivery arrangements weekly to ensure all partners are engaged in and supporting our collective response.

There is still work to do to develop some of the component parts of the detailed plans set out in summary above such that they generate the impact required to mitigate the significant risk experienced at present. There are in some areas a limited range of solutions, but work continues with leadership commitment, capacity and support afforded both from the Trust and the local system to do everything possible to improve this picture.

It is therefore important to recognise that at the time of writing a significant degree of risk still exists that the board are asked to acknowledge, as a result of the operating context and key challenges.

Report to the Trust Board of Directors

Report title: November 2021 Mortality Score Card	Meeting date: 24th November 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 go to the next Mortality Surveillance Group meeting 09/12/21 and has gone Quality Improvement Group Meeting 16/11/21.
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 then 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	**Board Assurance Framework**	X	**Risk score**		
	Risk Register		**Risk score**		
External standards affected by this report and associated risks	**Care Quality Commission**	X	**Terms of Authorisation**		
	NHS Improvement		**Legislation**		
	NHS England	X	**National policy/guidance**	X	

Public

Report title: November 2021 Mortality Surveillance Score Card	Meeting date: 24th November 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	97.5
• B. Summary Hospital Mortality Index (SHMI)		DH SHMI data		103.21
Appendix 2 • Unadjusted Mortality Rate • By number • By location		Trust Data ONS Data	Yearly Average ≤3%	3.49%

Appendix 3 • Mortality Analysis		Trust Data Dr Foster DH HSMR data	CUSUM alerts greater than 1 in last 12 months	CuSuM Flags Acute Renal Failure
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 below the expected level of 100 for our population for June 2021 although this is not statistically significant. The HSMR for the latest 12-month period is within the expected range.

The Trust has a slightly lower than average palliative care coding rate although this coding rate is stable over time (3.82% vs a national average of 4.6%). The Trust also has a lower than average Charlson co-morbidity upper quartile rate (93 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 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 December 2020 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

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

The latest month's data, June 2021, has a relative risk of **94.6** (basket of 56 diagnostic groups) and is below the 100 average although the confidence interval encompasses 100.

Diagnoses - HSMR | Mortality (in-hospital) | Jul 2020 - Jun 2021 | Trend (month)
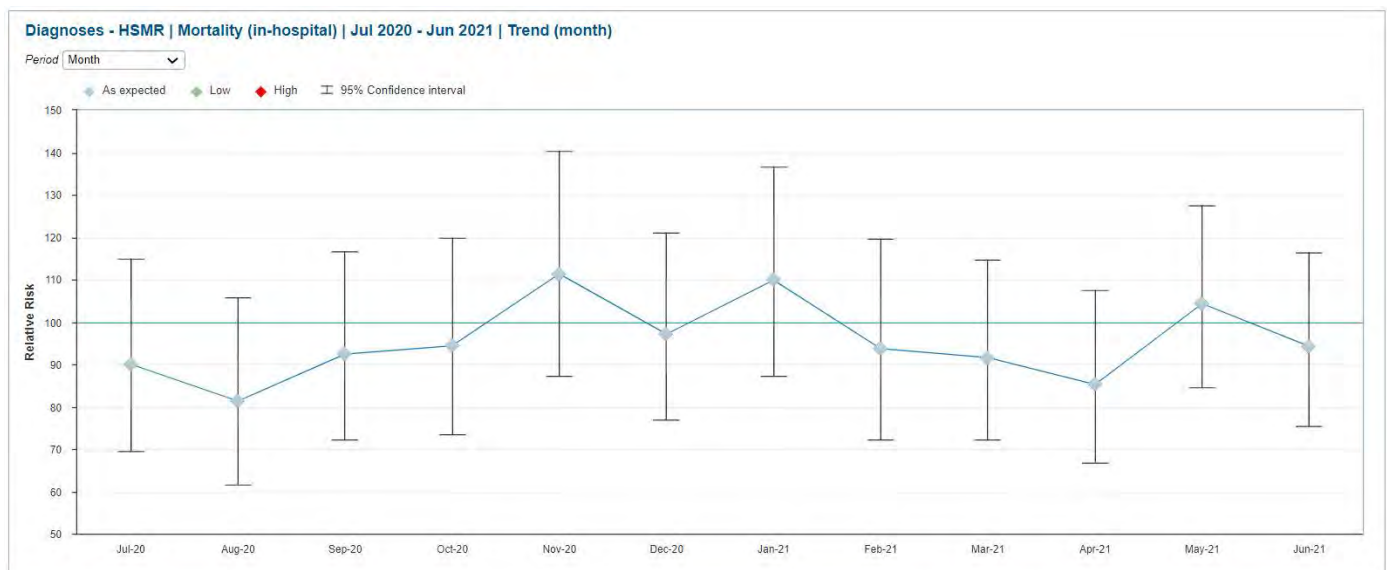
Chart 2, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12-month annual total. The monthly **12-month annual total** is just below the 100 line and within the standard deviation lines. This measure is being observed via the Mortality Surveillance Group (MSG)

Diagnoses - HSMR | Mortality (in-hospital) | Jul 2020 - Jun 2021 | REGION (acute)
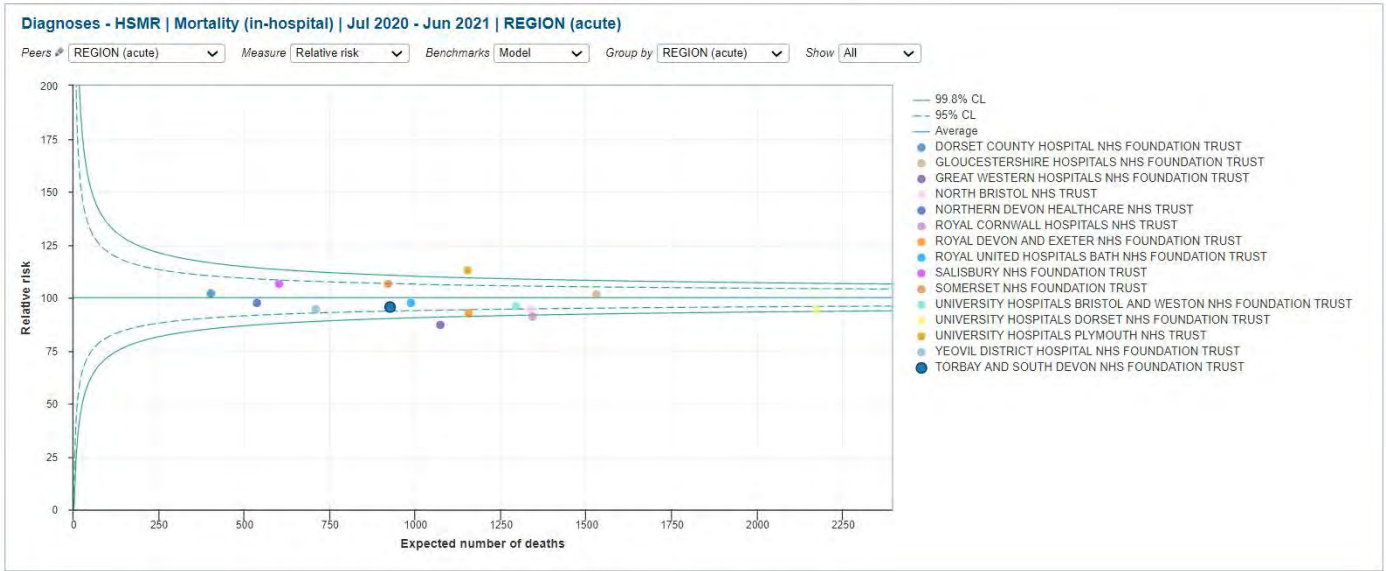
Chart 3 displays the above data as a 'Peer Comparison', and ranked as a bar chart. The 12-month average HSMR is near the expected rate. Torbay and South Devon is not an outlier during this time period.

Diagnoses - HSMR | Mortality (in-hospital) | Jul 2020 - Jun 2021 | REGION (acute)

Public

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 following data is based on the* **May 2020 –April 2021** *data period and is different to HSMR.*

Chart 4, as below, highlights SHMI by quarterly periods with all data points within the expected range except one, which exceeds the average 100 relative risk mark. This data period is from the first wave of Covid in Q1 of 2020/21 when hospital activity was greatly reduced. The data period thereafter, shows SHMI returning to its normal variance, as activity increased.
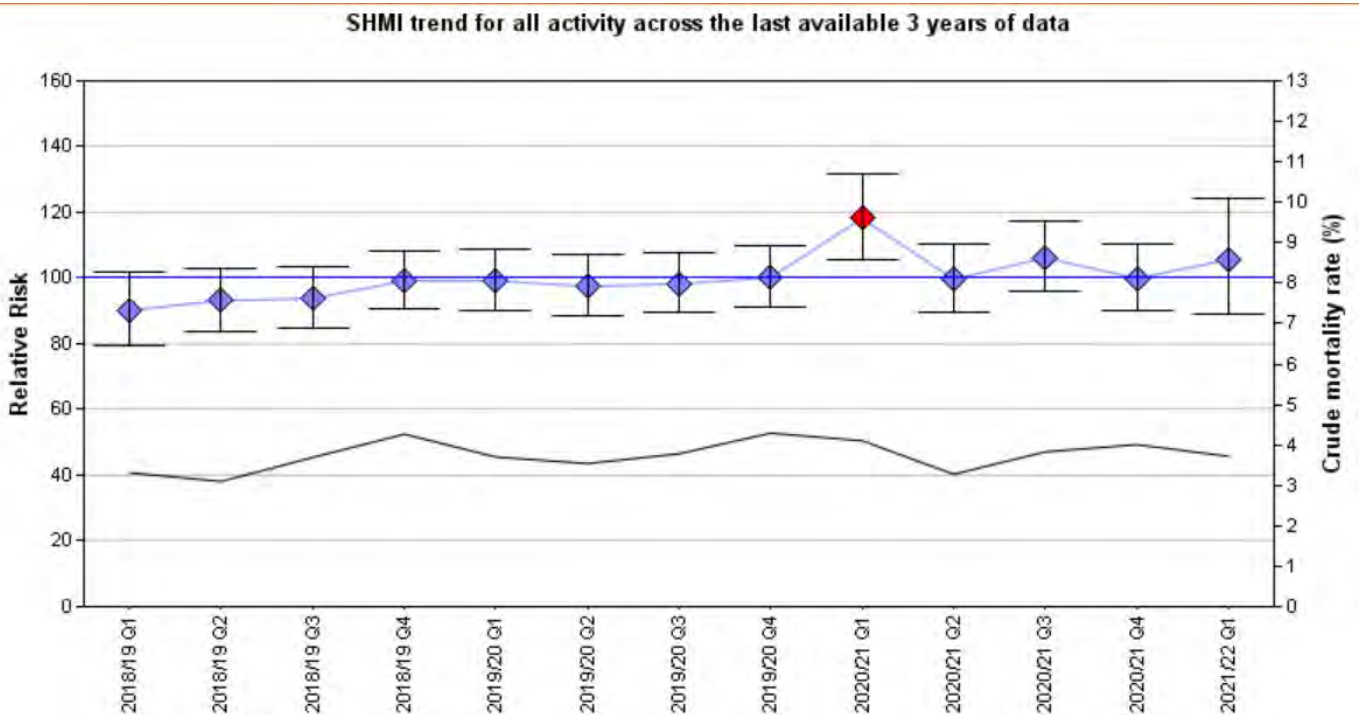
Chart 5 (as below) details - SHMI all deaths, SHMI in hospital deaths, and HSMR comparison, all within normal limits

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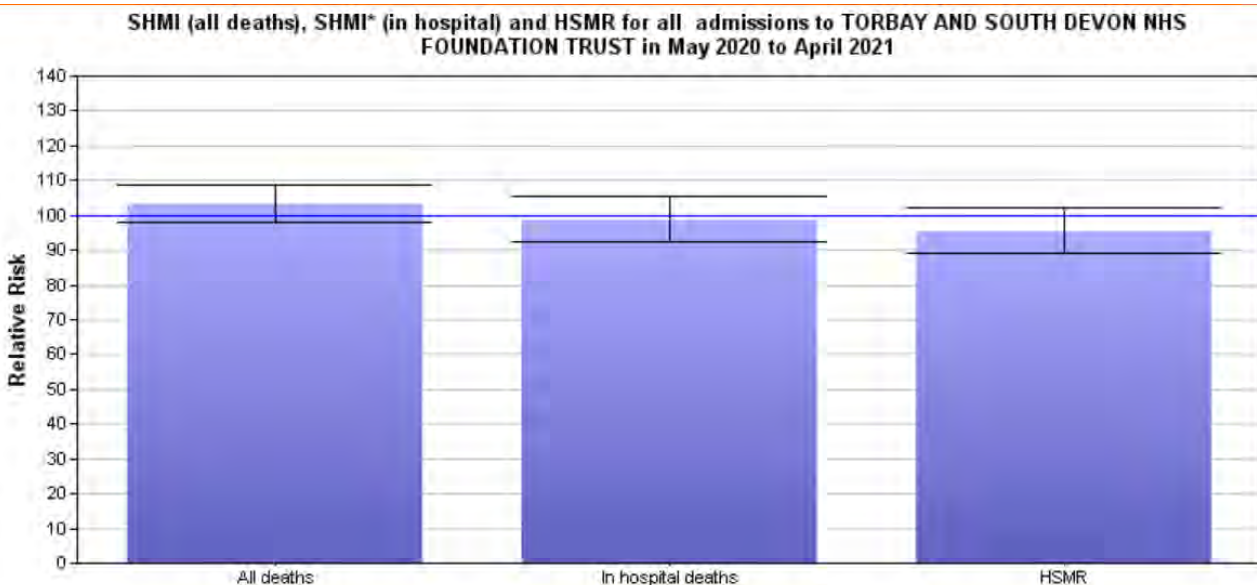
Chart 6, below, expresses the 12-month rolling SHMI data by time period. The mortality index is reporting the expected number of deaths during this time period.

SHMI by data period
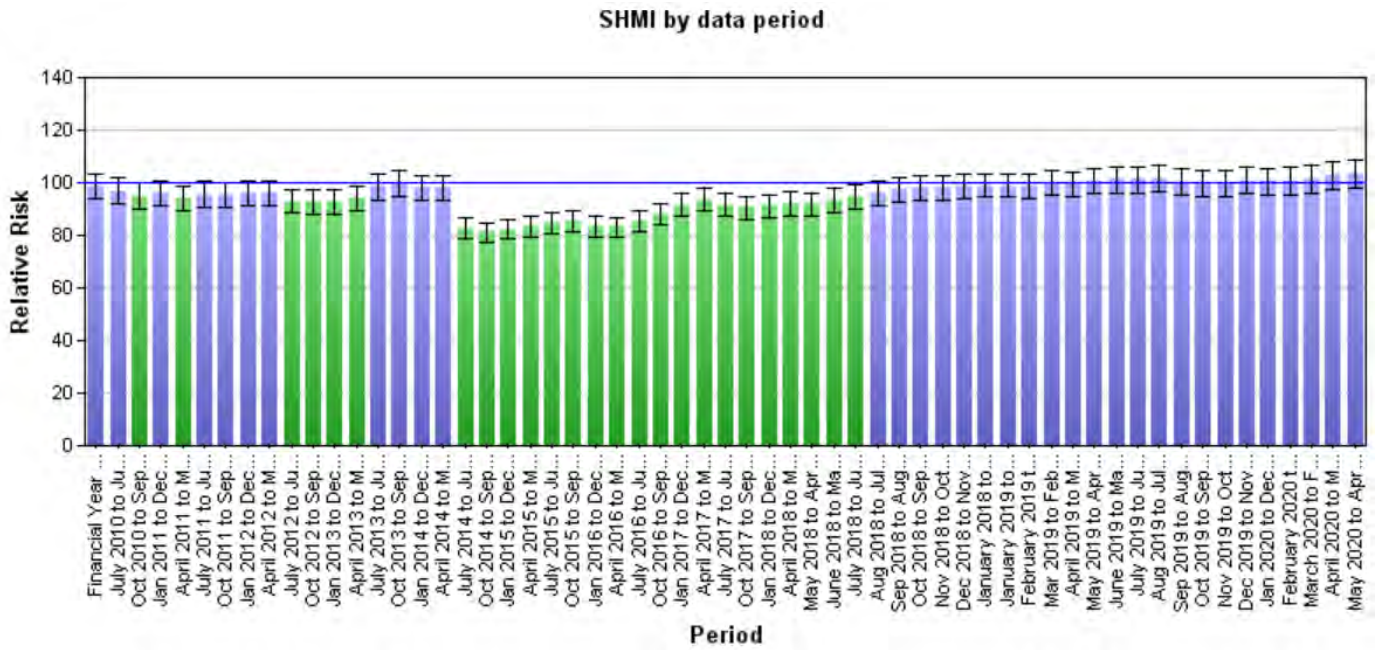
Appendix 2 – Unadjusted Mortality Rate

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 remains within normal limits for the Trust.

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 comparatively low numbers during Summer 2020. As hospital activity increased following the initial pandemic lockdown, the number of hospital deaths has also increased. The pattern of increased deaths related to winter pressures appears to be re-emerging after a relatively low number of in-hospital deaths last winter.

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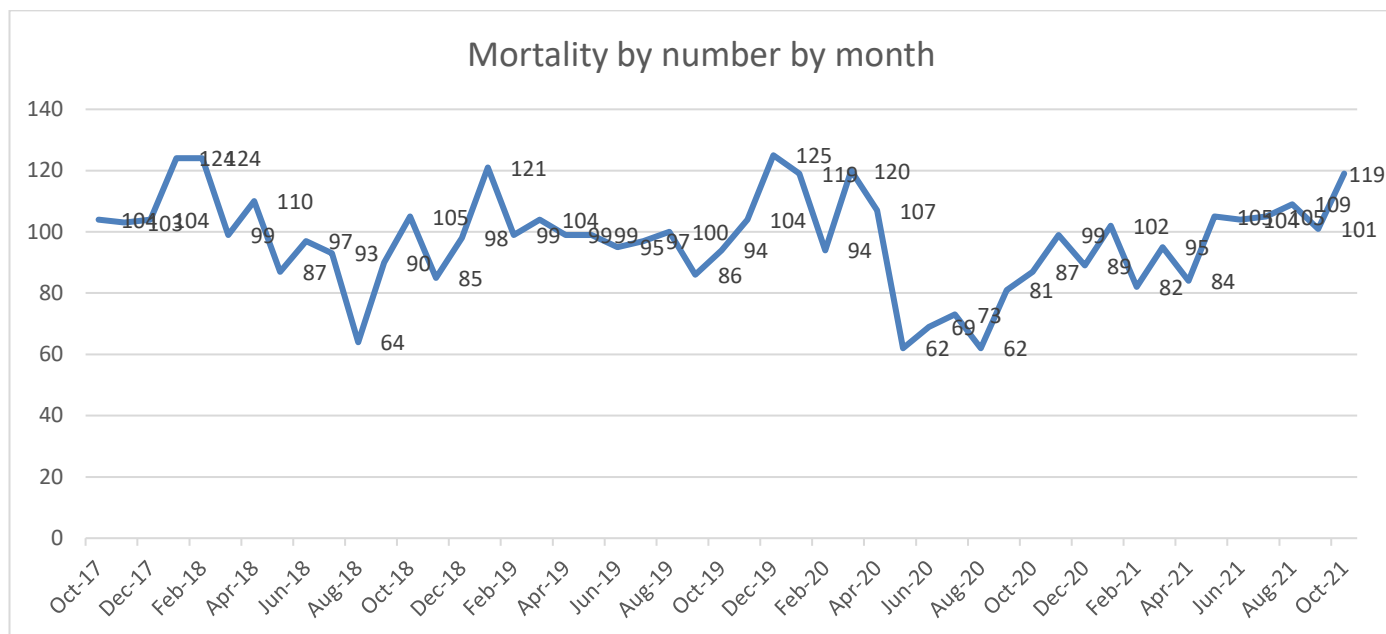
Chart 9, records hospital and community deaths (people's homes) and includes a comparator year, 2019.

There is a rise in total deaths in March and April 2020, 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 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.

Total deaths for area (hospital and community combined)

Public
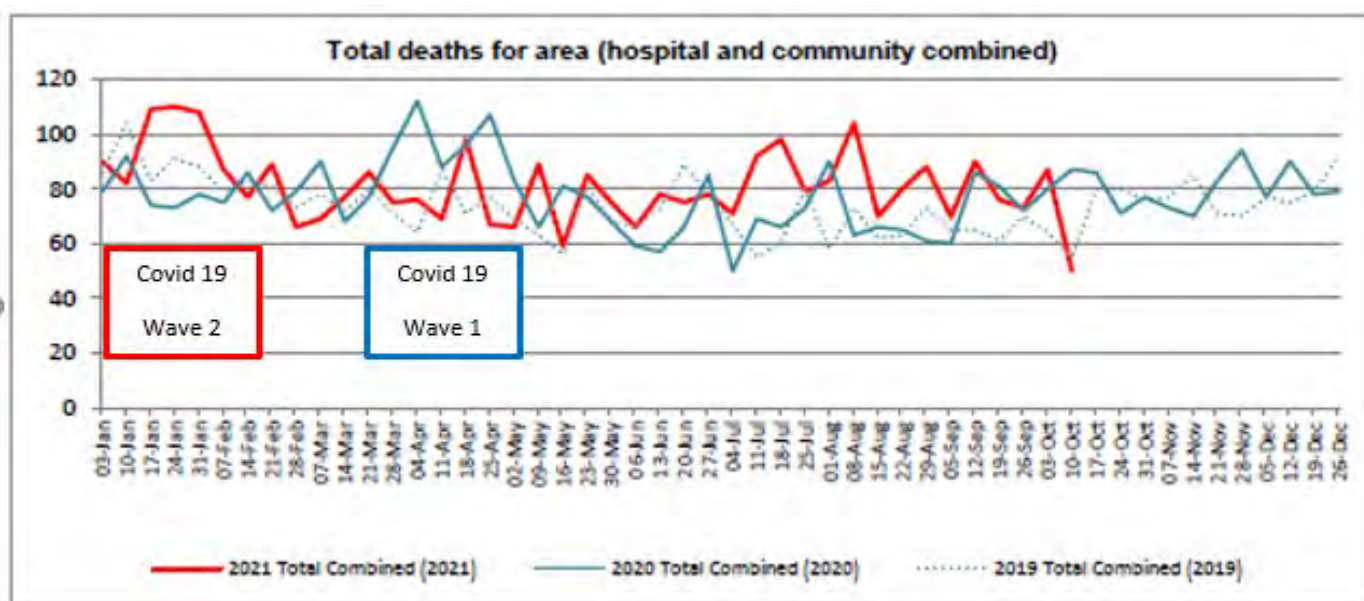
Chart 10 - Total Deaths by ISU locality

Total deaths for Torquay

— 2021 Torquay (2021)   — 2020 Torquay (2020)   ······ 2019 Torquay (2019)

Total deaths for Paignton/Brixham

— 2021 Paignton/Brixham (2021)   — 2020 Paignton/Brixham (2020)   ······ 2019 Paignton/Brixham (2019)

Total deaths for Newton Abbot

— 2021 Newton Abbot (2021)   — 2020 Newton Abbot (2020)   ······ 2019 Newton Abbot (2019)

Total deaths for Coastal

— 2021 Coastal (2021)   — 2020 Coastal (2020)   ······ 2019 Coastal (2019)

Total deaths for Moor to Sea

— 2021 Moor to Sea (2021)   — 2020 Moor to Sea (2020)   ······ 2019 Moor to Sea (2019)

Public

Appendix 3 – Mortality Analysis

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

	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	Jul-21	Aug-21	Sep-21	Oct-21	
Torquay ISU																		
DELIVERY SUITE											1							
LCHDU																		
LOUISA CARY	1																	
MOTHER AND BABY																		
Paignton and Brixham ISU																		
BRIXHAM	1			3	4	2	6	4			5	1	1	1	1	2		
CARDIAC CATHETER SUITE													1					
CHEETHAM HILL	8	14	7	12	6	11	11	12	10	11	10	11	7	9	11	12	10	
DUNLOP	6	3	5	6	2	4	3	4		5	4	3	3	4	8	6	4	
MIDGLEY	11	10	3	13	13	10	7	13	16	14	13	18	12	18	16	17	17	
SIMPSON	4	7	4	7	6	10	8	5	2	8	9	16	12	8	4	7	9	
TORBAY CHEST PAIN UNIT																	1	
TORBAY CORONARY CARE BEDS	2	1	3			2	3	1	2	1		2	2	3	4		3	
TURNER			2	4	5	2	3	2	3	8		5	6	7	5	5	5	
ELIZABETH							3	1	3	1	1	1						
WARRINGTON			1	2	2		2	1	1	2	2	2	2	2	3	3	4	
Newton Abbot ISU																		
ACUTE MEDICAL RECEIVING UNIT	1																	
MEDICAL RECEIVING UNIT											1		3	4	1	3		
EAU3	6	2	4	1														
EAU4	5	7	6	11	7	7	9	17	10	11	8	9	16	11	11	8	16	
INTENSIVE CARE UNIT	5	5	8	7	5	6	12	2	5	4	5	10	16	7	11	3	8	
RECOVERY INTENSIVE CARE UNIT																		
TEIGN WARD	5	5	2	3	1	3	2	2	1	2	1	3	2	2		4	2	
TEMPLAR WARD	1		4		3			1		1	2	4		1	1		1	
TEMPORARY INTENSIVE CARE UNIT								1	1									
Coastal ISU																		
AINSLIE		1		2		2	1	2	1	1	1			4	7	3		
ALLERTON	4	7	5	3	7	8	8	2	3	8	4	6	4	3	7	2	8	
CROMIE	1	1		1	8	8	7	13	6	2	2	7	2	5	5	5	5	
DAWLISH	1	3	1	1				4	1	1				1	1	2		
ELLA ROWCROFT	1	2		4	3					3		1			2	1		
FORREST	1						4	5	4					4	5	8	13	
THEATRES								1							1			
Moor to Sea ISU																		
DART				1	1	1				2	3	3		1		1	3	
GEORGE EARLE	5	7	5	9	14	16	9	8	4	8	10	8	13	8	9	9	10	
Grand Total	69	73	62	81	87	99	89	102	82	95	84	105	104	105	109	101	119	

Public

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 (38 observed v 25.6 expected). A case notes review was organised by the Director of Patient Safety and a Renal Consultant which suggested this is **not** related to coding issues but to a tendency to record deaths as due to 'acute renal failure' rather than the underlying medical condition which resulted in acute renal failure. This was reported in September 2021 Mortality Scorecard.

Deaths due to intestinal infection are higher than expected (15 observed v expected 9.1). This does not appear to be due to coding issues and has been discussed at Mortality Surveillance review.

Deaths due to 'other connective tissue disease' represents the only new alert since September 2021 dashboard. Preliminary analysis of the data suggests the majority of the deaths due to 'other connective tissue disease' occur in the frail, elderly cohort and 8 out of the 14 deaths are coded as having 'a tendency to fall'. Next steps in analysis will be a review of coding in these patients.

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

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
Relative risk & CUSUM alerts							
All Diagnoses	1 5	72251	1104	1278.3	1.5	86.4	
HSMR (56 diagnosis groups)	1	28312	885	927.6	3.1	95.4	
Acute and unspecified renal failure	2	244	38	25.6	15.6	148.3	
Alcohol-related mental disorders	1	186	3	0.6	1.6	486.5	
Digestive congenital anomalies	1	17	1	0.0	5.9	4798.3	
Intestinal infection	1	625	15	9.1	2.4	164.1	
Other connective tissue disease		844	14	5.8	1.7	240.6	
Syncope	1	348	5	1.6	1.4	309.3	

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. This month's position demonstrates increased mortality due to 'Septicaemia' in deaths occurring after discharge. This diagnosis group is not alerting for in-hospital deaths on Dr Foster. Further analysis will be discussed with the Director of Patient Safety.

Public

SHMI* TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST split by in hospital/all deaths by CCS group for all admissions to TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST in May 2020 to April 2021

Other gastrointestinal disorders
Intracranial injury
Intestinal obstruction without ...
Fluid and electrolyte disorders
Urinary tract infections
Acute and unspecified renal f...
Gastrointestinal haemorrhage
Chronic obstructive pulmonar...
Acute myocardial infarction
Cancer of bronchus, lung
Senility and organic mental dis...
Fracture of neck of femur (hip)
Aspiration pneumonitis, food/v...
Secondary malignancies
Congestive heart failure, nonh...
Septicemia (except in labour)
Residual codes, unclassified
Acute cerebrovascular disease
Pneumonia
All *

Relative Risk

All deaths

In hospital deaths

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 1 September 2021. For the 12-month period April 2020 to March 2021 there were no alerts in these patient safety indicators. The Trust has a statistically lower than expected relative risk for six of the indicators (green in 'Relative risk' below).

Table 4 – Patient Safety Indicators

Patient Safety Indicators

Period: 12 months (Apr 20 to Mar 21)

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk
Accidental puncture or laceration	46680	53	71.2	1.1	1.5	74.4
Deaths after surgery	399	21	32.2	52.6	80.8	65.1
Deaths in low-risk diagnosis groups	17227	50	84.1	2.9	4.9	59.4
Decubitus ulcer	6840	339	424.9	49.6	62.1	79.8
Infections associated with central line	8928	1	0.6	0.1	0.1	175.0
Obstetric trauma - caesarean delivery	506	1	2.3	2.0	4.6	43.1
Obstetric trauma - vaginal delivery with instrument	214	14	14.7	65.4	68.7	95.2
Obstetric trauma - vaginal delivery without instrument	986	38	28.9	38.5	29.3	131.5
Postoperative haemorrhage or haematoma	10786	3	4.6	0.3	0.4	64.6
Postoperative physiologic and metabolic derangement	8249	0	1.6	0	0.2	0.0
Postoperative pulmonary embolism or deep vein thrombosis	11026	19	43.5	1.7	3.9	43.7
Postoperative respiratory failure	7281	0	8.0	0	1.1	0.0
Postoperative sepsis	93	0	1.6	0	17.4	0.0
Postoperative wound dehiscence	456	0	0.4	0	0.9	0.0

Public

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. Further updates are awaited.

Number of Neonatal, Perinatal, and Maternal Deaths

In September 2021 we had two antenatal stillbirths

- Case 1 - A Mother who presented with abdominal pain and high blood pressure at 33 weeks, and on examination there was no fetal heart.
- Case 2 - A mother attended her routine antenatal appointment with a history of reduced fetal movement for 24 hours, on examination there was no fetal heartbeat, this was confirmed following admission to the Maternity assessment unit on ultrasound scan.

We had no intrapartum stillbirths, neonatal deaths or maternal deaths.

Chart 12 – Stillbirth, Neonatal Deaths and Late Fetal Losses
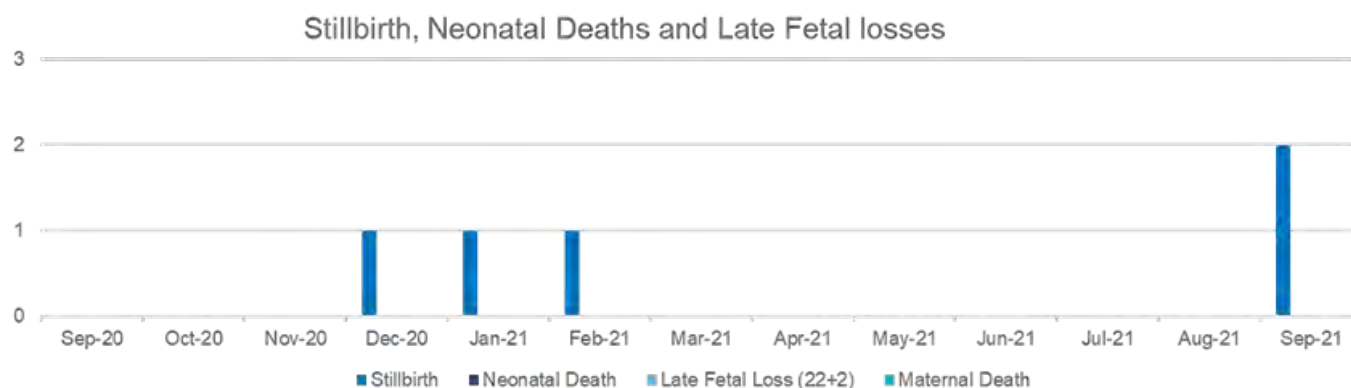
Number of child deaths

September 2021-October 2021

There has been one death of a less than one-month old baby. The cause of death is a medical cause; however, the baby was on Child Protection Plan for neglect. This case is put forward to the Child Safeguarding Practice review panel for consideration. This would help review whether any changes in decision making and planning for this baby may have helped prevent the death. Bereavement support will hopefully be offered by the Named Bereavement midwife in this case. Further Child Death processes are still on going for this case.

The final CDRM (Child Death Review meetings) for the previous cases of this year are to be held on 10/11/21 with the relevant professionals involved.

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

During September and October 2021 there have been 3 concerns raised.

2 regarding patient property – 1 closed, 1 being investigated
1 regarding a delay in coronial referral - Closed

Medical Examiners

The Medical Examiners Service continues to be impacted by sickness, resulting in reduced Medical Examiner capacity. To mitigate this the medical examiner officer are reviewing all cases and liaising with the next of kin to identify any areas of concern as sanctioned by the Regional Medical Examiner.

In preparation for the statutory roll out the service to cover all community deaths, a successful Medical Examiner recruitment process has been undertaken. The new Medical Examiners are expected to commence work during November after which detailed project planning and pilots will commence.

During September and October, 5 incidents have been raised by the Medical Examiner's Office regarding delays in referrals. This has resulted in delays in scrutiny and completion of the MCCD's.

Table 5 – Medical Examiners Performance Summary

Month	Performance					Outcomes							
	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
Jul-21	114	26	76	66.7%	86.4%	3	3.9%	66	90.4%	36	49.3%	7
Aug-21	117	28	67	57.3%	75.3%	4	6.0%	51	81.0%	34	54.0%	4
Sep-21	97	18	43	44.3%	54.4%	3	7.0%	30	75.0%	16	40.0%	0
Oct-21	127	17	78	61.4%	70.9%	5	6.4%	54	74.0%	27	37.0%	6
Nov-21				#DIV/0!	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	
Dec-21				#DIV/0!	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	

National Cardiac Arrest Audit 2020/2021

Full year audit data for 2020 / 2021 indicates nothing outwith 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 September and October 2021 there were twelve Coroner's requests for information. There were five inquests during this time with no Trust attendance. There were a total of six cases closed during these months

The Trust has no outstanding Regulation 28 reports.

Public

Trust learning: Serious Adverse Event Group September and October 2021

Key Issues	Learning and actions taken
Treatment / Diagnostic learning The SAE group discussed 4 investigations in September and 6 in October 2021 3 investigations relating to complications occurring as a result of errors in operational processes A fall of a patient at a community hospital sustaining a significant head injury	Operational processes based on paper forms with no audit trail, and reliant on a few key individuals are not robust Issues around recognition of deteriorating patient after a fall

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.

Report to the Trust Board of Directors		
Report title: Annual Incidents Report 2020/2021		Meeting date: 24th November 2021
Report appendix	Appendix 1: Incident Analysis Appendix 2: Review of pressure Ulcer and Falls Incidents Appendix 3: Drug and Alcohol deaths Appendix 4: Medicine Management	
Report sponsor	Chief Nurse	
Report author	System Director of Nursing and Professional Practice (South Devon) Interim Quality Lead	
Report provenance	Quality Improvement Group Quality Assurance Committee	
Purpose of the report and key issues for consideration/decision	The purpose of the report is to provide the Trust Board with an annual summary of principal activity and outcomes relating to the patient safety incidents that occurred in the Trust during 2020/21 and Q1 of 2021/22. This report provides evidence to support the Board on the Trust's quality of care. It is intended to afford information that will provide assurance regarding compliance with external requirements for Serious Incidents (SIs), Never Events and patient safety incidents. The paper will also refer to activity and outcomes from; • Drugs and alcohol deaths (Appendix 3) • Medicines incidents; (Appendix 4)	
Action required (Choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to note: • Increase in adverse Incidents across the Trust in the 12-month period by 40%, the proportionality of the categories (near miss, no harm, low harm, moderate, severe) remain the same • The drivers for the increase in reporting are specifically pressure ulcers, falls • Note the opportunities to strengthen the systems and processes to ensure effective and timely investigation • Note the nature of harms impacting patients. • Note the actions and interventions being taken to reduce the risk of harm to patients	

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

Is this on the Trust's Board Assurance Framework and/or Risk Register				
	Board Assurance Framework	x	**Risk score**	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		**Terms of Authorisation**	
	NHS Improvement		**Legislation**	
	NHS England		**National policy/guidance**	

Report title: Annual Incidents Report 2020/2021		Meeting date: 24th November 2021
Report sponsor	Chief Nurse	
Report author	System Director of Nursing and Professional Practice (South Devon) Interim Quality Lead	

1.0 Introduction

The purpose of the report is to provide the Trust Board with an annual summary of principal activity and outcomes relating to the patient safety incidents that occurred in the Trust during 2020/21 and Q1 of 2021/22. This report provides evidence to support the Board on the Trust's quality of care. It is intended to afford information that will provide assurance regarding compliance with external requirements for Serious Incidents (SIs), Never Events and patient safety incidents.

The paper will also refer to activity and outcomes from;
- Drugs and alcohol deaths (Appendix 3)
- Medicines incidents (Appendix 4)

2.0 Context

It is important to note, that the reporting period April 2020 – June 2021 is at a time of the Covid-19 pandemic, and therefore admission profiles and clinical areas are likely to have been subject to operational changes as result of this. With many teams working outside of their usual environment or clinical areas.

Current Trust practice follows the National Framework for Serious Incident (2015) and Never Event investigation (Feb 2021). Utilising an incident management and reporting data system (Datix) that uploads patient safety incidents to the existing National Reporting and Learning System (NRLS). This enables the Trust to benchmark nationally, regionally and locally.

3.0 Analysis of Incident Data

From April 2020 to June 2021 a total of 12,187 incidents were categorised as affecting patients and reported onto the Trust Incident Management System (Datix). The Trust benchmarks favourably nationally with the National Reporting Learning System (MRLS) and is not an outlier in reporting incidents.
Of these 9,177 (75%) are reported to have caused harm by the organisation meaning that they directly affected patient care delivery, and of these 9177, a total of 461 (5%) were reported to have caused Moderate, Severe or Death harm.

Initial analysis in line with the previous years stated that the top two reported categories of incident remain Falls and Pressure Ulcers. This trend in top two reported incidents is also seen nationally.
The remaining 3,010 of 12,187 were incidents that affected our patients but were attributable to another organisation.

The total number of incidents by harm category have seen an increasing trend over 2020 – June 2021 (figure 1)
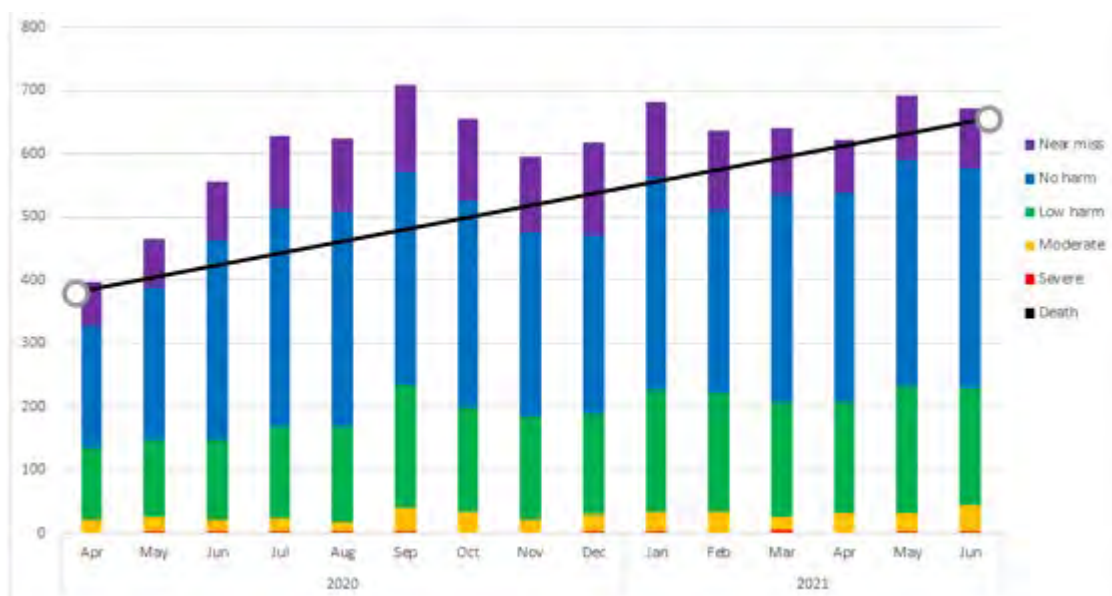
Fig.1 Total number of incidents by Harm categories Q1 2020/21- Q1 2021/2022

The drivers for these include:
- Increased awareness of incidents and the importance of reporting via training and education and overall promotion of a positive reporting culture
- Increased operational demand observed during summer 2021
- Covid activity in line with the observed national peaks (September and January)

The overall majority of reported patient incidents caused Low to No harm.

3.1 Key themes from all incidents reported

On analysis, the majority of patient incidents occur within Newton Abbot, Paignton and Brixham and Coastal ISU's. This is reflective of where the majority of the organisation in-patient activity occurs. The overarching top 10 categories reported by way of themes are; Falls and Pressure Ulcers consistently feature high on this list, these are consistent with national profiling of incidents (NRLS, 2021).

To highlight Top 10			
1. Pressure ulcer	4. Transfer and discharge	7. Documentation	10. IP&C
2. Falls	5. Medication	8. Deteriorating patient and care planning	
3. Security	6. Blood transfusion	9. Obstetrics	

3.2 Near Miss Incidents

18% of all incidents (1,6512 of the 9,177) are categorised as near misses (A near miss is an incident that had the potential to cause harm, loss or injury but was prevented (NHS Incident reporting Policy). Of the near miss incidents, the top four areas are:

- Blood transfusion and sample incidents
- Transfer of patients and discharges
- Documentation
- Security or crime related.

From analysing the blood transfusion and sample incidents these relate to incorrect labelling of samples, and blood transfusion process not always in line with the requirements of the Blood Safety and Quality Regulations 2005 (amended). It is recommended that further focus on this area is required to understand the potential harm to patients.
Improvement interventions include:

- Education and Training program review
- Communication roadshow
- Regular meetings with the ISU's

3.3 Overview of Moderate and Above incidents

During 2020/21 the Trust saw 327 patient safety incidents reported as moderate harm and above, with a running quarterly average of 82 incidents. However, in Q1 of 2021/22 a 25% increase was noted with a total 110 moderate and above incidents reported. This is attributable to delayed treatment in planned an and unplanned care as an outcome of covid pandemic, alongside data validation and cleansing and a review of patient safety system processes. This increase and variance in incidents reported can be observed within Figure 1

As previously stated, and as demonstrated in Figure 3, The top three reporting of moderate and above harm to patients are:

- Falls
- Pressure ulcers

- Implementation of care and ongoing monitoring, this is related to the response to the deteriorating patients within prescribed care and the care pathway such as delayed delivery of planned and unplanned care.

Further analysis is provided in appendix 2 for falls and pressure ulcers. It is noted most falls reported within the Trust result in no, or low harm, the Trust reported a rate of falls of between 3.3 and 6 patients per 1000 bed days; the national average is noted to be 6.63 (RCP, 2015).

The analysis of care delivery within the ISU's in regard to moderate and above incidents provide insight into areas where either contributing factors or root cause analysis is portrayed these include;
- Human Factors such as teamwork, tasks and equipment.
- Documentation including completion of risk assessments, care implementation, referrals to services
- Communication such as handover, written, discussion with families and carers

Improvement interventions in:
- Human factors include revitalisation of training and education framework
- Documentation has seen the introduction of icare tool as an audit to facilitate the review and assurance of key deliverables
- Within communication we have recommended the working with us panel to gain real time feedback to assist with reviewing improvements

3.4 StEIS reportable Incident's comparison

Over the 15-month period of 2020-2021 and Q1 2021/2022, there were 82 incidents that were StEIS reportable. Figure 4 provides a detailed account of categories. You will see that the top 3 are Falls, pressure ulcers and implementation of care.

Fig.4 Total StEIS reportable Incidents by Category
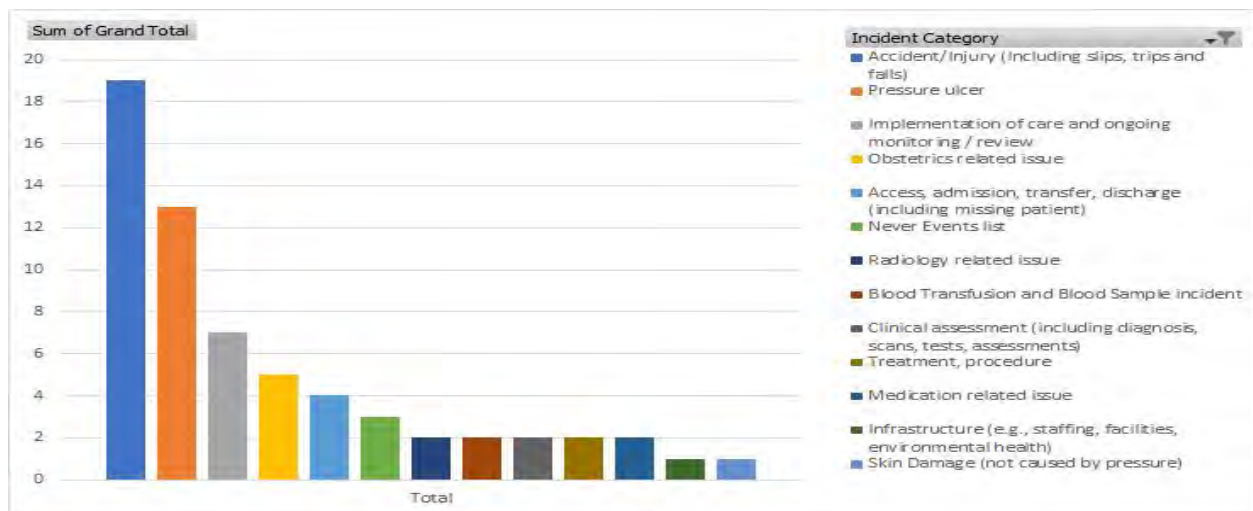
In 2020/2021 a comprehensive review of serious incidents was undertaken which revealed that a number of incidents, although reported in the internal incident reporting system. Annual reconciliation around incidents identified a number had either not been reported or grading reclassified had not been reported externally. Through validation and reclassification, Figure 5 demonstrates an increase of 50% in the number of STEIS reported in April 2021 compared to April 2020 within Q1 2021 in comparison to Q1 2020.

Fig.5 Q1 2020 and 2021 Comparison by category
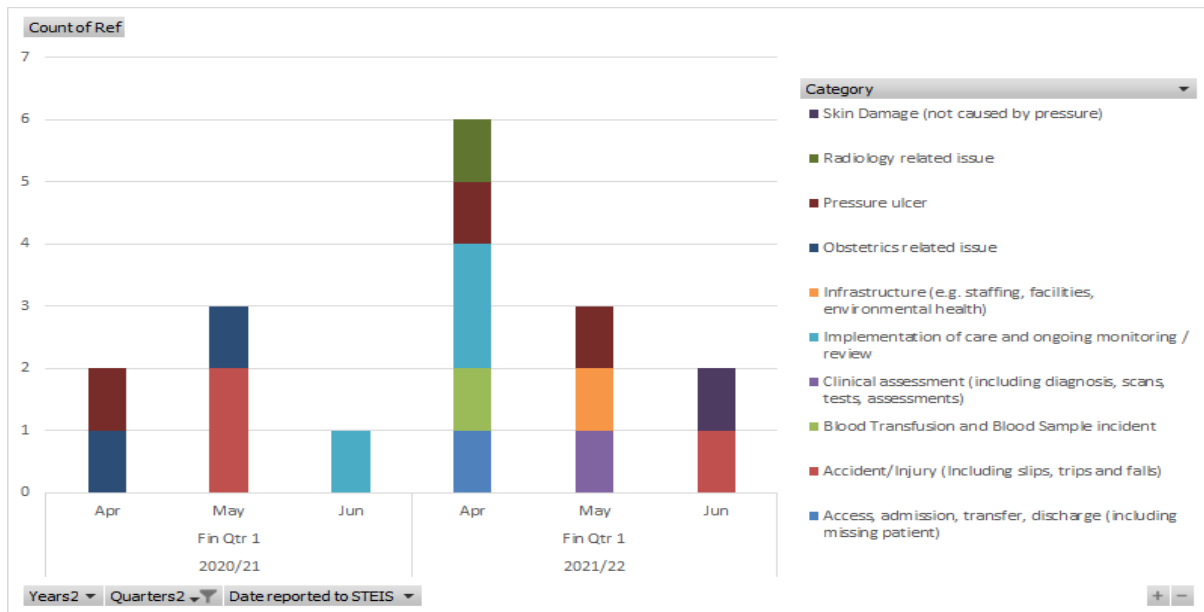
Q1 2021 provides an altering position of STEIS reportable to include infrastructure and clinical assessment, this can be triangulated with the increase in covid admissions, staff sickness related to covid and activity that exceeds levels seen at winter.

3.5 Never Events

We have seen an increase in reported Never Events in 2020/2021 compared to previous years (2 reported in both 2018/19 and 2019/20 and 5 in 2020/21). This trend is also being seen nationally and has been the catalyst to a review of patient safety, with the release of The NHS Patient Strategy and Patient Safety Framework both released in 2020 for organisations to establish new ways of viewing Patient Safety.

The Trust had one never event withdrawn as early examination established that TSDFT identified the never event with care being delivered in another organisation and has therefore not been considered as part of this analysis.

Retained foreign objects and wrong site surgery are consistently the highest reported cause over the last few years and specifically in 2020/2021. This has also been the case within the South West Region and Nationally.

The table shows a summary of the 4 incidents that were investigated by the Trust:

Ref	Incident date	Directorate	Department	Subcategory	Severity
INC-66998	14/09/2020	Newton Abbot ISU	Intensive Care	Retained foreign object post-procedure	Low harm
INC-67222	20/09/2020	Coastal ISU	Anaesthetics	Wrong site surgery	Low harm
INC-68372	20/10/2020	Coastal ISU	Ophthalmology	Wrong Implant Prosthesis	No harm
INC-73605	13/03/2021	Moor to Sea ISU	Stroke Team	Misplaced naso- or oro-gastric tubes not detected prior to feeding or flushing	Death

The themes from the investigations of the Never Events include;
- human factors such as teamwork, tasks and equipment.
- communication such as handover, written, discussion with families and carers, safety briefings

At a national level a review of the surgical (WHO) checklist processes is being conducted to seek alternative processes to refresh and revitalisation and review the safety in theatres and the patient pathway.

Locally our improvement interventions include;
- reviewing the safety framework that includes safety briefings, huddles to standardise and refocus

4.0 Conclusions

This paper has provided an analysis of the patient safety incidents that have occurred over the period 2020/2021 and Q1 2021/2022. The reporting culture is in line with national reporting and the themes that have been identified as those causing serious harm such as falls and pressure ulcers are also being seen nationally.

The has been an increase in never events within the Trust, this is also reflective nationally, with covid-19 seen as a contributory factor.

Early indicators for the current year QI (2021/22) suggest that 12-hour trolley breaches, compliance of VTE assessment and the restoration of planned care services determining the level of harm caused will be some of the more prevalent incidents reported alongside the most frequent incidents that may cause harm such as Falls and Pressure Ulcers.

The New Patient Safety Strategy provides the desired approach and framework for a continuous improvement approach towards patient care and experience with the core themes being falls, pressure ulcers and deteriorating patients, with human factors, communication and documentation as areas of improvement.

5.0 Recommendations

Board is asked to note;

- Increase in adverse Incidents across the Trust in the 12-month period by 40%, the proportionality of the categories (near miss, no harm, low harm, moderate, severe) remain the same
- The drivers for the increase in reporting – specifically pressure ulcers, falls
- The opportunities to strengthen the systems and processes to ensure effective and timely investigation
- The nature of harms impacting patients.
- The actions and interventions being taken to reduce the risk of harm to patients

Appendix 1:

Analysis of Incident data

Fig.2 Incidents by Severity % Q1 2020/21- Q1 2021/2022
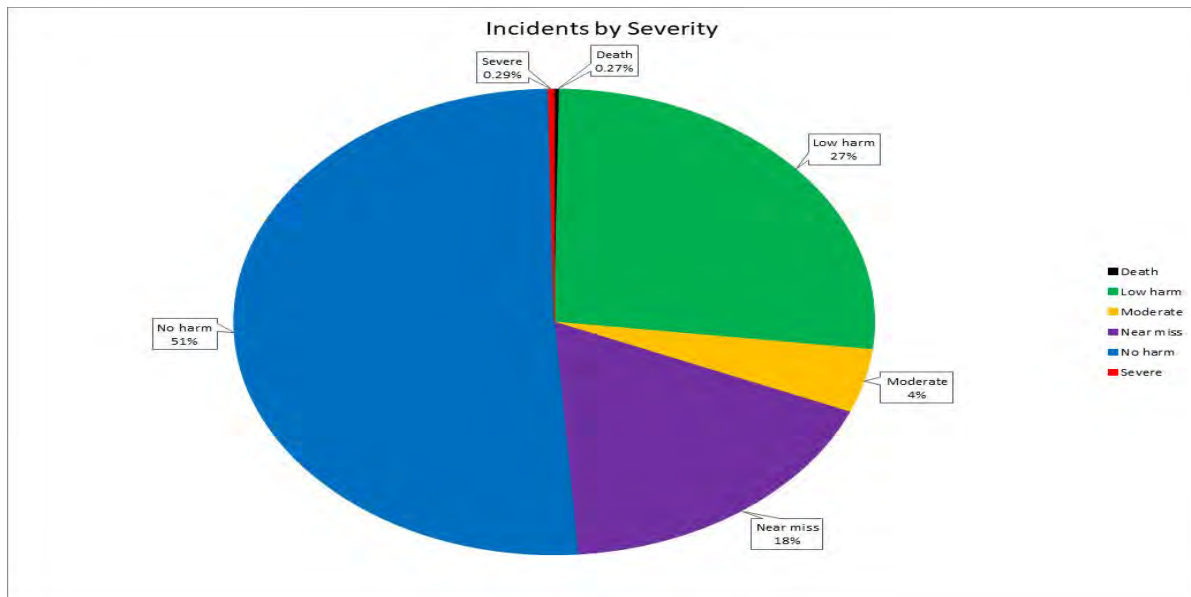
It is recognised that security incidents have 14 subcategories with the mains areas reported being Patient/Visitor monitoring, threatening abusive behaviour and missing/absconded person. Whilst these will have triggered individual investigation (of various levels) an appreciative enquiry would provide further analysis into the detail of the key drivers that lead to patient harm caused and highlight areas of improvement.

Documentation is also a prevalent theme throughout all incident categories, and is particularly cited within the Root Causes in SI investigations which will be demonstrated further into the paper.

Presentations on Discharge, Falls and Pressure Ulcers have been presented to the Quality Improvement Group and Quality Assurance Committee in 2021.

Triangulating total incidents with areas and categories causing harm to patients this is explored in more detail. It is also evident that the moderate and severe harm to patients and total incidents are occurring within Coastal, Paignton and Brixham and Newton Abbot ISU's which demonstrates the areas with the majority of inpatient areas.
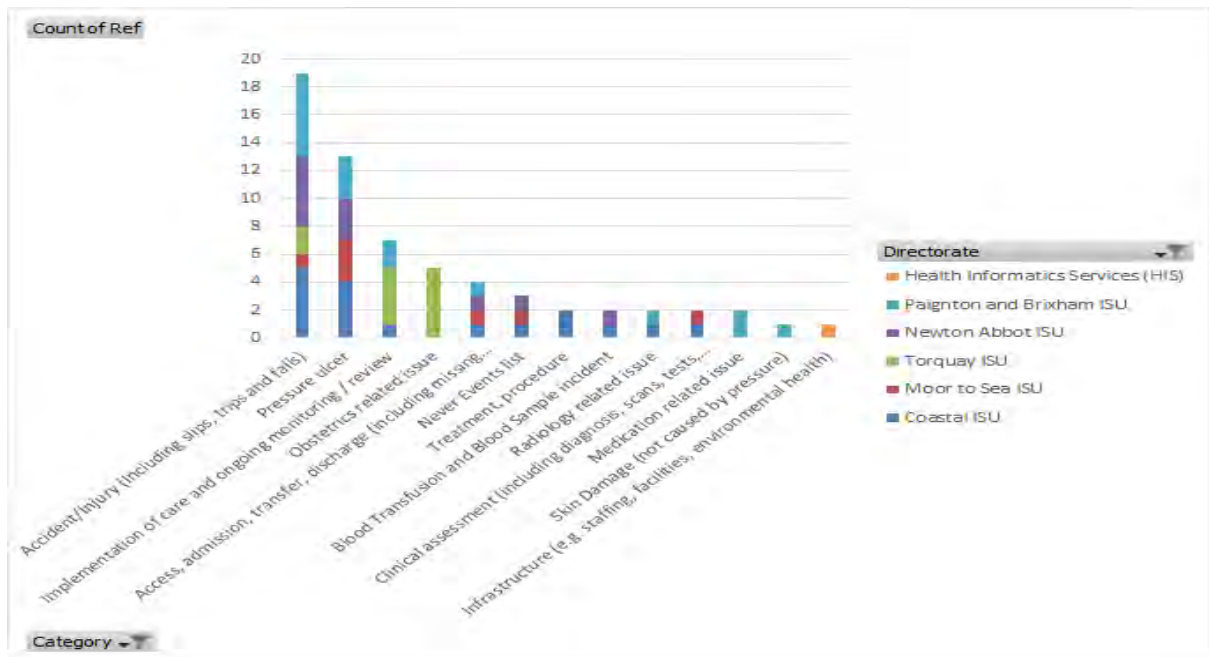
Fig.3 Moderate and above by ISU

Appendix 2:

Top 2 Clinical Themes (Pressure Ulcers and Falls)

Pressure Ulcers: 2020-2021

TSDFT has a good reporting culture and a very strong and rigorous approach in the management of Pressure Ulcers investigations with a Pressure Ulcer Prevention (PUP) Group performing as a sub- committee of Quality Improvement Group (QIG).

Due to the very specific nature and requirement of reviewing and investigating pressure ulcer incidences the Lead for Tissue Viability has developed a PU SSKIN Checklist tool/template which enables the investigator to complete the entire review in one go. This has been supported and endorsed by the CCG.

During 2020/2021 a 10.1% reduction in pressure ulcers acquired in our care was noted compared to 2019/2020. This equates to 89 less pressure ulcers acquired, however the changes in the admission profile during the pandemic will almost certainly have contributed to the observed reduction.

Generally, TSDFT has very small incidences of serious harm caused by pressure damage and/ or Category 4, attributable to lapses in care. Of the 269 reported Cat.3/4 pressure ulcers acquired in our care for the period 2020-2021, 12 were declared to StEIS as being due to lapses in care by Trust staff.

Key themes identified were:
- Documentation
- Pressure area risk assessments

It is to be noted that in all areas that underwent an SSKIN investigation robust and rigorous training has been delivered and no further cases gave been reported in those clinical areas.

The improvement interventions include:
- The introduction of icare as a real-time auditing tool to review documentation and risk assessments
- Reframing of the education and training package

Fig.6 Total number of Pressure Ulcers
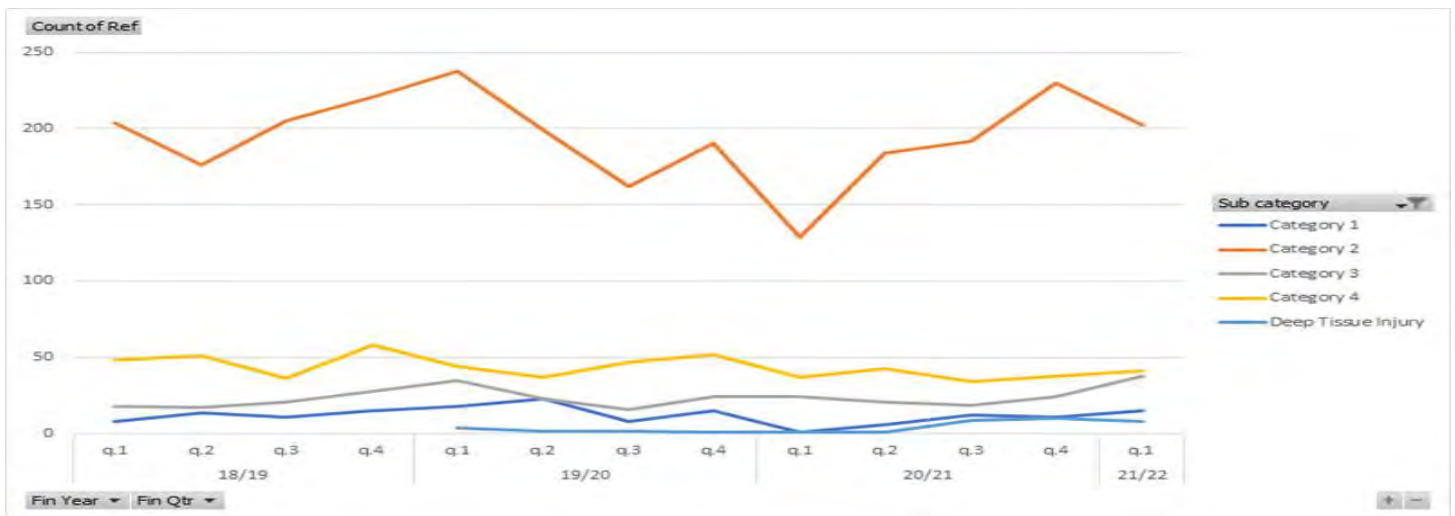
Fig. 7 Total number of StEIS reportable Cat3/4 Pressure Ulcers
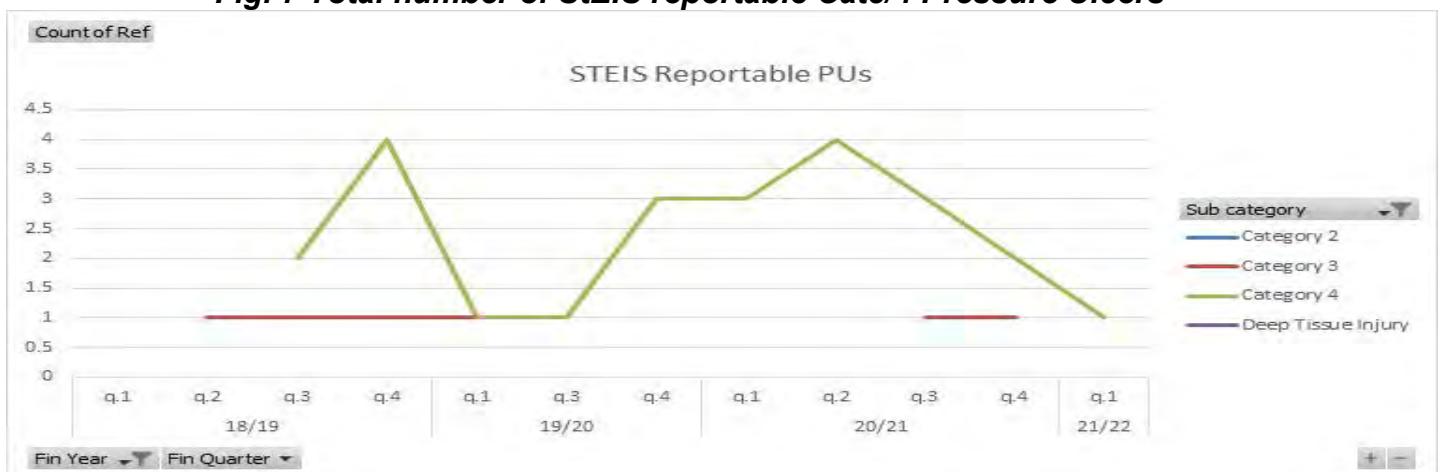
It can be observed that there is direct correlation between the restrictions of the first Covid-19 lockdown directly affecting community nursing visits to people own homes and residential settings and when visiting began to increase again there is an observed spike in category 3/ 4 pressure Ulcers.

Pressure Ulcers: Q1 2021/2022

In 2021 Q1 (April – June), there were 78 pressure ulcer Category 3 and 4 reported as acquired or deteriorated in our care. The equates to a 37% increase when compared to Q1 2020. 63 of these were reported by the health and wellbeing teams which include Community Nursing and Intermediate care in the 5 ISUs. The increase can be attributed to a working assumption of not accessing care and advice and restrictions to community care during covid pandemic. As this is being observed nationally and is nationally being reviewed.

For each of these the PU SSKIN Checklist process was followed, and which showed that 77 showed no lapses in care by TSDFT and 1 which did indicate a lapse in care, noted as a category 4 incident.

The application of the SSKIN tool identified lapses in care in relation to:
- poor documentation and
- limited evidence of discussion with the patient educating them of the importance of re-positioning and off-loading of the heels, to prevent pressure damage and injury.

As per the SSKIN process robust action plans were evident in all case with local monitoring conducted by Ward manager as part of their weekly processes.

Whilst there is evidence that there has not been an increase in StEIS reportable incidents there is a noted increase in category 2 pressure ulcers. Whilst the Tissue Viability leads have not been able to identify any specific causal factor of the increase in Category 2 pressure ulcers in Q1 21/22 when compared to Q1 20/21. It has been recognised this is representational of the national picture and not unique to the Trust.

Fig.8 Pressure Ulcer by Category
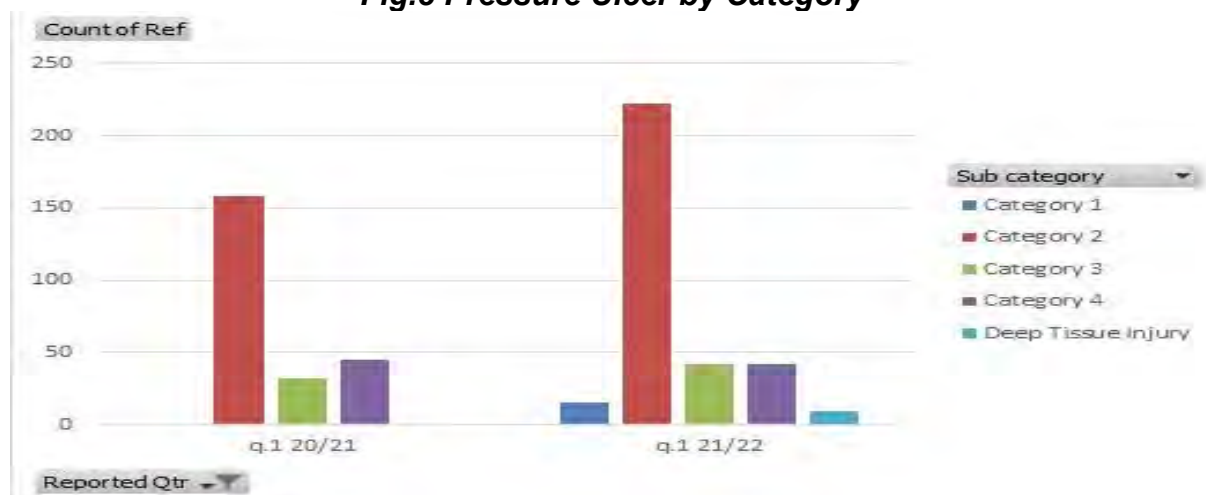
Falls
Across England, Falls are the most frequently reported incident affecting hospital inpatients and, in the context of STEIS reportable incidents, this is true for TSDFT (n=19) for the period under review.

An overall decrease in inpatient falls was observed during 2020/21 in comparison to 2019/202 and this likely attributable to the altered admission profile experienced by the Trust in the early stages of the Covid-19 pandemic (Q1). As normal levels of admission resumed, falls-related incidents have also increased. However, it should be noted that patients found to require unplanned care are presenting as both more complex and with higher acuity during this time.

The changing presentation of older, frail, patients has resulted in a concurrent increase in requests for support from the Falls Prevention Leads, with acknowledged capacity issues following from this increased demand.

For context, it is worth noting most falls reported within the Trust result in no, or low harm. And the Trust experienced a rate of falls of between 3.3 and 6 patients per 1000 bed days; the national average is noted to be 6.63 (RCP, 2015).

Fig.9 Total Fall Incidents by Harm Caused
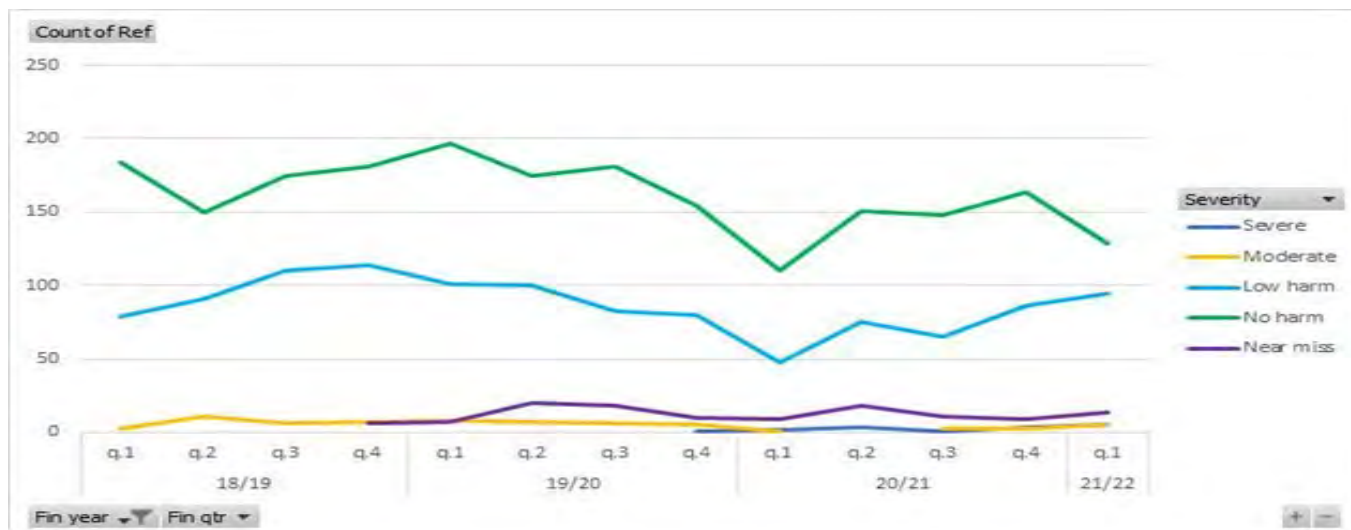
There were 19 falls related SI's in the period under review, the investigation reports identified 2 key themes;

- Human Factors (Patients)
- Documentation

The Trust contributes to the National Adult Inpatient Fall Audit (NAIF) and has a dedicated Falls Prevention team, who gather relevant data and report it appropriately, which includes the learning from incidents and improving patient experience and care pathways.

Improvement interventions for falls include:

- Revising education and training package
- Undertaking quality improvement as a Trust in relation to falls rather than reviewing each incident in each area.

Fig.10 StEIS Reportable Falls by year

The change noted in figure 10 above, from higher numbers of moderate-harm falls incidents, to more severe-harm falls being recorded, relates to the Trust adopting the National Audit Inpatient Falls audit recommendation from Autumn 2020 to reclassify those falls resulting in hip fractures (fractured neck of femur) deemed as moderate to severe.

Appendix 3:

Drug and Alcohol Death

Alcohol deaths amongst Torbay residents accessing or who have recently accessed Torbay Drug and Alcohol Service have increased from 7 in 2018-19 and 6 in 2019-20 to 15 in 2020-21. The reporting of deaths has changed during this period to include deaths of individuals who died of physical health related disease directly resulting from alcohol use i.e. liver cirrhosis, ascites etc.

Therefore, this may account for some of the increase in number. However, it is unfortunately very clear that the trend locally is upwards with an increasing number of alcohol users overdosing on prescribed medication (anti-depressants, pregabalin, gabapentin, dihydrocodeine).

There has also been an increase in the number of 'street homeless' and those living in our local homelessness hostel dying as a result of alcohol related diseases, overdoses often believed to be accidental but, in some cases appear to be suicide and, a number where pneumonia is stated as the cause of death.

There appears to be quite a direct link to the increase in alcohol deaths during lockdowns due to COVID-19.

Fig.11 Alcohol Related Deaths 2018-21

In relation to drug deaths there were two less deaths in 2020-21 than in 2019-20. However, there is still a fairly significant increase upon 2018-19.

Fig.12 Drug Related Deaths 2018-21
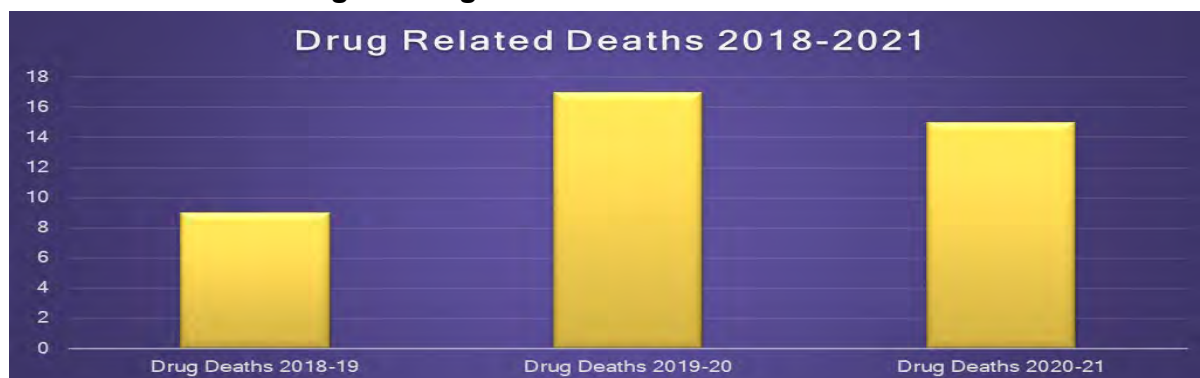
For context this is reflective of the National picture.

Overall Torbay has seen a reduction in drug related deaths in 2020-21. However, the sudden spike following ease of covid-19 lockdown in June 2020 resulted in a number of actions to ensure that the service reduced the likelihood of deaths wherever possible. Alcohol related deaths in Torbay increased significantly from 6 in 2019-2020 to 15 in 2020-21 – this constitutes a rise of 150%.

As a result of the spike in drug deaths and the substantial rise in alcohol deaths a number of key improvements were implemented and continued to be monitored. A full paper was presented to Quality Assurance Group in September 2021.

Improvement interventions include:
Drug Deaths
➢ Introduction of a Torbay 'Drug Related Death Review Group' (DRDRG). Meets quarterly.
➢ Poly-pharmacy issue has resulted in a piece of work developing Devon-wide with the CCG, LMC, LPC and other Drug and Alcohol providers to examine how we can support prescribers (with a particular focus on GPs) to reduce and/ or manage prescribing of high-risk medications amongst drug users.
➢ A Band 7 Poly-pharmacy role has been funded by the commissioners for 12 months to support this work.
➢ Torbay D&A service has developed a new discharge planning protocol to reduce inappropriate 'drop outs' from treatment.

Actions Related to Alcohol Deaths
➢ The frequency of mandatory Physical Health Assessments reviews for alcohol users was increased from annually to quarterly.
➢ The commissioners have used some PHE funding to purchase 30 weeks of inpatient detox for alcohol for financial year 2021-22 – 15 placements.
➢ Extra support and more frequent appointments built into pathways for Recovery Coordinators for alcohol users suffering from mental health issues.
➢ The Substance Misuse Homelessness Nurse (TSDFT employee) based within the local hostel to link in vulnerable individuals (physical of mental health needs) to access appropriate healthcare in drop in sessions at the hostel.
➢ Continued development of Alcohol Pathways within Torbay Hospital to ensure appropriate admissions can take place in a timely manner. The community

D&A service is supporting hospital discharges with the gastro team to enable to two-way process to develop.

➢ Continued support to develop an Alcohol Care Team in the hospital. This would reduce inappropriate admissions and manage appropriate admissions more effectively with the aspiration of improving outcomes for alcohol dependent patients.

Appendix 4:

Medicines Management

Medicine incidents are in the top 10 highest category of incident raised. All medicines incidents are sent to the Governance Pharmacist / Medication Safety Officer (MSO) and the Director of Pharmacy.

The Medicines Governance team work with the Clinical Governance Co-ordinators, incident owners and Patient Safety and Quality Team. All moderate and serious incidents or those of particular concern, where no harm occurred, are discussed with the Director of Pharmacy by the Governance Pharmacist / MSO.

There is quarterly reporting on incidents to the Medicines Governance Committee and the themes observed include:

- Missed doses are still the leading cause of reported administration incidents.
- High risk medicines accounted for 63% of medicine incidents reported in the last year and of these the top 3 were:
  - controlled drugs (31%),
  - insulin (15%)
  - anticoagulant (14%).

Our no harm rates this year was 88% compared to the latest NRLS data for medication incidents of 88% which is in line with national trends and are not an outlier. There were no never events involving medicines reported this year.

In response to the identified themes our improvement interventions will be:

- Monthly "Supporting Medicines Safety" newsletters are circulated picking up on themes or concerns from incidents and sharing any learning.
- QI project on improving prescribing has led to the F1/2 buddying scheme where Foundation pharmacists link with a named doctor.
- Explore how pharmacists can assist ward managers with their Medicines Round Competencies to support the safe administration of medicines.
- Investigate a medicines safety dashboard on HIVE for the ward managers to give oversight on essential medicines related learning e.g. CD eLearning, Safer use of insulin.
- Conduct a detailed review of insulin & anti-coagulant incidents with a view to starting QI project work

Report to the Trust Board of Directors	
Report title: Care Quality Commission (CQC) NHS Patient Experience Surveys 2020 Reports	Meeting date: 24th November 2021
Report appendix	Appendix 1: Report for NHS Adult Inpatient Survey 2020 Benchmarking Report published on the CQC Website 19 October 2021
Report sponsor	Chief Nurse
Report author	System Director for Nursing and Professional Practice (Torbay)
Report provenance	Feedback and Engagement Group November 2021
Purpose of the report and key issues for consideration/decision	The purpose of the report is to briefly highlight the current CQC patient experience survey schedule, with a view to providing a detailed analysis of the results of the NHS Adult Inpatient Survey 2020 and highlights from the Urgent and Emergency Care survey. The paper will describe and outline the improvement plan for the NHS Adult Inpatient Survey. The Board should note the Trust is not an outlier compared to the results of other Trusts, however, we recognise there are improvements to be made, specifically in the following areas: • Ward noise at night from other patients • Ward noise at night from staff • Ward lighting at night impacting on sleep • Support to eat meals where the person is unable to be fully independent. • The lack of opportunity to give feedback during the hospital stay on the quality of the care
Action required (choose 1 only)	**For information** ☐ **To receive and note** ☒ **To approve** ☐
Recommendation	The Board is asked to support the following recommendations: • Note the schedule of CQC Patient Surveys and the proposed reporting to the Board • Note the findings from the Adult Inpatient Survey 2020 and the five areas for improvement with the outline plan described in the report are supported and agreed. • Note the next steps with regard to the Urgent and Emergency Care Survey findings • Note the proposed communication plan

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

Report title: Care Quality Commission (CQC) NHS Patient Experience Surveys 2020 Reports.	**Meeting date: 24th November 2021**
Report sponsor	Chief Nurse
Report author	System Director for Nursing and Professional Practice (Torbay)

1. Introduction

A programme of Patient Experience Surveys is commissioned by the Care Quality Commission to support their programme of regulation, monitoring and inspection of NHS acute Trusts in England. The survey field work for a number of surveys were completed in 2021 with a publication schedule for these surveys in late 2021 and early 2022. These include:

The Adult Inpatient Survey
The Urgent and Emergency Care Survey
The Children and Young Peoples Inpatient Survey
The Maternity Survey.

The aim of the report is to provide detailed analysis and insight into the Adult Inpatient Survey results and highlights of the Urgent and Emergency Care Survey results.

2. Background and Context

2.1 Urgent and Emergency Care Survey

2.1.1 The 2020 Urgent and Emergency Care Survey received feedback nationally from 41,206 people who attended a type 1 department a response rate of 30.5%. 126 Trusts took part in the survey of which 59 trusts had both a 'Type 1' and a 'Type 3' department and 67 had only a Type 1 department.

2.1.2 The Trust provides Type 1 Urgent and Emergency Care at Torbay hospital to people attending the service. This means the Trust provides" a major, consultant -led A&E department with full resuscitation facilities operating 24 hours a day, 7 days a week." **major, consultant-led A&E department with full resuscitation facilities operating 24 hours a day, seven days a week**
2.1.3 The Urgent and Emergency Care Service Survey included 950 patients that attended the Urgent and Emergency(U&E) Care department in September 2020 and the survey field work was completed between November 2020 and March 2021.The response rate was 37% (343 responses) with an average score of 76.9% (up 0.1% from 2018)

2.1.4 Each trust is assigned one of five bands compared with other Trust: 'much worse than expected', 'worse than expected', 'about the same', 'better than expected' or 'much better than expected'. The Trust achieved the Band 'about the same.'
The CQC publish an outlier report alongside the findings of the U&E Care Survey and the Trust is not an outlier in the results of the survey.

2.1.5 The questions within the survey are categorised into three responses with an example set out below:

Q17 (Type 1 questionnaire). Did the doctors and nurses listen to what you had to say?
- Yes, definitely – most positive
- Yes, to some extent – middle
- No – most negative

2.1.6 Each trust also received a rating of 'Better', 'About the same' or 'Worse' for each section of the survey.
- Better: the trust is better for that particular question compared to most other trusts that took part in the survey
- About the same: the trust is performing about the same for that particular question as most other trusts that took part in the survey
- Worse: the trust did not perform as well for that particular question compared to most other trusts that took part in the survey

2.1.7 Below are the results for each section of the patient survey. Overall compared to other Trusts we are performing about the same.

Responses were received from 343 people at Torbay and South Devon NHS Foundation Trust.

Patient survey	Patient response	Compared with other trusts
Arrival	8.4/10	About the same
Waiting times	6.6/10	About the same
Doctors and nurses	8.3/10	About the same
Care and treatment	8.3/10	About the same
Tests (answered by those who had tests)	7.1/10	Worse
Hospital environment and facilities	8.3/10	About the same
Leaving A&E (answered by those who were not admitted to a hospital ward)	6.7/10	About the same
Respect & dignity	9.1/10	About the same
Experience overall	8.2/10	About the same

The questions asked of people attending where the Trust scored worse compared to other Trusts was in 'Tests'. Set out below is the subsection of questions that were asked and it is evident that one specific question scored low at 4.3/10 relating to how people would get the results of tests taken in the U&E care department that did not receive them during their visit.

Tests (answered by those who had tests)	7.1/10	Worse
• **Clear explanations about tests** for feeling that staff explained **why they needed tests** in a way they could understand	8.2/10	About the same
• **Timely test results** for receiving test results before leaving A&E	7.3/10	About the same
• **Clear explanations about test results** for those who received test results while in A&E, feeling staff **explained their test results** in a way they could understand	8.4/10	About the same
• **Information about how to get test results** for those who did **not** receive test results while in A&E, being told how they would receive them	4.3/10	About the same

2.1.8 For our Type 3 Urgent Treatment Centre (UTC) at Newton Abbot of the 420 people eligible to contribute 188 responded. For all areas the UTC scored about the same as other Type 3 facilities across England.

Responses were received from 188 people at Torbay and South Devon NHS Foundation Trust.

Patient survey	Patient response	Compared with other trusts
+ Arrival	8.2/10	About the same
+ Waiting times	7.4/10	About the same
+ Health professionals	9.3/10	About the same
+ Care and treatment	9.2/10	About the same
+ Tests (answered by those who had tests)	9.6/10	About the same
+ Environment and facilities	8.7/10	About the same
+ Leaving the urgent treatment centre (answered by those who went home / somewhere else)	8.1/10	About the same
+ Respect & dignity	9.7/10	About the same
+ Experience overall	9.0/10	About the same

2.1.9 The detail of these results are currently under review by the Urgent and Emergency Care leadership team who will be formulating an improvement plan which will be presented at the Quality Improvement Group and Quality Assurance Committee in January 2022.

Link Type 1: https://www.cqc.org.uk/provider/RA9/survey/4

Link Type 3: https://www.cqc.org.uk/provider/RA9/survey/15

2.2   Adult Inpatient Survey

2.2.1   The Trust level benchmarking report which sets out the results of the Adult Inpatient Survey for 2020 was published on the 19 October 2021. This is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS acute Trusts in England.

2.2.2   The trust survey results provide an opportunity to gain greater insight and understanding of the experiences of people who use our adult inpatient services and utilises this valuable feedback to reflect on what we have been told. This allow us to focus on what matters to the people we care for, and work to improve experience by taking positive action and embedding change.

2.2.3   It is essential that the survey results are shared and understood widely by staff working across the organisation, as the experience of those people who are inpatients will interface with a broad range of services, teams, wards and individuals. To a greater or lesser extent everyone has a role to play in our improvement journey. The communication plan developed by the communication team will be comprehensive and inclusive to meet this requirement.

2.2.4   The Feedback and Engagement Group for the trust includes a wide membership both internally and with our local system partners. Members of this group will hold accountability for overseeing the delivery of the improvement plan developed in response to the survey results. This will be regularly reported to monitor key milestones within the plan.

2.2.5 The 2020 Adult Inpatient Survey involved 137 NHS trusts in England. Patients were eligible for the survey if they were aged 16 or older, had spent at least one night in hospital and were not admitted to a maternity or psychiatric unit. The inpatients included in the sample included those discharged during November 2020. The field work for the survey, which is the time where questionnaires are sent out and returned, took place between January and May 2021. Nationally response was received from 73,015 patients, a response rate of 46%.

2.2.6   Following from the success of the pilot study in 2019, this year the adult inpatient survey had become the first survey in the NHS Patient Survey Programme to transition from using an entirely paper-based to mixed-mode data collection methodology, aligning with CQC's ambitions to create a digital method of survey delivery.

2.2.7   The pilot results showed that changing the survey methodology impacted the way patients responded to questions, meaning the 2020 survey's transition to a mixed-mode method can no longer yield comparable results to previous years. Further information about the changes made to the survey can be found in the Survey Development report. Each trust has been assigned one of five bands: 'much worse than expected', 'worse than expected', 'about the same', 'better than expected' or 'much better than expected'.

2.2.8   To provide a comprehensive picture of inpatient experience within each NHS trust, CQC calculated the overall proportion of responses each trust received for the 'most negative', 'middle' and 'most positive' answer option(s) across the scored

questions in the survey. Question 8 from the 2020 adult inpatient survey shows how responses are categorised as either 'most negative', 'middle' and 'most positive':

Q8. How clean was the hospital room or ward that you were in?

- Very clean – **most positive**
- Fairly clean – **middle**
- Not very clean – **middle**
- Not at all clean – **most negative**

Where people's experiences of a Trust's inpatient care are better or worse than elsewhere, there will be a significant difference between the trust's result and the average result across all trusts. Each trust is then assigned a banding of either 'much worse than expected', 'worse than expected', 'about the same', 'better than expected' or 'much better than expected' depending on how significant that variation is.

For example, if a trust's proportion of responses breaks down as: 'most negative' 12%, 'middle' 14% and 'most positive' 74%. This is then compared to the average of 'most negative' 11%, 'middle' 22% and 'most positive' 67% for all trusts. An 'adjusted z-score'[1] is calculated for the difference between 'most positive' trust proportions, which in this example is -2.50. This means this trust has a higher proportion of 'positive' responses than average. This is considered significant with a p-value of less than 0.25 but not less than 0.01. As a result, the trust is classed as 'better'.

NB:[1] Z scores give an indication of how different a trust's proportion is from the average

2.2.9   To complement the trust bench marking survey there is also an outlier report this report allow analyse of trust variation, CQC focus on identifying significantly higher levels of better or worse patient experience **across the entire survey**.

2.2.10 This holistic approach is different to the technique used to analyse results within trust benchmarking reports. In those reports trust results, for each scored question, are assigned bands when compared with the findings for all other trusts. This provides feedback on specific areas where trusts can target improvement. However, trust benchmark reports do not attempt to look across all questions concurrently and as a result do not provide an overall assessment of the proportion of positive or negative patient experience reported across the entire survey.

3. Discussion- Analysis of Benchmarking report

3.1 The full benchmarking report for the Adult Inpatient Survey 2020 results are set out in appendix 1 and provided for completeness. Within the main body of the report salient facts will be highlighted, focused upon and responded to.

3.2 1,250 patients who had experienced adult inpatient services provided by Torbay and South Devon NHS Foundation Trust (TSDFT) in November 2020 were invited to take part. 619 responses were completed and submitted to CQC (86% aligned to urgent and emergency care and 14% planned care). The response rate was 52% compared to 2019 of 53% and the average across all trusts of 46%.

The demographic of those taking part are included in the tables below:

Ethnicity

White	98%
Mixed	<0.5%
Asian or Asian British	<0.5%
Black or Black British	0%
Arab or other ethnic group	<0.5%
Not known	1%

Religion

No religion	25%
Buddhist	1%
Christian	69%
Hindu	0%
Jewish	0%
Muslim	<0.5%
Sikh	0%
Other	2%
Prefer not to say	2%

Sex

At birth were you registered as…

Female	51%
Male	49%
Intersex	0%

<0.5% of participants said their gender is different from the sex they were registered with at birth.

Age

- 16-35: 6%
- 36-50: 8%
- 51-65: 23%
- 66+: 64%

81% of participants said they have a physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").

3.3 A summary of findings for the trust compared with other trusts demonstrates that we performed "about the same" for 44 of the 45 questions (see table below). For one question we performed "somewhat worse than expected". This was question 5 in section 2 The hospital and ward which asked "***were you ever prevented from sleeping at night by hospital lighting*** "and answered by 539 of the 619 people responding to the survey. Overarchingly the Trust did not perform "much worse than expected "for any question or "worse than expected "for any question nor did we perform "better than expected" or "much better than expected" for any question in the survey.

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.

Much better than expected	0
Better than expected	0
Somewhat better than expected	0
About the same	44
Somewhat worse than expected	1
Worse than expected	0
Much worse than expected	0

Comparison with last year's results

Results for the Adult Inpatient 2020 survey are not comparable with results from previous years. This is because of a change in survey methodology, extensive redevelopment of the questionnaire, and a different sampling month. More information on this is available in the survey development report.

The Adult Inpatient 2021 benchmark reports will include an overview of the number of questions at which your trust's performance has significantly improved, significantly declined, or not significantly changed compared with your result from the previous year.

3.4 The tables below set out the best and worst performance relative to the trust average. The top five results for the trust are set out and are the highest scores compared with the trust average. This means the trust best performance may be worse than the trust average and where this is the case the result closest to the trust average is chosen. The bottom five results for the trust are the lowest compared to the trust average. If none are below the trust average then the result closest to the trust average is chosen.

Top five scores (compared with trust average)

		Your trust score
The hospital and ward	Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	7.7
The hospital and ward	Q4A. There were restrictions on visitors in hospital during the coronavirus (COVID-19) pandemic. Were you able to keep in touch with your family and friends during your stay?	8.4
Leaving hospital	Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.2
Admission to hospital	Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?	8.0
Leaving hospital	Q44. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?	6.9

Bottom five scores (compared with trust average)

		Your trust score
The hospital and ward	Q5. Were you ever prevented from sleeping at night by noise from other patients?	5.3
The hospital and ward	Q5. Were you ever prevented from sleeping at night by hospital lighting?	7.8
The hospital and ward	Q5. Were you ever prevented from sleeping at night by noise from staff?	7.6
The hospital and ward	Q13. Did you get enough help from staff to eat your meals?	7.4
Feedback on care	Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?	1.0

3.5 The top five areas included one question from admission to hospital *"How did you feel about the length of time you were on the waiting list before your admission to hospital?"*

In November 2020 at the height of the pandemic most patients being seen and therefore responding to this question would have required urgent treatment for serious conditions such as suspected cancer or presenting with other urgent presentations e.g. stroke, heart attack or pneumonia and therefore their wait would have been aligned to the national standards. We are now experiencing significantly longer waiting lists as the pandemic continues to impact, with demand for COVID inpatient care and the requirement to maintain social distancing measures resulting in limitations in providing diagnostics and treatments for non- urgent care. The Trust adopts a risk -based approach to ensure every patient waiting for care is prioritised based on need.

Two questions from the hospital and ward domain of the survey were in the top five. One related to explanations given at night when a ward change had to be made Q7 *Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?* This is an area the trust works hard not to have to move patients at night and it is heartening to see when this is required staff explain to patients the rationale.

The survey took place during the COVID pandemic and significant restrictions in visiting. Q4A *There were restrictions on visitors in hospital during the coronavirus (COVID-19) pandemic. Were you able to keep in touch with your family and friends during your stay?* relates to family and friends being able to keep in contact with patients during their stay. The Trust certainly found this challenging at the outset of the pandemic but develop a range of communication routes for loved ones to keep in contact. This included the purchase of ipads on inpatient wards to connect patients to their loved ones with the support of staff. On our website a "sending messages" facility

was developed led by the Feedback and Engagement Team. This ensured any message received through the website by 10 am would be delivered to the patient that day.

Two question in the top five related to leaving hospital Q41 asked "***did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?".*** The trust has a range of discharge leaflets to give to patients which have been developed a ward and service level. A large number often require onward care that is provided by the trust as an acute and community provider of Health and adult social care which supports an integrated approach. This aligns with ***Q44 "After leaving hospital did you get enough support from health and social care services to help you recover and manage your condition?"*** This is the vision and journey for the Trust as an integrated health and social care organisation with services to support people to live their best lives with a network of services close to home.

3.6 The bottom five scores have a consistent theme with four of the questions relating to the section "The hospital and ward". Three questions related to patients being prevented from sleeping due to noise from other patients, noise from staff and hospital lighting. This has been identified in our real time patient feedback questionnaire and as a result sleep packs have been developed with eye shields and ear plugs available on all in patient wards. We know a number of patients decline these packs and based on the national inpatient survey for 2020 we will need to work with the people who use our services, estates and staff to implement a range of changes to improve inpatients experience at night.

The fourth question in the "hospital and ward" section of the survey was **Q13** *Did you get enough help from staff to eat your meals?*

This question was responded by 124 of the 619 people who took part in the survey score is particularly concerning. Prior to the report findings being published we had identified that nutritional risk assessments for inpatients were not always completed within the trust time frame of 24 hours from admission to the ward. The completion of the risk assessment then results in an appropriate care plan to meet each patient's needs. This recognised deficit on some wards from the monthly risk assessment and care plan audit had resulted in a focus on improvement by the ward managers, and Matron's overseen by the Associate Directors of Nursing and Professional Practice across the ISU's. The survey results to this question have propelled the decision to implement a nutrition and hydration trust wide improvement plan. The Nutritional Steering Group for the Trust is led by the Head of Dietetics where this improvement plan will be developed and progressed. The plan will be overseen by the Torquay ISU Associate Director for Nursing and Professional Practice and will adopt Quality Improvement methodology with robust milestones and evidence to demonstrate improvement. The progress of this work will be monitored through the Nutritional Steering Group and report to the quality Improvement Group.

The fifth question was a question in the feedback on care section Q47 which asked "***During your hospital stay, were you ever asked to give your views on the quality of your care?"*** This scored exceptionally low and in line with other Trust across England. This would reflect the requirement, due to the pandemic, to suspend our real time patient experience questionnaire that was normally administered by volunteers at this time. We also had to suspend our Friends and Family Test (FFT) as it was paper

based and infection prevention and control risks outweighed continuing with the questionnaire at this time.

The Real Time Patient Experience survey is supported by trust volunteers and with IPC oversight a number of volunteers are returning to support reinstating this valuable survey. The survey allows results to be given to the ward manager in real time for any concerns to be addressed promptly. This work will be overseen by the Real Time Patient Experience Group currently being reinstated.

The trust has now reinstated the FFT is in the process developing a range of opportunities for people using our services to respond both paper based and digital. This work is being led by the FFT Task and Finish Group recently set up.
See Bar graph below:
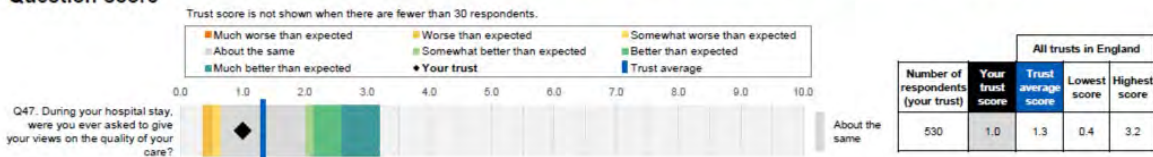
3.7 Section 9 questions relate to dignity and respect both areas that the Trust embody in the care model. The Trust scored 9.2 which although is about the same as many other trusts demonstrates the care and compassion of the staff who work within the trust.
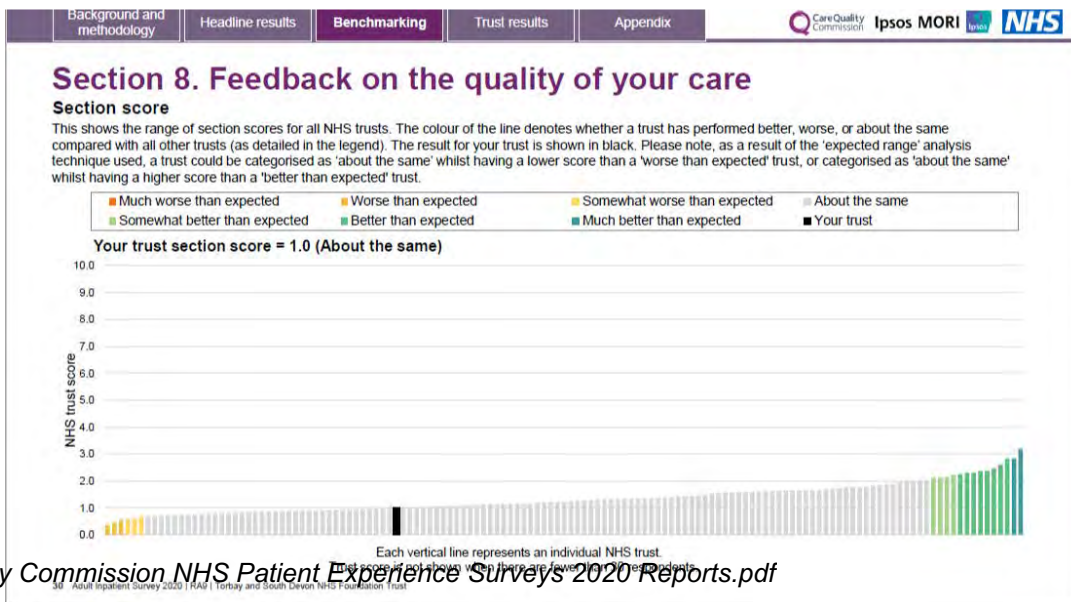
Section 9. Respect and dignity

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- Your trust

Your trust section score = 9.2 (About the same)

Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.
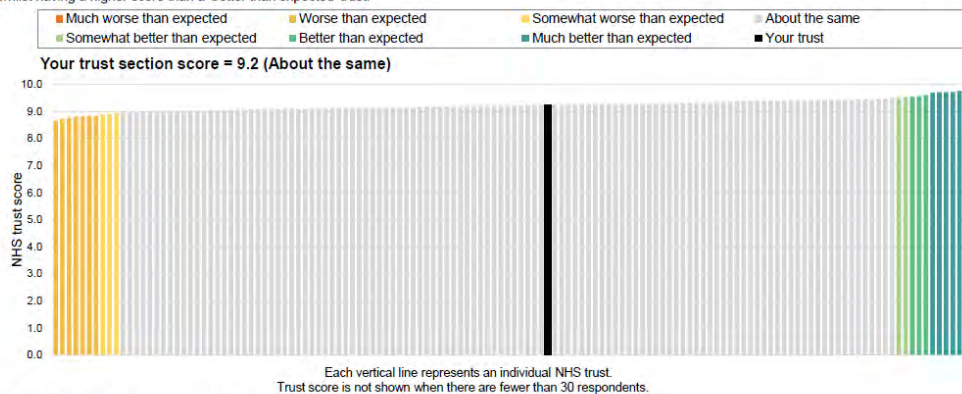
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Section 9. Respect and dignity (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.

- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- Your trust
- Trust average

		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
614	9.2	9.2	8.6	9.9

Q45. Overall, did you feel you were treated with respect and dignity while you were in the hospital? — About the same

3.8 Section 10 questions related to overall experience and the Trust was similar to other trusts neither performing better or worse.

Section 10. Overall experience

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- Your trust

Your trust section score = 8.3 (About the same)

Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.
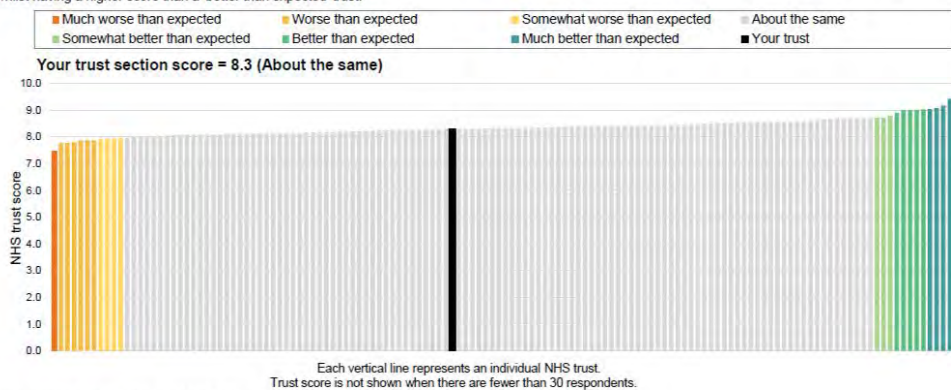
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This is an area of focus for the trust during 2021/22 we are developing and nurturing a new relationship with our local community to understand what matters to them. As a Trust we are cognisant that to develop and enhance our health and care services the voice of our community is central. The people who access, interface and use our health and care services are pivotal in developing a co-designed patient and service user experience and engagement 3-5-year long term plan.

A facilitated meeting led by Health Watch on 3 November 2021 included over 25 voluntary and statutory organisations across our local community. This has provided a range of themes and areas to enable us to focus on improving the experience of our health and care services across our integrated care organisation. The aim is the members of this group will form a reference group to support the Trust as we work in a collaborative partnership in the future.

4. Communication Plan

4.1 The communication team will lead on the communication plan to disseminate the results across the organisation. This includes:

- Trust Talk on 25 November – hosted by Chief Executive Officer Liz Davenport and Chief Nurse Deborah Kelly
- Article in ICO News sharing top lines and action we are taking, links to published reports to be included
- Highlighted in the Vlog closest to the publication date in ICO News
- Article for website as per above but with less detail
- Highlight top lines in Healthy Futures newsletter (issued monthly to stakeholders)

5. Conclusion

The Adult Inpatient survey for 2020 provides clarity on areas where experience is best and areas where patient experience can be improved.
See Tables below.

Where patient experience is best

- ✓ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night
- ✓ Keeping in touch during the COVID-19 pandemic: patients being able to keep in touch with family and friends during their stay in hospital
- ✓ Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital
- ✓ Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- ✓ Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital

Where patient experience could improve

- ○ Noise from other patients: patients not being bothered by noise at night from other patients
- ○ Disturbance from hospital lighting: patients not being bothered at night from hospital lighting
- ○ Noise from staff: patients not being bothered by noise at night from staff
- ○ Help with eating: patients being given enough help from staff to eat meals, if needed
- ○ Feedback on care: patients being asked to give their views on the quality of their care

These topics are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the average of all trusts. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts.

The Results provide us with an anchor to celebrate what we are doing well, understand areas where we are preforming similar to other trusts and through focused effort and improvement work address deficits. However, our primary focus initially is to address the challenges that adult inpatients contributing to this survey have very clearly identified above in the areas we can improve. These five areas will underpin phase 1 of our improvement plan.

Recommendation

The Board is asked to support the following recommendations:

- Note the schedule of CQC Patient Surveys and the proposed reporting to the Board.
- Note the findings from the Adult Inpatient Survey 2020 and the five areas for improvement with the outline plan described in the report are supported and agreed.
- Note the next steps with regard to the Urgent and Emergency Care Survey findings.
- Note the proposed communication plan.

NHS Adult Inpatient Survey 2020 Benchmark Report

Torbay and South Devon NHS Foundation Trust

NHS

Care Quality Commission

Ipsos MORI

Ipsos

Contents

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3. Benchmarking	4. Trust results
Section 1. Admission to hospital	Section 1. Admission to hospital
Section 2. The hospital and ward	Section 2. The hospital and ward
Section 3. Doctors	Section 3. Doctors
Section 4. Nurses	Section 4. Nurses
Section 5. Your care and treatment	Section 5. Your care and treatment
Section 6. Operations and procedures	Section 6. Operations and procedures
Section 7. Leaving hospital	Section 7. Leaving hospital
Section 8. Feedback on care	Section 8. Feedback on care
Section 9. Respect and dignity	Section 9. Respect and dignity
Section 10. Overall experience	Section 10. Overall experience

This work was carried out in accordance with the requirements of the international quality standard for Market Research, ISO 20252, and with the Ipsos MORI Terms and Conditions which can be found at http://www.ipsos-mori.com/terms.

Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme

- information on the Adult Inpatient 2020 survey

- a description of key terms used in this report

- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Adult Inpatient Survey has been conducted annually since 2002. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS acute trusts in England.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The Adult Inpatient Survey 2020

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos MORI. A total of 169,176 patients were invited to participate in the survey across 137 acute and specialist NHS trusts. Completed responses were received from 73,015 patients, an adjusted response rate of 45.9%.

Patients were eligible to participate in the survey if they were aged 16 years or over, had spent at least one night in hospital, and were not admitted to maternity or psychiatric units. A full list of eligibility criteria can be found in the survey sampling instructions.

Trusts sampled patients who met the eligibility criteria and were discharged from hospital during November 2020. Trusts counted back from the last day of November 2020, sampling every consecutively discharged patient until they had selected 1,250 patients. Some smaller trusts, which treat fewer patients, included patients who were treated in hospital earlier than November 2020 (as far back as May 2020), to achieve a large enough sample.

Fieldwork took place between January and May 2021.

Trend data

The Adult Inpatient 2020 survey was significantly different to previous years' surveys with regards to methodology, sampling month and questionnaire content. This year's survey was conducted using a push-to-web methodology (offering both online and paper completion). The questionnaire was amended significantly, with changes to both question wording and order. The 2020 results are therefore not comparable with previous years' data and trend data is not available. In future years, trend data will be incorporated into these reports.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.

- To learn more about CQC's survey programme, please visit the CQC website.

Key terms used in this report

The 'expected range' technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement.

This report also includes site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that the performance ratings presented here may differ from that presented in the trust level benchmarking.

More information can be found in the Appendix.

Standardisation

Demographic characteristics, such as age and gender, can influence patients' experience of care and the way they report it. For example, research shows that men tend to report more positive experiences than women, and older people more so than younger people.

Since trusts have differing profiles of patients, this could make fair trust comparisons difficult. To account for this, we 'standardise' the results, which means we apply a weight to individual patient responses to account for differences in demographic profile between trusts.

For each trust, results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to reflect the 'national' age, sex, and method of admission distribution (based on all respondents to the survey).This helps ensure that no trust will appear better or worse than another because of its profile, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results. Site level results are standardised in the same way.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example Q1) and others are 'routing questions', which are designed to filter out respondents to whom the following questions do not apply (for example Q6). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

Trust average

The 'trust average' mentioned in this report is the arithmetic mean of all trusts' scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document.

Using the survey results

Navigating this report

This report is split into five sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.

- **Headline results** – includes key trust-level findings relating to the patients who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.

- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve.

- **Trust results** – includes the score for your trust; a comparison with other trusts in your region; a breakdown of scores across sites within your trust. It may be helpful to compare yourself with regional trusts, so you can learn from and share learnings with trusts in your area who care for similar populations. Internal benchmarking may be helpful so you can compare sites within your organisation, sharing best practice within the trust and identifying any sites that may need attention.

- **Appendix** – includes additional data for your trust; further information on the survey methodology; interpretation of graphs in this report.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; A-Z list to view the results for each trust; technical document: www.cqc.org.uk/inpatientsurvey

- National and trust-level data for all trusts who took part in the Adult Inpatient 2020 survey: https://nhssurveys.org/surveys/survey/02-adults-inpatients/year/2020/. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.

- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys

- Information about how the CQC monitors hospitals: www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-nhs-acute-hospitals

Headline results

This section includes:

- information about your trust population

- an overview of benchmarking for your trust

- the top and bottom scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.

1,250 invited to take part

619 completed
86% urgent/emergency admission
14% planned admission

52% response rate
46% average response rate for all trusts
53% response rate for your trust last year

Ethnicity

- White **98%**
- Mixed **<0.5%**
- Asian or Asian British **<0.5%**
- Black or Black British **0%**
- Arab or other ethnic group **<0.5%**
- Not known **1%**

Religion

- No religion **25%**
- Buddhist **1%**
- Christian **69%**
- Hindu **0%**
- Jewish **0%**
- Muslim **<0.5%**
- Sikh **0%**
- Other **2%**
- Prefer not to say **2%**
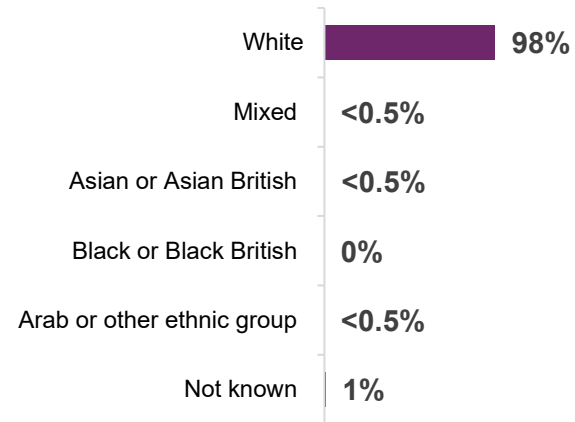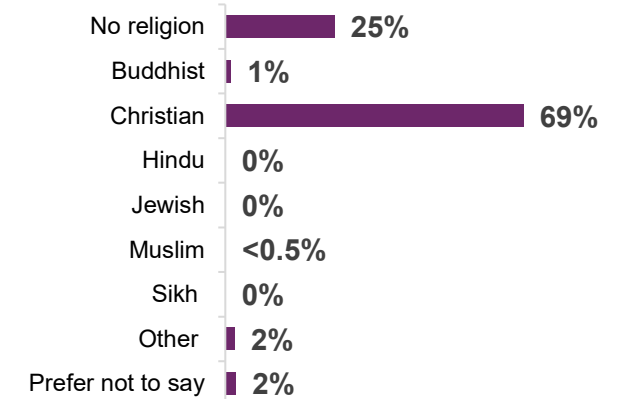
Long-term conditions
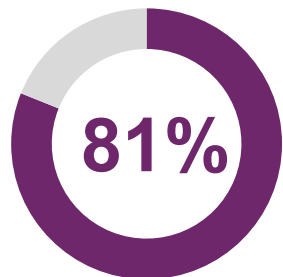
81% of participants said they have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").

Sex

At birth were you registered as…

- Female **51%**
- Male **49%**
- Intersex **0%**

<0.5% of participants said their gender is different from the sex they were registered with at birth.

Age

- 16-35 **6%**
- 36-50 **8%**
- 51-65 **23%**
- 66+ **64%**
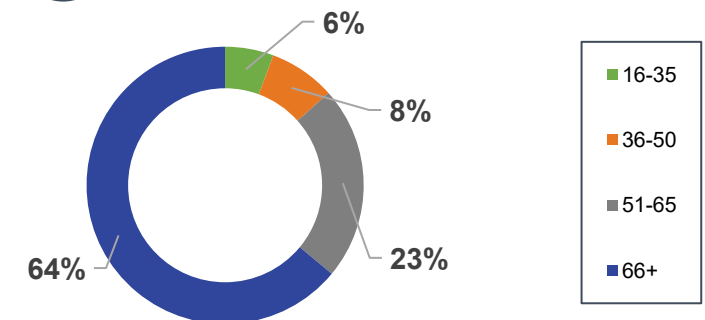
Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.

Much better than expected	0
Better than expected	0
Somewhat better than expected	0
About the same	44
Somewhat worse than expected	1
Worse than expected	0
Much worse than expected	0

Comparison with last year's results

Results for the Adult Inpatient 2020 survey are not comparable with results from previous years. This is because of a change in survey methodology, extensive redevelopment of the questionnaire, and a different sampling month. More information on this is available in the survey development report.

The Adult Inpatient 2021 benchmark reports will include an overview of the number of questions at which your trust's performance has significantly improved, significantly declined, or not significantly changed compared with your result from the previous year.

For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "comparison to other trusts".

Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average.
- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.

Top five scores (compared with trust average)

Your trust score   Trust average

The hospital and ward	Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	7.7
The hospital and ward	Q4A. There were restrictions on visitors in hospital during the coronavirus (COVID-19) pandemic. Were you able to keep in touch with your family and friends during your stay?	8.4
Leaving hospital	Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.2
Admission to hospital	Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?	8.0
Leaving hospital	Q44. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?	6.9

Bottom five scores (compared with trust average)

Your trust score   Trust average

The hospital and ward	Q5. Were you ever prevented from sleeping at night by noise from other patients?	5.3
The hospital and ward	Q5. Were you ever prevented from sleeping at night by hospital lighting?	7.8
The hospital and ward	Q5. Were you ever prevented from sleeping at night by noise from staff?	7.6
The hospital and ward	Q13. Did you get enough help from staff to eat your meals?	7.4
Feedback on care	Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?	1.0

Benchmarking

This section includes:

• how your trust scored for each evaluative question in the survey, compared with other trusts that took part

• an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts

NHS

Care Quality Commission

Ipsos MORI

Section 1. Admission to hospital

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

| ■ Much worse than expected | ■ Worse than expected | ■ Somewhat worse than expected | ■ About the same |
| ■ Somewhat better than expected | ■ Better than expected | ■ Much better than expected | ■ Your trust |

Your trust section score = 7.7 (About the same)
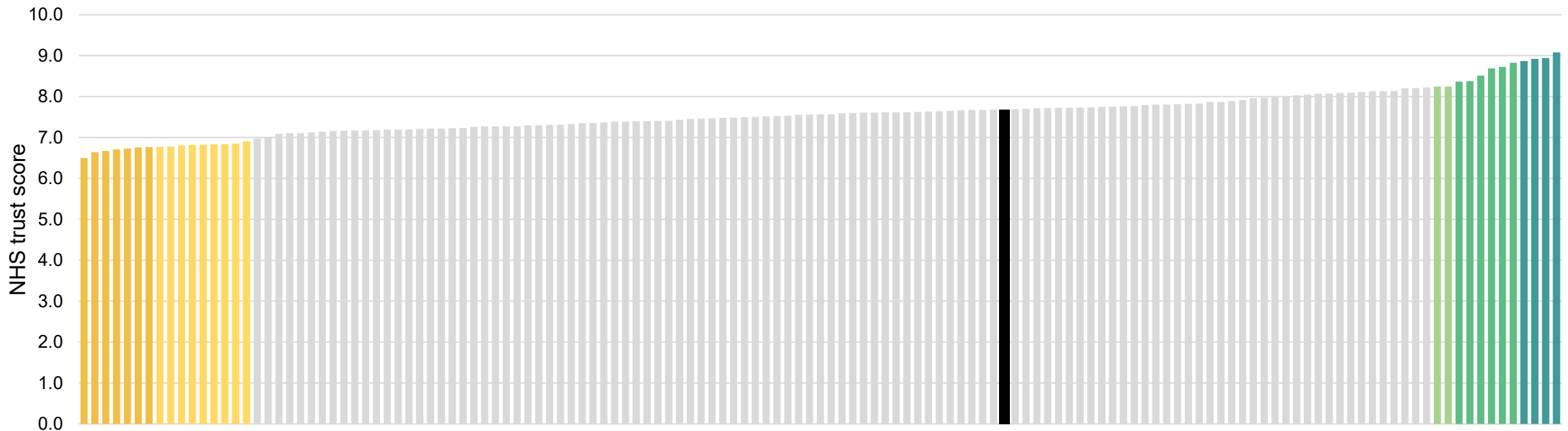
Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 1. Admission to hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

Legend	
■ Much worse than expected	■ Worse than expected	■ Somewhat worse than expected
■ About the same	■ Somewhat better than expected	■ Better than expected
■ Much better than expected	◆ Your trust	▌Trust average

	Number of respondents (your trust)	Your trust score	All trusts in England		
			Trust average score	Lowest score	Highest score
Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?	88	8.0	7.7	5.8	9.1
Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	585	7.4	7.5	6.0	9.3

Q2 benchmark: About the same
Q3 benchmark: About the same
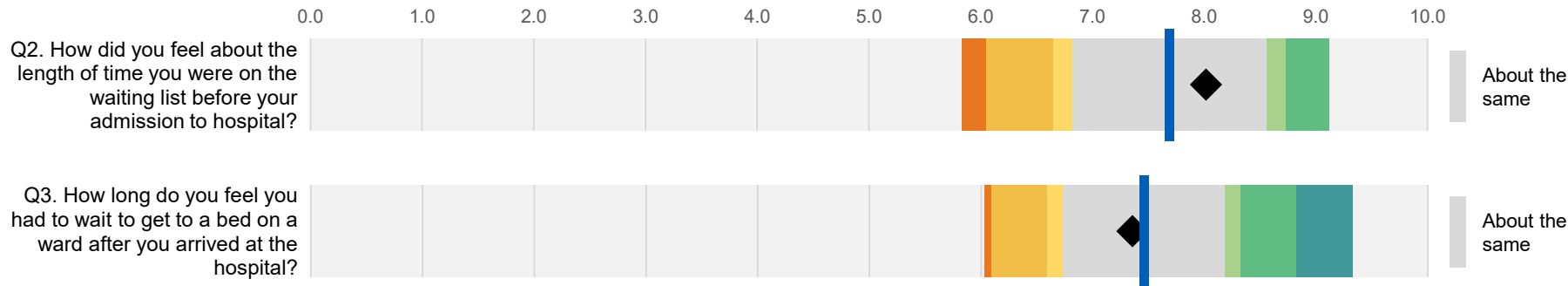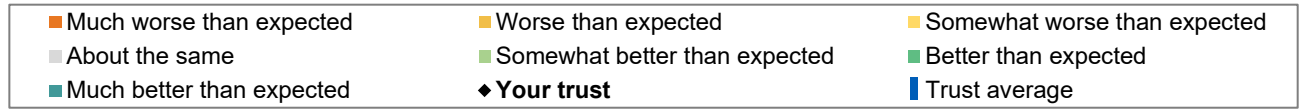
Section 2. The hospital and ward

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- Your trust

Your trust section score = 7.9 (About the same)
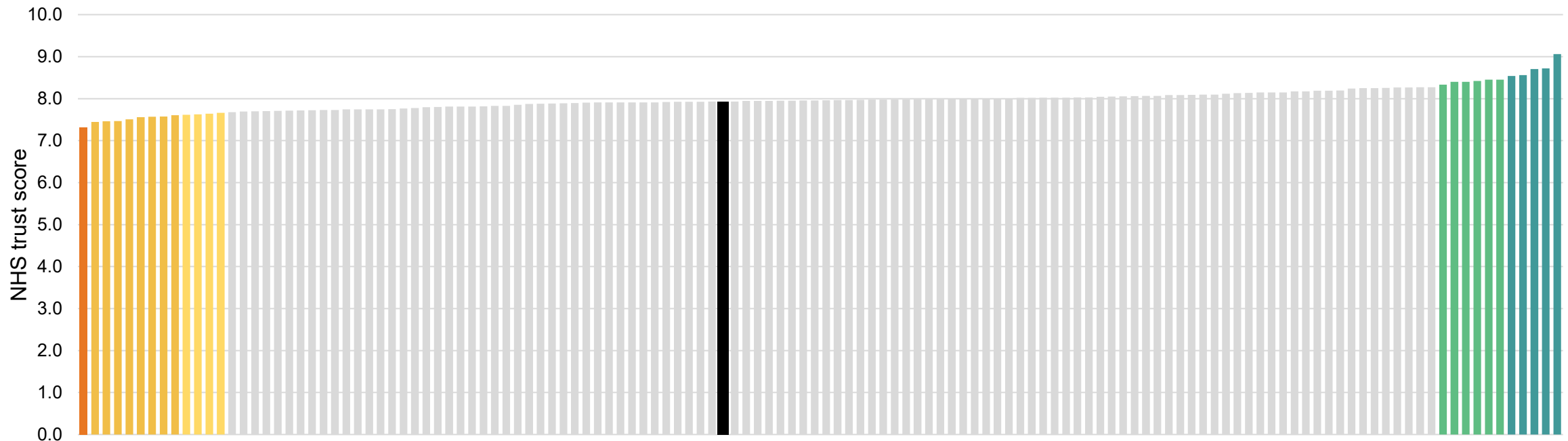
Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

Legend:
- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- ◆ Your trust
- ▮ Trust average

Question		Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Q4A. There were restrictions on visitors in hospital during the coronavirus (COVID-19) pandemic. Were you able to keep in touch with your family and friends during your stay?	About the same	532	8.4	8.0	6.8	9.0
Q5. Were you ever prevented from sleeping at night by noise from other patients?	About the same	539	5.3	6.2	4.7	9.4
Q5. Were you ever prevented from sleeping at night by noise from staff?	About the same	539	7.6	8.0	7.0	9.0
Q5. Were you ever prevented from sleeping at night by hospital lighting?	Somewhat worse	539	7.8	8.2	7.3	9.0
Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	About the same	98	7.7	7.1	5.2	8.5

All trusts in England (column group header over: Trust average score, Lowest score, Highest score)

Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

- ■ Much worse than expected
- ■ Worse than expected
- ■ Somewhat worse than expected
- ■ About the same
- ■ Somewhat better than expected
- ■ Better than expected
- ■ Much better than expected
- ◆ Your trust
- ▮ Trust average

	Number of respondents (your trust)	Your trust score	All trusts in England		
			Trust average score	Lowest score	Highest score
Q8. How clean was the hospital room or ward that you were in?	606	9.3	9.2	8.5	9.9
Q9. Did you get enough help from staff to wash or keep yourself clean?	441	8.6	8.5	7.4	9.7
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?	327	8.2	8.3	7.3	9.5
Q11. Were you offered food that met any dietary requirements you had?	301	8.4	8.3	7.0	9.3
Q12. How would you rate the hospital food?	580	7.1	7.0	6.2	8.9
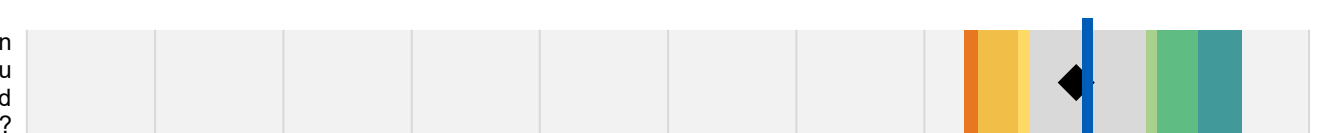
Q8 – About the same
Q9 – About the same
Q10 – About the same
Q11 – About the same
Q12 – About the same

Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

- ■ Much worse than expected
- ■ Worse than expected
- ■ Somewhat worse than expected
- ■ About the same
- ■ Somewhat better than expected
- ■ Better than expected
- ■ Much better than expected
- ◆ Your trust
- ▌ Trust average

	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
			All trusts in England		
Q13. Did you get enough help from staff to eat your meals?	124	7.4	7.8	5.5	9.6
Q14. During your time in hospital, did you get enough to drink?	572	9.4	9.5	8.8	10.0
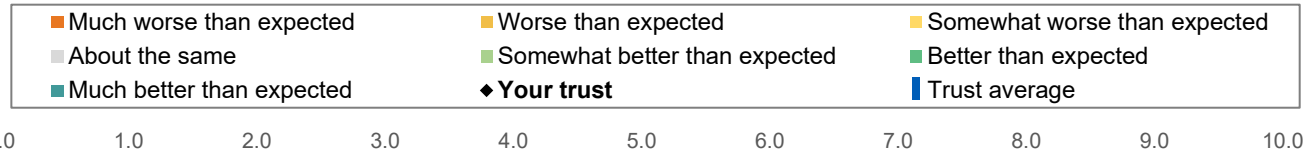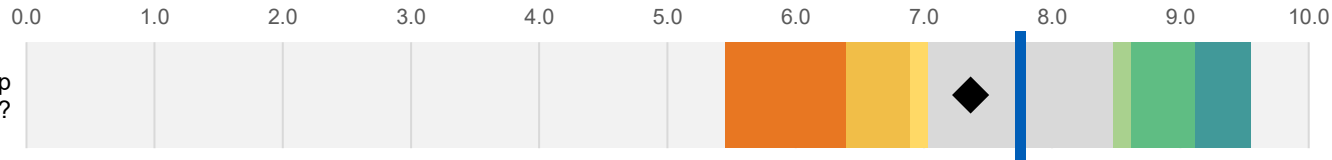
Q13. Did you get enough help from staff to eat your meals? — About the same

Q14. During your time in hospital, did you get enough to drink? — About the same

# Section 3. Doctors

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

■ Much worse than expected	■ Worse than expected	■ Somewhat worse than expected	■ About the same
■ Somewhat better than expected	■ Better than expected	■ Much better than expected	■ Your trust

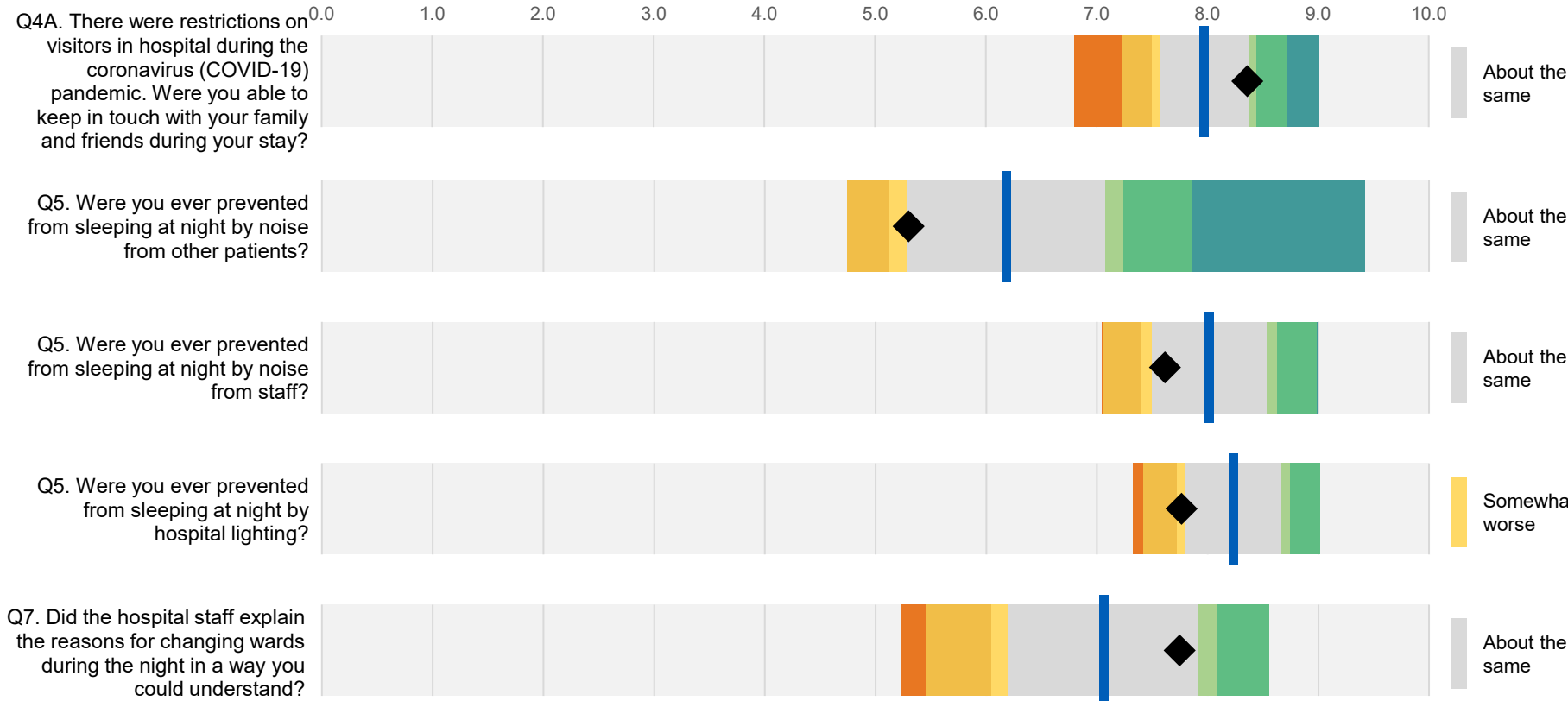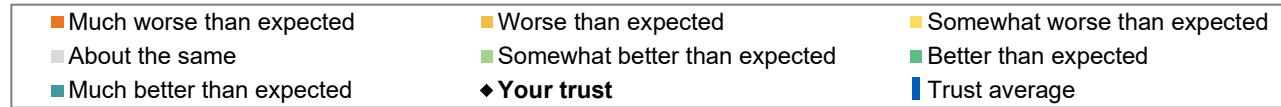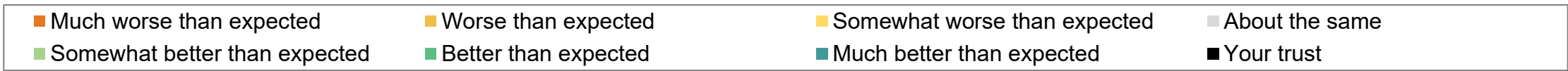**Your trust section score = 8.9 (About the same)**

Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 3. Doctors (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

- ■ Much worse than expected
- ■ Worse than expected
- ■ Somewhat worse than expected
- ■ About the same
- ■ Somewhat better than expected
- ■ Better than expected
- ■ Much better than expected
- ◆ Your trust
- ▌Trust average

	Number of respondents (your trust)	Your trust score	All trusts in England		
			Trust average score	Lowest score	Highest score
Q15. When you asked doctors questions, did you get answers you could understand? — About the same	555	8.8	8.8	8.2	9.6
Q16. Did you have confidence and trust in the doctors treating you? — About the same	611	9.2	9.2	8.7	9.9
Q17. When doctors spoke about your care in front of you, were you included in the conversation? — About the same	608	8.8	8.6	7.9	9.6

Section 4. Nurses

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- Your trust
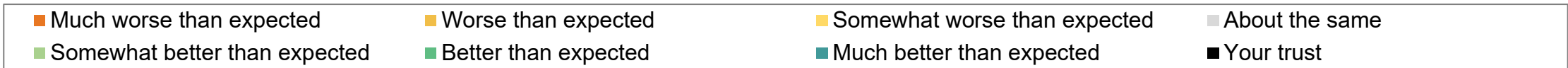
Your trust section score = 8.7 (About the same)

NHS trust score

Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 4. Nurses (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

- ■ Much worse than expected
- ■ Worse than expected
- ■ Somewhat worse than expected
- ■ About the same
- ■ Somewhat better than expected
- ■ Better than expected
- ■ Much better than expected
- ◆ Your trust
- ▮ Trust average

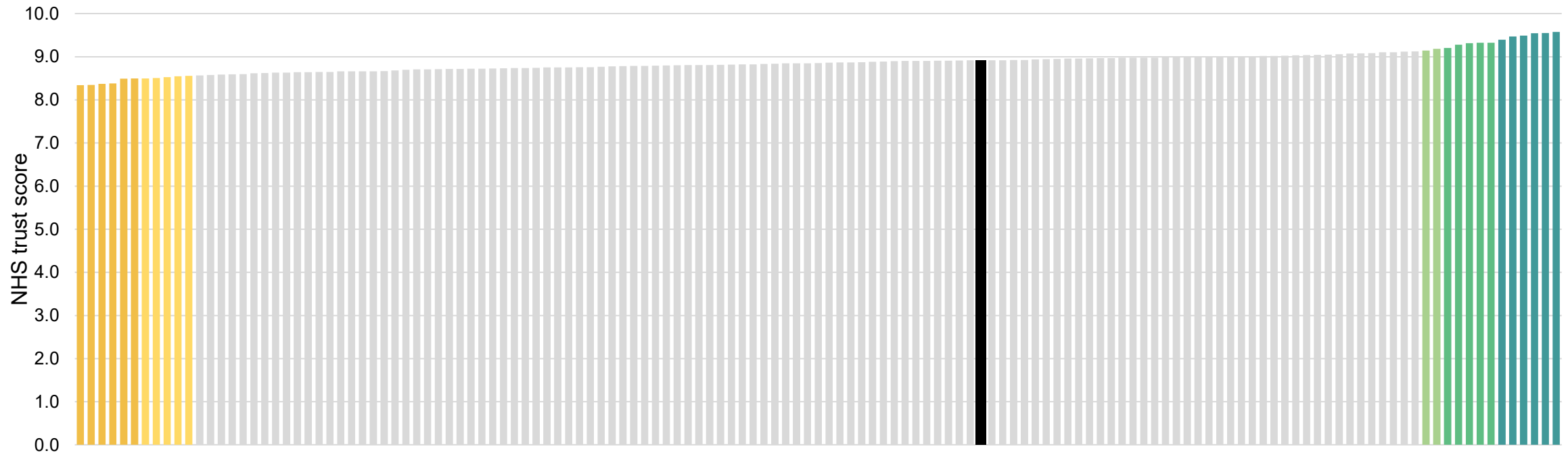| | Number of respondents (your trust) | Your trust score | All trusts in England | | |
			Trust average score	Lowest score	Highest score
Q18. When you asked nurses questions, did you get answers you could understand?	569	8.9	8.9	8.1	9.6
Q19. Did you have confidence and trust in the nurses treating you?	612	9.1	9.1	8.6	9.7
Q20. When nurses spoke about your care in front of you, were you included in the conversation?	607	8.8	8.7	7.6	9.6
Q21. In your opinion, were there enough nurses on duty to care for you in hospital?	610	7.9	7.9	6.4	9.3

Section 5. Your care and treatment

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

- ■ Much worse than expected
- ■ Worse than expected
- ■ Somewhat worse than expected
- ■ About the same
- ■ Somewhat better than expected
- ■ Better than expected
- ■ Much better than expected
- ■ Your trust

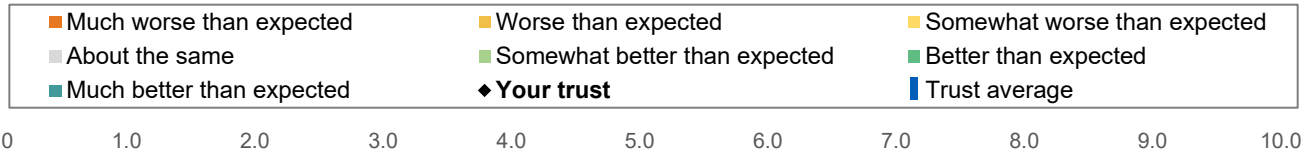**Your trust section score = 8.1 (About the same)**
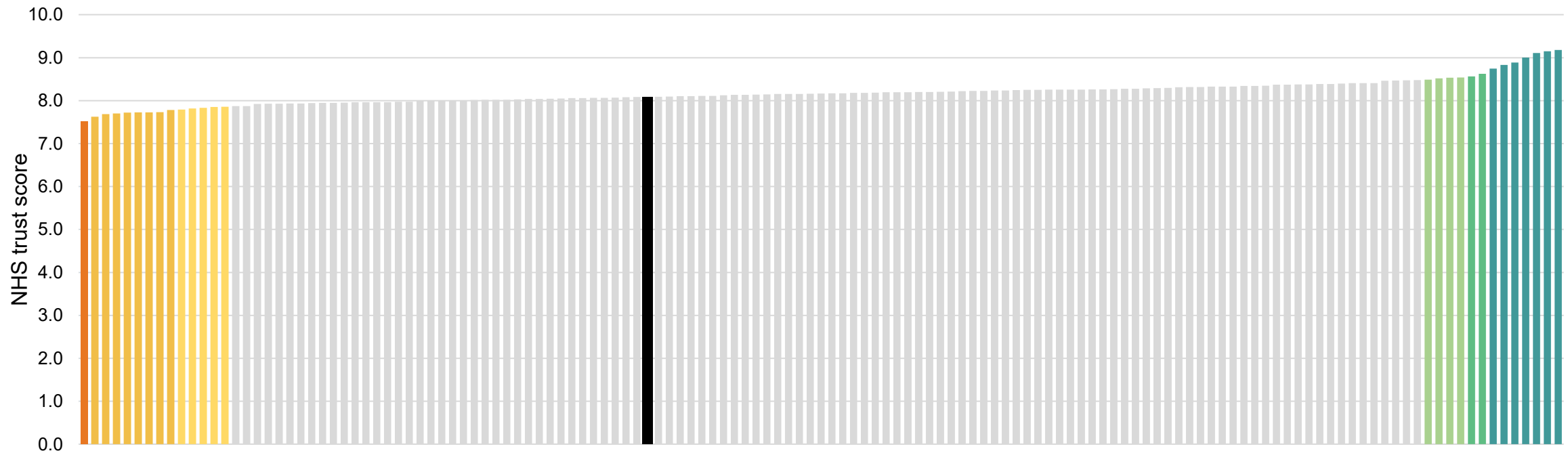
NHS trust score

Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

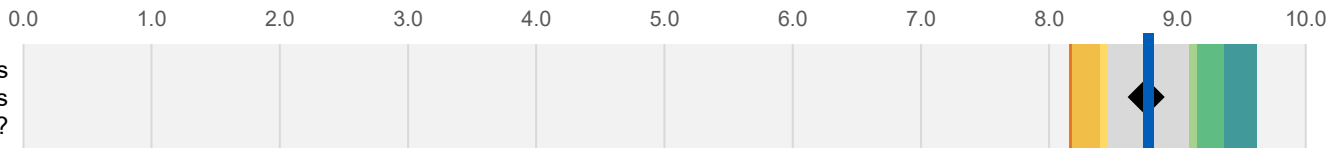# Section 5. Your care and treatment (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

Legend:
- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- ◆ Your trust
- ▮ Trust average

		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score

Q22. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff? — About the same

| 542 | 7.8 | 8.0 | 7.4 | 9.1 |

Q23. To what extent did staff looking after you involve you in decisions about your care and treatment? — About the same

| 583 | 7.2 | 7.2 | 6.5 | 8.4 |
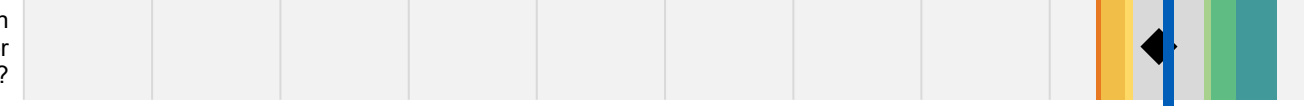
Q24. How much information about your condition or treatment was given to you? — About the same

| 583 | 8.9 | 8.9 | 8.4 | 9.8 |
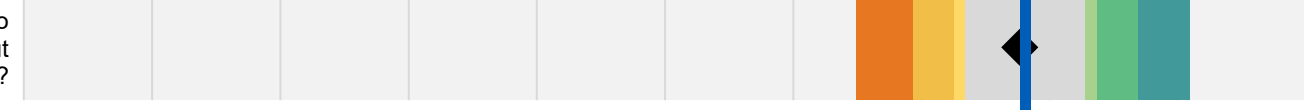
Q25. Did you feel able to talk to members of hospital staff about your worries and fears? — About the same

| 511 | 7.8 | 7.8 | 6.5 | 9.1 |

Q26. Were you able to discuss your condition or treatment with hospital staff without being overhead? — About the same
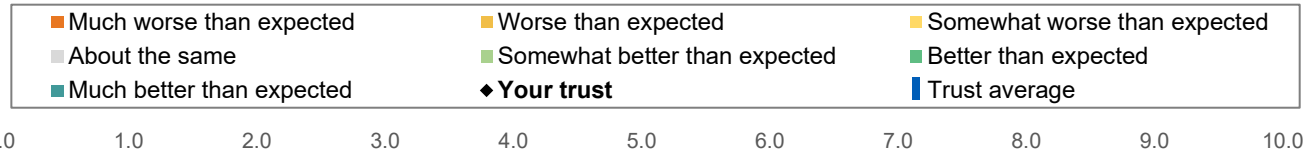
| 562 | 6.3 | 6.6 | 5.5 | 9.6 |

Section 5. Your care and treatment (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

■ Much worse than expected　　■ Worse than expected　　■ Somewhat worse than expected
■ About the same　　■ Somewhat better than expected　　■ Better than expected
■ Much better than expected　　◆ Your trust　　❙ Trust average

	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
			All trusts in England		
Q27. Were you given enough privacy when being examined or treated?	600	9.5	9.5	9.1	9.9
Q28. Do you think the hospital staff did everything they could to help control your pain?	504	9.0	9.0	8.3	9.7
Q29. Were you able to get a member of staff to help you when you needed attention?	567	8.3	8.3	7.4	9.5

Q27. About the same
Q28. About the same
Q29. About the same

Section 6. Operations and procedures
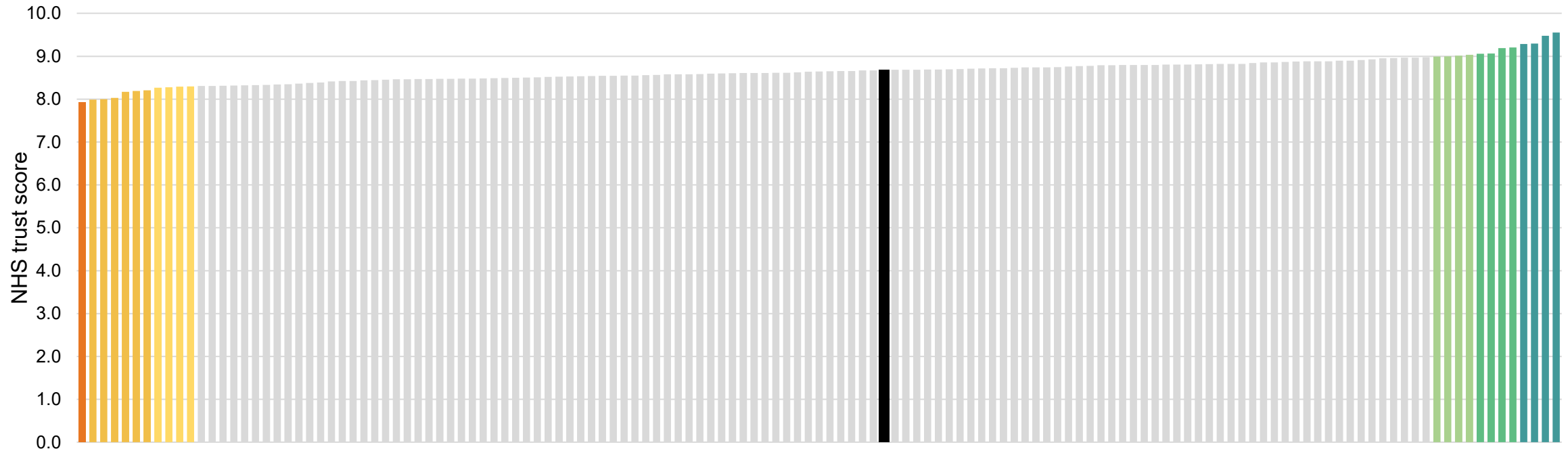
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

| ■ Much worse than expected | ■ Worse than expected | ■ Somewhat worse than expected | ■ About the same |
| ■ Somewhat better than expected | ■ Better than expected | ■ Much better than expected | ■ Your trust |
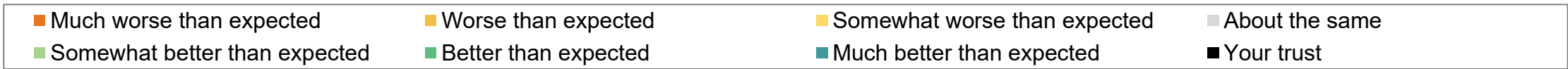
Your trust section score = 8.4 (About the same)

NHS trust score

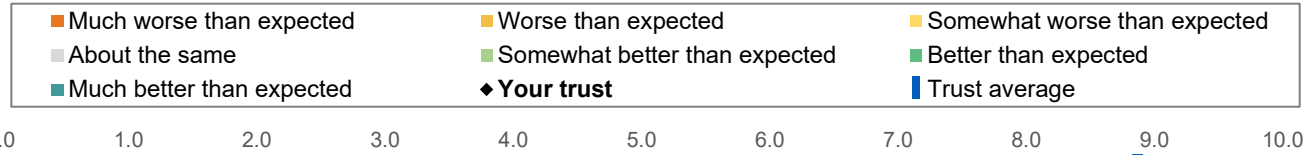Each vertical line represents an individual NHS trust.
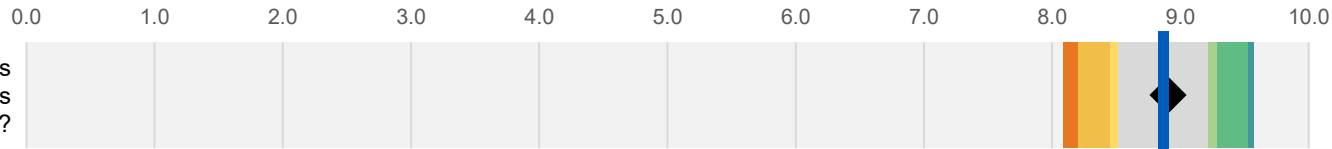Trust score is not shown when there are fewer than 30 respondents.

Section 6. Operations and procedures (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

Legend		
■ Much worse than expected	■ Worse than expected	■ Somewhat worse than expected
■ About the same	■ Somewhat better than expected	■ Better than expected
■ Much better than expected	◆ Your trust	▮ Trust average

		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
250	9.2	9.0	8.4	9.6

Q31. Beforehand, how well did hospital staff answer your questions about the operations or procedures? — About the same

Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
264	7.8	7.8	7.0	9.1

Q32. Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures? — About the same

Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
270	8.1	8.1	7.1	9.0

Q33. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone? — About the same
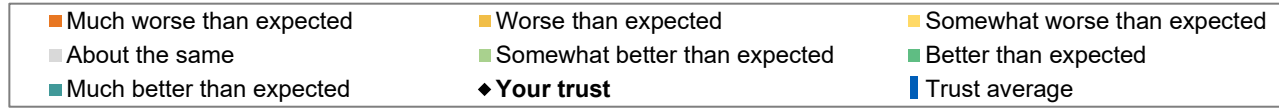
Section 7. Leaving hospital

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- Your trust

Your trust section score = 7.3 (About the same)
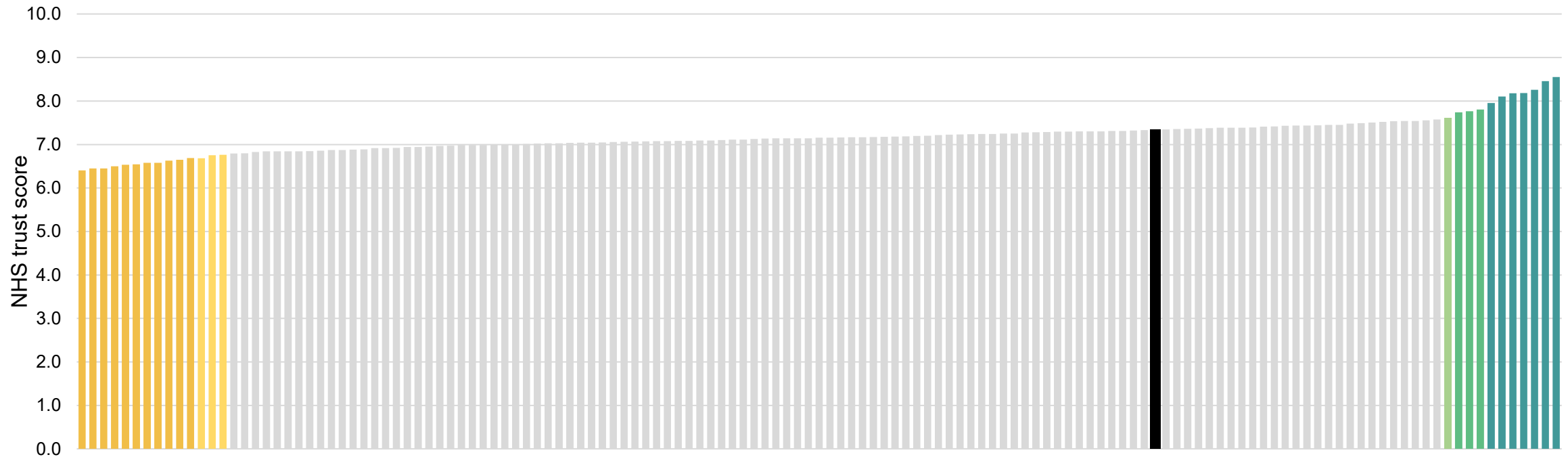
Each vertical line represents an individual NHS trust.
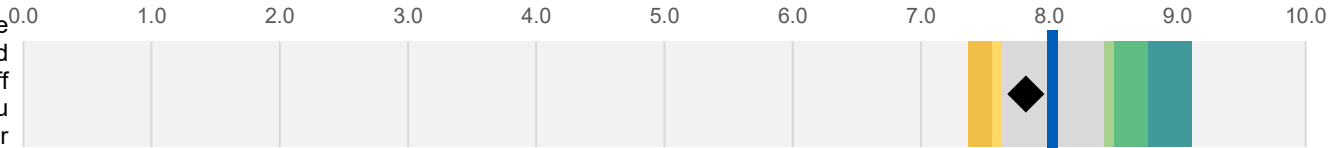Trust score is not shown when there are fewer than 30 respondents.

Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- ◆ Your trust
- ▌Trust average

	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
			All trusts in England		
Q34. To what extent did staff involve you in decisions about you leaving hospital? — About the same	598	7.1	7.1	6.4	8.5
Q35. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital? — About the same	473	7.6	7.4	6.2	8.8
Q36. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital? — About the same	238	8.7	8.5	6.4	9.8
Q37. Were you given enough notice about when you were going to leave hospital? — About the same	610	7.4	7.2	6.4	8.5
Q38. Before you left hospital, were you given any written information about what you should or should not do after leaving hospital? — About the same	561	7.3	7.3	6.0	9.5

7.05 Care Quality Commission NHS Patient Experience Surveys 2020 Reports.pdf

Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

Legend:
- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- ◆ Your trust
- | Trust average

		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
426	5.0	4.9	3.7	6.3
544	6.7	6.7	5.7	8.7
566	8.2	7.8	6.6	9.7
328	8.5	8.3	6.9	9.6
357	6.9	6.6	4.5	8.0

Questions:
- Q39. Thinking about any medicine you were to take at home, were you given any of the following? — About the same
- Q40. Before you left hospital, did you know what would happen next with your care? — About the same
- Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? — About the same
- Q42. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? — About the same
- Q44. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition? — About the same

Section 8. Feedback on the quality of your care
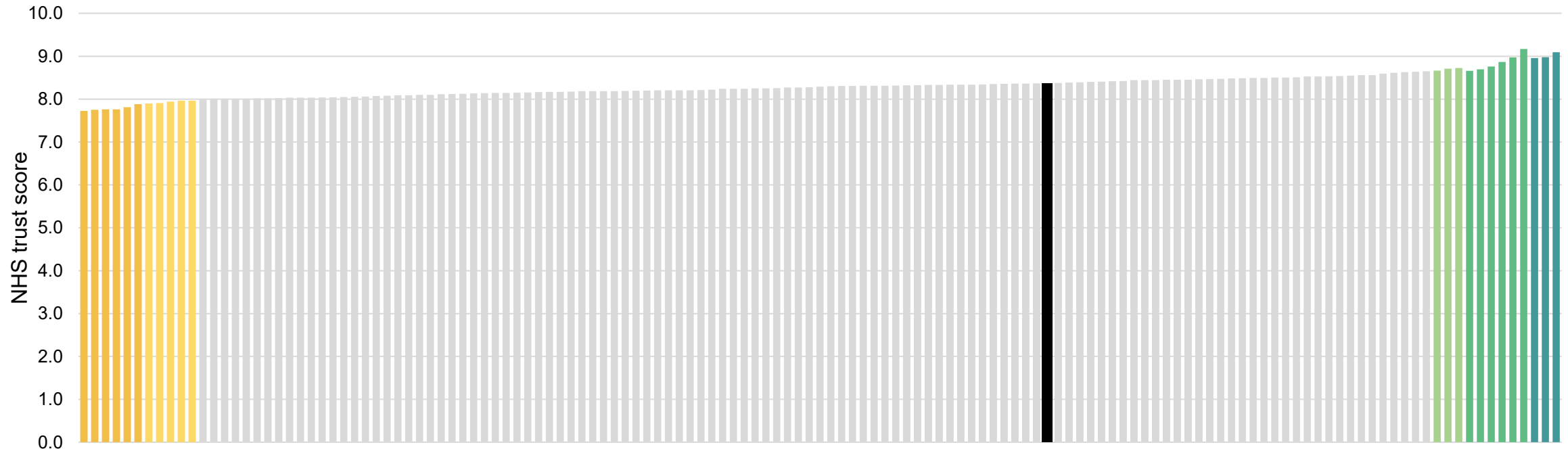
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
- Your trust
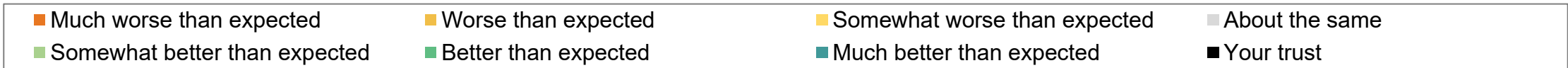
Your trust section score = 1.0 (About the same)
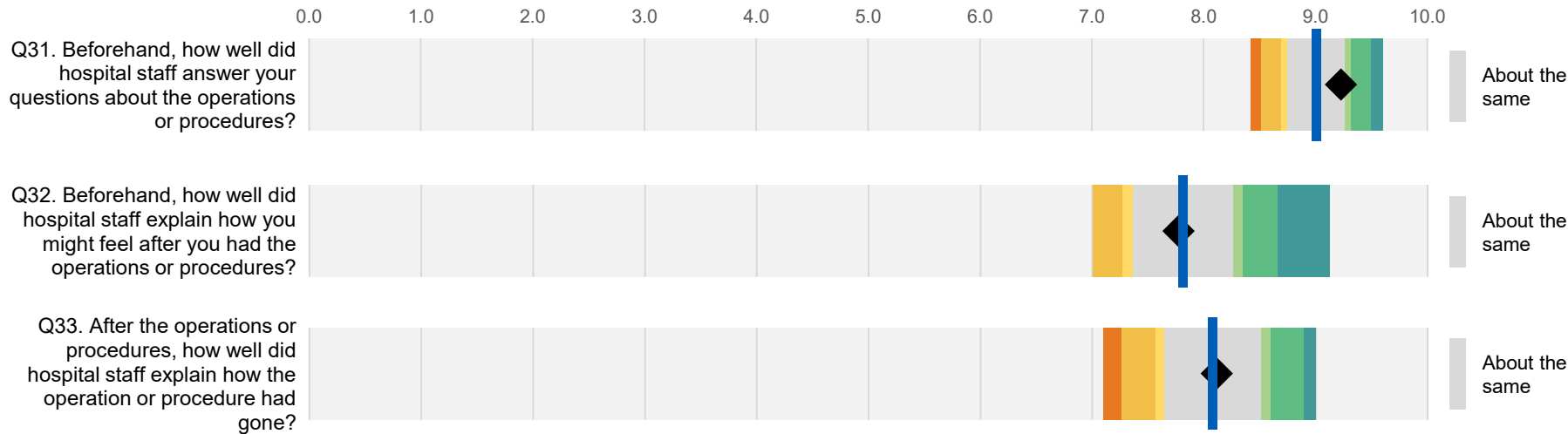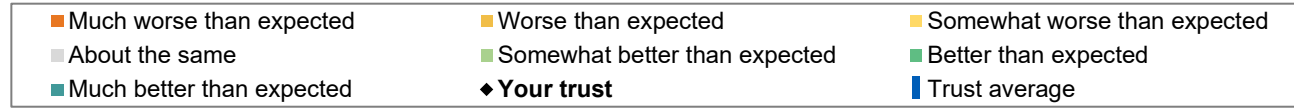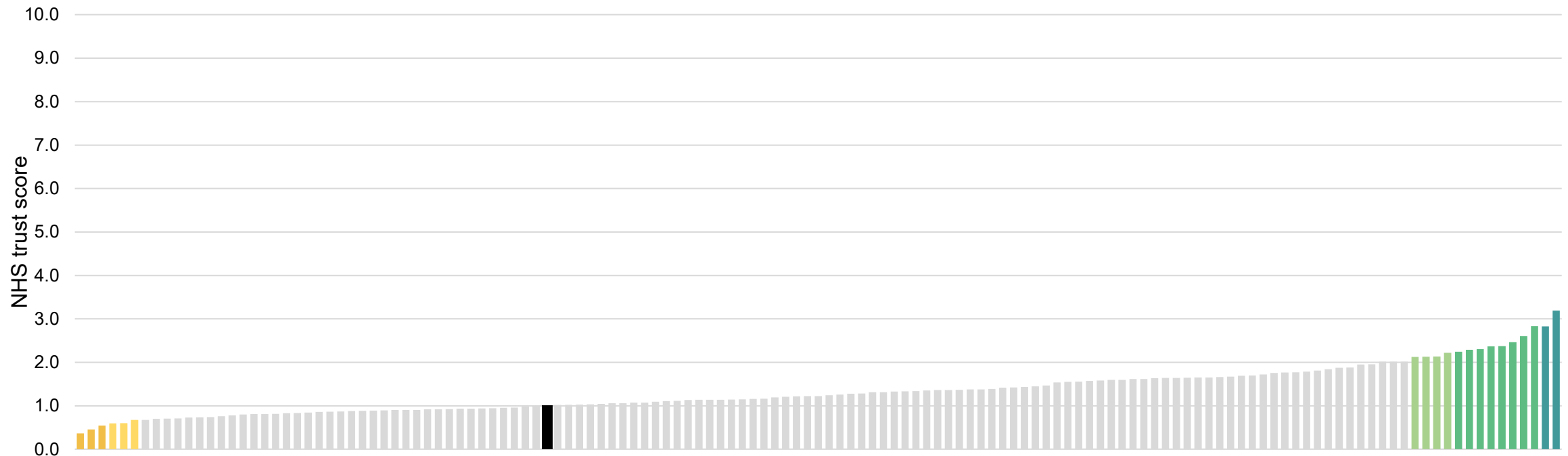

Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 8. Feedback on the quality of your care (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.

■ Much worse than expected	■ Worse than expected	■ Somewhat worse than expected
■ About the same	■ Somewhat better than expected	■ Better than expected
■ Much better than expected	◆ Your trust	▮ Trust average

Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?

About the same

| | | All trusts in England | | |
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
530	1.0	1.3	0.4	3.2

# Section 9. Respect and dignity

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

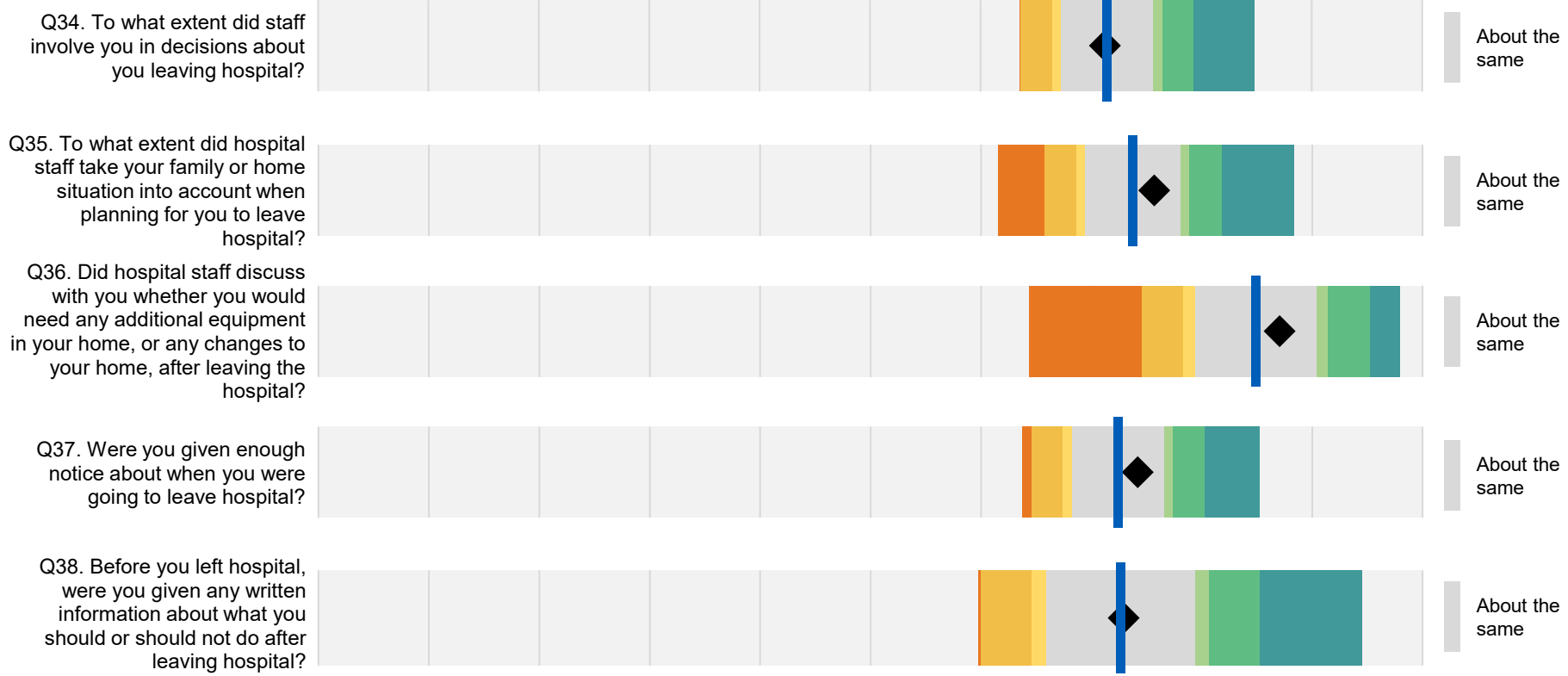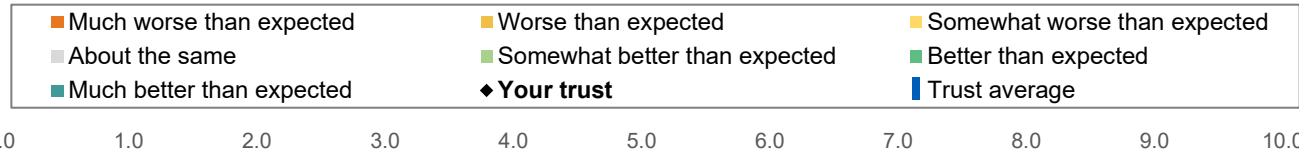| ■ Much worse than expected	■ Worse than expected	■ Somewhat worse than expected	■ About the same
■ Somewhat better than expected	■ Better than expected	■ Much better than expected	■ Your trust

Your trust section score = 9.2 (About the same)

Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Section 9. Respect and dignity (continued)

Question score

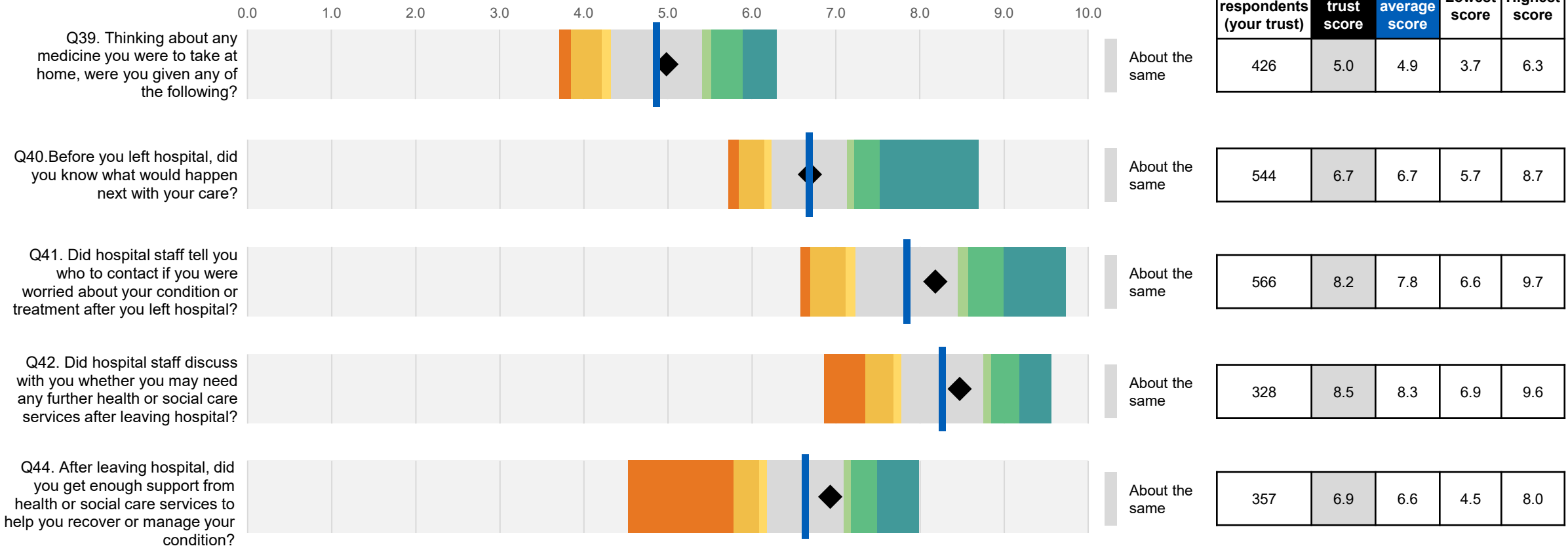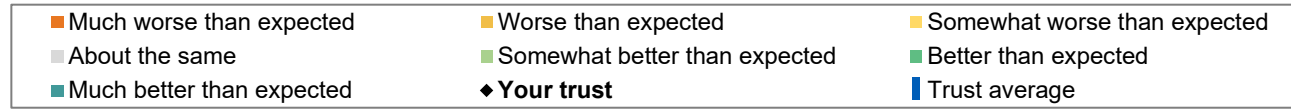Trust score is not shown when there are fewer than 30 respondents.

■ Much worse than expected	■ Worse than expected	■ Somewhat worse than expected
■ About the same	■ Somewhat better than expected	■ Better than expected
■ Much better than expected	◆ Your trust	▌Trust average

Q45. Overall, did you feel you were treated with respect and dignity while you were in the hospital? — About the same
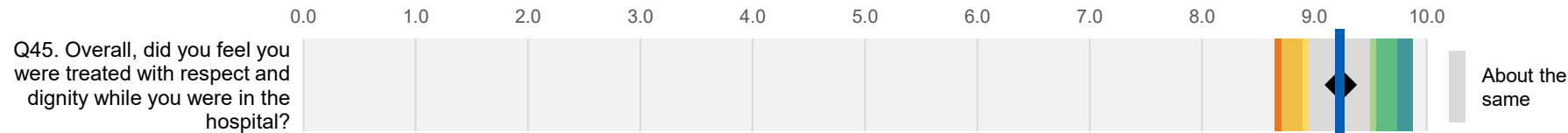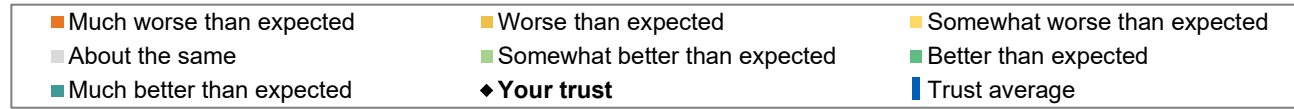
| | | All trusts in England | | |
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
614	9.2	9.2	8.6	9.9

Section 10. Overall experience

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

- Much worse than expected
- Worse than expected
- Somewhat worse than expected
- About the same
- Somewhat better than expected
- Better than expected
- Much better than expected
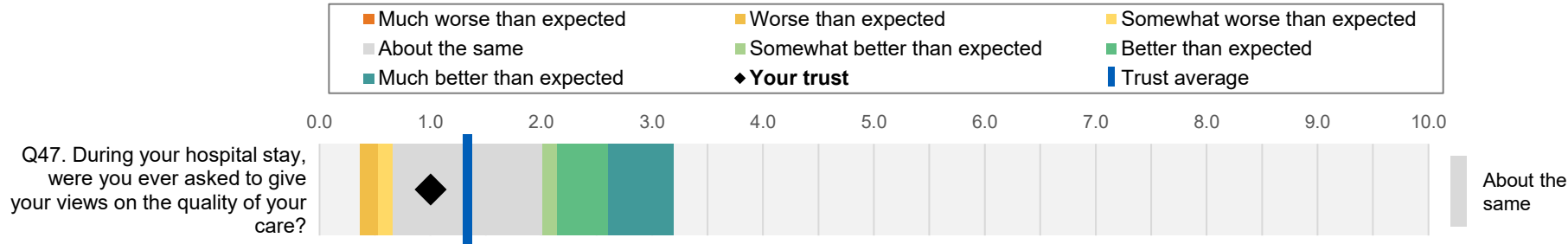- Your trust

Your trust section score = 8.3 (About the same)

Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

7.05 Care Quality Commission NHS Patient Experience Surveys 2020 Reports.pdf

Section 10. Overall experience (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.

Legend:
- ■ Much worse than expected
- ■ Worse than expected
- ■ Somewhat worse than expected
- ■ About the same
- ■ Somewhat better than expected
- ■ Better than expected
- ■ Much better than expected
- ◆ Your trust
- ▌ Trust average
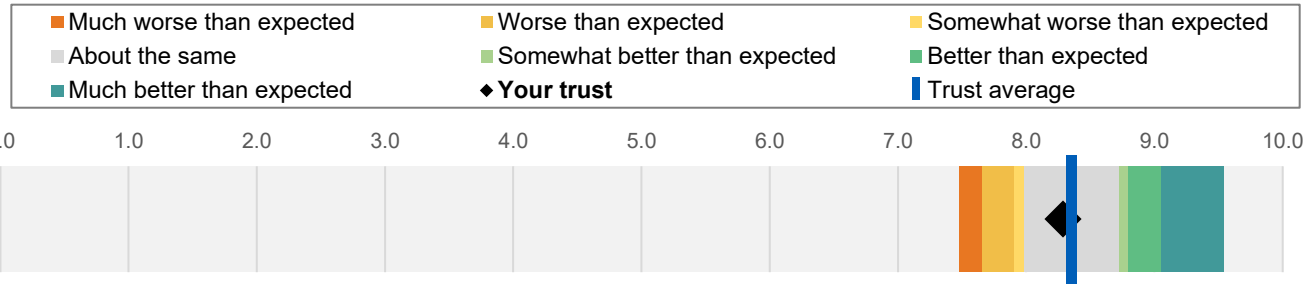
Q46. Overall, how was your experience while you were in the hospital? — About the same

| | | All trusts in England | | |
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
613	8.3	8.4	7.5	9.5

Trust results

This section includes:

• an overview of results for your trust for each question, including:

  o the score for your trust

  o a comparison with other trusts in your region

  o a breakdown of scores across sites within your trust

  Note: If fewer than 30 responses were received from patients discharged from a site, no scores will be displayed for that site.

NHS Q **CareQuality Commission** **Ipsos MORI** Ipsos

Admission to hospital: Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?

Results for your trust
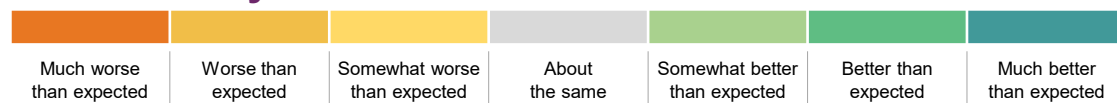
| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **8.0**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **8.1**

Site 1

Torbay Hospital (80)

Comparison with other trusts within your region

Top five trusts

Royal Devon and Exeter NHS Foundation Trust	**8.5**
Salisbury NHS Foundation Trust	**8.4**
Somerset NHS Foundation Trust	**8.3**
Royal Cornwall Hospitals NHS Trust	**8.2**
Torbay and South Devon NHS Foundation Trust	**8.0**

Bottom five trusts

Northern Devon Healthcare NHS Trust	**7.1**
Royal United Hospitals Bath NHS Foundation Trust	**7.1**
University Hospitals Dorset NHS Foundation Trust	**7.7**
Great Western Hospitals NHS Foundation Trust	**7.8**
North Bristol NHS Trust	**7.8**

Admission to hospital: Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?

Results for your trust
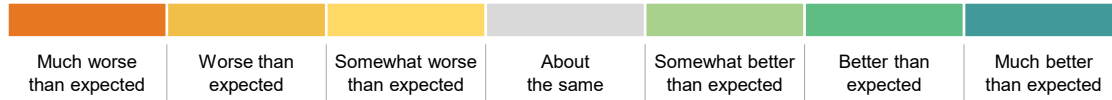
| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **7.4**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **7.2**

Site 1

Torbay Hospital (545)

Comparison with other trusts within your region

Top five trusts

Somerset NHS Foundation Trust	**8.4**
University Hospitals Dorset NHS Foundation Trust	**7.9**
North Bristol NHS Trust	**7.9**
Salisbury NHS Foundation Trust	**7.9**
Dorset County Hospital NHS Foundation Trust	**7.8**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**6.6**
University Hospitals Plymouth NHS Trust	**7.2**
Great Western Hospitals NHS Foundation Trust	**7.3**
Torbay and South Devon NHS Foundation Trust	**7.4**
University Hospitals Bristol and Weston NHS Foundation Trust	**7.4**

The hospital and ward: Q4A. There were restrictions on visitors in hospital during the coronavirus (COVID-19) pandemic. Were you able to keep in touch with your family and friends during your stay?

Results for your trust
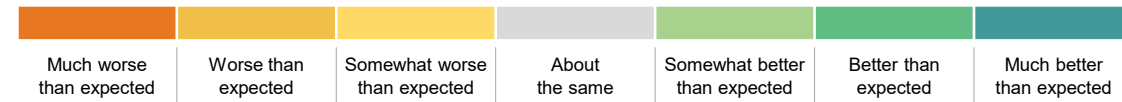
| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
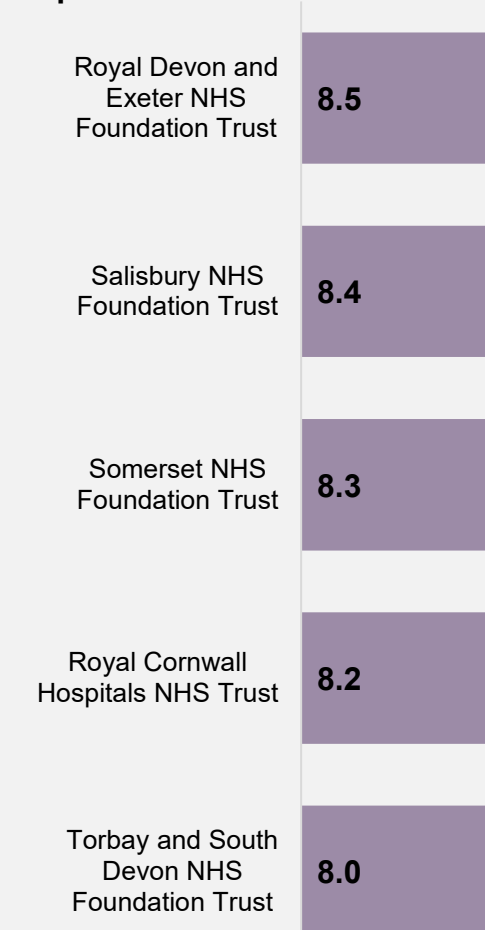
Your Trust **8.4**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
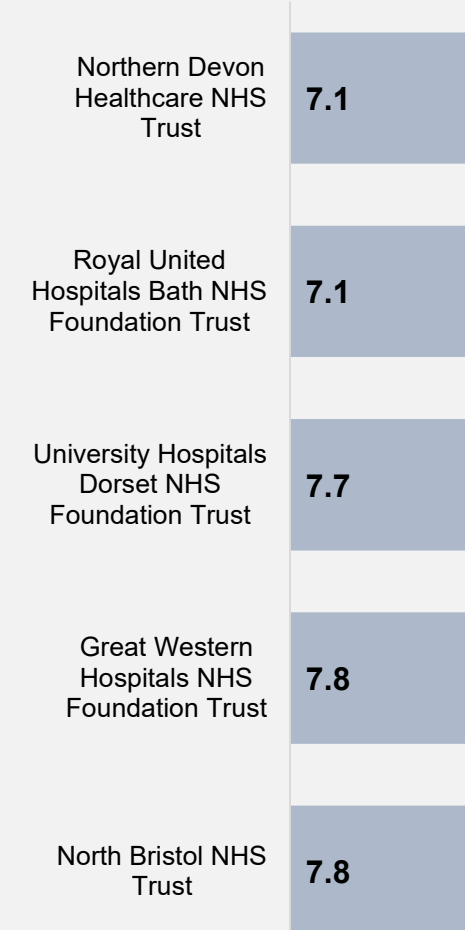
Site #1 **8.4**

Site 1

Torbay Hospital (492)

Comparison with other trusts within your region

Top five trusts

Salisbury NHS Foundation Trust	**8.6**
Dorset County Hospital NHS Foundation Trust	**8.5**
Torbay and South Devon NHS Foundation Trust	**8.4**
Great Western Hospitals NHS Foundation Trust	**8.3**
University Hospitals Plymouth NHS Trust	**8.3**

Bottom five trusts

University Hospitals Bristol and Weston NHS Foundation Trust	**7.9**
Gloucestershire Hospitals NHS Foundation Trust	**7.9**
Somerset NHS Foundation Trust	**8.0**
University Hospitals Dorset NHS Foundation Trust	**8.1**
North Bristol NHS Trust	**8.1**
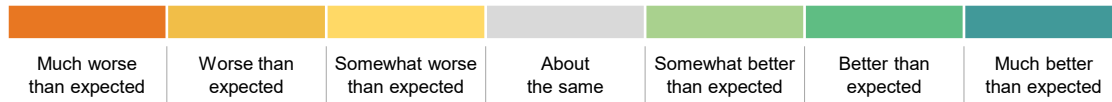
The hospital and ward: Q5. Were you ever prevented from sleeping at night by noise from other patients?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust: **5.3**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1: **5.2**

Site 1

Torbay Hospital (498)

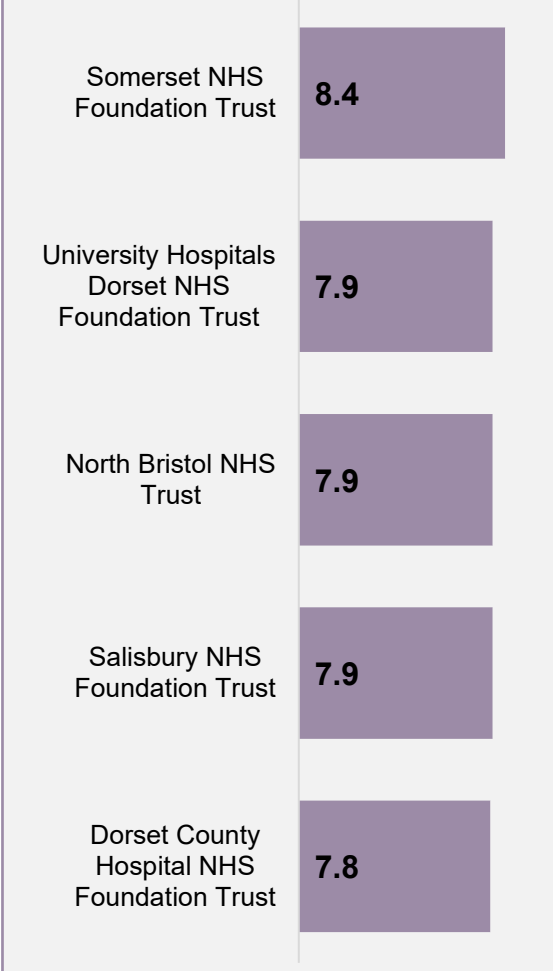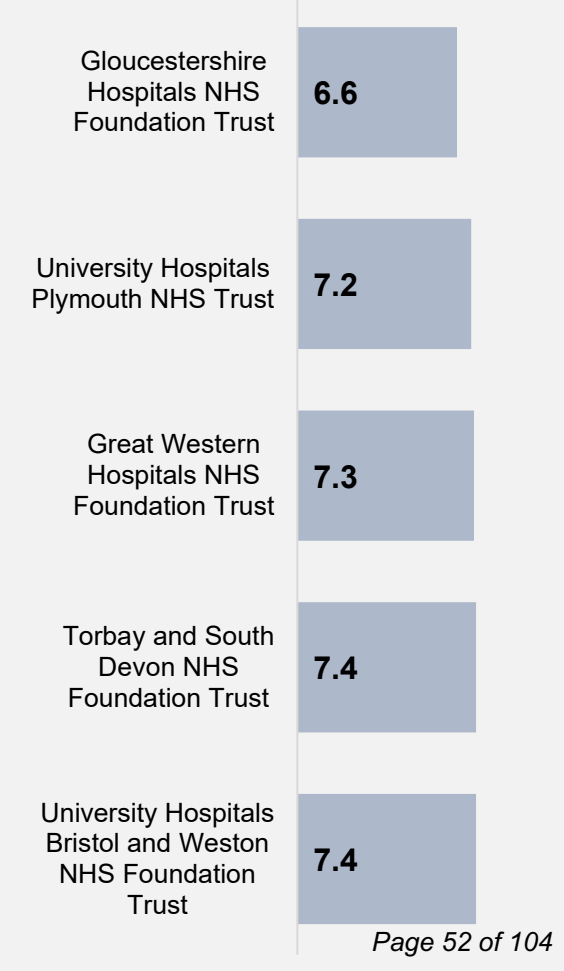## Comparison with other trusts within your region

Top five trusts

Trust	Score
North Bristol NHS Trust	7.7
Somerset NHS Foundation Trust	6.2
University Hospitals Dorset NHS Foundation Trust	6.1
Royal United Hospitals Bath NHS Foundation Trust	6.0
Dorset County Hospital NHS Foundation Trust	6.0

Bottom five trusts

Trust	Score
Salisbury NHS Foundation Trust	5.1
Torbay and South Devon NHS Foundation Trust	5.3
Royal Cornwall Hospitals NHS Trust	5.4
Royal Devon and Exeter NHS Foundation Trust	5.4
Yeovil District Hospital NHS Foundation Trust	5.7

The hospital and ward: Q5. Were you ever prevented from sleeping at night by noise from staff?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **7.6**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **7.6**

Site 1

Torbay Hospital (498)

Comparison with other trusts within your region

Top five trusts

Salisbury NHS Foundation Trust	8.4
Northern Devon Healthcare NHS Trust	8.2
North Bristol NHS Trust	8.2
Somerset NHS Foundation Trust	8.1
Royal Cornwall Hospitals NHS Trust	8.1

Bottom five trusts

Great Western Hospitals NHS Foundation Trust	7.3
Torbay and South Devon NHS Foundation Trust	7.6
University Hospitals Plymouth NHS Trust	7.7
Gloucestershire Hospitals NHS Foundation Trust	7.8
Dorset County Hospital NHS Foundation Trust	7.8

The hospital and ward: Q5. Were you ever prevented from sleeping at night by hospital lighting?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
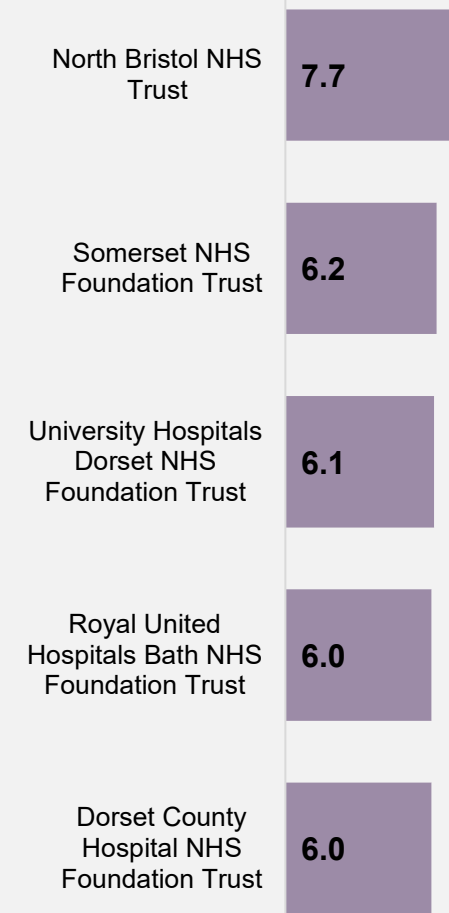
Your Trust **7.8**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
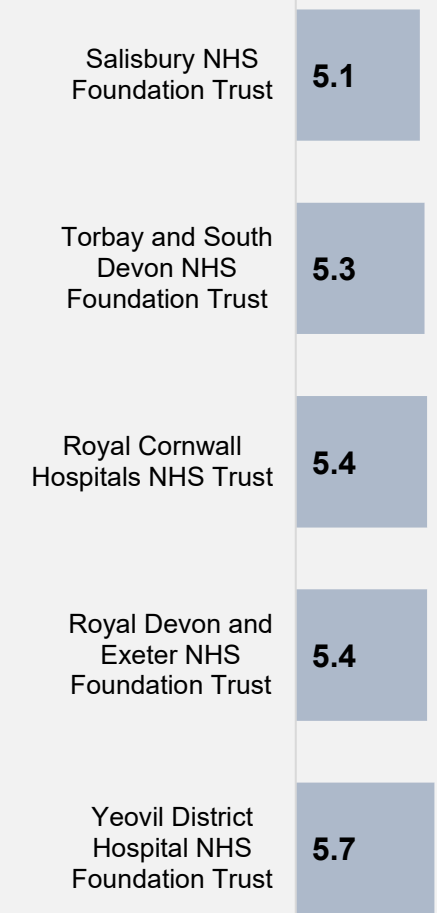
Site #1 **7.7**

Site 1

Torbay Hospital (498)

Comparison with other trusts within your region

Top five trusts

Royal Cornwall Hospitals NHS Trust	**8.6**
Northern Devon Healthcare NHS Trust	**8.6**
Royal Devon and Exeter NHS Foundation Trust	**8.4**
University Hospitals Dorset NHS Foundation Trust	**8.4**
Salisbury NHS Foundation Trust	**8.3**

Bottom five trusts

Great Western Hospitals NHS Foundation Trust	**7.3**
University Hospitals Plymouth NHS Trust	**7.6**
Torbay and South Devon NHS Foundation Trust	**7.8**
University Hospitals Bristol and Weston NHS Foundation Trust	**7.9**
Royal United Hospitals Bath NHS Foundation Trust	**7.9**

The hospital and ward: Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
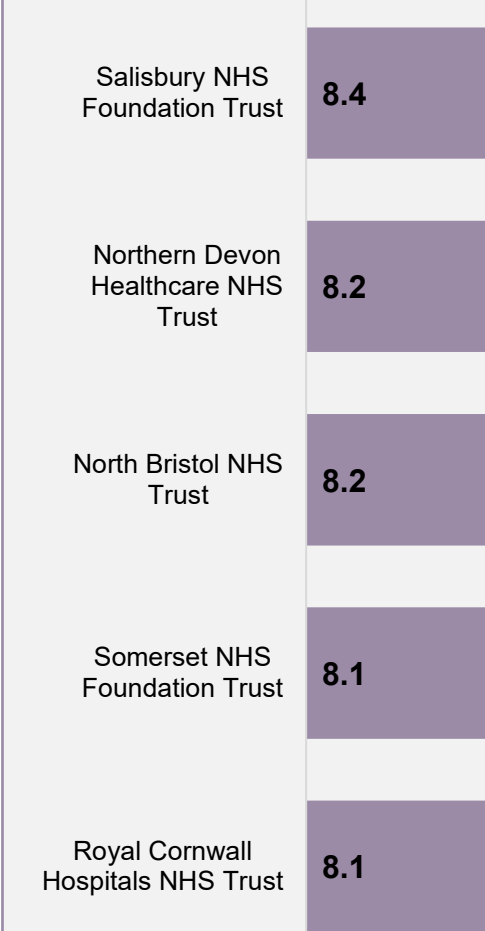
Your Trust **7.7**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
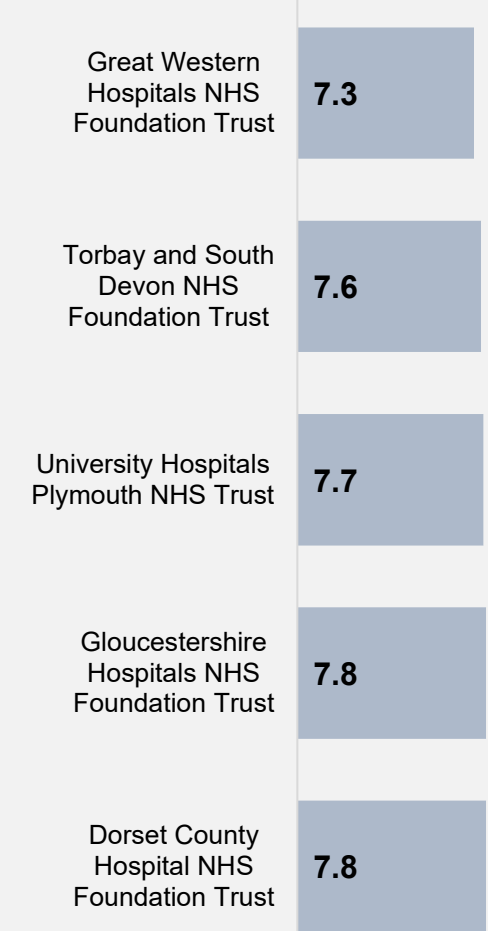
Site #1 **7.7**

Site 1

Torbay Hospital (94)

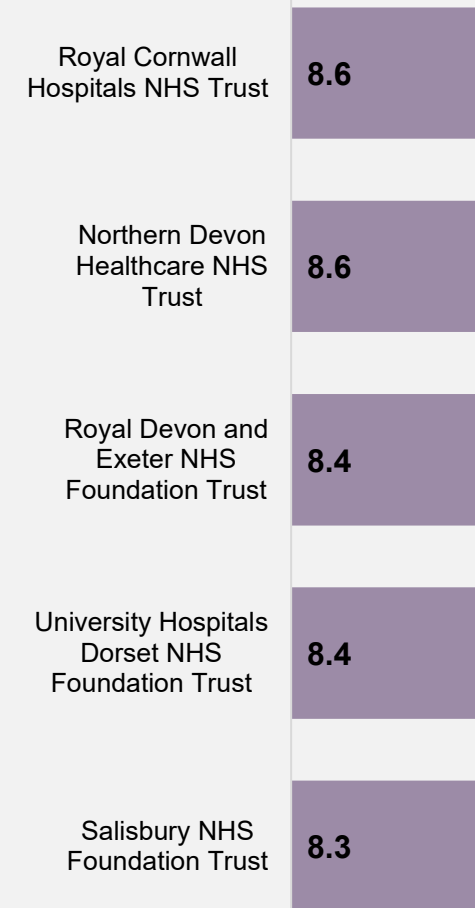## Comparison with other trusts within your region

Top five trusts

University Hospitals Bristol and Weston NHS Foundation Trust	**8.1**
Dorset County Hospital NHS Foundation Trust	**8.1**
Northern Devon Healthcare NHS Trust	**8.0**
North Bristol NHS Trust	**7.9**
Salisbury NHS Foundation Trust	**7.9**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**6.1**
Great Western Hospitals NHS Foundation Trust	**6.6**
University Hospitals Dorset NHS Foundation Trust	**6.9**
Royal Cornwall Hospitals NHS Trust	**6.9**
University Hospitals Plymouth NHS Trust	**6.9**

The hospital and ward: Q8. How clean was the hospital room or ward that you were in?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **9.3**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
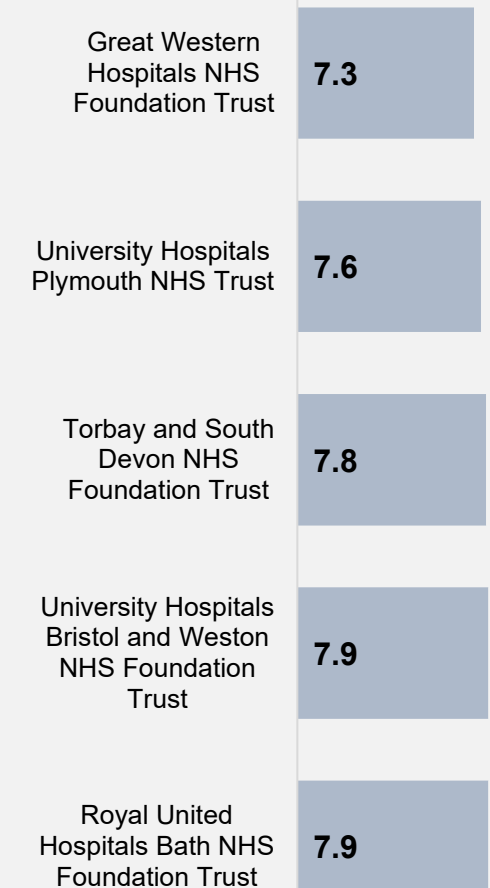
Site #1 **9.3**

Site 1

Torbay Hospital (563)

Comparison with other trusts within your region

Top five trusts

North Bristol NHS Trust	**9.5**
Dorset County Hospital NHS Foundation Trust	**9.5**
Northern Devon Healthcare NHS Trust	**9.5**
University Hospitals Bristol and Weston NHS Foundation Trust	**9.4**
Royal Devon and Exeter NHS Foundation Trust	**9.4**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**8.9**
Great Western Hospitals NHS Foundation Trust	**9.0**
Salisbury NHS Foundation Trust	**9.0**
University Hospitals Dorset NHS Foundation Trust	**9.2**
Royal United Hospitals Bath NHS Foundation Trust	**9.2**
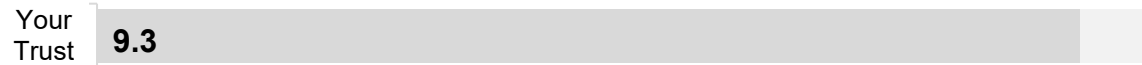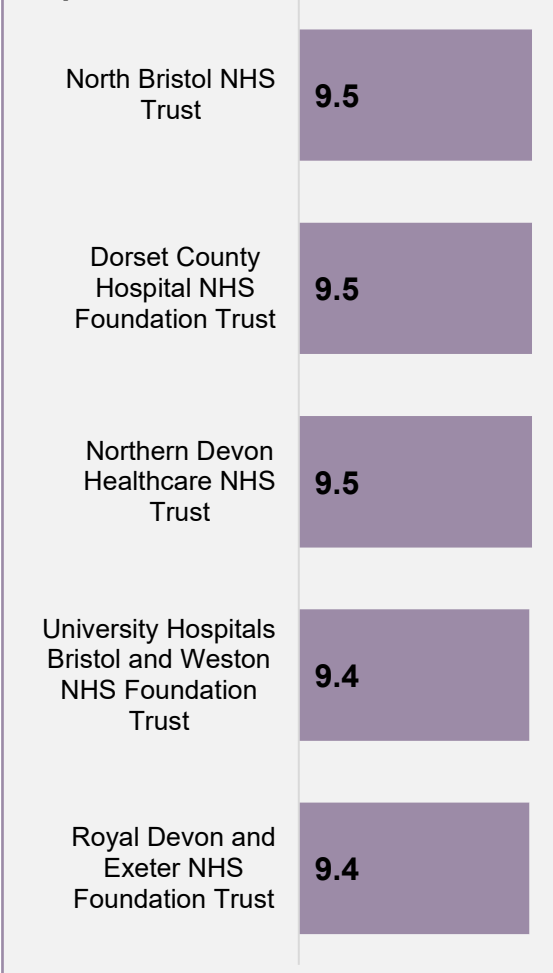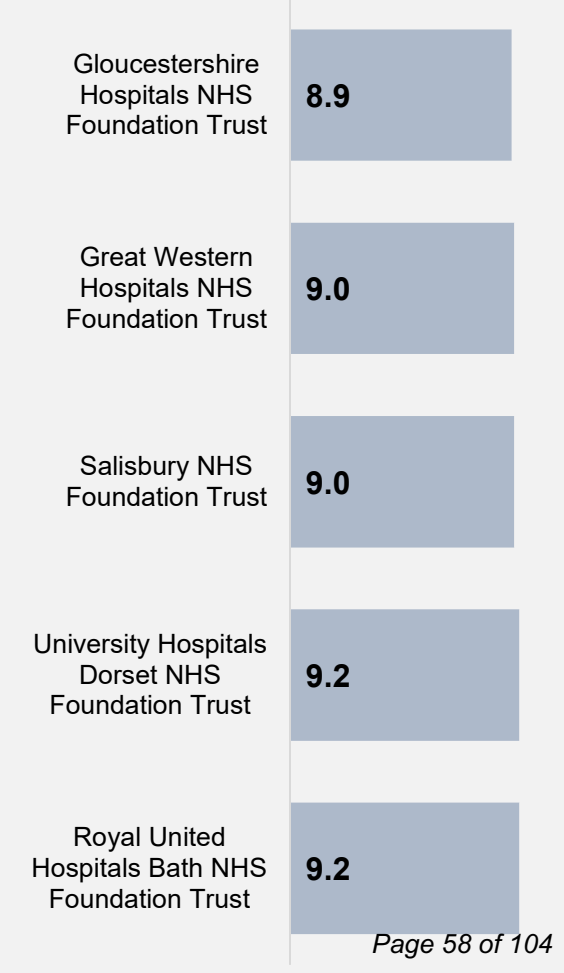
The hospital and ward: Q9. Did you get enough help from staff to wash or keep yourself clean?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **8.6**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **8.6**

Site 1

Torbay Hospital (397)

Comparison with other trusts within your region

Top five trusts

|	
Northern Devon Healthcare NHS Trust	**9.0**
University Hospitals Plymouth NHS Trust	**8.9**
Dorset County Hospital NHS Foundation Trust	**8.8**
Royal Cornwall Hospitals NHS Trust	**8.7**
Royal United Hospitals Bath NHS Foundation Trust	**8.6**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**8.1**
Great Western Hospitals NHS Foundation Trust	**8.2**
Yeovil District Hospital NHS Foundation Trust	**8.4**
University Hospitals Dorset NHS Foundation Trust	**8.5**
Somerset NHS Foundation Trust	**8.5**
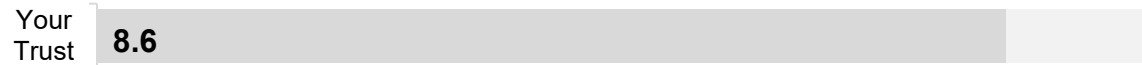
The hospital and ward: Q10. If you brought medication with you to hospital, were you able to take it when you needed to?

Results for your trust
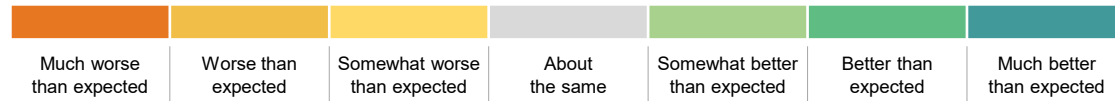
| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **8.2**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
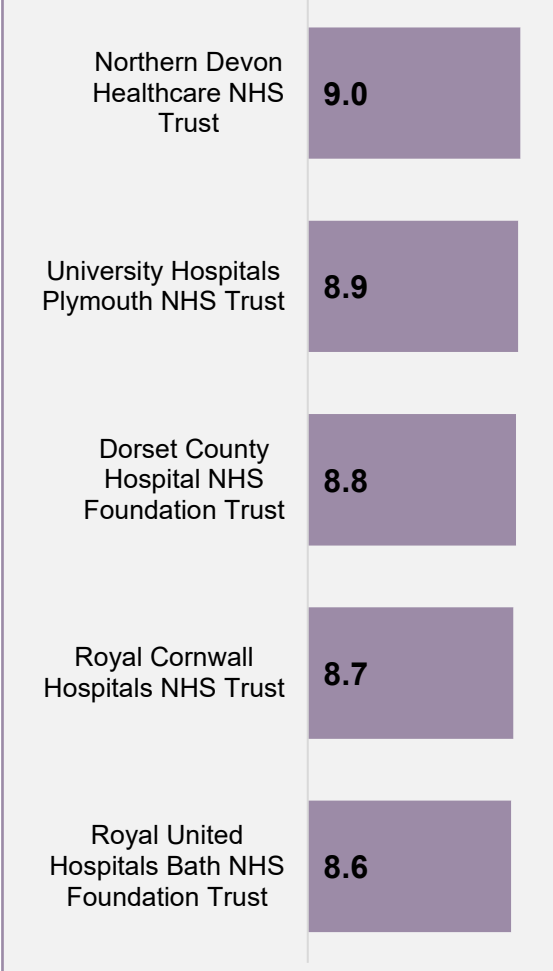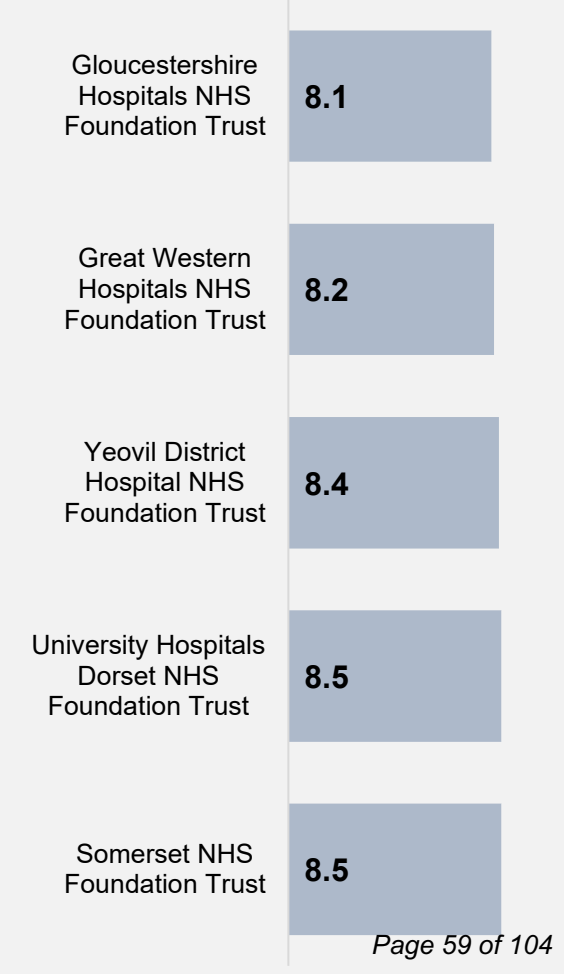
Site #1 **8.2**

Site 1

Torbay Hospital (299)

Comparison with other trusts within your region

Top five trusts

Royal United Hospitals Bath NHS Foundation Trust	**8.7**
Salisbury NHS Foundation Trust	**8.6**
Somerset NHS Foundation Trust	**8.5**
University Hospitals Bristol and Weston NHS Foundation Trust	**8.5**
North Bristol NHS Trust	**8.4**

Bottom five trusts

Great Western Hospitals NHS Foundation Trust	**7.8**
Yeovil District Hospital NHS Foundation Trust	**8.0**
Dorset County Hospital NHS Foundation Trust	**8.1**
Royal Cornwall Hospitals NHS Trust	**8.2**
Torbay and South Devon NHS Foundation Trust	**8.2**

The hospital and ward: Q11. Were you offered food that met any dietary requirements you had?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust: **8.4**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
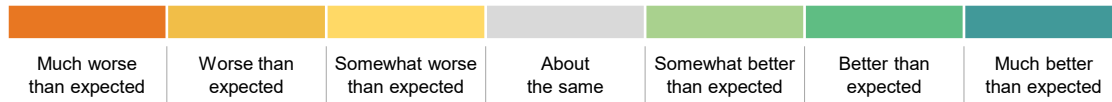
Site #1: **8.5**

Site 1

Torbay Hospital (284)

Comparison with other trusts within your region

Top five trusts

Salisbury NHS Foundation Trust	**9.0**
Northern Devon Healthcare NHS Trust	**8.9**
Royal Cornwall Hospitals NHS Trust	**8.7**
Royal Devon and Exeter NHS Foundation Trust	**8.7**
University Hospitals Plymouth NHS Trust	**8.6**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**7.9**
University Hospitals Bristol and Weston NHS Foundation Trust	**7.9**
North Bristol NHS Trust	**8.1**
Great Western Hospitals NHS Foundation Trust	**8.2**
University Hospitals Dorset NHS Foundation Trust	**8.3**
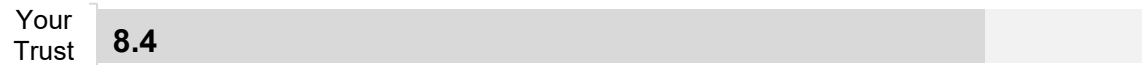
The hospital and ward: Q12. How would you rate the hospital food?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
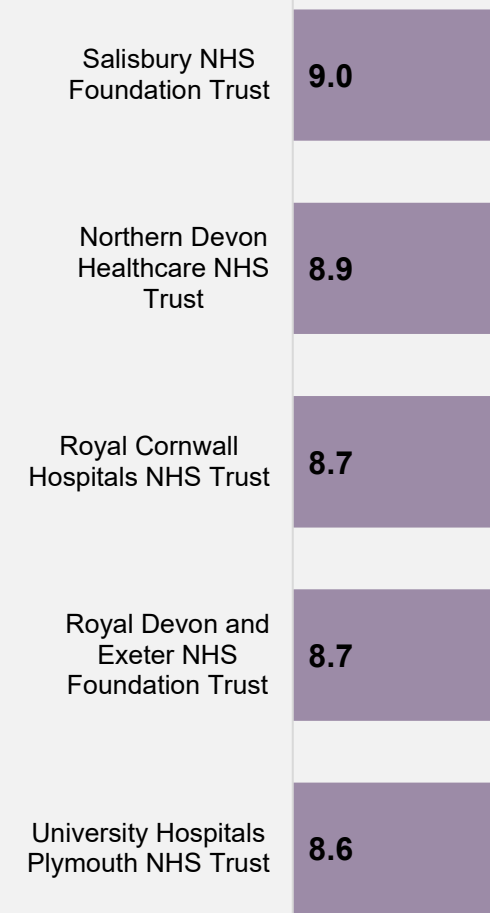
Your Trust **7.1**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
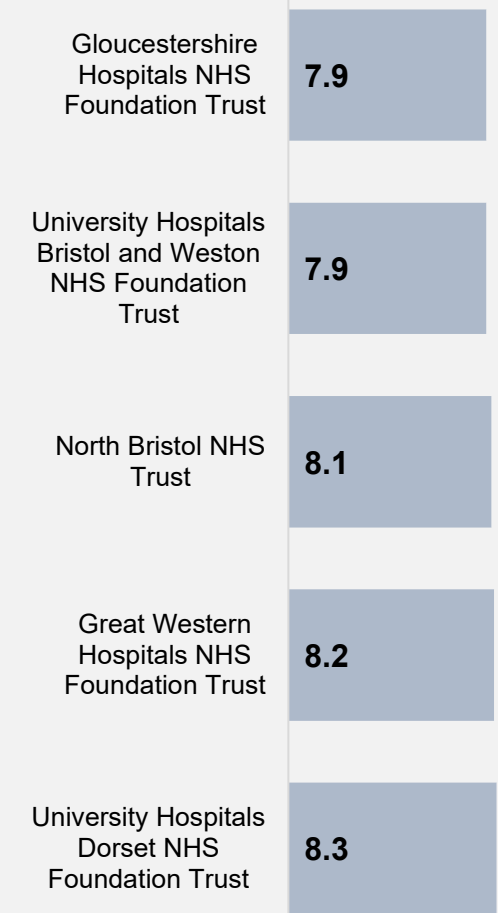
Site #1 **7.1**

Site 1

Torbay Hospital (537)
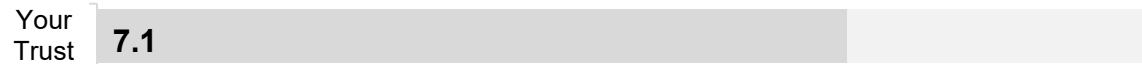
Comparison with other trusts within your region

Top five trusts

Salisbury NHS Foundation Trust	7.5
Northern Devon Healthcare NHS Trust	7.5
Yeovil District Hospital NHS Foundation Trust	7.4
University Hospitals Plymouth NHS Trust	7.4
North Bristol NHS Trust	7.3

Bottom five trusts

University Hospitals Bristol and Weston NHS Foundation Trust	6.6
Gloucestershire Hospitals NHS Foundation Trust	6.7
Great Western Hospitals NHS Foundation Trust	6.8
Royal United Hospitals Bath NHS Foundation Trust	7.0
Royal Cornwall Hospitals NHS Trust	7.1

The hospital and ward: Q13. Did you get enough help from staff to eat your meals?
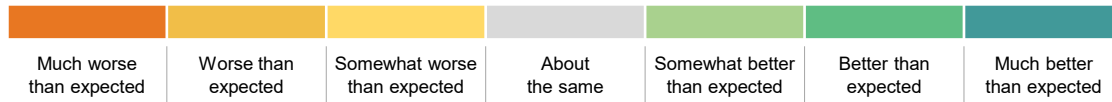
Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust 7.4

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 7.4

Site 1

Torbay Hospital (109)

Comparison with other trusts within your region

Top five trusts

Royal Devon and Exeter NHS Foundation Trust	8.5
Somerset NHS Foundation Trust	8.3
Northern Devon Healthcare NHS Trust	8.3
Dorset County Hospital NHS Foundation Trust	8.2
Royal Cornwall Hospitals NHS Trust	8.2

Bottom five trusts

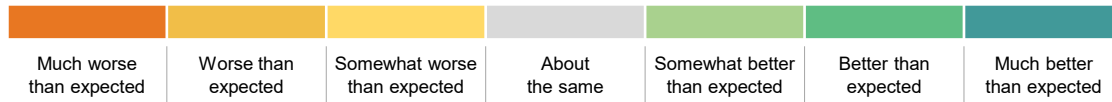| Great Western Hospitals NHS Foundation Trust | 7.2 |
Torbay and South Devon NHS Foundation Trust	7.4
University Hospitals Dorset NHS Foundation Trust	7.7
Gloucestershire Hospitals NHS Foundation Trust	7.7
North Bristol NHS Trust	7.9

The hospital and ward: Q14. During your time in hospital, did you get enough to drink?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **9.4**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **9.4**

Site 1

Torbay Hospital (531)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**9.7**
Somerset NHS Foundation Trust	**9.7**
Royal Devon and Exeter NHS Foundation Trust	**9.6**
University Hospitals Bristol and Weston NHS Foundation Trust	**9.6**
Royal United Hospitals Bath NHS Foundation Trust	**9.5**

Bottom five trusts

Great Western Hospitals NHS Foundation Trust	**9.1**
University Hospitals Dorset NHS Foundation Trust	**9.3**
Salisbury NHS Foundation Trust	**9.3**
Torbay and South Devon NHS Foundation Trust	**9.4**
North Bristol NHS Trust	**9.4**
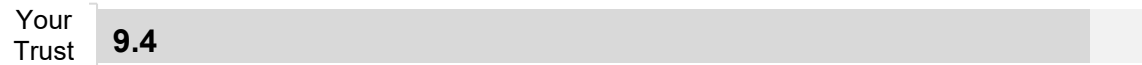
Doctors: Q15. When you asked doctors questions, did you get answers you could understand?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
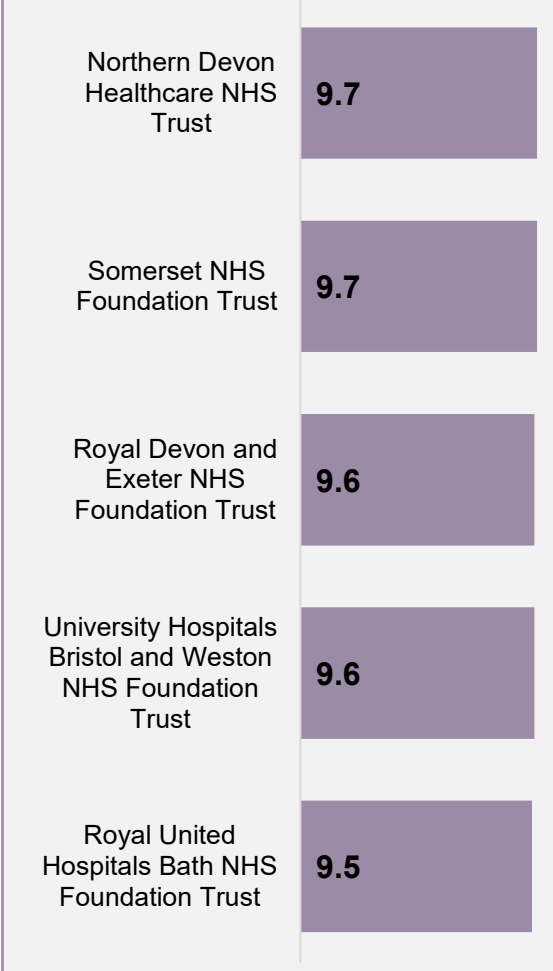
Your Trust **8.8**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
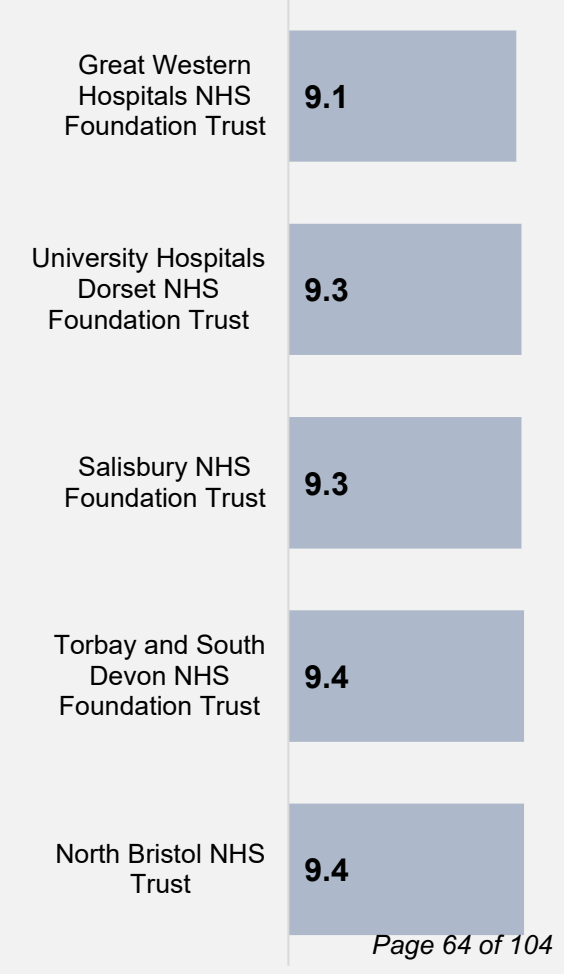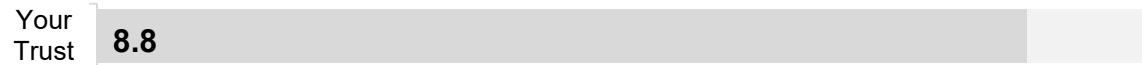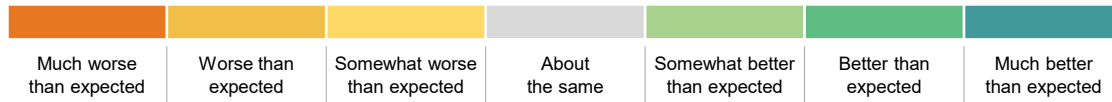
Site #1 **8.8**

Site 1

Torbay Hospital (520)

Comparison with other trusts within your region

Top five trusts

Royal United Hospitals Bath NHS Foundation Trust	**9.1**
University Hospitals Bristol and Weston NHS Foundation Trust	**9.0**
Somerset NHS Foundation Trust	**8.9**
Dorset County Hospital NHS Foundation Trust	**8.9**
Royal Devon and Exeter NHS Foundation Trust	**8.8**

Bottom five trusts

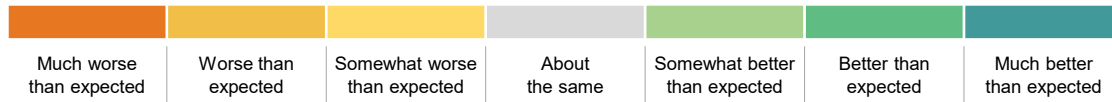|	
Yeovil District Hospital NHS Foundation Trust	**8.6**
Great Western Hospitals NHS Foundation Trust	**8.6**
Gloucestershire Hospitals NHS Foundation Trust	**8.7**
North Bristol NHS Trust	**8.7**
Torbay and South Devon NHS Foundation Trust	**8.8**

Doctors: Q16. Did you have confidence and trust in the doctors treating you?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust — **9.2**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 — **9.2**

Site 1

Torbay Hospital (568)
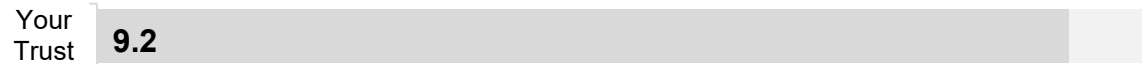
Comparison with other trusts within your region

Top five trusts

University Hospitals Dorset NHS Foundation Trust	**9.4**
University Hospitals Bristol and Weston NHS Foundation Trust	**9.3**
Dorset County Hospital NHS Foundation Trust	**9.3**
University Hospitals Plymouth NHS Trust	**9.3**
Royal United Hospitals Bath NHS Foundation Trust	**9.3**

Bottom five trusts

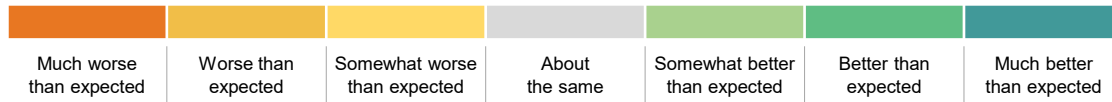| Yeovil District Hospital NHS Foundation Trust | **9.1** |
Great Western Hospitals NHS Foundation Trust	**9.2**
Gloucestershire Hospitals NHS Foundation Trust	**9.2**
Torbay and South Devon NHS Foundation Trust	**9.2**
Salisbury NHS Foundation Trust	**9.2**

Doctors: Q17. When doctors spoke about your care in front of you, were you included in the conversation?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **8.8**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **8.9**

Site 1

Torbay Hospital (567)

Comparison with other trusts within your region

Top five trusts

Royal Cornwall Hospitals NHS Trust	**9.0**
University Hospitals Dorset NHS Foundation Trust	**8.9**
Royal United Hospitals Bath NHS Foundation Trust	**8.9**
Somerset NHS Foundation Trust	**8.9**
Torbay and South Devon NHS Foundation Trust	**8.8**

Bottom five trusts

Northern Devon Healthcare NHS Trust	**8.4**
Great Western Hospitals NHS Foundation Trust	**8.5**
Gloucestershire Hospitals NHS Foundation Trust	**8.5**
University Hospitals Plymouth NHS Trust	**8.5**
University Hospitals Bristol and Weston NHS Foundation Trust	**8.6**
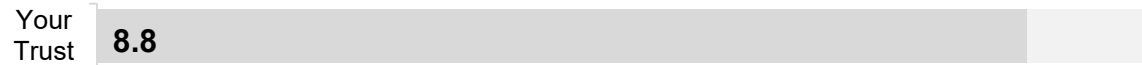
Nurses: Q18. When you asked nurses questions, did you get answers you could understand?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
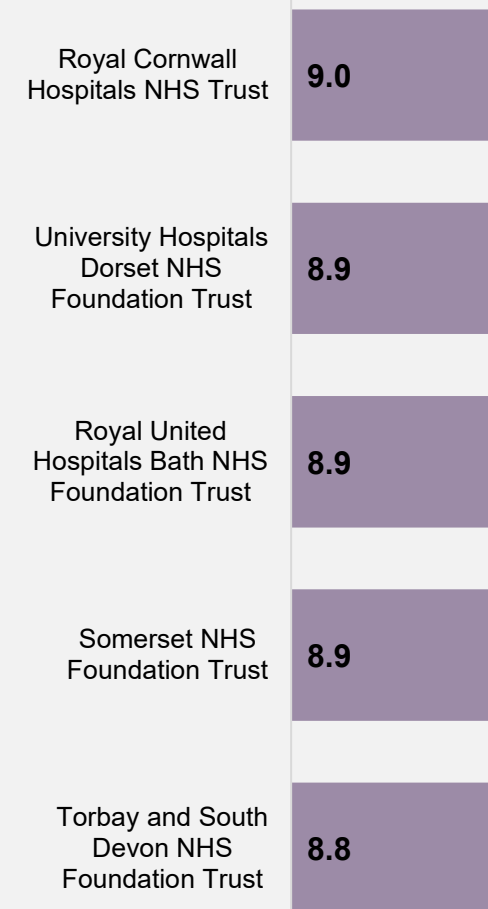
Your Trust **8.9**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
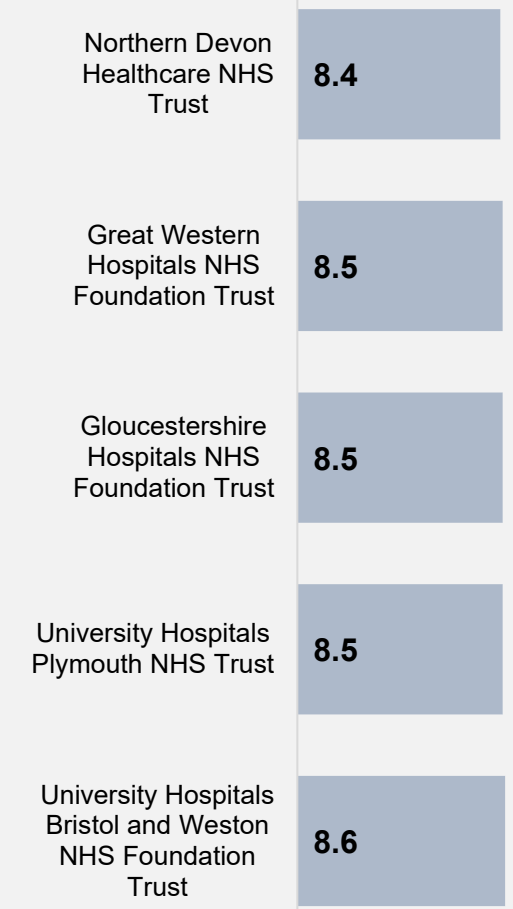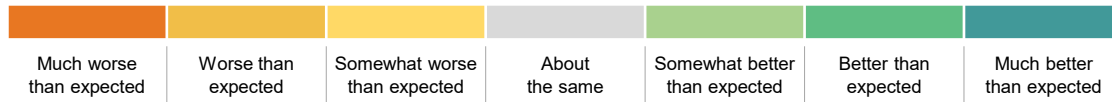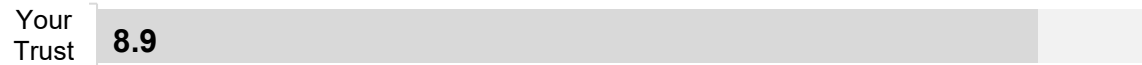
Site #1 **9.0**

Site 1

Torbay Hospital (531)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**9.3**
Royal United Hospitals Bath NHS Foundation Trust	**9.1**
Royal Cornwall Hospitals NHS Trust	**9.1**
Royal Devon and Exeter NHS Foundation Trust	**9.0**
University Hospitals Plymouth NHS Trust	**9.0**

Bottom five trusts

Yeovil District Hospital NHS Foundation Trust	**8.7**
Great Western Hospitals NHS Foundation Trust	**8.7**
Gloucestershire Hospitals NHS Foundation Trust	**8.8**
University Hospitals Bristol and Weston NHS Foundation Trust	**8.9**
Somerset NHS Foundation Trust	**8.9**

Nurses: Q19. Did you have confidence and trust in the nurses treating you?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
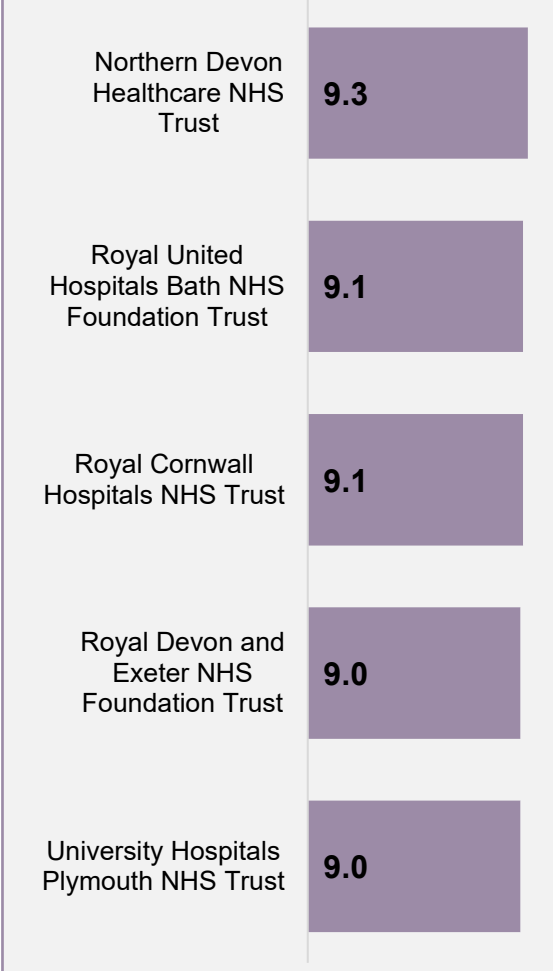
Your Trust **9.1**

Breakdown of scores for sites within your trust:

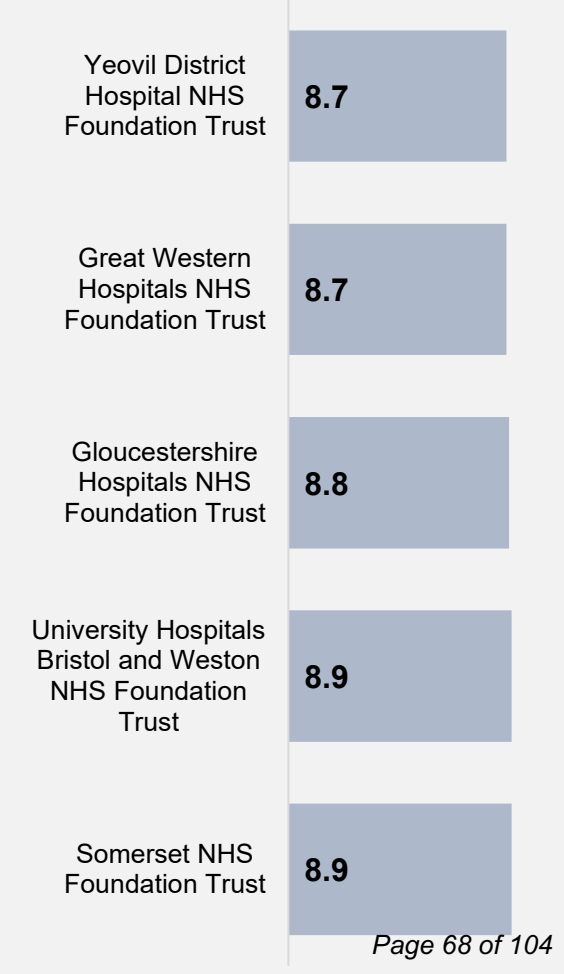This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **9.1**

Site 1

Torbay Hospital (569)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**9.5**
University Hospitals Bristol and Weston NHS Foundation Trust	**9.3**
Salisbury NHS Foundation Trust	**9.3**
Royal Cornwall Hospitals NHS Trust	**9.3**
Royal United Hospitals Bath NHS Foundation Trust	**9.3**

Bottom five trusts

Great Western Hospitals NHS Foundation Trust	**8.9**
Gloucestershire Hospitals NHS Foundation Trust	**9.0**
Yeovil District Hospital NHS Foundation Trust	**9.1**
Torbay and South Devon NHS Foundation Trust	**9.1**
Royal Devon and Exeter NHS Foundation Trust	**9.1**
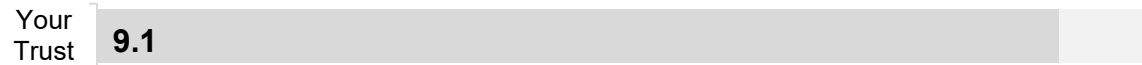
Nurses: Q20. When nurses spoke about your care in front of you, were you included in the conversation?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
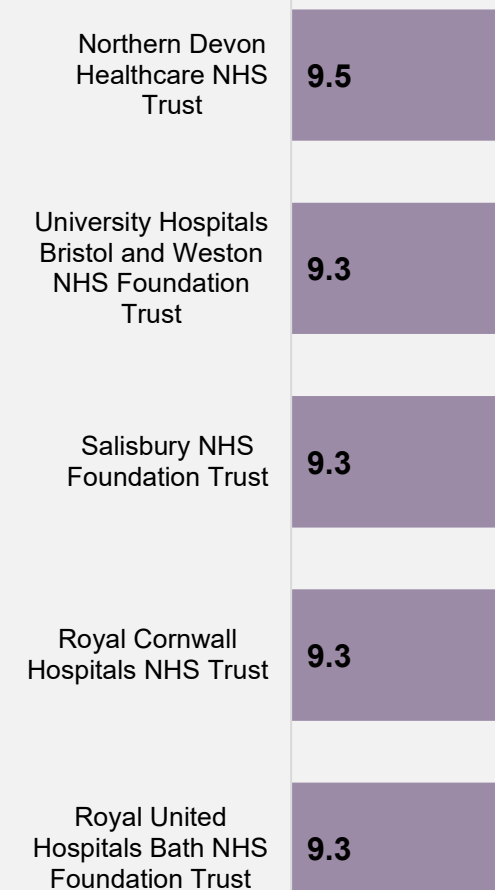
Your Trust **8.8**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
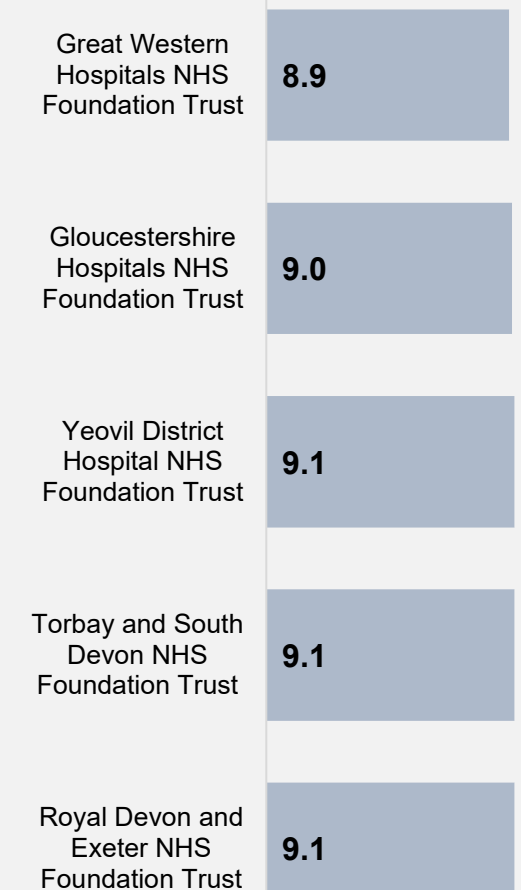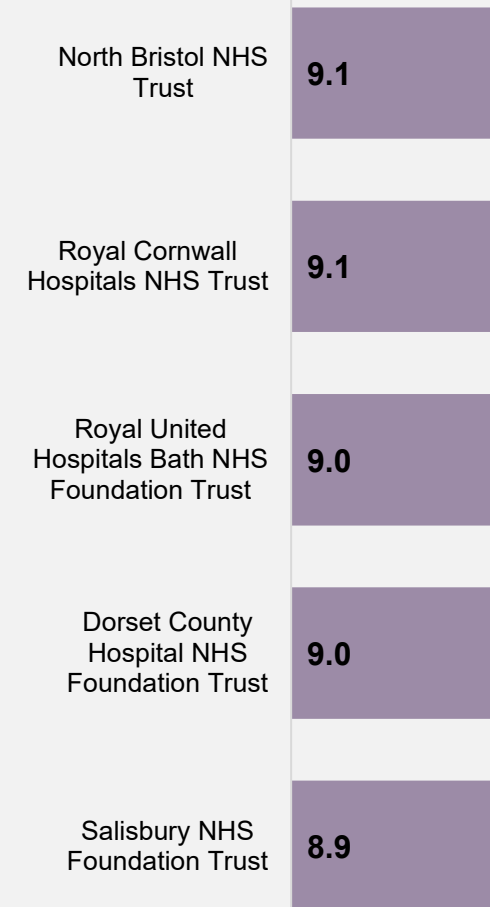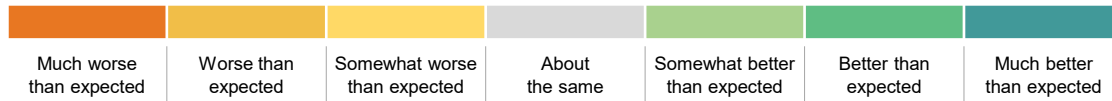
Site #1 **8.9**

Site 1

Torbay Hospital (564)

Comparison with other trusts within your region

Top five trusts

North Bristol NHS Trust	**9.1**
Royal Cornwall Hospitals NHS Trust	**9.1**
Royal United Hospitals Bath NHS Foundation Trust	**9.0**
Dorset County Hospital NHS Foundation Trust	**9.0**
Salisbury NHS Foundation Trust	**8.9**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**8.5**
Great Western Hospitals NHS Foundation Trust	**8.6**
Yeovil District Hospital NHS Foundation Trust	**8.7**
University Hospitals Bristol and Weston NHS Foundation Trust	**8.7**
Royal Devon and Exeter NHS Foundation Trust	**8.7**

Nurses: Q21. In your opinion, were there enough nurses on duty to care for you in hospital?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **7.9**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
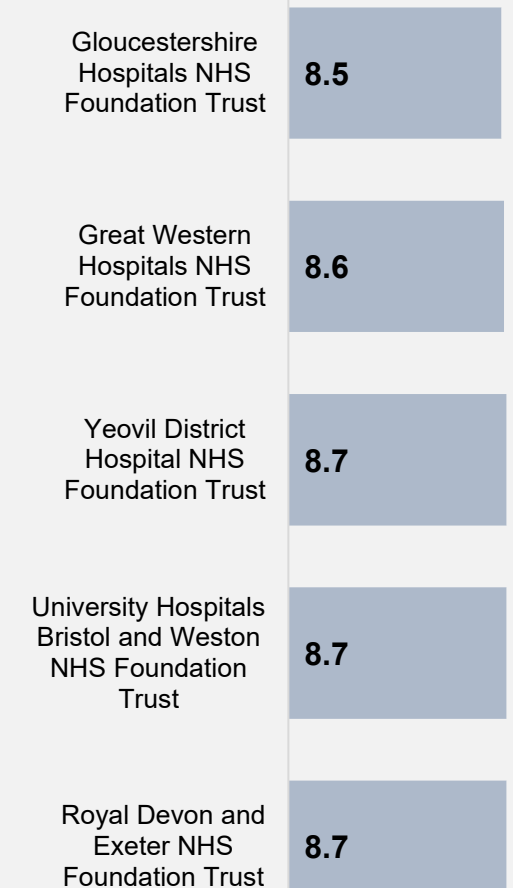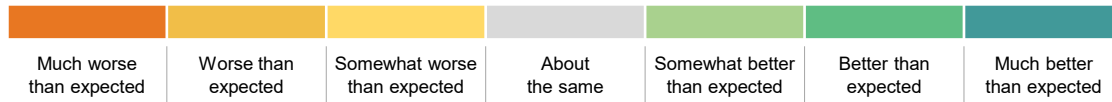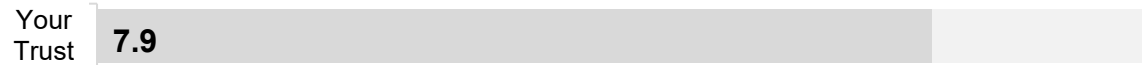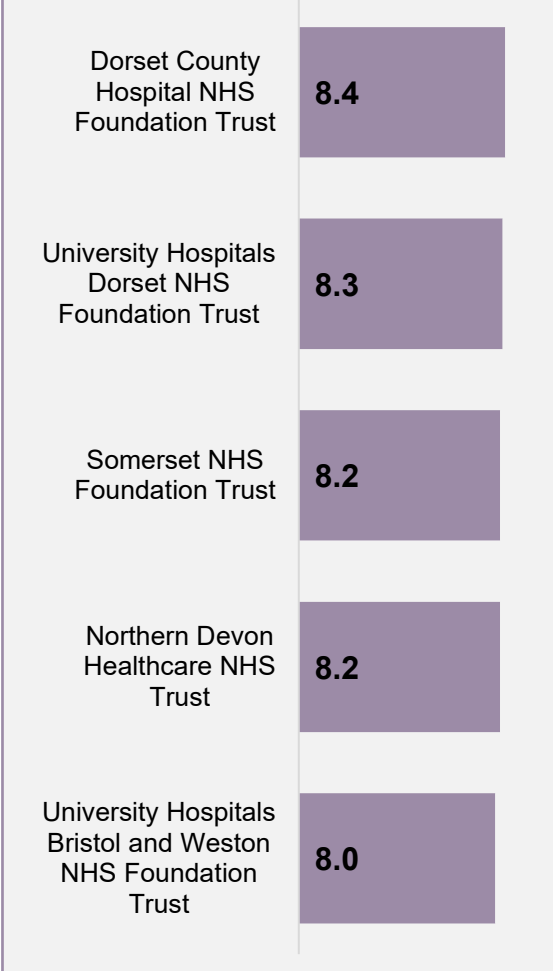
Site #1 **7.9**

Site 1

Torbay Hospital (567)

Comparison with other trusts within your region

Top five trusts

Dorset County Hospital NHS Foundation Trust	**8.4**
University Hospitals Dorset NHS Foundation Trust	**8.3**
Somerset NHS Foundation Trust	**8.2**
Northern Devon Healthcare NHS Trust	**8.2**
University Hospitals Bristol and Weston NHS Foundation Trust	**8.0**

Bottom five trusts

North Bristol NHS Trust	**7.6**
Great Western Hospitals NHS Foundation Trust	**7.6**
Royal Devon and Exeter NHS Foundation Trust	**7.6**
Royal Cornwall Hospitals NHS Trust	**7.6**
University Hospitals Plymouth NHS Trust	**7.7**

Your care and treatment: Q22. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **7.8**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
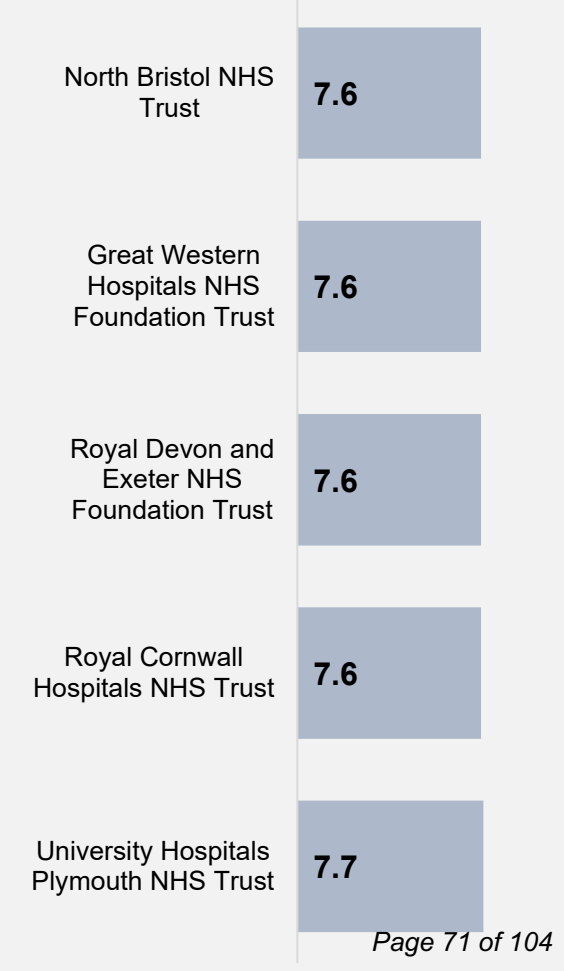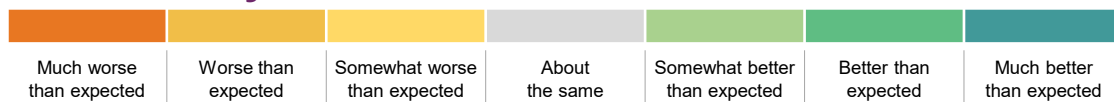
Site #1 **7.9**

Site 1

Torbay Hospital (509)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**8.6**
Royal United Hospitals Bath NHS Foundation Trust	**8.4**
University Hospitals Bristol and Weston NHS Foundation Trust	**8.3**
Royal Cornwall Hospitals NHS Trust	**8.2**
Somerset NHS Foundation Trust	**8.2**

Bottom five trusts

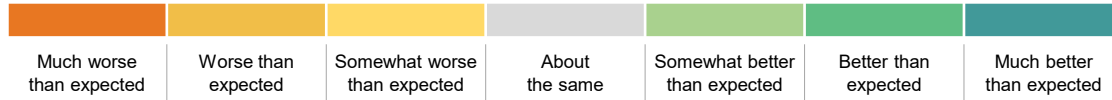|	
Great Western Hospitals NHS Foundation Trust	**7.6**
Torbay and South Devon NHS Foundation Trust	**7.8**
Gloucestershire Hospitals NHS Foundation Trust	**7.9**
University Hospitals Plymouth NHS Trust	**7.9**
University Hospitals Dorset NHS Foundation Trust	**7.9**

Your care and treatment: Q23. To what extent did staff looking after you involve you in decisions about your care and treatment?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
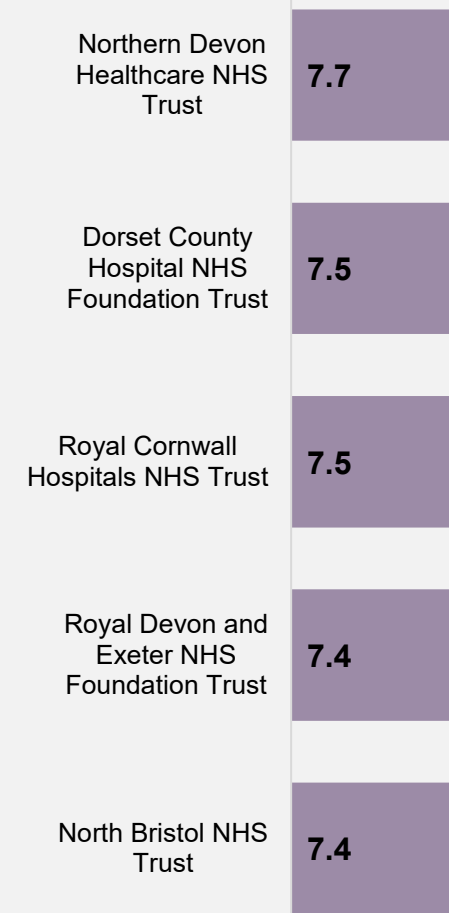
Your Trust **7.2**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **7.2**

Site 1

Torbay Hospital (548)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**7.7**
Dorset County Hospital NHS Foundation Trust	**7.5**
Royal Cornwall Hospitals NHS Trust	**7.5**
Royal Devon and Exeter NHS Foundation Trust	**7.4**
North Bristol NHS Trust	**7.4**

Bottom five trusts

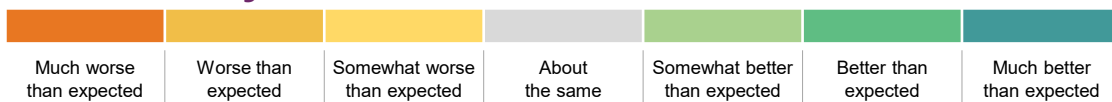|	
Great Western Hospitals NHS Foundation Trust	**7.0**
University Hospitals Dorset NHS Foundation Trust	**7.0**
Gloucestershire Hospitals NHS Foundation Trust	**7.0**
University Hospitals Plymouth NHS Trust	**7.1**
Torbay and South Devon NHS Foundation Trust	**7.2**
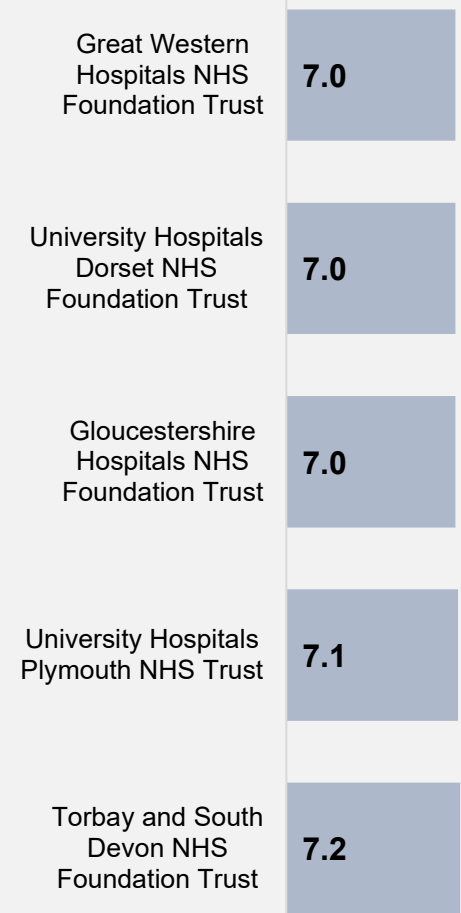
Your care and treatment: Q24. How much information about your condition or treatment was given to you?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
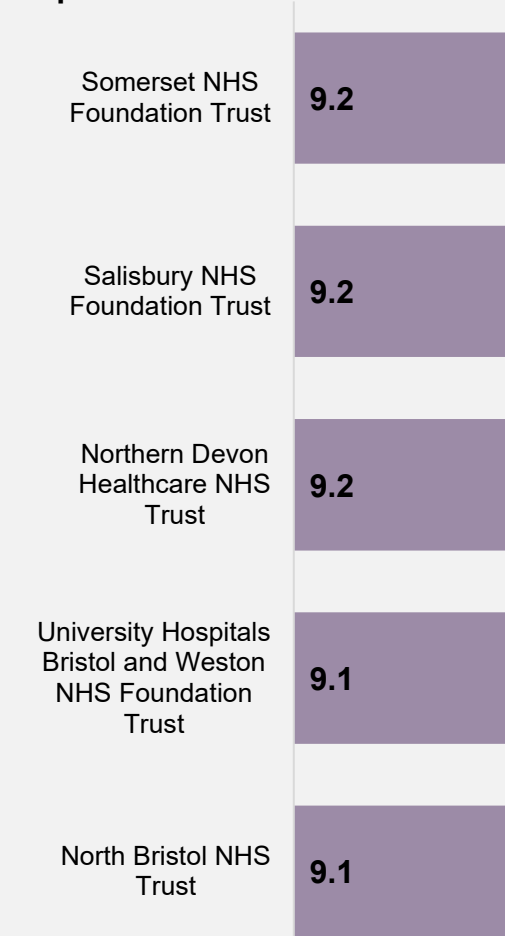
Your Trust **8.9**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
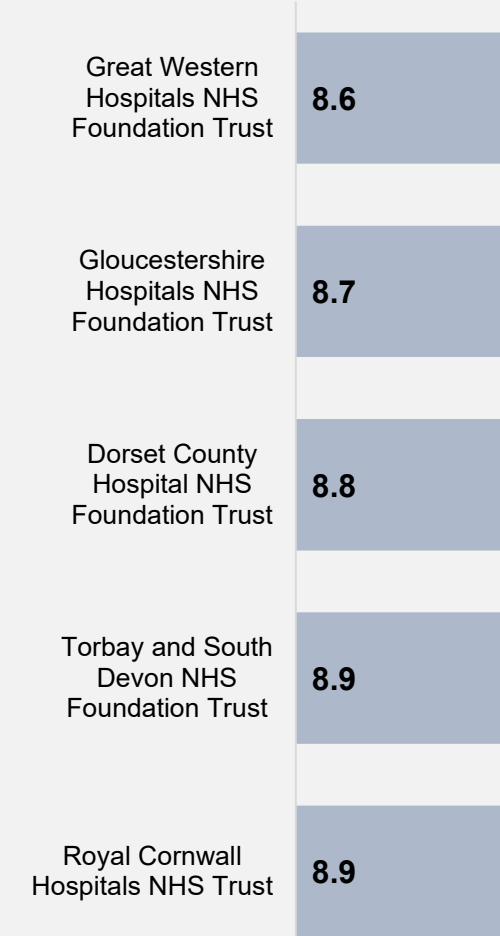
Site #1 **8.9**

Site 1

Torbay Hospital (546)

Comparison with other trusts within your region

Top five trusts

Somerset NHS Foundation Trust	**9.2**
Salisbury NHS Foundation Trust	**9.2**
Northern Devon Healthcare NHS Trust	**9.2**
University Hospitals Bristol and Weston NHS Foundation Trust	**9.1**
North Bristol NHS Trust	**9.1**

Bottom five trusts

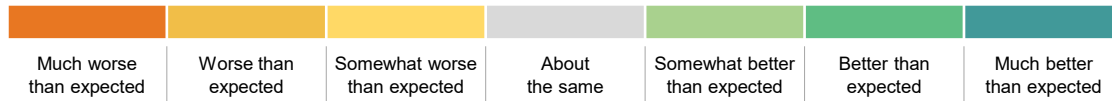|	
Great Western Hospitals NHS Foundation Trust	**8.6**
Gloucestershire Hospitals NHS Foundation Trust	**8.7**
Dorset County Hospital NHS Foundation Trust	**8.8**
Torbay and South Devon NHS Foundation Trust	**8.9**
Royal Cornwall Hospitals NHS Trust	**8.9**

CareQuality Commission Ipsos MORI Ipsos NHS

Your care and treatment: Q25. Did you feel able to talk to members of hospital staff about your worries and fears?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
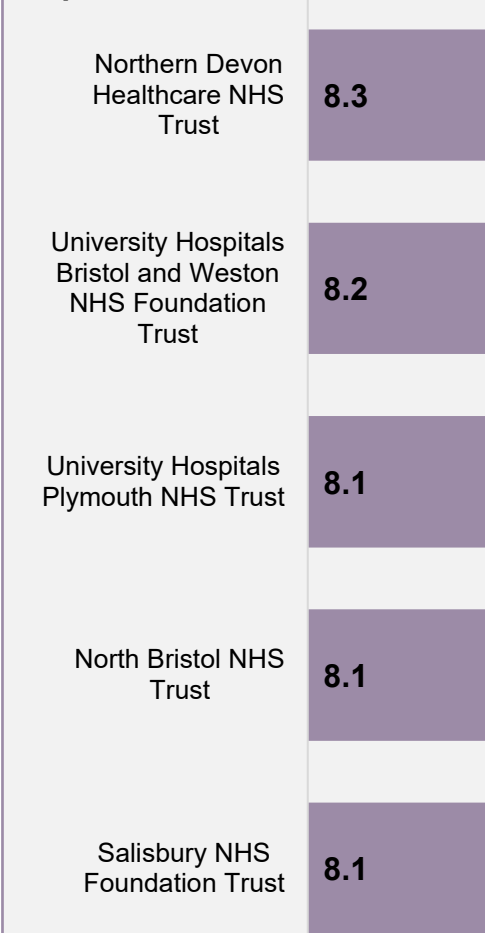
Your Trust **7.8**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
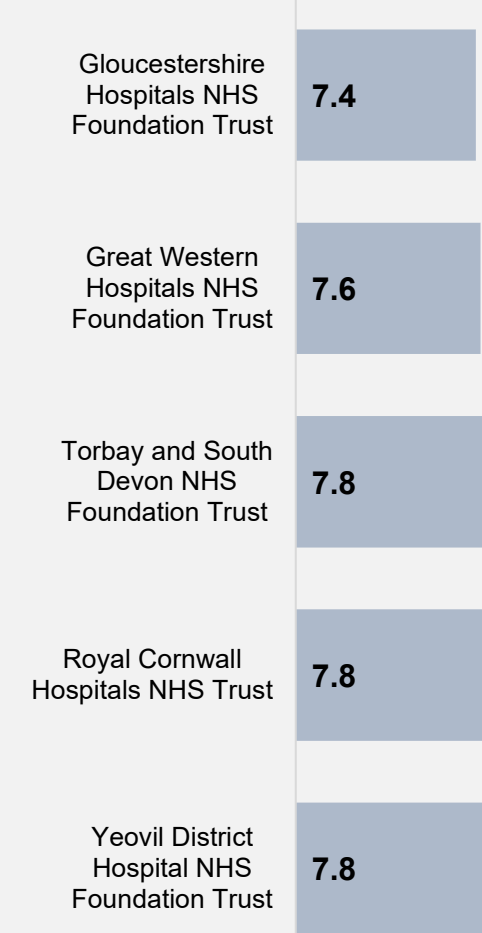
Site #1 **7.8**

Site 1

Torbay Hospital (475)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**8.3**
University Hospitals Bristol and Weston NHS Foundation Trust	**8.2**
University Hospitals Plymouth NHS Trust	**8.1**
North Bristol NHS Trust	**8.1**
Salisbury NHS Foundation Trust	**8.1**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**7.4**
Great Western Hospitals NHS Foundation Trust	**7.6**
Torbay and South Devon NHS Foundation Trust	**7.8**
Royal Cornwall Hospitals NHS Trust	**7.8**
Yeovil District Hospital NHS Foundation Trust	**7.8**

CareQuality Commission · Ipsos MORI · Ipsos · NHS
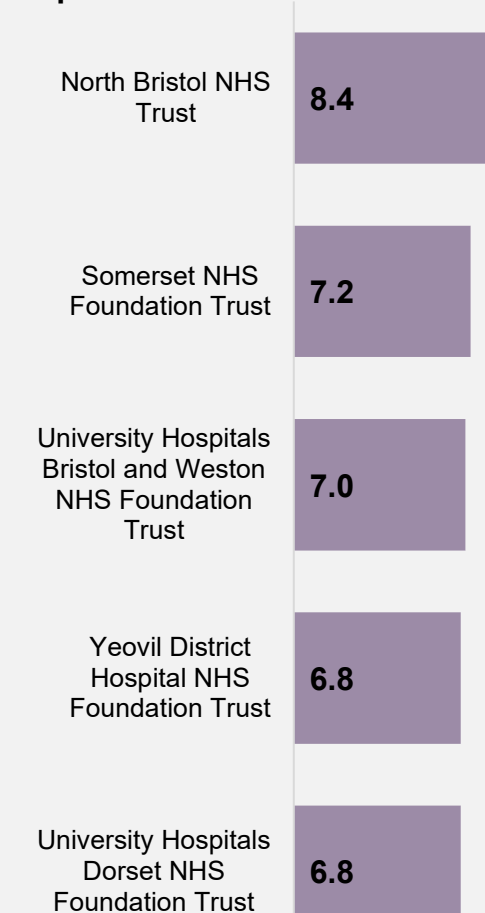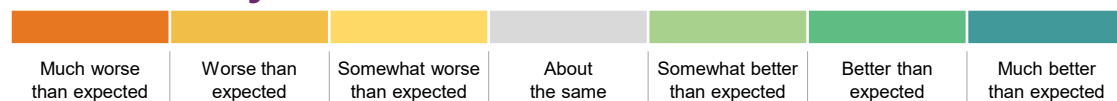
Your care and treatment: Q26. Were you able to discuss your condition or treatment with hospital staff without being overheard?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust: **6.3**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
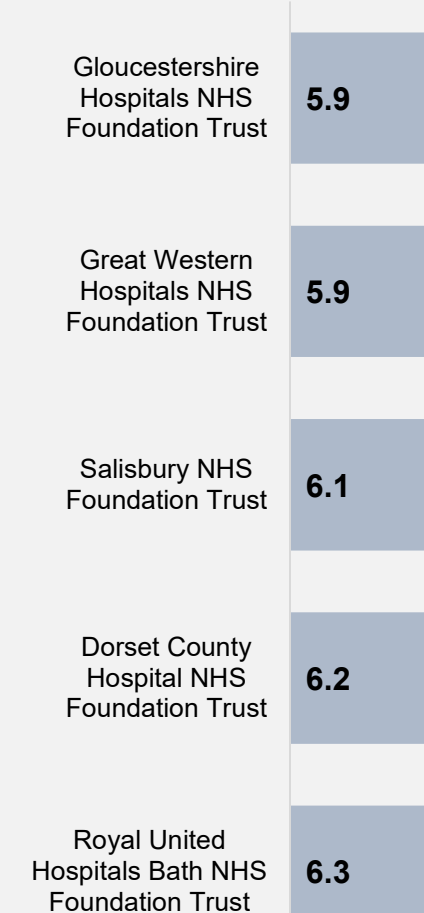
Site #1: **6.3**

Site 1

Torbay Hospital (521)

Comparison with other trusts within your region

Top five trusts

Trust	Score
North Bristol NHS Trust	8.4
Somerset NHS Foundation Trust	7.2
University Hospitals Bristol and Weston NHS Foundation Trust	7.0
Yeovil District Hospital NHS Foundation Trust	6.8
University Hospitals Dorset NHS Foundation Trust	6.8

Bottom five trusts

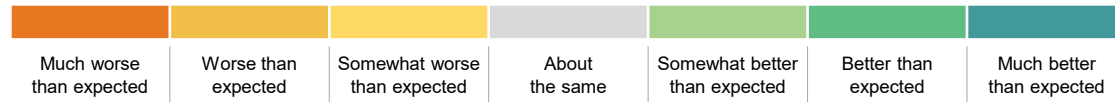| Trust	Score
Gloucestershire Hospitals NHS Foundation Trust	5.9
Great Western Hospitals NHS Foundation Trust	5.9
Salisbury NHS Foundation Trust	6.1
Dorset County Hospital NHS Foundation Trust	6.2
Royal United Hospitals Bath NHS Foundation Trust	6.3

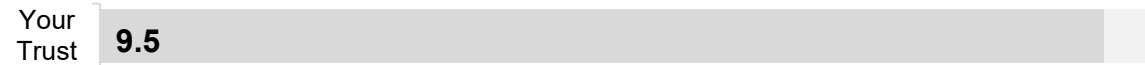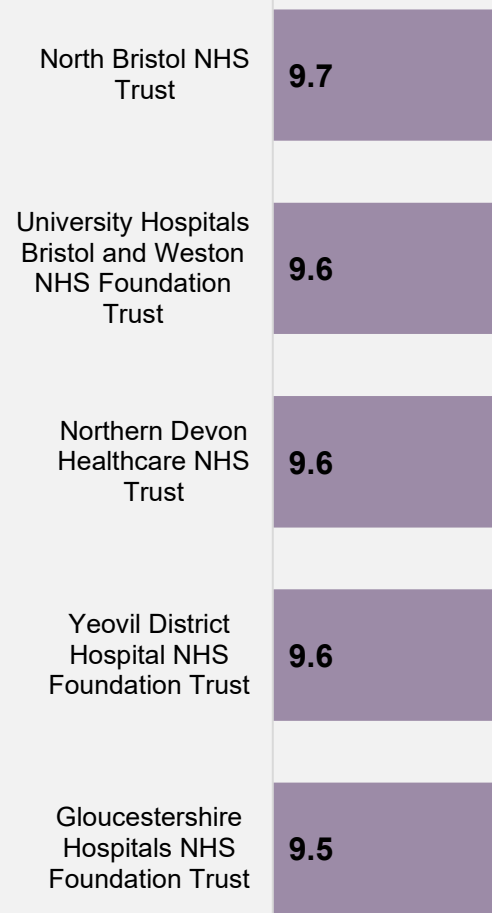# Your care and treatment: Q27. Were you given enough privacy when being examined or treated?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **9.5**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
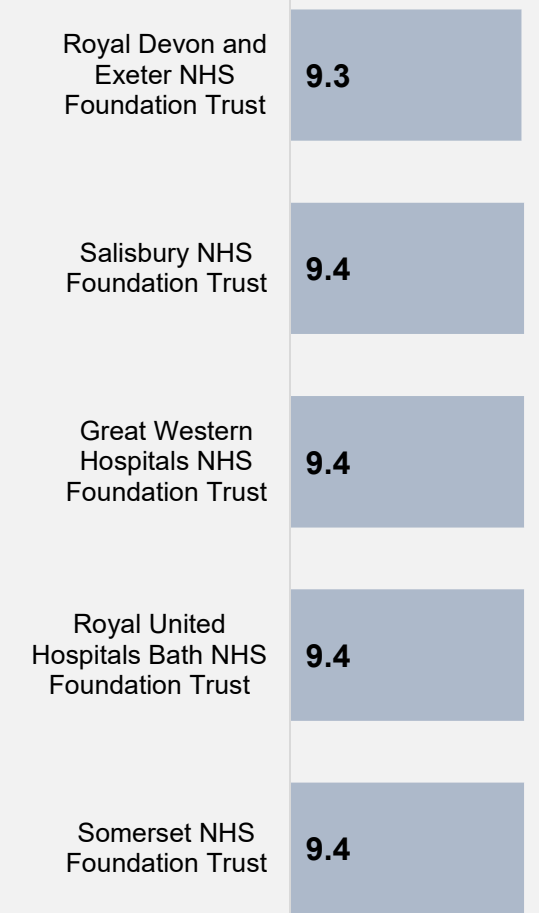
Site #1 **9.5**

Site 1

Torbay Hospital (558)

Comparison with other trusts within your region

Top five trusts

North Bristol NHS Trust	**9.7**
University Hospitals Bristol and Weston NHS Foundation Trust	**9.6**
Northern Devon Healthcare NHS Trust	**9.6**
Yeovil District Hospital NHS Foundation Trust	**9.6**
Gloucestershire Hospitals NHS Foundation Trust	**9.5**

Bottom five trusts

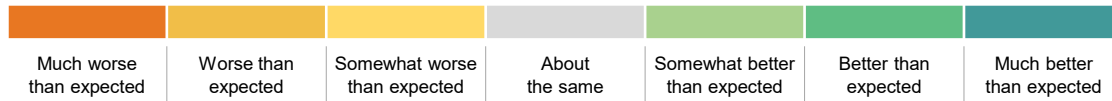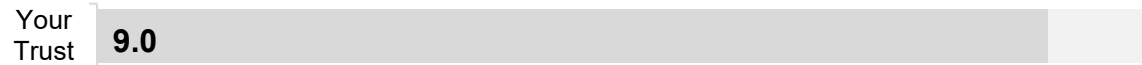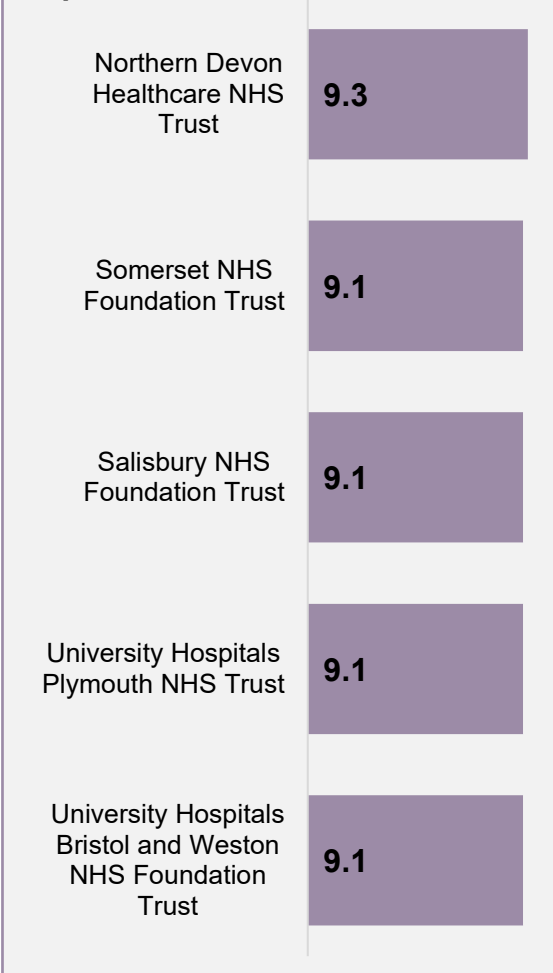| Royal Devon and Exeter NHS Foundation Trust | **9.3** |
Salisbury NHS Foundation Trust	**9.4**
Great Western Hospitals NHS Foundation Trust	**9.4**
Royal United Hospitals Bath NHS Foundation Trust	**9.4**
Somerset NHS Foundation Trust	**9.4**

Your care and treatment: Q28. Do you think the hospital staff did everything they could to help control your pain?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **9.0**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
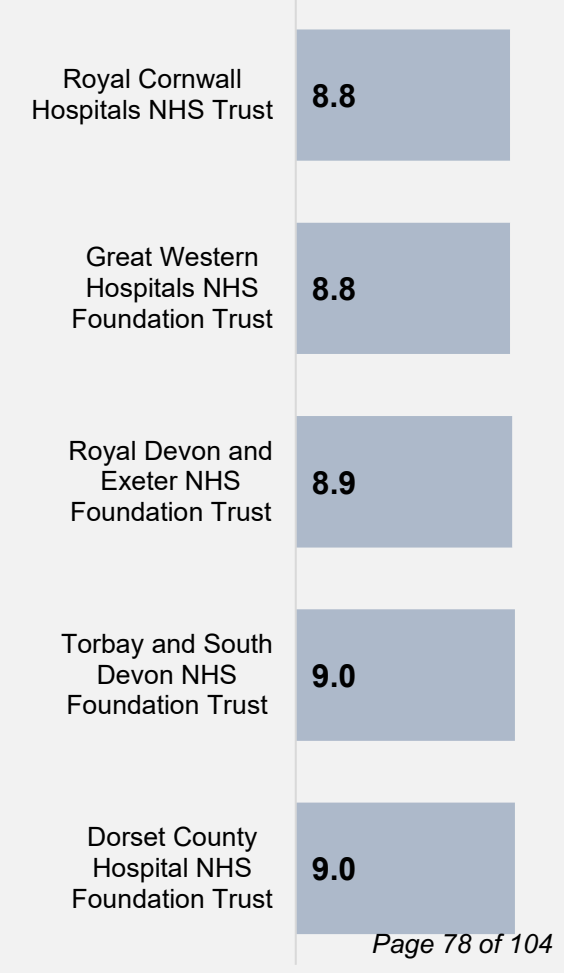
Site #1 **9.0**

Site 1

Torbay Hospital (470)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**9.3**
Somerset NHS Foundation Trust	**9.1**
Salisbury NHS Foundation Trust	**9.1**
University Hospitals Plymouth NHS Trust	**9.1**
University Hospitals Bristol and Weston NHS Foundation Trust	**9.1**

Bottom five trusts

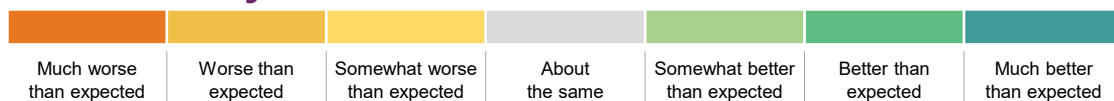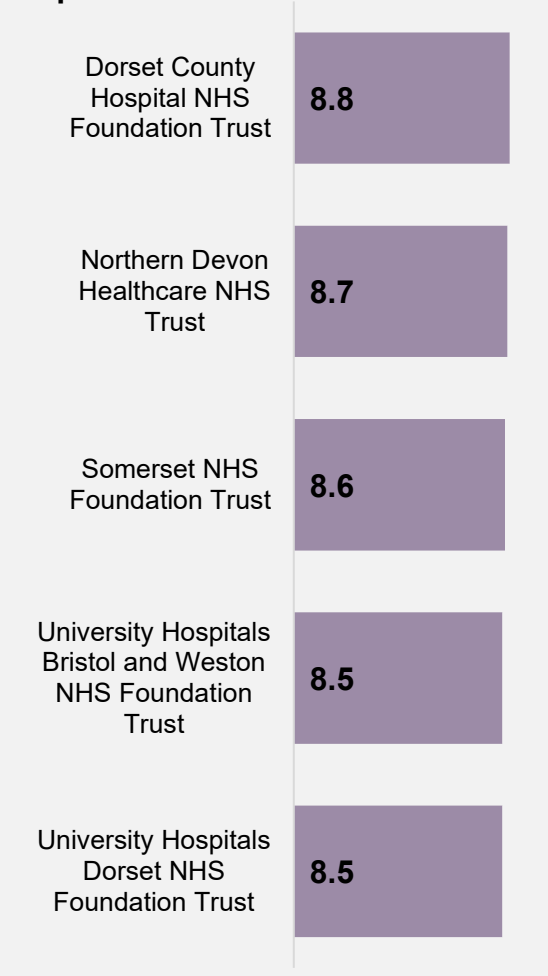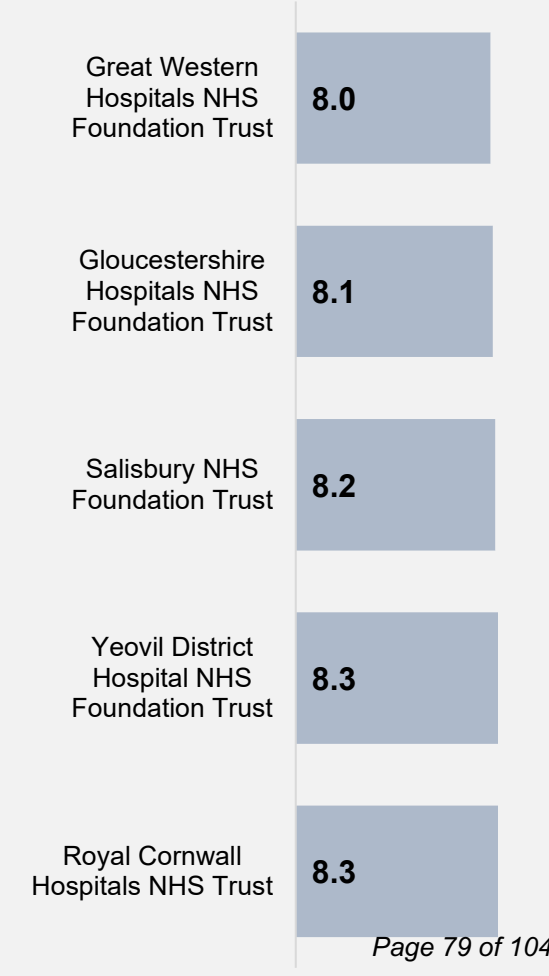| Royal Cornwall Hospitals NHS Trust | **8.8** |
Great Western Hospitals NHS Foundation Trust	**8.8**
Royal Devon and Exeter NHS Foundation Trust	**8.9**
Torbay and South Devon NHS Foundation Trust	**9.0**
Dorset County Hospital NHS Foundation Trust	**9.0**

Your care and treatment: Q29. Were you able to get a member of staff to help you when you needed attention?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **8.3**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **8.4**

Site 1

Torbay Hospital (525)

Comparison with other trusts within your region

Top five trusts

Dorset County Hospital NHS Foundation Trust	**8.8**
Northern Devon Healthcare NHS Trust	**8.7**
Somerset NHS Foundation Trust	**8.6**
University Hospitals Bristol and Weston NHS Foundation Trust	**8.5**
University Hospitals Dorset NHS Foundation Trust	**8.5**

Bottom five trusts

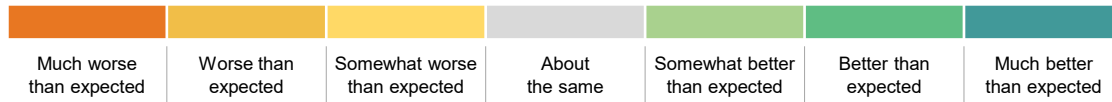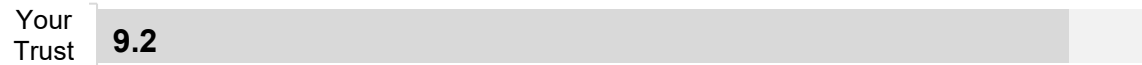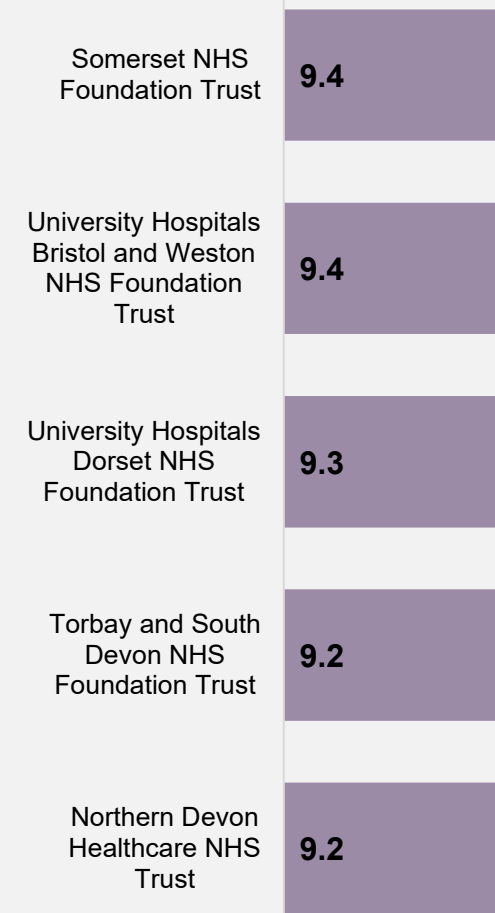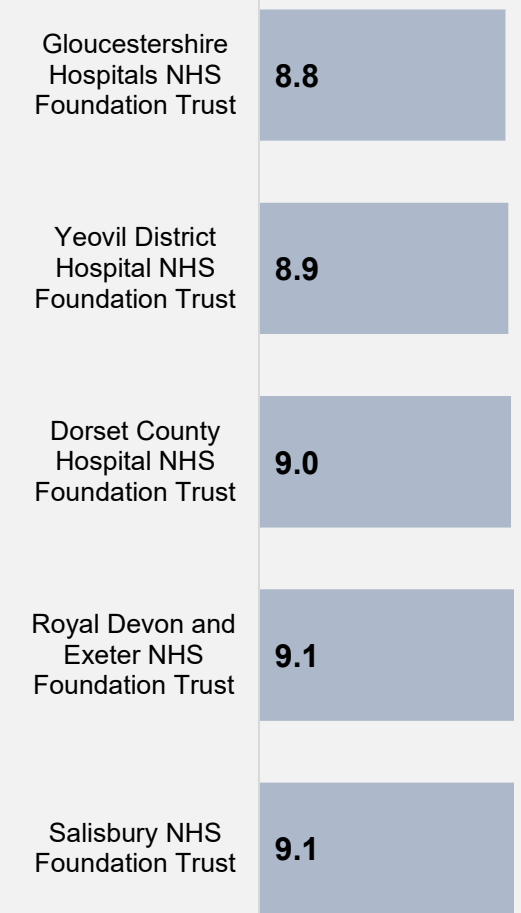|	
Great Western Hospitals NHS Foundation Trust	**8.0**
Gloucestershire Hospitals NHS Foundation Trust	**8.1**
Salisbury NHS Foundation Trust	**8.2**
Yeovil District Hospital NHS Foundation Trust	**8.3**
Royal Cornwall Hospitals NHS Trust	**8.3**

Operations and procedures: Q31. Beforehand, how well did hospital staff answer your questions about the operations or procedures?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **9.2**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **9.2**

Site 1

Torbay Hospital (247)

Comparison with other trusts within your region

Top five trusts

Somerset NHS Foundation Trust	**9.4**
University Hospitals Bristol and Weston NHS Foundation Trust	**9.4**
University Hospitals Dorset NHS Foundation Trust	**9.3**
Torbay and South Devon NHS Foundation Trust	**9.2**
Northern Devon Healthcare NHS Trust	**9.2**

Bottom five trusts

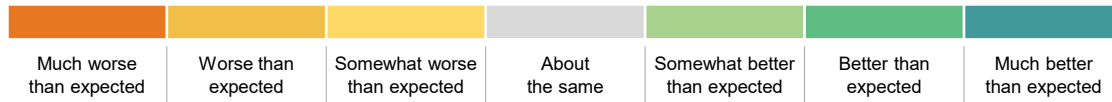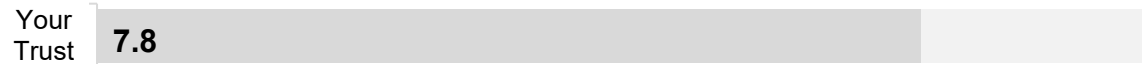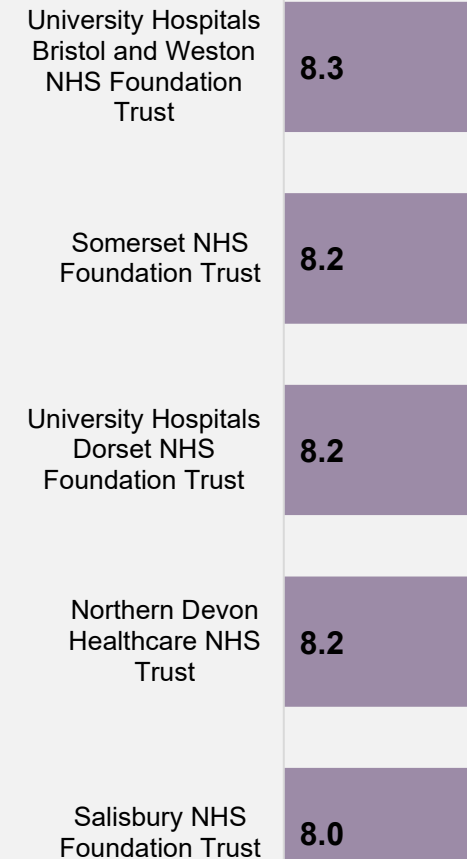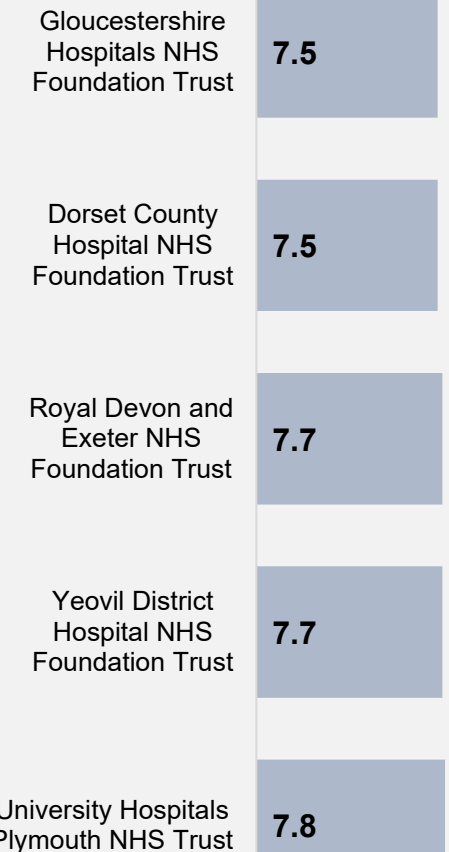|	
Gloucestershire Hospitals NHS Foundation Trust	**8.8**
Yeovil District Hospital NHS Foundation Trust	**8.9**
Dorset County Hospital NHS Foundation Trust	**9.0**
Royal Devon and Exeter NHS Foundation Trust	**9.1**
Salisbury NHS Foundation Trust	**9.1**

Operations and procedures: Q32. Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **7.8**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **7.8**

Site 1

Torbay Hospital (260)

Comparison with other trusts within your region

Top five trusts

University Hospitals Bristol and Weston NHS Foundation Trust	**8.3**
Somerset NHS Foundation Trust	**8.2**
University Hospitals Dorset NHS Foundation Trust	**8.2**
Northern Devon Healthcare NHS Trust	**8.2**
Salisbury NHS Foundation Trust	**8.0**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**7.5**
Dorset County Hospital NHS Foundation Trust	**7.5**
Royal Devon and Exeter NHS Foundation Trust	**7.7**
Yeovil District Hospital NHS Foundation Trust	**7.7**
University Hospitals Plymouth NHS Trust	**7.8**

Operations and procedures: Q33. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?

Results for your trust
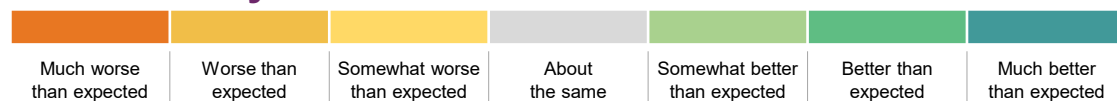
| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
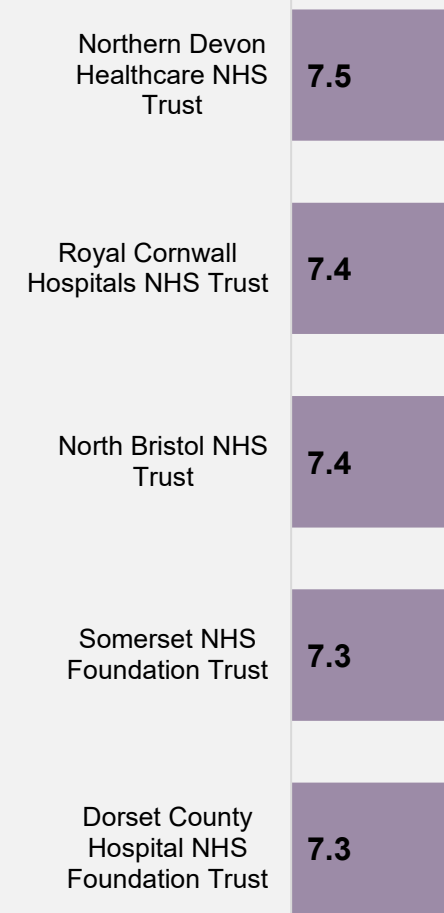
Your Trust **8.1**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
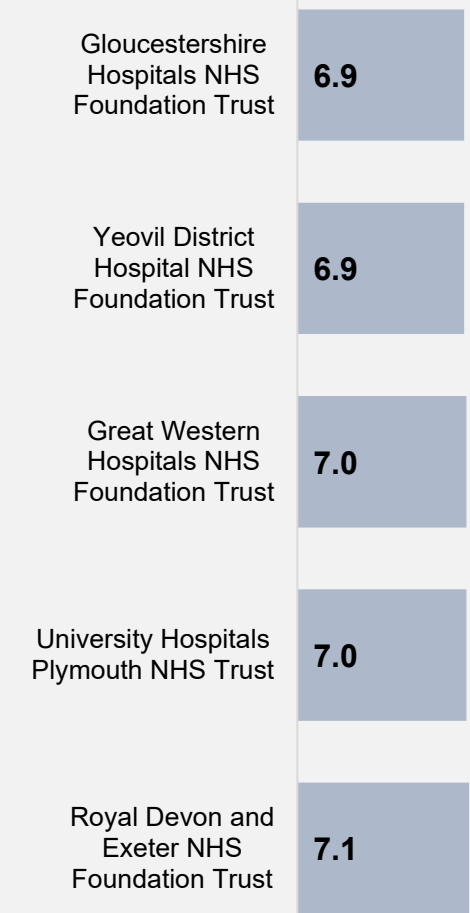
Site #1 **8.2**

Site 1

Torbay Hospital (265)

Comparison with other trusts within your region

Top five trusts

University Hospitals Dorset NHS Foundation Trust	**8.6**
Somerset NHS Foundation Trust	**8.5**
Salisbury NHS Foundation Trust	**8.4**
Dorset County Hospital NHS Foundation Trust	**8.4**
Yeovil District Hospital NHS Foundation Trust	**8.3**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**7.6**
Great Western Hospitals NHS Foundation Trust	**7.8**
Torbay and South Devon NHS Foundation Trust	**8.1**
North Bristol NHS Trust	**8.1**
Royal Devon and Exeter NHS Foundation Trust	**8.2**

Leaving hospital: Q34. To what extent did staff involve you in decisions about you leaving hospital?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **7.1**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **7.2**

Site 1

Torbay Hospital (555)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**7.5**
Royal Cornwall Hospitals NHS Trust	**7.4**
North Bristol NHS Trust	**7.4**
Somerset NHS Foundation Trust	**7.3**
Dorset County Hospital NHS Foundation Trust	**7.3**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**6.9**
Yeovil District Hospital NHS Foundation Trust	**6.9**
Great Western Hospitals NHS Foundation Trust	**7.0**
University Hospitals Plymouth NHS Trust	**7.0**
Royal Devon and Exeter NHS Foundation Trust	**7.1**

7.05 Care Quality Commission NHS Patient Experience Surveys 2020 Reports.pdf
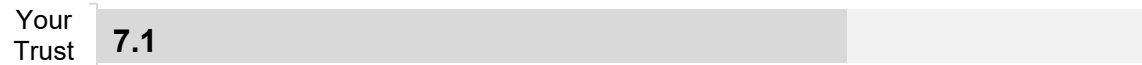
Leaving hospital: Q35. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
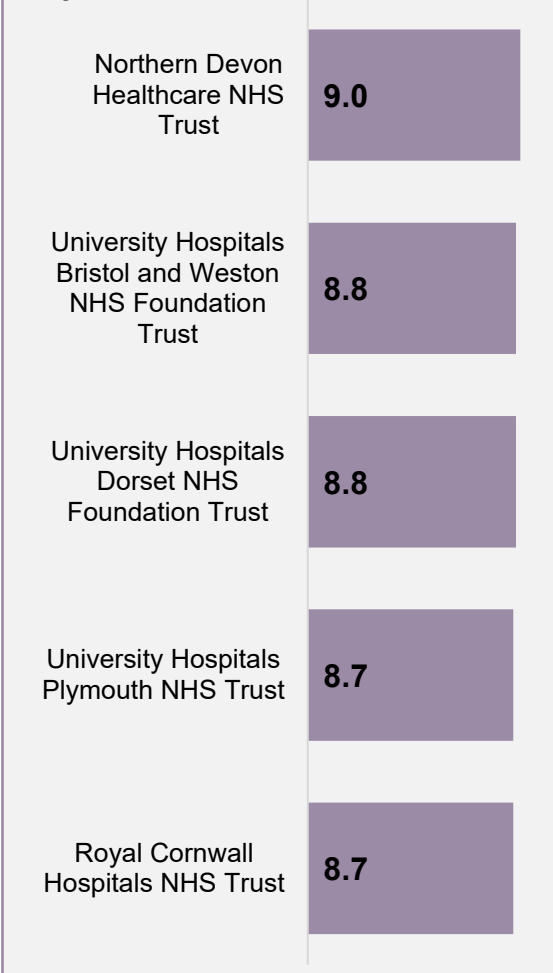
Your Trust **7.6**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
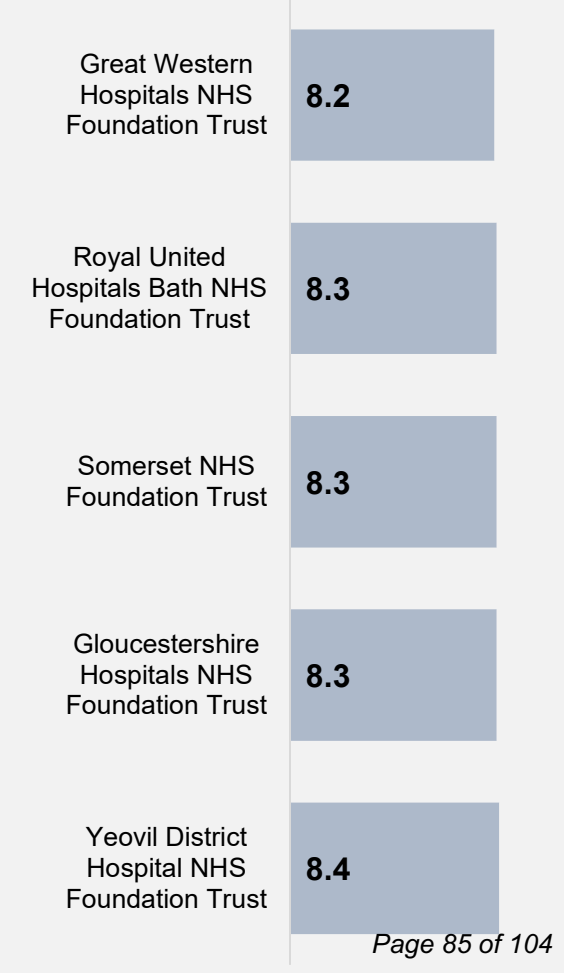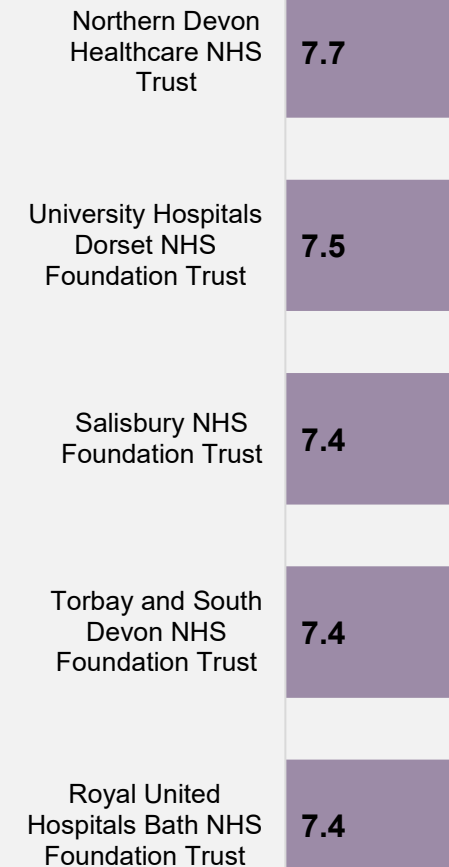
Site #1 **7.5**

Site 1

Torbay Hospital (433)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**7.9**
Salisbury NHS Foundation Trust	**7.9**
Dorset County Hospital NHS Foundation Trust	**7.7**
Royal Devon and Exeter NHS Foundation Trust	**7.6**
North Bristol NHS Trust	**7.6**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**7.1**
Great Western Hospitals NHS Foundation Trust	**7.1**
University Hospitals Bristol and Weston NHS Foundation Trust	**7.2**
Yeovil District Hospital NHS Foundation Trust	**7.2**
University Hospitals Plymouth NHS Trust	**7.3**

Leaving hospital: Q36. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?

Results for your trust
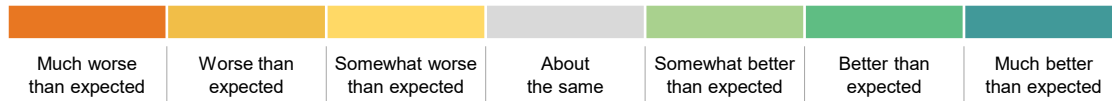
| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **8.7**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
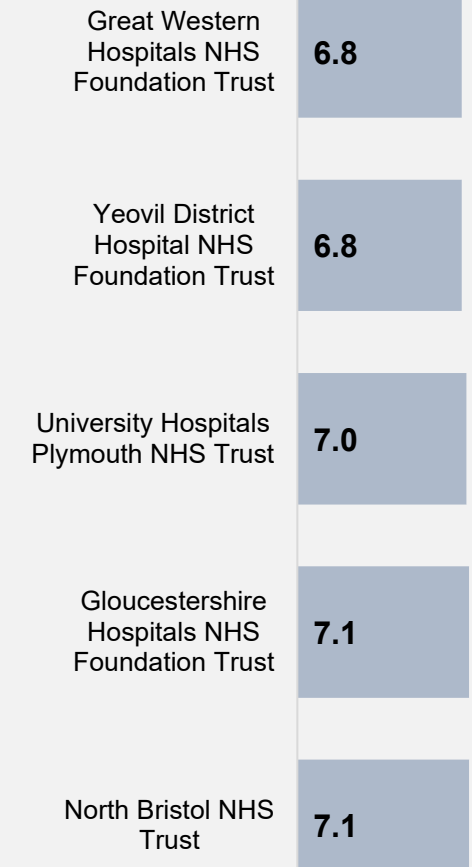
Site #1 **8.7**

Site 1

Torbay Hospital (200)

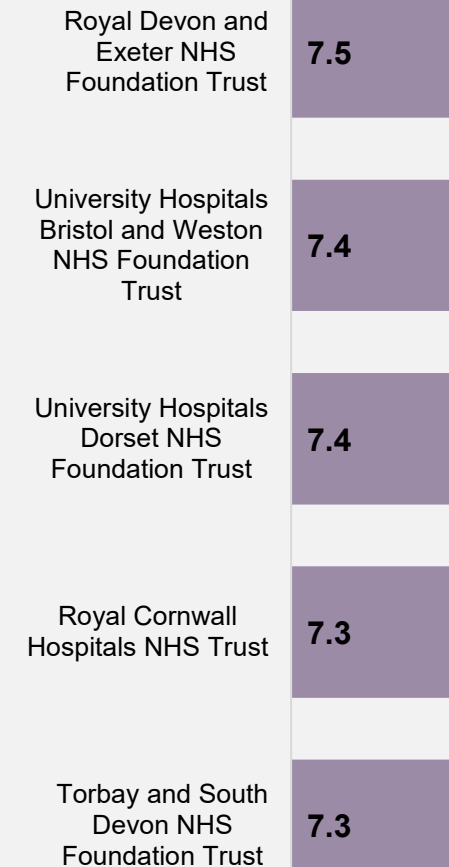## Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**9.0**
University Hospitals Bristol and Weston NHS Foundation Trust	**8.8**
University Hospitals Dorset NHS Foundation Trust	**8.8**
University Hospitals Plymouth NHS Trust	**8.7**
Royal Cornwall Hospitals NHS Trust	**8.7**

Bottom five trusts

Great Western Hospitals NHS Foundation Trust	**8.2**
Royal United Hospitals Bath NHS Foundation Trust	**8.3**
Somerset NHS Foundation Trust	**8.3**
Gloucestershire Hospitals NHS Foundation Trust	**8.3**
Yeovil District Hospital NHS Foundation Trust	**8.4**
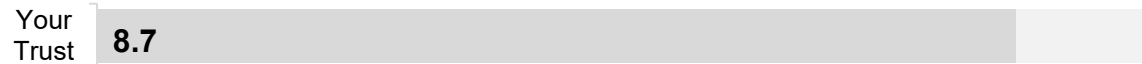
Leaving hospital: Q37. Were you given enough notice about when you were going to leave hospital?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **7.4**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
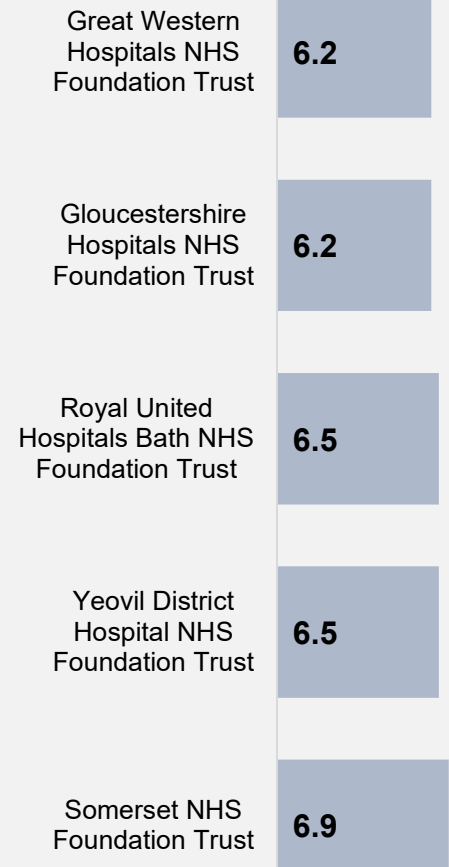
Site #1 **7.5**

Site 1

Torbay Hospital (566)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**7.7**
University Hospitals Dorset NHS Foundation Trust	**7.5**
Salisbury NHS Foundation Trust	**7.4**
Torbay and South Devon NHS Foundation Trust	**7.4**
Royal United Hospitals Bath NHS Foundation Trust	**7.4**

Bottom five trusts

Great Western Hospitals NHS Foundation Trust	**6.8**
Yeovil District Hospital NHS Foundation Trust	**6.8**
University Hospitals Plymouth NHS Trust	**7.0**
Gloucestershire Hospitals NHS Foundation Trust	**7.1**
North Bristol NHS Trust	**7.1**
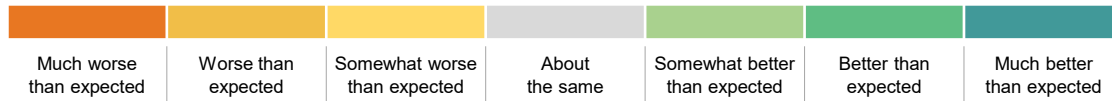
Leaving hospital: Q38. Before you left hospital, were you given any written information about what you should or should not do after leaving hospital?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **7.3**

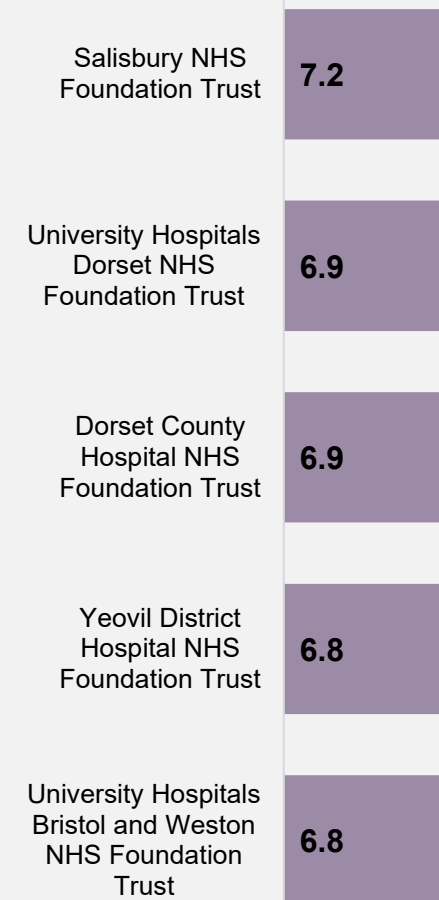**Breakdown of scores for sites within your trust:**

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
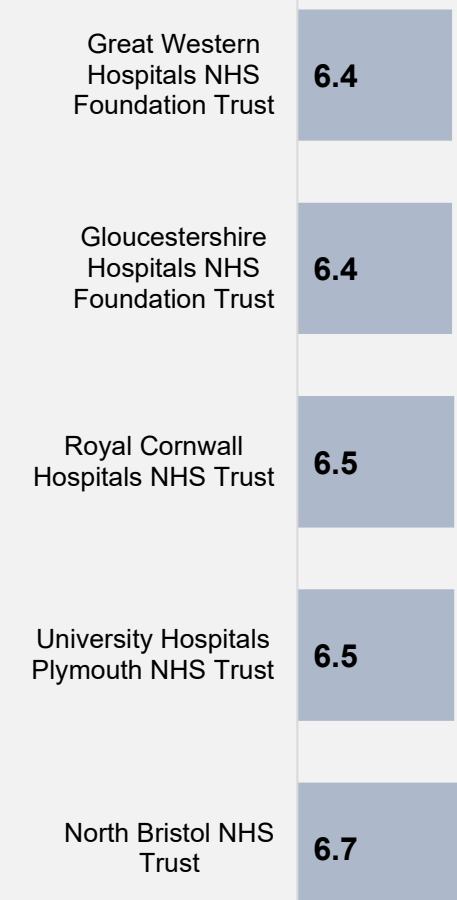
Site #1 **7.4**

Site 1

Torbay Hospital (522)

Comparison with other trusts within your region

Top five trusts

Royal Devon and Exeter NHS Foundation Trust	**7.5**
University Hospitals Bristol and Weston NHS Foundation Trust	**7.4**
University Hospitals Dorset NHS Foundation Trust	**7.4**
Royal Cornwall Hospitals NHS Trust	**7.3**
Torbay and South Devon NHS Foundation Trust	**7.3**

Bottom five trusts

Great Western Hospitals NHS Foundation Trust	**6.2**
Gloucestershire Hospitals NHS Foundation Trust	**6.2**
Royal United Hospitals Bath NHS Foundation Trust	**6.5**
Yeovil District Hospital NHS Foundation Trust	**6.5**
Somerset NHS Foundation Trust	**6.9**
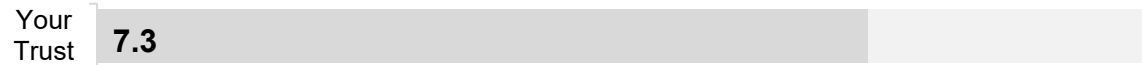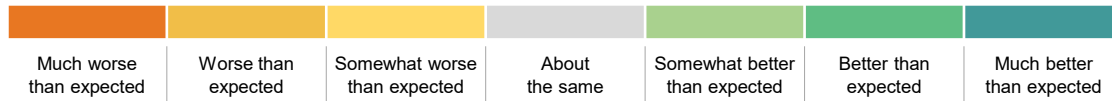
Leaving hospital: Q39. Thinking about any medicine you were to take at home, were you given any of the following?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust: **5.0**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
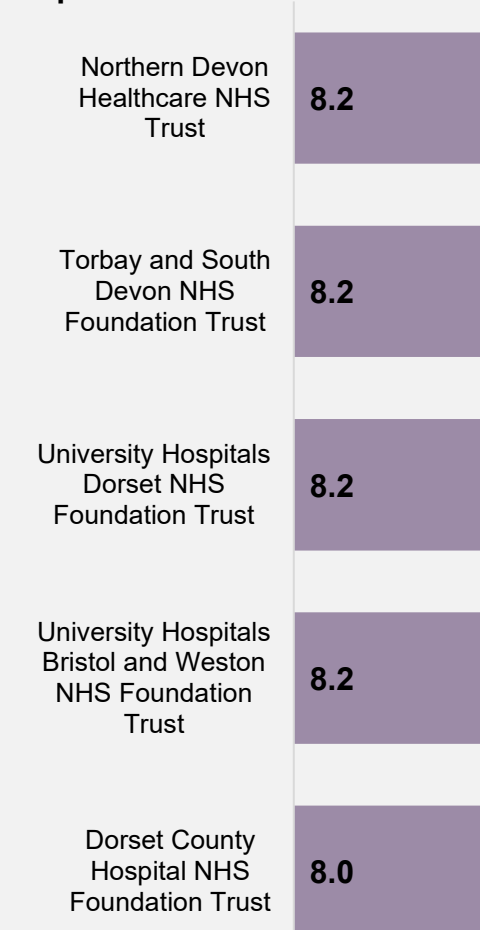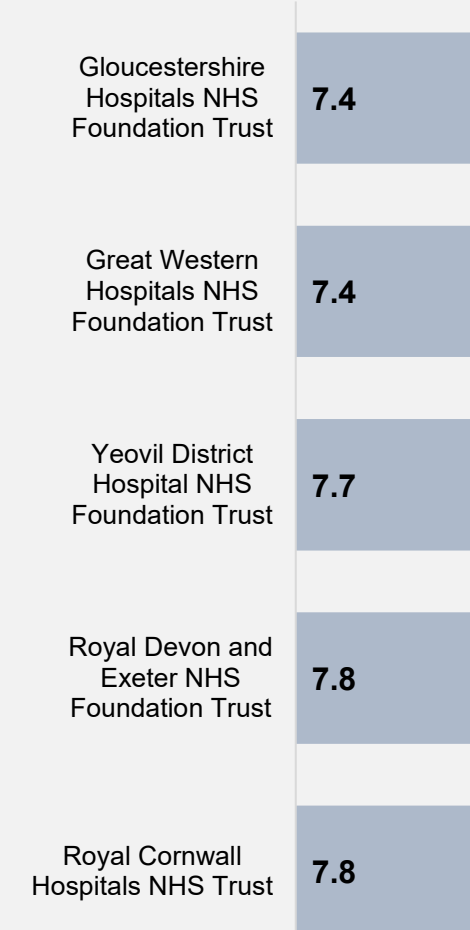
Site #1: **5.0**

Site 1

Torbay Hospital (394)
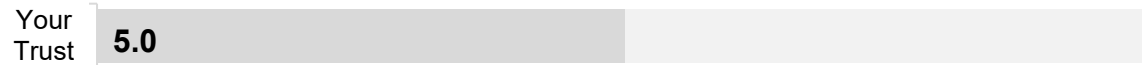
Comparison with other trusts within your region

Top five trusts

Trust	Score
University Hospitals Bristol and Weston NHS Foundation Trust	5.4
Royal Cornwall Hospitals NHS Trust	5.3
Dorset County Hospital NHS Foundation Trust	5.2
University Hospitals Dorset NHS Foundation Trust	5.1
Gloucestershire Hospitals NHS Foundation Trust	5.1

Bottom five trusts

Trust	Score
University Hospitals Plymouth NHS Trust	4.4
Great Western Hospitals NHS Foundation Trust	4.6
Somerset NHS Foundation Trust	4.7
Royal Devon and Exeter NHS Foundation Trust	4.8
North Bristol NHS Trust	4.8

Leaving hospital: Q40. Before you left hospital, did you know what would happen next with your care?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
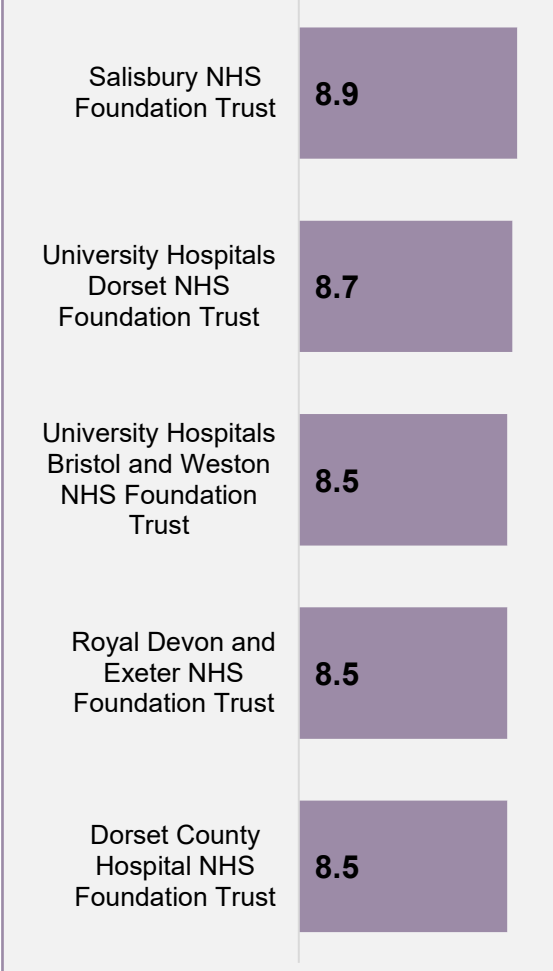
Your Trust **6.7**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
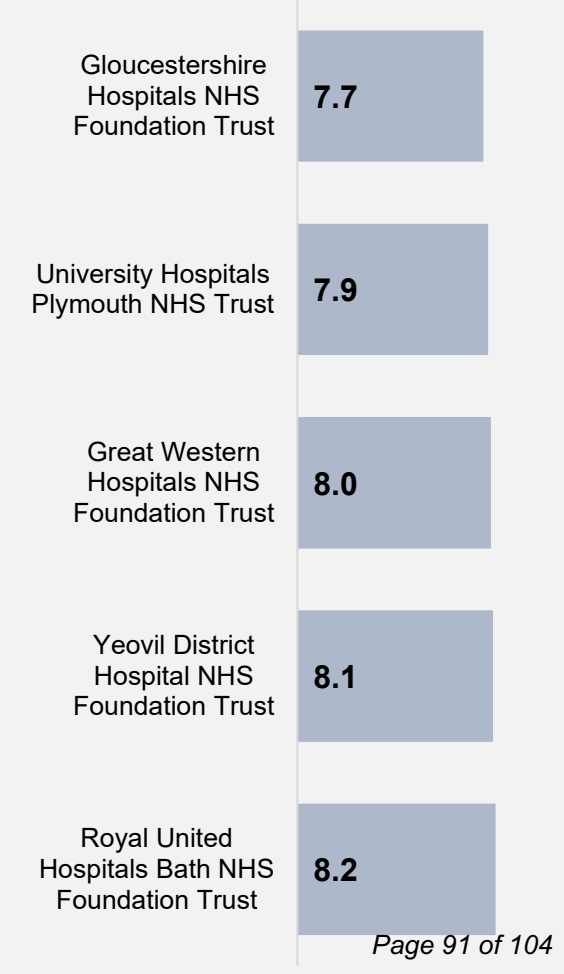
Site #1 **6.7**

Site 1

Torbay Hospital (502)

Comparison with other trusts within your region

Top five trusts

Salisbury NHS Foundation Trust	**7.2**
University Hospitals Dorset NHS Foundation Trust	**6.9**
Dorset County Hospital NHS Foundation Trust	**6.9**
Yeovil District Hospital NHS Foundation Trust	**6.8**
University Hospitals Bristol and Weston NHS Foundation Trust	**6.8**

Bottom five trusts

Great Western Hospitals NHS Foundation Trust	**6.4**
Gloucestershire Hospitals NHS Foundation Trust	**6.4**
Royal Cornwall Hospitals NHS Trust	**6.5**
University Hospitals Plymouth NHS Trust	**6.5**
North Bristol NHS Trust	**6.7**

Leaving hospital: Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
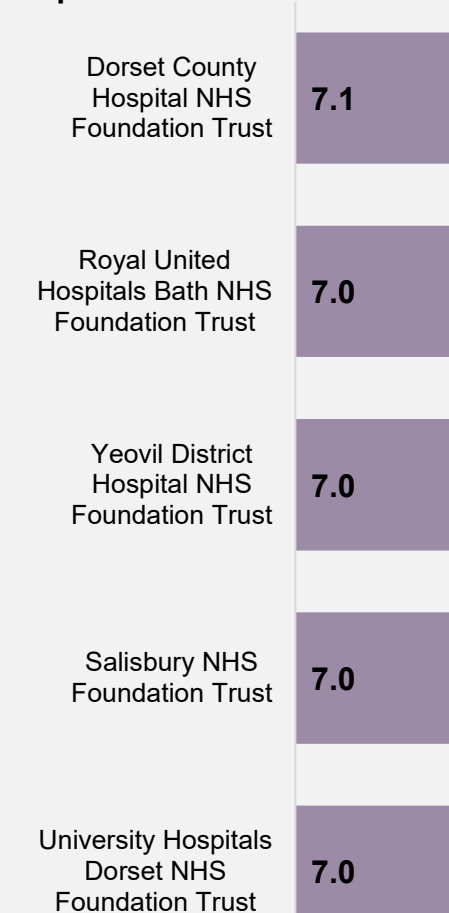
Your Trust **8.2**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
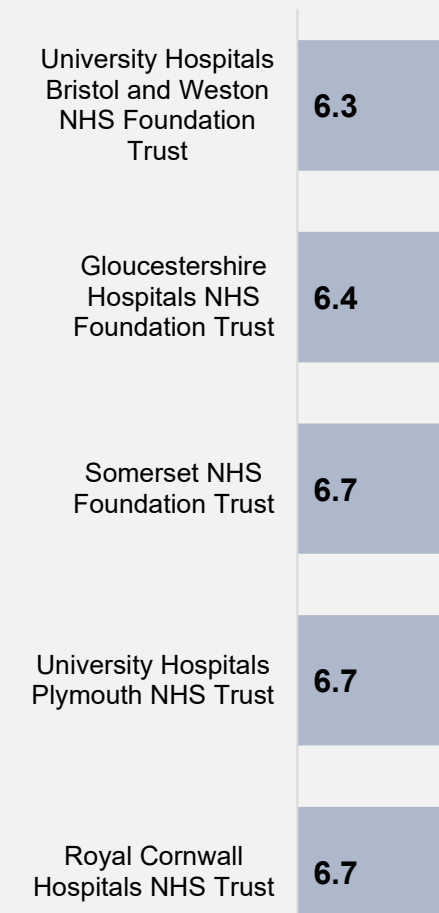
Site #1 **8.3**

Site 1

Torbay Hospital (532)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	**8.2**
Torbay and South Devon NHS Foundation Trust	**8.2**
University Hospitals Dorset NHS Foundation Trust	**8.2**
University Hospitals Bristol and Weston NHS Foundation Trust	**8.2**
Dorset County Hospital NHS Foundation Trust	**8.0**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**7.4**
Great Western Hospitals NHS Foundation Trust	**7.4**
Yeovil District Hospital NHS Foundation Trust	**7.7**
Royal Devon and Exeter NHS Foundation Trust	**7.8**
Royal Cornwall Hospitals NHS Trust	**7.8**

7.05 Care Quality Commission NHS Patient Experience Surveys 2020 Reports.pdf

Leaving hospital: Q42. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?

Results for your trust

Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected
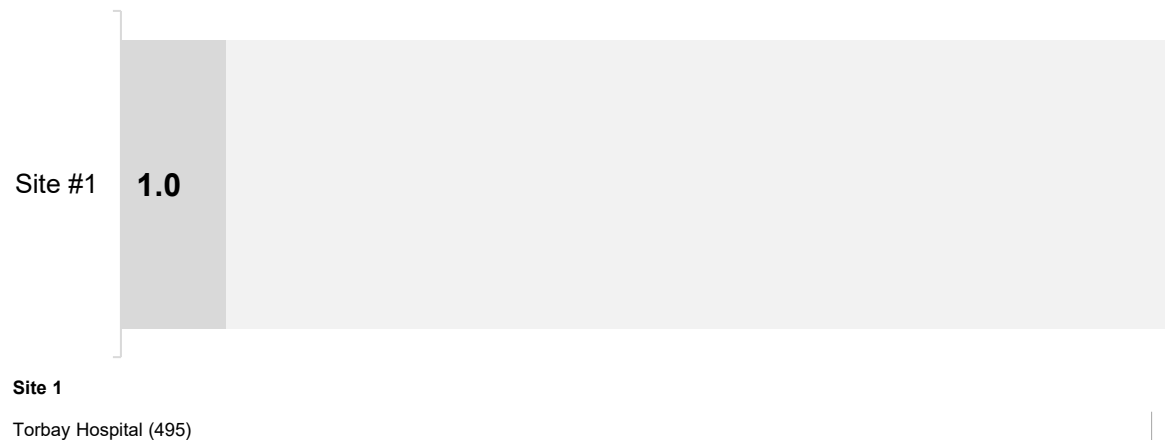
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.
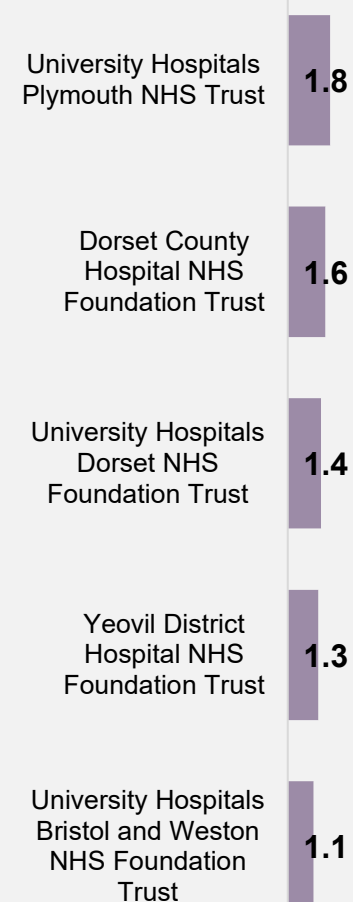
Your Trust **8.5**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **8.4**

Site 1

Torbay Hospital (292)

Comparison with other trusts within your region

Top five trusts

Salisbury NHS Foundation Trust	**8.9**
University Hospitals Dorset NHS Foundation Trust	**8.7**
University Hospitals Bristol and Weston NHS Foundation Trust	**8.5**
Royal Devon and Exeter NHS Foundation Trust	**8.5**
Dorset County Hospital NHS Foundation Trust	**8.5**

Bottom five trusts

Gloucestershire Hospitals NHS Foundation Trust	**7.7**
University Hospitals Plymouth NHS Trust	**7.9**
Great Western Hospitals NHS Foundation Trust	**8.0**
Yeovil District Hospital NHS Foundation Trust	**8.1**
Royal United Hospitals Bath NHS Foundation Trust	**8.2**

7.05 Care Quality Commission NHS Patient Experience Surveys 2020 Reports.pdf

Leaving hospital: Q44. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **6.9**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **6.9**

Site 1

Torbay Hospital (319)

Comparison with other trusts within your region

Top five trusts

Dorset County Hospital NHS Foundation Trust	**7.1**
Royal United Hospitals Bath NHS Foundation Trust	**7.0**
Yeovil District Hospital NHS Foundation Trust	**7.0**
Salisbury NHS Foundation Trust	**7.0**
University Hospitals Dorset NHS Foundation Trust	**7.0**

Bottom five trusts

| University Hospitals Bristol and Weston NHS Foundation Trust | **6.3** |
Gloucestershire Hospitals NHS Foundation Trust	**6.4**
Somerset NHS Foundation Trust	**6.7**
University Hospitals Plymouth NHS Trust	**6.7**
Royal Cornwall Hospitals NHS Trust	**6.7**

Feedback on care: Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?

Results for your trust
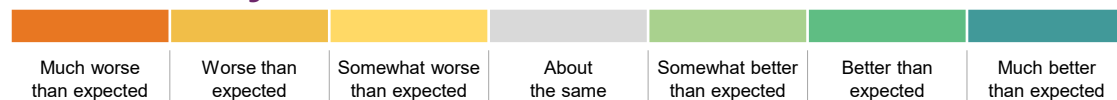
Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **1.0**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.
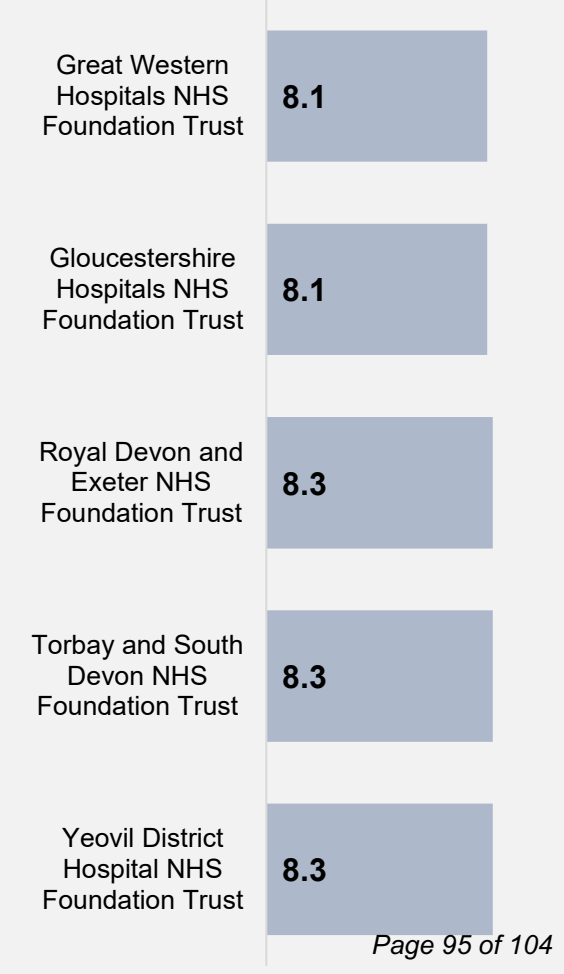
Site #1 **1.0**

Site 1

Torbay Hospital (495)

Comparison with other trusts within your region

Top five trusts	
University Hospitals Plymouth NHS Trust	**1.8**
Dorset County Hospital NHS Foundation Trust	**1.6**
University Hospitals Dorset NHS Foundation Trust	**1.4**
Yeovil District Hospital NHS Foundation Trust	**1.3**
University Hospitals Bristol and Weston NHS Foundation Trust	**1.1**
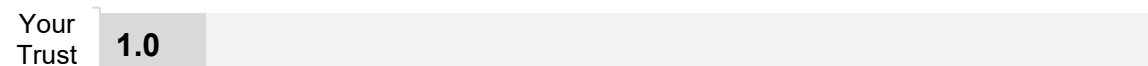
Bottom five trusts	
Gloucestershire Hospitals NHS Foundation Trust	**0.5**
Royal Devon and Exeter NHS Foundation Trust	**0.7**
Salisbury NHS Foundation Trust	**0.9**
North Bristol NHS Trust	**0.9**
Somerset NHS Foundation Trust	**1.0**

CareQuality Commission   Ipsos MORI   Ipsos   NHS

Respect and dignity: Q45. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Results for your trust

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **9.2**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **9.3**

Site 1

Torbay Hospital (571)
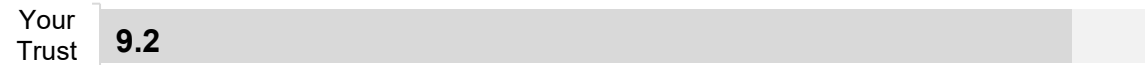
Comparison with other trusts within your region

Top five trusts

University Hospitals Bristol and Weston NHS Foundation Trust	**9.5**
North Bristol NHS Trust	**9.4**
Dorset County Hospital NHS Foundation Trust	**9.4**
Northern Devon Healthcare NHS Trust	**9.4**
Salisbury NHS Foundation Trust	**9.4**

Bottom five trusts

Great Western Hospitals NHS Foundation Trust	**9.0**
Gloucestershire Hospitals NHS Foundation Trust	**9.1**
Royal Cornwall Hospitals NHS Trust	**9.2**
University Hospitals Plymouth NHS Trust	**9.2**
Torbay and South Devon NHS Foundation Trust	**9.2**

Overall: Q46. Overall, how was your experience while you were in the hospital?

Results for your trust

| Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected |

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Your Trust **8.3**

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site #1 **8.3**

Site 1

Torbay Hospital (570)

Comparison with other trusts within your region

Top five trusts

Northern Devon Healthcare NHS Trust	8.7
North Bristol NHS Trust	8.6
University Hospitals Bristol and Weston NHS Foundation Trust	8.6
University Hospitals Plymouth NHS Trust	8.5
Somerset NHS Foundation Trust	8.5

Bottom five trusts

Great Western Hospitals NHS Foundation Trust	8.1
Gloucestershire Hospitals NHS Foundation Trust	8.1
Royal Devon and Exeter NHS Foundation Trust	8.3
Torbay and South Devon NHS Foundation Trust	8.3
Yeovil District Hospital NHS Foundation Trust	8.3
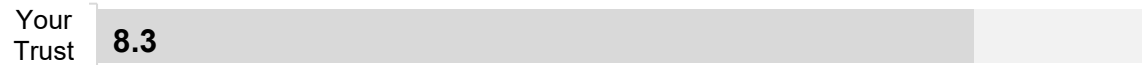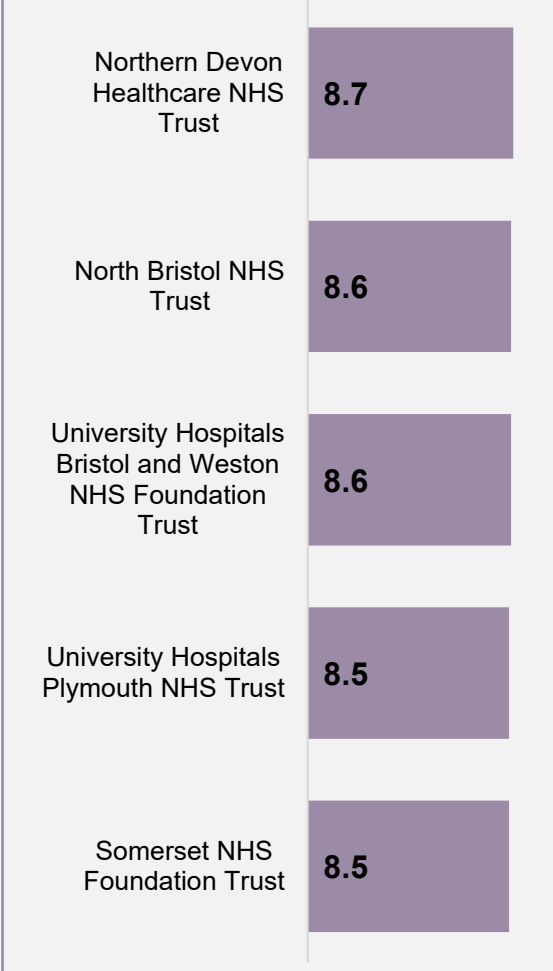
For further information

Please contact the Coordination Centre for Mixed Methods:
InpatientCoordination@ipsos-mori.com

NHS

Care Quality Commission

Ipsos MORI

Ipsos

Appendix

Comparison to other trusts

The questions at which your trust has performed much worse or worse compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected	Worse than expected
• Your trust has not performed "much worse than expected" for any questions.	• Your trust has not performed "worse than expected" for any questions.

Comparison to other trusts

The questions at which your trust has performed somewhat worse or somewhat better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected	Somewhat better than expected
• Q5. Were you ever prevented from sleeping at night by hospital lighting?	• Your trust has not performed "somewhat better than expected" for any questions.

Comparison to other trusts

The questions at which your trust has performed better or much better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected	Much better than expected
• Your trust has not performed "better than expected" for any questions.	• Your trust has not performed "much better than expected" for any questions.

NHS Adult Inpatient Survey 2020

Results for Torbay and South Devon NHS Foundation Trust

Where patient experience is best

✓ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night

✓ Keeping in touch during the COVID-19 pandemic: patients being able to keep in touch with family and friends during their stay in hospital

✓ Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital

✓ Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital

✓ Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital

Where patient experience could improve

o Noise from other patients: patients not being bothered by noise at night from other patients

o Disturbance from hospital lighting: patients not being bothered at night from hospital lighting

o Noise from staff: patients not being bothered by noise at night from staff

o Help with eating: patients being given enough help from staff to eat meals, if needed

o Feedback on care: patients being asked to give their views on the quality of their care

These topics are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the average of all trusts. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts.

This survey looked at the experiences of people who were discharged from an NHS acute hospital in November 2020. Between January 2021 and May 2021, a questionnaire was sent to 1250 inpatients at Torbay and South Devon NHS Foundation Trust who had attended in late 2020. Responses were received from 619 patients at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

How to interpret benchmarking in this report

Trust level benchmarking

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.

- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.

- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.

- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.

- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.

- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.

- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.

Legend: Much worse than expected · Worse than expected · Somewhat worse than expected · About the same · Somewhat better than expected · Better than expected · Much better than expected · Your trust

Your trust section score = 7.6 (About the same)

NHS trust score

Each vertical line represents an individual NHS trust.
Trust score is not shown when there are fewer than 30 respondents.

Trust score is not shown when there are fewer than 30 respondents.

Legend: Much worse than expected · Worse than expected · Somewhat worse than expected · About the same · Somewhat better than expected · Better than expected · Much better than expected · ◆ Your trust · Trust average

	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Q15. When you asked doctors questions, did you get answers you could understand? (Somewhat better)	438	9.2	8.8	8.2	9.6
Q16. Did you have confidence and trust in the doctors treating you? (About the same)	469	9.3	9.2	8.7	9.9
Q17. When doctors spoke about your care in front of you, were you included in the conversation? (About the same)	467	8.6	8.6	7.9	9.6

All trusts in England

How to interpret benchmarking in this report (continued)

Trust level benchmarking

The 'much better than expected,' 'better than expected', 'somewhat better than expected', 'about the same', 'somewhat worse than expected', 'worse than expected' and 'much worse than expected' categories are based on an analysis technique called the 'expected range'. Expected range determines the range within which a trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust's performance is 'about the same' as other trusts. Where a trust is identified as performing 'better' or 'worse' than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Site level benchmarking

The charts in the 'trust results' section present site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that there may be differences between the average score of the sites provided and the overall score for the trust. This may be related to the size of the sites, results for suppressed sites or weighting, as sites and trusts are weighted separately. In addition, if a single site result is presented for a trust, the 'expected range' category may differ: although the score achieved will be the same for both the site and for the trust, the upper and lower boundary levels will differ between the two due to them being calculated differently in each case.

Additional information on the 'expected range' analysis technique can be found in the survey technical report on the NHS Surveys website.

An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the patient's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question 15 "When you asked doctors questions, did you get answers you could understand":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive patient experience possible.

- The answer code "Sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.

- The answer code "No, never" would be given a score of 0, as this response reflects considerable scope for improvement.

- The answer codes "I did not have any questions" and "I did not feel able to ask questions" would not be scored, as they do not have a clear bearing on the trust's performance in terms of patient experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the survey technical document.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

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90   Adult Inpatient Survey 2020 | RA9 | Torbay and South Devon NHS Foundation Trust

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Report to the Trust Board of Directors

Report title: Feedback, Complaints and Patient Advice and Liaison (PALS) Policy	Meeting date: 24th November 2021
Report appendix	Appendix 1: Feedback, Complaints and Patient Advice and Liaison (PALS) Policy
Report sponsor	Chief Nurse
Report author	System Director for Nursing and Professional Practice (Torbay)
Report provenance	Feedback and Engagement Group Care and Clinical Policies Group Health Watch NHS Devon Clinical Commissioning Group Quality Assurance Committee
Purpose of the report and key issues for consideration/decision	The purposes of bringing this policy to the Board is to seek approval of the Policy and provide assurance of the policy framework to support the Feedback, Complaints and Patient Advisory and Liaison Service of the Trust. The Board should note that the current Policy changes include: • Changes in organisational roles and responsibilities • Changes in internal processes to enhance the quality of responses to complaints. The Policy has now been shared with Health Watch and NHS Devon Clinical Commissioning Group and includes feedback from the Clinical Commissioning Group. The Policy attached is the final document submitted to Board as proposed in September 2021. The report is being presented without Appendices. The Policy and Appendices were reviewed and approved at Quality Assurance Committee earlier in the month. The Appendices are available to Board members on request. The Board should note that the Trust responds to all complaints and concerns within the statutory time frame required and Complaints are managed in line with the Trust's policy and NHS complaints regulations.

Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	To acknowledge the final policy that underpins the Trust meeting its statutory requirements in relation to the Feedback, Complaints and		

	Patient Advisory and Liaison Service and approve the changes and updates in the Policy.
Summary of key elements	

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

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

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

NHS
Torbay and South Devon
NHS Foundation Trust

Document Type:	Policy	
Reference Number : **1473**	Version Number: **8**	Next Review Date: **21 August 2023**
Title:	**Feedback, Complaints and Patient Advice and Liaison (PALS)**	
Document Author:	System Director for Nursing and Professional Practice (Torbay)	
Applicability:	As indicated in document	

This document has been drafted in accordance with the Freedom of Information Act 2000 and is classified as 'OPEN'. It has undergone Equality Impact Assessment Screening and is compliant with Human Rights and Equality and Diversity Legislation.

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1   Introduction

- Torbay and South Devon NHS Foundation Trust (the Trust) recognises the value of feedback from patients, service users, carers, members of the public and others. The Trust aims to resolve any concerns locally and as soon as possible after they have been raised.

- Feedback is invaluable to the Trust and can provide an audit trail that gives an early warning of failures in service delivery. It provides an opportunity for the Trust to improve its services and reputation.

- This policy sets out the process when receiving feedback about the Trust and the roles and responsibilities of those involved in the process.

1.1   Handling Complaints - Delivering our Values

- The NHS Constitution makes clear what people should expect when they complain. The Care Quality Commission (CQC) requires registered providers of services to investigate complaints effectively, learn lessons from them, and implement changes as required.
- The Trust has amended its Complaints Policy in line with the NHS Constitution, recommendations from the Francis Report (2013), a Review of NHS hospital complaints handling "Hard Truths- putting the patients first" Clwyd 2013 and " A review into the quality of NHS Complaints investigations" Parliamentary and Health Service Ombudsman (PHSO) 2015.

The Trust subscribes to the NHS constitution values:

- The Trust upholds the view that everyone has the right to expect a good service from public bodies and to have things put right if it goes wrong. Good complaints handling means that patients, their relatives and carers receive the service they are entitled to expect. It must focus on outcomes that are fair, proportionate and sensitive to the complainant's needs. The process should be clear, straightforward and readily accessible.

- It is important to acknowledge that patients and their families may be reluctant to complain due to fear of consequences, and every effort must be made to enable people to tell us about their experiences, and not to feel disadvantaged by doing so.

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1.2 Feedback: key priorities:

- Create a culture which encourages and welcomes feedback and acts on it to improve services.

- Provide clear and widely available information about how to feedback.

- If a formal complaint is raised, to provide complainants with sufficient support to enable them to participate fully in the complaints process.

  - i) Promote a prompt, open, flexible dialogue with the complainant throughout the duration of the investigation and the response to the complaint.
  - ii) Conduct a thorough, honest and balanced investigation and provide and full and understandable response.
  - iii) Provide evidence of learning and follow up action, where appropriate.

- The Parliamentary and Health Service Ombudsman (PHSO) and the Local Government and Social Care Ombudsman (LGSCO) set out principles that are expected from public bodies when dealing with complaints which are:

  - i) Getting it right
  - ii) Being customer focused
  - iii) Being open and accountable
  - iv) Acting fairly and proportionately
  - v) Putting things right
  - vi) Seeking continuous improvement

- Ongoing training and development, continual assessment of performance and the active involvement of all staff are prerequisites of this procedure to ensure it delivers real improvements and sees complainants as equal partners.

- The Trust Board and Executive Team will ensure these priorities are met through Quarterly reports to the Quality Improvement Group, which include the themes arising in the complaints, monitoring and oversight of actions as well as performance monitoring of the complaints procedure.

2. Definitions:

2.1 Complaint
An expression of dissatisfaction which requires a formal investigation and either a written response or a planned Local Complaints Resolution Meeting. These can be received in writing, email, verbally or in person.

2.2 Concern
A verbal or written expression of dissatisfaction that was resolved as quickly as possible.

2.3 Comment
An idea or suggestion which the Trust could use to improve experience, or the safety and effectiveness of, its service delivery.

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2.4 Compliment

Somebody telling the Trust about something it did well.

2.5 Patient Advice and Liaison Service (PALs)

The Patient Advice and Liaison service is a confidential service that is provided by the Trust and aims to provide information and support to help individuals and staff resolve problems and concerns arising from the provision of health services and related issues.

These definitions are for guidance only- it is acknowledged that not all feedback will always fit neatly into a definition and the wishes of the individual will be taken into account.

3. Who can provide feedback to the Trust?

- Every existing or former health or social care client, their friend, relative, carer or advocate has the right to bring to the attention of the Trust any aspects of a patient, client, or service user's care and treatment.

- The boundaries between services and organisations are not always clear to patients, clients and members of the public. As a general rule, the Trust will review feedback received by or on behalf of patients and clients who receive services commissioned or provided by the Trust. Where services are commissioned or contracted by the Trust, the enquirer would be asked to approach the service provider in the first instance. If the individual is dissatisfied with the response from the service provider, the Trust will then investigate.

- Where the feedback also relates to a service provided by another organisation; a lead organisation will be identified to co-ordinate the investigation and provide the overall response. Consent will be gained from the individual to share their information with the other organisations.

- If the person concerned is unable to act for his or herself, or has died, the complaint can be accepted from a close relative, friend or other body or individual suitable to act as a representative. When a complaint is made on behalf of another person the Trust will need to ensure that consent is obtained before a response is made. Where there are complex issues surrounding consent, including capacity, advice will be sought from the Data Protection Team.

4. How will this feedback be managed?

4.1 Patients, clients, relatives and carers are encouraged to feed back to staff about their experiences. In the event of concerns, best practice is to attempt to address the situation locally at the earliest opportunity by listening to the concerns raised in an appropriate and empathetic manner.

  - Every effort should be made to resolve the complaint and satisfy the complainant there and then. If this is not possible, refer the complainant to a more senior person, such as the Senior Sister/Charge Nurse, Ward Manager, Matron, Associate Director of Nursing (ADN), Assistant Director (AD), Social Work Lead or the On-Call Manager, for further attempts to resolve the matter. Consider offering PALs support.

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- The confidentiality of the individual and their medical condition should be maintained, in line with Data Protection Act. All information provided will be treated in confidence and only disclosed in order to investigate the issues raised.

- If the feedback comes from a third party, the consent of the individual should be obtained before sharing confidential information with the third party. If it is not possible to obtain such consent e.g. if the person has died or is incapable of giving it, senior managers will consider the particular circumstances in deciding whether to investigate. Advice is available from the Feedback and Engagement Team and Data Protection Team.

- Whether the individual wants their concern investigated and resolved at a local level, or as a formal written complaint via the Chief Executive's office, should be established. If the latter, the individual should be provided with a copy of the feedback information leaflet.

- The complaint must be recorded on the "Datix" risk management system.

4.2 The Feedback and Engagement Team, which includes the Patient Advice and Liaison Service (PALs), will discuss with the person and work with them to resolve their concerns in the best possible way. This is to ensure:

- Feedback is dealt with efficiently

- PALs is promoted as an informal, confidential, client focused service that deals with problems and concerns as quickly and effectively as possible

- People are treated with respect and courtesy

- Complaints are properly investigated

- People receive help to understand the complaints procedure

- People receive advice on where they may obtain assistance with the procedure

- People receive a response that provides an explanation and response to their complaint and are clear about the outcome of the investigation

- That action is taken, if necessary, to ensure the Trust learns from the feedback

- Good practice is recognised and acknowledged

5   Key roles and responsibilities – Complaints

5.1   The Chief Executive is responsible for ensuring the Trust complies with the complaints regulations. The Chief Executive will delegate the responsibility for the effective delivery of the Trust's policy to the Chief Nurse.

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5.2   The Chief Nurse will, in turn, delegate to the System Director for Nursing and Professional Practice (Torbay) the responsibility for the management of the Trust's complaints handling in line with this policy.

5.3   Under the management of the System Director for Nursing and Professional Practice (Torbay), the Interim Matron for Feedback and Engagement will be responsible for the operational management of the Feedback and Engagement Team comprising of the Complaints and Patient Advice and Liaison Service (PALS). The Feedback and Engagement Team will support the Trust in the delivery of this policy.

5.4   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.

5.4.1   At an Integrated Service Unit (ISU) level, the Associate Director of Nursing and Professional Practice (ADNPP) or Associate Director for Operations (ADO) will be responsible for ensuring complaints are investigated and responded to in line with the policy and for ensuring, where appropriate, that lessons are learnt and remedial action is implemented and evaluated.

5.4.2   During complaint investigations staff will be required to provide comments, and when indicated, written statements.

5.4.3   The corporate responsibility for ensuring lessons are learned across the organisation is primarily through the "*Feedback and Engagement*" group led by the System Director for Nursing and Professional Practice (Torbay).

6.   **Key areas of responsibility when managing feedback**

6.1   **Chief Executive's office and Chief Nurse.**

6.1.1   The Chief Executive's office will receive written feedback addressed to the Chief Executive (CE). The Chief Executive Office will ensure that letters are date stamped on the same working day and passed to the Feedback and Engagement Team.

6.1.2   Feedback received by email, or electronically through the Trust's public website, will be passed to the Feedback and Engagement Team and dealt with in the same way as a letter written to the CE.

6.1.3   Telephone calls from individuals wishing to provide feedback will be forwarded to the Feedback and Engagement Team.

6.1.4   The Chief Executive`s Office will receive response letters answering formal complaints and the completed 2 step investigation pack from the Feedback and Engagement Team by email. Once signed by the Chief Executive, the response letter is scanned and emailed to Feedback and Engagement Team. In the absence of the Chief Executive the response letters will be signed by the Chief Nurse.

6.1.5   Dispatch the signed letter by first class post and clearly marked "Private and Confidential".

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6.1.6   Any complaint from someone which specifically states they have or are applying for a gender recognition certificate; please seek immediate advice from the Trust's Equality and Diversity Lead before commencing the complaint process. The Feedback and Engagement Team will confirm with the enquirer how they would like to be addressed.

6.2   Feedback and Engagement Team

6.2.1   Review feedback to assess whether it falls within the parameters of the NHS Complaints Regulations. See Section 11, "Definitions and Limitations" and Section 12, "Who can make a complaint".

6.2.2   On the day of receipt of the letter or email, where possible, telephone the individual to:

- Thank the enquirer for letter or email

- Confirm or establish precise nature of the feedback

    If it is a complaint:
    o   Complaints must be made not later than 12 months after either, the date the incident occurred or, if later, the date the matter came to the notice of the complainant. This may be waived if the Trust is satisfied the complainant has good reasons for not raising it earlier *and* that it is possible to investigate the complaint effectively and fairly.

    o   This procedure only relates to complaints made by members of the public about services provided, or funded, by the Trust. It does not relate to requests for information under the Freedom of Information Act 2000 or Data Protection Act 1998. Staff grievances are covered by separate Trust policies. Nor does it relate to the management of potential litigation cases which are dealt with under a separate policy.

    o   If the representative is making a complaint on behalf of someone else, the Trust will write and ask for consent. If consent has not been received within 20 working days then the Trust will write again and close the complaint until consent received.

    o   If a representative makes a complaint on behalf of a child, the Trust must not consider the complaint unless satisfied there are reasonable grounds for the complaint being made by the representative and not the child. The Trust will ask for consent from the child where appropriate, seeking advice from the Data Protection Team and the service involved.

    o   If the Trust is not satisfied, it must explain the decision in writing to the representative.

    o   If a representative makes a complaint on behalf of a person who lacks capacity within the meaning of the Mental Capacity Act 2005, and the Trust is satisfied that the representative is not acting in the enquirer's best interests, the Trust must write to the representative explaining why the complaint will not be further considered.

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- o Discuss other options available: the role of the Independent Complaints Advocacy Service SEAP/Devon Advocacy Consortium (DAC). If necessary, advise the enquirer that they can ask the Clinical Commissioning Group (CCG) to investigate.

- o Establish the enquirer's expectations and discuss the likelihood of meeting these. This should include if there is a request for a written response or Local Complaints resolution meeting.

- o Discuss the standard response time of 6 (7 for the Emergency Department) weeks and agree a timescale for a full response to complaint. If it is immediately evident that the scale and number of issues that form the complaint may mean we will be unable to respond in 6 weeks then discuss that possibility of a longer timescale with the complainant.

- o Identify any requirements for reasonable adjustments in relation to Equality and Diversity e.g. response in another language, large format.

- o Confirm the preferred means of communication, e.g. letter, email or telephone. Advise the person of the policy around emailing any patient identifiable information to insecure email accounts.

- o Within 3 working days of receiving the letter, prepare and send an acknowledgement (Response Plan) letter to the complainant. Enclose a copy of Trust Complaints Leaflet and for health complaints a copy of "Health Complaints Advocacy Service" SEAP/DAC leaflets and for social care Devon Advocacy Consortium Leaflet, if required.

- o If the complaint carries the risk of litigation or a potential admission of liability discuss this with the Litigation Department.

- o Log the complaint on the Risk Management System (Datix) and give a unique identification number to the complainant.

- o Review the database to see if there is an incident already logged and let the Service delivery unit know an incident form has been completed via the complaint synopsis.

- o Email the complaint letter or initial contact details, the Trust acknowledgement letter, the 2-step investigation document and information received to: Integrated Service Unit ADNPP or ADO, Complaints Coordinator (if applicable), Quality and Experience Lead and where applicable service Manager. The System Directors for Nursing and Professional Practice will receive complaints aligned to ISU's under their system i.e. Torbay or South Devon and have oversight of all complaints.

- o Where the complaint refers to issues in two or more ISU's, identify which ISU will take the lead in coordinating the response.

- o Where the complaint concerns a Clinical Director, ensure the Medical Director is copied in to the original complaint information.

- o Where the complaint concerns an ISU Manager or Associate Director, this will transfer to the Chief Operating Officer for investigation.

- o Where the complaint concerns an Associate Director for Nursing and Professional Practice (ADNPP), this will transfer to the System Director for Nursing and Professional Practice for the system identified and Chief Nurse.

- o Record the pertinent issues identified during dialogue with the complainant on the database and send this and a copy of the complaint letter to the relevant ISU.

- o Update the complainant if necessary as to progress.

- o Draft response will be reviewed for quality and accuracy by the System Directors for Nursing and Professional Practice, aligned to the system leading the complaint and in partnership with the ADNPP or ADO. The final version and sign off will take place and be submitted to the Feedback and Engagement Team via the central e mail account.

- o For the complaints relating to adult social care provision within the Torbay system (where the trust holds delegated responsibility for ADC) this will be reviewed by the Deputy Director for Adult social services, together with the ADO for the relevant Torbay ISU.

- o Send the final version to the Chief Executive for sign off

- o Receive a copy of the signed response letter from the Chief Executive. Attach this and any other documentation, such as details of remedial action, to the database.

- o Close the complaint. Consider any learning for the Trust`s "Feedback and Engagement" group. Keep the actions in the archive file until they are closed. Liaise with ISU`s as to progress of actions and review after 12 months as to their effectiveness.

- o Survey complainants to gain feedback of their experience, if consent gained to contact them.

If Feedback:

- Discuss with the individual how they would like their issue resolved
- Engage the support of the PALs Service if appropriate
- Collaborate with relevant staff for learning and feedback

6.3   ISU's/ Departments – Complaint

6.3.1   Receive copy of complaint letter or email and associated documentation from Feedback and Engagement Team on a 2 step investigation pack.

6.3.2   Identify all aspects of the complaint that need investigation and response. See Appendix 1, "Guidance on conducting an Investigation into a Complaint"

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6.3 3   Initiate the investigation by requesting statements from the staff involved in the care or incident being complained about. The approach to an investigation must match the seriousness of the issues raised and appropriate escalation to a senior manager should be undertaken to determine the level of action required. Provide "Guidelines on writing a Statement as part of an investigation into a complaint or incident" to all staff asked to provide one. Appendix 2.

6.3.4   Allocate a lead person for the investigation who will be responsible to updating the ADNPP or ADO on the progress of the investigation.

6.3.5   Identify and obtain the documentation to be reviewed to gain a full and complete picture of the case.

6.3.6   If during the course of the investigation, it becomes apparent that the complaint is more serious than originally thought, the lead should discuss this with the ADNPP or ADO urgently. Consider appointing a Single Point of Contact (SPOC).

6.3.7   Maintain contact with the complainant to ensure the complainant is kept properly informed about any significant change to the agreed timetable and focus for the investigation and final response.

6.3.8   Keep full, accurate and timely records (including dates and times) of such contacts and any significant elements of the investigation on the Risk Management System (Datix). Remember that all documentation, whether electronic or hard copy, is potentially disclosable to third parties.

6.3.9   The ADNPP or ADO to review the relevant investigation documentation and the draft letter of response, in the name of the Chief Executive.   See Appendix 3, "Guidance on preparing a letter of response".

6.3.10 If the response asserts that, in our view, the complainant's care and/or the Trust's position were appropriate, the investigator must provide evidence to support such claims, by for example, referring to national guidance or best practice.

6.3.11 If the response carries the risk of an admission of liability, discuss this with the Feedback and Engagement Team and the Litigation Department.

6.3.12 Where appropriate, complete an incident form and utilise any investigation Root Cause Analysis reports that have been completed if an incident form exists.

6.3.13 If there are delays in receiving responses from relevant staff then this can be escalated through the line management system for resolution.

6.3.14 The ADNPP or ADO or a senior member of staff nominated by them, who has had no involvement with the investigation, to review the response and ensure it meets the standards set out in "Guidance in preparing a letter of response" – see Appendix 3. When satisfied, to sign the Investigation Plan.

6.3.15 The ADNPP or ADO will review the final draft with the System Director for Nursing and Professional Practice aligned to the ISU and the response will be reviewed for quality and accuracy.

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6.3.16 All adult social care complaints also require the Assistant Director for Adult Social Care to review and approve aligned to the delegated accountability for adult social care held by TSDFT.

6.3.17 The ADNPP or ADO will send the final version to the Feedback and Engagement Team for final formatting and include the System Director for Nursing and Professional Practice for the system into this submission.

6.3.18 Once this review is completed the Feedback and Engagement Team will email the final response letter and the completed Investigation Plan to the Chief Executive.

6.3.19 Share the response letter with staff involved in the complaint together with details of remedial and follow-up action.

6.3.20 Implement any remedial or follow-up action that has been agreed. Keep records of action taken on the risk management system, including dates, key personnel and evidence to demonstrate compliance. Ensure Feedback and Engagement Team are aware of actions and status of these.

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6.3   Complaints addressed to staff other than the Chief Executive

Letters of complaint sent to members of staff other than the CE, will either be acknowledged, in writing and within 3 working days, by the staff member to whom the letter is addressed or passed to the Feedback and Engagement Team who will complete the acknowledgement. If, in exceptional circumstances, it is appropriate for the addressee to respond to the complaint directly, this must be discussed with the Feedback and Engagement Team to ensure a consistent approach.

6.5 Ensuring patients or their relatives/carers are not treated differently or unfairly as a result of a complaint

- Every assistance will be given to individuals who wish to make a complaint, including the provision of interpreter services or any other service or body which may serve to enhance the communication of the complaint to the organisation.

- People must be supported in expressing their concerns and must not be led to believe either directly or indirectly, that they may be disadvantaged because they have made a complaint. Making a complaint or raising a concern does not mean that a service user or complainant will receive less help or that things will be made difficult for them. The Trust will adhere to the Being Open Policy.

- The Care Quality Commission's Key Lines of Enquiry covers this issue, it states "*making a complaint will not cause them to be discriminated against or have any negative effect on their care, treatment or support*".

- Everyone can expect to be treated fairly and equally regardless of age, disability, gender reassignment, marriage and civil partnership, race, religion and belief, gender and sexual orientation.

- The Trust does not expect any patient to be treated differently as a result of making a complaint and a complaint must not be recorded in an individual's care records.

6.6 Complainants who cannot be satisfied by the Trust's procedure

- Occasionally a situation may arise where, despite every effort made by the Trust, the complainant remains dissatisfied and continues to make complaints. The Trust will make every effort to answer the concerns raised and will offer reasonably opportunities to do that. However if the complainant continues to raise concerns and the Trust believes it has done all it can to answer the complaint the complainant will be reminded of their rights to request an Independent Review from the Ombudsman and the decision may be made to close the complaint. This decision will be taken by the ADNPP/ADO and Feedback and Engagement Team.

- The Feedback and Engagement Team will write to the complainant informing them of this decision and that no further action will be taken by the Trust on their complaint, but re-iterating the alternatives open to the complainant.

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6.7 Handling unreasonable complainants

On rare occasions, despite our best efforts to resolve a complaint, a complainant can become unreasonable. The Department of Health has issued guidance on handling unreasonable complaints and the Trust has adopted this as best practice. See Appendix 5, "Handling unreasonable complainants".

6.8 Remedy

- If the investigation into the complaint has established that the Trust is in the wrong, it must try to put things right.

- A full explanation of what went wrong plus details of what action has or will be taken to change and improve practices are essential. These should be accompanied by a full and sincere apology.

- Over and above this the Trust should, wherever possible, put someone in the position they would have been if the fault had not occurred. This may, for example, mean financial compensation for travel costs or for the loss of personal property.

- The issue of financial compensation for inconvenience and distress is complex and the existing guidance focuses on principles. When the issue of financial compensation for inconvenience and distress is raised it should be discussed with senior service delivery unit staff and the Feedback and Engagement Team. Decisions reached must be done so after full reference to the Ombudsman's "Principles for Remedy" and the Treasury's advice on "Managing Public Money" – Annex 4.14 - Complaints and Remedy. See Appendix 6, "Managing Public Money" – Annex 4.14 – Complaints and Remedy, and Appendix 7, Ombudsman's "Principles for Remedy".

7.   Ombudsman's Investigations

- If, after everything possible has been done to resolve a complaint, the complainant remains dissatisfied, they can ask the Parliamentary and Health Service Ombudsman (PHSO) or Local Government Ombudsman (LGSCO) to review the matter.

- The Trust's information leaflet and final response letters will explain this right and the relevant contact details.

- All dealings with the Ombudsman's office will be handled through the CE and the Feedback and Engagement Team.

- When investigating a complaint, the Ombudsman will seek access to all relevant records and documentation kept by both the Feedback and Engagement Team and the ISU. All such records and documentation must be made available within the requested timescale.

8.   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.

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- 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 ISU's to ensure that issues and the resulting action plans are appropriately shared.

- The Feedback and Engagement Team will work with the ISU's to ensure actions are monitored and accurately recorded on the Risk management system.

- Where appropriate staff should incorporate the learning into their annual appraisal process with their manager.

- The capture and sharing of significant learning from complaints is led by the Trust's *Feedback and Engagement Group,* See Appendix 8, Terms of Reference.

9. Reporting arrangements

- The Feedback and Engagement Team will provide a quarterly report to the Quality Improvement Group

- The ISU's can be set up with live dashboards of their complaints data via the Datix Administrator as required.

- Each complainant who has given their consent will be invited to complete a quality response survey approximately 3 months after receipt of the Trust's final response letter. The survey will cover aspects of complaint management and quality of investigation and response. The Feedback and Engagement Team will review these responses and share with the ISU's and the Learning from Complaints group. They will also be part of the quarterly reports.

- The Feedback and Engagement Team will meet its obligations to provide reports to the Department of Health and to other statutory bodies as required and as specified in the Regulations.

10. Training

- The Trust understands the importance of staff training and development to ensure it to deliver effective complaints handling. The Feedback and Engagement Team will deliver training for front-line staff. When requested, the department will also provide whatever support and training it can to individual departments and staff groups.

11. Contact details

Feedback and Engagement Team
First Floor
Bowyer Building
Torbay Hospital
Lowes Bridge
Torquay
TQ2 7AA
Tel: 01803 655838

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Health Complaints Advocacy Service (SEAP)
SEAP Advocacy
PO Box 375
Hastings
TN34 3UY
Tel: 0330 440 9000

Devon Advocacy Consortium (DAC)
Tel: 0845 231 1900

The Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London SW1P 4QP
Tel: 0345 015 4033

The Local Government and Social Care Ombudsman
0300 061 0614, email advice@lgo.org.uk, or postal address: The Local Government and Social Care Ombudsman, PO Box 4771, Coventry, CV4 0EH. Further information about the Local Government and Social Care Ombudsman is available at www.lgo.org.uk

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Report to the Trust Board of Directors

Report title: Smokefree 2030 - the All Party Parliamentary Group (APPG) on Smoking and Health	Meeting date: 24th November 2021
Report appendix	Appendix 1: APPG on Smoking and Health June 2021 Executive Summary
Report sponsor	Health & Care Strategy Director
Report author	Health & Care Strategy Director
Report provenance	Not applicable
Purpose of the report and key issues for consideration/decision	This report summarises the Government's *Smokefree* by 2030 initiative and seeks Board support for the delivery of this and associated actions, as applicable to Devon. This initiative shows leadership from Britain by becoming *Smokefree* by 2030, whereas the EU target is to be smoke-free by 2040. The All Party Parliamentary Group (APPG) on Smoking and Health published its support and action plan in June 2021. The Devon commitment is substantial, together we are already focusing on smoking in maternity, mental health, manual workers and NHS sites. As a Board, we can demonstrate our support and commitment to improving all our people's health and wellbeing by recognising the APPG's recommendations and working through partnerships to achieve Smokefree 2030.

Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board are asked to approve the enclosed and to offer their for the APPG on Smoking and Health initiative.		

Summary of key elements				

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

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

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

Report title: Smokefree 2030- the All Party Parliamentary Group (APPG) on Smoking & Health	**Meeting date:** 24th November 2021
Report sponsor	Health & Care Strategy Director
Report author	Health & Care Strategy Director

Introduction

Smoking continues to be a significant risk factor in the health and wellbeing of our population. As a habit it all to frequently leads to mental and physical ill-health, disability, early death and is closely associated with poverty and addiction thus increasing health inequities.

In the past ten years the number of people smoking in the United Kingdom has continued to decline, dropping from 1 in 5 people to 1 in 7. We now have an opportunity to further capitalise on this progress and drive this rate down further as well as focusing on the more vulnerable smokers who may need more support to reduce or stop smoking. With this aim in mind, Smokefree 2030 is an important target to aim for all of us.

The AGPP on Smoking & Health (June 2021) sets out key strategic approaches to reach this ambitious state in 9 years' time. These are outlined below and build the case for our organisational commitment in this area. Furthermore, this commitment speaks to the heart of our organisational purpose and vision for better health and care for all as we support the people of Torbay & South Devon to live well.

Discussion

Why support Smokefree 2030?

As a society we continue to experience the effects of smoking in both health (80000+ deaths a year, plus it is a major cause of healthy years lost in older age) and more broadly (it is a significant contributor to poverty with 1:3 manual workers still smoking). Following the Chancellor's Budget this month, the cheapest (legal) packet of 20 cigarettes is £9.73.

We are particularly affected as Torbay has one of the highest levels of smoking in the south west and we are in the bottom third for England (higher rate worse); health index data 2019.

How is Smokefree 2030 being supported nationally?

The AGPP report recommends three areas of action:

- setting course for Smokefree Britain with legislation for tobacco companies to repair harm caused by contributing to a central fund
- behaviour change policies with a focus on levelling up in manual workers, maternity and mental health
- shaping the consumer environment e.g. NHS prescription of e-cigarettes

<u>What are we doing locally already in line with the AGPP recommendations?</u>

The Devon Smokefree Alliance is active in these areas with a particular focus on the behaviour change recommendations. Our maternity services have been working on reducing smoking rates during pregnancy with significant progress made in the past five years already. In 2016/17 our rates of smoking in pregnancy were 20% and are now around 10%.

Furthermore:

- we are working to ensure our sites are smoke-free through supporting interventions such as the Ask, Advice, Act campaign which is for a short, effective interaction between staff member and smoker
- funds made available to support Smokefree are further focusing in smoking during pregnancy e.g. supplying women with a nicotine replacement substance for a full twelve-week course of the product
- improving our offer to staff for stopping smoking

Conclusion

Smokefree 2030, a target worth stretching for as relevant to individuals as well as us as on organisation. As a Board we can take a lead in this area by showing our commitment and support, as a Board and working with partners both across our footprint of Torbay and South Devon and across the whole of Devon to achieve an important milestone in health and well-being generally.

Recommendations

As a Board we can support the APPG on Smoking and Health and our colleagues across the full range of our services who are working in this important area to deliver better health and care for all.

All Party Parliamentary Group on Smoking and Health

Executive Summary

Delivering a Smokefree 2030: The All Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021

June 2021

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About the All Party Parliamentary Group on Smoking and Health

The All Party Parliamentary Group (APPG) on Smoking and Health is a cross-party group of Peers and MPs which was founded in 1976 and is currently chaired by Bob Blackman MP. Its agreed purpose is to monitor and discuss the health and social effects of smoking; to review potential changes in existing legislation to reduce levels of smoking; to assess the latest medical techniques to assist in smoking cessation; and to act as a resource for the group's members on all issues relating to smoking and public health. The secretariat of the group is provided by Action on Smoking and Health.

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Foreword

The Government's ambition for England to be Smokefree by 2030 is strongly supported by the APPG on Smoking and Health, as it is by the public. Achieving this ambition is a prerequisite for the delivery of manifesto commitments to increase healthy life expectancy by five years by 2035, while reducing inequalities and levelling up the nation.

However, as the Secretary of State himself stated, this will not be delivered by "*business as usual*". The APPG therefore welcomes the Government's commitment, in setting up the Office of Health Promotion within the Department of Health and Social Care, that health will no longer be the business of the DHSC alone, but a core priority for the whole of government. Smokefree 2030 remains, however, an "*extremely challenging*" ambition which will require "*bold action*".

The APPG agrees with the Secretary of State's assessment and we have risen to his challenge. This report sets out our recommendations for the "*bold actions*" we believe must be included in the new Tobacco Control Plan if it is to deliver a Smokefree 2030.

Government action is needed and wanted, because this is an addiction most smokers were trapped into as children. Two thirds of those who try smoking go on to become regular smokers, only a third of whom succeed in quitting during their lifetime. Most smokers want to quit and many more regret ever having started.

However, to end smoking will require funding and the APPG believes, as do the public, that the tobacco manufacturers should be made to pay. This is an industry, which, as the Chief Medical Officer reminded us recently, kills people for profit, and is likely to have killed more people last year than COVID-19.

The UK, home to the tobacco industry, led the way into the tobacco epidemic in the 20th Century. In the 21st Century, we are now showing global leadership in forging the path out. Brexit gives the UK the opportunity for our global leadership in tobacco control to shine on the international stage. While we were part of the EU, the EU spoke for us. Now we can speak for ourselves and we should use this to highlight our ambition to make smoking obsolete and be Smokefree by 2030.

Bob Blackman MP
Chairman of the All Party Parliamentary Group on Smoking and Health

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Executive Summary and Conclusions

1. This report sets out the All Party Parliamentary Group on Smoking and Health's recommendations for the Tobacco Control Plan to deliver a Smokefree 2030.[1] Government action to end smoking is both needed and wanted, with three quarters of the public supporting both the ambition and Government action to deliver it. As a world leader in tobacco control and strong supporter of the full implementation of the international tobacco treaty, the WHO Framework Convention on Tobacco Control (FCTC),[2] our nation quite rightly seeks to be among the first in the world to end the tobacco epidemic.

2. Achieving the Government's Smokefree 2030 ambition,[3] of smoking prevalence of less than 5%,[4] is an essential step towards reducing inequalities and increasing healthy life years,[5][6] as half the difference in life expectancy between the richest and poorest in society is due to smoking,[7] and for every smoker who dies another thirty are suffering serious-smoking related diseases.[8][9] On average, smokers have difficulty carrying out everyday tasks like dressing, eating and walking across a room, seven years earlier than never smokers and need care support ten years earlier than never smokers.[10][11]

3. And although in 2020 COVID-19 killed around 80,000 people prematurely in the UK,[12] smoking kills on the same scale every year,[13] and will go on doing so for many years to come unless we make smoking obsolete. We are taking the necessary steps to end the coronavirus pandemic; we must do the same for smoking.

4. The economic, as well as the health benefits, of Smokefree 2030 will be most keenly felt among the most disadvantaged groups and in the most disadvantaged regions. The coronavirus pandemic has thrown a spotlight on the devastating impact of inequalities. Increasing healthy life expectancy by five years by 2035 while reducing inequalities, and levelling up society, in line with Government manifesto commitments will be a greater challenge post-pandemic than it was before.[14][15]

5. The APPG therefore welcomes the Government's commitment that its public health reforms "*aim to ensure that the public's health is given the status it deserves – at the very heart of government's priorities for action, policy and investment, nationally and locally, across government and across the NHS.*" Also welcome is the decision to strengthen the role of the Chief Medical Officer (CMO) as the lead independent public health advisor across government.[16]

6. The EU's ambition is to be Smokefree by 2040;[17] our Government plans to get there a decade earlier. This is achievable but we must go further and faster than we have ever done before. Smoking rates declined by two thirds over the last half century while smoking-related inequalities grew. To be Smokefree by 2030 we need to reduce smoking by two thirds in only a decade, and by three quarters for smokers in routine and manual occupations.[13] We are not yet on track.

7. At current rates of decline we will miss the target by seven years, and double that for the poorest in society.[18] There are still nearly 6 million smokers in England, one in seven of the adult population. We will only achieve a Smokefree 2030 by motivating more smokers to make a quit attempt using the most effective quitting aids, while reducing the number of children and young adults who start smoking each year. The evidence about what policy levers work is clear, what is needed is for Government to pull them to their fullest extent.[19][20]

8. Achieving a Smokefree 2030 cannot be done on the cheap, it will require investment. But the investment required can be counted in millions compared to the billions it costs to treat smoking-related diseases, and in lost productivity caused by smoking-related disability and premature death.

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9. The benefits will far outweigh the costs. Smoking does not just damage physical health, but mental health too. One in three smokers show signs of poor mental health, and quitting is linked to improvements in wellbeing at least as great as from anti-depressants.[21]

10. Smoking also drives over a million people into poverty, including over a quarter of a million children, leaching money out of local economies, particularly in disadvantaged communities where household income is lowest.[22]

11. Total spending on tobacco based on weighted average prices is estimated to be over £14 billion a year. Only a tiny proportion of the total stays in local communities, with over 90% going up in smoke, in taxes and tobacco manufacturers' profits. Tax revenues nowhere near cover the economic cost of smoking to society. Making smoking obsolete will significantly increase disposable income among poorer smokers and in poorer communities, increasing welfare and jobs.[23]

12. The Government's decision that health will no longer only be the business of the DHSC, but a core priority for the whole of government is welcome. Other Government Departments also have a role to play in delivering a Smokefree 2030, for example HM Treasury on taxation, HMRC on the illicit trade in tobacco, and DEFRA on the environmental impact of tobacco.

13. However, the recommendations set out in this report are for DHSC for inclusion in the forthcoming Tobacco Control Plan. They relate to England with respect to devolved measures like health and to the UK with respect to reserved matters such as our international role in tobacco control. There is no time to be lost if we are to get on track to be Smokefree by 2030 so these measures need to be put in place by the end of 2021 and sustained until at least 2030.

14. A recommendation that interim targets be set for 2025 is included, so that if we are not on track for a Smokefree 2030 by then, the Tobacco Control Plan can be reviewed and enhanced.

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Recommendations

Setting course for a Smokefree 2030

Recommendation 1: Legislate to make tobacco manufacturers pay for a Smokefree 2030 Fund to bring an end to smoking

Recommendation 2: Take our place on the world stage as a global leader in tobacco control.

Recommendation 3: Set interim targets for 2025, and update our strategy if we are not on track to a Smokefree 2030 by then

Behaviour Change Policy and Interventions for a Smokefree 2030

Levelling up through targeted investment

Recommendation 4: Deliver anti-smoking behaviour change campaigns targeted at routine and manual and unemployed smokers (C2DE).

Recommendation 5: Ensure all smokers are advised to quit at least annually and given opt-out referral to Stop Smoking Services.

Recommendation 6: Target support to give additional help to those living in social housing or with mental health conditions, who have high rates of smoking.

Recommendation 7: Ensure all pregnant smokers are given financial incentives to quit in addition to smoking cessation support.

Recommendation 8: Fund regional programmes to reduce the use of illicit tobacco in deprived communities.

Shaping the Consumer Environment

Recommendation 9: Legislate to put health warnings on individual cigarettes, quit messaging on pack inserts and close other loopholes in existing regulations.

Recommendation 10: Reduce the appeal and availability of e-cigarettes and other nicotine products to children.

Recommendation 11: Make the route to medicinal licensing fit for purpose to allow e-cigarettes to be authorised for NHS prescription.

Recommendation 12: Consult on raising the age of sale for tobacco from 18 to 21.

7   Delivering a Smokefree 2030: The All Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021

7.07 Smokefree 2030 - the All Party Parliamentary Group on Smoking and Health.pdf   *Page 11 of 14*

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8 Delivering a Smokefree 2030: The All Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021

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Cover image: www.zefrog.eu

Copies of the report can be downloaded from the APPG website at: ash.org.uk/APPG

Report to the Trust Board of Directors

Report title: Freedom to Speak Up Guardian Six Monthly Report		Meeting date: 24th November 2021
Report appendix		
Report sponsor	Chief People Officer	
Report author	Lead Freedom to Speak Up Guardian	
Report provenance	NHS National Contract	
Purpose of the report and key issues for consideration/decision	The Freedom to Speak Up Guardian report is submitted every six months to enable the Board to maintain a good oversight of Freedom to Speak Up matters and issues.	

Action required (choose 1 only)	For information ☐	To receive and note ☒	To approve ☐
Recommendation	The Trust Board of Directors receive and note the contents of the Freedom to Speak Up Guardians six month report.		

Summary of key elements

Strategic objectives supported by this report				
	Safe, quality care and best experience		**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		**Risk score**	
	Risk Register		**Risk score**	

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

Report title: Freedom to Speak Up Six Monthly Report	Meeting date: 24th November 2021
Report sponsor	Chief People Officer
Report author	Lead Freedom to Speak Up Guardian

1.0 Introduction

1.1 Speaking up protects patients and workers, but is only effective if leaders listen up and follow up with leaders setting the tone from the top. Freedom to Speak Up is about more than the ability to raise concerns about patient safety. It is about being able to speak up about anything which gets in the way of doing a great job. That can be about ideas for improvement, ways of working or behaviours.

2.0 Assessment of cases

2.1 Since the last Board report in May there have been 35 concerns raised through the Freedom to Speak Up Guardians. The highest number of cases relate to poor behaviour ranging from low level incivility to sexual harassment. In these cases, staff had tried to raise concerns but were not listened to or given a poor response and have sought an alternative route to speak up. There was a fear amongst staff that they would not be believed.

2.2 The main themes from the concerns are detailed below:

Bullying and Harassment - 14
Patient Safety - 1
Failure to follow process - 3
Diversity and Inclusion - 3
Staff Safety - 5
Culture of organisation - 7
Fraud - 2

2.3 Staff group speaking up included:

Medical - 6
Nurse - 6
Midwife - 1
AHP - 7
Senior Manager -3
HCSW/AP - 11
A&C – 12
EFM - 5

2.4 As can be seen the highest number of staff who spoke up were admin and clerical, healthcare support workers and allied health professionals. In some cases, concerns had been previously raised with line managers but staff had not felt listened to. The Freedom to Speak Up Guardians play an important role for staff to raise concerns when other reporting processes have not worked or felt appropriate.

2.5   A number of concerns have been raised regards gender phobic comments and intolerance in the workplace.

2.6   A number of staff have come forward when they are subject to a disciplinary process that they feel they have no voice in.

3.0   **Feedback from speaking up**

These are an example of quotes of individuals who have received support from the Freedom to Speak Up Guardians, demonstrating the positive impact of the roles:

"Yes I will definitely speak up again if anything happens in the future. The support I have received has helped very much. It is good to know this is available and I will encourage others to speak up"

"Thanks again for all your support I am so grateful - I actually feel like I have some support finally."

"Thank you – it feels so positive with you supporting us."

"I want to thank you for your time and support, it means a lot to feel you are going to help us to make our ward a happy more positive environment for all to work in."

4.0   **Changes to the NHS Staff Survey**

4.1   The NHS Staff Survey has undergone significant changes in line with the People Plan. As a result, some of the questions which comprised the FTSU Index have dropped, in light of this the FTSU index will no longer be published. Last year's survey included a new question asking whether workers feel safe to speak up about anything that concerns them in their organisation.

Last year's survey included a new question asking whether workers feel safe to speak up about anything that concerns them in their organisation. That question will now be accompanied by a new follow-up question: "If I spoke up about something that concerned me, am I confident my organisation would address my concerns."

All organisations are asked to consider using this question as an indicator of the speaking up culture and arrangements.

4.2   The most recent case review led by the National Guardian Office was published In October 2021. Recommendations and findings from the review of speaking up at Blackpool Teaching Hospital will be analysed against our current speaking up service and data.

5.0   **Actions to continue to improve our FTSU culture**

5.1   Active recruitment to the Freedom to Speak Up Champion role. These roles are a

listening ear and sign poster in the workplace. There will be a robust interview process to ensure credibility and confidence in Freedom to Speak Up. Training and support will be provided to ensure the champions have the confidence and competence to support staff.

5.2 Listening sessions have been and are being held in specific areas where a number of concerns have been raised. These sessions have been held with Maternity, Brixham Hospital and currently with George Earle ward staff.

5.3 **Procurement of 'WorkInConfidence'** has been delayed and roll out now due in early 2022. This platform will support staff in speaking up anonymously. It also offers a case management system which will support accurate recording of cases and help to identify themes and trends.

5.4 **Update on Speak Up training** provided by Health Education England on behalf of the National Guardian Office include three levels of interactive digital training:

- **Speak Up** for workers – all workers to undertake at least once now available on the HIVE

- **Listen Up** for managers – all managers existing and new now available on the HIVE

- **Follow Up** for senior leaders – including Board members with a recommendation that all levels are undertaken at least once due to be launched early 2022

6.0 **Non - executive Director for Freedom to Speak Up**

6.1 We would like to take the opportunity to formally appreciate and thank Jon Welch for his commitment and support. Jon has given his wise council and support to us all during his time as the Freedom to Speak Up Non-Executive Director. He has been a safe pair of hands for us during our development and has supported us with some of our most difficult cases.

Report to the Trust Board of Directors				
Report title: Research and Development Annual Report 2020/21			Meeting date: 24th November 2021	
Report appendix	Appendix 1: Examples of good news stories/commendations for research at Torbay Appendix 2: Examples of the Impacts and outcomes from studies Torbay Hospital has been involved in			
Report sponsor	Medical Director			
Report author	Director of Research and Development			
Report provenance				
Purpose of the report and key issues for consideration/decision	The purpose of this report is to provide the Board of Directors with an annual account of Trust Research and Development (R&D) activity and performance in 2020/21. The report also covers updates and progress up to Q2 in 2021/22.			
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐		**To approve** ☐
Recommendation	The Trust Board is asked to consider the risks and assurance provided within this report and to agree any further action required.			
Summary of key elements				
Strategic objectives supported by this report				

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

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

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

External standards affected by this report and associated risks				

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

Report title: Research and Development Annual Report 2020/21	Meeting date: 24th November 2021
Report sponsor Medical Director	
Report author Director of Research and Development	

1.0 Scope

- The purpose of this report is to provide the Board of Directors with an annual account of Trust Research and Development (R&D) activity and performance in 2020/21. The report also covers updates and progress up to Q2 in 2021/22.

2.0 Introduction and Background:

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

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

- The Trust is a partner in the NIHR South West Peninsula CRN (SWP: CRN) and is commissioned and funded separately to patient care by the NIHR; to provide a clinical trials delivery service locally for NIHR studies; in line with relevant national R&D strategies and policies and the NIHR Performance and Operating Framework contracts.

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

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

Why is research important?
- Research happens every day, right across all health and care services - from the community to acute trusts. The COVID-19 pandemic has shown just how important research is. Research is critical to help discover which interventions work better for patients and ensures existing treatments are used in the best possible ways. It helps to find answers, fill gaps in knowledge and ensure best practice.

Research is...

Good for patients:
- Patients value the opportunity to participate in research studies and evidence shows that those who receive care in research-active institutions have better health outcomes.

Good for staff:
- Best patient care is based on the best clinical evidence and many healthcare professionals say they find the experience of being involved in research studies positive and rewarding as well as helping their career.
- **In a [survey carried out by the Royal College of Physicians,](#)** 80% of physicians said they participated in research because it improves patient care, with 75% agreeing working within research allows them to develop a wider set of skills.

Good for your organisation:
- Research is now part of Care Quality Commission (CQC) assessments of how trusts are supporting and using clinical research to improve patient care.

3.0: Summary of Research Activity and Performance:

- Since March 2020 research; like all other parts of the Trust and the NHS has been impacted by the covid pandemic. As the COVID-19 global pandemic escalated in the UK, DHSC and NIHR prioritised research activity within the NHS to be directed towards Urgent Public Health (UPH) COVID 19 research (Observational and Therapeutic Intervention trials), UPH COVID 19 vaccine research (Early to Late phase trials), and research trials offering lifesaving treatments.

- The Government considered '*Research is fundamentally our only effective route out of this pandemic so it is imperative the UPH studies are prioritised and all Trusts support to their best ability*'.

- As a consequence; R&D had to re-focus and pivot the majority of research effort to deliver UPH Covid 19 trial activity. However, we were able to also keep open most of the cancer research trials activity and a few other trials requiring minimal support from our delivery teams; for example, the PROTECT dementia study (general public responding to advertised media campaigns).

- However most other non covid research was 'paused', especially during the first wave. This involved reviewing over 200 studies, suspending recruitment to studies and where possible follow up activity providing safety was not compromised. This enabled staff and our limited resources to focus on the UPH covid-19 research programme as part of the Governments response to the pandemic.

- The R&D team has worked hard and tirelessly to maximise Torbay's opportunities to access studies, supporting the clinical teams and we played our part in this crucial national UPH covid-19 programme. Torbay has been involved with 16 covid-19 studies (see table below) and recruited 1,516 participants (excluding the Valneva study – see below); to covid studies to date (data cut 01/11/2021) with further studies in the future.

RECOVERY	UKOSS
RECOVERY-RS	PAN COVID
REMAP-CAP	NEONATAL
ISARIC	SIREN
GENOMICC	CLARITY
FALCON	PACE
BRACE	(Valneva)# - see below under vaccines
CO@H	VROOM

- The studies are a mixture of data collection, genetic, interventional and devices studies covering both inpatient and outpatient covid-19 patients.
- Torbay consistently had the highest conversion rate of those admitted with COVID being offered and enrolled in a study across the region: Across the 12 recruiting sites in the Peninsula; Torbay ranked 2nd highest for open studies for several months during the pandemic.
- Some studies involve staff: The SIREN Study: (Sarscov2 Immunity & REinfection EvaluatioN): This is the key PHE's antibody research testing programme recruiting over 10,000 health workers nationally.

    ➢ This study also serves as the only clinical surveillance programme on site. It requires testing staff every 2 -4 weeks (both swabbing and blood testing) over 12-18 months plus completion of symptomatic diaries. This is ongoing and due to close in March 2022.
    ➢ The South West Peninsula is the highest recruiting region to SIREN in England.
    ➢ Torbay recruited 434 (target was 250) staff members in total. We are very grateful to all staff who have volunteered their time and to their managers for allowing their staff to take time out briefly throughout to attend the research clinics on JRU.

- Staff also worked responsively to instigate rapid reviews to expedite set up and authorise UPH covid studies within a new 9-day turnaround target.

- During this time prioritising research and gaining the support, involvement and engagement throughout the organisation was a refreshingly positive experience with everyone coming together to serve a common goal and showed a true collaborative spirit.

- In addition, during this time, some R&D clinical staff were redeployed; working in ICU and ED in response to the Trust's requirement for assistance to support front-line services. In addition, some of our non-clinical staff supported several ad hoc activities such as making face masks (e.g. over 700 in less than 3 days, help with re arranging and re purposing Level 2 OPD etc).

- R&D had to suspend all on site monitoring visits by sponsors (required as part of regulatory and quality control and assurance programmes). The R&D governance and management team had to switch and support external review and monitoring of research activities, throughout the pandemic through the rapid implementation of remote monitoring of our commercial and non-commercial research. This ensured our studies were compliant; keeping our patients, staff and the study sponsor staff safe.

- R&D also maximised a digital first approach – Attend anywhere, phone, self-reporting, e-consent, video, etc.

- Our involvement in these studies has helped save lives locally, and has had global impact. Please refer to Appendices 1 and 2 for more details on impacts and outcomes.

3.1: Covid -19 Vaccines:

- Nationally all Trusts were asked to prepare for the roll out of a programme of late phase clinical trials at scale and pace. A regional response was required.

- Torbay was part of the regional vaccine group established; to feed into the Governments National Vaccine Task Force (VTF), which provided a local platform for networking and shared learning. We needed to be both agile and responsive; as this is a very fast moving and fluid agenda; constantly changing. The planning of vaccine studies involves complex logistics and the need for large numbers over short periods and to set up and deliver studies at scale and pace. This group was cross disciplinary and cross organisational; allowing a system wide joined up approach to best use resources and serve our local populations.

- Internally, R&D established a vaccine trials working party to oversee the Torbay response; with clinical leadership from Drs Halkes, Clark and Anning.

- The NIHR and Government VTF provided additional funding to support this work, to ensure Trusts were trial ready. This has funded the lease of a portacabin outside of the relocated JRU (outside of Crowthorne) to facilitate the symptomatic pathway – so trial sites are able to review symptomatic participants; separate to the Trusts local pathways. The funding also helped purchase much need equipment (-20 and -70 freezers for both pharmacy and labs, fridges, replacement centrifuges and refrigerated centrifuges in labs, protective clothing and Laptops and iPads, etc).

- For operational reasons we were only able to accommodate vaccine clinics over the weekends due to the lack of clinic space during the week. As a consequence, Torbay was unable to host a Vaccine study on site. But we did the next best thing and was part of a successful collaboration:

3.1.1: Valneva Covid-19 Vaccine Trial: TSDFT / UHPNT collaboration:

- The collaboration between Torbay and Plymouth Research teams delivered the highest UK recruitment into the national VLA2001 COVID vaccine study, surpassing our target by giving 268 local residents the chance to be involved in this nationally important study. Whilst everything was run from the one site at Derriford; staff at all levels, from admin to doctors went over to Plymouth from Torbay on a rota. Participants were recruited from both sites, so that Torbay residents also had the opportunity to access the trial.

- This collaboration allowed both parties to deliver a study that would have been a real struggle to deliver as an individual organisation. It gave valuable research and leadership experience to nurses and Drs who wouldn't have otherwise had that experience. It also developed an innovative cross organisational support system for our PI and investigators. Feedback from individual team members is that this was a really enjoyable and worthwhile project – it has helped develop skills clinically and in teamwork. It paves the way for future collaborations between Torbay and UHP.

- The initial results from the study were recently published, showing excellent safety and efficacy. See Appendices 1 and 2 for more details.

3.2: NIHR / DHSC RESTART Framework: Recovery, Resilience and Growth (RRG).

- During the Summer of 2020, following the first wave; R&D were asked to 'RESTART' non covid-19 activity alongside continuing to support covid -19 research. Similar to NHSEs plans, R&D had to look at how best to restart and restore a fully active portfolio, open new NIHR research and prioritise our resources. The Prioritisation framework was based on urgency and importance to maximise use of limited research capacity and resources:

  - Level 1a: UPH covid-19 studies – interventional studies including vaccines
  - Level 1b: UPH covid-19 studies – observational / data collection
  - Level 2: potentially life-preserving or life-extending treatment not otherwise available to the patient
  - Level 3: all other research.

- R&D has been working closely with study Sponsors, Trust staff and our clinical and supporting services to restart activity (both paused & new). We needed to assess viability of studies within covid secure operational environments etc. Plans had to link into / align with when and how Trust services were reinstated.

- R&D is no different to other NHS services. It is a complicated balancing act between all our research activity and demands, need for safety, within a very challenged workforce, operational and financial environment; and as with many other sectors of NHS business; with competing priorities for staff, time, labs, radiology and clinic space etc.

- By 20/21-year end, R&D had reviewed and restarted over 80% of pre covid activity. The graph below shows the RESTART status of Torbay compared to all regional partners within the NIHR SWP: CRN.
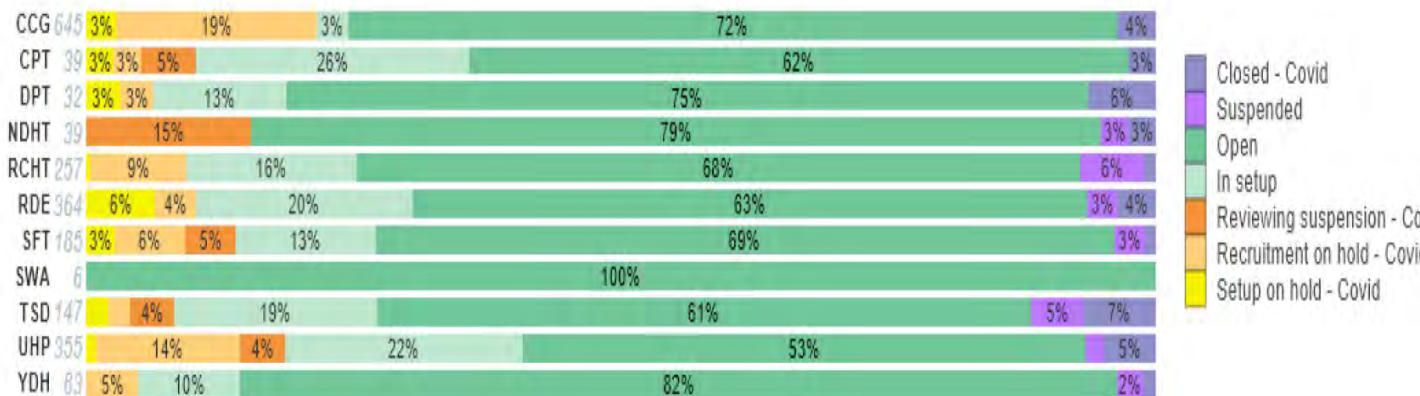
The graphs below charts the impacts of covid and progress since March 2020 (needing to pause activity then re-open studies), with our current status shown in the bottom graph (Oct. 2021).
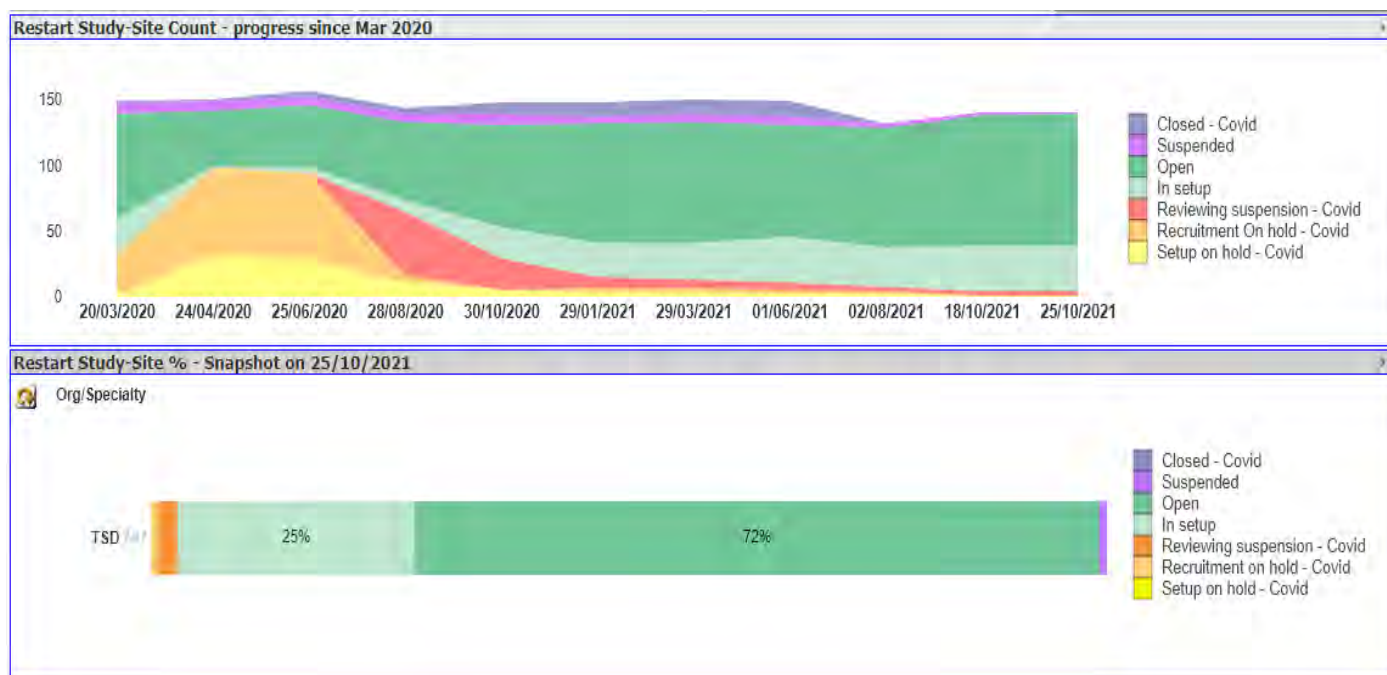
In addition, R&D has reinstated some form of on-site monitoring with new SOPs to manage the requests to keep visits minimal and safe; whilst recognising this is part of 'essential; work as forms part of legal and regulatory requirements for most drug-based studies.

2021/22:

The 'restart' or Recovery, Resilience and Growth is not just returning to our previous ways of working. The priorities remain in 21/22: an ambition to get activity to pre-covid levels at least and restart all paused activity where possible, close down any non-viable studies and open up to new

business. A key change is the removal of Urgent Public Health (UPH) status and to treat covid as a new disease speciality we need to support. In summary:

NIHR / DHSC priorities (links to HLOs)

- **Expand Research in:**
  - Prevention
  - Multimorbidity
  - Public Health
  - Social Care
  - Care Homes
  - Primary care
  - Community care
  - Mental Health

- **Health Targeting:**
  - Asthma
  - COPD
  - Cancer
  - Dementia
  - Diabetes
  - Heart Failure (CV)
  - Mental Health (Common)
  - Mental Health (Severe)
  - Stroke

  - Covid (vaccines / non vaccines)

- **Other:**
  - Managed Recovery (back to pre covid activity)
  - Place studies where the health & care need is.
  - Equality, Diversity, Inclusion (EDI)
  - Digital / Data
  - UK Plc (Life sciences – commercial)
  - Fast set up & delivery to time and target (T2T) (especially next 12 months)

3.2.1: New NIHR Primary Care Strategy:

- Introduced in May 2021, the Government released new additional funding (£12.5M), distributed across Local CRNs to support an increase in 'non-secondary care-based' or non-acute hospital-based research activity, to support the development of a wider and more diverse research portfolio:

- Locally the primary care Clinical Support Team (CST) managed by the CRN will be expanded and renamed to become a new Agile Delivery team, to support activity outside of the acute hospital setting not just in primary care but in all other settings, recruiting new staff to support research in mental health, community care, social care and public health alongside their current primary care activities working with relevant providers accordingly. This is in its infancy and R&D will need to work with the new Agile Delivery Team to expand research opportunities in these areas.

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

In 2020/21 due to covid, the NIHR's HLOs were suspended. New HLOs were introduced instead as part of a revised NIHR performance and operating framework:

New Commercial studies - Time to target (T2T) = 70% (New' indicates opened on or after 1 April 2020 and closed to recruitment on or before 31 March 2021).	N/A: No eligible studies
UPH Study site set-up time: Target = 9 working days as all are expedited (selection to confirmation / approval). The Ambition value was determined by experience setting up Urgent Public Health Studies earlier in this reporting year, under two working weeks being both ambitious and feasible.	*Our median = **6 days** (n= 12 studies)*
Recruitment to UPH study ISARIC >12% of admission rates	**Target met >12%**

RESTART metrics: A) Percentage of paused commercial contract studies that are no longer paused at 31 March 2021 (Ambition value 80%. The denominator, the number of 'Paused' studies, is the number of studies recorded by the CRNCC as 'Paused' on 18 May 2020. 'No longer paused' implies an update to the study status from 'Paused' to another status)	*100% -paused 10 commercial studies that were open to recruitment, of which 6 subsequently closed and the other 4 have reopened. (We also paused 15 commercial in set up – 4 were abandoned, 7 opened and 4 ongoing)*
RESTART metrics: (B) Percentage of paused non-commercial studies that are no longer paused at 31 March 2021 (Ambition value 80%. The denominator, the number of 'Paused' studies, is the number of studies recorded by the CRNCC as 'Paused' on 18 May 2020. 'No longer paused' implies an update to the study status from 'Paused' to another status)	*95% - We paused 75 non-commercial studies and there are 4 still left paused – sponsors unable to re-open yet*

NIHR High level objectives for 2021/22:
The NIHR has re-introduced some formal performance monitoring. There has been a shift in emphasis from number of patients recruited to trials as a metric, to research delivery performance and recruiting to time and to target.

HLO 1
- *Recruitment into NIHR portfolio studies (suspended still in 21/22 only an ambition target)*
- **1483/1200 = 124%**

HLO 2a&2b
- *Time to Target NIHR commercial and non commercial studies (closed studies)*
- *Target = 80%*
- **Commercial = 40% (2/5)** *with 3 of open commercial studies due to close 21/22 are at target and 5 are not*
- **Non Commercila = 56% (5/9)** *13 of open non commercial studies due to close 21/22 are at target and 10 are not*

3.4: Activity summary:

	2019/20	2020/21	2021/22 Y2D
Total number of recruits commercial studies	95	37	33
Total number of recruits non-commercial studies	1401	2178	1450
Total number of recruits (Commercial & Non-Commercial)	1496	2215	1483
Total No. recruited into Covid-19 studies (excluding Valneva)	48	1161	307
Total number of recruits interventional studies	332	143	507
Total number of recruits observational studies	1164	2072	976
Total number of recruits (Interventional & Observational)	1496	2215	1483
Total No. New Commercial Studies Approved	13	8	6
Total No. New Non-Commercial Studies Approved	44	27	19
Total No. New Studies Approved (Commercial & Non-Commercial)	57	35	25
Total No. Expression of Interests (EOI's) Rec'd	358	339	252
No. Positive EOIs submitted	64	56	46
No. 'No' Response to EOI (negative response)	154	150	99
% No Response	43%	44%	39%
% Total Positive	18%	17%	18%
No. Amendments processed	244	334	193
2021/22: Studies in set up / pipeline currently: ***39 (9 commercial, 30 non-commercial (4 of which are non-portfolio)***			

- The Trust recruited a record 2,215 participants of which 52% were to covid-19 studies; but recruited into a fewer number of studies overall during 20/21.

- Covid restricted the opening of several new studies (paused in set up). This reflects the decrease in total number of new studies approved in 20/21 of which 15 were covid studies.

- Similarly, only 8 new commercial studies were approved (23%) compared to 13 new commercial studies (23%) in 20/21.

- Unsurprisingly the recruitment distribution and study type for 20/21 were also skewed; due to covid, with reduced recruitment to commercial trials seen (2% compared to 6%) and less recruited into interventional studies (6% vs 22%) compared to 2019/20 (see below).

% Split between Source of Recruitment 2019/20

6%

94%

■ Non-Commercial   ■ Commercial

% Split between Source of Recruitment in 20/21

2%

98%

■ Non-Commercial   ■ Commercial
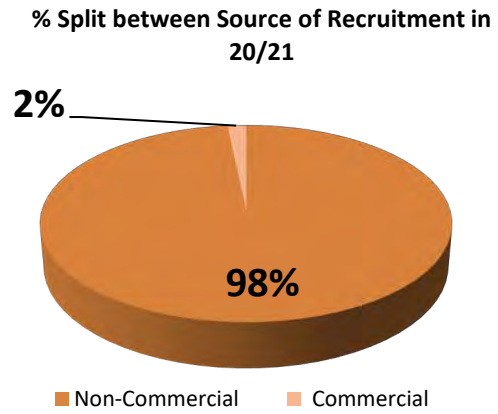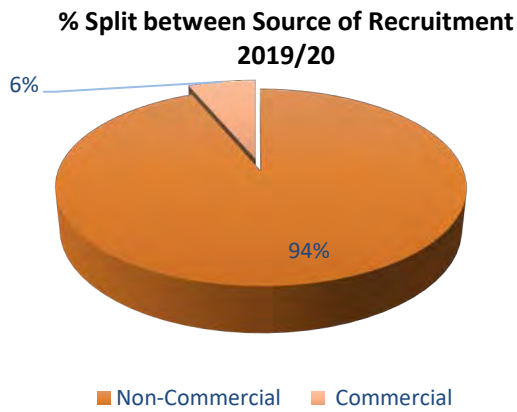
Please note these figures DO NOT include the Valneva Covid-19 vaccine study. This is because recruitment was only at Derriford Hospital and therefore officially assigned to UHPT. A total of 238 participants were recruited in a short time window; through a collaborative effort with our R&D staff working alongside Plymouths research staff at Derriford.

% Split between Study Type 19/20

22%

78%

■ Interventional   ■ Observational
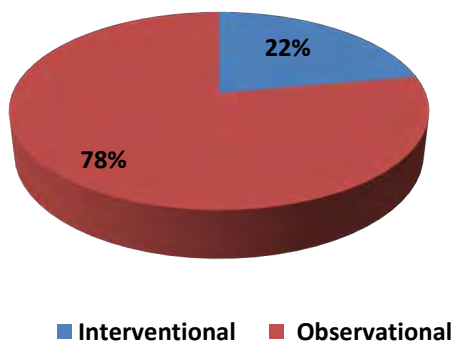
% Split between Study Type in 20/21

6%

94%

■ Interventional   ■ Observational
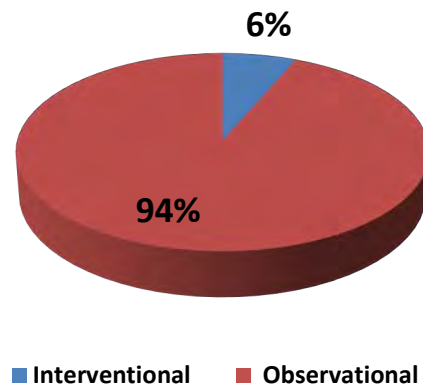
Usually we report on activity per speciality / ISU. However, covid completed skewed activity and therefore no data is meaningful in 20/21 so not presented in this year's report.

2021/22:

- Our Recovery and Restarting of new activity is encouraging, improving and gaining pace and momentum. The mid-year 2021/22 activity shows the number of new studies approved = 25; of which 6 (24%) are commercial studies with recruitment already at 1,438 in total. Similarly, we have seen an increased in the proportion recruited to interventional studies year to date (34%).

- However, the number of open studies remains 33% less than previously with 80 studies open to recruitment. We are wanting to return to at least 120 open studies. Whilst we have 39 studies in the pipeline, we also have a similar number of studies due to close in year; so, we still have work to do to establish pre covid activity levels.

3.5: Expressions of Interest (EOIs) – potential new business

- The Number of Expressions of Interest (EOIs) received is an indication of potential new business opporunties. The pandemic did not affect too badly the numbers received compared to the previous year, although many were for covid studies. The number seen in 21/22 at the mid point is already n=252; suggesting a strong pipeline of potential new studies to come on stream. Our positive response rates have remained similar.

- Our number of 'no' responses is still high and we are keen to reduce this. The work with ISUs and the new dashboards (see section 8.2) have stimulated more conversationas as to why we are turning down studies and we remain hopeful this will lead to new avenues to explore within ISUs to enable a higher positive response rate and therefore greater potential to be selected / tender for more studies to grow our activity and with this our income generation (actual and potential).

Analysis of Outcome EOI's - Reason for Decline

	1 - No Suitable PI	2 - Lack of clinical staff capacity	3 - Lack of research staff capacity	4 - Lack of eligible patients	5 - Competing studies	6 - Facilities / Equipment	7 - Issues with Trial Design / Protocol	8 - No PI interest	9 - No Response	a11- Withdrawn by sponsor - prior to response	P - Positive
2021/2022 Y2D	4	12	5	37	5	11	3	19	99	1	46
2020/2021	1	22	35	31		5	24	11	150	4	56
2019/2020	31	30	3	40	3	8	11	12	154	2	64

3.6: NIHR SWP: CRN portfolio recruitment figures: Benchmarking against other Regional Trusts

The graph below benchmarks Torbay with our regional partner organisations as part of the SWP: CRN.

Participant Recruitment CRN South West Peninsula: Activity

Recruitment by Partner Organisation
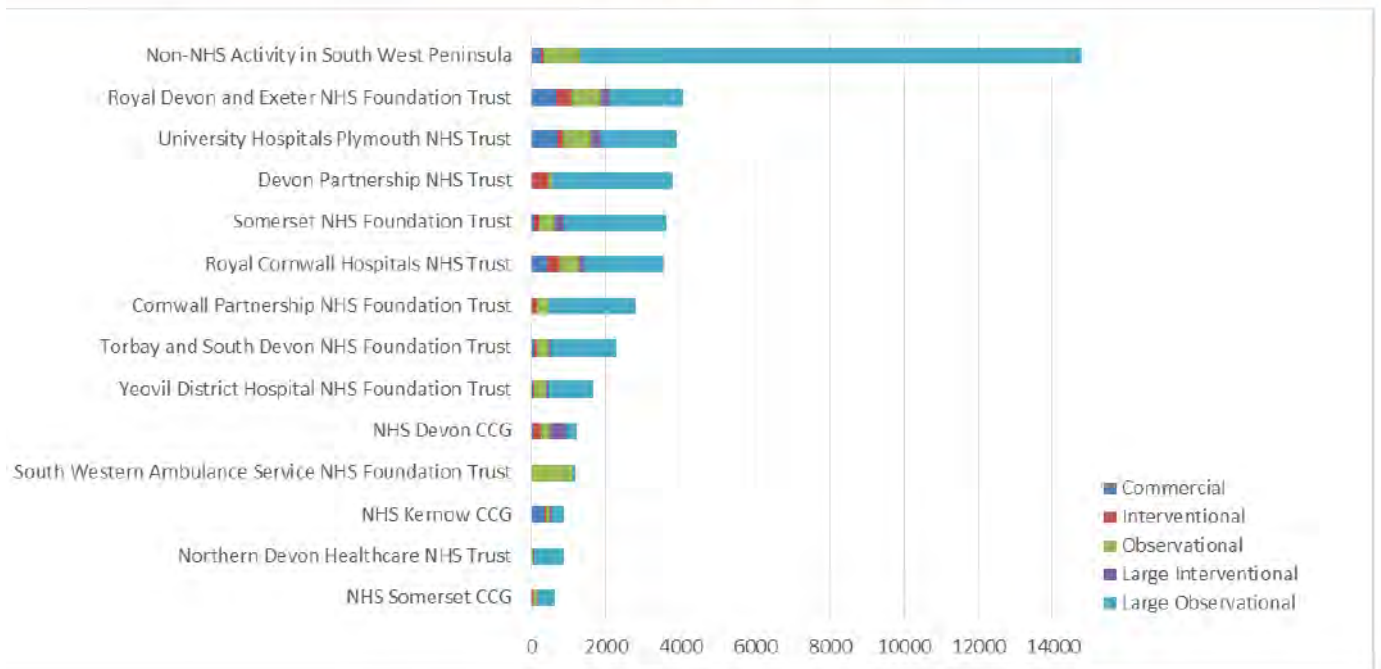
3.7: NIHR portfolio recruitment figures: National benchmarking against other Trusts of a similar size

A type of national NIHR benchmarking is against Trusts of a similar size in England (population outpatient attendances). The graphs below show where Torbay sits against the next nearest 10 similar sized organisations: Torbay rank 4th best in class overall, but 2nd in class for commercial studies

Graph 1: All NIHR activity

Benchmarking

See how your research activity compares to 10 organisations in the same category (acute, care, CCG etc).
Attendance (trusts) or population (CCGs) is used as a proxy for measuring similarity.
The charts show the most similar organisations at the top, with similarity decreasing down the chart.
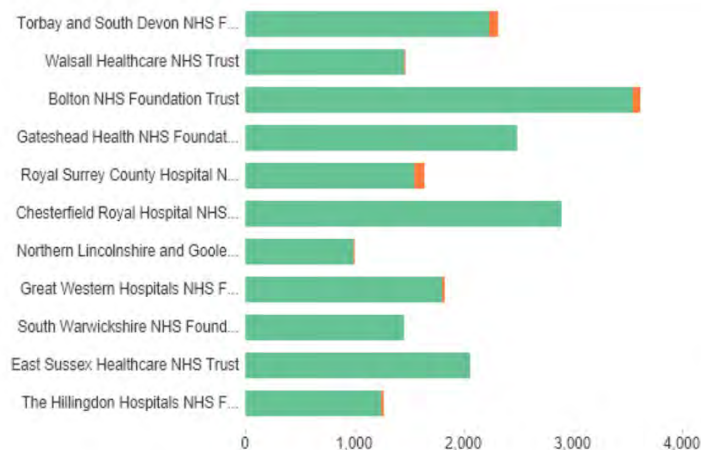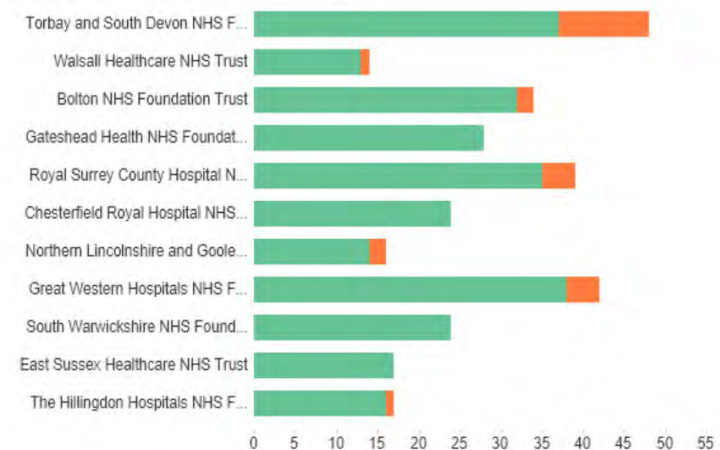
Average set-up time (days) per recruiting site in 2020/21

Please note, values have been grouped rather than stacked as this chart shows averages
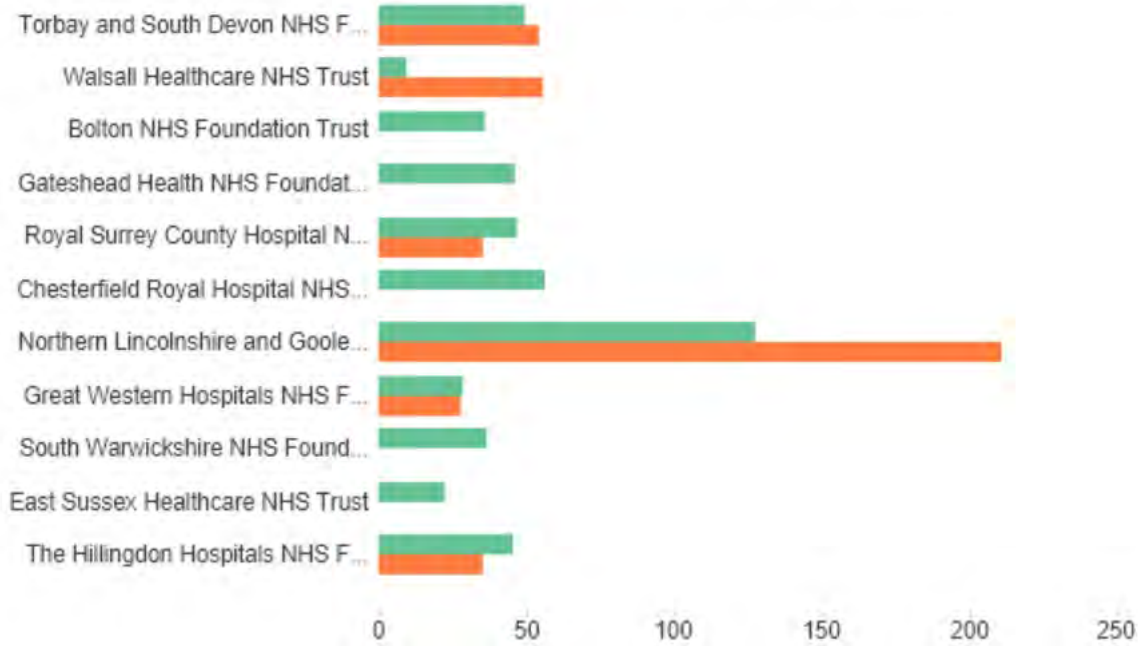
Graph 2: Commercial NIHR activity
Recruitment in 2020/21
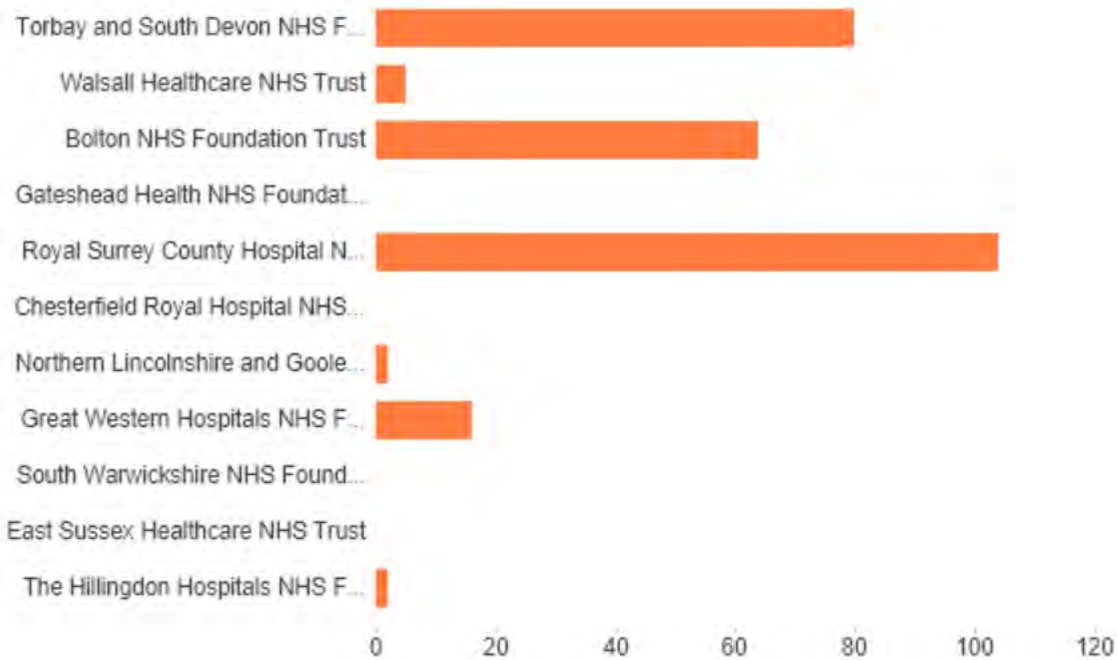
4.0 Sponsored / Trust led activity and Research Grants:

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

Project Title	Applicant	Amount Awarded
Provision of a daily high protein and high energy meal: effects on the physical and psychological wellbeing of community-dwelling malnourished elderly adults	Prof. Bowtell UoE Elizabeth Wardle (TSDFT)	£100,914
Understanding the high numbers of children in statutory care in Torbay: an engaged approach to supporting families and communities	Dr Thomas (University of Exeter) with Torbay Public Health team / Children Services	£208,619
Building a Brighter Future (BBF) bid 'An investigation of the role of the Torbay and South Devon NHS Foundation Trust New Hospital Programme in supporting the continued integration of person-centred care whilst not increasing the number of inpatient beds currently provided at Torbay Hospital'.	Dr Joanne Watson (In collaboration with UoP)	Not approved. Asked to amend and re submit
A study to explore the implementation of the Enhanced Health in Care Homes framework in eight care homes in Torbay and South Devon	Dr Susie Peace (UoP) / Torbay Clinical School	£71,797
PEER CONNECT: A feasibility randomised controlled trial of a targeted peer coaching service for outpatients with long-term conditions.	Dr Agne Straukeine and Helen Davies Cox	£125,975

N.B TMRF did not meet for most of 2020 which compromised applications for research grants during this period.

4.2: National NIHR grant application - collaborative bid with University of Plymouth

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

- Establishment of the Peninsula Adult Social Care Research Collaborative (PARC) - submitted a £2.5M grant proposal in response to a NIHR Social Care commissioned call: Successful stage 1 application. Unsuccessful stage 2 application.
- A revised smaller and more focused application is being made in 21/22 – awaiting outcome.

5.0 Patient & Public Involvement (PPI)

5.1 NIHR CRN Patient Experience of Research Participation (PRES) 2020/21

The annual Patient Research Experience Survey (PRES) is mandated by the NIHR to help capture the experience of patients that have participated in research and organised locally through our SWP: CRN. The 2020/21 PRES was conducted across all partner organisations in

the region between 30th September 2020- 14th February 2021 and was an entirely digital survey; to reduce transmission and resource impacts. The results collated from all regions to give a national picture shows that the public want to be treated in research active organisations:

- 93% of participants felt valued by researchers for taking part in research.
- 98% said research staff have always treated them with courtesy and respect.
- 94% of participants said they would consider taking part in research again.
- 96% felt they received adequate information before they took part in the study.
- 89% said they had been kept updated during the study.

Covid has reinforced the public opinion and need for research.

- Locally – as part of the Valneva covid vaccine trial collaboration between Torbay and Derriford (with UHPT) during Summer 2021: Feedback via the NHS 'Friends and Family test' captured 148 respondents in the vaccine research clinics, 147 classed their experience as 'very good' and 1 classed it as 'good'. Participants commented on the professionalism and knowledge of the team and how enjoyable the research experience was.

5.2   Patient Research Ambassadors (PRAs)

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

- Elizabeth Welch; who is also a Trust Governor was appointed as Torbay's Patient Research Ambassador PRA (or sometimes known as Research Champions) in 2019. Elizabeth has helped support and promote research through her contacts as a governor and working with the R&D team. Whilst activity has been restricted during covid; as part of returning back to better / business as usual; our research champion will be returning and will help us with our 21/22 PRES, promote other campaigns and studies such as Join Dementia Research (JDR), International Clinical Trials Day (celebrated on May 20th each year); and talk to groups when asked for help.

- Our research champion has helped promote the 'Be Part of Research' NIHR campaign and offers her services to the recently formed Clinical Academic Forum Exchange (CAFÉ) where clinical academics meet and offer peer support. Our research champion has offered members of the CAFÉ a PPIE perspective on protocols and research materials prior to their submissions for approvals. The general feedback from the CAFÉ group is very positive with regards to this useful resource.

6.0   R&D Workforce:

- The R&D Department has approximately 44WTEs comprising of clinical delivery staff (registered and non-registered), A&C staff, as well as dedicated staff within the supporting services (labs, pharmacy and radiology). R&D is a small team of specialist trained staff to cover the many aspects of the R&D service and business; including: R&D management, research advice, regulatory affairs, information, finance, research governance and clinical trials delivery.

- The majority of staffing supports our primary business of hosting clinical trials. To expand academic and Trust led studies to apply for large national research grants would require additional capacity, skills and experience e.g. methodologists, statistics, governance etc.

- Our 12-month rolling turnover = 14.29% (Trust avg = 11.32%); with 42% full time workers and 21% over the age of 55 (Ref: October 2021 workforce report). We also currently have 3 staff on 12 months maternity leave, one of which the assistant manager and lead for research governance. We have not been able to get maternity cover in place which is limiting work in this area and currently being covered by the R&D Director / Head of R&D.

- As a small and specialist team; our main risks remain resilience and depth. With minimal staffing levels, alongside the time needed for training and gaining of specialist experience and skills required in a highly regulated environment, this makes cover for absences or shortages, let alone developing, growing and succession planning difficult. As a consequence, the R&D service is both fragile and vulnerable. Developing a 'bank' of research trained staff would help.

- Another significant issue is the need for more investigators: The lack of time and capacity for our Trust staff to get involved and become or remain investigators, to feel valued and incentivised is an increasing problem. Equally too there is an issue regarding a lack of parity and equity between medical and other clinical staff. There is a need for recognition of research activity in all job descriptions and job plans for all staff. The covid pandemic has reinforced this feeling and messaging more so. But the lack of funding, time and capacity in Job plans; means we are still too overly reliant on a few interest individuals trying to support the important research agenda in their own time. This 'good will' is being tested and is waning. This is a well-recognised and an increasingly significant risk area for R&D both at Torbay and across the UK. The messaging needs to change that research is core business and not an optional extra or add on; and we need to work together locally, regionally and nationally to address this historical but increasingly significant issue.

- The increasing lack of senior clinicians willing, able or interested in becoming investigators needed to support and lead clinical trials (needed as part of ethics and legal approvals) is resulting in R&D turning down new studies. With diminishing activity this leads to decreasing funding and unable to cover R&D costs. This places R&D staffing and infrastructure at further risk.

6.1.   Developing the research workforce and investigators of the future:

There are several schemes, nationally, regionally and locally to provide more opportunities to help develop a research ready, willing and able workforce. These opportunities and courses; working in partnership with the NHS, HEIs and the NIHR help with upskilling and enabling healthcare staff to get experience and exposure to research; increase their confidence and ability to engage in and become more research active. However once completing their training the unresolved issue remains: how to retain staff in the NHS and remain research active, to embed 'research into practice' through new roles, role models, job plans etc. More focus and work are needed in this area.

6.1.1: Regional / National NIHR CRN Clinical Speciality Leads:

In 20/21 the following Trust consultants were appointed to NIHR posts:

- Dr Kirsten Mackay – National Co- Clinical Speciality Lead for the Musculoskeletal portfolio
- Dr Kirsten Mackay – Regional Clinical Speciality Lead for the Musculoskeletal portfolio
- Dr Tom Clarke - Clinical Sub- Speciality Lead for the Anaesthetics portfolio (left Trust in Feb 2021)
- Dr Agne Straukeine Clinical Sub Speciality Lead for the Multiple Sclerosis portfolio

6.1.2: NIHR 70@70 Research Leader programme

Chris Dixon, Lead Research Nurse is one of 70 senior nurses and midwives from across the UK to be accepted onto the national scheme. This NIHR-funded three-year programme ends in March 2022 and was set up to champion research, innovate and drive improvements in future care. A summary of achievements include:

- Linking with the Torbay clinical school/HR to develop Clinical Academic Career Infrastructure for TSDFT.
- Cementing the CAFÉ as a permanent group.
- Ensuring the 70@70 legacy proposal has the philanthropic outcomes intended before the end of the 70@70 project in 2022.
- Embedding Research Event (Dec 2021) - to create attention on how we can embed research in nursing & midwifery practice: a strategic approach to improve patient care by investing in Nurses and Midwives to sustain excellence in care, attract new staff, retain existing staff and create the new clinical expert who blends a clinical and academic career but predominantly stays in the clinical arena.
- TMRF funding application Nov 21- "What are the barriers to 'Clinical academic' career progression for Nurses, Midwives and Allied Health Professionals and what are the barriers managers encounter in enabling 'clinical academic' career progression for their staff in Torbay & South Devon?".
- Helped to organise the Torbay and South Devon Clinical School Annual Conference

6.1.3: National Institute for Health Research (NIHR) and Council for Allied Health Professions Research (CAHPR) Champion:

Dr Richard Collings; a Trust Podiatrist, graduated this summer after completing his PhD part time at the University of Plymouth and funded by the NIHR. Richard is one of 13 NIHR Allied Health Profession (AHP) research champions; serving as ambassadors and to champion the research work of AHPs, encouraging more AHPs to be aware of and get involved in health and social care research and the work of the NIHR for the benefit of patients.

Chris and Richard continue to work tirelessly as research leaders. They are passionate and advocate that to modernise our research delivery service and raise the profile of clinical academic research amongst nurses, midwives and AHPs we need to 'blend 'academic roles into our R&D clinical delivery team and within the clinical services across our organisational footprint. This aligns well with the new 2021 UK Clinical Research Strategy (see section 11) and recognised as a national priority area to address the imbalance regarding numbers, access and opportunities for non-medics compared to medics and research.

6.1.4: The NIHR Associate PI Scheme

The NIHR's Associate Principal Investigator (PI) Scheme aims to develop junior doctors, nurses and allied health professionals to become the PIs of the future and provides formal recognition of a trainee's engagement in NIHR Portfolio research studies through the conferment of Associate PI status endorsed by the NIHR and the various professional Royal Colleges:

During 20/21, three Torbay staff (junior / middle grade medics) participated in this scheme and a further 2 staff (one medic and one nurse applying to be part of the scheme). We anticipate more staff will become part of this scheme as it expands to cover more clinical specialities and with the increased interest in research as a result of experiences during covid.

6.1.5: NIHR-Academy of Medical Royal Colleges (AoMRC) Clinician Researcher Credentials Framework: The University of Exeter is one of a few successful universities funded to develop and deliver the postgraduate courses.

Clinician Researcher development programmes are aimed at experienced clinicians who are new to research. to provide a range of practical, postgraduate / Master's level training. The Framework will help healthcare practitioners from any regulated profession (including medicine, nursing, midwifery, pharmacists, allied health professions, healthcare scientists and others) develop the skills required to work in clinical research delivery. The introduction of these credentials will increase the capacity for research across the workforce and enable the NHS to deliver high-quality clinical research in everyday clinical settings.

Professor Ramesh Arasaradnam, academic vice president of the Royal College of Physicians, said, *"The value of clinical research has been clearly demonstrated during the pandemic and more and more clinicians are keen to get involved, but many feel they lack the necessary skills. This qualification, and the wider researcher credentials framework, is key to bridging that gap. Ultimately this will mean more clinicians are able to contribute positively to research, which brings benefits to patients in ordinary as well as extraordinary times, through better services and outcomes."*

To maximise these development and outcomes this needs to translate into changes at Trust level too, to facilitate and accommodate the upskilled staff to continue and able to incorporate research into their jobs.

6.1.6: National awards / grants: NIHR / HEE Fellowships / Internships:

Year	Grant	Details	Progress / Status
2017/18	£270,033	Dr Richard Collings, podiatrist: NIHR Clinical Fellowship awarded to undertake a part time PhD with the University of Plymouth, entitled: 'Reducing Foot Plantar Pressure (ReFPres) in people with diabetes using an instant insole solution: a mixed methods pilot study'.	Completed part time PhD and graduated in Summer 2021
2018/19	£319,952	Rachel Rapson, Physiotherapist: NIHR Clinical Fellowship to study for a part time PhD part time with the University of Plymouth looking at 'A novel interactive dynamic training device to improve walking ability and quality of life for children with cerebral palsy: A mixed methods study'.	Paused due to covid. Restarted in 2021. Study design has had to be modified to enable the study to progress.
2020/21	£9,906	Justine Tansley, Podiatrist HEE/NIHR ICA PCAF Pre-doctoral Clinical Academic Internship 2020 - with University of Plymouth. Funding for 6 months starting September 2020.	Completed. Successful application for a Fellowship – see below
2021/22	£53, 390	Justine Tansley, Podiatrist HEE/NIHR ICA PCAF: Pre-doctoral Clinical Academic Fellowship 2021 - with University of Plymouth.	Awarded: 12 months starting October 2021.

6.1.7: NIHR regional CRN Fellowships / 70@70 Research Associate / internships

To compliment the NIHR/HEE awards, our Local Clinical Research Network also provides some funding to clinical staff to spend up to one day per week for 6 or 12 months. It is recognised that, for some individuals, embarking on formal academic training may feel daunting and there are some staff who are interested in research delivery but are reluctant to move away from their clinical work. The Research Internship provides a unique opportunity for clinical and research skills to complement each other and may act as a springboard for the postholder to develop the confidence to pursue further research and academic training.

Staff work alongside R&D staff and the Torbay Clinical School to upskill and expose staff to running of clinical trials by supporting the delivery of current portfolio studies. In addition; offering coaching, mentorship and support to help develop training and skills for academic research careers or putting research into practice; supporting investigators of the future.

2020/21:

- Rebecca Stride (CT Radiographer): 1 day a week for 12 months - October 2020- October 2021
- Angela Foulds, research nurse 1-day a week for 2 years - Sept 1st 2020-August 31st 2022.
- Abi McWhinney (Community midwife): 1 day a week for 6 months – October 2020-March 2021

2021/22:

- Rebecca Stride (CT Radiographer): 0.3WTE for 12 months - October 2021- October 2022
- James Bruce (Occupational Therapist from ICU): 0.2 WTE for 6 months Oct 21-March 22
- Joan Redome (Research Nurse): 0.2 WTE for 6 months Oct 21-March 22

6.1.8: Torbay Clinical Schools

R&D aims to develop a stronger clinical academic pathway within the Trust and build on our track record of success in supporting staff with applications for CRN Research fellowships, HEE/NIHR Integrated Clinical Academic Pre-doctoral and Doctoral awards.

The Trust has close relationships with both the universities of Exeter and Plymouth and, with the launch of the Torbay Clinical School in 2018, there is a strong academic presence in the organisation to support local clinical academics. The aspirations of the Research and Development Department is to provide opportunities for clinical staff across the Trust to kick-start a blended clinical and academic career. The aims of these post are to:

➢ promote and foster closer working relationships between the clinical service and the Research and Development (R&D) department
➢ increase the profile of research in the clinical service: supporting clinicians to develop as Principal Investigators (PIs) and embed clinical trials into their services
➢ embed NIHR and 'good clinical research' practice in the clinical area
➢ improve the adoption and implementation of the evidence into clinical practice
➢ provide career opportunities for staff to become involved in research
➢ demonstrate the organisational benefits of a 'blended post' as a means of attracting, developing and retaining staff

6.1.9: Trust / UoP Clinical Schools / TMRF Fellowship programme:

- As an organisation we are very lucky to be able to collaborate with the local charity the Torbay Medical Research Fund (TMRF) and the Torbay Clinical School (Professor Mary Hickson &

Professor Susie Pearce), Plymouth University. In partnership with the Trust; funding has been secured to support three doctoral and three pre-doctoral fellowships for nurses, midwives and allied health professionals. An application to extend this scheme will be made to the TMRF in November 2021.

- The scheme focuses specifically on nurses and allied health professions because developing research capability within these professional groups is a national priority and the value of supporting this goal locally is seen as highly beneficial.

- The scheme aims to increase local opportunities for staff to compliment the CRN, NIHR, HEE programmes to develop talented staff to be the clinical academics or senior clinical leaders of the future with research training and expertise integral to their roles to lead on and support research in action, quality and improvement.

- The availability of these fellowships has been notable in providing a powerful message to Trust staff that research and education is valued and supported, underpinning and pivotal to providing high quality clinical care. This has encouraged staff to have the ambition to work towards these higher academic qualifications. Ultimately, this will attract and retain high quality staff to the Trust by providing alternative, challenging career pathways and in turn will contribute to the delivery of excellent and innovative care to the people of Torbay and South Devon.

Fellowship awardees for the Torbay Research Fellowship Scheme and areas of their research:

Year	Award	Awardee	Topic area
2019	Pre-doctoral	Harriet Hughes Physiotherapist	Improving mobility in children with cerebral palsy
	Doctoral	Kathryn Bamforth Physiotherapist	The WELLBEING Study: Exploring the psychological wellbeing of healthcare professionals
2020	Doctoral	Corinne Lyndsey Nurse	The importance of nursing culture for patient care
2021	Doctoral	Harriet Hughes Physiotherapist	Improving mobility in children with cerebral palsy
	Pre-doctoral	Vanessa Kavanagh Podiatrist	Improving outcomes after bunion surgery
	Pre-doctoral	Stephanie Janka-Spurlock Nurse	Improving dementia care in care settings

6.1.10: Clinical Academic Research Exchange (CAFÉ):

- Studying at postgraduate level and simultaneously working clinically is challenging and stimulating but it can also be a lonely experience. A key part of developing as a clinical academic is becoming an independent learner, however, this does not mean it has to happen in isolation. With the above initiatives growing there are a growing number of clinical academics across the Trust studying at a variety of post-graduate levels.

- With a few early pioneers as PhD students and research advocates, Kathryn Bamforth & Richard Collings started to meet with fellow clinicians enrolled on academic programmes to share experiences. As part of Chris Dixon's 70@70 National Research leader role, the Clinical Academic Forum and Exchange (CAFÉ) was formerly established and now meets monthly aiming to:

    o Create a regular central place for clinical academics to meet informally
    o Provide peer support, advice and guidance

- o Provide education on research and research processes.
- o Raise the profile of research across the organisation

- There are approximately 20 clinicians on the distribution list. A diverse range of staff from non-medical clinical backgrounds and with academic interests ranging from Masters to Post-Doctoral Students. Through their work and endeavours through the Clinical School, the following staff have been awarded honorary research contracts with the University of Plymouth:

With the School of Health Professions, they are:

Claire Morgan	Research Associate
Justine Tansley	Research Associate
Becky Stride	Research Associate
Sarah Pavior	Research Associate
Harriet Hughes	Research Associate
Jen Williams	Research Associate
Richard Collings	Research Fellow
Rachel Rapson	Research Fellow

And from the School of Nursing and Midwifery:

Angie Foulds	Research Associate
Abi McWhinney	Research Associate
Kathryn Bamforth	Research Fellow
Corinne Lindsey	Research Fellow
Chris Dixon	Research Fellow

7.0   Clinical Trials Unit (Jubilee Research Unit - JRU)

- During covid, JRU was relocated twice. Initially moved out completely from old Elizabeth ward and for a time R&D had no facilities at all. R&D was then successful in securing space on Level 2 Outpatients. JRU was then relocated again at short notice to accommodate the Level 2 / MRU building works. JRU is now based in Crowthorne.

- We secured £10K capital funding from the Government's Vaccine Task Force (VTF) funding to cover essential refurbishment works (partly completed / ongoing). To create extra clinic space and make the area more fit for purpose. In addition, the VTF provided further funding to lease a portacabin, which sits just outside of Crowthorne to compliment our clinic spaces - essential for covid research trials.

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

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

8.0 Information: and Communications:

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

8.1: Torbay deprivation study

During 20/21 we were commissioned by the Local CRN to pilot a study linking research recruitment data to postcodes and deprivation data. Mia Jones our Information and Finance Officer led the programme. This was presented to the NIHR and Dr William Van't Hoff the new NIHR CEO; as this is increasingly a higher priority to increase better access to research through the Equality, Diversity and Inclusion (EDI) campaigns. The NIHR now wants to roll out across to other regions / Trusts.

8.2: ISU and QIG Summary Research Reports / Dashboards:

- Historically research has been undertaken and driven by interested individuals and the level of engagement from peers and colleagues is very variable across specialties. ISU reports are part of the R&D strategy to raise awareness and increase visibility to help influence and shift organisational ethos and culture. It is important research is driven at ISU level and not by a few interest individuals, to help research become more 'normal'; embedded and seen as part of core NHS business and everyone's responsibility.

- Following pilots with Moor to Sea and Torbay ISUs; effective from April 2021; monthly ISU research summary reports are issued by R&D to each ISU and also provided to QIG as part of the ISUs reporting responsibilities. The aim is to routinely include research as an agenda item at the governance meetings and to review the data and dashboards and create wider conversations which aim to:

  - Showcase and measure clinical research activity within the ISU
  - Show 'Impact & Value' of published research, any wider savings or if the research results could change practice
  - To identify and help overcome blocks, capacity & capability issues to undertake research
  - To identify and talent spot potential future academic researchers / encourage more investigators
  - To share funding opportunities & encourage research equity, facilitation and awareness across the ISU
  - To grow research activity and increase income and savings through research
  - Improve resilience and sustainability

- This is an evolving and iterative process and we will continue to respond to feedback to help improve the visibility and usefulness of research data for our ISUs. This has stimulated new and increasing conversations and dialogs between teams and R&D which is a great step forward and improvement.

- We have further planned to link the research data, working with information colleagues to use 'Tableau' for better visual reporting to help integrate into Trust reporting systems and processes. In addition, we aim to up load reports on to a revamped and new intranet page;

hopefully by next year; where staff can see summary reports as well as able to drill down and interrogate research activity, performance and data at a more granular level.

9.0. **Finance:**

- R&D has been commissioned separately to patient care services since mid-1990. DHSC deliberately created ring fenced and separate R&D budgets to protect and ensure research continued in the NHS. R&D's primary source of income comes from our commissioners (NIHR CRN). The other key source of funding comes from our clinical trial contracts; especially commercial trials. Over the years our Core CRN funding has decreased from circa £1.2M down to £800K pa; despite increasing activity and good performance; due to the peculiarities of the national competitive funding models; drawing funding back to the bigger centres over time. Feedback is that the models and CRN contracts are no longer fit for purpose. However, in the interim; as a consequence, R&D has had to become more reliant on more commercial trials to subsidise this decrease in CRN funding. We have to hope new CRN funding contracts from 23/24 are based on new funding models.

- In 20/21 the Trust received the same core budget from the NIHR CRN as in 2019/20. However new funds were made available during the pandemic primarily through the Governments Vaccine Task Force (VTF) to ensure all NHS sites were ready to support covid / vaccine trials especially. The investments would also provide infrastructure to support future research studies.

- This additional funding supported:

    o Additional staff – though bank, ad hoc / extra hours, temporary extension to current staff contracted hours, new fixed term contracts – to provide the extra capacity needed to support the covid studies / vaccine trials especially.
    o 12 months - lease hire of a portacabin – required to manage any patients as part of UPH covid symptomatic trial pathways / assessments.
    o Procurements of equipment: 2 x -70 freezers and -20 freezers, fridges, centrifuge, refrigerated centrifuge, temperature probes, protective aprons, gloves and googles, laptops and iPads etc.

- The Trust received a small increase in core CRN funding for 21/22, and again additional contingency funding has also been made available in year to help with the recovery of research activity.

- The graph below summarises the R&D income streams over the years (N.B. excludes research grants / fellowship awards etc).
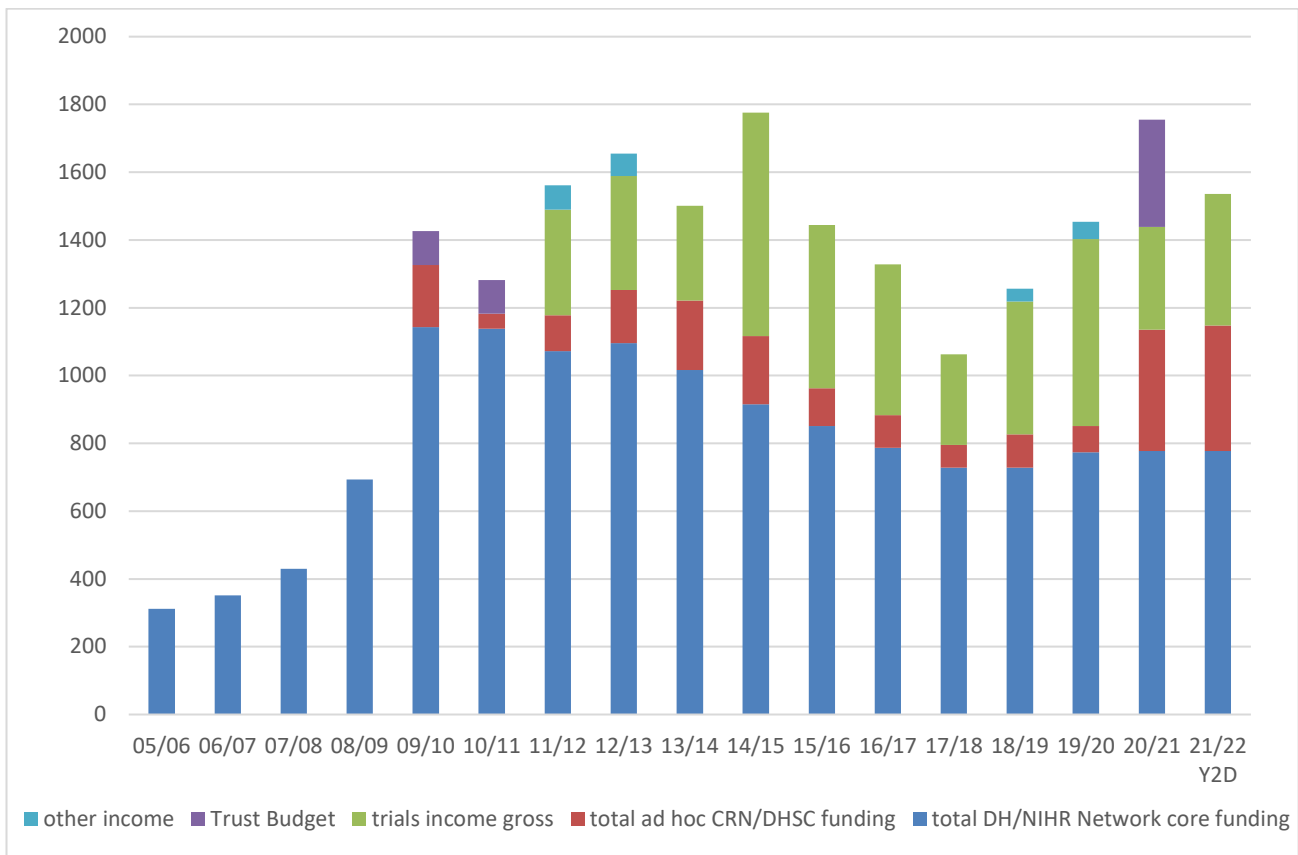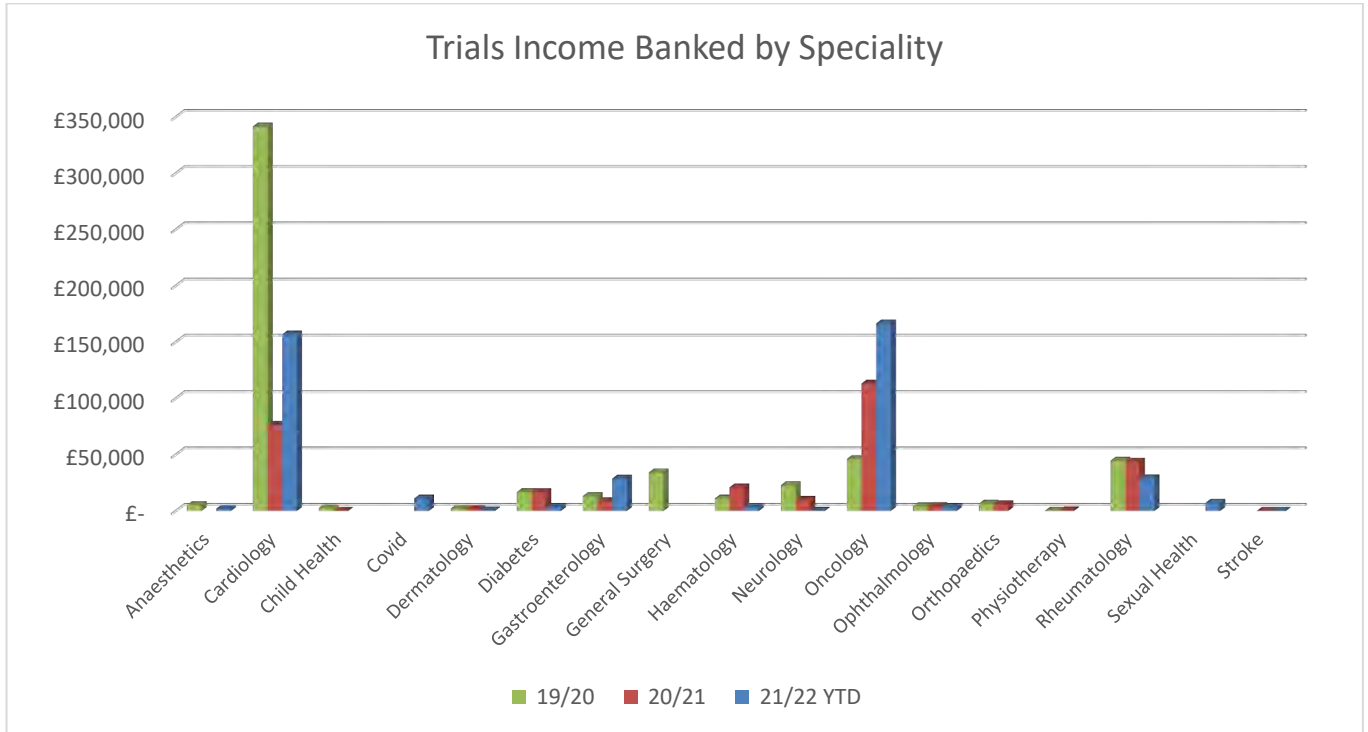
- R&D income was impacted significantly by covid as we had to pause most of our non covid research. The graph below shows total gross trials income was reduced by approx. 45% compared to 2019/20. The income in 21/22 is higher primarily due to the significant increase in commercial activity within oncology and that they were able to continue to recruit to studies during covid.
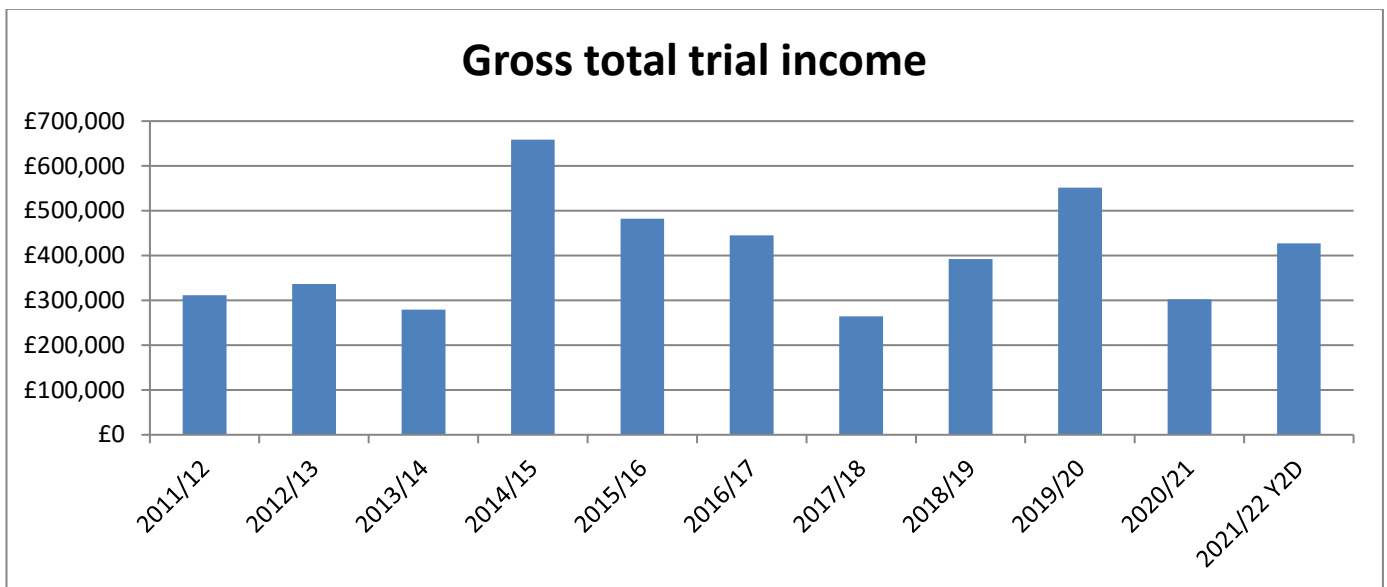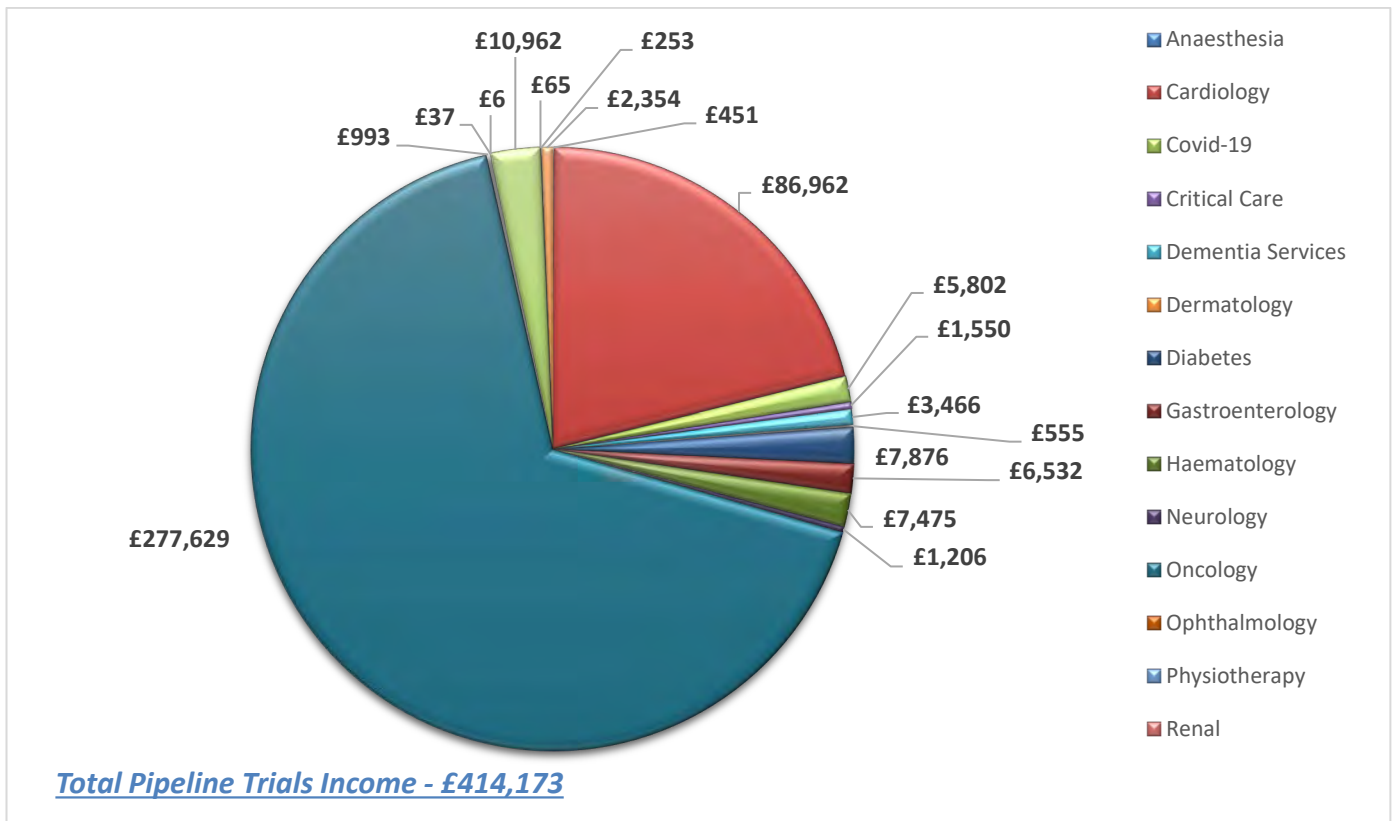

- Below splits out the distribution of income generation over the past few years and show oncology's increase in commercial activity; taking over as the primary income generator from Cardiology which was limited in 20/21. These are the 2 main income generating commercially active specialities. However; Cardiology is at significant risk due to the primary research consultant retiring in September 2022. To date we are struggling to put in place a viable succession plan and as a consequence cardiology are turning down studies, reducing their activity. In addition, some of the patient pathways have changed e.g. in Heart Failure (HF)

patients and lucrative HF studies now going to primary care as a result. The loss of this income stream will be significant to R&D overall.

- We need to increase commercial trials activity and in other specialities to mitigate this loss and there is a pipeline of studies we are turning down. The primary reason is no funding, time or capacity for Consultants in Job plans. R&D will continue to work with and lobby to try to find mutually viable ways forward to address the issue locally, regionally and nationally.

Trials Income Banked by Speciality (bar chart showing income by speciality for 19/20, 20/21, 21/22 YTD)

The graph below shows our income pipeline. This is income for activity undertaken to date but as yet payments not been made. Again, this is primarily oncology and cardiology.

Pie chart of pipeline trials income by speciality: £277,629; £86,962; £10,962; £253; £6; £65; £2,354; £451; £37; £993; £5,802; £1,550; £3,466; £555; £7,876; £6,532; £7,475; £1,206. Legend: Anaesthesia, Cardiology, Covid-19, Critical Care, Dementia Services, Dermatology, Diabetes, Gastroenterology, Haematology, Neurology, Oncology, Ophthalmology, Physiotherapy, Renal.

Total Pipeline Trials Income - £414,173

- During 20/21 our losses were mitigated through the Covid budget arrangements put in place to cover:

    o Costs of the SIREN study (Public Health England) – testing staff every 2-4 weeks both swabs and bloods, evaluating immunity levels etc. (new funding arrangements in 21/22)
    o To help R&D Departments reach a breakeven year end position. The financial impact and risk to research was significant due to loss of activity and as a consequence loss of research income and grants during covid. This was to avoid destabilisation and putting staff at risk.
    o Whilst these arrangements for 20/21 were welcome, they are not available in 21/22.

- Whilst we are opening up new studies, we are still in a managed recovery process and as a consequence with continued reduced activity, financial recovery will take longer. We will need to address the imbalance between what we can earn and what we need to earn, thus improving the financial sustainability of the service and staff on site. However, recovery of business is expected to take at least 2 years and therefore we are expecting to make losses in 21/22 and to continue into 22/23 at least.

- Also, recovery post covid will be predicated on staff having the time and capacity; having a more inclusive and engaged community to sustain improvements as well as capacity in our services and support departments (e.g. MRI capacity etc). All these factors are not within R&D's gift. If activity cannot be recovered sufficiently, more quickly, then a financial recovery plan will need to be put in place to reduce costs / mitigate the financial risks. This will mean reducing the workforce and the level of activity we can support. This is risk.

- Nationally all NHS R&D Departments have raised concerns regarding the impact of covid. With the stopping of 80-90% of research activity, whilst the NIHR contract, as Government funding has continued; the trials income has significantly reduced by circa 50% during 20/21 with reduced income still during recovery in 21/22 and 22/23 expected.

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

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

For each patient recruited onto a commercial clinical trial, on average, the NHS in England:

Period 2016/17 to 2018/19:

received £9,189 from life sciences companies

saved £5,813
This is the estimated pharmaceutical cost-saving for each patient recruited into a commercial study, where a trial drug replaced the standard of care treatment

- In recognition of savings through research, since 2019, the STP / SCG as a pilot agreed to invest £250K pa; to support an increase in radiotherapy trials and awarded each radiotherapy centre in the region £51K. To date the overall response by all organisations has shown this investment has provided significant savings to the system over and above this investment through reduced RT fractions etc associated with RT clinical trials activity.

- This was the first-time commissioners invested in research recognising system savings alongside enhancing quality of care. This has helped us to employ a research radiographer, increase our RT trials; support training and quality assurance to enable commissioning of new SABRE technology; building on and enabling the new technology advancements and capabilities we now have through our new linear accelerators. See Appendix 1 for more details.

- This funding is due to end in March 2022. With the creation of the ICS' we need to 'start the conversations' again and currently there is great uncertainty if the funding will continue. We will continue to lobby for not only this funding to continue but also the need for more sustained wider and new investment from NHSE on the back of added value, the benefits and system wide savings through research.

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

CRN SWP Research Awards 2021 –TSDFT Shortlist

The table below details to 29 nominations for TSDFT across the 3 eligible categories. All are local Heroes and will be celebrated later in November by the SWP: CRN. One from each category has been put forward for the regional award, to be presented at a Virtual Awards Ceremony in December.

AWARD CATEGORY: Going the Extra Mile	AWARD CATEGORY: Outstanding Research Delivery Team
1. Sharon Criddle - Research Nurse: 2. Lou Anning - Respiratory Consultant: 3. Rebecca Stride - Research Radiographer: 4. Liz Florey - ED consultant: 5. Mia Jones - Information and Finance Officer: 6. Deborah Brierley - Research Bank Nurse: 7. Michelle O'Neill - Research Bank Nurse: 8. Catherine Marshall - Research Assistant Practitioner: 9. Shelley Chamberlain - Research Assistant Practitioner: 10. Fiona Roberts: R&D Director	1. Research Team Leaders: 2. All research staff: 3. Torbay Clinical School: 4. Oncology Research Team: 5. Joanne Holman and Alison Cornwell (ICU Research Team) 6. Cardiac Research Team: 7. TSDFT / UHPNT collaboration **AWARD CATEGORY: Outstanding Research Support Team** 1. Bank team supporting SIREN 2. Nurse and Doctor team - Prominent Study: 3. R&D Clinical Trials Co-ordinating Team:

11. Matt Halkes - Consultant anaesthetist:	4. Generic Research Team:
12. Adam Revel - Consultant anaesthetist:	5. Research Admin team:
13. John Buckley - oncology research team lead.	6. Research pharmacy team (x2 nominations):
14. Sarah Knight - R&D Assistant Manager:	7. Pathology Research Team:
15. Chris Dixon – Lead Research Nurse	

Appendix 1 summarises some further good news stories and provides examples of and a flavour of the Trusts research activity and performance

Appendix 2 summarises examples of impacts and outcomes from research activity and studies the Trust are or have been involved in and recently reported on. These provide a flavour of how research has informed the evidence base and influenced quality improvements, clinical care and services.

11.0: Research & Development forward look: What's next?

- As we return to normality, building back better; bolstering the delivery of clinical research across all phases, all treatment types and all conditions offers a precious opportunity to improve patient care and address health inequalities – all while stimulating economic growth right across the UK.

- In March 2021, the UK government released a report outlining a vision for the future of clinical research delivery. Shaped by the significant contribution of research during the Covid 19 pandemic, 'Saving and Improving lives: The Future of UK Clinical Research Delivery' calls for a more inclusive, patient-focused research ethic within the NHS, with a particular focus on data-driven research enabled by digital tools.

https://www.gov.uk/government/publications/the-future-of-uk-clinical-research-delivery#:~:text=The%20future%20of%20clinical%20research,capitalise%20on%20cutting%2Dedge%20innovations

- The pandemic has showcased the clear link between research and better outcomes – for individuals and the NHS.
    - *'research is the single most important way in which we improve our healthcare – by identifying new means to prevent, diagnose and treat disease'.*
    - *This means '**embedding** clinical research at the heart of patient care across the NHS, making participation as easy as possible and ensuring all health and care staff feel empowered to support research'.*

- The focus and priority moving forward is the pursuit of a new common goal – to create a clinical research delivery ecosystem which will shape the future of healthcare and improve people's lives for years to come; within the context of an emerging health and social care system not previously known and changing frequently within a new challenging operating environment. We need to plan how we work together over the next phases and it is imperative R&D is no longer viewed or seen as an optional extra.

- Through this strategy and by bringing together all relevant stakeholder to create a new UK wide cross sector co-ordinated programme of work; to create a clinical research ecosystem which is more efficient, more resilient and more effective than ever before.

Programme delivery partners

- The key to enablers identified in the new policy / strategy is how successful NHS Trusts at Board level and all the other stakeholders (regionally and nationally) embrace the strategy and ensure alignment of policies, implementation plans etc.
  - Pursuit of a new common goal – to create a clinical research delivery ecosystem which will shape the future of healthcare and improve people's lives for years to come.
  - New funds are needed to address the lack of time and capacity in job plans, as well as other issues.

- The report identifies 5 key themes for developing the future best practice of clinical research delivery:

  1. **Streamlined, efficient and innovative research** – so the UK is seen as one of the best places in the world to conduct fast, efficient and cutting-edge clinical research;
  2. **Clinical research embedded in the NHS** – to create a research-positive culture in which all health and care staff feel empowered to support and participate in clinical research as part of their job;
  3. **Patient-centred research** – to make access to, and participation in, research as easy as possible for everyone across the UK, including rural, diverse and under-served populations;
  4. **Research enabled by data and digital tools** – to ensure the UK has the most advanced and data-enabled clinical research environment in the world, which capitalises on our unique data assets to improve the health and care of patients across the UK and beyond; and
  5. **A sustainable and supported research workforce** – which offers rewarding opportunities and exciting careers for all healthcare and research staff of all professional backgrounds – across the length and breadth of commercial and non-commercial research.

- The plan is part of a wider government drive to support clinical research and life sciences:
  - Building upon existing commitments and priorities set out in the NHS Long Term Plan, the Life Science Sector Deals,
  - Inclusion into CQC inspections
  - Aligning plans for clinical research with wider government strategies to ensure the UK is at the forefront of health innovation,
  - By breaking down barriers to support research across the UK the plan will complement other initiatives to unlock the power of data to drive research. This

includes those set out in the UK's [National Data Strategy](#) (NDS) published in September 2020, the draft [Data Strategy for Health and Social Care](#) for England
  o Inclusion into the new ICS Design Framework <u>if research is not part of the language of our regulators for our organisations and systems we will perpetuate the divide between care and the evaluation of best care (research).</u>

- Taking these steps in delivering the plan will need the ongoing participation of everyone across the sector. By working together, we can begin to turn the vision into a reality – creating a clinical research ecosystem which capitalises on innovation, is resilient in the face of future healthcare crises and offers fresh hope for patients right across the country.

- R&D is well placed through national and regional roles linking into strategic planning and delivery for 21/22 and into 22/23, as well as incorporating and linking into key Trust agendas:
- Building a Brighter Future (BBF):
  o Digital Strategy including EHR and increase in digital / AI trials etc.
  o New Health and Care strategy
- Updated Clinical Governance Framework
- New Trust Organisational strategy
- New Trust Quality Improvement Strategy

Appendix 1: Examples of good news stories / commendations for research at Torbay:

Cardiology Research Team (Dr Keeling PI): SELECT study Semaglutide effects on cardiovascular outcomes in people with overweight or obesity.

- The first UK site to reach 50 randomised patients
- 'On behalf of everyone here in Novo Nordisk, I would like to congratulate you all on reaching this fantastic milestone and thank you for the exceptional work and dedication you have all put into this study so far, your contribution has made a significant difference to the success of this trial, and you and your team are a real inspiration to all of us as well as the other clinical sites taking part in the study'.

Oncology Research Team (Dr Anna Lydon PI): MSD. MK-3475-992 study: A Phase 3, Randomized, Double-blind, Placebo-controlled Clinical Trial to Study the Efficacy and Safety of Pembrolizumab (MK-3475) in Combination with Chemoradiotherapy (CRT) versus CRT Alone in Participants with Muscle-invasive Bladder Cancer (MIBC) (KEYNOTE-992

- 1st patient recruited to the trial in the UK.

Oncology Research Team – (Oct 21): second-highest recruiter to commercial drug studies across the South West.

Staff Bulletin June 8th 2020: Research and Development

'Shout out for the Research and Development team who have managed to do really well in their recruitment this year in spite of significant challenges. Then, on top of that, they are right at the forefront of enrolling in trials relating to Covid-19. The Torbay R&D team has enrolled in the second highest number of research studies for Covid-19 in the South west and has new studies in its sights. Although we are a relatively small centre, the chances of a Covid-19 patient being recruited to a research study is higher in Torbay than anywhere in the peninsula. So, we are really doing our bit to increase the learning about Covid-19 and to give our patients opportunities to test new drugs.
This is down to the energy and enthusiasm of the team led by Fiona Roberts and Chris Dixon, now with some help from Dr Matt Halkes. It is also entirely dependent on the willingness of already very busy clinicians to act as investigators and to recruit patients. We should thank all of our staff involved in these studies. A special thanks to the COVID research team of nurses, AHPs and administrators, Dr Tom Clark, Dr Louise Anning and the respiratory team. This has been a fantastic effort and means we will continue to deliver on this Urgent Public Health Agenda.
Keep it up team!'
Rob Dyer, Medical Director

Staff Bulletin October 28th 2021: Research and Development

Successful collaboration for Valneva vaccine study

The collaboration between our research team and University Hospitals Plymouth's research team has delivered the highest UK recruitment into the national Valneva (VLA2001) COVID-19 vaccine study, surpassing our target and giving 268 local residents the chance to be involved in this crucial study which has found Valneva to be a safe and effective vaccine.
Both teams worked together to identify potential participant groups and recruit. We pre-screened potential participants over the phone to ensure that we provided a high quality, fast service on clinic days.
Participants were recruited from both areas, meaning that our communities had the opportunity to access the trial. The collaboration also included members of the CRN CST team supporting work in clinics. Participants had an overwhelmingly positive research experience and out of 148 participants, feedback collected by the NHS 'Friends and Family test' reported that 147 classed

their experience as 'very good', and 1 classed it as 'good'. People commented on the professionalism and knowledge of the team and how enjoyable the research experience was. The collaboration with another trust made this study possible, and it gave valuable research and leadership experience to nurses and doctors. Feedback from individual team members is that this was a really enjoyable and worthwhile project which helped develop skills clinically and in teamwork. It paves the way for future collaborations with University Hospitals Plymouth.

Dr Louise Anning said: "It is fantastic to see the results from this national vaccine study that Torbay and South Devon and Plymouth collaborated on, showing that Valneva is both effective and safe. The more options available for vaccination the better to help us find a way out of the pandemic. It was a pleasure to work jointly with Plymouth and it really showed what can be achieved with teamwork across sites. Thank you to all the staff involved and, of course, to the patients who volunteered to participate in the study."

ALL STAFF: ICONews Monday 1 February 2021: Research update

Rebecca Stride is a CT radiographer and recently became a 70@70 Research Associate in October 2020. Rebecca is seconded one day a week to gain experience in research whilst continuing to work in clinical practice.

With this scheme, there is regular support from a Research Supervisor and Academic Mentor and Rebecca was recently successful in gaining funding from Health Education England South West to study a Post Graduate Certificate (PGCert) in CT (Computerised Tomography) Scanning at the University of the West of England (UWE). Rebecca would like to develop a career in Clinical Academia, maintaining her clinical role in CT as well as pursuing education and training for colleagues and encouraging their participation in research. Rebecca hopes to complete her PGCert and progress ultimately to undertaking a doctorate.

Rebecca says: "Encouraging staff to get involved in research ensures that our practice is up-to-date, and evidence based. It is widely acknowledged that departments that are active in research have better patient care outcomes. Without the support of my manager, mentor and supervisor provided through the 70@70 Research Associateship, I do not think I would have been successful in my PGCert in CT application, and it gives me great pleasure to let them know that their efforts and investment in me is being rewarded".

Radiotherapy research trial aims to improve cancer treatment for local patients

(February 2021)

A pioneering research trial for cancer patients in Torbay and South Devon could lead to improved cancer treatments for local people.

Torbay and South Devon NHS Foundation Trust's Oncology Research and Development department will soon be opening the pioneering Radiotherapy trial PACE. This makes the Trust the first site in the South West Peninsula to open the trial.

The PACE trial is a pioneering study that involves the use of stereotactic ablative radiotherapy (SABR) to treat prostate cancer patients. SABR is a new technique that will allows Radiotherapy departments to deliver more focused, higher dosed radiotherapy over a smaller number of visits. It can see radiotherapy patients attend hospital for as little as 5 visits as opposed to the 20-25 visits currently.

The treatment is seen as an excellent alternative to surgery, while facilitating treatment closer to home and avoiding the need for patients to travel as frequently. The treatment will also dramatically increase the Trust's capacity to treat cancer patients while allowing vulnerable patients to reduce the amount of time they visit hospital.

SABR has recently been described by NHS Chief Executive Sir Simon Stevens as "potentially lifesaving" and has been something Lead Consultant Clinical Oncologist Dr Anna Lydon has been keen to bring to Torbay and South Devon NHS Foundation Trust with the help of research radiographer Sophie Norman.

Dr Lydon said: "Introducing this trial enables us to offer SABR for the first time in Torbay and South Devon. Not only is this an exciting treatment for men with prostate cancer, but it will form a key part of future treatments for other tumour types.

"The significant investment made by purchasing two new radiotherapy treatment machines between 2016 and 2018 has enabled this, and it ensures that the Trust continues to offer the

most up to date radiotherapy treatments for our patients close to home. We are delighted to be the first radiotherapy centre in the South West to open this exciting trial."

The PACE Trial is sponsored by The Royal Marsden NHS Foundation Trust and coordinated by the Cancer Research UK-funded Clinical Trials and Statistics Unit at The Institute of Cancer Research, London. The trial is funded by The Royal Marsden Cancer Charity, Accuray and Varian.

Pioneering PACE trial begins at Torbay Hospital

After lots of hard work, planning and preparation, our Radiotherapy department are delighted that they have treated their first patient using stereotactic ablative radiotherapy (SABR) as part of the pioneering PACE trial.

It was announced earlier this year that we would be the first in the South West to open the PACE trial to treat prostate cancer patients.

The PACE trial involves the use of a new technique called SABR which uses advanced imaging technologies with sophisticated computer planning to safely deliver precisely targeted radiotherapy using fewer higher doses of radiation. This means patients attend hospital for as little as five visits as opposed to many more over several weeks.

It has taken a lot of hard work by our teams in Radiotherapy, Medical Physics and Oncology Research and Development departments, as well as many other staff who provided support which made this possible.

A special thank you must also go to our patients who are taking part, including Barry Jarvis who is the first patient to be treated as part of the trial at Torbay Hospital.

Update: Oct 2021 - the PACE trial has recruited 13 patients this year, 6 of which received the stereotactic radiotherapy (SABR) arm. This particular type of therapy means that patients only require 5 treatment visits instead of the standard 20, saving the Trust a total of **90** patient visits thus far! This is one of many examples of Radiotherapy research that hugely benefits both the service as well as our local population.

2021: Ground breaking SYMPLIFY cancer research trial opens

Torbay has been selected as one of 13 NHS sites to take part in the ground-breaking **SYMPLIFY** Research Trial. The trial is offering patients, who have been referred on selected two week-wait cancer pathways, the opportunity to be part of validating a new blood test which hopes to identify up to 50 different cancer signals.

The GALLERI test uses a single blood sample to detect signals from the most likely primary cancer site prior to patients undergoing diagnostic and sometimes invasive tests. NHS England hopes that once validated this test could increase the number of cancers detected early and reduce the number of unnecessary investigations carried out, while streamlining patient care. NHS England and the Oxford Clinical Trials Office have challenged selected sites to recruit thousands of patients over a three-month period. The study was opened here in record time in July 2021 thanks to the enthusiasm of our fantastic Research and Development teams. The teamwork, support and engagement from all the identified two week-wait teams is something that our cancer services teams should be very proud of. The warm welcome, enthusiasm and 'extra mile' attitude of the teams involved during a period of pressure and high demand has been heartening and the feeling of achieving something positive in the current climate cannot be underestimated. As a result of this overwhelming engagement we are currently one of the top recruiters in the UK.

Dr Louise Medley, Principal Investigator for the study, said: "Using the significant advances in the understanding of cancer signals, it really feels as if we are moving closer towards the ultimate goal of improving cancer survival. Through earlier diagnosis, targeted investigations, and molecularly driven treatments we can really aim to 'get it right first time'. I am delighted that Torbay and South Devon has been given this opportunity to show how we can embed research into everyday clinical practice."

October 2021 update:

'The Chief Investigator for the Simplify study, Prof Mark Middleton, contacted Dr Medley today to let us know that out of all of the sites taking part we are officially the best at bleeding people! We have the lowest percentage of drop outs for no blood across the trial which is amazing! Torbay leading the way with excellent clinical skills. Thank you, Catherine, Jas, Andrea, Fred, Tracey and Shelley, for all of the excellent work delivering this study'.
'It has also been pointed out that between Truro and ourselves we have recruited >10% of the patients for this trial which considering the size of our sites and the size of the other sites taking part this is incredible'.

Also: *'The Chief Operating Officer for the Southwest Peninsula Clinical Research Network, Michael Visick, has just informed us that we have overtaken Truro to become the top recruiting site for Cancer research across the South West Peninsula!'*

COVID-19: Urgent Public Health Research:

Clarity IBD study	New evidence indicates the commonly-prescribed inflammatory bowel disease (IBD) drug infliximab blunts the immune system to COVID-19 infection, potentially increasing the risk of reinfection. The study findings which recruited 6,935 patients with Crohn's disease and ulcerative colitis found that fewer than half of people with IBD who were treated with infliximab had detectable antibodies after SARS-CoV-2 infection, the coronavirus that causes COVID-19. The study is led by gastroenterologists at the Royal Devon and Exeter NHS Foundation Trust and the University of Exeter Medical School and supported by Crohn's and Colitis UK and the National Institute for Health Research (NIHR) Clinical Research Network South West Peninsula (CRN SWP). Careful monitoring of patients with IBD treated with infliximab, who have been vaccinated against COVD-19, will be needed to ensure they mount a strong enough antibody response to ward off the infection, they advise. The CLARITY IBD study will continue to follow participants for 40 weeks to investigate important questions regarding the impact of immunosuppressive drugs on immunity to SARS-CoV-2 infection and COVID-19.
GENOMMIC Study	This study has identified potential treatments for Covid-19 after the discovery of five genes associated with the most severe form of the disease. Genetic evidence is second only to clinical trials as a way to tell which treatments will be effective in a disease. Existing drugs that target the actions of the genes reveal which drugs should be repurposed to treat Covid-19 in clinical trials, experts say.
RECOVERY TRIAL	The results from the RECOVERY trial add significant and important information to our knowledge on how best to treat COVID-19. Through the study many of our local patients have had access to these treatments: In March 2020, the RECOVERY (Randomised Evaluation of COVid-19 thERapY) trial was established as a randomised clinical trial to test a range of potential treatments for COVID-19. The RECOVERY trial was the world's first study to show that **low dose dexamethasone**; a cheap and available steroid; typically used to reduce inflammation **reduces death by up to one third in hospitalised patients with severe respiratory complications of COVID-19 and by one fifth in other patients receiving oxygen only.** Subsequently the study has shown that **tocilizumab** - an anti-inflammatory rheumatoid arthritis treatment; reduces the risk of death for hospitalised patients with severe COVID-19. Patients who have significant inflammation and require oxygen, a combination of a systemic corticosteroid - such as dexamethasone - alongside tocilizumab reduces

mortality by about one third for patients requiring simple oxygen and nearly one-half for those requiring invasive mechanical ventilation. Researchers also found that the drug reduces the length of hospital admission, and the risk of patients requiring mechanical ventilation. RECOVERY is now the second NIHR-supported study to demonstrate the effectiveness of tocilizumab as a treatment for COVID-19 patients, after results from the REMAP-CAP study.

The RECOVERY trial has also shown the following treatments were not effective in hospitalised COVID-19 patients:

- lopinavir-ritonavir (an antiviral treatment commonly used to treat HIV)
- Hydroxychloroquine
- Azithromycin (a commonly used antibiotic). The data showed no significant difference in the primary endpoint of 28-day mortality (19% azithromycin vs. 19% usual care).
- Convalescent plasma (collected from donors who have recovered from COVID-19 and contains antibodies against the SARS-CoV-2 virus).

RECOVERY trial: Regeneron's monoclonal antibody combination reduces deaths for hospitalised COVID-19 patients who have not mounted their own immune response

Among patients who had not mounted a natural antibody response of their own on beginning treatment (seronegative), the antibody combination significantly reduced the primary outcome of 28-day mortality by one-fifth compared with usual care alone (24% of patients in the antibody combination group died vs 30% of patients in the usual care group). These results mean that for every 100 such patients treated with this treatment, six lives would be saved.

The antibody treatment also reduced the length of hospital stay for patients in the seronegative group by an average of 4 days from those in the usual care group (median 13 days vs. 17 days).

For seronegative patients who were not already on mechanical ventilation at baseline, the antibody treatment also reduced the risk of their health deteriorating to require invasive ventilation, or their risk of dying. These benefits were only found in the seronegative group at baseline.

Recovery-RS	- Landmark UK trial compared three commonly used respiratory interventions to establish which works best for COVID-19 patients with acute respiratory failure. - Participants who received continuous positive airway pressure (CPAP) were less likely to require invasive mechanical ventilation from COVID-19. - Researchers found no benefit from high flow nasal oxygenation (HFNO) over standard oxygen therapy. - Based on this evidence, the authors say CPAP should be considered for hospitalised patients with COVID-19 needing increasing oxygen - reducing the need for invasive ventilation and relieving pressure on intensive care services.

	The NIHR-supported Respiratory Strategies in COVID-19; CPAP, (RECOVERY-RS) trial has demonstrated that treating hospitalised COVID-19 patients who have acute respiratory failure with reduces the need for invasive mechanical ventilation. Preliminary data from the trial also suggests that the routine use of high flow nasal oxygenation (HFNO), which can consume large amounts of oxygen, should be reconsidered as it did not improve outcomes for COVID-19 patients compared with conventional oxygen therapy.
REMAP-CAP Trial	**South West patients contribute to study which finds arthritis drugs effective in improving survival in sickest COVID-19 patients:** Patients across the UK who are admitted to intensive care units due to COVID-19 are set to receive a treatment that can reduce the time spent in hospital by up to 10 days, an international study supported by the National Institute for Health Research has found. Results from the REMAP-CAP clinical trial, which is running locally at five hospitals - University Hospitals Plymouth NHS Trust, Royal Cornwall Hospitals NHS Trust, Royal Devon and Exeter NHS Foundation Trust, Somerset NHS Foundation Trust and Torbay and South Devon NHS Foundation Trust - evaluated the effect of treatments on a combination of survival and length of time patients need support in an intensive care unit (ICU). Patients receiving tocilizumab and a second drug called sarilumab - both types of immune modulators - have a significant impact on patient survival and can reduce the relative risk of death by 24% when administered to patients within 24 hours of entering intensive care.
SIREN Study	**Study supported locally finds past coronavirus infection provides some immunity for at least 5 months, but people may still carry and transmit the virus:** NHS Trusts across the South West rallied to support a study which has given key insight into immunity to COVID-19. The SIREN Study, developed by Public Health England (PHE), has released results which indicate recovering from coronavirus (COVID-19) provides some immunity for at least 5 months. Beginning in June 2020, the study involved regular testing of tens of thousands of volunteer healthcare professionals. The study was supported locally by staff from Somerset NHS Foundation Trust, Royal Cornwall Hospitals NHS Trust, University Hospitals Plymouth NHS Trust, Yeovil District Hospital NHS Foundation Trust, Northern Devon Healthcare NHS Trust, Royal Devon & Exeter NHS Foundation Trust, Torbay & South Devon NHS Foundation Trust, Cornwall Partnership NHS Foundation Trust and Devon Partnership NHS Trust. Pfizer-BioNTech vaccine provides high levels of protection against infection and symptomatic disease from the first dose. Data shows one dose reduces the risk of catching infection by more than 70%, rising to 85% after the second dose. This suggests the vaccine may also help to interrupt virus transmission, as you cannot spread the virus if you do not have infection.

| Valenva Vaccine study | The phase 3 trial compared Valneva's VLA2001 COVID-19 vaccine against the AstraZeneca AZD1222 (ChAdOx1-S) vaccine.

The study shows that VLA2001 generated a stronger immune response (>95%) than the AstraZeneca (AZ) vaccine - with higher levels of neutralising COVID-19 antibodies in the blood compared to AZD1222 Researchers also found no severe cases of COVID-19 amongst participants receiving the Valneva vaccine, despite the Delta variant being in circulation during the trial. |
|---|---|

Other studies (non covid-19 studies)

Clinical Specialty	Study details
Cancer (breast)	**FAST Forward Trial a randomised clinical trial testing a 1-week course (5#) of curative whole breast radiotherapy against a standard 3-week schedule (15#) in terms of local cancer control and late adverse effects in women with early breast cancer (76 participants recruited at Torbay)**

The results showed that one week was just as safe and effective at five years after radiotherapy treatment. Results were very similar in terms of cancer recurrence, which was very low in all groups, and both short term and longer-term side effects for the five and 15 treatment schedules.

Since many UK radiotherapy centres had participated in the trial, they were already familiar with delivering the new five treatment schedule and this was therefore rapidly implemented in many departments. To help centres who had not participated, the trial team made the protocol and radiotherapy planning guidance documents available ahead of publication. This meant that patients with breast cancer could continue to receive safe and effective treatment in a significantly reduced number of visits to hospital. Since breast cancer is so common and accounts for a large proportion of a radiotherapy department's workload, this reduction from 15 to five treatments per patient also released capacity to ensure that patients with other cancers could continue to be treated safely.

The Fast-Forward trial is just one example of a large number of UK led radiotherapy trials which have influenced both UK and international practice in recent years, often resulting in more convenient treatment schedules for patients. |
| Cancer (Colorectal) | **FOCUS4 study: Molecular selection of therapy in colorectal cancer: a molecularly stratified randomised controlled trial programme**

A new drug has shown promise in slowing the regrowth of tumours among some bowel cancer patients. The subset of patients who took part in the **FOCUS4-C** trial, looked at whether a drug called adavosertib, taken in the form of a daily pill, could delay tumour regrowth among patients with an aggressive sub-type of inoperable bowel cancer who have limited treatment options.

Comparing 44 patients who took adavosertib with 25 patients who did not, the researchers found that the drug delayed tumour growth by |

	about two months on average and had relatively few side effects. The drug had more effect in the 31 patients with left-sided/rectal tumours, increasing overall survival – that is, patients lived longer. The researchers caution that these are early results and that larger trials are needed to establish whether the drug improves survival compared to standard treatment. The trial tested adavosertib among patients who were on a treatment break following chemotherapy but the drug could potentially benefit patients with other types of bowel cancer or alongside standard treatments in other lines of therapy. Lead author Dr Jenny Seligmann, of the University of Leeds, said: "These results show promising signs that adavosertib may be effective in delaying re-growth of bowel cancer in some patients and is well tolerated. The findings are particularly encouraging as the subset of patients involved represent a third of all bowel cancer patients and, while other patients have treatments developed specifically for their tumour types, this group currently has very limited treatment options." A second new study from a separate part of the FOCUS4 trial called **FOCUS4-N**, looked at outcomes among patients who had a complete break from treatment following chemotherapy, comparing them to outcomes among those who continued chemotherapy using a simpler tablet called capecitabine. The researchers found that, among those who had a complete break, the cancer started to grow somewhat sooner than in those on continued maintenance therapy, but that maintenance therapy did not lead to an increase in how long people lived. Lead author Professor Richard Adams, of Cardiff University, said: "The findings will help to inform discussions between patients and clinicians about treatment options at the end of four months of therapy - that is, whether to stay on oral chemotherapy long-term or have a complete break in treatment – giving patients better control of their cancer management." FOCUS4-N CONCLUSION: Despite strong evidence of disease control with maintenance therapy, OS remains unaffected and FOCUS4-N provides additional evidence to support the use of treatment breaks as safe management alternatives for patients who are stable or responding to first-line treatment for mCRC.
Cancer (renal)	**RADICALS Trial: Radiotherapy and Androgen Deprivation in Combination After Local Surgery (18 participants recruited at Torbay)** Men with prostate cancer, who have had surgery to remove their prostate, do not need immediate radiotherapy according to the results of the RADICALS trial that was conducted at Torbay Hospital. This trial aimed to see whether giving radiotherapy to patients soon after surgery would delay or prevent the recurrence of their cancer.

	RADICALS found that having radiotherapy soon after surgery did not make a substantial difference to the time patients would see a recurrence in their Cancer. Dr Lydon, the principal investigator for this study, commented 'These findings suggest that following surgery, patients whose cancer is confined to the prostate, or has spread only to nearby tissues or organs, can safely be spared routine postoperative radiotherapy and its associated side effects. Radiotherapy need only be given to men if they show early signs that the cancer may be returning after their operation. These results suggest that tracking a patient's PSA and waiting until recurrence before treating with Radiotherapy would be a more preferable option and potentially save a significant number of patients from unnecessary radiotherapy treatment. This is an important step in identifying the best treatment pathway for our prostate patients. The RADICALS trial was funded by the MRC and Cancer Research UK and took place in hospitals throughout the UK, as well as Canada, Denmark and Ireland.
Cancer (upper GI)	**The GO2 Phase 3 Randomized Clinical Trial: Efficacy of Reduced-Intensity Chemotherapy with Oxaliplatin and Capecitabine on Quality of Life and Cancer Control Among Older and Frail Patients with Advanced Gastroesophageal Cancer (6 patients recruited at Torbay)** Question Do older and/or frail patients with advanced gastroesophageal cancer benefit from less intensive palliative chemotherapy, and can a formal geriatric assessment assist treatment decision-making? Conclusions and Relevance: This trial found that reduced-intensity chemotherapy provided a better patient experience without significantly compromising cancer control and should be considered for older and/or frail patients. Baseline geriatric assessment can help predict the utility of chemotherapy but did not identify a group benefiting from higher-dose treatment.
Children	**TORPEDO study:** Compared with oral therapy, intravenous antibiotics did not achieve sustained eradication of P aeruginosa in a greater proportion of patients with cystic fibrosis and was more expensive. These results do not support the use of intravenous antibiotics to eradicate P aeruginosa in cystic fibrosis.
Dermatology	**BADBIR study: Randomized Trial Replication Using Observational Data for Comparative Effectiveness of Secukinumab and Ustekinumab in Psoriasis.** Secukinumab resulted in more patients achieving a PASI of 2 or lower after 12 months of therapy compared with ustekinumab in patients with psoriasis

Health Services Research	**Evaluation of the Impact of High-Intensity Specialist-Led Acute Care (HiSLAC) on Emergency Medical Admissions to NHS Hospitals at Weekends** A major NIHR-funded study revealed that a lack of available specialist consultants in hospitals at the weekend is not the cause of the so-called 'weekend effect'. In the last two decades research has shown that patients admitted to hospitals at weekends are slightly more likely to die than those admitted during the week – a phenomenon that has been coined the 'weekend effect'. One of the causes was thought to be too few doctors in the hospital at weekends, making healthcare less reliable - but there was no evidence to prove this. Now the findings of the five-year study have shown that the weekend effect is not caused by a lack of consultants in hospitals at weekends but is associated with factors in the community preceding hospital admission. The High-intensity Specialist-Led Acute Care (HiSLAC) study, found: • The weekend effect is not linked to specialist availability. Patients admitted at weekends are sicker, frailer, and less likely to have been referred to hospital by their general practitioner. These findings have worsened over the last five years. • The quality of care in hospital is actually slightly better at weekends than on weekdays and has improved with time. • There are now more specialists in hospital at weekends and on weekdays, but this has been outstripped by the rise in emergency admissions. • Increasing the number of specialists may be cost-effective, not by preventing the weekend effect but by promoting earlier discharge of patients from hospital. • The 'weekend effect' may be related to what happens to people in the community before hospital admission. This needs further investigation.
Orthopaedics	**UK Frost study:** Management of adults with primary frozen shoulder in secondary care (UK FROST): a multicentre, pragmatic, three-arm, superiority randomised clinical Three effective treatments for frozen shoulder have different costs and benefits, study shows. A so-called frozen shoulder is painful and stiff for months and sometimes years. People with the condition may be unable to move their arm or shoulder and the pain may disturb their sleep. The three treatments most often offered by the NHS are physiotherapy, manipulation of the shoulder under general anaesthesia, and a form of keyhole (minimally-invasive) surgery called arthroscopic capsular release.

	The largest comparison of these treatments to date found that, after a year, all three approaches were effective, but they had different benefits and drawbacks. Physiotherapy could be delivered more rapidly but was more likely to require follow-up treatment. Surgery carried higher risks and costs. Manipulation under anaesthesia was the most cost-effective treatment, but waiting times were longer than for physiotherapy.

The findings should help patients and clinicians decide on the most appropriate treatment. The study could reduce the use of surgery for people with a frozen shoulder, and make considerable cost savings for the NHS. |
| **Rheumatology** | **Intensive therapy for moderate established rheumatoid arthritis: the TITRATE research programme (37 patients recruited at Torbay)**

This research programme showed 12 months' intensive management increased remissions and was acceptable to patients without increasing adverse events, although not all patients benefitted.

Background

Rheumatoid arthritis is a major inflammatory disorder and causes substantial disability. Treatment goals span minimising disease activity, achieving remission and decreasing disability. In active rheumatoid arthritis, intensive management achieves these goals. As many patients with established rheumatoid arthritis have moderate disease activity, the TITRATE (Treatment Intensities and Targets in Rheumatoid Arthritis ThErapy) programme assessed the benefits of intensive management.

Limitations

The main limitations comprised (1) using single time point remissions rather than sustained responses, (2) uncertainty about benefits of different aspects of intensive management and differences in its delivery across centres, (3) doubts about optimal treatment of patients unresponsive to intensive management and (4) the lack of formal international definitions of 'intensive management'.

Conclusion

The benefits of intensive management need to be set against its additional costs. These were relatively high. Not all patients benefited. Patients with high pre-treatment physical disability or who were substantially overweight usually did not achieve remission.

Future work

Further research should (1) identify the most effective components of the intervention, (2) consider its most cost-effective delivery and (3) identify alternative strategies for patients not responding to intensive management. |

Urology	**Urodynamics tests for the diagnosis and management of bladder outlet obstruction in men: the UPSTREAM non-inferiority RCT**
	## Background
	Lower urinary tract symptoms (LUTS) in men may indicate bladder outlet obstruction (BOO) or weakness, known as detrusor underactivity (DU). Severe bothersome LUTS are a common indication for surgery. The diagnostic tests may include urodynamics (UDS) to confirm whether BOO or DU is the cause, potentially reducing the number of people receiving (inappropriate) surgery.
	## Objectives
	The primary objective was to determine whether a care pathway including UDS is no worse for symptom outcome than one in which it is omitted, at 18 months after randomisation. Rates of surgery was the key secondary outcome.
	## Conclusions
	Inclusion of UDS in the diagnostic tests results in a symptom outcome that is non-inferior to a routine care pathway, but does not affect surgical rates for treating BOO. Results do not support the routine use of UDS in men undergoing investigation of LUTS.
	## Future work
	Focus should be placed on indications for selective utilisation of UDS in individual cases and long-term outcomes of diagnosis and therapy.

Report to the Trust Board of Directors		
Report title: Single Oversight Framework – exit criteria		Meeting date: 24th November 2021
Report appendix	None	
Report sponsor	Deputy Chief Executive Officer and Chief Finance Officer	
Report author	Deputy Chief Executive Officer and Chief Finance Officer	
Report provenance	Reviewed at Finance Digital & Performance Committee, Board Strategy Day and Executive Team Meeting	
Purpose of the report and key issues for consideration/decision	The Trust is required to develop its criteria for improving its rating under the System Oversight Framework (SOF). These were considered at the November Board strategy day. Following informal review at ICS level, the "partnership" domain has been expanded to reference the Trust's commitment to shaping the Devon clinical strategy. The attached document represents the latest Trust's proposals, which will be subject to local (ICS) and regional (NHSE/I) review and moderation. In particular, congruence between these exit criteria, other providers' exit criteria and the ICS's own exit criteria will be a crucial outcome of the review and moderation process. As such, the exit criteria are presented in draft for endorsement prior to entering into the review and moderation process described.	

Action required (choose 1 only)	For information ☐	To receive and note ☐	To approve ☒
Recommendation	The Board is asked to approve the draft exit criteria.		

| 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	20
	Risk Register	X	Risk score	20
	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.			

	BAF Objective 3: To achieve financial sustainability, enabling appropriate investment in the delivery of outstanding care.			
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**

SOF 3 – Exit Criteria

Trust Board
24 November 2021

Dave Stacey, DCEO & Chief Finance Officer

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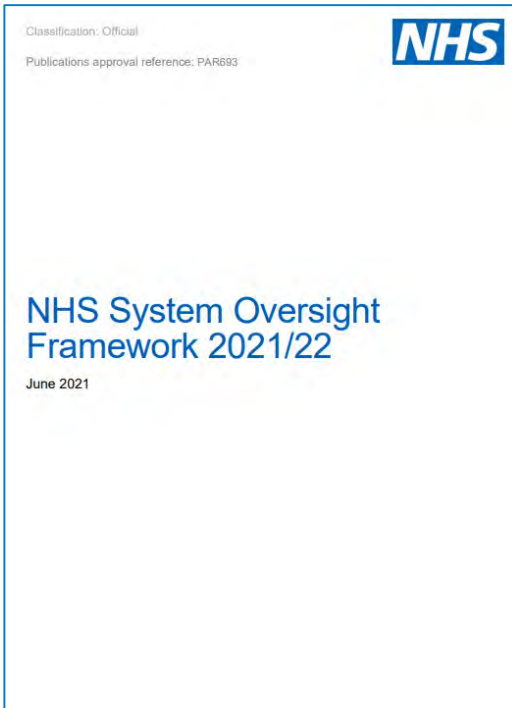
Role and purpose of ICS

- improving population health and healthcare
- tackling unequal outcomes and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

Scope of the system oversight framework

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- People
- Finance and use of resources
- Leadership and capability
- Local strategic priorities (including provider collaboration)

Devon system: SOF 4

- Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support, leading to:
    - Mandated intensive support delivered through the Recovery Support Programme
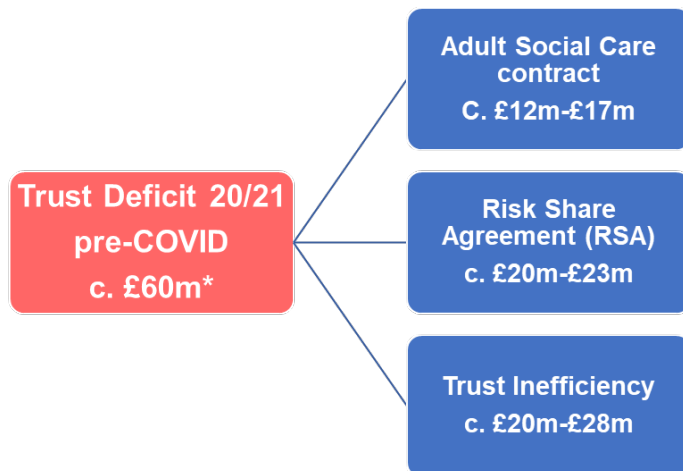
Trust rating: SOF 3

- Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence, leading to:
    - Bespoke mandated support through a regional improvement hub, drawing on system and national expertise as required

Context: how did we get here?

Devon system is in SOF 4 - Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support

The system's own analysis indicated a deterioration in its underlying deficit position from £233.1m 19/20 outturn to £333.7m as at 20/21. The system needs to take action quickly to a) manage the expected challenge in H2 and beyond when additional COVID funding disappears and b) to prevent further deterioration of the underlying deficit.

Trust perspective:

Trust Deficit 20/21 pre-COVID c. £60m*

- **Adult Social Care contract C. £12m-£17m**
- **Risk Share Agreement (RSA) c. £20m-£23m**
- **Trust Inefficiency c. £20m-£28m**

- The historical position and drivers of the Trust's deficit are well understood. In addition to a system-wide review, T&SD engaged KPMG to undertake an assessment of the Trust's underlying position – September 2019.
- The KPMG assessment flagged contributing factors to the Trust's underlying deficit, including a shortfall on its **Adult Social Care contract** together with organisational inefficiency compared to peers, partly driven by **historic underperformance in delivery of CIP** (Cost Improvement Programmes).
- Prior to the impact of COVID the Trust's financial plan for 20/21 led to a c. £41.4m deficit. This position included the removal of the risk share agreement (£23m income) at the request of the STP, although it is accepted this was never a contractually signed-off position. The deficit was also predicated on the delivery of c. £18.6m of efficiencies.

- Given that savings requirements were suspended during the pandemic, all things being equal the **Trust's underlying deficit at the initial planning stage is therefore at least £60m**.
- Further risks to the financial position as we look forward include:
  - Safer staffing
  - Ockenden impact
  - Flowers case
  - Liberty Protection Standards
  - Recurrent CIP quantum & site / system escalation

Overview: exit criteria

The task: *The NHS England and NHS Improvement regional team will agree the criteria that must be met for the trust to exit mandated support (exit criteria) and Trust will develop an improvement plan with an indicative timescale for meeting the exit criteria.*

Theme	Exit criterion	Lead indicators	Closure evidence	Assurance	Timescale
H2 delivery	Deliver required financial performance for H2	Monthly financial reporting	Successful delivery	FPDC, Board, Audit	April 2022
			Quick wins implemented	FPDC, FIP stage 1 report	December 2021
			Bridge H1 to H2 and 19/20 to H2 exit	FPDC	December 2021
			H2 spend movements signed off through ICS	STEC	December 2021
Financial improvement programme (FIP)	External support identified and appointed	N/A	Successful appointment & launch	FPDC	December 2021
	Successful delivery of FIP ROI (>£15m recurrent CIP 2022-23)	FIP highlight reports Monthly financial reporting	2022-23 exit run rate improved vs 2021-22 actual	FPDC	April 2023
Multi-year financial recovery plan (2022-23 to 2025-26)	Clear & agreed multi-year plan	Quarterly updates - FPDC	MTFP published	FPDC, Board, ICS	July 2022
	Embed GIRFT & Model Hospital	Progress vs specialty review timetable	All specialties tracking and closing GIRFT actions	FPDC	Ongoing / quarterly
	4% recurrent efficiency identified	Savings pipeline	Delivery of 4% requirement & reduction in ref costs	FPDC	Ongoing / monthly
	LTP benefits identified and plans in place	Significant interventions agreed ± clear plans for public consultation	Interventions delivered	ICS governance	TBC

Continued

Theme	Exit criterion	Lead indicators	Closure evidence	Assurance mechanism	Timescale
Partnerships	Clear alignment and involvement in system clinical strategy Drive provider collaboration through SEND	Work programme with high impact specialties identified	Productivity and quality benefits through service networks / transfers Agreement on governance for shared corporate services e.g. move of IM&T services from the current local provision to the shared service	FPDC, Trust Board	Ongoing / bi-annual
Workforce	Improve workforce efficiency (~£30m per Model Hospital)	Vacancy rate Sickness absence Staff turnover	Compliance with agency cap Reduced sickness absence to 4% rolling Reduced vacancy rate to 2.5% Staff turnover <10%	PC / FPDC	Ongoing / bi-monthly
Balancing measures & investment	Robust quality impact assessment Digital NHP	EQIA process operating Bid submissions (various) Seed allocation O/FBC progress	Quarterly & annual EQIA reports Approved & funded Digital OBC & FBC including "enabling" business case investment (revenue) OBC approval 6:1 RoI tests met	QAC FPDC, Board BBF Cttee, FPDC BBFC, FPDC, Board	From Jan 2022 April 2023 TBC

Torbay and South Devon NHS
NHS Foundation Trust

Other matters – not included explicitly but picked up through other governance and assurance mechanisms:

- *Torbay Council and funding quantum associated with ASC contract*

- *CCG funding baseline and historic dispute - ~£23m recurrent / non-recurrent*

- *Performance - specifically elective / diagnostic recovery*

- *Hospital services – de-escalation and sustained Opel 1/2*

- *Capital availability & access – e.g. Wave 3 scheme, Torbay Pharma*

- *Resource allocation and link to reducing health inequalities*

Next steps

Proposed as follows:

- *Reflect informal Board feedback on shaping the exit criteria – done*

- *Further informal discussion with ICS and region – done / ongoing*

- *Establish ICS governance / sign off requirement – next two weeks*

- *Formal adoption through FPDC and Trust Board – November meetings (today)*

- *Recommendation to ICS & Regional teams – December 2021*

- *Reflection in workplans & risk registers – December 2021*

- *Development of assurance scorecard – January 2022*

Report to the Trust Board of Directors

Report title: Building a Brighter Future Programme update		**Meeting date:** 24th November 2021
Report appendix		
Report sponsor	Director of Transformation and Partnerships, SRO	
Report author	Building a Brighter Future Programme Director	
Report provenance		
Purpose of the report and key issues for consideration/decision	To give members of the Trust Board an update on the latest position regarding the Building Brighter Future Programme	
Action required (choose 1 only)	**For information** ☐ / **To receive and note** ☒	**To approve** ☐
Recommendations	Members of the Trust Board are asked to note the contents of this 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	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 Update	Meeting date: 24th November 2021
Report sponsor	Director of Transformation and Partnerships, SRO
Report author	Building a Brighter Future Programme Director

1.0 Introduction

This paper has been prepared to give members of the Trust Board an update on the Building a Brighter Future (BBF) programme, with particular reference to the current status of the Strategic Outline Case (SOC) that was presented to NHSE/I on 28th July 2021. The Board is also provided with an update on the work currently being undertaken by the BBF programme group.

Members of the Trust Board are asked to note the content of this report.

2.0 Strategic Outline Case summary position

As highlighted the Strategic Outline Case was submitted to the NHSE/I Regional Office on 28th July and the BBF programme office received initial feedback on the review of the fundamental criteria that should be included within the document. The initial review feedback was provided to the programme office on 26th August and a full response was provided to the Regional Office on Friday 10th September 2021.

A second review took place on 14th October to review the status of all fundamental criteria, in readiness for submission to the New Hospital Programme (NHP) national team, and there are now only 2 amber rated criteria. A more detail assessment of the amber rated criteria is noted in the section below.

3.0 Main issues noted

Following the second fundamental criteria review that took place, the NHSE/I regional team highlighted 2 Amber areas that required further clarification. These are noted below along with the trust response to each issue noted. The elements highlighted in **bold** are the amber rated criteria and the Trust position is noted in full.

Support from other Organisations (CCG / STP) - The Trust should provide written letters of support demonstrate support from all major commissioning CCGs and the wider STP for the proposed service provision/ proposal.
Trust position We have updated the capital funding sources as required. However, a further CCG letter is now required by the Regional Office to confirm that the CCG is supportive of the requirement for the Trust to invest £20m of local capital into the project with effect from 2025/26. This matter has been escalated to the CCG Director of Finance and this letter has now been received

> **Consultation - For major reconfigurations requiring capital investment, commissioners and providers will need to confirm consultation requirements and there these are required consultation will need to be completed prior to SOC submission (where required) with the business case reflecting the outcomes of consultation and how that has shaped the business case options appraisal.**

> Trust position
>
> Following discussion with the Devon Health and Overview Scrutiny Committee a letter of support was provided by the chair of the committee, Cllr Sara Randle– Johnson, on 28th October. The letter of support from the CCG in this regard will be provided as part of the letter noted in the section above.
>
> All wording associated with public consultation has now been changed in accordance with the instruction of the Regional Office.

It should be noted however, that the national team are not able to confirm when the SOC will be reviewed. Their current focus is the delivery of New Hospital Programme schemes that are within phases 1-3 of the national timetable, and Torbay and South Devon NHS Foundation Trust is currently noted as a phase 4 project within the programme and the national team have not been able to confirm when the cases within phase 4 are likely to be reviewed.

4.0 BBF Programme Group Update

This section provides an update on the discussions that have taken place in the last month at the BBF programme group. The main issues discussed were as follows

The main issues discussed were as follows

- Workstream/Risk register update – the programme group an overview of the workstreams leads feedback.

  Progress –the main issue for discussion was the revised cycle of discussion that will now be taking place to ensure that the workstream and risk review process is proactively managed. The programme director will continue to chair these meetings with a view to ensuring that each workstream is able to demonstrate full compliance with any emerging national project governance requirements

- Digital Outline Business Case (OBC) – the Digital Programme lead now has a regular agenda item at the programme group meetings to enable all members of the team to be updated on the progress associated with the Digital OBC.

  Progress – the group received an update on the following issues:

  o **Digital OBC – an update on the progress being made towards the development of the digital OBC is now provided to each programme group meeting.**

- o **Digital stakeholder engagement sessions being planned for the reminder of October.**

- Infrastructure Outline Business Case (OBC) timetable- the revised OBC timetable was provided to the programme group.

  Progress – the OBC timetable confirms that the planning assumptions in relation to the 'seed' allocations have resulted in the OBC presentation and submission not be able to take place until April 2023. Whilst this will not delay at start date of construction, it does represent a 6-month delay on the original timetable completed in August 2020.

- Outline Business Case 'seed allocation – the programme group receives a regular update on the progress being made with the 'seed' funding application.

  Progress – the national office has now received the OBC 'seed' allocation application, and the programme office now understands that the allocation is likely to be released in two separate phases. Firstly, the initial instalment will cover the costs of project teams and consultancy support, whereas the final phase (for technical advisors) will not be released until the national guidance on issues such as Net Zero Carbon and Modern Methods of Construction has been completed and published.

  The programme office is still awaiting confirmation from the national team in relation to the timing of this release.

5.0 Visit from the Regional Delivery Director

A visit has been arranged for 23rd November for Chris Cale, Regional Delivery Director, NHP to come to the Torbay Hospital site. This meeting will be hosted by the SRO and the Programme Director. A feedback report will be provided to the BBF committee at their December meeting.

6.0 Conclusion

Members of the Trust Board are asked to note the contents of this report.

Report to the Trust Board of Directors			
Report title: 2021 NHSE/CCG external assessment of the Trust against EPRR responsibilities and national standards.		Meeting date: 24th November 2021	
Report appendix	Appendix 1: Core standards action plan		
Report sponsor	Chief Operating Officer		
Report author	Emergency Preparedness, Resilience and Response Lead		
Report provenance	• EPRR Steering Group • IGG		
Purpose of the report and key issues for consideration/decision	To provide assurance to the Trust Board on compliance with legislation, standards and regulatory requirements relating to Emergency Preparedness Resilience and Response (EPRR).		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	• The Trust Board to note recommendation that the new Major Incident Plan will be an Incident Response Plan. • The overall EPRR assurance has been rated as Partial Compliance. • Please note work underway on the 10 specific actions listed in the EPRR Assurance Action Plan 2021/2022.		

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 4: To provide safe, quality patient care and achieve best patient experience, responding to the new paradigm of harm and safety as a result of COVID-19			

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

Report title: 2021 NHSE/CCG external assessment of the Trust against EPRR responsibilities and national standards.		Meeting date: 24th November 2021
Report sponsor	Chief Operating Officer	
Report author	Emergency Preparedness, Resilience and Response Lead	

Introduction

This report provides the output of the formal assessment by NHS England and the CCG of the Trust's EPRR performance against the core national standards for the year ending 2021. The assurance process included an assessment of the organisation's state of emergency preparedness using the same compliance levels as utilised in the 2020 assurance process, namely: Fully, Substantially, Partially or Non-Compliant.

The Trust Board is formally required to receive and sign off the outcome of the assessment and accompanying improvement plan in recognition of its responsibilities as a Category 1 responder under the Civil Contingencies Act (2004).

Discussion

The Board can take assurance that the Trust is partially compliant in this year's assurance. Out of 46 standards, the Trust has scored: 36 fully compliant, 8 partially compliant and 2 non-compliant therefore making the Trust overall partially compliant.

Partial compliance in the following key areas:

Governance: The Trust does not have an EPRR Policy statement in place outlining EPRR resource and continuous improvement process, learning from incidents and exercising through debriefing.

Duty to Maintain Plans: The Trust has scored non-compliant for its current Major Incident Plan because it was written in 2017 for review in 2019 but has only been addressed in 2021. This is because the Trust has been responding to the COVID19 pandemic and has adapted the estate significantly to support the COVID19 response. During the pandemic the EPRR team resource was depleted. Following a review of the Major Incident Plan it has been decided to produce an Incident Response Plan which will cover Business Continuity, Critical and Major Incident. This rewrite will accommodate the Trusts ongoing COVID19 response plans. First draft of the Incident Response Plan will be December 2021 with publication January 2022.

CBRN[1]: The Trust has scored partial compliance as the CBRN response arrangements outlined in the Major Incident Plan are out of review date. The Trust has the capability to respond to a CBRN incident within the current infrastructure and ongoing recertification of volunteer training. The Trust will be compliant in this area once the Incident Response Plan has been published.

The EPRR team have been operating with limited resourcing due to the specific response to the COVID19 pandemic and limited time had been dedicated to EPRR policy review. The Trust is now increasing EPRR resilience with a dedicated EPRR lead and support team to progress compliance with the Action Plan.

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[1] Chemical, Biological, Radiological and Nuclear

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Conclusion

Following the Trust's overall partial compliance, the EPRR team are working on the action plan as agreed with the CCG (Appendix 1) to improve Trust preparedness and compliance.

Although the Trust major incident plan was non-compliant it has been acknowledged that the Trust has the capability (Cat 1) to respond to an incident within the existing infrastructure (IT, Incident Control Rooms, Action Cards and Equipment). The Trust has a 24/7 command structure for day to day business including its major incident response; decisions will be made and documented, with the appropriate rationale, in a dedicated log-book whilst the Incident Response Plan is completed.

Winter preparedness training slides have been created and shared with all managers throughout across the organisation. This provides refresher training in incident concepts and principles to support managers during the winter period whilst the Incident Response Plan is developed. This will include the response to a specialist incident as well as a mass casualty eventuality.

Recommendations

- The Trust Board to note the full re-write of the Major Incident Plan and the recommendation for this to be included within an Incident Response Plan.

- The Trust Board to note the EPRR assurance overall rating: Partial Compliance.

- The Trust Board to note the ongoing work to complete the 10 actions listed in the EPRR Assurance Action Plan 2021/2022.

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APPENDIX 1

EPRR Assurance 2021 Action Plan							
Standard Ref Number	Domain	Standard	Criteria	Scoring	Action Plan	Led by Whom	Due Date
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Partial Compliance	EPRR Policy is currently in the 2017 Major Incident Plan. A new EPRR Policy has been drafted as a separate document following a full rewrite of the MIP to an Incident Response Plan. The new EPRR Policy current going through draft changes and consultation.	Liam Ferris	Published by December 2021
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Partial Compliance	EPRR Policy is currently in the 2017 Major Incident Plan. A new EPRR Policy has been drafted as a separate document following a full rewrite of the MIP to an Incident Response Plan. The new EPRR Policy current going through draft changes and consultation.	Liam Ferris	Published by December 2021
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Partial Compliance	EPRR Policy is currently in the 2017 Major Incident Plan. A new EPRR Policy has been drafted as a separate document following a full rewrite of the MIP to an Incident Response Plan. The new EPRR Policy current going through draft changes and consultation.	Liam Ferris	Published by December 2021

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12	Duty to maintain plans	Major Incident Plan	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Non-Compliant	The current Major Incident Plan is dated 2017 and recently tested during a live major incident where key findings identified that the MIP was not fit for purpose. Whilst scoring Non-Compliant, the MIP is still to be used by the trust in anger during an incident as the concepts and guidance is still relevant. A new Incident Response Plan is being created which is the rewrite of the Major Incident Plan. The MIP has been added to the EPRR Risk Register and will stay there in till the new one is published and tested	Liam Ferris	Published by January 2022
14	Duty to maintain plans	Cold Weather Plan	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Partial Compliance	Review the 4x4 Extreme Weather Plan to ensure it is in date.	Liam Ferris	Review to be completed by December 2022
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Partial Compliance	Scored partial compliance due to MIP dated 2017. The MIP is still to be used as the guidance for Mass Cass is still relevant. Once the Incident Response Plan is published. Mass Cass will be tested throughout the plan.	Liam Ferris	Published by January 2022
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Partial Compliance			
34	Response	Situational Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Partial Compliance	Partial compliance scored due to SitReps in the 2017 MIP which has NC as per above. In an incident the concept of Silver & Gold Command Structure would be used to sign off sitreps.	Liam Ferris	Published by January 2022
57	CBRN	CBRN Planning	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Partial Compliance	TSDFT has a CBRN capability. Partial Compliance as the MIP is dated 2017 but the same guidance applies for CBRN. This will be compliant by the time the new IRP is published	Liam Ferris	Published by January 2022
64	CBRN	PPE Disposal Arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Partial Compliance	Waste Management Policy requires and updated review	Liam Ferris	Published by January 2022

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