Torbay and South Devon NHS Foundation Trust
Public Board of Directors

The Boardroom, Hengrave House/MS Teams
26 January 2022 11:30 - 26 January 2022 14:00

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	Consent Agenda (Pre Notified Questions)		
3.1	Committee Reports		11:40 - 11:50
3.1.1	Finance, Performance and Digital Committee Chair's Report - 22 November 2021 and 14 December 2021 Receive and Note 3.01.01 Finance Performance and Digital Committe... 11 3.01.01 Finance Performance and Digital Committe... 15	P Richards	
3.1.2	People Committee Chair's Report - 20 December 2021 Receive and Note 3.01.02 - People Committee Chairs Report.pdf 17	V Matthews	
3.1.3	Quality Assurance Committee Chair's Report - 22 November 2021 Receive and Note 3.01.03 Quality Assurance Committee Chairs Repo... 19	J Lyttle	

#	Description	Owner	Time
3.1.4	Building a Brighter Future Committee Chair's Report - 14 December 2021 Receive and Note 3.01.04 Building a Brighter Future Committee Chair... 23	C Balch	
3.1.5	Charitable Funds Committee Chair's Report - 7 January 2022 Receive and Note 3.01.05 Charitable Funds Committee Chairs Report... 25	J Lyttle	
3.2	Reports from Executive Directors (for noting)		11:50 - 12:00
3.2.1	Chief Operating Officer's Report - January 2021 Receive and Note 3.02.01 Chief Operating Officer's Report - January... 27	COO	
4	For Approval		12:00 - 12:10
4.1	Unconfirmed Minutes of the Meeting held on the 24 November 2021 and Outstanding Actions Approve 4.01 Unconfirmed Minutes of the meeting held on th... 37	Ch	
5	For Noting		12:10 - 12:25
5.1	Parking Lot of Deferred Items For Information 5.01 Public Board Parking Lot of Deferred Items - 2... 53	DCG	
5.2	Report of the Chairman Verbal	Ch	
5.3	Chief Executive's Report Receive and Note 5.03 Chief Executive's Report.pdf 55	CE	
6	Safe Quality Care and Best Experience		12:25 - 13:00

#	Description	Owner	Time
6.1	Integrated Performance Report (IPR): Month 9 2021/22 (December 2021 data) Receive and Note 6.01 Integrated Performance Report Month 9 2021... 71	DTP	
6.2	January 2022 Mortality Safety Scorecard Receive and Note 6.02 January 2022 Mortality Score Card.pdf 137	MD	
6.3	CQC Focused Inspection Report Receive and Note 6.03 CQC Focused Inspection Report.pdf 159	CN	
6.4	Maternity Governance and Safety Report 1 October 2021 - 30 December 2021 Receive and Note 6.04 Maternity Governance and Safety Report 1 Oc... 167	CN	
7	Valuing our Workforce		
7.1	No agenda items submitted		
8	Improved Well-Being Through Partnerships		13:00 -13:30
8.1	Building a Brighter Future Programme Update Receive and Note 8.01 Building a Brighter Future Programme Update.... 181	DTP	
8.2	Outcome Paper: Healthwatch Devon community engagement survey relating to the disposal of the former Dartmouth and Kingswear Cottage Hospital site Receive and Note 8.02 Trust Board Paper Healthwatch Report Dartm... 187	CFO	
8.3	Dartmouth Neighbourhood Plan – Trust 2nd Response Approve 8.03 Dartmouth Neighbourhood Plan – Trust 2nd R... 219	CFO	

#	Description	Owner	Time
8.4	Community Wealth Build - Memorandum of Understanding Approve 8.04 Torbay Community Wealth Build - Memorandu... 333	DTP	
9	Well-Led		13:30 - 14:00
9.1	ICS Devon SOF 4 Exit Criteria Receive and note 9.01 ICS Devon SOF 4 Exit Criteria.pdf 339	CEO	
9.2	Trust Strategy Approve 9.02 Trust Strategy.pdf 355	DTP	
9.3	Terms of Reference: People Committee and Quality Assurance Committee Approve 9.03 Terms of Reference - People Committee and... 373	DCG	
10	Compliance Issues		
11	Any Other Business Notified in Advance Note	Ch	
12	Date and Time of Next Meeting - 11.30 am, Wednesday 23 February 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'.

Torbay and South Devon
NHS Foundation Trust

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

Committee meeting date:	22 November 2021
Report author + date:	Paul Richards, Non-Executive Director 18 January 2022
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 BAF and CRR, noting in particular updates to Objective 2 to take account of the increased level of demand the Trust and wider system was experiencing, including the ongoing impact of the Covid pandemic. The Committee also noted the merging of objective 4 and Objective 12.

Further discussion was held on objective 6 (to provide and maintain a fit for purpose digital infrastructure ensuring service continuity at all times), noting that some Trusts in the system had chosen to go ahead with market testing around EPR. It was noted that a risk assessment had been undertaken and would be discussed by the Committee.

Finally, given reliance on non-recurrent mitigations to balance the financial position, it was agreed that a further deep dive into the efficiency programme would be undertaken.

Strategy & long-term planning

The CFO presented a report on local planning authority (LPA) engagement, explaining the Section 106 framework and the Trust's role in supporting other organisations within the system. The Committee welcomed the change in approach to LPAs over the last two years, maturing from a transactional to a proactive relationship to ensure the Trust was engaged at the start of any planning.

Medium-term planning

The Committee received an update on the GIRFT programme, noting some difficulty in embedding recommendations from reviews into business as usual. A robust discussion was held, concluding that the overarching Clinical Governance Framework should be the most effective vehicle to appraise progress achieved through a multi-disciplinary approach to the work.

The Committee also received a report outlining the recommended Exit Criteria from the Single Oversight Framework. It was noted that, following approval, the report would be submitted to the system improvement team for moderation and consistency checking. The Committee endorsed the draft exit criteria for further discussion at Trust Board.

The Committee received a crucial Business Case regarding digital, which highlighted the need to invest c £1.7m in digital services. Having exhausted internal funding solutions, it was proposed that this was escalated to the Integrated Care System Digital Transformation Group given the significant residual risk the Trust was facing. A comprehensive discussion ensued, regarding the practicalities of recruitment, scope for mutual support and sharing of services, local and regional disparities and the significant residual risk facing the Trust. In conclusion, the Committee felt the report would provide the ICS with the information to make an informed decision on what action to take and also to understand the risk the Trust currently held in respect of its digital infrastructure. It was also noted that the Business Case could also be used at a tool to support for the Trust's Digital Outline Business Case and as a lever for support from the national team.

Finally, the Committee received a confidential update on the plans for the Teignmouth Health & Wellbeing Centre.

Performance

Winter Planning

The Committee received the Winter Planning Arrangements Report, which detailed the arrangements being put in place to support the Trust through the winter period,

The Committee discussed in particular:

- How the system would be flexed to support the Trust when demand increased;
- The key risks and mitigations approaching the winter period;
- Arrangements for how patients would be kept safe whilst at the Trust, in particular within the Emergency Department environment; and
- The Trust's span of control to influence versus where system support would be required.

The committee received the M7 Integrated Performance Report, noting:

Performance/Quality

The number of Covid patients in Torbay Hospital remained high. Four beds in the Trust's Intensive Care Unit continued to be used for Covid 19 patients, which was the maximum number the Trust could support. Prevalence of Covid 19 in the community also remained high. This was impacting the Trust's ability to provide other services such as elective orthopaedic procedures.

The Trust had taken the difficult decision to step down elective orthopaedic capacity from the 1st December 2021 to ensure care could continue to be delivered to acutely unwell patients. However, it was expected that from January 2022 the Trust would be able to access the Nightingale Hospital to undertake orthopaedic procedures. Work was currently taking place to ensure the sessions were resourced properly and that pathways were optimised.

The Committee also noted a significant issue with care capacity in the community workforce affecting the Trust's ability to discharge patients. This meant patients spent longer in hospital than necessary, impacting on flow from the Emergency Department and increased ambulance handover times. The Committee sought assurance over the widening gap between domiciliary care demand and delivery, noting that funding had allocated to either support the residential

nursing sector or to support increased care workforce in the independent sector, including an additional £2 per hour in pay for the domiciliary care workforce.

In respect of Cancer performance, it was noted that Dermatology, Urology and Upper GI continued to be significantly challenged. The Committee noted the significant increase in breast care referrals due to a national campaign.

Finance

The Trust reported a £200k surplus in Month 7 and year to date performance was in line with plan. Pressures and drivers to the position remained those as reported in previous meetings including actions to support Opel 4 namely increased agency spend alongside the need to escalate to side rooms to accommodate unplanned care demand. However, the Committee noted that the Trust's cash position remained good. £800k of Cost Improvement Programme savings had been delivered in month, but this was under plan by £349,000 which was offset by non-recurrent savings. There was a forecast end of year shortfall of £4m and mitigating actions were being implemented.

Other matters

The Committee also discussed:

- The capital expenditure position and plan
- An update on cost and schedule for the HSVL Project at Torbay Pharmaceuticals
- Emerging guidance with respect to planning for future years, 2022-23 and beyond
- Efforts to increase non-face-to-face care, particularly in outpatients
- The approach to the Digital investment Outline Business Case
- Lessons learned from the Electronic Prescribing and Medicines Administration project

Items for escalation

From its discussion, the committee seeks to highlight:

- The fragility of the Trust's digital environment and urgent need for investment
- The need to develop a focused and coordinated ICS plan for Covid recovery and wider strategic change

Key decision(s)/recommendations made by the Committee

Approved:

- The draft SOF 3 exit criteria for the Trust
- The escalation of digital investment needs to the ICS
- The winter planning arrangements for the Trust and South LCP
- The approach to Teignmouth Health & Wellbeing Centre
- The approach to developing the Digital Outline Business Case

Torbay and South Devon
NHS Foundation Trust

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

Committee meeting date:	14 December 2021
Report author + date:	Paul Richards, Non-Executive Director 18 January 2022
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

This meeting was mainly a joint BBF / FPDC meeting to review and recommend to Trust Board the Outline Business Case for the Digital/Electronic Patient Record (EPR) component of the BBF Programme.

However, a standalone and more detailed Committee discussion was held regarding the several and complex funding streams designed to support the Trust's winter response.

The Committee received an overview of the sources of funding available to the Trust to support elective recovery and the Winter Plan, which would provide financial support until 31 March 2022.

The sources of funding were explained as follows:

- Targeted Investment Fund – originally to support the Trust to reopen the Day Surgery Unit and move the Medical Assessment Unit back to the ward environment. Given the current level of escalation this was not possible, however the funding would be used to de-escalate the system as much as possible. There was flexibility around how the funding could be deployed.
- Elective Recovery Fund (ERF) – the system would need to achieve 89% of previous activity to obtain this funding. The Committee noted the proposed areas of focus to support either day case or inpatient activity.
- Elective Recovery Fund+ - schemes focused on diagnostics and other areas not included in the criteria for the original ERF.

The Committee emphasised the need for strong governance around delivery of the projects detailed in the paper. Assurance was provided by that the same governance approach would be taken as for previous Covid preparedness exercises or internal incidents, namely a focused set of financial instructions which covered urgent decisions which were required outside of normal process.

One of the projects to be funded by the Elective Recovery Funding + was noted to be a handover pod for ambulance conveyances. The Chief Operating Officer provided an overview:

The proposal sought to address the current process of holding patients between two sets of sliding doors whilst waiting for admission to the Emergency Department (ED), to enable ambulance crews to be released back in the system, and the withdrawal by the Ambulance Service of the Hospital Advisory Liaison Officer (HALO) Team that supported handover of patients from ambulance crews to the Trust.

The creation of a pod would accommodate patients waiting for admittance to the ED. Work was underway to agree a shared care model with the Ambulance Service with clear lines of accountability in terms of patient handover. It was recognised that a pod was not an ideal solution, however a solution needed to be found to ensure ambulance crews could be released quickly back into the system and patients were kept safe whilst waiting to be admitted to the ED.

The Committee was asked to approve the proposal that if clinical protocols could not be agreed, delegation out of Committee be enacted to approve deployment of the funding into alternative means to reduce ambulance handovers. It was noted the Trust had reinstated the critical incident financial instructions that had been in place during the first wave of the pandemic, to support financial decision-making in extremis.

The Committee noted that NHSE/I were expected to define the current Omicron Covid wave a national incident, and if this took place, the NHS would be required to follow national directives in terms of managing emergency patients which could affect the plans as detailed in the Business Case.

The Committee approved the Torbay Pod and Emergency Department Business case, noting the need to agree clinical protocols with the Ambulance Trust and to secure clear timelines around when a pod could be provided.

Key decision(s)/recommendations made by the Committee

Approved:

- The SWAST handover pod business case
- Approach to re-purposing external funding subject to strict compliance with incident processes

Torbay and South Devon NHS
NHS Foundation Trust

Report of the People Committee Chair to the Board of Directors

Meeting date:	20th December 2021
Report by:	Vikki Matthews
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☐
Public or Private *(please select one box)* ***[If the Board requires information on sensitive or confidential matters please mark 'Private']***	Public ☒ or Private ☐

The meeting was reduced to one hour in acknowledgement of the Trust's operational challenges. Some agenda items were deferred, other papers were taken as read with no discussion. Items/ risks to be raised to the Board are as follows:

- **Talent retention and morale** – with sickness continuing to rise (5.43 % for November) and turnover increasing to 11.51%, the Committee was updated on the measures that the Trust are taking to help with talent retention and to improve morale. Whilst there is no easy solution, committee members took some assurance by learning that a range of targeted measures are being taken to address the issues and the Trust fully understands the level of risk this poses. This led to a discussion on leadership retention and an observation from the CPO and MD that there is the concerning turnover in our Senior Management population. The Committee acknowledged the risk of losing this experience and knowledge from the Trust and agreed that the matter should be added to the Board Assurance Framework.
- **BAF updates** – given the current workforce challenges and associated risks, the Committee proposed increasing the current risk assessment for Objectives 8 and 9 to 16 and also requested some updating of the commentary.
- **Mandatory vaccination** - the Committee discussed the potential impact of mandating a Covid vaccine for patient facing roles and noted the short timelines for implementation (end of March 2022). We noted that full guidance had not yet been received at the time of the meeting but reiterated the need for the Trust to start making plans to engage with its staff on this matter in the very near future. The Committee also expressed its hope that there would be a level of consistency of approach across the Trusts within the ICS.

Key decision(s)/recommendations made by the Committee:
[list any approvals made by the Committee here eg business cases, Regulator statements, report &a/c's]

1. The Committee asked that the CPO brought back any data that was available on the issue of leadership turnover and retention.
2. The Committee recommended that the risk assessments for objectives 8 and 9 of the BAF be increased given current workforce challenges.

Report of Quality Assurance Committee Chair to TSDFT Board of Directors

Meeting date:	22 November 2021
Report by + date:	Jacqui Lyttle Committee Chair 6th December 2021
This report is for:	Information☒ Decision ☐
Link to the Trust's strategic objectives:	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private	Public ☒ or Private ☐

Key issues discussed and decisions made

1. **Operational Pressures –** the committee received a comprehensive verbal briefing on the current level of demand and operational pressures facing the Trust:

- The prevalence of Covid 19 in the community and the rest of Devon was increasing.
- It was becoming more difficult to secure support in the community due to increasing pressures. Where possible other Trusts in the system had been providing support however they were also experiencing increased levels of demand.
- The Trust had plans in place in case it was necessary to open a second Covid Ward.
- The Trust's Infection Prevention and Control (IPC) and Microbiology teams have provided a significant amount of support to ensure patients and staff remained safe.
- There had been several instances of patients testing negative for Covid 19 on admission, but subsequently testing positive, reinforcing the need for robust IPC measures to be in place.
- The Trust had a much lower number of nosocomial infections than other Trusts, which was a testament to the robustness of its IPC measures.
- The increasing demand had impacted on the availability of elective beds, which in turn restricted flow. This also affected the length of ambulance handover times. The Trust was working with the region and system to try to find solutions to ease the pressure.
- The difficult decision had been taken to cease elective orthopaedic capacity with effect from 1 December to try to ease the pressure and improve flow. The same approach had already been taken by other providers in the system.
- In respect of cancer performance, Dermatology, Urology and Upper GI continued to be challenged with increases in referrals. The Trust was working with the South, East and North Devon (SEND) Alliance to try to identify a networked solution.

The committee was assured that appropriate plans and measures were in place to mitigate harm and manage risk.

2. **Board Assurance Framework (BAF) and Corporate Risk Register (CRR)** – the committee received the BAF and CRR and noted:

- That objective 4 '*to provide safe care and achieve best patient experience, responding to the new paradigm of harm and safety as a result of Covid 19'* and objective 12 '*to mitigate the long-term impact of Covid 19 on the quality and safety of services for the local population*' had been merged to reflect the increased level of harm and safety as a result of Covid 19. The key actions and objectives had also been reviewed and updated. The initial risk rating score remained at 16, with the current risk assessment at 20.

3. **Quality Care Commission (CQC) NHS Patient Experience Surveys 2020 Reports**

The committee was presented with the outcomes of the recent CQC reviews of Urgent and Emergency Care and Adult Inpatient Survey, along with a detailed report which highlighted areas of best practice along with some requiring improvement. Each Trust was allocated a rating of 'better'; 'about the same' or 'worse' for each section of the survey

a) **Urgent and Emergency Care**

- 126 trusts had taken part in the survey.
- The survey included 950 patients that attended the Trust's Accident and Emergency Department at Torbay Hospital and 420 who attended the urgent treatment centre at Newton Abbot Hospital.
- The trust scored 'about the same' in the all the sections apart from 'tests' where it scored 'worse'. This related to how patients would receive the results of their test if they did not receive them during their visit. An improvement plan was currently being put in place to improve this issue. The trust was not seen as an outlier by the CQC .

b) Adult Inpatient Survey

- The survey included 137 trusts.
- The detail of the survey was quite complex and due to changes in methodology the results could not be compared to those from previous years.
- Against the majority of criteria, the Trust scored 'about the same', with one being scored 'somewhat worse than expected'. This related to the question 'were you ever prevented from sleeping at night by hospital lighting?'.
- In addition, other areas where the Trust scored slightly less than the overall average were as follows:
    - Were you ever prevented from sleeping at night by other patients?
    - Were you ever prevented from sleeping at night by noise from staff?
    - Did you get enough help from staff to eat your meals?
    - During your hospital stay, were you ever asked to give your views on the quality of your care?

- Areas where the Trust scored better than the overall average were:
    - Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?
    - There were restrictions on visitors in hospitals during the Covid 19 pandemic. Were you able to keep in touch with your family and friends during your stay?
    - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
    - How did you feel about the length of time you were on the waiting list before your admission to hospital?
    - After leaving hospital did you get enough support from your health or social care services to help you recover or manage your condition?

- Where the Trust had scored poorly, a common theme could be identified in respect of being prevented from sleeping. This was an issue that had also been identified through real time feedback and as a result sleeping packs for patients had been developed including eye shields and ear plugs.
- In respect of support for eating meals, a task and finish group had been established to lead the work to improve support for patients. It was noted that, during the pandemic, support such as that from family and friends, protected mealtimes and also meal time assistants had been stood down and were now in the process of being reinstated.
- Delivery of improvement plans would be overseen by the Trust's Feedback and Engagement Group.

The Committee received and noted the Care Quality Commission NHS Patient Experience Surveys Report and were assured that robust improvement plans were in place.

4. **Quality Report -** The committee received the report and noted the following:

- Demand on the Trust had continued during September and October with increased numbers of patients attending and being admitted who were Covid 19 positive.
- There had been an increase in the number of bed closures in September and October due to outbreaks of Norovirus.
- Work continued to ensure the Trust had completed all of the 'must dos' and 'should dos' CQC recommendations.
- The Trust also continued to plan and prepare for a likely CQC visit in the near future.
- Venous Thromboembolism (VTE) compliance had slightly reduced from 94.4% in July and August to 91.9%. This was partly due to the changes in bed base across the Trust, however work continued to take place to improve performance.
- Performance against the stroke target of patients spending at least 90% of their time on a stroke ward continued to be below target. This was a direct result of the current pressures facing the Trust and the need to close the Trust's stroke ward due to a Covid outbreak. Assurance was provided that stroke patients continued to receive the quality of care they required, both in the Trust's Emergency Department and onwards. The Trust's Stroke Team provided an outreach service for patients who were not being cared for on the dedicated stroke ward.
- The number of patients waiting over 12 hours on a trolley in the Emergency Department had significantly increased in October. Assurance was provided that no harm had come to them due to the extended waits and that a 14-day harm review was undertaken for each patient affected.
- There had been several still births during September and October. Three had occurred during the anti-natal period and did not meet the criteria for referral to the Health Care Safety Investigation Branch (HSIB). There had been one full term baby who required 'cooling' and therefore met the criteria for referral to HSIB. All stillbirth cases were the subject of an internal review.
- There had been seven Strategic Executive Information System (STEIS) reported incidents in September and October. This was lower than average.
- Work continued to close, where appropriate, incidents that had been reported on the Trust's incident Datix system as many were significantly out of date.

The committee received and noted the quality report and were assured that controls were in place to reduce risks and mitigate harm in underperforming areas. The committee also received assurance that patients were not suffering from adverse outcomes due to being cared for on a non-stroke ward.

5. The committee received and noted the QIG assurance report noting no new risks for escalation to the board

6. The committee received the SAE assurance report and can confirm no new risks to escalate to the board.

7 Research and Development Annual Report – the committee received a presentation and the annual report and noted the following:

- Due to Covid 19 the service had relocated to new premises.
- At the start of Covid there had been a lot of uncertainty around the virus and how it should be treated. Through research at the Trust and other providers treatment protocols had been identified and vaccines developed.
- The impact of the pandemic on research other than for Covid had been significant with resource removed and patients feeling isolated and vulnerable. The Trust, however, had managed to retain most of its cancer trials throughout the pandemic and staff redeployment had been kept to a minimum
- In particular the Trust was pioneering a PACE trial for patients with prostate cancer and was running a multi-cancer early detection blood study which, if successful, could increase the number of cancers detected early in a patient's pathway.
- Research supported the quality agenda in that it was protocol driven with data integrity; there was a rigorous research approval process; and regular external quality control and assurance checks.
- Research offered staff funding opportunities; increased their knowledge; and research active sites tended to be early adopters of the research evidence base.
- Concerns around the Trust's Research and Development Department included the need for completion of outstanding estates works in their current location; workforce; activity levels; system pressures; and funding.

Torbay and South Devon
NHS Foundation Trust

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

Meeting date:	14th December 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 (December 2021):

1. The Committee received a presentation jointly with the Finance, Performance and Digital Committee on the Outline Business Case for the Digital/Electronic Patient Record(EPR) component of the BBF Programme.

2. Following detailed discussion and debate and subject to some suggested amendments to the recommendations, the Committee endorsed the Business Case which still remains dependent upon identifying clear sources of funding for the required investment.

3. The Committee agreed with the recommended approach to procurement which provides the opportunity for a number of outcomes and welcomed the collaborative approach to funding and delivery being pursued with our system partners.

4. The Committee noted the timescale challenge facing the Trust which has to replace critical IT systems which are reaching 'end of life' status. Given the uncertainties which still exist over the delivery of an EPR the Committee noted the need for contingency arrangements to be put in place.

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

Report of Charitable Funds Committee Chair to TSDFT Board of Directors

Meeting date:	7th January 2022
Report by + date:	Jacqui Lyttle, Committee Chair 18th January 2022
This report is for:	Information☒ Decision ☐
Link to the Trust's strategic objectives:	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private	Public ☒ or Private ☐

Key issues to highlight to the Board:

1. **External audit –** Grant Thornton presented the 2020-21 Annual Report and Accounts. The Committee noted that no significant issues had been identified during the audit process and were assured that there were no weaknesses in the management of investments or controls.

2. **COVID- 19 donations update** – the committee received a detailed update on the work undertaken since the last meeting, which covered fundraising activity and use of the COVID funds. The committee was assured that the funds were being managed in line with other funds and that front line staff were continuing to benefit from the appeals activities.

Key Decision(s)/Recommendations Made:

Audit – the committee

1. Noted the Audit Findings Report.
2. Approved the Letter of Representation and delegated the Deputy Chief Executive/Chief Finance Officer to sign the letter outside of the meeting.
3. Approved the Annual Report and Accounts for 2020/21 noting that Sarah Wollaston would need to be removed as she was no longer a Non-Executive Director and delegated the Committee Chair and Deputy Chief Executive/Chief Finance Officer to sign them outside of the meeting.
4. Approved the Charity Commission Return.
5. Noted the Audit Risk Report and confirmed management responses were in line with Committee understanding.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report - January 2022			**Meeting date:** 26th January 2022
Report sponsor	Chief Operating Officer		
Report author	System Directors		
Report provenance	Due to service delivery pressures this month the contents reflect an abridged update from management leads across the Integrated Service Units (ISUs) and Children and Family Health Devon (CFHD)		
Purpose of the report and key issues for consideration/decision	This report provides an operational update to complement the Integrated Performance Report (IPR) monthly reports, including performance metrics. The report offers greater visibility of activity not fully covered in the IPR; in particular this month focusses on the Trust surge response to the Covid-19 pandemic. The report explains the key activities, risks and operational responses to support delivery of services through this phase of the pandemic surge and winter including actions to increase delivery of high priority cancer and elective services. The impact of securing the beds needed for ongoing hospital flow and workforce challenges are also covered. Covid-19 preparedness plans and the quarter 4 winter plan for the Trust and the wider system are being operationalised and overseen by the Trust Incident Control Centre (ICC). Positive improvements are identified with respect to waiting times for two of the Trusts most challenged cancer pathways, Dermatology and Urology.		
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			

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<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
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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
</td></tr>
<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td>X</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>X</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>X</td><td>National policy/guidance</td><td></td></tr>
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Report title: Chief Operating Officer's Report		**Meeting date:** 26th January 2022
Report sponsor	Chief Operating Officer (COO)	
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 six Integrated Service Units and Children and Family Health Devon.

2. Introduction

The organisation has continued to experience significant consequences to service delivery from the pandemic. In particular from the recent surge in covid-19 infections, inpatients and staff absences. It was necessary to escalate into a second ward for covid-19 inpatients in early January and as a result there is reduced capacity available for urgent care. This has led to patients spending significantly longer in the ED and in ambulances.

Increased challenges have also been experienced from the requirement to restrict access to inpatient beds to support Infection, Prevention and Control (IPC) measures. At times up to 7 ward areas have been restricted in terms of access to beds which has further impacted on urgent care, these IPC measures are essential to secure the safest care possible. The Board IPR details the impact in terms of the number of ambulance hours lost and time spent in the ED.

The Trusts Incident Control Centre (ICC) and Covid Preparedness Response meeting is led by the COO. This group and the associated support cells lead day to day delivery of the Trusts pandemic and winter response. The objectives for the daily meetings are to;

- Provide strategic oversight to the Tactical Team and Operational Cells
- Lead delivery of the tactical plan based on current operational demand.
- Make decisions based on recommendations and evidence.
- Review and approve Situation, Background, Assessment and Recommendation (SBAR) forms provided by the Operational Cells
- Manage emerging risks.
- Record decisions.

Detailed planning, preparation and delivery through the ICC and Covid Preparedness Meeting has secured the quarter 4 and the Covid response plan. These plans are supported by the whole system locally and for example include deployment of additional Adult Social Care (ASC) grant funding. In addition, planning and delivery in partnership with the Trusts Independent Sector providers is in place to ensure robust support is provided when needed.

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 are progressing delivery of the action plan from the EPRR Assurance Report. The team are pleased to report the EPRR Policy has been updated to include plans for on-going improvements and is being reviewed through the Trust approval process.

The EPRR Team's focus for February 2022 is to publish the new Incident Response Plan replacing the Major Incident Plan, support and provide EPRR advice across the organisation at an operational, tactical and strategic level and train and educate staff in specialist roles during a major incident e.g. Loggist and Commander Training.

4. COVID -19 response plan

The Trusts high level summary covid response plan is included as appendix 1 and highlights the service delivery changes made to this point in time in the Trusts covid-19 response.

As highlighted in the plan, in order to respond effectively to the current wave from covid many services have moved location. Some teams have moved multiple times over the course of the last 24 months. The impact on services from the significant changes made to the location of services is referenced within the ISU updates below. The impact on individuals and teams is also significant and the Executive and wider leadership team is constantly exploring additional way to support our people in these extremely difficult times.

Work continues with staff-side representatives, individuals and teams to support colleagues with these changes. Timely, regular and comprehensive communications are essential particularly at this time, the Trusts Associate Director of Communications and Partnerships advises and supports the process.

The Chief Nurse has met with the CQC to set out the requirements for the service changes and CCG commissioners are also kept updated to ensure the necessary approvals and support is in place.

The Recovery Cell has been commissioned to ensure safe and rapid de-escalation plans are agreed ready to be mobilised as soon as it is possible to do so.

5. Children and Family Health Devon (CFHD)

The CFHD team have finalised the transformation plans necessary to move the service to the integrated physical and mental health basis which was set out in the original service specification. The outcome has been tested through the CFHD Alliance Board and is undergoing a process review with NHS Devon.

6. Coastal ISU: Elective / Planned Care – Surgical Activity

The Trusts Covid surge plan included stepping down elective orthopaedic inpatients from the 1st December 2021. The decision-making process to define and agree the plan underwent the required governance through the ICC. These are very difficult and balanced decisions to ensure service changes respond to the pandemic effectively and are aligned to optimise management of the clinical risks being carried by the Trust. The process is clearly defined, clinically led and incorporates commissioner agreement following scrutiny of the Quality and Equality Impact Assessments (EQEIA).

Patients waiting for inpatient elective orthopaedic procedures represent the greatest number of patients waiting over 104 weeks for treatment. The ICC has commissioned the Recovery Cell to oversee the plans to rapidly deescalate and secure capacity for all patients as soon as it is safe to do so.

The Nightingale orthopaedic pathway is due to commence in February subject to confirmation of workforce. As a result of challenges in securing staffing for the unit the start date has moved from mid-January to early February. In addition, private healthcare providers will be utilised as part of the recovery phase. Clinical acceptance criteria of the private providers restrict the case mix of patients who can be treated in private sector units. Many of the Trusts patients waiting a long time do not meet the clinical criteria for these services and therefore require treatment with an NHS provider. This means the Trust will not be able to reduce the number of 104-week waiters to the target level by the end of March 2022.

The Nightingale is also setting up ophthalmology capacity, glaucoma testing which the local team will utilise as soon as the facility is ready.

Insourcing for endoscopy and cataracts is continuing with extra weekends planned before the end of March. An ophthalmic high street company with a local base has capacity that will be used for cataract surgery utilising the Elective Recovery Funding (ERF+). The team are working with the company and the Finance Team and plan to start February 2022.

7. Paignton and Brixham ISU: – Cancer and Diagnostics Update

7.1 Cancer Performance

Although waiting times for the Trusts cancer patients have extended in the reported month as covered in the IPR, some additional capacity has been secured which is having an impact in January. The Cancer Alliance has provided a fully staffed urology mobile unit which started to treat patients on the 13th January. Initially this unit will deliver trans-perineal biopsies and cystoscopy pathways. The Cancer Alliance has agreed to retain this capacity with the Trust until waiting times are reduced back to acceptable levels.

In addition to the Cancer Alliance, recognition goes to the Coastal Operational Mangers supporting the Urology Team who worked tirelessly over the festive period

to deliver this solution at very short notice. Waiting times for dermatology patients on the 2-week wait pathway are also reducing. Clinics bookings have reduced from a 6 week wait to 3 weeks and it is anticipated from the start of February that patients will be being booked within the 2-week target.

The Cancer Team has recommended the establishment of a Cancer Cabinet to coordinate activities across ISU's with the Clinical Director for Cancer Services and the Chief Operating Officer holding the Chair and Co-Chair roles. This will support greater coordination of clinical and support services to achieve the optimum capacity to recover and then hold delivery of cancer services within national standards.

7.2 Diagnostics

CT and MRI imaging waiting times have increased as referral levels have picked up and the service is challenged in being able to provide sufficient capacity. There is increased focus on is area with the Performance Team working closely with operational leads to maximise and model the impact of all opportunities available including the capacity at the Nightingale Hospital in Exeter. More information will be included in next month's report.

7.3 Mortuary

The multi-agency process of caring for our deceased patients requires constant attention to ensure there is sufficient capacity at every stage. Recently the Trust has brought in 2 additional units to support our patients securely and safely.

8. Newton Abbot ISU: - Urgent & Emergency Care

The Trusts Emergency Department (ED) and assessment units continue to operate under extreme pressure, the time patients are spending in the department or in ambulances waiting to be seen in the ED is extended. The ED team continue to apply internal escalation protocols to ensure every space within the department which can be safely used is, and the wider Trust continually seeks to optimise capacity supporting safe patient flow.

The impact of supporting patients with Covid and keeping both these patients and those without Covid safe puts significant pressure on the IPC team. The team is constantly balancing risks to individual patients with risks to safe flow in support of ambulance off-loading and care within the ED and the assessment units. In order to achieve this balance, it is sometimes necessary to restrict access to a number of beds or even whole wards. Since the start of January up to 7 wards have had restricted access at any one time. This picture is mirrored in the Care Home Sector and as a result there are more patients on the complex discharge list than under normal circumstances. The number of people waiting in hospital beds for care homes has nearly doubled to an average of 40 per day.

9. Torquay ISU: Child Health /Paediatrics

The Paediatric outpatient clinical space has been temporarily relocated from level 2 to level 7 alongside the Short Stay Paediatric Assessment Unit (SSPAU). This allows

for surge planning to release space for level 2 to be used as a discharge lounge. This is also part of the Covid preparedness and quarter 4 plan to ensure effective flow, optimise beds and reduce ED waits and ambulance handover delays.

The Louisa Cary ward is also supporting Trust wide surge plans by accommodating 18-25-year olds and streaming from ED once patients have been triaged.

The waiting list for community clinics has increased as expected, although actions taken by the team has slowed the increase. The List has, however, increased from about 880 at the end of November to 902 in January, some children are waiting up to 15 months, the general waiting list is 5 months.

The team is working with ED to create a paediatric escalation safety matrix to understand and measure acuity of the department to enable and support decisions when in escalation with capacity from within the Child Health Department.

The department are working with surgery to prepare for a visit from the SW Surgery in Children Operational Delivery Network, the visit is scheduled for 16th February. This will be a supportive visit not an inspection, to establish what is working well and how the experience for children and young people may be further improved.

There are a number of nominations submitted from across the Child Health department for individuals and teams for the Paediatric Awards for Training Achievements (PATA) which is due to be held in March 2022.

10. Torbay System: Community Services and Independent Sector

10.1 Children's 0-19 Service

The service needs suitable clinical space in the community in order to meet the contracted contacts for families during the early years for all Torbay babies and children and at key developmental reviews at 1 year and 2.3 years, the Trust estates team are supporting the progress of this essential work at St Edmunds.

The Health Visiting (HV) service is piloting a new approach around emotional wellbeing using the Institute of Health Visiting (IHV) integrated assessment tool and intervention framework this in turn will inform the support HV's provide to mothers with mental health problems.

10.2 Healthy Lifestyles Service

Staff within the team are currently supporting the wider Trust escalation and are being redeployed on to the wards to provide valuable support at mealtimes to support vulnerable patients with their nutrition and hydration. In addition, they will be supporting communication channels between patients and their relatives.

11. South Devon System:

11.1 Moor to Sea

Interim medical cover for Totnes Community Hospital has been secured until the end of February. As part of the Trusts quarter 4 winter plan additional clinical capacity has been contracted to enable an increase from 14 to 18 beds from 4th January. The longer-term model is still in discussion and there is risk in securing solution in the required timescale.

The community team is working with a number of homes to provide support and maintain safe care within those homes.

Moor to Sea has successfully reduced the number of outstanding support packages. This has contributed to very few Moor to Sea residents currently waiting on the complex discharge list for additional support in order to be discharged for hospital beds. The complex discharge list is where the Trust Discharge Hub match patients' needs for domiciliary care (pathway 1) and bed-based community care (pathways 2 and 3), with available capacity.

12. Southern Devon Community Services

Community teams are only doing priority 1 and 2 work in order to release capacity to prioritise hospital discharge including Discharge to Assess (D2A). The Trusts Intermediate Care (IC) and nursing teams are assessed as working at red or amber due to staff absences and with high numbers of end of life patients being supported.

Covid outbreaks in care homes across the patch are increasing; as at 30th December there are 16 providers reporting outbreaks and 11 providers with a single case.

13. Conclusion

Despite the challenges identified in the report teams across the entire Trust continue to demonstrate inspirational efforts in keeping patients safe and seeking to deliver the best possible experience in the challenging circumstances.

14. Recommendation

The Board are asked to review and note the contents of this report.

Appendix 1 Covid-19 Escalation

Covid Level	Name	Estate : impact on services			Trigger
		COVID locations	Non-covid urgent & emergency care	Planned care	
Covid 0	Business as usual	Blue ED	ED, MRU on Forrest, SRU, SSPAU LC, EAU4 on Level 6 - short stay medical	DSU, Allerton, Cromie on level 4 , Warrington, Ella Ainslie, Allerton	
Covid 1	Covid decant	EAU4 on Level 6: Annexe (8 beds)	EAU4/L6 medicine for area outside the annexe	As above	Ist Covid inpatient
Covid 2	Covid enlarge	EAU4/L6	MRU move to DSU & Forrest short stay medical Ainslie 50% medical McCallum - potential medical capacity *(maternity and SCBU no dependent)*	Ella: 50% daybeds 50% trauma, Ainslie 50% trauma DSU reduced/closed Allerton 100% surgical	Covid inpatients exceed annexe capacity
Covid 3	Covid expand	EAU4/L6 & Forrest (COVID hub)	As above	As above	Covid inpatients exceed 1 ward capacity

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 24TH NOVEMBER 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
	* Mrs V Matthews	Non-Executive Director
	* Mrs J Lyttle	Non-Executive Director
	* Mr R Sutton	Non-Executive Director
	Ms L Davenport	Chief Executive
	* Mr I Currie	Medical Director
	* Ms A Jones	Director of Transformation and Partnerships
	* Ms D Kelly	Chief Nurse
	* Mr J Harrison	Chief Operating Officer
	* Mr D Stacey	Deputy Chief Executive and Chief Finance Officer
	* Dr J Watson	Health and Care Strategic Director
	* Mrs E Long	Director of Corporate Governance and Trust Company Secretary
In attendance:	Mrs S Byrne	Board Secretary
	* Dr J Harris	Associate Director of Communications Partnerships
	* Mrs J Phare	System Director of Nursing and Professional Practice, Torbay
	* Mr D Armitage	Deputy Director of People
	* Dr R Allison	Associate Director of Nursing and Professional Practice, Moor to Sea
	* Mr B Isles	Attendee - User experience
	* Mrs S Burns	Lead Freedom to Speak Up Guardian

* via Microsoft Teams

212/11/21 **Welcome and Introductions**

The Chairman welcomed all those present and in attendance to the meeting.

Preliminary Matters

213/11/21 **Apologies for Absence and Quoracy**

The Board noted apologies of absence from Mrs Falcao, Chief People Officer; and Dr Wollaston, Non-Executive Director.

The Board noted Mr Armitage's attendance on behalf of the Chief People Officer.

214/11/21 **Board Corporate Objectives**

The Board received and noted the Board Corporate Objectives.

215/11/21 **Declaration of Interests**

There were no declarations of interest.

216/11/21 **Board User Experience Story**

Mrs Allison, introduced Mr Isles whose wife, Jean Isles, who had various health needs had been admitted to the Trust (Torbay and Brixham) and received treatment a number of times during 2020/2021.In particular, Mr Isles wished to speak of his experience during his wife's admission to the George Earl Ward for stroke treatment; he explained that whilst he felt the standard of care his wife received was good that communication had been poor.

Mr Isles explained to the Board whilst his wife was on George Earl ward there were issues with telephone calls not being answered and a stringent visit booking policy, which did not align to the policy of other ward's, making it unnecessarily difficult for him to visit his wife.

Mr Isles acknowledged that whilst the approach taken of appointing one visitor per patient was appropriate, the application had been too rigid. He explained that on the George Earl ward, the designated visitor had to call at 9am promptly on the morning of the intended visit, as opposed to booking in advance, but that it was often difficult to get through to make the booking. In addition, when he did speak to someone to book and seek an update that the Nurses were often too busy to speak with him. Furthermore, as the physiotherapists did not offer telephone updates, and were often not on the wards post 4pm when he chose to visit, that he found getting information on this aspect of his wife's care challenging.

He explained that upon discharge the Social Worker was very risk averse and therefore unwilling to listen to Mr Isles who was advocating for his Wife. He knew his wife would not want a hospital bed, hoist, equipment or the extensive level of support offered and that their home could not accommodate it, but the Social Worker would not listen to him. This led to Mr Isles moving his own bed out of their home and purchasing a single bed to accommodate the necessary aids. However, once his wife returned home she successfully demonstrated that she could walk with the support of a frame and Mr Isles, she could get out of bed and sit in her chair and the aids were redundant. As such, when the Occupational Therapist visited and Mrs Isles progress acknowledged, a week later, it was agreed that the equipment could be removed from their home, with one or two carer visits a day.

Mr Isles thanked the Board for the opportunity to speak with them and reflected on his and his wife's experiences. He suggested that every ward had a patient-relative liaison officer, whose sole role was to communicate between the ward and relatives, leaving the clinical staff to focus on delivering care to their patients.

The Chairman thanked Mr Isles for his well-articulated insight to the Board, assuring him that the Board recognised the importance of communication and that change was required as the Trust continues on its journey of improvement.

Ms Davenport, thanked Mr Isles for his candour, she agreed with the need for staff to listen and understand the requirements of patients and their families when they return home and that action was being taken to address issues which he had raised.

Mrs Allison, explained the work which had already been undertaken on the George Earle Ward, with thanks to his feedback, and that there had been a misinterpretation of the visiting guidance. A communication project, based on the patient-liaison model Mr Isles suggested had been piloted on Cheetham Hill Ward with the support of the Carer's Team and Heath Watch. She also reflected on how Mr Isle's experience linked to the Trust's aspiration to improve the discharge model, focussing more on what matters to the individual patient and their family. In support of this, Mrs Allison, confirmed that immersive communication workshops had been piloted, focussing on the clinician better understanding what matters to the patient and their family. She explained that the pilot was being rolled out and would be scaled up based on learning.

Mrs Matthews, highlighted the need to feed the organisational cultural risk into the People Plan to ensure Board oversight. **ACTION: Mrs Matthews**.

Mr Richards, asked for the Board to be sighted on the cultural improvements made through the Quality Assurance Committee. Mrs Lyttle, undertook for the Quality Assurance Committee to ensure the Board were sighted. **ACTION: Mrs Lyttle**

Ms Davenport, commended the need to consider the culture and risk management of the Trust to enable staff to make decisions autonomously.

Mr Isles left the meeting

Consent Agenda (Pre-notified questions)

Reports from Board Committees

218/11/21 **Finance, Performance and Digital Committee – 25th October 2021**

The Board received the Chair's Report of the Finance, Performance and Digital Committee meeting held on 25th October 2021, as previously circulated, from Mr Richards.

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

219/11/21 **People Committee - 25th October 2021**

The Board received the Chair's Report of the People Committee held on 25th October 2021, as previously circulated, from Mrs Matthews.

The Board received and noted the Chairs report of the People Committee.

220/11/21 **Building a Brighter Future Committee Chairs Report – 17th November 2021**

The Board received the Chair's Report of the Building a Brighter Future Committee held on 17th November 2021, as previously circulated, from Professor Balch.

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

Reports from Executive Directors

221/11/21 **Chief Operating Officer's Report November 2021**

The Board received the Chief Operating Officer's Report of November 2021, as previously circulated, from Mr Harrison.

The Board received and noted the Chief Operating Officers Report.

222/10/21 **Estates Performance and Compliance Group Report**

The Board received the Estates Performance and Compliance Group quarterly report, as previously circulated, from Mr Stacey.

The Board received and noted the Estates Performance and Compliance Group Report

For Approval

223/11/21 **Minutes of the Meeting held on 27th October 2021**

The Board approved the minutes of the meeting held on 27th October 2021.

Mr Stacey, updated action 204/10/21 and confirmed he had spoken with Sam Riley, Head of Improvement Analytics for NHSEI, and a development session was being arranged. The Chairman agreed the action could be closed.

Mr Harrison, updated the Board on action 204/10/21, he confirmed the virtual appointment data had been presented at Finance Performance and Digital Committee and was noted in the Chairs report. The Chairman agreed the action could be closed.

The Chairman reflected on action 206/10/21 and said there would always be cultural barriers to reporting and the profile had been raised therefore the action would be closed. Mr Currie, Medical Director confirmed he had raised the concern around cultural reporting with Jacquie Rees-Lee, Consultant, General Surgery.

The Board approved the minutes of the meeting held on 27th October 2021

For Noting

224/11/21 **Report of the Chairman**

The Chairman verbally briefed the Board on the following key events:

- The Trust hosted it's first 'Proud to be…' virtual event on 27th September 2021 with a range of inspirational speakers including Michael Caines MBE, Alexandra Ankrah and Dr Habib Naqvi MBE.
- The Trust marked Remembrance Day with a 2 minute silence and held a Remembrance Service on Sunday 13 November 2021.
- Dr Wollaston, had been appointed as the interim Chair for the Devon Integrated Care Board and would therefore stand down from her Non-Executive Director role within the Trust, effective 28 November 2021. The Board wished her well in her future system orientated task, which was an important part of the NHS structure and looked forward to collaborating with her in this new role.
- Councillor James MccInnes had been appointed as the new cabinet member for Devon County Council, Adult Social Care and Health services. The Trust looked forward to working with him.

225/11/21 **Report of the Chief Executive**

Liz Davenport, Chief Executive, presented her report, as previously circulated, highlighting the following key issues:

- Emily Long had been appointed as Director of Corporate Governance and Trust Company Secretary, she was welcomed to her first Board meeting.
- There had been positive engagement in the Dartmouth Health and Well Being Strategy from the town.
- The Trust were awaiting the decision, from the independent reconfiguration panel in respect of Teignmouth Hospital.
- There had been an increase of Covid19 infection within the local community, which would impact services, an emphasis was placed on the importance of immunisation against influenza and Covid19. It was reiterated with an increased level of infection, best practice was to follow and reinforce the guidance on hygiene, space and fresh air.
- Discharge from the Trust was pressured due to pressures within community settings. However, there was a need for the Trust to maximise capacity for planned care and the Nightingale Hospital was to be re-purposed to support planned care for Devon.
- The System Oversight Framework (SOF) positions had been confirmed, Devon Integrated Care System (ICS) would be in SOF segment 4 with the

Trust in SOF segment 3. The Trust's plan would align to the overarching plan for Devon ICS.

- The implementation of the Pathway to Excellence Accreditation had been embedded and in November Allerton, Midgely, Turner, Teign and Templar Wards had been assessed and successfully achieved the quality standards.
- The Connect plus app had won a national award from Building a Better Healthcare for best patient-centred healthcare software.
- The Trust's medical education team had ran the prestigious Royal College of Physicians PACES Exam.

Professor Balch, asked whether the Nightingale Hospital being repurposed to support elective care wait list backlogs, would prejudice the Building a Brighter Future (BBF) plans to build a support elective care centre within the Trust. Ms Davenport, explained the Nightingale Hospital presented an opportunity to build capacity over the winter period with the support of Elective Recovery Fund monies. There was a national focus on protected elective capacity and the need for equity of care across the region. The Long Term Plan, supported by the BBF programme, would be the vehicle to ensure services were delivered in a sustainable, equitable way across the region.

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

Safe Quality Care and Best Experience

226/11/21 **Integrated Performance Report – Month 7, 2021/22**

Dr Watson, presented the Integrated Performance Report for month 7, 2021/22, as previously circulated, and drew the following to the Board's attention:

Quality and Safety

- The percentage of stroke patients spending their time on the Stroke Ward fell to 35.9% in October;
- Venous Thromboembolism (VTE) performance for August was reported at 91.9%, the VTE prevention group had been operationalised and the inaugural meeting took place in November.
- Infection control: There had been one Clostridium difficile case, with no lapses of care, there were however more than 460 bed closures in October due to norovirus and diarrhoea; notably the Trust reported strong performance in managing the lowest number of ward Covid19 outbreaks in the region.
- The maternity department had seen an increase in deliveries; one baby was still born in October. The maternity department continued to report a challenged staffing position.

Workforce

- Sickness and absence rates were high at 5.82%. The Trust have put well-being offers in place for staff to support the sickness rate; which would support the performance of the Trust.
- The achievement review rate was reported at 77.86%.

- The current overall mandatory training rate was reported at 89.02%; overall training. Compliance had stayed stable and had not been impacted whilst the Trust was under operational escalation pressures.
- Trust agency spend for month 7 was £1.23m, the financial year to date figure was £7.476m.

Performance

- The Trust were managing a stable covid position of 20 admissions however, based on modelling a significant increase in Covid admissions was expected.
- The Emergency Department saw 753 patients wait in excess of 12 hours for treatment; with 125 patients experiencing over an hour ambulance handover delay upon arrival.
- A rise in the number of patients waiting over 18, 52 or 104 weeks for elective care had continued to rise.
- The elective care recovery plans had been pressured by a rise in Covid19 cases, the rise in cases were likely to require elective care to be stood down.
- The cancer services 2 week wait pathway had reported a challenged position.
- Diagnostic waiting times continued to be pressured due to an increase in referrals.
- The levels of unfilled packages of care in the community had continued to increase. The urgent care team capacity continued to be diverted to ensure packages of care were delivered for the most at risk patients.

Finance

- The total income for the year to date was £2.6m favourable to plan but there was expenditure risk around workforce and agency due to the Trust continuing to be in Opel 4.
- There was a gross risk of £5.9m overspend before mitigations. The deficit was due to the projected shortfall in delivery of Cost Improvement Plans (CIP) and weakening of the trading outlook for Torbay Pharmaceuticals.

Professor Balch, noted the Trust had recorded its highest sickness rate and enquired how this compared to other providers in Devon and whether Covid19 had personally impacted the workforce. Mr Armitage, confirmed the Trust's staff sickness statistic for Covid19 absences was low but, the Trusts overall sickness rate was similar. Devon had been recognised nationally as an outlier for sickness and a deep dive to understand the high proportion (33%) of staff suffering mental health sickness had been undertaken and a range of health and well-being interventions were now in place.

Mr Richards, highlighted the difficulties of achieving the Cost Improvement Plan (CIP) targets and how the increased winter pressures exacerbated by Covid19 showed how important innovation (Building a Brighter Future) was to support patient flow and provide quality care. He asked if there were opportunities for the Devon ICS to support the Trust's plans to innovate.

Ms Davenport, recognised that the system needed to focus on care at home for short term conditions and winter planning required a Devon wide approach. She acknowledged the new resources the Trust were building in the next five years Acute Medical Unit (AMU); and digital transformation but the best solution would be for patients to be able to be cared for in their own homes.

The Board received and noted the Integrated Performance Report – Month 7, 2021/22.

227/11/21 **Winter Planning Arrangements**

Mr Harrison, sought the Board's approval for the winter plan which had been developed in partnership with Devon ICS, the proposal for which had been previously circulated.

Ms Davenport, explained the winter plan focused on collaborative working with system partners and the independent and voluntary sector.

The Board approved the Winter Planning Arrangements

228/11/21 **November 2021 Mortality Score Card**

Mr Currie, presented the Mortality Score Card, as previously circulated. He confirmed the Trust was not an outlier compared to peers.

The Dr Foster mortality data had identified the Trust was an outlier for deaths of intestinal infection, it had been confirmed this was not a coding issue and had been escalated for mortality surveillance review.

Two still births were reported which would not trigger a HSIB review but the maternity team had undertaken a review to seek learning.

There had been one death of a one month old child and a Child Death review was being undertaken by Dr Channer.

The Board were asked to note from April 2022 it would be a statutory requirement for the Medical Examiner to provide an independent review of acute and community deaths.

The Board received and noted the November 2021 Mortality Safety Scorecard

229/11/21 **Annual Incidents Report 2020 21**

Ms Kelly, presented the Annual Incidents Report 2020-21 to the Board, as previously circulated, which would feed in to the Trust's improvement plans.

The Trust had seen a 40% increase in incident reporting, which demonstrated a healthy reporting culture, with the majority being marked as no harm or low harm; the increase in reporting enabled broader learning within teams. The primary driver of the incidents was falls and pressure ulcers and this was in line with national data.

Mrs Matthews, correlated the increase in incident reporting to the increase in pressure within the Trust. She acknowledged the concern about staffing levels; and patients who presented with complex mental health needs would impact on staff.

Ms Davenport, asked how learning was communicated back to staff at an operational level. Ms Kelly confirmed learning would be briefed at the daily safety

briefings, circulated in monthly newsletter and be escalated through the governance framework.

The Chairman asked how community teams accessed learning from incidents, Ms Kelly confirmed learning was placed on the intranet.

The Board received and noted the Annual Incidents Report 2020-21

230/11/21 **Care Quality Commission NHS Patient Experience Surveys 2020 Reports**

Ms Kelly, informed the Board the mandated CQC NHS Patient Experience Survey results for 2020 had been published, as included in the report previously circulated as an appendix. She asked the Board to note the timing of the patient survey, as an improved position could now be reported and a detailed report into the survey results in respect of the Emergency Department would be brought to January Board.

She said the Trust had held a 'Citizens Senate' conference in the summer with partner organisations from the community to improve the relationship between the Trust and its patients and enable patient's voices to be heard.

Overall, the survey spoke to the outstanding care the Trust offered and she gave recognition to the need to build ensuring patients receive a positive experience.

She highlighted areas the Trust needed to focus on which included managing noise at night; and hydration and nutrition training.

Professor Balch, noted the survey was reflective of poor performance correlating with the estate and he highlighted how the Building a Brighter Future project would address this. He also reflected on Mr Isles, feedback and the correlation between the survey results and Patient Advice and Liaison Service.

Ms Kelly, acknowledged the estate and the need to consider effective communication with staff and patients were areas that required focus.

The Board received and noted the Care Quality Commission NHS Patient Experience Surveys 2020 Reports

231/11/21 **Feedback, Complaints and Patient Advice and Liaison (PALS) Policy**

Ms Kelly, asked for the Board's approval in respect of the revised Complaints Policy and Statutory Framework, as previously circulated, she confirmed that there were no significant changes.

Mrs Matthews, highlighted the need to create an environment with the opportunity to learn for the Patient Advice and Liaison Service and although she approved with the policy she asked for this to be considered. **ACTION: Ms Kelly**

The Board approved the Feedback, Complaints and Patient Advice and Liaison (PALS) Policy

232/11/21 **Smokefree 2030 - the All Party Parliamentary Group on Smoking and Health**

The Chairman introduced, Dr Watson and the Smokefree 2030 - the All Party Parliamentary Group on Smoking and Health**.** He acknowledged this was an integral part of Trust's Health and Care Strategy and in line with a smoke free country by 2030.

Dr Watson, talked to her report which had been previously circulated, she explained that it was Devon's ambition to create a smoke free generation and the All Party Parliamentary Group paper on Smoking and Health aligned with the ambition.

The Chairman acknowledged the request was for the Board to support the All Party Parliamentary Group on Smoking and Health.

The Chairman reflected on the implications the Smokefree 2030 ambition would have on the Trust's staff and the population it served and the Board needed to be cognoscente on the impact it would have.

Dr Watson, acknowledged that it would not be easy for people to give up smoking and there would be a need to establish support for people; Mrs Falcao, was leading on this work but, it would derive benefits for the Trust in the long term.

The Board approved to support the Smokefree 2030 - the All Party Parliamentary Group on Smoking and Health

Valuing our Workforce

233/11/21 **Freedom to Speak Up Guardian Six Monthly Report**

Mr Armitage, introduced the Freedom to Speak Up Guardian six month report, as previously circulated, confirming that it had been considered at the People Committee.

Mrs Burns, informed the Board that circa two concerns were typically escalated to the Freedom to Speak Up Guardians a week. This demonstrated a positive culture of feeling empowered to 'speak up' within the Trust although there were still people within the Trust who did not feel able to 'speak up'. She informed the Board that the Trust was taking part in the 'Restorative Just and Learning Culture' initiated by NHS Mersey Care, which supported organisations to adjust their cultural approach to align with the 'lived' experiences of patients and staff. She asked the Board whether it felt the Trust's culture was currently aligned to staff and patients.

The Board debated the cultural approach of the organisation to speaking up and whether there was a disconnect with staff and patients. Mrs Matthews, considered the question and, said she did not believe the Trust was currently consistently culturally aligned although the Board were committed to improving this. She reflected that culture underpinned the Restorative Just and Learning Culture experience and they implemented a restorative approach for psychological safety, it was endorsed as an important pillar of work together with civility, respect and ensuring people processes were fair.

Ms Kelly, agreed there were areas of staff where culture was challenging and she proposed a diagnostic safety culture survey was disseminated to staff to provide the Board with an understanding of what supportive measures could be put in place to improve culture. **ACTION: Ms Kelly**

It was noted that the Restorative Just and Learning Culture initiative took six years to implement and deliver, as culture does not change in short time frame and would require stewardship and leadership from the Board, as well as being captured in the People plan.

The Chairman, on behalf of the Board, acknowledged the importance of the Freedom to Speak Up Guardian role and reflected on the need for middle management to understand that cultural change described, had the support of the Board.

Mrs Burns, acknowledged the positive way the Trust Board worked with the Freedom to Speak Up Guardian and the good rapport between the Board and staff, although effective communication with staff remained a difficulty.

Mrs Burns was thanked for her report and support in this ongoing work to effect cultural change.

The Board received and noted the Freedom to Speak Up Guardian six monthly report

Well Led

234/11/21 **Research and Development Annual Report**

Mr Currie, talked to the report as previously circulated. He noted the excellent work of the team supporting both the Trust and NHS at a national level in combatting the COVID19 pandemic and that in reading the reports the Board should remember the operational benefits of supporting the work of the team. He asked the Board to note the following:

- During the pandemic the Research Team had undertook urgent public health research.
- The research undertaken within the Trust was embedded into care.
- The Trust had a good retention rate for researchers.

Mr Currie then challenged the Board as to whether the importance of research truly embedded and recognised by the Trust, providing examples of studies which had been declined due to there not being enough resource or clinicians called to deliver care.

Professor Balch, highlighted the importance of a plan being put in place for research to inform the development of the Building a Brighter Future project; furthermore he acknowledged the potential to grow the research offer due to the Trust being an Integrated Care Organisation.

The Board noted the report and supported Mr Currie's comments around the importance of research and development now and in the longer term in forming the BBF programme, ensuring resources and space are allocated to it.

The Board received and note the Research and Development Annual Board Report

235/11/21 **Single oversight Framework**

Mr Stacey, confirmed the Board that the Trust has been placed in segment 3 of System Oversight Framework (SOF) and the Trust was required to submit a proposal to improve its position and exit segment SOF 3 which would be subject to review from Devon ICS and NHSEI.

The Board reviewed Mr Stacey's proposal, as previously circulated, in the context of the Trust's financial position, commitment to performance and quality improvements, when considering the SOF exit criteria.

Following a detailed review and scrutiny at private Board and Committee meetings the Board were comfortable to acknowledge the paper, as previously circulated, and endorsed Mr Stacey's approach with their previous feedback adopted.

The Board approved the Single Oversight Framework – exit criteria

236/11/21 **BBF Programme Update**

Ms Jones presented the BBF programme update, as previously circulated. Ms Jones confirmed that the Strategic Outline Business Case (SOC) for the BBF programme had been presented to the regional team and it had almost reached completion and engagement work had taken place regarding the Digital Outline Business Case, the engagement from staff had been positive. The Board were asked to note that the Seed allocation funding had been delayed.

It was reported that the Trust had received a visit from Chris Cale, Regional Director of the New Hospital Plan, who understood the requirement for the Trust to be part of the New Hospital Plan and had been supportive of the case presented.

The Chairman, reflected the visit from Chris Cale was a good way of reinforcing the need for the Trust to be part of the New Hospital Plan.

Professor Balch, expressed frustration with the delayed national announcements. He said the longer the Trust had to wait for funding the greater the challenge would be to resolve the Estate and Digital Infrastructure problems.

Ms Jones, confirmed that the Board had supported the proposal to retain the New Hospital Plan Team until a formal announcement had been made by the New Hospital Plan national team as to funding allocation.

The Board received and noted the Building a Brighter Future Programme Update

237/11/21 **NHSE CCG external assessment of the Trust against EPRR responsibilities and national standards**

Mr Harrison, presented the annual external assessment against EPRR, as previously circulated, and asked the Board to note the partial compliance of the Trust; this was due to the requirement to re-write the NHSEI/CCG major incident plan due to the Trust re-purposing estate throughout Covid19. It was noted the trajectory to achieve compliance would be January 2022.

The Chairman noted the requirement to re-write the major incident plan and the ten actions that would enable compliance to be by January 2022.

Ms Davenport, acknowledged the methodical work that had been undertaken and work to ensure compliance was by January 2022.

The Board received and noted the NHSE CCG external assessment of the Trust against EPRR responsibilities and national standards

238/11/21 **Compliance Issues**

There were no compliance issues reported.

239/11/21 **Any Other Business Notified in Advance**

There was no any other business raised for discussion.

240/11/21 **Date and Time of Next Meeting:**

11.30 am, Wednesday 26th January 2021.

Exclusion of the Public

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

BOARD OF DIRECTORS

PUBLIC

No	Issue	Lead	Progress since last meeting	Matter Arising From
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	Dave Stacey, Deputy Chief Executive and Chief Finance Officer, confirmed he had spoken with Sam Riley, Head of Improvement Analytics for NHSEI, and a development session was being arranged. The Chairman agreed the action could be closed.	27.10.2021
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	John Harrison, Chief Operating Officer confirmed the virtual appointment data had been presented at Finance Performance and Digital Committee and was noted in the Chairs report. The Chairman agreed the action could be closed.	27.10.2021
206/10/21	Ian Currie would review and keep the Board updated on addressing cultural barriers to reporting.	MD	The Chairman reflected on action 206/10/21 and said there would always be cultural barriers to reporting and the profile had been raised therefore the action would be closed. Mr Currie, Medical Director confirmed he had raised the concern around cultural reporting with Jacquie Rees-Lee, Consultant, General Surgery.	27.10.2021

231/11/21	Ms Kelly to consider the opportunities for learning for the Patient Advice and Liaison Service.	CN	Ms Kelly explained the Patient Feedback and Engagement Group were leading the Trust Patient Experience strategy. Feedback and engagement were reported within the quality reports through the Quality Improvement Group on a monthly basis. Safety huddles and briefings on wards were to be reviewed. The weekly quality briefing, titled 'Patient First' was in development to include key messages for staff.	24.11.2021
233/11/21	Ms Kelly, proposed a diagnostic safety culture survey be disseminated to staff to provide the Board with an understanding of what supportive measures could be put in place to improve culture.	CN	Ms Kelly confirmed the diagnostic safety culture survey would be undertaken in financial year 2022/23 and would be overseen by the Quality Assurance Group.	24.11.2021

NHS
Torbay and South Devon
NHS Foundation Trust

Public Board of Directors

Parking Lot **Reviewed: 4th January 2022**

Item/action/issue/policy name	Meeting Date	Comment
Transformation and Partnership Quarterly Report – January 2022	26th January 2022	Deferred to 23rd February 2022
Seven Day Week Assurance Report	26th January 2022	Deferred to 23rd February 2022
Guardian of Safe Working Hours Report	26th January 2022	Deferred to 23rd February 2022
Midwifery Staffing bi-annual Report	26th January 2022	Deferred to 23rd February 2022
Torbay Pharmaceuticals quarterly Report	26th January 2022	Deferred to 23rd February 2022
Standing Orders, SFI's Report	26th January 2022	Deferred to 29th June 2022

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report			**Meeting date**: 26th January 2022
Report appendix	Board assurance framework summary		
Report sponsor	Chief Executive		
Report author	Associate Director of Communications and Partnerships		
Report provenance	Reviewed by Executive Directors 18 January 2022		
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: 26th January 2022
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 24 November 2021 are as follows:

3.1 Excellent population health and wellbeing

Flu vaccination programme for health and care staff
Based on our current data 67% of our substantive staff have received their flu vaccination. Many of our staff receive their vaccinations elsewhere (for example, at their GP surgery) – while we encourage them to tell us if they have had the flu jab elsewhere not all staff remember to do this. Therefore, we estimate that our actual vaccination rate is likely to be higher than 67%.

COVID-19 booster vaccinations
Our COVID-19 booster vaccination programme has now ended. All staff can access the national booking service for first, second and booster doses of the COVID-19 vaccination as needed. 83.6% of our staff have received their booster dose according to the latest published data (13 January 2022).

I'd like to take this opportunity to say a huge thank you to all our staff who ran our COVID-19 and flu vaccination clinics, most of which ran in the evenings and at weekends. I'd also like to thank everyone who has had their jabs.

Mandatory COVID-19 vaccinations for frontline health and care staff
Last year the Department for Health and Social Care announced that all individuals undertaking Care Quality Commission regulated activities must be fully vaccinated against COVID-19 no later than 01 April 2022. A copy of the national letter can be found here.

Staff who have any contact with patients need to have had their first dose by 03 February 2022, in order to have sufficient time to have had their second dose by 01 April 2022.

This includes substantive members of staff, Bank and Agency workers as well as volunteers, locums, students, trainees and anyone on an honorary contract that may be required to have face-to-face contact with patients and service users. Non-clinical workers not directly involved in patient care but who nevertheless may have direct, face to-face contact with patients, such as receptionists, ward clerks, porters and cleaners, are also in scope.

The latest published data (13 January 2022) shows that 95% of our staff have received two doses of the COVID-19 vaccination.

Phase 2 of the Government guidance has yet to be published and we are therefore awaiting further clarity on next steps.

Changes to visiting arrangements
In view of the rising number of COVID-19 cases in our communities and our hospitals we have made changes to our patient visiting arrangements.

Each patient will continue to have one allocated and named visitor for one hour per day. This is the same person for the duration of the patient's stay and not a different person each day, unless agreed with the ward manager in exceptional circumstances.

All named visitors are now required to undertake a lateral flow test prior to visiting and to bring proof of their negative test with them – either in a clear plastic bag or by photographing the test result on a mobile device and showing the photograph to ward staff.

We will continue to regularly review our visiting arrangements in line with NHS and Government guidance and local public health advice.

3.2 Excellent experience receiving and providing care

Current pressures
Demand for our services remains extremely high across acute, community and social care. Ambulance handovers continue to be an area of challenge as does patient flow through our hospitals from the front door of our buildings to our patients' front doors. People are waiting longer than we would like to be seen at our Emergency Department, particularly people who present with less urgent needs and waiting lists for operations, diagnostics and follow-up appointments continue to grow.

We are continuing to work closely with our system partners and our local VCSE organisations to address these challenges and make the best use of the available resources to support people who need our care. There is no simple solution to the complex challenges facing health and social care but by working together we can do more than we can alone.

In addition to the current challenges, the NHS has been asked to prepare for a COVID-19 surge, fuelled by the speedy transmission of the omicron variant. We expect to see an increase in hospitalisations and staff absences in our own communities and already we are seeing more staff testing positive for COVID-19.

Our expected Omicron peak is at the end of January/beginning of February and it could see as many as one in 13 people in Devon being infected, between 300 and 650 people in hospital in Devon with COVID-19 and a staff sickness absence rate of between 8 and 17% (with higher numbers among staff working in clinical services).

The winter months of January to March are always a very busy time for the NHS, so with the additional demands of the pandemic, we have been working hard to create extra capacity and resilience. A number of our administrative support staff and corporate staff have volunteered and been trained to work in our wards and clinical environments if needed and we have already stepped down some non-urgent activity, so that as many of our staff as possible can support urgent and emergency care for those who need it most.

In addition, we are creating extra capacity between January and March by identifying and using additional areas for patient care, including opening extra beds across our Torbay Hospital site and the temporary creation of a new ward which has been facilitated by the temporary relocation of the Ricky Grant Day Unit to the Horizon Centre.

We have opened our discharge lounge and we are working with carers, family members and friends to support people to get home as quickly and safely as possible. Personalised health budgets are being piloted by the Devon system to provide additional support for discharges by enabling people to purchase equipment (such as a microwave to heat meals) or enable family and friends to take time away from other commitments such childcare or work in order to provide support.

We are arranging around 150 extra packages of care to support people at home after they are discharged from hospital and booking more beds in nursing and care homes. The availability of beds in nursing and care homes is affected by COVID-19 outbreaks and staffing absences/vacancies. We fully recognise the challenges facing care homes, nursing homes and our partners in domiciliary care – there is no simple solution and we are committed to working together to do our best for the people of Torbay and South Devon.

We continue to do everything we can to protect space for our surgical teams to operate on high priority patients (life and limb threatening cases, emergency surgery and cancer pathways) and maximising every opportunity to start catching up with the elective backlog that COVID-19 has created. For example, our urology service has been working weekends and sharing facilities across Devon

to reduce their waiting lists. This month a mobile urology unit has been put in place at Torbay Hospital with the focus on reducing the waiting list for local anaesthetic transperineal prostate biopsies and cystoscopies and within the first week of operating, treated 52 patients.

We are acutely aware of the impact of the past two years on the wellbeing of our dedicated and hardworking staff. Our wellbeing team continue to offer a wide range of support and also to signpost people to local, regional and national support available.

We are working with system partners on recruitment including our international recruitment for nurses and our Proud to Care Devon campaign. Earlier this month we held an online recruitment open day for nurses and one for healthcare assistants which has enabled us to recruit a number of new starters – further online open days are planned over the next few months.

Increased MRI and CT provision at the Nightingale Hospital Exeter
People in Torbay and South Devon can now benefit from increased MRI and CT provision at the Nightingale Hospital in Exeter. We are strongly encouraging everyone who is offered a scan at the Nightingale Hospital to consider this carefully and attend there if they are able to do so.

We continue to provide diagnostic imaging onsite at Torbay Hospital and also through our mobile CT and MRI scanners which regularly visit Newton Abbot. However, without people using the scanners available in Exeter, we will not be able to provide the imaging services we need to and people will have to wait longer to be seen.

Dr Rhoda Allison MBE
Dr Rhoda Allison, Associate Director of Nursing and Professional Practice, was awarded an MBE in the Queen's new year's honours list for her services to physiotherapy.

Rhoda has worked with us for over 23 years and is highly regarded for her outstanding contribution to stroke rehabilitation. She was awarded a fellowship from the Chartered Society of Physiotherapy in 2019 for her contribution to the development of national policy, clinical guidelines, and quality assurance for stroke and brain injury services.

The work she pioneered here in Torbay and South Devon has become a 'gold standard' model for the rest of the country, and her citation describers her as 'an inspirational physiotherapy clinician, leader and researcher in the field of stroke and acquired brain injury rehabilitation.'

Silver Chief Nursing Officer Award
Chantal Baker, Nursing and Midwifery Excellence Lead Nurse, received the prestigious Silver Chief Nursing Officer Award, recognising the outstanding commitment she has given to her work, in particular in relation to the Nightingale Hospital Exeter in 2020 and 2021, during a virtual presentation from the Chief Nursing Officer for England, Ruth May, on 14 December 2021.

The Chief Nursing and Chief Midwifery Officer Awards recognise the significant and outstanding contribution made by nurses and midwives in England and their exceptional contribution to nursing and midwifery practice. The silver award recognises the performance of an individual that goes above and beyond expectations of the everyday, providing consistently outstanding care.

In view of the continuing pandemic, Ruth presented the award via video link, thanking Chantal personally for the leadership she has shown both at the Exeter Nightingale and in her current role.

Ward accreditations
During December two more of our wards were assessed under the scheme.

Ella Rowcroft ward achieved a gold award on their first accreditation.

Cromie ward achieved a silver award. Brixham Hospital were re-assessed and received and maintained their silver award.

DAISY awards
In November 2021 our DAISY award winner was Natalie Green, cancer nurse specialist. The nomination highlighted:

“Natalie was a very new Clinical Nurse Specialist (CNS) when she met a young gentleman who had been diagnosed with a metastatic oesophageal cancer. Natalie guided this patient and his partner through all his investigations and cancer treatments showing compassion professionalism empathy and respect at all times.

Time sadly became very short for this gentleman and Natalie organized at very short notice a beautiful wedding ceremony here in the rose garden at Torbay hospital before supporting his move to Rowcroft Hospice for end of life care.

At Rowcroft they were able to have another ceremony for all the family before the gentleman passed away only three days later. Natalie was asked to be a witness at the ceremony as a thank you from the patient and his fiancé for all she had done. Natalie is a very welcome addition to our team and we are very proud of the caring CNS she has become.”

In December 2021 our DAISY award winner was Leonie Poulain who work in the Outpatients Department at Torbay Hospital. The nomination highlighted:

“A patient attended Outpatients with no appointment. He approached reception and was very clearly distressed telling the receptionist that he was at his end with the pain could take no more and wanted to jump in front of a train. The patient was known to rheumatology. The receptionist approached Leonie for some assistance.

Leonie made a rapport with the patient and took them into a clinic room so they were away from the public area. She genuinely believed that with no help or assistance there was a realistic possibility that the patient may come to harm. Rheumatology were contacted and they phoned the patient back in the clinic room where Leonie had placed them. As a result of the telephone call the patient

had their medication reviewed and changed. The patient left outpatients felt listened to.

Leonie was back in work on two days later and decided to ring the patient back herself to make sure that the pain had improved and he was OK. This phone call and time to check the patient was OK was well outside our normal expectations of patient care within outpatients. The patient has subsequently written to express his enormous thanks for Leonie's time and care both on the day and with the phone call afterwards."

Staff heroes
We closed our Staff Heroes awards in November 2021 and in December we celebrated our annual Staff Heroes awards winners who were:

Right care in the right place – Individual – Frontline Care/ Clinical Services
Winner: Tony Quant (Operating Department Practitioner)

Right care in the right place – Individual – Support Services
Winner: Jayne Bancroft (Administration assistant, Breast care)

Right care in the right place – Team – Clinical / Frontline Services
Winner: COVID ICU Team (Intensive care unit)

Right care in the right place – Team – Support Services
Winner: Microbiology

Sharing Information
Winner: Wendy White (Complex care Team)

Strengthening Partnerships
Winner: Digital Horizon Team (Digital Media)

Wellbeing at work
Winner: Kevin Middleton (Domestic, Cellular Pathology)

Prevention and staying well
Winner: Rebecca Garside

Chairman's Award
Winner: Estates and Facilities

Next month we will be introducing our new Our People Awards which will be based around our people promise - helping us ensure that our people are recognised and rewarded.

CQC unannounced inspection
We received an unannounced inspection visit from the Care Quality Commission in December 2021. Two wards at Torbay Hospital were visited as well as our care of the elderly services. We expect the inspection report to be published in February/March 2022.

CQC/Ofsted SEND Inspection Report
A new report from Ofsted and the Care Quality Commission (CQC) has identified significant weaknesses in services for children with special educational needs and/or disabilities (SEND) and says Torbay Council, education and NHS partners must do better.

In November 2021, a team of inspectors from Ofsted and the CQC spent five days in Torbay talking to children and young people with SEND, parents, carers and education, social care and health partners. Their findings were published on 13 January 2022. The report is available here: Ofsted | Torbay Borough Council

Torbay Council and NHS Devon Clinical Commissioning Group (CCG) must now produce a 'Written Statement of Action' to explain how they will tackle eight areas of 'significant weakness'.

3.3 Excellent value and sustainability

Redevelopment of former site of Dartmouth and Kingswear community hospital
We are currently supporting Dartmouth Town Council in its efforts to develop a community bid for the site of the former cottage hospital. The aim is to create a development plan that will deliver both social and economic value for the people of Dartmouth and its surrounding communities, whilst also enabling the Trust to meet its legal and financial requirements for the sale of the site. The council is currently in discussions with several potential development partners and aims to select a preferred partner next month.

Working with the town council, we jointly commissioned Healthwatch to carry out a survey to find out what 'social value' local people would like to see on the site of the former hospital. The survey was live from 08 November to 12 December 2021 and people could either complete a paper copy or fill it in online. It was promoted via the Dartmouth Chronicle, BBC Spotlight, BBC Radio Devon, social media and a household leaflet distribution via Royal Mail. 642 responses were received and the outcomes are currently being collated in a full report, which will be shared with Board members before being published to coincide with the town council's next meeting on 07 February. Ideas for delivering social value range from key worker housing to community and commercial facilities.

We need the income from selling the site before April 2023 in order to honour our financial commitment to the new Health and Wellbeing Centre. We expect to bring a report to Board in March outlining whether the community bid is viable. If a community bid proves unsuccessful, the site will be sold on the open market later this year.

New Health and Wellbeing Centre for Dartmouth and surrounding communities
Work is progressing on the new £4.8m Health and Wellbeing Centre in Dartmouth. The project is currently on schedule for completion in August 2022 and anticipated to be fully operational by the autumn.

4. Chief Executive engagement December and January

I have continued to engage with external stakeholders and partners – in the main with the aid of digital technology. Along with the executive team, I remain very conscious of the need to maintain direct contact with our staff, providing visible leadership and ongoing support, as our teams continue to strive to deliver excellent care during exceptionally challenging circumstances across all our services.

Internal	External
• Video blog sessions • Staff side • Drumbeat programme – building a brighter future • Medical Staffing Committee Meeting • Board to Council of Governors • Staff Heroes Presentation – Simon Robertson, Security • League of Friends Chairs meeting with the Chairman • Lead Governor meetings • Chief Nursing Officer's Presentation for Chantal Baker, Nursing and Midwifery Excellence Lead Nurse • Visit to Outpatients Level 2 and Head and Neck Specialist Leads	• Chief Executive of Integrated Care System for Devon (ICSD) • Deputy Chief Executive of Devon Clinical Commissioning Group (CCG) • Medical Director, ICSD • Director Long-Term Plan, Devon CCG • Chief Executive, Devon Partnership Trust • Locality Director, South & West, Devon CCG • Chief Executive Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust • Chief Executive Office, University Hospital Plymouth • Anthony Mangnall MP for Totnes • Devon NHS Chief Executives Meeting • Anne-Marie Morris MP • Kevin Foster MP • Speaker for Exeter University • Leading for Inclusion Workshop • Regional Director of Improvement and Delivery, NHS England and Improvement South West • ICS Partnership Board • South West Regional Chief Executives • Director of Public Health, Torbay Council • South West Talent Community of Practice • Good Governance Institute • Director of Children's Service, Torbay Council • Chair of ICB • South West Regional Roadshow • Chief Executive Officer, Health Watch, Torbay and Plymouth • South West ICP Board • Health and Adult Care Scrutiny Committee, Torbay Council

5. Local health and care economy developments

5.1 Partner and partnership updates

5.1.1 Devon integrated care system – national ICS launch delayed until July

A new target date for the establishment of statutory Integrated Care Systems (ICSs) and Integrated Care Boards (ICBs) has been confirmed by NHS England and NHS Improvement.

To allow sufficient time for the remaining parliamentary stages of the Health and Care Bill, a revised target date of 01 July 2022 has been agreed. This replaces the previous target of 01 April 2022 and means the current arrangements will remain in place until 01 July.

Devon has already made significant progress, so these additional three months will provide extra flexibility to prepare for the new arrangements and manage the pandemic response, while maintaining momentum towards more effective system working.

The establishment of statutory ICSs and the timing remains subject to the passage of the Bill through Parliament.

5.1.2 ICS development

The ICB Board structure has been agreed, with recruitment for most roles underway – including non-executive stakeholder panels and interviews held on 12 and 13 January with interviews later this month. Led by the ICS chair, Dr Sarah Wollaston, the Board includes executive and non-executive posts plus members from provider, local authority, primary care, and public health.

A draft Integrated Care Partnership (ICP) structure has also been produced, which Dr Sarah Wollaston is discussing with stakeholders and partners.

The ICP will bring together NHS leaders and local authorities with important stakeholders from across the system and community to generate a strategy to improve health and care outcomes and experiences, for which all partners will be accountable.

A consultation on the ICB executive structure has taken place, with adverts for four of the roles being advertised externally:

1. Chief medical officer
2. Chief delivery officer
3. Chief finance officer
4. Director of workforce strategy

The remaining roles are subject to similarity assessments with current CCG executives.

The first draft of the ICB Constitution was submitted to the regulators (NHS England and NHS Improvement) on 03 December. Feedback was received 17 December, which was largely positive. There were a small number of minor points to address, which will be completed ahead of the final deadline in March 2022 and meetings with NHS England continue to help develop the constitution.

A ‘functions and decisions map’ process is also being developed, which sets out where decisions are made (e.g. system, local care partnership, provider collaborative, primary care network etc…). The ICS aims to make decisions as close to patients as possible (known as ‘subsidiarity’).

5.1.3 System Oversight Framework (SOF)

The final exit criteria for the system to move out of level 4 of the NHS England’s System Oversight Framework (SOF) have been agreed internally and approved by the region.

In early December, this was sent to Trusts and the CCG to take through their individual Boards for noting.

The detail of the improvement plan is now being finalised and there will be a Board-to-Board meeting with the regional and the national teams early in the new year.

The new regional SOF oversight arrangements for both the system and Trusts will commence in January. This will be the key vehicle for monitoring progress against the improvement plans and generating recommendations to the national committee about any changes in the SOF rating early in 2022/23 financial year.

The critical work now is to progress the actions to deliver the necessary improvements in both urgent and emergency care and financial performance.

This will require a whole-system approach and discussions are underway with Chairs and Chief Executives as to the best mechanism for collaborative working and decision-making going forward.

5.1.4 Devon Long-Term Plan latest

A broad narrative that outlines how partner organisations in the Integrated Care System for Devon will need to work together to meet current day-to-day challenges and ensure that services are able to meet the challenges of the next 20 years is being developed. It will be shared more widely in due course.

The aim is that the narrative becomes a foundation for the more detailed plans of day-to-day operational function, system recovery, the Long-Term Plan and New Hospitals Programme.

Separately, the Integrated Care System for Devon is working with the statutory health and adult care Overview and Scrutiny Committees at Devon County Council, Plymouth City Council and Torbay Council to explore the feasibility of a Joint Committee between the councils so that LTP work that crosses Local Authority boundaries can be considered and scrutinised collectively by representatives of each of the Scrutiny Committees in the county.

A paper providing a detailed update on the latest Long-Term Plan work that seeks agreement on the joint way of working is due to be considered by each committee, starting with Devon County Council's Health and Adult Care Scrutiny Committee on 20 January 2022.

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

Recent key media releases and responses:

- Carers Rights Day –a joint release with our local authority colleagues outlining the fantastic plans our local carers services have for Carers Rights Day, which included support and advice drop-in sessions, as well as a celebration event on Saturday 27 November at Paignton Library
- Rise in COVID-19 patients – a regional release was issued which highlighted the increase in COVID-19 patients in Devon, which we expect to continue to rise, and what people in Devon can do to support the NHS
- Emergency Department performance enquiries – following the publication of data on 4-hour+ waits in A&E departments, we responded to enquiries from the HSJ outlining the challenges that we face, both nationally as the NHS and unique to our trust, and the plans we have in place to improve the experience of people using our services
- Baby and young children remembrance weekend – release promoting our little ones' memorial weekend; an opportunity for families to join us and remember a little one they have lost
- Devon healthcare app wins national award – celebrating the news that the CONNECTPlus app, co-developed by our trust and HCI, won a national award for best patient-centred healthcare software
- Seeking local people's views on the former Dartmouth Hospital site – promoting Healthwatch's consultation on the site of the former hospital as we work with Dartmouth Town Council on their community bid
- 'Devon residents urged, "Get Boosted Now"' – promoted the regional release encouraging members of the public to receive their booster vaccinations
- NHS 111 online – regional release on how NHS 111 can help the public ahead of a 'winter like no other'
- Ambulance queues at Emergency Department – received many enquiries following reports of a large queue at ED. Response detailed the pressures the whole health and care sector is facing, and how this is being evidenced at our front door. We are working closely with our partners, and we are still here for those that need us, but signposted the public to more appropriate settings if their need isn't urgent. Ian Currie, Medical Director had interviews with ITV and the BBC to discuss the challenges we face
- Christmas parties – answered queries about the decision to ask staff to cancel gatherings at Christmas, and our response outlined the potential

impact this could have on services which is underlined by the pressures we face

Recent engagement on our social media channels includes:

- Healthcare Assistant opportunities – promoting our opportunities for both apprentices and bank healthcare assistants to join our organisation
- Flu and COVID-19 vaccinations – using national assets to highlight the importance of both flu and COVID-19 booster vaccinations this winter, and signposted to the national booking system
- Governor elections – promoted our governor election campaign as we are looking for both staff and public governors. Nominations close on Friday 10 December
- RSV awareness – highlighted the rise in respiratory illnesses during this time of year, particularly amongst children, and raised awareness of when to seek help for a child
- Maternity services update – shared the good news that the number of supporters for people giving birth has increased and visiting times have been extended
- Norovirus video – video produced and shared featuring Dr Joanne Watson, Director of Infection Prevention and Control, which highlighted the impact norovirus can have on our services and how we can reduce the spread and keep well
- Ward accreditation success – celebrated four of our fantastic wards at Torbay Hospital who have recently completed their ward accreditation
- Trainee Assistant Practitioners concept fair – recognised the hard work of our trainee Assistant Practitioners in presenting their health and wellbeing ideas at a concept fair which received very positive feedback
- World Radiography Day – thanked our radiographers who highlighted why they got into the profession and what they love about their jobs
- Return to nursing – promoted opportunities for those who have left the profession to return to nursing practice and the support that's available
- 12 Days of Christmas – our annual Christmas shout-out campaign saw us thank 12 teams from across our services and departments for their hard work this year
- Christmas Day messages – sharing photos and messages sent in by staff who were working on Christmas Day this year
- Help your local hospital – outlining what people can do to support our hospitals, including choosing the right service and supporting loved ones to return home
- Choosing well – promoting our Urgent Treatment Centre and local pharmacies as alternatives for seeking help over the bank holiday periods
- Christmas Day baby – sharing the news that on Christmas Day, our maternity department saw one family get the greatest gift of all as they welcomed their new baby
- Healthcare support workers open day – promoting an open day which encourages those interested in a career in healthcare to find out more about the opportunities we have available
- Sending Love – promoting our sending love initiatives which supports members of the public to get a message to their relatives in one of our hospitals

- Phone line issues – used our channels to inform the public about issues with our phone lines due to an IT failure, and advised when these were back up and running
- Thank you and how you can help – shared a video featuring Ian, our Medical Director where he thanks the public for their support and highlights what they can do to help us this winter
- Public Governor elections – final reminders before nominations close for people to become one of our public governors
- Former Dartmouth Hospital site public survey extension – encouraging the public in Dartmouth to feedback on what they would like to see on the site of the former hospital, following the extension of the survey
- Cold weather alerts – using national resources which highlighted the importance and provided guidance on keeping warm and well at winter

Development of our social media channels:

Channel	End of year target	As of 31 March 2021	As of 31 December 2021
LinkedIn	5,000 followers	2,878	3,519 ↑ 641 followers
Facebook	15,000 likes	12,141	12,696 ↑ 555 followers
	15,000 followers	12,499	13,107 ↑ 608 followers
Twitter	8,000 followers	6,801	7,180 ↑ 379 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 v16

Torbay and South Devon NHS Foundation Trust

Ref	Executive Owner	Corporate Objective	Current risk	Target risk	Strength of Controls	Strength of assurance	Executive Comment
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	Red	Red	Nov 21 - Strength of controls amended from Amber to Red. Narrative updated to reflect level of demand Trust & wider system experiencing incl ongoing impact of Covid.
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 COVID-19	20	16	Amber	Amber/Red	Objective 4 merged with objective 12
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	Updated to reflect risk of some Trusts in the system choosing to go to tender for an electronic patient record system, the outcome of which could affect patient pathways and efficiencies of working
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*'	16	8	Amber	Amber	Dec 21 - curent risk score increased to 16
9	Judy Falcao Chief People Officer	To ensure management practice, leadership capacity and capability to deliver high-quality, sustainable care for the local population	16	8	Amber	Amber	Dec 21 - curent risk score increased to 16
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 it meets the needs of the local population and the Peninsula System	16	12	Amber	Amber	December 21 - risk score increased from 12 to 16

Report to the Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 9 2021/22 (December 2021 data)			Meeting date: 26th January 2022
Report appendix	M9 2021/22 IPR focus report M9 2021/22 Dashboard of key metrics		
Report sponsor	Deputy CEO and Chief Finance Officer		
Report author	Head of Performance		
Report provenance	ISU and System governance meetings – review of key performance risks and dashboard Executive Directors: 20 January 2022 Integrated Governance Group: January meetings stood down due to operational pressures Finance, Performance, and Digital Committee: 24 January 2022		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to bring together the key areas of delivery (including, quality and safety, workforce, operational performance, and finance) into a single integrated report to enable the Trust Board to: • Review evidence of overall delivery, against national and local standard and targets • Interrogate areas of risk and plans for mitigation • provide assurance to the Board that the Trust is on track to deliver the standards required by the regulator. Areas of exception that the Board will want to focus on are highlighted below and detailed in the attached Focus Report.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to **review** the documents and evidence presented.		

Summary of key elements

Strategic objectives supported by this report

Safe, quality care and best experience	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	**X**	**Terms of Authorisation**	
NHS Improvement	**X**	**Legislation**	
NHS England	**X**	**National policy/guidance**	**X**

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 9 2021/22 (December 2021 data)		**Meeting date:** 26th January 2022
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

CQC: A Focused inspection of Medical Care took place on 1st December 2021, EAU4 (COVID), Forrest (escalation) and George Earle were inspected regarding concerns raised on staffing levels and nutrition and hydration care needs.

Immediate actions were taken and action plan in place reviewed weekly by the nutrition and hydration task and finish group. This has been presented to Quality Assurance Committee and monitored through Quality Improvement Group. The draft inspection report is expected to be received mid-February

Incidents: In November there were 3 severe incidents (fall, fractured hip, ophthalmology, sepsis) and 5 deaths (post fall, child, 2 relating to drug and alcohol, surgical) these are all following our investigating process, one death investigation has been commissioned for an external investigation.

There was one severe incident reported in December related to major trauma and child safeguarding. Currently under investigation and multi-agency

Stroke: The percentage of time stroke patients are spending on a stroke ward remains below the 90% target for November and December this was 50% which was an increase from the 35% in October. The impact of blue and green pathways (COVID/Non-COVID) from 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.
- There is a meeting with the Stroke Network and TSDFT week 24th January 2022, who are working alongside other Trusts to understand performance in this area and foster any good practice that can be shared

VTE assessment: The compliance in December achieved a slight increase to 95.1% (ICO). The COVID surge plan in December was instigated, this has increased the bed base across the Trust with fluctuating escalation beds.

No additional changes have occurred since the introduction of these key elements:

- 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.

Infection, Prevention, and Control: December bed closures have increased to 285 from November position of 218, these closures have included: Diarrhoea no known cause, Covid positive on admission and outbreaks during admission. The number of C.Diff cases have dramatically reduced since August 2021. The predominate infection control focus has been on COVID-19 outbreaks which have affected the organisation.

Maternity: There has been a rise in the induction of labour rate in December to 42.9% and also an increase in the caesarean section rate to 41. 6% from 36.6% in November. Further clinical review and audit of inductions and labour cases to be completed to provide further clarity regarding the rise of caesarean section. There was one baby who was stillborn at 26 weeks gestation in December**.**

Staffing: The covid safer staffing risk framework is in place, wards are in an amber position overall with mitigations and reassignment to areas.

Hospital Standardised Mortality Rate (HSMR): The HSMR score is worked out by looking at performance in the NHS and adjusting the mortality risk in a spell of patient care for risk factors such as their age, gender and health conditions. The HSMR uses risk models to provide the number of 'expected deaths' per trust per month, compared with the number of actual deaths at the trust. This helps to produce the level of risk, called the 'relative risk figure' for each trust, which shows how each trust performs against the NHS average.

The latest mortality data available through the Dr Foster/Telstra Health benchmarking tool (to September 2021) is showing an increase in 'relative risk' the over the period May 2021 to August 2021. The Medical Director, Director of Patient Safety, and the Performance Team will be undertaking an in-depth review to provide a deeper analysis of factors contributing to this increase. The findings will be reported through the Mortality Surveillance Group to the Quality Improvement Group. The January 2022 Mortality Surveillance Scorecard contains further information on the HSMR methodology and the Trust's performance against the NHS average.

2. Workforce Headlines

The annual rolling sickness absence rate was 4.66% to end of December 2021; this is against the target rate for sickness of 4% and is the highest figure since July 2007 and will likely increase due to very low absence in January to March 2022. The monthly sickness figure for December was 5.38% which is a slight decrease from November and the October 5.87%. There is an investigation underway to review how we can improve the data accuracy of the daily report due to the current challenged systems and processes.

The Achievement Review rate for the end of December 2021 was 78.57%; a reduction from the 79.15% as at the end of November.

The Trust's turnover rate now stands at 11.97% for the year to December 2021 and is within the target range of between 10%-14%.

The current overall mandatory training rate is 88.38% for December 2021 against a target of 85%. Overall training compliance continues to be only marginally impacted by the current system pressures however subjects with multiple levels still need improvement.

The Month 09 Trust Agency spend was £1.248m giving Financial YTD figure of £10.097m (£4.4m above plan as at the end of month 9).

3. Performance Headlines

Operational headlines

Covid: Throughout December the Trust continued to care for a number of Covid patients in the single dedicated acute ward averaging 17 to 20 daily in hospital; with up to 3 patients being cared for in the Intensive Care Unit. The Omicron surge in infections, staff sickness, and increased hospitalisations is now being seen. In response the Incident Control Centre (ICC) and drumbeat of daily meetings to oversee the escalation planning and incident response has been established. Revised trajectories reviewed on 12 January 2022 predict that 55 beds will be required by mid-January. This is expected to be a sharp peak of demand and to reduce as quickly. Plans to escalate to this level and beyond to a worst-case scenario have been developed. These plans require significant stepping down of non-urgent activities, re-deployment of staff, and relocation of services to create additional bed capacity. This is a fast-moving incident with planning under continuous review. Whilst planning to create maximum bed capacity is critical to meet predicted demand, the anticipated impact on staff sickness rates is an equally challenging risk. Detailed staffing escalation planning is taking place to ensure re-deployment and flexible staffing arrangements are ready for implementation if required. The covid modelling indicates that peak staff absences may already have been seen or is about to be seen, this is predicted to happen before the peak in admitted patients.

Urgent Care: Urgent and emergency services continued to be challenged throughout December. There was some easing of bed pressure over the Christmas holiday period with Opel 2 declared on Christmas Eve. However, as anticipated, this was followed by a renewed surge in demand and increased discharge delays into the New Year and the first weeks of January. The Trust continues to see high bed occupancy resulting in delays to ambulance handover, extended waits in ED and assessment areas, and patients bedded in ED and assessment areas overnight.

Access to inpatient beds remains the primary contributor to the length of time patients are spending in the Emergency Department. Available inpatient beds have reduced further by 1 acute ward and 1 community hospital ward as a result of the response to the latest covid surge. In December there were 712 people who spent 12-hours or more in the Emergency Department with ambulance handover delays remaining high, meaning 616 patients experienced a delay of over an hour once arriving to the Emergency Department (of the 18 South West trusts TSDFT ranks sixth worst against the 30-day rolling average of greater than 60-minute handover delays).

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. With the continued capacity constraints on the acute site, capacity within the private 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 continue to be developed as a strategy 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. Capacity at the Nightingale Hospital Exeter for orthopaedic day case is delayed and will come on line in late February.

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 admissions prioritising cancer treatments and the most urgent patients. Routine elective orthopaedic surgery was paused again in December to support bed capacity for urgent medical admissions.

Cancer care: An increase in referrals and reduction in capacity from covid escalation for surgical and diagnostic stages of care has led to a continued deterioration in the cancer performance. At 44.1%, our two week wait performance is the lowest performance for 15 months. Meeting the 28-day cancer diagnosis target has also been a challenge, recording 51.6% against the 75% target and the fourth month of decreasing performance. There is a continued reduction in the 62-days to treatment target at 60.6% where the backlog of patients waiting has doubled over the last year. The Executive Team have received details of cancer action plans and approved the establishment of the Cancer Cabinet to commence in January 2022. Improvements in Dermatology 2-week-wait time have been seen in recent weeks reducing from 5 to just over 3 weeks from referral, and a mobile unit to support clearance of backlog for urology prostate biopsies and cystoscopies opened on 12 January 2022 on the Torbay Hospital site. The preservation of capacity to support cancer pathways remains central to planning however the impact of wider escalation to manage hospital pressures can be seen in several of these metrics.

Diagnostic waiting times: 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 December the number of 21- day and 7-day length of stay patients has remained significantly higher than normal levels with an average of 48 patients over 21 days in hospital compared to 14 last December, and 157 over 7 days compared to 91 last December. In December the length of stay for patients discharged from community hospitals has increased to 17 days compared to 10.5 days seen across 20/21 and 13 days reported in September.

There remains a significant number of patients who are medically fit with no ‘criteria to reside’ who 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 remains high and impacting on patient flow and discharge from community and acute settings of bedded care. 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 domiciliary care; it is noted that in April 2022 the same rules will apply to domiciliary care, voluntary sector, and front-line NHS staff.

4. Finance headlines

For the month of December (M9) the Trust is reporting a £0.1m surplus and for the year to date the Trust is reporting a £0.8m surplus. Both M9 and year to date actuals are marginally ahead of plan (£50k favourable in month, £40k year to date).

Total income for the year to date is £6.4m favourable to plan. Key drivers are as follows:

COVID related income e.g. Council funding stream	£4.9m
Education and training, R&D grants and other	£2.1m
ASC client contribution income	£0.7m
Offset by:	
ERF income recovery & elective cancellations	(£0.6m)
Reclassification from patient care income to other income	(£0.3m)

Operating expenditure and financing cost in the year to date is £6.8m adverse to plan. Key drivers are as follows:

COVID related costs not initially budgeted	(£4.9m)
Agency spend	(£4.4m)
Bank spend	(£3.1m)
Undelivered CIP	(£0.8m)
Increased clinical supplies and services costs	(£1.0m)
ASC bad debt provision	(£0.5m)
Consultancy and other costs	(£0.4m)
Offset by	
Underspend on substantive pay due to vacancies	£6.7m
Underspend within CFHD alliance	£1.6m

The cash position remains strong with a month end balance of £30.3m. To date the Trust has spent c. £13.7m on capital schemes, an increase of c. £1.8m from Month 8.

The Trust's efficiency requirement for H2, in total, is £7.2m. To date schemes have been identified which total c. £3.6m with a further c. £0.9m now validated.

The phased plan for efficiencies at Month 9 required c. £1.2m, against which c. £0.9m has been assessed as being delivered, a shortfall of c. £0.3m. Year-to-date, for H2, delivery is recorded as c. £2.5m against a plan of c. £3.6m, a shortfall of c. £1.1m.

For H1 the Trust's efficiency target was c. £0.8m, against which c. £1.0m was recorded as delivered. Therefore, the combined position for efficiencies as at Month 9 is c. £3.5m delivered against a plan of c. £4.4m, giving a shortfall of c. £0.8m.

Whilst the current expectation is that non-recurrent measures and other mitigating actions will cover the shortfall, it should be noted that the current level of unidentified efficiencies together with the adverse variance to plan gives an overall risk of under-performance between £2.7m-£3.8m. Work is ongoing with ISUs and departments to identify additional schemes, both recurrent and non-recurrent, to close their gaps to target which will be supported further by input from Deloitte as part of the Financial Improvement Programme.

The Trust has reviewed its forecast in the light of the continuing pressures from Covid, but offset by a reduction in spend in elective areas, whilst still maintaining delivery against activity targets. As a result, the unmitigated forecast out-turn has improved to a shortfall against plan of £2.1m. The Trust has identified mitigations which will cover the potential shortfall.

With regards to ERF the threshold percentage in H2 has been amended from 95% of SUS submitted activity to 89% of RTT stop clock activity. The system as a whole did earn ERF in October, following an error correction by NHSE / I. As a result, of the error, we are awaiting confirmation of November's performance. With expected further winter / COVID pressures, there is a risk that the System might not achieve any ERF in the remainder of H2.

There are additional funding streams in H2 i.e. ERF+ and TIF and ISU's have undertaken a review of likely spend/activity to date and expected during the remainder of H2. These other funding streams are fixed / guaranteed income values and the Trust will maximise spend and benefit against these allocations. This will minimise any spend badged against ERF, reducing the financial risk to the Trust if the System does not meet the 89% threshold.

Looking beyond this financial year, the following key risk areas are noteworthy:

- Efficiency requirement for 2022-23. This is under development with the ICS, but **could exceed £20m**
- The reintroduction of commissioner contracts and specifically the aligned incentive payment mechanism, which would see the Trust lose income if elective activity fails to achieve the required levels
- The future of the Hospital Discharge Programme. The Trust is forecast to have recovered £3.4m of costs under this scheme in 2021-22 – the scheme ends on 31 March
- Capital planning for 2022-23 and beyond – it is expected that there will be significant pressure on the ICS capital envelope (CDEL)

Integrated Performance Focus Report (IPR) Trust Board

Torbay and South Devon NHS Foundation Trust

January 2022: Reporting period December 2021 (Month 9)

	Section 1: Performance
	Quality and safety
	Workforce
	Community and Social Care
	NHSI operational performance with local performance metric exceptions
	Children and Family Health Devon
	Section 2: Finance
	Finance

Quality and Safety Summary

CQC: A Focused inspection of Medical Care took place on 1st December 2021, EAU4 (COVID), Forest (escalation) and George Earle were inspected regarding concerns raised on staffing levels and nutrition and hydration care needs.
Immediate actions were taken and action plan in place reviewed weekly by the nutrition and hydration task and finish group. This has been presented to Quality Assurance committee and monitored through Quality Improvement Group. The draft inspection report is expected to be received mid-February

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VTE assessment
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- 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.
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Staffing: The covid safer staffing risk framework is in place, wards are in an amber position overall with mitigations and reassignment to areas.

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.

Following the Executive Evidence Review, a number of the Must Do actions that have been deemed closed by the CQCCAG group, were reopened as the evidence did not meet the requirement. The 9 Must Dos have not met evidence review and remain open:

- 6 are related to training - Currently reviewing policy to set overarching target of 85% to be achieved over 3 years, with a view of setting improvement goal at:
    - 40-60% year 1,
    - 60-70% year 2,
    - 70-85% year 3
- 1 to appraisal - Currently reviewing the appraisal policy in similar manner as mandatory training, Standard will remain unchanged, Achievement of standard 95% over 2 years in view of medical dispensation in 20/21
- 1 to a rolling equipment replacement policy - Task and Finish Group to undertake a deep dive review in this area, Webpage built on ICON to set out the equipment procurement process, Communication strategy being developed to highlight the process and governance to all staff.
- 1 to clutter free premises - Estates and facilitates capital programme in place to address these areas including storage facilities

A Focus inspection of Medical Care took place on 1st December 2021, EAU4 (COVID), Forest (escalation) and George Earle were inspected regarding concerns raised on staffing levels and nutrition and hydration care needs.
Immediate actions were taken and action plan in place reviewed weekly by the nutrition and hydration task and finish group. The draft inspection report is expected to be received mid-February.

***Table 1: The status of Must Dos and Should Dos per CQC core service*.**

CQC Compliance Actions Status						
CQC Core Service	No. of Actions		Completed		Overdue / Concern	
	Must Do	Should Do	Must Do	Should Do	Must Do	Should Do
Trustwide	1	0	0	n/a	1	n/a
Urgent and Emergency	8	6	6	5	2	1
Medical Care	9	12	5	9	4	3
Surgery	4	5	3	1	1	4
Maternity	4	11	3	11	1	0
Children and Young People (Acute)	1	5	1	5	0	0
Community Inpatients	1	4	1	4	0	0
TOTAL	**28**	**43**	**19**	**35**	**9**	**8**

Achieved
Never Events
Formal complaints - Number received
Hand hygiene - Community
Reported Incidents – Severe
Reported Incidents – Death
Medication errors resulting in moderate harm
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams
Strategic Executive Information System (STEIS)
VTE - Risk Assessment on Admission (ICO)

Under Achieved
Safer Staffing - ICO – Daytime
Safer Staffing - ICO – Night time
Avoidable New Pressure Ulcers - Category 3 + (reported 1 month in arrears)

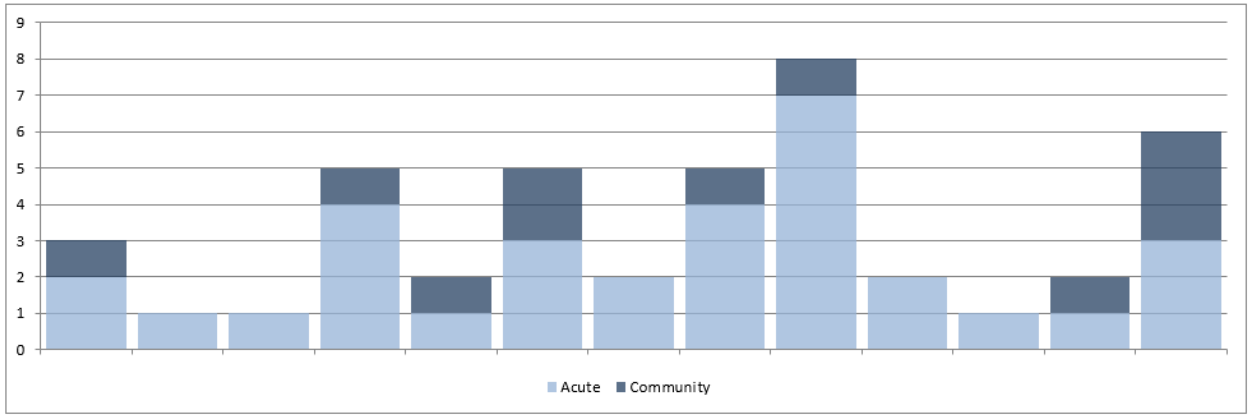
Not Achieved
Stroke patients spending 90% of time on a stroke ward
Follow ups 6 weeks past to be seen date
Fracture Neck Of Femur - Time to Theatre <36
Infection Control - Bed Closures - (Acute)
Hospital Standardised Mortality Rate (HSMR) rolling 12 months

No target set
Medication errors - Total reported incidents

Data not currently available
Hand hygiene - Acute

Number of Clostridium Difficile cases

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



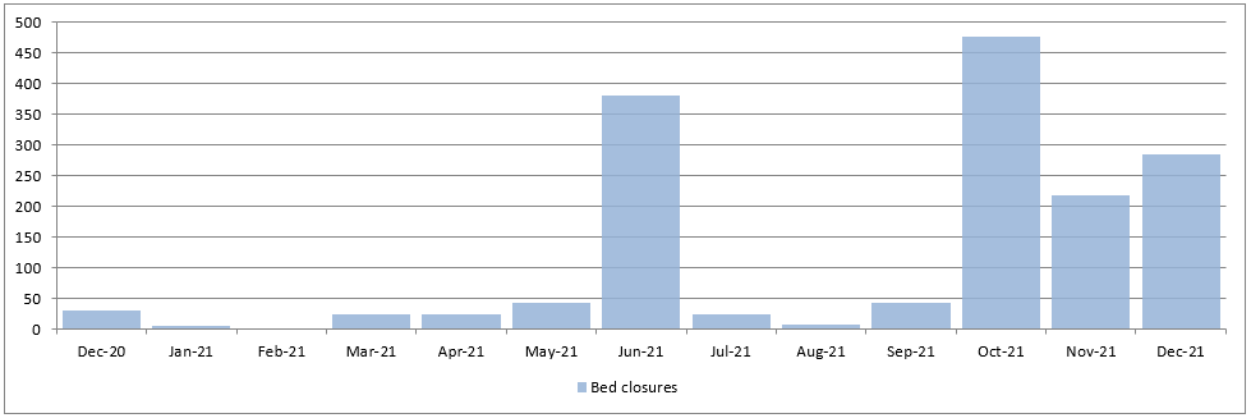
The number of C.Diff cases for December is 6;

- 3 of which is hospital onset
- 3 are community onset

There are no themes and particular areas where there have been more than 1 identified. Root causes are being conducted and audit of hand hygiene methods are collected

Infection control - Bed closures (Acute)

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Bed closures	30	6	0	23	24	42	381	24	8	42	476	218	285



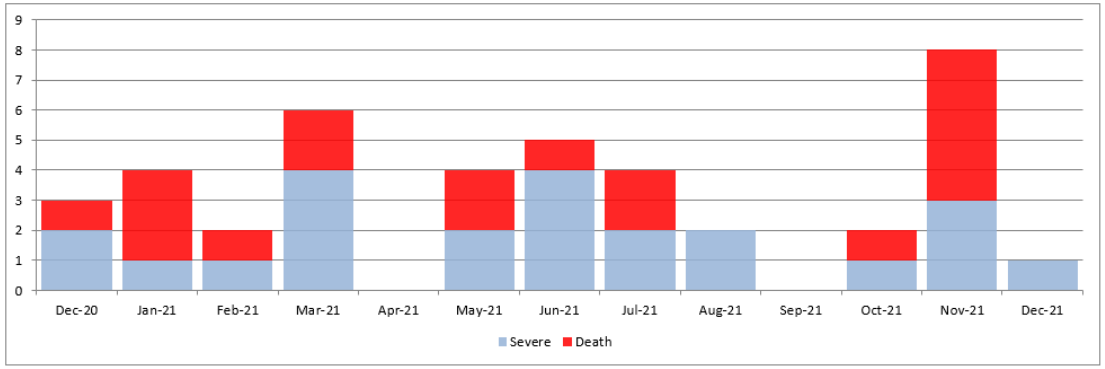
December bed closures have increased slightly to 285 from November position of 218
The reason for these closures have included:

- Diarrhoea no known cause;
- Covid positive on admission and outbreaks during admission.

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

Reported Incidents - Severe and Death

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

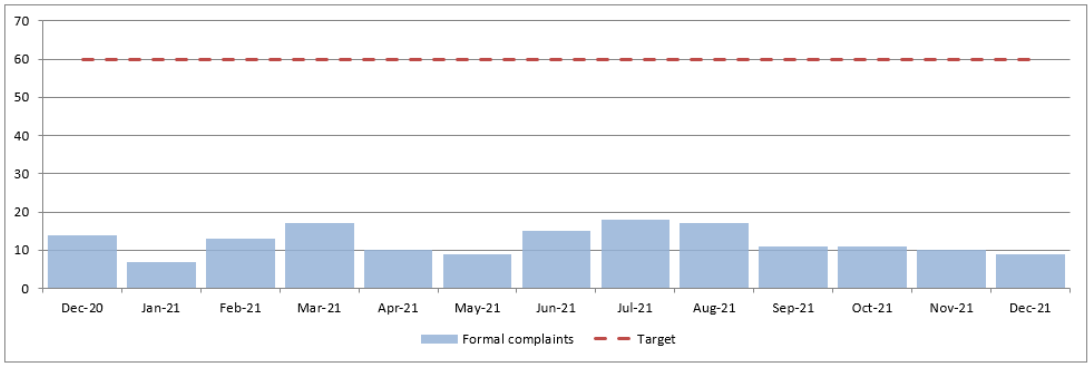


In November there were 3 severe incidents (fall, fractured hip, ophthalmology, sepsis) and 5 deaths (post fall, child, 2 relating to drug and alcohol, surgical) these are all following our investigating process, one death investigation has been commissioned for an external investigation.

There was one severe incident reported in December related to major trauma and child safeguarding. Currently under investigation and multi-agency

Formal complaints

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Formal complaints	14	7	13	17	10	9	15	18	17	11	11	10	9
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



The Trust received 9 formal complaints in December, this is consistent picture of 9-11 since September 2021.

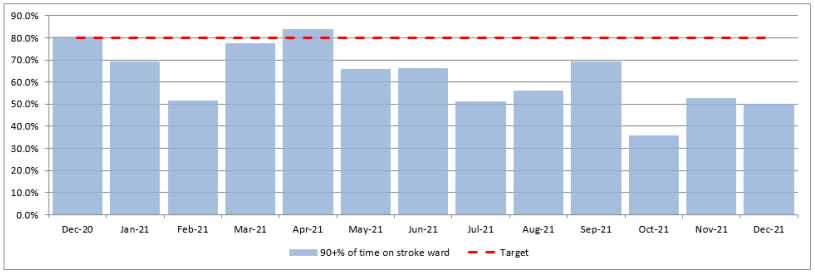
Themes of complaints included:

- Treatment – related to different services
- Assessment – access to services
- Care delivery - communication

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

Stroke

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
90+% of time on stroke ward	80.4%	69.4%	51.6%	77.5%	84.1%	65.9%	66.1%	51.4%	56.3%	69.2%	35.9%	52.8%	50.0%
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%

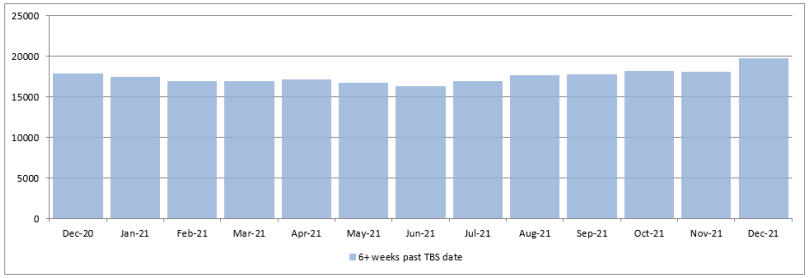


Stroke: The percentage of time stroke patients spend on a stroke ward remains below the 90% target for November and December, this was 50% which was an increase from the 35% in October. The impact of COVID and no-COVID pathways from ED and number of closed beds due to infection have contributed to this 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.
- There is a meeting with the Stroke Network and TSDFT in January 2022, and have requested to work alongside other trusts to understand performance in this area and foster any good practice that can be shared

Follow ups 6 weeks past to be seen by date

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
6+ weeks past TBS date	17837	17489	16986	16950	17118	16713	16323	16967	17651	17789	18231	18069	19797

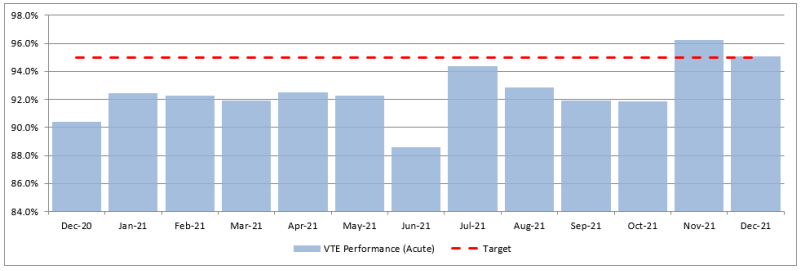


Follow ups: The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' has increased from 18069 in November to 19797 in December.

- Review of all services across the Trust has been conducted and further services have been stepped down to respond to the Omicron COVID-19 variant in December .
- Harm Review meetings are being progressed and thematic reviews being conducted against our longest waiting patients.

ICO VTE risk assessment on admission

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
VTE Numerator	4903	4705	4457	5307	5491	5400	5518	5685	4962	5188	5058	5418	4951
VTE Denominator	5423	5091	4831	5775	5938	5851	6228	6024	5344	5643	5508	5631	5207
VTE Performance (Acute)	90.4%	92.4%	92.3%	91.9%	92.5%	92.3%	88.6%	94.4%	92.9%	91.9%	91.8%	96.2%	95.1%
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

The compliance in December achieved a slight increase to 95.1%. The COVID surge plan in December was instigated, this has increased the bed base across the Trust with fluctuating escalation beds.

No additional changes have occurred since the introduction of these key elements:

- 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.

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	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
% of Caesarean sections	25-30%	28.70%	24.30%	29.50%	34.00%	31.40%	36.20%	40.20%	37.80%	34.10%	28.40%	36.60%	41.60%	33.60%
Breast feeding rates	>75%	78.10%	75.70%	81.80%	73.50%	76.20%	75.30%	74.40%	76.40%	78.10%	71.00%	80.30%	72%	76.20%
% of women booked for 'Continuity of carer' model	>35%	61.70%	62.30%	67.90%	57.00%	64.20%	64.30%	64.90%	59.70%	65.30%	69.50%	54.00%	65.50%	63.00%
No. of stillbirths	0	1	1	0	0	0	0	0	0	2	1	0	1	**6**

- During December 2021, there was a slightly reduced number of births within the Maternity Service of 165 births in month. There are 162 deliveries projected for January 2022, 163 for February and 168 for March.

- The acuity of women seen within the service remains very high and this, in turn, leads to higher rates of intervention, including increased induction of labour, caesarean section and admission to the Special Care Baby Unit. There has been a rise in the induction of labour rate in December to 42.9% and also an increase in the caesarean section rate to 41. 6%. There has been a rise in the number of women presenting to the maternity service who are positive for COVID-19, which is in line with the increase in both local and national Covid-19 rates. Further clinical review and audit of inductions and labour cases to be completed to provide further clarity regarding the rise of caesarean section.

- Sadly, there was one baby who was stillborn at 26 weeks gestation in December.

- We continued to face significant staffing challenges through December, from both a midwifery and obstetric perspective. This has been due to a combination of long term sickness and absence due to Covid-19 sickness and self -isolation . In order to maintain staffing levels within the maternity service managers, ward managers and specialist midwives have undertaken clinical shifts and we continue to utilise agency staff. Medical staff have been 'acting down' in order to provide adequate medical cover. We are actively trying to recruit to vacant posts created from staff movement and the increase the midwifery establishment following agreement at the September Trust Board. This incudes production of a recruitment video, highlighting the benefits of working within our Trust and the local area.

Performance exceptions and actions

Staff sickness/absence: RED for 12 mths and RED for current mth
The annual rolling sickness absence rate was 4.66% to the end of December 2021 which is the highest since July 2007 and will likely continue to increase due to the very low unseasonal figures Jan-Mar 2021 - This is against the target rate for sickness of 4%. The monthly sickness figure for December was 5.38% (this may change a little as retrospective updates are made) . Mental Health continues to account for 33% of calendar days for the last 12 months however December has seen an increase ratio of Covid related sickness at 14% against 11% for the last 12 months and Colds & Flu up to 11% for December against a 12 month average of 6%.

Appraisal rate: **Red**
The Achievement Review rate for the end of December 2021 was 78.57% a reduction from the 79.15 % as at the end of November.
The continuing high sickness absence and system pressures are drivers for the appraisal rate to continue to be well below the high of 86.61% in May however over the last 6 months the average has been 79.52% so no indication the compliance is continuing to deteriorate.

Turnover (excluding Junior Doctors): **GREEN**
The Trust's turnover rate now stands at 11.97% for the year to December 2021 and continues to be well within the target range of between 10%-14%. The Devon ICS retention project has identified two key groups with the highest turnover risks across the system. They are later stage career nurses aged 50+ and early stage career support to nursing staff aged <29. The primary data gathering phase is underway and emerging trends suggest work life balance and work flexibility choices are key retention drivers. The project will focus on increasing retention and engagement levels for these groups. 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 88.38% for December 2021 against a target of 85% and this is a small reduction from the 88.75% in November. Overall training has not been impacted as significantly as achievement reviews as the average for the last 12 months has been 89.46% so the current level is not dissimilar to the long-term average.
There are 4 of the11 CSTF subject that are below the target compliance which are IG / IC / MH & SC. Of those training subjects that have multiple levels such as SC / SA / MCS and Life Support 15 are currently Rag Rated red below the compliance target.

Agency Expenditure: As at Month 09 the Trust Agency spend was £1.247m giving Financial YTD figure of £10.097m (£4.4m above plan) – increased recruitment of overseas Nursing in the coming months and increased HCA staff should start to reduce the need for Agency once trained and up to speed. High sickness rates in the seasonally high period for sickness will continue to be a significant factor in the on-going high overall agency expenditure however the potential to carry-over more holiday and the winter incentive payments where staff can work their holiday and be paid overtime will also help to mitigate agency usage.

Vacancy Rate: The Trust vacancy rate continues to rise with a total of 382 FTE vacancies including 138 FTE qualified Nursing vacancies. Detailed vacancy reporting is still difficult in a number of areas at cost centre and occupational code level.

Update of Progress Against Our People Promise and Plan

A further progress report was submitted for review at the People Committee in December 2021.
Reflecting on the KPIs reviewed above, the plans in place to address improvements are built into our strategic People Plan; progress against the 5 pillars is described below.

Our People Plan dashboard includes the national staff survey findings, which has been reviewed nationally to ensure the findings align to the People promise enabling us to robustly measure how effectively we are delivering the People Promise – this will be supplemented by the quarterly people pulse survey, which will provide a more regular pulse check.

It is important to note that activities against our people promise and plan has been revised and prioritised in light of the operational escalation, with a particular focus on looking after our people and resourcing:

1. Looking After Our People

- Wellbeing listening sessions are taking place in hotspot areas and for teams that are being moved due to COVID escalation plan. These include, Forrest, Brixham Hospital, ED, EAU4 and Pathology.
- Wellbeing Buddies – Training for our Wellbeing buddies continues with a plan for monthly training sessions through to June and monthly catch up sessions with our wellbeing buddies to support them, share ides etc. We currently have 109 trained Wellbeing Buddies across the Trust.
- Support to our COVID areas continues via our Charitable Funds
- Communications have gone out to our people and managers regarding the requirement for all individuals undertaking CQC regulated activities to be fully vaccinated against COVID-19 no later than 1 April 2022. We will soon be asking for confirmation of the vaccination status (or medical exemption) for every member of staff. At present, we believe there are less than 10 per cent of our staff who have not yet had their first dose of the COVID-19 vaccination. We are committed to maintaining a supportive approach in helping staff to make the decision that is right for them.

2. Growing for Our Future

- Our first recruitment event of the year took place 8th January, which was a true collaboration with Education, Resourcing and members of clinical teams. This event focussed on HCSWs, and due to qualify nurses.
- Increased resourcing marketing continues with social media presence more prominent, with new videos being produced including most recently, maternity, to support their recruitment campaign.
- Implementation of new volunteering database continues, the new system will support the recruitment and retention of our NHS volunteers.
- New targeted new-to-care recruitment campaign for HCSWs being developed, with a focus on recruiting locally in the Torbay area, converting careers into healthcare.
- New ward clerk pilot underway; a redesign of how we recruit, train and deliver an improved and professional team.

3. New Ways of Working and Delivering Care

- Payment for additional clinical work undertaken by medics have been aligned with University Hospitals Plymouth.
- The ICS medical recruitment campaign is ongoing; with two key projects.
- The ICS is leading on developing an ICS approach to workforce planning which will align to the ICS Workforce Strategy.
- H2 interim workforce plans completed to support 2021-2022 business planning, supported by the People Business Partners with their ISUs to develop their plans. The national framework for business planning for 2022-23 has been issued, but the timeline is still to be published. Work has started on 3-year workforce plans.
- The Workforce Planning intranet site is now complete and live and provides guidance and case studies.
- 3 key pieces of work have begun to develop robust workforce plans in preparation for our future BBF workforce plan:
    - Aligning financial and workforce data
    - Broader cultural change and engagement to promote better workforce planning
    - To develop a toolkit to support People Business Partners and operational managers

4. Belonging

- Through the WRES and staff survey BAME colleagues stated that there are barriers to their personal development and career progression. To address and understand the barriers a series of workshops have been set up to run from January – March. The first session has been undertaken and the themes will be collated and appropriate improvement plans and action will be taken with the involvement of BAME colleagues.
- A further cohort of 11 people have successfully achieved their training to become organisational mediators. This will enable us to embed mediation as an early intervention for addressing conflict and improving relationships in the workplace which in turn will reduce the number of formal grievances.

5. Creating the Conditions to Enable Transformation

Increasing Skills and Confidence in Improvement: Plan to launch Improvement & Innovation Framework April 2022. QI 4 day Practitioner course to recommence May 2022. Progress made on development of a single improvement project repository to record, track and report. Plan to develop video on Introduction to QI for staff induction. Embedding of QI methodology into the BBF Drumbeat Programme to support speciality teams with clinical pathway transformation. Ongoing work to create a physical improvement and innovation hub – a space for support and creativity.
Cultural Framework and Manager's Essentials; Established 12 priorities for iManage by engaging with our managers, iManage/HIVE restructured to work better to suit managers. Plan to launch iManage early in the new year.

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

Indicator	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Performance
Month Sickness %	4%	4.20%	4.14%	4.04%	3.98%	4.12%	4.63%	4.75%	5.06%	5.41%	5.87%	5.52%	5.38%	
Mental Health Days % of Sickness (12 mth)	N/A	30.45%	35.10%	33.97%	33.29%	32.03%	32.37%	35.70%	37.03%	33.84%	33.44%	33.29%	32.67%	
12 Mth Rolling Sickness %	4%	4.11%	3.92%	3.78%	3.57%	3.98%	4.04%	4.13%	4.24%	4.36%	4.50%	4.56%	4.66%	
Achievement Rate %	90%	78.78%	78.45%	82.37%	85.95%	86.61%	84.73%	81.26%	80.56%	79.69%	77.86%	79.15%	78.57%	
Labour Turnover Rate	10-14%	10.17%	10.18%	10.00%	10.83%	11.03%	11.28%	10.95%	11.73%	11.32%	11.57%	11.51%	11.97%	
Overall Training %	85%	89.75%	89.51%	89.58%	90.06%	90.10%	90.51%	89.53%	89.36%	88.95%	89.02%	88.75%	88.38%	
FTE Vacancy	N/A	**228**	**178**	**151**	**183**	**196**	**183**	**257**	**117**	**208**	**344**	**379**	**382**	
Vacancy Factor	<10%	**3.83%**	**2.99%**	**2.53%**	**3.06%**	**3.28%**	**3.05%**	**4.25%**	**1.93%**	**3.41%**	**5.53%**	**6.07%**	**6.11%**	
Monthly Agency Spend	£630K	**£667**	**£572**	**£1,053**	**£756**	**£827**	**£1,096**	**£1,284**	**£1,090**	**£1,090**	**£1,231**	**£1,373**	**£1,248**	
Nuring Staff Average % Day Fill Rate- Nurses		90%	86%	83%	89%	92%	87%	90%	87%	82%	86%	89%	88%	
Nuring Staff Average % Night Fill Rate- Nurses		89%	88%	85%	90%	90%	89%	93%	88%	75%	81%	84%	81%	
Safer Staffing- Overal CHPPD		8.52	8.46	8.39	8.39	8.08	7.71	7.73	7.75	7.55	7.56	7.78	7.93	

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	2021/11	2021/12	Change since March 2021	% Change
Allied Health Professionals	524.97	527.08	528.95	524.64	519.16	524.63	538.34	536.58	528.76	527.30	2.32	0.44%
Health Care Scientists	94.17	95.17	93.71	93.71	93.71	94.39	92.69	92.70	93.80	92.40	-1.77	-1.88%
Medical and Dental	531.34	527.82	524.87	527.65	556.82	557.43	561.16	561.56	554.68	553.85	22.50	4.24%
NHS Infrastructure Support	1122.74	1120.22	1121.66	1126.62	1123.82	1121.33	1122.71	1124.58	1133.69	1134.71	11.97	1.07%
Other Scientific, Therapeutic and Technical Staff	341.40	342.77	343.99	341.63	348.60	346.41	345.03	346.02	346.89	342.63	1.23	0.36%
Qualified Ambulance Service Staff	10.72	9.52	9.52	9.33	10.33	10.53	10.53	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	1267.50	1271.48	29.54	2.38%
Support to clinical staff	1906.40	1880.31	1889.59	1902.13	1898.32	1901.54	1904.65	1899.35	1914.09	1908.06	1.66	0.09%
Grand Total	5773.68	5740.22	5751.33	5763.49	5798.91	5810.30	5842.46	5838.17	5849.93	5840.95	67.27	1.17%

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 30 FTE and M&D by 23 FTE since March.

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

	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC
Cost	£	£	£	£	£	£	£	£	£	£	£	£
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	£22,229,296	£22,000,915
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	£1,155,652	£1,170,666
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	£1,373,403	£1,247,147
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	£24,758,351	£24,418,728
WTE Worked	WTE	WTE	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	5,852.42	5,861.51
Bank	248.71	331.21	301.34	328.09	269.23	317.11	336.05	247.74	313.21	272.84	350.26	343.70
Agency	116.38	102.39	160.15	115.40	116.45	161.63	151.10	143.60	174.75	174.59	182.45	172.07
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	6,385.13	6,377.28

The reduction in Agency costs in the main are due to a significant reduction in Nursing agency usage.
Bank costs increased slightly by £15k from the November figure but the overall FTE usage reduced by 6.6 FTE which indicates N&M coverage for shifts were increasingly supplied by Bank rather than agency.

Workforce – Vacancies (12 months rolling) - (New Ways of Working - Growing for the Future)

Staff Group	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Medical And Dental	532.11	532.75	530.01	541.66	542.30	543.04	545.08	546.21	546.61	551.92	552.62	554.97
Nursing And Midwifery Registered	1,318.38	1,322.60	1,323.27	1,325.10	1,321.76	1,323.84	1,331.03	1,332.16	1,342.46	1,408.99	1,411.72	1,412.10
Support To Clinical Staff	1,873.08	1,874.40	1,878.97	1,917.95	1,917.53	1,921.00	1,947.00	1,957.12	1,971.99	2,016.16	2,027.12	2,027.91
Add Prof Scientific and Technic	436.21	436.14	437.55	431.92	431.19	434.19	435.19	436.19	436.19	445.02	445.02	446.02
Allied Health Professionals	490.23	490.83	491.07	493.43	495.28	498.80	504.60	512.00	512.00	508.88	508.41	509.58
Healthcare Scientists	104.43	104.43	104.43	99.60	99.60	100.02	102.19	103.19	103.19	104.19	103.91	104.90
Administrative And Estates	1,182.75	1,183.84	1,184.64	1,157.25	1,157.46	1,162.98	1,164.98	1,167.06	1,169.22	1,186.88	1,186.88	1,192.92
Total Staff Budgeted WTE	5,945.82	5,953.62	5,958.57	5,972.71	5,970.92	5,989.69	6,035.89	6,059.75	6,087.48	6,228.84	6,242.48	6,255.19

Staff Group	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Medical And Dental	517.75	533.98	527.31	524.76	522.61	524.21	521.61	616.14	545.85	551.08	543.11	534.76
Nursing And Midwifery Registered	1,237.38	1,240.80	1,244.21	1,246.22	1,246.20	1,246.99	1,248.93	1,258.71	1,266.77	1,272.47	1,273.93	1,280.61
Support To Clinical Staff	1,849.09	1,883.86	1,905.39	1,898.96	1,878.21	1,909.51	1,887.68	1,928.06	1,934.83	1,916.68	1,911.69	1,909.88
Add Prof Scientific and Technic	406.15	405.08	405.12	406.84	406.93	410.04	411.09	424.86	413.28	418.97	403.66	413.99
Allied Health Professionals	485.89	481.30	482.42	479.38	480.14	479.20	470.70	473.80	482.36	488.14	485.86	484.17
Healthcare Scientists	99.17	99.17	99.17	99.17	100.17	98.72	98.72	99.40	98.16	97.69	99.30	97.80
Administrative And Estates	1,114.21	1,122.69	1,135.62	1,128.59	1,134.90	1,132.52	1,134.71	1,133.17	1,132.60	1,132.84	1,139.50	1,144.93
Total Staff Worked WTE	5,718.16	5,777.59	5,809.97	5,794.64	5,774.76	5,807.70	5,780.96	5,942.54	5,881.46	5,888.47	5,864.67	5,873.75

Staff Group	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Medical And Dental	14.36	-1.22	2.70	16.90	19.69	18.83	23.47	-69.93	0.76	0.84	9.51	20.21
Nursing And Midwifery Registered	81.00	81.80	79.05	78.88	75.56	76.85	82.10	73.46	75.69	136.52	137.78	131.48
Support To Clinical Staff	23.99	-9.46	-26.42	18.99	39.32	11.49	59.32	29.07	37.17	99.48	115.43	118.03
Add Prof Scientific and Technic	30.06	31.07	32.44	25.08	24.26	24.15	24.10	11.33	22.91	26.05	41.36	32.03
Allied Health Professionals	4.34	9.53	8.65	14.05	15.14	19.61	33.90	38.21	29.64	20.74	22.55	25.41
Healthcare Scientists	5.26	5.26	5.26	0.43	-0.57	1.30	3.47	3.79	5.03	6.50	4.61	7.10
Administrative And Estates	68.54	61.14	49.02	28.66	22.56	30.46	30.27	33.90	36.63	54.04	47.38	47.99
Total Staff Worked WTE	227.55	178.12	150.70	182.99	195.96	182.70	256.65	119.82	207.83	344.18	378.62	382.26

Vacancies: Vacancy data based on Finance Reporting from Unit 4 Agresso – December shows another increase in vacancies up to 382 FTE with the Vacancy Factor now at 6.11%.

A working group has been set up to review 2021/22 Q4 data at Cost Centre and Occ Code levels as this continues to be a challenge for the organisation with increased focus from NHSI and the CCG for vacancy data.

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.
December's agency spend of £1.2m was a reduction for the financial year high in November and was a reduction of £125k. This was predominantly due to a big reduction in Nursing agency spend that reduced by £106k from November.
The negative agency spend against HCA's is due to Finance corrections against forecasted usage.

Torbay and South Devon NHS Foundation Trust	2020-2021			2020 -2021	2021 -2022									
Total Agency Spend Financial Year 2020/21 + 21/22 YTD	Jan	Feb	Mar	Total	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Registered Nurses	310	289	316	3012	356	348	468	584	520	599	557	676	570	4678
Scientific, Therapeutic and Technical	12	14	32	504	43	99	142	122	110	112	162	140	144	1074
of which Allied Health Professionals	6	1	25	336	31	45	63	58	65	47	65	70	80	524
of which Other Scientific, Therapeutic and Technical Staff	6	13	7	168	12	54	79	64	45	65	96	70	64	549
Support to clinical staff (HCA)	31	56	45	214	-1	-10	-3	7	-8	2	15	19	13	34
Total Non-Medical - Clinical Staff Agency	353	359	393	3730	398	437	607	713	622	713	734	835	727	5786
Medical and Dental Agency	193	47	442	2704	243	262	353	455	328	317	322	390	378	3049
Consultants	178	141	310	1961	213	203	281	344	178	171	212	278	245	2126
Trainee Grades	15	-94	132	743	30	59	72	111	150	146	110	112	133	923
Non Medical - Non-Clinical Staff Agency	121	166	218	1196	114	128	136	116	140	162	174	148	143	1261
Total Pay Bill Agency and Contract	667	572	1053	7630	755	827	1096	1284	1090	1192	1231	1373	1248	10097

Safer Staffing –Planned versus Actual (New Ways of Working - Growing for the Future)

Ward	Day						Night						Total Patients	Day			Night		
	RN / RM		Nursing Associates		Care Staff		RN / RM		Nursing Associates		Care Staff			Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)
	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours							
Ainslie	1783	1290	0	0	1783	2029	1426	989	0	0	1070	1265	769	72.4%	0.0%	113.8%	69.4%	0.0%	118.3%
Allerton	2933	1740	0	0	1070	1660	1426	1238	0	0	1070	1108	763	59.3%	0.0%	155.2%	86.8%	0.0%	103.6%
Cheetham Hill	1426	1617	357	0	2139	2275	1070	840	357	0	1426	2013	669	113.4%	0.0%	106.3%	78.5%	0.0%	141.1%
Coronary Care	1426	1385	0	0	0	0	1070	1070	0	0	0	0	377	97.1%	0.0%	0.0%	100.0%	0.0%	0.0%
Cromie	1691	1525	0	0	891	1023	1070	968	0	0	713	743	709	90.2%	0.0%	114.8%	90.5%	0.0%	104.2%
Dunlop	1426	1457	0	0	1248	1306	1070	874	0	0	1070	1081	732	102.1%	0.0%	104.7%	81.7%	0.0%	101.1%
Forrest - Summer Escalation	1783	1646	713	0	1426	1487	1783	1414	713	0	1426	1145	765	92.3%	0.0%	104.3%	79.3%	0.0%	80.3%
EAU4	1783	1332	0	0	1426	1061	1783	1380	0	0	1426	977	611	74.7%	0.0%	74.4%	77.4%	0.0%	68.5%
Ella Rowcroft	1070	924	0	0	1426	965	1024	749	0	0	713	633	383	86.4%	0.0%	67.7%	73.2%	0.0%	88.7%
Warrington	1070	1104	0	0	713	987	713	701	0	0	713	805	496	103.2%	0.0%	138.4%	98.3%	0.0%	112.9%
George Earle	1426	1816	357	0	2139	1947	1070	989	0	0	1426	1986	854	127.3%	0.0%	91.0%	92.5%	0.0%	139.3%
ICU	3565	2622	0	0	0	316	3209	2437	0	0	0	35	193	73.5%	0.0%	0.0%	75.9%	0.0%	0.0%
Escalation (McCullum)	713	464	0	0	713	495	713	341	0	0	713	463	192	65.0%	0.0%	69.4%	47.8%	0.0%	64.9%
Louisa Cary	2139	1705	0	0	713	1191	2139	1566	0	0	713	893	467	79.7%	0.0%	167.0%	73.2%	0.0%	125.2%
John Macpherson	1070	881	0	0	552	538	713	749	0	0	713	684	315	82.4%	0.0%	97.5%	105.0%	0.0%	95.9%
Midgley	1783	1689	0	0	1783	1866	1783	1254	0	0	1426	1319	817	94.8%	0.0%	104.7%	70.3%	0.0%	92.5%
SCBU	1070	1006	0	0	357	155	1070	875	0	0	357	240	188	94.1%	0.0%	43.5%	81.8%	0.0%	67.3%
Simpson	1426	1809	357	0	1783	2409	1070	1195	0	0	1070	1710	834	126.9%	0.0%	135.1%	111.7%	0.0%	159.8%
Turner	1070	1105	0	0	1783	2103	713	656	0	0	1426	1075	489	103.3%	0.0%	118.0%	91.9%	0.0%	75.4%
Total (Acute)	*30648*	*27115*	*1782.5*	*0*	*21942*	*23812*	*24909*	*20283*	*1069.5*	*0*	*17469*	*18170*	*10623*	88.5%	0.0%	108.5%	81.4%	0.0%	104.0%
Brixham	868	763	434	0	1302	1865	1023	748	0	0	682	979	593	87.9%	0.0%	143.2%	73.1%	0.0%	143.5%
Dawlish	868	1000	0	0	1085	1235	744	677	0	0	682	725	514	115.1%	0.0%	113.8%	91.0%	0.0%	106.2%
Newton Abbot - Teign Ward	1953	1362	0	0	1953	2317	1023	682	0	0	1023	1230	921	69.7%	0.0%	118.6%	66.7%	0.0%	120.2%
Newton Abbot - Templar Ward	1736	1440	0	0	2205	1963	1023	737	0	0	1116	1392	904	82.9%	0.0%	89.0%	72.0%	0.0%	124.7%
Totnes	868	761	0	0	1302	948	744	682	0	0	682	419	475	87.7%	0.0%	72.8%	91.7%	0.0%	61.4%
Organisational Summary	36941	32439	2217	0	29789	32139	29466	23809	1070	0	21654	22914	14030	87.8%	0.0%	107.9%	80.8%	0.0%	105.8%

- The Registered Nurse (RN) average fill rate for day has decreased in December to 80.7% from Nov 21's of 86.1% and night fill rate has decreased to 72.5% in December from 80.9% in November. This is associated with an increased staff absence associated with an increase in COVID-19 sickness.
- The Health Care Support Worker (HCSW) average fill rate for day was 106.8% and night was recorded as 105.7% in December.
- The higher than planned fill rate for HCSW is to backfill into RN shifts to maintain patient safety as well as providing supportive observation to those patients that require 1:1 care.

Areas to note in December 21	Driver	Mitigations
Allerton (non COVID-19)	Increased RN vacancies, fluctuating bed capacity due to COVID during December	Backfill with HCSW to maintain patient safety. Ward closed to admissions for 10 days therefore reduced patient numbers and reduced RN requirement.
McCullum (Medical patients /non COVID)	Escalated beds (10)	Planned RN numbers not required as reduced patient numbers
SCBU	Increased patient acuity on Louisa Cary so HCSW reassigned	Reduced acuity on SCBU so HCSW safely reassigned on night duty to Louisa Cary

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	7.20	3.00	0.00	4.30	20	30	0	3	64.5%	96.8%	0.0%	9.7%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	7.50	3.90	0.00	3.60	17	25	0	1	54.8%	80.6%	0.0%	3.2%	7.74	4.74	0	2.91
Cheetham Hill	7.39	2.88	0.41	4.11	10.10	3.70	0.00	6.40	1	2	31	0	0.0%	6.5%	100.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.50	6.50	0.00	0.00	5	5	0	0	16.1%	16.1%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.53	3.54	0.00	1.99	6.00	3.50	0.00	2.50	6	12	0	5	19.4%	38.7%	0.0%	16.1%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.40	3.20	0.00	3.30	12	18	0	8	38.7%	58.1%	0.0%	25.8%	7.74	4.74	0	2.91
Forrest - Summer Escalation	10.12	4.60	1.84	3.68	7.40	4.00	0.00	3.40	0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
EAU4	8.28	4.60	0.00	3.68	7.80	4.40	0.00	3.30	22	21	0	19	71.0%	67.7%	0.0%	61.3%	7.74	4.74	0	2.91
Ella Rowcroft	6.57	3.29	0.00	3.29	8.50	4.40	0.00	4.20	1	1	0	6	3.2%	3.2%	0.0%	19.4%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	7.30	3.60	0.00	3.60	3	6	0	3	9.7%	19.4%	0.0%	9.7%	7.74	4.74	0	2.91
George Earle	7.39	2.88	0.41	4.11	7.90	3.30	0.00	4.60	7	4	31	8	22.6%	12.9%	100.0%	25.8%	7.74	4.74	0	2.91
ICU	24.28	24.28	0.00	0.00	28.00	26.20	0.00	1.80	6	9	0	0	19.4%	29.0%	0.0%	0.0%	7.74	4.74	0	2.91
Escalation (McCullum)	11.50	5.75	0.00	5.75	9.20	4.20	0.00	5.00	19	21	0	14	67.9%	75.0%	0.0%	50.0%	7.74	4.74	0	2.91
Louisa Cary	7.36	5.52	0.00	1.84	11.50	7.00	0.00	4.50	0	4	0	0	0.0%	12.9%	0.0%	0.0%	7.74	4.74	0	2.91
John Macpherson	5.18	2.88	0.00	2.30	9.10	5.20	0.00	3.90	0	0	0	2	0.0%	0.0%	0.0%	6.5%	7.74	4.74	0	2.91
Midgley	7.53	3.97	0.00	3.57	7.50	3.60	0.00	3.90	17	23	0	10	54.8%	74.2%	0.0%	32.3%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	12.10	10.00	0.00	2.10	10	6	0	17	32.3%	19.4%	0.0%	54.8%	7.74	4.74	0	2.91
Simpson	6.57	2.88	0.41	3.29	8.50	3.60	0.00	4.90	0	2	31	0	0.0%	6.5%	100.0%	0.0%	7.74	4.74	0	2.91
Turner	10.73	3.83	0.00	6.90	10.10	3.60	0.00	6.50	19	20	0	20	61.3%	64.5%	0.0%	64.5%	7.74	4.74	0	2.91
Brixham	6.95	3.05	0.70	3.20	7.30	2.50	0.00	4.80	8	27	31	0	25.8%	87.1%	100.0%	0.0%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	7.10	3.30	0.00	3.80	10	16	0	13	32.3%	51.6%	0.0%	41.9%	7.74	4.74	0	2.91
NA - Teign Ward	6.40	3.20	0.00	3.20	6.10	2.20	0.00	3.90	20	31	0	0	64.5%	100.0%	0.0%	0.0%	7.74	4.74	0	2.91
NA - Templar Ward	6.50	2.97	0.00	3.53	6.10	2.40	0.00	3.70	22	28	0	6	71.0%	90.3%	0.0%	19.4%	7.74	4.74	0	2.91
Totnes	8.29	3.71	0.00	4.57	5.90	3.00	0.00	2.90	30	24	0	31	96.8%	77.4%	0.0%	100.0%	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
	7.56	4.14	0.21	3.21	7.93	4.01	0.00	3.92
Total Planned Beds / Day	517							
Days in month	31							

- The overall CHPPD position has been maintained in the month of December 21, however this does not reflect the overall reduction in the RN position.
- The RN CHPPD for TSD remains at 4.01 which is below the Carter recommendation of 4.7.
- The HCA CHPPD is at 3.92 which is above the Carter recommendation of 2.91.
- The Trust has continued to see a high demand for acute and emergency services and 26 days in Dec 21 declared OPEL 4, hence the total actual number of care hours per patient day being slightly above the total planned at 7.67 in order to maintain patient safety.

Areas of concerns	Driver	Mitigations
Summer Escalation (Forrest)	Reduced patient numbers requiring a reduction in care hours	Reviewed twice daily at staffing meetings and staff reassigned if necessary
Totnes Hospital	Increased staff absence related to COVID-19	Matron and ward managers on site to support staff and patient safety

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)

Data not currently available
Percentage of reablement episodes not followed by long term SC support (ASCOF)
Number of Delayed Discharges (Community) - national return suspended
Number of Delayed Transfer of Care (Acute) - national return suspended

Due to reduced staffing levels, a summary for Adult Social Care and the Independent Sector and improvement programme is not available this month.

Below is information relating to one of the ASC improvement projects currently underway.

The Front Door Project

The Front Door project is aimed to ensure that Adult Social Care acts in a preventative manner to provide support to individuals early and prevent the emergence of, or reduce further development of, individual needs; this support is provided via the community voluntary sector. Callers to Adult Social Care with support needs that can be met via the community / voluntary sector and who do not require or request a Care Act Assessment are transferred to the Community Helpline where their need for support is triaged.

To date the project has diverted between 10% and 20% of ASC calls each month (*Over 4 months, 242 people were referred into the Community Helpline 47 people came back through to ASC for further assistance. Of those 47 people, a dual approach between statutory and community/voluntary was found).*

Support offered includes shopping, housing support, mental health support, debt and benefit advice. They also meet many of the requirements to provide Information Advice and Guidance.

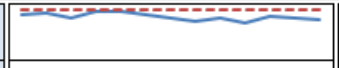
Social Care and Public Health performance metrics - Torbay

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 December 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%	19.6%	Not meeting target (313 / 1595). DPs will be addressed as part of the ASC improvement plan.
Permanent admissions (18-64) to care homes per 100k population (rolling 12 month)	14.0	14.0	23.1	A low outturn signifies better performance. Not meeting target (17 admissions compared to target of 10)
Permanent admissions (65+) to care homes per 100k population (BCF) (rolling 12 month)	450.0	450.0	376.9	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 / 473).
% Adults with learning disabilities in settled accommodation	80%	80%	81.6%	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	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Year to date 2021/22
PUBLIC HEALTH SERVICES																
% of face to face new birth visits within 14 days *	95.0%		88.0%	90.0%	80.2%	91.9%	92.5%	86.6%	80.4%	74.4%	81.0%	72.9%	83.8%	82.1%	77.7%	81.0%
Children with a child protection plan *			223	223	207	223	234	213	201	171	165	147	147			147
4 week smoking quitters (Quarterly) **	200		199			334			117			291				291
Opiate users - % successful completions of treatment (Quarterly) **	Var		4.4%			3.7%			4.3%			5.2%				5.2%

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	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Year to date 2021/22
COMMUNITY BASED SERVICES																
Nursing activity (F2F)			7,697	7,165	7,031	8,064	7,601	7,424	7,755	7,601	7,043	7,613	7,439	7,143	7,098	66,717
Therapy activity	65,415		2,638	2,783	3,016	3,593	3,763	3,337	3,493	3,226	4,014	4,243	3,806	3,116	2,610	31,608
No. intermediate care urgent referrals	0		235	175	146	155	165	155	129	158	191	238	221	237	211	1,705
No. intermediate care placements			19	13	14	42	39	39	39	41	46	30	35	30	42	341
Intermediate Care - placement average LoS			28.7	37.4	34.1	21.0	27.6	17.8	25.6	28.3	23.9	29.7	23.6	26.1	28.8	25.8

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 - December-21

	Act. 20/21 Outturn	Oct-21	Nov-21	Dec-21	Total
Admissions / Discharges					
Total Admissions (General)	2,677	213	174	182	1,952
Direct Admissions (General)	186	15	13	26	132
Transfer Admissions (General)	2,491	198	161	156	1,820
Stroke Admissions	220	17	11	24	181
Transfers from CH to DGH	179	20	14	10	205
Beds					
Bed Occupancy [1]	84.5%	97.6%	98.9%	96.6%	97.4%
Bed Days Lost to Bed Closure	244	27	131	90	260
Length of Stay					
Delayed Discharges		59	0	0	230
Average Length of Stay - Overall (General)	10.4	14.1	15.6	17.6	13.5
Average Length of Stay - Direct Admissions	8	10.9	10.6	11.4	10.0
Average Length of Stay - Transfer Admissions	10.5	14.3	15.9	18.2	13.8
Average Length of Stay - Stroke	14.4	24.1	25.6	23.9	21.1
Long LoS (>30 days)	246	25	17	29	149
MIUs					
Total MIU Activity	22,487	2,859	2,592	2,442	27,104
New MIU Attendances	20,310	2,587	2,315	2,152	24,641
All Follow Up Attendances	2,177	272	277	290	2,463
Planned Follow Up Attendances	1,650	195	200	227	1,780
Unplanned Follow Up Attendances	527	77	77	63	683
MIU Four Hour Breaches	1	0	0	0	13
Average Waiting Time (Mins) - 95th Pctile	43	95	86	186	73

Community Hospitals

Bed occupancy remains high at 96.6% in December.

Average length of stay has risen to 17.6 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 2,442 attendances in December with zero four-hour breaches and an increase in average waiting time to 186 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.

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.

Chart 1- Hours of care given

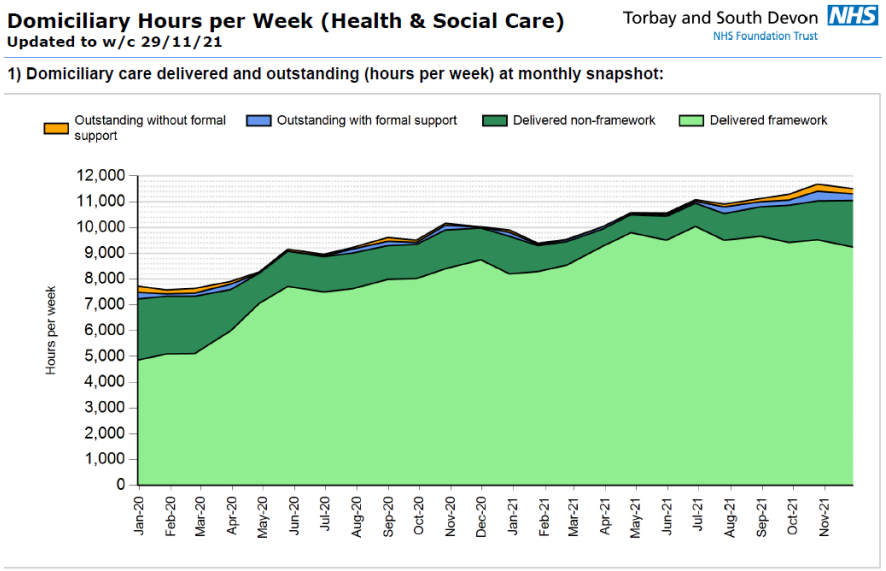


Chart 2 -Unmet packages of care

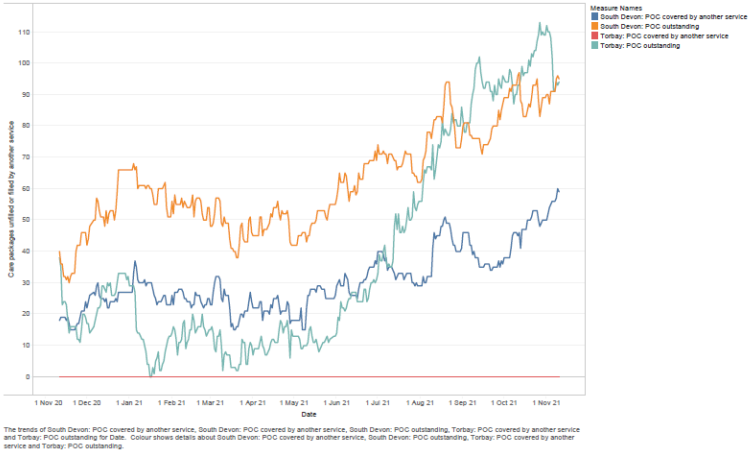


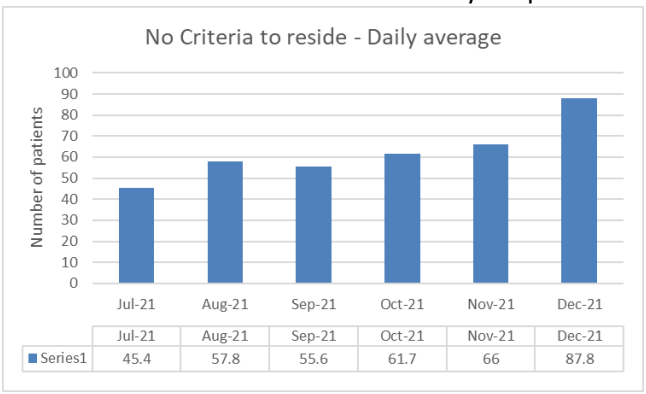
Chart 1 – 'Hours of care given' shows the latest data available for total commissioned domiciliary hours by week for Torbay. The increase in overall hours is seen along with the unmet/outstanding demand. The outstanding hours without formal support are of highest concern. On 18th January there were 40 clients and 219 hours identified as outstanding without formal support in Torbay.

Chart 2- "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:

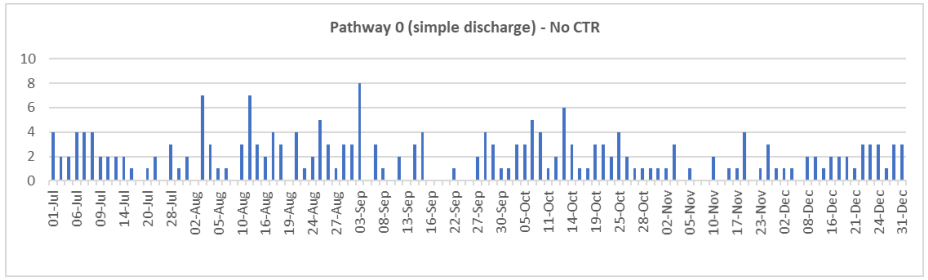


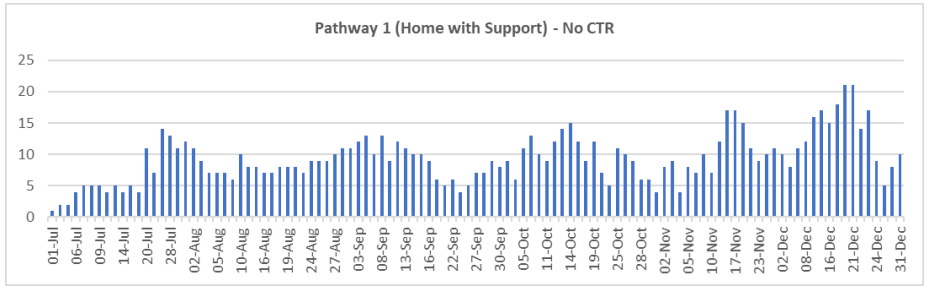
The average number of patients with no criteria to reside is increasing. There is a strong correlation to the increase in unfilled packages of care.

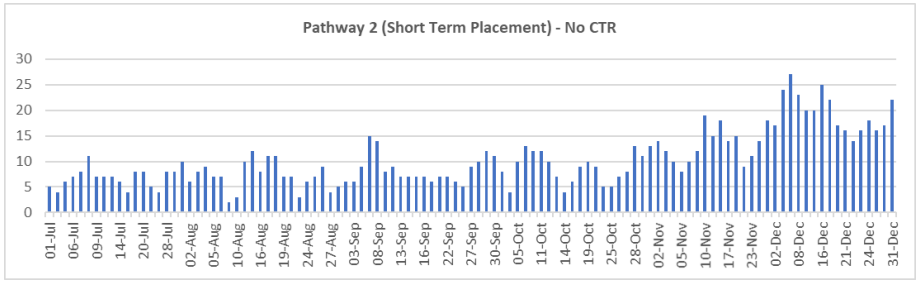
The graphs opposite show the split of patient per day by discharge pathway; there is a recent increase in the number of patients on Pathway 1 being Home with support and Pathway 2 being patients identified as needing short term support.

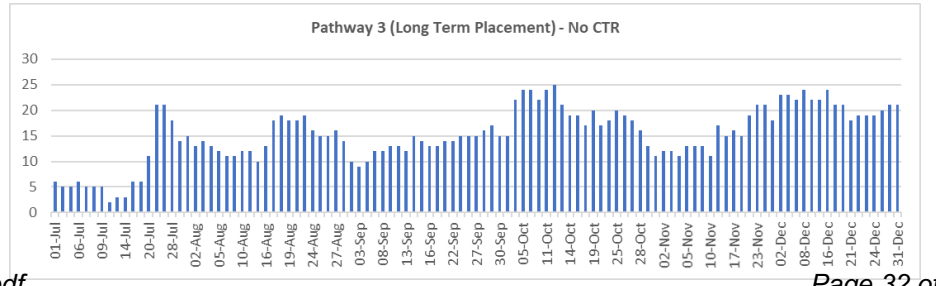
Pathway 3 remains the largest daily cohort of patient occupying a hospital bed with No criteria to reside

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









Operational performance summary: Chief Operating Officer

Covid: Throughout December the Trust continued to care for a number of Covid patients in the single dedicated acute ward averaging 17 to 20 daily in hospital; with up to 3 patients being cared for in the Intensive Care Unit. The Omicron surge in infections, staff sickness, and increased hospitalisations is now being seen. In response the Incident Control Centre (ICC) and drumbeat of daily meetings to oversee the escalation planning and incident response has been established. Revised trajectories reviewed on 12 January 2022 predict that 55 beds will be required by mid-January. This is expected to be a sharp peak of demand and to reduce as quickly. Plans to escalate to this level and beyond to a worst-case scenario have been developed. These plans require significant stepping down of non-urgent activities, re-deployment of staff, and relocation of services to create additional bed capacity. This is a fast-moving incident with planning under continuous review. Whilst planning to create maximum bed capacity is critical to meet predicted demand, the anticipated impact on staff sickness rates is an equally challenging risk. Detailed staffing escalation planning is taking place to ensure re-deployment and flexible staffing arrangements are ready for implementation if required. The covid modelling indicates that peak staff absences may already have been seen or is about to be seen, this is predicted to happen before the peak in admitted patients.

Urgent Care: Urgent and emergency services continued to be challenged throughout December. There was some easing of bed pressure over the Christmas holiday period with Opel 2 declared on Christmas Eve. However, as anticipated, this was followed by a renewed surge in demand and increased discharge delays into the New Year and the first weeks of January. The Trust continues to see high bed occupancy resulting in delays to ambulance handover, extended waits in ED and assessment areas, and patients bedded in ED and assessment areas overnight.
Access to inpatient beds remains the primary contributor to the length of time patients are spending in the Emergency Department. Available inpatient beds have reduced further by 1 acute ward and 1 community hospital ward as a result of the response to the latest covid surge. In December there were 712 people who spent 12-hours or more in the Emergency Department with ambulance handover delays remaining high, meaning 616 patients experienced a delay of over an hour once arriving to the Emergency Department (of the 18 South West trusts TSDFT ranks sixth worst against the 30-day rolling average of greater than 60-minute handover delays).

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. With the continued capacity constraints on the acute site, capacity within the private 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 continue to be developed as a strategy 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. Capacity at the Nightingale Hospital Exeter for orthopaedic day case is delayed and will come on line in late February.
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 admissions prioritising cancer treatments and the most urgent patients. Routine elective orthopaedic surgery was paused again in December to support bed capacity for urgent medical admissions.

Operational Performance Summary – Page 2

Cancer care: An increase in referrals and reduction in capacity from covid escalation for surgical and diagnostic stages of care has led to a continued deterioration in the cancer performance. At 44.1%, our two week wait performance is the lowest performance for 15 months. Meeting the 28-day cancer diagnosis target has also been a challenge, recording 51.6% against the 75% target and the fourth month of decreasing performance. There is a continued reduction in the 62-days to treatment target at 60.6% where the backlog of patients waiting has doubled over the last year. The Executive Team have received details of cancer action plans and approved the establishment of the Cancer Cabinet to commence in January 2022. Improvements in Dermatology 2-week-wait time have been seen in recent weeks reducing from 5 to just over 3 weeks from referral, and a mobile unit to support clearance of backlog for urology prostate biopsies and cystoscopies opened on 12 January 2022 on the Torbay Hospital site. The preservation of capacity to support cancer pathways remains central to planning however the impact of wider escalation to manage hospital pressures can be seen in several of these metrics.

Diagnostic waiting times: 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 December the number of 21- day and 7-day length of stay patients has remained significantly higher than normal levels with an average of 48 patients over 21 days in hospital compared to 14 last December, and 157 over 7 days compared to 91 last December. In December the length of stay for patients discharged from community hospitals has increased to 17 days compared to 10.5 days seen across 20/21 and 13 days reported in September.
There remains a significant number of patients who are medically fit with no 'criteria to reside' who 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 remains high and impacting on patient flow and discharge from community and acute settings of bedded care. 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 domiciliary care; it is noted that in April 2022 the same rules will apply to domiciliary care, voluntary sector, and front-line NHS staff.

Operational Performance Quadrant

Achieved
A&E - patients recorded as greater than 60 min corridor care
Cancer - 31-day wait from decision to treat to first treatment
Cancer - 31-day wait for second or subsequent treatment - Drug
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy
Cancer - 31-day wait for second or subsequent treatment – Surgery

Under Achieved
Dementia Find (NHSI)
Cancer - Patient waiting longer than 104 days from 2 week wait

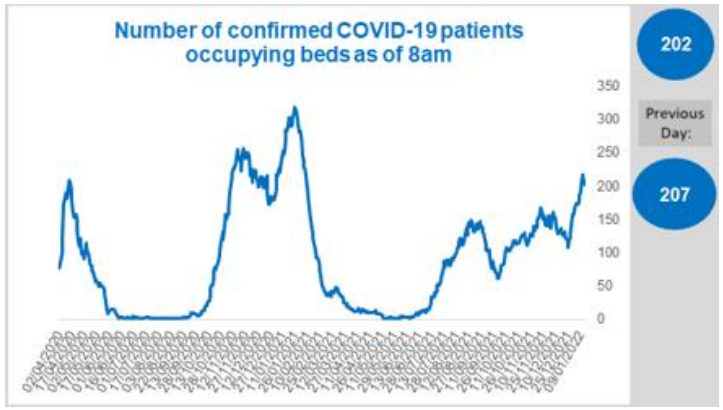
No target set

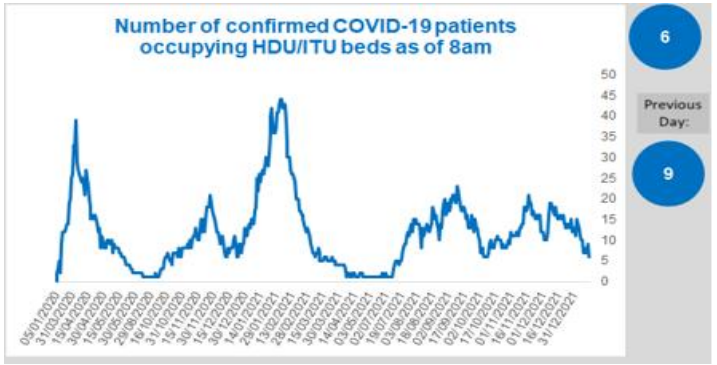
Data not available
Number of Clostridium Difficile cases reported
Clinic letters timeliness - % specialties within 4 working days

Not Achieved
A&E - patients seen within 4 hours (NHSI)
Ambulance handover delays > 30 minutes
Ambulance handover delays > 60 minutes
Cancer - Two week wait from referral to date 1st seen
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients
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 patients >7 days LoS (daily average)
Number of extended stay patients >21 days (daily average)
On the day cancellations for elective operations
Cancelled patients not treated within 28 days of cancellation

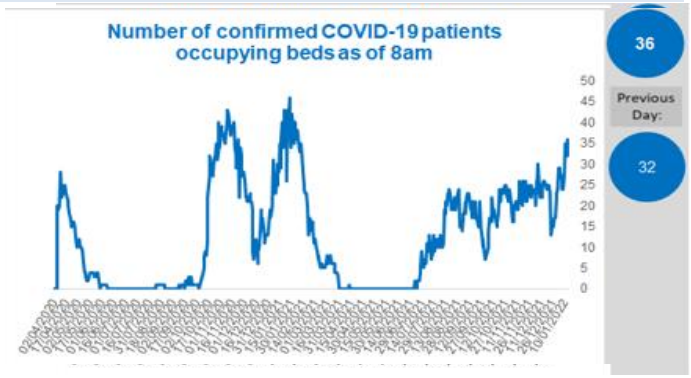
Covid - Hospitalisations

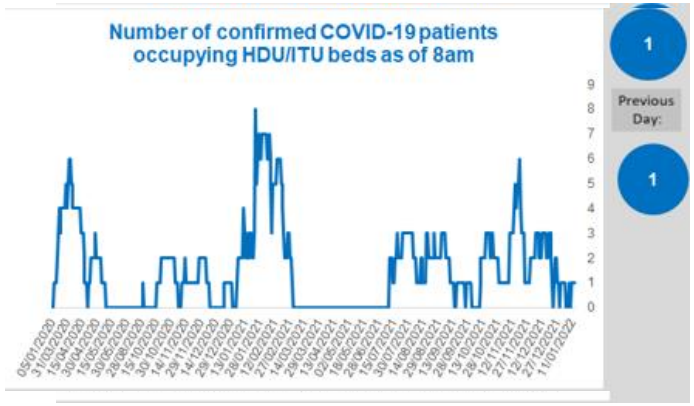
Devon ICS
(as at 14 January 2022)





Torbay and South Devon NHS FT
(as at 14 January 2022)





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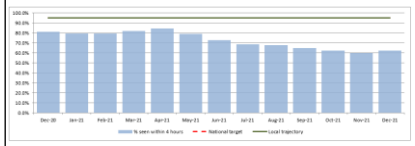
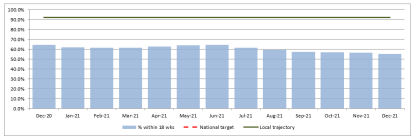
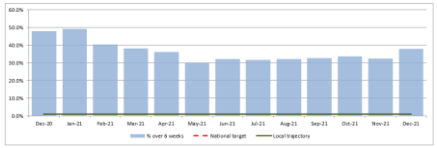
NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Patients seen within 4 hours in A&E	Performance M9 62.5% Performance M8 59.8% Target 95% Risk level HIGH	The Urgent and Emergency services remains challenged with access to inpatient beds continuing to contribute to delays in the department and also with Ambulance handover. In December, 712 patients experiencing a 12-hour stay in the department comparing to 18 in December 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 with one of the highest number of hours lost in the region 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)	
Patients waiting longer that 18 weeks from Referral to Treatment	Performance M9 55.6% Performance M8 56.9% Target 92% Risk level HIGH	The total number of people waiting for treatment has increased by 866 from last month. 532 patients are waiting longer that 78 weeks and 148 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. The protected inpatient orthopaedic beds have unfortunately been re-allocated to support the COVID response. The use of Mount Stuart Hospital facilities has been extended to offset some of the lost capacity. Use of the Nightingale for T&O has been delayed until late February 2022. 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 Business planning. Insourcing continues at weekends in ophthalmology and endoscopy. Additional insourcing weekends are being scheduled using Elective Recovery Fund funding.	

Activity variance vs 2019/20 baseline	M8	M9
Op new	1.9%	-4.4%
OP Follow up	-2.7%	-7.0%
Day Case	-11.7%	-12.6%
Inpatient	-37.0%	-33.5%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Cancer 62 day wait for 1st treatment from 2-week wait referral	**Performance M9** **61.9%** **Performance M8** **57%** **Target** 85% **Risk level** HIGH	Performance against the 62-day referral to treatment standard remains below target (85%) in December. 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 with mobile urology diagnostic investigations unit in place from early January.	
Diagnostic tests longer than 6 weeks	**Performance M9** **37.9%** **Performance M8** **32.4%** **Target** 1% **Risk level** HIGH	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 is impacting on additional sessions that can be provided from current workforce.	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. Insourcing for weekend endoscopy list (3 weekends per month) funded through ERF have continued. Proactive recruitment and training initiatives continue to support teams that are operating with vacancies to minimise locum and bank staff.	

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Dementia Find	Performance M9	Performance against the Dementia Find assessment standard has dropped to 87.3% in December. Performance against this indicator is reliant on support from a Health Care Assistant, performance will be impacted by annual leave and HCA availability.	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.	
	87.3%			
	Performance M8			
	95%			
	Target			
	90%			
	Risk level			
	LOW			

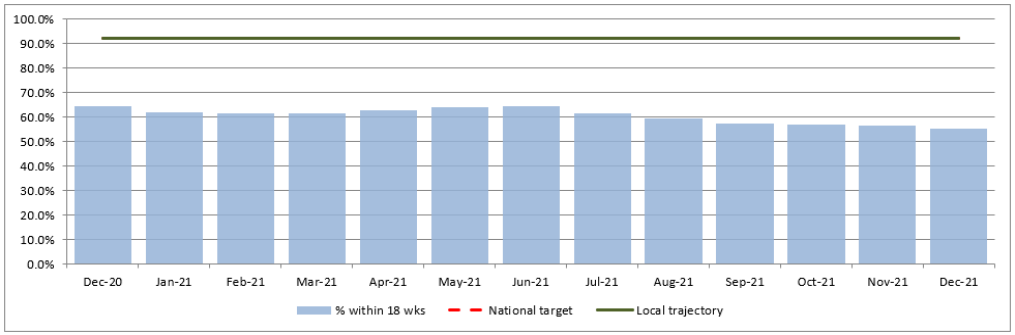
NHSI Performance – Referral to Treatment (RTT)

Services with greater than 100 patients waiting over 18 weeks

NOVEMBER 2021 Incomplete 92% Table - National Specialty

	>126			
Submitted Spec	Incomplete IPDC	Incomplete OP	Grand Total	% < 18wk
Pain Management	50	156	469	56.08
Endocrinology		275	566	51.41
Neurology	9	447	893	48.94
Respiratory Medicine		472	1214	61.12
Gastroenterology	301	302	1933	68.8
Gynaecology	286	328	1939	68.33
Colorectal Surgery	122	604	1344	45.98
Paediatrics	10	802	1693	52.04
Dermatology	1	865	2037	57.49
Oral Surgery	351	639	2159	54.15
Cardiology	54	951	2622	61.67
Upper Gastrointestinal Surgery	440	568	1601	37.04
ENT	206	881	2317	53.09
Urology	338	1135	2608	43.52
Trauma & Orthopaedics	1249	497	3010	41.99
Ophthalmology	307	1528	4257	56.89
Grand Total	3796	10950	33065	55.4

Referral to Treatment – incomplete pathways



Referral to Treatment: RTT performance in December has deteriorated with the proportion of people waiting less than 18 weeks at 55.6%; this is behind the Operational Plan trajectory of 82% and national standard of 92%. We have continued to see an increase in the total number of incomplete pathways (waiting for treatment) to 33,089 from 32,223, an increase of 866 from the November position.

52 week waits: For December 2,384 people will be reported as waiting over 52 weeks and is an increase from 2,147. Overall long waits are increasing, but patients waiting longer than 78 weeks have decreased to 532 in December from 565, with 104 weeks waits continuing to increase to 148 from 117 in November. The loss of elective activity due to emergency pressures on beds continues to be seen, with non-urgent outpatient activity being stood down and only P1 and P2 priority patients being admitted.

Recovery planning: Teams are being asked to restart identifying patients that are suitable for Mount Stuart Hospital for T&O, UPGI, Urology, Colorectal and Gynae. Plans have been delayed for patients to be treated through the recommissioned Nightingale Hospital Exeter, it is anticipated that this will now start late February 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 Dermatology as well as looking at options to bolster overall Anaesthetic provision, options are also be considered to carry out cataract operations at a local private provider Optimax. To ease pressure on the prostate cancer pathway, Urology are commencing transperineal biopsies using a mobile van to clear their backlogs, then moving to cystoscopies.
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 2022/23 planning guidance, and meetings are now in place with the CCG and NHSE/I to monitor performance, all options are being considered by the CCG including securing independent sector capacity out of area. The waiting time forecast however is showing that there will remain between 195 – 305 104 week waits on our lists at 31st March 2022. 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 all categories has increased in December. The longest waiting cohort (greater than 18 weeks) has seen a significant increase of 1,162.

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 28.11.2021		
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	703	1217	5115
Rheumatology	215	356	1187
Ear Nose Throat	175	283	843
Paediatrics	168	357	487
Neurology	174	210	662
Orthoptist	157	164	397
Urology	27	51	366
Gynaecology	43	63	166
Respiratory Medicine (Chest)	48	104	146
Orthodontics	47	48	245
Colorectal Surgery	25	66	341
Orthopaedics	76	72	135
Dermatology	187	282	183
Geriatric Medicine	29	24	99
Cardiac Testing	14	17	10
Gastro-Enterology	142	175	171
Breast Surgery	47	29	268
Cardiology	100	104	56
Pain Management	36	68	57
Oral Surgery	79	93	55
Plastic Surgery	45	46	53
Diabetic	66	69	31
Upper Gastrointestinal Surg	34	24	77
Respiratory Technician	29	17	103
Endocrinology	31	39	33
Grand Total	2759	3994	11319

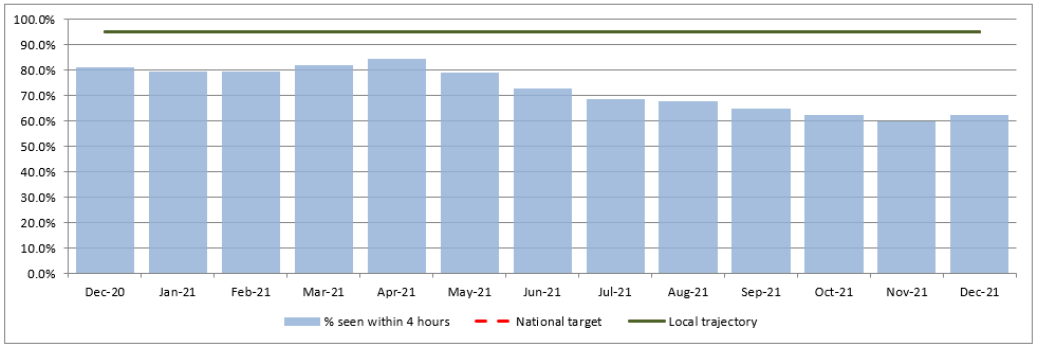
Specialtities with highest Follow-Up Backlog	Passed TBS as at 04.01.2022		
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	812	1216	5524
Rheumatology	204	345	1255
Ear Nose Throat	227	275	915
Paediatrics	215	360	570
Neurology	135	238	706
Orthoptist	138	192	437
Urology	42	50	368
Gynaecology	69	56	183
Respiratory Medicine (Chest)	78	99	192
Orthodontics	56	54	246
Colorectal Surgery	32	62	352
Orthopaedics	115	96	168
Dermatology	168	293	322
Geriatric Medicine	43	36	108
Cardiac Testing	23	14	17
Gastro-Enterology	193	174	238
Breast Surgery	59	30	271
Cardiology	127	148	81
Pain Management	45	55	85
Oral Surgery	69	113	83
Plastic Surgery	25	60	47
Diabetic	53	88	42
Upper Gastrointestinal Surg	36	37	89
Respiratory Technician	49	42	106
Endocrinology	22	45	38
Grand Total	3087	4229	12481

Variance		
06-12 Weeks	12-18 Weeks	18 Weeks +
109	-1	409
-11	-11	68
52	-8	72
47	3	83
-39	28	44
-19	28	40
15	-1	2
26	-7	17
30	-5	46
9	6	1
7	-4	11
39	24	33
-19	11	139
14	12	9
9	-3	7
51	-1	67
12	1	3
27	44	25
9	-13	28
-10	20	28
-20	14	-6
-13	19	11
2	13	12
20	25	3
-9	6	5
328	235	1162

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

A&E and MIU patients seen within 4 hours

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Patients	6227	5436	5365	7118	7947	8802	9622	9536	9072	8738	8415	7483	6923
4 hour breaches	1171	1118	1103	1268	1238	1860	2636	2990	2935	3052	3155	3010	2596
% seen within 4 hours	81.2%	79.4%	79.4%	82.2%	84.4%	78.9%	72.6%	68.6%	67.6%	65.1%	62.5%	59.8%	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%



Performance 4 hour standard: Performance has improved in December 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 26 days at OPEL 4.

12 hour Trolley wait: 162 patients are reported as having a 12-hour trolley wait from decision to admit to admission to an inpatient bed.

Ambulance Handovers: 616 ambulance delays over 60 minutes; 952 ambulance handover delays of over 30 minutes.

Patients with a greater than 12-hour visit time pathway: 712 patients had a greater than 12-hour visit time.

Corridor Care: No patients recorded as receiving corridor care.

Operational delivery:

Performance remains a significant challenge through December with the Trust at OPEL 4 for the majority of the month. Flow out of the department has been difficult and this has led to significant delays to transfers and patient moves.

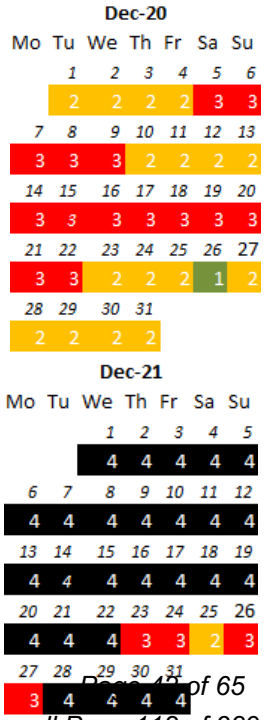
Demand for urgent and emergency care is lower than pre covid levels although the acuity of the patients presenting is higher with the average length of stay increased. The number of patients attending the Emergency department in December is 10% higher than last year.

Safety remains the highest priority while as the Trust manages the demands on all of its services through the pandemic.

Escalation status

Opel status	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Opel 1	1	0	0	1	3	2	0	0	0	0	0	0	0
Opel 2	16	4	0	23	26	16	1	0	0	0	0	0	1
Opel 3	14	26	28	7	1	13	21	7	7	5	3	1	4
Opel 4	0	1	0	0	0	0	8	24	24	25	28	29	26
4-hour Performance (ICO)	81.2%	74%	79%	82%	84%	79%	73%	69%	69%	65%	62%	60%	63%
Bed Occupancy (Acute)	83%	89%	89%	85%	87%	92%	95%	95%	95%	94%	93%	93%	93%
Ambulance handover delays >1 hour	19	15	20	32	19	26	173	165	120	72	125	617	616
Dom Care - hours outstanding*	*490*	*58*	*174*	*51*	*189*	*235*	*467*	*613*	*994*	*1,261*	*1,357*	*1,288*	*468*
No Criteria To Reside - daily average (weekday)								45	58	56	62	66	88

* From December 2021 data to only include outstanding hours where client is without formal support and client receiving formal support not at home



As at 11.01.2022	2021											
	October				November				December			
target_type	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf
14 day - 2ww Referral	777.0	723.0	1,500.0	51.8%	853.0	1,020.0	1,873.0	45.5%	705.0	892.0	1,597.0	44.1%
14 day - Breast Symptomatic Referral	75.0	3.0	78.0	96.2%	77.0	16.0	93.0	82.8%	33.0	7.0	40.0	82.5%
28 day - Faster Diagnosis Standard	796.0	631.0	1,427.0	55.8%	972.0	885.0	1,857.0	52.3%	820.0	768.0	1,588.0	51.6%
31 day - 1st Treatment	162.0	3.0	165.0	98.2%	204.0	7.0	211.0	96.7%	174.0	6.0	180.0	96.7%
31 day - Subsequent Treatment - Drug	87.0	0.0	87.0	100.0%	73.0	0.0	73.0	100.0%	86.0	0.0	86.0	100.0%
31 day - Subsequent Treatment - Radiotherapy	59.0	1.0	60.0	98.3%	63.0	0.0	63.0	100.0%	51.0	0.0	51.0	100.0%
31 day - Subsequent Treatment - Surgery	22.0	0.0	22.0	100.0%	35.0	1.0	36.0	97.2%	28.0	0.0	28.0	100.0%
31 day - Subsequent Treatment - Other	16.0	0.0	16.0	100.0%	24.0	0.0	24.0	100.0%	19.0	0.0	19.0	100.0%
62 day - 2ww referral	72.0	26.5	98.5	73.1%	67.0	45.5	112.5	59.6%	63.0	41.0	104.0	60.6%
62 day - Screening Referral	7.0	1.0	8.0	87.5%	14.0	3.0	17.0	82.4%	7.0	1.0	8.0	87.5%
62 day - Consultant Upgrade	0.0	1.0	1.0	0.0%	0.0	1.0	1.0	0.0%	1.0	0.0	1.0	100.0%

Cancer standards The table above shows the position for December 2021 (as at 11th January 2022). *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: 44.1% (unvalidated) is below the standard of 93%. Skin breaches have started to reduce with waits currently at 3 weeks and 3 days. We are continuing to see increased referrals in Breast which are impacting December performance with waits currently at 3 weeks and 3 days. The most challenged pathways are Skin (11.0%) 500 breaches, Breast (19%) 208 breaches and Urology (55%) 63 breaches.

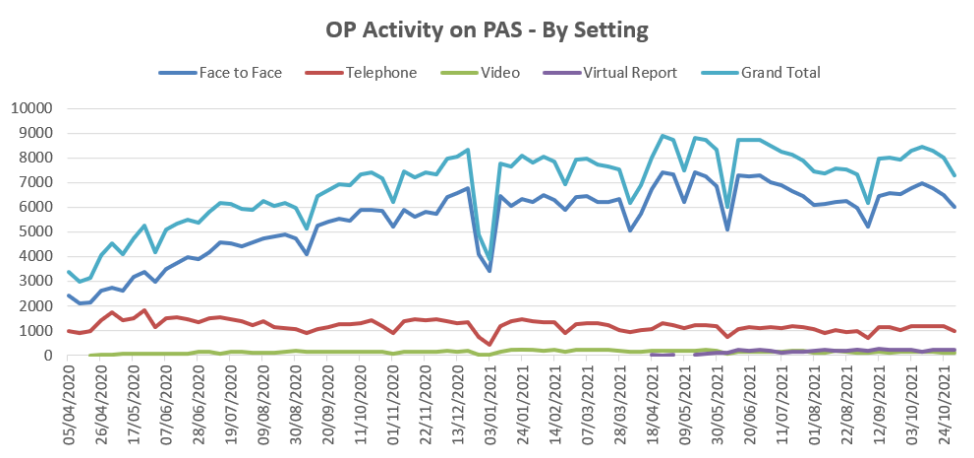
28 days From Referral to Diagnosis: Performance in December is 51.6% (unvalidated) against the target of 75% and reflects the impact of the high number of breaches for Skin (360) ,Lower GI (185), Breast (61) and Urology (56).

NHSI monitored Cancer 62 day standard: The 62-day referral to treatment standard continues to plateau in December at 60.6% (unvalidated) against the target of 85% with 63 patient being seen within 62 days, however, 42.5 patients falling outside the target time; Urology account for 15 breaches, Skin 11.5 breaches and LGI 6.5 breaches being (78%) of all breaches.

104-day wait: Currently there are 25 (unvalidated) patients with a greater than 104-day wait in December, 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 15 patients waiting longer than 104 days, 10 with confirmed cancers.

Virtual appointments (Non-face-to-face)

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



The actual performance for non face-to-face is:

	July	Aug	Sept	Oct	Nov	Dec
New	14%	15%	9%	14%	14.5%	12.4%
Follow Up	22%	21%	21%	21%	23.6%	21.7%
Combined	**20%**	**19%**	**18%**	**19.5%**	**21.1%**	**19.3%**

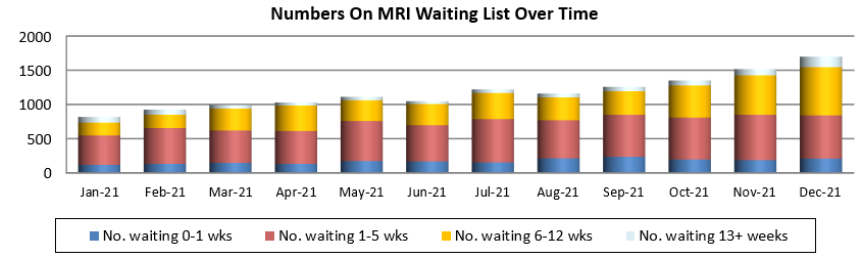
December performance is below the nationally set requirement of 25% and the lowest in the Devon providers. Achieving 25% at Integrated Care System level is linked to achieving financial incentives into the Elective Recovery Fund and remains one of the business planning standards. The programme of in-depth specialty reviews with clinical and operational teams is progressing however the focus of operational teams on escalation for covid is delaying progress. Opportunities are being identified as well as increased awareness of outpatient utilisation and productivity. A number of activities recorded on other clinical systems (InfoFlex) are being identified where non-face-to-face clinical activity is captured and needs be reported in our national returns. To incorporate these non PAS events will require a resourced programme of work.

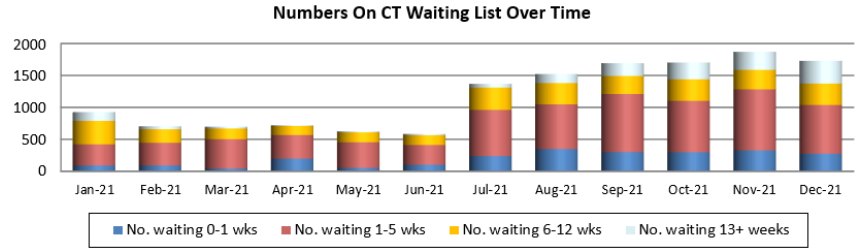
Actions

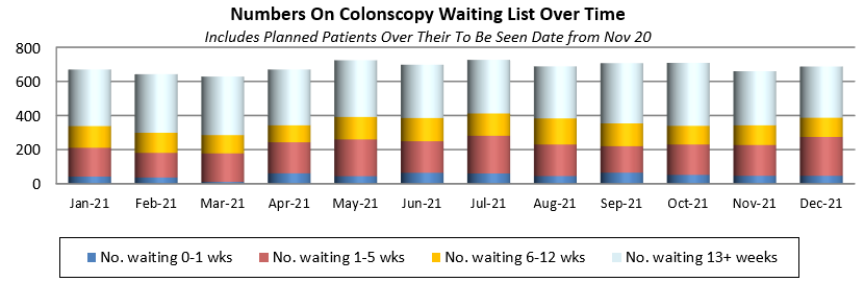
The following actions are being taken to improve Trust performance:

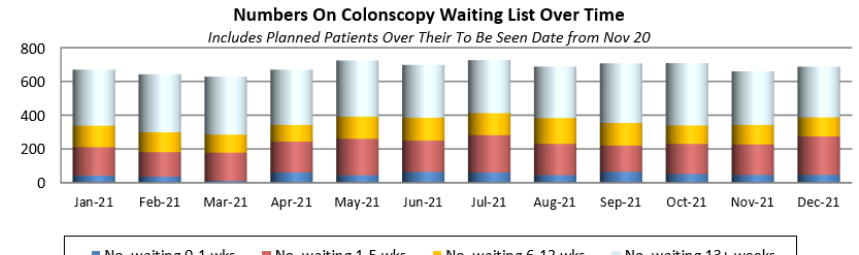
- Shared learning with North Devon services that are achieving higher non-face-to-face rates;
- Sharing good practice from one service to another wherever possible/appropriate;
- Providing service and clinic level performance reports highlighting where there are areas for improvement;
- Improving the 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.

NHSI indictor - patients waiting over 6 weeks for diagnostics



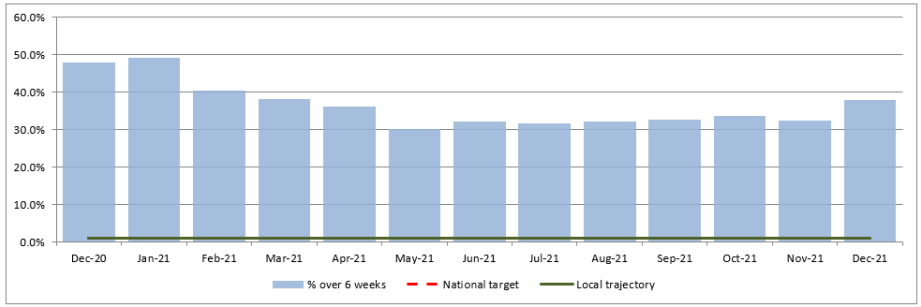






Diagnostic tests longer than the 6 week standard

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Patients	4989	5013	4934	4957	4876	4909	4702	5682	5655	5542	5591	5846	5899
Waiting longer than 6 weeks	2389	2462	1992	1892	1768	1478	1516	1799	1821	1808	1888	1894	2237
% over 6 weeks	47.9%	49.1%	40.4%	38.2%	36.3%	30.1%	32.2%	31.7%	32.2%	32.6%	33.8%	32.4%	37.9%
National target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Local trajectory	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%



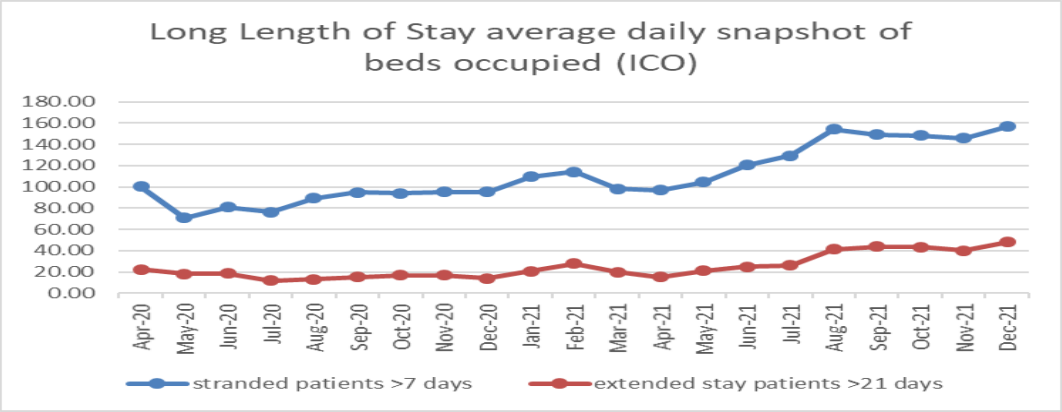
All modalities are continuing to see patients with urgent need with appropriate Infection, Prevention and Control precautions.

CT numbers waiting and waiting times for routine tests remain above target with 691 pts waiting over 6 weeks. There are increasing staffing pressures to maintain capacity for in-house scans, reporting and vetting of referrals. Additional capacity at the Nightingale Hospital will continue to support capacity. Radiographer vacancies in workforce continue to limit the ability to fully utilise scanner capacity.

Colonoscopy numbers and routine waiting times remain high with 413 over 6 weeks. 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 with 859 over 6 weeks. This reflects the continued high demand and capacity pressures. Capacity is reliant on the support of mobile scanner visits with all in house scanner capacity being utilised. 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.

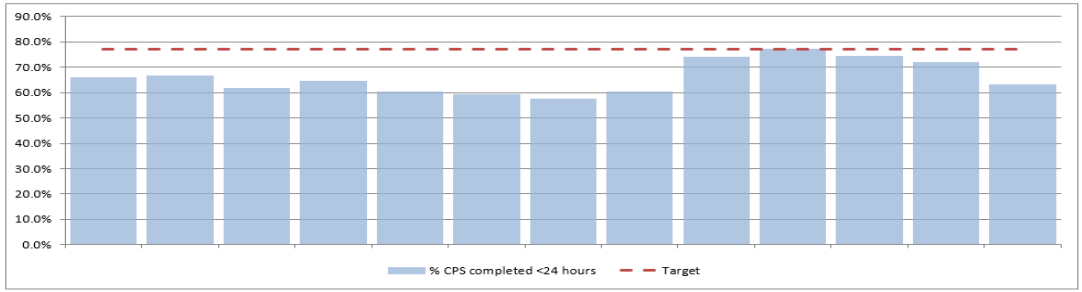


Long Length of Stay (LOS)

In December 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 continued to increase. 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 will be included in the daily list of patients identified as no criteria to reside and on complex discharge pathways (P1-3).

Care Plan Summaries completed within 24 hours of discharge - Weekday

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Discharges	1436	1157	1049	1282	1434	1484	1474	1341	1286	1424	1263	1347	1239
CPS completed within 24 hours	950	774	650	828	866	883	848	812	953	1101	941	970	781
% CPS completed <24 hours	66.2%	66.9%	62.0%	64.6%	60.4%	59.5%	57.5%	60.6%	74.1%	77.3%	74.5%	72.0%	63.0%
Target	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%

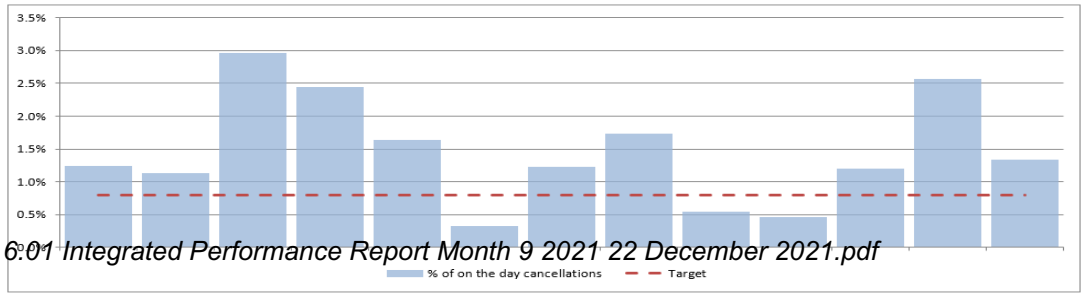


Care Planning Summaries (CPS)

Hospital Care Planning 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.
93 patient discharges in December had no CPS completed.
A trial is currently taking place on Allerton Ward to improve CPS completion within 24-hours.

On the day cancellations for elective operations

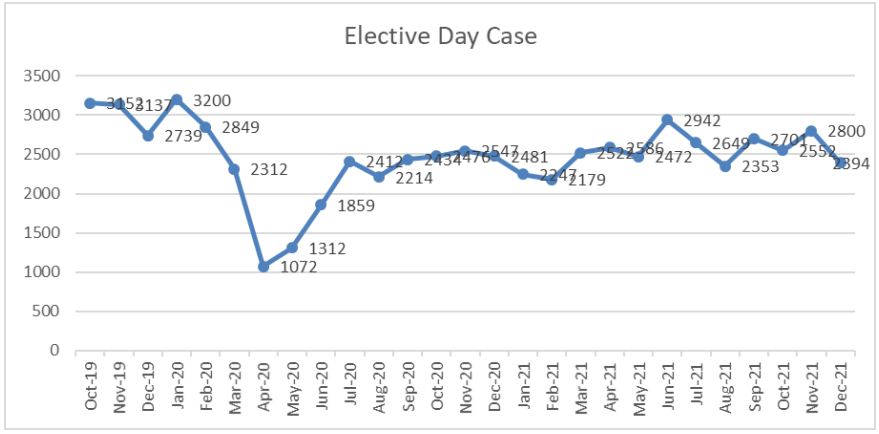
	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Cancellations	35	29	71	71	48	9	40	51	14	14	34	79	36
Elective spells	2835	2550	2400	2904	2922	2760	3276	2933	2602	2994	2830	3074	2691
% of on the day cancellations	1.2%	1.1%	3.0%	2.4%	1.6%	0.3%	1.2%	1.7%	0.5%	0.5%	1.2%	2.6%	1.3%
Target	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%

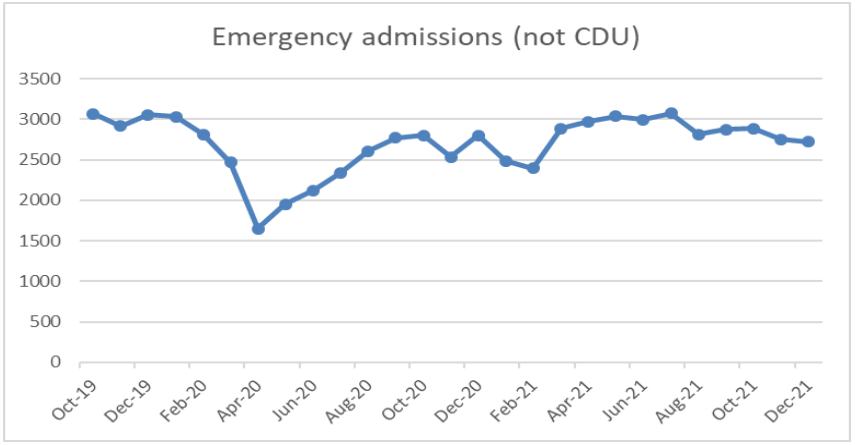


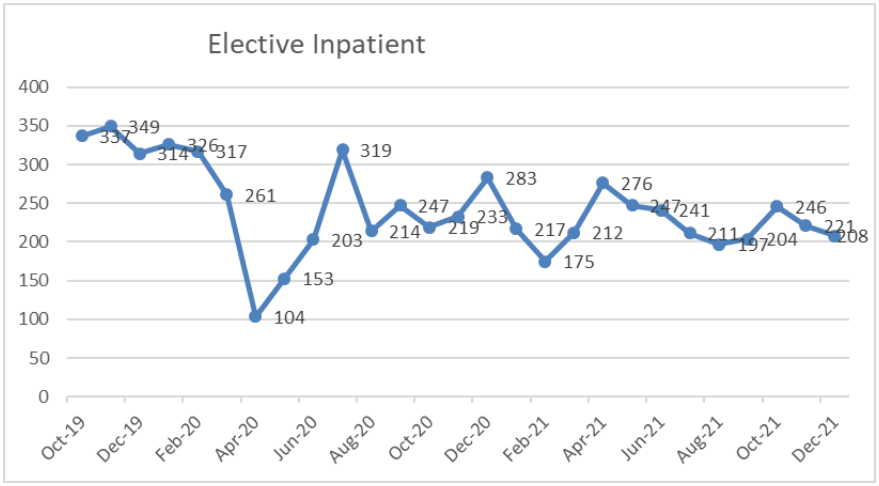
Cancelled operations

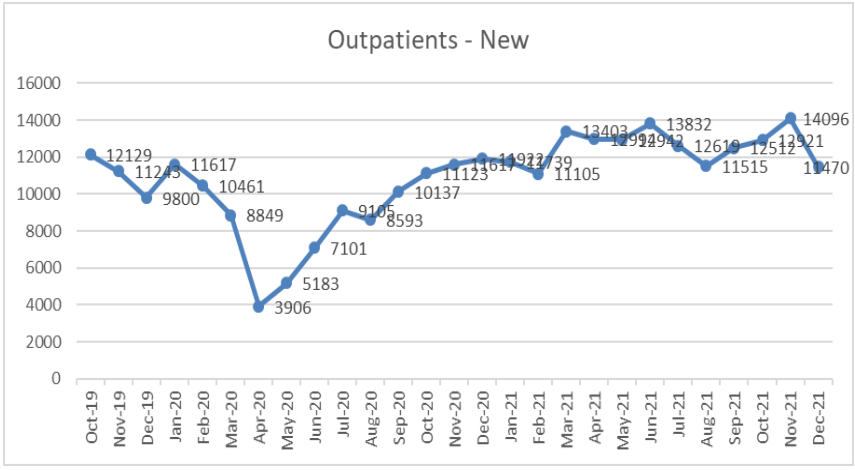
36 patients (1.3%) were cancelled on the day of an elective operation. 12 of those patients cancelled were not treated within 28 days of the cancellation.

Headline acute activity comparisons 2019/20 v 2020/21









The charts above show the monthly activity run rate of reported contract activity to end of December 2021.
Compared to 19_20 pre covid level comparisons are elective DC = 87% Elective inpatient = 66% Outpatient new = 117% Emergency admission = 89%.
In December further escalation to support the demand for medical inpatient care resulted in the closure of the orthopaedic ward hence the elective activity reduced overall.
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.
Capacity at the Nightingale Hospital Exeter will commence however due to recruitment challenges the start date has been delayed to end of February.

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. Vacancy rates in CAMHS have stabilised and there are some improvements in waiting times noted. The service leads are fully sighted on their challenges and action plans are closely 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) continues fortnightly. The working model for the service is efficient and integrated between core and virtual.
- 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.
- Additional investments for Speech and Language Therapy and Occupational Therapy were not operationalised in 20-21 due to significant challenges in service lines and availability of bank and agency staff.

	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 December	FY 2022 December	FY 2021 December	FY 2022 December	FY 2021 December	FY 2022 December
Community Children's Nursing (CFH Devon)	0	0	100.0%	100.0%	266	298
Learning Disability (CFH Devon)	0	1	97.5%	93.8%	290	237
Mental Health and Wellbeing	13	49	78.6%	55.2%	4137	4190
Occupational Therapy (CFH Devon)	1	0	60.1%	62.0%	1218	1031
Palliative Care (CFH Devon)	0	0	100.0%	NA	42	43
Physiotherapy (CFH Devon)	0	0	80.9%	78.5%	523	494
Special School Nursing (CFH Devon)	0	0	NA	100.0%	462	549
Specialist Autism Spectrum Assessment Team (CFHD)	1292	1351	18.4%	16.9%	3368	3046
Specialist Children's Assessment Centre (CFHD)	19	35	46.2%	42.0%	726	1013
Speech & Language Therapy (CFH Devon)	253	528	56.6%	31.0%	4832	5095

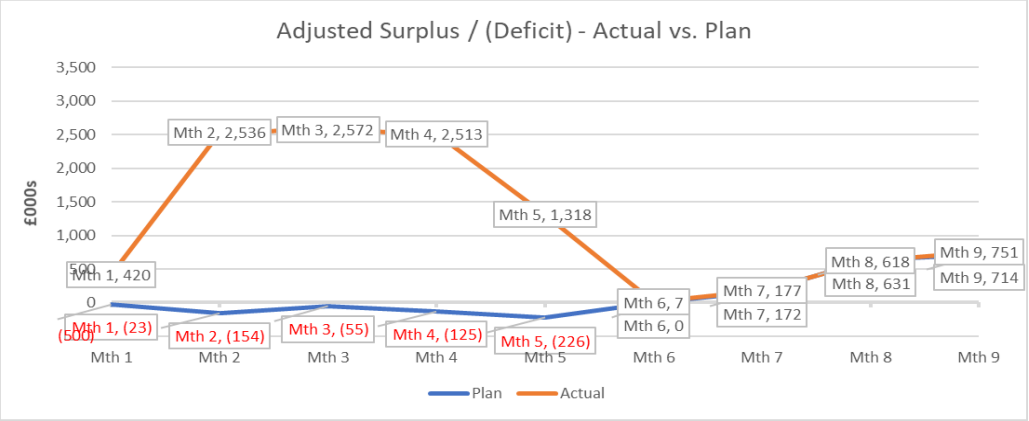
Financial Performance – Month 9 (December)
FY 2021 / 22

Financial Overview – Month 9, December 2021

High Level Summary

For Period ended - 31 December 2021, Month 9	Plan £m	Actual £m	Variance £m
Total Operating Income	429.40	435.77	6.37
Total Operating Expenditure and Financing Cost	(429.30)	(436.05)	(6.75)
Surplus/(Deficit)	0.10	(0.28)	(0.38)
Add back: NHSE/I Adjustments	0.61	1.03	0.42
Adjusted Surplus/(Deficit)	0.71	0.75	0.04
CIP	4.36	3.53	(0.83)
Capital	33.15	13.65	(19.49)
Cash & Cash Equivalents		30.31	

Adjusted Surplus / (Deficit)



Operating Income

Operating income for the year to date totals £435.8m, within which income for patient care activities totals £397.3m. Total income for the year to date is £6.4m 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 and H2 (£4.9m favourable), education and training, R&D grants and various income (£2.1m favourable) and ASC client contribution income (£0.7m matched by cost) offset by: lower ERF income owing to the changes in funding threshold alongside increasing cancellation of elective surgery (£0.6m adverse), reclassification of renal transport income and audit income from patient care income to other income and pass through drugs within block contract income (£0.3m adverse).

Operating Expenditure

Total operating expenditure and financing cost of £436.1m, which includes £218.4m of staff costs. Operating expenditure and financing cost in the year to date is £6.8m adverse to plan. Key drivers are as follows: COVID related costs including those council funding stream not initially budgeted in H1 and H2 (£4.9m adverse matched by income), increase in Agency (£4.4m adverse) and Bank spend (£3.1m adverse), undelivered CIP (£0.8m adverse), increased clinical supplies and services cost (£1.0m adverse), ASC bad debt provision (£0.5m adverse), consultancy and other cost (£0.4m adverse) offset by lower substantive pay due to vacancies (£6.7m favourable) and lower CFHD alliance cost £(1.6m favourable).

Adjusted Surplus / (Deficit)

At month 9 the Trust is recording a surplus of £0.75m against plan of £0.71m.

CIP

At month 9 the Trust delivered £3.53m of savings against plan of £4.36m.

Capital

To date the Trust has spent c. £13.7m on capital schemes. A separate capital report has been prepared for the Trust's FPDC.

Cash

The Trust is showing a healthy cash position at the end of Month 9, with £30.3m held in cash and cash equivalents. A planned cash position was not required as part of the H1 and H2 submission.

I&E Position – Month 9, December 2021

Income & Expenditure – Performance versus Plan

£m	M9 - In Month			M9 - YTD		
	Budget	Actual	Variance	Budget	Actual	Variance
Patient Income - Block	32.40	32.43	0.03	294.18	293.84	(0.34)
Patient Income - Variable	3.63	3.76	0.13	33.99	33.66	(0.33)
ERF/TIF/Capacity Funding	0.93	1.07	0.14	5.61	5.01	(0.60)
ASC Income - Council	4.58	4.58	(0.00)	41.25	41.28	0.03
Other ASC Income - Contribution	1.00	1.18	0.17	8.90	9.59	0.68
Torbay Pharmaceutical Sales	1.85	2.02	0.17	15.97	15.99	0.02
Other Income	2.86	3.28	0.42	25.18	27.24	2.06
Covid19 - Top up & Variable income	0.65	1.05	0.40	4.32	9.17	4.85
Total (A)	**47.90**	**49.36**	**1.45**	**429.40**	**435.77**	**6.36**
Pay - Substantive	(23.95)	(23.17)	0.78	(211.88)	(208.27)	3.61
Pay - Agency	(0.90)	(1.25)	(0.35)	(5.67)	(10.10)	(4.43)
Non-Pay - Other	(12.00)	(12.98)	(0.98)	(115.02)	(113.93)	1.09
Non- Pay - ASC/CHC	(8.80)	(9.92)	(1.12)	(77.23)	(84.28)	(7.05)
Financing & Other Costs	(2.24)	(2.55)	(0.31)	(19.50)	(19.47)	0.03
Total (B)	**(47.89)**	**(49.87)**	**(1.98)**	**(429.30)**	**(436.05)**	**(6.75)**
Surplus/(Deficit) pre Top up/Donated Items and Impairment (A+B=C)	**0.01**	**(0.51)**	**(0.52)**	**0.10**	**(0.28)**	**(0.38)**
NHSE/I Adjustments - Donated Items / Impairment / Gain on Asset disposal	0.07	0.64	**0.57**	**0.61**	**1.03**	**0.42**
Adjusted Financial performance - Surplus / (Deficit)	**0.08**	**0.13**	**0.05**	**0.71**	**0.75**	**0.04**

In Month 9 the Trust recorded a surplus of £0.13m and for the year to date the Trust is reporting a £0.75m surplus.

Both M9 and year to date actuals are marginally ahead of plan (£50k favourable in month, £40K year to date).

In Month Position:

Income

The key variances are below:

- Patient income variable £0.13m – higher NHSE contract income offset by lower pass through income.
- ERF funding - £0.14m higher than plan.
- ASC Client contribution income is £0.17m higher in month (matched by cost).
- Torbay Pharmaceutical sales were £0.17m higher than planned due to non NHS sales.
- Other income is £0.42m higher than plan due to education income.
- COVID income is £0.40m higher in month due to additional income received.

Pay

- In Substantive pay there is a net favourable variance in month (£0.78m) mainly due to unfilled vacancies.
- Agency cost is £0.35m higher than budget across the various staff groups: Ancillary £0.13m (COVID and TP production requirement), Nursing and HCA (£0.11m) due to clinical activity and other Clinical staff (£0.11m) due to vacancies.

Non-pay

- The main drivers of the adverse non-pay other position (£0.98m) are as follows: ASC bad debt provision £0.43m, undelivered CIP £0.24m, increased Drugs cost £0.22m and clinical supplies £0.21m, TP cost of sales £0.18m, security and computer equipment £0.16m offset by reduction in CFHD contract £0.46m.
- The £1.12m adverse position for ASC/CHC costs is due to: COVID workforce grant £0.58m, ASC £0.35m due to higher than anticipated costs on Residential Long Stay Care and increase in bad debt provision, Placed People £0.19m due to unachieved CIP.
- Financing costs £0.31m adverse. This relates to £0.55m COVID ventilators that were initially provided by NHSE / I and are now returned by the Trust offset by lower depreciation £0.24m. (The COVID ventilators are below the line for system reporting).

H2 Plan and Risks and Mitigations

H2 Plan

The Trust submitted the H2 plan in November to NHSE / I. 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

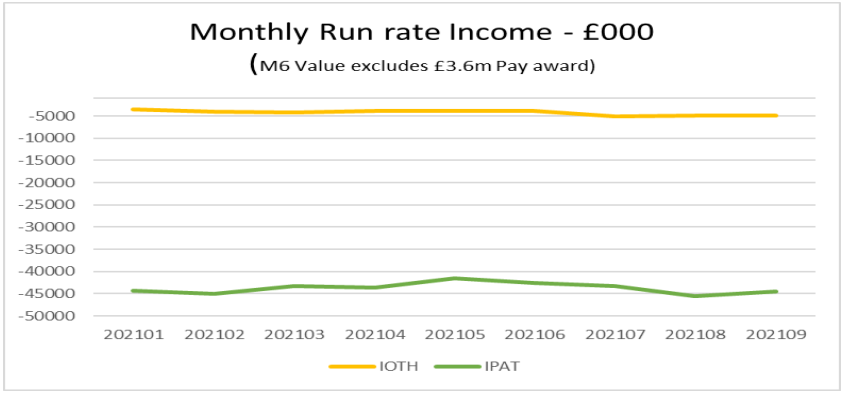
The Trust has reviewed its forecast in the light of the continuing pressures from Covid, but offset by a reduction in spend in elective areas, whilst still maintaining delivery against activity targets. As a result, the unmitigated forecast out-turn has improved to a shortfall against plan of £2.1m. The Trust has identified mitigations which will cover the potential shortfall.

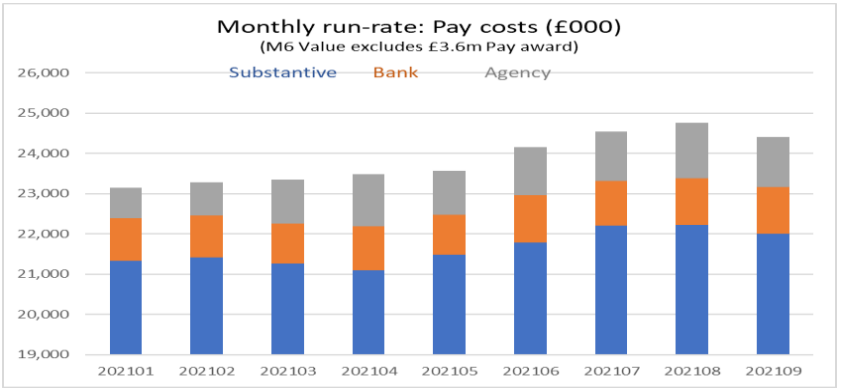
With regards to ERF the threshold percentage in H2 has been amended from 95% of SUS submitted activity to 89% of RTT stop clock activity. The system as a whole did earn ERF in October, following an error correction by NHSE / I. As a result, of the error, we are awaiting confirmation of November's performance. With expected further winter / COVID pressures, there is a risk that the System might not achieve any ERF in the remainder of H2.

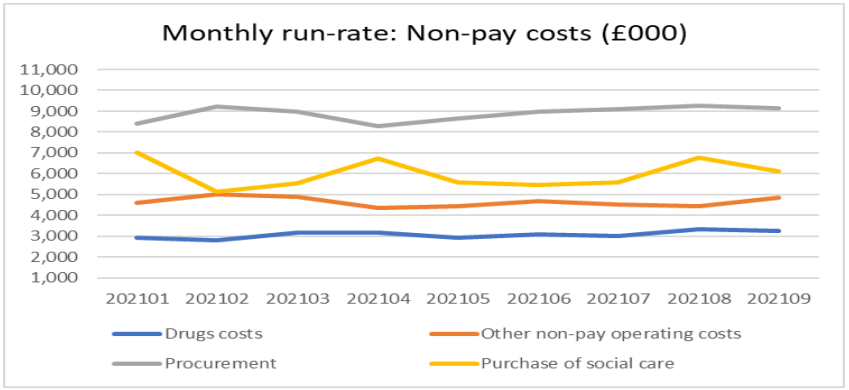
There are additional funding streams in H2 i.e. ERF+ and TIF and ISU's have undertaken a review of likely spend/activity to date and expected during the remainder of H2. These other funding streams are fixed / guaranteed income values and the Trust will maximise spend and benefit against these allocations. This will minimise any spend badged against ERF, reducing the financial risk to the Trust if the System does not meet the 89% threshold.

Looking beyond this financial year, the following key risk areas are noteworthy:

- Efficiency requirement for 2022-23. This is under development with the ICS, but could exceed £20m
- The reintroduction of commissioner contracts and specifically the aligned incentive payment mechanism, which would see the Trust lose income if elective activity fails to achieve the required levels
- The future of the Hospital Discharge Programme. The Trust is forecast to have recovered £3.4m of costs under this scheme in 2021-22 – the scheme ends on 31 March
- Capital planning for 2022-23 and beyond – it is expected that there will be significant pressure on the ICS capital envelope (CDEL)

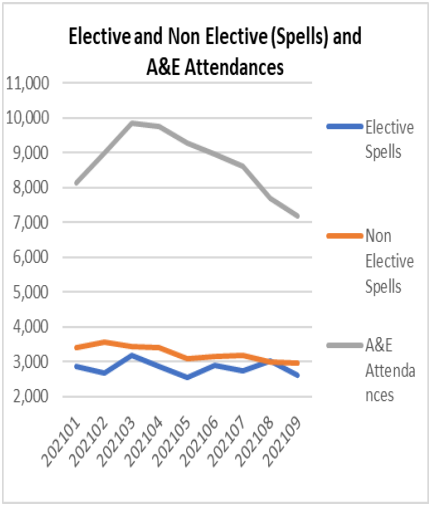


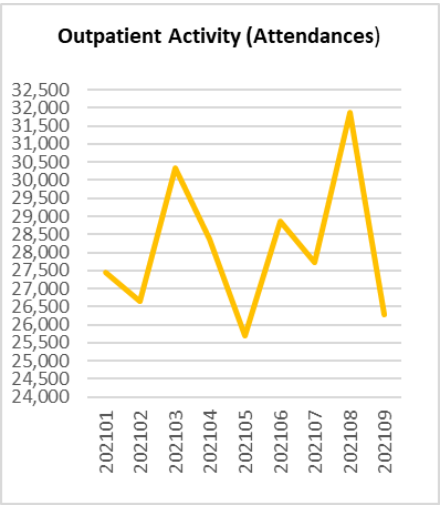




Change in Activity Performance – Month 8 to Month 9

		Plan	Nov-21	Dec-21	Change	% Change		Dec-20	% change
Activity Drivers	A&E Attendances		7,699	7,175	-524	-7%		*6,424*	12%
	Elective Spells	2,980	3,021	2,602	-419	-14%		*2,764*	-6%
	Non Elective Spells		2,996	2,947	-49	-2%		*3,002*	-2%
	Outpatient Attendances	25,921	31,874	26,280	-5,594	-18%		*26,217*	0%
	Adult CC Bed Days		173	221	48	28%		*321*	-31%
	SCBU Bed Days		204	114	-90	-44%		*209*	-45%
Bed Utilisation	Occupied beds DGH		9,767	9,934	167	2%		*8,648*	15%
	Available beds DGH		10,481	10,674	193	2%		*10,368*	3%
	Occupancy		93%	93%	0%	0%		83%	10%
Resource Consumption	Medical Staff Costs - £000's	5,314	5,395	5,397	2	0%		*5,001*	8%
	Nursing Staff Costs - £000's	6,077	6,041	5,742	-298	-5%		*5,280*	9%
	Temp Agency Costs - £000's	898	1,373	1,247	-126	-9%		*741*	68%
	Total Pay Costs - £000's	24,851	24,758	24,419	-339	-1%		*22,912*	7%





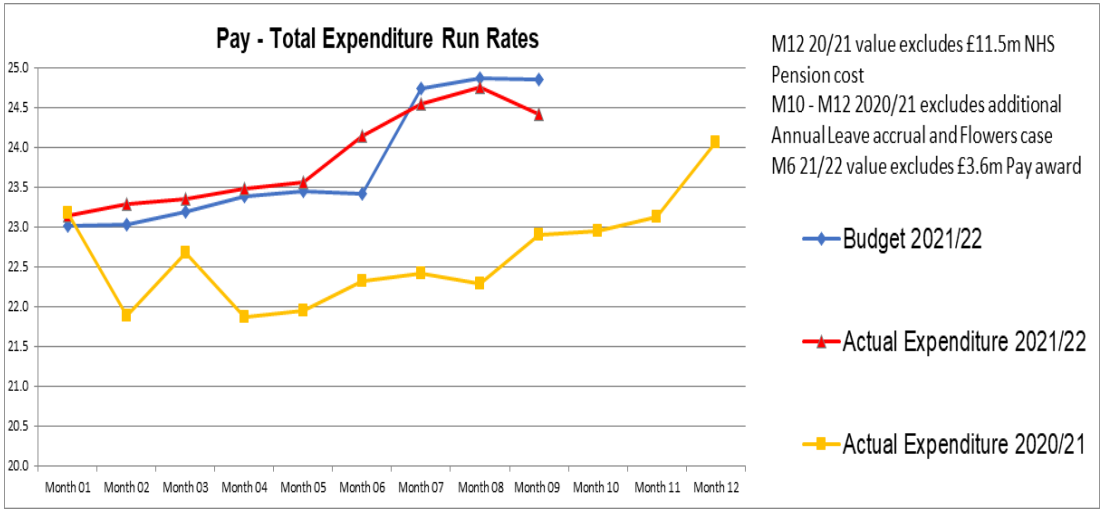
Activity Drivers

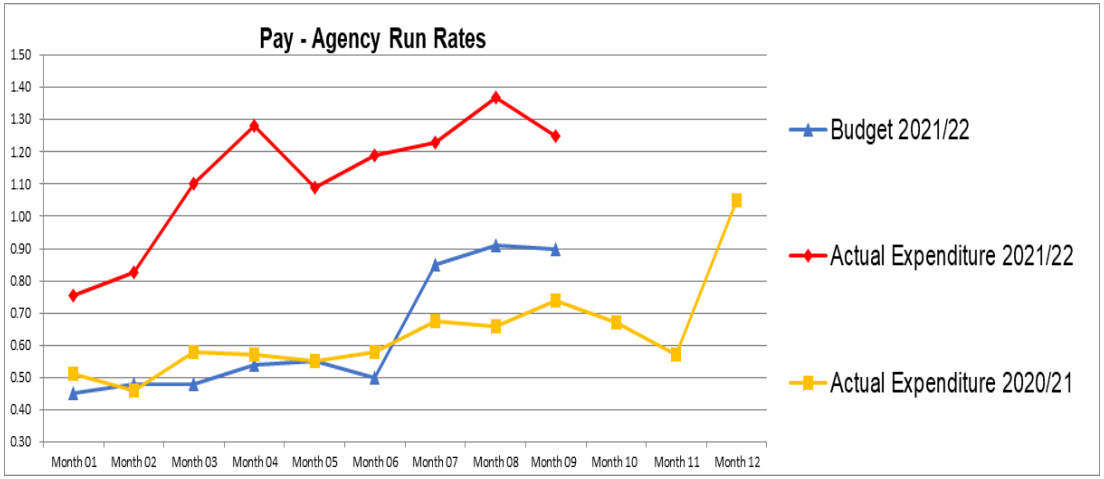
- No formal plan (for contracting purposes) has been created for A&E, Non Elective, or ACC/NCC. This is as a result of the focus being on the recovery of elective activity from the centre.
- Overall, elective activity level is below plan at Month 9 but, above plan for Outpatients. In comparison against 2019/20, which is the comparator year for NHSE/I purposes, the Trust achieved 93% overall Elective/Outpatient activity in M9. At least part of the reason for this is because elective activity was cancelled in December 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 additional ERF+ funding available to increase capacity to see more patients to reduce waiting lists and ensure patients are treated as quickly as possible.
- The draft 2022/23 guidance has now been issued and the Trust is working with the STP to ensure a consistent approach to planning. This will enable the STP to submit an aligned activity and financial plan to the regional team. As a result of the new guidance and change in requirements, providers will undertake a separate ERF plan process to share back with the STP for review.

Bed utilisation

- In December, overall bed occupancy at 93% remains above required levels to support patient flow to avoid emergency care delays and reduced elective capacity. Bed modelling shows a deficit of funded beds to meet the current levels of demand and this is being exacerbated by the levels of delayed transfers of care.
- Access to beds for medical and surgical emergencies has continued to be a major operational constraint with patient regularly staying overnight in assessment units and ED. This backlog of patient awaiting a bed is contributing to 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 day surgery with elective admission prioritised for Cancer treatments and the most urgent patients. Routine elective orthopaedic surgery has been stood down in December with the bed capacity used to support the emergency medical pathways of care. The number of patients staying over 14 and 21 days is at the highest levels recorded along with the number of patients identified as occupying a bed and classed as medically fit for discharge.
- Planning for the January "Omicron" Covid surge together with the underlying normal bed pressure will see every possible bed space escalated.

Pay Expenditure – Month 9, December 2021



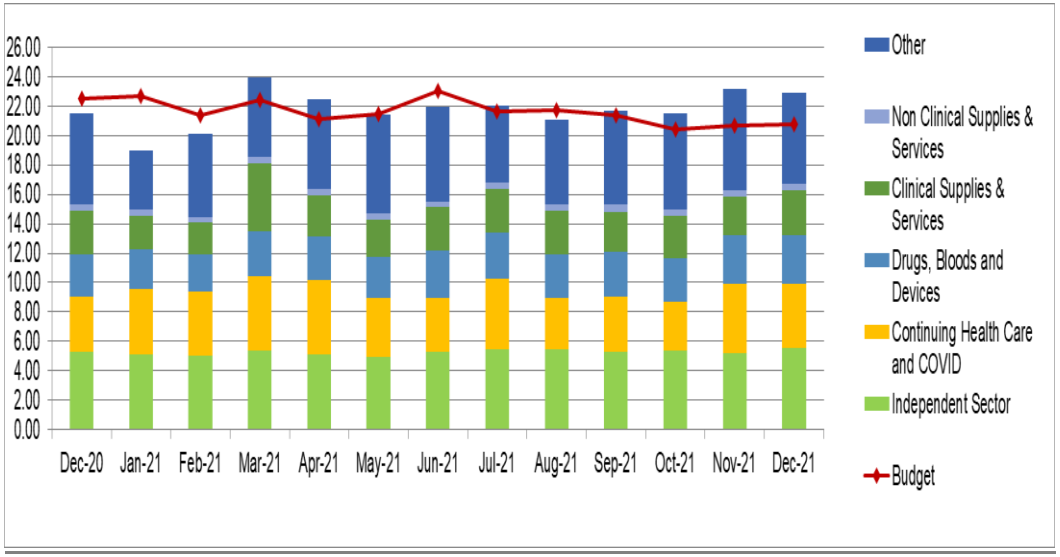


In Month 9 the total pay expenditure is £24.42m, which is £0.34m lower compared to Month 8 (£24.76m).

Further details are provided below:

- Substantive pay decreased by £0.23m primarily within Nursing staff (£0.18m).
- Bank pay increased by £0.02m primarily within HCA's.
- Agency costs were £0.13m lower than Month 8 mainly due to lower Nursing agency use linked to lower Clinical activity.
- The Agency costs as at M9 totals £10.10m which is significantly higher than the FY 2020/21 full year spend of £7.63m. The particularly high Agency use this financial year is due to operational pressures along with COVID, sickness absence and difficulty in recruiting.
- The Apprentice levy balance at Month 9 is £2.22m (same as in M8). The Trust's apprenticeship strategy is reviewed regularly and actions are being taken.

Non-Pay Expenditure – Month 9, December 2021



The total non-pay run rate in Month 9 (£22.90m) is £0.27m lower in comparison to previous month (£23.17m), key details are provided below:

- Decreases in:
  - Net Operating expenditure – £0.70m relates mainly to reduction in CFHD alliance costs.
  - COVID related funding £0.51m (hospital discharge, testing, infection prevention and control) matched by income.
  - Drugs costs – £0.06m lower primarily in Healthcare at Home drugs (£0.30m) offset by increase in various Drugs cost (£0.24m); offset by:

- Increases in:
  - Clinical supplies – £0.50m, primarily increased spend on medical and surgical supplies £0.22m, contract testing £0.19m and increased TP cost of sales £0.09m
  - Independent Sector – £0.33m higher. This relates to there being one day more in December than there is in November combined with an increase in the bad debt provision.
  - Placed People - £0.17m primarily driven by an extra day of care in December.

Hospital Discharge and Other COVID Information – Month 9, December 2021

Hospital Discharge, Rapid Testing and Infection Control COVID	Total Cost Actual 31/12/2021 YTD £'000	CCG Income Actual 31/12/2021 YTD £'000	Council Income Actual 31/12/2021 YTD £'000	Provider Refunds Actual 31/12/2021 YTD £'000
Hospital Discharge Programme (HDP) Scheme 2	2,268	(2,268)		
Infection Control, Rapid Testing & Vaccines	3,538		(3,372)	(166)
Domiciliary Care - H2 Incentive & Retention scheme	314		(314)	
Independent Sector Workforce Recruitment and Retention	520		(520)	
General & Sustainability Fund	221		(126)	(104)
Total	**6,860**	**(2,268)**	**(4,332)**	**(270)**

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 just under £6.9m, with a contribution of £4.3m received from Torbay Council towards this.
- Rapid Testing and Infection Control grants (H1 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 under £1.0m has been received and to date £0.9m of this has been passported to providers.
- Tranche 1 of the Independent Sector Workforce Recruitment and Retention grant (Round 1) has been allocated and in December £520K was distributed to providers with a matched income from Torbay Council.
- Hospital discharge costs (year to date just under £2.3m) being reclaimed through Devon CCG. Discharge criteria saw client's 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 to support market sustainability.

  - £0.3m funding specifically for Domiciliary Care providers (Living well at Home). This is specific and targeted funding focusing on workforce Incentive / retention schemes and was fully paid to these key providers during November.

  -£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. To date £0.1m of this fund has been paid to providers

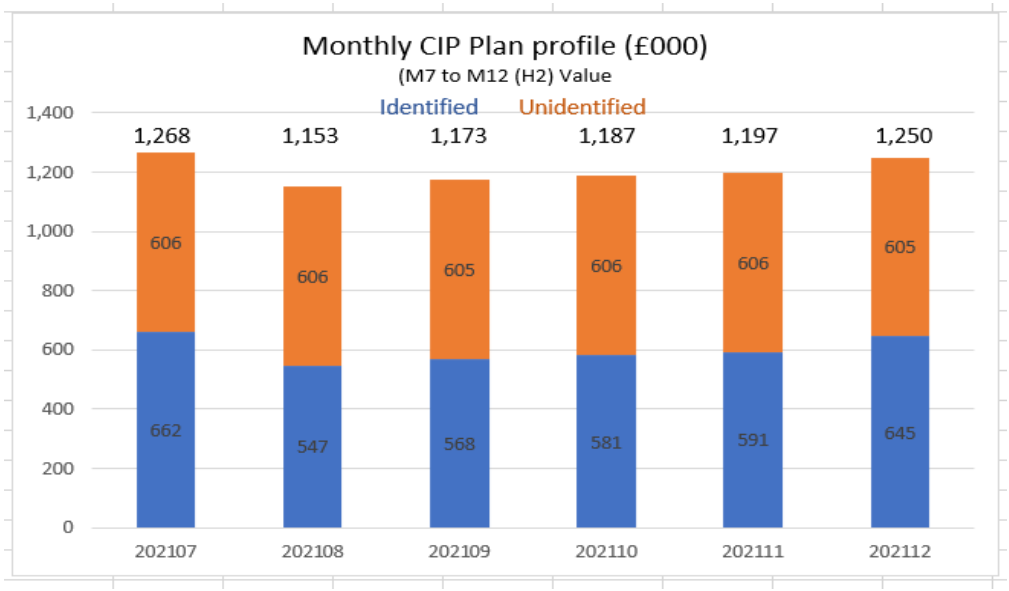
- Recently Torbay Council has received notification that it will receive further new grant funding of just over £1.0m for workforce recruitment & retention (round 2) and schemes are currently being developed with payments envisaged to providers late January and throughout February.

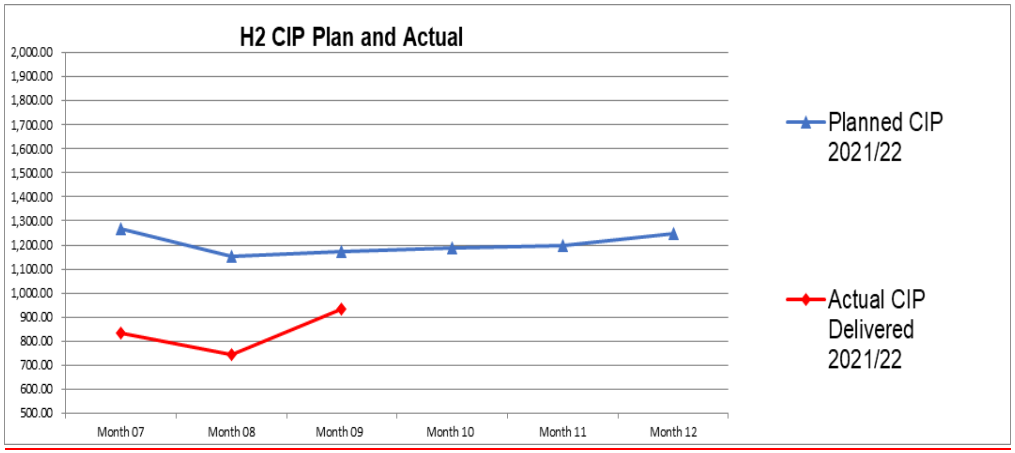
Key Drivers of System Positions – Month 9, December 2021

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 M9 is £0.17m higher than plan primarily due non NHS sales; year to date is in line with plan.
Corporate	EFM	The H2 year to date position at M9 is an overspend of £156k mainly arising from non pay overspend of £167k plus an income shortfall of £47k (largely shortfall in lease/rental income & visitor car parking) offset by a CIP overachievement of £57k. The non pay overspend relates to repairs & maintenance & increased utility costs.
	Exec. Directors	The H2 year to date position at M9 is an underspend of £589k. However, there is a £444k overspend on non pay due to £128k overspend on International Recruitment costs, £137k overspend on Devon IR hub (but offset by income), £85k on relocation expenses plus various smaller overspends across other directorates. Pay is overspent by £127k mainly due to posts funded by income in Education & Transformation & Partnerships which is included in the Income overachievement of £583k – income also includes Devon IR hub & Education income. Non recurrent CIP (slippage) has been transacted across most directorates (but largely Education income) resulting in an overachievement of £592k.
	Financing Costs	Excluding items outside the NHSE/I control total, costs are £0.4m 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 M9 against budget with £1.8m being non pay £0.4m, pay £0.7m, other income £0.3m offset by under delivery of CIP £0.5m. Continued reduction in elective activity due to the ongoing response to Covid and green surge, delays in recruitment, and reduced spend in theatre supplies. Run rates are expected to increase in Q4 but forecasting an underspend at year end.
	Newton Abbot	Overspent against M9 YTD budget by £2.1m 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 £1.9m and Acute Medicine (including all Gen Med Junior Doctors) by £0.6m, unachieved CIP £0.2m. These cost pressures are expected to continue due to winter demand but are offset by underspends in UTC, ICU, vacant posts £0.3m. Run rates have slightly decreased, but expected to be relatively constant until year end.
	Moor to Sea	Overspent against M9 YTD budget by £0.5m, is mainly due to the continued cost pressures on the four Wards £0.4m to cover Patient activity, staff absence and also specialist security for a Patient. Intermediate Care Beds are overspent by £0.4m but this will reduce considerably when the DCC contribution has been agreed. All other net variances are £0.3m underspent. Run rates are expected to remain relatively constant until year end.

	Shared Operations	Underspent against M9 YTD budget by £0.1m, which is mainly due to vacant posts of £0.2m combined, offset by increased patient transport demand £0.1m due to response to winter surge. Run rates are expected to remain relatively constant until year end.
Torbay System	Independent Sector	ISU is circa £0.3m overspent against a YTD budget envelope of £67.7m. Non-Pay cost is £7.0m higher than budget but this is primarily due to COVID related spend (£6.0m) 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 £6.0m of additional Covid related funding and £0.7m of ASC client contributions.
	Torquay	ISU has a circa YTD £0.35m overspend against a YTD budget envelope of circa £32.1m. There are two main areas of risk. Firstly, 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. Secondly, Intermediate Care spend is higher than budgeted with regard short term placements in Torbay nursing homes.
	Paignton and Brixham	ISU has a circa YTD £0.3m overspend against a YTD budget envelope of circa £64.6m. Underlying this the main areas to note is a material £1.0m pay / non-pay underspend linked to medical vacancies, ERF slippage and labs medicine but this is offset by £1.3m under recovery of income. Other Labs Medicine income (£0.8m) 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) £4.5m of Elective Recovery Funding (ERF) and £0.5m of TIF at M9 from the CCG. 2) C. £2.3m additional income via the CCG relating to the Hospital Discharge Programme (HDP). There is a corresponding cost to offset this. 3) An additional c. £3.4m relating to grants received by Torbay Council, which is then passported to us to pay out as per the grant conditions to providers such as care homes to cover costs for extra IPC and rapid testing.

CIP – Month 9, December 2021





CIP H2 Plan and M9 Actual

H2 Plan

The target CIP requirement for H2 is £7.23m profiled as shown in the table opposite.

M9 Actual and year to date

The M9 CIP plan is £1.17m with actual delivery of £0.93m, a shortfall of £0.24m.

Year to date, CIP delivery in H2 is £2.5m.

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

CIP plans identified to date total £3.6m with a further c. £0.9m now validated.

Whilst the current expectation is that non-recurrent measures and other mitigating actions will cover the shortfall, it should be noted that the current level of unidentified efficiencies together with the adverse variance to plan gives an overall risk of under-performance between £2.7m-£3.8m. Work is ongoing with ISUs and departments to identify additional schemes, both recurrent and non-recurrent, to close their gaps to target which will be supported further by input from Deloitte as part of the Financial Improvement Programme.

Cash Position – Month 9, December 2021

	YTD at M09 £m
Opening cash balance	**45.45**
Capital Expenditure (accruals basis)	(13.66)
Capital loan/PDC drawndown	3.73
Capital loan repayment	(3.39)
Proceeds on disposal of assets	0.00
Movement in capital creditor	(8.89)
Other capital-related elements	(1.26)
Sub-total - capital-related elements	**(23.47)**
Cash Generated From Operations	18.96
Working Capital movements - debtors	(8.10)
Working Capital movements - creditors	3.57
Net Interest	(2.29)
PDC Dividend paid	(2.88)
Other Cashflow Movements	(0.94)
Sub-total - other elements	**8.33**
Closing cash balance	**30.31**

Better Payment Practice Code	Paid year to date	Paid within target	% Paid within target
Non-NHS - number of bills	98,503	85,653	87.0%
Non-NHS - value of bills (£k)	185,440	157,119	84.7%
NHS - number of bills	1,405	1,014	72.2%
NHS - value of bills (£k)	16,022	11,515	71.9%
Total - number of bills	99,908	86,667	86.7%
Total - value of bills (£k)	201,462	168,634	83.7%

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 £15.1m. Noteworthy components are the paying down of capital creditors (£8.9m) and an increase in debtors (£8.1m) from the unusually low year end level. These movements are partly offset by cash generated from operations being £5.3m greater than capital expenditure.
- 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.

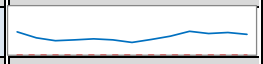
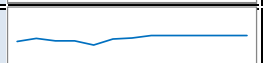
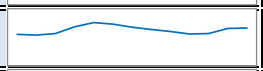
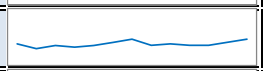
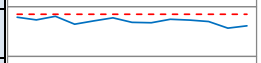
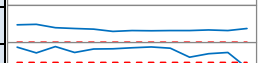
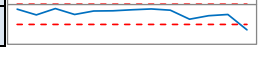
Statement of Financial Position (SoFP) – Month 9, December 2021

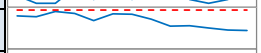
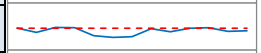
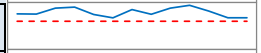
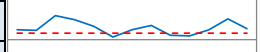
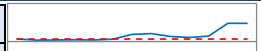
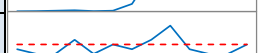
	Month 09		
	Position 31 March 2021 £m	Position 31 Dec 2021 £m	Movement £m
Non-Current Assets			
Intangible Assets	10.09	12.82	2.73
Property, Plant & Equipment	202.37	200.54	(1.84)
On-Balance Sheet PFI	17.11	16.77	(0.34)
Other	2.04	2.04	(0.00)
Total	**231.61**	**232.16**	**0.55**
Current Assets			
Cash & Cash Equivalents	45.45	30.31	(15.14)
Other Current Assets	33.20	41.45	8.25
Total	**78.64**	**71.76**	**(6.89)**
Total Assets	**310.25**	**303.92**	**(6.34)**
Current Liabilities			
Loan - DHSC ITFF	(4.80)	(4.81)	(0.01)
PFI / LIFT Leases	(1.17)	(1.28)	(0.11)
Trade and Other Payables	(61.81)	(54.85)	6.96
Other Current Liabilities	(10.44)	(13.48)	(3.04)
Total	**(78.23)**	**(74.42)**	**3.81**
Net Current assets/(liabilities)	**0.41**	**(2.66)**	**(3.08)**
Non-Current Liabilities			
Loan - DHSC ITFF	(29.08)	(25.68)	3.40
PFI / LIFT Leases	(16.60)	(15.57)	1.03
Other Non-Current Liabilities	(15.88)	(14.33)	1.55
Total	**(61.55)**	**(55.58)**	**5.98**
Total Assets Employed	**170.47**	**173.92**	**3.45**
Reserves			
Public Dividend Capital	130.76	134.48	3.73
Revaluation	49.15	49.15	0.00
Income and Expenditure	(9.44)	(9.71)	(0.28)
Total	**170.47**	**173.92**	**3.45**

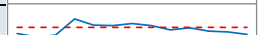
Key points of note:

- Non-current assets have increased by £0.5m during the year to date, principally as capital expenditure (£13.7m) has exceeded depreciation (£12.6m).
- Cash has reduced by £15.1m, as explained in the commentary to the cashflow statement.
- Other current assets have increased from the unusually low year-end level by £8.3m, principally due to increased debtors (e.g. CCG HDP £2.5m, CCG ERF/TIF £1.2m, DHSC Covid reimbursement £1.0m, ASC contributions £1.0m), and insurance / rates prepayments £1.8m.
- Trade and other payables have reduced by £7.0m, principally due to the paying down of the capital creditor £8.9m and agreed repayment of 2020/21 CCG funding £4.0m, partly offset by increased PDC Dividend creditor £1.3m and increased general payables.
- Other current liabilities have increased by £3.0m, due to increased deferred income.
- Non-current liabilities have reduced by £6.0m, principally due to scheduled loan / lease repayments.
- PDC reserves have increased by £3.7m due to receipt of capital PDC funding.

	ISU	Target	13 month trend	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		2	1	1	4	0	2	4	2	2	0	1	3	1	15
Reported Incidents - Death	Trustwide	<1		1	3	1	2	0	2	1	2	0	0	1	5	0	11
Medication errors resulting in moderate harm	Trustwide	<1		0	0	2	0	0	1	1	0	0	0	0	0	0	2
Medication errors - Total reported incidents	Trustwide	N/A		34	41	51	54	50	64	57	47	38	47	58	46	59	466
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		0	0	1	1	0	1	0	2	0	0	1	1		5
Never Events	Trustwide	<1		0	0	0	1	0	0	0	0	0	0	0	0	0	3
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		3	7	6	6	5	7	11	8	8	6	1	12	12	35
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	0	0	0	0	0	0	2	0	0	0	2
Formal complaints - Number received	Trustwide	<60		14	7	13	17	10	9	15	18	17	11	11	10	9	110
VTE - Risk Assessment on Admission	Trustwide	>95%		90.4%	92.4%	92.3%	91.9%	92.5%	92.3%	88.6%	94.4%	92.9%	91.9%	91.8%	96.2%	95.1%	92.5%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		104.5	106.5	106.8	105.8	102.6	105.5	106.6	108	110.2	108.4				86.4
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		89.7%	90.3%	85.8%	82.5%	89.0%	90.2%	87.1%	89.5%	87.0%	81.9%	81.9%	89.3%	87.81%	86.9%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		88.5%	88.6%	88.3%	85.4%	90.3%	88.5%	89.4%	93.4%	88.0%	74.6%	74.6%	83.7%	60.32%	85.0%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		30	6	0	23	24	42	381	24	8	42	476	218	285	1500
Hand Hygiene	Trustwide	>95%		97.0%	98.3%	95.3%	92.8%	96.0%	94.8%	97.6%	98.9%	97.1%	96.5%	98.5%	96.2%		97.9%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		75.6%	85.3%	94.4%	78.8%	73.2%	90.3%	84.8%	91.2%	82.1%	81.0%	82.1%	60.0%	68.6%	84.9%
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		80.4%	69.4%	51.6%	77.5%	84.1%	65.9%	66.1%	51.4%	56.3%	69.2%	35.9%	52.8%	50.0%	60.1%
Follow ups 6 weeks past to be seen date	Trustwide	6400		17837	17489	16986	16950	17118	16713	16323	16967	17651	17789	18231	18069	19797	19797
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		4.3%	4.2%	4.1%	4.0%	4.0%	4.0%	4.1%	4.1%	4.2%	4.4%	4.5%	4.6%		4.1%
Appraisal Completeness	Trustwide	>90%		80.4%	78.8%	78.4%	82.4%	85.9%	86.6%	84.7%	81.3%	80.6%	79.7%	77.9%	79.2%	78.6%	82.4%
Mandatory Training Compliance	Trustwide	>85%		89.6%	89.7%	89.5%	89.6%	90.1%	90.1%	90.5%	89.5%	89.4%	89.0%	89.0%	88.8%	88.4%	89.6%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.5%	10.2%	10.2%	10.0%	10.8%	11.0%	11.3%	11.0%	11.7%	11.3%	11.6%	11.5%	12.0%	

	ISU	Target	13 month trend	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Carers Assessments Completed year to date	Trustwide	40% (Year end)		95.8%	98.0%	96.3%	96.3%	93.3%	97.5%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Children with a Child Protection Plan (one month in arrears)	Trustwide	NONE SET		223	223	207		234	213	201	171	165	147	147			234
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET		199						117			291				117
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET		4.4%						4.3%			5.2%				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		658	617	615	616	0	608	629	631	564	546	604	590	628	604
Intermediate Care - No. urgent referrals	Trustwide	113		235	175	146	155	165	155	129	158	191	241	219	229	211	1258
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		242	249	205	255	282	294	292	297	233	229	243	191	200	1870
ADULT SOCIAL CARE TORBAY KPIs																	
Proportion of clients receiving self directed support	Trustwide			76.4%	75.1%	73.8%	74.0%	72.9%	71.9%	71.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Proportion of carers receiving self directed support	Trustwide			95.8%	98.0%	96.3%	96.3%	93.3%	97.5%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% Adults with learning disabilities in employment	Trustwide			8.2%	8.1%	8.3%	8.3%	7.5%	7.4%	7.4%	7.4%	7.1%	7.1%	6.8%	7.0%	6.8%	6.8%
% Adults with learning disabilities in settled accommodation	Trustwide			80.5%	80.4%	80.6%	81.8%	82.6%	82.3%	81.7%	81.3%	81.0%	80.6%	80.6%	81.5%	81.6%	80.6%
Permanent admissions (18-64) to care homes per 100k population	Trustwide			18.9	14.8	17.5	16.2	17.5	20.2	23.1	17.7	19.0	17.7	17.7	20.4	23.1	17.7
Permanent admissions (65+) to care homes per 100k population	Trustwide			579.0	587.2	540.8	464.3	499.8	510.8	487.3	498.1	511.5	449.6	422.7	411.9	376.9	422.7
Proportion of clients receiving direct payments	Trustwide			22.4%	21.7%	21.2%	21.1%	20.1%	19.8%	19.5%	19.6%	19.5%	19.0%	19.4%	19.4%	19.6%	19.4%
% reablement episodes not followed by long term SC support	Trustwide			85.5%	85.4%	85.7%	85.8%										..
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		81.2%	79.4%	79.4%	82.2%	84.4%	78.9%	72.6%	68.6%	67.6%	65.1%	62.5%	59.8%	62.5%	69.3%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		64.3%	61.8%	61.4%	61.4%	62.7%	63.9%	64.4%	61.7%	59.4%	57.4%	57.0%	56.5%	55.6%	59.7%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		78.9%	73.8%	80.9%	64.8%	71.8%	77.9%	68.8%	67.8%	75.0%	73.3%	70.5%	57.0%	61.9%	69.1%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		47.9%	49.1%	40.4%	38.2%	36.3%	30.1%	32.2%	31.7%	32.2%	32.6%	33.8%	32.4%	37.9%	33.3%
Dementia - Find - monthly report	Trustwide	>90%		97.7%	94.8%	98.0%	95.0%	96.7%	96.9%	97.4%	97.8%	97.2%	92.7%	94.4%	95.0%	87.3%	95.1%

	ISU	Target	13 month trend	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3		3	1	1	5	2	5	2	5	8	2	1	2	6	33
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		78.9%	77.1%	89.6%	85.1%	67.7%	83.9%	83.0%	71.3%	54.6%	55.6%	50.5%	45.2%	44.3%	61.4%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		94.0%	75.0%	96.3%	95.2%	61.9%	54.1%	56.7%	91.0%	77.8%	92.4%	95.1%	79.8%	82.5%	75.5%
Cancer - 28 day faster diagnosis standard	Trustwide			75.9%	72.2%	77.3%	75.0%	75.6%	75.6%	76.0%	76.4%	77.4%	60.6%	58.8%	52.5%	52.8%	66.8%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		97.5%	97.5%	98.8%	99.0%	97.4%	96.7%	98.5%	97.5%	98.8%	99.4%	98.2%	96.7%	96.8%	97.7%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		100.0%	98.8%	100.0%	100.0%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		96.0%	100.0%	100.0%	100.0%	98.5%	100.0%	97.0%	98.3%	96.4%	98.6%	98.4%	100.0%	100.0%	98.5%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		93.3%	96.4%	97.0%	84.8%	100.0%	96.7%	97.7%	100.0%	97.3%	100.0%	100.0%	97.1%	100.0%	98.6%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		66.7%	77.8%	83.3%	100.0%	75.0%	73.3%	85.7%	78.6%	92.3%	71.4%	87.5%	82.4%	77.8%	80.9%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			14	11	6	15	15	17	10	10	13	15	29	14	26	26
RTT 52 week wait incomplete pathway	Trustwide	0		1435	1570	1823	2041	1895	1596	1562	1648	1799	1943	2093	2169	2384	2384
On the day cancellations for elective operations	Trustwide	<0.8%		1.2%	1.1%	3.0%	2.4%	1.6%	0.3%	1.2%	1.7%	0.5%	0.5%	1.2%	2.6%	1.3%	1.2%
Cancelled patients not treated within 28 days of cancellation *	Trustwide	0		1	5	6	8	6	11	3	10	17	5	3	30	12	92
Outpatient virtual appointments (non-face-to-face)	Trustwide	25%		19.8%	22.0%	20.4%	20.4%	18.6%	19.2%	19.1%	20.0%	19.6%	20.3%	20.5%	21.1%	19.3%	
Bed Occupancy	Overall System	80.0%		89.8%	94.4%	93.4%	99.5%	94.2%	96.1%	98.0%	97.4%	98.5%	98.8%	97.6%	98.9%	96.6%	97.3%
No Criteria to Reside - daily average - weekday (ICO)	Trustwide	No target									45	58	56	62	66	88	
Number of patients >7 days LoS (daily average)	Trustwide			95.1	109.5	114.2	98.2	97.0	104.5	120.5	129.4	154.4	149.1	148.4	145.7	157.0	106.8
Number of extended stay patients >21 days (daily average)	Trustwide			14.0	20.8	27.8	19.9	15.2	21.3	25.0	26.3	41.5	43.9	43.6	39.9	48.0	20.3
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		138	75	82	94	90	128	380	421	266	219	285	959	952	3700
Ambulance handover delays > 60 minutes	Trustwide	0		19	15	20	32	19	26	173	165	120	72	125	617	616	1933
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			18	18	27	28	14	46	246	438	534	491	753	788	712	4022
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		1	2	3	5	2	3	32	157	188	69	130	139	162	882
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		2	1	1	4	1	3	2	4	7	2	1	1	3	24
Number of Clostridium Difficile cases - (Community)	Trustwide	0		1	0	0	1	1	2	0	1	1	0	0	1	3	9
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		66.2%	66.9%	62.0%	64.6%	60.4%	59.5%	57.5%	60.6%	74.1%	77.3%	74.5%	72.0%	63.0%	66.3%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		32.4%	47.4%	30.9%	41.0%	25.5%	33.1%	32.4%	34.2%	46.6%	46.4%	45.5%	50.7%	39.2%	38.9%

	ISU	Target	13 month trend	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			2378	3635	937	3180		2623	2551	2438	1240	-367	-327	-401	-609	
Agency - Variance to NHSI cap	Trustwide			-0.20%	-0.20%	-0.20%	-0.25%		-1.40%	-1.80%	-2.10%	-2.10%	-2.10%	-2.10%	-2.00%	-2.00%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide													-332	-593	-833	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			6653	9748	11822	2305		2004	3206	4292	5275	9080	12336	16029	19492	
Distance from NHSI Control total (£'000's)	Trustwide			1858	3993	1179	655		2690	2621	2638	1539	7	8	-13	37	
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			-0.9%	-21.7%	-14.0%	26.8%	-5.3%	-15.9%	0.6%	-20.4%	-14.4%	-4.8%	-19.4%	1.9%	-4.4%	-9.5%
Outpatients - Follow ups	Trustwide			-8.5%	-25.3%	-17.0%	16.8%	-7.6%	-12.9%	-0.9%	-13.1%	-10.2%	-5.9%	-19.1%	-2.7%	-7.0%	-9.0%
Daycase	Trustwide			-9.4%	-29.8%	-23.5%	9.1%	-8.9%	-20.5%	5.1%	-12.2%	-18.4%	-4.5%	-20.7%	-11.7%	-12.6%	-11.8%
Inpatients	Trustwide			-9.9%	-33.4%	-44.8%	-18.8%	1.8%	-19.8%	-15.4%	-33.1%	-35.2%	-24.4%	-25.8%	-37.0%	-33.5%	-25.4%
Non elective	Trustwide			-13.3%	-20.2%	-16.5%	18.0%	4.5%	3.8%	8.1%	3.9%	-5.3%	-0.8%	-7.9%	-9.6%	-15.0%	-2.2%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			494	473	464	502	590	564	574	560	472	525	511	537	0	
Intermediate Care GP Referrals	Trustwide			106	106	98	95	94	79	81	77	73	74	74	76		
Average length of Intermediate Care episode	Trustwide			11.798	12.237	12.336	12.498	11.735	12.593	12.42	16.361	13.455	14.568	12.192	12.2	0	
Total Bed Days Used (Over 70s)	Trustwide			8796	9271	8636	9898	9713	8593	4035	9171	9240	9881	9871	0	0	
- Emergency Acute Hospital	Trustwide			5522	5575	5561	6021	5257	4953		5179	5298	5238	6022	0	0	
- Community Hospital	Trustwide			2844	3172	2461	3353	3268	2981	3240	2973	2867	3318	3377	0	0	
- Intermediate Care	Trustwide			430	524	614	524	1188	659	795	1019	1075	1325	472	0	0	

Report to the Trust Board of Directors			
Report title: January 2022 Mortality Score Card			Meeting date: 26th January 2022
Report appendix	Appendices 1 to 5		
Report sponsor	Medical Director		
Report author	Medical Director		
Report provenance	The report went to the Mortality Surveillance Group meeting 13/01/22 and Quality Improvement Group Meeting 18/1/22 and Quality Assurance Committee 24/01/22		
Purpose of the report and key issues for consideration/decision	The report is for monthly assurance to ensure learning from deaths.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board are asked to receive and note this report.		

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	X	**Risk score**	4
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		**Legislation**	
NHS England	**X**	**National policy/guidance**	**X**

Report title: Mortality Surveillance Score Card		Meeting date: 26th January 2022
Report sponsor	Medical Director	
Report author	Medical Director	

1.0 Introduction

The document 'National Guidance on Learning from Deaths' was first published by the NHS National Quality Board in March 2017 and provides a framework for NHS Trusts for identifying, reporting, investigating and learning from deaths in care. The Trust must have an executive director who is responsible for the learning from deaths agenda and a non-executive director who provides oversight of the progress. From April 2017, Trusts have been required to collect and publish, on a quarterly basis, specified information on deaths by submitting a paper to public Board.

For some patients, death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However, some patients experience poor quality provision of care resulting from multiple contributory factors. The purpose of reviews and investigations where problems in care may have contributed to death, is to learn in order to improve and prevent recurrence.

Since April 2020, it has been an aspiration that all in-patient deaths are scrutinised by a suitably trained Medical Examiner. Some deaths which cannot be readily identified by a doctor as due to natural causes are referred to HM Coroner for investigation instead. Medical Examiners are mandated to give bereaved relatives a chance to express any concerns and to refer to HM Coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

During 2021/22 the services provided by the medical examiner offices will start to be extended beyond acute Trusts to provide independent scrutiny of all non-coronial deaths wherever they occur.

Some deaths require a case record review, looking at the care provided to the deceased as recorded in their case records in order to identify any learning. This would particularly apply where bereaved families and carers or staff have raised concerns about the quality of care provision.

Lastly, some deaths require a formal investigation as guided by the Serious Incident Framework.

Data Sources

The indicators for this Scorecard have been collated from a variety of data sources using defined methodology. The report is designed to give a top-level view of our mortality data 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	Sept '21 84.9 12-month average 108.4
• B. Summary Hospital Mortality Index (SHMI)		DH SHMI data		103.2 (July 20 – July 21)
Appendix 2 • Unadjusted Mortality Rate • By number • By location		Trust Data ONS Data	Yearly Average ≤3%	3.94%
Appendix 3 • Mortality Analysis		Trust Data Dr Foster DH HSMR data	CUSUM alerts greater than 1 in last 12 months	CuSuM Syncope
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 September 2021 at 84.9. However, the rolling 12-month position exceeded the expected range for the 12-months to August 2021 with a relative risk of 110 against a 100 benchmark with May, June, July, and August recording a greater than 110 relative risk.

Understanding the relatively higher mortality rate over the summer of 2021 will follow the 'pyramid of investigation for special cause variation' model set out in Appendix 3. The investigative process starts with ensuring that the coding reflects accurately what happened to patients.

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 Trust is also exploring the coding of short stay patients admitted to medical and surgical assessment areas (MRU, SRU) and the Clinical Decision Unit (CDU).

The investigation will next consider any changes to case-mix and to structure and process of patient care. It is noted that the period of increased HSMR over the summer months coincided with a period of significant challenge with movement of the medical receiving unit (MRU) back onto Day Surgery and the need to provide inpatient beds in the assessment areas and even the emergency department on occasions. The significant pressures on urgent and emergency care with possibly higher acuity patients is unusual for the summer months.

Lastly, the investigation may identify clinical services with significantly higher than expected mortality rates requiring a case note review.

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. The Medical Examiner Office highlighted to the Trust that there have been increasing delays in death referrals and completion of the Medical Certificate of Cause of Death due to the current system pressures. The Medical Examiner Office is supporting additional operational processes to address this issue.

In summary, this month's report is identifying a number of increases in mortality and measured through both SHMI and HSMR for the period Q2 2021/22. The Performance Team, along with the Director of Patient Safety will be reviewing this position to provide a deeper analysis of factors contributing to this increase. Covid-19 is expected to be one of these factors as there has been an increase in the number of Covid-19 deaths reported in this period.

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

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

The latest month's data, September 2021, has a relative risk of **84.9** (basket of 56 diagnostic groups) and is below the 100 average. The high HSMR recorded May to August is noted for further review.

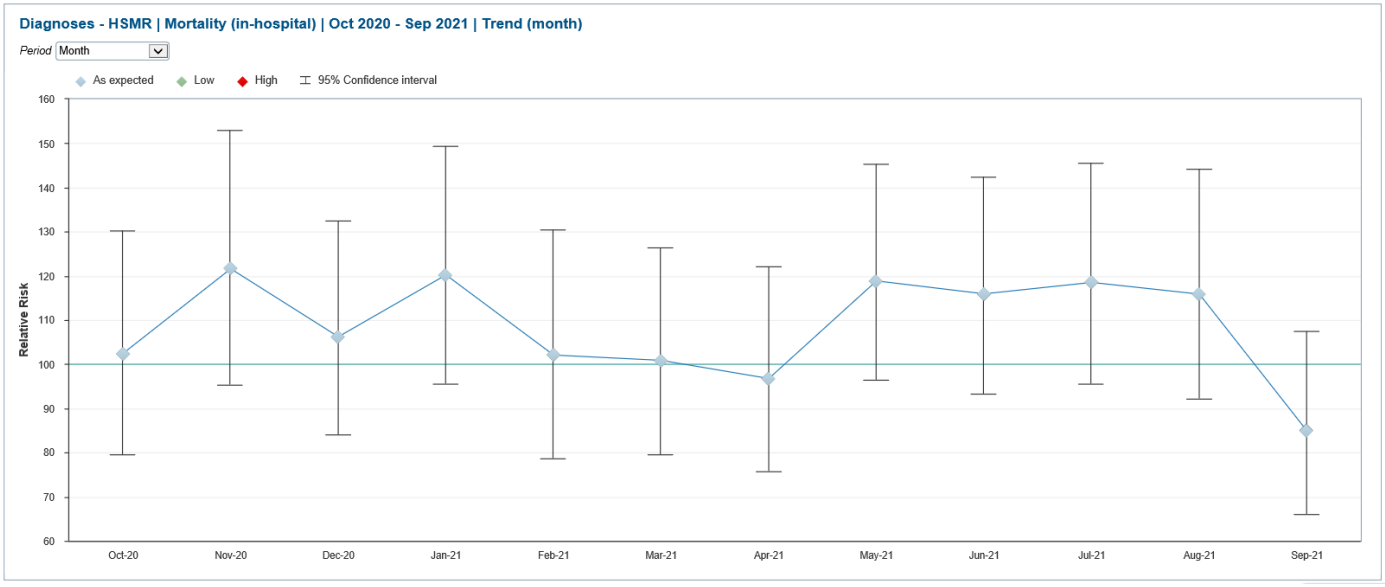


Chart 2, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12-month annual total. The monthly **12-month annual total** is just above the 100 line and within the standard deviation lines. This measure is being observed via the Mortality Surveillance Group (MSG)

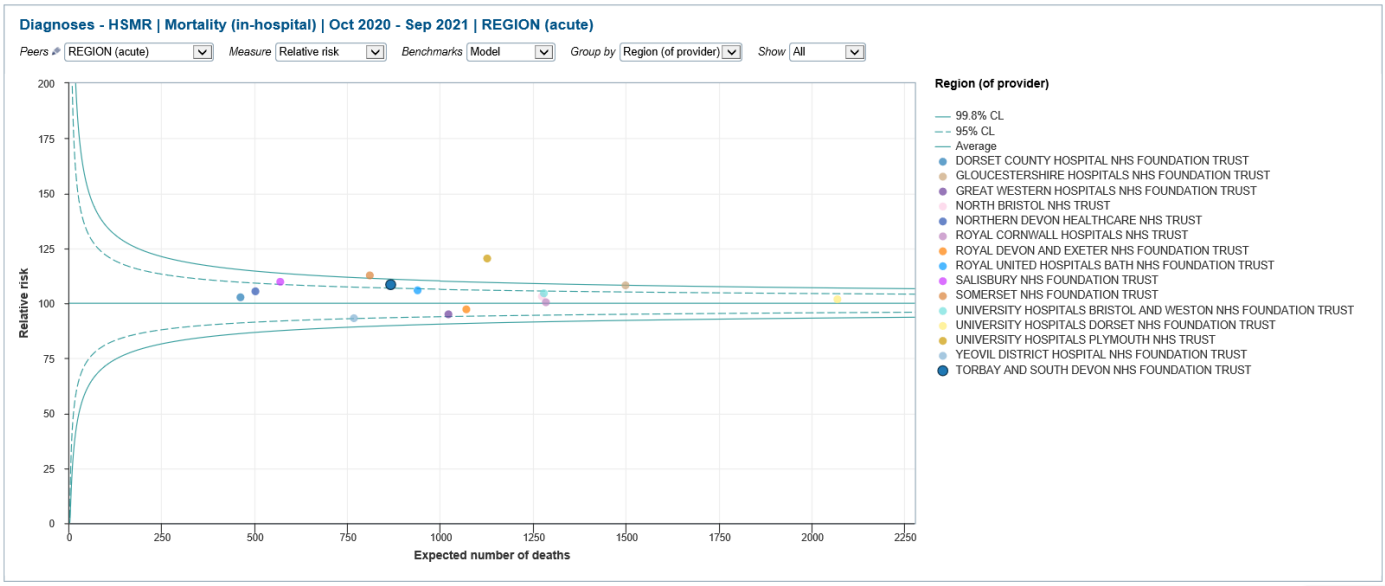
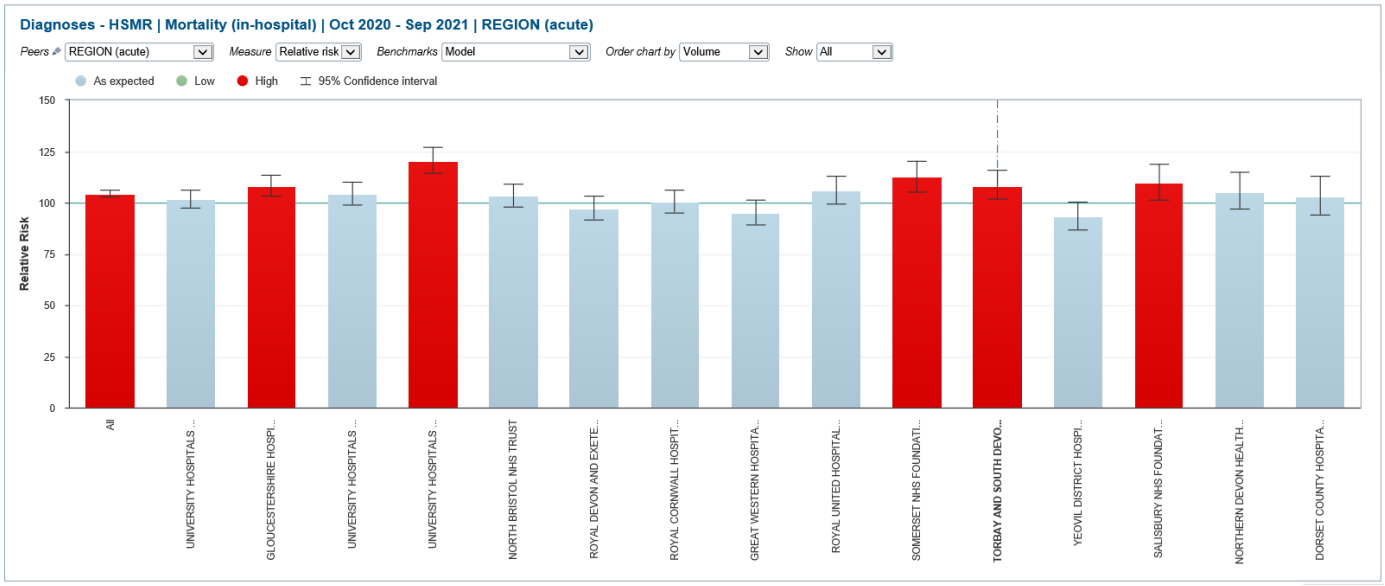


Chart 3 displays the above data as a 'Peer Comparison', and ranked as a bar chart.
The 12-month average HSMR is above the expected rate. Torbay and South Devon is flagged as an outlier during this time period. This is driven by high HSMR in May to August and will be subject to further review.



1B Summary Hospital Mortality Index (SHMI) Reporting Period July 2020 –June 2021

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* **July 2020 – June 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 two, which exceeds the average 100 relative risk mark. The first flag is Q1 2021 and relates to the first wave of Covid-19. The second flag for the most recent quarter, Q2 2021/22 will be subject to further review to confirm factors driving the increase.

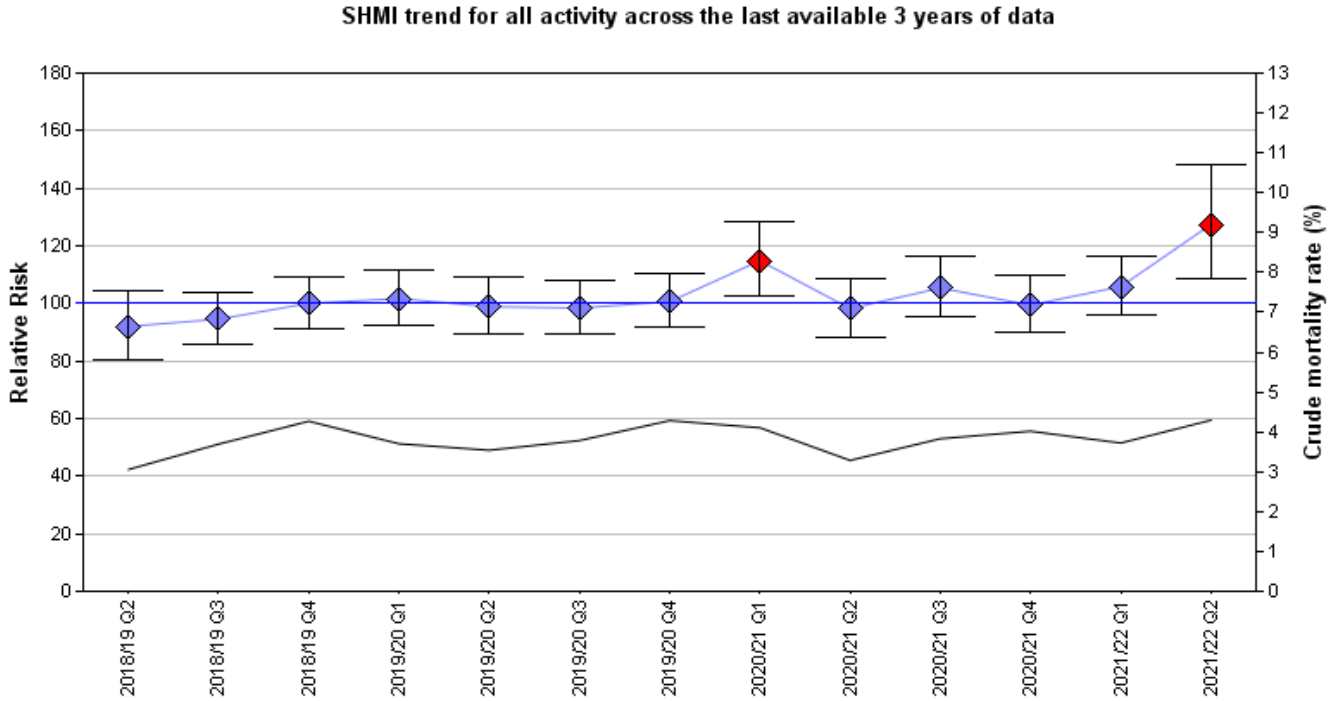


Chart 5 (as below) details - SHMI all deaths, SHMI in hospital deaths, and HSMR comparison, all within normal limits

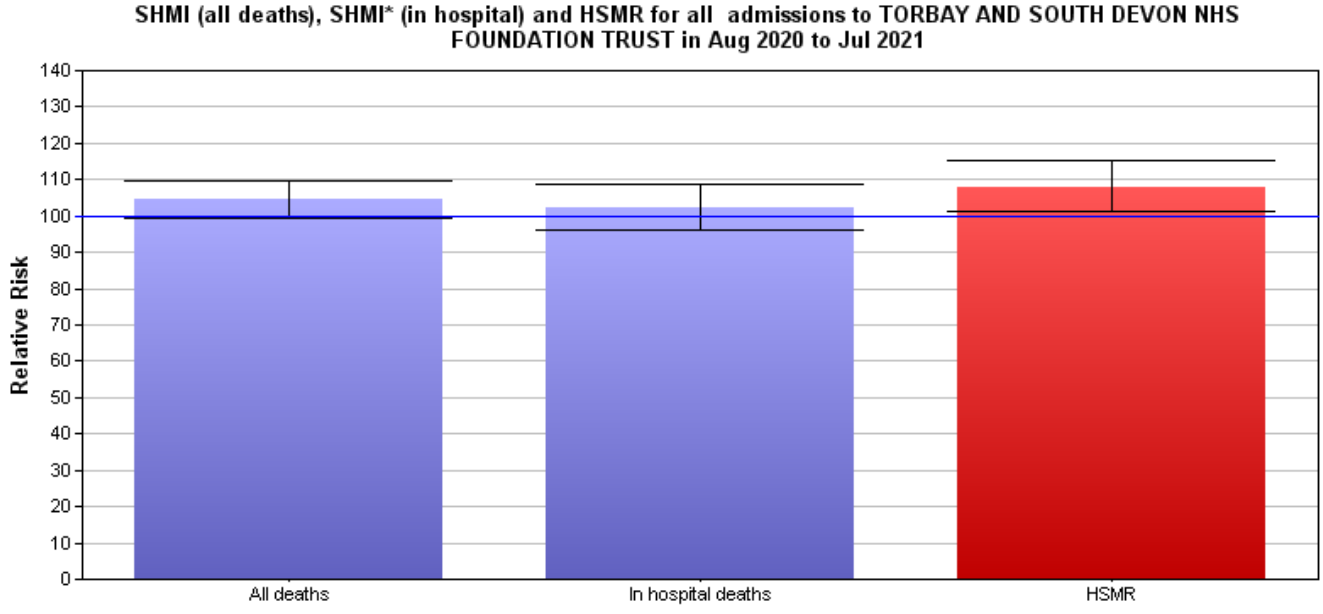
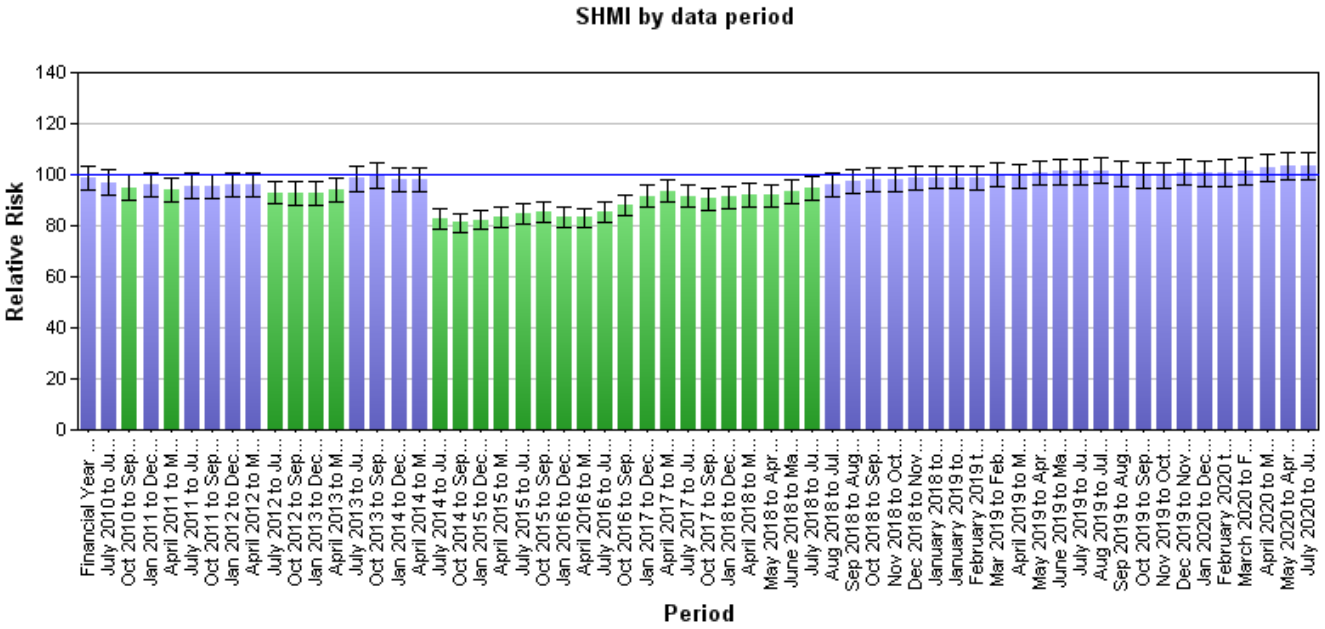


Chart 6, below, expresses the 12-month rolling SHMI data by time period. The mortality index is reporting the expected number of deaths during this time period (July 2020 – June 2021). The increasing trend is noted and will be subject to further review.



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.

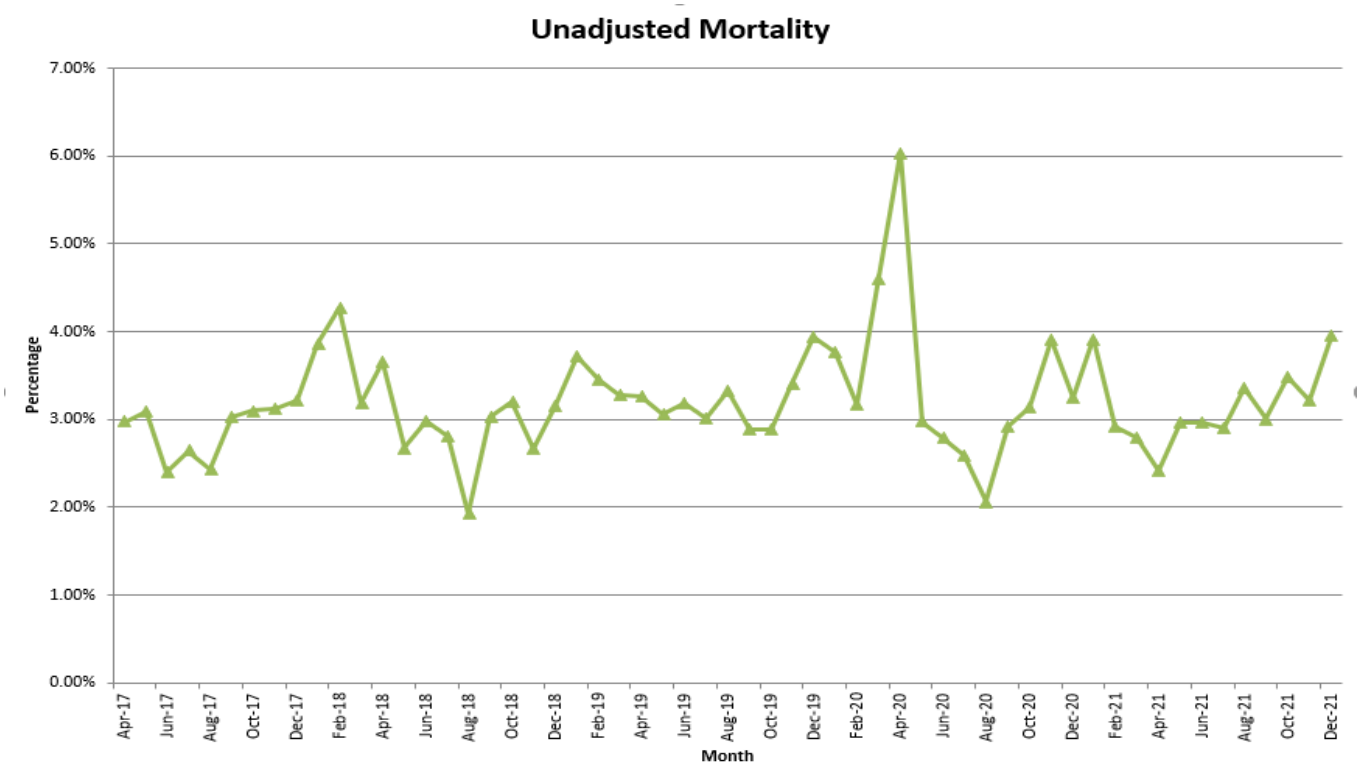


Chart 8 As below, indicates the monthly number of hospital deaths. This shows a rise in March and April 2020 partly due to Covid, before decreasing to comparatively low numbers during Summer 2020. As hospital activity increased following the initial pandemic lockdown, the number of hospital deaths has 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.

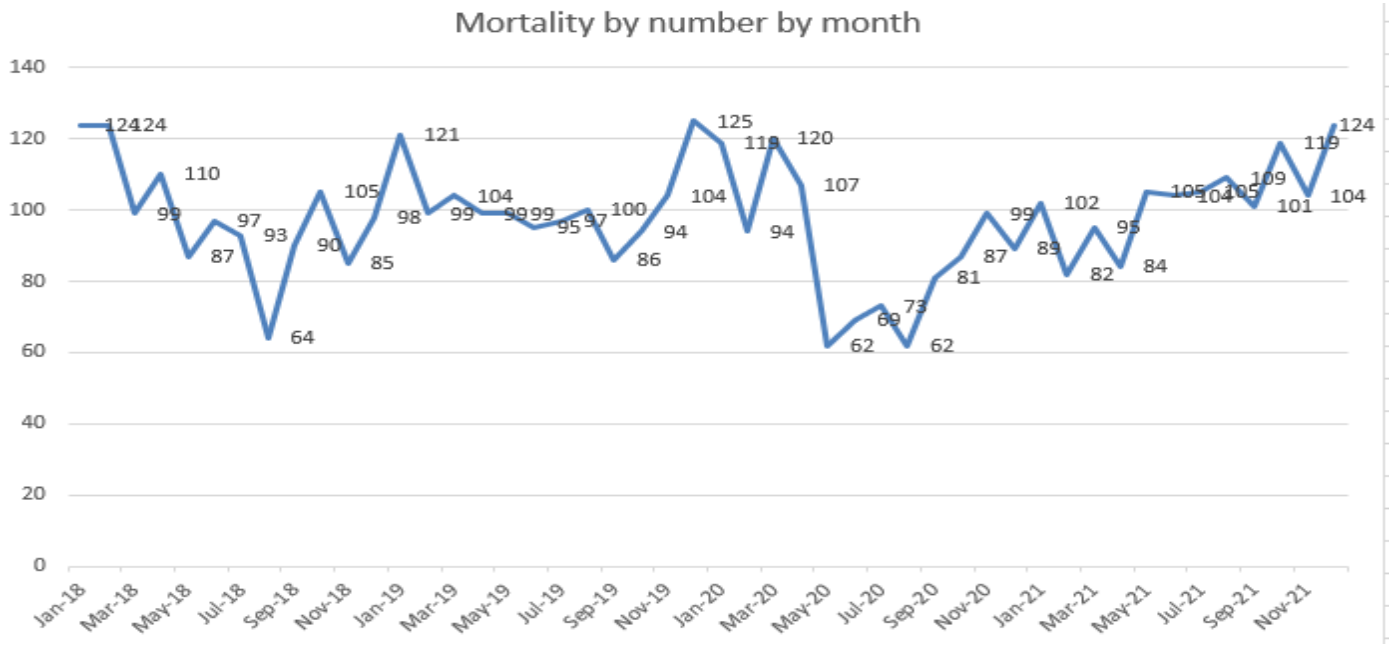


Chart 9, records hospital and community deaths (people's homes) and includes a comparator year, 2019.

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.

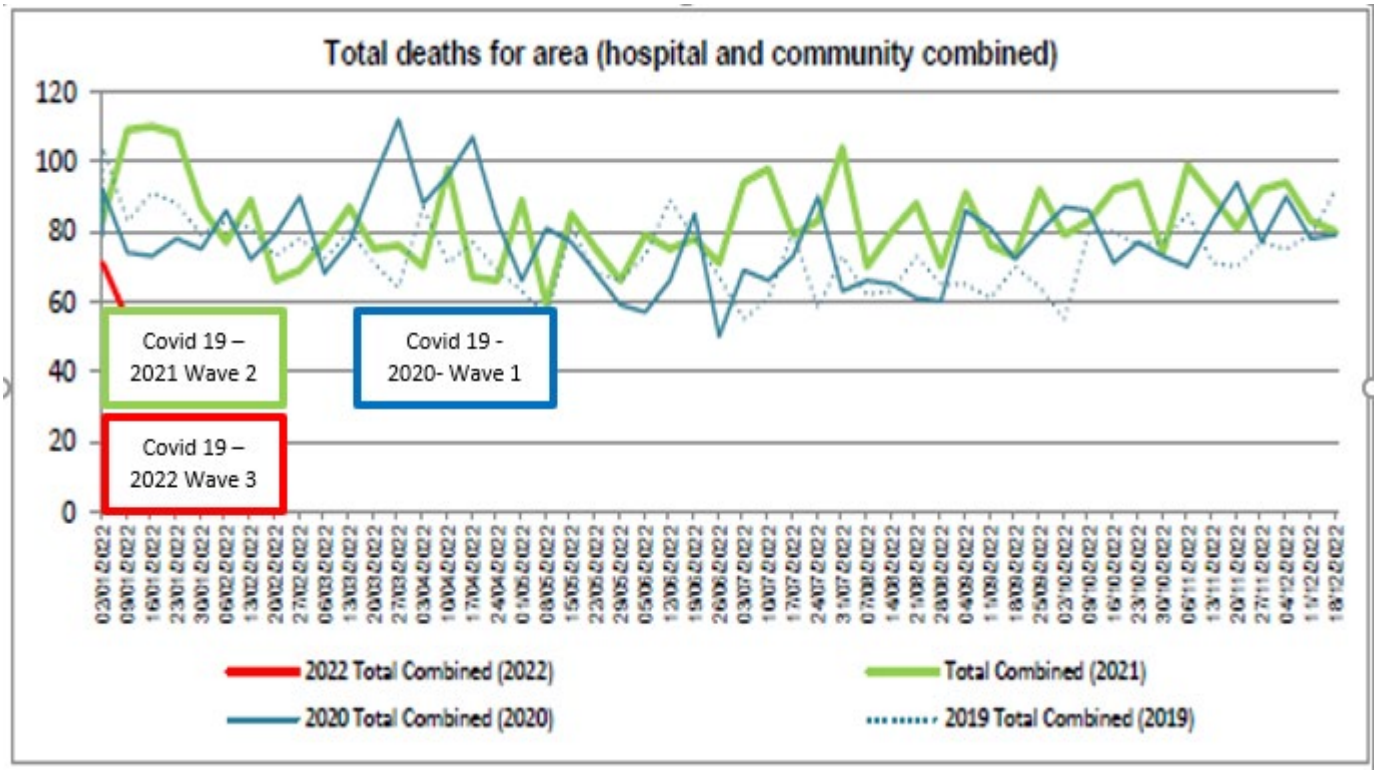
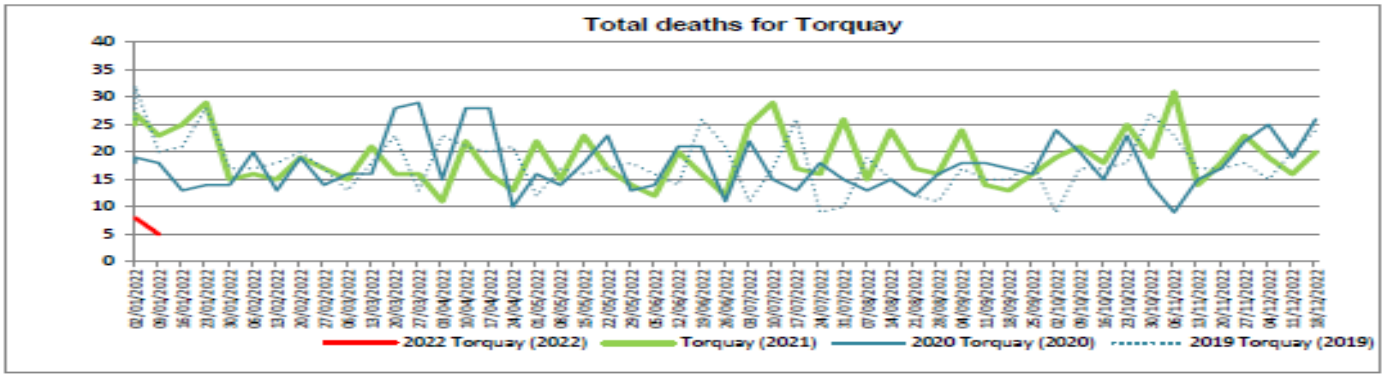
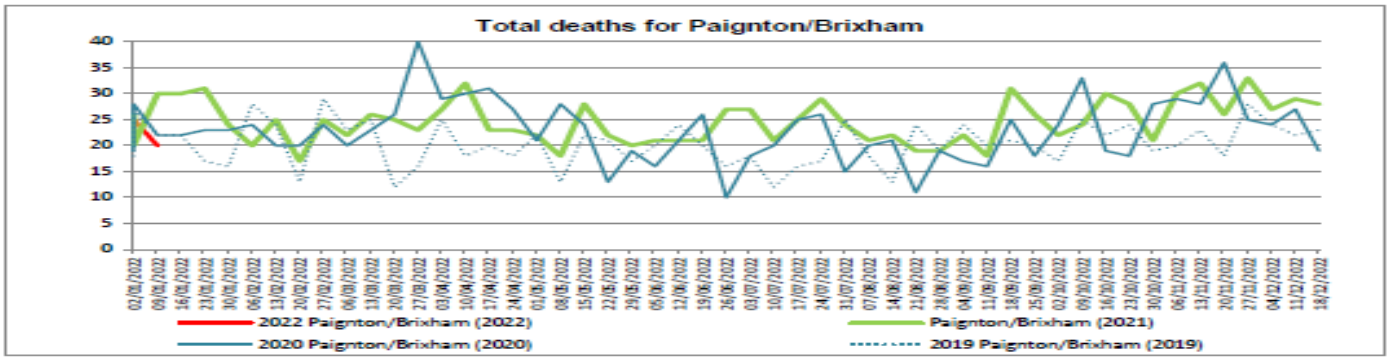
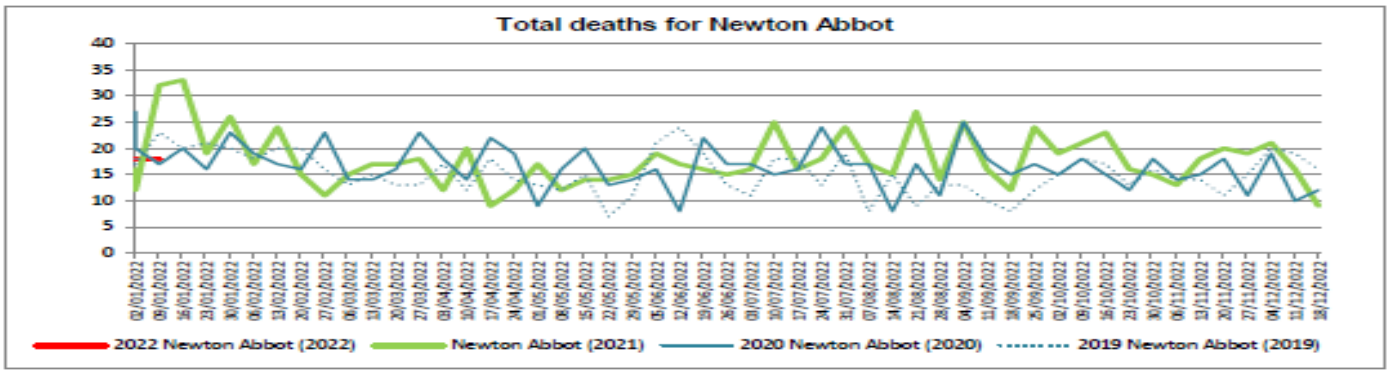
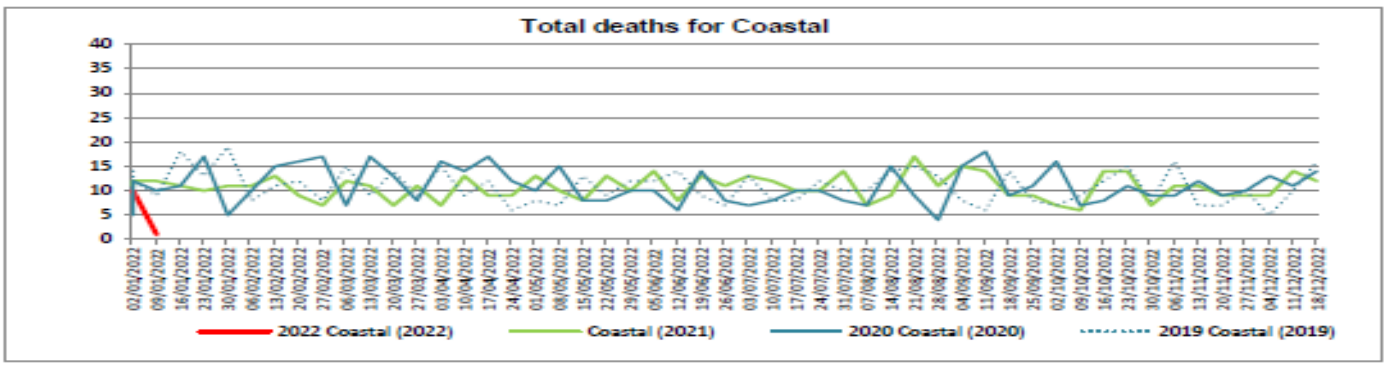

Total deaths for area (hospital and community combined)
120
100
80
60
40
20
0
Covid 19 – 2021 Wave 2
Covid 19 - 2020- Wave 1
Covid 19 – 2022 Wave 3
2022 Total Combined (2022)
Total Combined (2021)
2020 Total Combined (2020)
2019 Total Combined (2019)

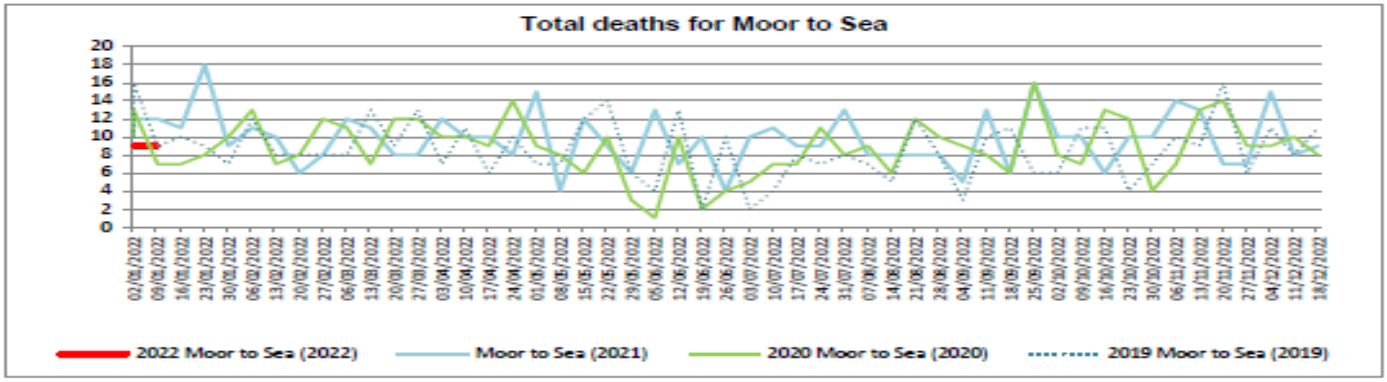
Chart 10 - Total Deaths by ISU locality











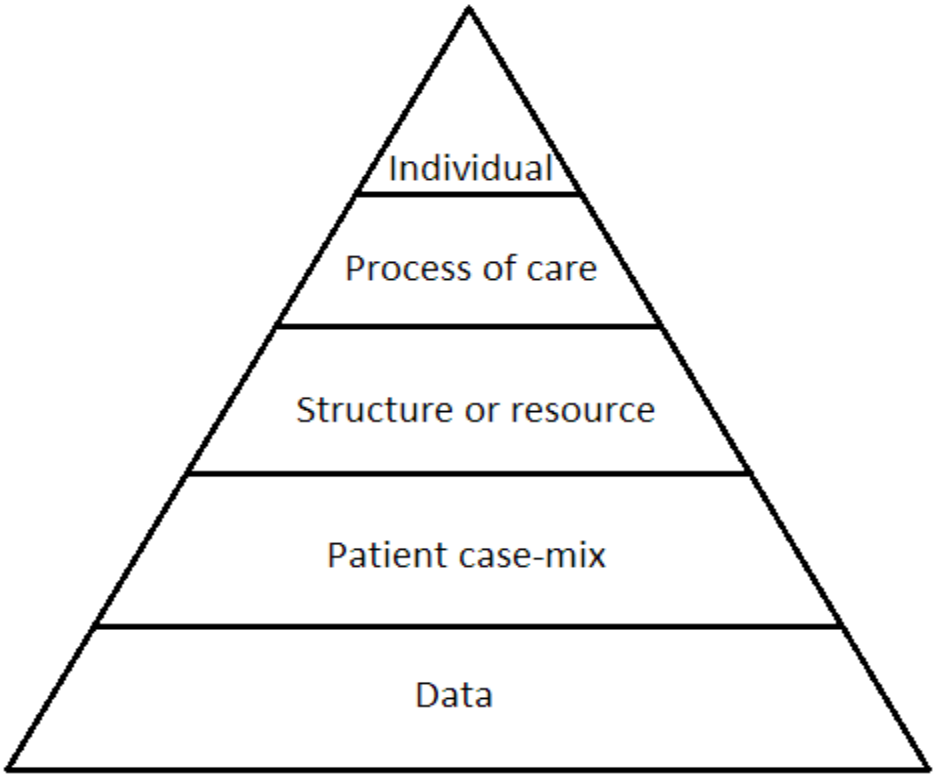
Appendix 3 – Mortality Analysis

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

	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	Nov-21	Dec-21	
Torquay ISU																		
DELIVERY SUITE								1										
LCHDU																		
LOUISA CARY																		
MOTHER AND BABY																		
Paignton and Brixham ISU																		
BRIXHAM			3	4	2	6	4		5	1	1	1	1	2		1	1	
CARDIAC CATHETER SUITE											1							
DUNLOP	5	6	2	4	3	4		5	4	3	3	4	8	6	4	7	6	
MIDGLEY	3	13	13	10	7	13	16	14	13	18	12	18	16	17	17	15	12	
TORBAY CHEST PAIN UNIT															1			
TORBAY CORONARY CARE BEDS	3			2	3	1	2	1		2	2	3	4		3	2	3	
TURNER	2	4	5	2	3	2	3	8		5	6	7	5	5	5	5	7	
ELIZABETH					3	1	3	1	1	1								
WARRINGTON	1		2	2		2	1	1	2	2	2	2	3	3	4	3	1	
Newton Abbot ISU																		
ACUTE MEDICAL RECEIVING UNIT																		
MEDICAL RECEIVING UNIT									1		3	4	1	3		2	6	
EAU3	4	1																
EAU4	6	11	7	7	9	17	10	11	8	9	16	11	11	8	16	9	10	
INTENSIVE CARE UNIT	8	7	5	6	12	2	5	4	5	10	16	7	11	3	8	13	12	
RECOVERY INTENSIVE CARE UNIT																		
TEIGN WARD	2	3	1	3	2	2	1	2	1	3	2	2		4	2	1	2	
TEMPLAR WARD	4		3		1		1	2	4		1	1			1		2	
TEMPORARY INTENSIVE CARE UNIT						1	1											
Coastal ISU																		
AINSLIE		2		2	1	2	1	1	1			4	7	3		1	7	
ALLERTON	5	3	7	8	8	2	3	8	4	6	4	3	7	2	8	7	7	
CROMIE		1	8	8	7	13	6	2	2	7	2	5	5	5	5	3	6	
DAWLISH	1	1				4	1	1			1	1		2			3	
ELLA ROWCROFT	2		4	3			3		1			2		1				
FORREST						4	5	4				4	5	8	13	7	12	
THEATRES						1							1					
Moor to Sea ISU																		
CHEETHAM HILL	7	12	6	11	11	12	10	11	10	11	7	9	11	12	10	13	6	
DART		1	1	1				2	3	3		1		1	3		1	
GEORGE EARLE	5	9	14	16	9	8	4	8	10	8	13	8	9	9	10	6	12	
SIMPSON	4	7	6	10	8	5	2	8	9	16	12	8	4	7	9	9	8	
Grand Total	**58**	**74**	**81**	**89**	**81**	**97**	**80**	**87**	**75**	**89**	**92**	**97**	**105**	**94**	**110**	**95**	**116**	

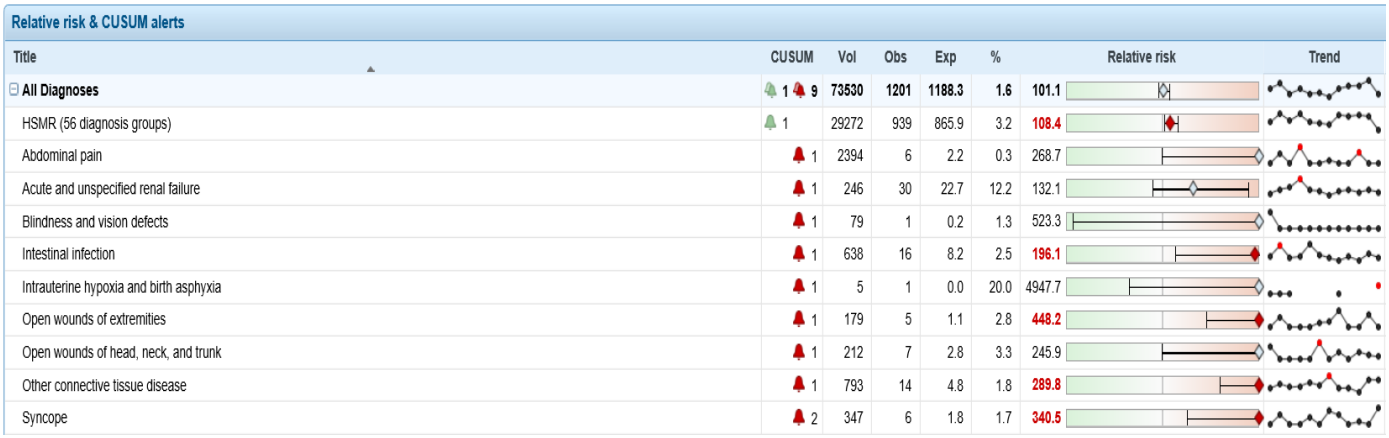
Alerts by Clinical classification

An ‘alert’ is raised when the expected number of deaths is significantly exceeded by the actual number of deaths. The Trust adopts the ‘pyramid of investigation for special cause variation’ shown below to further investigate alerts.



1) 1st Step **Data**: has the data been coded accurately, have all the comorbidities been recorded and coded, does the coding reflect what actually happened to the patient?
2) 2nd Step **Patient case-mix**: Has something happened locally to affect the case mix? For example, patients admitted for end of life care and if so has a palliative care coding been recorded?
3) 3rd Step **Structure or Resource**: were there any changes to the structure and availability of resources e.g. availability of beds, equipment and staff?
4) 4th Step **Process of car**e: have new treatment guidelines been introduced, have appropriate care pathways been consistently followed, have there been changes to admission or discharge practices?
5) 5th Step: **Individual:** An individual is rarely the cause of an alert. A consultant name may be recorded against the primary diagnosis but many individuals and teams are involved in providing care. Have there been any changes to staff or teams during the investigation?

Table 3 – Dr Foster Alerts by clinical classification



Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend
All Diagnoses	1 9	73530	1201	1188.3	1.6	101.1	
HSMR (56 diagnosis groups)	1	29272	939	865.9	3.2	108.4	
Abdominal pain	1	2394	6	2.2	0.3	268.7	
Acute and unspecified renal failure	1	246	30	22.7	12.2	132.1	
Blindness and vision defects	1	79	1	0.2	1.3	523.3	
Intestinal infection	1	638	16	8.2	2.5	196.1	
Intrauterine hypoxia and birth asphyxia	1	5	1	0.0	20.0	4947.7	
Open wounds of extremities	1	179	5	1.1	2.8	448.2	
Open wounds of head, neck, and trunk	1	212	7	2.8	3.3	245.9	
Other connective tissue disease	1	793	14	4.8	1.8	289.8	
Syncope	2	347	6	1.8	1.7	340.5	

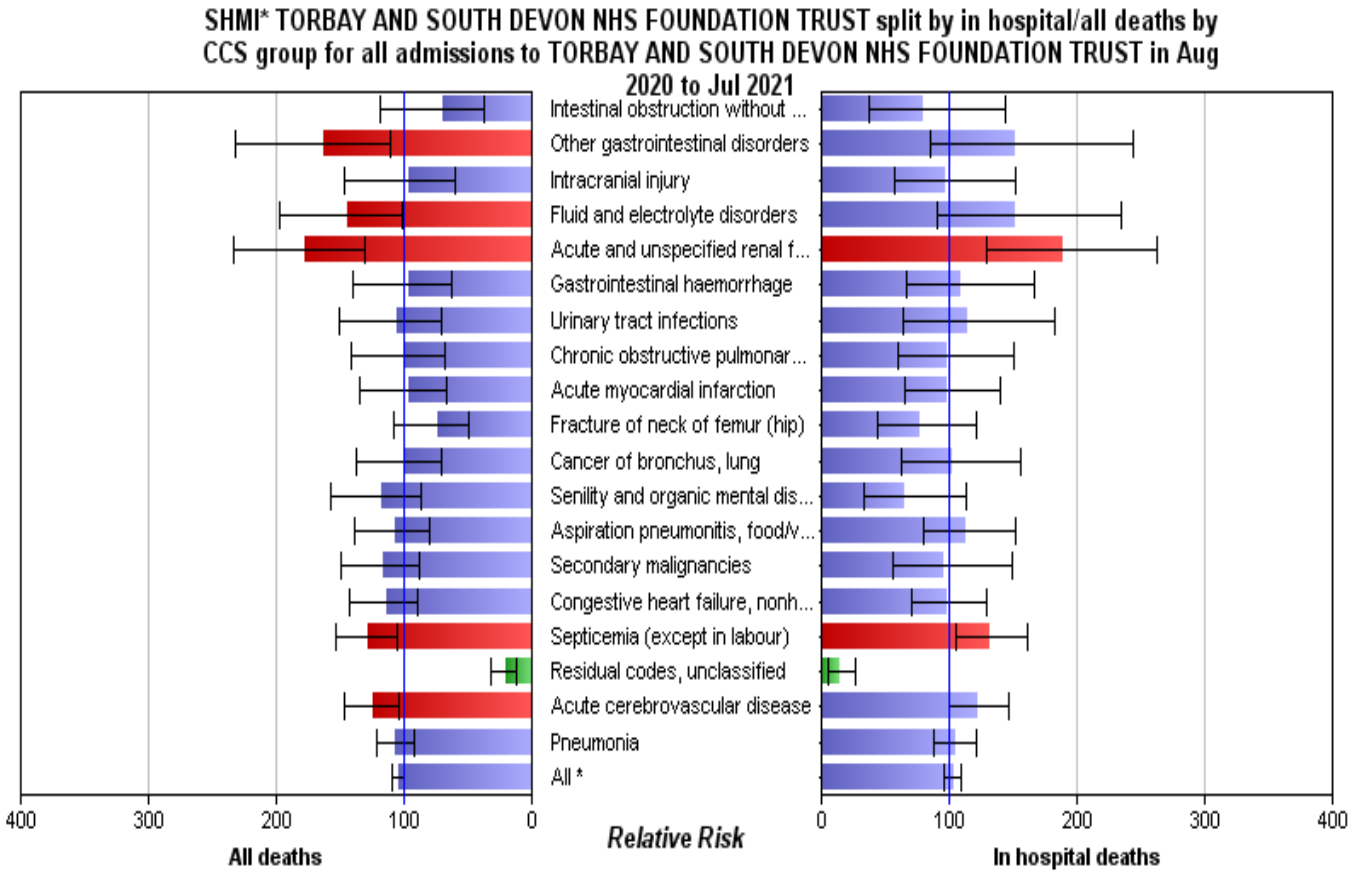
Alerts with observed deaths greater than 10 are currently under investigation:

i) 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.

ii) Deaths due to intestinal infection are higher than expected (16 observed v expected 8.2). This does not appear to be due to coding issues and has been discussed at Mortality Surveillance review.

iii) Deaths due to ‘other connective tissue disease’. 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.

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 continues to show an alert for mortality due to septicaemia and unspecified renal failure and in deaths occurring in hospital and up to 30 days after discharge. Other gastro disorders, fluid and electrolyte disorders and acute cerebrovascular is not alerting for in-hospital deaths but alerting for deaths up to 30-days post discharge. Further analysis will be discussed with the Director of Patient Safety.



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

Number of deaths of a patient with a Learning disability

Patients with learning disabilities currently have a life expectancy at least 15-20 years shorter than other people. The Learning Disabilities Mortality Review (LeDeR) programme requires an independent case review following the deaths of people with Learning Disabilities. All deaths involving patients with a learning disability are reviewed through the LeDeR process. This feeds back into the Trust any learning. Currently up to date data from the LeDeR process is not available but the central patient safety team and CCG are working together to provide timely feedback. 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

A stillbirth is when a baby born dead after 24 completed weeks of pregnancy. It occurs in around 1 in every 200 births in England.

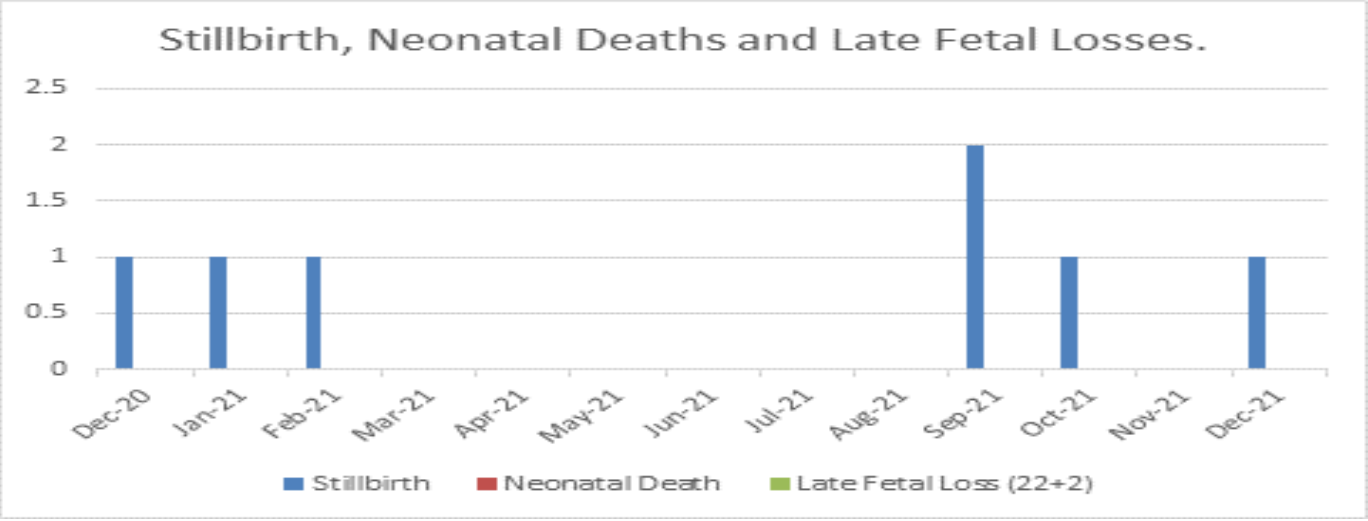
Between October and December 2021, we had two stillbirths.

Case 1 - A Mother presented with absent fetal movements at 25 weeks. At the routine anomaly scan, a fetal abnormality was diagnosed. A Post-mortem is being undertaken to try and determine the cause of death.

Case 2 - A Mother attended for her routine anomaly scan and severe growth restriction was identified in the Baby. A high chance of stillbirth was discussed with the parents. The Mother presented at 26 weeks and an intrauterine death was diagnosed and the Baby was extremely growth restricted at birth.

There were no intrapartum stillbirths (a baby is thought to be alive at the onset of labour but is born dead), early neonatal deaths (a baby dies within the first week (0-6 days) of life from any cause) or maternal deaths (death of a women during pregnancy or within 42 days of the end of pregnancy). These types of death are investigated by the Health Safety Investigation Branch (HSIB) using a standardised process.

Chart 12 – Stillbirth, Neonatal Deaths and Late Fetal Losses



Number of child deaths

Over the last 20 years the UK has gone from having one of the lowest mortality rates for 0-14-year olds to one of the highest in Western Europe. There is a strong association between deprivation and mortality; for example, infant mortality is more than twice as high in the lowest compared with the highest socio-economic groups.

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 were 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 2 complaints raised.

1 regarding delay to surgery and medication received – under investigation
1 regarding delay in treatment plan – under investigation

Medical Examiners

The Medical Examiners Service continued to be impacted by sickness throughout November and December 2021, impacting on the number of cases scrutinised. To mitigate this the medical examiner officer reviewed all cases and liaised with the next of kin to identify any areas of concern as sanctioned by the Regional Medical Examiner.
Recruitment of additional Medical Examiners was successful and the recruitment processes are underway with the first ME commencing mid-January. Recruitment off additional Medical Examiner Officer resource in now underway.
The Medical Examiners office have highlighted that there have been increasing delays in death referrals and increased breaches to the completion of the Medical Certificate of Cause of Death within the required 5-day period for registration. It is recognised this is due to the current system pressures resulting from the Omicron Covid surge and additional operational processes have been put in place in an attempt to resolve this issue.

Table 5 – Medical Examiners Performance Summary

	Performance					Outcomes						
Month	Total number of adult deaths	Number not currently included in ME process (COVID ward / direct to coroners)	Number scrutinised by ME	% Total deaths scrutinised	% deaths included in ME process scrutinised	Number scrutinised referred to coroner	% referred to coroner	Number MCCD issued within 5 days (non coroners)	% MCCD issued within 5 days (non coroners)	Number MCCD issued within 3 days (non coroners)	% MCCD issued within 3 days (non coroners)	Number raised to clinical governance
Jan-21	104	46	45	43.3%	77.6%	10	22.2%	23	65.7%	11	31.4%	5
Feb-21	81	7	67	82.7%	90.5%	16	23.9%	41	80.4%	31	60.8%	8
Mar-21	97	13	68	70.1%	81.0%	9	13.2%	49	83.1%	30	50.8%	10
Apr-21	72	13	55	76.4%	93.2%	8	14.5%	42	89.4%	31	66.0%	3
May-21	92	11	66	71.7%	81.5%	6	9.1%	52	86.7%	31	51.7%	0
Jun-21	113	24	77	68.1%	86.5%	6	7.8%	65	91.5%	40	56.3%	9
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	111	17	75	67.6%	79.8%	6	8.0%	55	79.7%	36	52.2%	0
Dec-21	129	22	84	65.1%	78.5%	2	2.4%	65	79.3%	33	40.2%	1

National Cardiac Arrest Audit 2020/2021

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

Learning from Inquests

During November and December 2021 there were twelve Coroner's requests for information. There were three inquests during this time with two attended by the Trust. There were a total of four cases closed during these months

The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 Report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths. Any full response to a Regulation 28 report should be made within 56 days of the date of the report.
The Trust has no outstanding Regulation 28 reports.

Trust learning: Serious Adverse Event Group November and December 2021

Key Issues	Learning and actions taken
Treatment / Diagnostic learning The SAE group discussed investigations into 2 deaths in November and no deaths in December 2021	
1. Intrapartum stillbirth at 39/40+5 possible issues of placenta previa	HSIB investigation findings include provision of urgent discussion of unusual USS findings with fetal medicine team. Communication between obstetric and paediatric team re management of neonatal anaemia. Difficulty in potential for early delivery if USS findings not clear.
2. Possible late diagnosis of myocardial infarction leading to arrest in ED and death 5 day later on ICU	Impact on medication delay, difficulties of patient management in an ED with very significant demand

Glossary of Terms

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

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

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

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

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

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: CQC Focused Inspection report			Meeting date: 26th January 2022
Report appendix	Appendix 1: CQC Letter to the Trust		
Report sponsor	Chief Nurse		
Report author	System Director of Nursing and Professional Practice – South Devon		
Report provenance	Quality Improvement Group		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to provide the Trust Board with the outcome and actions taken of the focused unannounced CQC inspection on the 1st December 2021.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to: • Note the contents of report • Note the concerns raised by the CQC • Note the improvements and interventions made • Note assurance		
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**: 5; **Risk Register**: ; **Risk score**: 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**	X	**Terms of Authorisation**	
	NHS Improvement		**Legislation**	
	NHS England		**National policy/guidance**	

Report title: CQC Focused Inspection report		Meeting date: 26th January 2022
Report sponsor	Chief Nurse	
Report author	System Director of Nursing and Professional Practice – South Devon	

1. Introduction

The purpose of this report is to provide the Trust Board with the outcome of the focused CQC inspection that occurred at the Trust on 1st December 2021.

2. CQC Focused Inspection Context

On 1st December 2021 the CQC carried out an unannounced focused inspection of Medical Care core services. The focused inspection was undertaken in Forrest Ward, EAU 4 and George Earle (Stroke and healthcare of the older patient) as a result of concerns raised regarding staffing levels and assessment and delivery of nutrition and hydration to our patients.

The inspection team were advised that EAU4 remained an active COVID ward, therefore their inspection of observation of this area was delivered through the review of medical records, discussions with staff and information requests.

3. Initial Feedback and Outcome

The Trust received an initial feedback letter from the CQC on 2nd December 2021 (Appendix 1). The findings of the CQC inspection are set out below;

- We found that intentional rounding was completed as intended.
- MUST assessment, actions identified and audit trail were not available or completed in a timely manner.
- Staff could not demonstrate what patients had to eat and if this was enough to meet their needs.
- Fluid balance record was not completed consistently.
- Staffing on EAU4 is a concern and especially with the acuity of patients at night.
- On the stroke ward, we found that records were completed consistently and staff fully supported patients with their nutrition and hydration needs.
- The leadership team were fully aware of the current risks. The leadership team were able to describe the actions they were taking and the challenges they faced in managing those risks, both in the short and long term.

Following the CQC review of the data submissions on the 6th December, a further letter was received by the Trust from the CQC on the 13th December 2021. This outlined six areas of serious concerns that remained which required the Trust to respond to with an immediate action by 16th December. The Trust responded further and the CQC have been satisfied that the action taken is appropriate.

The Trust remains under inspection conditions until the final report has been released. A draft report is estimated to be received early February 2022.

4. Existing Interventions Pre-Inspection

Nutrition and Hydration has been a focus of improvement across the Trust for a significant period, specifically the quality of and completion of risk assessments and care planning. The Trust has struggled to maintain consistently high standard in risk assessments and this was previously identified by Internal Audit.

In 2020/21 much work has been progressed to address this including:

- Monthly audits of MUST risk assessments and ongoing care completed as part of the monthly safety assessments
- Daily Safety Briefings
- Daily SAFER ward rounds (multi-professionally attended)
- Daily audit of 5 sets of notes – review all aspects of risk assessment and care planning booklet

In 2020/21 much of this work has been destabilised and it is clear that staff shortages do impact the nursing community to complete documentation in a timely and consistent manner. Notwithstanding the operational challenges the NMC sets out very clear guidance and standards for Nurses and Midwives around the need for contemporaneous record keeping. As such the Trust is committed to upholding these standards and will take all necessary steps to ensure and assure compliance.

5. Immediate Actions and Longer-Term Plans

Following the concerns by the CQC from their initial visit and subsequent letter added 13th December, a range of interventions to enhance existing measures were implemented in order to provide absolute assurance around nutrition and hydration, these included;

- Risk Assessment
- Care Planning
- Governance
- Recording of fluid and food charts
- Referral and follow up of specialist services
- Leadership
- Capacity

An immediate senior nursing leadership meeting was held to discuss the initial findings from the report and an immediate nutrition and hydration action plan was produced for EAU 4 and Forrest Ward with the following key components, which have been ongoing since 15th December 2021;

- Daily auditing of MUST risk assessments are completed each morning with actions if required, and additional reassessment within the afternoon to ensure actions have been completed. Since 15th December EAU4 and Forrest have been compliant at 100%.
- Observations of care have been completed every day since the 15th December and these have provided usual insights into delivery of meals, including the organisation and preparation. Actions have been identified and are reviewed daily for completion.

- Senior nursing attendance at safety briefings, the review of information to alert staff to patients requiring assistance with nutrition and hydration is documented clearly.
- Meetings stepped down over mealtimes to ensure direct patient care is observed. Clinical resource has been reassigned to assist with delivery of mealtimes and documentation of food and fluid balance charts
- Meal time companions – who assist the domestic to deliver meals to patients,
- Multi-professional assistance with mealtimes including adherence to protected mealtimes. This is demonstrated with a bell to alert that mealtime is about to begin, EAU 4 medical staff stop ward rounds and assist I the delivery of food and drink to patients
- Ward manager and Matron changes on EAU 4, these changes have taken place in December and fully transitioned in January

Exception reporting of the outcomes of the safety briefings and audits of nutrition and hydration is reported to the safety cell and Incident Command Cell.

A Nutrition and Hydration Task and Finish Group was launched to monitor the immediate interventions and transition the immediate plan into the workplan of the recently reinstated Nutrition and Hydration Steering Group.

6. Recommendations

Trust Board is asked to note the contents of the report and actions taken.

- Note the contents of report
- Note the concerns raised by the CQC
- Note the improvements and interventions made
- Note assurance

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Our reference: INS2-11976821551

Ms Liz Davenport
Torbay Hospital
Lawes Bridge
Torquay
Devon
TQ2 7AA

By e-mail to: liz.davenport@nhs.net

Date: 2 December 2021

Dear Ms Davenport

Re: CQC focused inspection of Medical Care at Torbay Hospital.

Following the feedback meeting with Yogiraj Ragoo, Tracy Hipkin-Wale and Gail Richardson on 1 December 2021, I thought it would be helpful to give you written feedback.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 1 December 2021 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our preliminary findings

- We would like to thank the whole of the team for the time they took to make us feel welcomed, and the arrangements they had made. Please also thank everyone for taking the time to talk to us.
- We stated when we arrived on site that the inspection was focused on medical care following information of concerns and complaints we had received previously. The inspection was particular focused around patients receiving nutrition and hydration on Forest ward and EAU4. However, for comparison, we also visited the stroke ward.

- We found that intentional rounding was completed as intended.
- There was a lack of audit trail to demonstrate patients received nutrition and hydration adequately and in a timely manner. Staff could not demonstrate what patients had to eat and if this was enough to meet their needs.
- We observed full bowls of food and drinks had been collected from patients. Staff could not tell us which patient had not consumed the food or drink and whether it was because patients did not like what was offered, or if patients had not received support with their food or drink.
- MUST assessment and actions identified from the assessment were not completed in a timely manner. For example, we reviewed the records for one patient where it was identified a dietician referral was required. From the records we reviewed, the referral had not been completed.
- Fluid balance record was not completed consistently. Five out of six records we looked at did not have a fluid balance chart. There was no assurance that patients were receiving enough fluid.
- We also suggested that the audit process (ICARE) was re-visited as we were unclear about the information that fed into the audit.
- Staffing on EAU4 is a concern and especially with the acuity of patients at night.
- On the stroke ward, we found that records were completed consistently and staff fully supported patients with their nutrition and hydration needs.
- The leadership team were fully aware of the current risks. The leadership team were able to describe the actions they were taking and the challenges they faced in managing those risks, both in the short and long term.

- The inspection is still ongoing as we need to review the information requested once this is sent and speak to a few members of staff to clarify a few points.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Ben Roe at NHS Improvement.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Yogiraj Ragoo

Inspection Manager

c.c.

Ben Roe

John Scott

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Maternity Governance & Safety Report (1 October – 30 December 2021)			**Meeting date:** 26th January 2022
Report appendix	Appendix 1: PCQS Minimum Dataset Information Summary		
Report sponsor	Chief Nurse		
Report author	Head of Midwifery and Gynaecology Clinical Governance Co-ordinator Quality Improvement Midwife Deputy Head of Midwifery		
Report provenance	The content of this report is a summary of the safety improvement activities implemented by the Maternity Governance Group within the Trust to meet the national priority to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025. This is informed by the Safety workstream of the Devon Local Maternity & Neonatal System (LMNS).		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to inform the Trust Board of the work being undertaken by the Maternity Governance Group. It also informs the membership of recent recommendation made within the Ockenden Interim Report (Dec 2020). • The paper specifically sets out the Trust position and compliance with the Ockenden Report as of 30 September 2021. • Setting out the Trust position in relation to perinatal mortality and morbidity, specifically reduction in still births. • Progress and next steps with regard to achievement of CNST key safety actions An expectation of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme is that a quarterly report will be presented to the Trust Board.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board of Directors are asked to: • Note the progress and compliance position with regard to the priority areas • Note the key quality and safety issues identified in the report • Note progress and next steps with regard to the CNST process		
Summary of key elements			

Strategic objectives supported by this report	

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

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

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

External standards affected by this report and associated risks	

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

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

Report title: Maternity Governance & Safety Report (1 October – 30 December 2021).		**Meeting date:** 26th January 2022
Report author	Rachael Glasson, Associate Director of Midwifery & Professional Practice/HoM Anne Marie Whiting, Clinical Governance Co-ordinator Maria Mortimore, Maternity Safety Champion/Deputy Head of Midwifery Jo Blackler, Quality Improvement Midwife	

1.0 Introduction

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

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

This is the fifth quarterly report since the publication of Ockendon. As with the previous reports, it will be constructed to meet the recommendations within the Ockenden report. We plan for this to be an iterative process, with the Trust Board and maternity services working to review, amend and strengthen existing reporting mechanisms, supported by NHS England & Improvement (NHSEI) with the provision of additional resources where available to enhance our safety culture.

This quarterly report will look back at the period 1 October 2021 – 31 December 2021

2.0 Review and monitoring of safety within maternity services

2.1 Governance process

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

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

2.2 Ockenden Interim Maternity Review

The Ockenden Interim Report into Maternity Services at Shrewsbury and Telford NHS Trust was published in December 2020. In conjunction with this, NHS England and Improvement set out a series of immediate and essential actions.

The maternity task and finish group summitted evidence of compliance with the recommendations to a 'portal' on the 30 June 2021. This extensive piece of work has been reviewed by the Regional Commissioning Support Unit. A draft report was received by the Trust, which highlighted a number of areas of non-compliance.

Following the review, the Trust has worked with the Devon Local Maternity and Neonatal System (LMNS) and the Regional Team to review the additional evidence submitted and it was agreed that evidence had been provided for nearly all areas. Key areas to continue to develop include:

- Continue to embed the role of the non-executive safety champion.
- Development of maternal medicine pathways and the development of a births option clinic. An action plan to achieve this is currently being developed. This is monitored monthly at the Maternity assurance meeting and recorded within an excel database and the ongoing action plan will be embedded in the monthly Maternity Clinical Governance Meeting.

It is anticipated that the final Ockenden Report will be available from April 2022.

2.3 Perinatal Clinical Quality Surveillance Model

As part of the Ockenden Review and the NHSEI 12 urgent actions, a model has been proposed to improve oversight of safety metrics within Maternity and Neonatal Services. The Perinatal Clinical Quality Surveillance (PCQS) Model is based on three levels, with level one relating specifically to the Trust level, level two at System level and level three at Regional level.

Level one focuses on strengthening our approach and oversight of quality, with 6 requirements set out below. Progress against these are detailed in Table 1.

Table 1: Perinatal Clinical Quality Surveillance Model (PCQS)

PCQS Requirements	TSDFT position
1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.	In place ✓ Sally Taylor, NED
2. Monthly review of maternity and neonatal safety and quality is undertaken by the trust board.	In place ✓ Maternity metrics included within Integrated Performance Report (IPR)
3. That all maternity Serious Incidents (SIs) are shared with Trust Boards and the LMNS, in addition to reporting as required to HSIB.	In place
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in the Trust IPR, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.	In place ✓ Dashboard included in IPR. ✓ SI's – as above ✓ Minimum dataset being reported within quarterly report to Board. See Table 3.

5. Review the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMNS) lead and regional chief midwife. Formalise how Trust-level intelligence will be shared to ensure early action and support for areas of concern or need.	In Place ✓ Perinatal clinical quality surveillance model reviewed in collaboration with the local maternity system (LMNS) lead and regional Chief Midwife. ✓ Agreement reached to formalise how Trust-level intelligence will be shared to ensure early action and support for areas of concern or need. ✓ Standard operating procedure in place
6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model	In place ✓ Board Level, NED, Obstetric and Midwifery Safety Champions ✓ Monthly Safety walkarounds with Board Level and Midwifery Safety Champion ✓ Bi-monthly safety reports provided for Board Level Safety Champion ✓ NED involvement in Maternity meetings and walkarounds Action: • Review NED capacity • Key maternity meetings form part of the NED's diary • Benchmark against safety champion toolkit and how to guides

2.4 Trust Board Reporting – Quality and Safety within Maternity Services

As described above maternity metrics are now reported as part of the Board Integrated Performance Report. Metrics include:

- Still birth rate,
- caesarean section rate
- smoking status at time of birth.

The full PCQS dataset forms part of the maternity service monthly Governance report. This is also reviewed on a monthly basis at the following key governance groups:
Torquay ISU Governance meeting

- Quality Improvement Group
- Integrated Governance Group
- Quarterly Safety and Governance Board reports that are submitted to the Quality Assurance Committee and the Trust Board. See Table 2 for PCQS minimum dataset information summary

2.5 PCQS Minimum Dataset Information Summary (Appendix 1)

2.5.1 Perinatal Mortality Review Tool (PMRT)

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

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

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

2.5.1.1 PMRT - Notifications

During October - December 2021, we had two cases that met the reporting criteria.
These were two antepartum stillbirths. Both of the Mothers presented to the Maternity service prior to labour. The Mothers were 25+4 weeks and 26 weeks gestation. Both of these cases have undergone duty of candour and will have a multidisciplinary case review using the PMRT process for review. On initial review both of these babies had abnormal scan findings prior to birth.

Case 1 –A Mother, 37 years old at the time of her routine anomaly scan had an abnormality of the abdominal umbilical vein diagnosed. This is an extremely uncommon condition. The Mother was referred to the fetal medicine consultant and counselled on the possible outcome. Regular scans were planned. At 25^{+4} the Mother presented to the Delivery suite with no fetal movements and delivered a stillborn Baby girl. The parents consented to a Postmortem. These findings will form part of the review process.

Case 2 - A Mother had diagnosed at the routine anomaly scan an extremely growth restricted baby and was counselled on the increased risk of stillbirth. The Mother presented the delivery suite at 26 weeks for follow up following a referral from the community and an intrauterine death was diagnosed. The Mother delivered an extremely growth restricted Baby girl. Non-invasive testing was consented to by the parents.

2.5.1.2 *PMRT – Completed Reviews*
During this reporting period we have completed two PMRT reviews. Both families have been offered follow up and the findings from the PMRT.

2.5.2 Healthcare Safety Investigation Branch (HSIB)

2.5.2.1 Referrals to HSIB

HSIB continue to investigate births and maternal deaths that meet their referral criteria. This includes any baby that requires active cooling treatment. This is given to babies where there has been a potential shortage of oxygen around the time of and during the birth which can lead brain injury in a newborn baby. The aim of the treatment is to slow down the processes that cause brain damage. During COVID HSIB have made the decision to only investigate Babies with an abnormal MRI scan following active cooling.

In the reporting timescale of October -December 2021 one case has been investigated by HSIB.

Case 1: A Mother in her first pregnancy was induced at 37+5 weeks gestation due to the Baby being identified as growth restricted. The induction was cancelled on two occasions due to reduced capacity. Once the labour was induced the Mother was being cared for on the antenatal ward and an abnormality with the fetal heart was recognised and the Mother transferred to the delivery suite. The birth was expedited. The baby was born in poor condition and required specialist neonatal care in a level 3 neonatal unit. The Baby's MRI was normal, however the family requested HSIB investigate the Mothers and Baby care and they agreed.

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2.5.2.2 Finalised investigation reports from HSIB

A finalised report was received in the previous report. Since then the family have had a tripartite meeting with HSIB and the Trust. An action plan has been developed and is being monitored through the Trust Serious Adverse Event group.

2.5.2.3 Quarterly Engagement Visit with South West Maternity Investigation Team

We have not had any meetings with the South West team during this reporting time, we have one planned for 10 January 2021.

2.5.3 NHS Resolution

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

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

2.6 Safety Improvement

2.6.1 Maternity and Neonatal Health Safety Improvement Programme (MATNEOSIP)

Work on the Perinatal Excellence to Reduce Injury in Premature Birth (PERIPrem) Project continues. The bundle of 10 elements, have all been introduced at Torbay and South Devon and we are working to embed the elements into normal practice. In house training was held on 13 October 2021 focussing on optimal cord clamping at LSCS. The latest PERIPrem dashboard demonstrates that we have improved compliance with delayed cord clamping and thermoregulation and now need to focus on antenatal steroids, magnesium sulphate administration and intrapartum antibiotics. The PERIPrem project is being registered as a QI project focussing on antenatal steroid admin and will be a standing agenda item in our O&G audit meeting

The Obs Cymru QI Programme (Obstetric Bleeding Strategy for Wales) remains paused due to pressures from the current Covid 19 pandemic and staffing capacity. Discussions are now taking place with the provider of the Rotem machine (Point of Care coagulation testing) regarding training. A Patient Safety Network event was held on 3 December 2021 presentations were provided on:

- Silver QI training and shared learning on ERA system (Emergency Role Allocation) this is an electronic call bell system that displays the type of emergency that is taking place in a room on Delivery Suite and enables responders to allocate roles before entering room bringing the appropriate equipment with them, thereby improving outcomes. The Deputy Head of Midwifery has nominated Torbay to be a pilot site for the ERA system – decision awaited.
- Culture Competency and Safety training
- The Perinatal Equity Programme
- Service User Voice Representation

2.6.2 Saving Babies Lives Care Bundle

Saving Babies Lives Care Bundle Version 2 (SBLCB v2) was launched in March 2019. This builds on the existing bundle, but adds a fifth element (preventing risk of preterm birth) for

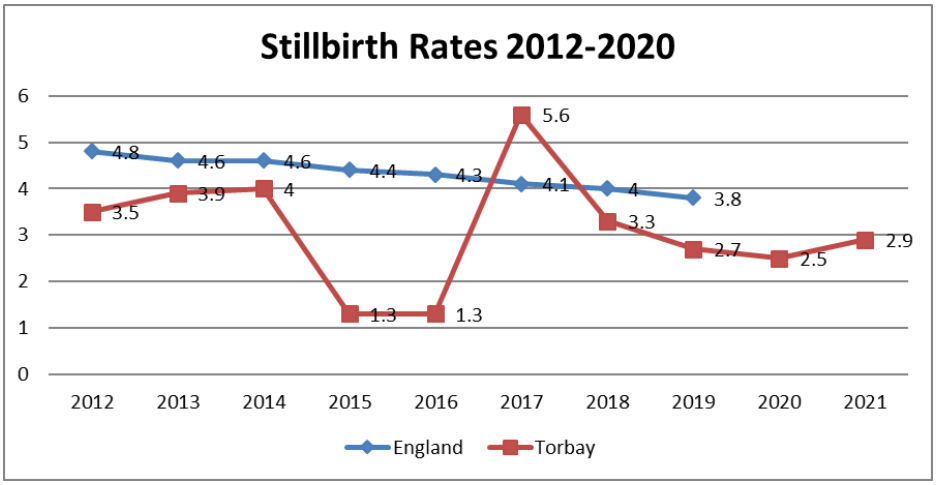
implementation. Full implementation of the care bundle was achieved by the expected date of 31 March 2021.

At the final SBLCBv2 quarterly report submitted in April 2021 we were able to demonstrate full compliance. We therefore fully meet the standard 3 of the CNST safety actions. The expectation for further quarterly reports has been put on hold from a national perspective due to current Covid pressures, however we intend to continue to collect all data and this will inform future reports.

2.6.3 Stillbirth Rate

One of the aims of SBLCB v1 and v2 is to reduce the number of stillbirths. Our 2021 annual data is now available and has shown that the stillbirth rate has slightly increased at TSDFT but is still below the national rate trajectory. This is shown in Table 3 (Note: national comparative data is not yet available for 2020).

Table 3: Annual Stillbirth Rate per 1000 births

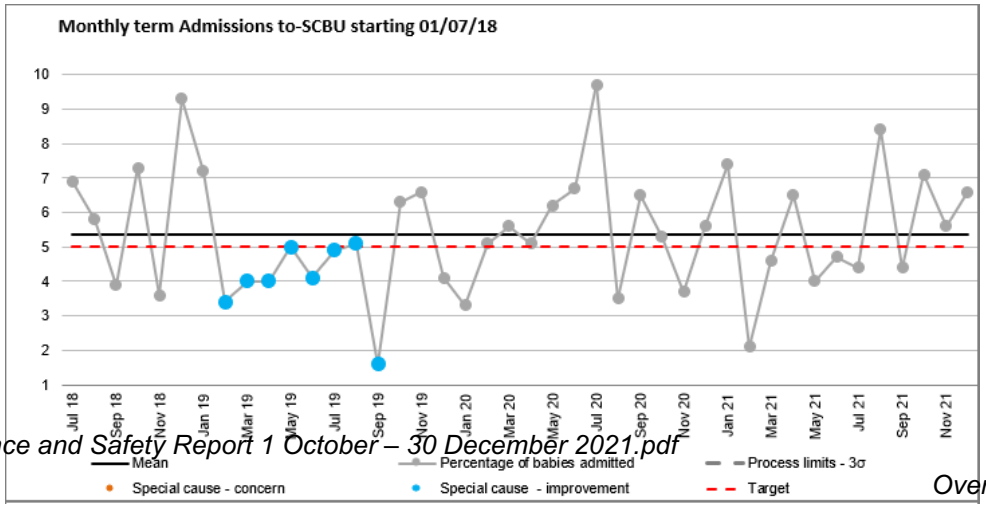


Avoiding Term Admissions into Neonatal Units – ATAIN

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

For this reporting period, 6.5% of term babies were admitted to the Special Care Baby Unit. This is an increase from the last reporting period and is above the target of 5% or less, but does not demonstrate a worrying trend as within expected quarterly range. This will continue to be monitored closely. See table 4 for monthly term admission to SCBU rate.

Table 4: Monthly Term Admission to SCBU Rate



As a service we are at the limits of what we can achieve in relation to this important safety and quality action. This is due to space and capacity issues within the clinical area. The estates strategy for the Women's Health Unit, which had been approved prior to the COVID-19 pandemic and was awaiting allocation of capital funding, includes provision of dedicated Transitional Care Facilities. This would enable us to continue our improvement journey to support the on-going care of babies with additional needs, but not requiring SCBU and ensuring mothers and babies are not separated. The team are in the process of refreshing the estates strategy.

Key Messages re Service user Feedback

From 1 October 2021 to 31 December 2021 we received 2 formal concerns and 2 informal concerns. Concerns related to care on the ante/postnatal ward, care in labour and the early postnatal period.

We have received 45 Friends & Family responses for this period. Of these 37 rated the service as very good and 8 rated it as good. The feedback that was received highlighted thorough, competent, respectful and dignified care. The ability to ask for advice, informative midwives, midwives taking note of women's wishes and women feeling listened to and supported. Positive home water birth experience, outstanding professionalism, exceptional care and medical support.

We have also received excellent feedback via social media with comments including:

"Incredible midwives that are currently under so much strain but I still had such a positive experience"

"The best delivery I have experienced out of my three - so encouraging and knowledgeable and not afraid to say what she thought would benefit me"

"We felt we had an amazing team behind us for the birth and my midwife at the surgery was great too. The midwives, the doc and our anaesthetist were all fantastic through our water birth and eventual c section"

Key Messages re staff feedback

Work is currently in progress to obtain real time staff feedback.
Staff are able to raise any concerns through a variety of mechanisms as described below in the Maternity Safety Champion section.

2.7 Maternity Safety Champions

The Maternity and Neonatal Safety Champions continue to meet monthly and are undertaking safety walkarounds with the Board Level Safety Champion (BLSC). These meetings and walkarounds aim to provide maternity & neonatal staff an opportunity to raise safety concerns which can be acted upon and escalated to the Board if necessary. The Non-Executive Director representing Maternity has also been able to attend a maternity walkaround and is scheduled to join the safety walkaround in January 2022.

Maternity & neonatal staff are also able to raise safety concerns anonymously through the safety boxes in situ in all clinical areas These are discussed at the monthly Maternity and Neonatal Safety Champion meeting, the minutes from these meetings are stored on shared drives accessible to all Maternity and Neonatal staff.

Recent concerns that have been raised and actions taken include:

- **Temperatures and ventilation within Women's Health Unit** – concerns raised by antenatal clinic regarding ventilation and temperature due to the aging fabric of the windows. The air conditioning in Women's Health Unit is being reviewed by the Estates Dept and new window mechanisms are being investigated.
- **Environment** – issues raised regarding the Estate especially on Delivery Suite. These are described on the Risk Register and escalated to the Estates Dept.
- **Triaging system within Day Assessment Unit** – Current triage processes within the maternity service could be improved to provide more effective and efficient prioritisation and flow. Triage processes within the Maternity Unit will be considered by a Task & Finish group. An audit will be undertaken to assess the current processes and potential improvements explored.

An internal Well Led Executive Evidence Review of Maternity Services was undertaken on 15 October 2021. Findings were that all standards were met other than medical staff being up to date with all mandatory training, to include safeguarding training. This was partially met due to challenges regarding doctors on rotation, with lack of clarity on mandatory training status of new doctors on arrival at the Trust. This is now being followed up centrally.

3 CNST: 10 Key Safety Actions

Year four of the Maternity Incentive Scheme launched on 9 August 2021. Achievement of all 10 of the safety actions will result in a rebate of part of the CNST contribution to the Trust. The new submission date is 30 June 2022.The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. The team have re-established the 'CNST' task and finish group in order to ensure achievement of the standards in year 4 and progress is monitored through the monthly Maternity Assurance Meeting.

A letter was sent to Trusts by NHS Resolution on 23 December 2021. In recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements relating to demonstrating achievement of the maternity incentive scheme (MIS) 10 safety actions are paused with immediate effect for a minimum of 3 months.

Trusts have been asked to continue to apply the principles of the 10 safety actions, due to the importance of the delivery of safer maternity care. Continuing principles should include: undertaking midwifery workforce reviews, ensuring that, as far as possible, oversight continues to be provided by the maternity, neonatal and board level safety champions continue, as well as the use of available on-line training resources.

Trusts need to continue to report to MBRRACE-UK and report eligible cases to the Health Safety Investigation Branch (HSIB). Every reasonable effort will be made to continue to make the Maternity Services Data Set submissions to NHS Digital.
The reporting period for MIS year 4 will be kept under review and may potentially be extended further by the MIS Collaborative Advisory Group (CAG) who will reconvene in February 2022.

4 COVID-19 Pandemic

The maternity team continue to maintain a full maternity service, following the NICE schedule of care during the Covid-19 pandemic. However, the service is facing increasing pressure to provide this due to staff absence from Covid sickness, isolation and sickness for other reasons. See section 5 Staffing.

The COVID-19 maternity plan is updated as necessary and whilst this is available on a shared drive for maternity staff at present, consideration is being given to publishing this on the Intranet.

We are continuing to see a rise in the number of pregnant women who have tested positive for COVID-19. Maternity staff provide up to date information and guidance at regular intervals during a woman's pregnancy on the benefits of covid vaccinations, to ensure women make an informed choice regarding uptake of the vaccinations for themselves.

We are working collaboratively with the Devon LMNS and the Maternity Voices Partnership to ensure that the system approach is equitable to families using maternity services and have now introduced pulse oximetry testing for pregnant women who have COVID-19. We continue to enable partners to attend with women for all scans, antenatal and postnatal appointments. Two birth partners are able to be present for labour and birth and one partner/supporter is able to visit on the antenatal & postnatal ward.

5 Staffing

The staffing levels throughout this reporting period have been extremely challenging and minimum safe staffing levels have been very hard to meet. This is due to a number of factors, including a rise in the level of sickness absence, in particular mental health symptoms, maternity leave, altered duties, and self-isolation requirements. The maternity service plans for a minimum of 9 midwives overall working on each shift on Delivery Suite and John Macpherson ward, this is comprised of a combination of community and hospital-based midwives. Throughout the period 1 October 2021 to 31 December 2021, the minimum staffing levels were achieved on 64.9% of the shifts, 35.1% of shifts were not staffed at the minimum levels. This was due to a combination of Covid-19 absence (both self-isolation and sickness), short term sickness, long term sickness, maternity leave and vacancy. Work is currently underway to actively recruit to vacant posts and ongoing support is being provided to staff to support them to return to work following sickness absence.

Colleagues have continued to be extremely flexibility and committed. However, both substantive and temporary staff are reporting high levels of fatigue, resulting in colleagues not being able to work additional shifts.

Mitigations

A number of actions have been taken to increase the level of staffing and mitigate the risks associated with not meeting the minimum recommended standards. This includes:

- Pausing mandatory training,
- Specialist midwives and managers working in clinical roles,
- Use of agency midwives and nurses, medical staff 'acting down'.
- Daily monitoring of staffing was put in place to ensure all actions were taken to maximise staffing levels.

The risk register was reviewed and score raised to a corporate level score, along with the risk being escalated to the Senior Leadership Team, including Executive and Non-Executive Safety Champions.

The Trust continues to recruit against revised baseline following funding uplift from Board in September. The current vacancy position is at 10.48wte, this is largely due to the uplift in establishment. Maternity services across the country are facing recruitment challenges at present, due to the nation-wide uplift in maternity staffing. Active recruitment processes are underway at TSDFT, this includes the development of a recruitment video advertising the benefits of working in the maternity service at TSDFT and promoting the local area as a place to live and work and involvement in Trust recruitment open days. We have also recruited a midwife on a 'Return To Practice' course and are investigating international recruitment.

6 Conclusion

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

7 Recommendations

The Trust Board of Directors are asked to:

- Note the progress and compliance position with regard to the priority areas
- Note the key quality and safety issues identified in the report and the mitigation in place
- Note progress and next steps with regard to the CNST process

Appendix 1: PCQS Minimum Dataset Information Summary

	October	November	December
Findings of review of all perinatal deaths using the real time data monitoring tool	Perinatal Mortality Review Tool (PMRT) completed for case 77807 within time frame.	PMRT completed for case 77439	PMRT in use
Findings of review all cases eligible for referral to HSIB. Report on: The number of incidents logged graded as moderate or above and what actions are being taken	**Incidents -** 4 Stillbirth of a Baby at 25+4 weeks gestation. Two Term Babies transferred to Level 3 NNU for active cooling -both cases did not fit the criteria for HSIB as the babies MRI scans were normal One family requested an HSIB investigation. One Mother admitted to ICU with sepsis following delivery. audit with Micro of four women with postdelivery infections undertaken.	**Incidents -1** Baby transferred for level 3 care at Great Ormond street with recurrent pneumothoraxes (collapse of the lung)	**Incidents** – 2 *Stillborn Baby at 26 weeks gestation
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	**Training -** 90-100% compliance	**Training –** 68-90% compliance	**Training** – 57%-100% compliance-
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.	Midwifery shifts 61.3% met minimum levels	Midwifery shifts 73.3% met minimum levels	Midwifery shifts 60.2% met minimum levels
Service User Voice feedback	Feedback mechanisms in place	Feedback mechanisms in place	Feedback mechanisms in place

Staff feedback from frontline champions and walk-abouts	Completed	Completed	Completed
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Nil	Nil	Nil
Coroner Reg 28 made directly to Trust	Nil	Nil	Nil
Progress in achievement of CNST 10	Full compliance with 10/10 standards	Year 4 standards launched.	CNST Task and Finish group re-established

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

Report to the Trust Board of Directors			
Report title: Building a Brighter Future Programme Update			**Meeting date:** 26th January 2022
Report appendix			
Report sponsor	Director of Transformation and Partnerships, SRO		
Report author	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**	16
Risk Register		**Risk score**	

BAF Risk – 11 To develop and implement the New Hospital Plan (Building a Brighter Future) ensuring that it meets the needs of the local population and 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 Programme Update		**Meeting date:** 26th January 2022
Report sponsor	Director of Transformation and Partnerships, SRO	
Report author	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. There is particular reference to the following aspects of the programme:

- Strategic Outline Case
- Digital Outline Business Case
- Confirmed 2021/22 'seed' allocation

The paper will also cover a brief update on other programme governance issues that continue to be managed by the programme office
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 were now only 2 amber rated criteria which have now also been resolved. The two tables below highlight the fundamental criteria areas have now been addressed.

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 was required confirm that the CCG is supportive of the requirement for the Trust to invest £20m of local capital with effect from 2025/26. This matter was 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
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.

At the Board Development meeting that took place on Wednesday 10th November, it was agreed that the Electronic Patient Record (EpR) element of the New Hospital Programme could be decoupled from the BBF business case process. Following this discussion, the Programme Director wrote to the Regional Delivery Lead to seek clarification on the potential requirement for the SOC to be redrafted to reflect a lower level of overall digital investment. Written feedback has not been provided. As soon as this written feedback is provided, the BBF programme office will inform the Trust Board of the advice being provided. However, based on informal feedback it is likely that the SOC will require a refresh before being submitted to the national team for review. Whilst this likelihood has been reflected in the programme office workplan over the next 3 months, we are not currently about to progress the resubmission of the SOC until the national team clarify the position.

3.0 Digital Outline Business Case

The draft Digital Outline Business Case was endorsed by the Trust Board at its extraordinary meeting on 15th December 2021 subject to a number of recommendations for further action.

Work continues to resolve sources of external funding that would allow this investment to proceed. Discussion with the Devon ICS are active and ongoing to ensure we have a consistent view on available funds and the scale of the gap. Further discussions with regional and national NHSX/NHP teams have been arranged to take place in January 2022 and it is likely that further meetings and discussions will be required to escalate this matter to a achieve satisfactory resolution.

Further work to finalise the OBC document is in hand and progressing well including:

- Subjecting the draft to a “critical friend review” by PWC which has been arranged to be completed in January 2022.
- Incorporating feedback from the initial fundamental criteria review meeting with the NHSEI regional team
- Incorporating feedback from the BBF Committee

Further work with the Devon ICS providers is in had to articulate the collective EPR solution(s) for the region and to agree a collective benefits case for shared EPR(s).

The BBF Programme Team is already looking ahead beyond OBC and planning and beginning the next phases of work relating to preparation for procurement and preparing for FBC development.

4.0 Confirmed seed allocation

Background - Following the approval from the BBF Committee, the original request for 'seed' funding was made to the New Hospital Programme (NHP) national team on 24th June 2021. This original request was for £13.94m (over a 2-year period) and would have addressed all the funding requirements for the development of the Outline Business Case (OBC) for the infrastructure element of the project.

The original funding request was broken down into the following:

- 2021/22 – £9.1m
- 2022/23 - £4.8m

Since this original application was made, the national team have been signalling that the next tranche of 'seed' allocation, would effectively only cover project team costs through to 31st March 2022. This approach was to ensure that all work with technical advisors on the development of infrastructure OBC's would not be able to commence until the national team had received confirmation from HM Treasury that their own programme business case had been approved. The national programme business case will set the overall NHP programme budget from January 2025 onwards, and will also set the timetable for the delivery of the phase 4 schemes within the programme. Torbay and South Devon NHS Foundation is within phase 4 of the programme.

In order to cover project team costs, the initial £3.7m funding resource for the delivery of the Strategic Outline Case was being extended as far as possible, however this would only be possible until the end of November 2021. As a result, the Trust Board agreed to fund the project team costs 'at risk' should the 'seed' allocation not be forthcoming by the end of November 2021.

In relation to the confirmed allocation for the remainder of 2021/22, an initial discussion took place with the NHP National team on 9th December with a further meeting on 14th December. The outcome being that the Trust agreed to a final settlement figure of £2.809m to the end of March 2022. The breakdown of this allocation is noted below: -

	Trust requirement
	£000's
April – November project costs	1,952
December – March project costs	755
- Less existing MOU already in place	-579
Further technical support	651
Total for 21/22 seed allocation release	2,809

It is important to note that this 'seed' allocation must be spent in this financial year and any underspends cannot be carried forward into 2022/23. Therefore, before any settlement was agreed the programme office undertook a detailed assessment of planned expenditure to ensure that the settlement figure can realistically be managed within this financial year.

It is also important to note that the £1.4m of carrying forward from 2020/21, that had originally been agreed by the Regional office has not be provided within the settlement for 2021/22. Therefore, the settlement for 2021/22 must cover this cost pressure. On that basis, the £651,000 of technical advisor support is the only additional element that the programme office has available to progress the project at the current time. Nonetheless it does now give the programme office to progress the business case that will be required for the site enabling works. This business case will be presented to the Trust Board in April 2022 and in order to deliver the requirement the technical adviser support budget will be fully utilised in the remainder of this financial year.

5.0 BBF Programme Group Update

Given the operational pressures that are ongoing within the Trust at the current time, the BBF programme group did not take place in December. However, this has provided the Programme Director and the Senior Responsible Officer with an opportunity to review the terms of reference of the Programme Group. Once this review, has been completed, the revised terms of the reference will be provided to the BBF committee for their review.

6.0 Visit from the Regional Delivery Lead

The Trust hosted a site visit on 23rd November by Chris Cale, Regional Delivery Lead, NHP. In addition to a site tour, this visit also involved separate discussions with the Chief Executive Officer, Chief Finance Officer, HIS Director, Senior Responsible Officer and Programme Director. The main objective of the visit was for the 'case for change' and the need for the investment in both infrastructure and digital to be made very clear to the Regional Delivery Lead. Following feedback from the discussions, it was clear that this objective was achieved.

It is also important to note that the Trust has been very clear that it will manage the programme within its overall allocation of £350 million. (and overall affordability of £370m.) This approach has been received very well at a national and regional level.

7.0 Conclusion

Members of the Trust Board are asked to note the contents of this report.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Outcome Paper: Healthwatch Devon community engagement survey relating to the disposal of the former Dartmouth and Kingswear Cottage Hospital site			Meeting date: 26th January 2022
Report appendix	Draft Feedback Report: Use of the former Dartmouth and Kingswear Cottage Hospital site. Healthwatch Devon		
Report sponsor	Deputy Chief Executive and Chief Finance Officer		
Report authors	Interim Director of Environment		
Report provenance	Trust Board 31.03.21. Trust Board 26.04.21 Trust Board 28.08.21		
Purpose of the report and key issues for consideration/decision	This report is submitted further to the disposal development reports considered and approved by the Trust Board in March 2021, April 2021 and August 2021. It describes the process adopted to establish what local people would like to see from any future development of the site of the former Dartmouth and Kingswear Cottage Hospital. Kevin Dixon, Chair of Healthwatch Devon leads the Dartmouth Hospital Stakeholder Engagement Group which is facilitated on behalf of the Trust by Chris Balch, Non-Executive Director. The Trust and Dartmouth Town Council commissioned Healthwatch Devon to undertake a public consultation exercise that concluded in December 2021. This paper summarises the draft findings from the consultation.		
Action required	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to note that the Healthwatch public survey has been completed and to note the outputs from this work.		
Summary of key elements			
Strategic objectives supported by this report	**Safe, quality care and best experience** x; **Valuing our workforce** x **Improved wellbeing through partnership** x; **Well-led** x		
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework** ; **Risk score** **Risk Register** ; **Risk score**		

External standards affected by this report and associated risks	

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

Significant reputational risk to both Trust and CCG in the event of not reaching a disposal conclusion that provides a level of social value to the community of Dartmouth and surrounding villages.

Risks of not securing the minimum financial return required and £1.4m capital for investment in the Dartmouth H&WBC in 2022

Report title: Outcome Paper: Healthwatch Devon community engagement survey relating to the disposal of the former Dartmouth and Kingswear Cottage Hospital site		**Meeting date:** 26th January 2022
Report sponsor	Deputy Chief Executive and Chief Finance Officer	
Report author	Interim Director of Environment	

1. Introduction

This paper describes the approach adopted by Healthwatch Devon to garner the views of the population of Dartmouth and its surrounding villages in terms of the future use of the former Dartmouth & Kingswear Community Hospital site. The paper includes the Draft Report from Healthwatch and summarises the findings from this work.

2. Background

The Trust ran a series of four Stakeholder Engagement sessions between July and December 2021 to ensure that the approach to the former hospital site disposal was both transparent and collaborative. Chaired by Kevin Dixon of Healthwatch Devon and facilitated by Chris Balch, Trust Non-Executive Director, the Stakeholder Group agreed that undertaking a public survey was the optimal approach to determine what residents wanted to see from the disposal of the former hospital site.

The survey ran from 8th November to 10th December 2021 and consisted of four questions asking people for their opinions and suggestions about the use of the site, two questions asking respondents how they would like to be contacted with updates about the redevelopment, plus nine optional questions collecting demographic information.

The survey was available both in a paper format and online and was promoted in local media, including radio interviews on Radio Devon with a Town Councillor and via social media. By the close of the survey period, 642 responses had been received.

3. Summary of Key Survey Findings

The full results from the survey are described in the attached Report. The key findings of the 642 respondents are identified as follows:

- When asked if they would want Dartmouth Town Council (DTC) to be involved in a community bid, 85% of respondents said yes and 15% said no. Respondents ranked homes for key workers and affordable homes for local people as the most preferable options for the use of the site. Accessible offices for Dart Harbour and Navigation Authority and meeting space to support marine activities were ranked as the least preferable.
- Alternative suggestions for the use of the site included the following: rehabilitation, convalescent, and care services; a minor injuries or urgent care centre; primary care services; community and social groups and services; using the site for commercial purposes or selling it; police services; and parking.

It is noted that the survey generally supports the Trust's approach to working collaboratively with DTC to identify whether DTC can achieve a credible bid for the former hospital site.

4. Recommendations/Decisions required by the Trust

The Trust Board is asked to note the outputs of the Healthwatch Survey.

healthwatch Devon

DRAFT Use of the former Dartmouth and Kingswear Cottage Hospital site

Feedback Report

February 2022

Contents

Introduction

Healthwatch in Devon, Plymouth, and Torbay is the health and social care champion for people using health and care services in Devon. Healthwatch listens to what people like about services and what could be improved. We make sure NHS leaders and other health and social care decision makers hear your voice and use your feedback to improve care.

Healthwatch was asked to assist Torbay and South Devon NHS Foundation Trust (the Trust) and Dartmouth Town Council in finding out what local people would like to see from any future development of the site of the former Dartmouth and Kingswear Cottage Hospital.

The NHS has been changing the way it provides health services, moving away from a reliance on hospital beds to provide more services in people's communities. Building work started in June on a new £4.8m Health and Wellbeing Centre in Dartmouth, which is due to open in late Summer 2022. Part of the funding for the new building will come from the sale or re-development of the former Dartmouth and Kingswear Cottage Hospital site, which closed in 2017. The Trust's board of directors recognised that it would not be cost-effective or within the NHS remit to develop the site, but considering the importance of the site to the community, agreed to explore how future development of the site could benefit the local community.

There are two options for the development of the site. Under **Plan A,** Dartmouth Town Council would like to buy the site and manage how it is developed, in partnership with other local stakeholders, so that both the local economy and community would benefit. If the Town Council is unable to secure funding to support a community bid for the site, the Trust will advertise it for sale on the open market in 2022, so that it has the funds needed by March 2023 to pay its share of the costs for the new Dartmouth Health and Wellbeing Centre **(Plan B**). The following survey was developed by the Trust and Dartmouth Town Council to find out whether community would support such a bid.

What we did

The survey was open from 8th November to 10th December 2021. The survey consisted of four questions asking people for their opinions and suggestions about the use of the site, two questions asking respondents how they would like to be contacted with updates about the redevelopment, plus nine optional questions collecting demographic information.

The Trust and Town Council established a task and finish stakeholder group, with representation from across the local community, to share thinking about development of the site, including plans to engage with the local community about what they would like included. Three stakeholder meetings were facilitated by Kevin Dixon, interim steering group lead for Healthwatch in Devon, Plymouth, and Torbay, between July and September 2021; another was held in January 2022 and further meetings will be held as appropriate, if the community bid proceeds. A membership list can be found in Appendix 3.

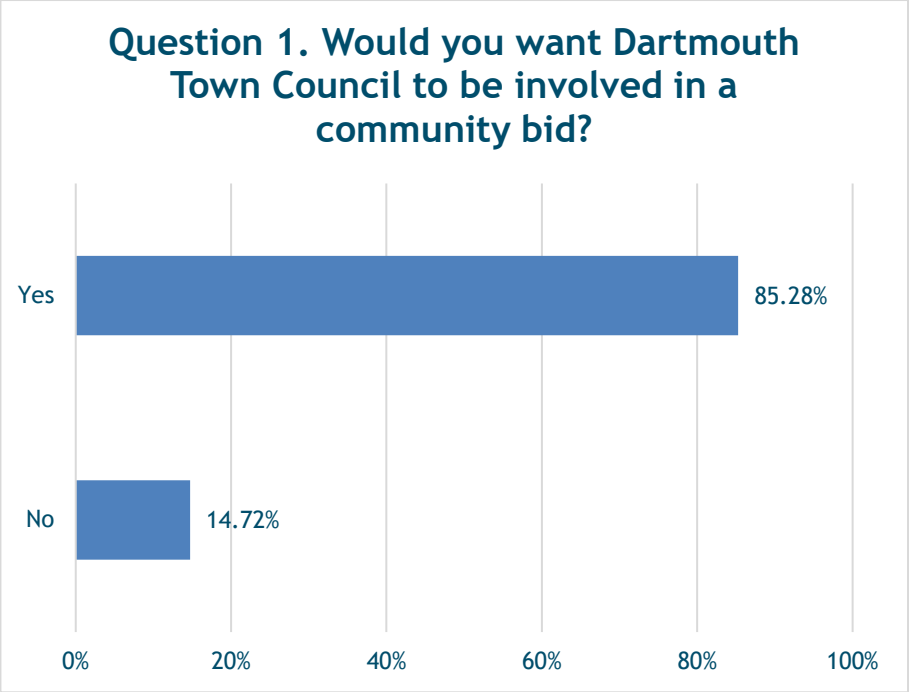
Respondents were able to complete the survey on paper or online. Paper surveys were made available at several locations in Dartmouth and the surrounding areas (see Appendix 1 for a full list). A flyer (Appendix 1) promoting the survey was distributed to 8,014 households in the Dartmouth and Kingswear area via Royal Mail. A news release was issued to local media and coverage featured in the Dartmouth Chronicle and on Radio Devon, incuding two interviews with Cllr Ged Yardy during the course of the survey. The engagement plan was shared with Dartmouth Town Council and the Trust board as well as its governors. The local MP was kept informed. The survey was also promoted using social media (see Appendix 2 for an example). 642 respondents completed the survey. 528 people completed the survey online and 114 people completed a paper survey.

Key findings

- 642 people responded to the survey. 85% lived in the TQ6 area, and 70% of respondents were over 55. Of the respondents who did not live in TQ6, 90% lived in surrounding TQ areas.
- When asked if they would want Dartmouth Town Council to be involved in a community bid, 85% of respondents said yes and 15% said no.
- Respondents who did not want Dartmouth Town Council to be involved in a bid gave the following reasons: lack of confidence in the council's judgement, expertise, or ability to manage such a project; the belief that council resources should not be used or that council tax will increase because of the bid; lack of trust that the council will act in the best interests of the community; belief that the bid should be handled by another organisation; and the belief that the hospital should instead be sold on the open market.
- Respondents ranked *homes for key workers* and *affordable homes for local people* as the most preferable options for the use of the site. *Accessible offices for Dart Harbour and Navigation Authority* and *meeting space to support marine activities* were ranked as the least preferable. There were no notable differences between the preferences of those 55 and under and those over 55.
- Alternative suggestions for the use of the site included the following: rehabilitation, convalescent, and care services; a minor injuries or urgent care centre; primary care services; community and social groups and services; using the site for commercial purposes or selling it; police services; and parking.

Detailed findings

Question 1. If a community bid is put forward, as outlined above, would you want Dartmouth Town Council to be involved in this?



618 respondents answered this question and 24 respondents did not. 85.28% of respondents (527 people) answered yes and 14.72% (91 people) answered no.

Question 2. If you answered "no" to the previous question, what are your reasons for giving this answer?

99 respondents answered this question and 543 did not. Some people who answered "yes" to question 1 also used this question to share their reservations and concerns. The most common reason (54 comments) was a lack of confidence in the council's judgement, expertise, or ability to manage such a project. Other reasons included financial concerns (e.g. the belief that council tax may increase because of a bid, or that council resources should not be used; 14 comments), a lack of trust that the council will act in the best interests of the community (13 comments), a belief that the project would be better handled by another organisation (seven comments), or preferring that the site be sold (seven comments).

Confidence in council's ability or expertise (54 comments)

- "I don't think they are capable of dealing with it. No confidence."
- "Too big a project for [Dartmouth Town Council]. Cost of demolition and redevelopment will be far beyond DTC funding/management/marketing skills."

Financial concerns (14 comments)

- "Council tax has increased dramatically. I fear this will add to these increases."
- "Councils are already financially [strained] and this will be an added burden."

Belief that council will not act in community's interests (13 comments)

- "Lack of trust that it would benefit local people."
- "Not sure they would have the best interests of the community and local residents at heart over financial gain."

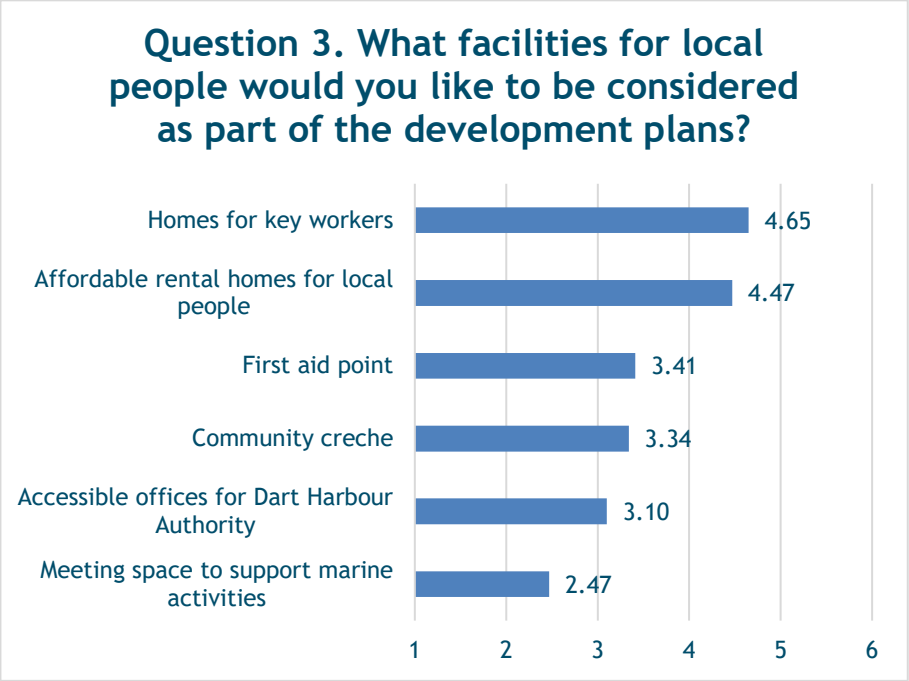
Belief the bid should be handled by another organisation (seven comments)

- "I would support DTC in encouraging and facilitating development by others."
- "Exceeds role and remit of a parish council."

Prefer the site to be sold (seven comments)

- "I really think that prime development land should be sold and the funds used for the community rather than this site used for the community."
- "The site needs to be sold to help with [the] payment of [the] new medical centre."

Question 3. What facilities for local people would you like to be considered as part of the development plans?



580 respondents answered this question and 62 did not. The six potential options that were suggested to respondents are ranked below in order of importance.

1. **Homes for "key workers" such as teachers, nurses and social workers (average rating: 4.65/6).** Of the 536 respondents who provided a ranking for this option, 39.55% (212 people) ranked it as their most preferable choice and 6.90% (37 people) ranked it as their least preferable choice.
2. **Affordable rental homes for local people (average rating: 4.47/6).** Of the 533 respondents who provided a ranking for this option, 31.89% (170 people) ranked it as their most preferable choice and 8.26% (44 people) ranked it as their least preferable choice.
3. **First aid point during summer and festivals (average rating: 3.41/6).** Of the 515 respondents who provided a ranking for this option, 11.26% (58 people) ranked it as their first choice and 15.34% (79 people) ranked it as their least preferable choice.
4. **Community creche (average rating: 3.34/6).** Of the 499 respondents who provided a ranking for this option, 5.01% (25 people) ranked it as their most preferable choice and 10.22% (51 people) ranked it as their least preferable choice.
5. **Accessible offices for the Dart Harbour and Navigation Authority and facilities for mariners (average rating: 3.10/6).** Of the 487 respondents who provided a ranking for this option, 12.73% (62 people) ranked it as their most preferable choice and 20.53% (100 people) ranked it as their least preferable choice.
6. **Meeting space to support marine activities such as training and education (average rating: 2.47/6).** Of the 481 respondents who provided a ranking for this option, 5.41% (26 people) ranked it as their most preferable choice and 34.30% (165 people) ranked it as their least preferable choice.

35 respondents who completed paper questionnaires ticked or circled the facilities they would like to be considered but did not rank the options. The number of respondents that ticked or circled each option is listed below in brackets. The preferences of these 35 respondents does not differ notably from the rank order of the 580 respondents who ranked the options.

1. **Affordable homes for local people (28 respondents)**
2. **Homes for key workers (25 respondents)**
3. **First aid point during summer and festivals (21 respondents)**
4. **Community creche (12 respondents)**
5. **Meeting space to support marine activities (nine respondents)**
6. **Accessible offices for Dart Harbour and Navigation Authority (seven respondents)**

Question 4. Do you have any other suggestions for the use of the site?

361 respondents answered this question and 281 did not. Health and social care services were the most commonly suggested, particularly rehabilitation and care (87 respondents), minor injuries or urgent treatment (70 respondents), and primary care (19 respondents). 21 respondents suggested health and wellbeing services but did not specify which. Eight respondents had other suggestions, including an ambulance or paramedic base, or physiotherapy clinics. 60 respondents said they would like the site to be used for community purposes, e.g. social and support groups, information, education, or leisure activities. 56 respondents said they wanted the site to be sold or used for commercial purposes, e.g. hospitality and tourism, small business space, banking, or for-profit housing. 46 respondents wanted the space to be used for housing that was affordable or limited to key workers and permanent residents (i.e. not holiday lets or second homes). 18 respondents wanted police services to be available from the space and 12 respondents suggested it could be used for parking.

Health and social care services

Rehabiliation, convalescence, and care (87 comments)

- "Convalescent beds to relieve pressure on Torbay Hospital."
- "A place for people who are in our main hospitals waiting to go home."
- "Care provision in [the] lower town."
- "Respite and day care for the elderly."

Minor injuries/urgent treatment centre (70 comments)

- "Having an on-the-spot accident centre would be invaluable to the people of Dartmouth because of the type of activities that go on here and considering the problem of using the ferry to get to the other side of the river and on towards Torbay Hospital."
- "Out-of-hours emergency services that are this side of the river and are closer than [a] one hour's drive away."

General (21 comments)

- "As a hospital."
- "Other pop-up health and wellbeing clinics."

Primary care (19 comments)

- "Provision of primary care in [the] lower town for an increasing number of older age ranges."
- "I would like Dartmouth Medical Centre to conduct satellite clinics on that site."

Other (8 comments)

- "Physiotherapy day centre."
- "Base for paramedics [and] local ambulance."
- "Psychiatric follow up."

Community and social use (60 comments)

- "A community hub for senior citizens."
- "[A] memory café for those with dementia, or disabled [people] who don't get much opportunity to get out for social engagement. A drop-in training centre for all ages, whether computer skills, DIY skills, educational, or other."
- "Space for wellbeing activities for young and old."
- "A Dartmouth club with café, games rooms, youth club, relaxation areas for quiet or conversation, for use by local village residents."
- "Drop-in centre for parents to be supported."
- "I would like to see a focus on youth facilities for this site. These might include climbing, skateboarding, art, music, table sports, sociable space, etc."

Sell or use for commercial purposes (56 comments)

- "Boost the local economy and employment prospects with business start up space, hot desking and meeting space."
- "A good option would have been that the Trust sells the property for the very highest price to a developer or whoever, and undertake to put the money into providing more beds in Torbay."
- "Restaurant or bar in the commercial part, given its waterfront location and lovely views."
- "Provision of an area where several banks could offer banking facilities on a shared basis as Dartmouth is devoid of these."

Affordable accommodation e.g. for locals and keyworkers (46 comments)

- "Affordable homes for older people."
- "Low cost rent for key workers would be essential, those key workers should be long-term residents, local families living here for more than five years."
- "Affordable homes for local young people would be the best idea. They are currently priced out of the market and can only buy if they have wealthy parents to help them."
- "I would like a possible work place accommodation scheme, providing you work in the town from outside the area then you qualify for a living space. People who want to come and work here have no available accommodation; businesses need staff due to a major shortfall."

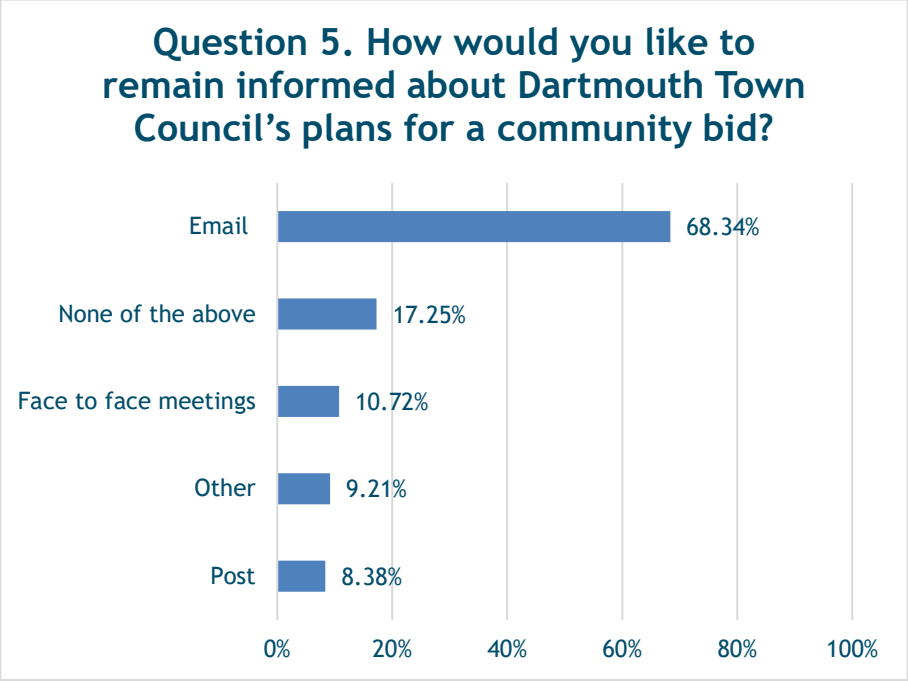
Police services (18 comments)

- "A local police office to be re-established in Dartmouth."
- "We could also have the police service back. Perhaps they can be there to help the forever growing community."

Parking (12 comments)

- "Car park. I may then get to go into town a bit more."
- "Parking for key workers and carers who travel to Dartmouth to work."

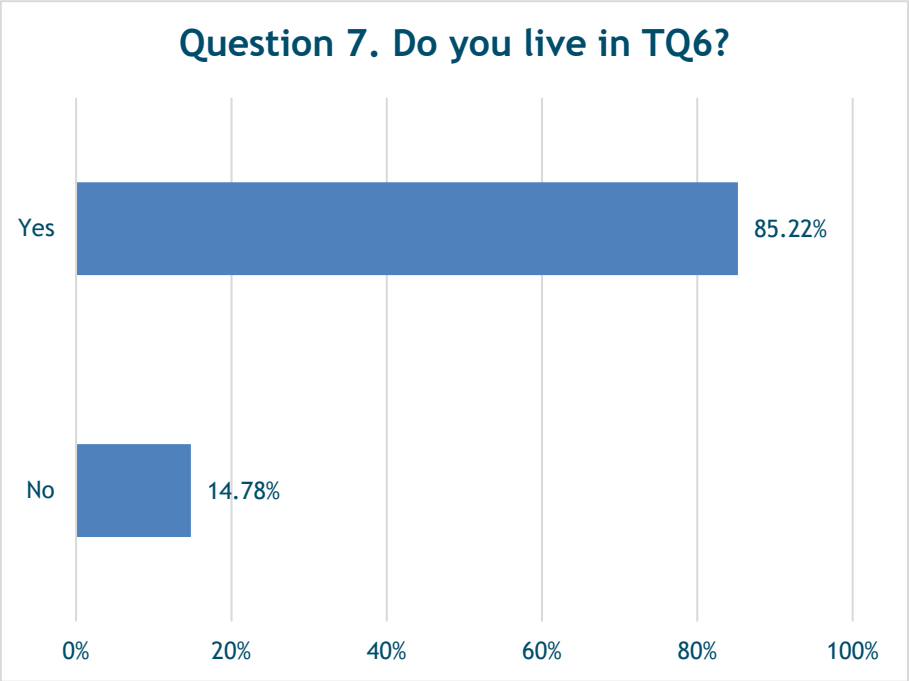
Question 5. How would you like to remain informed and engaged about Dartmouth Town Council's plans for a community bid for the hospital site?



597 respondents answered this question and 45 did not. As respondents could select more than one answer, percentages may total greater than 100. 68.34% of respondents (408 people) wished to be contacted by email, 17.25% (103 people) selected "none of the above," 10.72% wanted face-to-face meetings, and 8.38% (50 people) wanted to be contacted via post. 9.21% of respondents (55 people) selected other. Of those respondents, 23 people said they would like to be updated via local news (e.g. Dartmouth Chronicle or ITV Spotlight), 16 people wanted to be updated via social media or websites (e.g. Facebook, or the Dartmouth Town Council website), five people wanted to be updated via newsletters or noticeboards, four people wanted to be updated via community groups or forums, and two people wanted to be contacted via phone. 11 respondents who selected "other" did not name another form of communication.

Demographics information

Question 7. Do you live in TQ6?



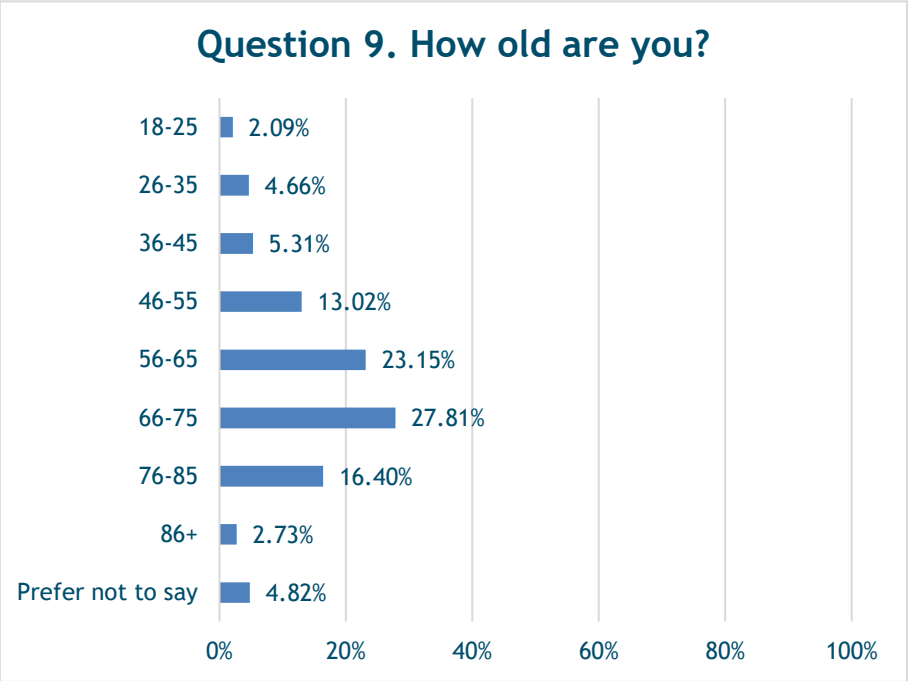
636 respondents answered this question and six did not. 85.22% of respondents (542 people) answered yes and 14.78% (94 people) answered no.

Question 8. If you do not live in TQ6, what is the first part of your postcode?

Only respondents who answered "no" to the previous question have been included in this analysis; of those respondents, 90 answered this question and 4 did not. The postcodes are listed below, with the number of respondents in brackets. Two respondents gave postcodes that were unclear or non-existent.

- **Inside TQ (81)**
  - TQ9 (57)
  - TQ7 (8)
  - TQ5 (5)
  - TQ3 (4)
  - TQ12 (3)
  - TQ1 (2)
  - TQ2 (1)
  - TQ4 (1)
- **Outside TQ (7)**
  - EX1 (1)
  - B73 (1)
  - GL5 (1)
  - SW16 (1)
  - PL4 (1)
  - PO13 (1)
  - CF3 (1)
- Unclear/non-existent (2)

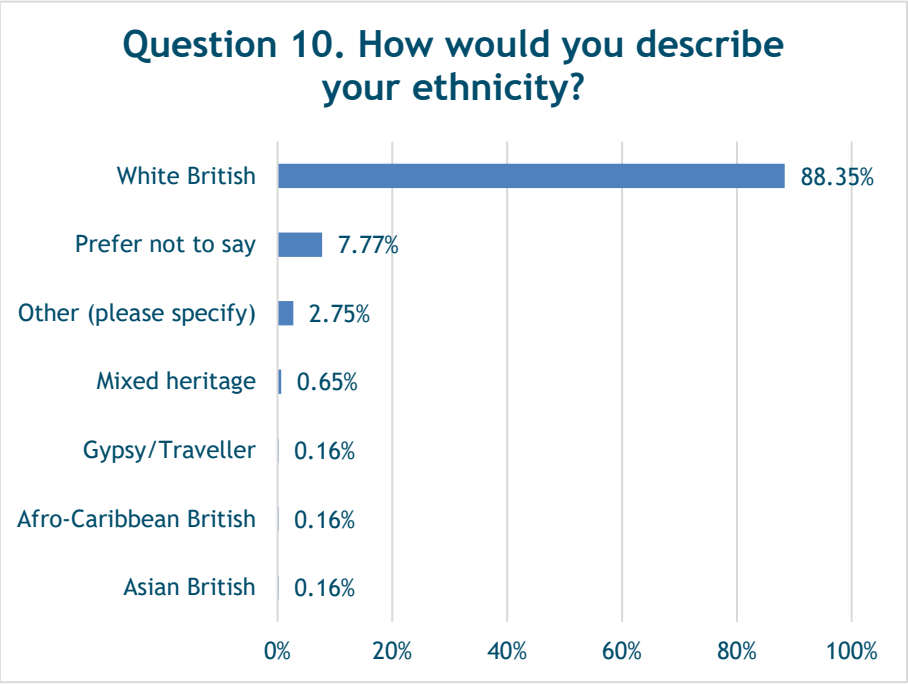
Question 9. How old are you?



622 respondents answered this question and 20 did not. 2.09% of respondents (13 people) were aged 18 to 25, 4.66% (29 people) were aged 26 to 35, 5.31% (33 people) were aged 36 to 45, 13.02% (81 people) were aged 46 to 55, 23.15% (144 people) were aged 56 to 65, 27.81% (173 people) were aged 66 to 75, 16.40% (102 people) were aged 76 to 85, 2.73% (17 people) were aged over 86, and 4.82% (30 people) selected "prefer not to say." None of the respondents were under 18.

According to data from Devon County Council, the Dartmouth area (including Dartmouth, Blackawton, Dittisham, Kingswear, Stoke Fleming, and Strete) has a population of 9,312. 50.76% (4,727 people) are under 55 and 49.24% (4,585 people) are over 55.

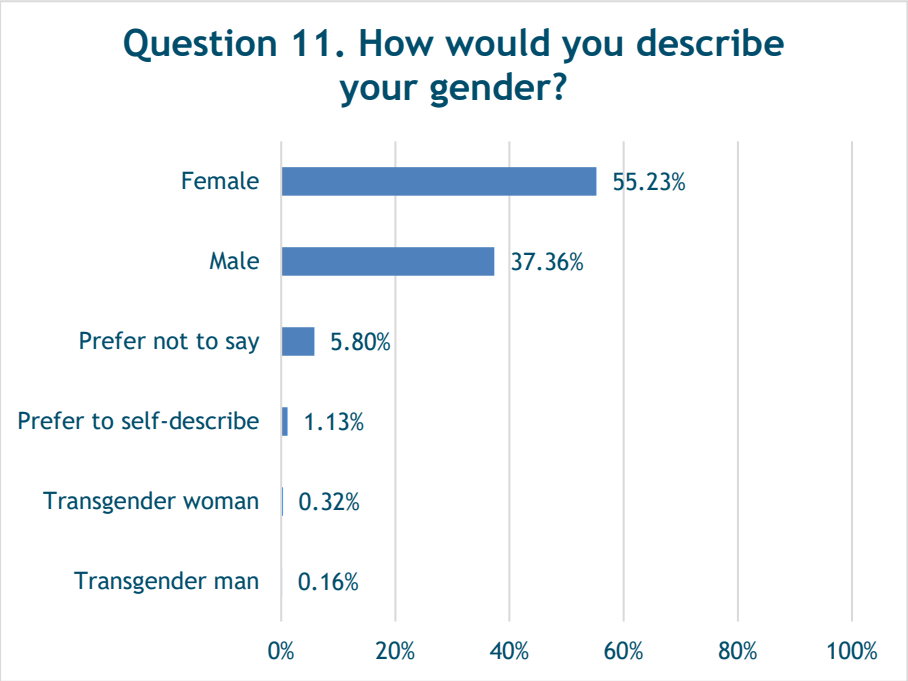
Question 10. How would you describe your ethnicity?



618 respondents answered this question and 24 did not. 88.35% (546 people) were White British, 0.65% (four people) were of mixed heritage, 0.16% (one person) was Asian British, 0.16% (one person) was Afro-Caribbean British, and 0.16% (one person) was a Gypsy/Traveller. 7.77% (48 people) selected “prefer not to say” and 2.75% (17 people) selected “other.” Of the respondents who selected other, three said they were “White European,” and one respondent each described themselves as “White,” “White English,” “African (White),” “White Caribbean,” “Persian,” “New Zealander,” and “Devonian.” The other seven respondents criticised the question as irrelevant and did not provide an answer.

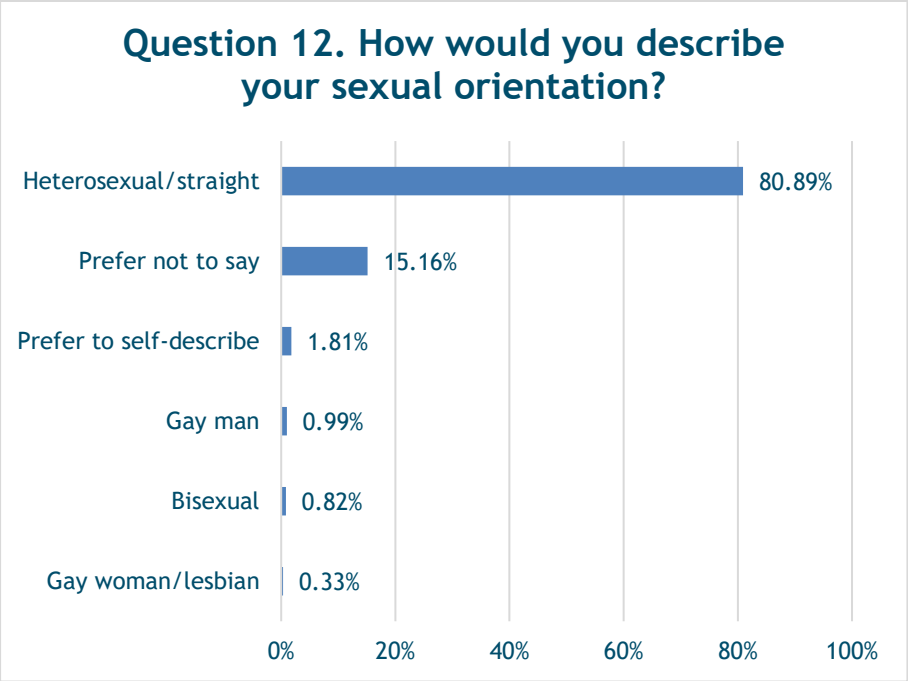
According to data from the Office for National Statistics, the population of the South Hams District Council area is 98.37% White, 0.79% from mixed or multiple ethnic groups, 0.55% Asian, 0.15% Black, and 0.15% “other.”

Question 11. How would you describe your gender?



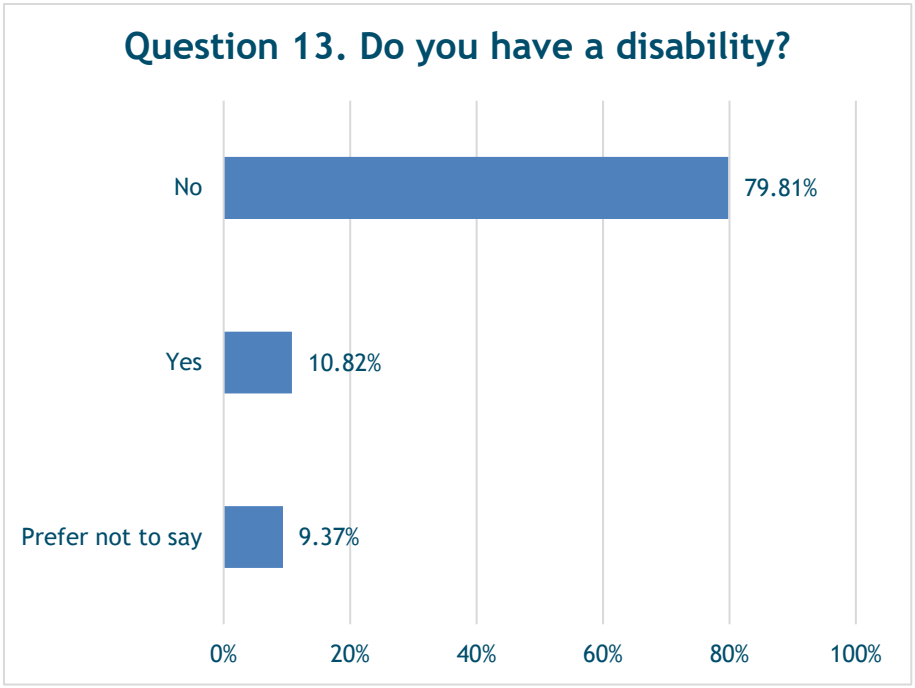
621 respondents answered this question and 21 did not. 55.23% (343 people) were female, 37.36% (232 people) were male, 0.32% (two people) were transgender women, and 0.16% (one person) was a transgender man. 5.80% (36 people) selected “prefer not to say” and 1.13% (seven people) selected “prefer to self-describe.” Of the respondents who preferred to self-describe, one said they were female and the other six criticised the question as irrelevant.

Question 12. How would you describe your sexual orientation?



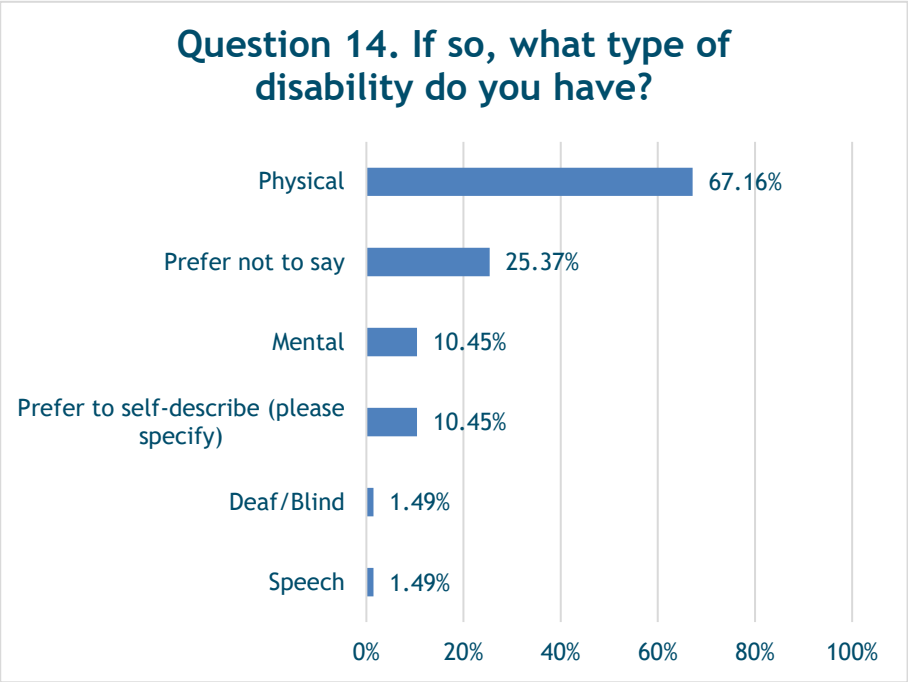
607 respondents answered this question and 35 respondents did not. 80.89% of respondents (491 people) were heterosexual/straight, 0.99% (six people) were gay men, 0.825 (five people) were bisexual, and 0.33% (two people) gay women/lesbians. 15.16% (92 people) selected “prefer not to say,” and 1.81% (11 people) selected “prefer to self-describe.” Of the respondents who preferred to self-describe, none provided an answer and all but one criticised the question as irrelevant.

Question 13. Do you have a disability?



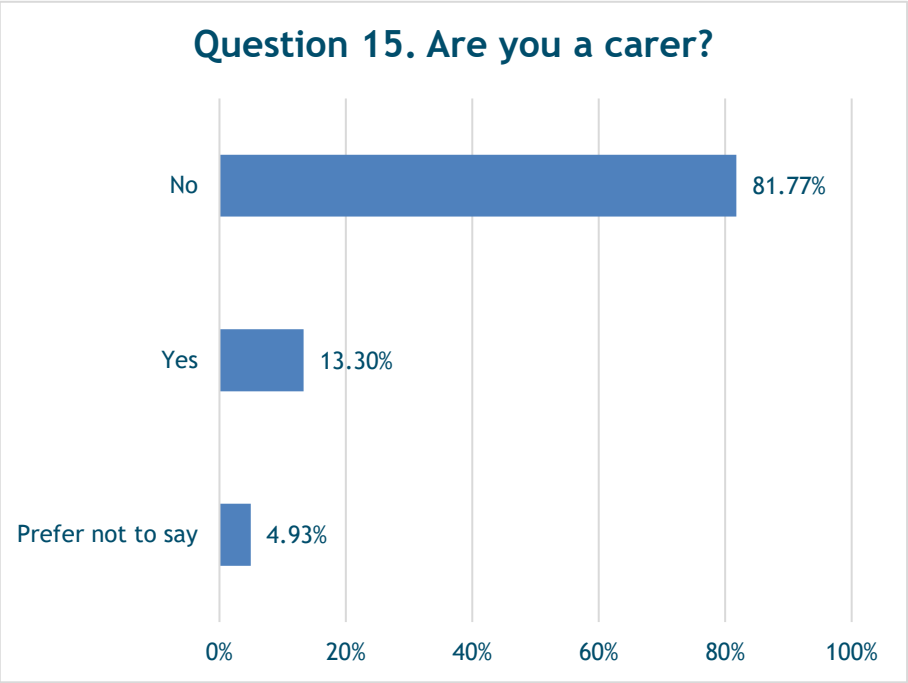
619 respondents answered this question and 23 did no. 79.81% of respondents (494 people) did not have a disability, 10.82% (67 people) had a disability, and 9.37% (58 people) selected “prefer not to say.”

Question 14. If so, what type of disability do you have?



Only respondents who answered "yes" to the previous question have been included in this analysis; of those respondents, 67 answered this question. As respondents could select more than one answer, percentages may total greater than 100. 67.16% (45 people) had a physical disability, 10.45% (seven people) had a mental disability, 1.49% (one person) was Deaf/Blind, and 1.49% (one person) had a speech disability. 25.37% (17 people) selected "prefer not to say" and 10.45% (seven people) selected "prefer to self describe." Of the seven respondents who preferred to self-describe, two had heart and lung diseases, one had Parkinson's, one had osteoarthritis and fibromyalgia, one had hearing difficulties, one had ADHD, and one described their disability as "extreme old age."

Question 15. Are you a carer?



609 respondents answered this question and 33 did not. 81.77% of respondents (498 people) answered no, 13.30% (81 people) answered yes, and 4.93% (30 people) selected "prefer not to say."

Statement from [name]

Recognition

Healthwatch in Devon, Plymouth, & Torbay would like to thank all the people who took the time to complete the survey and give their feedback. We would also like to thank the Torbay and South Devon NHS Foundation Trust, Dartmouth Town Council, and local community and voluntary sector groups for their support in distributing the survey in the local area.

Appendix

Appendix 1. Flyer promoting the survey distributed by post

Paper copies of the survey can be collected from the following locations:

Blackawton Community Shop	Main Street, Blackawton, Totnes, TQ9 7BG
BP Garage Post Office	Townstal Road, Dartmouth, TQ6 9LW
Church of St Thomas of Canterbury	Church Hill, Kingswear, TQ6 0BX
Dartmouth Clinic	2 Mayor's Avenue, Dartmouth, TQ6 9NF
Dartmouth Medical Practice	35 Victoria Road, Dartmouth, TQ6 9RT
Dartmouth Town Council	The Guildhall, Victoria Road, Dartmouth, TQ6 9RY
Dittisham Post Office	The Level, Dittisham, Dartmouth, TQ6 0ES
Flavel Library	The Flavel Arts Centre, Flavel Place, Dartmouth, TQ6 9ND
Stoke Fleming Village Hall	Dartmouth Road, Stoke Fleming, TQ6 0QT
The Hunters Lodge Inn	Cornworthy, Totnes, TQ9 7ES
The Village Shop	Strete, TQ6 0RW
Townstal Spar	1 Mayflower Close, Townstal Crescent, Dartmouth, TQ6 9JP

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Appendix 2. A Healthwatch Devon Facebook post promoting the survey

Healthwatch Devon
17 November 2021 ·

Share your views!

Torbay and South Devon NHS Foundation Trust and Dartmouth Town Council are working together to explore whether the community can buy the former Dartmouth Hospital site, and whether its redevelopment could include uses specifically to benefit people in and around Dartmouth.

They now want to hear about what new facilities local people would like to see on the site.

Find out more at: https://healthwatchdevon.co.uk/.../nhs-and-local-council.../

Appendix 3. List of stakeholder group invitees

Stakeholder group (attendance at each meeting varied; the following is the complete list of invitees to the workshop in January 2022)

Key stakeholder group (re-development of former Dartmouth and Kingswear Hospital)	
Devon County Council/South Hams District Council	Cllr Jonathan Hawkins
Dartmouth Town Council	Cllr Ged Yardy
Governors & Trust members	Craig Davidson, Mary Lewis Jonathan Shribman
Dartmouth Medical Practice Patient Participation Group (PPG)	Dave Cawley
League of Friends	Carol Lingard
South Hams District Council	Cllr Hilary Bastone
Dartmouth Business Club	Jonathan Sutton
Dartmouth Neighbourhood Plan	Robert Brooke, Tony Tudor, Paul Talbot
Dartmouth Together	Trustees asked to nominate a representative
Dartmouth Trust	Manager
Dartmouth and Kingswear Society	Robert Brook
Commissioners (CCG)	Jenny Turner
Torbay and South Devon NHS FT representatives	Chris Balch, Non-Executive Director; Adrien Cooper, Director of Environment; Helen Elkington, Associate Director, Strategic Estates Development; Corinne Farrell, Head of Communications
The Trust's strategic estates partner: gbpartnerships (advisory role)	Ian Tuddenham, Darrel Coltrini

TQ6	Wendy Price
Dartmouth United Charities	Jill Cawley
Dartmouth Museum	Brian Parker
Dart Harbour Authority	Capt Geoff Holland, Rob Everitt, Tim Dewing
School Governor/PTA rep	Nic Perrott
South Hams District Council equality & diversity rep	None nominated

Contact us

healthwatch Devon

Jan Cutting Healthy Living Centre
Scott Business Park
Beacon Park Road
Plymouth
PL2 2PQ

www.healthwatchdevon.co.uk
t: 0800 520 0640 (Freephone)
e: info@healthwatchdevon.co.uk
tw: @HwDevon
fb: facebook.com/healthwatchdevon

healthwatch Plymouth

Jan Cutting Healthy Living Centre
Scott Business Park
Beacon Park Road
Plymouth
PL2 2PQ

www.healthwatchplymouth.co.uk
t: 0800 520 0640 (Freephone)
e: info@healthwatchplymouth.co.uk
tw: @HealthwatchPlym
fb:facebook.com/HealthwatchPlymouth

healthwatch Torbay

Room 17
Paignton Library
Great Western Road
Paignton
TQ4 5AG

www.healthwatchtorbay.org.uk
t: 08000 520 029 (Freephone)
e: info@healthwatchtorbay.org.uk
tw: @HWTorbay
fb: facebook.com/HealthwatchTorbay
Registered Charity No: 1153450

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Dartmouth Neighbourhood Plan – Trust 2nd Response			**Meeting date:** 26th January 2022
Report appendix	Dartmouth Neighbourhood Plan DRAFT 03.12.21.		
Report sponsor	Deputy Chief Executive and Chief Finance Officer		
Report author	Interim Director of Environment and Chris Balch, Non-Executive Director		
Report provenance	Trust Executives		
Purpose of the report and key issues for consideration/decision	To appraise the Board of the revised Dartmouth Neighbourhood Plan Consultation document and to share a recommended response.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	To note and approve the Trust's response to the latest draft of the Dartmouth Neighbourhood 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**	**x**
NHS Improvement		**Legislation**	**x**
NHS England		**National policy/guidance**	**x**

Report title: Dartmouth Neighbourhood Plan – Trust 2nd Response		**Meeting date:** 26th January 2021
Report sponsor	Deputy Chief Executive and Chief Finance Officer	
Report author	Interim Director of Environment and Chris Balch, Non-Executive Director	

1. Introduction & Background

At the extraordinary Trust Board on 1st September 2021, the Trust Board was appraised of the Draft Dartmouth Neighbourhood Plan and the proposed Trust response to that plan.

The Dartmouth Neighbourhood Plan working group have incorporated our initial response in a subsequent revision. Chris Balch, Non-Executive Director has reviewed the latest version on behalf of the Trust.

The neighbourhood plan will ultimately sit alongside the Plymouth and South West Devon Joint Local Plan adopted by South Hams District Council. Decisions on planning applications will be made using both the local plan and the neighbourhood plan, and any other material considerations.

This paper describes the key considerations made within the latest version of the neighbourhood plan and sets out the proposed Trust response. The Trust's response to the draft is important, as neighbourhood plans can start to impact on planning decisions even before they have been fully adopted.

2. Key Considerations and Proposed Response

Following review of the updated document, it is clear that a number of key concerns remain within the Dartmouth Neighbourhood Plan, as follows:

- The Plan continues to describe a need for health and care facilities in the Lower Town when the Trust plan is to move services to Townstal in the Upper Town.
- The former hospital site is still described in an area of the town earmarked as the primary and secondary shopping area of Dartmouth.
- The old section of the former hospital is included as a local non-designated heritage asset, despite no reference to the Trust as freeholder nor evidence of discussion with English Heritage.
- The description and requirements of health care provision are inconsistent with both the Trust and Devon Clinical Commissioning Group (CCG) strategies.
- The Plan continues to be at odds with the Trust's approach to disposal and if adopted in its current form, could constrain the organisation in terms of the options for disposal and development.

Given the strategic importance placed on a Neighbourhood Plan, it is clear that the concerns identified could have ramifications for the Trust and its ambitions in Dartmouth, both in terms of health care provision and disposal of the former hospital site. The narrative within Appendix One is proposed as the Trust's response.

3. Recommendations

The Trust Board is asked to note the continued concerns in relation to the redrafted Dartmouth Neighbourhood Plan and endorse the recommended response.

Appendix One:

Draft Response to the Neighbourhood Plan

1. It is noted that the DNP highlights the problems of traffic and parking in Lower Town as a major issue – through the SWOT analysis, survey finding, business survey and PBA report on the town centre. This seems to support the decision to locate the Health and Wellbeing Centre (H&WBC) in Upper Town. This is noted as being served by a half hourly bus service between Lower and Upper Town as well as a 20-minute park and ride bus service between April and October. However, the current Draft Reg 15 document seems to argue for replicating health and care facilities in the Lower Town despite the acknowledged access difficulties in this location.

2. It is suggested that the following rewording of 5.8.1 and 5.8.2 in adopted from sentence 3. This is in order to present up to date and forward-looking evidence of health provision in the NP area.

   'Following the creation of Torbay and South Devon NHS Foundation Trust (TSDNHSFT) as an integrated care organisation combining acute and community services, a new model of care has been developed which seeks to support individuals as close to their home as possible. A consultation led by South Devon CCG in 2016 (check date) resulted in the decision to close Dartmouth Cottage Hospital and strengthen community provision.

   At the moment, TSDNHSFT provides a limited range of services in the Dartmouth Clinic in the centre of town at Zion Place and two intermediate care beds are commissioned from the beacon Park care home. There are also two pharmacies operating in the centre of town. A new £4.8m H&WBC is under construction on the park and ride overflow car park at the top of the town; this is due for completion in late summer 2022. This will house the Dartmouth Medical Centre (GP Practice), services provided by TSDNHSFT, Dartmouth Caring's voluntary operations, a retail pharmacy and a cafe. This will help secure greater integration of health services locally as envisaged by the model of care. However, residents will continue to need to travel for minor injuries (Totnes – currently temporarily closed due to Covid -19 pressures), urgent treatment (Newton Abbot) and accident and emergency (Torbay Hospital). The town is served by an existing Ambulance Station and Devon Air Ambulance can land at Coronation Park. Devon CCG is currently undertaking a review of minor injury provision across its footprint. Currently the Dartmouth GP practice is commissioned to provide a limited service which is not well publicised and access to urgent and emergency care remains a concern for residents given the relative inaccessibility of the town.'

3. Policy DNP EC4 Support for the primary and secondary shopping area of Dartmouth

It is noted that this includes the former hospital within the primary shopping frontage where policy seeks to retain business and retail uses, including restaurants and cafes. It is difficult to understand the justification for this as the hospital is flanked by residential properties which result in a substantial gap in active frontages. At the most the frontage should be considered as secondary, if included in the shopping area at all.

4. Section 6.3.3 sets out an aspiration for the transport study of Dartmouth which is supported by the Trust particularly as point d) highlights 'measures to improve regular bus services linking Lower and Upper Town with the park and ride and H&WBC.' This is seen as a pragmatic approach to ensuring that there is good accessibility to the H&WBC for all residents rather than seeking to replicate facilities in the Lower Town which is considered both unnecessary and very difficult to deliver.

5. Section 6.4.5 - Policy DNP TE3 Other designated heritage assets. It is noted that the old section of the former hospital is included as a local non-designated heritage asset. Has there been any specific consultation with the Trust as owner on this point? We are not aware of any or of the criteria used to identify the hospital as a non-designated heritage asset? Have Historic England been consulted on the proposed list?

6. Policy DNP TE4 Respect, protection and enhancement of civic spaces. Noted that this includes South Embankment which fronts the former hospital where improvements in public realm will be sought.

7. Policy DNP TE5 – Is the former hospital included in the Appendix referred to where intensification or redevelopment will be favourably looked at? It is not clear from the information provided. It is considered that the former hospital should be on this list.

8. Section 6.6.2 Health Facilities This is the main section of concern which deals specifically with health facilities. It is felt that the narrative is not up to date and presents a backward-looking view of health provision in the town and sets unrealistic expectations. The following wording is put forward as a clearer basis for the subsequent policy.

   'Health facilities in the plan area will need to enable the delivery of services to meet the needs of the expected increase in population over the plan period including the new West Dart neighbourhood. In addition, by 2030 there is expected to be a 37% increase in people aged over 75 in the South Hams (it would be better to include more local projections if they are available) resulting in increased health and social care needs.

   To meet the growing demand within human resource and financial constraints the NHS at national, system (Devon) and local level are developing/have developed Long Term Plans for the way in which services are delivered. Following its creation as the country's first

integrated care Trust, TSDNHSFT has pursued a care model which aims to move away from reliance on hospital beds to provide more services close to people's homes and in their communities.

This approach has led to the closure of Dartmouth Cottage Hospital in 2017 (following consultation led by South Devon CCG) and plans for the creation of a new H&WBC which is currently under construction in Upper Town and due for completion late summer 2022. While the loss of the Cottage Hospital is keenly felt in some sections of the community, the new H&WBC will bring together primary, secondary, and voluntary health services in a modern facility enabling greater integration of care. The relocation of facilities and services from the Lower Town to the Upper Town is a source of concern locally, particularly given the older profile of residents in the Lower Town.

However, the new facility:

- *Allows space for future expansion in line with the planned population growth at Little Cotton Farm and the ageing demographic of the plan area*
- *Ensures good access by car and public transport as a result of parking provision and existing and potential improved bus links between Lower and upper Town*
- *Improves access for that part of the community in greatest economic and social need thereby helping to address health inequalities.*

The relocation of services within the plan area means that the former hospital is now surplus to requirements. Indeed, its disposal forms part of the funding package agreed for the new H&WBC. At the current time there are no firm proposals for the disposal of Dartmouth Clinic at Zion Place which may be retained to support new ways of working in a post pandemic world.

There is an expectation within the local community that the redevelopment/reuse of former health facilities should address community needs such as affordable and/or key worker housing, new community uses, especially where these have a health and wellbeing emphasis. This has been confirmed in a recent survey of local views commissioned by TSDNHSFT and Dartmouth Town Council and undertaken by independent body, Healthwatch. This expectation also reflects the knowledge that a covenant covers a small part (16%) of the former hospital which states that 'the land…. Shall be for the use and benefit of the Dartmouth and Kingswear Cottage hospital…and …used for hospital purposes.

While the nature of the covenant is personal and therefore unenforceable if, and when the land is disposed of, TSDNHSFT as current guardians of the property on behalf of the NHS, acknowledge the spirit of the covenant which is reflected in:

- *The planned use of receipts from the disposal of the hospital to part fund the H&WBC as a 21st century facility to serve the health needs of Dartmouth and surrounding villages. The remainder of the funding has been secured by South Hams DC against the long lease which TSDNHSFT has entered into.*
- *The agreement to work closely with the local community to unlock 'social value' from the former hospital site. TSDNHSFT preferred approach is for a community bid led by Dartmouth Town Council for the site providing that this meets its financial and fiduciary responsibilities. Only if an acceptable community bid is not forthcoming within agreed timescales will TSDNHSFT proceed with an open market disposal.*

9. Section 6.6.3 sets out community aspirations for health care in Dartmouth. No comment other than cautioning against raising unrealistic and undeliverable expectations.

10. Policy DNP HW This policy as currently drafted is simply unworkable. It is confused, does not provide the certainty which a landowner or developer need and it is very difficult to see how development managers in South Hams DC could use it.

    It is suggested that the policy should not apply to the Dartmouth Clinic but focus on the former hospital site.

    The first sentence is undeliverable. The CCG who fund health services in the town will not support additional services over and above those to be provided through the H&WBC. The provision of services has been consulted upon and is largely set. The only mechanism by which additional services could be provided would be through a voluntary or charitable body. However, if one were to adopt a wider definition of wellbeing one might envisage health prevention and support activities organised either on a commercial or voluntary basis e.g. pilates/exercise classes, memory cafes etc. This suggests that the policy is seeking to be too specific in terms of health and wellbeing. It is suggested that 'community provision capable of being used to support the health and wellbeing of the local population' is used as the wording in the policy.

    It is unclear what the requirement to examine options entails. How could one test whether options had been satisfactorily examined? It is suggested that this is a meaningless and unworkable policy requirement.

    It is therefore respectfully suggested that this policy needs to be recast. A possible approach might be as follows:

    "A development brief should be prepared in advance of a planning application. The preparation of the brief should be undertaken in such a way as to allow local residents and businesses the opportunity to shape the future of the former hospital site. The following requirements should be addressed in preparing the brief:

- *The need, if still required, for the redevelopment to contribute to the funding of the new H&WBC in Upper Town*
- *The provision of community space capable of supporting health and social care facilities/services, particularly for the use of residents of and visitors to Lower Town*
- *The massing and design of the development given its prominent location as part of Dartmouth's historic waterfront and Conservation Area.*
- *The need to respect and avoid significant harm to existing designated and non-designated heritage assets*
- *The need to address flood risk particularly in respect of ground floor uses*
- *Other relevant policies as contained in the Development Plan*

A key purpose of the development brief should establish the balance to be struck between the commercial/residential market, the provision of affordable/key worker housing, if required, and community uses."

11. Note on Factors affecting Dartmouth H&WB needs and provision

This note draws on a 2013 JSNA report for Dartmouth dated 2013-14. Since that date Torbay and South Devon NHS Foundation Trust has been established as an Integrated Care Trust bringing together acute and community hospital provision. A new model of care has been introduced to deal with the challenges of delivering care to an ageing population with increasingly complex needs across the Trust's footprint. It would be useful if the note acknowledged the change which has and continues to take place in the delivery of care which aims to look after people as close to home as possible. For example, the NHS is placing increasing emphasis on accessing healthcare advice and support using digital tools e.g. NHS 111 and remote consultation tools (e.g. Attend Anywhere, specialist Apps).

The paper focuses exclusively on Dartmouth and Townstal wards and while this is understandable from the viewpoint of the NP it is not the basis on which provision is made by health planners. The health facilities in Dartmouth serve a wider population in the surrounding villages.

The note makes no reference to the consultation process undertaken by the then South Devon CCG which led to the closure of the Dartmouth Community Hospital and the decision to establish a Health and Wellbeing Centre to serve the population of Dartmouth and surrounding settlements. This facility will bring together primary care, secondary care (clinics and outpatient services) and voluntary provision (Dartmouth Caring) into one modern facility with good access to parking and public transport. The facility will also include a pharmacy. The H&WB facility is the expression of the model of care illustrated above.

The note makes no reference to the challenges faced by the NHS over the past two years because of the Covid 19 pandemic. This largely

explains the temporary closure of the Totnes MIU as a result of the need for infection prevention and control and staff shortages/redeployment.

Dartmouth is receiving an investment of £4.8m in the creation of a new H&WBC - the first within the TSD footprint. It is well located for that part of the local population which experiences the greatest economic and social need – and hence health inequalities. Providing health care to serve a relative remote, yet comparatively small population is always going to be a challenge particularly when financial and human resources are limited and change is inevitable. Maintaining a dedicated MIU to serve the town is unlikely to happen – hence the arrangement which the CCG entered into with the local GP practice.

12. Note on the travel impact of locating health facilities in Upper Town

    This is a detailed piece of work which seeks to demonstrate that there will be more journeys made as a result of locating the H&WBC in Upper Town and closing existing facilities in Lower Town. Given that SHDC have accepted the argument for developing the H&WBC which is now under construction it is unclear how this note adds to the evidence base of the NP other than arguing for improved public transport connections.


DARTMOUTH
NEIGHBOURHOOD PLAN




SUBMISSION VERSION (REGULATION 15)

NOVEMBER 2021

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Foreword

Dear Dartmouth Resident,

The beauty and appeal of our town cannot be taken for granted. Despite the obvious benefits of having a plan agreed by residents that offers a roadmap for our future and carries legal weight, producing a Dartmouth Neighbourhood Plan (DNP) has been a challenging process. Many of the issues we are tackling now have been around and identified for up to 20 years in some cases.

Over this time, there have been several studies to propose solutions to the particular issues facing our lovely town and its infrastructure. Dartmouth Town Council (DTC) agreed to resurrect the DNP in January 2019 and agreed its Terms of Reference. We have been assisted by their positive contribution and their approval of the current plan.

The economic circumstances of Dartmouth residents varies considerably across the Parish. Although large parts of the plan area are the least deprived areas in England, Townstal falls within 30% of the most deprived areas particular with respect to lowest in income ,employment and health .There are signs that the deprivation scores for Townstal are rising but they remain a serious concern and the policies of this plan seek to address these inequalities.

Our DNP should be sustainable and deliverable, cater for the needs of current generations and an ageing population but ensure that growth does not mean worse lives for future generations. It seeks to sustain the natural and historic qualities of the Parish and to conserve them for the future enjoyment of all. Our vision, contained within this plan, will help shape the future of the area in which we live and work through to at least 2034.

In drawing up our plan, the policies and the process we have followed respect the Neighbourhood Planning (General) Regulations 2012. I am indebted to all members of the Steering Group and the Topic Groups for their diligence and hard work. We are grateful also for considerable help and input from the community at large and from a wide range of people and local organizations, via public surveys, our website and via consultations. The views and comments received form part of the evidence base that supports and shapes the plan.

The policies of this plan focus on land use matters and views expressed most strongly by the community such as safeguarding our natural environment and setting within the South Devon Area of Outstanding Natural Beauty (AONB), protecting our historic environment, improving our year round economy on a sustainable basis, helping address long standing transport and parking issues, improving our community facilities, providing truly affordable homes for those who need them and addressing the inequalities across our Parish. We recognise the delicate balance that must exist between protecting our heritage and providing for the future needs of a well-rounded community. To this end, we propose a coordinated approach by all key stakeholders in finding workable solutions for the common good, either as policy proposals or as aspirations that need resolution.

We now have a Plan which we believe is worthy of your attention and approval. This Plan has not been imposed on us by any other body. All local residents on the Electoral Roll can elect to decide whether or not to adopt this Neighbourhood Plan through a local referendum. It is submitted on behalf of DTC who have endorsed this version.

We hope you will support us and help to secure a positive, vibrant and healthy future for our lovely town and its residents.

Robert Brooke, Chair Neighbourhood Plan Steering Group

'The future success of our town depends on an understanding of the delicate balance between many competing factors'

Extract from the Plan Vision

Contents **Page Number**

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List of Maps

1. Introduction and a vision for Dartmouth Parish

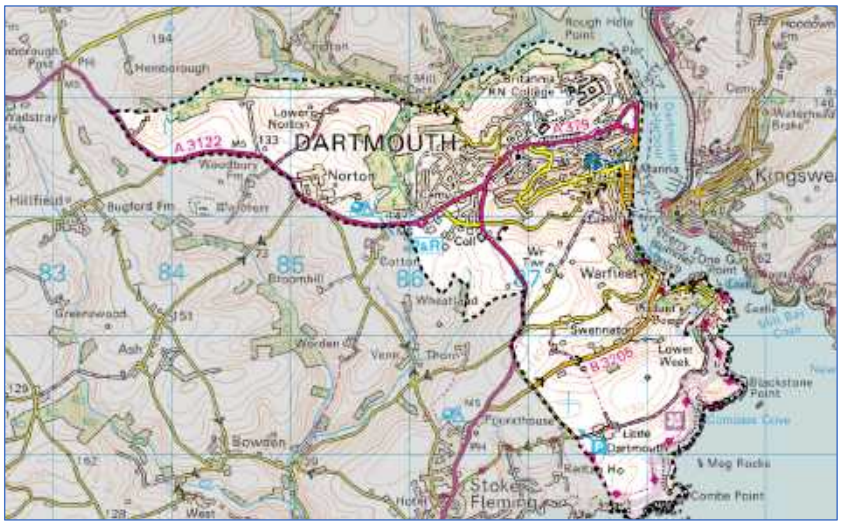
1.1 Dartmouth is a beautiful coastal town situated at the mouth of the River Dart . It is rich in heritage, maritime history and much of the parish lies within the South Devon Area of Outstanding Natural Beauty (AONB) – one of Britain's finest protected landscapes loved for its rugged cliffs, estuaries, inspiring coastal foot paths, coves, rolling hills and peaceful countryside. This community has been forged through links to the sea, stretching back to the Middle Ages. The town and parish has evolved, into the 21st Century with the local economy diversifying, most notably, into a major UK tourism destination motivated by the town's heritage, vibrancy, idyllic coastal and river landscape.

1.2 The economic circumstances of Dartmouth residents varies considerably across the Parish. Although large parts of the plan area are the least deprived areas in England, Townstal falls within 30% of the **most** deprived areas (28% 2019, 24% 2015) and the Indices of Multiple Deprivation (IMD) scores lowest in income deprivation (19%) employment (15%) and health (19%).There are signs that the level of deprivation in Townstal is reducing but it remain a concern and the policies of this plan seek to address these inequalities.

1.3 The experience from the Covid Pandemic has exposed the town's dependence on tourism as an economic driver, the shortage of affordable housing, notably for key workers and the need to be more economically sustainable long term, attracting and retaining more types of businesses and creating a more diverse economic structure.

1.4 This Plan has been prepared and led by Dartmouth residents. Feedback from local residents, landowners, statutory consultees has been sought and acted upon in the final version. The whole parish of Dartmouth was formally designated as a Neighbourhood Plan Area through an application made on 5th September 2014 under the Neighbourhood Planning Regulations 2012 (Part 2) and approved by South Hams District Council (SHDC) on 11th December 2014.

1.5 The area covered by the Plan is Dartmouth parish and illustrated in Map1 . The Plan will run until 2034, in parallel with the adopted Plymouth and South West Devon Joint Local Plan (JLP) or the Development Plan. Once adopted the Plan will join the JLP as part of the Development Plan



Map 1 Dartmouth Neighbourhood Plan Area

1.6 A considerable body of evidence has been sourced and collated during the production of the Plan. The background data on which the Plan is based is included in the Appendices.

1.7 This document is the Pre- Submission (Regulation 15) Submission version of the Plan. It requires a second period of public and stakeholder consultation, the Plan will be sent to an independent Examiner to review , if it is considered sound subject to amendments it can go to a referendum. Those living within the designated Parish of Dartmouth and on the electoral role will then get the opportunity to vote for whether or not the Plan should be adopted. If successful at a local referendum the Plan will then form part of the Development Plan of the South Hams alongside the Joint Local Plan. This statutory status as part of the Development Plan gives a Neighbourhood Development Plan far more weight than some other community planning documents, such as parish plans, community plans and village design statements. As a formal planning document it can be used in determining planning applications.

1.8 In due course (at Regulation 15) a Formal 'Consultation Statement' and 'Basic Conditions Statement' will be submitted to SHDC and thence to the Examiner alongside this Plan.

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1.9 SHDC will also carry out a Strategic Environmental Assessment (SEA) and Habitat Regulations Assessment (HRA) screening on the Pre-submission Plan.

1.10 A Vision for Dartmouth

1.10.1 During the Neighbourhood Planning Process the Steering Group drafted a vision for the Parish and Plan; this was posted on the Plan website and refined through a facilitated event. The following version was subsequently adopted.

Dartmouth towards 2034 – Planning our future

With its exceptional setting between dramatic coastline and countryside in an area of outstanding natural beauty, it is no surprise that historic Dartmouth with its naval traditions is so loved by residents and visitors alike. The future success of our town depends on an understanding of the delicate balance between many competing factors. We identify these factors, and endeavour to sustain and nourish those elements that will enable Dartmouth to thrive for future generations.

The beauty and appeal of our town cannot be taken for granted. With only limited space available, increasing demands for development must be balanced by the need to enhance our environment and protect our heritage. We wish to conserve our matrix of green spaces, vital for the wellbeing of wildlife and people, young and old alike. A healthy community is a cohesive one. We identify opportunities for housing, employment and recreation. These, combined with more efficient and sustainable transport, good communications, excellent schools, and health and social facilities that cater for all needs, will help all members of our community. And we will encourage biodiversity and effective protection against coastal erosion and flooding from climate change. New technological advancements will offer new and exciting opportunities to improve our lives; we intend to embrace them.

Careful planning, done for the benefit of all, will enhance our town so that our healthy and vibrant community can continue to grow and flourish.

1.11 Assumptions and constraints

In developing this vision, some working assumptions must be stated.

- The historic town centre by the river is spatially constrained. Identifying suitable and deliverable areas for future development is part of the Neighbourhood Planning process.
- A majority of the NDP is contained within the South Devon AONB. All development must also be aligned to AONB policies for conserving and enhancing this exceptional landscape.
- The Dartmouth Conservation area, Heritage Coast and Undeveloped Coast should be significant considerations in the Plan.
- Any actions to develop the town's built environment or manage the surrounding natural environment must meet the criteria of sustainability and protection of bio-diversity.
- The town's resilience in the face of rising sea levels and the increased frequency of severe weather events must be addressed in the period covered by the NDP.

1.12 A key part of the plan process was to set up topic groups reporting to the Steering Group to address the interrelated social, economic and environmental issues to be covered by the plan;

- Our Economy
- Infrastructure
- Our Green Environment
- The Town Environment

Each topic group's work focused primarily on the use and development of land and the associated planning issues. The inter-relatedness of the topics made liaison between the topic groups essential. The work of the topic groups is summarised in topic papers that have informed the Plan and policies and included in Appendix B.

1.13 The Plan has been developed following extensive engagement with the community. Since 2015 the engagement process has identified issues, policy options and sought feedback on the emerging plan. Activities have included:

- Public exhibitions and drop-in events
- Press coverage
- A dedicated website
- Face-to-face sessions with local organisations
- Questionnaires and community surveys distributed to all households and students
- Coordination and update meetings with the Town Council

2.0 Key themes, priorities and objectives

2.1 In this section we describe the themes that underpin the vision and policies of the plan. These have been taken directly from the responses to community surveys and developed by the steering group and its topic groups in consultation with the Town Council.

2.2 To summarise the issues facing the parish the following Strengths, Weaknesses, Opportunities and Threats (SWOT) assessment was developed at a workshop with the Steering Group and is regularly reviewed and updated through the production of the plan.

Strengths	Weaknesses
• 63% Parish within the AONB • Coastal location • Estuary • Surrounding countryside and natural environment • Locally distinctive and iconic views • Historic environment with many heritage assets • Distinctive urban and natural character • Locally distinctive vernacular architecture • Marine/naval heritage • Network of green spaces • Full statutory 3-16 yr. schooling provision in Parish • Active community all year round • High level of community led activities • Diverse cultural activity with many participants • Many festivals (food, music, heritage, culture) • Established and loyal tourism industry • Active sports clubs • High number of independent traders • Town has one principal centre although this is changing • The presence of the Naval College(BRNC) in the town	• Ageing population • 37% outside the AONB,(leaving it vulnerable to more change) • Shortage of affordable housing • Holiday short term letting undermines long term rental market and community life • No coordinated development /growth strategy • Poor traffic environment • Lack of economic/employment opportunities • No sixth form in the Parish • Lack of a clear settlement/ growth strategy • Poor connectivity with district and region, especially out of hours • 'End of the line' • Lack of investment in infrastructure • No clear car parking strategy • Reliance on seasonal working • Low level of good year round employment • Footpath network in poor condition • Public realm requires improvement • Lack of bus shelters • Inappropriate design • High levels of light pollution • Planning and AONB policy not enforced
Opportunities	**Threats**
• Affordable Housing • Encourage more permanent residents • More local employment , business and job opportunities • Controls on second homes • Protect green spaces and link together • Improve biodiversity • Adapt to and mitigate against climate change • Community (not developer) led change • Improve cohesion across the community • Making better use of brownfield land • Improve appearance and quality of industrial estates • Improve transport infrastructure • Support for marine businesses and activity • Infrastructure and services for changes in work patterns and home working • Remove barriers to business • Strengthen design quality • Reinforce the AONB design guidance • Better use of materials • More holistic 'blue skies' approach • Accelerate improvements and change	• Loss of Green Infrastructure • Loss of the Naval College • Loss of primary and a secondary education • Flooding • Development and developer led change • No space and opportunities for long term attractive employment • Insufficient affordable housing • Insufficient training and career opportunities for young people • Lack of support from key stakeholders to future change • Poor fit between national legislation and the town (e.g. Permitted Development not always appropriate) • National economic challenges impacting long term on the town.

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2.3 Themes and Objectives

The themes and objectives tabled below are derived from the community consultation responses and developed by the topic groups and steering group. The objectives listed directly relate to the policies of the plan.

Theme	Objective
Green Environment	• Achieve adaption and mitigation against climate change and carbon reduction • Protection of a matrix of green spaces, trees and links, through hedgerows, historic walls, green lanes and paths • Protect and expand the network of walks and cycleways • Safeguard water quality and the blue (water) environment • Prevention of upstream and downstream flooding and soil erosion • Protect and enhance the AONB and mitigate against inappropriate development • Safeguarding and enhancing biodiversity and the importance of Green Infrastructure and a green matrix. • Designation of Local Green Spaces • Maintain and enhance the landscape character, condition and quality of the river/estuary • Protect Locally Important views
Economy, Jobs and training	• Support sustainable employment growth commercially and individually • Enable upgrading and intensification of existing employment uses • Support and safeguard tourism related activity and infrastructure • Support new emerging start-up businesses • Support a green economy • Safeguard and enhance the town centre and local centre(s) for retail, tourism, hospitality and service sectors • Safeguard space for education and training • Support training and apprenticeships and links to FE and HE
Infrastructure	• Prevention of downstream flooding within the town through Green Infrastructure improvements • Review private car usage • Improved public transport infrastructure • Plan car and cycle charging hubs • Control of goods and delivery traffic with an out of town hub • New ferry (to Noss) • Support a Transport Study and emerging transport strategy including the preparation of a robust car parking strategy • Improve internet and broadband communications • Retention and improvement of public services e.g., toilets

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Built and Town Environment	• Designate a Settlement Boundary • Design quality and controlling inappropriate development • Protection and sympathetic enhancement of historic buildings and their setting • Design in sympathy with the historic environment, identifying and celebrating positive precedents including materials and styles • Prevent inappropriate sub division of existing urban plots and gardens • Safeguarding heritage assets and listing local assets • Protection,exapansion and enhancement of civic spaces, townscape and the conservation area • Prioritising Brownfield development first • Promote more employment land
Housing and homes	• Less priority given to market housing • Prioritising affordable housing for local people and ways to deliver this(e.g. exception sites) • Principal residence requirement controlling second homes • Additional homes for older people
Health and Wellbeing	• Potential to expand health facilities as population expands • Easy access to health facilities for the whole parish • Re-use of former NHS sites to include community uses • Safeguarding and improving community facilities • Improved social care facilities • Improved open space for active recreation • Improved access to the water for recreation

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3.0 Why we need a Neighbourhood Plan?

What is a Neighbourhood Plan?

A Neighbourhood Plan (officially called a Neighbourhood Development Plan) is a way of helping local communities like Dartmouth guide and influence the future development and growth of the area in which they live and work. Generally proposals require the support of the owners of land affected.

3.1 A Neighbourhood Development Plan can....

- Develop a shared vision for our neighbourhood;
- Choose where new homes, shops, businesses and other development should be built;
- Identify and protect important local green spaces;
- Influence what new buildings should look like;
- Promote more development than is set out in the Joint Local Plan (or Development Plan);
- Enhance the historic environment with heritage assets not previously recorded through their listing as Non-Designated Heritage Assets.

3.2 A Neighbourhood Development Plan cannot...

- Conflict with the strategic policies in the Joint Local Plan prepared by SHDC;
- Be used to prevent development that is included in the Joint Local Plan;
- Be prepared by a body other than a parish or town council or a neighbourhood forum.

Planning Context

3.3 Neighbourhood Plans are required to be in general conformity with the National Planning Policy Framework (NPPF) 2021 and the strategic policies of the Local Plan. The planning policies for the South Hams District are set out in the Joint Local Plan (JLP) for Plymouth and South West Devon .The JLP was adopted in March 2019.

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3.4 The relevant sections of the adopted Supplementary Planning Document (SPD) to the JLP July 2020 are respected in the Plan. In addition the following previously adopted Development Plan which although they no longer have a planning status helped to inform this Plan;-

- South Hams Local Development Framework Core Strategy (2006)
- South Hams Rural Areas Site Allocations Development Plan Document(DPD) 2011
- 'Saved' policies from the South Hams Local Plan (1996)

3.5 The Neighbourhood Plan must also be in conformity with EU legislation extending beyond the 2020 transition period until such time as new legislation is introduced to withdraw or amend such legislation by the UK Government. Locality advises that the EU requirements for strategic environmental assessment and habitat regulations (SEA and HRA) will continue to apply in the interim.

3.6 The Countryside and Rights of Way Act 2000 makes specific reference (s85) that Town and Parish Councils as public bodies must have regard to the statutory purpose of an AONB to conserve and enhance natural beauty . This obligation can be reinforced through their Neighbourhood Plans. The NPPF provides specific guidance for those preparing Neighbourhood Plans that include AONBs. This includes;-

- the presence of AONBs can restrict development in order to help achieve sustainable development;
- 'great weight' should be given to conserving and enhancing their landscape, natural and scenic beauty;
- AONBs have the highest status of protection in relation to landscape and scenic beauty, equal to National Parks;
- the conservation of wildlife and cultural heritage is important in AONBs;
- Major development in AONBs should be refused unless it meets specific special tests.

3.7 In 2020 a JLP Supplementary Planning Guidance document was adopted by South Hams, West Devon and Plymouth Councils . It gives guidance on implementation of policies in the JLP. It also comments on how implementation of the JLP can play a role in supporting Climate Emergency and Biodiversity Emergency and actions towards low carbon solutions and carbon neutrality.

3.8 The Thriving Towns and Villages (TTV) approach set out in the Development Plan (JLP) is focused on achieving sustainable development and rural sustainability for the Main Towns of which Dartmouth is one of four in the South Hams. Building self-sufficiency and resilience of the local employment market to meet local needs and attract new sectors and investment is seen as part of creating this strategic outcome, set out in Strategic Objective SO7, as is enhancing the links between the Main Towns and the surrounding countryside to support healthy communities. The highest levels of growth are targeted at the Main Towns, with a view to this enhancing their role as service centres as well as provide for their own growth. Specifically for Dartmouth the Development Plan sets out a spatial priority SP1 which is included below.

JLP (2019) Spatial priorities (SP1) for development in Dartmouth
The plan seeks to enhance the vibrancy and sustainability of Dartmouth. This will include:

1. Providing for mixed use development to help meet local housing need and increase employment opportunities to support the long term resilience of the town.
2. Maintaining and strengthening the town's traditional marine industry and recreational / leisure offer.
3. Recognising and enhancing the relationship with the surrounding AONB.
4. Conserving and enhancing the town's historic and maritime character.
5. Maintaining the existing retail offer, protecting the integrity of the town centre and enhancing its character.
6. Identify the opportunities to invest in enhanced connections between Dartmouth town centre and Townstal.
7. Identify opportunities to secure and enhance ferry links across the River Dart.
8. Ensuring appropriate infrastructure is delivered alongside new development.
9. Working with relevant authorities to look for appropriate solutions to manage traffic flow in and around the town.

3.9 Separately, the JLP sets out its approach to economic development which is supportive of new and existing businesses and greater rural economic resilience. Policy DEV15 sets out where support for rural economy proposals would be relevant, including maintaining/expanding existing employment sites, supporting home working/business start-ups and improving internet connectivity.

3.10 SHDC does not have a current district-wide economic policy although a Corporate Plan with a section on the economy is expected later in 2021. Its most recent strategy publications relate to the Council's own assets and their management or use. SHDC has in 2020 taken steps to create a business engagement framework which would provide a structured approach to communication between the Council and local businesses on economic development issues, support their effective representation within the Local Enterprise Partnership, Team Devon and facilitate the development of sector specific projects and support of economic strategies.

4.0 How the plan was prepared

4.1 The idea to prepare a Neighbourhood Plan for Dartmouth was first put forward in 2014. With support from the community a steering group was formed, membership of the group has evolved, and the latest membership includes three representatives of the Town Council mostly dating from 2019. There have been a number of engagement events held to identify the issues, consider proposals and policies to be incorporated in the Plan. This Plan has only been possible with considerable volunteer support, with many local residents participating in meetings, steering groups and internet based discussions. Since 2020 a consultant was employed to help progress and finalise the Plan, and supplement this volunteer effort.

4.2 Plan timeline

Date	Key Activities
September 2014	1st meeting of the NP working Group and was restricted to Councillors.
October 2014	3rd meeting was the first at which the public were invited
December 2014	Neighbourhood Plan Area Designated
February 2015	Open meeting with the Dartmouth and Kingswear Society
April 2016	Community Questionnaire issued to all households in the Parish
July 2016	Questionnaire responses received and collated
August 2016 to July 2017	There was no further meetings during this period during which time the questionnaires were being analysed
July 2017	Public meeting that reorganised the working group and re-focussed the process
August to November 2017	Themed Topic Group meetings held.
December 2017 to November 2018	Limited progress by the Topic Groups
November 2018	Dartmouth Town Council resolved not to pursue the plan
July 2019	Dartmouth Town Council resolved to re-start the plan
September 2019	New Steering Group and Topic Groups formed with support from the Town Council
Spring 2020	New plan website launched
June-July 2020	Leaflets promoting the plan and inviting feedback issued
August 2020	Consultant appointed to support the Steering Group
October 2020	Steering Group briefed the Town Council on the progress of the plan and findings of the Topic Groups
October to November 2020	Topic Group Papers produced for each theme and form the basis of the Plan
December 2020 to February 2021	Business survey carried out
February 2021	First draft of plan presented to the NP Steering Group
March 2021	First draft of plan issued to the Town Council and key stakeholders
June 2021	Regulation 14 Pre-Submission Consultation Version of the Plan issued
July 2021	Regulation 14 draft approved by the Town Council
August to September 2021	Regulation 14 consultation
??? 2021	Regulation 15 approved by the Town Council
??? 2021	Regulation 15 submitted to SHDC

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4.3 Summary of the community engagement responses and surveys

4.3.1 In 2016 a survey was delivered to all households in the Parish, it set out to establish which subjects people felt were important to be addressed in developing the Plan. A total of 3646 surveys were sent out including 538 second homes and around 600 businesses. 562 individual responses were received which is a high rate of return for this type of survey. 54% of the respondents were over the age of 65, 37% between 45 and 64 and 9% under 44, there were no responses from people under the age of 24. A full record and summary of the community responses is included in Appendix K1. 78% of the respondents were either 'very satisfied' or 'satisfied' with Dartmouth, 12% were 'neutral' and 10% were either 'dissatisfied' or 'very dissatisfied'. The community were asked what they liked or disliked about Dartmouth (responses are summarised in the earlier SWOT analysis).They were also asked what topics the plan should consider, and advice requested on any specific action, initiative or change they would like included . Set out below is a summary of the main areas that attracted comment. In brackets alongside the description of the theme is the number of specific points raised related to that subject concerned. The numbers include both comments and suggestions all of which have been considered by the Steering Group and the topic groups.

Theme	Issue raised by the community
Parking (783)	Better parking
	Review restrictions
	More car parking
	Resident only parking scheme
	Employee parking scheme
	Improve park and ride and make more affordable
	Restrict/ control coach influx
	Area to replace Little Cotton Caravan Park
	Herringbone parking along the Embankment
	Comprehensive parking survey
Transport , traffic and Pedestrians (1247)	Better bus routes locally and to major towns and cities
	Less reliance on the car
	Community bus service (like Bob the Bus-Totnes)
	Better accessibility
	Pedestrianise parts of the town centre
	Reduce HGVs in town
	Speed control in Victoria Road
	Shared car and pedestrian access in town centre
	Better link between steam railway and national network
	Electric vehicles
	Use more technology to control, traffic, parking.
	A pavement along Victoria Road up to College Way
	More cycle friendly
Second Homes/Affordable Housing/ Development (507)	More affordable housing for local people
	Restrictions on second homes
	Better integration between Townstal and the historic town
	Restrictions on holiday lettings
	Better design quality on the river side
	Housing to rent, not to buy
	More social care and homes for older people
Economy, Employment and Tourism (1078)	Safeguard independent businesses
	Improve facilities for tourists and extend the season

	Business support for local people Affordable business premises Attract new businesses especially high tech. Better promotion of the town as a tourism destination Faster broadband and more internet based services BRNC play a more active role in the town Cruise ships help the economy
Shops , town centre and heritage (1046)	Diverse range of shops Raise the urban quality Keep the town's individuality and character Better signage More convenience shopping Repair and re-cycling café More seats on the riverside, others say fewer in Bayards Cove The Tourist Information Centre is crucial for the town Better public spaces by the Boat Float and improve appearance Regenerate Castle Estate More places to perform music Upgrade the market Fewer art shops Limit development to 3 stories Move Travis Perkins and introduce affordable housing Control development in the conservation area
Healthcare, Hospital, Social Care ,Health and wellbeing (1240)	Dartmouth hospital Another doctor's surgery Re-provide hospital services New health and wellbeing centre A and E needed More facilities in the leisure centre More night classes Better support for the school Expand ambulance service Keep open air pool More formal sports up by the swimming pool
Natural Environment Open spaces, and waterside.(910)	Conservation of green spaces More energy conservation and eco housing Develop and improve Coronation Park (underground car park) Do not build on Coronation Park No development in the AONB Move bowling green (to Coronation Park) Stop building on good farm land Less light pollution, turn off street lights earlier Protect the community Orchard Better facilities for boating/rowing Access to the water for all River and beach cleans
Education (397)	Training support Education and training during low season Language school
Rubbish/Seagulls/dog mess etc (51)	Better recycling (continental style underground) Dog mess Clean up the town Seagulls Control anti-social behaviour
Miscellaneous (143)	Not a summer town only

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	A town of two halves Close liaison between the BRNC and the town Free public toilets Consider all generations young and old Stop in-fighting Integrated joined up community leadership Criticisms of the District Council More transparency in project development More police presence in the evenings Why have a Neighbourhood Plan-do we want change? Review the MCTI recommendations Development of Jawbones Celebrate and acknowledge the number of voluntary groups Enhance the Undercliffe

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4.3.2 The Neighbourhood Plan website has run a community feedback page since July 2020 This media which was promoted online and through leaflet distribution has identified a number of issues that informed the plan and is summarised in the following table:

Theme	Comment
Natural Environment	Address the risk of flooding in Lower Town
	Mitigate against air and water pollution
	Protect and maintain green spaces
	Support biodiversity
	Address climate change and reduce carbon
	Safeguard and improve
	Extensions to Public Rights of Way
	Countryside at risk
	Green Economy
	More local food production
	Promote Community and individual Renewable Energy
	Improve access to Sandquay Woods and other open spaces
	Nomination of Local Green Space including Coronation Park, Jawbones Beacon Park ,Warfleet Creek, Sugary Green (leading down to. Sugary Cove) and Crosby Meadow
	Online petition of over 1600 people supporting Manor Gardens as Local Green Space
Economy	Support small and start-up businesses
	Support edge of town employment space
	See separate business survey below
Transport Infrastructure	Secure underground parking in the town
	Residents parking scheme (some objections)
	Electric/ smart vehicles/buses/taxis/ferries
	Electric charging points in car parks
	Park, Walk and Ride
	Improve access to the coast path and countryside
	Complete footpath to Stoke Fleming
	Sustainable, frequent transport link from Park and Ride to town\
	More local re-cycling
	Low energy street lights/ control light pollution
Town Environment	Preservation of the Historic Environment
	Expand the museum
	Improve the shopping experience
	More pedestrian friendly and pedestrianisation
	More outside dining

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	Town information service hub linking services of the Devon Visitor Centre (DVC) and library. Safeguard existing stone walls throughout the town Convert empty retail to housing Nomination of Local Heritage Assets including the DVC, Newcomen Engine, Piscatorie Statue, Crowthers Hill, Helicopter Control Tower and Water Tower
Housing	Affordable and Eco-friendly housing for local people
Health Wellbeing and Education	Training support
	Townstal community hall needs more support and funding
Other issues	A sense of community
	Better cohesion between the top and bottom of town Comments on the Planning White Paper (2020) Natural burial ground/ pet cemetery

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4.3.3 The Plan has sought to engage with the local businesses as well as resident communities. There were extensive consultations with the local community in 2016. The Plan has also been able to benefit from a number of other surveys and studies initiated by others including the Development Plan. Since 2020, the key focus has been on the needs of existing businesses. To identify the most current concerns and opportunities, between late 2020 and early 2021 the group invited local businesses to complete a comprehensive survey. The full responses are included in Appendix K2 with a summary below;

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- There were 41 responses, 32% categorised themselves leisure related and 27% hospitality;
- 46% of businesses considered themselves to be tourism focussed;
- 90% were local independent businesses;
- 70% of staff employed live in Dartmouth;
- Of those staff who commute 79% travel to work by car;
- The lack of affordable housing has a major impact to many recruiting and retaining staff;
- The lack of car parking and broadband speed are other factors holding back businesses;
- Shortage of access to appropriate training is an issue to many;
- Key factors affecting businesses locating in Dartmouth are the town's special qualities, access to a tourism economy and the lifestyle offered.

4.4 Inclusion, Diversity and Equality

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The Steering Group has been keen to seek broad and inclusive representation from the community in the production of the Plan . Care has been taken throughout the preparation of this plan and the consultation process to engage as many members of the community as possible; these include residents, second home owners, landowners, businesses, employees, and special interest groups. The Steering Group has been keen to obtain a broad perspective on equality and diversity matters and has endeavoured not to discriminate on grounds of race, gender, and disability or on any other grounds. All venues for events held were fully accessible. The consultation process has been adapted during the Covid pandemic relying predominantly on video conferencing however this has not compromised the measures to avoid discrimination.

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5. About the town and parish of Dartmouth– key facts, background, history and challenges for the future.

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5.1 A Brief History of Dartmouth sourced from Dartmouth Conservation Area Appraisal (2013 South Hams District Council) and Wikipedia.

5.1.1 Dartmouth has a rich history as a port and commercial centre, and whilst attempts have been made to document the development of the town, there is limited referenced information available from which to draw an accurate picture of how this history influenced the physical growth of the town.[1] The earliest settlement of what is now the town of Dartmouth was on the flatter land at the top of the hill at Townstal, about a mile west of the shore. It is thought that the Normans were the first to appreciate fully the fine natural harbour of Dartmouth, placed so conveniently opposite the Channel Islands and Normandy, and it seems likely that they brought over Frenchmen to build houses and port facilities. The names of the tenants in the earliest deeds of the town were French, not English.

5.1.2 During the Middle Ages to either side of the Creek, at the foot of the two spurs dropping from Townstal Hill to the river, two small fishing hamlets grew. The two hamlets were physically separated by a large inlet (known as the Mill Pool) running along the line of North Ford Road and South Ford Road. The northern hamlet was known as Hardness and the southern one Clifton. The first houses were built along the steep slopes above the high tide line. Development was restricted by the lack of suitable land and the difficulty of access down the steep routes to the water's edge. At this time, water was the predominant mode of transport. The history of the physical growth of the town is reflected in the changes in the quay frontage .Changes began in the 13th C with the damming of the inlet between Hardness and Clifton-Dartmouth, thus harnessing the tide to run a mill. Over subsequent centuries, especially the 19th, large quantities of land were reclaimed from the river to build a port that was accessible from the land. Land reclamation continued into the 20th C, the quay gradually expanding and widening to meet the changing development requirements of the town and to prevent flooding.

5.1.3 Between the 12th and 14thC Dartmouth was a commercial and military port, linked with Henry I's acquisition of the South West provinces of France and the wine trade. A fleet of more than 150 ships carrying around 13,000 troops departed from Warfleet Creek in May 1147, ready for the Second Crusade. Warfleet Creek proved its worth again in April 1190, when Richard the Lionheart sent his fleet of 30-40 warships from Dartmouth to join the Third Crusade. Due to its prominent position at the mouth of the River Dart, sea defences are a distinctive feature of the shore-line and are thought to date back to the late 15thC. The Town has seen many periods of growth; the Newfoundland fishing trade and the renewed growth of the cloth trade fuelled expansion from the late 16th to mid 17thC. Buildings such as the Butterwalk and those along the Quay, date from this time (most now with later frontages).

[1] Historical Information has drawn largely from R Freeman, 'Dartmouth and its Neighbours', (London: Phillimore,) 1990 republished in 2007 with additional material by Richard Webb, Publisher, Dartmouth.

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The port was naturally of great significance during the Civil War. The Royalist forces captured the town in 1643 and considerably strengthened the defences, but nevertheless the port finally capitulated to the Parliamentarians in 1646.

5.1.4 The building of the Embankment left a section of river isolated between Spithead and the New Ground, known as The Boatfloat, and is linked to the river by a bridge for small vessels under the road. The coming of steam ships led to Dartmouth being used as a bunkering port, with coal being brought in by ship or train. Coal lumpers were members of gangs, who competed to bunker the ships by racing to be first to a ship. This led to the men living as close as possible to the river, and their tenements became grossly overcrowded, with the families living in slum conditions, with up to 15 families in one house, one family to a room. The area to the north of Ridge Hill was a shallow and muddy bay ("Coombe Mud") with a narrow road running along the shore linking with the Higher Ferry. The mud was a dumping ground for vessels, including a submarine. The reclamation was completed in 1937 by the extension of the Embankment and the reclamation of the mud behind it, which became Coronation Park.

5.1.5 In the 1920s, aided by government grants, the council made a start on clearing the slums. This was aided by the decline in the use of coal as a fuel for ships. The slums were demolished, and the inhabitants were rehoused in new houses in the Britannia Avenue area, to the west of the old village or hamlet of Townstal. The process was interrupted by the second world war, but was resumed with the construction of prefabs and later more houses. Community facilities were minimal at first, but a central area was reserved for a church, which was used by the Baptists and opened in 1954, together with a speedway track. The latter was later used for housing, but a new community centre was opened nearby, together with a leisure centre, an outdoor swimming pool, and later an indoor pool, and supermarkets, light industrial units were also constructed. Between 1985 and 1990 the Embankment was widened by 6 metres and raised to prevent flooding at spring tides. A tidal lock gate was provided at the Boatfloat bridge, which could be closed at such times.

5.1.6 All the above historical developments left an impression on the town. The former settlement of Hardness was associated with the ship building industry, and wealth generated by the town's merchants was often invested in buildings. Merchant houses survive today in several streets, including Duke Street, Anzac Street, and Fairfax Place. The Street layout and land reclamation projects were a product of the changing trading requirements of the port. Historically, access to the town was by sea, resulting in narrow streets, which were not designed for vehicles. Ease of access through the town relied upon the series of vertical paths that connect the layers of buildings vertically, in contrast to the horizontal streets that follow the contours. Freight from the hinterland was brought to the town by pack-horse, resulting in steeply stepped, narrow roads between houses that were tightly packed to use the small amount of building land available.

5.1.7 The influence of the military on Dartmouth is considerable. From the 16th C artillery fort at Bayard's Cove Castle through to the Britannia Royal Naval College, the impact of the military can be seen in many places. To the south of the town (and outside the conservation area), the 14th C Dartmouth Castle was later refortified by Henry VIII, whilst the Gallants Bower earthworks above this were constructed by Royalists in 1645 during the English Civil War. Evidence for military remains from these periods may also be found in the town. As a harbour

and embarkation point, as well as a defended settlement, the town has been used by the military for centuries. Dartmouth has been an important defended site and an important location for artillery. From the medieval period, through the Tudor, Civil War, Victorian and World War II periods, evidence of coastal artillery may still be found. The Embankments were built out with ramps during World War II, and together with the slipway at the Higher Ferry, enabled vehicles to board US landing ships prior to and during the D-Day campaign. Opposite Dartmouth, Kingswear has medieval castles at Gommerock (little now remains of this) and Kingswear Castle, as well as more modern military fortifications such as the Torpedo battery built in 1940.

5.1.8 The Royal National Lifeboat Institution (RNLI) opened a lifeboat station at the Sand Quay in 1878, but it was closed in 1896 during this time only one effective rescue was made. An inshore lifeboat station was opened in 2007 after being closed for 111 years operating a D class boat and in 2020 a larger B class was installed afloat off the Low Water Landings. The station is of strategic importance for the safety of recreational and commercial craft.

5.1.9 Paintings and photographic records show Dartmouth Quay to have been a busy place in the past. Today, the activity is still present in the form of tourists and yachts attracted by the sheltered location, the charm of the town and good sailing.

5.2 The green environment

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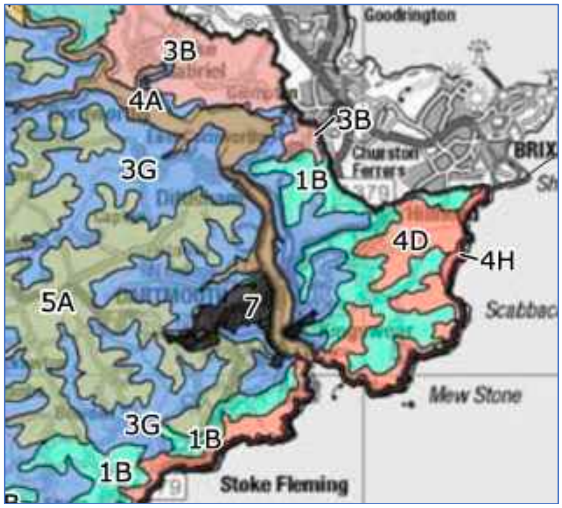
5.2.1 This plan presents an opportunity at a pivotal moment, when we can collectively consider the importance of our green environment, assess the risks to it and decide what action to take to protect ourselves, the town and our environment. Clearly, a collaborative approach must be taken, locally, regionally, nationally and internationally. The climate is not restricted by parish boundaries; carbon emissions and pollution produced by one area affects another. Issues of climate change and diminished biodiversity are interlinked; it is in everyone's interest to follow recommended strategies, led by science and environmental experts, in order to tackle both simultaneously.

5.2.2 The landscape character of the Parish



Map 2 South Hams Landscape Character types (LCT) for the area[2] The LCTs for the plan area are illustrated in greater detail in Map 2 included in the Appendix and evidence base.

Few towns can offer the returning resident or visitor more dramatic setting for a town as Dartmouth which has been moulded by the natural environment. Approaching from the sea the Undeveloped Coast within the South Devon Heritage coastline stretches westwards to Warren Point and cove, and the cliffs (South Hams Landscape Character Type 4H) and open coastal plateau landscape (LCT 1B) carry the South West Coastal Path, a national trail along a landscape designated as County Wildlife Sites (CWS) from Redlap in the west to the Dart estuary within the town. The agricultural land behind this protected fringe is a hot spot for the cirl bunting, an endangered species. Closer to the mouth of the Dart estuary Coastal Slopes and Combes (LCT 4D), covered in broadleaf woodland encircle the historic collection of castles protecting the harbour entrance. The heritage coast continues into the estuary (LCT 4A), past Gallants Bower, another CWS and to the parish boundary within Old Mill Creek, itself a CWS. The landscape is broken by River Valley Slopes and Combes (LCT 3G) entering the river Dart at Warfleet and Old Mill Creek. Once within the bight the vista broadens to include the townscape and the historic buildings of the Britannia Royal Naval College (BRNC). At this point the views enjoyed by the seafarers open to those approaching Dartmouth by the 3 ferries crossing the Dart from Kingswear. The charm of the Historic town (LCT 7) is augmented by the encircling woodland and agricultural land to the South and West and to the North by the open green spaces surrounding the BRNC, creating a natural amphitheatre within which the town nestles, a feature recognised as important in the Development Plan Supplementary Planning

[2] Landscape Character Assessment for South Hams and West Devon Feb 2017- LUC

Guidance (New Work in Conservation Areas – SPG notes 2001). Much of the present town lies on land reclaimed during the 16th to the 19th century, and at low water remnants of the original mud flats are evident at Bayards Cove, which would still be recognisable to the Pilgrim Fathers who left from here to settle in America 400 years ago, and along the North embankment and extensively within Old Mill Creek.

5.2.3 South Devon AONB

All of the Parish land visible from the sea and river, including the Heritage Coast and land within the river Dart from the HW mark to the skyline, lies within the South Devon AONB (map 1). Indeed almost two thirds (63%) of the Parish lies within the South Devon AONB. The landscape character policies of the current South Devon AONB Management Plan (Appendix L2) clearly define the special qualities to be respected if development is considered in settlements like Dartmouth within the AONB including;-

- Maintaining and enhancing the levels of tranquility to further ensure this special quality is not further devalued, Policy Lan/P4;
- The importance of the existing skyline and need to protect this against the visual intrusion of insensitive buildings and infrastructure, Lan/P5;
- Protecting long uninterrupted views of the open undeveloped seascape, Lan/P6;
- Help maintain the rural quality and character and the overall setting of the AONB Lan/P7.

5.2.4 Locally Important Views

There are a number of views across Dartmouth viewed from public land and routes that are considered by the community as locally important. The views to the settlements, River Dart, natural and historic features should be safeguarded and respected in all future development within the Plan area. The views identified help define the landscape character of the AONB as outlined in the latest AONB Management Plan (Policy Lan/P6)

Locally Important View V47 from Yorke Road

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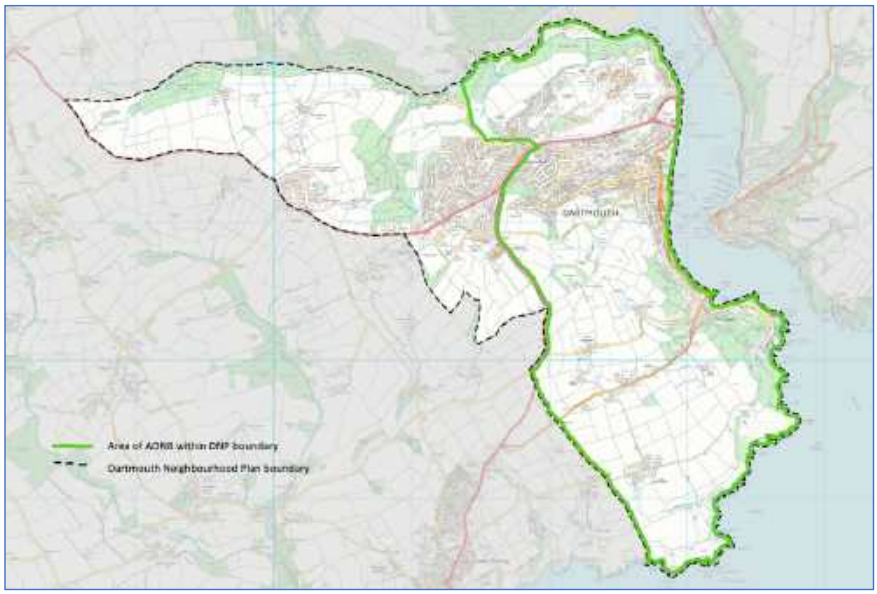
5.2.5 Undeveloped Coast and Heritage Coast

Development Plan(JLP) policy DEV 24 is the starting point for ensuring that development does not have a detrimental effect on the Undeveloped Coast and Heritage Coast designations in the Plan area. In their guidance [3] the Devon Landscape Policy Group set out a series of principles to help maintain the character of Devon's Undeveloped Coast (DUC)- refer to Map 6. They stated that the DUC '*should be treated as a designation and be defined on policy maps within Local, Neighbourhood and Marine Plans'*, and that the DUC *'should be regarded as a finite resource for the enjoyment of everyone now and in the future. Local, Neighbourhood and Marine Plans should therefore include strongly-worded planning policies that establish a presumption against development within or affecting Devon's Undeveloped Coast unless it can be successfully demonstrated that it satisfies all of the following criteria;-*

- *Maintain the intrinsic character of the landscapes affected:*
- *Protect and enhance valued landscapes affected, giving great weight to conserving landscape and scenic beauty in National Parks, AONBs and Devon's Heritage Coasts;*
- *Cannot be accommodated reasonably outside the undeveloped coast; and*
- *Take opportunities available, where reasonable, for improving public access to and enjoyment of the coast.'*



Map 3 Extent of the South Devon AONB designation within the Parish

[3] Devon Landscape Policy Group Guidance note 3 November 2013

The coastline of the parish forms part of the South Devon Heritage Coast defined by Natural England (see Map 5).There is no statutory designation process for this. Natural England defines the national purpose of Heritage Coasts as including the conservation of their natural beauty, their marine flora and fauna and their heritage features. This plan sets out to retain the character of the undeveloped coast, protecting and enhancing its distinctive landscapes, particularly in areas defined as Heritage Coast.

5.2.6 Wildlife, Biodiversity and a Green Matrix

The area covered by Dartmouth's Neighbourhood Plan - next to the sea and along a large estuary with a backdrop of hills cut through by small coombes - ensures that it has a diverse flora and fauna. The mix of urban, rural, and maritime environments provides habitat for a range of resident species and its position on the south coast makes the area important for migratory species moving between mainland Europe and the British Isles and points further afield. The seven landscape character types and sub-types found in the plan area reflect its underlying geology. Different sorts of habitat occur within each type of landscape, creating a complex, green matrix in which plants and animals establish themselves, and through which they spread or move. The core areas of a matrix include such habitats as woodland and grassland, but also urban parks and gardens. Some may enjoy legal protection, and require particular types of management. However, the routes through the matrix are also of principal concern and may not enjoy the same level of protection. They may be more or less permeable, either helping or hindering movement according to the particular capabilities of a species. The connectivity within a matrix may be structural (i.e. core areas of habitat physically linked, for example, by hedgerows, banks or streams, so that species can pass along them) or functional (i.e. permeable areas that species can pass through to get from one habitat to another, for example, open fields or urban gardens). This connectivity mitigates habitat fragmentation which is a contributory cause of loss in biodiversity. A description of the Dartmouth green matrix with core sites of high biodiversity value and their principal means of connection is contained in Appendix E1 and illustrated in Map 7.

5.2.7 Open Space

As long ago as 2004 The Dartmouth Community Plan for the Market and Coastal Towns initiative (MCTi) [4] had as one of its objectives the protection and enhancement of the *"natural environment of the area"*. More recently the survey undertaken in 2016 confirmed the priority given to "*Green spaces and Nature*" by the Dartmouth community. This topic was the 4th highest in importance amongst the topics identified in the survey. Whilst Dartmouth has been considered to have an adequate network of open spaces which provide such cover there is a recognised deficiency in the provision of 2ha sites within 300m within Dartmouth (South Hams Green Infrastructure Framework 2015). In addition growing concerns regarding obesity in adults and children have added emphasis to this provision such that all present facilities merit protection and opportunities to enhance provision should be sought (South Hams District Council, Open Space, Sport and Recreation (OSSR) Study 2017). Whilst the Cotton development lies outside the Parish its road access, public transport and geographical location will cause the population residing there to look to Dartmouth for its recreational and sporting

[4] MCTI 2004 Dartmouth Final Report included as Appendix M1

needs .An inventory of the existing open spaces network is included in the Appendices as Table 1 and in Map 7 below.

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5.2.8 Climate Change Mitigation

The environmental policies of this Plan support the principle of adopting nature-based solutions to address climate change. Safeguarding and restoring biodiversity, restoration of habitats, supporting local food production, flood risk reduction, promoting a green economy and reinforcing the green infrastructure network of the Parish will all provide essential benefits to local people. In July 2019, SHDC declared a Climate Change and Biodiversity Emergency, recognising that urgent action needs to be taken to reduce carbon emissions and protect ecosystems and wildlife. Many Dartmouth residents and businesses have good reason to be concerned about the effects of climate change, especially young people who will inherit this issue. From the start of the plan period there has been a sharp increase in the frequency and severity of extreme weather events over previous years; including gales, snow, prolonged heavy rainfall, and drought. Most people who live or work in the plan area have been affected by these accelerating climatic changes; by work days lost, reduction of tourist visits to the town, schools, shops and business closures, damage to garden structures, trees and roofs, road closures or diversions, damage to farm crops, or distressed livestock. The higher areas of the town including the residential area of Townstal, are exposed to more storms and gales from all directions; these are increasing in strength and frequency and reaching 60-80 mph. The lower town is more sheltered from the dominant north/east and prevailing westerly winds, they are more likely to be at risk of flooding and soil erosion due to rising river level, heavy rainfall, from 'urban runoff' through streets and the runoff from farmland on the hills. One of Dartmouth's three seaward coves, Compass Cove, is now closed due to a landslide. The River Dart's tidal waters are encroaching on town's embankment and adjacent properties. The river flooded 45 times between 2015-2020. By the end of the plan period, the river may already have risen significantly. DCC has set up various initiatives: Devon Climate Emergency Response Group, a Net-Zero Task Force which is deciding a realistic target for net zero emissions, using specialist knowledge to produce an evidence-led Devon Carbon Plan. Another initiative, the Climate Impacts Group is using its collective knowledge to create a Devon Adaptation Plan. This will consider how Devon and its citizens can adapt to living in a warmer world, aiming to "create a resilient, net-zero carbon Devon - where people and nature thrive." It stresses: "Achieving this will require collaborative action from everyone across Devon".

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5.3 Economy, Jobs and training

5.3.1 Dartmouth is a key service centre for South Hams providing shopping, primary education, employment, medical and professional services. There are limited employment opportunities in the surrounding rural area and the large proportion of current employment opportunities are further afield in Torbay, Totnes and, even, Exeter and Plymouth. A small number of people commute to London. Whilst there are limited opportunities to commute by non-car modes, inevitably, the majority of people working away from Dartmouth will travel to work by car. A key objective of the Plan is to ensure that the town's economy aims at being more sustainable. Central to this will be the creation of more high value, full time jobs which offer opportunities for local people which, in the longer term, will reduce a dependence on outward commuting. The plan will focus upon the need to increase opportunities and will encourage start-up and growing businesses in the interests of existing and emerging business

owners, of the resident community and young people hoping to establish themselves in high skill, well paid, sustainable jobs. This plan does not support the loss of any existing employment opportunities and the buildings and sites associated with them.

5.3.2 A retail and leisure study by consultants PBA in 2017 prepared as evidence for the Development Plan and included as Appendix M2 emphasised the important market town role that Dartmouth plays for its wider hinterland. The principle that Dartmouth has a wider economic and social hinterland and that building upon existing tourism provision to enhance out of season attraction to the town has informed the policies of this plan. The PBA study also recognises that access to Dartmouth town centre is one of the main issues affecting the economic sustainability of the town, this is addressed in the transport and infrastructure section of this plan.

Strengths	Opportunities
• Attractive harbour and seafront • Strong tourism industry and facilities to cater to tourist and visitor demand • High quality built form, including well maintained historic timber framed buildings	• Build upon existing strength of the tourism industry to support the local economy • Attract tourism from further afield through increasing tourism offer
Weaknesses	**Threats**
• Inadequate provision of public car parking • Relatively incoherent network of streets, with poor street signage on smaller streets • Minimal leisure uses for existing residents, due to existing leisure uses targeted towards tourism industry	• Failure to cater for local needs through over representation of shops and services targeted towards tourism demand • Decline of tourism pull due to relative inaccessibility of the town centre (driven by poor parking provision) • Competing tourist demand from more accessible or 'up and coming' town centres in SHDC

SWOT Analysis of Dartmouth Town Centre (Retail and Leisure Study) PBA Consultants February 2017

5.3.3 This plan supports the actions of the Interim Devon Carbon Plan[5] and the Heart of the South West Local Enterprise Partnership (HotSWLEP), to put clean ,green and inclusive growth at the heart of the local economic strategy. This plan recognises the transformational change taking place in the global and local economies, in order to address climate change and the rise of new employment . The HotSWLEP runs the Devon Growth Hub, which supports start-ups

[5] https://www.devonclimateemergency.org.uk/interimcarbonplan/

of any low carbon businesses. This plan identifies the types of employment that contribute to the economy as a whole and particularly the green economy which include;-

- High tech electronics
- A marine cluster including specialist research with local universities
- Climate and environmental science research linking to the Met Office in Exeter
- Healthcare research
- Clean and renewable energy installations and research

The UK Clean Growth Strategy suggests that the low-carbon sector has the potential to create up to 700,000 jobs across England by 2030;nearly half of these jobs will be in clean electricity generation and low-carbon heat manufacture and installation, a fifth will be in energy efficiency equipment installation, a further fifth in low-carbon services (finance, IT, legal) and the remainder in manufacturing low-emission vehicles and the associated infrastructure.

5.3.4 The town does recognise that overdependence on tourism in the future may compromise its long term sustainability. This plan sets out to support opportunities to develop emerging markets with considerable potential for diversification of the economy, without compromising tourism.

5.3.5 The town has a wealth of activities throughout the year, most notably the Dartmouth Royal Regatta, which has been in existence since 1834 and became the Royal Regatta in 1856 and the Port of Dartmouth Royal Regatta in 1895, towards the end of the 20th century, new initiatives resulted in more annual events including food and music festivals. Most services and facilities, particularly, those meeting the needs of tourists are located in the lower town with two larger supermarkets, leisure centre and most industry located in Townsal, in the upper town.

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5.3.6 Dartmouth has an ageing population which will present two key problems over the plan period. It will almost certainly generate increasing demand for services to meet the specific needs of that ageing population and it will, without significant interventions, not have an indigenous population fully able to meet existing and emerging needs going forward.

5.3.7 Drawing on the 2011 census, of the residents aged between 16 and 74 (of which there are 4192 in Dartmouth), 2907 residents (69 %) were available to work. Of these 34% were full time employees, 15% were part-time employees, 16 % were self- employed. 2.4 % of residents were unemployed which is similar to the district and 7.4 % across England. Covid will affect these statistics in the short / medium term. There may be permanent changes to the local, and indeed national labour market. The plan sets out to support existing employees in their current roles and to reposition people to take advantage of emerging opportunities.

5.3.8 69% of residents in Dartmouth (source 2011 census) are economically active (classified as aged between 16 and 74). Of those aged over 16, 29% of the population of the town has NVQ Level 4 or above, compared to 46% in South Hams and 34% in England. The number of people in Dartmouth with no formal qualifications at all stands at 21%. The 2011 Census

highlights the significant role played by retail, accommodation services, construction and public services, likely principally defence. Whilst the health and social care element might have reduced as a result of NHS restructuring, it is probable that the broad percentages in the key areas have remained broadly constant.

5.3.9 In the context of this plan past and current statistics on working from home and travelling to working would be misleading as work patterns have been enforced during the Covid pandemic. It is expected that post Covid work practices will change with opportunities for more home working and the frequency and mode of travelling to work might also change.

5.4 Transport and Infrastructure

5.4.1 Dartmouth is a small town with significant visitor numbers but beset by difficulties in terms of general access getting to the Lower Town, and access within the Lower Town, especially the historic core next to the estuary. The main road access is from the A3122 which links into the A379 Totnes to Kingsbridge route. This provides for the majority of vehicles requiring access to Dartmouth from the national network. Freight and distribution vehicles either stay in the Upper Town where the main industrial and shopping facilities are located or they proceed on to the Lower Town, mainly along College Way. The latter is a good quality road, leading to the Embankment and, thence, to the Lower Town, and tightly built- up area of mixed shops, businesses and houses in mainly narrow streets.

5.4.2 Vehicle access is also provided from the two ferries crossing the Dart Estuary. The current Higher Ferry is guided by a cable system. It can accommodate larger vehicles, such as coaches, but not large lorries. It operates between the northern end of the Embankment, at the end of College Way, and the continuation of the A379, leading into the Torbay urban area. This route is used for students studying at Churston Grammar School and South Devon College as well transport to Torbay Hospital. In turn, this now provides an alternative access to the national road network –onto the A380 and A38. On leaving the Ferry vehicles either travel along the Embankment into Lower Town or drive up College Way to the Upper Town or onwards out of Dartmouth. The second ferry –the Lower Ferry –serves a more local purpose, linking Dartmouth with the village of Kingswear. This is a small ferry able to take 8-10 cars and smaller commercial vehicles. On arriving on the Dartmouth side, the vehicles are immediately in the close built-up area of the Lower Town. Queuing for access to the Ferry on the Dartmouth side is along the South Embankment, an occasional issue with high traffic volumes in the main holiday season. Passenger ferries also link the town to Kingswear as well as ones to Totnes and Dittisham/ Greenway Quay . A second passenger ferry service to Dartmouth is planned to be provided as part of the Noss Marina development with associated car parking.

5.4.3 There is a railway station at Kingswear in the adjoining parish served by a passenger ferry across the river Dart with a direct line to the mainline station at Paignton which links to the national rail network. Tourist trains are available in season but there is along held aspiration to have a regular normal non-tourist service.

5.4.4 Bus services are infrequent and as follows:

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- A service to Totnes and beyond - an hourly and part 2 hourly weekday service of 8 buses operating between 6 am and 6.25 pm
- The coastal route from Dartmouth to Kingsbridge and then onto Plymouth –a broadly hourly weekday service between 5 am and 5.15 pm
- A local service between Lower Town and the residential areas of the Upper Town - –Townstal. This operates a weekday service on a half hourly basis from 7.30 am to 11.30 pm

In addition, there is a seasonal (April to October) service linking the Town Centre with the Park and Ride. It is a seasonal service operating between Easter and the end of October (on a 20 minute frequency) with occasional out of season services for the Music, Food and Regatta Festivals. The weekday service runs from 8am to 7pm.South Hams District Council working in partnership with First Devon and Cornwall operates the bus service which comes into the car park to collect and drop off passengers. The service runs from the car park just outside Dartmouth on the A3122, where it joins with the A379 by the Lidl supermarket, to Dartmouth town centre. The rear part of the Park & Ride location is to be developed with a Health and Well-Being Centre. All bus services arrive and depart from the North Embankment adjoining the Boat Float in the Lower Town. The bus stops also serve as dropping off and picking up points for the numerous coaches which provide trips to include Dartmouth. These coaches mainly serve visitors staying in hotels in the Torbay area, but also from further afield.

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5.5 Marine transport and harbour activity

5.5.1 The river Dart provides a key transport link with other local towns and villages. It is a major source of employment based around servicing commercial activity such as construction and fishing, recreational boating, transport links and tourism. Those arriving in Dartmouth by water contribute a significant part of the income for the town as do those attracted by the opportunity to take part in water-based activities ranging from swimming through paddle boarding up to international yachting events.

5.5.2 The Dart Harbour and Navigation Authority (Dart Harbour) has a statutory responsibility for most activities in the river and works closely with various bodies representing the interests of users, statutory authorities, local authorities and Town Councils, the Duchy of Cornwall and individuals. It offers a range of services which benefit users of the river and the local economy ranging from the provision and maintenance of moorings to pilotage for larger vessels coming into and out of Dartmouth (e.g. cruise ships and super yachts) and suitable landing and embarkation facilities. It is in itself a significant employer in the town. This plan supports the objectives of the Dart Harbour Strategic Plan https://www.dartharbour.org/wp-content/uploads/2019/05/Strategic-Plan-Lo-Res-2016-2026.pdf Various initiatives are underway with the intention to enhance accessibility to the river. These include improving access for those with limited mobility arriving by boat and providing connectivity between Dartmouth and the new facilities being created at Noss Marina. Another initiative under the guidance of a charitable trust is the potential development of an improved public slipway to assist users to launch and retrieve small to medium sized vessels.

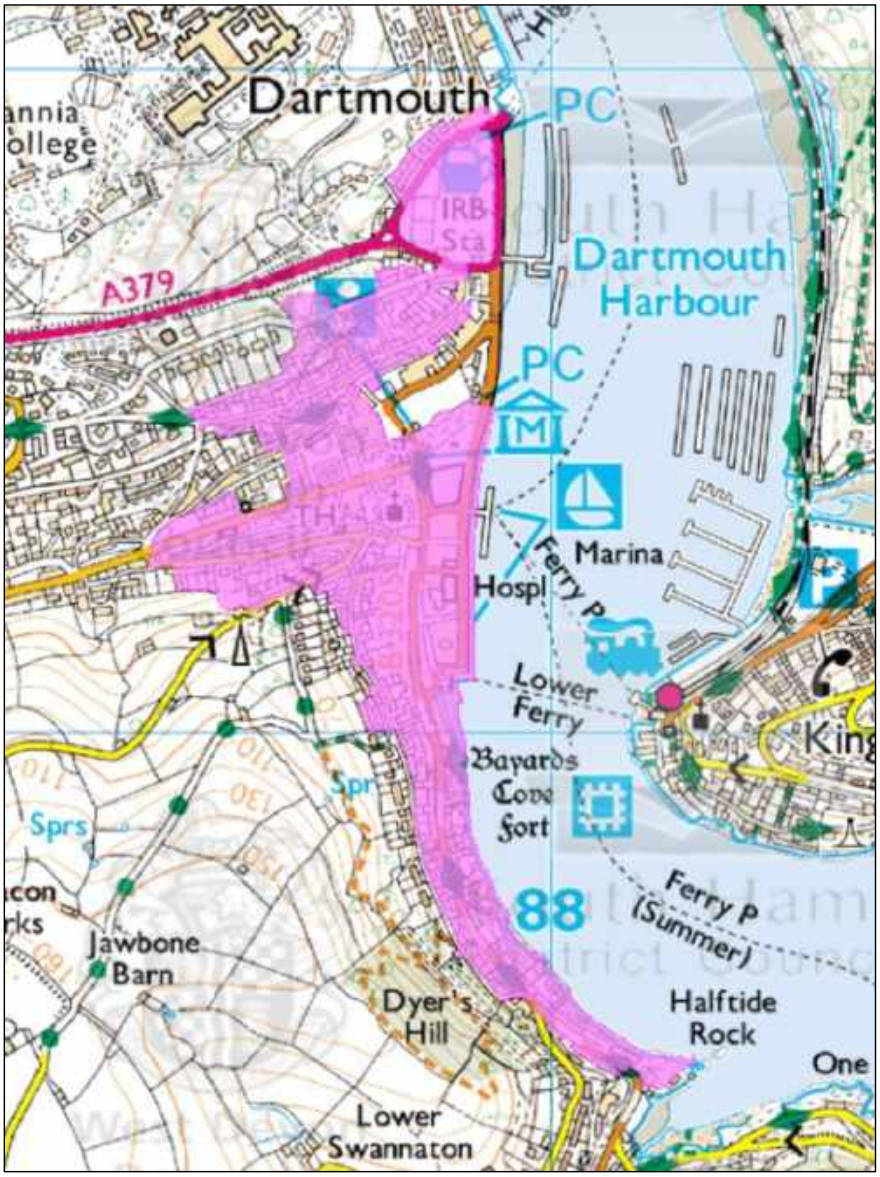
5.6 Town and historic environment

5.6.1 Dartmouth's rich historic environment, its buildings, archaeological sites, landscapes and streetscapes, is exceptional in its quality and diversity. Making the most of our historic environment - protecting and enhancing it for everyone's enjoyment, making it more accessible for the social, economic and health benefits this can bring - is therefore an important part of this Plan.

The position of Dartmouth at the mouth of the river Dart is of such strategic military and commercial importance, and its sheltered natural harbour so perfect, that it developed into an important town from the Middle Ages on, despite being inaccessible to wheeled transport until the 19th century. While it addresses the water, Dartmouth is a town of intimate spaces, unexpected flights of steps or pathways and steep, narrow streets with architectural jewels like St Saviours Church or the houses of the Butterwalk set amongst them. As the medieval town grew, development tended to follow the contours of the steep valley sides giving much of the town a terraced form and affording dramatic views of the estuary from the streets and the houses built along them.

Source: SHDC Dartmouth Conservation Appraisal 2013

5.6.2 Dartmouth's conservation area contains many heritage and non- heritage assets as well as a number of unique historical, green and urban spaces which require protection, enhancement and conservation. The Dartmouth Conservation Area appraisal 2013 study (Appendix L1) undertaken by SHDC set out to explain what makes the Dartmouth Conservation Area special, what needs to be conserved and what needs to be improved. This appraisal document is still very relevant and is the bedrock of the heritage and town environment policies of this plan .The town and historic environment policies of this plan build and on help deliver the recommendations of the conservation area appraisal.



Map 4 Dartmouth Conservation Area shaded pink

5.6.3 It is important to achieve a high level of design quality that makes a positive contribution to the historic environment and the conservation areas of Dartmouth. The SHDC Supplementary Planning Document 2020 Appendix 5 outlines the design principles to be adopted in conservation areas and these are supported by the Dartmouth Neighbourhood Plan.

5.7 Housing

5.7.1 To thrive as a coastal market town in the future, as a place to live, work and visit, Dartmouth will require a diverse and balanced population and age structure. Any new housing must reflect, therefore, the needs of such a population. The plan area is constrained topographically, with very few sites within the lower town suitable for the delivery of new homes. As such, any sizeable growth to support the future needs of the town will continue to the south-west of the town centre. Although the Dartmouth population has remained relatively static (Dartmouth Population in 2001 census **5,504 -** Dartmouth Population in 2011 census **5,605**) as with many coastal communities Dartmouth has an ageing population with households becoming smaller and the number of families decreasing. the ONS produces mid-year population estimates for parishes throughout the country. The mid-2019 population estimate for Dartmouth parish is **5,427** indicating population decline of around 178 individuals since 2011. This level of population decline (3.2%) is broadly consistent with the lack of growth in the number of dwellings in residential use, along with the trends of under occupation, second homes and population ageing. The decline would be addressed by a growth in specialist housing for older people, single person households, couples without children and lone parents. There is, therefore, an increasing requirement for smaller houses, whether because of demographics, the requirement to downsize or issues of affordability.

5.7.2 The Housing Needs Assessment 2021 prepared for this Plan and included as Appendix N states that Dartmouth in particular and South Hams generally, is an expensive area with local people increasingly unable to afford local house prices. Local earnings have not kept pace with house prices in the South Hams area with the affordability ratio now standing at 11 (earnings to house price ratio) for both median and lower quartile earners.

5.8 Health and Wellbeing

5.8.1 In terms of healthcare provision the resident population quoted above increases to about 8,000 based on temporary visitor registrations with the sole GP practice located in Victoria Road. The additional registered numbers also come from surrounding parishes. After the closure of the Dartmouth Cottage Hospital on the South Embankment in 2016, the only remaining health facility is the Dartmouth Clinic, in the centre of town in Zion Place this accommodates limited health services. Two intermediate care beds are also commissioned from the Beacon Court care home. There are currently two pharmacies operating in the centre of town.

5.8.2 The Board of Torbay and South Devon NHS Foundation Trust has agreed to site a new Health and Wellbeing Centre at the top of town, at the site of the current overflow car park for the Park and Ride Service. Construction is planned to start in 2021. The new Health Centre will house the Dartmouth Medical Centre, which will relocate from the centre of town, the existing services provided from the Dartmouth Health and Wellbeing Centre in Zion Place, a retail pharmacy and rooms for the Dartmouth Caring charity, as well as a café. The nearest

District General Hospital is Torbay Hospital. There is an existing ambulance station in Dartmouth and the Devon Air Ambulance is also able to land in Coronation Park

5.9 Education

The main education provision for all school age pupils is through the Education South West (ESW)Trust, a multi-Academy Trust which runs the Dartmouth Academy an all-through school, providing for pupils from age range 3 to16 (nursery, primary and secondary), and located on the edge of the Upper Town. St John the Baptist Primary School is the other school in Dartmouth catering for pupils below secondary school age. The Academy (September 2020) has around 450 pupils on roll. Current buildings are designed for a roll of 650+ In September 2017, Dartmouth Academy received a full OFSTED inspection, and was graded as overall 'good'. Partly as a result of this, secondary school numbers are starting to grow. At age 16+ school leavers from Dartmouth generally attend on one of South Devon College (for vocational and practical studies), or Kingsbridge Community College (to study A level or equivalent qualifications). Small numbers of students choose to travel to Totnes, Exeter or Churston for sixth form education. Sixth form provision in Dartmouth is not considered viable. About two-thirds of its pupils live locally (predominantly in Townstal). Two buses, paid for by the Academy transport students from Torbay. The school reports no particular problems with pupil transport at the present time. Good use is made of local leisure facilities, and there are strong links with BRNC for sports and outdoor activities.

5.10 Britannia Royal Naval College (BRNC)

Beginning in 1863 the training hulks Britannia and Hindostan were moored on the river side of a hilly peninsula called Mount Boone, the majority of which was owned by the estate of Sir Walter Raleigh, who had received the property by Royal Grant from Queen Elizabeth I. The present buildings date from 1905, the architect was Sir George Aston Webb, whose previous commissions included Admiralty Arch and the East Front of Buckingham Palace. The foundation stone was laid by King Edward VII in March 1902 and the first cadets entered the College three years later. The bombing of the College in September 1942 forced a change in training policy and both staff and students were evacuated to Eaton Hall, Cheshire, until the end of the war. Bomb damage sustained to the quarterdeck in 1942 The Royal Naval College re-opened in September 1946 and although structurally it remained unchanged, the number and character of its courses was greatly expanded. By the mid-seventies the number of graduate entrants had significantly increased. The tradition by which the sons of our Monarchy attend BRNC goes back to the time of Queen Victoria. The late HRH Prince Phillip studied there and of the present Royal family, Prince Charles and the Duke of York were also cadets. The range of courses continued to expand; two important new groups of officers came with the arrival of the Special Duties Officers Pre-qualifying Course, St. George, in 1974 and the WRNS Officers' Training Course, Talbot in 1976. The training of female Naval Officers was integrated into that of their male counterparts in 1990 and the Special Duties Officers' Greenwich course moved to Dartmouth in 1996. The College, as a major presence in the Plan area, an employer and significant contributor to the economic and social sustainability of Dartmouth is as relevant as ever. Future changes in Government policy in the way naval training and maritime defence is delivered must be mindful of what impact they will have on the Plan area.

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5.11 Dartmouth Green Partnerships

Formerly known as Dartmouth in Bloom the Dartmouth Green Partnerships (DGP) is a registered charity (www.dartmouthgreenpartnerships.org.uk) and has been in existence since 1974. Over the years they have won many awards for horticultural excellence from the Royal Horticultural Society and South West in Bloom. The purposes of DGP are two-fold; firstly to promote horticulture and floriculture for the benefit of the public generally and in particular those who live in or visit Dartmouth by the provision of floral displays, shrubs and landscapes in places visible to the public and through the conservation of the environment and community involvement. In addition DGP sets out to advance the education of the public in ecological sustainability, conservation, recycling and biodiversity. Volunteers takes care of several sites in Dartmouth and with others are keen to preserve and enhance the town's green spaces as places for health and wellbeing as well as public enjoyment.

5.12 Dartmouth Together

Dartmouth Together (https://covid.dartmouth.edu) is a voluntary sector partnership established in 2018, with support from local government and the NHS, that aims to improve the health and wellbeing of those living in the community. Dartmouth Together is aiming to help existing community groups, such as sports, education and arts societies reach more people and increase membership.

5.13 TQ6 Community Partnership (TCP)

TCP (https://www.c2connectingcommunities.co.uk/our-impact/tq6-community-partnership/) is a partnership set up in 2009 of local people and services who work together to address local issues and community concerns to improve life in Dartmouth, Townstal and the surrounding villages. TCP aim to create greater community cohesion through activities and creating opportunities for the community to do things for themselves. Dartmouth is a town of two halves with visible affluence and hidden poverty. An historic focus on the affluence of the town and the tourist economy has long taken priority over the real challenges and needs locally. Like many coastal communities, Dartmouth, particularly Townstal at the top of the hill, is suffering from the impact of austerity cut back to services, seasonal work and the increase of zero-hour contracts, reduction and automation of essential services, high levels of digital exclusion, rural isolation, infrequent and expensive public transport and its local hard-working population are underrepresented in local decision-making.

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5.14 Dartmouth Rotary

The group raises over £10,000 per annum and awards around 60% of this to local groups in need; including food banks, providing computers, and other school equipment and funding trips and helping schools with reading buddies. They also support other charities such as Community Chest. The remaining funds go to international charities including Shelterbox, Mercy Ships, End Polio Now and Disaster Relief. In normal times the group organises the Summer Fete, Beer festival and collections at Candlelit Dartmouth, at Christmas,

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5.15 Friends of Dartmouth Community Orchard

The group was founded in November 2014 now has 194 members, it was set up to protect the Community Orchard and provide maintenance and improve facilities. The Friends have gained

Community Asset status for the Orchard and have persuaded the Town Council to voluntarily register it for Village Green status. The Orchard now has improved all-weather paths, a shelter with a green roof ,with around 140 trees with many varieties of Devon apples. The group organise an annual summer picnic and apple pressing in the autumn.

5.16 Dartmouth Community Chest

Dartmouth Community Chest (DCC) is a local charity that is completely run by volunteers. They collect used good quality furniture and white goods and redistribute it all to low income families and individuals. They rescue tons of perfectly good items every year from ending up in landfill. DCC runs a series of initiatives to help the community. They provide emergency food parcels and free hot lunches every Friday. Representatives from housing associations, CAB and other organisations attend these lunches regularly to provide help and advice. They are working to support local households who rely on minimum wage seasonal work as poor transport links limit the job options for many, in a town with the lowest level of car ownership in Devon. Their work has helped countless people in Dartmouth and attracted national recognition.

5.17 Dartmouth and Kingswear Society

The Society is a charity whose members seek to preserve and enhance the area of Dartmouth and its surrounding villages, the River Dart and the neighbouring coastline and countryside. Much of this area is part of the South Devon Area of Outstanding Natural Beauty and includes a number of Conservation Areas. Objectives include the preservation, protection, development and improvement of features of historic or public interest as well as the natural beauty of the district together with the maintenance of a viable local economy, all in keeping with its character, design and history. The Society endeavours to promote high standards of planning and building and to prevent damage in the area. Where issues arise which need action or initiatives to meet these objectives the Society will respond accordingly. The Society also seeks to provide a range of enjoyable activities and events for members each year including occasional talks, receptions and visits to local places of interest and non-members are welcome to join in where possible.

5.18 The Old Dartmothian's Association

The Association was formed in 1923 at the Royal Regatta, it's objects are: 'For the renewal of old friendships and acquaintances of Dartmothians who revisit the scene of their youth and who would be likely to visit the town at the Annual Royal Regatta'; also, to keep in touch and with current events in the town; to advance the welfare of the home town; care of the old folk of Dartmouth and deceased members' widows; maintain an interest in the educational welfare of the young and encourage Dartmouth sporting traditions. The Association makes regular donations to local charities, youth organisations and sporting clubs, disability clubs and hospitals. Members give their time in supporting St Petrox, St Saviours and St Clement churches when needed and other town assets such as the fountain, the shelter on Coronation Park and replacing the Middleton Arch.

5.19 Dartmouth Museum

The town is well-served by a small but well-formed museum located in part of the iconic Butterwalk, a row of rich merchants' houses dating from 1640. The main themes of the

Museum are the people and town of Dartmouth, and its naval and maritime connections, supported by displays and archives. The Museum attracts around 10,000 visitors a year on foot and handles an increasing demand worldwide for genealogical and academic research enquiries. Exhibits are regularly updated including a model as part of the Mayflower 400 celebrations. The Museum survives in difficult commercial conditions, largely by being entirely staffed by volunteers. Further details can be found at https://www.dartmouthmuseum.org

5.20 Flavel Arts Centre

The Arts Centre was opened in 2005, and now plays a vital role as a community hub, providing cinema and live theatre, meeting rooms, a branch of Devon Libraries, an exhibition space and a café, and is open 363 days a year. The centre is supported by a team of over 100 volunteers. It is the only venue to provide this range of facilities and activities in Dartmouth and the wider area.The Flavel has a varied programme of live events with performances by some well-known artists; the cinema has more than 400 screenings per year; 36 different groups meet regularly including pilates and yoga classes and the Flavel is home to the local U3A. The library has over 20,000 visits a year, and the café provides a regular meeting place for locals and visitors alike.

5.21 Dartmouth Caring

Dartmouth Caring is a registered charity, established for over 30 years. In 2018 we were awarded the Queen's Award for Voluntary Service in recognition of the work we have been doing, and continue to undertake. Our aims are simple, to support those in need. Each year we support over 750 people (10% of the local population) across Dartmouth and the surrounding villages. Much of our work is funded through local fundraising and small grants. We work from our base by the GP practice using staff and a team of over 120 volunteers to deliver our services. Our aim is to enable people to live happy and vibrant lives, connecting those who are isolated to others and improving health and well-being within our community. We provide a range of 20+ services.

5.22 The Food Bank

This food bank, has been operating since 2012 is open every Wednesday morning 11 AM to 1 PM at Ivy Lane Dartmouth. We provide bags of ambient food to anyone in need and welcome referrals from local agencies. Food parcels are available at Dartmouth Caring and the Guildhall for collection when we are closed. We deliver to those who cannot collect in person.

5.23 The Flavel or Dartmouth pantry

In Dartmouth there is often unseen food and fuel poverty, partly due to the seasonal nature of the jobs in the hospitality sector. To help address this need ,which has been even more marked through the 2020/21 covid pandemic, Flavel Church operates a pantry where fresh food, bread and other essentials can be obtained free of charge by whoever needs it. The project is supported by local businesses and charities in the town. The pantry is available Regularly during the week and whenever the Church's Flavour Coffee Lounge is open. The lounge is open to people of all faiths and none, and it provides a safe haven where individuals and groups can meet; to chat; to knit; to relax; to meditate; or to pray.

5.24. Dartmouth Visitor Centre

The centre is situated in the heart of the town in the Mayor's Avenue car park. It provides a welcoming face to visitors providing information about local events, attractions, travel arrangements and accommodation advice. The team of staff and volunteers have excellent local knowledge and help plan visits and days out. It is open 7 days a week. At the centre you will also find the oldest working model of the first atmospheric steam engine; invented in Dartmouth by local man Thomas Newcomen c 1712. This engine was used by the Coventry Canal Company for pumping water into the canal at Hawkesbury Junction, Warwickshire and was brought back to its birthplace in 1963 by The Newcomen Society.

6. Proposed policies for the Plan area

6.1 Green Environment

6.1.1 Background

The NPPF states that "Planning policies and decisions should contribute to and enhance the natural and local environment" by "protecting and enhancing valued landscapes". This is supported in the JLP in DEV25 which confirms that nationally designated landscapes such as the South Devon AONB should be protected from inappropriate development and activity.

Map 5 South Devon Heritage Coast Policy Area (JLP Dev 24) shaded blue

Map 6 Undeveloped Coast Policy Area (JLP Dev 24) shaded purple

Policy DNP GE 1 Impact on the South Devon Area of Outstanding Natural Beauty (AONB)
Undeveloped Coast and Heritage Coast

In addition to National and Development Plan policies and guidance controlling development in and within the setting of the South Devon AONB, Undeveloped Coast and Heritage Coast, development within the designated landscapes must demonstrate, where appropriate due to the size and scale of the development the following;-

a) how it maintains and enhances the intrinsic Landscape Character Areas and Types (LCT) of the landscapes affected as set out in the latest Landscape Character Assessment for the South Hams;
b) why it cannot be accommodated reasonably outside the Heritage Coast and Undeveloped Coast designation;
c) How the natural assets and constraints of a development site including existing trees have been assessed. Substantial harm to or loss of irreplaceable habitats such as ancient woodland and within historic boundary features, walls, hedges, banks and ditches should be wholly exceptional;
d) how opportunities for improving public access to and the enjoyment of the coast have been included.

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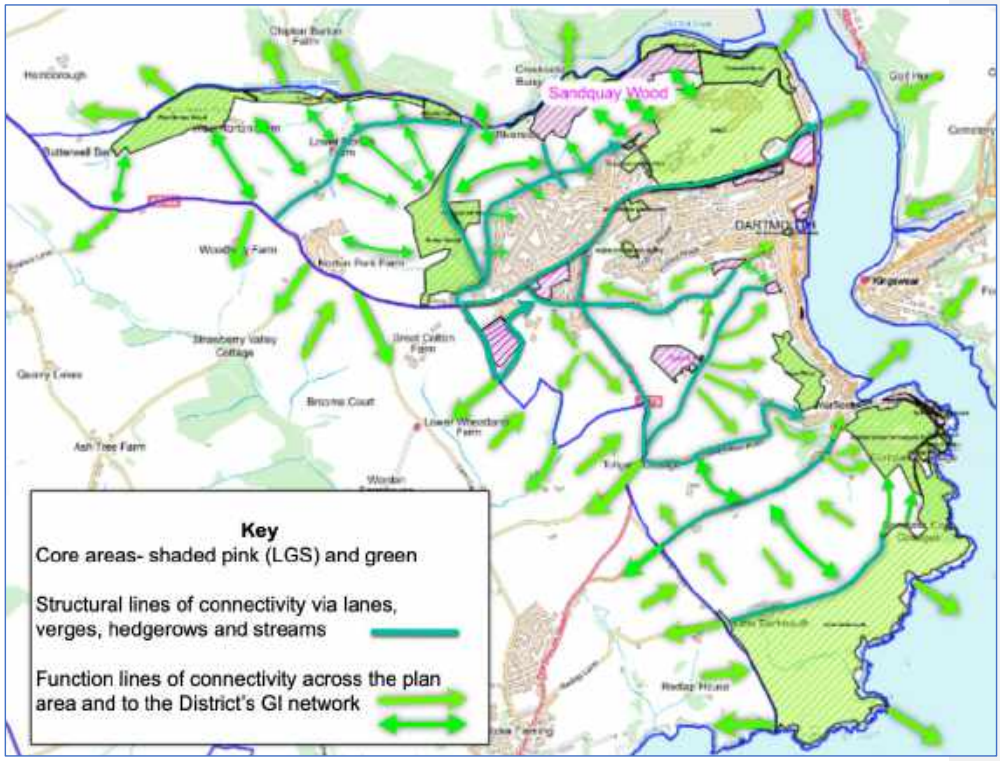
6.1.2 Safeguarding biodiversity and Green Matrix through the plan area

Planning policy at all levels must aim at enhancing biodiversity, seek to protect the core areas of the green matrix, the network of routes that connect them, and the species present in them. The policy below seeks to at a local level ensure legal requirements are met, and that specific development plans prevent or mitigate the loss of biodiversity.



Map 7 The Green Matrix of Dartmouth Parish

The Green Matrix links habitats and the wildlife they support. They provide a vital role in allowing all kinds and sizes of wildlife, from mammals to invertebrates, to move safely between home patches which otherwise would be isolated. They promote healthy and resilient biodiversity of plants and animals and help prevent genetic inbreeding and local extinctions. Typical components may be lanes, the banks of watercourses, unsprayed field margins, hedges and strips of woodland. Their essential feature is connectivity, with different types of corridor linking to provide larger and more valuable wildlife resource. Designation should alert Planning Authorities of the need to preserve this connectivity by avoiding development which will, for example, remove sections of hedgerows or clearance of

woodland. The protection of existing, and creation of new green corridors is a prime objective of the South Hams Infrastructure Framework 2015.

Policy DNP GE 2 Safeguarding the biodiversity and Green Infrastructure throughout the Parish

Where appropriate due to the size and scale development proposals should;-

a) Include a Green Infrastructure plan to show how the development can improve greenspaces and corridors for people and nature, in the context of the parish and where possible connecting to the green matrix of the plan area and the broader green infrastructure of South Devon. The individual components of the green matrix illustrated in Map 7 Appendix E1 and wildlife resources included in Appendix E2 should be protected. Opportunities should be sought to improve accessibility, enhance and extend this matrix. The presence and importance of the Greater Horseshoe Bat Consultation Zone in the Plan area should be recognised.

b) Include a biodiversity action plan which includes details of how the development will achieve a net gain in biodiversity in compliance with national policy requirements.

c) Retain on site natural features such as Devon banks, stone walls, steps, hedgerows, protecting existing mature trees beyond those protected within a Tree Preservation Order or the Conservation Area.

d) Where possible replace any alien and foreign species of trees considered invasive or harmful with indigenous species.

e) Promote where reasonable opportunities for improving access to heritage assets and green space through new walking routes.

f) An increase in paved areas resulting in loss of habitats and increased flood risk is generally not supported.

6.1.3 Community aspiration; to protect and create net gains in biodiversity

This plan supports DTC in actively encouraging local landowners to participate in DEFRA's Higher Level Stewardship scheme (and its post-Brexit equivalent) to enhance biodiversity on agricultural land within the parish or otherwise to adopt practices that achieve the same aims. In addition the plan supports DTC drawing up management plans for the sites of wildlife interest that it owns; each plan to incorporate measures for protecting and enhancing biodiversity. Dartmouth based groups and individuals are encouraged to work with conservation bodies and contribute to monitoring schemes in order to develop a richer picture of the biodiversity within the parish.

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6.1.4 Local Green Space

NPPF para 99 allows the designation of land as Local Green Space through Neighbourhood Plans, allowing communities to identify and protect green areas of particular importance to them. Para 100 establishes the criteria for such designation of a green space;-

- In reasonably close proximity to the community it serves;
- Demonstrably special to a local community and holds a particular local significance, for example because of its beauty, historic significance, recreational value (including as a playing field), tranquillity or richness of its wildlife; and
- Local in character and is not an extensive tract of land.

Consultation with the local community regarding the audit of open spaces and nomination of those suitable for Local Green Space designation was undertaken at public meetings, notification of Landowners by phone and email, meetings of the Green Environment Topic Group, through publicity on the website, through newsletters and the development of a team of "Local Champions." Landowners were consulted for all of the nominated sites. The sites nominated for Local Green Space designation are shown in Map 8 and in Table 3 included in the appendices which summarises the evaluation of these sites.

Policy DNP GE 3 Local Green Spaces

The following green open spaces within the plan area are designated as Local Green Space. These areas illustrated in Map 8, 8a and detailed in Table 3 are small tracts of land, meet the criteria described in NPPF paragraph 102. All development within or in the vicinity of the LGS must respect and not compromise this designation;-

LGS1 Coronation Park
LGS2 Royal Avenue Gardens
LGS3 Community Greenhouse and adjacent gardens
LGS4 Green spaces and shelter beside Dartmouth Castle Wall (excluding Hawley's Fortalice wall)
LGS5 Castle Estate
LGS6 Jawbones Allotments
LGS7 Milton Lane Allotments
LGS8 Longcross cemetery
LGS9 Community Orchard
LGS10 Warfleet Creek, Lime Kilns, Quay and Slip.
LGS11 Sandquay wood
LGS12 Norton Wood
LGS13 Norton Field
LGS14 Manor Gardens and viewing platform
LGS15 Crosby Meadow
LGS16 Jawbones Beacon Park
LGS 17 Bowling Green
LGS 18 Play area at the junction of Victoria Road and Vicarage Hill

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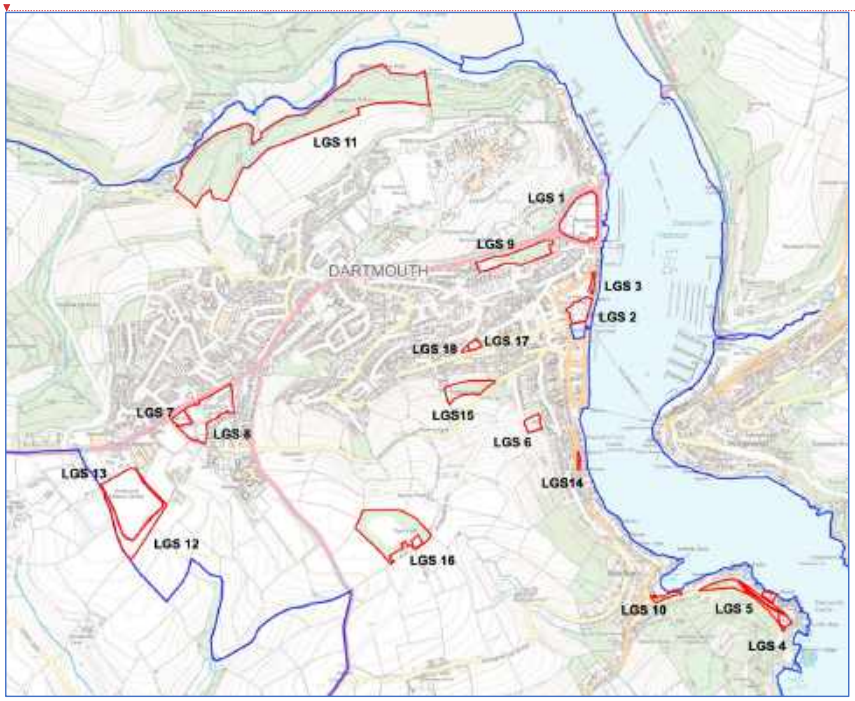

Map 8 Local Green Space designations lined in red, parish boundary in blue

6.1.5 Allotments

There are 0.7ha of allotments in Dartmouth, divided between 2 sites, this is adequate for the present population but is slightly below the target for Devon established by the English Allotments Survey in 1987 (0.15 ha/1000 population) and adopted in the JLP policy DEV5. One site Milton Lane is on flat ground and owned and operated by DTC, the other on the steep slope of Jawbones Hill, owned by the Dartmouth Trust and operated by the Jawbones Allotment Society. Both sites are judged to be adequate by the occupants with provision for storage and accessible water and are fully occupied with a waiting list for vacant plots. The Milton Lane site has car parking. It is important that both sites are retained for this purpose and that provision is monitored as the Cotton Farm development becomes populated. The need for further provision should be monitored in line with demand from increased waiting lists and the needs of new residents.

Policy DNP GE4 Allotments

The allotments at Milton Lane and Jawbones will be retained. The importance of Milton Lane and Jawbones allotments as assets to the community, and local food production is recognised by their designation in this plan as Local Green Spaces. The re-purposing or encroachment on these existing sites will not be supported.

Development that includes provision for community allotments will be supported.

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6.1.6 The Dart Estuary

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Dartmouth has an intimate relationship with the river from which it takes its name. This relationship requires pro-active management through the Dart Harbour Authority, The South Devon AONB, District , Parish and Town Councils. The AONB Estuaries Management Plan for the Dart Estuary and the Dart Harbour Strategic Plan in force at the time should be material considerations in determining any future planning applications where it is relevant to the planning proposal. Regard is given to the objectives of the Water Framework Directive (https://environment.data.gov.uk/catchment-planning/ManagementCatchment/3081) the River Dart is Moderate Ecological Status in this location. New development must not cause deterioration from the present status and opportunities to achieve a good status should be sought. This would have benefits for the environment, as well as the community and attracting economic investment.

Policy DNP GE5 Maintaining the character and the environmental quality of the river

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The natural characteristics of the Dart estuary should be retained in any development along the waterside. For any future waterside development consideration should be given to respect the following criteria;-

a) All existing wooded areas visible from the river, particularly those running to the water's edge and/or where they start at the visible natural ridge line should be retained;
b) Any adverse impact on the health and quality of the river from development must be mitigated against; this includes impact from noise, pollution, such as sewage and litter;
c) There should be an overall positive impact on the wildlife designations along the river edge as indicated in the Green Matrix strategy (Map7) and the Wildlife Resource Map for the Plan Area (Appendix E2) Designations that must be safeguarded include; Special Areas of Conservation, County Wildlife Sites, Strategic Nature Areas and Other Sites of Wildlife Interest.

6.1.7 Locally Important Views (LIV)

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There are many impressive, iconic, and locally distinctive views within the parish. Those selected after consultation with our community are listed in the following policy. The views support the setting of the town within the South Devon AONB and should inform future development. The LIVs are listed in Appendix F and their arc of view illustrated in Map 5,they fall into 3 categories:

- Natural and sequential approaches to Dartmouth; these represent green highways variously consisting of Devon banks, historic walls, and hedgerows with assorted shrubs and trees that are important for their visual qualities, imbue a sense of tranquillity and provide important habitats for biodiversity.
- Views from the town; to the sea and river, the network and matrix of green spaces, woodland and agricultural land which create the varied landscape and seascape character types and provide the setting for Dartmouth.
- Views into the new and old parts of the town emphasising the setting of the built environment.

Policy DNP GE 6 Locally Important Views

Development within the foreground or middle ground of the views shown in Map 9a and b , and Appendix F should not harm and should, where possible, contribute positively to the existing composition of natural and built elements. Development should not be overly intrusive, unsightly or prominent to the detriment of the view as a whole, or to the landmarks within the view.

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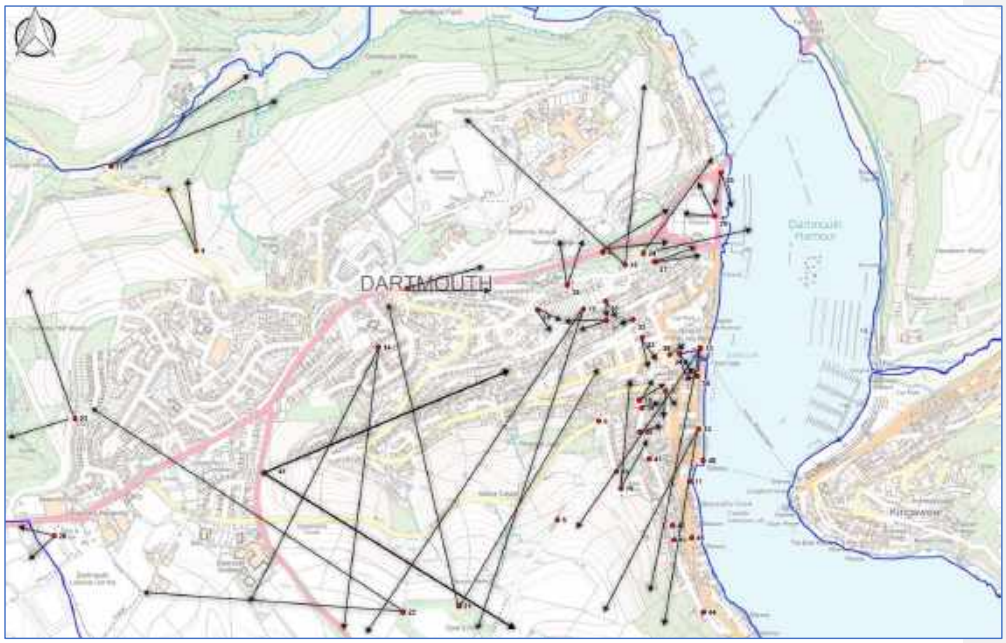
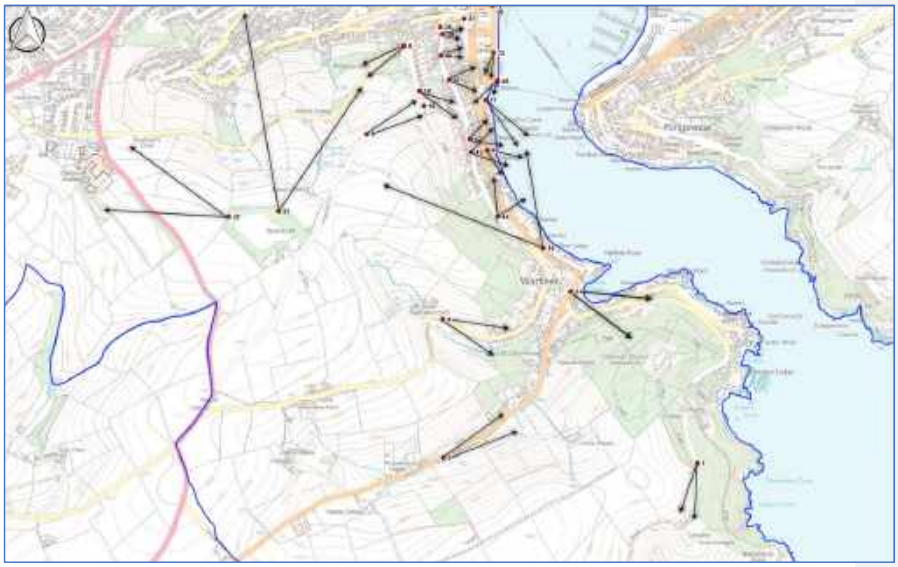
Add additional view from Yorke Road to river

Photographs of Locally Important Views; a full set of views and their justification are included in Appendix F





Maps 9a and 9b Locally Important Views

6.1.8 Mitigation against climate change and achieving net-zero carbon emissions

Concerned individuals, families and businesses are already making choices to reduce their carbon footprints; for instance, buying electric vehicles, installing renewable energy heating systems and better insulation, choosing green energy tariffs, recycling, reducing car journeys. Sustainable tourism is becoming increasingly popular; for example, adopting measures like solar or electric powered ferries and tour boats, hydrogen-powered buses. (see Appendix G, section 2).In order to meet the Intergovernmental Panel on Climate Change target of reducing carbon emissions by 45% by 2030 and SHDC's declaration of a climate change and biodiversity emergency on 25th July 2019 and setting a target of net-zero emissions by 2050, this plan supports the adoption a variety of measures. (also see Appendix G, section 1b).

Policy DNP GE7 Actions to mitigate against climate change and carbon reduction

This Plan supports the objectives contained in the Devon Climate Change Strategy (September 2018) and the emerging Devon Carbon Plan. All new development should;-

a) Assess and monitor the carbon footprint of the development, its impact on the local community, infrastructure and economy including tourism, employment, transport, farming. Proposals should assess its own operations to enable it to reduce carbon in the development and future operation.

b) Make the town and employment activities more innovative, environmentally friendly and responsible, carbon neutral and sustainable. This applies to all businesses in the Plan area but in particular the most prevalent sectors such as tourist accommodation, river activities, ferry companies, the marina, hospitality, and seasonal events,

c) Include composting and recycling facilities or access to a local community composting facility providing suitable management procedures are in place.

6.1.9 Trees and hedgerows perform a number of important roles in supporting biodiversity, providing attractive shade/shelter and generally improving health and amenity. Trees will also help the plan area adapt to the effects of Climate Change. New development should include the provision of suitable tree planting where appropriate.

Policy DNP GE 8 Promotion of tree planting

All appropriate development where it is demonstrated that the proposals achieve an increase in biodiversity and carbon capture through additional tree and other planting and appropriate land management will be supported.

Development that damages or results in the loss of ancient trees or trees of good arboricultural and amenity value will not normally be permitted. Proposals should be designed to retain ancient trees or trees of arboricultural and amenity value. Proposals should be accompanied by evidence that establishes the health and longevity of any affected trees.

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New tree planting should use only native and locally appropriate species and must not conflict with and should complement wildflower rich grasslands.

Community based initiatives to plant trees and enhance biodiversity, wildlife habitats and corridors within the plan area will be supported where appropriate.

6.1.10 This Plan supports JLP policy DEV35 (Renewable and low carbon energy). Through the consultation process the community have expressed interest in supporting more renewable energy generation in the parish. Not all technologies are appropriate for this sensitive landscape; there is potential for biomass, hydro-electric and small scale roof mounted solar. Solar farms or wind turbines are not considered suitable for the parish.

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Policy DNP GE 9 , Encouraging renewable energy

The development of small scale renewable energy generation where supported by the community will be encouraged, this includes;-

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- Biomass; where material is sourced from the coppicing local woodland and hedgerows;
- Hydro power generation from local watercourses;
- Technologies making use of the River Dart;
- Small scale solar power when roof mounted on domestic, employment and agricultural buildings;
- Ground source and air source heat pumps;
- Community heating and combined heat and power.

Wind turbines and large-scale ground mounted solar power are not considered appropriate methods of generation within the parish.

Where appropriate proposals should demonstrate that they will not affect the integrity of the Statutory and Non-Statutory wildlife sites within the parish and will have no detrimental impacts on South Devon AONB. Where necessary proposals must be supported by protected species surveys and the identification of any necessary mitigation measures.

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For the purposes of this policy small scale is defined as less than 50Kwp.

6.1.11 Community aspiration; to mitigate against Climate change:

The plan supports the introduction of carbon reduction measures within DTC and harbour operations:

- Consider facilitating a salary sacrifice scheme for electric cars, getting an electric car pool and changing the vehicle fleet to electric. (See Appendix G, section1c);
- Install renewable energy systems in its buildings to reduce energy use and improve efficiency;
- Buy fewer consumables and reduce waste (e.g. plastics especially for single use).
- Ensure that clear, visible signs are installed and maintained at ferry queues to prevent idling vehicle engines,
- Introduce greener low carbon ferries and ensure that existing ferries do not idle when stationary,
- Adopt a communications policy to encourage a local movement for behaviour change,
- support a local awareness campaign to keep local residents, businesses and visitors up to date with current recommendations and legislation issued by national and local government and environmental organisations (Appendix G, section 4).

Local businesses are encouraged to contribute to a 'Green Recovery Plan', putting sustainable initiatives at the heart of economic recovery from the Coronavirus Covid 19 pandemic. This plan encourages the adaption of existing businesses and the welcoming of new businesses to achieve this. For example, existing or new businesses could adapt to retrofitting domestic and marine powering systems with clean energy. (Appendix G, section 1a)

6.1.12 Light Pollution: new development that increases the level of artificial light is a factor that threatens the survival of protected and threatened local wildlife and adversely affects human health, South Devon AONB Management Plan Policy Lan P4(Tranquility) and Lan P5 (Skylines and visual intrusion) seek to reduce the impact of external lighting and nighttime scenic intrusion. When outside lighting is used on private and public premises, including floodlighting, encouragement will be given to ensure that it is neighbourly in its use. All external lighting should be deflected downwards rather than outwards or upwards and should when possible be switched off after midnight; any movement-sensors should be regulated to reduce illumination periods to a minimum.

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Policy DNP GE 10 Prevention of light pollution;
Development should not detract from the unlit environment of Dartmouth and surrounding countryside and should minimise their impact on the night sky. The impacts of a development on dark skies and the proposed colour rendering and frequencies must be considered at application stage following generally the guidance of the Institute of Lighting Professionals and in particular on the impact of bats on lighting schemes (guidance note 8, Bats and Artificial Lighting)[6] The following will not be supported; -

a) The use of a high proportion of glass in walls and roofs without consideration of the impact on the environment when internally lit,

b) Security lighting, outside lighting, and floodlighting that is not designed to minimize their impact on the night sky with lighting deflected downwards and switched off after midnight.

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6.1.13 Flood Prevention

Dartmouth is at risk of flooding by fluvial, tidal and wave action. The Environment Agency (EA) completed a tidal flood risk modelling update for Dartmouth in 2017. The study assessed the flood risk in Dartmouth for a range of events and has used the results to update the tidal procedures for Dartmouth. The model results show that there are areas of the town susceptible to regular flooding. These areas include the Lower Ferry Slipway, the North and South Embankment, Coronation Park, Bayard's Cove and Dart Marina (Appendix G, Section 4A) This modelling helps the community better understand the risks helps DTC work with partners such as the EA, and SHDC to identify works that can be done to mitigate the impact of these risks.

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Policy DNP GE 11 Prevention of Flooding;
Development within flood risk areas must be avoided unless no alternative sites are available.

Where there is no alternative to developing within a flood risk area, new development must be designed to be safe from flooding, not increase flood risk elsewhere and, where possible, reduce flood risk overall. Proposals should address the latest national guidance on meeting the challenge of climate change through flooding and coastal change. Where necessary proposals must demonstrate that the impact on the existing foul and surface water system has been assessed and includes details of on-site mitigation if required.

Any proposals in the proximity of the Environment Agency flood risk areas illustrated in map 10, and subsequent revisions to the Flood Map, and highlighted in their flood risk modeling should have due regard to historic flooding incidents and the reports of these prepared on behalf of Dartmouth Town Council, included as Appendix O.

There should be no adverse impact on local streams, leats, flood channels and neighbouring properties.

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[6] https://theilp.org.uk/resources/#professional-lighting-guides

The design of any flood defences should be carried out in consultation with the community and appropriate to the historic and natural settings of the plan area. Materials used should be in accordance with the policies of this plan and the planning guidance of the South Devon AONB.

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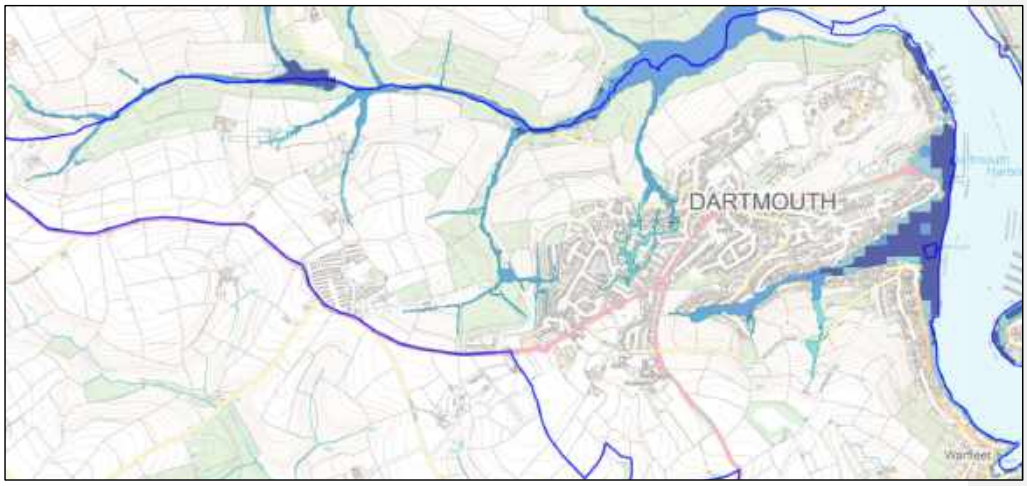

Map 10 Flood Risk areas for Dartmouth Zone 2 light blue, Zone 3 dark blue

6.1.14 Settlement Boundary and avoidance of coalescence

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Dartmouth is one settlement ,however at the western edge of the Parish the developed area is close to the Parish boundary and risks coalescence with adjacent settlements and hamlets. This plan considers that green infrastructure around the settlement is important to the open character of the town, maintaining a high environmental quality and achieving the green matrix referred to in Policy DNP GE2. To safeguard these features and prevent coalescence a settlement boundary and avoidance of coalescence policy is included in this Plan. The settlement boundary proposed restricts development in the open countryside, will be used to ensure that development proposals do not individually or cumulatively result in the coalescence and the loss of the separate identity of Dartmouth. The principles applied to determine a settlement boundary to inform the JLP (TTV Topic Paper June 2018) were used to help define the boundary. For proposed development sites located outside the settlement boundaries Plan Policy DNP H2 (Rural Exception Sites outside the settlement boundary), DNP EC6 (Employment Uses in the Countryside),the criteria of JLP Policies TTV 27 (Meeting local housing needs in rural areas) and TTV26 (Development in the Countryside) will also apply.

Policy DNP GE12. Settlement Boundary and the avoidance of coalescence;
A settlement boundary for Dartmouth is designated in this Plan and illustrated in Map 11. Development inside the settlement boundary is acceptable in principle subject to National Policy and Guidance and the Development Plan.

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Development proposals outside the settlement boundary will be treated as development in the open countryside.

To protect the character and appearance of Dartmouth, development which erodes the visual separation of the settlement will not be permitted.

Map 11 Settlement Boundary for Dartmouth lined in red, existing parish boundary lined blue . For a more detailed map refer to Appendix Map 11

6.2 Economy, jobs and training

6.2.1 Background

This plan acknowledges the key economic benefits provided by tourism , the Britannia Royal Naval College (BRNC) and related marine industries and seeks to support expansion and add value to these activities. The Plan also supports the careful expansion of the existing employment sites to maximise good job opportunities. The Plan promotes Dartmouth's marine, digital, design and marketing industries, and to have the best broadband links to compensate for its relatively isolated geographic location. The positive impact of seasonal activities such as festivals, events and visiting cruise ships are recognized in the Plan. The economic strategy of this plan sets out to exploit the town's key assets of river location, tourism venues and distinctive character to position Dartmouth as a unique and sustainable place to live, work, visit and learn in.

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6.2.2 This Plan supports and expands on the employment policies of the adopted Development Plan including:-

Dev 14: Maintaining a flexible mix of employment sites
Dev 15: Supporting the Rural Economy;
Dev 18: Protecting local shops and services
Dev 19: Provision of local employment and skills

6.2.3 Bringing further vitality and greater viability to the town centre is supported by this plan together with diversifying the retail offer and adding value to the current retail activities. The plan must have regard not only to the daytime economy, but also to the nighttime economy, which are essential components in supporting the town centre and tourism industry and providing high quality jobs in hospitality and catering.

6.2.4 Tourism is and will remain a fundamental part of the local economy. However, increasing competition from elsewhere as well as the seasonal nature of tourism, means the plan must seek ways to enhance the value of its tourism offer throughout the year. The Dartmouth Visitor Centre provides a vital role in the town's tourism infrastructure, delivering helpful and knowledgeable face to face representation of the town's facilities and attractions. Tourism accommodation in Dartmouth comprises a mixture of family run hotels and guesthouses, self-catering accommodation including Airbnb's and a limited number of exclusive residential seafront and harbour-side apartments near the Dart Marina and within Lower Town. Appropriate support needs to be given to these as long as they do not operate to the detriment to their local neighbours and the wider community. Additional tourism development would not only contribute to the economy but may also offer excellent opportunities to re-use and protect older buildings, improve the public realm and increase employment. Dartmouth's tourism infrastructure should be enhanced to take into account modern visitor expectations and that the full potential of the town's cultural, environmental and social assets is realised. This plan supports the re-use of redundant buildings which may lend themselves well to adaptation and modernisation for tourism uses. The conversion and change of use of former hotel premises to secondary residential uses has been a major concern to the area and is not supported.

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Policy DNP EC 1 Tourism related employment and retention of hotels

The change of use or redevelopment of a hotel and associated hospitality services to non-hotel use will generally not be supported . Such a change will only be supported provided that;-

a) The proposed use would be compatible with the existing building and its surroundings and setting within the Dartmouth Conservation Area and South Devon AONB;

b) No loss of hotel accommodation in the Parish or detriment to local employment will result;

c) Demand for the hotel accommodation no longer exists. Where the loss of a hotel or tourism related site is justified as no longer viable the applicant must demonstrate through an independent assessment that the vacant unit has been actively marketed and offered at a reasonable sale price (comparable with valuations achieved elsewhere in the District) for a minimum period of 2 years.

Development may include;-

d) Change of use to residential care or extra care which supports the Plan objectives to both provide employment and specialist affordable housing for the elderly.

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6.2.5 Tourism is recognised in the HotSW LEP Strategic Economic Plan (SEP) 2014 to 2030 and the Development Plan as one of the highest economic drivers and core traditional sectors in the area. The SEP also recognises the challenge to extend the season and develop all year round tourism employment. The policy below sets out to encourage more innovation and diversification in the sector.

Policy DNP EC 2 Promotion of innovative tourism businesses

This plan supports development that includes new, innovative and sustainable tourism related uses. Activities include but are not limited to;-

a) Green , low carbon and sustainable tourism
b) River and water based leisure activity;
c) The research and development of technologies that support the marine leisure industry;
d) Activities that link to the SW Coastal Path and cycle routes;
e) Cycle and electric cycle hire supporting sustainable tourism and transport.

The proposed uses should be compatible with their surroundings and setting within the town, river, countryside and conserve and enhance the South Devon AONB.

6.2.6 Some employment locations in Townstal and on the periphery of the NP area suffer from poor environment / access with mixed quality buildings and environment and awkward layout, which tend not to attract inward investment and potentially restrict development and expansion and can cause negative customer impressions that can restrict competitiveness. There is a need to encourage and enable upgrading, intensification and enhancement of existing employment sites with poor environments / access. The lack of adequate storage on existing sites has also been identified as an issue in the local business survey (see AppendixK2).

6.2.7 The Business Survey undertaken for this Plan (see Appendix K2) identified a wish to see additional rental premises or that current premises can be more readily adapted for modern office based activity. There may be opportunities for development of existing buildings to achieve this whilst maintaining and enhancing the heritage and townscape value of the area. Office development in high quality accommodation adjacent to the main road network is more likely to be sustainable, providing occupants with easy access to a range of services and to public transport links. Providing new employment opportunities in the Townstal area would help to sustain retail and service businesses located there and provide quality employment opportunities.

Policy DNP EC3 Additional employment land and safeguarding of existing employment uses.

a) Retention of existing employment sites is supported unless other suitable sites are found that are more compatible with the existing transport infrastructure and surrounding residential neighbourhoods. Changes of use resulting in the loss of employment land will generally not be supported.

b) Upgrading, intensification and enhancement of existing employment sites with poor environments and access is supported. Provision of additional storage space on existing sites will be supported.

c) In order to consider improvements on a comprehensive basis rather than piecemeal a Development Brief and masterplan for their regeneration should be prepared in consultation with the Town Council. A model brief is included in the Appendix P1. All development should respect and respond to the agreed brief.

d) Where other suitable sites are identified and the loss of an existing employment related site is considered justified as no longer viable and a change of use to non-employment use is proposed the applicant must demonstrate through an independent assessment that vacant units has been actively marketed and offered at a reasonable sale price (comparable with valuations achieved elsewhere in the District) for a minimum period of 2 years.

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6.2.8 The existing business space in the town should be supported and retained in order to maintain and encourage Dartmouth's local economy and ensure that people will have good opportunities for and access to high quality seasonal and permanent local employment. The loss of shops, restaurants and cafés to other uses particularly in the Primary Shopping Area

for Dartmouth included in the JLP Supplementary Planning Document (2020) and the secondary area further South and illustrated in map 12 should be resisted due to their contribution to the local economy and community. Vacant space above shops in the town centre should be identified for commercial, business or residential use. The town has a relatively low vacancy rate shop premises in the town centre but not all property is of a size or quality to address some of the 'community' needs should someone wish to provide those services. A flexible approach should be adopted permitting appropriate properties to be subdivided to be converted into smaller retail units or start up units or small retail and exhibition space, if it can be shown that that is in line with market needs.

Policy DNP EC4 Support for the primary and secondary shopping area of Dartmouth

All development in the primary and secondary Shopping Areas illustrated in Map 12 should retain business and retail uses (User Class E) including restaurants and cafes. With the exception of those granted under Permitted Development other changes of use that compromises the primary and secondary shopping areas will not be supported .

Subdivision of existing retail and business units will generally be supported.

At upper levels of the Primary and Secondary Shopping Area this plan supports development of flats over shops in vacant or under-used accommodation. Adequate parking must be provided in accordance with Plan Policy DNP ST2. Ancillary uses will be permitted providing they do not undermine the shopping and historic characteristics of the Conservation Area and the Primary Shopping Area. The amenity of existing uses should not be compromised with new development through noise, smells and congestion on pavements.

Where the loss of a retail or business related use is justified as no longer viable the applicant must demonstrate through an independent assessment that the vacant unit has been actively marketed and offered at a reasonable sale price (comparable with valuations achieved elsewhere in the District) for a minimum period of 2 years.

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Map 12 Primary shopping area for Dartmouth JLP SPD 2020 (Appendix 4)lined in red with the secondary area identified by the community lined in blue.

6.2.9 This plan supports business start-ups, the effect of the Covid pandemic may increase the demand to set up new businesses or relocate either in premises or working from home. Start-up businesses will require access to workspace on flexible, 'easy-in, easy-out' terms. The analysis in Appendix K2 indicates that Dartmouth can attract a reasonably well-qualified workforce. It is therefore important for the viability of the town to ensure that employment land and vacant / potential underused premises are retained and used to meet local needs for a provision of a range of types and sizes, including start- ups and micro businesses. This will also encourage younger people of working age to remain in the area rather than seeking work in the surrounding area or further afield.

Policy DNP EC 5 **Business start-ups and mixed use employment** including living over the shop, and live work.

This plan supports the development of business start-up units within new and existing employment areas through the development of Brownfield sites and the upgrading of existing sites and the combination of employment and living accommodation, providing;-

a) The development is in keeping with the scale of the surrounding residential area and other businesses;
b) The new use will not have any detrimental impact on local residential amenities;
c) Significant amounts of traffic and a need for parking will not be generated that cannot be adequately catered for by the existing infrastructure locally;
d) The proposal will not have a harmful visual impact on the town or the adjacent open countryside.

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6.2.10 For new employment uses to be successful it is important to be able to demonstrate the existence of a viable jobs market to encourage people who have left the area for further education and training to return. The HotSW LEP Strategic Economic Plan (SEP) 2014 to 2030 makes clear that broadening the employment base to support the bedrock sectors and diversification into further 'transformational' sectors has the potential to bring in some higher value employment opportunities to the plan area. To further opportunities in existing and emerging employment sectors this plan supports developing training links with Higher Education (HE) e.g. University of Plymouth or Further Education (FE) providers e.g. South Devon College .

6.2.11 There is a move towards pursuance of artisan skills with many individuals seeking a more sustainable approach to their work and to work closer to and with their customers. Whilst it may not immediately create many jobs, it is in tune with the desire of many people to relocate from urban areas and establish a more sustainable lifestyle. There is a critical marine based area on Old Mill Creek comprising high value boat building and repairing businesses This plan supports the development of local and rural skills to maintain them for future generations and the existing heritage and traditional skill based enterprises, notably in the marine sector, to develop skill training programmes and work to secure local employment opportunities.

Policy DNP EC 6 Employment uses in the countryside
The conversion of redundant agricultural buildings, their expansion or development of new buildings for small-scale employment uses will be acceptable in principle within the countryside provided that;-

a) The scale of employment use is appropriate to the accessibility of the site by public transport, cycling and standard of local highways;

b) Proposals respect the character and qualities of the landscape and environment as outlined in Policy DNP GE1 and include effective mitigation measures to avoid adverse effects or minimise them to acceptable levels.

An existing building is considered redundant if it has remained vacant for a period exceeding two years. Evidence in the form of dated photographs will be required to confirm the period that the building has remained vacant.

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6.2.11 The loss of traditional and rural construction skills is a concern to the community. The plan supports working with local and national bodies to make sure these valuable traditional skills are not lost. The hospitality, rural construction and marine industries are evolving employment sectors, with a range of exciting career opportunities. All future development within the parish in these sectors should work with further education colleges including but not limited to South Devon College and Plymouth City College to ensure the greatest opportunities are afforded to local people.

6.2.12 Community aspiration; support for training links that reinforce the existing skills base and emerging new types of employment.

Opportunities for the development of employment uses that promote hospitality, tourism, event organisation/management, local traditional, marine and rural skills and safeguarding these for future generations will be encouraged.

The introduction of opportunities for new and emerging clean employment types that include but not limited to marine, technology, graphics, and digital, will also be encouraged.

Development proposals in the above sectors will be supported where they provide training facilities to improve the knowledge and skills of local people.

Development proposals that establish training links with the South West's universities and further/higher education facilities will also be supported.

6.3 Sustainable Transport ,Infrastructure, and connectivity

6.3.1 Background

Parking and public transport issues were within the top five issues raised in the community consultation survey of 2016 (see section 4.3). The key issues raised were:

- Localised "choke" points for vehicles, especially larger ones on the A3122.
- Narrow streets within the historic core of the Town causing conflict between vehicles and pedestrians.
- Delivery and utility vehicles impeding free flow of traffic and many narrow streets.
- Lack of parking spaces and garaging for a number of properties which affects the availability of on street public parking spaces.
- A view that there are insufficient parking spaces in the Town for visitors, residents, local businesses and their employees.
- The suitability and frequency of the seasonal Park and Ride service.
- Insufficient sustainable transport links between Townstal and the Lower Town.
- Access to the growing number of commercial and community facilities in the Upper Town, from Lower Town.
- The lack of a coordinated transport strategy for all those using the town, whether travelling by car or public transport.

These issues not only affect residents throughout the town, but also businesses, residents in the local catchment villages who rely on Dartmouth for shopping and facilities, and visitors, both day visitors and those using holiday accommodation. There is a seasonal variation, given Dartmouth's importance as a tourist and holiday destination. This plan sets out to help solve the current problems of congestion and parking in the Lower Town. It also supports sustainable transport links between the Upper Town, where the bulk of new development is to be located, and the Lower Town.

6.3.2 A Transport Study

Transport challenges in the town are not new, in 2003 DCC commissioned transportation consultants, Parsons Brinckerhoff Ltd, to carry out a study. In the initial Issues report of June 2004 stated;

"The major transport concerns within the town relate to parking and access and traffic calming and pedestrian areas. We would therefore recommend that potential schemes in these areas be considered as highest priority"

The full report is included in Appendix Q. The recommendations remain relevant today and in the context of this plan. However, they need an update in the light of new policy directions on transportation issues, in particular on sustainability, carbon reduction and the use of electric vehicles. Whilst a number of the minor recommendations have been implemented the report was not taken forward comprehensively by DCC, SHDC or the Town Council. In parallel with the plan process an updated transport study will be commissioned. The following recommendations that have not been taken forward will be revisited;

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- A Community Travel Plan to help communities take ownership of the issues.
- Respect for the latest Devon Local Transport Plan.
- Recommendations for parking respecting narrow streets and steep gradients with a large proportion of parking in Dartmouth is on-street, with only one full-time dedicated car park in the town.
- Relieving congestion in the town centre particularly around St Saviour's Church and the accident data reflects this.
- A joint parking strategy devised by the Town, District and County Councils. This should consider the current stock, the assessed need, the charging and permit policy for parking on and off street.
- A longer-term solution to Dartmouth's parking problems including a new car, bus and coach parking .
- Controlling excessive vehicle speeds across the Parish and within the town consideration of 20mph zones and other, physical, traffic calming measures.

6.3.3 Community aspiration; a transportation study for Dartmouth

It is an aspiration of the Plan that a sustainable solution be found early in the Plan period to manage and control traffic through the town and plan area. The Town Council will commission a Transport Study and work with the stakeholders listed below to achieve this.

The Transportation study should update and refresh the recommendations 2004 Parsons Brinckerhoff Study, commissioned by Devon County Council. The brief for the study will be agreed in detail with Devon County Council, South Hams District Council and Dartmouth Town Council. In particular, the study will assess and propose measures in respect of the following-

a) The adequacy of existing public parking throughout both the Lower and Upper Town including the Park and Ride facility.

b) Sites for accommodating further car, coach and bus parking areas should they be required.

c) A set of parking management proposals to resolve the identified issues in the Lower Town.

d) Measures to improve regular bus services linking the Lower Town with the Upper Town and with the Park and Ride, the proposed Health and Well Being Centre and adjoining commercial and residential proposed development.

e) Measures to ensure regular and emergency transport is available for the whole parish to healthcare facilities within the Parish and to Primary Care Facilities in Totnes and Torbay.

f) Enhancing the relationship between vehicle requirements and the historic and built environment in the Lower Town for the benefit of businesses, residents and visitors.

g) Pedestrianisation and traffic calming in the centre of the Town.

h) Traffic improvements to facilitate the safe crossing of the A379 by craft and users when launching and retrieving craft in the area of Coronation Park.

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i) Throughout, priority will be given to the introduction and provision of electric powered means of transportation.

The Study's proposals and recommendations will be the subject of a robust engagement and consultation strategy with the community.

6.3.4 Footpaths and cycleways

Public Rights of Way (PRoW), cycle paths and other routes that provide public access not only contribute to physical and mental health but encourage awareness of the natural environment and an appreciation of biodiversity, whilst offering a sustainable network of transport links within the community. The JLP policy SPT12 supports the protection of these routes and encourages their extension. In the JLP SPD para. 3.110 states *"There are opportunities to work creatively with landowners to improve connectivity, particularly linking new development sites to existing recreational areas, green spaces, PRoW and other recreational trails. Opportunities to increase, or improve, PRoW alongside new development, will be actively pursued"*. Strategy 11 within the MCTi report of 2004 sought *"to make the natural environment more accessible"* by proposing a number of additional footpaths. A list of existing PRoW, and "aspirational" extensions to existing routes which would enable circular walks or improve accessibility for existing routes are listed in Table 4 and are shown in Map 6. The definitions, rights and restrictions of the 4 categories of PROW and other types of public access routes can be found on https://www.devon.gov.uk/prow/what-are-public-rights-of-way . A detailed audit of the Public Rights of Way and other paths listed in Table 4 is given in Appendix D. Maintenance of PRoW by DCC should be informed by a process which allows the notification of defects by members of the public and walking groups, such as the Dart Area Landscape Access Group (DALAG), via the website of DTC. Proposals for new footpaths, changes in existing PRoW, new surfaces and structures must follow due legal process and obtain consent of the landowners and the Highways Authority.

Policy DNP ST1: Footpaths and cycleways

The existing PRoW and other access routes to the natural environment of Dartmouth should be protected and enhanced. All new development in the Plan area should link to a safe path network that connects the Parish, surrounding settlements, and the SW Coast Path where feasible. Where appropriate, opportunities to improve and extend the existing network will be sought as part of any development proposals. New and existing footpaths should:

a) where appropriate and excluding the SW Coast Path promote their use as cycleways;
b) in consultation with landowners introduce and help establish new routes which include completing the footpath links between Stoke Fleming and Dartmouth on the A379 and linking safely Dartmouth Academy, Jawbones and Crowthers Hill. The route is illustrated on Map 13
c) have durable surfacing and effective drainage;
d) be easy to navigate with discreet signage;
e) be accessible to those with special needs where feasible;
f) facilitate the use of electric bikes with charging points at location agreed with Devon County Council;
g) include improved footbridges and stiles where required.

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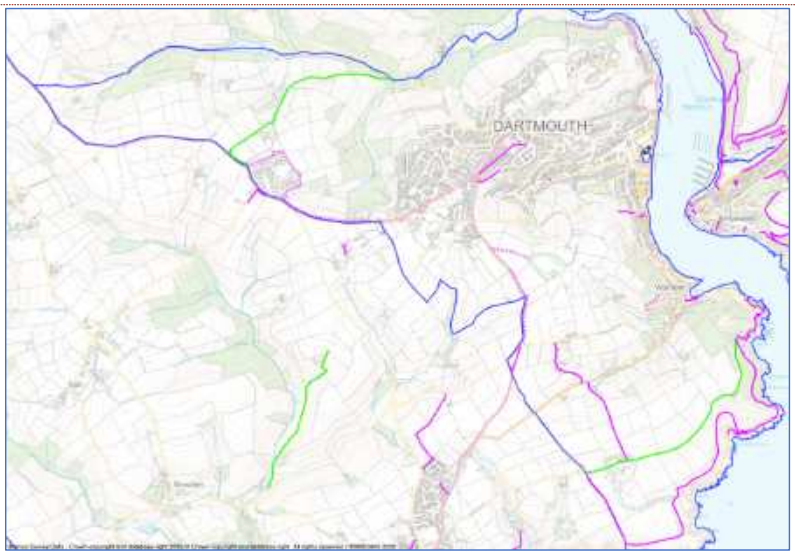
No new footpath, bridleway or multi access route should have a detrimental impact on wildlife habitats as outlined in the Wildlife Resource Map (AppendixE2) and any future revision.

The existing footpath network is shown in Map 13



Map 13 PRoW in the Parish lined in pink and green. Proposed extensions lined in pink dotted. Parish boundary lined in blue

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6.3.5 Car Parking and Coach Parking

One of the most contentious aspects of land use in Dartmouth is parking facilities. It affects businesses, workers, residents and visitors alike because there is insufficient parking to satisfy all their needs. The problem is particularly severe in the Lower Town. Many properties have no off-street parking facilities. There is, also, little if any available land which might accommodate additional parking provision. These problems are accentuated by new development proposals on particular sites generating new vehicle movements and new/altered access arrangements, often affecting the historic core of the Lower Town. The presence of coach parking within the Parish is essential for bringing in visitors to the town and buses operating locally. The area identified off the A3122 and adjacent to the Park and Ride on Map 14 should be retained for this use. If the future Transport Study recommends amendments to the current arrangements for both the Park and Ride and Coach Parking this requirement will be reviewed in future versions of the Plan.

Policy DNP ST2: Car Parking and Coach Parking

a) Existing public car parking should be managed to support the functional sustainability of the town and follow the recommendations of the DCC Transport Study (Appendices Q1 and

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Q2) and the emerging Transport Study. Where new development has impacts on public car parking these should be neutral or positive in terms of this requirement.

b) No development will be supported that causes the significant loss of public car parking. Should spaces be relocated there should be no material reduction in their convenience to the town and local centres unless it can be demonstrated that the parking is no longer needed due to changes in vehicle use.

c) All proposals which are likely to generate an increase in on-street car, trailer and boat parking will be resisted, unless designed as part of an overall parking strategy within a development.

d) New residential development including sheltered housing must ensure there is no increase in on-street car parking.

e) Where achievable the indicative on-site parking standards set out in the JLP SPD (2020)[7] should be met;

1 bedroom	1 space plus 1 space per 3 dwellings for visitors;
2 bedrooms	2 spaces;
3 or more bedrooms	3 spaces.

This standard can be provided off site if such provision would be of greater overall benefit to the functional sustainability of the town and the development in question, and that off-site provision can be guaranteed as permanently available to the development.

f) Parking and charging facilities for electric vehicles, car club/pool vehicles and autonomous vehicles should take priority over petrol and diesel cars. Where new housing development can demonstrate a reduced need for parking due to the utilisation of car club/pool vehicles and autonomous vehicles this will be supported, provided that there are measures in place to support their use.

g) Provision for cycle, ebike, scooter, and motorcycle storage, parking and EV charging should be provided wherever appropriate.

h) New car parking proposals which adversely affect the setting of a development and surrounding landscape features will be discouraged.

i) The area shaded in Map 14 should be safeguarded for coach and bus parking . No other use will be supported unless other suitable locations for coach and bus parking can be found.

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[7] JLP SPD (2020) DEV 29.3 Table 30

Map 14 Area safeguarded for Coach Parking shaded blue.

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6.3.6 Broadband

Broadband coverage in the South Hams is falling behind the UK, out of 650 UK parliamentary constituencies, Totnes is ranked 608th for superfast coverage. Within South Hams superfast availability is 78%, compared to a UK average of 95%. In addition, gigabit availability is 18%, compared to the UK average of 36%. This is all exacerbated in large parts of the Plan area which also have poor mobile coverage, leaving some communities completely disconnected from vital online services. The combination of the National and Local Planning context provides adequate justification and evidence for the following policy. To address the rural digital connectivity gap new development will be expected to provide the required industry standard infrastructure to allow for the installation and maintenance of full fibre optic broadband. With broadband technology constantly improving and the continued goals of increasing speed, there is also a requirement to allow for the upgrade of current broadband with minimal disruption to customers.

DNP Inf 1 Broadband Infrastructure

This Plan supports the provision on site infrastructure for the installation of, and allow the future upgrade and maintenance of, fibre optic broadband technology.

a) All development is required to submit a connectivity statement to set out the proposed broadband provision. The statement shall include which broadband supplier(s) can provide full fibre or fixed wireless coverage to the development to provide gigabit capable broadband provision.

b) All developments must be served with an appropriate open access fibre optic infrastructure to enable high speed and reliable broadband connection to enable high speed and reliable broadband connection in accordance with national and local objectives to increase coverage unless there is evidence which demonstrates that providing the required infrastructure is not feasible or economically viable.

c) Installed infrastructure should allow all premises that form part of the approved development to access superfast or better broadband prior to occupancy.

d) The creation of a building to act as a fibre hub to enable fibre connections within the area will be supported.

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6.4 Town (urban) Environment (heritage and town centre)

6.4.1 Background

The 2016 community survey responses expressed a desire to strengthen adherence to stricter design principles. There was particular concern about maintaining the character of the Town from inappropriate development, respecting the AONB setting and heritage, concerns regarding infill development; loss of gardens, overdevelopment, lack of parking.

6.4.2 Theme Objectives

- Supporting SHDC towards preparing a Conservation Management Plan for the Dartmouth Conservation area;
- Support design quality on development within and outside the conservation area;
- Identify and respect important views to and from the conservation area and the surrounding AONB;
- Work with the Environment Agency to understand the threats from climate change and risk of flooding of the town and conservation area;
- Ensuring heritage assets are put to viable uses consistent with their conservation;
- Preserve the wider social, cultural, economic and environmental benefits that conservation of the historic environment can bring;
- Ensure new development makes a positive contribution to local character and distinctiveness and respects the heritage of the town centre;

- Mapping and updating a record of heritage assets and non-heritage assets important to the character of the town environment;
- Ensure development around heritage assets respected in design, scale and density.

6.4.3 There may be opportunities for replacement dwellings and conversions and subdivision of plots within the town and settlement boundary . However this will only be supported if adequate parking can be provided as outlined in Policy DNP ST2. Any such development which is harmful to the character or appearance of the Dartmouth Conservation Area and the South Devon Area of Outstanding Natural Beauty will not be supported. There are several past examples within the Plan area where proposals to sub-divide plots would compromise the character of the town and the following policy adds clarity to the provsions of the JLP. Details of relevant applications since 2018 have been provided to the LPA, the majority of these were refused or withdrawn.

Policy DNP TE1–Subdivision of existing plots .
The subdivision of existing plots will only be supported where;

a) There is no loss to the character or environmental quality of the surroundings including the Conservation Area and South Devon AONB;

b) The site is serviced by a suitable existing highway on one or more boundaries;

c) The proposed plot sizes and dwelling sizes are in keeping with other building plots and dwelling sizes in the surrounding area;

d) The amenity of adjoining properties is not compromised;

e) Adequate amenity space provision is made creating useable private garden space for both the existing and proposed dwellings;

f) The existing front building line, where appropriate, is maintained;

g) There is adequate space for off street parking as outlined in Policy DNP ST2.

h) The increase in hard surfaces and resultant surface water run-off is mitigated on-site and does not exacerbate habitat loss and flooding risks.

6.4.4 Past pressure for development and eroding design quality generally has had an adverse impact on the plan area and instilled a general lack of confidence of the proposals assessed through the planning system. Any new development in the plan area should be of the highest quality respecting national, local policy and guidelines including the National Design Guide (January 2021) JLP Policies Dev 20 to 22 and the JLP SPD 2020. All development should be commensurate with its sensitive natural and historic location. It should also contribute to the overall enhancement, improvement and resilience of the area. This applies to both new buildings and spaces and surface treatments. All new development and spaces must apply the

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Crime Prevention through Environmental Design (CPtED) attributes together with the practices and principles of Secured by Design[8].

Policy DNP TE2: Design Quality throughout the Parish

Development proposals in Dartmouth Parish should demonstrate high quality design and will be supported where;-

a) The design is locally distinctive, reflecting the appearance and character of the area in which the development is to be located. Innovative contemporary design solutions will be supported providing they do not have a detrimental effect on the overall appearance and character of the area.
b) The height, scale and density of development reflects the existing grain, height, density and pattern of development in the surrounding area. The design should be in keeping with the site and its setting and respect the scale, character and siting of existing and surrounding buildings.
c) Strategically important , sensitive and prominent schemes of all scales should be considered at an independent, bespoke Design Review Panel, such an approach is outlined in JLP SPD 2020.[9] This is of particular importance where proposals impact on the South Devon AONB , Conservation Area and heritage assets.
d) The external materials used should be locally distinctive, natural and where possible sourced within South Devon;
e) Building setbacks reflect adjoining buildings;
f) They incorporate the principles of sustainable and low carbon design as defined by this Plan and Development Plan Policy Dev 32;
g) It has regard to the requirements of CPtED and 'Secured by Design' to minimise the likelihood and fear of crime and acts of anti-social and unacceptable behaviour and community conflict in the built environment;
h) It reduces the dependence on the private car by supporting and connecting directly, where achievable to other more sustainable modes such as walking, cycling and public transport;
i) It retains and protects, wherever possible existing trees, verges, stone walls and hedges in situ. Any lost trees or hedges should be replaced elsewhere on site. Any wall affected should be reinstated;
j) It does not exacerbate flooding risks;
k) Existing footpaths or public rights of way must be retained, or acceptable diversions agreed.
l) There is a safe means of access to the site, that does not result in the unacceptable loss of natural features, or the need to provide excessive widening of local roads.
m) Adequate off street car parking is provided;
n) The infrastructure needs of the development can be put in place prior to the commencement of the main development.

[8] Secured by Design guidance including the key attributes of CPtED
https://www.securedbydesign.com/guidance/design-guides
[9] JLP SPD 2020 paragraph 6.12

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6.4.5 Heritage

This plan supports a positive strategy for the conservation and enjoyment of the historic environment of the town centre and wider parish, including heritage assets most at risk through neglect, decay or other threats. Maintaining and enhancing these features in a progressive but sensitive way, so that it remains an attractive destination for residents and visitors alike, will be essential to the future prosperity of the Town. The community as a whole were invited to nominate buildings, structure and other features that they considered should be included on the list of local heritage assets whether designated or non-designated. Great weight shall be given to the conservation of both designated and non-designated heritage assets identified in appendices J1 and J2 Special regard shall be given to the merit of preserving the asset and its setting and any features of special architectural or historic interest which it possesses.

Policy DNP TE3 Safeguarding Designated and Non-Designated heritage assets and the conservation area of Dartmouth

All proposals in the Dartmouth conservation area and in the vicinity of Designated and Non-Designated Heritage Assets must comply fully with National planning policy and the Development Plan relating to the Historic Environment and;-

a) Respect and enhance the Dartmouth Conservation Area and make a positive contribution to the heritage assets and their setting. Have regard to the Dartmouth Conservation Area Appraisal January 2013 including the four extensions to the area. All proposals must give due regard to one of the ten character areas listed below within which the proposal sits. The prevalent traditional materials, finishes and typical building forms outlined in the appraisal should also be respected.

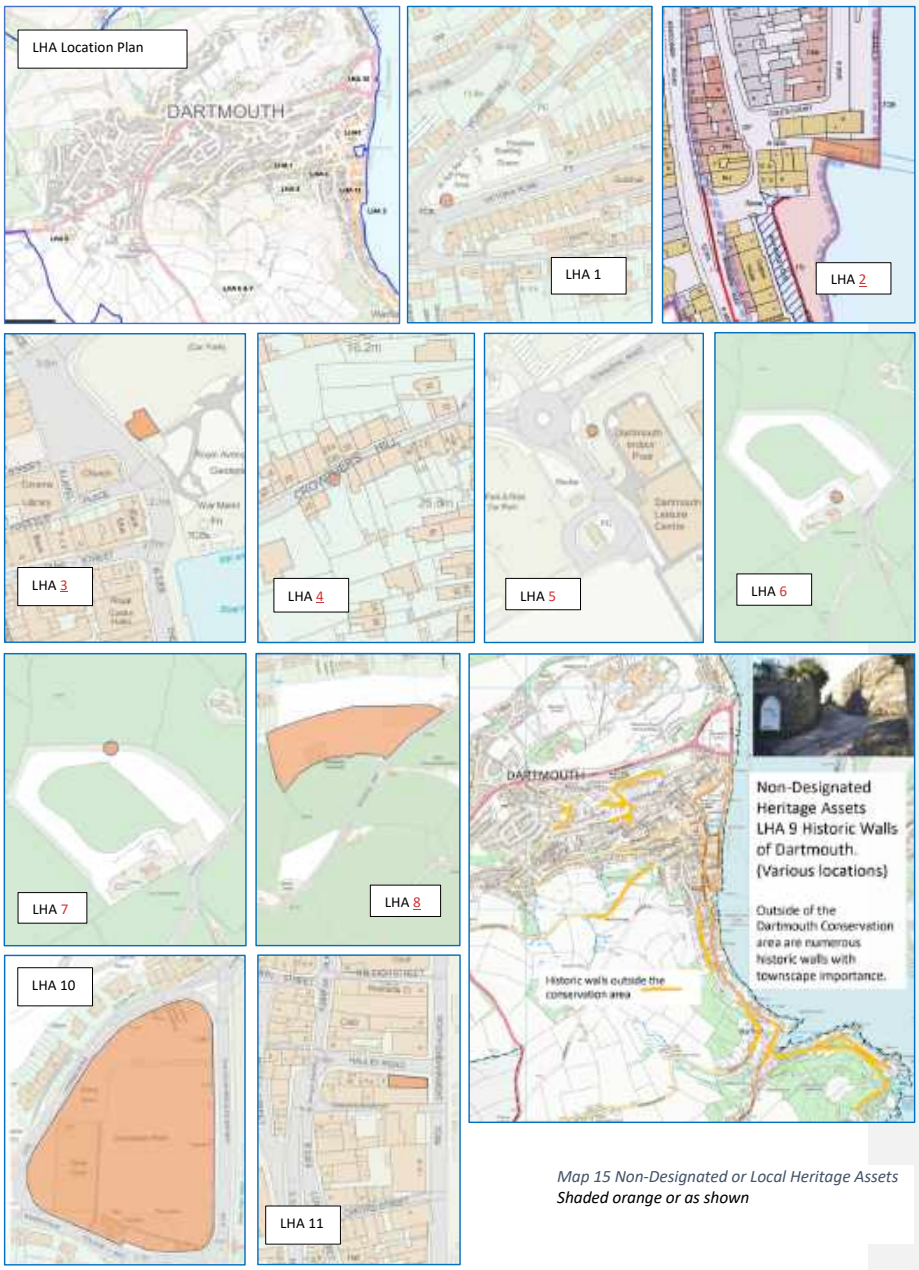
b) Give due regard to the asset and demonstrate an awareness of the Devon Historic Coastal and Market Towns survey(DHCMTS) and the Historic Urban Character Areas (HUCA) for Dartmouth produced by Devon County Council and English Heritage which is included as Appendix J3. Due consideration should be given to the historic character of the area within which a proposal sits.

c) Where relevant, include design features such as setbacks, stone or render walls and roof details that reflect the character and appearance of the surrounding buildings. For extensions, new doors, windows and roofing materials should be of a similar appearance to those used in the construction of the exterior of the original building.

d) Proposals that directly or indirectly affect the significance of Designated Heritage Assets included in Appendix J2 and the following Non-Designated Heritage assets and described in Appendix J,J1 and illustrated in Map 15 should be judged according to the scale of any harm or loss and the significance of the asset to the parish. Heritage assets that should inform development include archaeological features and historic field boundaries.

LHA1 Telephone Box, Victoria Road
LHA2 Dartmouth Lower Ferry
LHA3 Dartmouth Visitor Centre

LHA4 Pony hoops, Crowthers Hill
LHA5 Former Norton Heliport Control Tower
LHA6 Water tower, Jawbones Hill
LHA7 The Armada Memorial Beacon, Jawbones Hill
LHA8 Crosby Meadow
LHA9 Historic walls of Dartmouth in various locations (see Map 15)
LHA10 Coombe Recreation Ground, Coronation Park
LHA11 Dartmouth Cottage Hospital



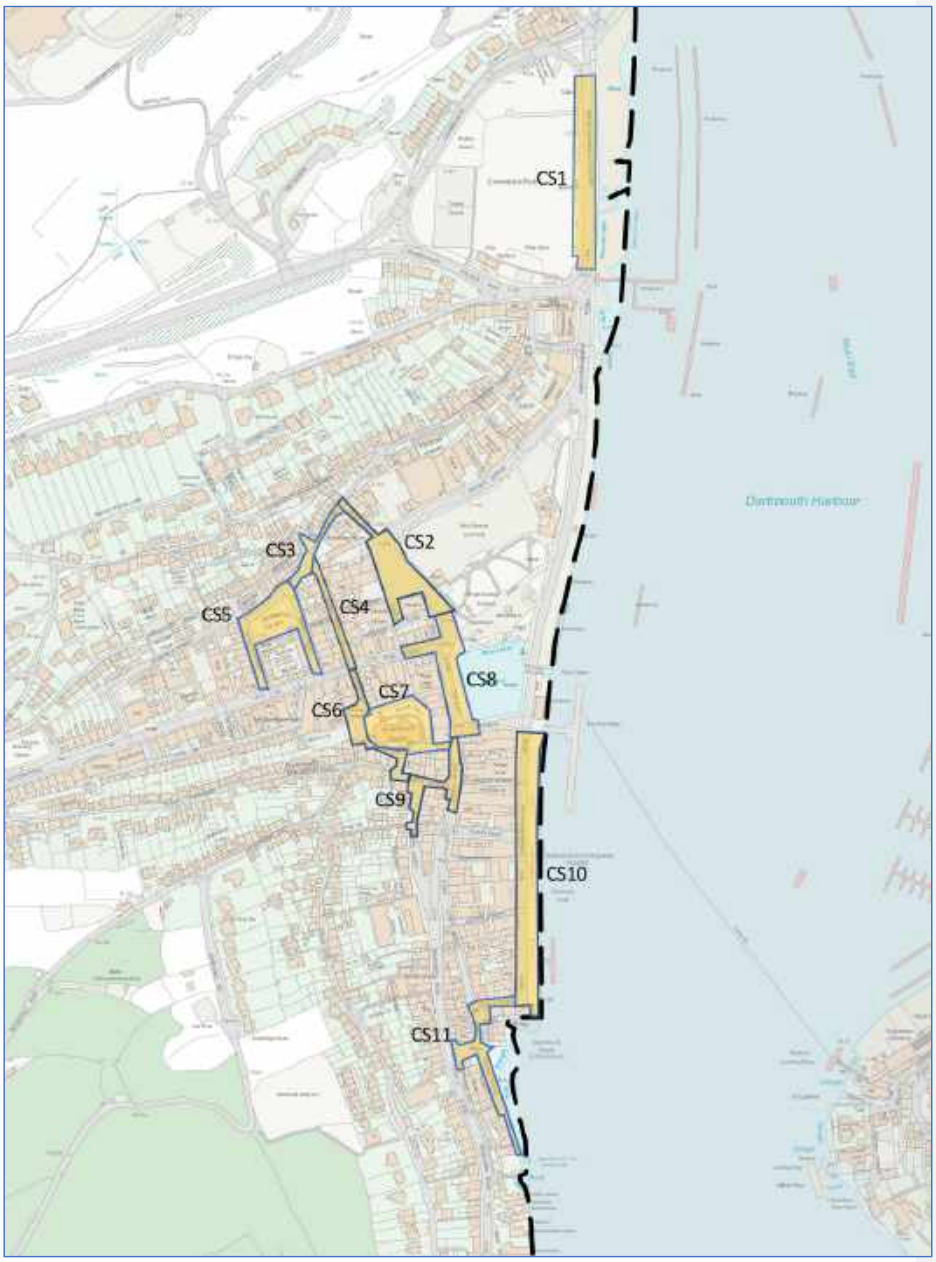
Map 15 Non-Designated or Local Heritage Assets
Shaded orange or as shown

Character Area	Location
1	Clarence Hill, Clarence Street, Undercliff, Broadstone and Newport Street
2	Foss Street, Flavel Street, Union Street, Duke Street, Flavel Place, Anzac Street, Church Close, and Foss Slip
3	South Embankment, The Quay, Spithead, Hauley Road, Mansion House Street, Oxford Street, Lower Street, Giles Court, and Bayards Cove,
4	Market Square, Market Street, Charles Street, Ivy Lane, Lake Street, Victoria Place, and Victoria Road
5	Crowthers Hill, Smith Street, Higher Street, Fairfax Place, and Above Town
6	Newcomen Road and Southtown
Extension 1	Ridge Hill, part of the Community Orchard and Mount Boone Lane
Extension 2	Victoria Road and Southford Road
Extension 3	Coronation Park
Extension 4	The southern part of Southtown and Above Town and Warfleet Road

Dartmouth Conservation Area Character Areas,-Source Dartmouth Conservation Area Appraisal January 2013

6.4.6 Civic Spaces, Public Realm and Townscape

This plan sets out to respect, protect and enhance the civic spaces of the town, creating positive places which contribute to people's quality of life, engender local pride and attract visitors. These spaces identified in the Conservation Area appraisal provide a setting for civic buildings, areas for public events, markets and busy thoroughfares. Civic areas identified in the plan are highlighted in yellow in Map 16. Civic spaces should encourage social Interaction and delivering health and wellbeing benefits. Civic spaces are important and the character and quality of them support the civic pride of the town .



Map 16 Location of Civic Spaces(CS) marked in yellow

Policy DNP TE 4 ; Respect, protection and enhancement of civic spaces

The following spaces illustrated in map 16 and Appendix R1 are identified as civic spaces within Dartmouth;-

CS1 Rue de Courseulles Sur Mer/ Coronation Park Riverside
CS2 Flavel Place / The Quay
CS3 Bottom of Brown's Hill / Foss Street
CS4 Foss Street
CS5 Market Square
CS6 Anzac Street
CS7 St. Saviour's Church (areas to the North, West and South sides)
CS8 The Quay/Boatfloat
CS9 Pillory Square (Higher Street/ Smith Street)
CS10 South Embankment
CS11 Bayards Cove/ Coles Court

Commented [ps3]: Review civic spaces around St Clement's Church, Townstal, and St Petroc's Church.

All development in the vicinity of these civic spaces should where appropriate;-

a) Respect, protect and enhance the physical qualities of the space expressed in the Conservation Area appraisal 2013 and the Historic Urban Character areas of the Devon Historic Coastal and Market Towns Survey for Dartmouth 2016.

b) Support community uses in the space, which can include but not limited to;-

- External seating areas;
- Shared surfaces for vehicles and pedestrians;
- Pedestrian priority;
- Improved public realm including soft landscaping, street furniture, durable and sustainable paving surfaces;
- Public art.

c) Facilitate greater economic activity in the spaces through external seating, events, dining and temporary 'pop up' uses.

d) Support active street frontages to attract social interaction and facilitate natural surveillance and the prevention of crime.

e) Facilitate clear, safe and legible public routes.

f) Support pedestrianisation on a temporary or permanent basis as and when appropriate.

g) Facilitate litter and recycling facilities within the spaces.

h) Any loss of car parking spaces within the civic spaces should be re-provided elsewhere within the town and respect the provisions of Policy DNP ST2.

i) Discourage activities that risk causing public nuisance such as noise pollution.

The plan also supports the introduction of new civic spaces within new residential areas that should also respect the above qualities.

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6.4.7 Brownfield Land

A core principle of the NPPF is to "*encourage the effective use of land by reusing land that has been previously developed (brownfield land), provided that it is not of high environmental value*". The plan area's rich heritage, need for affordable housing, and employment space and the natural landscape constraints make the reuse of brownfield land an essential part of the delivery of new sites for development. While it is acknowledged that not all brownfield land is suitable for development, latest statistics from the Homes and Communities Agency indicate an estimated 61,920ha of brownfield land in England. Of this, 54% is derelict or vacant, while the remainder is in use but with potential for redevelopment. DCLG figures (2010) suggest that approximately 35,000ha is considered suitable for housing. The Campaign for Rural England Housing Foresight Report (2014) suggested that brownfield land has the capacity to support over 1.8 million new homes. However, despite the identified high housing capacity, the most recent government figures have shown a decline in the proportion of dwellings delivered on brownfield land. The Housing Needs assessment (Appendix N) recognises the need for affordable housing and more provision for the elderly in Lower Town. The re-development of brownfield land in Lower Town will help address the housing needs of the area and supporting community facilities over the plan period above the JLP allocations for the Dartmouth area. It is recognised that a number of the brownfield sites are at risk of flooding in Flood Zones 2 and 3 (see map 10). Housing development should be directed towards the sites and levels at lowest risk of flooding. Any development proposals considered necessary within the floodplain to achieve the wider sustainability benefits must acknowledge the risks and be fully justified.

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Policy. DNP TE5 Brownfield first

This Plan promotes the redevelopment of previously developed land or 'brownfield'-first strategy before greenfield sites. All proposals must demonstrate conformity with other policies of this Plan with respect to the protection of the natural and historic environment. This approach will minimise encroachment on the countryside and AONB unless there is proven demand that cannot be met by the brownfield-first approach. The brownfield sites considered suitable for long term re-development as and when there is landowner support and they become available include existing builders' merchants, former health facilities, post office, carparks located within the urban area of Dartmouth. Within the lifetime of the Neighbourhood Plan such sites may become redundant or would benefit in the long term from intensification of existing employment sites and more effective use of land or change of use

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to C2 Residential Institutions C3 Housing or mixed use (C3 Housing and E Commercial, Business and Service.)

As stated in policy DNP EC3 changes of use resulting in the loss of employment land to the plan area will not be supported.

A schedule of sites that the community may look favourably on for intensification or re-development with a plan locating these and suggested uses are included as Appendix R2 and R3.

The conversion of existing buildings are also subject to the other policies of this plan. Priority will be given to new uses that provide maximum community benefit and are appropriate for the site in terms of accessibility and minimum traffic generation.

In order to consider development of brownfield and existing buildings is undertaken on a comprehensive basis a Development Brief should be prepared in advance of a planning application in consultation with the Town Council. A model brief is included in the Appendix P2 All development should respect and respond to the agreed brief.

Re-development of brownfield sites should be subject to a comprehensive survey of existing heritage assets and must avoid harm to these assets and protect and enhance the historic environment as set out in national and local policy.

All proposals on brownfield land will be required to set out the development expectations to address flooding risk and must address level 2 and 3 flood risks; the Sequential Test must first be successfully applied. The Exception Test may also need to be applied for certain components of the proposed redevelopment. As a minimum, as well as being safe from flooding over its lifetime, development on such sites must also contribute to reducing the overall flood risk to the town.

All detrimental water impacts of any brownfield site on the river environment through surface water run off during construction and operation must be fully assessed prior to a planning application for re-development.

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6.5 Housing and homes

6.5.1 Background

There were two main housing concerns and re-occurring themes taken from the Dartmouth 2016 community survey:

- The need for more affordable housing for local people especially the young;
- Restrictions on second homes and to introduce a Principal Residence requirement to control the further development .

6.5.2 The problem of affordability in Dartmouth has been exacerbated by the increasing purchase of the existing housing stock for second homes and holiday lets especially in the lower town. Second homes have increased house prices beyond the means of local people, particularly the young, resulting in them moving to the further extents of Dartmouth or out of parish altogether. In 2020 50% of house sales were to purchasers for holiday lets or second homes (Source: Local Estate Agents).

6.5.3 In view of the challenges of affordability of homes for all ages in the plan area and those associated with an older population a Housing Needs Assessment (HNA) was commissioned in 2021 from consultants AECOM. The full HNA is included in Appendix N and a summary of the key recommendations included below. The recommendations of the HNA are reflected in the housing policies of this Plan.

Housing Needs Assessment 2021 AECOM Consultants

1. Dartmouth's current tenure mix exhibits a lower rate of home ownership than South Hams and England, correspondingly more social renting and similar amounts of private renting and shared ownership. There is an opportunity to lift rates of home ownership in Upper Town, including through affordable routes to ownership, and to address the undersupply of social rented accommodation in Lower Town.

2. The development at Cotton Farm is planned to deliver 89 affordable homes, of which 50% or 45 units will be for affordable rent. The other allocated site at Noss will provide a financial contribution in lieu of onsite provision, which may eventually be collected by Kingswear or Dartmouth. This quantity of expected delivery will go some way towards meeting the needs of Dartmouth households, although it leaves a shortfall of approximately 40 units – a conservative figure that does not take into account the tendency of local households in need to be ineligible or not apply, nor the mismatch between the need and supply of affordable rented homes by size. **There is therefore a clear case to maximise the delivery of affordable rented housing in Dartmouth wherever possible, as part of Section 106 obligations on allocated sites and any potential community-led or exception schemes**. The estimate of potential demand for affordable housing for sale is in the region of **25 homes per annum** however there is no policy or legal obligation on the part either of the Local Authority or Neighbourhood Plan to meet such needs in full.

3. Between the 2001 and 2011 Censuses, Upper Town experienced a significant 134% increase in private renting. This trend, which exceeds the pattern nationwide, is often an indicator of the declining affordability of home ownership. While rates of private renting are not especially low in Dartmouth, high-quality and affordable private renting can perform an important function in the market for key workers, young households, and others.

4. Home values in Dartmouth have increased over the last ten years, with the result that the median home now costs around £55,000 more than in 2011. The current median house price is £335,000 for Dartmouth as a whole, the median is £185,000 in Upper Town and £430,000 in Lower Town.

5. There is evidence of intense competition for rental properties in Dartmouth. The speed at which new lettings are taken up, being a signal of demand outstripping supply, is closely associated with price increases. However, it also presents a broader problem: even if rents were to be affordable, there may simply not be enough rented housing to meet local needs.

6. There is a relatively large group of households in Dartmouth who may be able to afford to rent privately but cannot afford home ownership. They are typically earning between around £21,000 per year (at which point entry-level rents become affordable) and £41,000 (at which point entry-level market sale homes become affordable – in Upper Town only). This 'can rent, can't buy' cohort may benefit from the range of affordable home ownership products such as First Homes and shared ownership. These products would provide value to different segments of the local population, **with shared ownership (25%)** and rent to buy potentially allowing lower earning households to get a foot on the housing ladder, while First Homes – **which should be delivered at the maximum possible discount level of 50%** – provides better long-term support to those with slightly higher incomes.

7. For Dartmouth as a whole the demographic mix is imbalanced in favour of older households (when compared to the district and country). Therefore to attain greater balance between population age brackets, **an intervention would be needed to favour the dwelling sizes preferred by younger people**. these are homes with fewer bedrooms. As such, the recommended mix might be balanced out to promote more smaller properties (chiefly those with 2 bedrooms since 1 bedroom homes are well supplied already). To a degree, the balance could be achieved through greater circulation of Dartmouth households between Upper and Lower Town, rather than through new construction. While this is not a matter the Neighbourhood Plan can directly control, any efforts to dissolve the affordability barrier between the two areas or to provide diversity by directing larger homes to Upper Town and more affordable options to Lower Town, could be beneficial.

8. While it is certainly the case that many older households wish to under-occupy their homes in order to accommodate guests and possessions, and will have the financial capability to do so, there may also be an **opportunity to improve Dartmouth's offering to older households through new developments aimed at downsizers with well thought-out, adaptable and high-quality designs**. The HNA suggests that **focusing the provision and adaptation of age-friendly housing in Lower Town** would best serve the local population and avoid moves away from existing social and support networks, it also states that there is also an opportunity to create more balanced communities by delivering such housing in Upper Town to encourage circulation of age groups between the two areas.

9. While the serious and worsening challenge of housing affordability can be combatted through the provision of subsidised tenures, the affordability of market housing can be generally improved by **delivering smaller and/or denser housing types**.

10. The potential need for specialist housing with some form of **additional care for older people is estimated at a range of 98 to 126 specialist accommodation units during the Plan period**. These estimates are based on the projected growth of the older population, thereby assuming that today's older households are already well accommodated. **The need for sheltered housing may be the focus of any additional provision in the area beyond the existing allocations.** That said, this need is by definition driven by those with less severe support needs, which have the potential to be met though adaptations to the existing housing stock. Another avenue is to require **standards of accessibility and adaptability in new development to be met at more ambitious levels than those mandated in the JLP.**

6.5.4 There is evidence of housing need for the elderly, especially Extra Care Housing (ECH), this is provided in the Extra Care Housing Study commissioned by Devon County Council (2009) and refreshed in August 2015 (included in Appendix H1).

6.5.5 This plan sets out to help redress the historic imbalance of housing provision locally. This is expressed and supported in Policy Dev 8 and paragraph 4.11 for Thriving Towns and Villages in the JLP SPD adopted July 2020.

6.5.6 This plan supports the provision of First Homes for young families .In the Government's response to the 2020 consultation on First Homes, they said;

'Yet we acknowledge that in some parts of the country where property prices are very high a 30% discount(for First Homes) may not be sufficient to make homes affordable LPAs will therefore be able to require a higher minimum discount of either 40% or 50% on First Homes built in their local area, provided they are able to evidence the need for and viability of homes at this higher discount rate through the local plan making process.'

6.5.7 SHDC advise that they would be seeking, subject to viability a higher First Home discount in parts of the district where property prices are very high, such as Dartmouth, Salcombe, Newton & Noss . The District's Affordable housing team support higher discounts be included in Neighbourhood Plans.

6.5.8 Planned housing development

Taken together, Dartmouth(JLP TTV4) and Noss (JLP TTV5) provide 576 new homes, providing a varied mix of dwelling types, size and tenures. It is, therefore, not the intention of this plan to consider or support any additional sites other that the support for infill development and delivery of affordable homes through rural exception sites.

Policy DNP H1 - Market Housing

The principle of new market housing on infill sites is supported within the settlement boundary. In addition, market housing forming part of an exception site as set out in Policy DNP H2 where it is required to cross subsidise the affordable housing scheme will be supported. All development should meet the following requirements;-

a) The housing should respond to local housing needs in terms of type, size and tenure .

b) Consideration should be given to provision of places for housing for the increasing number of older people in the parish in the form of market sale sheltered, specialist accommodation, extra care , or assisted living housing. By further consideration of older people this Plan also supports opportunities for existing residents to downsize and make more larger units available to the market.

c) Higher standards of accessibility , adaptability and for wheelchair users should be considered beyond the JLP as evidence by the 2021 Housing Needs Assessment prepared for this Plan.

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6.5.9 Affordable Housing

The need for affordable housing was a common theme expressed in the 2016 public survey. South Hams is generally an expensive area with a combination of high house process and low earnings. This plan will support the delivery of housing, which provides homes for local people, which is truly affordable whether for rent or purchase, delivered through existing allocated sites within the JLP and or Rural Exception sites. There is a particular necessity to provide suitable housing for young people to ensure key workers can live and work in Dartmouth to ensure the viability of the local economy. In 2021 141 households registered on Devon Home Choice who have a postal address of Dartmouth. 30 households are considered to have a high or medium need.

Bedroom Need	Band B High Housing Need	Band C Medium Housing Need	Band D Low Housing Need	Band E No Housing Need	Total
1B	9	2	40	31	
2B	2	6	4	28	
3B	1	5	1	7	
4B	3	1	0	0	
5B	1	0	0	0	
Total	16	14	45	66	141

Source: SHDC Housing Specialist May 2021
South Hams District Council

6.5.10 There may well be more people than this in need of affordable housing in Dartmouth, not everyone is registered on the Council's housing waiting list. The principal affordable housing provision for Dartmouth would rely on the Cotton Farm development, out of the total of 450 dwellings this is total of 89 affordable houses and apartments. The provision of affordable housing is divided into two tenures: 50% Affordable Rent (max 80% of local market rents) 50% Intermediate (Discount market houses or shared ownership)The mix of dwellings will be:

Mix of affordable housing at Cotton Farm			
	nos		%
1 bed	13		15
2 bed	40		45
3 bed	27		30
4bed	9		10
Totals	89		100

6.5.11 The rate of delivery at Cotton (market and affordable housing) although this is subject to change is as follows:

Predicted rate of delivery (market and affordable housing) at Cotton Farm						
Year	**2021**	**2022**	**2023**	**2024**	**2025-34**	
No of Dwellings	15	40	40	50	305	**450**
						Total

The first Phase of 116 dwellings will be front loaded with 30% affordable housing consisting of 1 and 2 bed apartments and 2 and 3 bed houses.

6.5.12 The affordable provision at Noss is by way of a Section 106 contribution, SHDC have confirmed that the monies may be allocated to Dartmouth or Kingswear as a contribution towards affordable housing and that this is the expectation of the Town Council.

6.5.13 At present there is an immediate shortfall of supply and mix of dwellings set against the households registered on Devon Home Choice. The provision of affordable housing at Cotton, which has been agreed with SHDC in terms of provision and mix will be over a number of years. Clearly, the pressure to provide more affordable housing in Dartmouth will not abate in the future. The Dartmouth Neighbourhood Plan would support Exception Sites and Community led projects to provide more affordable housing.

Policy DNP H2- Exception Sites outside the settlement boundary
The use of Exception Sites adjoining the settlement boundary to deliver affordable housing will be supported where they comply with National and Development Plan policy and the policies of this plan. A site will only be permitted if;-

a) It meets a proven need for affordable housing for local people

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b) The needs of the local community are addressed

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c) Management of the scheme will ensure that the dwellings continue to meet such proven needs for initial and subsequent occupiers

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d) The development should reflect the character and scale of the parish and be physically integrated with it in terms of design, scale and pedestrian access

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e) The proposal conserves and enhances the landscape, scenic and natural beauty of the AONB and the design is in compliance with the latest South Devon AONB Management Plan and AONB Planning Guidance

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f) Cross subsidy through the provision of open market housing on the scheme will be allowed only where it ensures the delivery of the affordable housing and shall comprise the minimum number of open market dwellings necessary to ensure the delivery of affordable housing as part of the same development proposal, to be demonstrated by a viability appraisal of the full scheme.

Policy DNP H3 Affordable Housing;
Proposals for affordable housing development within the settlement boundary or as exception sites will be supported where;-

a) The number of affordable homes to be delivered is in line with the need as defined by Devon Homes Choice or the local affordable housing register in place at the time and where a need has been identified, this includes custom and self-build plots where feasible.

b) Affordability is determined with consideration of the particular circumstances of Dartmouth, namely high average property prices and low salaries.

c) The range and size of dwellings especially single bed units is in line with the need as defined by Devon Homes Choice or the local affordable housing register in place at the time.

d) Discounted 'First Homes' for young families shall be provided in line with National policy. Discounts should be 50% on the new home price to ensure First Homes are affordable to local incomes.

e) Homes should be occupied by people with a demonstrable local connection to the Parish which is defined within the SHDC Adopted Local Allocation Policy (2017).The early and urgent needs of key workers including teachers, healthcare workers, fire brigade and lifeboat crew should be considered exceptional circumstances under the provisions of the allocation policy.

f) Affordable housing for sale is subject to a legal restriction to ensure the homes remain affordable and that the discount is maintained in perpetuity.

g) Development in or within the visual impact of the AONB conserves and enhances the landscape, scenic and natural beauty of the AONB and the design is in compliance with the latest South Devon AONB Management Plan and AONB Planning Guidance.

Such developments could include proposals for Community Led Housing.

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6.5.14 Second Homes

Dartmouth is a desirable holiday destination, as with many other coastal locations, there has been an increase in the purchase of the housing stock for second homes and holiday lets increasing house prices and displacing local people, especially the young. The survey of the local community carried out in 2016 raised concerns about the impact second homes on the balance and viability of home ownership, house prices and the effect on the community. Many of the responses of the survey asked for restrictions on second homes and to devise a Principal Residence Policy to control the further development of second homes.

6.5.15 A survey was carried out by the plan group of existing residential properties in the parish and a review of data held within the census, valuation records, electoral role and properties registered as businesses, this is included as Appendix H2 This survey indicates that in 2020 Dartmouth has a significantly higher number of second homes than in 2010. In 2011 it was 22.6% which was already above the 20% threshold commonly used as a benchmark figure in relation to the inclusion of a principal residence provision in a plan. At the end of November 2020, it stands at 37.8%. The survey also indicated that in Lower Town the number of second homes is far higher than the average and is in the region of 51.2% The river or sea views and level walks to tourist related facilities make the area particularly attractive for second home owners and holiday lettings.

6.5.16 The policy below will support the housing needs of local people and bring greater balance and mixture to the local housing market and create new opportunities for people to live and work here and strengthen the community and local economy. This policy applies to all new build development both allocated and windfall sites where open market housing is proposed within the plan area.

6.5.17 SHDC supports in principle the inclusion of a Principal Residence Requirement within Neighbourhood Plans where such a requirement is justified. In response to the question from the JLP Examination Inspectors whether 'a restriction on the use of new dwellings as holiday homes was justified in the South Hams? 'JLP Council's response was as follows: [10]

8.94 The number of homes not used as primary residence is particularly high in the South Hams part of the TTV. Both South Hams and West Devon received a substantial sum of money to deliver more affordable homes through the Community Housing Fund in recognition of this. Evidence also exists of in HO3, HO9, TP3, SHMA and CTB1 (council tax reports) and the Strategic Housing Market Assessment Part 1: The Housing Market Area and Updating the Objectively Assessed Need (HO13).

8.95 At this time it is considered that the appropriate mechanism to bring such a policy forward is a Neighbourhood Plan. It is through NO (sic) *that the above District / Borough wide evidence can be reviewed, analysed and supplemented with a view to informing the need, justification and effectiveness of a restrictive policy.*

8.96 To this end the Council (South Hams) resolution of 15 December 2016 stated that 'this Council notes the ruling of the High Court (Case No: CO/2241/2016) in support of a housing policy known as 'H2. Full Time Principal Residence Requirement' as set out in St Ives Area Neighbourhood Development Plan and which provides that: 'New second homes and holiday lets will not be permitted at any time …' and 'supports Town and Parish Councils within the South Hams District to adopt similar policies in their own Neighbourhood Development Plan'

[10] [10]PSWDJLP Examination Hearing Statement Matter 8 Question 8.5(vi) https://www.plymouth.gov.uk/sites/default/files/JLPCouncilsResponseMatter8PolicyAreaStrategiesThrivingTownsVillages.pdf

Policy DNP H4 - Principal Residence

a) New open market housing, excluding replacement dwellings, will only be supported where there is a restriction to ensure its occupancy as a principal residence guaranteed through a planning condition or legal agreement. This policy is as a result of impact upon the local housing market of second or holiday homes. New unrestricted market homes will not be supported at any time.

b) Principal residence is defined as one occupied as the residents' sole or main residence, where the residents spend the majority of their time when not working away from home. The condition or obligation on new open market homes will require that they are occupied only as the primary (principal) residence of those persons entitled to occupy them.

c) Occupiers of homes with a Principal Residence condition will be required to keep proof that they are meeting the obligation or condition, and will be obliged to provide this proof if and when SHDC requests this information. Proof of Principal Residence includes but is not limited to residents being registered on the local electoral register and being registered for and attending local services including healthcare, and schools.

d) This policy applies to all new build development both allocated and windfall sites where open market housing is proposed within the Neighbourhood Plan Area.

e) A replacement dwelling is defined as a single new build dwelling replacing an existing dwelling. of equivalent size and design as the original dwelling.

f) Where a non-domestic property is converted to residential use through planning consent or by Permitted Development Rights such dwellings are considered new dwellings for the purposes of this policy.

6.5.18 Housing for Older People

Dartmouth has an ageing population increasingly living alone. The 2011 census indicated 35% of the total Dartmouth parish population was over 60 years of age and this trend is rising. There is a growing demand for smaller dwellings for older people who wish to downsize or require to maintain their independence but with assisted living. This plan does not support the loss of any existing homes for older people and supports new assisted living schemes, residential care and nursing homes. The Cotton development is in negotiation to provide an assisted living scheme of approximately 55 apartments, this is welcome but may not address the full need for the plan period. Many older households wish to under-occupy their homes in order to accommodate guests and possessions, and will have the financial capability to do so. This Plan sets out to improve Dartmouth's offering to older households through new developments aimed at downsizers with well thought-out, adaptable and high-quality designs.

6.5.19 The Dartmouth Housing Needs Assessment 2021 (HNA) included in Appendix N Supports the need for specialist housing with some form of additional care for older people which is estimated at a range of 98 to 126 specialist accommodation units of older people

during the Plan period. The need for sheltered housing may be the focus of any additional provision in the area beyond the existing allocations. This need is by definition driven by those with less severe support needs, which also have the potential to be met though adaptations to the existing housing stock.

6.5.20 Another recommendation of the HNA is to require standards of accessibility and adaptability in new development to be met at more ambitious levels than those mandated in the JLP. Policy DEV9 requires that at least 20% of dwellings on schemes of 5 or more dwellings should meet national standards for accessibility and adaptability (Category M4(2)), and at least 2% of dwellings on schemes of 50 or more dwellings should meet national standard for wheelchair users (Category M4(3)). The evidence gathered in the HNA justifies seeking a higher target in Dartmouth where viable.

Policy DNP H5 Specialist Accommodation for Older People ,residential care nursing homes and loss of existing residential care.

a) Additional Specialist Residential care provision will be supported in the Plan area. This should be provided with reference The Dartmouth Housing Needs Assessment 2021 (HNA) by AECOM Consultants and included in Appendix H1 The provision may comprise;-

- Extra Care
- Sheltered Housing
- Affordable Specialist Accommodation
- Market Specialist Accommodation

b) Loss of existing residential care and nursing homes for older people

The change of use or redevelopment of a care home or nursing home will only be permitted providing that new facilities of a similar type are provided in the parish to replace the facilities being lost; or there is a proven absence of demand for the continuation of the use and the site has been marketed effectively for such use over a period of at least 24 months at an appropriate level. In circumstances where the loss of an existing care home or nursing home is considered to be acceptable, the site should be used for an alternative provision for the elderly, such as the provision of dwellings specifically designed for the elderly, and subject to an occupancy restriction to ensure that the dwellings are used for this purpose in perpetuity.

c) New homes for older people

All new development for older people which can form part of developments of mixed ages and tenures should comply with all the other housing policies of this plan and should be on previously developed land or sites within the settlement boundary, within easy access to local centres and meet the other policies of the plan, including those relating to design quality. Any new development should ensure that the appearance and character of the town or surrounding countryside are not harmed.

d) Design Standards for Specialist Accommodation for older people

Where viable the access standards should exceed the provisions of JLP Policy DEV9 against national standards for accessibility and adaptability (Category M4(2)), and for wheelchair users (Category M4(3)).

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6.6 Health and Wellbeing

6.6.1 Background

JLP Strategic Objective SO6 promotes: *"school, health, and recreation facilities of a high quality in order to reinforce strong communities."*

6.6.2 Health Facilities

Health facilities in the plan area will need to accommodate residents and visitors and the expected increase of population over the plan period including the new West Dart neighbourhood. By 2030 there is expected to be 37% more people aged over 75 compared to today, in the South Hams area, with resulting increased health and social care needs. While the new proposed Dartmouth Health and Well-being Centre proposal will make a major contribution to meeting these objectives, the loss of Dartmouth Hospital has been keenly felt by local residents. The new Health and Well-being Centre will move the centre of gravity of healthcare provision from the Lower Town to the Upper Town, nearer the expanding population base. This will leave no health care facilities in the Lower Town for the resident population, many of whom are elderly and less able. The new centre highlights the following objectives for this plan;-

- Allow space for future expansion of the centre, in line with planned population growth, and increases in the age profile of the town.
- Ensure that good transport, parking and access is available, particularly improved public transport links, between the Lower Town and the new Centre.
- The reuse of the NHS sites to be vacated: the Hospital on the South Embankment and the Clinic at Zion Place. There is a presumption within community that new development and uses should incorporate and focus on the needs of key workers, new community uses, especially with a health and well-being emphasis.
- Take into account the covenants existing in the deeds on parts of the hospital site included in Appendix S which stipulate "the land shall be held by the purchasers (TSDFT) as Trust Property for ever hereafter for the use and benefit of the Dartmouth and Kingswear Cottage Hospital" … and …" used for hospital purposes. These provisions were clearly intended to provide and protect benefits for the residents of Dartmouth and Kingswear.
- Establish that when the TSDFT is considering the future use of the hospital it should ensure that this reflects the spirit of the original intention of those who created the facility to benefit the community albeit that the use would not be that of an operational hospital. This could be best achieved by uses such as residential accommodation for key workers including nurses and other staff such as occupational therapists and for assisted housing. This would, in essence, provide a continuum of "hospital use".
- The covenant was originally enforceable by the Dartmouth Town Council but the creation of the NHS and the transfer of property rights to SHDC when that body was formed need to be taken into account. It is understood that the Secretary of State responsible for the NHS is the authority which can enforce or vary the covenants on the hospital and needs to be approached to agree with variations necessary for the

continuation of the protection of benefits for Dartmouth and Kingswear residents who remain the beneficiaries under the original covenants.

6.6.3 Community Aspiration; Healthcare for Dartmouth

a) There should be adequate GP provision within the Parish including out of hours care, for an expanding population with minimal waiting times for patients and choice of seeing their own GP. Suitable and safe reception and waiting areas and links to in-house pharmacy.

b) Easy access for the whole population to the wider multi-disciplinary health team is available ideally within the same building, including physiotherapy, pharmacy, mental health nurses and nurse prescribers.

c) Adequate provision of NHS Dental Care for the whole population.

d) Ensure adequate pharmacy services at both the new Health and Wellbeing Centre and in the Centre of town.

e) Ensure adequate district nurse, health visitor, midwifery, occupational therapy and "hospital at home" provision for all who require these services, to enable home based care as far as possible, linked with both GP and hospital based clinicians.

f) Ensure that health and social care are effectively coordinated for all patients and that third sector (voluntary) care is best embedded in the system.

g) When access to urgent medical services is not available within an appropriate time frame, consideration should be given to expansion of services if feasible. Access to emergency medical services should be provided safely with a rapid and efficient ambulance service within accepted national time frame standards.

Policy DNP HW 1 Re-use of the former hospital site and health centre Zion Place.
This plan supports maintaining a portion of health and wellbeing facilities in Lower Town once the facilities to be provided in the new Health and Wellbeing Centre at the top of town are established.

The options for re-use or redevelopment of the sites should include in all or part appropriate health and social care facilities, as part of a package to meet the on-going identified health and wellbeing needs in the Lower Town. Facilities could include but not be limited to; a first aid facility, community creche and multi-purpose community and meeting space.

A development brief expanding on the above criteria should be prepared in advance of a planning application. All redevelopment proposals should respect this brief.

Evidence supporting the continued need for health and wellbeing facilities in Lower Town is included in Appendix S2.

Re-development of the sites should be subject to a comprehensive survey of existing heritage assets and must avoid harm to these assets and protect and enhance the historic environment as set out in national and local policy.

All proposals will be required to set out the development expectations to address flooding risk and must address level 2 and 3 flood risks; the Sequential Test must first be successfully applied. The Exception Test may also need to be applied for certain components of the proposed redevelopment. As a minimum, as well as being safe from flooding over its lifetime, development must contribute to reducing the overall flood risk of the town.

All detrimental water impacts on the river environment through surface water run off during construction and operation must be fully assessed prior to a planning application for re-development.

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6.6.4 Community Facilities

As stated in the green environment section the social and health benefits, both physical and mental, provided by open green spaces are supplemented in Dartmouth by a range of facilities for play, sports and leisure. Provision for such facilities is enshrined in para 96 of the NPPF. There will be increased demand and pressure on open space now that a large number of new homes is being built during the plan period at the Cotton Farm development, on the very margin of our Parish. The open space, sport and recreational (OSSR) provision for the parish is being updated as a result of this additional demand and reflected in this plan. NPPF para. 97 places emphasis on safeguarding existing provision of community facilities .These principles are supported within the JLP policies DEV3 and 4.

6.6.5 There is the wide range of community organisations in the Town. The plan group has engaged with the community groups, identified the facilities and venues they use and

understand their importance to the Dartmouth community (see Dartmouth OSSR Appendix C1). The main objectives include;

- to support, preserve and sustain the wide range of community facilities in Dartmouth for the continued health and well- being of the community and visitors.
- Identify deficiencies in the existing community facilities within the plan area;
- Support the opportunities for enhancing community facilities or creating new ones.

6.6.6 Whilst overall provision in Dartmouth is in line with recommended levels there are deficiencies in certain categories and improvements required in individual sites. An audit of these sites was undertaken, and the quality of provision assessed by conversations with users and through verbal and email correspondence with a number of stakeholders;-

Dartmouth and District Sports Association
Dartmouth Amateur Athletic Club
Dartmouth Amateur Rowing Club
Dartmouth Rugby Union Football Club
Dartmouth Association Football Club
Dartmouth and District Cricket Club
Dartmouth Club de Petanque
Dartmouth Yacht Club and its canoe section
Dartmouth Hockey Club
Dartmouth Bowling Club
Dartmouth Gig Club
Dartmouth Jubilee Tennis Club
Dartmouth Leisure Centre
Dart Valley U3A Walking Group
Dart Area Landscape Access Group
Walk and Talk Group

6.6.7 The inventory of Community facilities and their assessment is contained in Table 3 and shown in Map 20. The evidence gathered from these sources is available in Appendix C2. The concerns raised during consultation are summarised below.

6.6.8 Play Facilities (LAPs, LEAP, NEAP)

Generally the present spread of LEAP facilities within the upper and lower town areas should be retained. The LEAP play area in Victory Road is derelict and in an unsuitable location for this purpose and should be permanently decommissioned . It is temporarily fenced off by agreement between SHDC and DTC but it is still accessible for antisocial activities. The resultant deficiency in LEAP provision should be rectified and the possibility of providing a LAP/LEAP within the Rock Park area should be explored.

6.6.9 Sport and Leisure use at Norton Field.

This large open area, 3.57ha, is the only facility of its kind in the Parish justifying its nomination for Local Green Space (see Table 2). It is on relatively flat ground, is conveniently located for Townstal with its younger population and adjacent to the West Dart development, and there

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is parking provision adjacent. Despite this it is underutilised because of its serious deficiencies. The Dartmouth Community Plan, MCTi 2004 recognised the importance of the Norton Field sports facility and listed a number of enhancements. These included provision for;-

- A floodlit all weather hockey pitch
- A floodlit grass pitch
- A cricket square and pitch
- A 200 m athletics practice track and athletics field sports facility
- Skateboard and BMX biking facilities

Dartmouth and District Sports Association has undertaken its own assessment of the various bids for facilities on Norton Field. Their evidence in presented in Appendix C. Policy DEV 4 in the JLP places emphasis on the importance of playing pitches in the health and welfare of communities. It is understood that a Playing Pitch Strategy is presently under review by SHDC and it is hoped will produce its recommendations by Spring 2021. However, it is believed that the improvements at Norton Field are consistent with the aims and need identified by the SHDC OSSR report of 2017, prepared for the development of the JLP. Norton Field should receive the highest priority for major improvements as funds become available. The existing rugby pitch and the seasonal athletic provision for field and track events should be retained and enhanced. A sports centre should be provided with shower and changing facilities for 2 teams/genders and officials, secure storage and an area for social events. This may be on ground behind the Leisure Centre, presently occupied by a Skate park, which could be sited elsewhere with improved surveillance and more challenging facilities.

6.6.10 Coronation Park

A single storey shelter and storage facility should be provided on Coronation Park as funds become available. Such a facility must be sensitively designed and located that does not conflict with the proposed designation of the park as a Local Green Space. It could be located in the SW corner adjacent to the retaining wall in an area near to the tennis courts.

6.6.11 Emergency and Community Services

The existing ambulance and fire services support facilities located on College Way provide an essential service to the town. Accommodation for a local police presence has also been added to the site recently. Other uses on this site will not be supported.

Policy DNP HW 2, Community Facilities

a) Development that results in the loss of community facilities and public spaces as outlined above in paragraphs 6.6.4-10 or that results in any harm to their character, setting, accessibility, appearance, general quality and amenity value will only be permitted if they are replaced by community facilities and/or public spaces of equal or higher quality, economic viability and value to the community or it can be demonstrated they are no longer needed.

b) New residential development will where practicable be expected to deliver new community facilities including Open Space, Sports and Recreation (OSSR) facilities on site. On smaller sites or where this is not practicable a planning obligation will be sought

to mitigate the impact of new residents through new and improved provision in an appropriate location. For OSSR facilities this should be in accordance with the priorities and projects identified in the latest SHDC and DTC OSSR Plans and SHDC's Playing Pitch Strategy.

c) Proposals that involve the use of land in the countryside to facilitate and enhance informal recreational activities and access related to the enjoyment and interpretation of the countryside will be supported where they would not have an adverse effect on the AONB, countryside, historic environment, and other land uses in the vicinity. Any proposals that improve access to existing public rights of way will be supported.

d) Proposals that promote the public awareness and enjoyment of the historic and natural environment such as heritage and nature trails will be supported. Any future development should include the appropriate enhancement of adjacent heritage and nature trails.

e) Ancillary facilities to public spaces must, where practicable, be accommodated in existing buildings. New facilities should be in keeping with their surroundings and respect policy DNP TE2(Design Quality throughout the Parish).

f) The area shaded in Map 17 is safeguarded solely for emergency and community services to serve the Parish. Other uses will not be supported.

Deleted: Facilities identified include new play facilities at Rock Park to replace those at Victory Road, improvements at Norton Field recreation ground and a shelter and storage at Coronation Park.

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Map 17 Area shaded pink safeguarded for emergency and community services on College Way

6.6.12 Access to the river

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Residents and visitors require ready access to launch small motor boats, dinghies and an increasingly wide range of personal water craft; canoes, kayaks and stand up paddleboards

(SUP). The volume of this sport has increased enormously in recent years www.dartharbour.org/news-and-notices/news/2020/09/18 . Provision of safe storage facilities for boats, and trailers has been provided by SHDC in recent years, and now provision falls to DTC. JLP DEV 3.2 confirms that *"access to the water such as to the sea, estuaries and rivers/etc. for recreation, whether alongside, on, or in the water, is of key importance to the Plan Area."* At present in Dartmouth there is a narrow slip adjacent to the Higher Ferry and an improved safer, wider, and easier to access slipway with associated short-term parking is proposed for the North embankment (see Map 18) which will provide much needed extra capacity. The launch slip at Warfleet Creek is associated with a storage rack facility, SUPs are being launched here with increasing frequency. The present launch and boat and trailer storage facilities in Warfleet and at the Higher Ferry are over capacity.

6.6.13 The main boat and trailer storage capacity is in the northern area of Coronation Park. Users have pointed out the dangerous issue of visibility when crossing the road from Coronation Park to the slip adjacent to the Higher Ferry with vehicles crossing the queue for the ferry close to this point. This is exacerbated when pedestrians are transporting water craft and when the top of the slip is cluttered with large vehicles and trailers whilst their owners launch their vessels. This plan supports improved and safe access to the river especially at the Higher Ferry. The existing traffic system controlling alternating entry to the Higher ferry or the passage of cars in to the town should have a pedestrian phase added to allow boaters to cross the road in safety. Provision should also be made for short term parking of vehicles and trailers whilst water craft are launched and secured.

Policy DNP HW3 Improved water access for recreational users.

This plan supports new and improved access and infrastructure to the River Dart for recreational water craft users. Improvements should be focussed at North Embankment in the vicinity of the Higher Ferry and include the following:

a) An improved slipway on the North Embankment indicated in Map 18.
b) The present boat storage facilities on Coronation Park should be retained and enhanced;
c) Short term parking provision for craft and vehicles adjacent to the slipways indicated in Map 18.

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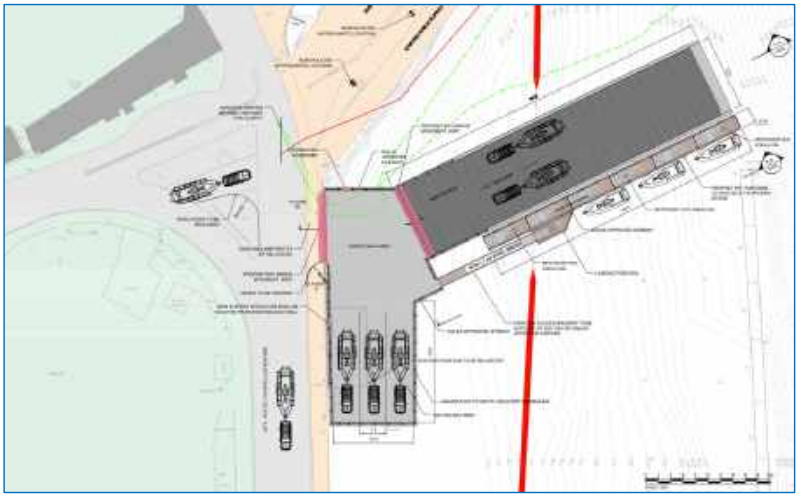
Moved up [1]: <#>Associated traffic improvements to facilitate the safe crossing of the A379 by craft and users when launching and retrieving craft;¶



Map 18 Proposed slipway and associated short term craft and vehicle parking in the vicinity of the Higher Ferry.- Source; the Dartmouth Public Slipway Trust and AECOM consultants

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6.6.14 Education

The Key education issue for the Plan is to ensure that adequate land is available for future education provision. allowance must be made for a potential significant increase in school-age population through housing development at Cotton through JLP Policy TTV4**.**There should also be safe access to education facilities. Proposed land use for educational facilities should also benefit the town, such as parking, transportation, recreation and community use of facilities out of hours and term time.

POLICY DNP HW4 Education Facilities

a) Further development required by The Dartmouth Academy for education and sports purposes during the period of the Plan shall be supported providing such proposals meet the other policy requirements of this Plan and the JLP.

b) Development that results in the loss of existing education facilities or causes any harm to their function, character, setting, accessibility, appearance , general quality, and amenity value will only be permitted if they are replaced by education facilities of equal or higher quality, economic viability and value to the community or it can be demonstrated they are no longer needed.

c) The area illustrated in Map 18 encompassing the Dartmouth Academy and grounds is safeguarded solely for education and community related uses. Other uses will not be supported.

Map 19 Dartmouth Academy area safeguarded for education and community uses lined in red

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7. A sustainable and deliverable plan

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7.1 Sustainable Development

7.1.1 One of the fundamental factors underlying this Plan is that it contributes to making Dartmouth and the plan area more sustainable. This Plan respects the Government's approach to sustainable development as set out in the National Planning Policy Framework. A clear definition of sustainable development provided by Locality[11] is;

'Enabling growth to cater for the needs of current generations but ensuring that growth doesn't mean worse lives for future generations'

7.1.2 Some of the features of this Plan that make Dartmouth more sustainable are:

- A high level of community engagement;
- Mixed transport options encouraging use of public transport, walking and cycling;
- More local employment opportunities;
- Improved community facilities to promote health and wellbeing;
- Promotion of high quality design;
- New housing that responds to local needs and all ages;
- Protection and enhancement of the AONB, wildlife areas and measures to support biodiversity net gain;
- Conserving historic buildings and environments;
- Recognising the importance of landscape and open space, protection of historic landscape features.

7.2 Delivery

7.2.1 The Dartmouth Neighbourhood Plan Steering Group was set up by Dartmouth Town Council to develop, champion and engage the community on the Neighbourhood Plan. In due course the Steering Group will transfer the responsibilities for delivering the Plan back to the Town Council who will take on the responsibility of co-ordinating, stimulating and supporting policies and community aspirations identified in the Plan. It is recommended that the success of the plan is reviewed annually with a major review every 5 years carried out in consultation with the community and Local Planning Authority. This is to ensure the Plan is still current and remains a positive planning tool to deliver sustainable growth in Dartmouth.

7.2.2 Some projects will simply be brought forward by private individuals and independent organisations wishing to invest in site(s) and policies. However, many aspects of the Plan will be driven by public and community investment. Funding bids may have to be prepared and submitted and resources allocated.

7.2.3 For the Plan to be successful the Town Council will need to take a strategic role as owners of the Plan and keeping the 'whole picture' across the plan area in focus. Some aspects

[11] Locality Neighbourhood Plans Road Map Guide

of the Plan will need to be explored in greater depth with a focussed group of participants that may have particular interests, covering each policy area;

- The natural environment
- Business, town centre regeneration and the economy
- Sustainable transport
- The town and built environment
- Affordable housing
- Health, wellbeing and leisure

7.2.4 The above groups should be provided with simple reporting and governance/terms of reference in order to ensure proper co-ordination. It is recommended that a member of the Town Council might chair each group. In order to be effective, these groups will have the liberty to co-opt individuals such as representatives of key external agencies. It is very important that such inclusion within the governance, decision-making or delivery structures of these initiatives does not mean that community representation is relegated to a minority stake.

7.2.5 To further the sustainability and carbon reduction policies and community aspirations of the Plan the establishment of a local social enterprise is supported . This could be similar to the Plymouth Energy Community whereby local people benefit from low cost renewable energy, investors get a fair return and a community benefit fund is generated to be able to support projects reducing fuel poverty and carbon emissions. (Appendix G, section 3).

7.2.6 Delivery groups for housing and business will be critical to the success of the plan. In parallel with the neighbourhood planning process the community in discussion with the Town Council may wish to consider the merit of a Community Land Trust (CLT) for the plan area as one of the delivery mechanisms for parts of the Plan. A CLT is a not for profit body that develops and stewards affordable housing, employment space, and other community assets on behalf of a community. The concept balances the needs of individuals to access land and maintain security of tenure with a community's need to maintain long term affordability, economic diversity and local access to essential services. CLTs are usually formed to deliver community-led housing, set up and run by members of a community to develop and manage these homes. However, they can also manage other assets important to the community, like employment spaces. There are now over 260 Community Land Trusts [12]in England and Wales. The largest Community Land Trusts have over 1000 members each. Community Land Trusts have developed over 900 permanently affordable homes to date and are in the process of developing a further 16,000 homes.

[12] Community Land Trust Network http://www.communitylandtrusts.org.uk

8. What happens next?

8.1 This version of document is still in draft; it has been prepared for the Submission Stage (Regulation 15) of the Neighbourhood Planning process.

8.2 This version of the plan will be presented for further consultation by SHDC as part of Regulation 15 and will be available for review by the community and other key stakeholders. The minimum requirement for consultation by SHDC includes;

- Publication of the revised PJan, a Consultation Statement, and a Basic Conditions Statement that brings it to the attention of people who live, work and run businesses in the Parish;
- Opportunities to view and make comments on the plan;
- Arrangements to make comments on the plan, which must be for a minimum period of 6 weeks from the date it was first publicised;
- Consultation with statutory consultation bodies and individuals particularly those who have previously commented at Regulation 14.

8.3 The plan and supporting evidence shall be published by SHDC on https://www.neighbourhoodplanning.swdevon.gov.uk and will also be available on the Dartmouth Neighbourhood Plan website page https://dartmouthplan.org and will be available for viewing at the Town Hall, Flavel Centre and Dartmouth Visitor Centre.

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Deleted: whose interest may be affected by the Plan, these include, South Hams District Council, The South Devon AONB Partnership, Devon County Council, the Environment Agency, Natural England and Historic England.

Deleted: 8.3 We shall also consult all neighbouring parishes, significant landowners and local community organisations, societies and trusts including the National Trust.¶

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9. List of acronyms and glossary

BRNC Britannia Royal Naval College
CAB Citizens Advice Bureau
CLT Community Land Trust
CWS County Wildlife Sites
CPtED Crime Prevention through Environmental Design
DCC Devon County Council
DGP Dartmouth Green Partnerships
DHCMTS Devon Historic Coastal Market Town Survey
DUC Devon's Undeveloped Coast
DTC Dartmouth Town Council
DVC Dartmouth Visitor Centre
EA the Environment Agency
GI Green Infrastructure
HE Highways England
HotSW LEP Heart of the South West Local Economic Partnership
HUCA Historic Urban Character Area
IMD Indices of Multiple Deprivation
JLP the Development Plan or Joint Local Plan for South Hams, Plymouth and West Devon Councils (2014 to 2034)
LAP Local Area for Play
LEP Local Enterprise Partnership
LEAP Local Equipped area for Play
LGS Local Green Space
MCTI Market and Coastal Town Initiative
NE Natural England
NEAP Neighbourhood Equipped Area for Play
NPG the Neighbourhood Plan Group for Dartmouth
NPPF the National Planning Policy Framework
ONS Office of National Statistics
OS Ordnance Survey
OSSR Open Spaces, Sports and Recreation Plan
SAC Special Area of Conservation
SEP Strategic Economic Plan
SHDC South Hams District Council
SPD Supplementary Planning Document
SSSI Sites of Special Scientific Interest
TTV Thriving Towns and Villages
TSDFT Torbay and South Devon NHS Foundation Trust
NP Neighbourhood Plan
MW Megawatt
UK United Kingdom
SW South West

10. Appendices ,tables and supporting evidence base

A1 Basic Condition Statement	
A2 Consultation Statement	
A3 Habitat Regulations and Strategic Environmental Assessment	To follow
B1 to B5 Topic Group Papers	Refer to https://dartmouthplan.org/appendices/
C Dartmouth Town Council OSSR Plan	
C2 D and DSA submission re Norton Field	
C3 Evidence from sports clubs	
D Footpath Evaluation	
E1 Green Matrix Sites	
E2 Wildlife Resource Map and Report DBRC 2020	
F Locally Important Views	
G Climate Change Evidence	
H Housing evidence and census data	
H1 DCC Extra Care Housing Study Updated 2015	
H2 Existing Second Homes data 2020	
J Local and Non-Designated Heritage Assets	
J1 Non-Designated Heritage Assets	
J2 Designated Heritage Assets	
J3 Devon Historic Coastal and Market Towns Survey and Historic Urban Character Areas for Dartmouth	
K1 Summary of 2016 Consultation Responses	
K2 Summary of 2021 Business Survey Responses	
L1 Dartmouth Conservation Area Appraisal	
L2 South Devon AONB Management Plan	
M1 Market and Coastal Town Final Report 2004	
M2 Retail and Leisure Study 2017 PBA	
N Housing Needs Assessment 2021 AECOM	
O Historic Flooding Incident Report	
P1 Development Brief Employment Sites	
P2 Development Brief Brownfield Sites	
Q1 Transport Study 2004 by Parsons Brinckerhoff for DCC Issues Report	
Q2 Transport Study 2004 Proposals Report	
R1 Civic Spaces	
R2 Brownfield Sites Schedule	
R3 Brownfield Sites Map	
S Dartmouth Hospital Covenant (to follow)	
S1 Dartmouth Hospital Register Plan	
S2 Support for Health and Wellbeing facilities in Lower Town	

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NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Torbay Community Wealth Building – Memorandum of Understanding			**Meeting date:** 26th January 2022
Report appendix	Appendix 1. MOU Torbay Community Wealth Building		
Report sponsor	Director of Transformation and Partnerships		
Report author	Director of Transformation and Partnerships		
Report provenance	Request from Torbay Community Wealth Building sub-group of Torbay Together		
Purpose of the report and key issues for consideration/decision	Representatives from Trust Board have regularly attended the Torbay Together Group and Community Wealth Building Group. As an anchor institution the Trust holds an important role in working with strategic partners to improve the economic prosperity of Torbay with the intended outcome of improving the wider determinants of health. This partnership is aligned to the delivery of the Trust strategy. The attached report outlines the strategic intentions of the Community Wealth Building partnership, provides supporting research reports and seeks approval from the Trust Board to commit to, and adopt, community wealth building practices.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendations	The Trust Board are asked to: a. Note the content of this report and appendices b. To commit to the principles and adoption of community wealth-building practice c. For members of the Trust to sit on the Community Wealth Building group, Employment sub-group and Procurement sub-group		
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

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<tr><td>Risk Register</td><td>X</td><td>Risk score</td><td>20</td></tr>
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BAF Risk – 1 To develop and implement the long-term plan with partners and local stakeholders, to deliver the ICO strategy
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<tr><td>External standards affected by this report and associated risks</td><td>
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<tr><td>Care Quality Commission</td><td></td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td></td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td></td><td>National policy/guidance</td><td>X</td></tr>
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Report title: Torbay Community Wealth Building – Memorandum of Understanding		**Meeting date:** 26th January 2022
Report sponsor	Director of Transformation and Partnerships	
Report author	Director of Transformation and Partnerships	

1. Background

The Torbay Development Agency (TDA) commissioned the Centre for Local Economic Strategies (CLES) to develop a Community Wealth Building (CWB) action plan for Torbay in September 2019.

The key principles behind CWB are to adopt a fresh approach to local economic growth by creating a fairer, more socially just, and sustainable economy by focusing on social value, environmental sustainability, and the distribution of prosperity.

CWB requires key anchor institutions to catalyze the economic benefits in a place by retaining the wealth generated through their activities within the locale by focusing on five key areas:

- **Progressive procurement of goods and services** – procuring goods and commissioning locally, in order to develop dense local supply chains within the local business community.
- **Good employment and just labour markets** – progressive practice to stimulate the local economy and bring social improvements to local communities, by paying the living wage, and creating career progression opportunities.
- **Plural ownership of the economy** – wealth and profits generated within the economy to stay in the locality.
- **Making financial power work for local places** – directing financial investments through pension funds and local authority investments towards local priorities, and bringing transformative capital to locally rooted enterprises.
- **Socially productive use of land and property** – through the development of under-utilized assets for community use.

As part of the CWB in Torbay we would predominantly be focusing initially on the good employment, and progressive procurement work streams.

2. The importance of the ICO contribution to CWB

The Trust is the single largest anchor institute in Torbay employing over 6,236 (5,565 FTE) staff and spending over £441M per year, compared to Torbay Council which spends around £292M per year.

The Torbay economy is amongst the weakest in England, and has declined in recent years with the;

- lowest economic output per person in England,
- ranked the 48th most deprived LA in England
- over 27.4% of people in Torbay living in the bottom 20% most deprived areas
- the 3rd highest rate of personal insolvency nationally.

There is widening health inequality in Torbay with over 21.2% (4,810) children living in low income families, and life expectancy for both men and women lower than the England average. Even within Torbay there is a widening inequality with life expectancy being 10.5 years lower for men and 8.1 years lower for women in the most deprived areas of Torbay compared to those in the least deprived areas in Torbay. Wider determinants of health include income levels, employment, GCSE attainment, homelessness, and levels of violent crime.

The Health Foundation highlights how the NHS could make a greater contribution to improving social and economic conditions for people in local areas, by supporting community wealth building and development, and in doing so, advance the welfare of local people.

Through the Torbay and South Devon Foundation Trust committing to CWB in Torbay we can address both the health and economic inequalities, and support future prosperity.

3. Recommendation

The Trust Board is asked to:

- To note the report and action plan
- For the Torbay and South Devon Foundation Trust to commit the principles and adoption of Community Wealth Building practices.
- Representatives of the Trust to sit on the; Community Wealth Building Group, Employment sub-group, and procurement sub-group. Commitment of 2 hours per quarter each (total 24 hours per year) and ad-hoc reporting.

The Board are referred to the following publications:

Inclusive and sustainable economies: leaving no-one behind

Building healthier communities: the role of the NHS as an anchor institution

Torbay is embarking on a bold and new economic model to deliver a resilient, sustainable, and inclusive local economy, with more local employment, and a larger and more diverse business base, to ensure that wealth is locally owned and the benefits are felt by local people.

We face a range of social, economic and environmental challenges, both locally and nationally. The Torbay Community Wealth Building (CWB) approach draws upon anchor institutions to support a sustainable and inclusive approach to the local economic wellbeing.

This memorandum of understanding (MoU) sets out how we as anchor institutions will work as an organisation and with partners, from the goods that we buy, to the people that we employ, the assets we own, and the powers that we have, to bring about positive change and maximise the local economic opportunities.

Working together, we all have a role to play in effecting the change that is needed to deliver the CWB agenda locally in Torbay.

At the centre of the CWB approach there are five pillars for harnessing existing resources. As local anchor institution's we commit to adopting the following approaches:

1. **Procurement** – Progressive procurement which develops well integrated and dense supply chains with local enterprises, SMEs, employee owned businesses, social enterprises, cooperatives and other forms of community owned enterprise.
2. **Employment** – Recruitment from lower income areas, commitment to paying a living wage and building routes of progression for workers are all examples of the actions anchor institutions can take to stimulate the local economy, raise living standards, and bring social improvements to our local communities.
3. **Land and Assets** – Anchor institutions are often major land holders and can support investment and regeneration of under-utilised assets for the communities benefit.
4. **Financial Powers** – CWB seeks to increase flows of investment within local economies by harnessing the wealth that exists locally. It can enable financial inclusion, reduce regional inequalities, and boost local financial resilience.
5. **Plural Ownership** – Encourage the democratic ownership of the local economy by encouraging the growth of a diverse business base through cooperatives, mutually owned businesses, SMEs and municipally owned companies which enables the wealth generated to benefit the local community and provides a positive impact on society.

Torbay

Community Wealth Building

Memorandum of Understanding

TORBAY COUNCIL

Signed .....

South Devon College

Signed .....

NHS Torbay and South Devon NHS Foundation Trust

Signed .....

tda

Signed .....

TORBAY COUNCIL

Our Ambition

We want Torbay and its residents to thrive.

We want Torbay to be a place where we have turned the tide on poverty and tackled inequalities; where our children and older people will have high aspirations, and where there are quality jobs, good pay and affordable housing for our residents.

We want Torbay to be the premier resort in the UK, with a vibrant arts and cultural offer for our residents and visitors to enjoy; where our built and natural environment is celebrated and where we play our part in addressing the climate change emergency.

What we will do

1. Progressive Procurement

We will use our spend to actively encourage and support a growing, diverse and resilient local business base, and to support a low carbon economy.

We will:

- Develop the corporate culture and status of procurement as a key feature of Community Wealth Building.
- Establish an anchor institution Procurement Sub-group to explore and identify opportunities for more local procurement and progress joint opportunities.
- Support our local business base – including a wide range of business models and processes such as co-creation – to enhance their capacity to bid for public sector contracts.
- Promote upcoming procurement opportunities more proactively including local 'Meet the Buyer' events.
- Enhance our procurement through market supply analysis and increase knowledge of local suppliers, and identify gaps in the market to create locally-driven economic opportunities.
- Maximise our approach to community benefits by ensuring they meet our Community Wealth Building ambitions and the needs of our communities.
- Review and give full consideration to the sustainability and environmental impacts resulting from procurement.
- Encourage local businesses to explore integrating their supply chains within the locality to support the local and regional economy.

2. Good Employment

We will encourage the creation of 'good' and meaningful jobs with progression opportunities to unlock the potential of our residents.

We will:

- Establish an anchor institution Employment Sub-group to share good practice and review workforce policy to improve employment opportunities and career progression for local people.
- Support our businesses to implement good work principles which maximise the potential of employees.
- Seek opportunities to help re-skill and re-train local residents ready for work.
- Work with the local VCSE sector to undertake more community outreach where there are anchor recruitment opportunities and encourage the private sector to target excluded groups.
- Take a more proactive approach to being a Disability Confident employer and encourage others to adopt this approach.
- Consider how our recruitment application process could be more accessible and how we could advertise more in local places, including social media pages.
- Consider apprenticeship and recruitment opportunities for young adults under Torbay Council's care.

3. Land and Assets

We will support the wider regeneration of our community by maximising all of our land and assets including exploring alternative uses for community and business benefit.

We will:

- Explore the opportunity to use anchor assets to develop an approach within a locality – focusing on town centre regeneration, and underutilised and derelict land and buildings.

4. Financial Power

We will invest locally and encourage regional and national institutions to invest in our communities.

We will:

- Promote local financial institutions.
- Encourage staff to spend locally.
- Continue to empower our communities by promoting available funding opportunities.

5. Plural Ownership of the Local Economy

We will support the creation and sustainability of a range of business models including SMEs, social enterprise, employee ownership, cooperatives, municipal activity and community enterprises.

We will:

- Work with Local Spark and the Torbay Community Development Trust to support wider forms of business ownership including employee ownership, cooperatives, community businesses, and social enterprises.
- Support our business base on progressive business models, workplace innovation and good employment practices to create a fair, diverse and resilient local economy.
- Proactively extract social value and community benefit from local construction projects for the benefit of the community.
- Support the exploration of new business model such as a care cooperative or community energy companies.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: ICS Devon SOF 4 Exit Criteria			Meeting Date: 26th January 2022
Report appendix	Appendix 1 – Strategic Oversight Framework		
Report sponsor	ICS Chief Executive		
Report author	System Improvement Director (NHSE/I national team) Independent Advisor Regional NHSE/I team		
Report provenance	ICS Executive Committee		
Purpose of the report and key issues for consideration/decision	The 2021 System Oversight Framework outlines a new integrated system focused Recovery Support Programme (RSP) which aims to support organisations and systems to identify risks and facilitate collective action to address challenges and make sustainable improvements. Whilst the statutory responsibilities of NHS England and NHS Improvement and the accountabilities of individual organisations remain unchanged, the framework also starts to position the ICSs' role in the collective management of system resources and performance as outlined in the 2021/22 Operational Planning Guidance and in the oversight arrangements for organisations in their system. In line with the national guidance, South West Region has made an assessment of the support required for the Devon ICS and partner NHS organisations to deliver on their statutory duties and allocated them to the relevant segment of the SOF as outlined in the attached paper.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	Board are asked to: • Discuss and note the Devon ICS SOF 4 exit criteria • Agree that the Trust, as a key partner in the ICS will play a full part in delivering the actions necessary to meet the requirements of the exit criteria		

Summary of key elements	
Strategic objectives supported by this report	

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

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

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

External standards affected by this report and associated risks			

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

Strategic Oversight Framework 2021/22

1. CONTEXT

The 2021 System Oversight Framework outlines a new integrated system focused Recovery Support Programme (RSP) which aims to support organisations and systems to identify risks and facilitate collective action to address challenges and make sustainable improvements.

Whilst the statutory responsibilities of NHS England and NHS Improvement and the accountabilities of individual organisations remain unchanged, the framework also starts to position the ICSs' role in the collective management of system resources and performance as outlined in the ***2021/22 Operational Planning Guidance*** and in the oversight arrangements for organisations in their system (**Table 1**)

Table 1: ICS development and oversight approach

	Relative level of ICS development and governance arrangements →		
	By exception	**Typical oversight arrangement***	
ICS	ICS leadership will **work in partnership** with the regional team, attending and contributing to discussions relating to place-based† systems and individual organisations within the ICS Provide **advice and guidance** on place-based systems† and individual organisations within the ICS	**Jointly conduct** oversight and drive improved performance for place-based† systems and individual organisations within the ICS alongside regional teams **Participate** in any place-based system or organisational support and intervention carried out by NHS England and NHS Improvement, other than in exceptional circumstances	**Lead** the oversight of place-based† systems and individual organisations in line with the principles of this document **Co-ordinate** any support and intervention carried out by NHS England and NHS Improvement, other than in exceptional circumstances
NHS England and NHS Improvement	**Lead** the oversight of the ICS, and work in partnership on the oversight of place-based systems† and individual organisations in line with the principles of this document **Engage** with the ICS before any escalation action/ intervention is finalised and enacted through a single identified system lead	**Lead** the oversight of the ICS and contribute to the oversight of all place-based systems† and individual organisations alongside the ICS Only engage with organisations with the knowledge and participation of the ICS through a single identified lead (other than in exceptional circumstances)	Gain assurance of place-based systems† and individual organisations through the ICS, other than in exceptional circumstances†† Undertake the least number of formal assurance meetings possible with individual organisations

*Where individual provider or commissioning organisations are subject to formal regulatory intervention, NHS England and NHS Improvement will take a direct role alongside ICSs in enhanced oversight.

† Where the ICS is built on more than one place-based system.

This means that the direct oversight of delivery of the ICS Improvement Plan will be undertaken by the Southwest Region and that the ICS Chief Executive will also have a role in the regional oversight process for the delivery of the SOF4 and SOF3 improvement plans for the relevant Trusts.

There is a requirement for 'exit criteria' to be developed for each System and Trust and movement between segments will dependent upon evidencing continued and sustained improvement.

There is an expectation that the interdependencies between the ICS and Trusts to deliver improvement actions is articulated and obligations outlined in the respective exit criteria.

The governance and oversight arrangements will need to ensure that organisations are held to account for delivering their own actions and their agreed contributions to the improvement plans of others.

In line with the national guidance, South West Region has made an assessment of the support required for the Devon ICS and partner NHS organisations to deliver on their statutory duties and allocated them to the relevant segment of the SOF as outlined in Table 2.

Table 2 : SOF Segmentation – Devon System

Organisation	SOF Segment	Segment Descriptor	Key reason given for segmentation	Scale and nature of support needs
Devon ICS	**4**	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support		Mandated intensive support delivered through the Recovery Support Programme
University Hospitals Plymouth NHS Trust	**4**	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support		Mandated intensive support delivered through the Recovery Support Programme
Northern Devon Hospitals NHS Trust	**3**	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)	**Finance** - size of deficit; underlying deficit; deterioration in position (19/20 – 20/21)	Bespoke mandated support through a regional improvement hub, drawing on system and national expertise as required
Royal Devon and Exeter NHS Foundation Trust	**3**		**Performance** (elective care & cancer) **Quality** (patient flow in & out of hospital)	
Torbay and South Devon NHS Foundation Trust	**3**		**Finance** – underlying deficit	
Devon Partnership NHS Trust	**2**	Plans that have the support of system partners in place to address areas of challenge. Targeted support may be required to address specific identified issues		Flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package

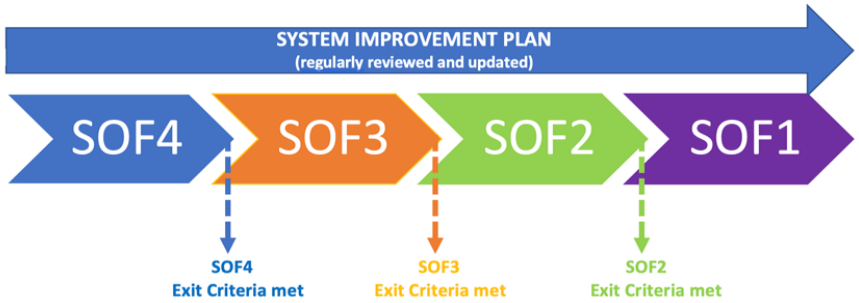
3. DEVELOPING THE SYSTEM IMPROVEMENT PLAN

The National Oversight Framework outlines the process and expectations on the ICS and Trusts to deliver continued and sustained performance improvement. There is a formal assessment process every 6 months against all 6 domains:

- Quality of care, access, and outcomes
- Preventing ill health and reducing inequalities
- Finance and use of resources
- People
- Leadership and capability
- Local strategic priorities

Organisations will enter the framework at a given point based on an evidence-based recommendation from the Region and will de-escalate based on delivering agreed exit criteria. Overall progression will be based on evidence of significant and sustained improvement in line with an agreed improvement plan that covers all aspects of the framework. It must be acknowledged that progression is not necessarily linear - significant deterioration in any of the domains, at any point, could result in further escalation.

A System Improvement and Assurance Group (SIAG) will be established (similar to the previous Strategic Oversight Groups) to oversee the progress of the System against its exit criteria, the exit criteria of the component organisations (except UHP which will be reviewed separately) and the wider System improvement plan. The Improvement and Assurance Group for UHP will exception report into SIAG so as not duplicate reporting or cause confusion. The governance is being designed to recognise the importance and contribution of all partners into the Systems recovery programme, including DPT in relation to the delivery of the transformation plan and CIP.



Discussions with Region have confirmed that the reasons for Devon ICS being assessed as SOF4 are:

- The scale of the financial deficit (both in-year and underlying)
- The need to accelerate the pace of agreement and delivery of a system-wide clinical strategy that underpins the Long-Term Plan with clear plans and trajectories for delivering the requisite transformational service changes

Working on the assumption that the reasons for being assessed for entry into SOF4 should form the basis of the SOF4 exit criteria, these two key areas together with the system-wide improvement actions in UEC (aligned to the separate SOF4 exit requirements for University Hospitals Plymouth NHS Trust) are included in the draft SOF4 exit criteria as presented in **Table 3** below.

Table 3 : Draft Devon ICS SOF4 Exit Criteria

Theme	Ref	Draft Exit Criteria	Proposed Evidence	Assurance mechanism	Timescale

1. Finance	**1.1**	Development and delivery of agreed financial plan for H2 21/22	• 21/22 H2 plan with clarity on:
			  ○ Bridge from H1 to H2
			  ○ Bridge from 19/20 to H2 exit run rate
			  ○ Availability and use of non-recurrent mitigation.
			• Monthly system finance report including forecasts of year end and exit run rate
				SIAG	31st Dec 21

	1.2	A shared list of Quick Wins to be realised in H2 e.g Grip and Control areas such as sickness absence	• PIDs for quick wins identifying when the savings will be realised with clear owners and a QIA completed for each. • Trajectory of savings evidencing actual versus planned	SIAG	Dec 21
	1.3	Financial planning framework developed and agreed by the ICS and all partner Trusts to include expectations regarding:	• Board assurance report evidencing that efficiency programmes have been stood back up and are delivering the national efficiency targets	SIAG	March 22

Theme	Ref	Draft Exit Criteria	Proposed Evidence	Assurance mechanism	Timescale
		• Approach to organisational efficiency measures including the use of GIRFT, Model Hospital etc to drive improvements • Alignment of financial planning with system objectives including thresholds and ongoing process for ICS scrutiny of investment proposals • Financial management within the affordability constraints of the system allocation	• Minutes of meetings confirming H2 system review of new expenditure commitments • Revised integrated business planning process for 2022/23 in place • Operational financial plan in place for 2022/23 that improves the position by at least the requirements set out in the national planning guidance		
	1.4	Financial recovery plan produced with clear trajectories that reduces the underlying deficit.	• Long-term financial plan produced that builds on the (19/20 to H2) exit run rate and includes modelling of the financial implications of: ○ LTP transformation programmes ○ Merger of RD&E and North Devon Trusts ○ Proposed HIP2 schemes	SIAG	March 22
	1.5	Operational financial plan produced for 2022/23 in line with the agreed financial framework and the outline recovery plan	○ Resource and demand growth assumptions ○ Organisational efficiency programmes ○ System-wide collaboration	SIAG	March 22
	1.6	Clear evidence of system working to deliver best use of existing and future resources	• Sustained delivery against 22/23 plan in Q1 with a review date in Q2 • Minutes of Board meetings confirming agreement and plans in place to deliver. at	SIAG SIAG	August 22 March 22

Theme	Ref	Draft Exit Criteria	Proposed Evidence	Assurance mechanism	Timescale
			least one significant area of system/Provider collaboration in 2022/23		

Theme	Ref	Draft Exit Criteria	Proposed Evidence	Assurance mechanism	Timescale
2. Quality – Financial improvement enabler	**2.1**	The ICS will have developed and agreed a clinical case for change that is approved by all Boards and the regional team	• Clinical Case for Change Document produced • Single Board paper that outlines the case and the supporting evidence of clinical engagement presented to each Board • Minutes of Board meetings confirming approval • Minute of Professional and Clinical Cabinet confirming approval	SIAG	February 2022 March 2022
	2.2	Building on the work of the previous reviews and the draft LTP, the ICS will have developed an outline clinical strategy and a clear timeline for approval by Boards which is agreed with the regional team	• Clinical Strategy document and roadmap produced • Minute of Professional and Clinical Cabinet confirming approval • Copies of relevant action plans and progress update reports.	SIAG	March 2022 March 2022
	2.3	Significant progress made in improving the management of risk within the UEC system across Devon. This includes: • Development of a UEC strategy • Delivery of the system actions arising from the Urgent Care Summit, aligned to the strategy • Establishment of a Winter task force • Demonstrable progress against the system actions identified in the UHPT ED Culture Review	• Minutes of the Devon Urgent Care Board confirming progress against actions • Progress update report from AW/RA and amended action plan approved through Devon Urgent Care Board. Evidence of progress via subsequent minutes • Development of the Winter Taskforce; TOR; work programme; update reports to include demonstrable progress against agreed KPIs • Copy of Risk Management Framework and minutes confirming approval	SIAG	Monthly February 2022 Nov/Dec 2021 Dec/Jan 2022

Theme	Ref	Draft Exit Criteria	Proposed Evidence	Assurance mechanism	Timescale
		• Identification and delivery of the high-impact place-based actions to support winter planning including SDEC in primary care and an agreed risk framework to manage escalation	• Minutes of place-based Urgent care Boards confirming agreed priority actions and progress updates		Monthly

Theme	Ref	Draft Exit Criteria	Proposed Evidence	Assurance mechanism	Timescale
3. Strategic leadership & transformation - Financial Improvement enabler	**3.1**	A joint decision-making framework has been produced and agreed by all Boards as a key enabler for system-wide transformation	• Comprehensive decision-making framework in place • Single Board paper • Minutes of Board meetings confirming approval	SIAG	February 2022
	3.2	An Intensive engagement exercise has been undertaken with CEOs, Chairs and Boards within the system to reposition and reinforce responsibilities for system working alongside organisational accountabilities	• Engagement plan shared with regional team • Board agreement to the financial planning framework, clinical case for change and decision-making framework	SIAG	March 2022
	3.3	A refresh of the roadmap for delivery of the key components of the LTP and clinical strategy is completed to include: • The key short, medium, and long-term transformational changes required to deliver clinical and financial sustainability • Requirements for any public consultation • Timelines for production of any Pre-consultation Business Case • Routes to decision-making	• Single comprehensive document that outlines the critical path	SIAG	March 2022

Note: It is expected that the above criteria will partly be demonstrated through partnership working with Cornwall & Isles of Scilly ICS

The remaining areas integral to the wider improvement plan include **workforce and culture**, **performance**, and **system governance**
The key actions in line with these domains (**Annex 1**) will be progressed with the same pace and priority as those outlined in **Table 3** – the only difference being that they are not formally part of the current SOF4 exit criteria. The importance of addressing all the domains in the improvement plan is fully recognised in the context of the ambition to move to SOF3 when the next assessment is made.

4. PROCESS FOR AGREEING THE DEVON ICS SOF4 EXIT CRITERIA

There were technically 3 stages to the formal approval process for the SOF4 criteria:

Phase 1 Approval through the internal ICS governance structures via the ICS Executive Committee

Phase 2 Approval by NHSEI South West Region Via the RSP meeting held on the 29th November '21

Phase 3 Endorsement by the NHS England and NHS Improvement System Oversight Committee via the SOC meeting

The timelines as follows were adhered to;

Date	Meeting	Action
26 -10-21	ICS CEO Meeting	Initial discussion of draft exit criteria to confirm expectations of Trust to contribute to delivery of actions and align with their own organisational SOF exit criteria
27 -10-21	RSP Group	Consideration of first draft SOF4 exit criteria and proposed approach to development of wider Improvement Plan
10-11-21	RSP Group	Final draft SOF4 exit criteria for agreement for onward approval through internal governance structures
16-11-21	ICS Executive	To approve draft SOF4 exit criteria
25-11-21	Devon CCG Governing Body	To approve draft SOF4 exit criteria
29-11-21	Regional RSG	To approve draft SOF4 exit criteria
01-12-21	ICS Partnership Board	To approve draft SOF4 exit criteria

It is also expected that each of the Trusts would take the ICS Improvement Plan and SOF4 Exit Criteria through their own Boards in public for endorsement with the commitment to playing their full part in delivering the requisite outcomes reflected in their own SOF exit criteria.

Together for Devon

ANNEX 1

Table 4: Draft Criteria for inclusion in overall Improvement Plan (? Also forming the basis for SOF3 criteria at the appropriate time)

Theme	Ref	Draft Exit Criteria	Proposed Evidence	Assurance mechanism	Timescale
1. Finance - continued	**1.2**	Realisation of Quick Wins from H2 into 22/23	• Trajectory of savings evidencing actual versus planned	SIAG	
4. Workforce and culture		The system has a higher overall absence rate (5%) than the current regional average (4.7%), and it is the highest system, regionally, for absence related to anxiety/stress/depression. The ICS to take actions through partner organisations that improve Health & Wellbeing among staff, consequently reducing staff absence.	SUGGESTED BY REGION – TO BE DISCUSSED AND EXPLORED FURTHER AT NEXT RSP		
	4.1	The ICS has led the work to drive forward system-wide workforce solutions to support: • Optimising social care capacity • Multi-professional clinical validation (111 and SWAST) • Workforce redesign including apprenticeships, nurse associates and other new roles			
	4.2	The ICS has worked with Trusts to identify the common themes arising from the staff survey			

Theme	Ref	Draft Exit Criteria	Proposed Evidence	Assurance mechanism	Timescale
	4.3	results to develop a 'once-for-Devon' approach to staff health and wellbeing where appropriate The ICS will have an approved 2-year OD programme in place with clear objectives relating to: • Strengthening leadership capacity and capability • Behavioural change (balancing system and organisational priorities)			
5. Performance	**5.1**	The ICS will demonstrate how whole-system actions and specific out-of-hospital improvement actions have been taken forward to support Trusts to stabilise / improve performance against key SOF metrics including: - 12 hour waiting times - Ambulance handover delays - Elective recovery activity v 19/20 baseline - Elective 104 week waits - Cancer 62 day waits	• System-wide action plans with clear trajectories and progress reports • Targeted commissioning plans and resource allocations to support key actions and initiatives • Relevant dashboards demonstrating performance above the bottom quartile nationally and/or demonstrable improvement		
	5.2	Each LCP will have an approved delivery plan for 2022/23 with clearly defined targets, trajectories and accountabilities for delivery			

Theme	Ref	Draft Exit Criteria	Proposed Evidence	Assurance mechanism	Timescale
6. Governance	**6.1**	The new ICS corporate governance framework will be fully established with roles, accountabilities and committee structures fully aligned to deliver effective oversight and decision-making at system and place levels.			
	6.2	A specific SOF governance framework will have been agreed between the ICS and Regional Team and established to ensure: • Effective ICS involvement in the oversight of Trust SOF improvement plans • Alignment of deliverables and holding to account arrangements for actions between and across organisations	• Approved Governance Framework • Clear TOR and membership • Notes of oversight meetings • ICS and Regional Team confirmation of the level of Trust engagement in the process (particularly in delivering their obligations to partners)		

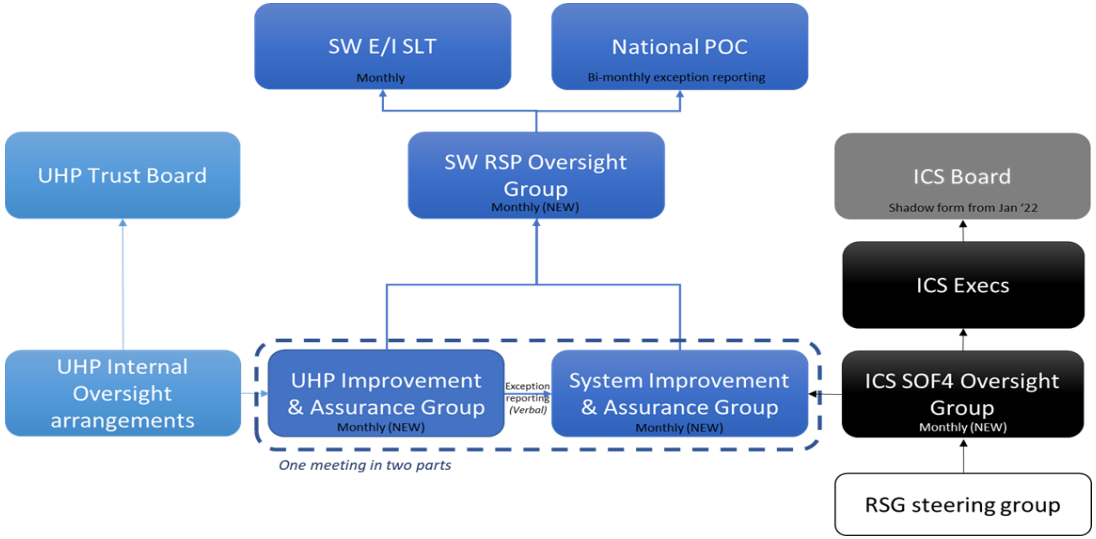
5. SOF GOVERANCE ARRANGEMENTS

The following governance infrastructure has been designed to oversee the progress of both the System and its component organisations in relation to their achievements against the exit criteria. The reasons for entering SOF form the basis for the respective exit criteria.

The design principles include:

- this new regional oversight will replace the current SOM arrangements
- for SOF4 organisations it will be led by the Regional Team
- for SOF3 organisations it will be initially led by Region alongside the ICS Team with a view to transitioning to ICS leadership over the coming months
- Work has commenced on internal ICS governance arrangements for system SOF4 which will support the oversight arrangements

It is important to note that the SOF status of all organisations is reviewed on a 6 monthly basis against ALL SOF domains. Therefore, we must work together across all domains (not just focus on the exit criteria) to prevent any deterioration in other areas.



NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Trust Strategy			**Meeting date:** 26th January 2022
Report appendix	Trust Vision, Values and Strategy Document		
Report sponsor	Director of Transformation and Partnerships		
Report author	Director of Transformation and Partnerships		
Report provenance			
Purpose of the report and key issues for consideration/decision	The Trust Strategy has been developed over several months of engagement with members of the Trust Board. The strategy is a living document that we improve iteratively as we develop and deliver the strategic enabling plans. The document represents the combined views of a diverse set of individuals and preferences across the Board. There will always be an opportunity to refine and improve the document, and it is presented to Trust Board as the best overall fit that will provide clear and effective direction for at least the next 12 months. The Trust Strategy document is owned by the Trust Board. Following approval we will develop summary materials that communicate our ambitions to our staff, patients, stakeholders and regulators. There will be a formal review and monitoring process. It is intended that the Strategy document is refined and re-presented to Board in January 2023.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendations	The Trust Board are asked to approve the Trust Strategy		
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

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<tr><td>Risk Register</td><td>X</td><td>Risk score</td><td>20</td></tr>
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BAF Risk – 1 To develop and implement the long-term plan with partners and local stakeholders, to deliver the ICO strategy
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Torbay and South Devon
NHS Foundation Trust

Our Vision, Values and Strategy

21st Jan 2022

Contents

WELCOME

A warm welcome to our Strategy. This document describes our vision for the future, why it matters to us and our local communities, what this means for the way we run our services and how we will work together to deliver it.

What is clear across our communities is that the pandemic has impacted our health and welfare in a way that will have a far-reaching impact on how we organise and deliver services in the future.

Never has our vision for better health and care for all, been more important. The impact of COVID-19 has not only increased the pressure across all aspects of health and social care, but those who live in our most deprived coastal communities have seen an increasing gap in health inequalities.

Our strategy to deliver high quality integrated care with our communities, through collaboration with partners, is now also a key part of the Government's legislation for the creation of Integrated Care Systems.

This reinforces our longstanding commitment to ensure that we care for people by focusing on what matters to them, putting them at the centre of everything we do and integrating services around them, is now supported nationally.

The quality and safety of care sits at the heart of our strategy, advancing new models of care and service delivery will better enable us to address delays in diagnostics and treatments and access to services. Our primary quality and patient safety goals are to ensure that we:

- Zero avoidable deaths.
- We continuously seek out and reduce harm
- We achieve excellence in clinical outcomes and experience for patients

We are proud pioneers in integrating health and social care nationally, and passionate about achieving these quality goals together. By further building on our strong local partnerships, built over decades, we will do more to provide better health and care for all.

We will build on the excellence of our clinical services e.g. Day Surgery, and work collaboratively in our Integrated Care System to ensure that our local people have timely access to the diagnostics, treatment and operations that they need, when they need it.

We will focus on prevention, improving equity of access to services and better outcomes for our most vulnerable people and communities.

All of this will be underpinned by a relentless focus on quality improvement, support and development for our valued workforce and investment in our buildings, our digital systems and people.

There is no doubt that there is a lot to do, and we have a long road ahead. We have built great foundations on which we can accelerate delivery of our ambitions. This is why in presenting this strategy, we are excited and confident that, working in partnership, we can build our brighter future together.

Liz Davenport and Sir Richard Ibbotson

About us

Who are we and what do we do?

We are Torbay and South Devon NHS Foundation Trust and since 2015 have been one of the few Integrated Health and Social Care Organisations in the country.

We serve our local people by providing joined up care across our communities. We deliver acute services from Torbay Hospital and community-based health and social care, in people's homes and across a wide range of community buildings stretching from Dawlish to Dartmouth.

In addition, we work flexibly with our partners to provide services in community buildings to ensure our local people can access the support they need e.g. in job centres.

We serve a resident population of approximately 286,000 people, plus around 100,000 visitors at any one time during the summer holiday season.

We employ over 6,500 highly skilled and compassionate staff working across our communities, including doctors, nurses, home care support workers, occupational therapists, social workers, health and wellbeing coaches.

We have 800 volunteers who directly support our services and a wide range of community partnerships with the voluntary, community and social enterprise sector, to better support people in our communities with their health and wellbeing.

Increasingly, we are providing more care as close to home as possible, helping people to live well in their communities.

We support around 500,000 face-to-face contacts with patients in their homes and communities each year and see over 78,000 people in our Emergency Department annually. From a social care perspective, we support approximately 2,300 adults with long stay care packages and a further 500 with complex healthcare needs alongside social care requirements.

We have a proven track-record of innovation both in terms of our integrated care services and with some of our specialist clinical services, for example day surgery, being nationally recognised nationally for their best practice.

Our commitment to working in partnership to improve services underpins everything we do. We are the lead provider for the Devon Children and Families Alliance, and we share clinical services across other hospitals for cancer, vascular surgery, sexual health services, plastic surgery and many more.

At our core, we are deeply connected to, and rooted in, the values of the NHS. We work together for patients and our communities. We make sure that everyone counts and that every voice is heard. What matters to our people, matters to us. We are strongly committed to improving the quality of everything we do and working with compassion, dignity and respect at all times. Our values make us great people to work with, and by working together we can support better health and care for all.

OUR COMMUNITY'S HEALTH AND CARE NEEDS

Torbay and South Devon is a beautiful part of the West Country and a popular tourist destination. The population reflects that of many coastal communities, with a significant level of health inequality and high levels of deprivation.

Our older population

Our community has a larger proportion of older people than the national average, largely due to the attraction for affluent, older people to relocate to the South West for their retirement. Torbay has 27% of the population aged over 65, with the national average being 17%. We have more people living longer, with one or more long term conditions, and we expect to see the largest population growth for people over the age of 70.

This leads to greater demand for older peoples health and care services, with less young people in our labour market to provide care.

High levels of deprivation

There are significant levels of socio-economic inequalities across our community, with Torbay being the most highly deprived community in the South West. As with many coastal towns there are high levels of poverty and deprivation, with not enough opportunities for younger people. There is a low wage and low skill local economy with a heavy reliance on tourism.

Poverty and deprivation are key determinants of health and as a result we see significantly more alcohol and self-harm related admissions, poorer mental health outcomes and alongside this we see poorer physical health outcomes.

High rates of suicide and self-harm

Torbay and South Devon have some of the highest rates of self-harm and suicide in the country as a result of the high levels of deprivation. 1 in 6 adults experience a mental health problem and poor mental health is the second leading cause of ill-health.

The suicide rates in our community are significantly higher than the national average, alongside high rates of self-harm and high levels of domestic abuse.

Positive wellbeing influences our choices, whether that is maintaining a healthy lifestyle or better managing a long-term condition. Supporting people to better manage their own well-being is a critical factor in helping people to have better health outcomes.

The impact on young people

Many local children start their lives at a disadvantage. We have high numbers of looked after children and children with protection arrangements in place.

Hospital admissions for young people with self-harm is significantly higher than the national average, with 44% of all self-harm admissions relating to 10-24 year olds.

We also see high levels of admissions for alcohol related issues, high rates of teenage pregnancy and high numbers of children experiencing the trauma of witnessing domestic abuse.

In Torbay we are seeing some concerning measures that tell us we need to focus on services for our younger people including:

- 21% children from a low-income family
- 58% babies not breastfed at 6-8 weeks
- 25% of reception age children are overweight
- 35% of children have 5 or more decayed teeth
- 18% of our children have special educational needs.

Better health and wellbeing for all

Our local people need us to provide services that meet their needs and improve their life chances. We will use our strengths to help those who need us most.

PART OF A WIDER HEALTH AND CARE SYSTEM

We are part of the Devon Integrated Care System (ICS). By working together, partner organisations across Devon can care better for more people more fairly – balancing different needs of communities and reducing health inequalities.

Our priorities across Devon are:

Efficient and effective care Ensuring evidence-based care, tackling unwarranted clinical variation and improving productivity everywhere so that Devon taxpayer's money is used to achieve best value for the population

Integrated care Enhancing primary care, community, social care and voluntary and community service to provide more care and support out of hospital care Including urgent response

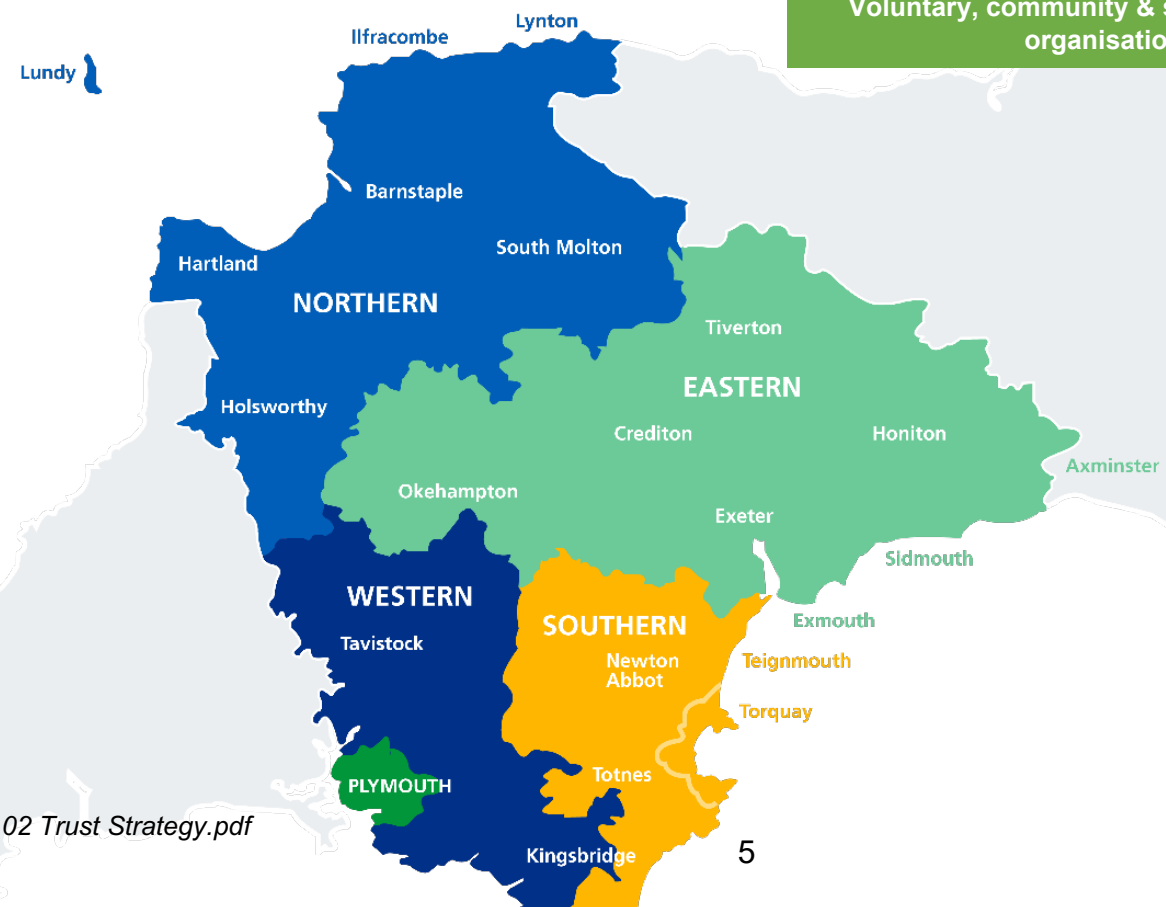
Equally well Working together to tackle the inequalities in the physical health of people with mental illness, learning disabilities and/or autism

Digital Devon Investing to modernise services using digital technology

Children and young people Investing more in children and young people to have the best start in life, be ready for school, be physically and emotionally well and develop resilience throughout childhood and on into adulthood

Patient-led care Nurturing a patient-led approach to health and care which reduces variations in outcomes, gaps in life expectancy and health inequalities in Devon

1.2 million people	**Eight** District, borough & city councils	**Three** Upper tier local authorities and health and wellbeing boards
One CCG	**Four** acute hospitals	**31** primary care networks
Two mental health providers	**One** ambulance service	**Six** local care partnerships (LCPs)*
Voluntary, community & social enterprise organisations		



CONTINUING OUR JOURNEY TOWARDS GREATER INTEGRATION

The core principles of our strategy were developed with local partners in 2005, when we were focussed on integrating health and social care to improve our offering for local people and their families. In 2015, we were one of the first Integrated Care Organisations nationally to integrate social care with both community and hospital healthcare. This helps us to ensure all services that many people access are completely joined up.

Our current strategy builds on this foundation, determining our strategic priorities as we build a brighter future for local people.

Our services are organised into Integrated Service Units (ISU's) each of which encompass community, hospital and specialist services. The ISU's each have a focus on part of our local community to ensure that health and social care services, are meet the needs of local people. Integrated teams ensure that the investment in care is directed to where it will have the greatest impact for local people. There are few healthcare organisations that have developed the infrastructure to make doing the right thing, easier to do.

We have built strong relationships with primary care and now have GP leaders as part of our ISU teams. We invest in primary care support to ensure that our intermediate care services are optimised and have one of the lowest acute bed bases and lengths of hospital stays, in the country. Helping our local people to remain at home and independent.

Our strong relationships with the local authority, our care homes, domiciliary care and voluntary sector continue to build in strength and impact. Our focus on improving wellbeing and prevention, to reduce the long-term impact of ill health on health and social care services, is demonstrated in many services; such as our 0-19 service, that provides multi-agency support for the younger people in our community.

Optimising the opportunities for younger people is a key focus for us, underlining our leadership of Child and Family Health Devon. Supporting our most vulnerable children effectively, in their formative years, is critical to optimise their life chances and to reduce the risk of poor health as they grow.

Our acute and specialist services continue to develop in partnership with Trusts across Devon and this will be the cornerstone of the way we deliver healthcare in the future.

We already have some of the best day surgery services nationally and many of our clinical leaders have national roles to spread this learning. We continue to drive clinical innovation and have developed digital solutions to help people to manage their long-term conditions and are trialling the use of immersive technologies.

We have recognised that specialist services have changed, and we have adapted our approach to ensure that our local people have access to high quality specialist care. Working alongside our colleagues across the Integrated Care System (ICS) we have continued to develop strength and resilience in our specialist services, by working across the network of hospitals in Devon. An example of this is our very successful partnership to deliver vascular services.

Our workforce is our greatest asset and we have many examples of highly skilled and talented teams working collaboratively to deliver excellent care. We will continue to grow and develop the skills and talents of our workforce to ensure that our Trust remains a fantastic place to work.

We remain pioneers of health and care integration and much of what we have already achieved is being underpinned by a shift in national policy. We have built great foundations and this gives us confidence that we can deliver the ambitions outlined in the next phase of our strategy.

NEW STRATEGIC CHALLENGES

As we refresh this strategy, the challenges that we are experiencing in our organisation, across our Devon ICS and in our communities, could not be more acutely felt.

The Covid-19 pandemic has had a detrimental impact on those who are most vulnerable and the inequality gap has increased at an accelerated pace.

For us, this means that our older people have greater needs, due to social restrictions, fear of leaving their homes, lack of social interaction and delays in receiving care.

Therefore, we have more older people, in greater need for our health and care services. Delivering these services in our communities, designed around what matters to our patients, in their own homes, will help to maintain their independence and will help us to deliver care to more people.

The most deprived people in our community have been impacted. Mental health services for local people are more important than ever, as are the partnerships with our community and voluntary sector to ensure that local people have access to food and receive the help they need.

Our most vulnerable children are waiting longer to receive specialist services and our transformation of clinical pathways for our children and family health services could not be more important.

Waiting times for specialist hospital services have deteriorated at speed due to the need to prioritise immediate care for patients with Covid-19 and urgent care. Our planned care services are critical aspects of keeping people healthy and well.

Our current waiting times for diagnostics, outpatients and planned operations are unacceptably long. We need to re-design the way we deliver these services, with our partners across Devon, to reduce waiting times and improve the experience and outcomes for our local people, at pace.

Our staff work with us for a reason. They believe in our collaborative vision. They are passionate about supporting local people to live well. They are innovative, talented people who have a relentless ambition for quality improvement and caring with compassion. COVID-19 has made the work we do harder. We have an ageing workforce and as a result people are making decisions to retire or change career.

Our People Plan supports us to look after our staff – they are the beating heart of our services and our most valuable asset. It is more important than ever that we develop a local workforce, giving local people opportunities to work with us and supporting our communities to thrive.

Many of our buildings are some of the oldest NHS estate in the country and not fit for the purpose of modern healthcare. Our IT infrastructure is out of date. In order to provide the services that our local people and staff need and deserve, we require fit-for-purpose buildings supported by modern digital technology. Our Building a Brighter Future Programme describes how we will invest our share of the £3.7 billion government funding to build new hospital facilities, supported by local health and wellbeing centres and home-based care, making the most of digital technology to build a brighter future for everyone. This will require us to ensure our services are efficient and we innovative in order to attract investment into these much-needed facilities.

OUR PURPOSE

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

We are all different and we will celebrate that difference by ensuring that what matters to each person, matters to us. We will do this by ensuring that our care is personalised and led by our patients and their families.

Our goals underpin our purpose and help us to ensure that we are delivering against our strategic aims. We will measure our success by defining key measures for each year that will enable us to be confident that we are on the right path to delivering:

Excellent population health and wellbeing

We will focus on prevention and working with our community partners to reduce the inequalities experienced by local people.

Our community health and care services will focus on supporting people to build on their own strengths and prevent ill health by improving their wellbeing, providing timely support when people need it.

We are an influential institution in the community and will work with our local community to play our part in supporting the economic regeneration of Torbay and South Devon.

Excellent experience receiving and providing care

We will have a relentless focus on improving the quality of our services, to international best practice standards. Focussing on meeting the needs of local people, our patients and our staff, and what matters to them.

We will "Build our Brighter Future", with the development of a modern hospital, advanced digital technologies and health and wellbeing centres using national investment, to ensure that our staff and patients have modern facilities that deliver excellent care.

We will ensure that we involve our staff, patients and local people in the design and delivery of our services, to consistently improve how we care for our patients and our teams.

Local people will have good access to services that meet their needs and as a result, better outcomes. In our role within the Integrated Care System, we will ensure that local people get the treatment they need, when they need it.

Excellent value and sustainability

We will use every pound of public money, to invest wisely in effective and efficient services, that deliver excellent care for local people.

Our services will meet best practice standards, driving out unwarranted variation and ensuring that our local people have the best outcomes from their treatment.

Our specialist services will be delivered in partnership, by experts, in more resilient teams across Devon, that can provide specialist expertise when local people need it.

We will contribute to the sustainability of our environment through a commitment to net zero carbon.

Our commitment to buying local and offering employment opportunities to local people will contribute to building the wealth of our community. We will develop our labour market and have greater confidence in local supply chains. This is a critical part of our responsibility and opportunity to improve the health and wellbeing outcomes for local people.

Our vision for **"Better health and care for all"** will be delivered through our health and care plan. This plan is based on a set of key principles that will underpin the way we design and deliver our services.

Prevention and community development

Our clinical services will pay more attention to prevention of ill-health, with greater emphasis on digital support, advice and guidance to help people to manage their care. We will continue to build community partnerships, ensuring there are a range of support services in our local towns to help people live as well as they can.

What matters to me – personalised care

Conversations with our services will start with "what matters to me". Patients and their loved ones will be involved in leading their care, with the support of our specialist teams, to make good decisions ensuring they receive care that is right for them.

Support to be as independent as possible

We will continue to expand the range of our services that can be delivered at home, in care homes or in our community facilities both face-to-face and digitally enabled. In doing so we support people to remain independent, we reduce travel for local people and we ensure that we are more efficient in the way we use our resources.

Digitally enabled

In all aspects of our modern life, we use technology. Our services will be enhanced by digital systems and an electronic patient record that will ensure that people have access to all of the right information and tools and advice to look after their health. Our hospitals will be digitally connected across Devon with modern facilities, making our services reliable and of high quality.

Majority of services close to home

We will use our community health and wellbeing centres, community hospitals and diagnostic hubs to expand the range of services available closer to people's homes. We have a sustained track record of investing in community facilities and in doing so, we can provide more rapid access to the right treatments for local people.

Safe and effective general acute care

We will have a relentless focus on the improvement of quality in our hospital services. In partnership with GPs, we ensure that people rarely spend time in hospital beds. When people do need to come to hospital, urgent services will be delivered quickly and planned services will be available consistently. Following discharge, care will transition to expert teams providing rehabilitation and after-care at home or in community settings.

Specialist services in partnership

We have a large number of specialist services that are supported through effective partnerships across the hospitals in Devon. This will be expanded to ensure that people have reliable access to the best specialist care, with reduced waiting times. This will be underpinned by digital systems and electronic records, that mean that wherever you receive your care, the professionals working with you, have access to the right information to provide excellent care.

Equity of access

Our local people have some of the highest levels of inequality nationally and we will work tirelessly to improve their outcomes. In our commitment to personalised care and designing our services to meet the needs of our community, we will ensure that there is support for people to access the care they need in the way that is right for them, to improve their outcomes.

VALUES

We have adopted the NHS constitution values which apply across the NHS in England. Patients, public and staff have helped develop this expression of values that inspire passion in the NHS and that should underpin everything we do.

The NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS. The values are as follows:

Working together for people *Patients come first in everything we do*

Respect and dignity *We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits*

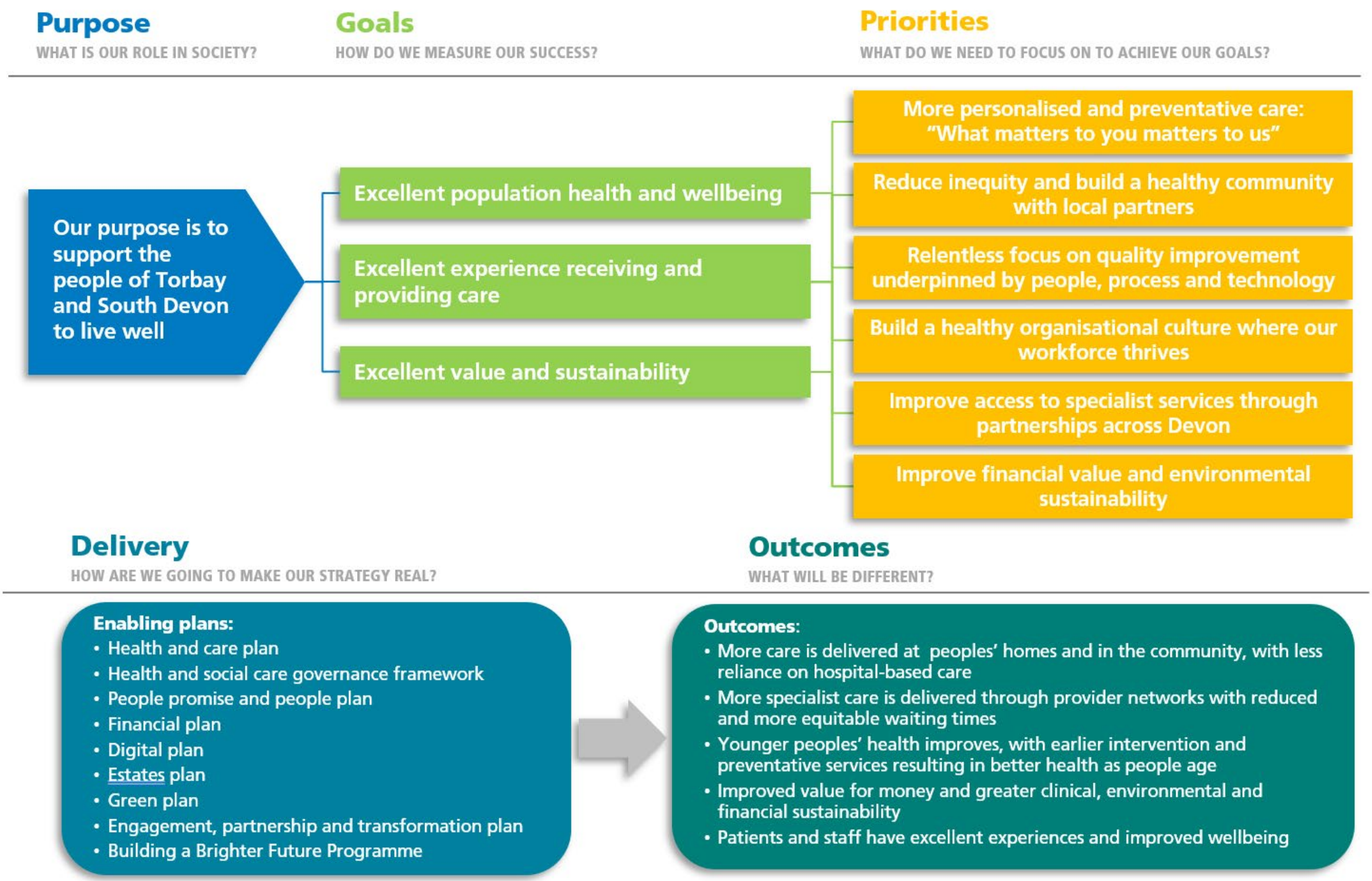
Commitment to quality of care *We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience right every time*

Compassion *We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need*

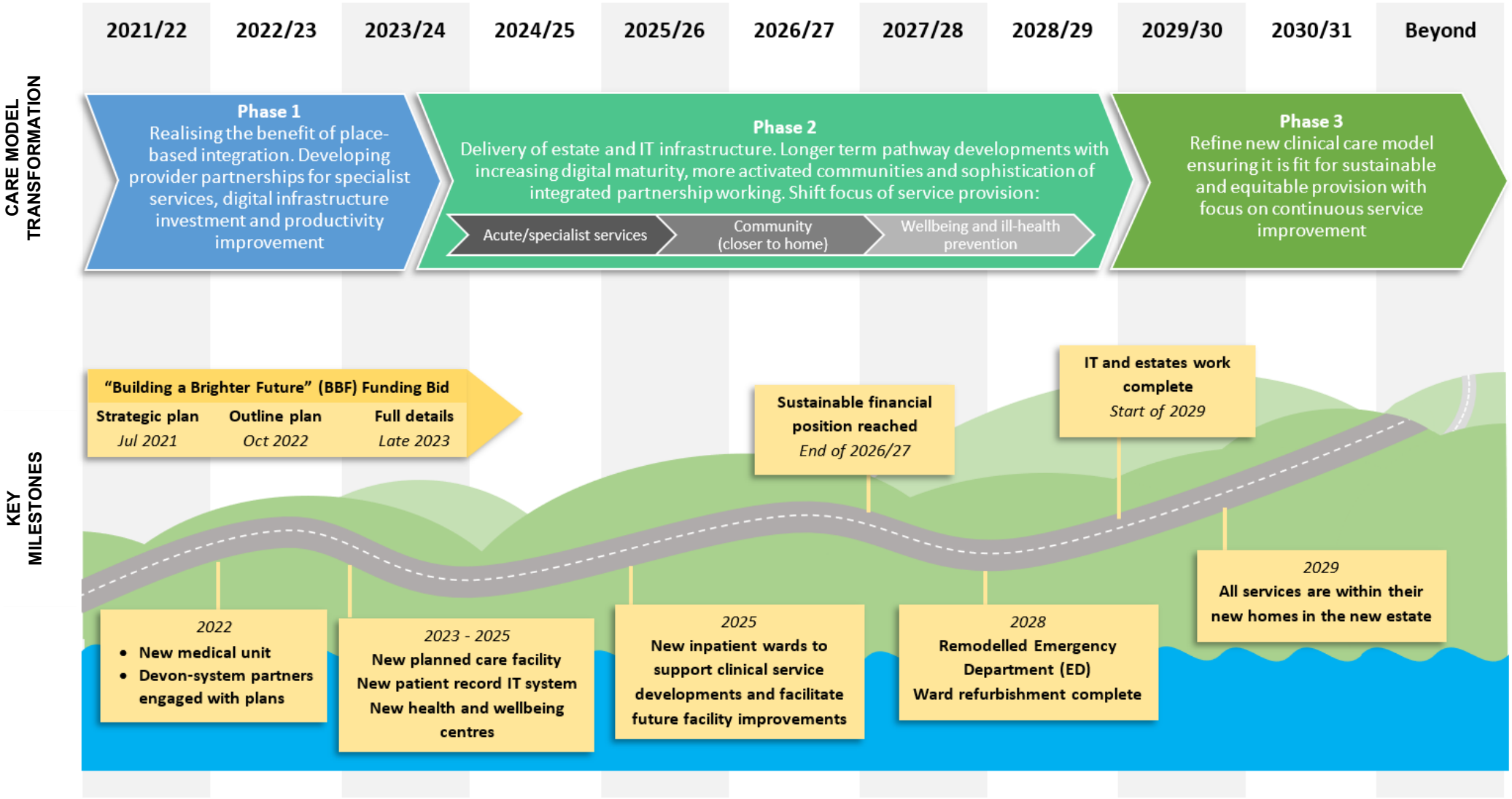
Improving lives *We strive to improve health and wellbeing and people's experiences of the NHS*

Everyone counts *We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind.*

STRATEGY ON-A-PAGE



STRATEGIC ROADMAP



DELIVERING OUR STRATEGY

Accountability for success

Our executive directors are responsible for delivering seven "enabling strategic plans" underlying our core strategy. These encompass the major changes required to deliver the strategy as well as improving the quality and value of our day-to-day business providing health and care services.

Each enabling strategic plan describes a five-year vision - components of the "future state" necessary to achieve our goals. These are backed by clear objectives and milestones through which we can ensure that they form a coherent backbone for delivering our strategy and hold ourselves to account for its delivery.

Our core services are intimately linked to our strategy through the "Integrated Service Units" (ISUs) that form the basis of our operational governance structure. Each ISU undertakes an annual business planning process (reviewed quarterly) that describes the year ahead in great detail with respect to services delivered, workforce, finance and improvement. This informs the first year of the ISU's strategic plan and is complemented by key aims and developments for the longer term.

Strategic plans to enable delivery

Health and care

Our health and care strategy will be developed and delivered through a large-scale change programme, which at its core is high engagement and involvement from our clinical teams and local people.

Through our flagship "drumbeat" initiative we will ensure that our health and care ambitions are described for our Building a Brighter Future programme. These ambitions will be delivered through our annual operational plans at Integrated Service Unit (ISU) level.

This health and care transformation will be supported by our Improvement and Innovation team, investment in digital technology and partnership across the Devon Integrated Care System.

People

Our people promise and plan have been developed with our people, underpinned by actions that will develop a healthy culture where we can all thrive. The essence of our plans to deliver on our promises are:

- We are compassionate and inclusive
- We recognise and value our staff
- We focus on "what matters to you"
- We prioritise wellbeing and look after ourselves and each other
- We are always learning. We invest in our development, we listen to feedback and are always improving
- We work flexibly to deliver what matters to our people
- We are a team and support each other and involve people in decisions that affect them

Quality

Our new quality governance framework will drive a relentless focus on quality improvement, with the following goals:

1. Zero avoidable deaths
2. Meeting basic care standards without exception
3. Improving care for deteriorating patients
4. Reducing avoidable harm
5. Improving peoples' experience of care

We will deliver against these goals through:

- Developing the capacity and capability within our front-line teams to lead quality improvement
- Setting up a quality improvement hub
- Making quality improvement everyone's business

Finance

Our financial plans set out how we will have the resources necessary to:

1. Deliver effective day-to-day services
2. Invest to deliver long-term priorities
3. Ensure that our services are efficient and offer best value for money

Although we (among other organisations in the region) are financially challenged, we have a plan to achieve a financially sustainable position while continuing to meet the needs of our local population. To support this we will deliver:

- ISU business plans that articulate the delivery of quality, performance, financial investment and workforce planning to achieve our strategic objectives
- A robust cost improvement plan that delivers year on year financial efficiencies
- An investment plan that ensures we work with partners in Devon, to make strategic investments that ensure our services are sustainable and of best value.
- Business intelligence that supports decision making, drives efficiency and service improvement to maximise productivity.

Digital

We will underpin the delivery of our strategy with modern digital technology that maximises the opportunity for partnership working and underpins high quality and effective clinical pathways. We will do this by:

- Implementing an Electronic Patient Record system
- Investing in digital innovation as a key enabler for our services
- Developing high quality IT services in partnership across Devon that brings the best technical expertise to support modern healthcare delivery

Estates

Our plan for the organisations facilities will ensure that facilities are:

1. Clean, safe, secure and suitable for the people we serve
2. Flexible to support efficient use and ongoing service improvements
3. Environmentally sustainable and good value for money.

To deliver this we will:

- Invest in new facilities on the hospital site alongside refurbishment of existing estates to ensure it is fit for the next 20 years.
- Complete the development of local health and wellbeing centres across South Devon to meet local needs.

Green plan

We have made a clear commitment to deliver our services sustainably. This will be achieved through:

- Embedding sustainability in every element of our organisational planning
- Setting clear targets for waste and carbon reduction

Engagement, partnerships and transformation

Through this plan we will deliver:

1. New services with better outcomes and user/staff experience
2. Stronger relationships and greater integration with local people and other organisations
3. More responsive and innovative approaches to transformation alongside continuous improvement

This will be implemented by:

- Using the best international expertise and local experience to guide the care model transformation programme
- Delivering an engagement programme with key partners, including the local community, other health and care providers and staff
- Leveraging our partnerships to ensure we deliver what local people need while also collaborating to support other services across Devon
- Creating a culture of continuous improvement, supported by innovation, best practice and a great team.

Building a Brighter Future

Our Building a Brighter Future programme is the route through which we will access national investment in digital technology and estates and facilities to support our long-term ambitions. It will do this through a process that involves wide engagement, careful design, business case development and implementation. Key deliverables include:

- Secure funding through completion of the business case process
- Ensure that the programme is consistent with long term plans across Devon
- Replace the existing digital infrastructure with a fully integrated Electronic Patient Record
- Ensure that the following four fixed points are delivered
  - all inpatient beds will be provided as new
  - separation of unplanned and planned care where appropriate
  - non-clinical support functions will be removed from the Torbay Hospital site where possible
  - Emergency Department and Same Day Emergency Care Services will be delivered from appropriate quality facilities

MONITORING AND DEVELOPMENT

We have in place a “light touch” framework to monitor progress against our goals and to continue to refine and adapt the strategy on a regular basis.

This strategy is backed by a strategic delivery plan that encompasses the enabling strategic plans and associated actions. Our operational teams will develop their own strategic delivery plans, that clearly outline the priorities for the people in their communities and the services they provide. In doing so we will ensure that our strategic ambitions become our reality.

The framework is overseen by a Strategy Group that involves executive directors, system directors and other relevant leads. Material changes to the strategy are approved by the Board of Directors, who also receive an annual report on progress delivering the strategy.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Terms of Reference: People Committee and Quality Assurance Committee			Meeting date: 26 January 2022
Report appendix	Appendix 1: People Committee Terms of Reference Appendix 2: Quality Assurance Committee Terms of Reference		
Report sponsor	Director of Corporate Governance		
Report author	Corporate Governance Manager		
Report provenance	Reviewed and agreed by each respective Board Sub-Committee		
Purpose of the report and key issues for consideration/decision	The annual review of the Terms of Reference for the following Board Sub-Committees have been undertaken and the following minor changes agreed which in the main reflect organisational changes: People Committee • Addition of Medical Director as member of the Committee • Removal of Equality Business Forum as a group that reports to the Committee – this group now reports through the People and Education Governance Group Quality Assurance Committee • Reflect revised guidance around the development of the Quality and Patient Safety Long Term Plan • General updates – changes to job titles. The Terms of Reference for each respective Board Sub-Committee have been updated and are presented for approval.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board is asked to approve the revised Terms of Reference for the People Committee and Quality Assurance Committee.		
Summary of key elements			
Strategic objectives supported by this report	**Safe, quality care and best experience**		**Valuing our workforce**	
	Improved wellbeing through partnership		**Well-led**	**X**
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework**	N/A	**Risk score**	
	Risk Register	N/A	**Risk score**	

External standards affected by this report and associated risks	

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

Torbay and South Devon
NHS Foundation Trust

PEOPLE COMMITTEE

TERMS OF REFERENCE

Version:	**3.0**
Approved by:	**People Committee**
Date approved:	**25 October 2021**
Approved by:	**Board of Directors**
Date approved:	**26 January 2022~~XXX~~**
Date issued:	**26 January 2022~~XXX~~**
Review date:	**October 2022**

Torbay and South Devon
NHS Foundation Trust

TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

PEOPLE COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1 The People Committee ('the Committee') is formally established as a sub-committee of the Board of Directors of Torbay and South Devon NHS Foundation Trust.

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

2. Authority

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

2.2 The Committee derives its power from the Board and has no executive powers, other than those specifically delegated in these terms of reference.

3. Purpose

3.1 The purpose of the Committee is to provide assurance to the Board on the quality and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to recruitment and retention, training, appraisals, employee health and wellbeing, learning and development, employee engagement, reward and recognition, organisational development, leadership, workforce development, workforce spend and workforce planning and employee culture, diversity and inclusion.

3.2 The Committee will assure the Board of the achievement of the objectives set out in the NHS People Plan and the Trust's People Plan and ensures alignment of work with the ICS Workforce Strategy.

3.3 The Committee may set up subgroups aligned to key areas of its activity as it deems appropriate.

3.4 The Committee will promote local level responsibility and accountability.

4. Powers

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

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

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

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

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

4.6 The Committee reserves the right to hold meetings in private ie comprising of Committee members only.

5 Duties and Responsibilities

5.4 The Committee is required to:-

5.4.1 Review national workforce guidance and strategies, for example the NHS People Plan, and their applicability to the Trust.
5.4.2 Consider and recommend to the Board, the Trust's overarching People Plan and associated activity/implementation plan(s) to support Trust forward strategy.
5.4.3 Obtain assurance and monitor delivery of the People Plan through the associated activity/implementation plan.
5.4.4 Consider and recommend to the Board the key people and workforce performance metrics and targets for the Trust.
5.4.5 Receive regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case.
5.4.6 Review and provide assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee, seeking where necessary further action/assurance.
5.4.7 Review workforce related risks identified on the Corporate Risk Register and seek assurance in relation to risk mitigation and future activity/plans.
5.4.8 Review workforce related elements of the Integrated Performance Report and seek assurance on the adequacy of the Trust's performance against operational workforce metrics.

5.4.9 Conduct reviews and analysis of strategic people and workforce issues at national and local level and, if required, agree the Trust's response.

5.4.10 Review workforce performance and metrics at intervals to be decided by the Committee.

5.4.11 Provide assurance to the Audit Committee that that arrangements are in place to allow staff to raise in confidence concerns about possible improprieties in financial, clinical or safety matters, and that those processes allow any such concerns to be investigated proportionately and independently.

5.4.12 Seek assurance on the adequacy and effectiveness of staff communication and levels of staff engagement

5.4.13 Seek assurance on any additional matter referred to the Committee from the Board.

6 Membership

6.1 The Committee shall consist of the following members:

- Non- Executive Director
- Non-Executive Director
- Non-Executive Director
- Chief People Officer
- Chief Nurse
- Medical Director
- Chief Operating Officer

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

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

- One Associate Director of Workforce and OD
- One System Medical Director
- One System Director
- One System Director of Nursing and Professional Practice
- Director of Corporate Governance and Trust Secretary (or their nominee)

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

- Freedom to Speak up Guardian
- Guardian of Safe Working
- Equality Business Forum Representative
- Governor observer (see 6.5 for appointment process)

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

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

considered appropriate.

7 Attendance

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

8. Quorum

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

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

8.3 Deputies will not count towards the quorum.

9. Administration

9.1 The Committee shall be supported by the Director of Corporate Governance and Trust Secretary or their nominee, whose duties in this respect will include:

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

10. Meetings

10.1 Meetings will be held on the following basis:

- Meetings will be held bi-monthly (every two months).
- Meeting duration will be no longer than 2.5 hours.
- Items for the agenda should be sent to the Committee Secretary a minimum of 7 days prior to the meeting. Urgent items may be raised under ‘any other business’.
- The agenda with be issued by email to the Committee members and attendees, one week prior to the meeting date, together with the action

schedule and other associated papers.

- An action schedule will be circulated to members following each meeting and must be duly completed and returned to the Committee Secretary for circulation with the following meeting's agenda and associated papers.

11. Reporting

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

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

11.3 A briefing from those Groups reporting up to the People Committee (see Appendix 1) detailing items for escalation and key risks (as applicable) will be received by the Committee along with exception reports as agreed.

12. Review

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

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

13. Monitoring effectiveness

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

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

Appendix 1

Groups reporting to the People Committee

People and Education Governance Group
~~Equality Business Forum~~

Torbay and South Devon
NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

TERMS OF REFERENCE

Version:	**32.0**
Approved by:	**Quality Assurance Committee**
Date approved:	**24 January 2022 ~~23 November 2020~~**
Approved by:	**Board of Directors**
Date approved:	**[26 January 2022] ~~25 January 2021~~**
Date issued:	**[26 January 2022] ~~25 January 2021~~**
Review date:	**January 2023~~2~~**

TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

QUALITY ASSURANCE COMMITTEE
TERMS OF REFERENCE

1. Constitution

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

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

2. Authority

2.1 The Quality Assurance Committee ('the Committee') is formally established as a sub-committee of the Board of Directors of Torbay and South Devon NHS Foundation Trust.

2.2 The Committee derives its power from the Board and has no executive powers, other than those specifically delegated in these terms of reference.

3. Purpose

3.1 The purpose of the Committee is to:

3.1.1 provide assurance to the Board that there is continuous and measurable improvement in the quality of services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care.

3.1.2 ensure that the risks associated with the quality of the delivery of patient care are identified and managed appropriately.

3.2 The Committee is responsible for:

3.2.1 reviewing proposed quality improvement priorities and monitoring performance and improvement against the Trust's quality priorities and the implementation of the Quality Account.

3.2.2 seeking assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.

3.2.3 the ongoing monitoring of compliance with national quality standards and local requirements.

4. Powers

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

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

4.3 The Committee may set up subgroups aligned to key areas of its activity as it deems appropriate.

4.4 The Committee will promote local level responsibility and accountability.

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

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

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

4.8 The Committee reserves the right to hold meetings in private ie comprising of Committee members only.

5. Duties and Responsibilities

The duties and responsibilities of the Committee, given below, cover quality improvement, governance and risk, quality and safety reporting and audit and assurance.

<u>Quality and Improvement</u>

5.1 Monitor and review the quality of clinical and social care services provided by the Trust. This will include review of:

5.1.1 the systems in place to ensure the delivery of safe, high quality, person-centred care

5.1.2 quality indicators flagged as ‘of concern’ through escalation reporting or as requested by the Trust Board

5.1.3 an action log evidencing progress toward completion

5.1.4 progress toward delivery of the Trust’s clinical strategy

5.2 Review variances against quality and operational performance standards.

5.3 Review proposed quality improvement targets as set out in the Annual Plan and by the Regulator. Provide assurance to the Board that improvement targets are based on achievable action plans and quality performance issues are acted upon.

5.4 Ensure there is a robust Quality and Equality Impact Assessment process to mitigate any adverse impact of service changes or reconfiguration.

5.5 Review the Trust's compliance with the Care Quality Commission essential standards of quality and safety and seek assurance regarding process with action plans in response to quality concerns identified from inspection findings, warning notices and compliance actions.

5.6 Receive, through the reporting schedule, assurance of high quality care provision and compliance with national and local guidelines, standards and requirements.

5.7 Oversee the development of the Quality and Patient Safety Long Term Plan supporting the organisation to deliver against national and Integrated Care System quality strategies and deliverables. ~~Account regarding accuracy of data and compliance with timescales for publication and review progress against these.~~

5.8 Establish, develop and maintain systems and processes for the regular evaluation and monitoring of compliance against any relevant internal and external assessment, standards or criteria.

5.9 Ensure the Trust learns from national and local reviews and inspections and implements all necessary recommendations to improve the quality of care.

Governance and Risk

5.10 Oversee how all quality risks are managed across the Trust and that appropriate review and assurance mechanisms are in place, receiving and reviewing quality risks on the corporate risk register and Board Assurance Framework.

5.11 Promote an open culture in which incident and risk reporting is encouraged and supported as part of the delivery of safe and effective healthcare.

5.12 Seek assurance on the process for reviewing and reporting complaints, adverse events and serious incidents and sharing the learning from these.

5.13 Seek assurance against compliance with national clinical standards including NICE guidelines/guidance and any rationale for non or partial compliance.

5.14 Oversee any procedural, policy or strategy document which fall within the remit of the Committee are appropriately written, ratified and monitored for

compliance in accordance with any key national standards and best practice.

5.15 Establish an annual work plan which the Committee will review at each meeting.

5.16 Produce an annual report against delivery of the terms of reference of the committee.

5.17 Undertake an annual review of the Committee's effectiveness

Quality and Safety Reporting

5.18 Receive reports from each of the Committee's sub-groups.

5.19 Receive and review submissions to national bodies and make recommendations for sign-off by the Trust Board.

5.20 Receive annual assurance reports in relation to (but not limited to) infection control and safeguarding.

Audit and Assurance

5.21 Receive and review the findings of quality related Internal Audit reports and seek assurance that recommendations are implemented in a timely and effective way.

5.22 Approve and oversee delivery of the Clinical Audit Plan and provide assurance to the Audit Committee of delivery.

5.23 Receive by exception information of national clinical audits where the Trust is identified as an outlier or a potential outlier.

5.24 Receive reports from invited service reviews and external visits (as appropriate) and seek assurance regarding delivery of actions.

5.25 Receive reports on significant concerns or adverse findings highlighted by external bodies in relation to quality and safety and the actions being taken.

6 Membership

6.1 The Committee shall consist of the following members:

- Non- Executive Director
- Non-Executive Director
- Non-Executive Director
- Medical Director
- Chief Nurse
- Chief Operating Officer
- Chief People Officer ~~Director of Workforce and Organisational Development~~

6.2 One of the Non-Executive Directors shall act as Committee Chair. In their

absence, one of the other Non-Executive Directors present shall be nominated and appointed as acting Chair for the meeting.

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

- Governor observer (see 6.4 for appointment process)
- CCG quality lead representative

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

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

7 Attendance

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

8. Quorum

8.1 The quorum necessary for the transaction of business shall be 4 members, of which two Non-Executive Directors and either the Medical Director or Chief Nurse must be present.

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

8.3 Deputies will not count towards the quorum.

9. Administration

9.1 The Committee shall be supported by the Director of Corporate Governance and Trust Secretary ~~Company Secretary~~ or their nominee, whose duties in this respect will include:

9.1.1 in consultation with the Committee Chair and Chief Nurse develop and maintain the reporting schedule to the Committee.

9.1.2 collation of papers and drafting of the agenda for agreement by the Chair of the Committee.

9.1.3 taking the minutes and keeping a record of matters arising and issues to be carried forward.

9.1.4 advising the Committee of scheduled agenda items.

9.1.5 agreeing the action schedule with the Chair and ensuring circulation.

9.1.6 maintaining a record of attendance.

10. Meetings

10.1 Meetings will be held on the following basis:

10.1.1 meetings will be held bi-monthly (every two months).

10.1.2 meeting duration will be no longer than 3 hours.

10.1.3 items for the agenda should be sent to the Committee Secretary a minimum of 7 days prior to the meeting. Urgent items may be raised under 'any other business'.

10.1.4 the agenda with be issued by email to the Committee members and attendees, one week prior to the meeting date, together with the action schedule and other associated papers.

10.1.5 an action schedule will be circulated to members following each meeting and must be duly completed and returned to the Committee Secretary for circulation with the following meeting's agenda and associated papers.

11. Reporting

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

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

11.3 A briefing from those Groups reporting up to the Committee detailing items for escalation and key risks (as applicable) will be received by the Committee along with exception reports as agreed.

12. Review

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

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

13. Monitoring effectiveness

13.1 In order that the Committee can be assured that it is operating at maximum

effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Board, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

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