Torbay and South Devon NHS Foundation Trust
Public Board of Directors

The Boardroom, Hengrave House/MS Teams
30 March 2022 11:30 - 30 March 2022 14:30

AGENDA

#	Description	Owner	Time
1	Welcome and Introductions Note	Ch	11:30-11:35
2	Preliminary Matters	Ch	11:35-11:40
2.1	Apologies for Absence and Quoracy Note	Ch	
2.2	Declaration of Interests Note	Ch	
2.3	Board Corporate Objectives Information 2.03 Board Corporate Objectives.pdf 7	Ch	
3	User Experience Story - Paignton & Brixham Note	CN	11:40-12:10
4	Consent Agenda (Pre Notified Questions)		
4.1	Committee Reports		12:10-12:15
4.1.1	Quality Assurance Committee Chair's Report - 24 January 2022 Receive and Note 4.01.02 Quality Assurance Committee Chair's Repo... 9	J Lyttle	
4.1.2	People Committee Chair's Report - 21 February 2022 Receive and Note 4.01.03 People Committee Chair's Report - 21 Febr... 13	V Matthews	
4.1.3	Charitable Funds Committee Chair's Report - 16 March 2022 Receive and Note 4.01.04 Charitable Funds Committee Chair's Report... 15	J Lyttle	

#	Description	Owner	Time
4.2	Reports from Executive Directors (for noting)		12:15-12:20
4.2.1	Chief Operating Officer's Report - February 2022 Receive and Note 4.02.01 Chief Operating Officer's Report March 202... 17	COO	
5	For Approval		12:20-12:25
5.1	Unconfirmed Minutes of the Meeting held on the 23 February 2022 and Outstanding Actions Approve 5.01 Unconfirmed Minutes of the Meeting held on th... 27	Ch	
6	For Noting		12:25-12:45
6.1	Parking Lot of Deferred Items For Information 6.01 Parking Lot of Deferred Items.pdf 39	DCG	
6.2	Report of the Chairman Verbal	Ch	
6.3	Chief Executive's Report Receive and Note 6.03 Chief Executive's Report.pdf 41	CE	
7	Safe Quality Care and Best Experience		12:45-13:30
7.1	Integrated Performance Report (IPR): Month 11 2021/22 (February 2022 data) Receive and Note 7.01 Integrated Performance Report Month 11 2021... 55	CNO	
7.2	Mortality Safety Scorecard Receive and Note 7.02 March 2022 Mortality Safety Scorecard.pdf 121	MD	

#	Description	Owner	Time
7.3	CQC Update Receive and Note 7.03 CQC Assurance Report.pdf 127	CN	
7.4	Safe Staffing Bi-Annual Review (August 21 - January 22) Receive and Note 7.04 Safe Staffing Bi-Annual Report August 2021-J... 137	CN	
7.5	Interim Maternity Governance Update Receive and Note 7.05 Interim Maternity Governance Update.pdf 151	CN	
7.6	Improvement plans developed in response to the results of the Care Quality Commission (CQC) NHS Patient Experience Surveys for 2021. NHS Maternity Survey Approve 7.06 NHS Maternity Survey Results.pdf 161	CN	
8	Valuing our Workforce		
8.1	No agenda items submitted		
9	Improved Well-Being Through Partnerships		
9.1	No agenda items submitted		
10	Well-Led		13:30-14:00
10.1	Violence, Protection and Reduction Strategy Approve 10.01 Violence Prevention and Reduction Strategy.... 175	COO	
10.2	Electronic Patient Record (EPR) Outline Business Case (OBC) Receive and Note 10.02 Electronic Patient Record EPR Outline Busin... 179	DTP	
11	Compliance Issues		
12	Any Other Business Notified in Advance Note	Ch	

#	Description	Owner	Time
13	Date and Time of Next Meeting - 11.30 am, Wednesday 27 April 2022 Note	Ch	

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BOARD CORPORATE OBJECTIVES

Corporate Objective:

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

Corporate Risk / Theme

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

Report of Quality Assurance Committee Chair to TSDFT Board of Directors

Meeting date:	24th January 2022
Report by + date:	Jacqui Lyttle Committee Chair 3rd March 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 discussed and decisions made

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

The committee received and noted the BAF and CRR relating to quality, safety, and risk. It received assurance that work was taking place to ensure the Trust's processes and procedures as part of the quality and clinical governance frameworks were embedded throughout the organisation.
It looked at 4 specific areas; impact on service delivery of staff vacancies, the high number of patients that were overdue for review, radiation safety and access to theatre for Obstetrics patients. It was agreed that these would be reviewed in detail outside of the committee with the BAF and CRR being updated. No new risks were identified.

2. Deep dive service review

The committee received a very comprehensive report and presntation detailing the quality assurance framework for independent providers. The committee were assured that we have appropriate controls and processes in place to minimise the risk of unsafe and poor-quality placements and that the trust had an early warning system in place to identify any providers of concern.

The committee acknowledged that the trust is on a journey to ensure social care oversight and scrutiny is part of its governance framework and was assured that appropriate processes are now in place to report performance to the QaC and the Board.

The committee acknowledged there had been gaps in the commissioning and contracting process in the past but received assurance that the trust was working with Torbay Council to review the contract mechanism and processes and strengthen them where necessary.

The committee requested an update be provided in December.

3. CQC Focused Inspection Report

The committee received the CQC Focussed Inspection Report following its unannounced visit on 1 December 2021.

The committee were fully assured that some immediate actions were put in place following the inspection and that a detailed action place is now in place to address all the concerns raised by the CQC.

The committee acknowledged that some of the issues raised by the CQC had been a concern for a long time and a cultural change was required to ensure they were embedded into day-to-day practice.

The committee were assured by the improvements and interventions being made and asked that updates to actions would be included in the regular Quality Reports to the Committee.

4. CQC Executive Evidence Review

The committee received a detailed report from internal audit reviewing the trusts evidence around the CQC 'must' and 'should' do actions following their last inspection.

The committee received and noted the CQC Executive Evidence Review Report and were satisfied that the actions could be signed off as completed, being assured that there were no outstanding risks relating to the CQC inspection.

5. Maternity Governance and Safety Report

The Committee received the Maternity Governance and Safety Report and were assured by

The Trust's position and compliance with the Ockenden Report,
Progress and compliance position regarding priority areas
Progress and next steps regarding Clinical Negligence Scheme for Trusts process.

6. Health and Social Care Quality Report and IPR

The committee received a detailed Quality Report and looked in detailed at a number of areas.

The quality metrics for November and December 2021, just before the Trust started to experience the effects of the Omicron Covid variant and were assured that appropriate processes and controls were in place to mitigate harm.

The impact of escalated areas on patient safety and staffing including medicines management and fundamentals of care and were assured that appropriate actions were in place through the gold and sile command structures.

12-hour trolley breaches, long waiters and the level of harm and were assured that appropriate actions were in place to ensure patient safety. Including the trusts harm review process, waiting list validation and clinical prioritisation.

Actions being taken to ensure safety of patients whilst waiting to be transferred from ambulances to the care of the Trust.

Actions being taken to meet the four-hour stroke pathway and the time patients spent on the Trust's stroke ward due to the impact of the Covid pathways and demand. The committee was assured that robust processes are in place to ensure those patients not on the Trust's stroke ward are safe and cared for appropriately. The committee also noted that the trust is part of a stroke network where best practice was shared.

The committee noted that during November and December there had been 24 reportable Strategic Executive Information System (STEIS) incidents. This was above average and due to the levels of demand the Trust was experiencing. The committee received assurance that the trust was working with the CCG to ensure any learning from the events was shared and embedded.

There had been 11 incidents in Ophthalmology during December that required 72-hour reports. Initial reporting suggested there remained a challenge with referral to treatment and follow up pathways. The Trust had agreed with the Clinical Commissioning Group that a combined investigation would take place to identify areas of learning and improvement. The committee receive assurance that actions were being undertaken and requested a deep dive review of Ophthalmology for the March committee.

The committee were assured by the quality and Equalities Impact Assessment (EQIAs) process being undertaken to help understand the impact of stepping down services in response to the expected impact of the Omicron variant.

The committee discussed in detail some services facing particular challenges this included dermatology, CT/MRI, cancer services and urology and received some assurance that robust plans are in place to mitigate risk and that the harm review and clinical prioritisation processes were embedded within the clinical areas and performance would remain under constant review.

The committee were assured by the quality report which supported the IPR and that actions are in place to mitigate risks the risks detailed within it. There were no new risks brought to the attention of the committee not covered by the update.

7. January 2022 Mortality Surveillance Scorecard

The committee received the January 2022 Mortality Surveillance Scorecard and noted the following:

The Trust's Hospital Standardised Mortality Rate (HSMR) had increased during May-August 2021, however had subsequently returned to normal levels. The committee were assured that work was taking place to understand the drivers to the increase in the summer months.
The committee noted that the trust does not code as deeply as other Trusts, the system is paper based, and benchmarking may be flawed. The benefit of a single Electronic Patient Record system in this respect was noted.

The committee were assured that whilst the number of deaths on wards had increased, due to increased number of patients, the percentage of deaths remained static.

The committee receive assurance that the trust was working with the CCG to improve the timeliness of providing feedback on deaths of patients with learning disabilities and the Trust was working with the CCG to improve this position.

The timeliness of issuing death certificates was raised, and it was acknowledged that the process could be streamlined to ensure that bereaved families did not have to wait extended periods of time for death certificates.

The committee were assured by the receipt of the report and details of the associated actions plans.

8. Annual terms of reference review

The Committee received and approved a revised Terms of Reference.

9.The committee received and noted the QIG assurance report noting no new risks

10. CQC NHS Patient Experience Surveys for 2020 (Adult Inpatient and Urgent and Emergency Care Surveys)

The Committee received a detailed report detailing the improvement plans put in place following receipt of the Adult Inpatient and Urgent and Emergency Care surveys.

It was noted that the themes raised were ones that had been highlighted by previous surveys including ward noise at night from other patients; noise at night from staff; ward lighting; and support at mealtimes.

The Committee received assurance through:

The improvement plan aligned to the Adult Inpatient Survey 2020 and the five areas for focused improvement

The improvement plan aligned to the Urgent and Emergency Care Survey

The recommendation that the Feedback and Engagement Group would oversee and monitor the progress of both plans.

Key Decision(s)/Recommendations Made:

1. There were no key decisions or recommendations made by the committee

2. There were no risks to escalate to the board

Torbay and South Devon NHS
NHS Foundation Trust

Report of the People Committee Chair to the Board of Directors

Meeting date:	21st February 2022
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 items/ risks to be raised to the Board are as follows:

- **Workforce planning** – the Board received an update on the work being undertaken to improve the Trust's approach to workforce planning. The presentation was well received and contained some useful information but it was felt that there was insufficient focus on how to develop the Trust's medium and longer term approaches and how this work aligned with the approaches being developed regionally by the ICB and nationally.
- **Partnership working** – linked to the above, the Committee continue to be concerned about partnership working across the region. An example was provided where an appointment for a Consultant in a scarce specialty had been made by a neighbouring Trust where the region would have been better served by a shared appointment.
- **Statutory and mandatory training** – the Trust's target for statutory and mandatory training is currently being met and showing as green but the risk of false assurance was raised by the Chief Nurse. There are some critical eLearning programmes with low compliance such as resuscitation which need attention and it was raised that some of these are in areas highlighted by the CQC. For assurance, a plan will be developed to ensure increasing compliance over the coming months.
- **Workforce information –** the workforce information received by the Committee continues to improve and this month's report was in a format aligned to the Trust's people plan which was helpful. The pack of data included some statistical process control charts which the Committee noted as very welcome.

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 a strategic overview of the work on short, medium and longer term workforce planning be brought to the Committee.
2. The Committee asked for assurance that the issues raised around identified mandatory eLearning prorgrammes be addressed and that this be discussed at a future meeting.

Report of Charitable Funds Committee Chair to TSDFT Board of Directors

Meeting date:	16th March 2022
Report by + date:	Jacqui Lyttle, Committee Chair 22nd March 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. **Review of Admin Charges –** the committee received a very comprehensive report detailing the trusts proposed administration charges.

   In accordance with the Charity Commission requirements over independence and the management of it conflict of interest with the trust. In the interest of the charity the committee was assured:
   - that the 2021/22 was reasonable and offered value for money.
   - that it remains reasonable to apportion administration charges partly on the basis of fund
   - balances and partly on the basis of expenditure incurred.

2. **Planning Priorities 2022/23 -** the committee reviewed the planning priorities for 2022/23

3. **Review of Investment Policy** - the committee reviewed its investment policy

4. **Review of Risk register –** the committee reviewed and approved the revised risk register, noting the residual risks highlighted

5. **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.

6. **Fundraising Strategy Framework –** the committee received an excellent presentation detailing the proposed fundraising strategy, process and timeline for the recruitment of a fundraising manager and how the trust proposes to work in collaboration with its fundraising partners.

7. **Review of terms of reference** – the committee reviewed its terms of reference and agreed to the establishment of a Charitable Funds Operational Working Group which would drive the fundraising strategy and report into the committee

8. **Review of guidelines for fund managers –** the committee reviewed the guidelines for fund managers and noted the following recommendation.
    - Increase in annual maximum spend per head from £30 to £40. (The committee noted this was the first increase since 2013, and RPI inflation has been 27%)

Key Decision(s)/Recommendations Made:

Audit – the committee

1. **Planning priorities 2022/23** – the committee agreed to maintain an emphasis on recovery from COVID and the health and well-being of staff, with fund managers being asked to prioritise expenditure on the following areas.
    - Recovery from COVID, including the health and well-being of staff
    - Purchase of medical equipment
    - Items to improve the experience of patients and their carers
    - Staff training/development

2. **Investment policy** – following a thorough review in September 2021 where principal changes were made to our overseas equities investment, the committee were assured that there were no material changes and approved the adoption of the investment policy.

3. **Funding raising strategy framework** – the committee approved the adoption of the strategy framework

4. **Terms of reference** – the committee approved the amended terms of reference and ask the board to ratify their adoption

5. **Review of guidelines for fund managers** – the committee approved the adoption of the new guidelines for fund managers being content that the increase in staff event expenditure was appropriate and would support social events and improved staff well-being .

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report March 2022			**Meeting date:** 30 March 2022
Report sponsor	Chief Operating Officer		
Report author	System Directors		
Report provenance	The report reflects updates 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; the recovery phase work is explored in this month's report alongside continued impact from Covid-19. 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.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the Chief Operating Officer's Report.		
Summary of key elements			

Strategic objectives supported by this report

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

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

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

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

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

Report title: Chief Operating Officer's Report		**Meeting date:** 30 March 22
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

This month has seen a continued pressure on services alongside focussed work to reinstate day surgery unit and Ella Rowcroft and set out the plans to restore activity, reduce length of stay and support improved patient experience. There have been personnel changes in the system leadership team with the appointment of Interim System Directors one to lead on Urgent care and recovery and the other Planned Care, long term conditions and diagnostics.

3. Emergency Preparedness Resilience and Response (EPRR)

The EPRR Team are in the final stages of completing the EPRR Assurance action plan set by NHSE in September 2021. This includes introducing a new EPRR Policy outlining the team's governance arrangements and the creation of an Incident Response Plan (IRP) which will replace the Major Incident Plan and will outline the planning, response and recovery stages to eventualities, including Business Continuity, Critical and Major Incidents.

The focus for April is to drive a new business continuity project across the organisation at an operational, tactical and strategic level to ensure service areas have up to date business continuity arrangements as well as trained and exercised plans and to promote awareness of the processes involved during the incident as well as the recovery back to normal operations.

4. COVID-19 response plan

The escalated pressure on beds and flow has continued through the month. There has also been a significant rise in the number of covid-19 in patients, covid-19 related staff absence has also seen a significant increase. All escalation areas are in operation.

The recovery plans are in the process of being finalised and enacted. This includes significant building works in Level 2 on the main hospital site to facilitate the move of the Medical Receiving Unit (MRU) from the Day Surgery Unit (DSU). The key objectives are to restore elective activity and reduce occupancy by reducing length of stay. A key enabler of this recovery plan is to release the DSU and the Ella Rowcroft elective orthopaedic ward. The first part of this plan has been the relocation of outpatient activity from level 2 to repurpose the area to deliver the MRU function. Weekly meetings are in place to oversee, problem solve and communicate the plan, this has been dynamic in the early phase in order to move at the pace required.

5. Children and Family Health Devon (CFHD)

Performance

Three services, Community Children's Nursing, Palliative Care and Specialist Nursing continue to maintain 100% referral to treatment (RTT). There are 5 services showing an improvement in waiting times – Learning Disability, Occupational Therapy, Autism Spectrum Assessment Service, Speech and Language Therapy and the Specialist Assessment Centre. Two services, CAMHS and Physiotherapy show a slight deterioration on last month's performance.

Children & Family Health Devon

IGG Summary Report

Last Updated: 23/02/2022 10:47:38

Report Month
January 2022

Overall RTT (Incomplete Pathway)

Service	Mean Wait	% waiting ≤ 18 weeks	% RTT ≤ 18 weeks compared to last month	% RTT ≤ 18 weeks over the last 12 months
Community Children's Nursing (CFH Devon)	1.9	100.0%	→	
Learning Disability (CFH Devon)	6.0	96.8%	↑	
Mental Health and Wellbeing (CFHD)	20.1	52.6%	↓	
Occupational Therapy (CFH Devon)	13.1	70.0%	↑	
Palliative Care (CFH Devon)	Null	Null	→	
Physiotherapy (CFH Devon)	13.9	71.5%	↓	
Special School Nursing (CFH Devon)	9.4	100.0%	→	
Specialist Autism Spectrum Assessment Team (CFHD)	47.6	25.6%	↑	
Specialist Children's Assessment Centre (CFHD)	42.7	31.3%	↑	
Speech & Language Therapy (CFH Devon)	31.1	35.9%	↑	

As at 1st March 2022 the ASD waiting list stood at 1,650 children, with a total of 1,880 children having been seen from the waiting list to commence their assessment. This represents a 40% reduction in the number of children waiting since the start of the waiting list project in April 2020. The mean wait time has reduced from 60 weeks to 47.6 weeks during the course of the project. It is planned that the project will continue to deliver improvements into 2022.

Inspections

Work is underway across the children's system in Torbay to develop the Written Statement of Action to address the eight areas of concern identified by the SEND inspectors. This will be submitted by 14th April and there is a very good level of engagement in this process from health colleagues.

The Devon County Council area SEND inspection is expected imminently.

Transformation

The CFHD senior leadership team is preparing for the start of phase 1 of a formal staff consultation on 4th April for a duration of 7 weeks, allowing for staff absence during the Easter period. Phase 1 will involve clinical and business support staff, Phase 2 of the staff consultation will start 3 weeks later involving office staff and corporate support functions. The changes impacting upon staff arise from the move

from services organised according to specialty, to needs-based clinical pathways which will be delivered by multi-disciplinary clinical pathway teams.

The team have begun to recruit to senior posts in the leadership structure with the appointment to two key posts - Associate Clinical Director / Clinical Lead for Psychological Therapies and the Deputy Director, both commencing in post in May. The addition of these posts will provide much needed leadership capacity to CFHD.

Work continues to re-design the governance and reporting structure for CFHD. The aim is to develop a more efficient governance architecture, which brings together the two provider organisations in such a way that supports the assurance requirements of individual organisations whilst supporting the effective delivery of an integrated service. Changes to the internal governance structure for CFHD will augment leadership of the quality agenda.

Children's Services Contracts Review

The jointly commissioned review continues and the draft report with findings and recommendations has been produced. Further discussions are needed to agree the content, findings and recommendations of the review.

Risks

Corporate level risks relate to CAMHS staff vacancies, increase in numbers of children waiting and waiting times and access to out of hours psychiatry for CYP presenting to Derriford Hospital.

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

Following plans to move MRU from DSU to L2, implementation plans are now being drawn up to reinstate surgery through DSU starting 25th April 22. This will also allow Ella Rowcroft day case recovery beds to revert back to orthopaedics inpatient beds. This news is lifting morale within the surgical team and all efforts are now focused on this date. Specialties displaced from level 2 are relocating to various areas, the Urology Team to Paignton Hospital. The building works will take a minimum of 4 weeks which means the Urology Team are being supported to pick up ad-hoc clinic space until then. Patient cancellations are being kept to a minimum.

Endoscopy plans to utilise a mobile unit are now well underway, replacing insourcing and MSH facilities both of which have become inefficient. Funds will be diverted to ensure there is no additional cost and improved efficiency will mean activity will be increased and rework reduced. This proposal will also boost the activity numbers for our clinicians who have struggled during the pandemic to maintain numbers.

The Nightingale orthopaedic pathway start date was 21st March, with 2 ½ days per week available. Discussions are underway with CCG and Devon wide trusts to reinstate provision to treat complex orthopaedic patients. UHP and RDE started their orthopaedic inpatient services in the week commencing 28th March. In addition, the CCG have commissioned capacity for a number of complex orthopaedic patients at SWLEOC until the end of June to support patients locally.

The Trust has submitted a mutual aid request for urology for the prostate 2ww pathway and local Trusts have confirmed capacity to support.

The first lists of cataract surgery at a high street company with base in Newton Abbot have been successfully completed. These are funded via the Elective Recovery Fund (ERF) and assuming funding for 2022 / 23 is confirmed these will continue from April.

As elsewhere across the trust high covid-19 related absences are impacting services, not just in terms of performance but pressure on those that remain.

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

7.1 Cancer Performance

In February, 48% of patients were seen within 2 weeks of referral (target 93%). The majority of tumour sites have struggled to achieve this standard, with Breast and Dermatology both meeting the target for only 19% of their patients. Performance in dermatology is improving, these patients are currently being booked under 2 weeks. The service remains concerned about meeting on going demand as referral levels increase during the seasonal upturn in Spring and Summer.

Whilst the two-week wait target is a useful proxy for how quickly patients are being seen, the 28-day standard gives an indication on how long it takes to give patients their diagnosis. For this standard the Trust is at 73% against the 75% standard, which presents an improvement on the past 3 months of performance, which were in the region of 53%. Urology and Lower GI, which inherently have more complex pathways, are both under 45%.

Performance against the 62-day Referral to Treatment has seen a sustained downturn with the Trust achieving 52% of patients meeting the 85% target.

The urology service is in a challenging situation with the recent relocation of a key surgeon. This is resulting in further increasing waits for prostate biopsies. The reinstatement of DSU is a vital step in recovery, this will provide space for biopsy and smaller, higher volume surgeries. Further plans are being formed around the use of our community hospital in Paignton that will provide a much-needed outpatient and potentially a comprehensive urology diagnostic investigation unit.

For Lower GI, the largest wait during the pathway is in diagnosis. Endoscopy is a key component of this, with current waiting times at 2 weeks for both flexible sigmoidoscopies and colonoscopies. Surveillance endoscopies present a larger concern for finding cancers at an earlier stage, there are 411 patients waiting for a colonoscopy. To recover this position the team has support for a mobile endoscopy unit as described above.

The limiting factor in Breast care is radiology capacity. Increased suspected cancer referrals, resuming of screening services and the requirement for interventional radiology has led to tougher competition for resource and longer waiting times. Whilst these challenges are well known this is an area that is hard to recruit to. Across multiple specialties, waiting times for radiology both internally and externally has added challenge. Power failures on the Torbay site have impacted CT capacity have added further delays albeit limited these delays represent a requirement to recover to avoid a knock on in cancer performance in the coming months.

Recognising the importance of the cancer agenda in Torbay and South Devon the Trust has just re-established a Cancer Cabinet. This group will provide support and assurance for the development and integration an organisation wide cancer strategy.

7.2 Diagnostics

CT & MRI waiting times have plateaued in recent weeks. This has been possible, in part, through greater use of the Nightingale facilities. However, the issue of medical cover for contrast scans at the Nightingale remain and therefore the capacity assigned to TSDFT is not being fully utilised as a result.

With regard to MRI, the Nightingale capacity has mitigated the capacity impacted through changes to the overtime payments to radiographers who were working additional hours. The service is anticipating a successful recruitment process in the coming weeks.

The availability of agency CT Radiographers is starting to have a positive impact. However, the loss of CT capacity due to the recent power outages has meant a large number of patients had to have their scans cancelled and re-booked. In common with MRI, this sub-speciality has presented recruitment challenges, although some success has been achieved recently. Nevertheless, the service envisages a continued use of agency staff for several months to come.

8. Newton Abbot ISU: - Urgent & Emergency Care

Urgent & Emergency care continues to feel the pressure from covid-19 and the effects of the pandemic on flow through the Trust's services. The Urgent Treatment Centre (UTC) continues to support urgent care across the communities while Dawlish and Totnes remain closed at this time due to reduced staff availability. The Trust continues to seek recruitment to these vacancies to enable the reopening of these MIU's at the earliest opportunity.

The Emergency Department (ED), MRU and Surgical Receiving Unit (SRU) have struggled to maintain a timely service due to the inability to move patients onto wards. However, improvements continue to be seen in the average waiting times for both ambulances and other attendances with the additional bed capacity recently opened and the enormous efforts across the Trust to improve patient flow.

9. Torquay ISU: Child Health /Paediatrics

Negotiations have taken place with the regional Neonatal Network to extend the current arrangement for cot reduction in SCBU to 7 cots from the 10 commissioned. The impact is being managed successfully and closely monitored and issues reported internally and back to the Neonatal Network.

The team where successful in securing additional funding of £15k in a Mental Health Urgent and Emergency Care bid. This will support a proposal for a range of mobile safety, sensory & distraction equipment for Children & Young People in acute psychosocial crisis or mental distress whilst in the hospital. This will be of direct benefit for both the Louisa Carey ward as well as the ED.

9.1 Torbay Send (Special Educational Needs/Disability)

The WSOA (Written statement of Action) required following the inspection in November is being supported by Child Health, Torbay 0-19 & CFHD colleagues aligned to the report and "areas for improvement". There are 4 workstreams focusing on joint commissioning, inclusive practice, transitions and quality assurance. In addition, cultural change has been highlighted as an important aspect to be included in the improvement plans. Building engagement of families children and young people that use the services is also a key aspect of the plan. The WSOA will be submitted on 14th April.

9.2 Healthy Lifestyles Service - The service has completed the re-certification process for accreditation by the Quality Institute for Self-Management, Education and Training (QISMET) and were successful in having the Healthy Living Programme for Type 2 Diabetes accredited.

Highlights from the report include:

The Healthy Lifestyles Team of Torbay and South Devon NHS Foundation Trust was found to be providing three very well-managed and documented programmes. The commitment and understanding shown by staff interviewed to the concepts of self-management was high, and this was reflected in the excellent feedback that has been obtained from programme attendees.

There is a clear commitment by the organisation and staff individually to continually improving the programmes, as was demonstrated by the improvements that are described above.

10. Torbay System: - Community Services and Independent Sector

The Government has mandated the Fair Cost of Care (FCC) work as part of Adult Social Care (ASC). Local Authorities are responsible for facilitating the efficient and effective operation of local care markets. Local Authorities are also required to begin preparing local markets for reform that protects people from unpredictable costs, offers choice and control and quality over the care they receive. The aim is to create a sustainable market. The TSD team have approached this swiftly with Torbay Council as the timeframe for delivery of the financial modelling and an accompanying market strategy is 30th September 2022. The project brief has been developed with the ambition to establish the model across the whole market rather than the minimum requirement of domiciliary care 18+ and 65+ residential care homes. This is because other areas such as complex dementia, learning disability and supported living need review.

Inflation rates have been approved by the Trust and shared with the market. There are many identified risks within the market as the recovery from covid-19 is slow and the workforce and retention issues continue to restrict growth and balancing service against the demand and complexity pressures. With inflation set to increase further throughout the year this is adding further pressure on providers. A marketing campaign has been developed with the domiciliary care providers which has been well received. This campaign is only 3 weeks in however the benefits of the bill boards, bus

posters and radio adverts is yet to have the impact we had hoped for. Social media links are due out in the next couple of weeks.

A new Supported Living tender is out to the market on Friday 11th March which should secure the market position and develop our offering for independent living in Torbay and housing-based models which offer an efficient and strength-based approach to supporting people with care needs.

11. Moor to Sea (M2S)

The situation across the Southern Devon community is reflected in M2S, however the team is still working on some transformational schemes. A project called “Think Ahead” is underway to identify people who are living with frailty and begin to have conversations with them based on “what matters to you”; helping residents to identify how they would wish to be supported in the future if they go into crisis. Work is ongoing developing an MDT hub in M2S, furthering our integrated approach to managing referrals. Staffing vacancies and sickness has delayed this but it should be up and running within the next month.

The first engagement session for the Dartmouth Health & Wellbeing Centre went well. There were discussions about how the various stakeholders would wish to come together to work in more integrated ways. A task and finish group has been set up to ensure this work can be taken forward.

The services in both the acute setting and Totnes Community Hospital continue to feel the pressure of the persistent demand on urgent and emergency care. In addition to the established 4 wards the ISU are also supporting McCullum ward from a nursing perspective and the consultants are supporting Joan Williams ward. This is however giving the team the opportunity to look at how they might manage flow to the speciality beds. Consultants and nursing teams are proactively identifying the most appropriate patients for these additional ward areas. The Acute Frailty Team continues to develop and there is now a consultant, a registrar, a consultant nurse and in the last month a second Frailty Co-ordinator as part of the team. The support framework describing the pathways and evidencing the benefit of the work is being created. The team has secured CCG funding for analytics support for Frailty – both for the Acute and wider community.

12. Southern Devon Community Services

Community services continue to be under pressure; Intermediate Care and Nursing teams are consistently reporting red or amber due to staffing pressures. Newton Abbot community services have been particularly pressured over the last month. The team has supported more than 90 patients in Intermediate Care and at one point were temporarily unable to accept referrals for Discharge to Assess. Ordinarily these referrals are prioritised due to their contribution to hospital discharge and flow. Other Southern Devon localities have been supporting where able. A new Deputy Community Services Manager post has been appointed to; this will give Community Service Managers (particularly in Newton) additional support.

The impact of covid-19 in care homes continues to be well managed however some homes have required additional support from the teams to manage the outbreak

control measures. There is also approximately an equal number of homes with single cases so the potential for homes in outbreak to continue to be challenging remains.

13. Conclusion

The pressure remains challenging however development of the recovery and restoration plans gives hope for the teams. Supporting the workforce recovery will be essential to achieve balance and improve effective delivery of safe care and figure in these recovery objectives.

14. Recommendation

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

Torbay and South Devon
NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARD ROOM, TORBAY HOSPITAL AND VIA MICROSOFT TEAMS
AT 11.30 AM ON WEDNESDAY 23 FEBRUARY 2022

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
	* Mr R Sutton	Non-Executive Director *(Arrived joined the meeting at 33/02/22, 11:51)*
	* Ms L Davenport	Chief Executive
	Mr I Currie	Medical Director
	* Ms A Jones	Director of Transformation and Partnerships
	* Ms D Kelly	Chief Nurse
	* Mrs J Falcao	Chief People Officer
	* Dr J Watson	Health and Care Strategic Director
In attendance:	* Mr O Raheem	Interim Director of Corporate Governance and Trust Company Secretary
	Mrs S Byrne	Board Secretary
	* Dr J Harris	Associate Director of Communications and Partnerships
	* Mr A Cooper	Interim Director of Environment *(Attended 48/02/22)*
	* Mrs Michelle Machin	System Director, Torbay
	* Tian Ze-Hao	Director of Operational Finance
	* Dr Kate Lissett	System Medical Director, South Devon *(Attended for 44/02/22)*
	* Dr Jacqui Rees-Lee	Surgical Consultant and Director of Medical Education *(Attended for agenda item 33/02/22)*
	* Mr Nick Peres	Head of Digital Education *(Attended for agenda item 33/02/22)*

* via Microsoft Teams

29/02/22 **Welcome and Introductions**

The Chairman welcomed all those in attendance to the meeting.

Preliminary Matters

30/02/22 **Apologies for Absence and Quoracy**

The Board noted apologies of from Mr Harrison, Chief Operating Officer, Mr Stacey, Chief Finance Officer and Mrs Long, Director of Corporate Governance and Trust Company Secretary who was on maternity leave.

The Board formally welcomed Mr Raheem, Interim Director of Corporate Governance and Trust Company Secretary to his first Board meeting. The Board noted Mrs Machin's attendance on behalf of the Chief Operating Officer; and Ms Hao's attendance on behalf of the Chief Finance Officer.

31/02/22 **Board Corporate Objectives**

The Board received and noted the Board Corporate Objectives.

32/02/22 **Declaration of Interests**

There were no declarations of interest.

33/02/22 **Digital Futures Presentations**

Mr Currie introduced Dr Rees-Lee, Consultant Plastic Surgeon and Director of Medical Education and Mr Peres, Head of Digital Education who presented 'Digital Futures' to the Board. They explained that 'Digital Futures' recognised the opportunity to use emerging technologies to treat and support the local population. They confirmed further that the Topol Review 'Digital Horizons' had secured funding from the HEE Innovation Fund. The funding had enabled the Trust to be a national leader in 'Digital Futures', with a lab established in 2016 and research into AI (Artificial Intelligence) supported.

They explained that the 'Digital Futures' Team had forged links with academic partners such as University of Plymouth. The Trust had two Digital Masters Students from Plymouth University working with Trust Consultant's to improve patient pathways.

The 'Digital Futures' Team had built confidence and prepared clinicians to effectively use digital technologies to support and improve patient pathways and offer bespoke packages of care to patients. For example:

- Offering long stay patients' outdoor space, tai chi using virtual reality headsets.
- Child and Adolescent Mental Health pathway used a digital information pack which was given to patients upon admission and through which a patient journey could be adapted into a 3d virtual environment with therapy spaces. The opportunities for this pathway to be interactive were recognised and support was being sought from the National Institute for Health Research.
- Work had been undertaken with the Intensive Trauma Unit pathway to support rehabilitation with 2d nature scenes moving into a 3d environment when appropriate; family portals where photos and timelines could be entered.
- A project utilising digital to benefit the 600 community MS patients was being progressed.

The Trust had been approached and were part of the PriceWaterhouseCooper national audit on the future of digital careers in the NHS.

For new trainees their induction incorporated the innovation hub ensuring digital solutions for the benefit of the Trusts patients would be built into the pathways and staff were being supported and encouraged to learn about new and emerging technologies.

The Chairman asked if consent and approval caused difficulties in building digital solutions into clinical pathways. Mr Peres explained the aim of one consent template for all departments and patients to enable smooth access to digital opportunities. He said empowering the workforce to recognise the opportunities that digital held was vital.

Mrs Matthews asked if there were identified areas that the digital team aspired to support. Dr Rees-Lee highlighted that areas of aspirations included:

- To support pain, anxiety and mental health on the Chronic Pain pathway; and
- To pre-load VR headsets with sanctuary and escape scenes for those patients who are in hospital for a long time to enable them to retreat to places of comfort and enjoyment.

Ms Kelly extended her thanks to Mr Peres, on behalf of the Board for his leadership on this agenda.

The Board agreed to visit the Digital Horizons lab. **ACTION: SB**

	Consent Agenda (Pre-notified questions)
	Reports from Board Committees
34/02/22	**Finance, Performance and Digital Committee Chair's Report – 24 January 2022** The Board received the Chair's Report of the Finance, Performance and Digital Committee meeting held on 24 January 2022, as previously circulated, from Mr Richards.
	The Board received and noted the Finance, Performance and Digital Committee Chairs Report.
35/02/22	**Audit Committee Chair's Report – 12 January 2022** The Board received the Chair's Report of the Audit Committee held on 12 January 2022 as previously circulated, from Mrs Taylor.
	The Board received and noted the Chairs report of the Audit Committee.
36/02/22	**Building a Brighter Future Committee Chair's Report – 19 January 2022 and 16 February 2022**

The Board received the Chair's Report of the Building a Brighter Future Committee held on 19 January 2022 and 16 February 2022, 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

37/02/22 **Chief Operating Officer's Report - February 2022**

The Board received the Chief Operating Officer's Report of February 2022, as previously circulated, from Mr Harrison.

The Board received and noted the Chief Operating Officers Report.

38/02/22 **Directorate of Transformation and Partnerships Quarterly Report**

The Board received the Directorate of Transformation and Partnerships Quarterly Report, as previously circulated, from Ms Jones.

Prof. Balch acknowledged the breadth of work the Transformation and Partnerships Directorate was undertaking and asked if the team was sufficiently resourced to support all workstreams effectively.

Ms Jones acknowledged the significant amount of work and the need to secure full time resource to develop the framework necessary to deliver the Trust Strategy. She confirmed a Business Case had been prepared which would describe the quality improvement resource to provide support for end to end pathway re-design which would be required for the delivery of the Trust's transformation plan. The work would also support the Cost Improvement Plan informed by the recent Deloittes review.

Ms Jones explained she would describe the proposal for two new roles in the April quarterly update to support the Trust's transformation plans. However, for the Board's information she described the two roles as:

- The Chief Nursing Information Officer role to support nursing and professional practice; and
- Digital and Professional Practice Officer to support the delivery of Building a Brighter Future.

Mrs Davenport recognised the breadth and significance of the work. She confirmed that feedback from Deloittes's review had identified the need for the right capacity to deliver the required benefits.

The Board received and noted the Directorate of Transformation and Partnerships Quarterly Report.

For Approval

39/02/22 **Unconfirmed Minutes of the Meeting held on the 26 January 2022 and Outstanding Actions**

The Board approved the minutes of the meeting held on 26 January 2022 subject to an amendment to page 10 paragraph 1 as follow:

Amend: "The opportunity for the Trust to influence the development plan for the health and well-being of the local population."
To read: "The opportunity for the Trust to become part of the development plan for the health and well-being of the local population."

Outstanding actions were noted as either complete or in progress.

The Board approved the minutes of the meeting held on 26 January 2022.

For Noting

40/02/22 **Parking Lot of Deferred Items**

The Board received and noted the Parking Lot of Deferred Items.

41/02/22 **Report of the Chairman**

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

- Following the Governor elections, he offered congratulations from the Board to the newly elected Governors and acknowledged the contribution made by retiring Governors, Lynne Hookings, Carol Day and Mary Lewis. He explained there would be a review and refresh of the Trust Governor observer roles on the sub-committees.
- The Governor Nominations and Renumeration Committee had met on 15 February 2022 and approved the recruitment of two Non-Executive Director posts due to one imminent retirement; and one vacancy.
- The Non-Executive Director Nominations and Renumeration Committee had met on 16 February 2022 and approved the recruitment process for the Trust's Chief People Officer.
- He had sat on the Consultant Interview Panel and had noted the high calibre of consultants who had applied and wished to work for the Trust.

The Board received and noted the report of the Chairman.

42/02/22 **Report of the Chief Executive**

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

- The Trust had encouraged staff to participate in the consultation of the future intent of the mandatory Covid19 vaccination policy.
- There had been a reduction in admissions of Covid19 patients.

- A continued area of focus and attention for the Trust would be the improvement of discharge arrangements to enable elective medical and surgical care across all specialties.
- Ward accreditation schemes had driven improvements at ward level for the benefit of patients.
- Further to the CQC unannounced inspection on 1 December 2021, the Trust had received the draft CQC report. Some issues of factual accuracy on the report had been submitted to the CQC and a final report was expected soon and would be published within the stipulated timescale.
- The second stage of the Ockenden Review had been published on 23 February 2022. The Trust had met with Professor Jacqueline Dunkley-Bent, Chief Midwifery Officer, NHSEI on 8 February 2022.
- The White Paper on Integration had been published on 9 February 2022. The paper had a strong focus on place, bringing together health and care and collaborative working.
- The People Awards had been launched on 14 February 2022 to give recognition to the huge contribution the Trust's staff and partners had made to deliver care within the footprint.
- Further to the recent Environmental Health Officer visit, catering services had received a 5* rating.
- Devon had been awarded levelling up funding and further information would be brought to the Board in due course.

Mrs Matthews asked about the implication of the white paper for the Trust. Mrs Davenport explained the paper articulated the ambition for local authority boundaries. However, she recognised the Trust operated across two local authorities and had positive working relationships with both. She confirmed the Trust together with Torbay Council and Devon County Council would undertake to work together to understand how the levelling up agenda can shape Devon.

The Chairman explained and welcomed how the Trust constitution was moving towards a collaborative agenda. He was supportive of the intent to not restrict recruitment of Governors and Non-Executive Director's from outside of the current Trust's footprint.

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

Safe Quality Care and Best Experience

43/02/22 **Integrated Performance Report – Month 10, 2021/22**

Ms Jones presented the Integrated Performance Report for month 10, 2021/22, as previously circulated, and drew the following to the Board's attention:

Quality and Safety

- Further to the CQC unannounced inspection and receipt of the draft CQC Report, the Trust continued to focus on the areas highlighted from the inspection.
- Venous Thromboembolism had reported a position of 89.7%, this was due to an increase in the bed base. There was continued focus on this.

Workforce

- There was a focus on staff retention.
- The rolling average for sickness was 5.54%.

Finance

- The Trust's agency spend was £1.025m; with a year to date spend of £11.122m; £4.5m above plan.
- Deloittes were developing a plan with the Trust to support the deficit which could be in excess of £53m in year 2022/23.

Performance

- Covid19 admissions were high with a requirement to open a second Covid19 Ward.
- The average length of stay for a patient was 17 days, which significantly impacted flow.
- The Emergency Department had held patients in their pathway for longer than 12 hours. South Western Ambulance Service Trust were undertaking a Devon wide spotlight review into the delays.
- The 2 Week Wait and 28 day cancer position had significantly improved. The Trust's Cancer Cabinet had been established to focus on risk and reduction in waiting times.
- Urgent and Emergency Care and Day Surgery pathways would be a significant part of the Trust's recovery plans but, the Board were asked to note there was a risk of underperformance of £1.6m.

The Board noted Mr Stacey had undertaken to refine the Integrated Performance Report to give focus to improvement positions. After meaningful engagement, this work was expected to conclude in July 2022.

Mrs Lyttle commented on the integrated performance report which was in the public domain and asked if there was a communications plan in place to ensure patients on cancer treatment pathways knew how clinical care was prioritised. Mrs Machin gave explanations on how the Cancer Cabinet had been set up to lead the development of the cancer improvement plan. She confirmed the Trust had worked closely with the Cancer Alliance to enable system working where practical to minimise waiting times for the benefit of patients across Devon.

The Chairman wished to highlight how Torbay's cohort of service users were of a demographic may struggle to access virtual consultations or require additional support to do so.

Mr Richards supported the need to consider the Integrated Performance data through the lens of a clinician to ensure variance against trajectories can be identified. It was confirmed a meeting was to take place to consider triangulation of the integrated performance data.

The Board received and noted the Integrated Performance Report – Month 10, 2021/22.

44/02/22 **Assurance Framework for Seven Day Hospital Services**

Dr Lissett presented the Assurance Framework for Seven Day Hospital Services, as previously circulated. She brought the Boards attention to:

- The Trust had improved upon its 14 hour standard to Consultant review, running at 60%. It was not meeting the national criteria of 70%.
- Weekend mortality rates had been higher over the last two months, they remained high by rolling year. A deep dive into patient's files had been agreed but, this may be a systemic issue that requires a system led deep dive and may take time to deliver. However, mortality rates at weekends was higher nationally as weekend admissions tend to be those who are sicker, older or frailer.
- Permanent seven day working would require a 2/5 uplift. It would take 5 to 7 years to recruit into the uplifted vacancies.
- During the BEST week six day working enabled 25 additional discharges.

Dr Lissett suggested the Board may consider an options appraisal being conducted to establish the cost benefit of extending medical staff more broadly to a full seven day service.

The Chairman asked for a self-assessment of the Trust's mortality position be undertaken with the findings presented within the next Assurance Framework for Seven Day Hospital Services Report and for the Trust's position to be benchmarked against comparative Trusts. Dr Lissett confirmed she would clarify if she could receive the national mortality data for comparison as requested.

Ms Kelly acknowledged the challenged position and sought assurance around mitigation out of hours to ensure patient safety and highlighted the need to embed Multi-Disciplinary Team and system wide working to manage and respond to risk.

Mrs Lyttle asked the Board to consider what the Trust could do within its existing resources to even out the peaks and troughs and what would require system support. Dr Lissett confirmed small, steady, realistic changes had been introduced to even out the peaks and troughs but, seven day working was a step change ambition.

Prof. Balch asked if seven day working could be enacted with the current resource and what the key obstacles were to seven day working. In answer to the questions, Dr Lissett explained this was not realistic because there was a requirement to deliver key components of work to ensure the wards ran smoothly. Those departments would require uplift to work over seven days to enable the wards to function. Dr Lissett added that not all community services were operating over seven days. Also, she highlighted during periods of escalation there was no additional resource to draw from that could support the seven day working.

Mrs Matthews asked if Doctors were working at the top of their license, with MDT support would this support seven day working and discharge. Dr Lissett acknowledged this would help seven day working but, there was a need to have senior decision makers on all shifts.

Mrs Davenport acknowledged seven day working would transform the ICO and the wider Devon system but there was a need to drive the ambition by the Trust to optimise the whole ICO.

The Board received and noted the Assurance Framework for Seven Day Hospital Services.

45/02/22 **Guardian of Safe Working Hours - Doctors and Dentists in Training**

Mr Currie presented the Guardian of Safe Working Hours - Doctors and Dentists in Training, as previously circulated. He brought the Boards attention to:

- The General Medicine and Surgery rotas were under pressure but this was being reviewed.
- Triangulation of the data via the GMC feedback had rated, 12 specialities as excellent; 12 specialities as good; and 1 speciality (Ear, Nose and Throat) as poor.

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

46/02/22 **Midwifery Staffing Oversight Report**

Mrs Kelly presented the Midwifery Staffing Oversight Report to the Board, as previously circulated. She brought the Boards attention to:

Vacancies

- Midwifery vacancies were being advertised and recruited into as part of the uplift approved by the Board in September 2021.
- A 95% fill rate had been achieved by recruitment had been challenging locally, regionally and nationally.
- The International Recruitment Hub had been approached to consider midwives within their recruitment remit.

Continuity of Care Model

- New guidance in respect of the continuity of care model had been received and although there was national commitment to continuity of care. Nationally there had been an agreement to offer local flexibility.
- The Trust would focus on offering midwives a greater level of flexibility around pathway preference to support the welfare of staff.

Mrs Davenport noted that midwifery sickness absence rates were above the national level, she asked if there was anything the Trust could to do support midwives. Mrs Kelly confirmed she had regular conversations with the midwives and engage with them in finding a solution. The Freedom to Speak Up Guardian listening sessions had taken place in 2020/21 and provided insight in to the need for midwives to be able to work more flexibly to ensure there was a work life balance.

The Board received and noted the Midwifery Staffing Oversight Report

Improved well-being through partnerships

47/02/22 **Digital Strategy Update**

Ms Jones presented the Digital Strategy Update, as previously circulated. She brought to the Board attention:

- Significant progress had been made on goals 1. Building a Digital Ready Organisation; and 3. Empower the Citizen with the support of Digital Horizons.
- Goal 4. Access to Systems Any Time Any Place required the Electronic Patient Record to be implemented and the governance to be strengthened when the Chief Nursing Information Officer was in post.

Prof. Balch highlighted the risk presented to the digital strategy if the broadband infrastructure was not adequate within our communities. The Chairman concurred the aspiration was predicated on the assumption patients know how to use a computer and have Broadband readily available. Ms Jones agreed to ensure that the digital infrastructure risk was articulated within the digital workstream. **ACTION: Ms Jones**

The Board received and noted the Digital Strategy Update

Well Led

48/02/22 **The Green Plan**

Mr Cooper presented The Green Plan, as previously circulated, which was a three year ambition, working with the ICS and developed in line with NHS requirements. He explained it was a starting position and he brought to the Boards attention:

- The Green Plan would be published in March 2022.
- The plan considered how the Trust can be carbon neutral when erecting buildings as well as de-carbonising how the Trust heat the buildings.
- Consideration was given to a sustainable supply chain.
- The huge opportunities post pandemic to consider how and where staff work from.

Ms Hao confirmed procurement were considering the social value leverage the Green Plan would enable through the supply chain.

Prof. Balch recognised the ambition of the Green Plan and reflected on the need to communicate and bring staff and patients along in the in this endeavour which was about behaviour change. Mr Cooper said he had been encouraged by level of engagement and culture change he had already seen. As a Trust he would like to see Green Champions at ward level to encourage cultural awareness.

The Board approved the green plan in principle.

It was agreed The Green Plan would report to the Board annually, in February. **ACTION: Mrs Byrne**

The Board approved the draft Green Plan

49/02/22 **Compliance Issues**

There were no compliance issues reported.

50/02/22 **Any Other Business Notified in Advance**

There was no any other business raised for discussion.

51/02/22 **Date and Time of Next Meeting:**

11.30 am, Wednesday 30 March 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
48/02/22	The Green Plan to become an annual agenda item.	BS	Added to workplan. Action closed.	23.02.2022
47/02/22	Ms Jones agreed to ensure the digital infrastructure risk was articulated within the digital workstream.	DTP		23.02.2022
33/02/22	SB to arrange a Board visit the Digital Horizons lab.	BS		23.02.2022
24/01/22	Ms Jones would develop proposals for the implementation of the strategy, supporting guidance and a framework to report back to the Board on delivery.	DPT	24/01/22 was to be closed. The proposal for the implementation of the strategy, supporting guidance and framework would spoke to in the April Directorate of Transformation and Partnerships Quarterly Report.	26.01.2022

Torbay and South Devon
NHS Foundation Trust

Public Board of Directors

Parking Lot **Reviewed: 1st February 2022**

Item/action/issue/policy name	Meeting Date	Comment
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**: 30 March 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 22 March 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**	
Risk Register	X	**Risk score**	

- BAF objective 1: to develop and implement the Long-Term Plan with partners and local stakeholders to support the delivery of our ICO Strategy - risk score 20
- BAF objective 10: to actively manage the potential for negative publicity, public perception or uncontrollable events that may impact on our reputation - risk score 9

External standards affected by this report and associated risks

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

Report title: Chief Executive's Report		Meeting date: 30 March 2022
Report sponsor	Chief Executive	
Report author	Associate Director of Communications and Partnerships	

1 Our vision and purpose

Our vision is better health and care for all. Our purpose is to support the people of Torbay and South Devon to live well.

2 Our strategic goals and our priorities

Our strategic goals and priorities have been set to help us achieve our purpose and our vision.

Our strategic goals are:

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

Our priorities are:

- More personalised and preventative care: what matters to you matters
- Reduce inequity and build a health community with local partners
- Relentless focus on quality improvement underpinned by people, process and technology
- Build a healthy organisational culture where our workforce thrives
- Improve access to specialist services through partnerships across Devon
- Improve financial value and environmental sustainability

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

3 Our key issues and developments

As our Board meeting is taking place during the pre-election period for local elections, the agenda is confined to those matters that need a Board decision or require Board oversight and does not include matters of future strategy or the future deployment of resources. The pre-election period runs from 28 March 2022 until the election results are announced on 06 May 2022.

Key issues and developments to bring to the attention of the Board since the last Board of Directors meeting held on 23 February 2022 are as follows:

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

Patient-led support group for people living with and beyond head and neck cancer

People who are living with, and beyond, head and neck cancer are now able to benefit from a patient-led support group which has been set up in Torbay and

South Devon thanks to the dedication and perseverance of our cancer support team in head and neck cancer.

The Swallows Head and Neck Cancer Support Group has been running monthly patient-led support groups since 2012 but until the Torbay and South Devon group was launched last month, there was no group in the south west.

While our original plans were delayed by the pandemic, we are delighted to finally be able to offer this additional support to our patients.

Patient-led support groups are a safe space for people to share their coping strategies and techniques as well as sharing personal experiences and feelings.

The group meets on the second Wednesday of each month at Kingskerswell community centre from 6.45pm. People can contact the group through their page on Facebook.

5k your way for people living with and beyond cancer
5k Your Way is a community-based initiative to encourage those living with and beyond cancer, families, friends, and those working in cancer services to walk, jog, run, cheer or volunteer at a local 5k Your Way parkrun event on the last Saturday of every month. There are now many 5k Your Way groups set up all over the country but prior to last month, when a Torbay group formed, there were none in Devon or Cornwall, with Taunton being the nearest option.

Cancer healthcare professionals from Torbay Hospital have set up a local 5k Your Way group, as they all feel passionately that getting active outdoors, with like-minded people, is hugely important for physical and mental wellbeing.

Our 5k Your Way launched on 26 February as part of the Torbay Velopark Parkrun, a free timed 5k event that takes place every Saturday morning.

ITV West Country news feature: our people's stories told through their eyes
Last month we worked with ITV West Country to showcase the work of our people through 'A day in the life of…' feature with three members of our staff who work across community settings and at Torbay hospital. The stories are available below:

- Ray Mwaro, staff nurse from Newton Abbot UTC https://bit.ly/3M3yfmj
- Kirsty Orchard a rapid response support worker https://bit.ly/3BOhC9J
- Holly Crawshaw, a Torbay Hospital porter https://bit.ly/3tea8sO

I'd like to take this opportunity to say thank you to Ray, Kirsty and Holly and their colleagues, managers and patients for supporting us to share their stories. I'd also like to thank Angela Cappello in the communication team who led the project from concept to delivery.

3.2 Excellent experience receiving and providing care

Current pressures
We currently have more patients with COVID-19 in our hospitals than at any time during the pandemic. While it is encouraging that the majority of our patients who have tested positive for COVID are in hospital for other conditions and are

asymptomatic or experiencing mild symptoms the impact that the presence of COVID has in our hospitals is really significant.

Under current infection prevention and control guidelines, one patient testing positive for COVID-19 can result in the closure of the whole ward, meaning that beds are unavailable for emergency admissions and for planned operations. This means people waiting longer for treatment in the community and operations being cancelled or postponed and long waits in Emergency Departments for people needing a hospital bed.

We continue to see the impact of COVID-19 across all our services with sustained and increasing staff sickness absence. Demand for our services remains very high across acute, community and social care. Ambulance handovers continue to be an area of particular area of focus for us, and despite significant work in this area, remain an area of challenge, as is 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.

Planning is well underway to return our day surgery unit to its original location on our Torbay Hospital site which will enable it to run at full capacity and we are looking to maximise opportunities for 7 day working. We hope to have it fully restored by the end of April although this will depend on a number of factors, not least of which is the number of patients in our hospitals with COVID-19.

We continue to work with the independent sector for those who have been waiting longest for treatment and care. Not all patients are suitable for treatment and care in the independent sector – many of our patients are frail or have complex conditions and require surgery or treatment at a hospital which has on-site intensive care facilities.

The Nightingale Hospital Exeter is an important resource for the system as it provides additional capacity. Around 160 of our patients each month are now benefitting from appointments at the Nightingale for MRI and CT scans and we are very pleased that from this month orthopaedic operations for our patients will be taking place there.

At present our visiting arrangements remain unchanged. Each patient has one visitor for one hour once a day. Every visitor has to show proof of a negative lateral flow test before visiting so that we can do what we can to reduce infection and keep our vulnerable patients as safe as possible.

There may be a point where we have to suspend visiting if the number of people with COVID-19 in our hospitals continues to rise. We recognise the hugely beneficial effects of visiting for our patients and would only move to this position if we felt it was absolutely necessary. If we do have to suspend visiting, compassionate visiting (end of life) would still continue and virtual visiting would enable the majority of patients to maintain contact with their loved ones.

Ward accreditations
During February 2022, two more of our wards were assessed under the scheme.

EAU4 ward achieved a silver award – this was their first assessment and a great achievement. EAU4 is our COVID-19 ward.

Macullum ward achieved a bronze award – this was their first assessment since the function of the ward was changed to support the current high level of demand.

DAISY awards
Our DAISY award winner for February 2022 has not yet been announced as we are awaiting their return from leave and plan to make the presentation in early April. Full details will follow in my report to next months' Board but I can say that the winner is someone who has won the award previously which is a fantastic achievement and recognition of their exceptional dedication to caring with compassion.

OFSTED inspection for Torbay Children's Services
This is due to start on Monday 21 March 2022. We will play our part in the inspection as a provider of health care for children and young people working in partnership with Torbay Children's Services.

How we are supporting Ukrainian colleagues
Our thoughts are very much with the Ukrainian people and our wellbeing team are focusing on supporting our Ukrainian colleagues at this very difficult time.

We are encouraging colleagues who wish to show their support in a practical way to donate through the Disasters Emergency Committee or to register for the Homes for Ukraine scheme.

4. Chief Executive engagement March

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 • MSC Meeting • Lead Governor meetings • Lead Head and Neck/Thyroid Cancer Clinical Nurse Specialist	• Chief Executive, Integrated Care System for Devon • Deputy Chief Executive, Devon Clinical Commissioning Group • Chair, Integrated Care System for Devon • Chief Nurse, Integrated Care System for Devon • Long Term Plan Programme Director, Integrated Care System for Devon • Improvement Director, NHS England and NHS Improvement

	• Chief Executive, Devon Partnership NHS Trust • Chief Executive, Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust • Chief Executive Office, University Hospital Plymouth NHS Foundation Trust • Chief Executive, Northumbria Healthcare NHS Foundation Trust • Chief Executive Officer, Torbay Council • Director of Children's Services, Torbay Council • Director of Adult Social Services, Torbay Council • Partnership Manager, Devon Children and Families Partnership • Devon NHS Chief Executive Officers meeting • South West Regional Chief Executives • Plymouth Council Overview and Scrutiny Committee • Neuro Rehab and Spinal Cord Injury Delivery within the South West • South West Academic Health Science Network event

5. Local health and care economy developments

5.1 Partner and partnership updates

5.1.1 Integrated Care System developments

Development of the Integrated Care Board (ICB) and Integrated Care Partnership (ICP)

An ICB structure has been drafted with proposed committees that feed into the board. Terms of reference are being drafted for these groups and these will be tested with partners to assess the suitability of the whole structure before full implementation on 01 July.

The ICB will aim to start operating in shadow form from 01 April to test structures and governance, in parallel with the statutory CCG board and committees until 01 July.

There is an expectation that governance and structures may need to be refined beyond 01 July as local and national learning is identified and shared.

ICP development is in progress, with a first draft of its functions to be discussed at two workshops with Health and Wellbeing boards in March and April. One workshop will include a discussion on the approach for developing the integrated care strategy for Devon. The workshops will also aim to agree how to work with wider

stakeholders on how the ICP will function to ensure real engagement with the wider system. The ICB is keen to ensure strength and depth in diversity of its leadership. The aim is to start operating the ICP in shadow form in May.

Local Care Partnership (LCP) Development
LCPs are sometimes referred to as place-based partnerships. There is no defined expectation of what stage of development LCPs should have reached by 01 July 2022 in the national guidance. There are six care partnerships in Devon; North, East, South, West, Plymouth and a Mental Health, Learning Disabilities and Autism care partnership. In Devon, the LCPs are at different stages of maturity, therefore require a tailored development roadmap.

The Integration White Paper published in February 2022 has set some national expectations around the level of development to be achieved by Spring 2023. By 1 July 2022 the expectation is that each LCP will have a bespoke development roadmap setting out function, form, governance and shared outcomes to be delivered. Longer term expectations are also set out in terms of digital development and population health management at place level which the roadmap will incorporate.

Click here for further information.

5.1.2 ICS appointments

NHS Devon Integrated Care Board (ICB) is pleased to announce a number of appointments.

This includes three further non-executive directors (NEDs) as well as the majority of the executive team:

NED for finance and remuneration – Kevin Orford
Kevin is an experienced board director who has held executive, non-executive and trustee positions on NHS, charity and government body boards for over 25 years.

Having held roles in acute and community trusts and strategic health authorities, Kevin is currently a NED for Northern Devon Healthcare NHS Trust and the Royal Devon and Exeter NHS Foundation Trust.

Kevin is committed to equality and diversity and was a board member of Stonewall Equality Ltd during the successful campaign for equal marriage. He is also a member of the Chartered Institute of Public Finance and Accountancy.

NED for audit and risk – Graham Clarke
Graham has held several high-profile executive and non-executive positions including in his current role as a NED for the Department of Health and Social Care, including its Audit and Risk Committee and COVID Therapeutic Task Force.

In previous roles, Graham has chaired the Audit and Risk Committees of the UK Health Research Authority and MIND (the mental health charity). Graham also has extensive experience of the pharmaceutical industry in a number of senior commercial roles including at GlaxoSmithKline and his own company, ImmBio.

NED for primary care – Judy Hargadon

Judy Hargadon has been undertaking a similar role for the CCG over the past few years and will continue to do so on an interim basis while a recruitment process for a permanent member is undertaken.

February's ICS for Devon Board Update included news of the appointment of three Non-Executive Directors of the Board:

- **Dr Thandiwe Hara – NED for Citizen and Community Involvement**
- **Professor Hisham Saleh Khalil – NED for Quality and Performance**
- **Professor Sheena Asthana – NED for Health Inequalities and Population Health**

Chair – Dr Sarah Wollaston
Dr Sarah Wollaston was appointed as the ICS chair in December 2021.

Board partnership members
The ICB Board will also have four members covering NHS providers, local authority, primary care, and population health and prevention. Recruitment is underway with appointments to be announced in due course.

Executive team
Chief executive – Jane Milligan
Jane Milligan was formally appointed as the designate chief executive last December, having joined the Devon system in April 2021.

Chief medical officer – Dr Nigel Acheson
Dr Nigel Acheson has been appointed as our chief medical officer, where he will provide strategic and clinical leadership.

Nigel has held several high-profile national and regional clinical and leadership roles including deputy chief inspector of the CQC, regional medical director for NHS England, and medical director for the South West Peninsula Cancer Network.

Having originally trained in Birmingham, Nigel was appointed as a consultant gynaecological oncologist, before moving to a joint consultant role at the Royal Devon and Exeter and South Devon and Torbay Hospitals to help develop gynaecological cancer services.

In previous roles, Nigel has been a consistent champion for involving patients as partners in their care. He has a focus on improving the safety and quality of health services, and his research in ovarian cancer surgery led to the award of a Doctorate in Medicine.

A number of other appointments to the ICB Board and executive team have also been confirmed – all of whom already work in the Devon system. The ICB executive team is as follows:

- Chief executive – Jane Milligan (voting member on ICB Board)
- Chief nursing officer – Darryn Allcorn (voting member on ICB Board)
- Chief medical officer – Dr Nigel Acheson (voting member on ICB Board)
- Chief transformation and strategic planning officer – Simon Tapley
- Chief communications and corporate affairs officer – Andrew Millward
- Director of workforce strategy – Paul Renshaw
- Director of commissioning: elective and urgent care – John Finn
- Director of commissioning: primary, community and mental health care – Jo Turl

• Director of digital – Malcolm Senior

Processes are ongoing to recruit to three ICB executive roles:
• Chief finance officer (voting member on ICB Board)
• Chief delivery officer
• Director of finance operations

5.1.3. **Planned care and elective recovery**

NHS organisations in Devon are working together to bring down waiting lists, after the Department of Health and Social Care published the NHS Elective Recovery Plan.

To enable our elective recovery, we also need to ensure we return to a stable situation in relation to mental health, children's services, diagnostics and cancer care.

Over the last two years, hospitals in Devon have focused on cancer and urgent planned care, while services continued to manage the pressures of the pandemic, in line with national policy.

All four acute trusts in Devon have a high percentage of patients waiting over 52 weeks for planned care. Orthopaedics (for example, hip and knee operations) and Ophthalmology (encompassing cataract removal and eye surgery) have seen the biggest increase in patients on waiting lists and therefore there will be a key focus on these specialties in 2022/23.

Our Devon recovery plan is focused on four areas of delivery:

- Protecting our elective capacity so that planned and emergency care are separated so that routine care can continue without being impacted by emergency requirements
- Prioritising diagnosis and treatment for patients
- Transforming the way we provide planned care to improve productivity and increase capacity for patients – by using 'best practice' ways of working adopted in other parts of the NHS
- Providing better information and support to patients on waiting lists to support them while they wait

Solutions to achieve these aims include:

- Nightingale Hospital Exeter – delivering orthopaedic, ophthalmology, and diagnostic services
- Additional capacity for eye surgery in Plymouth
- Restoration of orthopaedics, including phased implementation of 'protected' (lists not disrupted by emergency procedures) orthopaedic beds in each of the acute trusts; continuing to maximise independent sector capacity for orthopaedic procedures; a review of the orthopaedic pathways; a focus on identifying inequalities and inequities of access within the orthopaedic pathways starting with hip and knee.
- Maximising Independent Sector activity
- Additional elective capacity in Devon – including 20 schemes funded by £19 million from the national Targeted Investment Fund (TIF)
- Improving productivity in Devon
- Using funding to increase diagnostic capacity

- Protected Elective Capacity (see below)

We have established a long waits working group with a remit that includes supporting patients waiting for surgery; contacting patients who may be at risk of experiencing worsening outcomes due to health inequalities; reducing contacts to primary care and secondary care from patients asking for information; and reducing admissions to urgent care from patients on planned care waiting lists
Health inequalities have been further exacerbated by the pandemic and there is a risk that these could widen further if we don't address them now. We will be working to identify and reduce these by focussing on elective recovery.

Click here for further information.

5.1.4. Engagement on protected elective capacity

NHS organisations in Devon are working together on a local engagement programme to consider measures that could help protect planned operations from being postponed when hospitals face very demand for their urgent care services.

On 08 February 2022, the Department of Health and Social Care published the NHS Elective Recovery Plan that describes how the NHS will tackle the backlog of care built up during the Covid-19 Pandemic.

The plan aims to eliminate waits of longer than 18 months for planned care by April 2023 and waits longer than a year by March 2025. It refers to protecting elective capacity as a principal way of tackling the NHS backlog. Protected elective capacity (PEC) means separating planned from emergency care to avoid the current challenge where emergency cases can disrupt routine operations and cause cancellations or delays.

Between 02 March and 13 April 2022, the NHS in Devon is undertaking a period of targeted engagement with people who this work impacts the most (for example, those currently on waiting lists for surgery) to share our emerging thinking and discuss how we can protect elective capacity in Devon. Feedback will be used to support options development which we may need to consult on later this year.

5.1.5. Mental health, learning disability and autism provider collaborative

Progress with shaping the provider collaborative for mental health, learning disability and autism continues well, building on existing care partnership arrangements and the strong history of joint working between NHS, local authorities, the voluntary sector and people with lived experience.

A programme director and clinical director are now in post to drive forward this important strategic development that will strengthen both the design and delivery of care and improved outcomes for the population.

5.1.6. Workforce strategy update

Extensive engagement was undertaken in the latter part of 2021 across the system with c.100 leaders from clinical, professional and management roles across our system partners to support the development of the Workforce Strategy.

The emerging Workforce Strategy will cover the period through to 2030 and is informed by population demand data, current workforce data and known future workforce trends, recommendations on new roles and ways of working and also assumptions on required efficiencies.

The Workforce Strategy will be further informed by the ICSD Clinical Strategy and will also outline our approach to addressing the workforce elements identified within the Adult Social Care and Integrated Care White Papers.

A Workforce Strategy Steering Group has been established and at the most recent meeting on 04 March, members were updated on progress and reviewed the headline data that is informing the strategic intent.

Further engagement with human resources directors, medical directors and chief nursing officers is currently being planned for March and April.

The Workforce Strategy will be included within the Devon Plan and work is on track to meet the agreed deadline for a final draft to be presented for ICSD approval in May.

5.1.7. Digital developments

Work has begun to baseline all the digital technology and systems across the ICS so that we can develop a roadmap of managed convergence for digital infrastructure and associated contracts. This will enable us to maximise economies of scale and efficiencies across Devon.

It will also make things much simpler for front line workers, particularly those working between different facilities and organisations across the county.

This is in line with the national What Good Looks Like (WGLL) framework and the levelling up agenda.

5.1.8. War in Ukraine – support for colleagues

Ukrainian nationals and those of Ukrainian origin play a vital role the Devon health and care system, and local organisations doing all they can to support them.

A range of support is available to those who have been affected by the Ukraine conflict, including:

- The Devon Wellbeing Hub provides free, confidential support for individuals and teams
- Military veterans can access Devon's Veterans Service on 01392 207799 or by email
- Alternatively, the national service, Op COURAGE, can provide help and support
- NHS England have many wellbeing resources, including confidential support for mental health and wellbeing

The Secretary of State for Health and Social Care recently issued a letter to Ukrainian health and care staff regarding the extension of visas.

Meanwhile, through the NHS's coordinated work with the Department of Health and Social Care, the UK has already provided over 650,000 medicines and medical items such as wound packs and intensive care equipment, deployed a humanitarian team to the region, and is exploring further options to stand with our Ukrainian friends.

In addition to medical aid being delivered to Ukraine, the NHS is also working with government to plan for how we can help by receiving people affected by the conflict,

whether that is those who have had their treatment interrupted, have been injured or those who have become refugees.

To be most effective for the people who need it, these support efforts must be properly co-ordinated, as part of the overall UK Government-led response.

The government has published further information on how the public can help with support for Ukraine, which includes details of the Disasters Emergency Committee, a coalition of 15 leading UK charities, which has launched its collective appeal to provide emergency aid and rapid relief to civilians suffering during the conflict.

On 13 March, the government announced that 21 Ukrainian children with cancer have been brought to receive care through the NHS in England.

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

Recent key media releases and responses:

- ITV West Country 'day in the life of' features – three members of our staff; a nurse from Newton Abbot Community Hospital, a rapid response community support worker, and a Torbay Hospital porter, featured in a series on ITV West Country news following them on a day at work as they shared the challenges they face and why they love their job
- Local people back Dartmouth community bid – sharing the news that survey results show that people in Dartmouth back a community bid for the site of the former hospital, and we can continue to support the town council with their bid
- Our People Awards – launching our new staff recognition award scheme and encouraging the public to submit their nominations for the People's Choice award

Recent engagement on our social media channels includes:

- Learning to live with COVID-19 – shared advice and guidance as nationally we move into the next stage of living with COVID-19, while reminding people that advice and restrictions have not changed for hospitals and healthcare settings
- Continuing COVID-19 safety advice – using national resources to ask people to consider following infection control advice where appropriate following removal of restrictions
- Catering services 5* recognition – sharing the fantastic news that our catering service was awarded a five star rating in its recent environmental health inspection
- GP online consultations – regional campaign to encourage the public to utilise the online services that their GP offers

- Houses to rent – highlighted the need for local homes available to rent for members of staff joining us who are new to the area
- Healthy Lifestyles support – published a video featuring Nickie from our Healthy Lifestyles team, highlighting that while February is a time when resolutions can be forgotten, support to help reach your lifestyle goals is available
- Children's Mental Health Week – sharing information on the support available for young people struggling with how they are feeling, and additional training opportunities for staff to help them support young people
- HIV Testing Week – raising awareness of the importance of HIV testing and how easy it is to be tested, using national resources
- COVID-19 vaccinations abroad – promoting the opportunity for those who have received vaccinations abroad to get their records updated

Development of our social media channels:

Channel	End of year target	As of 31 March 2021	As of 28 February 2022
LinkedIn	5,000 followers	2,878	3,761 ↑ 883 followers
Facebook	15,000 likes	12,141	12,811 ↑ 670 followers
	15,000 followers	12,499	13,245 ↑ 746 followers
Twitter	8,000 followers	6,801	7,299 ↑ 498 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

Q4 2021/22 v18

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	
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	
5	Dave Stacey Chief Finance Officer	To provide and maintain a fit for purpose estate infrastructure ensuring service continuity at all times	25	16	Amber	Amber	
6	Adel Jones Director of Transformation & Partnerships	To provide and maintain a fit for purpose digital infrastructure ensuring service continuity at all times	25	25	Red	Red	
7	Adel Jones Director of Transformation and Partnerships	To implement the Trust plans to transform services, using digital as an enabler, to meet the needs of our local population	16	12	Amber	Red	
8	Judy Falcao Chief People Officer	To implement and continuously review the Trust People Plan, ensuring the Trust is a '*great place to work*'	16	12	Amber	Amber	General updates to reflect the current position
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	12	Amber	Amber	General updates to reflect the current position
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	Minor amendment to refelct removal of risk relating to allocation of seed funding

Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 11 2021/22 (February 2022 data)			Meeting date: 30 March 2022
Report appendix	M11 2021/22 IPR focus report M11 2021/22 IPR 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 Director: 24 March 2022 Integrated Governance Group: 23/24 March 2022 Finance, Performance, and Digital Committee: 28 March 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. ***Please note the attachments to this report are in the Boardpacks Knowledge Section – TSDFT Board Reading Room***		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to **review** the documents and evidence presented.		
Summary of key elements			
Strategic objectives supported by this report	**Safe, quality care and best experience**: Yes; **Valuing our workforce**: Yes **Improved wellbeing through partnership**: ; **Well-led**: Yes		

<table>
<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
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<tr><td>Board Assurance Framework</td><td>Yes</td><td>Risk score</td><td>20</td></tr>
<tr><td>Risk Register</td><td>Yes</td><td>Risk score</td><td>25</td></tr>
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<tr><td>External standards affected by this report and associated risks</td><td>
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<tr><td>Care Quality Commission</td><td>Yes</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>Yes</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>Yes</td><td>National policy/guidance</td><td>Yes</td></tr>
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This report reflects the following corporate risks:

• failure to achieve key performance standards;
• inability to recruit/retain staff in sufficient number/quality to maintain service provision;
• failure to achieve financial plan.
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Report title: Integrated Performance Report (IPR): Month 11 2021/22 (February 2022 data)		**Meeting date:** 30 March 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: Following the focused inspection of Medical Care that took place on 1st December 2021, where EAU4 (COVID), and Forest (escalation) wards were inspected, the final inspection report was published on 4th March 2022. The report was complimentary about staff feeling supported and valued and that they received mandatory training. However, the inspection did raise concerns around the standard of nursing documentation of patient risk assessments, nutrition and hydration risk assessments, and care plans. As a result of these findings the Trust received three improvement notices. February's point prevalence audit shows 86.7% of patients had a risk assessment performed within 24 hours of admission. Immediate actions are being taken post audit to ensure 100% of patients have a risk assessment.
An action plan has been created to address the actions above and strengthen our governance oversight that will be monitored though the Quality Assurance Committee.

Incidents: In February there were 4 severe incidents.

- x 4 in patient falls, all resulted in a fracture of a limb and all have been reported on STEIS.
- 1 death reported – Drug and Alcohol Service. 72hr report completed. No lapses in care. Cause of death pending.

Stroke: The percentage of time stroke patients are spending on a stroke ward remains below the 90% target for February, but there has been a significant improvement; data collection issues are now resolved.

- February 59% of time stroke patients spent on stroke ward.
- However, only 2.9% of stroke patients were admitted within 4 hours.

VTE assessment: The compliance in February has improved to 95.2 % from a position of 94.8% in January 2022.

- 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: Bed closures have decreased to 49 in February 2022 from 71 in January 2022. The number of C.Diff cases have increased within the acute hospital and community onset has reduced. The infection control focus has been on COVID-19 outbreaks which have affected the organisation.

Maternity: There has been a mandated change from NHSEI in the reporting of Caesarean Section (CS) rates. Providers must now use Robson Group categories rather than total CS rates. The Robson Group classification is a global standard and enables analysis of the CS data. No stillbirths or neonatal deaths were reported in February 2022. Extensive work is continuing to recruit and retain midwives; the improvement in staffing will support the Continuity of care workplan.

Safer Staffing: The Covid-19 nurse safer staffing risk framework is in place, wards remain in an amber position overall with mitigations and reassignment to areas according to need.

2. Workforce Headlines

The preliminary annual rolling sickness absence rate was 5.03% to the end of February 2022 which is continuing to increase due to the very low unseasonal figures for January to March 2021; the preliminary February figure is 6.14% which will be the highest month for sickness recorded in ESR; the sickness target is 4%.

The Achievement Review rate for the end of February 2022 was 75.22% a further reduction from the 76.13 % as at the end of January.

The Trust's turnover rate for the 12 months as at the end of February was 12.86% an increase from January's 12.60% but between the target rate of 10%-14%.

The current overall mandatory training rate is 89.22% for February 2022 against a target of 85%. The subjects with multiple levels such as Safeguarding and MCA still need improvement.

The Month 11 Trust Agency spend was £0.658m which was a large reduction of £367k from January's figures due to some technical timing adjustments; the year-to-date figure of £11.780m (£4.3m above plan as at the end of month 11).

3. Performance Headlines

Operational headlines

Covid: Throughout February, the Trust continued to care for a number of patients with covid averaging 21 daily in hospital; the number of patients requiring intensive care has remained low. The lifting of community restrictions and the reduction in community testing has made covid modelling a challenge to predict in terms of people presenting to the hospital and any change in infection rate. March has, however, seen a significant increase in the number of covid admissions with the highest number of covid patients in the hospital being recorded since the pandemic began. There are now over 70 Covid patients currently being cared for across two acute and one community ward with other wards reporting Covid nosocomial cases. Partners in care homes, nursing homes, and domiciliary care continue to be significantly impacted by Covid in terms of admissions and staffing which is contributing to delayed transfers of care from the hospital. Trusts across Devon and the wider South West are experiencing the same challenges.

Recovery Planning: The Trust continues to focus on recovery of elective care across all specialties and reducing waiting times for patients whilst not impacting negatively on emergency pathways.
The two key elements for this plan are the return of the Day Surgery Unit and increased elective beds to allow the commencement of routine inpatient operating, both now

scheduled to commence by the end of April. The System Capacity and Recovery Group continues to oversee this work and ensure rapid delivery of the required capacity.
To facilitate these developments a number of vital outpatient services have had to relocate from the main outpatient department. Further detail is provided in the Chief Operating Officer report.

Urgent Care: Urgent and emergency services continued to be challenged throughout February. High bed occupancy and patients with a long length of stay are impacting availability of beds resulting in delays to ambulance handover and extended waits in ED and assessment areas with patients being bedded in ED and assessment areas overnight. In February an improvement in the number of long waits over 12-hours in ED is seen along with a reduction in the average number patients with no criteria to reside. In February, there were 364 people who spent 12-hours or more in the Emergency Department (806 in January) with ambulance handover delays remaining high, meaning 438 patients experienced a delay of over an hour once arriving to the Emergency Department.

The average number of patients with no criteria to reside decreased in February. The number of delayed discharges continues to be impacted by capacity in the domiciliary care and independent sector.

People waiting for care: The number of patients waiting over 18-weeks, 52-weeks, and 104-weeks for treatment continues to increase in February. The forecast for end of March is to have 250 patients waiting over 104 weeks.

The plans to re-open the Day Surgery Unit and restart routine elective orthopaedic inpatient surgery will see an increased number of long-wait patients treated from end of April. This together with the plan to provide additional insourcing capacity funded through Elective Recovery Fund (TBC) means that achieving close to the national planning objective of having no 104-week waits by 30th June is possible if Covid demand subsides.

Capacity within the private sector remains important in supporting delivery of routine elective care along with continued 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 procedures is commencing on 25th March with 24 patients per month from TSD due to be treated.
The Trust is also engaged with the ICS system Waiting Well programme. Through this work non-clinical validation of long wait patients (>52 weeks) is being supported by the Devon Referrals Support Service contacting some of our longest waiting patients to give assurance and direct to wellbeing and lifestyle support. This Waiting Well project is also developing information links through various forms of media for patients to give further advice on waiting times and wider support. Recovery of waiting times is going to be a long-term challenge. Our communication with patients will be vital along with the clinical and non-clinical validation to minimise any harm due to long-waits.

Cancer care: An increase in referrals and reduction in capacity from covid escalation for surgical and diagnostic stages of care continues to impact on the delivery of the cancer performance standards. The cancer strategy for the Trust is vital for recovery of

cancer standards and the newly formed Cancer Cabinet provides the platform and executive oversight to ensure challenges and risks are reviewed with action plans in place. The Cabinet held its first meeting in March and reviewed cancer performance, 2022/23 planning guidance, diagnostic challenges, site specific risks, patient experience, and Cancer Alliance support.

A review of cancer action plans to secure improvement and delivery of standards is being led by the Chief Operating Officer and will be signed off through the Cancer Cabinet.

Diagnostic waiting times: MRI, CT, Endoscopy, and Cardiology continue to have a high number of patients waiting over 6 weeks for diagnosis. All modalities are continuing to see patients with urgent need with appropriate infection, control prevention and control precautions. The use of a mobile scanner, insourcing at weekends, and the use of the Nightingale Hospital facilities will continue to be critical to supporting capacity over the coming months.

Patients in hospital: In February the number of 21-day and 7-day length of stay patients has remained significantly higher than normal levels with an average of 60 patients over 21 days in hospital compared to 28 last February, and 165 over 7 days compared to 114 last February.
The increased length of stay is in part a result of the significant number of patients who are medically fit with no 'criteria to reside' who require ongoing support and care in community settings. The retention and recruitment of staff continues to be a significant challenge for independent sector providers providing nursing residential and domestic care packages of care. It is also 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.

Adult Social Care (ASC) and Independent Sector: 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 continue to be below desired levels.

Front End Service (FES) and Complex Care Service (CCS) have seen high volumes of work resulting in increasing waiting lists. Increased pressure on workforce, reducing waiting list productivity, is due to covid related sickness and outstanding vacancies. Both FES and CCS are improving their case closure rates, reducing inactive within cases and cases open for 180 days. The increase in activity is a result of productivity reporting developed over the previous two months and reported directly through the refreshed assurance and governance route giving greater detail and understanding of individual and team performances. Recruitment plans are in place and being implemented, regular flow meetings in place to focus on inactive and cases held open for over 180 days. Measures are being implemented to address outstanding reviews including flagging at the point of case allocation which reviews are outstanding, which ultimately supports TSDFT meeting Care Act statutory responsibilities for reviews.

Approved by TSDFT FDG and Joanna Williams (Torbay Council's Director of Adult Social Services) were the inflationary uplifts for 2022/23. Inflationary uplifts for 2022/23 cannot rectify disparity in the market or address financial issues which are linked to the

requirements to review/implement financial models or organic changes in how services are delivered. Developing the inflation proposal has come from partnership working with senior Torbay Council Commissioning staff. In addition to this, elements of inflationary uplift and pressures have been reflected in the ASC medium plan which has been discussed at senior levels across the Trust, Torbay Council and Devon CCG.

Fair Cost of Care (FCC) implementation, designed to ensure local authorities can prepare their markets for reform and move towards paying providers a fair cost of care as appropriate to local circumstances, is underway. It will complete a Cost of Care exercise from a broad market sample, understand the impact of reform on local markets through data on operational costs and quantity of self-funders, and improve commissioning oversight and market management to ensure the care sector is positioned to deliver reform and ambitions.

Adult Social Care Improvement Plan (ASCiP) will continue its work planning for the 2022/23 Cost Improvement Plan Savings. Current savings are £2.2M FYE in part as a result of adopting a strength-based approach to the reassessments in accordance with the Care Act 2014 outcome focused approach to social care. The second stage of transformation for 2022/23 will be prioritised alongside the initial stages of the central government requirements for social care charging reform (Care Accounts).

4. Finance headlines

For the month of February (M11) the Trust is reporting a £0.7m surplus and for the year to date the Trust is reporting a £1.5m surplus. M11 actuals is behind plan (£70K adverse in month) and year to date actuals is ahead of plan (£90K favourable year to date).

Total income for the year to date is £8.3m favourable to plan. Key drivers are as follows:

COVID related income	£5.4m
Education and training, R&D grants and other	£3.6m
ASC client contribution income	£0.9m
Offset by:	
Lower Council income	(£1.3m)
Reclassification from patient care income to other income	(£0.4m)

Operating expenditure and financing cost in the year to date is £8.6m adverse to plan. Key drivers are as follows:

COVID related costs not initially budgeted	(£5.4m)
Agency spend	(£4.3m)
Bank spend	(£3.5m)
Increased clinical supplies and services costs	(£1.9m)
ASC and Placed People increased cost	(£1.7m)
HIS N365 business plan	(£0.6m)
ASC bad debt provision	(£0.5m)
Drugs Cost	(£0.4m)
Increased Utilities Cost	(£0.4m)
Undelivered CIP	(£0.2m)
Offset by	
Underspend on substantive pay due to vacancies	£7.8m

Underspend within CFHD alliance	£1.7m
Underspend on non-healthcare contract	£0.4m
Underspend on Financing cost	£0.4m

The cash position remains strong with a month end balance of £41.5m. To date the Trust has spent c. £24.9m on capital schemes, an increase of c. £9.0m from Month 10.

The phased plan for efficiencies at Month 11 is c. £1.2m, against which c. £1.6m has been assessed as being delivered, an upside of c. £0.4m. Year-to-date, for H2, delivery is recorded as c. £5.5m against a plan of c. £6.0m, a shortfall of c. £0.5m.

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 11 is c. £6.5m delivered against a plan of c. £6.7m, giving a shortfall of c. £0.2m (taking into account rounding).

The Trust has reviewed its forecast in light of the continuing pressures from Covid, and is confident of achieving the required year-end result of £1.8m surplus.

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 Q3, mainly against activities delivered in Accelerator sites. There is still a risk that the System might not achieve any ERF in Q4.

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 low risk income values and the Trust will maximise the benefit of these allocations. This will complement the spend against ERF, reducing the financial risk to the Trust if the System does not meet the 89% threshold.

The Trust submitted a draft operational plan to NHSE / I for FY 2022/23 which showed a full year adjusted deficit of £32.71m. The following areas are worth noting:

- The plan is unlikely to be accepted by regulators.
- The efficiency requirement for 2022-23 is £28.45m, comprising CIP, transformation and Covid cost reduction initiatives.
- We expect a significant reduction (~60%) in COVID top-up funding.
- Commissioner contracts are being re-introduced with aligned incentive payment mechanisms for elective activity, which would see the Trust lose income if elective activity fails to achieve the required levels.
- There is no future funding for 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 plans for 2022-23 and beyond have been developed – 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

March 2022: Reporting period February 2022 (Month 11)

	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
	Section 3: Appendices
	Statistical Process Control charts – pilot

Quality and Safety Summary

CQC:
Following the focused inspection of Medical Care that took place on 1st December 2021, where EAU4 (COVID), and Forest (escalation) wards were inspected, the final inspection report was published on 4th March 2022. The report was complimentary about staff feeling supported and valued and that they received mandatory training. However, the inspection did raise concerns around the standard of nursing documentation of patient risk assessments, nutrition and hydration risk assessments, and care plans. As a result of these findings the Trust received three improvement notices. February's point prevalence audit shows 86.7% of patients had a risk assessment performed within 24 hours of admission. Immediate actions are being taken post audit to ensure 100% of patients have a risk assessment.
An action plan has been created to address the actions above and strengthen our governance oversight that will be monitored though the Quality Assurance Committee.

Incidents: In February there were 4 severe incidents.
- x 4 in patient falls, all resulted in a fracture of a limb and all have been reported on STEIS.
- 1 death reported – Drug and Alcohol Service. 72hr report completed. No lapses in care. Cause of death pending.

Stroke: The percentage of time stroke patients are spending on a stroke ward remains below the 90% target for February, but there has been a significant improvement; data collection issues are now resolved.
- February 59% of time stroke patients spent on stroke ward.
- However, only 2.9% of stroke patients were admitted within 4 hours.

VTE assessment: The compliance in February has improved to 95.2 % from a position of 94.8% in January 2022.
- 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: Bed closures have decreased to 49 in February 2022 from 71 in January 2022. The number of C.Diff cases have increased within the acute hospital and community onset has reduced. The infection control focus has been on COVID-19 outbreaks which have affected the organisation.

Maternity: There has been a mandated change from NHSEI in the reporting of Caesarean Section (CS) rates. Providers must now use Robson Group categories rather than total CS rates. The Robson Group classification is a global standard and enables analysis of the CS data. No stillbirths or neonatal deaths were reported in February 2022. Extensive work is continuing to recruit and retain midwives; the improvement in staffing will support the continuity of care workplan

Staffing: The Covid-19 nurse safer staffing risk framework is in place, wards remain in an amber position overall with mitigations and reassignment to areas according to need.

The CQCs Inspection Report, published on 2 July 2020 continues to be monitored through CQC and Compliance Assurance Group. The ongoing improvement plan has 9 Must Do and 8 Should Do actions to complete. Of the Must Dos, they fall into 4 main themes – Training, Appraisal, Clutter and rolling replacement programme. Despite best efforts these have all been impacted by the pandemic.
The Trust is creating a recovery programme for training and appraisal so these can be achieved over a realistic time period. In March, a paper was submitted to the People and Education Governance Group, detailing the assurance framework, action plans and improvement trajectories.

The rolling equipment replacement policy needs to be completed and made accessible and this work is being led by Estates with the support of ISU leads, to continue to secure and source storage areas to ensure clinical areas and corridors are clutter free.

Following the focused inspection of Medical Care that took place on 1st December 2021, where EAU4 (COVID), and Forest (escalation) wards were inspected, the final inspection report was published on the 4th March 2022. Whilst the report was complementary about staff feeling supported and valued and that they received appropriate mandatory training, concerns were raised concerns around nursing record keeping and documentation of patient risk assessments and particularly nutrition and hydration risk assessments and care plans. As a result of these findings the Trust received 3 improvement notices:

1. Ensure risk assessments are completed fully for each patient, within 24 hours of admission to hospital, in line with trust policy.
2. The service must ensure consistent and detailed up-to-date nursing records of patients' care and treatment are maintained and ensure patients requiring additional support with nutrition and hydration are quickly identified and actions taken
3. Ensure governance processes are improved to undertake consistent audits and these results are reviewed and acted upon.

***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**

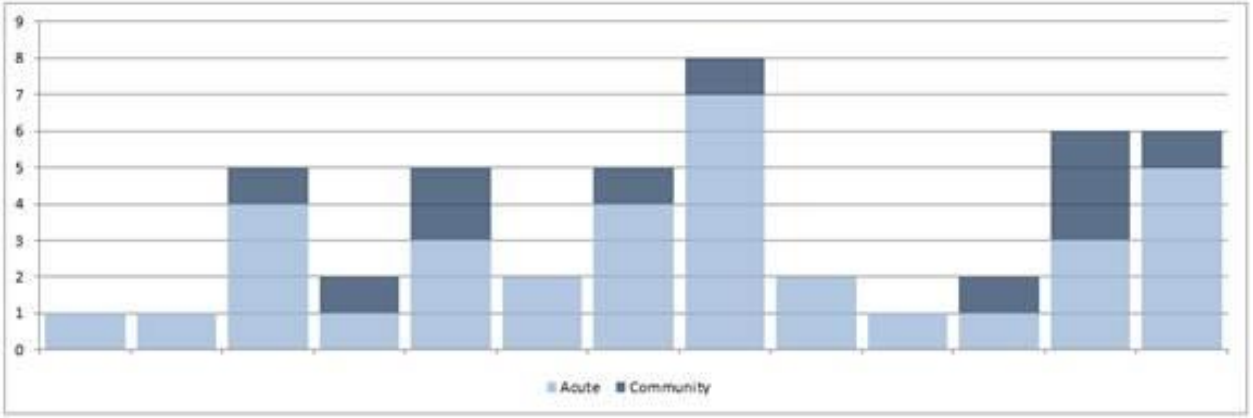
Quality and Safety Indicators

Key							
⬆ = Performance improved from previous month ⬇ = Performance deteriorated from previous month ⬌ = No change							
	Not achieved		Under-achieved		Achieved		No target set		Data not available

Reported Incidents - Severe		⬌
Reported Incidents - Death		⬆
Medication errors resulting in moderate harm		⬌
Medication errors - Total reported incidents		
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)		⬌
Never Events		⬌
Strategic Executive Information System (STEIS)		⬇
QUEST (Quality Effectiveness Safety Trigger Tool		⬆
Formal complaints - Number received		⬆
VTE - Risk Assessment on Admission		⬆
Hospital standardised mortality rate (HSMR)		⬆
Safer Staffing - ICO - Daytime		⬆
Safer Staffing - ICO – Night time		⬆
Infection Control - Bed Closures - (Acute)		⬆
Hand Hygiene		⬇
Fracture Neck Of Femur - Time to Theatre <36 hours		⬆
Stroke patients spending 90% of time on a stroke ward		⬆
Follow ups 6 weeks past to be seen date		⬇

Number of Clostridium Difficile cases

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Acute	1	1	4	1	3	2	4	7	2	1	1	3	5
Community	0	0	1	1	2	0	1	1	0	0	1	3	1



Due to capacity the February CDiff data is not available at the time of writing the report.

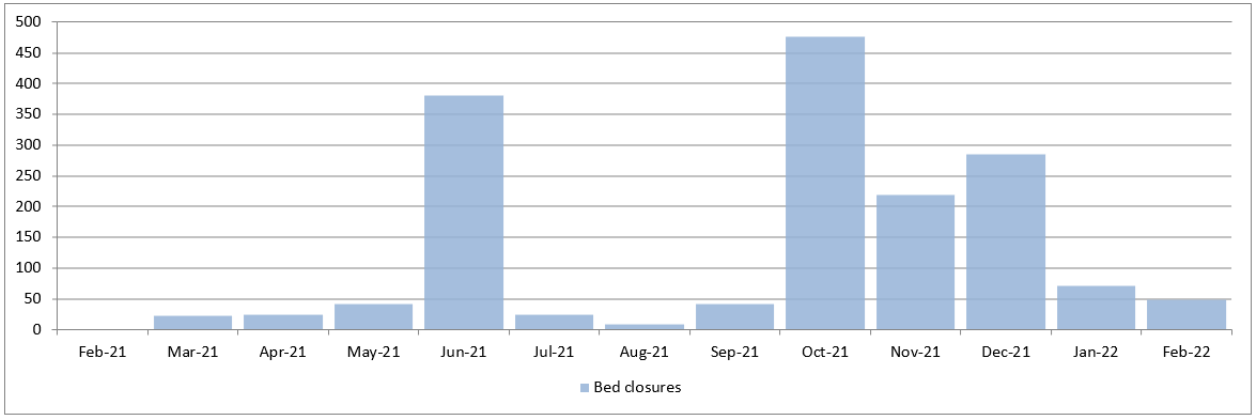
The number of C.Diff cases for January is 6;

- 5 of which is hospital onset
- 1 in the community

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)

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Bed closures	0	23	24	42	381	24	8	42	476	218	285	71	49



February bed closures have decreased to 49 from the January position of 71 which is a much improved position.

The reason for these closures have included:

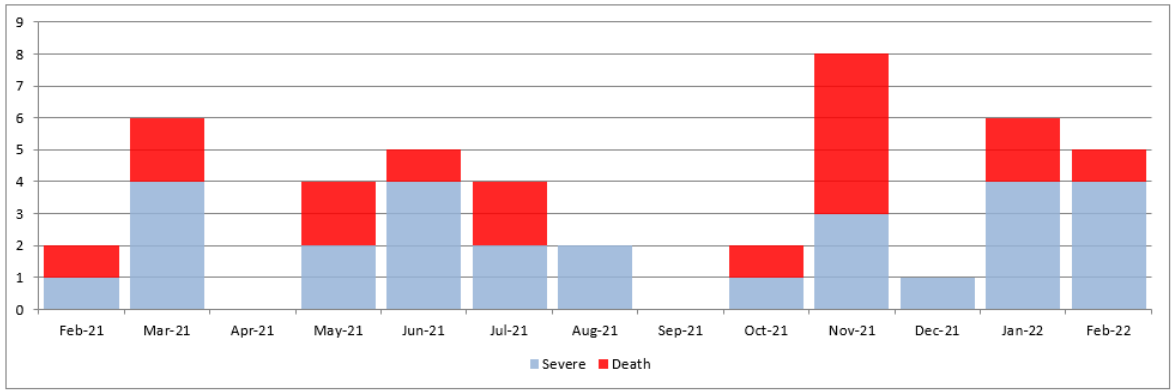
- Covid positive on admission and outbreaks during admission.

Management of these have followed IPC guidelines including Public Health England guidance.

Quality and Safety- Incident reporting and complaints

Reported Incidents - Severe and Death

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Severe	1	4	0	2	4	2	2	0	1	3	1	4	4
Death	1	2	0	2	1	2	0	0	1	5	0	2	1

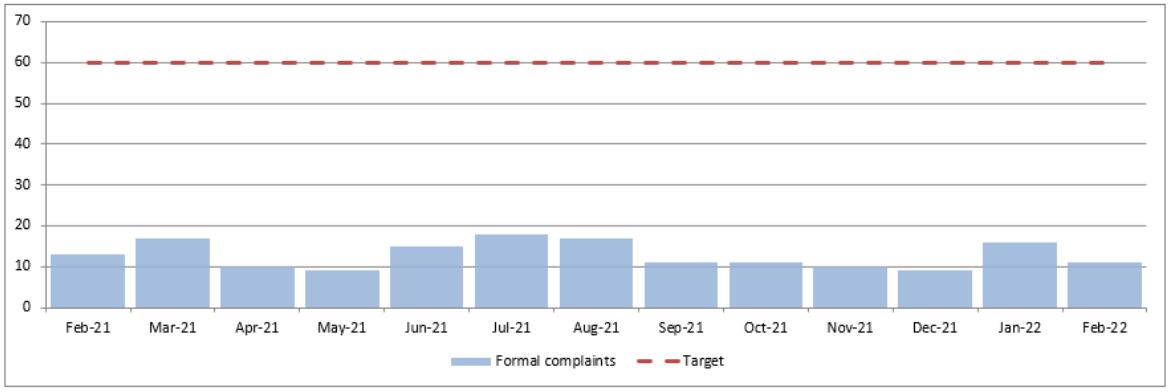


In February there were

- 4 inpatient falls, all resulted in a fracture of a limb and all have been reported on STEIS;
- 1 death reported – Drug and Alcohol Service. 72hr report completed. No lapses in care. Cause of death pending.

Formal complaints

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Formal complaints	13	17	10	9	15	18	17	11	11	10	9	16	11
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



The Trust received 11 formal complaints in February.

Of these 11 complaints :

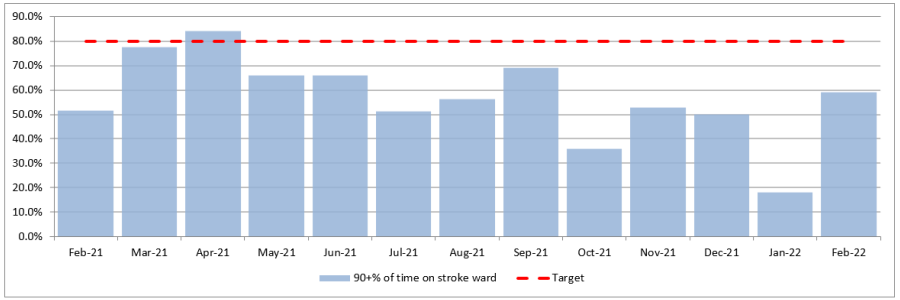
- X 4 with regards delays to treatment

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

Quality and Safety- Exception Reporting

Stroke

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
90+% of time on stroke ward	51.6%	77.5%	84.1%	65.9%	66.1%	51.4%	56.3%	69.2%	35.9%	52.8%	50.0%	18.2%	59.0%
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%



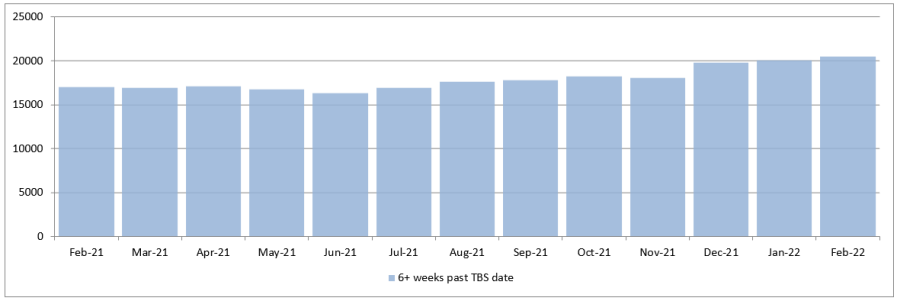
Stroke:

The percentage of time stroke patients spend on a stroke ward remained below the 90% target for December but there has been a significant improvement in February to 59%

- The stroke ward had a bay closed for 10 days in February which had an impact on the number of patients admitted to GE. Only 2.9% of stroke patients were admitted within 4 hours.
- SNP allocated to ED every day, to review and progress treatment and transfer to a stroke bed and oversee their care.
- The stroke team (nurses and therapists) outreach to see stroke patients on other wards.
- We are linking with the stroke network- performance is poor nationally
- Plans in progress to ringfence stroke beds.

Follow ups 6 weeks past to be seen by date

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
6+ weeks past TBS date	16986	16950	17118	16713	16323	16967	17651	17789	18231	18069	19797	20026	20496



Follow ups:

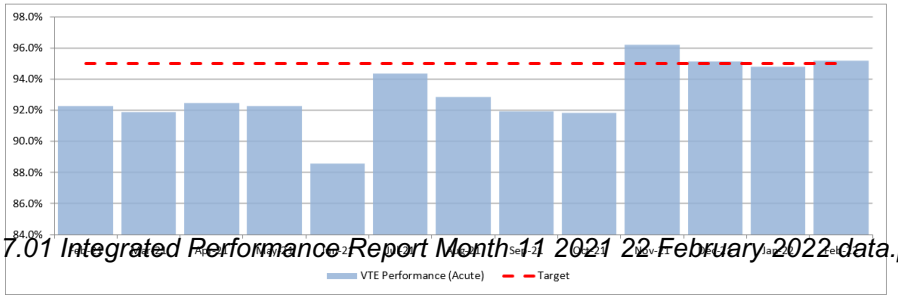
The number of follow up patients waiting for an appointment greater that six weeks past their 'to be seen by date' has further increased to 20,496 in February.

A review of all services across the Trust is in progress and plans are continuing to step up some services.

Harm Review meetings are being progressed and thematic reviews being conducted against our longest waiting patients.

ICO VTE risk assessment on admission

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
VTE Numerator	4457	5307	5491	5400	5518	5685	4962	5188	5058	5418	4951	5163	4996
VTE Denominator	4831	5775	5938	5851	6228	6024	5344	5643	5508	5631	5204	5447	5248
VTE Performance (Acute)	92.3%	91.9%	92.5%	92.3%	88.6%	94.4%	92.9%	91.9%	91.8%	96.2%	95.1%	94.8%	95.2%
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 February increased to 95.2% from 94.8% in January.

- 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 the medical education team.

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

	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Running Total
% of women booked for continuity of carer	67.9%	57.0%	64.2%	64.3%	64.9%	59.7%	65.3%	69.5%	54.0%	65.5%	61.9%	58.9%	62.8%
Number of Stillbirths	0	0	0	0	0	0	2	1	0	1	3	0	7
% Robson Group 1		12.0%	0.0%	18.5%	22.9%	3.7%	11.4%	20.0%	24.1%	22.2%	15.4%	10.0%	14.6%
% Robson Group 2		59.5%	47.6%	54.7%	48.1%	44.1%	62.5%	37.8%	51.6%	44.9%	57.1%	58.3%	51.5%
% Robson Group 5		87.5%	64.7%	68.0%	70.8%	84.6%	82.1%	69.0%	78.6%	88.2%	81.0%	79.2%	77.6%
% Breastfeeding at Delivery	81.8%	73.5%	77.4%	75.3%	74.4%	76.4%	78.1%	71.0%	80.3%	72.2%	80.5%	78.9%	76.7%

- *In February 2022 all Maternity units received a letter from NHS England and NHS Improvement to “recommend an immediate end to the use of total Caesarean Section percentages as a metric for Maternity services, and that this is replaced using Robson criteria”. The Robson system classifies all deliveries into one of ten groups on the basis of five parameters: obstetric history, onset of labour, fetal lie, number of neonates, and gestational age*
- During February 2022, there were 140 births in the month. There are 168 deliveries projected for March and 137 for April 2022. The induction of labour rate in February 27.1% fell compared to January which was 40.2%.
- We had no stillbirths or neonatal deaths in February, we had one late fetal loss at 23+3 weeks gestation.
- We have seen an improvement in staffing across all of the clinical teams in February 2022.
- We are actively trying to recruit we have 14.5 WTE midwife vacancies.

Performance exceptions and actions

Staff sickness/absence: RED for 12 mths and RED for current mth
The preliminary annual rolling sickness absence rate was 5.03% to the end of February 2022 which is continuing to increase due to the very low unseasonal figures for Jan-Mar 2021; the sickness target rate is 4%. The preliminary monthly sickness figure for February was 6.14% (this is the highest monthly figure going back to ESR recording of sickness in 2005 and only the second time the monthly sickness percentage has been over 6%). Covid related sickness accounted for 32% of February's absence against an annual figure of 15% and the first 10 days of February saw an average of 164 staff absent versus 124 absent over the last 10 days with Covid. Mental Health illness is still the highest sickness reason over the last 12 months at 32%

Appraisal rate: **Red**
February's Achievement Review rate was 75.22% which is a reduction from the 76.13 % as at the end of January and is the lowest level in the last 12 months.
High absenteeism and system pressures continue to impact the ability to perform Achievement Reviews.

Turnover (excluding Junior Doctors): **GREEN**
The Trust's turnover rate now stands at 12.86% for the year to February 2022 and is within the target range of between 10% - 14%, however, this is the highest figure we have seen in the last year and an increase from January's 12.60% so will need to be monitored against key teams and services.

Mandatory Training rate: **GREEN**
The February overall rate mandatory training figure increased to 89.22% against a target of 85% and this was from January's 88.38% figure. However, Information Governance, Manual Handling, Safeguarding Children and Infection Control are all below the target compliance level for Corporate Mandatory training; a further page has been added to highlight the multi-level training compliance.

Agency Expenditure: The Trust Agency reported figure for February was £0.658m giving Financial YTD figure of £11.780m (£4.3m above plan). February identified a big finance amendment of Medical and Dental Agency spend.

Vacancy Rate: The Trust vacancy rate total as at the end of February stood at 373 FTE vacancies including 126 FTE qualified Nursing vacancies with both of these figures slightly reduced from the end of January. Detailed vacancy reporting is still difficult in a number of areas at cost centre and occupational code level but is being reviewed on a regular basis and a new process is in place to improve this integrity.

Update of Progress Against Our People Promise and Plan

Updates on progress against the 5 pillars of our people plan are described below.
As we are approaching the end of the first year of our people promise and plan, we are reviewing the delivery and impact of the activities. The national framework for business planning has been published which describes workforce priorities aligned to the 4 pillars of the national people plan, which are integrated into our plan. This, along with our revised organisational strategy informs the context within which we are identifying the year two priorities, and we will seek feedback from our people to inform these priorities via planned Building a Brighter Future (BBF) roadshows.

1. Growing for Our Future

- Activity continues around developing our resourcing events – this month on 22nd March we have our HCSW open day event – the first face-to-face event since covid.
- Our social media presence is increasing with a growing confidence and professionalism around posts and adverts.
- A new marketing campaign is underway to fresh and revive our people story.. 'Care to join'. This is a close collaboration between resourcing and communications and engagement team to maximise investment and ensure we capture our messages in the best way. This month we have launched our video on social media platforms 'Care to Join' showcasing our staff and services and passion.
- A new banner 3m x 1.5m is being erected this month at the busy Lowes Bridge entrance with 'Care to Join' and contact details to promote working with the Trust.
- Resourcing events group is continuing to grow numbers with a very busy pipeline of local events lined up for the coming months to attract and reach more applicants than ever before.
- Our Accessible Recruitment task and finish group continues with a fresh focus on removing barriers to application to join us and will benefit all routes to join our Trust.
- Promoting 'Care to Join' and resourcing events ramps up on social media, hospital radio, Proud to Care.
- Increased close working with education and nursing workforce colleagues to develop our future workforce and the various 'supply routes, including the preparation for further increased numbers of international nursing recruitment during 2022/23.
- Collaboration with ICS partners around supporting improved ways of working around our resourcing activities is being refreshed and members from the Resourcing Hub involved in actively contributing to various task and finish groups, with the Resourcing Hub Service Manager leading many groups within the Devon ICS Resourcing Pillar. Progress and impact will be shared in coming months.

2. Looking After Our People

- Wellbeing listening sessions continue to take place to support COVID areas. Additionally requests are being received for sessions with teams affected by the system capacity recovery plans.
- 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 126 Wellbeing buddies across Podiatry, ED, Maternity, Audiology, IT, Transport, Templer Ward, Physiotherapy, Recruitment, Radiology, Speech and language therapy, Medical directorate, Healthy lifestyles team.
- ED, Maternity, Audiology, Union House, People Directorate, coaching collective, and Brixham.
- Support to our COVID areas continues via our Charitable Funds.
- Health and Wellbeing conversations are measured through our pulse survey. In January 2022 pulse survey 53% of those who responded said they had had the opportunity to discuss their wellbeing compared to 58% in July 2021. 78% said there was a positive outcome of the conversation on their wellbeing compared to 86% in July 2021.

3. New Ways of Working and Delivering Care

- The ICS is leading on developing an ICS approach to workforce planning which will align to the ICS Workforce Strategy.
- The national framework for business planning for 2022-23 has been issued, which includes priorities aligned to the People Plan, based on the four national pillars, which will be used to inform our organisational people plan for year two.
- The national workforce submission was completed on 17th March 2022. While working on the business plans process focusses on the workforce plans for the next 12 months, work has started on developing 3-year workforce plans.
- Further work aligned to the 3 key pieces of work are ongoing 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 improved workforce planning
    - To develop a toolkit to support People Business Partners and operational managers

4. Belonging

- Creating environments where there are high levels of Trust is critical to foster a sense of belonging which has been highlighted as a concern through staff surveys and feedback from our BAME staff. Active engagement through the BAME network has led to increasing confidence and trust which is reflected in the numbers in the network increasing to approx. 50.
- Welcoming, supporting and retaining our international nurses is critical and the following activities have been undertaken by volunteers from our BAME network: Becoming buddy's for International staff coming into the organisation and in addition have offered pastoral support and have attended the initial welcome meeting organised by the International nurses team.
- Building confidence to share their experience and to undertake personal development is a key finding within the WRES that requires improvement and in response a coaching and personal resilience course has been developed and delivered for BAME colleagues.
- Race Equality week in partnership with Unison was a huge success. 25-30 members of the network attended sharing their experiences of working with us. One of the themes of the session was building confidence for interviews and progressing into new roles. The EDI team are working in partnership with education to provide training for interview skills, holding mock interviews, leadership development and career pathways. This supports the outcomes and improvements needed through feedback from WRES, Model Employer feedback and staff survey.
- In response to the staff survey and feedback from disability network a group has been set up to look at the process of reasonable adjustments. This includes what steps managers can take if a member of their staff have expressed a need for a reasonable adjustment to continue in their role. This groups aims to simplify the process and ensure that reasonable adjustments are concluded in a timely manner.

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, fully booked with further cohorts planned. Development for leaders workshop planned. Embedding of QI methodology into the BBF Drumbeat Programme to support speciality teams with clinical pathway transformation. Single point of contact and central I&I repository in development – will include project resource pack
- Just and Learning Culture; please see update in Belonging pillar regarding a review of our Grievance policy and procedure through a JLC lens.
- Cultural Framework and Manager's Essentials; Imanage is a new on- stop resource for managers bringing together policies, procedures, and "how to Guidance" alongside training videos, e-learning and practical training designed to help new and existing managers effectively manage and lead their teams. It now includes Skills Boost training videos to complement locally generated content. Launch meeting with Comms planned for 28th March to go live. Feedback from managers continues to be positive. Work commencing on second phase content based upon requests and feedback.
- Digital Literacy: A portal on LMS for digital skills & literacy has now been created (which will be added to over time). Working with South Devon College on the creation of digital skills passports for workforce. Working with Plymouth University on digital technology support documentation & providing a reference guide for staff to understand current and emerging digital technologies (first ed. drafted). Developing a series of 'deep dive' technology workshops & hands on experiences for the workforce to attend at the Digital Futures Hub

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

Indicator	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Performance
Month Sickness %	4%	4.04%	3.98%	4.12%	4.63%	4.75%	5.06%	5.41%	5.87%	5.52%	5.46%	6.03%	6.14%	
Mental Health Days % of Sickness (12 mth)	N/A	33.97%	33.29%	32.03%	32.37%	35.70%	37.03%	33.84%	33.44%	33.29%	32.67%	32.18%	31.64%	
12 Mth Rolling Sickness %	4%	3.78%	3.57%	3.98%	4.04%	4.13%	4.24%	4.36%	4.50%	4.56%	4.67%	4.85%	5.03%	
Achievement Rate %	90%	82.37%	85.95%	86.61%	84.73%	81.26%	80.56%	79.69%	77.86%	79.15%	78.57%	76.13%	75.22%	
Labour Turnover Rate	10-14%	10.00%	10.83%	11.03%	11.28%	10.95%	11.73%	11.32%	11.57%	11.51%	11.97%	12.60%	12.86%	
Overall Training %	85%	89.58%	90.06%	90.10%	90.51%	89.53%	89.36%	88.95%	89.02%	88.75%	88.38%	88.62%	89.22%	
FTE Vacancy	N/A	**149**	**178**	**196**	**182**	**255**	**117**	**206**	**340**	**378**	**381**	**373**	**392**	
Vacancy Factor	<10%	**2.49%**	**2.98%**	**3.29%**	**3.04%**	**4.22%**	**1.93%**	**3.38%**	**5.46%**	**6.05%**	**6.10%**	**5.95%**	**6.23%**	
Monthly Agency Spend	£680K	**£1,053**	**£756**	**£827**	**£1,096**	**£1,284**	**£1,090**	**£1,090**	**£1,231**	**£1,373**	**£1,248**	**£1,025**	**£658**	
Nuring Staff Average % Day Fill Rate- Nurses		83%	89%	92%	87%	90%	87%	82%	86%	89%	88%	87%	88%	
Nuring Staff Average % Night Fill Rate- Nurses		85%	90%	90%	89%	93%	88%	75%	81%	84%	81%	78%	79%	
Safer Staffing- Overal CHPPD		8.39	8.39	8.08	7.71	7.73	7.75	7.55	7.56	7.78	7.93	7.64	7.61	

Statistical Process Control (SPC)

SPC is a method of quality control which employs statistical methods to measure, monitor, and control a process. It is a scientific visual method to monitor, control, and improve the process by eliminating special cause variation in a process.

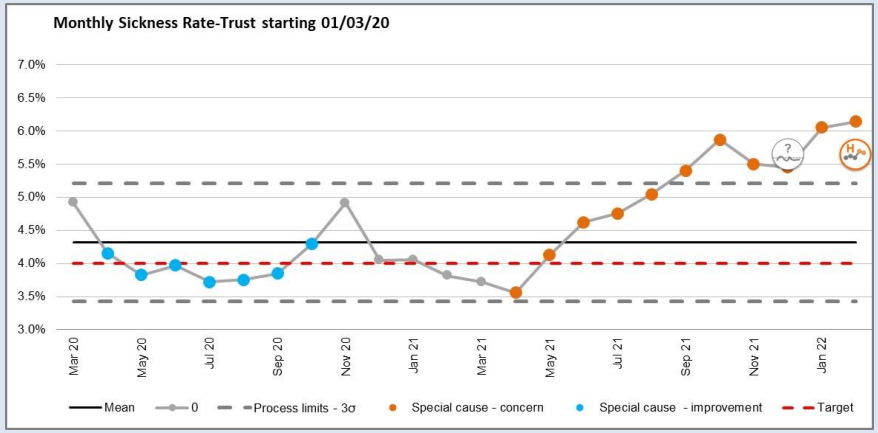
To help you interpret the data a number of rules can be applied.

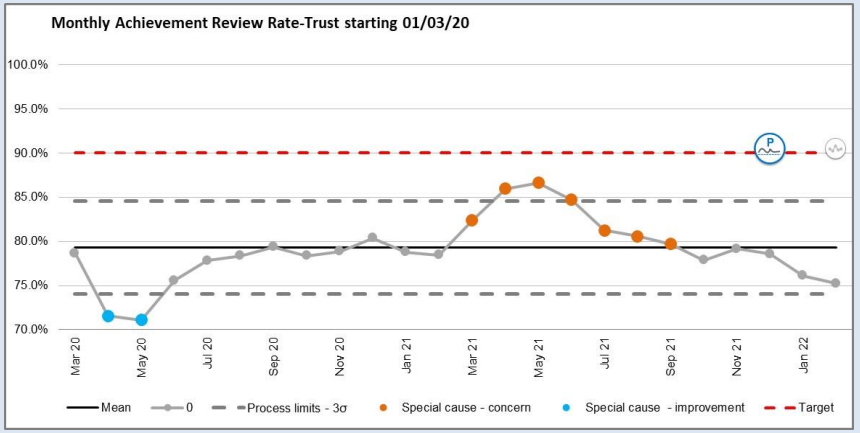
Any single point outside the process limits

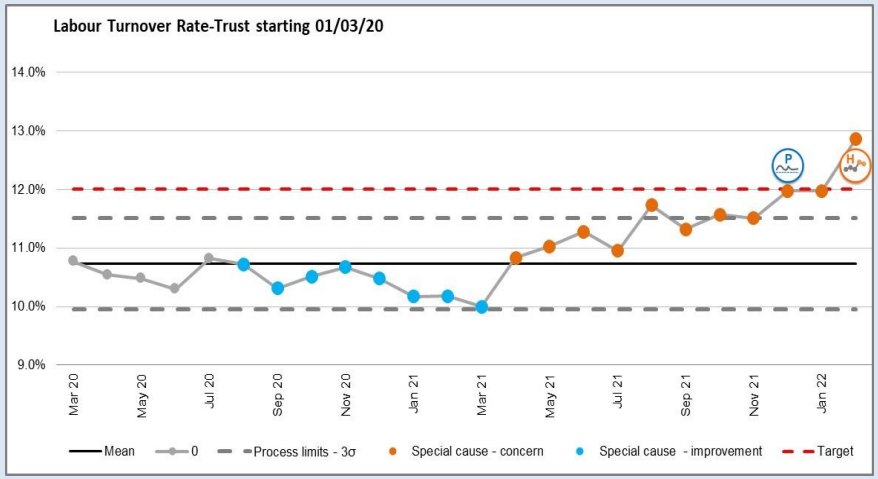
A run of 7 points above or below the mean (a shift), or a run of 7 points all consecutively ascending or descending (a trend).

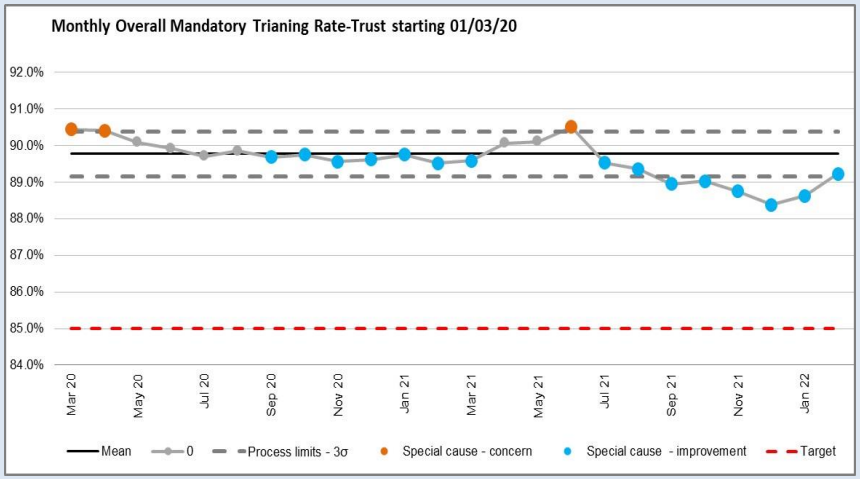
Any unusual pattern or trend within the process limits.

The number of points within the middle third of the region between the process limits is different from two thirds of the total number of points.









Comments: Sickness is showing the steady increase since August with February the highest month ever / AR shows a trend below the mean and is continuing to reduce followed by a trend above the mean but all well below target / LTR also shows two trends with the most recent the increase in turnover / overall Training compliance continues to improve and the most recent trend is below the mean average.

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

Multiple Level Training Breakdown

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Infection Control L1*	92.50%	91.75%	91.00%	90.91%	90.87%	91.62%	91.56%	91.52%	91.18%	90.84%	90.58%	90.77%
infection Control L2*	81.55%	82.15%	82.95%	84.74%	82.48%	82.71%	82.30%	82.28%	82.77%	82.00%	81.64%	82.40%
Moving & Handling L1*	90.93%	91.26%	91.17%	91.27%	90.70%	89.96%	90.61%	90.43%	89.85%	90.11	89.52%	89.69%
Moving & Handling L2*	55.59%	60.08%	63.06%	65.38%	66.45%	68.21%	68.54%	68.37%	67.07%	67.93	68.73%	69.31%
Safeguarding Adults L1	96.10%	96.30%	96.13%	96.09%	95.41%	94.60%	94.22%	94.29%	93.85%	93.55%	94.36%	94.47%
Safeguarding Adults L2	88.96%	89.50%	89.85%	89.95%	88.01%	88.33%	87.99%	87.83%	87.68%	87.07%	87.67%	88.04%
Safeguarding Adults L3	50.28%	49.29%	53.11%	57.42%	56.45%	57.26%	57.22%	59.03%	61.76%	62.90%	58.21%	58.47%
Safeguarding Adults L4	41.30%	50.00%	48.84%	59.09%	54.55%	53.49%	65.85%	63.41%	59.09%	65.91%	62.22%	62.22%
Safeguarding Adults L5	66.67%	33.33%	25.00%	25.00%	25.00%	25.00%	25.00%	75.00%	75.00%	80.00%	80.00%	80.00%
Safeguarding Adults L6	62.50%	66.67%	66.67%	66.67%	66.67%	66.67%	77.78%	77.78%	77.78%	77.78%	77.78%	77.78%
Mental Capacity Act L1	n/a	61.48%	65.92%	72.74%	75.47%	77.77%	79.69%	81.22%	81.87%	83.13%	84.44%	85.35%
Mental Capacity Act L2	n/a	47.33%	57.86%	66.58%	69.50%	73.82%	74.20%	76.76%	78.39%	79.06%	79.53%	80.52%
Mental Capacity Act L3	n/a	18.03%	22.21%	30.72%	35.84%	42.30%	44.77%	48.74%	51.91%	54.86%	56.81%	58.42%
Mental Capacity Act L4	n/a	n/a	20.00%	20.00%	20.00%	20.00%	20.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Mental Capacity Act L5	n/a	n/a	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	33.33%	33.33%	33.33%
Mental Capacity Act L6	n/a	n/a	0.00%	0.00%	0.00%	0.00%	85.71%	85.71%	85.71%	85.71%	85.71%	83.33%
Safeguarding Children L1	93.33%	93.51%	93.05%	93.53%	91.82%	91.56%	90.89%	90.98%	89.86%	89.56%	89.09%	89.38%
Safeguarding Children L2	83.23%	83.13%	82.51%	82.69%	80.53%	80.54%	80.29%	80.89%	80.87%	80.52%	80.58%	81.04%
Safeguarding Children L3	74.29%	74.73%	75.20%	72.57%	71.33%	74.04%	70.66%	73.00%	75.96%	73.60%	69.08%	69.12%
ABLS L1	96.82%	97.05%	96.94%	96.99%	96.78%	96.67%	96.61%	96.82%	96.69%	96.87%	98.18%	98.02%
ABLS L2	62.00%	66.53%	68.90%	73.41%	72.87%	74.15%	72.34%	72.87%	72.49%	70.95%	71.57%	70.17%
AILS L3	47.92%	55.14%	60.91%	66.13%	66.67%	65.61%	61.35%	63.49%	64.63%	64.85%	65.49%	61.22%
AALS L4	52.45%	54.11%	57.75%	59.44%	62.59%	34.25%	42.47%	47.22%	46.85%	52.11%	60.36%	60.00%
PBLS L2	59.85%	64.13%	66.25%	69.10%	68.56%	69.15%	69.08%	68.37%	67.96%	66.32%	65.08%	64.38%
PILS L3	17.39%	29.79%	36.23%	38.36%	46.58%	47.83%	52.86%	55.22%	38.10%	39.42%	44.30%	47.20%
PALS L4	21.57%	26.00%	22.73%	25.76%	46.15%	44.12%	41.79%	41.54%	41.79%	37.88%	35.37%	49.23%
NBLS L2	76.54%	85.80%	80.25%	84.47%	81.37%	81.13%	76.13%	67.70%	74.38%	68.75%	71.67%	69.78%

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

All the key staff groups are starting to see increased staff in post FTE based on the increased investment in clinical staffing groups. Nursing and Midwifery increasing by 52 FTE and Medical and Dental by 20 FTE since March and both these staff groups showing the biggest percentage increase. The reduction in agency costs are mainly due to an adjustment for lower than estimated agency costs; this is particularly highlighted in M&D costs which to correct previous months figures for February are £-63k.

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	2022/01	2022/02	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	524.64	522.34	-2.64	-0.50%
Health Care Scientists	94.17	95.17	93.71	93.71	93.71	94.39	92.69	92.70	93.80	92.40	91.36	92.36	-1.81	-1.92%
Medical and Dental	531.34	527.82	524.87	527.65	556.82	557.43	561.16	561.56	554.68	553.85	552.38	551.50	20.16	3.79%
NHS Infrastructure Support	1122.74	1120.22	1121.66	1126.62	1123.82	1121.33	1122.71	1124.58	1133.69	1134.71	1137.89	1147.56	24.82	2.21%
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	342.09	342.02	0.62	0.18%
Qualified Ambulance Service Staff	10.72	9.52	9.52	9.33	10.33	10.53	10.53	10.53	10.53	10.53	10.53	9.53	-1.19	-11.07%
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	1287.67	1293.75	51.81	4.17%
Support to clinical staff	1906.40	1880.31	1889.59	1902.13	1898.32	1901.54	1904.65	1899.35	1914.09	1908.06	1899.40	1897.31	-9.09	-0.48%
Grand Total	5773.68	5740.22	5751.33	5763.49	5798.91	5810.30	5842.46	5838.17	5849.93	5840.95	5845.95	5856.38	82.70	1.43%

Pay Report Summary for the last 12 months

	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB
Cost	£	£	£	£	£	£	£	£	£	£	£	£	£
Substantive	£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	£22,354,848	£22,715,706
Bank	£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	£1,090,632	£1,217,561
Agency	£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	£1,025,186	£658,009
Total Cost £	£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	£24,470,667	£24,591,276
WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	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	5,875.21	5,922.11
Bank	331.21	301.34	328.09	269.23	317.11	336.05	247.74	313.21	272.84	350.26	343.70	215.37	333.80
Agency	102.39	160.15	115.40	116.45	161.63	151.10	143.60	174.75	174.59	182.45	172.07	147.00	140.10
Total Worked WTE	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	6,237.57	6,396.02

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
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Medical And Dental	541.66	542.30	543.04	545.08	546.21	546.61	551.92	552.62	554.97	555.12	555.27
Nursing And Midwifery Registered	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	1,414.24	1,413.96
Support To Clinical Staff	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	2,035.32	2,037.44
Add Prof Scientific and Technic	431.92	431.19	434.19	435.19	436.19	436.19	445.02	445.02	446.02	446.02	460.53
Allied Health Professionals	493.43	495.28	498.80	504.60	512.00	512.00	508.88	508.41	509.58	509.78	509.78
Healthcare Scientists	99.60	99.60	100.02	102.19	103.19	103.19	104.19	103.91	104.90	104.90	104.90
Qualified Ambulance Service Staff	5.80	5.80	5.80	5.80	5.80	5.80	6.80	6.80	6.80	6.80	6.80
Administrative And Estates	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	1,193.92	1,196.97
Total Staff Budgeted WTE	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	6,266.10	6,285.64

Staff Group	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Medical And Dental	524.76	522.61	524.21	521.61	616.14	545.85	551.08	543.11	534.76	538.94	542.01
Nursing And Midwifery Registered	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	1,288.11	1,298.77
Support To Clinical Staff	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	1,913.99	1,898.81
Add Prof Scientific and Technic	406.84	406.93	410.04	411.09	424.86	413.28	418.97	403.66	413.99	414.68	416.53
Allied Health Professionals	479.38	480.14	479.20	470.70	473.80	482.36	488.14	485.86	484.17	485.77	476.60
Healthcare Scientists	99.17	100.17	98.72	98.72	99.40	98.16	97.69	99.30	97.80	96.36	96.36
Qualified Ambulance Service Staff	10.72	5.60	6.52	7.52	8.41	7.61	10.61	7.61	7.61	8.61	8.61
Administrative And Estates	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	1,146.70	1,156.45
Total Staff Worked WTE	5794.64	5774.76	5807.70	5780.96	5942.54	5881.46	5888.47	5864.67	5873.75	5893.15	5894.15

Staff Group	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Medical And Dental	16.90	19.69	18.83	23.47	-69.93	0.76	0.84	9.51	20.21	16.18	13.26
Nursing And Midwifery Registered	78.88	75.56	76.85	82.10	73.46	75.69	136.52	137.78	131.48	126.13	115.19
Support To Clinical Staff	18.99	39.32	11.49	59.32	29.07	37.17	99.48	115.43	118.03	121.33	138.62
Add Prof Scientific and Technic	25.08	24.26	24.15	24.10	11.33	22.91	26.05	41.36	32.03	31.34	44.00
Allied Health Professionals	14.05	15.14	19.61	33.90	38.21	29.64	20.74	22.55	25.41	24.01	33.18
Healthcare Scientists	0.43	-0.57	1.30	3.47	3.79	5.03	6.50	4.61	7.10	8.54	8.54
Qualified Ambulance Service Staff	-4.92	0.20	-0.72	-1.72	-2.61	-1.81	-3.81	-0.81	-0.81	-1.81	-1.81
Administrative And Estates	28.66	22.56	30.46	30.27	33.90	36.63	54.04	47.38	47.99	47.22	40.52
Total Staff Worked WTE	178.07	196.16	181.98	254.93	117.21	206.01	340.37	377.81	381.45	372.95	391.50

Vacancies: Vacancy data based on Finance Reporting from Unit 4 Agresso. The end of February total vacancy figure stands at 392 FTE with the Vacancy Factor now at 6.23% which is an increase from January. Nursing vacancies have reduced by 11 FTE over the last month.

A working group has been set up to review the vacancy data accuracy 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.

The table below shows the agency expenditure by staff Group monthly for the Financial Year 2021 – 2022 to date.
February reported number shows a significant reduction mainly due to finance adjustments to the Medical and Dental Totals.

The negative agency spend against HCA's is due to finance corrections against forecasted usage.

Torbay and South Devon NHS Foundation Trust	2021 -2022											
Total Agency Spend Financial Year 21/22 YTD	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Total**
Registered Nurses	356	348	468	584	520	599	557	676	570	432	408	5518
Scientific, Therapeutic and Technical	43	99	142	122	110	112	162	140	144	147	130	1351
of which Allied Health Professionals	31	45	63	58	65	47	65	70	80	88	86	698
of which Other Scientific, Therapeutic and Technical Staff	12	54	79	64	45	65	96	70	64	59	44	652
Support to clinical staff (HCA)	-1	-10	-3	7	-8	2	15	19	13	35	31	100
Total Non-Medical - Clinical Staff Agency	398	437	607	713	622	713	734	835	727	614	569	6969
Medical and Dental Agency	243	262	353	455	328	317	322	390	378	265	-63	3251
Consultants	213	203	281	344	178	171	212	278	245	167	11	2304
Trainee Grades	30	59	72	111	150	146	110	112	133	98	-74	947
Non Medical - Non-Clinical Staff Agency	114	128	136	116	140	162	174	148	143	146	152	1559
Total Pay Bill Agency and Contract	755	827	1096	1284	1090	1192	1231	1373	1248	1025	658	11780

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

Feb-22

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	1610	1322	0	0	1610	1899	1288	1024	0	0	966	1288	711	82.1%	0.0%	117.9%	79.5%	0.0%	133.3%
Allerton	2634	1603	0	0	966	1513	1288	930	0	0	966	1231	791	60.9%	0.0%	156.7%	72.2%	0.0%	127.4%
Cheetham Hill	1288	1840	322	0	1932	1973	966	885	322	0	1288	1990	777	142.9%	0.0%	102.1%	91.6%	0.0%	154.5%
Coronary Care	1288	1303	0	0	0	0	966	966	0	0	0	0	366	101.2%	0.0%	0.0%	99.9%	0.0%	0.0%
Cromie	1518	1219	0	0	805	926	966	909	0	0	644	674	559	80.3%	0.0%	115.0%	94.0%	0.0%	104.7%
Dunlop	1288	1231	0	0	1127	1183	966	748	0	0	966	1024	613	95.5%	0.0%	104.9%	77.4%	0.0%	106.0%
Forrest - Summer Escalation	1610	1235	644	0	1288	1250	1610	1185	644	0	1288	1010	686	76.7%	0.0%	97.1%	73.6%	0.0%	78.4%
EAU4	1610	1148	0	0	1288	1097	1610	1162	0	0	1288	1076	661	71.3%	0.0%	85.1%	72.1%	0.0%	83.5%
Ella Rowcroft	966	940	0	0	1288	775	920	667	0	0	644	609	344	97.3%	0.0%	60.1%	72.5%	0.0%	94.6%
Warrington	966	988	0	0	644	736	644	644	0	0	644	713	458	102.3%	0.0%	114.2%	100.0%	0.0%	110.7%
George Earle	1288	1527	322	0	1932	1575	966	908	0	0	1288	1748	744	118.5%	0.0%	81.5%	94.0%	0.0%	135.7%
ICU	3220	2271	0	0	0	321	2898	2082	0	0	0	35	156	70.5%	0.0%	0.0%	71.8%	0.0%	0.0%
Escalation (McCullum)	644	629	0	0	644	782	644	529	0	0	644	955	404	97.6%	0.0%	121.4%	82.1%	0.0%	148.2%
Louisa Cary	1932	1442	0	0	644	1069	1932	1219	0	0	644	713	367	74.6%	0.0%	166.0%	63.1%	0.0%	110.7%
John Macpherson	966	829	0	0	506	535	644	621	0	0	644	644	247	85.8%	0.0%	105.7%	96.4%	0.0%	100.0%
Midgley	1610	1532	0	0	1610	1499	1610	1037	0	0	1288	1174	778	95.1%	0.0%	93.1%	64.4%	0.0%	91.1%
SCBU	966	710	0	0	322	133	966	679	0	0	322	196	121	73.5%	0.0%	41.3%	70.2%	0.0%	60.7%
Simpson	1288	1615	322	0	1610	1872	966	845	0	0	966	1543	738	125.4%	0.0%	116.2%	87.5%	0.0%	159.7%
Turner	966	1037	0	0	1610	1555	644	679	0	0	1288	955	474	107.3%	0.0%	96.6%	105.4%	0.0%	74.1%
Total (Acute)	*27658*	*24419*	*1610*	*0*	*19826*	*20691*	*22494*	*17715*	*966*	*0*	*15778*	*17573*	*9995*	88.3%	0.0%	104.4%	78.8%	0.0%	111.4%
Brixham	784	833	392	0	1176	1346	924	640	0	0	616	784	533	106.3%	0.0%	114.5%	69.3%	0.0%	127.2%
Dawlish	784	744	0	0	980	1001	672	605	0	0	616	673	431	94.8%	0.0%	102.1%	90.0%	0.0%	109.3%
NA - Teign Ward	1764	1374	0	0	1764	1662	924	682	0	0	924	1100	832	77.9%	0.0%	94.2%	73.8%	0.0%	119.0%
NA - Templar Ward	1568	1290	0	0	1988	1745	924	715	0	0	1008	1177	832	82.2%	0.0%	87.8%	77.4%	0.0%	116.8%
Totnes	784	783	0	0	1176	1053	672	605	0	0	616	595	499	99.9%	0.0%	89.6%	90.0%	0.0%	96.6%
Organisational Summary	33342	29442	2002	0	26910	27498	26610	20962	966	0	19558	21901	13122	88.3%	0.0%	102.2%	78.8%	0.0%	112.0%

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
	7.40	4.06	0.20	3.14	7.61	3.84	0.00	3.76
Total Planned Beds / Day	528							
Days in month	28							

- The Registered Nurse (RN) average fill rate for day has increased in Feb22 to 88.3%% from 86.8% in Jan 22 and the night fill rate has increased to 78.8% in Feb 21 from 77.8% in Jan 21. This slight improvement in fill rate is multifactorial and includes increased temporary staffing fill and a slight reduction in Registered Nurse Vacancies (11WTE increase).
- The Health Care Support Worker (HCSW) average fill rate for day was 102.2% and night was recorded as 112.0% which is an increase for nights from 110.9% in January to provide additional support where the fill rate for RN's is below 80% and to provide supportive observation

Areas to note in February 2021	Driver	Mitigations
Forrest & EAU 4	Escalation beds open and staff reassigned to support .	Forrest backfilled with HCSW. EAU4 fill rate dependant upon bed occupancy.
Cheetham Hill , George Earl and Simpson	All areas slightly above planned hours due to supportive observation requirements reflecting the long waits for some patients for specialist EMI beds.	Increased fill rate for HCSW at night provided by temporary staffing to enable 1:1 care.

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

CHPPD Monthly Summary

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	7.80	3.30	0.00	4.50	11	23	0	0	39.3%	82.1%	0.0%	0.0%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	6.70	3.20	0.00	3.50	22	28	0	1	78.6%	100.0%	0.0%	3.6%	7.74	4.74	0	2.91
Cheetham Hill	7.39	2.88	0.41	4.11	8.60	3.50	0.00	5.10	0	0	28	1	0.0%	14.3%	100.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.20	6.20	0.00	0.00	3	3	0	0	10.7%	10.7%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.53	3.54	0.00	1.99	6.70	3.80	0.00	2.90	6	10	0	2	21.4%	35.7%	0.0%	7.1%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.80	3.20	0.00	3.60	12	19	0	4	42.9%	67.9%	0.0%	14.3%	7.74	4.74	0	2.91
Forrest - Summer Escalation	10.12	4.60	1.84	3.68	6.80	3.50	0.00	3.30	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	6.80	3.50	0.00	3.30	27	27	0	21	96.4%	96.4%	0.0%	75.0%	7.74	4.74	0	2.91
Ella Rowcroft	6.57	3.29	0.00	3.29	8.70	4.70	0.00	4.00	1	1	0	4	3.6%	3.6%	0.0%	14.3%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	6.70	3.60	0.00	3.20	1	4	0	3	3.6%	14.3%	0.0%	10.7%	7.74	4.74	0	2.91
George Earle	7.39	2.88	0.41	4.11	7.70	3.30	0.00	4.50	10	5	28	9	35.7%	17.9%	100.0%	32.1%	7.74	4.74	0	2.91
ICU	24.28	24.28	0.00	0.00	30.20	27.90	0.00	2.30	2	6	0	0	7.1%	21.4%	0.0%	0.0%	7.74	4.74	0	2.91
Escalation (McCullum)	6.13	3.07	0.00	3.07	7.20	2.90	0.00	4.30	4	12	0	2	14.3%	42.9%	0.0%	7.1%	7.74	4.74	0	2.91
Louisa Cary	7.36	5.52	0.00	1.84	12.10	7.30	0.00	4.90	0	2	0	0	0.0%	7.1%	0.0%	0.0%	7.74	4.74	0	2.91
John Macpherson	5.18	2.88	0.00	2.30	10.60	5.90	0.00	4.80	1	0	0	1	3.6%	0.0%	0.0%	3.6%	7.74	4.74	0	2.91
Midgley	7.53	3.97	0.00	3.57	6.70	3.30	0.00	3.40	25	26	0	18	89.3%	92.9%	0.0%	64.3%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	14.20	11.50	0.00	2.70	2	2	0	7	7.1%	7.1%	0.0%	25.0%	7.74	4.74	0	2.91
Simpson	6.57	2.88	0.41	3.29	8.00	3.30	0.00	4.60	0	4	28	0	0.0%	14.3%	100.0%	0.0%	7.74	4.74	0	2.91
Turner	10.73	3.83	0.00	6.90	8.90	3.60	0.00	5.30	26	15	0	26	92.9%	53.6%	0.0%	92.9%	7.74	4.74	0	2.91
Brixham	6.95	3.05	0.70	3.20	6.80	2.80	0.00	4.00	17	22	28	1	60.7%	78.6%	100.0%	3.6%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	7.00	3.10	0.00	3.90	12	16	0	11	42.9%	57.1%	0.0%	39.3%	7.74	4.74	0	2.91
NA - Teign Ward	6.40	3.20	0.00	3.20	5.80	2.50	0.00	3.30	23	28	0	11	82.1%	100.0%	0.0%	39.3%	7.74	4.74	0	2.91
NA - Templar Ward	6.50	2.97	0.00	3.53	5.90	2.40	0.00	3.50	23	26	0	10	82.1%	92.9%	0.0%	35.7%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	6.10	2.80	0.00	3.30	20	19	0	18	71.4%	67.9%	0.0%	64.3%	7.74	4.74	0	2.91

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
	7.40	4.06	0.20	3.14	7.61	3.84	0.00	3.76
Total Planned Beds / Day	528							
Days in month	28							

- The overall planned CHPPD has reduced slightly in the month of Feb 22, but this is due to an amended bed position for McCullum (reflects medical beds only)
- The RN CHPPD for TSD has increased to 3.84 in Feb 22 from 3.66 in Jan 22 which remains below the Carter recommendation of 4.7.
- The HCA CHPPD is at 3.75 which is above the Carter recommendation of 2.91.
- During February the operational position improved although 27 days were declared at OPEL 3 and 1 day at OPEL 4. The Trust has continued to use escalation beds, hence the total actual number of care hours per patient day of 7.61 being slightly above the total planned of 7.40 in order to maintain patient safety.

Areas of concerns	Driver	Mitigations
Forrest	High number of RN vacancies	Supported with increased HCSW staffing
EAU4	Escalation area with no substantive workforce – high level of staff sickness with CV19	Twice daily staffing meetings to support escalation and reassignment of staff. Ward Manager working clinically to support team

Community and Social Care Indicators

Key							
↑ = Performance improved from previous month ↓ = Performance deteriorated from previous month ↔ = No change							
	Not achieved		Under-achieved		Achieved		No target set		Data not available

Carers Assessments Completed year to date		↔
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)		
Safeguarding Adults - % of high risk concerns where immediate action was taken		↔
DOLS - Deprivation of Liberty Standard		
Intermediate Care - No. urgent referrals		
Community Hospital - Admissions (non-stroke)		
Proportion of clients receiving self-directed support (ASCOF)		↔
Proportion of carers receiving self-directed support (ASCOF)		↔
Percentage of Adults with learning disabilities in employment (ASCOF)		↔
Percentage of adults with learning disabilities in settled accommodation (ASCOF)		↑
Permanent admissions (18-64) to care homes per 100k population (ASCOF)		↑
Permanent admissions (65+) to care homes per 100k population (ASCOF)		↑
Proportion of clients receiving direct payments (ASCOF)		↔

Front End Service (FES) and Complex Care Service (CCS) have seen high volumes of work resulting in increasing waiting lists. Increased pressure on workforce, reducing waiting list productivity, is due to covid related sickness and outstanding vacancies. Both FES and CCS are improving their case closure rates, reducing inactive within cases and cases open for 180 days. The increase in activity is a result of productivity reporting developed over the previous two months and reported directly through the refreshed assurance and governance route giving greater detail and understanding of individual and team performances. Recruitment plans are in place and being implemented, regular flow meetings in place to focus on inactive and cases held open for over 180 days. Measures are being implemented to address outstanding reviews including flagging at the point of case allocation which reviews are outstanding, which ultimately supports TSDFT meeting Care Act statutory responsibilities for reviews.

Approved by TSDFT FDG and Joanna Williams (Torbay Council's Director of Adult Social Services) were the inflationary uplifts for 2022/23. Inflationary uplifts for 2022/23 cannot rectify disparity in the market or address financial issues which are linked to the requirements to review/implement financial models or organic changes in how services are delivered. Developing the inflation proposal has come from partnership working with senior Torbay Council Commissioning staff. In addition to this, elements of inflationary uplift and pressures have been reflected in the ASC medium plan which has been discussed at senior levels across the Trust, Torbay Council and Devon CCG.

Fair Cost of Care (FCC) implementation, designed to ensure local authorities can prepare their markets for reform and move towards paying providers a fair cost of care as appropriate to local circumstances, is underway. It will complete a Cost of Care exercise from a broad market sample, understand the impact of reform on local markets through data on operational costs and quantity of self-funders, and improve commissioning oversight and market management to ensure the care sector is positioned to deliver reform and ambitions.

Adult Social Care Improvement Plan (ASCiP) will continue its work planning for the 2022/23 Cost Improvement Plan Savings. Current savings are £2.2M FYE in part as a result of adopting a strength-based approach to the reassessments in accordance with the Care Act 2014 outcome focused approach to social care. The second stage of transformation for 2022/23 will be prioritised alongside the initial stages of the central government requirements for social care charging reform (Care Accounts).

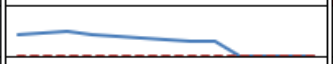
Social Care and Public Health performance metrics - Torbay

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 28 February 2022

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 / 1600). 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	19.0	A low outturn signifies better performance. Not meeting target (14 admissions compared to target of 10)
Permanent admissions (65+) to care homes per 100k population (BCF) (rolling 12 month)	450.0	450.0	476.5	A low outturn signifies better performance. Not meeting target (177 admissions compared to target of 167)
Outcome of short term support - % reablement episodes not followed by long term SC support	83%	83%	..	Data currently unavailable following changes to paris IC referral. 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%	6.6%	Not meeting target (32 / 483).
% Adults with learning disabilities in settled accommodation	80%	80%	81.8%	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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Year to date 2021/22
PUBLIC HEALTH SERVICES																
% of face to face new birth visits within 14 days *	95.0%		80.2%	91.9%	92.5%	86.6%	80.4%	74.4%	81.0%	72.9%	83.8%	82.1%	80.2%	78.8%	84.4%	81.3%
Children with a child protection plan *			207	223	234	213	201	171	165	147	147					147
4 week smoking quitters (Quarterly) **	200			334			117			291						291
Opiate users - % successful completions of treatment (Quarterly) **	Var			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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Year to date 2021/22
COMMUNITY BASED SERVICES																
Nursing activity (F2F)			7,031	8,064	7,591	7,417	7,747	7,594	7,038	7,630	7,437	7,187	7,158	6,601	6,274	79,674
Therapy activity	65,415		3,016	3,593	3,764	3,339	3,492	3,241	4,059	4,257	3,983	3,323	2,732	2,786	2,582	37,558
No. intermediate care urgent referrals	0		146	155	165	155	129	158	191	238	221	237	219	188		1,901
No. intermediate care placements			14	42	39	39	39	41	46	30	35	30	46	38		383
Intermediate Care - placement average LoS			34.1	21.0	27.6	17.8	25.6	28.3	23.9	29.7	23.6	26.1	28.8	31.0		26.3

The Community Hospital Dashboard should be reviewed in the context of the significant changes in services and service demand from the COVID-19 response. 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 - January-22

	Act. 20/21 Outturn	Nov-21	Dec-21	Jan-22	Total
Admissions / Discharges					
Total Admissions (General)	2,677	174	181	178	2,127
Direct Admissions (General)	186	13	22	11	139
Transfer Admissions (General)	2,491	161	159	167	1,988
Stroke Admissions	220	11	24	12	193
Transfers from CH to DGH	179	14	10	14	219
Beds					
Bed Occupancy [1]	84.5%	98.9%	96.6%	96.7%	97.3%
Bed Days Lost to Bed Closure	244	131	90	15	275
Length of Stay					
Delayed Discharges		0	0	0	230
Average Length of Stay - Overall (General)	10.4	14.6	15.1	15.9	13.3
Average Length of Stay - Direct Admissions	8	10.3	10.4	15.1	11.1
Average Length of Stay - Transfer Admissions	10.5	14.9	15.5	15.9	13.4
Average Length of Stay - Stroke	14.4	25.6	23.9	24.3	21.1
Long LoS (>30 days)	246	17	29	29	178
MIUs					
Total MIU Activity	22,487	2,592	2,442	2,465	29,566
New MIU Attendances	20,310	2,315	2,152	2,195	26,833
All Follow Up Attendances	2,177	277	290	270	2,733
Planned Follow Up Attendances	1,650	200	227	201	1,981
Unplanned Follow Up Attendances	527	77	63	69	752
MIU Four Hour Breaches	1	0	0	0	13
Average Waiting Time (Mins) - 95th Pctile	43	86	186	79	73

Community Hospitals

Due to available resources it is not possible to produce the Community Hospital Dashboard for February.

Operational update:

Community Hospital bed occupancy remains high with a number of patients requiring intentional rounding (hourly and 2-hourly patient checks), and high risk fall patients.

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 2,195 attendances in February with 4 four-hour breaches

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

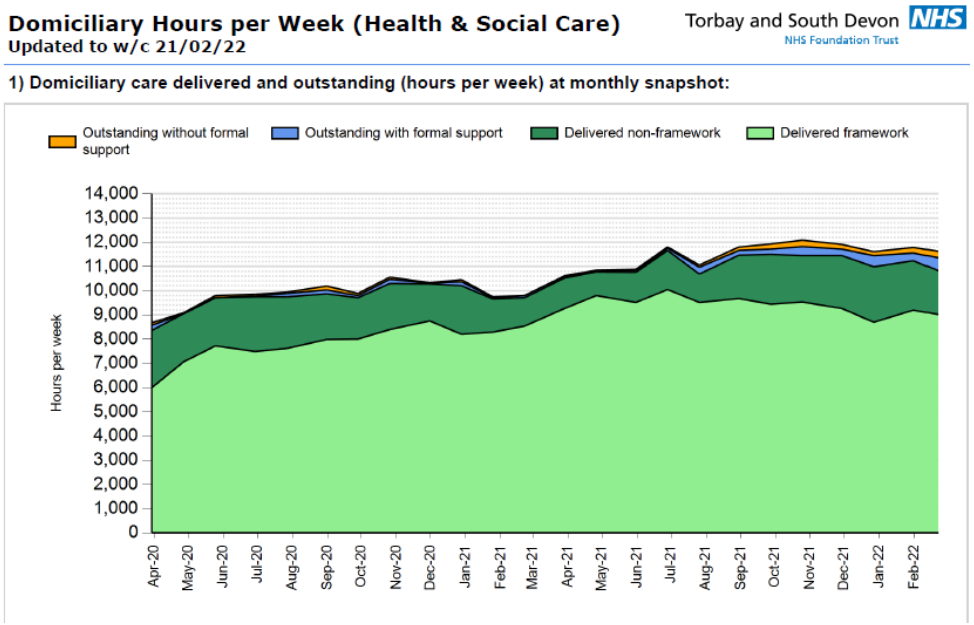


Chart 2 -Unmet packages of care

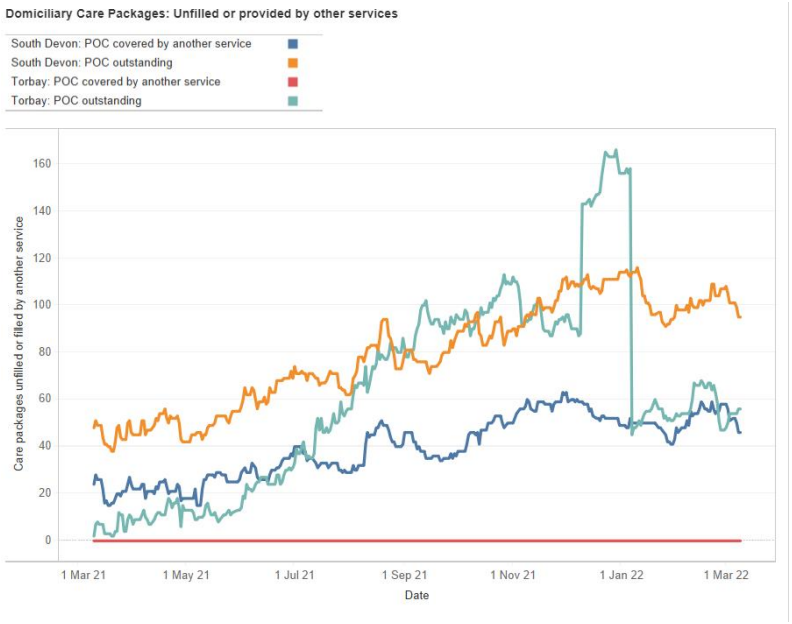


Chart 1 – 'Hours of care given' shows the latest data available for total commissioned domiciliary hours by week for Torbay. The amount of care provided is seen along with the unmet/outstanding demand. The outstanding hours without formal support are of highest concern. As at 14 March 2022 there were 47 clients (334 hours) identified as outstanding without formal support in Torbay.

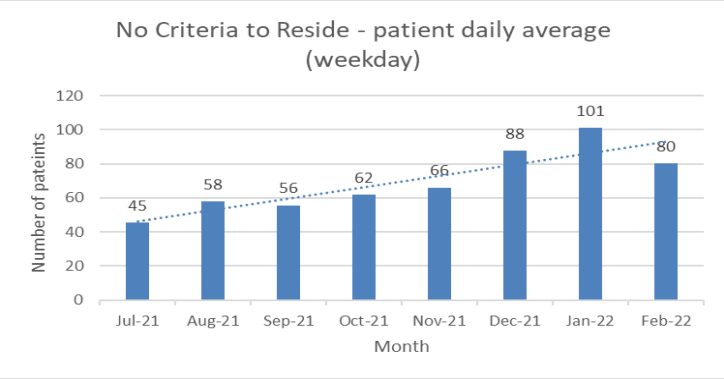
Chart 2- "Unmet packages of care" shows the number of unmet packages of care for South Devon (orange) and Torbay (Green) and where provided by diverting other NHS community provision (Blue). The Torbay data has been reviewed in January with identification of adjustments to more accurately reflect unmet packages of care.

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.

Community Services – hospital discharge and onward care

Criteria To Reside

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

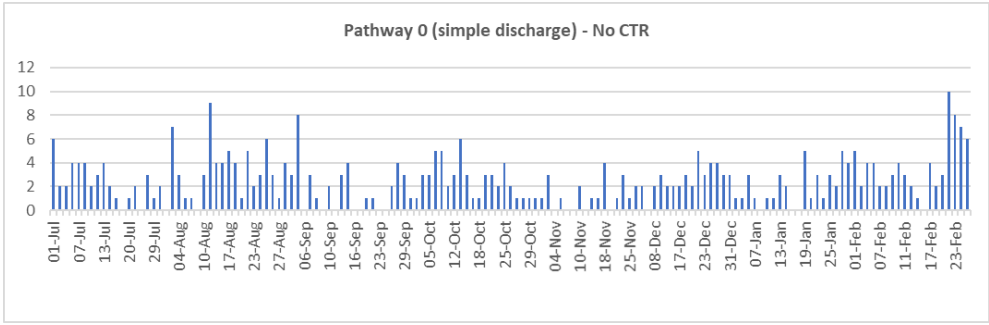


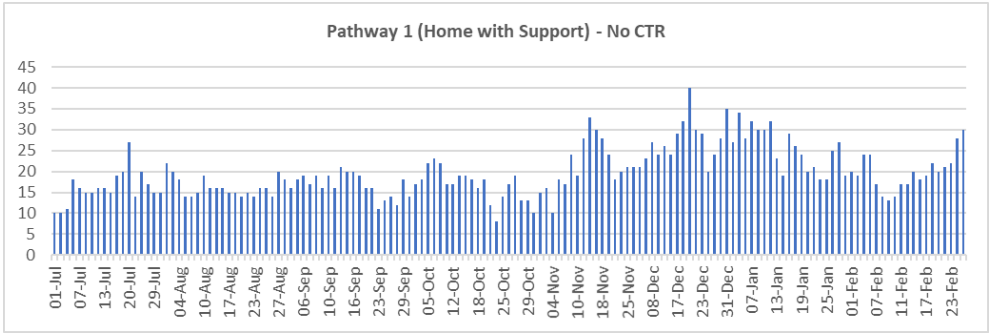
The average number of patients with no criteria to reside decreased in February. The number of delayed discharges continues to be impacted by capacity in the domiciliary care and independent sector.

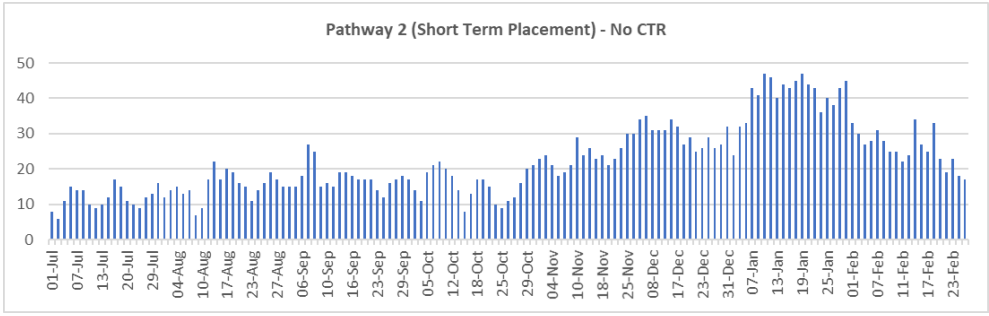
The graphs opposite show the split of patient per day by discharge pathway (taken as a snapshot) with No Criteria to Reside reported.

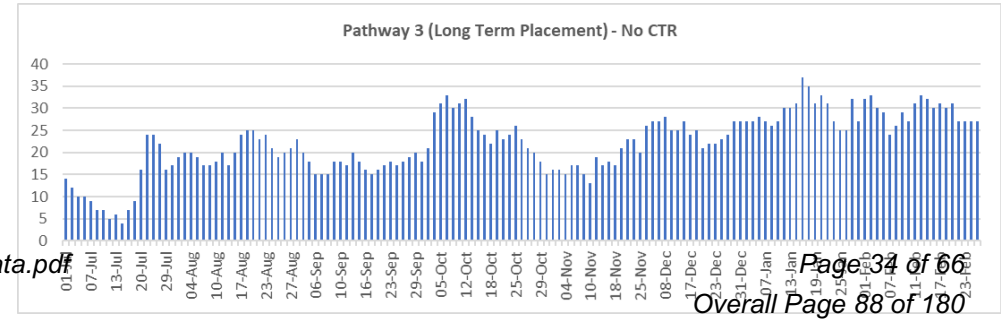
The graphs reflect a reduction in the number of patients waiting for a short-term placement, however, delays for long-term placement and home with support continue to be above historical levels.

All patients requiring a complex discharge are managed and reviewed through the Discharge Hub and are reviewed on a daily basis









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 – Page 1

Operational performance summary: Chief Operating Officer

Covid: Throughout February, the Trust continued to care for a number of patients with covid averaging 21 daily in hospital; the number of patients requiring intensive care however remained low reflecting reduced morbidity of covid infection. Staff sickness from the surge in covid infections has been felt. The workforce escalation plan to divert non-urgent clinical capacity and incentives to contribute to additional shifts to support hospital teams remains in place. March has seen an increase in covid admissions with two acute covid wards and one community site now supporting covid patients.

Recovery Planning: Recovery planning continues to look at stepping up elective care and reducing waiting times for patients. The two key elements for this plan are the return of the Day Surgery Unit and increased elective beds to allow the commencement of routine inpatient operating, both now scheduled to commence end of April. The System Capacity and Recovery Group continues to oversee this work and ensure rapid delivery of the required capacity.

Urgent Care: Urgent and emergency services continued to be challenged throughout February although OPEL 4 was only declared once with all other days at OPEL 3 level of escalation. High bed occupancy continued to affect delays to ambulance handover, extended waits in ED and assessment areas, and patients bedded in ED and assessment areas overnight.
364 people spent 12-hours or more in the Emergency Department this being a big improvement from January 806; ambulance handover delays remain high with 438 patients experiencing a delay of over an hour once arriving to the Emergency Department. It is noted however that the impact of surging Covid cases and sickness have seen increased levels of escalation in March leading to the declaring of significant internal incident escalation status and the reestablishment of the Incident Coordination Centre (ICC) daily meetings.

People waiting for care: The number of patients waiting over 18-weeks, 52-weeks, and 104-weeks for treatment continues to increase in February. The forecast for end of March is to have 250 patients waiting over 104 weeks. Plans to re-open the Day Surgery Unit and restart routine elective orthopaedic inpatient surgery are now advancing with a commencement data of 25th April. On this basis, an increased number of long-wait patients will be treated and with the addition of insourcing capacity funded through Elective Recovery Fund (TBC) achieving close to the national planning objective of having no 104-week waits by 30th June is possible if covid demand subsides.
Capacity within the private sector remains important in supporting delivery of routine elective care along with continued 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 procedures is commencing on 25th March with 24 patients per month from TSDFT due to be treated.
The Trust is engaged with the ICS system Waiting Well programme. Through this work non-clinical validation of long wait patients (longer than 52 weeks) is being supported by the Devon Referrals Support Service contacting some of our longest waiting patients to give assurance and direct to wellbeing and lifestyle support. This Waiting Well project is also developing information links through various forms of media for patients to give further advice on waiting times and wider support.

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 continues to impact on the delivery of the cancer performance standards. Of the 10 cancer performance indicators within the IPR dashboard, 7 are showing an improved position from January. Improvements in dermatology 2-week-wait time have been seen in recent weeks reducing from 5 weeks to 2 weeks from referral. In support of urology diagnostic backlog a mobile unit, arranged through the Cancer Network has been utilised in January to support clearance of backlog for urology prostate biopsies and cystoscopies although these backlogs are now increasing again.

Improvement against the 62-day Referral To Treatment standard (85%) remains a key challenge with 52% meeting the 62-day standard in February. This resulted in 51 patients receiving treatment greater than 62-days from referral with 17 in urology, 9 skin, 4 lung, and 8 lower GI pathway. A return of Day Surgery Unit capacity will be a significant factor in allowing teams to target the backlog of surgical treatment and invasive diagnostic tests to improve the overall 62-day performance.

Diagnostic waiting times: MRI, CT**,** Endoscopy, CT, and cardiology MRI remain challenged with a number of patients waiting over 6 weeks for diagnostic tests. The use of a mobile scanner, insourcing at weekends, and the use of the Nightingale Hospital facilities will continue to be critical to supporting capacity over the coming months.

Patients in hospital: In February, the number of 7-day and 21-day length of stay patients has remained significantly higher than normal levels.
The increased length of stay is in part a result of the number of patients who are medically fit with no 'criteria to reside' who require ongoing support and care in community settings. In February there was a reduction in the average number of patients per day recorded as having no criteria to reside from 101 in January to 80. The retention and recruitment of staff remains a significant challenge for independent sector providers providing nursing residential and domestic care packages of care. It is also 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.

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 continue to be below desired levels.

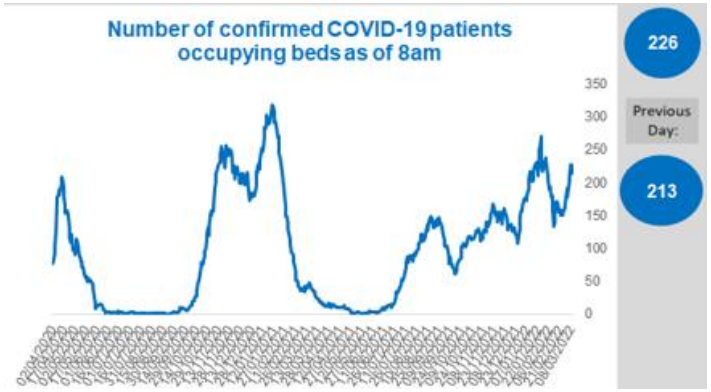
Operational Performance Indicators

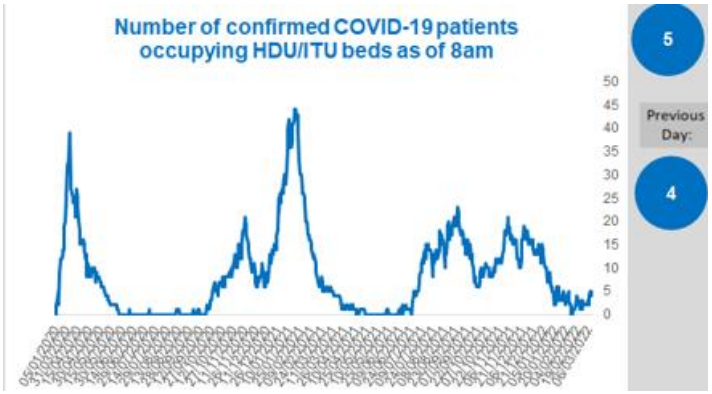
Key									
↑ = Performance improved from previous month ↓ = performance deteriorated from previous month ↔ = no change									
	Not achieved		Under-achieved		Achieved		No target set		Data not available		NHSI Indicator

A&E - patients seen within 4 hours (NHSI)		↓
Referral to treatment - % Incomplete pathways <18 wks (NHSI)		↔
Cancer - 62-day wait for first treatment - 2ww referral (NHSI)		↑
Diagnostic tests longer than the 6 week standard (NHSI)		↑
Dementia Find (NHSI)		↓
Number of Clostridium Difficile cases reported		
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 - 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		↓
Cancer – 62-day wait for first treatment – screening		↑
Cancer - Patient waiting longer than 104 days from 2 week wait		↓

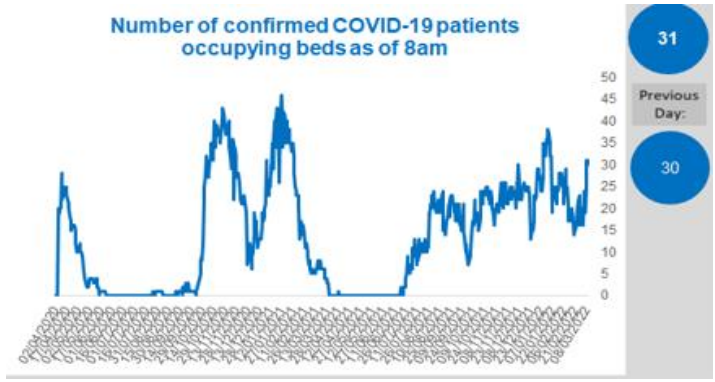
On the day cancellations for elective operations		↑
Cancelled patients not treated within 28 days of cancellation		↓
Outpatient virtual (Non-face-to-face) appointments		↑
Bed Occupancy (Acute)		↓
No Criteria to Reside - daily average - weekday (ICO)		
Number of patients >7 days LoS (daily average)		↑
Number of extended stay patients >21 days (daily average)		↑
Ambulance handover delays > 30 minutes		↑
Ambulance handover delays > 60 minutes		↑
A&E - patients recorded as greater than 60 min corridor care		↔
A&E - patients with >12 hour visit time pathway		↑
A+E Trolley waits> 12 hours from decision to admit		↑
Care Planning Summaries % completed within 24 hours of discharge – Weekend		↑
Care Planning Summaries % completed within 24 hours of discharge – Weekday		↑
Clinic letters timeliness - % specialties within 4 working days		↓

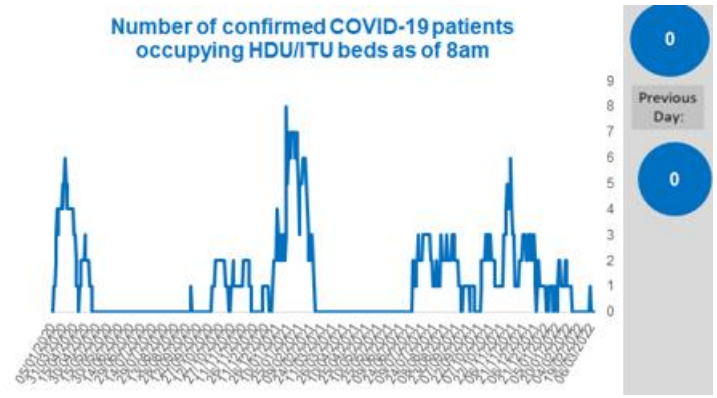
Devon ICS
(as at 13 March 2022)





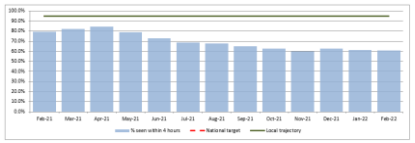
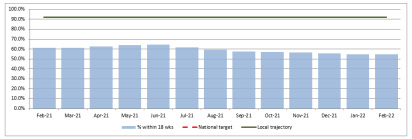
Torbay and South Devon NHS FT
(as at 13 March 2022)





Throughout February the Trust continued to experience a number of covid admissions and infections across the hospital requiring further escalation beyond the single dedicated covid ward averaging 21 daily in hospital; the number of patients requiring intensive care, however, remained low. The impact on staff sickness from the Omicron surge in infections has been felt however the workforce escalation plan to divert non-urgent clinical capacity and incentives to contribute to additional shifts to support hospital teams has helped to mitigate the overall impact. The Incident Control Centre (ICC) and drumbeat of daily meetings to oversee the escalation planning and incident response has been effective. Linked to the general easing of covid restrictions a surge of infections has been seen in March resulting in increased numbers of patient in hospital with covid, increased staff absence and increased nosocomial transmission within care sector settings.

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Patients seen within 4 hours in A&E	Performance M11	The Emergency Department remains challenged with access to inpatient beds continuing to contribute to ambulance handover delays. Ambulance handover delays have decreased but remain high. 364 patients experienced and 123 trolley waits of more than 12-hours from decision to admit. Across the wider system there continues to be capacity and workforce challenges to maintain the flow of patients out of hospital.	To improve access to beds the scaling back of elective inpatient programme and re-purposing of the Day Surgery Unit has continued. Additional escalation beds opened in January have been fully utilised. Work to relocate the Medical Receiving Unit is progressing at pace to allow the handing back of elective beds and Day Surgery Unit. Work continues with system partners to support capacity to target admissions avoidance and reduce delays to discharge patients medically fit.	
	60.6%			
	Performance M10			
	61.1%			
	Target			
	95%			
	Risk level			
	HIGH			
Patients waiting longer that 18 weeks from Referral to Treatment	Performance M11	The total number of people waiting for treatment has increased by 1,338 from last month. 649 patients are waiting longer that 78 weeks and 215 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. Plans are in train to open DSU and ring fence 11 Ella beds at the end of April 2022. The use of Mount Stuart Hospital facilities has paused for any further new patients and Endoscopy will cease at the end of March 2022. Use of the Nightingale for T&O will start on the 21st March 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 restoration of services and for 2022/23 Business planning. Insourcing continues at weekends in ophthalmology and endoscopy. Additional insourcing weekends are being scheduled using Elective Recovery Fund funding.	
	54.7%			
	Performance M10			
	54.7%			
	Target			
	92%			
	Risk level			
	HIGH			

Activity variance vs 2019/20 baseline	M10	M11
Op new	-18.8%	-6.9%
OP Follow up	-22.3%	-15.0%
Day Case	-22.3%	-14.7%
Inpatient	-47.5%	-37.6%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Cancer 62 day wait for 1st treatment from 2-week wait referral	**Performance M11** **51.9%** **Performance M10** **49.1%** **Target** 85% **Risk level** HIGH	Performance against the 62-day referral to treatment standard remains below target. Improvements in dermatology 2-week-wait time have been seen in recent weeks reducing from 5 weeks to just over 2 weeks from referral and in support of urology diagnostic backlog a mobile unit arranged through the Cancer Network has been utilised in January. Cancer pathways continue to be prioritised for admission, however, the ongoing escalation to manage covid-19 is seeing increasing waits for priority cancer pathway patients requiring access to theatre and recovery beds.	To support the reduction in surgical wait times the plans to reinstate elective day case capacity through the Day Surgery Unit and protected inpatients beds remain on track for 25th April 2022. This work is led by the COO. Radiotherapy and medical oncology has continued to maintain timely access for treatment from diagnosis and treatment although a change in location of the Day Unit has impacted on capacity in January. The COO is also leading the process to sign off and review recovery plans through the Cancer Clinical Cabinet.	
Diagnostic tests longer than 6 weeks	**Performance M11** **38.4%** **Performance M10** **41.3%** **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.	The use of insourcing and mobile scanner units continue to support in-house capacity. Radiology (MRI) are using capacity at the Nightingale Hospital Exeter; currently 2-days a week, 160 patients per month). Insourcing for weekend endoscopy list (3 weekends per month) funded through ERF have continued. Pro-active 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 M11	Performance against the Dementia Find assessment standard has deteriorated in February. 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.	
	89.7%			
	Performance M10			
	94.8%			
	Target			
	90%			
	Risk level			
	LOW			

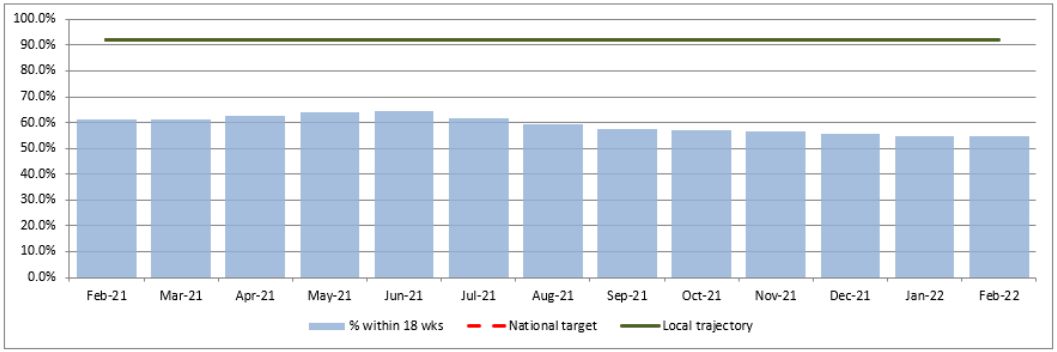
NHSI Performance – Referral to Treatment (RTT)

Services with greater than 100 patients waiting over 18 weeks

February 2022 Incomplete 92% Table - National Specialty

	>126		Grand Total
Row Labels	Incomplete IPDC	Incomplete OP	
Clinical Neuro-Physiology		108	183
Rheumatology	15	96	352
Pain Management	49	185	425
(blank)		292	539
Endocrinology		300	602
Colorectal Surgery	143	355	990
Neurology	13	536	998
Gynaecology	300	251	2128
Respiratory Medicine		591	1413
Gastroenterology	308	334	2030
Paediatrics	9	854	1923
Dermatology	1	964	2138
Upper Gastrointestinal Surgery	458	541	1616
Oral Surgery	417	758	2484
Cardiology	72	1187	2672
ENT	211	1076	2676
Urology	363	1197	2708
Trauma & Orthopaedics	1372	376	3340
Ophthalmology	326	1497	4248
Grand Total	4134	11923	35468

Referral to Treatment – incomplete pathways



Referral to Treatment: RTT performance in February continues to plateau with the proportion of people waiting less than 18 weeks at 54.7%; 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 35,468 from 34,130, an increase of 1,338 from the February position.

52 week waits: For February, 2,759 people will be reported as waiting over 52-weeks and is an increase from 2,509. Overall long waits are increasing, with patients waiting longer than 78-weeks having increased slightly to 649 in February from 587, 104 weeks waits continuing to increase to 215 from 183 in January. 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, however, where possible teams are dating P3 and P4 patients to maximise list efficiency so long as there are no P2 patients to date.

Recovery planning: Works are under way to re-open DSU in April 2022, to enable this MRU is moving to L2 Outpatients – to enable this, services have had to vacate L2, this has resulted in disruption to some services. The CCG have paused the sending of long-wait patients to Mount Stuart Hospital for T&O, UPGI, urology, colorectal and gynae. Extended the delay to recommencing this outsourcing will push waits out for routine patients, Mount Stuart Hospital has also given notice to cease Endoscopy and Bower Cancer Screening Programme from the end of March 2022. To mitigate the loss of Endoscopy at MSH plans are being worked up for a mobile van sited at the Annex. T&O are due to start operating at the recommissioned Nightingale Hospital Exeter W/C 21.03.2022. Further insourcing and outsourcing capacity is being sought through the Elective Recovery Fund (ERF) two insourcing companies have had site visits to discuss the to use theatres on site at weekends for urology, upper GI, and dermatology as well as looking at options to bolster overall anaesthetic provision. Cataract operations have commenced at Optimax, further lists are being schedules

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 we will have 250 104-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).

The table below shows the specialties with the highest backlog for follow-up appointments greater than 6 weeks. February has seen increases in the greater than 12 to 18-week and greater than 18-weeks categories (the 6 to 12-weeks saw a reduction).

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 31.01.2022		
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	852	1228	5476
Rheumatology	196	296	1283
Ear Nose Throat	177	323	880
Paediatrics	224	259	686
Neurology	97	214	730
Orthoptist	177	197	448
Urology	37	50	308
Gynaecology	59	64	187
Respiratory Medicine (Chest)	252	96	250
Orthodontics	52	46	238
Colorectal Surgery	33	58	373
Orthopaedics	85	94	98
Dermatology	152	265	386
Geriatric Medicine	85	57	109
Cardiac Testing	8	6	21
Gastro-Enterology	154	185	217
Breast Surgery	39	22	278
Cardiology	164	150	98
Pain Management	37	51	72
Oral Surgery	104	109	104
Plastic Surgery	28	46	66
Diabetic	57	91	44
Upper Gastrointestinal Surg	69	45	99
Respiratory Technician	42	54	129
Endocrinology	32	42	41
Grand Total	3272	4095	12662

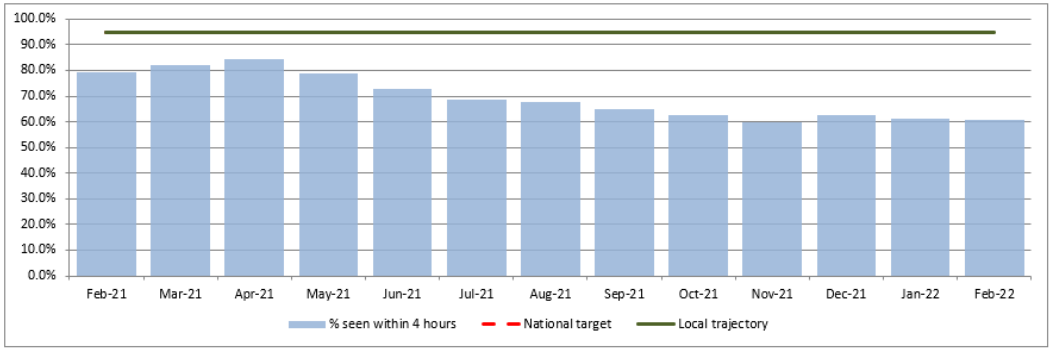
Specialtities with highest Follow-Up Backlog	Passed TBS as at 28.02.2022		
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	821	1306	5546
Rheumatology	218	298	1310
Ear Nose Throat	185	293	942
Paediatrics	171	276	645
Neurology	142	171	806
Orthoptist	191	228	480
Urology	38	58	301
Gynaecology	55	63	185
Respiratory Medicine (Chest)	171	249	273
Orthodontics	30	46	240
Colorectal Surgery	31	52	385
Orthopaedics	49	131	114
Dermatology	137	188	440
Geriatric Medicine	78	90	122
Cardiac Testing	26	8	22
Gastro-Enterology	109	203	216
Breast Surgery	37	26	288
Cardiology	98	193	149
Pain Management	40	53	82
Oral Surgery	78	101	138
Plastic Surgery	48	42	92
Diabetic	59	75	58
Upper Gastrointestinal Surg	42	77	97
Respiratory Technician		64	161
Endocrinology	32	33	42
Grand Total	2957	4359	13183

Variance		
06-12 Weeks	12-18 Weeks	18 Weeks +
-31	78	70
22	2	27
8	-30	62
-53	17	-41
45	-43	76
14	31	32
1	8	-7
-4	-1	-2
-81	153	23
-22	0	2
-2	-6	12
-36	37	16
-15	-77	54
-7	33	13
18	2	1
-45	18	-1
-2	4	10
-66	43	51
3	2	10
-26	-8	34
20	-4	26
2	-16	14
-27	32	-2
-42	10	32
0	-9	1
-315	264	521

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

A&E and MIU patients seen within 4 hours

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Patients	5365	7118	7947	8802	9622	9536	9072	8738	8415	7483	6923	7201	6819
4 hour breaches	1103	1268	1238	1860	2636	2990	2935	3052	3155	3010	2596	2800	2690
% seen within 4 hours	79.4%	82.2%	84.4%	78.9%	72.6%	68.6%	67.6%	65.1%	62.5%	59.8%	62.5%	61.1%	60.6%
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 deteriorated in February to 60.6%. Access to suitable inpatients beds has contributed to delays at peak times. The levels of escalation as recorded by the Daily OPEL score reflect the increased levels of escalation with 27 days at OPEL 3.

12 hour Trolley wait: 123 patients are reported as having a 12-hour trolley wait from decision to admit to admission to an inpatient bed.

Ambulance Handovers: 438 ambulance delays over 60 minutes; 727 ambulance handover delays of over 30 minutes.

Patients with a greater than 12-hour visit time pathway: 364 patients had a greater than 12-hour visit time.

Corridor Care: No patients recorded as receiving corridor care.

Operational delivery:

The number of patients waiting for a suitable bed continues to be the challenge that prevents improvements in performance and timely treatment of urgent patients. With a higher acuity of patients presenting and less available space to assess and treat, the Emergency Department is making the best flexible use of space to provide safe care to patients.

The 3rd wave of COVID continues to impact on the flow of patients with the necessary infection, prevention control measures in the department and into the rest of the hospital.

Feb-21

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

Feb-22

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

Escalation status

Opel status	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Opel 1	0	0	1	3	2	0	0	0	0	0	0	0	0	0
Opel 2	4	0	23	26	16	1	0	0	0	0	0	1	0	0
Opel 3	26	28	7	1	13	21	7	7	5	3	1	4	10	27
Opel 4	1	0	0	0	0	8	24	24	25	28	29	26	21	1
4-hour Performance (ICO)	74%	79%	82%	84%	79%	73%	69%	69%	65%	62%	60%	63%	61%	61%
Bed Occupancy (Acute)	89%	89%	85%	87%	92%	95%	95%	95%	94%	93%	93%	93%	93%	94%
Ambulance handover delays >1 hour	15	20	32	19	26	173	165	120	72	125	617	616	559	438
Dom Care - hours outstanding*	58	174	51	189	235	467	613	994	1,261	1,357	1,288	468	611	6.5.75
No Criteria To Reside - daily average (weekday)							45	58	56	62	66	88	101	80

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

As at 14.03.2022	2021				2022							
	Q4				Q1							
	December				January				February			
target_type	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf
14 day - 2ww Referral	712.0	895.0	1,607.0	44.3%	765.0	897.0	1,662.0	46.0%	789.0	850.0	1,639.0	48.1%
14 day - Breast Symptomatic Referral	39.0	6.0	45.0	86.7%	17.0	26.0	43.0	39.5%	45.0	18.0	63.0	71.4%
28 day - Faster Diagnosis Standard	877.0	780.0	1,657.0	52.9%	887.0	748.0	1,635.0	54.3%	1,144.0	422.0	1,566.0	73.1%
31 day - 1st Treatment	175.0	4.0	179.0	97.8%	178.0	6.0	184.0	96.7%	167.0	6.0	173.0	96.5%
31 day - Subsequent Treatment - Drug	89.0	0.0	89.0	100.0%	66.0	0.0	66.0	100.0%	66.0	1.0	67.0	98.5%
31 day - Subsequent Treatment - Radiotherapy	54.0	0.0	54.0	100.0%	35.0	1.0	36.0	97.2%	58.0	1.0	59.0	98.3%
31 day - Subsequent Treatment - Surgery	33.0	0.0	33.0	100.0%	29.0	1.0	30.0	96.7%	22.0	2.0	24.0	91.7%
31 day - Subsequent Treatment - Other	21.0	0.0	21.0	100.0%	9.0	0.0	9.0	100.0%	28.0	0.0	28.0	100.0%
62 day - 2ww referral	67.0	31.0	98.0	68.4%	58.0	51.5	109.5	53.0%	56.5	52.0	108.5	52.1%
62 day - Screening Referral	7.0	2.0	9.0	77.8%	8.0	2.0	10.0	80.0%	6.0	1.0	7.0	85.7%
62 day - Consultant Upgrade	1.0	0.0	1.0	100.0%	1.0	0.0	1.0	100.0%	1.0	0.0	1.0	100.0%

Cancer standards The table above shows the position for February 2022 (as at 14th March 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.*

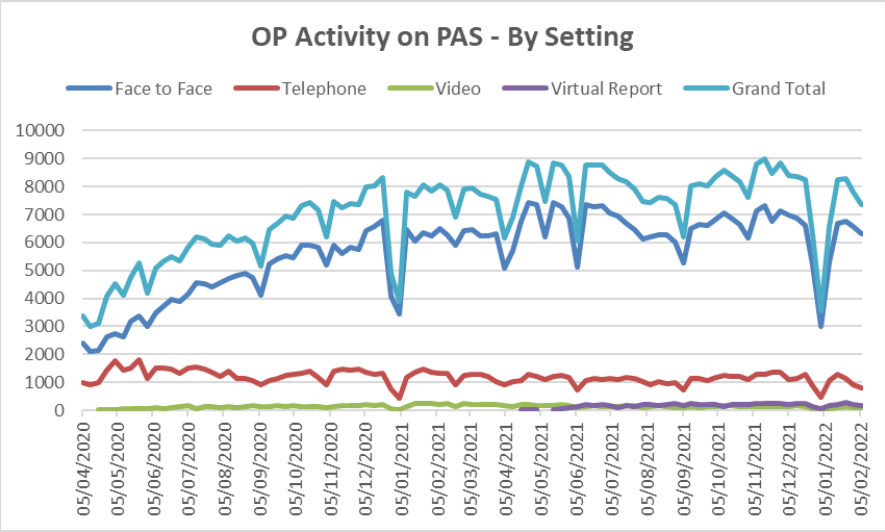
Urgent cancer referrals 14 day 2ww: 48.1% (unvalidated) is below the standard of 93%. Skin breaches continue to reduce with waits currently at 1 weeks and 4 days. Breast breaches have reduced slightly but will continue to impact February performance with waits currently at 2 weeks and 4 days. The most challenged pathways are Skin (18%) 462 breaches, Breast (19%) 193 breaches and Urology (49%) 60 breaches.

28 days From Referral to Diagnosis: Performance in February is 73.1% (unvalidated) against the target of 75%, a significant improvement on January (54.9%) and reflects the breach reductions in the key specialities for Skin (108) ,Lower GI (132), Urology (56) & Gynae (42)

NHSI monitored Cancer 62 day standard: The 62-day referral to treatment standard has improved slightly in February at 52.1% (unvalidated) against the target of 85% with 56.5 patient being seen within 62 days, however, 52 patients falling outside the target time; Urology account for 16 breaches, Skin 10 breaches, LGI 8 breaches, Lung 4 breaches, H&N 4 breaches and UGI 4 breaches being (88%) of all breaches.

104-day wait: Currently there are 45 (unvalidated) patients with a greater than 104-day wait in February, 15 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 29 patients waiting longer than 104 days, 10 with confirmed cancers.

Virtual appointments (Non-face-to-face)

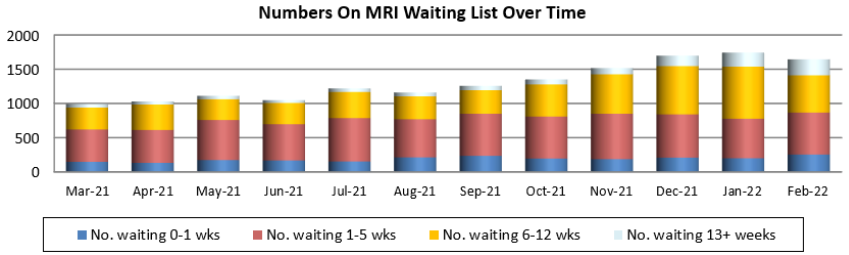


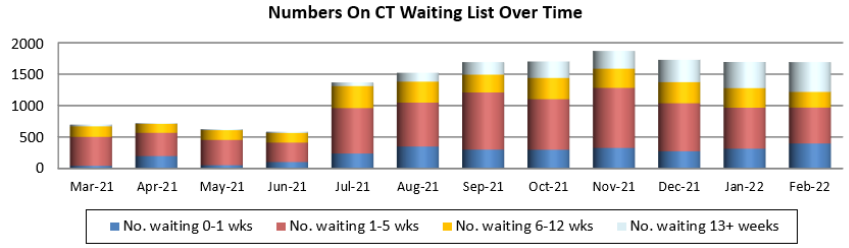
	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22
New	14%	15%	9%	14%	14.5%	12.4%	11.3%	14.3%
Follow Up	22%	21%	21%	21%	23.6%	21.7%	24.0%	23.9%
Combined	**20%**	**19%**	**18%**	**19.5%**	**21.1%**	**19.3%**	**20.7%**	**21.3%**

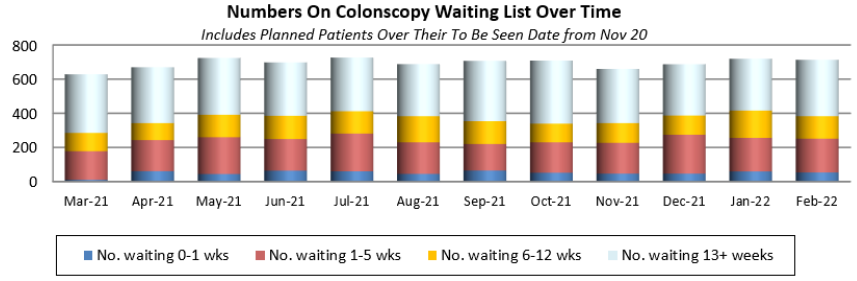
High Level Milestones	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Virtual Consultation Data - establish accurate recording and range of services.								
Review of current virtual appointments per service- • what is going well and why, and the learning from this shared • barriers to change, particularly for services reporting the lowest numbers and steps to address this.								
Communication and engagement around ambitions for Patient centred outpatients and review of what services are already doing to achieve this and map trust offer and use for gap analysis across services								
Establish clear processes, SOPS and clinical guidance to Virtual Consultations - focus on implementation, check and challenge through the PCO Board.								
25% of outpatient activity is completed virtually								

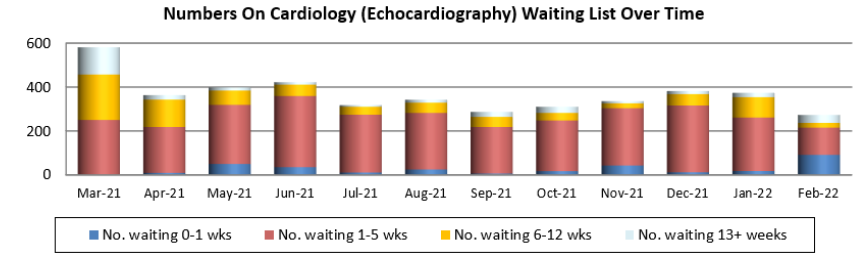
The Trust continues to see virtual appointment performance below the nationally set requirement of 25% and the lowest in the Devon providers. Achieving 25% at Integrated Care System level is linked to achieving financial incentives into the Elective Recovery Fund and remains one of the business planning 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.

NHSI indictor - patients waiting over 6 weeks for diagnostics



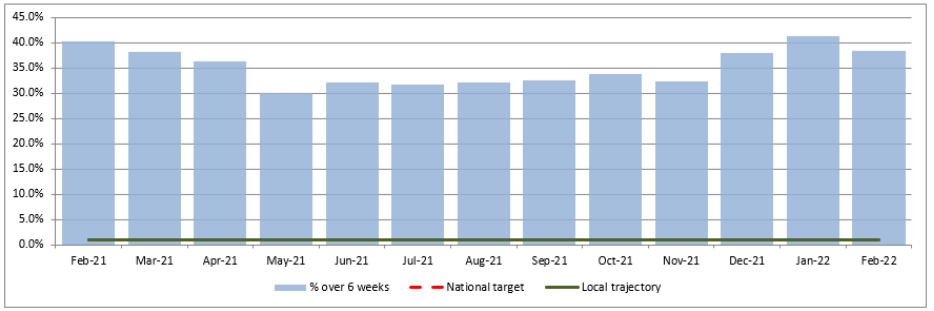






Diagnostic tests longer than the 6 week standard

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Patients	4934	4957	4876	4909	4702	5682	5655	5542	5591	5846	5899	6162	5862
Waiting longer than 6 weeks	1992	1892	1768	1478	1516	1799	1821	1808	1888	1894	2237	2546	2250
% over 6 weeks	40.4%	38.2%	36.3%	30.1%	32.2%	31.7%	32.2%	32.6%	33.8%	32.4%	37.9%	41.3%	38.4%
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.

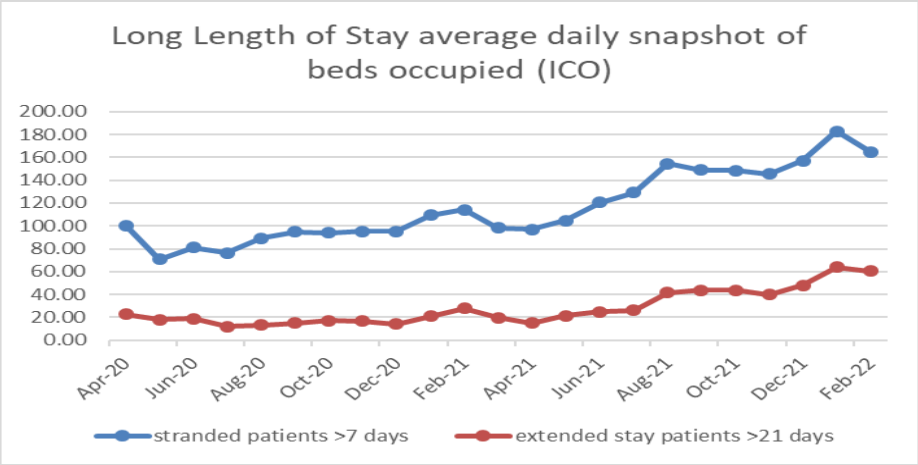
MRI waits and total numbers on the list continue to increase with 777 (967 in Jan) over 6 weeks. This reflects the continued high demand and capacity pressures. Capacity is reliant on the support of mobile scanner visits with all in-house scanner capacity being utilised. Access for mobile scanning units to increase capacity is limited as only one mobile pad available and needed for mobile CT.

CT numbers waiting and waiting times for routine tests have stabilised but remain above target with 724 patients (728 in Jan) waiting over 6 weeks. There are increasing staffing pressures to maintain capacity for in-house scans, reporting, and vetting of referrals. Insourcing using mobile units will continue to support capacity. Additional capacity at the Nightingale Hospital is planned once contrast capability is available. Radiographer vacancies continue to limit the ability to fully utilise in-house scanner capacity.

Colonoscopy numbers and routine waiting times remain high with 462 over 6 weeks. Weekend insourcing continues but is becoming less effective as different teams are attending. Overall capacity however remains insufficient to bring waits back to plan without continued significant insourcing support and investment. Urgent cancer pathways are being prioritised.

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.

Other performance exceptions

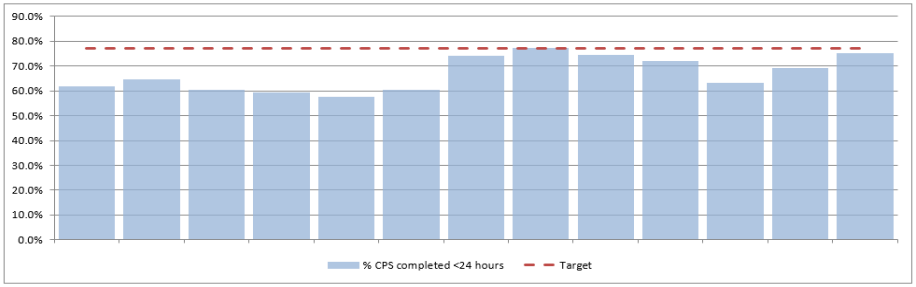


Long Length of Stay (LOS)

In February the average number of patients counted as having long length of stay greater than 7 and 21 days as measured in a daily census remains high. The number of patients experiencing long LOS is a critical measure as the Trust is challenged to maintain the flow of urgent patients requiring hospital care and treatment following emergency presentation. Many of these patient 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

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Discharges	1049	1282	1434	1484	1474	1341	1286	1424	1263	1347	1239	1024	1052
CPS completed within 24 hours	650	828	866	883	848	812	953	1101	941	970	781	709	791
% CPS completed <24 hours	62.0%	64.6%	60.4%	59.5%	57.5%	60.6%	74.1%	77.3%	74.5%	72.0%	63.0%	69.2%	75.2%
Target	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%

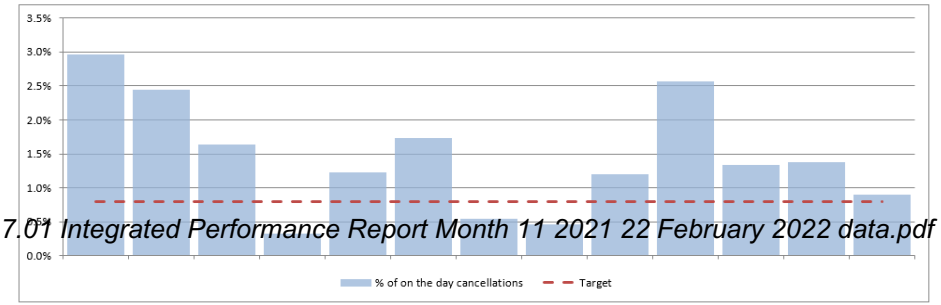


Care Planning Summaries (CPS)

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 improved from last month across weekday CPS completion.

On the day cancellations for elective operations

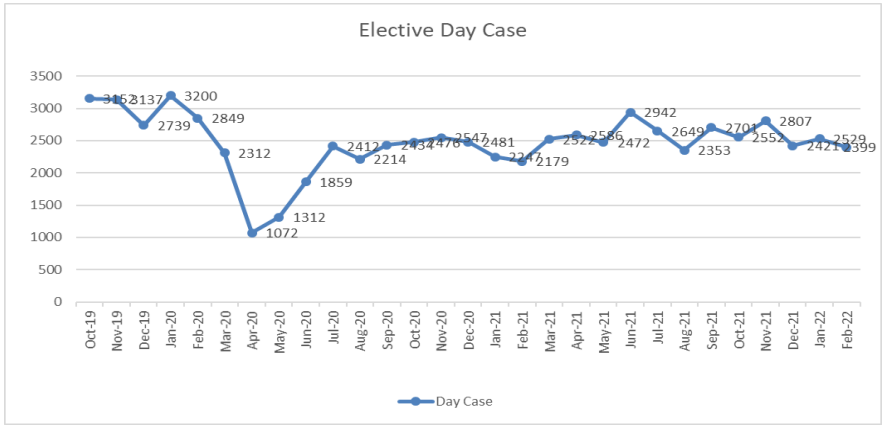
	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Cancellations	71	71	48	9	40	51	14	14	34	79	36	38	24
Elective spells	2400	2904	2922	2760	3276	2933	2602	2994	2830	3074	2691	2760	2686
% of on the day cancellations	3.0%	2.4%	1.6%	0.3%	1.2%	1.7%	0.5%	0.5%	1.2%	2.6%	1.3%	1.4%	0.9%
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%

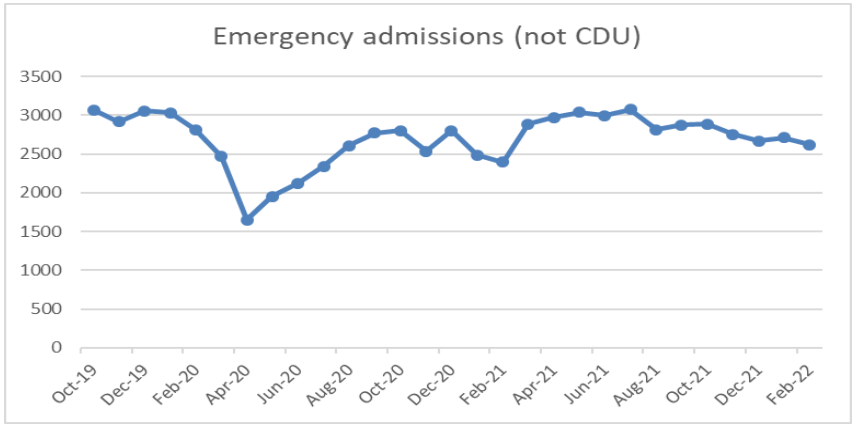


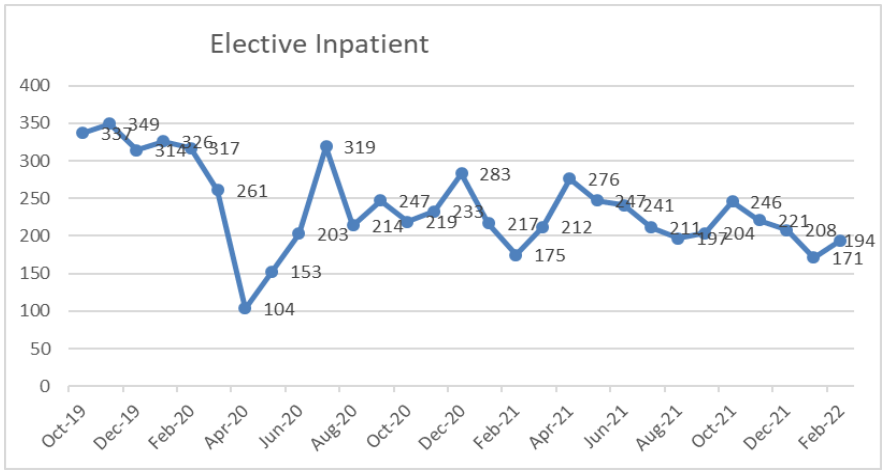
Cancelled operations

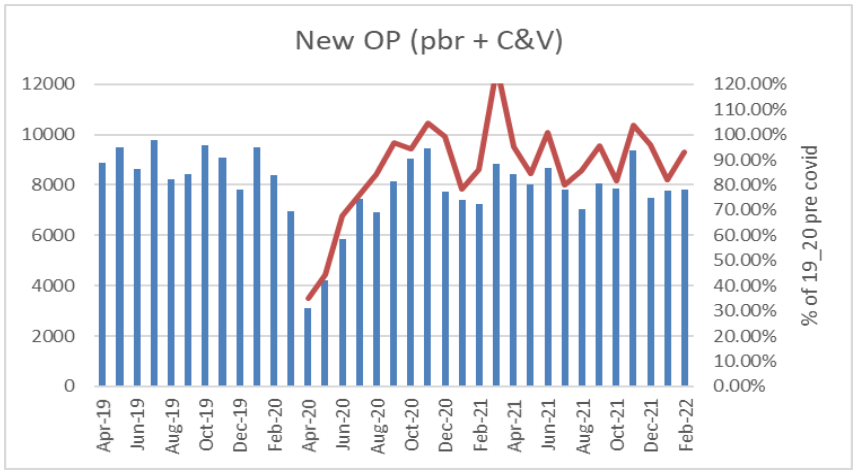
24 patients (0.9%) were cancelled on the day of an elective operation; 8 of those patients cancelled were not treated within 28 days of the cancellation.

Headline acute activity comparisons 2019/20 v 2020/21









The charts above show the monthly activity run rate of reported contract activity (Payment by Results & Cost and Volume) to end of February 2022. Compared to 2019/20 pre-covid level comparisons are:
elective day case = 84%, elective inpatient = 61%, outpatient new = 93%, emergency admission = 93%.

The need to increase the bed capacity and continued closure of the Day Surgery Unit to support the demand for medical inpatient demand and covid response has continued into February impacting elective activity levels. This is primarily impacting routine elective patients and waiting times have continued to increase with some patient waiting over 104 weeks for surgery measured from date of original referral.

The Day Surgery Unit is now scheduled to reopen together with plans also to reopen the orthopaedic ward for elective admissions from the end of April. These plans to reinstate pre-covid elective capacity together with plans to increase elective activity through the use of insourcing at weekends will increase activity to target the treatment of both urgent and longest waiting patient on our waiting lists.

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.

Integrated therapies and nursing

- Recovery plans for Autistic Spectrum Disorder (ASD) waiting times have progressed positively and will be extended into Q3, funded from underspend.
- Progress is positive with a sustained downward trend evident with 1k less CYP waiting than January 21. Reporting to NHS England and the Clinical Commissioning Group (CCG) continues fortnightly. An integrated virtual/core model has been developed which is robust and efficient.
- Speech and Language Therapy (SLT) remains the greatest challenge on reducing waiting times for treatment and this is compounded by the recent secondment of the SLT with no lead appointed at time of writing. Agency and bank continue to be explored. Additional resources have been identified by LA and CCG.
- Additional investments for Occupational Therapy were only partially operationalised in 20-21 due to significant challenges in service lines and availability of bank and agency staff.

CAMHS

- The CAMHS Service remains under pressure due to staff vacancy and recent increased levels of demand. Vacancy rates in CAMHS appear to have stabilised and are more in line with trust norm's. Service leads are fully sighted on the challenges and action plans are closely monitored. CAMHS waiting times have been published in the local press.
- Additional monies for crisis, easting disorder, and mental health in schools has been awarded and the service model developed, go live for these developments in April 2022

Estates

Work being undertaken to model the estate capacity for both clinical and administration functions, options include co-location of CFHD within an Exeter base.

	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 February	FY 2022 February	FY 2021 February	FY 2022 February	FY 2021 February	FY 2022 February
Community Children's Nursing (CFH Devon)	0	0	100.0%	100.0%	279	301
Learning Disability (CFH Devon)	0	1	96.4%	95.0%	275	251
Mental Health and Wellbeing	8	31	73.8%	55.3%	3881	3864
Occupational Therapy (CFH Devon)	2	1	66.4%	78.7%	1199	1006
Palliative Care (CFH Devon)	0	0	NA	NA	40	42
Physiotherapy (CFH Devon)	0	0	82.7%	66.5%	486	483
Special School Nursing (CFH Devon)	0	0	100.0%	100.0%	467	544
Specialist Autism Spectrum Assessment Team (CFHD)	1460	1129	19.0%	19.5%	3533	2461
Specialist Children's Assessment Centre (CFHD)	104	242	41.0%	32.8%	908	1426
Speech & Language Therapy (CFH Devon)	370	650	52.8%	35.6%	5119	5003

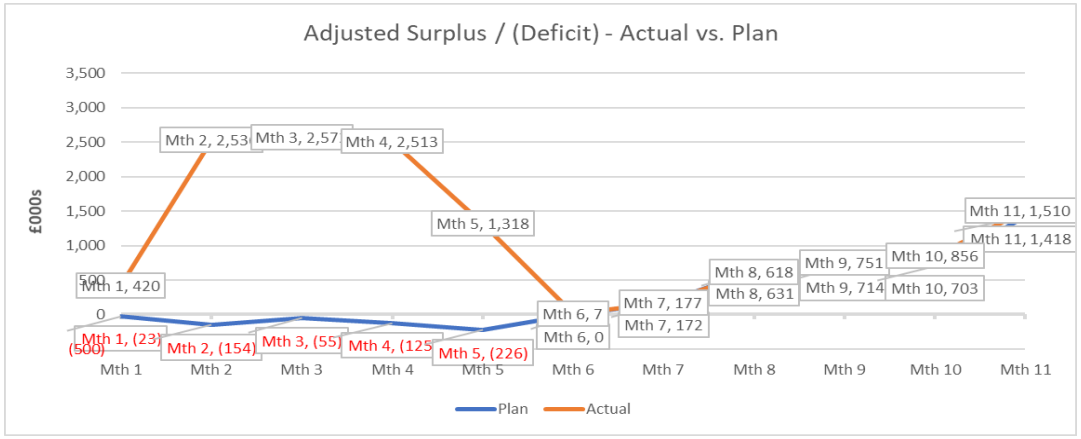
Financial Performance – Month 11 (February)
FY 2021 / 22

Financial Overview – Month 11, February 2022

High Level Summary

For Period ended - 28 February 2022, Month 11	Plan £m	Actual £m	Variance £m
Total Operating Income	525.91	534.18	8.27
Total Operating Expenditure and Financing Cost	(525.23)	(533.78)	(8.55)
Surplus/(Deficit)	0.68	0.40	(0.28)
Add back: NHSE/I Adjustments	0.74	1.11	0.37
Adjusted Surplus/(Deficit)	1.42	1.51	0.09
CIP	6.75	6.52	(0.22)
Capital	40.04	24.89	(15.15)
Cash & Cash Equivalents		41.48	

Adjusted Surplus / (Deficit)



Operating Income
Operating income for the year to date totals £534.2m, within which income for patient care activities totals £485.5m. Total income for the year to date is £8.3m 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 (£5.4m favourable), education and training, R&D grants and various income (£3.6m favourable) and ASC client contribution income (£0.9m favourable matched by cost) offset by: lower Council income (£1.3m), reclassification of renal transport income and audit income from patient care income to other income and pass through drugs within block contract income (£0.4m adverse).

Operating Expenditure
Total operating expenditure and financing cost of £533.8m, which includes £267.4m of staff costs. Operating expenditure and financing cost in the year to date is £8.6m adverse to plan. Key drivers are as follows: COVID related costs including those council funding streams not initially budgeted in H1 and H2 (£5.4m adverse but matched by income), increase in Agency (£4.3m adverse) and Bank spend (£3.5m adverse), increased clinical supplies and services cost (£1.9m adverse), ASC and Placed people due to increased CHC and residential long stay cost (£1.7m adverse), ASC bad debt provision (£0.5m adverse), HIS N365 business plan (£0.6m adverse) drugs cost (£0.4m adverse), increased utilities cost (£0.4m adverse) and undelivered CIP (£0.2m adverse offset by lower substantive pay due to vacancies (£7.8m favourable), lower CFHD alliance cost £(1.7m favourable), lower non healthcare contract cost (£0.4m favourable) and lower financing costs (£0.4m favourable).

Adjusted Surplus / (Deficit)
At month 11 the Trust is recording a surplus of £1.51m against plan of £1.42m and is forecasting to deliver the planned surplus of £1.80m at year-end.

CIP
At month 11 the Trust delivered £6.52m of savings against plan of £6.75m through either recurrent and non-recurrent means.

Capital
To date the Trust has spent c. £24.9m on capital schemes. A forecast underspend of £1.6m against approved budget is predicted at year-end, £1m of which will be utilised at the ICS level, the balance of £0.6m relating to Nationally funded PDC schemes will result in a return of PDC funds to the Department of Health during 2022/23, A separate capital report has been prepared for the Trust's FPDC.

Cash
The Trust is showing a healthy cash position of £41.5m at the end of Month 11 with a forecast year-end balance of £25.9m at year end.

I&E Position – Month 11, February 2022

Income & Expenditure – Performance versus Plan

£m	M11 - In Month			M11 - YTD		
	Budget	Actual	Variance	Budget	Actual	Variance
Patient Income - Block	32.40	32.63	0.23	358.98	359.02	0.04
Patient Income - Variable	3.63	3.52	(0.11)	41.25	40.85	(0.40)
ERF/ERF+/TIF/Capacity Funding	1.12	1.70	0.58	7.84	7.80	(0.04)
ASC Income - Council	4.58	3.98	(0.60)	50.42	49.15	(1.27)
Other ASC Income - Contribution	0.90	1.02	0.12	10.80	11.72	0.92
Torbay Pharmaceutical Sales	1.96	1.45	(0.51)	19.93	19.94	0.01
Other Income	3.03	3.52	0.49	31.08	34.72	3.64
Covid19 - Top up & Variable income	0.65	0.62	(0.03)	5.61	10.98	5.37
Total (A)	**48.27**	**48.44**	**0.17**	**525.91**	**534.18**	**8.27**
Pay - Substantive	(24.06)	(23.93)	0.13	(259.93)	(255.65)	4.28
Pay - Agency	(0.91)	(0.66)	0.25	(7.48)	(11.78)	(4.30)
Non-Pay - Other	(12.35)	(12.40)	(0.05)	(139.62)	(139.85)	(0.23)
Non- Pay - ASC/CHC	(7.97)	(8.59)	(0.62)	(94.01)	(102.72)	(8.71)
Financing & Other Costs	(2.33)	(2.29)	0.04	(24.19)	(23.78)	0.41
Total (B)	**(47.62)**	**(47.87)**	**(0.25)**	**(525.23)**	**(533.78)**	**(8.55)**
Surplus/(Deficit) pre Top up/Donated Items and Impairment (A+B=C)	**0.65**	**0.57**	**(0.08)**	**0.68**	**0.40**	**(0.28)**
NHSE/I Adjustments - Donated Items / Impairment / Gain on Asset disposal	0.06	0.08	**0.02**	**0.74**	**1.11**	**0.37**
Adjusted Financial performance - Surplus / (Deficit)	**0.72**	**0.65**	**(0.07)**	**1.42**	**1.51**	**0.09**

In Month 11 the Trust recorded a surplus of £0.65m and for the year to date the Trust is reporting a £1.51m surplus.

M11 actuals is behind plan (£0.07m adverse in month) and year to date actuals are ahead of plan (£0.09m favourable year to date).

In Month Position:

Income

The key variances are below:

- Patient income block £0.23m higher – additional income received linked to CFHD mental health support.
- Patient income variable £0.11m lower due to pass through income.
- ERF/ERF+ £0.58m higher – per the agreed value with the ICS.
- ASC Income council £0.60m – lower Council income.
- ASC Client contribution income is £0.12m higher in month (matched by cost).
- Torbay Pharmaceutical sales were £0.51m lower than planned primarily due to lower NHS sales and delayed shipment.
- Other income is £0.49m higher than plan from various sources (education and training, R&D, non patient services and Devon IR).
- COVID income is slightly lower than plan.

Pay

- In Substantive pay there is a net favourable variance in month (£0.13m) mainly due to unfilled vacancies.
- Agency cost is £0.25m lower than budget primarily in Medical locums (£0.44m), partly driven by a lack of availability and reflecting a short month, but it also reflects some technical phasing adjustments offset by increased cost in Ancillary staff group £0.14m (COVID, Estates and TP production requirement) and various other staff (£0.05m).

Non-pay

- The main drivers of the adverse non-pay other (£0.05m) position are as follows: higher Drugs spend (£0.23m) offset by CNST rebate (£0.18m).
- The £0.62m adverse position for ASC/CHC costs is due to: ASC (£0.36m) due to higher than anticipated costs on Residential and Nursing Long Stay Care and reduction in Direct Payment reclaims. Placed People (£0.25m) due to higher CHC costs in South Devon locality and Adult IPP.
- Financing costs is slightly lower than plan due to depreciation.

Risks and Mitigations and Forward Look

Risks and Mitigations

The Trust has reviewed its forecast in light of the continuing pressures from Covid, and is confident of achieving the required year-end result of £1.8m surplus.

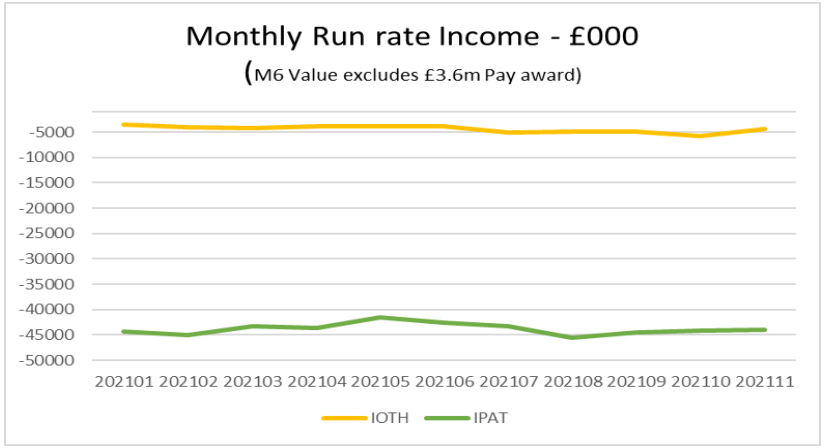
With regards to ERF the threshold percentage in H2 has been amended from 95% of SUS submitted activity to 89% of RTT stop clock activity. The system as a whole did earn ERF in Q3, mainly against activities delivered in Accelerator sites. There is still a risk that the System might not achieve any ERF in Q4.

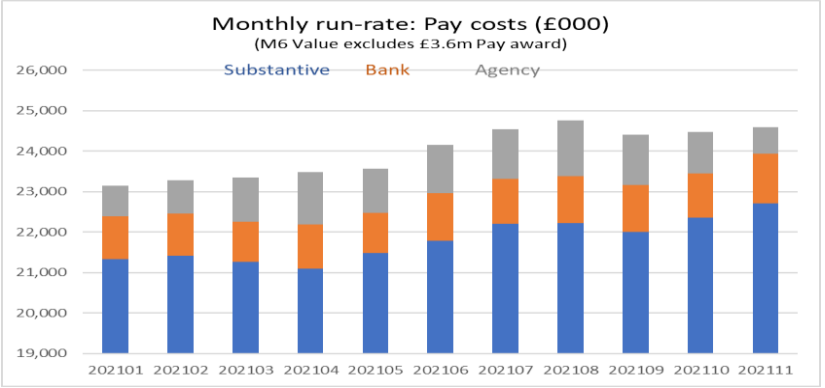
There are additional funding streams in H2 i.e. ERF+ and TIF and ISU's have undertaken a review of likely spend/activity to date and expected during the remainder of H2. These other funding streams are low risk income values and the Trust will maximise the benefit of these allocations. This will complement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

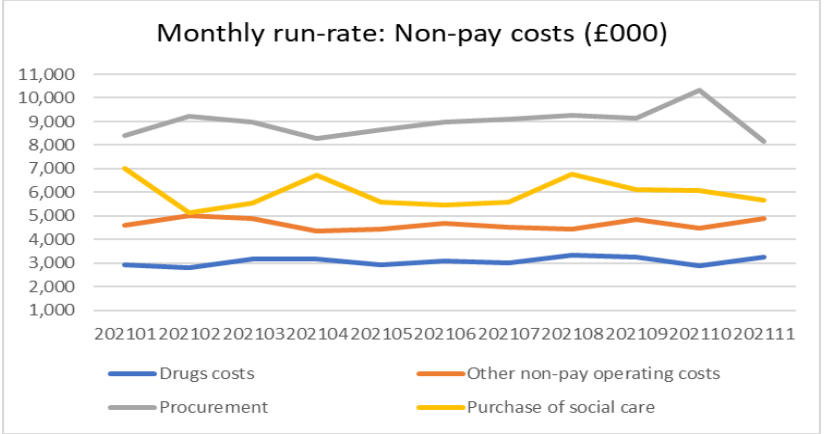
Forward Look

The Trust submitted a draft operational plan to NHSE / I for FY 2022/23 which showed a full year adjusted deficit of £32.71m. The following areas are worth noting:

- The plan is unlikely to be accepted by regulators.
- The efficiency requirement for 2022-23 is £28.45m, comprising CIP, transformation and Covid cost reduction initiatives.
- We expect a significant reduction (~60%) in COVID top-up funding.
- Commissioner contracts are being re-introduced with aligned incentive payment mechanisms for elective activity, which would see the Trust lose income if elective activity fails to achieve the required levels.
- There is no future funding for 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 plans for 2022-23 and beyond have been developed – it is expected that there will be significant pressure on the ICS capital envelope (CDEL).

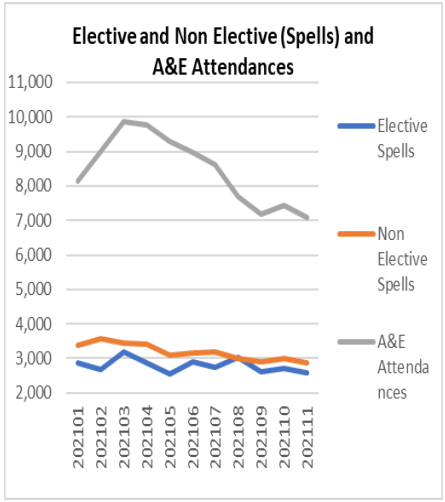


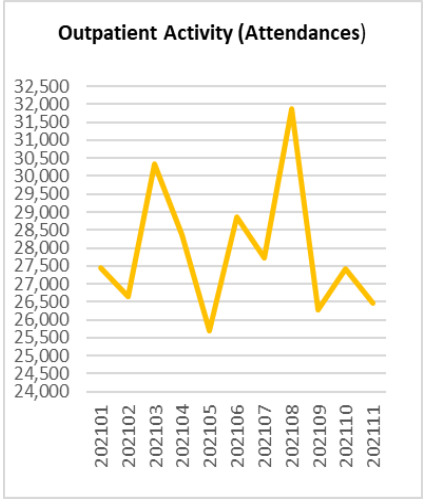




Change in Activity Performance – Month 10 to Month 11

		Plan M11	Jan-22	Feb-22	Change	% Change		Feb-21	% change
Activity Drivers	A&E Attendances		7,426	7,071	-355	-5%		*5,535*	28%
	Elective Spells	3,247	2,701	2,593	-108	-4%		*2,354*	10%
	Non Elective Spells		2,993	2,873	-120	-4%		*2,675*	7%
	Outpatient Attendances	27,985	27,417	26,461	-956	-3%		*25,496*	4%
	Adult CC Bed Days		176	134	-42	-24%		*235*	-43%
	SCBU Bed Days		236	91	-145	-61%		*162*	-44%
Bed Utilisation	Occupied beds DGH		10,223	9,779	-444	-4%		*8,439*	16%
	Available beds DGH		10,961	10,415	-546	-5%		*9,478*	10%
	Occupancy		93%	94%	1%	1%		89%	5%
Resource Consumption	Medical Staff Costs - £000's	5,314	5,297	5,002	-295	-6%		*4,759*	5%
	Nursing Staff Costs - £000's	6,093	5,799	5,882	82	1%		*5,486*	7%
	Temp Agency Costs - £000's	904	1,025	658	-367	-36%		*572*	15%
	Total Pay Costs - £000's	24,977	24,471	24,591	121	0%		*23,131*	6%





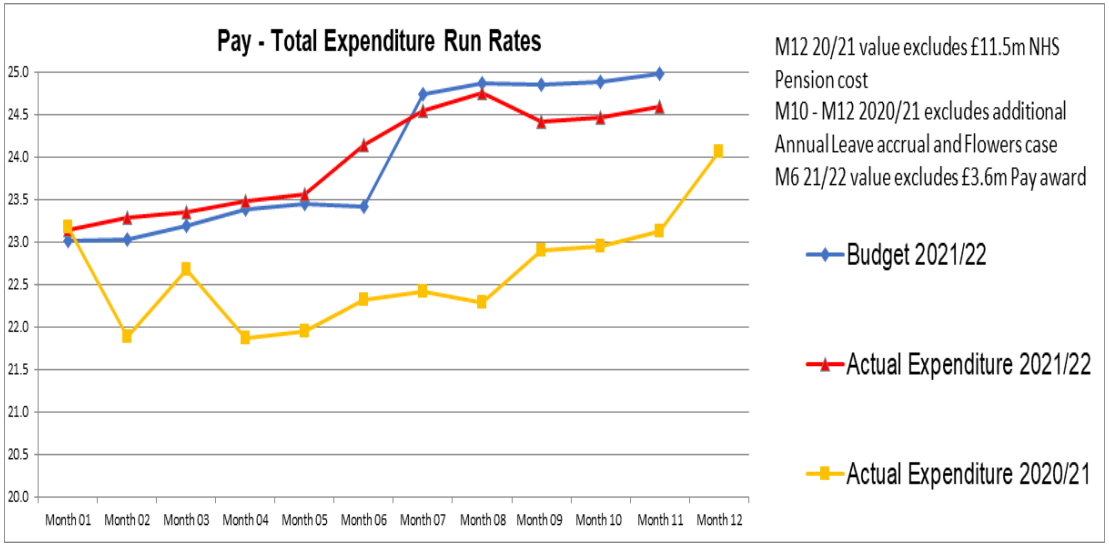
Activity Drivers

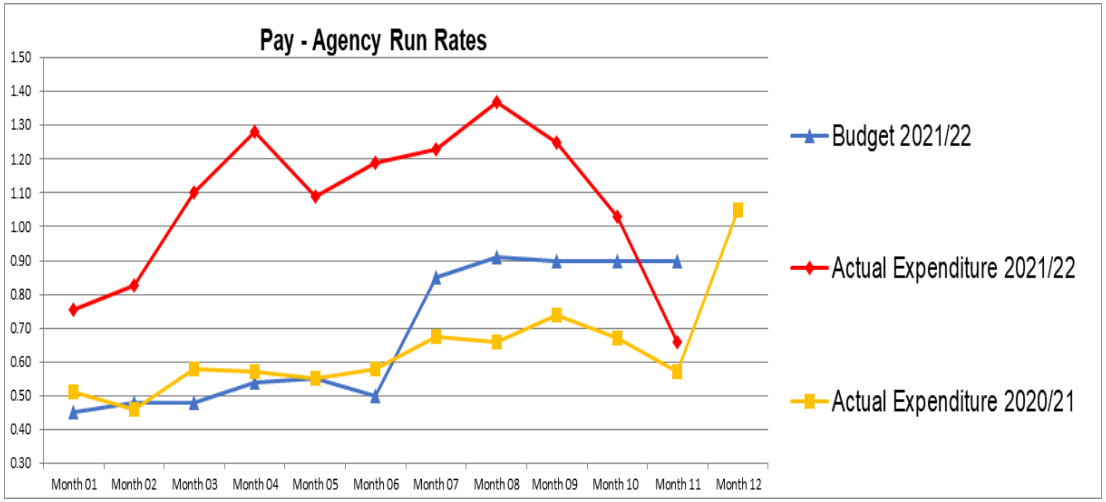
- No formal plan (for contracting purposes in 21/22) has been created for A&E, Non Elective, or ACC/NCC. This is as a result of the focus on the recovery of elective activity from the centre.
- Overall, elective activity level is below plan at Month 11 and lower levels of activity were delivered compared to M10 (fewer working days in Feb). In comparison against 2019/20, which is the comparator year for NHSE/I purposes, the Trust achieved 86% overall Elective/Outpatient activity in M11 (M10 78%). At least part of the reason for this is because COVID is still impacting on the Trust's ability to get back to 100% of 2019/20 activity levels. The Trust delivered 93% of its February 21 planned activity.
- 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 2022/23 guidance has now been issued and the Trust is working with the ICS to ensure a consistent approach to planning. This will enable the ICS 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 ICS for review in effort to target recovery at 104% of 19/20 activity levels.

Bed utilisation

- In February, the overall bed occupancy at 94% continues to be above required levels to support patient flow to avoid emergency care delays and reduced elective capacity. The bed capacity continues to be constrained by the levels of delayed transfers of care that averaged 60 patients per day who were classified as medically fit for discharge.
- 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. Recovery plans have been approved to see the relocation of the Medical Receiving Unit to a non ward area so not impacting on available beds and enable the planned reopening of the Day Surgery Unit from mid-April.
- During February, routine elective orthopaedic surgery continues to be stood down with the bed capacity used to support the emergency medical pathways of care.

Pay Expenditure – Month 11, February 2022



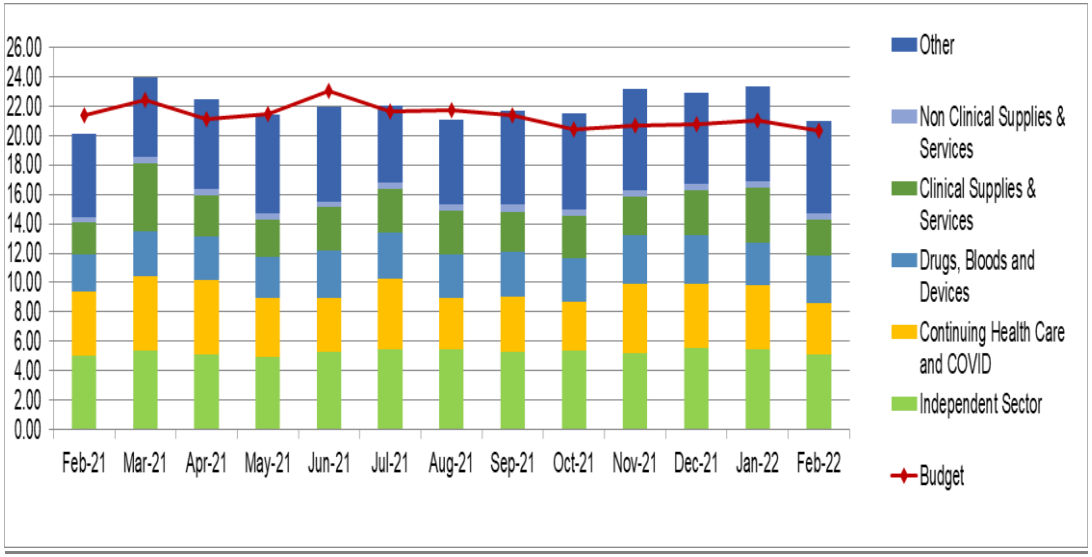


In Month 11 the total pay expenditure is £24.59m, which is £0.12m higher compared to Month 10 (£24.47m).

Further details are provided below:

- Substantive pay increased by £0.36m due to: MARS accrual (£0.62m) and Substantive staff appointment across various staff group (£0.19m) offset by adjustment in Flowers holiday pay accrual (£0.45m).
- Bank pay increased by £0.13m primarily within Nursing (£0.05m) and HCA's (£0.08m) due to specialling.
- Agency costs were £0.37m lower than Month 10. The trend of reduced agency costs seen since the peak in November has continued in the month. The majority of the reduction has been within medical locums partly driven by a lack of availability and reflecting a short month, but it also reflects some technical phasing adjustments. Costs for clinical and support staff are on a similar level to last month.
- The year to date Agency costs as at M11 totals £11.78m 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.
- Of the year to date pay costs, those associated with COVID account for £10.34m, comprised of:
  - Segregation of patient pathways - £4.24m,
  - Backfill for higher sickness absence - £1.40m,
  - Decontamination - £1.42m,
  - Ambulance Capacity - £1.09m,
  - Additional shifts of existing workforce – £1.07m,
  - Increase ITU capacity £0.44m,
  - Testing – £0.40m, and
  - Vaccination programme - £0.28m
- The Apprentice levy balance at Month 11 is £2.26m (£2.24m in M10). The Trust's apprenticeship strategy is reviewed regularly and actions are being taken.

Non-Pay Expenditure – Month 11, February 2022



The total non-pay run rate in Month 11 (£20.99m) is £2.39m lower in comparison to previous month (£23.38m), key details are provided below:

- Decreases in:
  - Clinical supplies – £1.28m, TP chemical consumables £0.90m (in M10 there was a pass through income / cost), lower TP cost of sales £0.22m and medical and surgical supplies £0.16m.
  - COVID funding £0.53m - related to the Workforce recruitment and retention funding round 2, that was paid out in January with no payments then made in February. This fully offset with income received from Torbay Council.
  - ASC - £0.40m and Placed People (including Continuing Healthcare) £0.35m, February spend is lower than January and this is due to there being three days less of costs in in month.
  - Net Operating expenditure – £0.22m primarily due to CNST rebate £0.18m; offset by:

- Increase in:
  - Drugs costs – £0.39m higher usage, mainly in Healthcare at Home drugs.

COVID and Other one-off Funding Analysis – Month 11, February 2022

COVID Expenditure	Inside Envelope Actual 28/02/2022 YTD £'000	Outside Envelope Actual 28/02/2022 YTD £'000	Total Actual 28/02/2022 YTD £'000
Staff and executive directors costs	9,659	679	10,338
Supplies and services – clinical (excluding drugs costs)	411	2,789	3,200
Supplies and services - general	332	1	333
Drugs	438	1	439
Establishment	88		88
Purchase of social care	1		1
Premises	424	15	439
Education and training - non-staff	40		40
Transport	58		58
Other	164		164
Total operating expenditure	**11,615**	**3,485**	**15,100**

Hospital Discharge, Rapid Testing and Infection Control COVID	Total Cost Actual 28/02/2022 YTD £'000	CCG Income Actual 28/02/2022 YTD £'000	Council Income Actual 28/02/2022 YTD £'000	Provider Refunds Actual 28/02/2022 YTD £'000
Hospital Discharge Programme (HDP) Scheme 2	2,702	(2,702)		
Infection Control, Rapid Testing & Vaccines	3,587		(3,421)	(166)
Domiciliary Care - H2 Incentive & Retention scheme	314		(314)	
Independent Sector Workforce Recruitment and Retention	1,126		(1,126)	
General & Sustainability Fund	268		(172)	(104)
Total	**7,997**	**(2,702)**	**(5,033)**	**(270)**

As highlighted above, within the Trust's pay position at Month 11 £10.34m is for COVID costs.

Within non-pay COVID costs account for £4.76m, comprised of:

- Testing - £2.79m,
- Segregation of patient pathways - £1.76m,
- Decontamination - £0.14m, and
- Patient transport and other - £0.07m

Hospital Discharge and other COVID Related 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 £8.0m, with a contribution of circa £5.0m 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 IS Workforce Recruitment and Retention grant (Round 1) has been allocated in December with Tranche 1 of Round 2 distributed in January.
- Hospital discharge costs (year to date circa £2.7m) 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 £0.15m of this fund has been paid to providers.

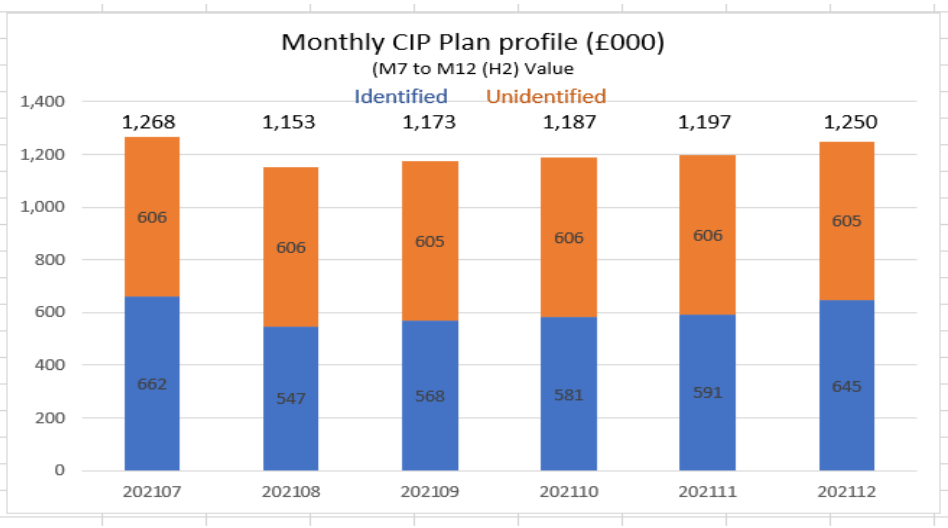
- During early March further payments will be made by the Trust in relation to providers in respect of Infection Control, Rapid Testing & Vaccines (H2, tranche 2) and IS Workforce Recruitment and Retention grant (Round 2, Tranche 2). This will be matched by income from Torbay Council.

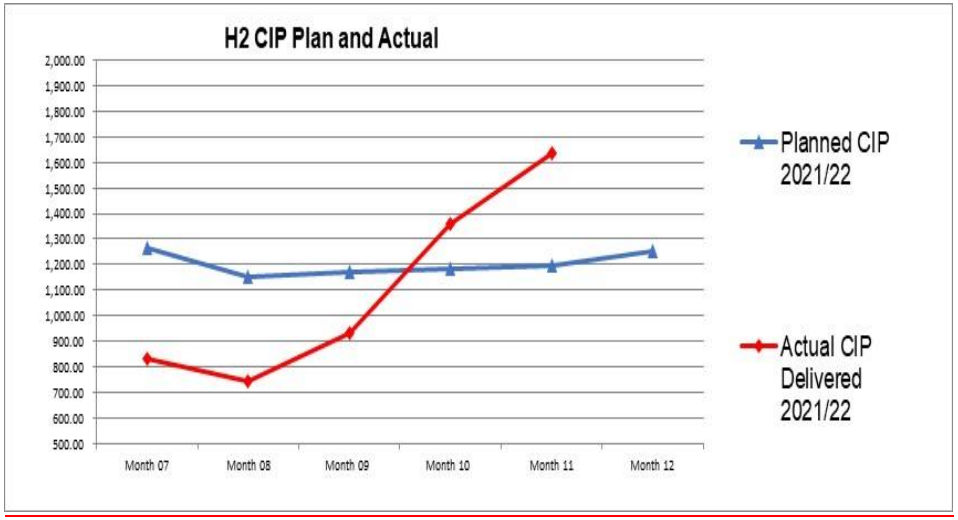
Key Drivers of System Positions – Month 11, February 2022

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 M11 is £0.50m lower than plan primarily due to lower NHS sales. Year to date is in line with plan.
Corporate	EFM	The H2 year to date position at M11 is an overspend of £304k mainly arising from non-pay overspend of £316k offset by a CIP overachievement of £126k. The non-pay overspend relates to repairs & maintenance, increased utility costs and laundry, linen and cleaning equipment and materials. The CIP achievement is largely from recurrent schemes.
	Exec. Directors	The H2 year to date position at M11 is an underspend of £0.15m. However, there is a £1.3m overspend on non-pay due to £0.6m agreed HIS N365 business plan, £0.32m overspend on Devon IR Alliance (offset by income), £0.22m overspend on International Recruitment costs, £0.07m on relocation expenses (offset by income), £0.07m ED cultural workshops, £0.06m on Information agency cover plus various smaller overspends across other directorates, offset by £0.09m reduction in legal fees. Pay is overspent by £0.04m mainly due to posts funded by income in Education and Transformation & Partnerships; offset by £0.07m International Recruitment & supernumerary pay and various vacancies. The income overachievement of £0.9m includes funding for Education posts, Devon IR Alliance income and relocation funding. Non-recurrent CIP (slippage) has been transacted across most directorates (but largely Education income) resulting in an overachievement of £0.5m.
	Financing Costs	Excluding items outside the NHSE/I control total, costs show a £0.83m favourable variance to plan. This is principally due to reduced depreciation charges, largely as a result of capital projects being completed later than planned.
	Other	Reserves includes plan adjustments, provisions for FNC backlog, legal fees & miscellaneous other small provisions.
South System	Coastal	Underspent against M11 YTD budget by £3.7m being non pay £2.8m, pay £1.3m, offset by adverse position for under delivery of CIP £0.8m. Continued reduction in elective recovery activity, ERF slippage, in response to Covid and green surge, delays in recruitment, reduced spend in theatre supplies and drugs. Run rates are broadly in line with the previous month, with an overall reduction over the past few months, but there is an expected increase in non pay equipment of £0.3m M12.
	Newton Abbot	Overspent against M11 YTD budget by £2.7m due to continued cost pressures in response to the green and Covid 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 £2.1m and Acute Medicine (including all Gen Med Junior Doctors) by £0.9m, unachieved CIP £0.5m. These cost pressures are expected to continue due to winter demand but are offset by underspends in UTC, ICU, vacant posts £0.8m. Marginally lower non pay costs than the previous month, with reductions in run rates over the past three months. Run rates are however predicted to increase in M12 due to current risk of escalation.

	Moor to Sea	Overspent against M11 YTD budget by £0.8m, is mainly due to the continued cost pressures on the four Wards £0.6m to cover Patient activity, staff absence and also specialist security. Intermediate Care Beds are overspent by £0.5m but this will reduce when the DCC contribution has been agreed, unachieved CIP £0.1m. All other net variances are £0.4m underspent. Pay and non pay run rates slightly higher than the previous month, but expected to remain relatively consistent.
	Shared Operations	Underspent against M11 YTD budget by £0.2m, which is mainly due to vacant posts of £0.3m combined, offset by increased patient transport demand £0.1m due to response to winter surge. Run rates lower than the previous month, but expected to remain relatively consistent.
Torbay System	Independent Sector	ISU is circa £1.2m overspent against a YTD budget envelope of £82.1m. Non-Pay cost is £8.7m higher than budget but this is primarily due to COVID related spend (£6.5m) which has no budget (Hospital Discharge 'H1', Rapid Testing and Infection Control). Additional pressures in ASC (Long Stay residential & Bad Debt provision) have adversely impacted non-pay cost as have unachieved CIP savings within Placed People. Partially offsetting the adverse non-pay cost there is £6.5m of additional Covid related funding and £0.9m of ASC client contributions.
	Torquay	ISU has a circa YTD £0.15m overspend against a YTD budget envelope of circa £39.4m. 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 £0.25m overspend against a YTD budget envelope of circa £79.1m. Underlying this the main areas to note is a material £0.9m pay / non-pay underspend linked to medical vacancies, ERF slippage and labs medicine but this is offset by £1.15m 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) £5.5m of Elective Recovery Funding (ERF and ERF+) and £0.8m of TIF at M11 from the CCG. 2) C. £2.7m additional income via the CCG relating to the Hospital Discharge Programme (HDP). There is a corresponding cost to offset this. 3) An additional c. £5.0m 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, rapid testing and workforce recruitment and retention scheme.

CIP – Month 11, February 2022





CIP H2 Plan and M11 Actual

H2 Plan

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

M11 Actual and year to date

The M11 CIP plan is £1.20m with actual delivery of £1.63m, an upside of £0.43m.

Year to date, CIP delivery in H2 is £5.51m.

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

CIP plans delivered for the year to date total £6.52m against the plan of £6.75m.

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 of c. £0.8m. 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 11, February 2022

	YTD at M11 £m
Opening cash balance	**45.45**
Capital Expenditure (accruals basis)	(24.89)
Capital loan/PDC drawndown	7.55
Capital loan repayment	(3.39)
Proceeds on disposal of assets	0.01
Movement in capital creditor	(4.69)
Other capital-related elements	(1.60)
Sub-total - capital-related elements	**(27.02)**
Cash Generated From Operations	23.86
Working Capital movements - debtors	(0.38)
Working Capital movements - creditors	6.23
Net Interest	(2.68)
PDC Dividend paid	(2.88)
Other Cashflow Movements	(1.09)
Sub-total - other elements	**23.06**
Closing cash balance	**41.48**

Better Payment Practice Code	Paid year to date	Paid within target	% Paid within target
Non-NHS - number of bills	131,631	113,227	86.0%
Non-NHS - value of bills (£k)	254,126	213,830	84.1%
NHS - number of bills	1,910	1,229	64.3%
NHS - value of bills (£k)	23,606	17,957	76.1%
Total - number of bills	133,541	114,456	85.7%
Total - value of bills (£k)	277,732	231,787	83.5%

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 £26m. This 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 £4.0m. Noteworthy components are the paying down of capital creditors (£4.7m).
- Should a high value of invoices in respect of 2021/22 capital expenditure not be received and paid by 31 March 2022, the forecast reduction in the cash balance may not be completed until the early months of 2022/23.
- 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 11, February 2022

	Month 11		
	Position 31 March 2021 £m	Position 28 Feb 2022 £m	Movement £m
Non-Current Assets			
Intangible Assets	10.09	10.23	0.14
Property, Plant & Equipment	202.37	211.57	9.19
On-Balance Sheet PFI	17.11	16.68	(0.43)
Other	2.04	2.07	0.03
Total	**231.61**	**240.54**	**8.93**
Current Assets			
Cash & Cash Equivalents	45.45	41.48	(3.96)
Other Current Assets	33.20	33.74	0.54
Total	**78.64**	**75.23**	**(3.42)**
Total Assets	**310.25**	**315.76**	**5.51**
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)	(61.95)	(0.14)
Other Current Liabilities	(10.44)	(14.41)	(3.96)
Total	**(78.23)**	**(82.45)**	**(4.22)**
Net Current assets/(liabilities)	**0.41**	**(7.22)**	**(7.64)**
Non-Current Liabilities			
Loan - DHSC ITFF	(29.08)	(25.68)	3.40
PFI / LIFT Leases	(16.60)	(15.42)	1.18
Other Non-Current Liabilities	(15.88)	(13.80)	2.08
Total	**(61.55)**	**(54.90)**	**6.65**
Total Assets Employed	**170.47**	**178.42**	**7.94**
Reserves			
Public Dividend Capital	130.76	138.30	7.54
Revaluation	49.15	49.15	(0.00)
Income and Expenditure	(9.44)	(9.04)	0.40
Total	**170.47**	**178.42**	**7.94**

Key points of note:

- Non-current assets have increased by £8.9m during the year to date, principally as capital expenditure (£24.9m) has exceeded depreciation (£15.4m).
- Cash has reduced by £4.0m, as explained in the commentary to the cashflow statement.
- Other current assets have increased by £0.5m, principally due to insurance / rates prepayments £0.9m.
- Trade and other payables have increased by £0.1m, principally due to increased PDC Dividend creditor £2.2m and increased general payables, partly offset by the paying down of the capital creditor £4.7m and agreed repayment of 2020/21 CCG funding £4.0m.
- Other current liabilities have increased by £4.0m, due to increased deferred income.
- Non-current liabilities have reduced by £7.9m, principally due to scheduled loan / lease repayments.
- PDC reserves have increased by £7.5m due to receipt of capital PDC funding.

Statistical Process Control (SPC) charts

It is understood that measurement is integral to the improvement methodology in healthcare but it is not always possible to see from the data if improvements are being made. There is an element of variation in the way services are delivered by individual departments, people, and different types of equipment.

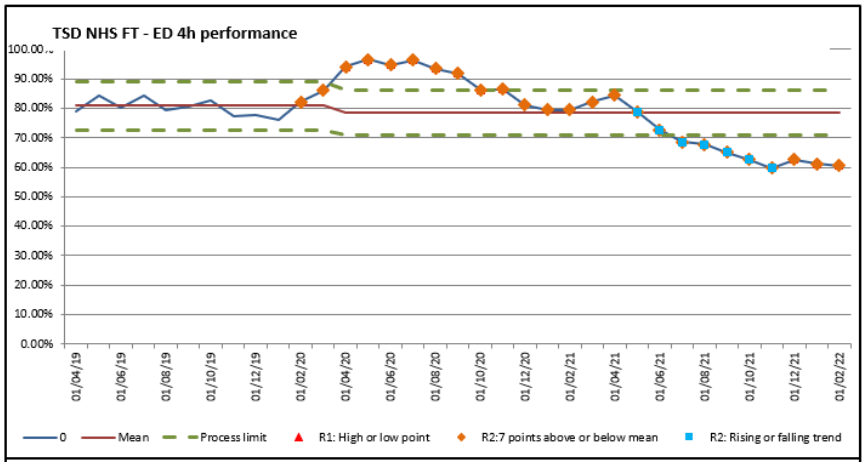
The main aims of Statistical Process Control (SPC) charts is to understand what is 'different' and what is the 'norm'. SPC charts can help to:

- 'predict' statistically whether a process is 'capable' of meeting a target;
- identify if a process is sustainable - i.e. are your improvements sustaining over time;
- identify when an implemented improvement has changed a process - i.e. it has not just occurred by chance;
- generally understand processes - helping make better predictions and thus improve decision making;
- recognise abnormalities within processes;
- understand that variation is normal and to help reduce it;
- prove or disprove assumptions and (mis) conceptions about services;
- drive improvement – used to test the stability of a process prior to redesign work, such as Demand and Capacity.

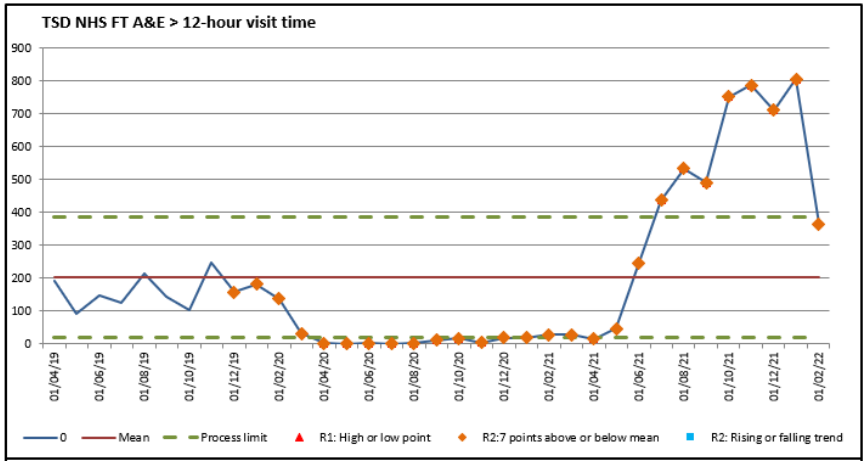
Control limits are the standard deviations located above and below the centre line of an SPC chart. If the data points are within the control limits, it indicates that the process is in control (common cause variation). If there are data points outside of these control units, it indicates that a process is out of control (special cause variation).

In preparing for fuller roll out, a selection of key metrics are presented below in SPC format.

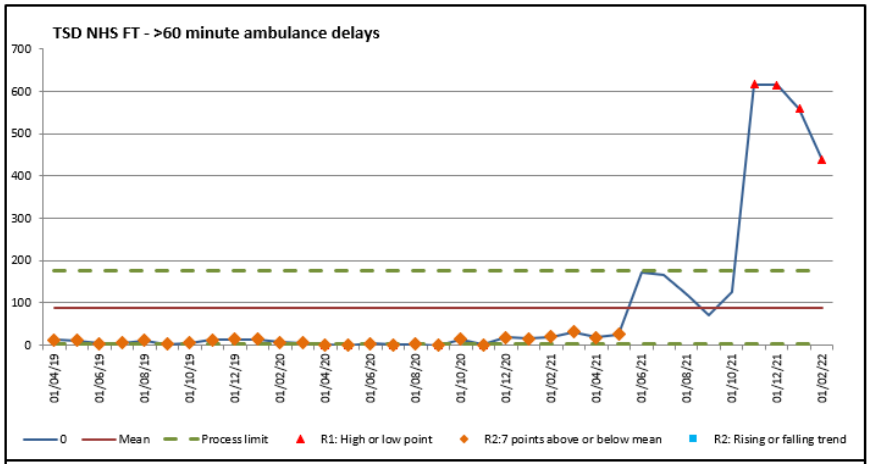
ED 4 hour performance



12h breaches

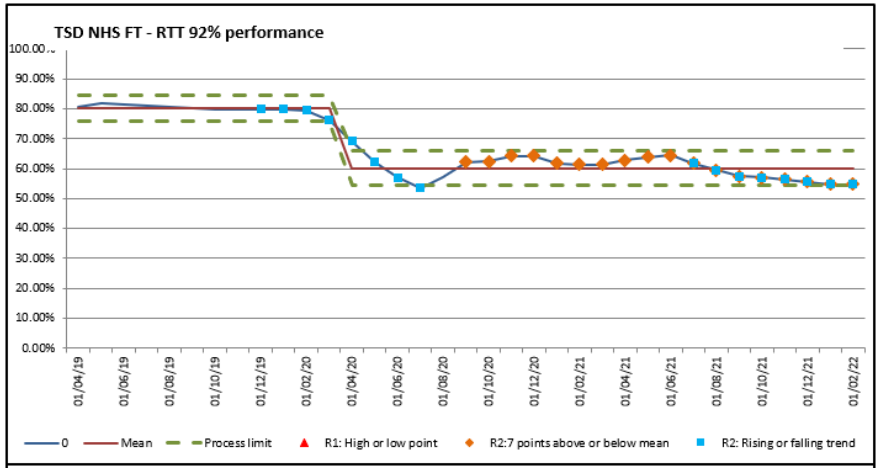


Greater than 60-minute ambulance handover delays

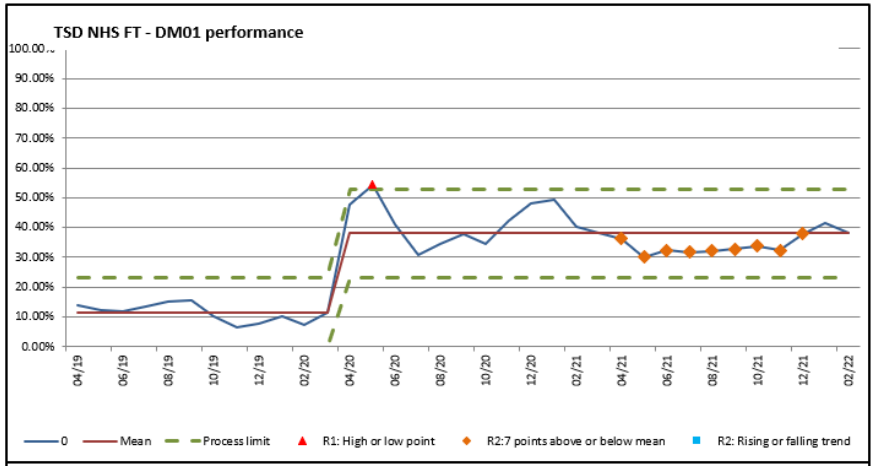


Key Indicators - Statistical Process Control (SPC) charts

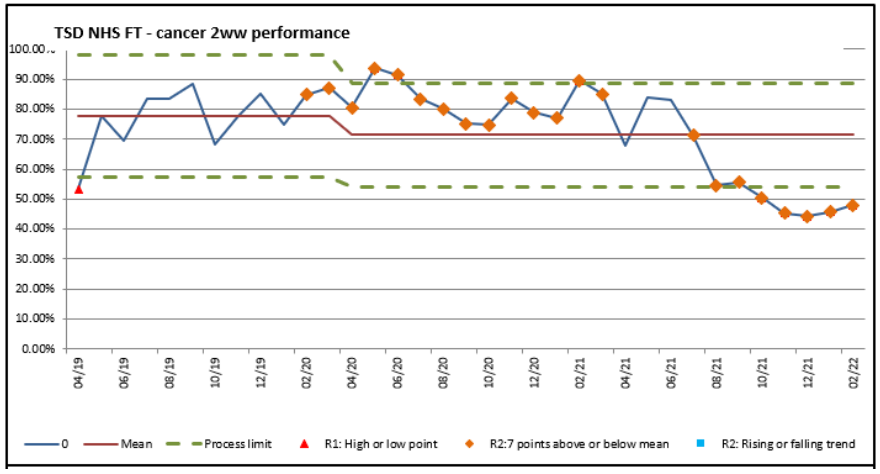
Referral To Treatment



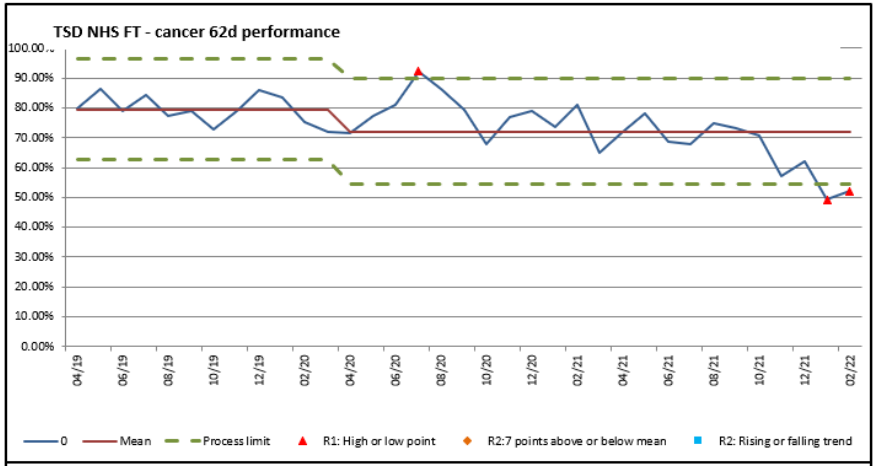
Diagnostics performance



Cancer 2-week-wait performance



Cancer 62-day performance



Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: March 2022 Mortality Score Card			Meeting date: 30 March 2022
Report appendix	Appendix 1 – Hospital Mortality Appendix 2 – Unadjusted Mortality Rate Appendix 3 – Mortality Analysis Appendix 4 – Dr Foster Patient Safety Dashboard Appendix 5 – Focused Mortality Reviews		
Report sponsor	Medical Director		
Report author	Medical Director		
Report provenance	The report will go to the next Mortality Surveillance Group meeting on 14 April 2022 and Quality Improvement Group meeting on 19 April 2022		
Purpose of the report and key issues for consideration/decision	The report is for bimonthly assurance to ensure learning from deaths. ***Please note that the attachments to this report are in the separate attachment pack.***		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is 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**	20
Risk Register		**Risk score**	

BAF Objective 4: To provide safe, quality patient care and achieve best patient experience, responding to the new paradigm of harm and safety as a result of COVID-19

External standards affected by this report and associated risks	

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

Report title: Mortality Surveillance Score Card		Meeting date: 30 March 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 a requirement 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.
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	Nov'21 85.8 12-month average 108.1
• B. Summary Hospital Mortality Index (SHMI)		DH SHMI data		103.2 (July 20 – June 21)
Appendix 2 • Unadjusted Mortality Rate • By number • By location		Trust Data ONS Data	Yearly Average ≤3%	3.62%
Appendix 3 • Mortality Analysis		Trust Data Dr Foster DH HSMR data	CUSUM alerts greater than 1 in last 12 months	Nil greater than 1
Appendix 4 • Dr Foster Patient Safety Dashboard		Dr Foster	All safety indicators positive	Not reported
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 the latest month reported; November 2021. The rolling 12-month position exceeded the expected range for the 12-months to November 2021 with a relative risk of 108 against a 100 benchmark. May, June, July, and August recorded a greater than 110 relative risk but with the monthly HSMR reducing in the autumn months. The SHMI data also show a rise in mortality for the summer months 2021.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.

The Trust has a slightly lower than average palliative care coding rate although this is stable over time. The Trust also had a lower than average Charlson co-morbidity rate although the number of patients recorded with a co-morbidity has increased since March 2021.

The weekly deaths show a rise in out of hospital deaths for some localities during January 2021 (Covid Wave 2) particularly Newton Abbot compared to previous years.

This report shows a continued increase in Medical Examiner (ME) activity with recent new appointments starting. Currently, 100% of non-coronial, in-patient deaths are scrutinised by medical examiners. There continues to be delays in the receipt of death referrals from the wards and breaches to the completion of the Medical Certificate of Cause of Death (MCCD) within the required 5-day period for registration. This is being actively managed on a daily basis with escalation via Control Room and senior medical leadership team.

3.0 Conclusion

Although Hospital Standardised Mortality rate has returned to below the expected level for the latest reported month, both HSMR and SHMI indicate a higher than expected mortality for the summer months of 2021. This period was also a time of unusual escalation in urgent and emergency care, requiring a further repurposing of the day surgery unit as a medical receiving unit. The summer months usually see a reduction in acuity of disease on presentation but initial assessment indicates this did not occur in 2021. The Performance and Patient Safety teams will continue to analyse the data to better understand the change in HSMR during this time.

There were 3 stillbirths between January and March 2022, which are under review. National stillbirth data 2012-2020 shows the rate for the Trust for 2020 to be below the average for England.

The paediatric team have successfully organised suicide prevention training for staff.

Scrutiny of non-coronial in-patient deaths by an expanded Medical Examiner team is now 100%. Further work is required to communicate the changes in the process for completion of Medical Certificate of Cause of Death (MCCD) certificate and to work with clinical teams to improve the time taken to complete the MCCD after death.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: CQC Assurance Report			Meeting date: 30 March 2022
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	System Director of Nursing and Professional Practice, South Devon; CQC Compliance Manager		
Report provenance	The CQC Compliance Assurance Group meeting held on the 25th January & 22nd February 2022 focused on the following areas within the agenda and CQC improvement plan. • Must Do Should Do Improvement action review • CQC Trust Activity • CQC Trust enforcement notice • CQC Updates		
Purpose of the report and key issues for consideration/decision	To update the Trust Board with the key areas of focus of the CQC and Compliance Assurance Group, including exception reporting on the Trust's progress towards addressing the CQC findings from the 2020 CQC Inspection, upcoming CQC regulation activities and actions to address the December 2021 improvement requirements		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to: • Note the key areas of challenge relating to the 2019/20 Must Do & Should Dos improvement requirements and actions undertaken • Note the improvement requirements relating to the December 2021 inspection and regulatory improvement requirements. • Note progress and actions to date around Nutrition and Hydration.		
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	<table><tr><td>**Board Assurance Framework**</td><td>x</td><td>**Risk score**</td><td>20</td></tr><tr><td>**Risk Register**</td><td>x</td><td>**Risk score**</td><td>12</td></tr></table> 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	<table><tr><td>**Care Quality Commission**</td><td>**x**</td><td>**Terms of Authorisation**</td><td></td></tr><tr><td>**NHS Improvement**</td><td>**x**</td><td>**Legislation**</td><td></td></tr><tr><td>**NHS England**</td><td>**x**</td><td>**National policy/guidance**</td><td>**x**</td></tr></table>

Report title: CQC Assurance Report		Meeting date: March 2022
Report sponsor	Chief Nurse	
Report author	System Director of Nursing and Professional Practice, South Devon; CQC Compliance Manager	

1. Introduction

This report provides an update to the Quality Assurance Committee on the following:

Section	Article
Section 2	Status & Exception Reporting on the CQC Improvement Plan
Section 3	Executive Evidence Reviews
Section 4	Update on CQC regulatory activities with TSDFT including the Dec 21 Focused Inspection visit update and report
Section 5	CQC News and Information

2. CQC Improvement Plan

The CQC Compliance and Assurance Group (CQCCAG) has the main oversight role of monitoring, challenging and tracking progress of the CQC Improvement Plan. This plan was created to address the 28 Requirement Notices (Must Dos) and the 43 Should Do improvements following the CQCs Inspection Report published on 2 July 2020.

The focus of the January and February meetings was for the ISU & Trustwide Improvement leads to present their plans for completion of each overdue Must Do actions (RAG-rated Red).

These meetings also included the re-opened Must Do actions, following the Executive Evidence Reviews, which had taken place through September & October 2021. A further set of meetings are required to review the Should Do actions. This was due to be planned for Dec but the rise in the Omicron variant has delayed this and it is likely to be undertaken in mid-April 2022.

Table 1 shows the status of the Must Dos (MD) and Should Dos (SD) per CQC core service as of the 2nd March 2022

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**

There remains with 9 Must Dos improvement actions outstanding, as listed below:

MDSD No	Description	Core Service
M1	Ensure the Trust has clear oversight of compliance with Resus training	Trust wide - Training
M3	MCA and MHA Training and understanding	U&E Care - Training
M6	All staff receive mandatory training	U&E Care - Training
M10	Mandatory Training	Medical Care - Training
M11	Annual Appraisals	Medical Care – Appraisals
M12	MCA MH training	Trustwide Training
M25	Medics Mandatory training	Maternity Care – Training
M17	Uncluttered clear premises	Medical Care, Estates
M21	Rolling replacement Programme	Medical Devices

3. Action Summary Table by Theme

The 9 Must Dos by theme are:

- x 6 correspond to training
- x1 to appraisal
- x to a rolling replacement program
- x1 clutter free premises.

3.1 Mandatory Training

The volume of work that has been applied to ensuring mandatory training is achieved has been marked, however the 85% target figure has not been achieved in a number of areas such as Mental Capacity Act training, certain resuscitation courses and Medics mandatory training within Maternity.

The Trust has developed a COVID Recovery Plan for Mandatory Training. This has been approved by the People Education Governance Group (PEGG) and will be presented to the People Committee in May for final approval. The recovery plan sets out a road map and improvement targets for the next 2 years supplemented by a descriptor of other key measures of assurance that sit alongside training.

The Education team continue to make changes to the reporting process and in May, the Hive will be used to generate area level reports along with recovery trajectories. The team are also progressing the Covid recovery plan.

Maternity specific training is up to date but targeted activity is planned to ensure Information Governance and Moving & Handling training hit the required numbers as these are the two areas where doctor compliance is not as required.

3.2 Appraisals

Moor to Sea/Paignton & Brixham – February compliance is at 68% and 78% respectively and Staff appraisals in the **Medical Core Service** have been greatly

affected by the latest Covid wave and a planned recovery process led by HR is in place. All efforts in the interim remain to ensure as many as possible receive a trust appraisal.

3.3 Rolling replacement programme

The day to day management and monitoring of our equipment takes place under the governance of the Medical Devices Group. The group and the Medical Devices team ensure all equipment used by the trust is recorded on an asset register, is risk assessed and maintained as per the regulations, guidance and instructions, with the review dates recorded.

All equipment that needs repair is referred to the Medical Devices Team who remove from service, replace where necessary and rectify as required. The Medical Devices team maintain a comprehensive website, including all referral, repair and replacement policies for staff to follow.

In the 2020/21 there has been continued investment in the rolling program for medical devices/ equipment the Trust and this has been accelerated in 21/22. It was forecast that the Trust would spend circa £2.4 on the replacement of medical devices in 21/22, however due to accelerated investment, the actual spend in this area has been £5.9m.

Replacement commitments being taken in to the 22/23 financial year amount to £2.4m and all capital investment in this area will be subject to a Quality and Equality Impact Assessment (QEIA) via the Capital Investment Delivery Group which is attended by the Trust Chief Nurse and Medical Director.

3.4 Storage & Clutter

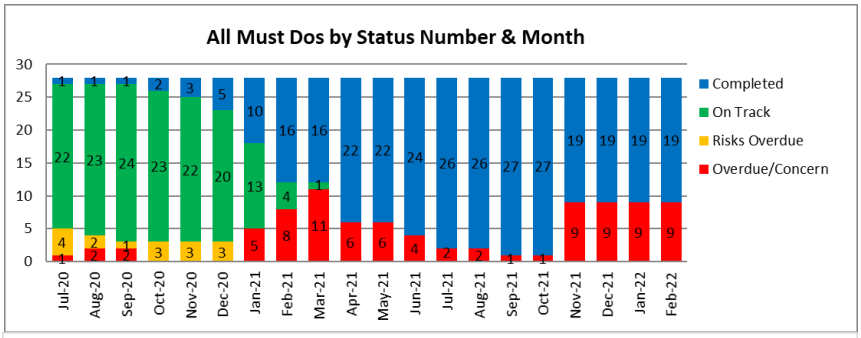
Removal of clutter from the ward environments is a key Must Do improvement action and ongoing challenge to achieve compliance due to the limited storage capacity at ward level. While the Trust is progressing the estate's transformation programme, a number of actions have been progressed to minimise the risk of clinical areas being cluttered, these involve:

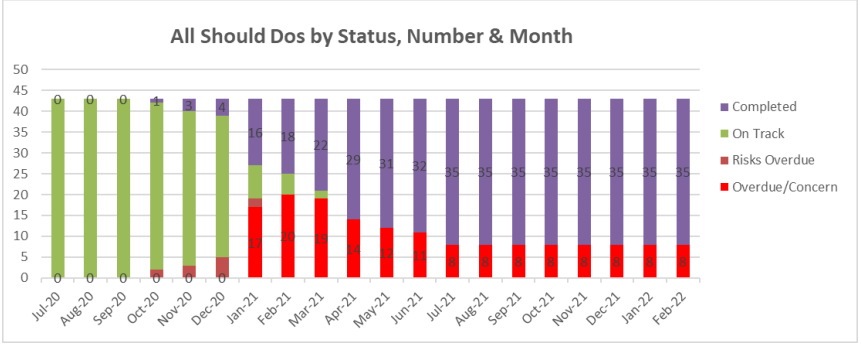
- Regrading clutter and storage several initiatives and physical adjustments have been implemented and undertaken in order to address issues with clutter and the inappropriate storage of equipment across the organisation.
- In a number of key clinical areas, under the leadership of the Associate Directors for Nursing and Professional Practice, Matrons are now undertaking monthly environment audits of ward areas and a significant proportion of this focusses on issues associated with storage of equipment and general clutter.
- The outputs of these audits have driven physical changes to the clinical environment, for example, works have been undertaken in both Warrington and Cromie wards to provide improved storage facilities locally within their areas.
- The Trust now has a fully functional Fire Safety Group (FSG) which is chaired by the Fire Safety Manager. The FSG is attended by both clinical and non-clinical representatives, and provides a forum for colleagues to discuss storage issues which pose a potential risk, particularly on evacuation routes. Any remedial requirements are captured, monitored and driven by the FSG chair.
- Physical adjustments to the TAIRU building have commenced and will conclude in quarter one of the 22/23 financial year. The purpose of these works is to create

a fit for purpose, dedicated storage space which will house bulk items that the wards may require but not want to store in their areas.

- The Estates and Facilities Management team are currently undertaking a feasibility exercise relating to the creation of additional dedicated storage space for beds and mattresses on level four of the tower block. This would involve repurposing washroom facilities in order to create more storage space. The feasibility works will conclude at the end of quarter one of the 22/23 financial year, and, if appropriate a proposal will be shared with the relevant clinical teams to agree the logistics and timeframes associated with repurposing the aforementioned space.

Charts 1 & 2 highlight the status of the Must Do Should Dos as of the 2nd March 2022. Please note the rise in number of Must Dos in Nov 21 is as a result of the Executive review





4. Executive Evidence Reviews

Dates for the review of the remaining Should Do actions and Trust Well Led assessment are being set for late April 2022 to complete our internal assurance process.

5. Update on CQC activity within the Trust

5.1 CQC Focused Inspection Visit 1st December 2021

On the 01 December and between 08.00 and 17.30 the CQC carried out a focused inspection of Medical Care at Torbay Hospital. The Inspection Team comprised Tracy Hipkin-Wale (lead inspector), Gail Richardson (second inspector) and Yogi Ragoo (Interim Inspection Manager) and the team inspected Forrest Ward and EAU4 following concerns raised regarding staffing levels, nutrition and hydration. They also visited George Earle ward, as a comparison ward, to observe nutrition and hydration at lunch time.

Following a factual accuracy check and amendments thereafter, the final report was released on the 4th March 2022. The Trust has continued to progress improvements in line with the Improvement Plan submitted to the CQC and Quality Assurance Committee in Jan 2022. The Trust resubmitted action plans on March 16th to demonstrate improvement actions to achieve full compliance with the following regulations.

- **Regulation 12 Safe Care and Treatment -** Ensure risk assessments are completed fully for each patient, within 24 hours of admission to hospital, in line with trust policy. The service must also ensure they consistently keep detailed clear and up-to-date nursing records of patients' care and treatment (Regulations 12 12(2)(a) and 12(2)(h)). Please
- **Regulation 17 Good governance -** Ensure patients requiring additional support with nutrition and hydration are quickly identified and actions taken (Regulation 17 2(c)(f)). Ensure governance processes are improved to undertake consistent audits and thereafter that these results are reviewed and acted upon (Regulation 17 17(2)(b)).

5.2 Progress against key actions includes:

All staff follow the Six Steps to Patient Safety that the Trust has created:

1. 10am - eyes on the patients, all patient records are reviewed to ensure risk assessments, care plans are completed, referrals have been made and food and fluid balance charts are completed and monitored
2. All patients identified at risk are recorded on the Swift Plus boards
3. The morning Safety Briefing identifies and allocates patients to staff who require support with nutrition & hydration
4. Protected Meal times are being enforced
5. Partnering with the Catering team to ensure clear roles and responsibilities at meal times
6. By 14:00hrs all documentation and care plans that are in updated including contemporaneous fluid and food charts

The daily audits are showing 100% compliance - The Trust is currently reviewing the audit and data submission to ensure that the Trust dashboards reflect 2pm audit position as opposed to the electronic Point Prevalence position.

The Trust led a successful Nutrition and Hydration campaign week commencing 14th March that involved a range of interventions to promote and embed our improvements, introducing our mascots *Nutricious & Hydratus*, coffee mornings on the wards, quizzes, crosswords, treasure hunts, Nutrition & Hydration ambassadors to name but a few.

5.3 CQC-TSDFT Engagement meeting

The January 2022 Engagement meeting focused on our 2020 action plan, update on our Nutrition & Hydration action plan, as well as discussing the current situation in terms of managing the Covid surge, staffing issues and ambulance waits. All documents requested were provided and the CQC accepted them with no further information requested. The next meeting is planned for the 6th April 2022.

5.4 CQCs Direct Monitoring Approach (DMA)

In line with the revised CQC monitoring approach all services are now reviewed by inspectors on a monthly basis, using an app-based monitoring system. Providers do not have access to the system, which will flag up any services it identifies as of potential risk. Medium risk will trigger direct monitoring activity (DMA), while those services deemed as high risk will receive an onsite inspection. DMA will involve direct communication between provider and the CQC and, should the DMA lead to an inspection, there will be no information published until the inspection report is released.

In line with the national roll out of DMA the Trust has been subject to a DMA in the Emergency Department, Maternity, Surgical Care, Medical Care, Patient Transport Services, Outpatients Department - no issues of concern have been raised by the CQC at any of the DMAs.

The planned DMAs for January and February were cancelled by the CQC due to the Covid surge, and the below core services are awaiting to be re-arranged by the CQC.

Core Service
Gynae Care
Critical Care Unit
Children & Young People
End of Life – Acute

5.5 New CQC Hospital Inspector

Denise Eastaff has taken up her place as our new Hospital Relationship Manager and has visited the Trust and met with our Chief Nurse, Deborah Kelly. Yogiraj Ragoo, our Interim Inspection Manager has now been replaced with Julie Foster, Inspection Manager. Our next quarterly Engagement meeting with the CQC is planned for the 6th April 2022

6 CQC News & Information

6.1 Inspection Activity

From the 1st February the CQC are returning to their normal inspection activity. Their immediate focus will be on Urgent and Emergency care as a complete pathway within the integrated care system. Our team are currently reviewing their practices and processes in preparedness for any local CQC inspection activity.

6.2 CQC News - Key Appointments

- The Secretary of State for Health and Social Care, Sajid Javid, has named Ian Dilks OBE as his preferred candidate for next Chair of CQC.
- Subject to approval by the Health and Social Care Select Committee, Ian Dilks will take over from the current Chair, Peter Wyman CBE DL, once his appointment ends.
- The Care Quality Commission (CQC) has appointed Dr Sean O'Kelly as the new Chief Inspector of Hospitals.

7. Recommendations

The Trust Board of Directors is asked to:

- Note the key areas of challenge and progress relating to the 2019/20 Must Do & Should Dos improvement requirements and actions undertaken
- Note the improvement requirements relating to the December 2021 inspection and regulatory improvement requirements.
- Note progress and actions to date around Nutrition and Hydration.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors		
Report title: Safe Staffing Bi Annual Review (Aug 21 – Jan 22)		Meeting Date: 30 March 2022
Report appendix	None	
Report sponsor	Chief Nurse	
Report author	Interim System Director of Nursing and Professional Practice	
Report provenance	Executive Directors Private Board	
Purpose of the report and key issues for consideration/decision	The purpose of this paper is to provide assurance to the Trust Board on how the organisation has discharged its responsibility for ensuring safe nurse staffing levels across its inpatient and community wards. It is also intended to provide assurance that the Trust is compliant with the requirements of NHS England/Improvement, the Care Quality Commission, and the National Quality Board Guidance in relation to the Hard Truths (2014) in response to the Francis Enquiry (2013). This paper provides assurance on the progress that has been made since the annual formal establishment review presented to the Trust Board in July 2021 and assurance on staffing levels in the last 6 months. The report contains a range of data that provides assurance of staffing levels at Torbay and South Devon inpatient bed base. The work that has been completed since the last report includes: • Introduced bi- monthly Nursing Workforce Programme Committee • Roll out of acuity and dependency tool in bed-based areas • Twice daily Matron meetings to monitor and assess daily staffing levels From the information available it can be concluded that: • The trust continues to comply with the requirements of NHS England, the CQC and the NQB Guidance in relation to the Hard Truths response to the Francis Enquiry • The Trust is engaged in a number of activities which are aimed at supporting the organisation to build a safe and sustainable workforce.	

<table>
<tr><td>Action required
(choose 1 only)</td><td>For information
☐</td><td>To receive and note
☒</td><td>To approve
☐</td></tr>
<tr><td>Recommendation</td><td colspan="3">Recommendations:
The Trust Board is asked to:
Receive and note the content of this report
Note the increasing challenges in delivery of safer staffing particularly in the current context of COVID-19
Be assured that safe staffing levels have been maintained during the last 6 months with the support of rostered and non-rostered nursing and MDT staff
Note the mitigations and action plans in place</td></tr>
<tr><td colspan="4">Summary of key elements</td></tr>
<tr><td>Strategic objectives supported by this report</td><td colspan="3"><table>
<tr><td>Safe, quality care and best experience</td><td>x</td><td>Valuing our workforce</td><td>x</td></tr>
<tr><td>Improved wellbeing through partnership</td><td></td><td>Well-led</td><td>x</td></tr>
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<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td colspan="3"><table>
<tr><td>Board Assurance Framework</td><td>x</td><td>Risk score</td><td>16</td></tr>
<tr><td>Risk Register</td><td>x</td><td>Risk score</td><td>16</td></tr>
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<tr><td>External standards affected by this report and associated risks</td><td colspan="3"><table>
<tr><td>Care Quality Commission</td><td>x</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>x</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td></td><td>National policy/guidance</td><td>x</td></tr>
</table>There is a risk of being non-complaint in safe staffing levels for all areas</td></tr>
</table>

Report title: Bi Annual Safer Staffing Report		**Meeting date: 30 March 2022**
Report sponsor	Chief Nurse	
Report author	Interim System Director of Nursing and Professional Practice	

1.0 Introduction

Following publication of the Francis Report 2013 and the subsequent Hard Truths (2014) document, NHS England and the CQC issued joint guidance to Trusts on publishing staffing data on nursing, midwifery and health care staff levels. These include;

- Report and publish a monthly return to NHSE/I indicating a planned and actual nurse staffing level by ward
- Publish information with the planned and actual registered and unregistered nurse staffing for each shift
- Provide a 6-monthly report on nurse staffing to the Trust Board

Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are enshrined within the National Health Service (NHS) Constitution, and the Health and Social Care Act (2912) which make explicit the Board's corporate accountability for quality.

In October 2018, NHSI published Developing Workforce Safeguards. This builds on the NQB guidance which includes new recommendations on workforce standards to strengthen the commitment to safe, high quality care. As an organisation we must ensure our staffing processes include evidence based tools, professional judgement and outcomes.

The Board received a paper in July 2021 outlining the requirements following the nursing establishment review against the NQB standards, detailing the analysis and associated recommendations.
This report covers the 6 monthly reporting period of August 2021 to January 2022. Staffing ratios, workforce metrics and rostering data is reviewed bi- monthly at the newly formed Nursing and Midwifery Workforce Programme Committee chaired by the Chief Nurse.

2.0 National and Local Context COVID Impact

This report provides a high-level summary of the key measures taken to ensure safe staffing during the last 6 months and highlight any significant changes related to safer staffing which have occurred since the last report.

Whilst there has been a slight reduction in admissions of patients with COVID-19 during Q3, the trust has seen an increase in patients attending for urgent and emergency care, a picture that is reflected across the country.

In responding to the new Omicron variant of COVID-19 the staffing surge and escalation plans were once again activated. The COVID-19 safest staffing risk framework (which was introduced and agreed at Board to provide assurance around Safer staffing in December 2020) has continued to be applied.

Senior nurses and their teams have made decisions regarding skill mix and nurse to patient ratios in conjunction with a review of patient acuity and dependency, professional judgement and the care environment. This has involved system wide reassignments of nurses and health care support workers during November and December 2021.

3.0 Organisational Alert Status

Over the last 6 months the organisation has been particularly challenged with urgent and emergency provision as well as trying to recover the waiting list position caused through the cessation of services during the pandemic.
The following table (1) shows the OPEL position for the last 5 months;

Table 1

Number of days	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22
OPEL 1	0	0	0	0	0	0
OPEL 2	0	0	0	0	1	0
OPEL 3	4	5	3	1	4	10
OPEL 4	27	25	28	29	26	21
% of month in OPEL 4	87%	83%	90%	97%	83%	67%

The table shows that the trust has constantly been in OPEL 3 & 4 status over the last 6 months and a high percentage of time has been in OPEL 4. The percentage of time spent in OPEL 4 is increasing and November was the highest at 97% further impacting on our clinical teams and patient experience.

This this has had a significant impact on our ability to maintain optimum staffing levels and we have had to use more temporary staffing than we would wish, including the use of off framework agencies.

In particular admission areas such as ED and MRU have seen an increase in the number of patients attending for emergency and urgent care and this has had an impact on staffing levels as more patients are requiring care.

4.0 Care Hours Per Patient Day (CHPPD)- Trust Position – Using the Model Hospital

The CHPPD calculation measures the combined number of hours of care provided to a patient over a 24-hour period by both nurses and healthcare support workers. From September 2018 this measure has been used to provide assurance externally of staffing levels and is published monthly on NHS Choices website. Model Hospital data tables below demonstrates that CHPPD for registered nurses for the Trust is in the lowest quartile at 3.7 which is currently below the peer average of 4.3 and

National average of 4.7, and unregistered CHPPD is higher at 3.8 than both peer at 3.3 and national median of at 3.2. (See Appendix 1 for full details)

Tables 2 & 3 below provide a breakdown of CHPPD for Registered Nurses and Health Care Assistants benchmarked against our local and national peers taken from the Model Hospital dataset.

Registered Nurses/Registered Midwives		
Trust value	**Peer Median**	**National Median**
3.7	4.3	4.7

Table 2

Health Care Assistants/Maternity Care Assistants		
Trust value	**Peer Median**	**National Median**
3.8	3.3	3.2

Table 3

Tables 4 and 5 below have been extracted from the model hospital and benchmarks TSDFT against other similar trusts nationally with regards Care Hours per Patient Day. (It should be noted that information from the model hospital is only updated until September 2021, therefore the impact of the uplift in nursing establishment will not be seen here).

The table below demonstrates that TSDFT is in the lowest quartile for registered nurses (identified by the black bar)

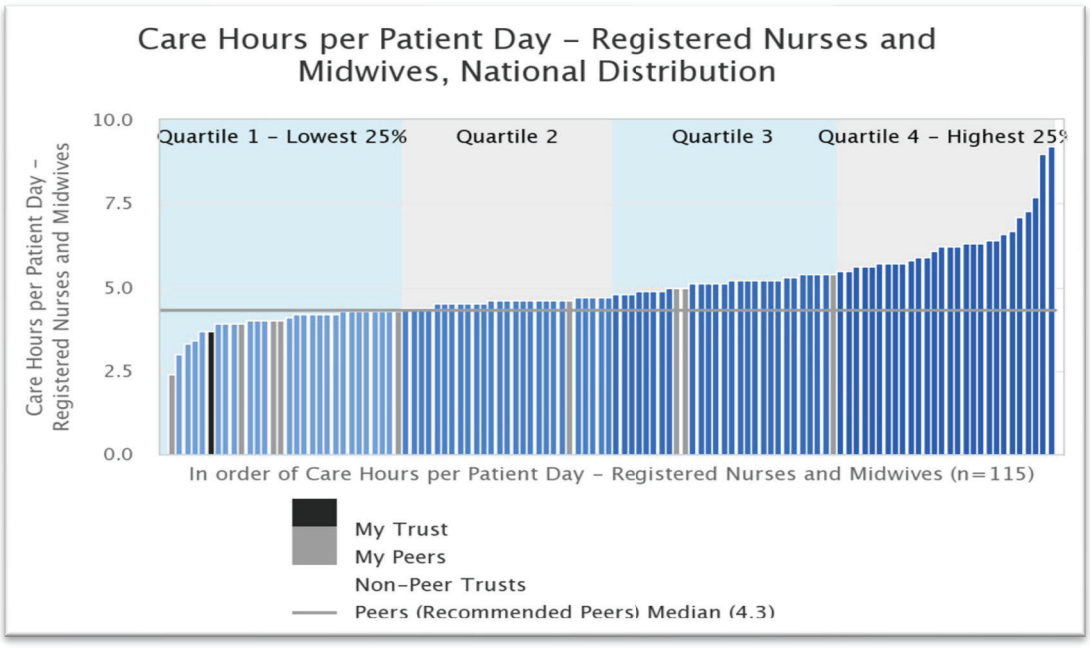


Table 4

Table 5 below demonstrates that TSDFT is in the highest quartile for Healthcare support workers. This has resulted in a higher than recommended RN to HCA skill mix (identified by black bar)

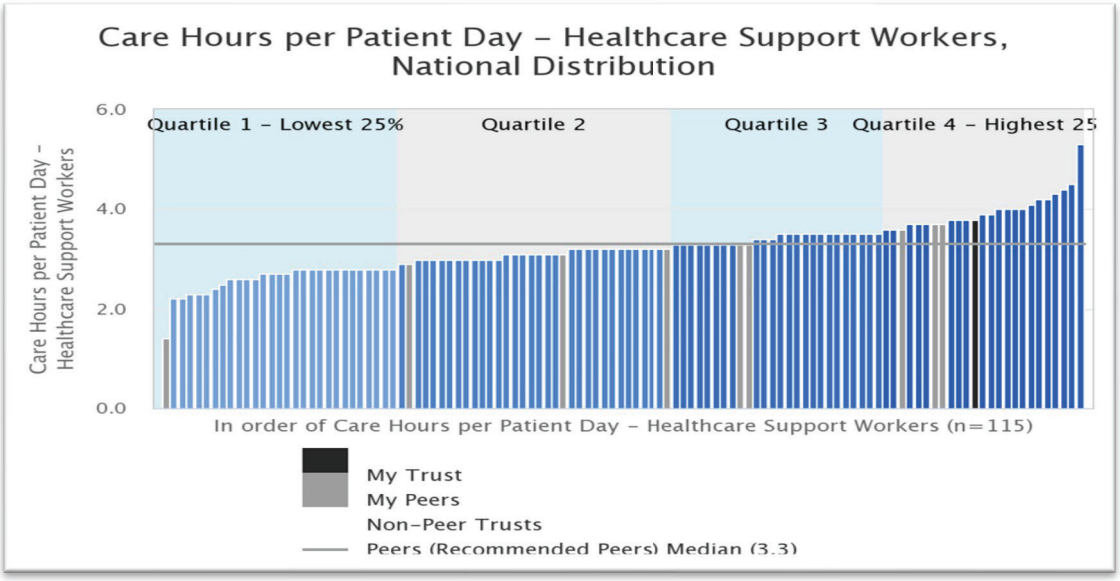


Table 5

The skill mix overall is leaner than average, particularly in medical wards and community inpatient wards, and this has been addressed within the safer staffing establishment review approved at Trust Board in July 21. This will rebalance this skill mix from 45:55 to 60:40, which is in line with the Royal College of Nurses 65:35 for inpatient areas and 80:20 for assessment areas.

From the monthly reporting we know that the assessment areas and the designated COVID-19 areas are often reporting actual staffing levels less than the planned CHPPD.

There has been an increased need to provide 1-1 care for patients requiring supportive observation and it has not always been possible to support this request. This results in ward staff having to deploy one nurse to provide 1:1 depleting the number of care hours available to the rest of the ward.

In order to mitigate risks, ward staff are redeployed on a daily basis and this is recorded.

5.0 Reassignment; Analysis and Impact

Table 6 below shows the number of staff who have been redeployed every month in order to provide patients with a safe level of care. The tool was introduced pre-pandemic but had a more targeted roll out in October. Following the appointment of the Safer Staffing Nurse Lead, this has provided an increase in recording using the system.

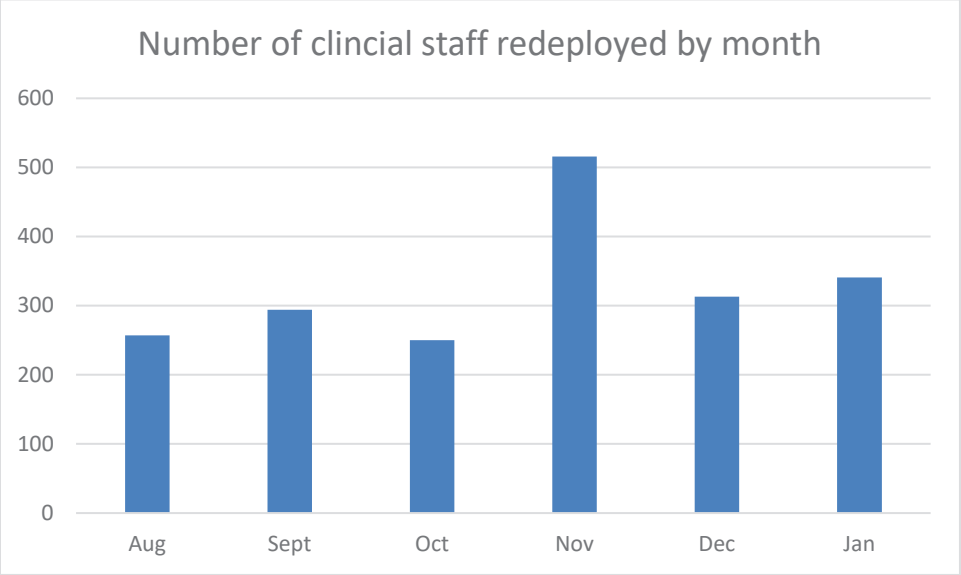


Table 6

The number of moves that take place each day is very challenging for all of our teams and staff have expressed concerns about moving so frequently. Decisions to move staff are undertaken following a risk assessment at the twice daily staffing meeting and staff are supported to ensure they have the necessary skills and competencies to work in the allocated area.

5.1 Ensuring safe Reassignment

Reassignment of staff during the last 6 months has caused significant disruption and upset for large parts of our nursing and midwifery workforce body. To strengthen our approach and provide wrap around support a reassignment framework has been developed in partnership with the Clinical Education team.

The aim of the framework is to provide clear practice guidance for the clinical skills required to work in different clinical areas. The document includes a local ward/area induction, the principles of Practice Standards for Registered Nurses, roles and responsibilities and a self-assessment for nurses to identify their training and development needs.

6.0 Current Acuity and Dependency

All patient's acuity and dependency care needs are assessed using the Safer Nursing Care tool twice a day. This is captured on the electronic Safe Care module and this information is used to inform staffing decisions at the twice daily Matron led staffing meetings. Every shift is RAG rated in line with our risk assessment framework. This ensures a more robust evidence-based approach to safely staffing the inpatient areas. (see table below for overview of last 6 months shifts)

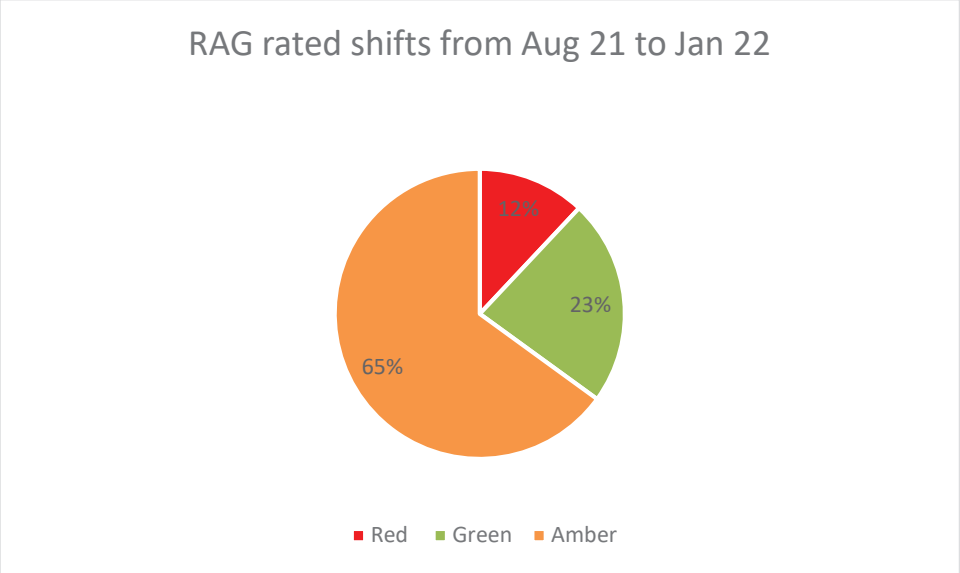


Table 7

The areas highlighted green are frequently SCBU, Ella Rowcroft Ward and Coronary Care.

The red areas during the day have mainly been the Emergency Department and assessment areas, with health care of the elderly wards also declaring red when they are unable to deploy sufficient staff to care for those patients requiring enhanced observation. During the day these shifts are escalated through to the twice daily staffing meeting and staff from other areas are asked to support. i.e. general theatres, ward managers and Matrons.

Overnight, the Emergency Department have declared red more than any other area due to increased operational pressures and less staff on duty to redeploy. During these times the clinical site practitioners take overall responsibility for staffing and will support themselves or find other resources such as critical care outreach team. The safer staffing COVID-19 escalation framework is operationalised during these times and staff redeployed as appropriate.

Whilst TSD have declared red at the start of 12% of the total shifts over the last 6 months, this is mainly due to short term sickness. The red areas will be reviewed at the twice daily staffing meetings and actions taken to mitigate risks. This has often meant that the ward manager is included in the staffing numbers to provide direct clinical care and not to act in the supervisory capacity as agreed in the safer staffing establishment review.

Patient safety is always paramount. Senior nurse presence will be available to support staff and review different ways of working to ensure patients receive the care that they need if no additional resources can be found.
There have been zero occasions where wards have worked in a grey or black status.

7.0 Profile of Acuity

ISU	Healthroster	Total % Acuity for 6 Months					
		1:1	0	1a	1b	2	3
Coastal ISU	Ainslie	6%	0%	9%	170%	0%	0%
	Allerton	6%	4%	53%	77%	20%	0%
	Cromie	3%	7%	72%	73%	17%	0%
	Ella Rowcroft	19%	1%	28%	146%	4%	0%
	Warrington	6%	3%	55%	109%	0%	0%
	Dawlish	14%	51%	9%	58%	0%	0%
Moor to Sea ISU	Cheetham Hill	38%	4%	20%	91%	1%	0%
	Dart Ward	4%	44%	15%	115%	0%	0%
	George Earle	13%	7%	12%	140%	3%	0%
	Simpson	24%	2%	29%	100%	0%	0%
	Teign	3%	89%	1%	68%	0%	0%
	Templer	3%	66%	1%	75%	0%	0%
Paignton & Brixham ISU	Brixham Hosp In patients	18%	5%	35%	109%	0%	0%
	Coronary Care Unit	1%	52%	76%	34%	13%	0.2%
	Dunlop	7%	36%	72%	42%	1%	0%
	EAU4	12%	0%	3%	81%	53%	0%
	Midgley	19%	8%	39%	107%	8%	0%

	Actual Census			Total Acuity for 6 Months TSDFT						Total % Acuity for 6 Months TSDFT					
TSDFT	08:00 (3077)	19:00 (3077)	Total No Of Beds Occupied	1:1	0	1a	1b	2	3	1:1	0	1a	1b	2	3
All Areas	2833	2333	68283	8108	15641	19934	64183	4535	4	12%	23%	29%	94%	7%	0.01%

The above table shows the level of patient acuity as a % of patients over the last 6 months. The red data shows the highest area for the level of acuity over the last 6 months. The levels of acuity are described below;

- 1:1 patient requiring supportive observation
- Level 0 – Patient needs met by provision of normal ward carers
- Level 1a – Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate
- Level 1b – Patients who are stable but are dependent upon nursing care to meet most of their daily needs
- Level 2- May be managed within clearly identified, designated beds, resources with the required expertise and staffing levels OR nay require transfer to a Level 2 unit
- Level 3 – Patients needing advanced respiratory support and / or therapeutic support

There is some work to do to further understand the patient profile and the assessment of patient's acuity. There is a low recording of level 0 patients in some ward areas and this may need some further peer review and benchmarking with other organisations.

Of note is the high percentage of patients who have scored a level 1b – these are patients who are fully dependent upon nursing staff to have their care needs met and these patients are generally medically stable.

8.0 Red Flag events

A red flag event is any event that could indicate patient safety is at risk if immediate actions are not taken. These red flag events are suggested by the NICE safer staffing guidance and organisations are able to introduce local red flags to support patient safety.

Table 8 below shows the number of red flags that have been raised by nursing staff in relation to any patient safety issues. It is not surprising that the majority of red flags raised are in relation to a shortfall of Registered nursing hours, but reassuringly there have been minimal red flags raised in relation to patients not receiving medication or having vital observations performed.

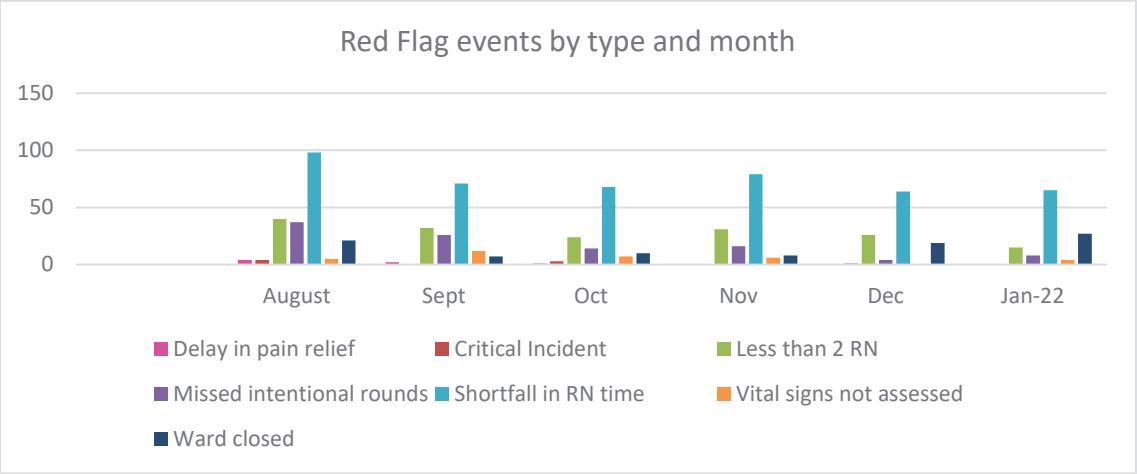


Table 8

9.0 E- rostering

The Trust is continuing to monitor the KPIs as recommended by NHSE/I to ensure the benefits of the e rostering system are delivered. The dashboard is now presented monthly at the Nursing Workforce Programme Committee overseen by the Chief Nurse.

Table 8 below shows KPI 2 – achieving the 6 weeks in advance publication; the dashboard shows the current compliance with this KPI and check and challenge meetings have now been set up with ADNPP's and Matrons to improve this metric. Improving this metric will ensure shifts are sent to bank staff earlier resulting in a higher uptake of shifts. There is still some work to do and an improvement plan is being led by the Lead Nurse for Safer Staffing.

	Fully Approved 6 Weeks in Advance																					
Roster Period	Ainslie	Allerton	Cromie	Ella	Warrington	Dawlish	Cheetham	Dart	GE	Simpson	ED	Teign	Templar	ICU	Brixham	CCU	Dunlop	Midgley	EAU4	Turner	LC	Meridian	SCBU
30th Aug - 26th Sep	Yes	Yes	No	Yes	Yes	No	No	No	Yes	No		Yes	No	No	Yes	Yes	Yes	No	Yes	No	No	No	No
27th Sep - 24th Oct	Yes	No	No	No	Yes	No	Yes	No	Yes	No		No	No	No	No	No	No	No	No	No	No	Yes	No
25th Oct - 21st Nov	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	No		Yes	Yes	No	Yes	Yes	No	No	No	No	No	Yes	No
22nd Nov - 19th Dec	Yes	No	No	No	Yes	No	No	No	No	Yes *		Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	NC	No	No
20th Dec - 16th Jan	No	Yes	No	No	No	Yes	Yes	No	No	No		Yes **	Yes	No	Yes **	No	No	Yes	No	NC	Yes	Yes**	Yes
17th Jan - 13th Feb 2022	No	Yes	Yes		Yes	No	No	No	No	No		Yes	Yes	No	Yes	No	Yes	No	No	No	Yes	Yes	No
14th Feb - 13th March	No	No	No	No	No	No	No	No	No	No		Yes	Yes	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
14th March - 10th April	Yes	No	Yes	Yes	Yes	No	No	No	No	No	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	No	Yes	Yes*	Yes

Table 9

An E- Rostering Project group has been introduced and overseen by the Head of Nursing Workforce to apply this check and challenge to each of the rosters and the ADNPP'S will start to approve the rosters using a set checklist to remind teams of the KPI's required. A monthly report is shared at the Nursing Workforce Programme Committee where the data is reviewed in detail.

10.0 Use of Temporary Staffing

The demand for Registered Nurses has decreased since October 2021 with a slight increase in demand in January 22. (Table 9)

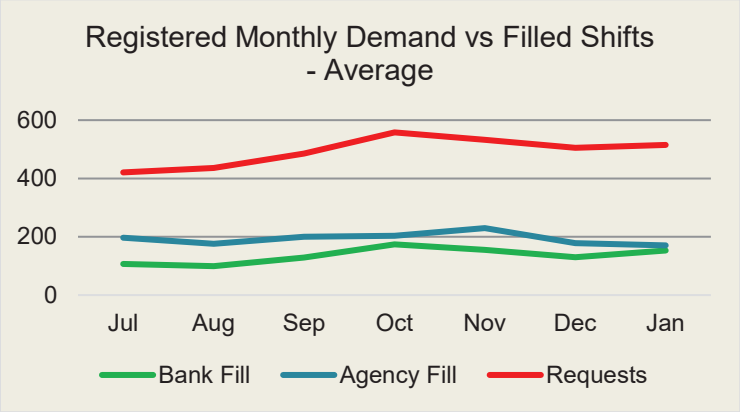


Table 10

A recruitment strategy is underway to fill the newly created vacancies following the safer staffing review. This gap is currently being filled with temporary staff and substantive staff working additional hours.

This slight increase in demand in January 22 is in line with the opening of more escalation areas across the acute and community sites to manage the increased demand for services, and the increase in staff absence due to nonsocimal COVID-19 infection rates.

The analysis of the key drivers for requesting bank and agency include:

- Enhanced supportive observation
- Sickness and COVID-19 related sickness
- Vacancies
- Caring for Covid-19 patients which requires a different nursing care model.

The senior nurses are working hard to try and reduce the number of off framework agency staff being used and there has been a steady reduction in use since Sept 2021.

The Workforce slides in the IPR report demonstrate that December's agency spend of £1.2m was a reduction £125k from November 21.

Bank costs increased slightly by £15k from the November figure but the overall FTE usage reduced by 6.6 FTE which indicates nursing shift coverage were increasingly supplied by bank rather than agency

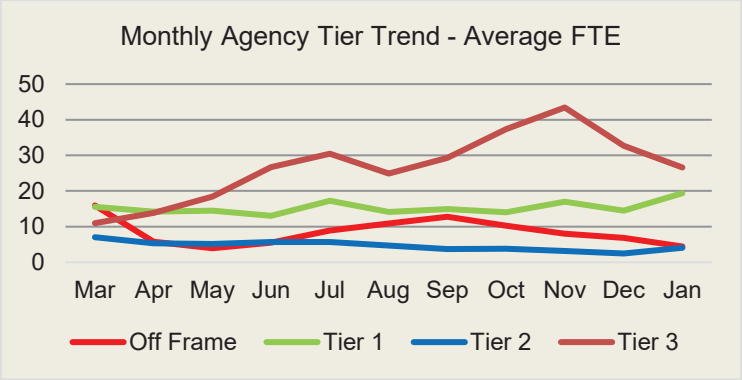


Table 11

11.0 Nursing recruitment

The overall nurse recruitment strategy continues and although the pandemic has had an effect on international recruitment, now the market has reopened there is a real opportunity to accelerate the recruitment and on boarding of international nurses. Working with the Devon IR hub, TSD have an ambition to recruit 240 IR nurses in 2022/23

Table 12 below shows the current fill rate for staff in post vs the current vacancy. There is an ambition to achieve a 95% fill rate for Registered Nurses and the following recruitment activity is in place. The declining fill rate in October 2021 (Table 12) as a % of the 95% reflects the uplift in establishment and consequently increased vacancy rate.

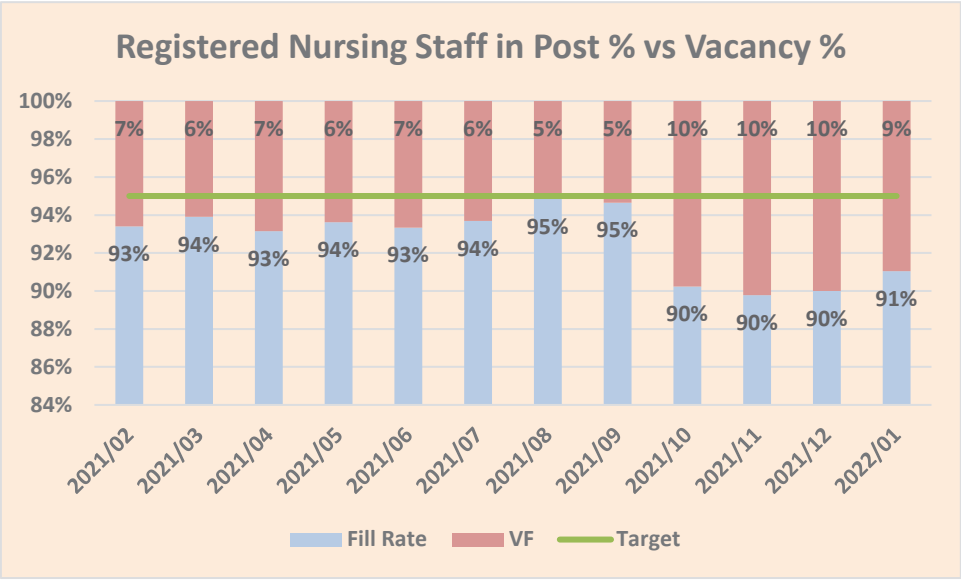


Table 12

- It is anticipated that the majority of nurses will be recruited through the IR hub and plans are in place to ensure that TSDFT will onboard 25 nurses a month between April – June 22.
- A corporate Nursing Retention strategy which will capitalise on the People Plan through associated career pathways including flexible careers, flexible working, temporary, staff involvement and engagement is in development.
- Targeted recruitment campaigns are underway for newly registered nurses and midwives and new to care HCSW's with a real emphasis on career pathways and apprenticeship opportunities.
- Busy social media presence and working with Indeed and other agencies to promote working in TSDFT, particularly for new to care workers
- Part of the Devon ICS Retention Project which aims to reduce turnover rates for nurses aged 50+ and to provide targeted support to early stage career nurses.

11.1 Recruitment Pipeline

11.1.1. Health care Support Worker Activity:

- Successfully recruited 7 Apprentice HCA's in January and have a further 5 expecting to commence employment on the 14th March 2022.
- Apprentice HCA Support Worker will go live April 2022.

11.1.2 International Recruitment (IR) Nurse Activity:

Arrival dates	24 Feb	24 March	28 April	May	June
Numbers	9	16	25	25	25

12.0 Conclusion

The Trust Board is asked to note this paper in line with the exceptional circumstances our nursing teams have been working in over the last 18 months, and to take assurance that processes are in place to ensure safe staffing levels are reviewed twice a day and all concerns are mitigated in real time.
Although it has remained a challenge to maintain safe staffing levels, actions taken have provided appropriate mitigation to maintain safety.

It is acknowledged that far greater focus needs to be placed on the correlation between safe staffing levels, patient experience and patient harm and this will be the focus with ISU's moving forward.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Interim Maternity Governance Update			Meeting date: 30 March 2022
Report appendix	Appendix 1: Maternity Self-Assessment Tool		
Report sponsor	Chief Nurse		
Report author	Interim Associate Director of Midwifery and Professional Practice / Head of Midwifery and Gynaecology		
Report provenance	This report has been produced at the request of the Chief Nurse to provide the Board an interim update on key issues in maternity.		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to provide the Trust Board with an update and to ensure the Board are sighted on key issues facing maternity services at time where a number of factors are influencing achievement and progress related to national maternity safety ambitions. The report will cover, • The requirements of the Maternity Self-Assessment Tool, the process of self-assessment and target dates for completion. • Provide an update of concerns related to CNST Maternity Incentive Scheme Standard 6, Carbon Monoxide monitoring and current results indicate that we be unable to demonstrate successful compliance with the overall scheme due this standard. • Progress towards achievement of Continuity of Carer. This is important as leadership within the senior midwifery is in a period of transition with the commencement of a new Head of Midwifery / Associate Director of Midwifery Professional Practice. ***Please note that the attachment to this report is in the separate attachment pack***		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to: ➢ Note the timescales for completion of the Maternity Self-Assessment Tool. ➢ Note the current underperformance in CO monitoring and actions to strengthen mother and baby safety ➢ Note the risks to risks to CNST Level 4 attainment		

	➢ Note the challenges with achieving Continuity of Carer at scale and actions being taken to recruit to and ensure model is fully adopted
Summary of key elements	
Strategic objectives supported by this report	

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

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

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

External standards affected by this report and associated risks

Care Quality Commission	**x**	**Terms of Authorisation**	
NHS Improvement	**x**	**Legislation**	
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.

Interim Maternity Governance Update		**Meeting date: 30 March 2022**
Report sponsor	Chief Nurse	
Report author	Interim Associate Director of Midwifery and Professional Practice / Head of Midwifery and Gynaecology	

1.0 Introduction

1.1 This Maternity Governance update report has been produced at the request of the Chief Nurse, to ensure the Trust Board is sighted on a number of key issues emerging within maternity service and to ensure that steps are being taken to manage and mitigate risks associated with these. The report will cover three areas,

- The requirements of the Maternity Self-Assessment Tool, the process of self-assessment and target dates for completion.
- Provide an update of concerns related to CNST Maternity Incentive Scheme Standard 6, Carbon Monoxide monitoring and current results indicate that we will be unable to demonstrate successful compliance with the overall scheme due low compliance with this standard.
- Progress towards achievement of Continuity of Carer

2.0 Maternity Self – Assessment Tool

2.1 The National Maternity Self- Assessment Tool provides support to all trusts seeking to improve their maternity service rating from 'requires improvement' to 'good', as well as a supporting tool to support trusts looking to benchmark their services against national standards and best practice guidance.

2.2 The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. The most recent version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

2.3 This tool is to be used as a benchmark self-assessment exercise for organisations in the core principles of good safety standards within Maternity services.
The tool covers 8 Key Lines of Enquiry and includes,

- Leadership and Development
- Pillars of good governance
- Quality improvement – application of methodology and tools
- National standards and guidance – service delivery of these
- Safety culture – no blame and proactive psychological safety
- Patient voice – co design and engagement
- Staff engagement
- Business planning

There are over 160 component parts to self-assess compliance against and

which evidence is required in order to RAG rate the service. The results of which provide a level assurance and potential gap analysis for areas of focus for quality improvement.

2.4 Maternity care has rarely been under as much scrutiny as in recent years and with the anticipated publication of the second Ockendon report, this is not likely to change. Completion of the maternity self-assessment tool is therefore an opportunity to review where we are against national review findings and recommendations for good safety principles with a fresh eyes approach.

2.5 It is recommended that maternity safety champion, non-executive and executive leads are involved in the self-assessment process and that input is sought from the Maternity Voices Chair to reflect the requirements of the patient voice, co-design and engagement.

2.6 Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation.

2.7 Boards are expected to robustly assess and challenge the assurances provided and should support the utilisation of the Trusts internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous.

2.8 In order to undertake this substantial self – assessment assurance work it is suggested the board set a target date of April 30th for completion and presentation of results to Trust Board by May 31st 2022 (Appendix 1)

3.0 Maternity Incentive Scheme Year 4 Safety Action 6 Carbon Monoxide monitoring

3.1 Safety action 6 for Year 4 comprises 5 elements of the Saving Babies Lives care bundle. Element 1 relates to reducing smoking in pregnancy and the requirement to offer and perform carbon monoxide monitoring prior to 14 weeks of pregnancy and again at 36 weeks of pregnancy. For this element the process indicators are:

- Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.
- Percentage of women where CO measurement at 36 weeks is recorded.

3.2 These process indicators should be recorded on our maternity information system (MIS) and data provided to the Trust Board on our average compliance over a six-month period. This average compliance must be a minimum of 80%. Below 80% constitutes a fail.

3.3 It should be noted that **Year 4** CNST standards have been paused due to the challenges of the COVID-19 OMICRON variant and in recognition of the current pressure on the NHS and maternity services. The majority of reporting requirements relating to achievement of the maternity incentive scheme 10 safety actions were paused from 23 December 2021. We are awaiting confirmation of how the scheme

will move forward, it might include a change in the compliance levels for this standard but until the update is published this cannot be confirmed.

3.4 The Trust Board should be reassured that the Maternity Incentive Scheme **Year 3** compliance was achieved as the requirement of an audit of 40 consecutive cases, based on the percentage of women asked whether they smoked at booking and 36 weeks, as CO monitoring had been suspended due to COVID-19. 80% compliance was achieved.

3.5 Despite our current maternity information system (STORK) requiring upgrade to meet other data criteria for the CNST standards, these two indicators can be recorded currently. Concerns were raised when monthly dashboard indicators suggested that CO measurement at booking ranges currently between 30-45% and at 36 weeks between 15-27% (for the period April to December 2021), and were below the expected standards of 80% compliance.

3.6 The concerns are that,

- CO monitoring is not being offered and measurements are not being taken.
- CO monitoring is being offered and the results recorded in hand held maternity records and not recorded on STORK.
- Based on our current data from our MIS we will fail this element of Safety Action 6 which in turn will mean we will fail the Maternity Incentive Scheme for Year 4.

4.0 Drivers around underperformance

4.1 A range of drivers have been identified that serve as significant barriers to achieving compliance includes,

- Reluctance of staff to perform a breath test, despite assurances that CO monitoring is not classed as an aerosol generating procedure.
- The environment of the clinic rooms has been risk assessed as non-COVID safe to perform CO readings even though CO readings are not classified as aerosol generating.
- Need to ensure that all staff are familiar with equipment use and maintenance
- Lack of time to complete CO readings in a busy clinic setting.
- Virtual bookings, no face to face appointment with midwife before 14 weeks.
- Booking bloods clinic run by Maternity Support Workers who have not been trained in CO monitoring.

4.2 An action plan has been devised to reduce/resolve the barriers identified and significant effort will be made to ensure that embedding this into normal practice within the whole multi-disciplinary. Key actions to strengthen approach to monitoring include:

- Raising awareness of importance and relevance of CO monitoring in ‘Saving Babies Lives’ care bundle
- COVID-19 risk assessment of venues
- Ensure consumables are well stocked
- Re-introducing the CO monitoring Standard Operating Procedure

- Continuing staff education and training
- Re-introduce face to face bookings
- Ensuring good quality data entry

In addition, further data validation has taken place to ensure we are accurately reporting the trust position.

5.0 Data Validation

5.1 Analysis of the audit of maternity records of women delivered between November 2021 – February 2022 has been commenced. The audit is nearing completion and the results suggest that the pre and post audit data is presented in Tables 1 and 2 below. The audit suggests that booking and 36-week monitoring there was missing data on STORK but even after updating STORK with audit data, we are below 80% compliance. It can be seen that compliance at 36 weeks monitoring is lower than booking compliance and will reflect the involvement of the wider multi-disciplinary team and possible reluctance of the whole team to engage in this important Saving Babies Lives standard.

Booking Data		**Nov 21**	**Dec 21**	**Jan 22**	**Feb 22**
Pre-audit data	**% women with Co reading at booking**	**40.7%**	**44.6%**	**42.9%**	**59.8%**
Post audit data	**% women with Co reading at booking**	**65.7%**	**69.5%**	**64.7%**	**66.5%**

Table1. CO Booking data

36-week Data		**Nov 21**	**Dec 21**	**Jan 22**	**Feb 22**
Pre-audit data	**% women with Co reading at booking**	**21.5%**	**26.7%**	**27.2%**	**46.4%**
Post audit data	**% women with Co reading at booking**	**22.7%**	**26.7%**	**34.9%**	**46.4%**

Table 2. CO 36-week data

6.0 Implications of not achieving the CNST level 4

6.1 CO monitoring has been an integral part of Stop Smoking strategy for many years, it became a Key Performance Indicator on the maternity dashboard in April 2020, being linked to the Saving Babies Lives care bundle and monitored as part of the CNST scheme.

6.2 Due to COVID-19, CO monitoring was paused during 2020 and not reintroduced until June 2021. We await the outcome of national guidance to determine if this standard will be included in the 2023 CNST scheme.

6.3 The implications of not achieving the standards in CNST Year 4 are that the Trust will not recover their contribution from the maternity incentive scheme but may be eligible for a small discretionary payment to help support actions towards achieving compliance, but this would be at a much lower level. There is also a reputational risk to the Trust of not achieving full compliance as it could imply elements of care are below expected standards.

7.0 Delivering Midwifery Continuity of Carer at full scale

7.1 Midwifery Continuity of Carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for MCoC to be the default model of care for maternity services, and available to all pregnant women in England – with rollout prioritised to those most likely to experience poorer outcomes. Where safe staffing allows and 'building blocks' in place, this should be achieved by March 2023.

7.2 MCoC is provided by midwives organised into teams of eight or fewer (headcount). Each midwife aims to provide antenatal, intrapartum and postnatal midwifery care to approximately 36 women per year (pro rata), with support from the wider team for out-of-hours care. MCoC is not antenatal or postnatal care only or 1:1 care in labour. The evidence for its benefits is clearly based on models employing continuity across antenatal, intrapartum and postnatal care, whereby, each team has a linked obstetrician and all staff in the maternity service contribute to achieving MCoC and must feel involved in its provision. MCoC is everybody's business.

7.3 Currently, the service is able to provide a model of continuity of carer which achieves 62% continuity of care for women during the antenatal period and 28% for women during labour

7.4 Trusts had been expected to have a local maternity system plan in place by 31 January 2022. Action 9 of Year 4 CNST Maternity Incentive Scheme required the board-level safety champions to have reviewed the 'building blocks' for a sustainable model of MCoC by March 2022. As mentioned above, on 23rd December 2021, the Year 4 maternity incentive scheme was paused. In addition, a national review a revised guidance was published round the MCOC approach in October 2021

7.5 As a trust a series of issues and challenges have emerged in 2021/22 around our existing approach to MCoC and ability of the midwifery service to proceed at full scale, which is a whole service of MCoC where all women receive continuity of care

across the pregnancy, birth and postnatal continuum. Some of the challenges to achieve this include,

- The prolonged challenges due to the ongoing COVID-19 pandemic have resulted in the resilience of the midwifery team to be at an all-time low.
- The challenges of recruiting to current midwifery vacancies has compounded this and no community team is fully established.
- Concern regarding the current system in place for covering the on-call requirements and staff have shared their concerns via a number of staff surveys and via the local Royal College of Midwives (RCM) staff side representatives.

7.6 The Trust board should also be aware that at a national level, on behalf of its members, the RCM have voiced some concern that a growing number of midwives, obstetricians and pregnant women are unhappy or dissatisfied with the implementation of MCoC nationally. Concerns have been raised that,

- Evidence should be reviewed to compare the outcomes of women experiencing full continuity and those with antenatal and postnatal continuity.
- What are the range of implementation models and what are the evaluations?
- What are the unintended consequences of MCoC?
- What resources are really needed to move forward?
- How can obstetricians and other members of the maternity team provide continuity too?
- These questions need answers if the NHS is to implement continuity in a safe and effective way.

7.7 While the Trust has experienced some challenges in maintaining and progressing MCoC at scale, we have continued to maintain a model that ensures women experience model of care where there is some opportunity for women to receive MCoC, we have targeted care on the vulnerable women with 82% BAME and 98% vulnerable women booked for MCoC during the antenatal period and 50% have received MCoC during labour and birth.

7.8 With the recent commencement in post of the new Head of Midwifery / Associate Director of Midwifery and Professional Practice, it is timely to allow her to assess the model of MCoC currently in place and develop a plan for a sustainable model going forward. There is an opportunity for her to work in a collaborative way, addressing all concerns that have been raised locally, regionally and nationally and develop a plan that meets the needs of women in our service and the strategic intentions of NHS England. It is anticipated that this will be plan will be completed within 3 months.

8.0 Conclusion

5.1 This report has been prepared to update the Trust board on a number of issues that have occurred and the board should be aware of outside the usual reporting schedule of the Maternity Governance report at the request of the Chief Nurse. These issues relate to the requirement to complete the maternity self-

assessment tool, concerns related to non-compliance with CO monitoring and the need to revise the plan to deliver MCOC at full scale as directed by NHS England.

9.0 Recommendations

The Trust Board is asked to:

- Note the timescales for completion of the Maternity Self- Assessment Tool.
- Note the current underperformance in CO monitoring and actions to strengthen mother and baby safety
- Note the risks to risks to CNST Level 4 attainment
- Note the challenges with achieving Continuity of Carer at scale and actions being taken to recruit to and ensure model is fully adopted

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board Directors			
Report title: Improvement plans developed in response to the results of the Care Quality Commission (CQC) NHS Patient Experience Surveys for 2021. NHS Maternity Survey			Meeting date: 30 March 2022
Report appendix	Appendix 1: Torbay ISU Maternity Service Improvement Plan.		
Report sponsor	Chief Nurse		
Report author	Interim Head of Midwifery Associate Director of Midwifery Professional Practice		
Report provenance	Feedback and Engagement Group March 2022		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to share with the Trust Board areas of good practice and to provide an update on the improvement plans to address the identified areas for development following publication of the Care Quality Commission (CQC) National Maternity Survey. The Board is asked to note that the Trust is not an outlier compared to the results of other Trusts across England. However, we recognise there are areas for improvement: • Antenatal check-ups, ensuring there is time to listen to women's concerns and answer questions they may have. • Labour and birth, ensure advice and support given is at the start of labour is appropriate. • Care after birth, ensuring women have a choice about where they receive postnatal care. • Care in hospital after the birth of their baby, allowing a partner to be involved in care and stay as much as women want. • Care after the birth of their baby, ensuring information is provided about physical recovery from birth. ***Please note that the attachment to this report is in the separate attachment pack***		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board is asked to support the following recommendations: • To support the improvement plan aligned to the Maternity Survey 2021 and the areas for focused improvement • The support the recommendation that the Feedback and Engagement Group will oversee and monitor the progress of both plans.		

Summary of key elements	
Strategic objectives supported by this report	

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

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

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

External standards affected by this report and associated risks

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

Report title: Improvement plans developed in response to the results of the Care Quality Commission (CQC) NHS Patient Experience Surveys for 2021. NHS Maternity Survey.	**Meeting date: 30 March 2022**
Report sponsor	Chief Nurse
Report author	Interim Head of Midwifery Associate Director of Midwifery Professional Practice

1. Introduction

1.1 The Care Quality Commission undertake a number of Patient Experience Surveys to support their programme of regulation, monitoring and inspection of NHS acute Trusts in England. The survey field work for the Maternity Survey was focussed on all women giving birth during February 2021 and is split into three sections that ask questions about:

- Antenatal Care
- Labour and Birth
- Postnatal Care

Results were published in February 2022.

1.2 The aim of this report is to acknowledge where the maternity service has performed 'better than expected' and provide assurance to the Board on the improvement plans being progressed in relation to areas in the Maternity Survey where it is indicated that quality of experience for women and their families could be improved. The detailed analysis of the survey was shared at the Patient Feedback and Engagement Group and Quality Improvement Group in March 2022 and this paper will focus on the areas for improvement and the work planned and progressed to date to address these areas.

1.3 The Trust level benchmarking report which sets out the results of the Maternity Survey for 2021 was published on 10 February 2022. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS acute Trusts in England.

1.4 The Trust survey results provide an opportunity to gain greater insight and understanding of the experiences of women who use our maternity services and utilises this valuable feedback to reflect on what we have been told. This allows us to focus on what matters to the people we care for, and work to improve experience by taking positive action and embedding change.

1.5 299 women who had experienced maternity services provided by Torbay and South Devon NHS Foundation Trust (TSDFT) in February 2021 were invited to take part. 180 responses were completed and submitted to CQC. The response rate was 61% compared to 2019 of 42% and the average across all trusts in England of 53%.

2. Summary of findings

2.1 The findings of the 2021 maternity survey suggest that women's experience of care is overall positive, which considering the impact on services caused by the COVID-19 pandemic is reassuring.

2.2 The table below (Table 1) indicates that the maternity service has performed 'somewhat and better than expected' in 13 areas, and in 36 areas 'about the same'. Only in 1 area performance was 'somewhat worse than expected'.

Table 1. Comparison with other Trusts

2.3 Survey questions where we have performed 'somewhat worse', 'somewhat better' and 'better than expected' are summarised in table 2 below.

Much worse than expected	Worse than expected
• Your trust has not performed "much worse than expected" for any questions.	• Your trust has not performed "worse than expected" for any questions.
Somewhat worse than expected	**Somewhat better than expected**
• F1. Were you given a choice about where your postnatal care would take place?	• B10. During your antenatal check-ups, did your midwives ask you about your mental health? • C16. Did the staff treating and examining you introduce themselves? • F2. When you were at home after the birth of your baby, did you have a phone number for a midwifery or health visiting team that you could contact?
Better than expected	**Much better than expected**
• B3. Were you offered a choice about where to have your baby? • B13. During your pregnancy, if you contacted a midwifery team, were you given the help you needed? • B15. Thinking about your antenatal care, were you involved in decisions about your care? • C21. Thinking about your care during labour and birth, were you spoken to in a way you could understand? • C23. Thinking about your care during labour and birth, were you treated with respect and dignity? • C24. Did you have confidence and trust in the staff caring for you during your labour and birth? • E3. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby? • F3. If you contacted a midwifery or health visiting team, were you given the help you needed? • F12. Did a midwife or health visitor ask you about your mental health? • F18. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?	• Your trust has not performed "much better than expected" for any questions.

Table 2. Summary of questions 'somewhat worse', 'somewhat better, and 'better than expected'.

2.4 The area where we have performed worse than expected is related to 'choice' of where postnatal care takes place. Due to the limitations in place as a result of COVID-19 pandemic midwives were, and are still, working out of community hubs, with our normal regime of providing home postnatal visiting being stopped. This should be an area of focus for our improvement plan, especially as COVID-19 restrictions are easing.

2.5 In areas where care has been identified as 'somewhat better than expected' this is likely to be as a result of the model of care our community midwives work, in that, the aim and philosophy of care is to build positive relationships with women and their families. Positive feedback about midwives asking about mental health, introducing themselves and providing contact information is encouraging and we should build on this in our endeavours to provide excellent care.

2.6 In questions where we have performed ‘better than expected’, this further reflects the positive achievement of relational care, women experience choice of place of birth, being involved in their care, being spoken to in a way that they understand and women have confidence in the team. It is also encouraging to see that women experienced ‘better than expected’ care six weeks after the birth of their baby, as this suggests there is collaborative working and good transfer of care to our Health Visitor and General Practitioner colleagues.

3. Antenatal care

3.1 The antenatal care section in the survey is divided into three sections,

- The start of your care during pregnancy
- Antenatal check-ups
- During your pregnancy

3.2 Survey results for the start of your care during pregnancy is represented in the bar chart below, (Table 3), each vertical line representing an individual NHS Trust across England, and demonstrates that TSDFT (Black, bold line) is within the highest score range and that we are performing well compared with other Trusts within our region.

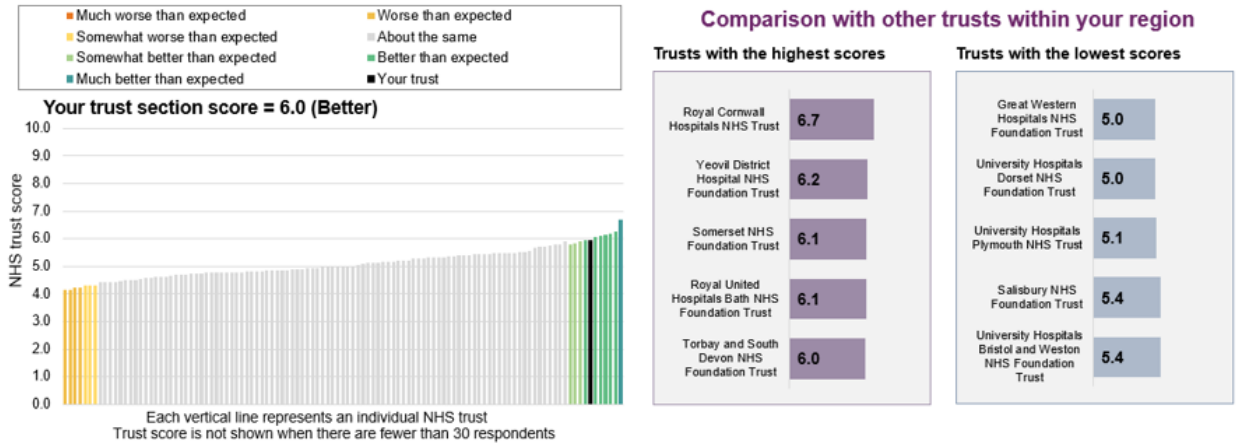
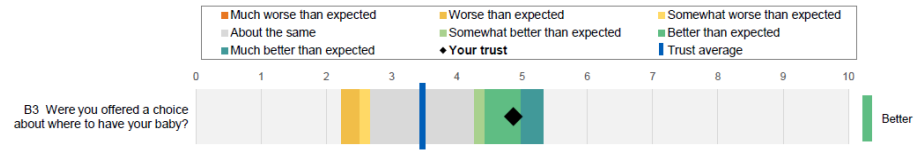


Table 3. Start of your care range of scores

3.3 The offer of choice for place of birth is 4.9, the highest score in all Trusts in England being 5.3. This reflects our philosophy of offering home birth, the option of Whitelake Birthing rooms and of course hospital birth within the main maternity unit.



	All trusts in England			
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
128	4.9	3.5	2.2	5.3

Table 4. Offered a choice about where to have your baby

3.4 Survey results for the antenatal check up questions suggest that we are ‘about the same’ and not in the highest or lowest scores across the region. The results are demonstrated in table 5 below.

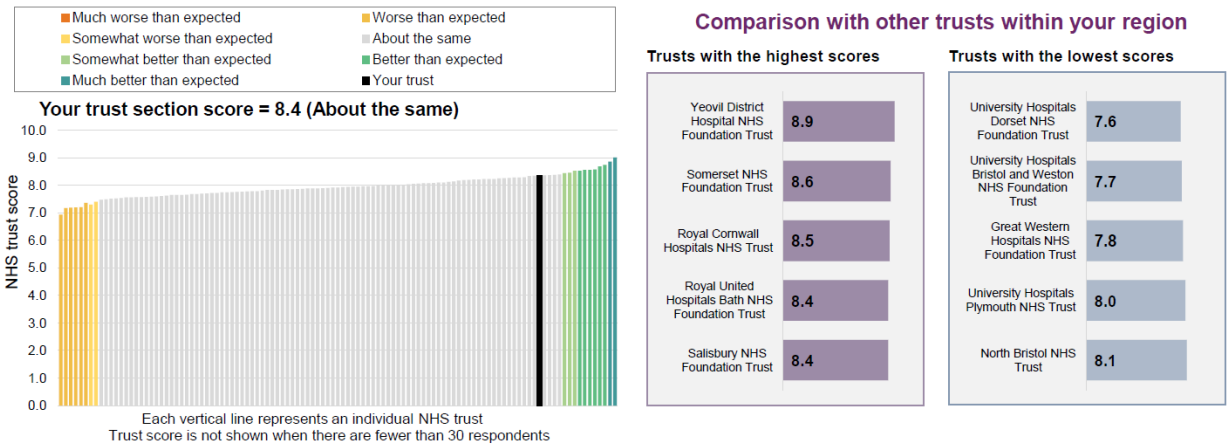


Table 5. Range of scores for antenatal check ups

3.5 Despite performing 'somewhat better' in question B10 and 'better' in questions B13 and B15 (as demonstrated in table 6), we should not be complacent, we should be aiming to find areas to build on the strengths of our continuity of carer model and aim to benchmark alongside other Trust which have higher scores.

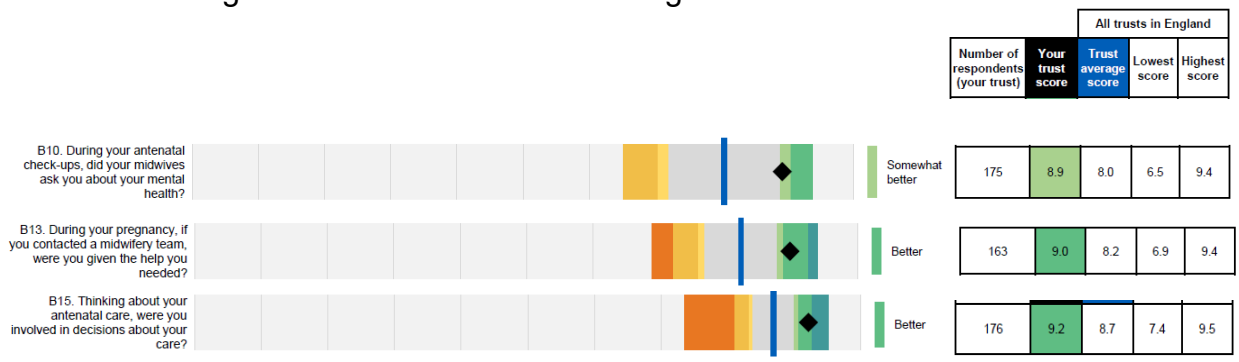


Table 6. Positive results for antenatal check ups

3.6 In order to push our scores towards the highest scores, the areas for development can be found when looking at the results of questions where we have performed 'about the same'. The Trust value of 'commitment to quality of care', encourages us to look for ways to improve patient experiences and not be comfortable with an 'about the same' position. In order to move us to a 'much better than expected' position we should focus on a few subtle areas of communication as suggested by the survey results such as:

- Midwives and doctors being aware of previous medical history,
- Providing time for women to ask questions
- Listening to women, and
- Speaking to women in a way that they understand.

3.7 Question B8, demonstrated below (Table 7), indicates that despite being about the same as other Trust with a score of 8.4, **this score is one of our bottom five scores**. To be in the top performing Trusts we should aim for a score of around 9.4 or above. Our improvement plan will focus on addressing the issues in paragraph 3.4.1 in order to achieve this improvement.

Table 7. Survey question B8 score

3.8 The improvement plan will include making the multidisciplinary team aware that during an antenatal check-up the importance of managing the time available to ensure women have had time to ask questions and ensuring women understand what has been discussed.

3.9 Responses to questions about the overall care during pregnancy were positive. TSDFT scored 8.8 overall which placed us 2nd in the region which should be celebrated and provide assurance to the Committee that Trust values are being upheld. Table 8 below demonstrates our performance in this section of the survey.

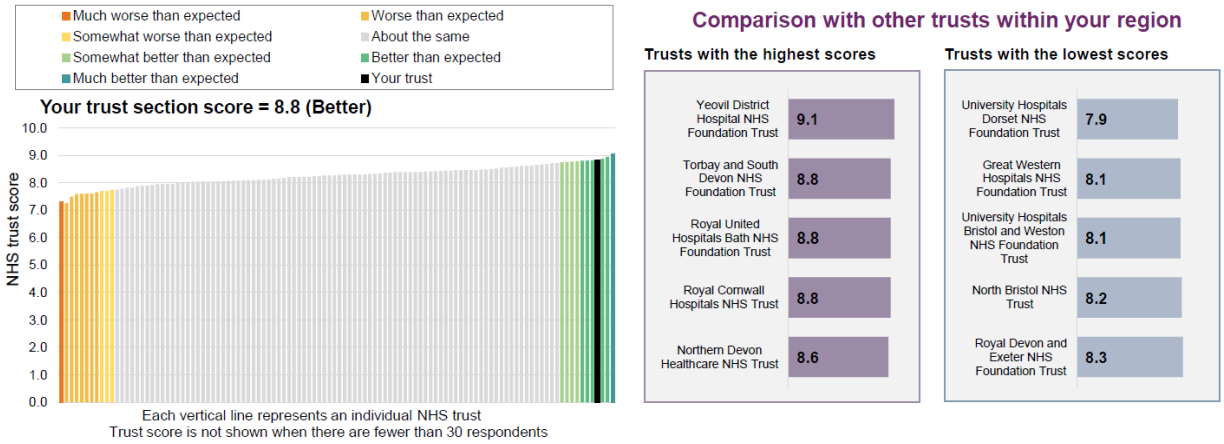


Table 8. Range of scores for care during pregnancy

4. Labour and Birth

4.1 The labour and birth section of the maternity survey is divided into three sections,

- Your labour and birth
- Staff caring for you
- Care in hospital after birth

4.2 Scores for 'Your labour and birth', were 8.4 and 'about the same' as other Trusts, not in the highest or lowest scores across the region.
Table 9 below demonstrates the range of scores and the TSDFT position.

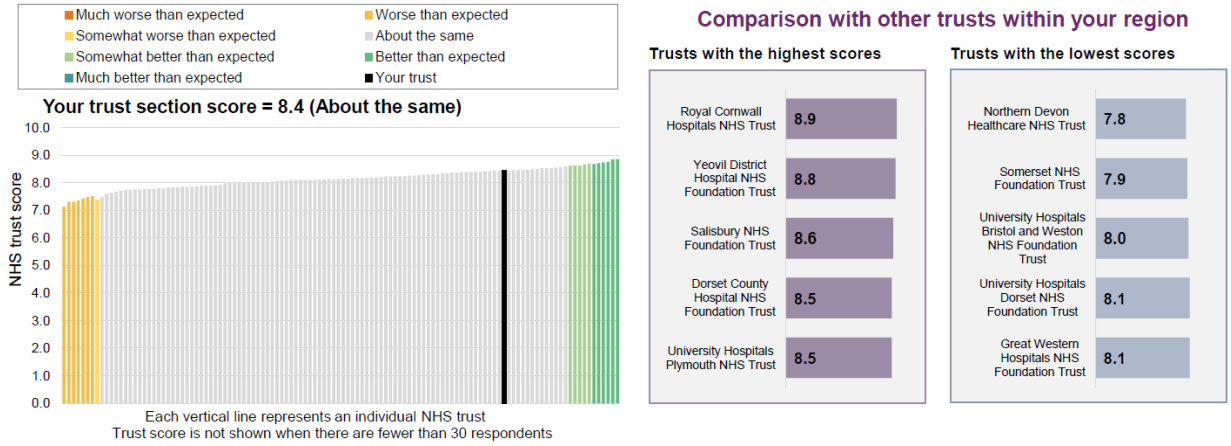
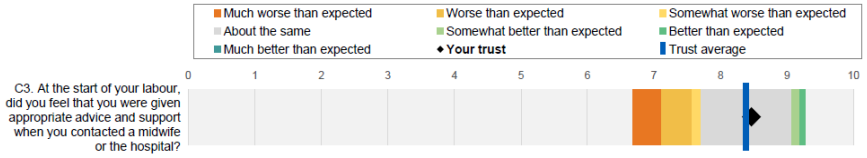


Table 9. Range of scores for 'your labour and birth'.

4.3 An area for focus for improvement, which is highlighted as one of our lowest results compared with the Trust average is demonstrated in question C.3, (Table 10). **This result is in our bottom five results**. Although our score of 8.5 is 0.1 above the England average score, there is room for improvement when compared to regional highest scores of 8.9 and England Trust highest score of 9.3



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
133	8.5	8.4	6.7	9.3

Table 10. Survey question C3 score

4.4 It should be remembered that at the time of the survey maternity services were facing continued challenges due to the pandemic. Staff shortages could have affected women's access to advice at the start of their labour. Midwives working in less familiar areas, temporary staff covering absences all could have impacted on this result. In 2019 the Trust score for this question was 9.1 and although not significantly different it does demonstrate that we have the opportunity to regain our previous high scores.

4.5 Scores for 'Staff caring for you', were 'somewhat better' with a score of 8.8 and compares well to the highest scores across the region, as shown in table 10 below we can see that Yeovil, Gloucestershire, Plymouth and TSDFT all scored 8.8

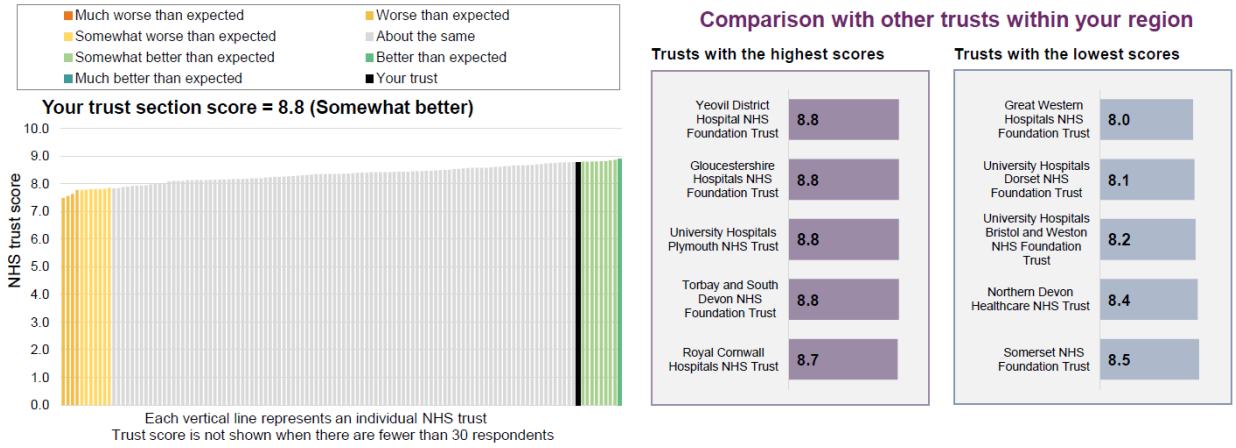
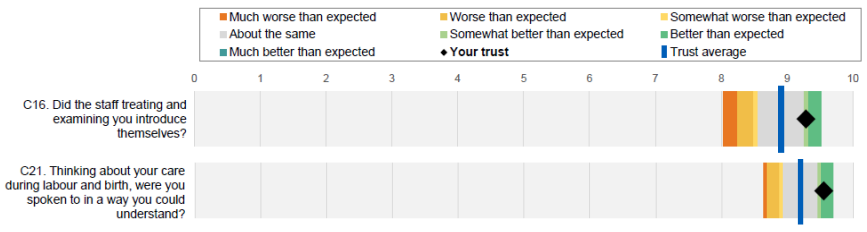


Table 11. Range of scores for staff caring for you

4.6 It is reassuring to see that staff on labour ward are treating women with respect and dignity and upholding Trust values, basic care such as introducing themselves, being spoken to in a way that women and their families can understand and having confidence in the team is a vital aspect of high-quality care. Table 11 indicates TSDFT high scores which compare well to the highest scores in England.



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
178	9.3	8.9	8.0	9.5
179	9.6	9.2	8.6	9.7

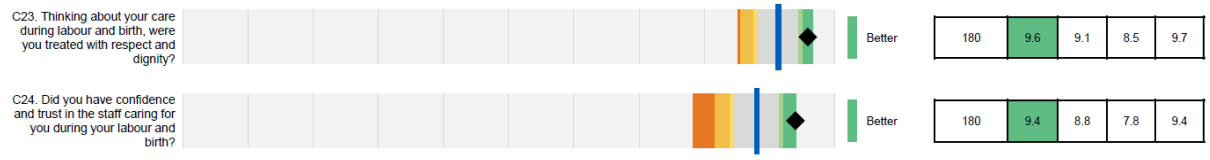


Table 12. Survey question C16, C21, C23 and C24 scores

4.7 Care in hospital after birth although is 'about the same' as others it does represent our weakest area of performance and is **in our bottom five results**. Table 13 demonstrates that we remain in the top five of highest regional scores but care in hospital, in particular question D7 (table 14) has scored 3.2, 0.3 below the average score and well below the highest scoring Trust in England of 9.8.

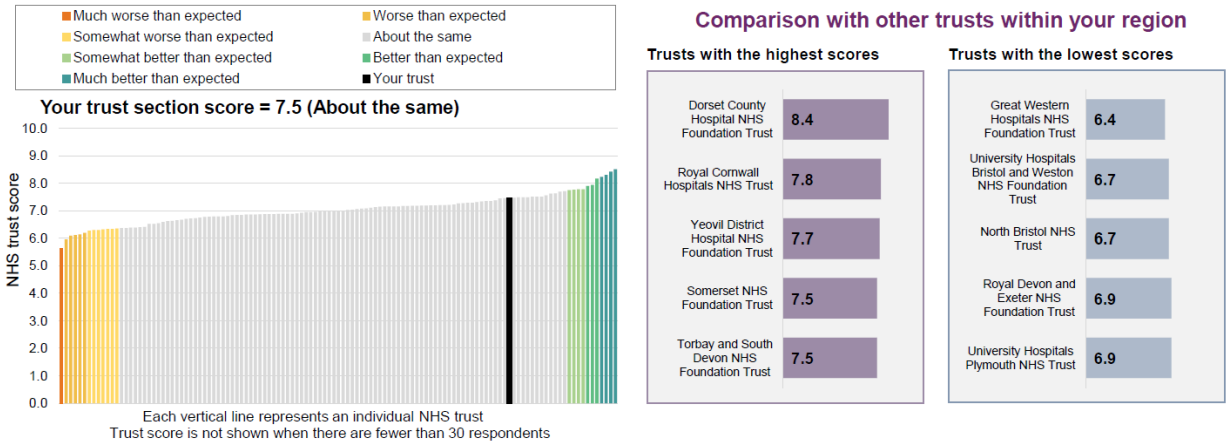


Table 13. Range of scores for care in hospital after birth

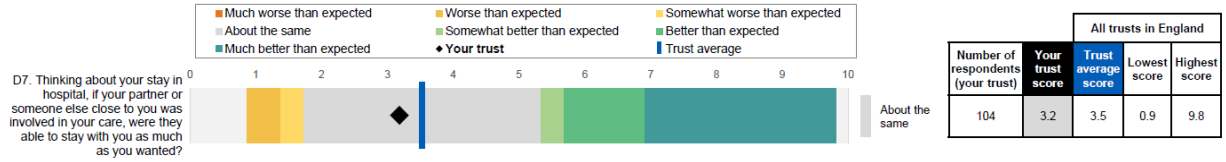


Table 14. Survey question D7 score

4.8 Question D7 would have been negatively impacted by the visiting restrictions that were imposed during the COVID-19 pandemic. It is difficult to make amends to those women who experienced the anguish of isolation in hospital during a major family life event such as the birth of a baby. In terms of planning for improvements, as restrictions are being lifted, it is incumbent upon us to ensure that our visiting policy is reflected of the national guidance and we remain proactive in making changes as soon as possible, keeping women and their families involved and aware of any changes.

5. Postnatal Care

5.1 The postnatal care section of the maternity survey covers two areas,

- Feeding your baby
- Care at home

This section of the survey shows some positive survey scores but also some areas for the main focus of our improvement plan.

5.2 Although the survey suggests that we are within the top 5 regional highest scores with 8.7 and therefore performing 'somewhat better' than expected we have more recent feedback in the form of complaints that suggest we need to review infant feeding

support on the postnatal ward. Table 15 below demonstrates the range of scores for feeding your baby.

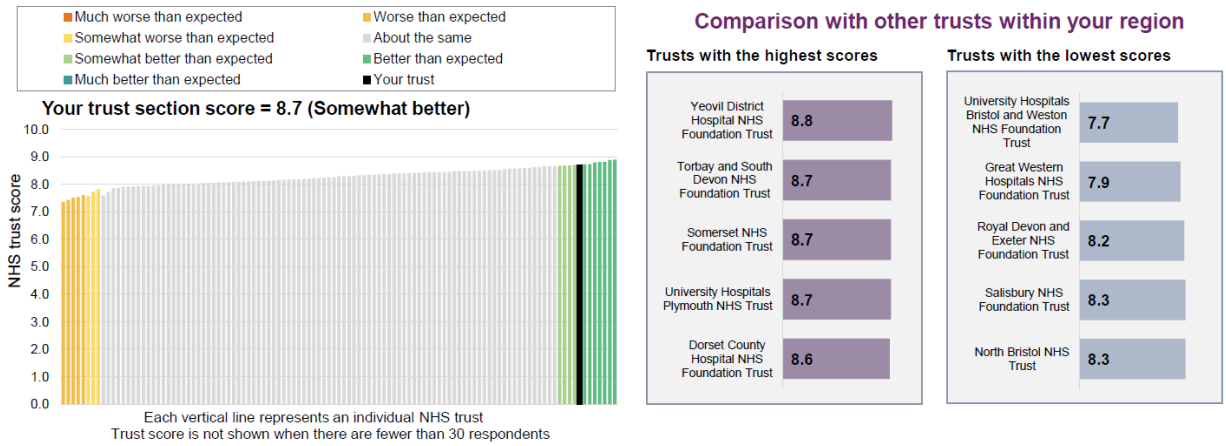


Table 15. Range of scores for feeding your baby

5.3 Care at home appears to be unremarkable with a score of 7.8 and 'about the same' as expected with TSDFT scores sitting in the middle range for the region as demonstrated in table 16 below.

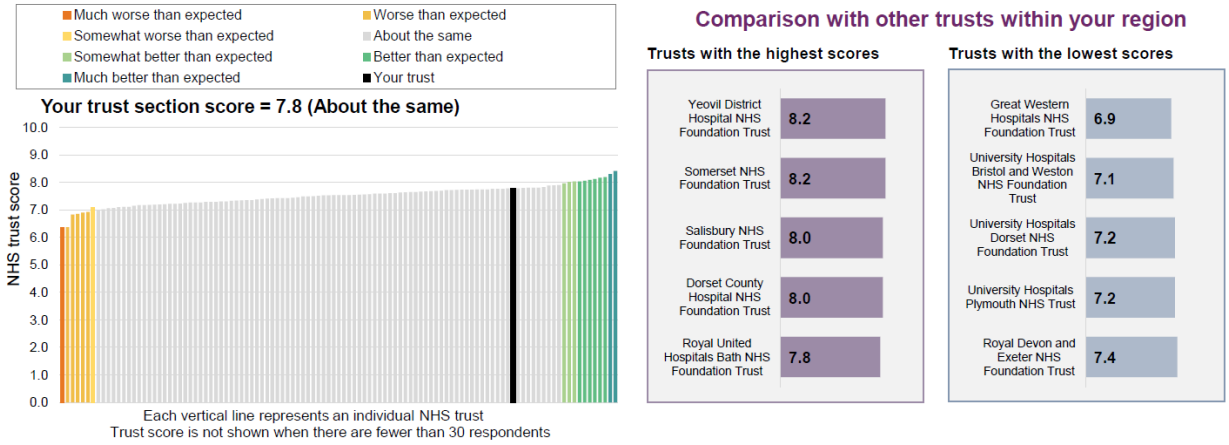
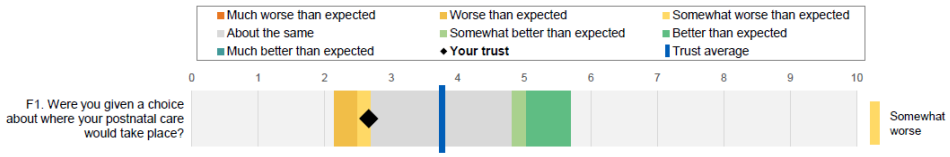


Table 16. Range of scores for care at home after birth

5.4 TSDFT performance drops considerably with responses to question F1 and is in the 'somewhat worse than expected' results and **the lowest score in our bottom five results**. All maternity services were experiencing the same restrictions due to COVID-19 but it appears that feedback for our service regarding choice of place for postnatal visits was particularly poor at 2.7, Trust across England achieved 3.8 and the highest score in England being 5.7. As demonstrated in table 17 below.



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
167	2.7	3.8	2.1	5.7

Table 17. Survey question F1 score

5.5 The lower than expected scores for question F1 will be multifactorial and involve the unprecedented restrictions due to the pandemic, these could have been compounded by the rural spread of the population and limited access to postnatal hub venues across our communities. As restrictions are now being lifted there is an urgent

need to make this the main focus for our improvement plan. Choice of place of postnatal care should include home visits, particularly in the first few days of being at home with a newborn baby.

5.6 Community hubs remain in place and whilst we have recently started to offer more home visits, getting the balance of choice and support in a suitable environment is the bedrock of high-quality care.

5.7 Women require information about the changes they experience during the postnatal period and their physical recovery following the birth of their baby. The survey question relating to this score is suggestive that we are about the same as expected for this but it appears as one of our bottom five scores, suggesting that we have room for improvement and therefore this is included in our improvement action plan.

6. Maternity Survey Improvement Plan

6.1 The improvement plan focuses on the five areas where the results were below the Trust average. (See Table 18 below).

6.2 In the spirit of working collaboratively with users of our maternity service we will reach out to the Maternity Voices Partnership (MVP) to seek their support, ideas and contribution to the maternity survey improvement plan. As this is achieved through the Local Maternity and Network System (LMNS), the timing and opportunity for this needs to be within the existing framework and schedule of work. At the time of writing this report this has still to be achieved. We have recently had feedback regarding ’15 steps’ and ideas for the postnatal ward areas for improvement which the MVP have provided the team with.

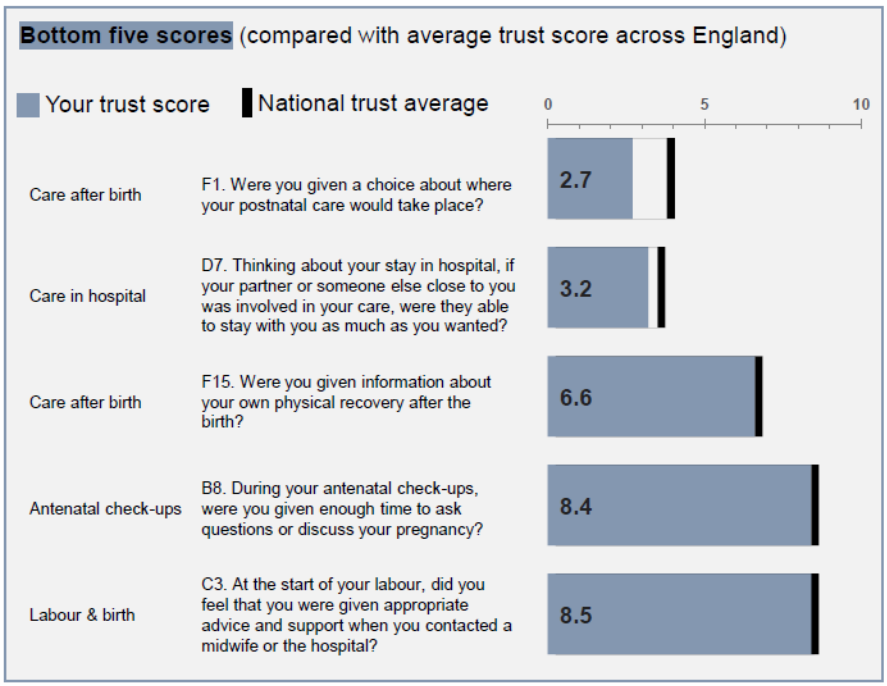


Table 18. Bottom five scores compared with Trust score across England.

6.2.1 What are we doing to respond to this feedback?

6.2.2 As COVID-19 restrictions are being lifted and routines are slowly returning to normal we need to ensure that we respond in a timely manner to lifting in hospital

visiting restrictions, including supporting partners to stay overnight, and also resume home postnatal visits in the early postnatal period. This will address our top 2 worst responses of the 2021 maternity survey, questions F1 and D7.

6.2.3 Information regarding postnatal recovery indicates we should review the discharge process during the postnatal period and the written information and access to resources that we provide women.

6.2.4 Listening to women's concerns and ensuring there is time for answering women's questions will be a balance between ensuring antenatal clinics run with adequate appointment slot time but also the provision of continuity of carer so that a relationship of trust is allowed to develop between the midwife and woman. Whilst the ambition is to provide continuity of carer across the care continuum, there should be a focus on the provision of a named midwife during the antenatal period whom the woman can see most times for her antenatal care and provides an opportunity for a relationship of trust to build.

6.2.5 Contacting the midwife or hospital at the start of labour is potentially a daunting prospect for women. We should review contact information and ensure this is visible and current. As the service is about to introduce a new maternity IT system there is the opportunity to review the system and as written maternity records / handheld records will be very different in the coming months this will be an important area of patient experience to focus upon.

6.3.1 How will we measure improvement?

6.3.2 Measuring improvement with the lifting of COVID-19 restrictions will be monitored during the weekly senior leadership meeting and team leaders should feedback on the current status of limitations and restrictions in place across the service. Operational matron will perform regular walk arounds to gain feedback from inpatient women. The head of midwifery will review the situation on a regular basis and confirm and agree that these are appropriate to the level of risk. Information to all staff should be confirmed at each change or update.

6.3.3 The Trust communication team will be involved in support to prepare messages for women and their families regarding any changes and these posted on the Trust website and social media.

6.3.4 Other areas will be monitored as part of the Friends and Family Test, this will require review of the questions to ensure questions regarding information regarding postnatal recovery, time for listening to concerns and contacting staff at the start of labour to ensure that there is a structured method of gaining feedback for these important areas of care.

6.3.5 Involvement of the MVP and senior walkabouts with operational matron, deputy head of midwifery, head of midwifery and clinical director should be in place to ensure informal and adhoc contact with women to gain feedback.

7. Conclusion

7.1 The Maternity Survey 2021 provides the Trust with an opportunity to hear the voice of patients using our services and understand their lived experience. The improvement plan will facilitate the Trust to enhance these services going forward.

7.2 These plans are against a back drop of recovering from the COVID- 19 pandemic and the uncertain future of the need to reimpose restrictions and ongoing possible staff absences due to COVID-19.

7.3 We recognise such changes will impact on patient experience e.g. the requirement to restrict visitors to inpatient wards to one nominated visitor for the entire hospital stay for one hour per person per day.

8. Recommendation

8.1 The Trust Board is asked to support the following recommendations:

- To support the improvement plan aligned to the Maternity Survey 2021 and the five areas for focused improvement
- The support the recommendation that the Feedback and Engagement Group will oversee the progress of plans.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Violence Prevention and Reduction Strategy			Meeting date: 30 March 2022
Report appendix	Violence Prevention and Reduction Strategy		
Report sponsor	Chief Operating Officer		
Report author	Clinical Safety Manager		
Report provenance	Health and Safety Committee - January 2022		
Purpose of the report and key issues for consideration/decision	The purpose of this report is for the board to approve the Violence Prevention and Reduction Strategy. This strategy has been written in response to The Violence Prevention and Reduction Standards (NHS England and NHS Improvement) which states that all NHS trusts need to develop a strategy which has been endorsed by the board The strategic aims are highlighted in the strategy and the document (in the attachment to this report), describes how the security management team will deliver these strategic aims by dividing them into six focus areas. Policies/Staff and Patient Experience/Training/Communication Links to Community/Equipment. ***Please note the attachment to this report is in a separate attachment pack.***		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The board is asked to approve the Violence Prevention and Reduction 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		**Well-led**	

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

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

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**

Report title: Violence Prevention and Reduction Strategy		**Meeting date: 30 March 2022**
Report sponsor	Chief Operating Officer	
Report author	Clinical Safety Manager	

Introduction

The Violence Prevention and Reduction Standards (NHS England and NHS Improvement) states that, "The organisation will develop a Violence Prevention and Reduction Strategy which has been endorsed by the board"

The purpose of the Violence Prevention and Reduction Strategy is to set out a plan for Torbay and South Devon NHS Foundation Trust to address the significant and increasing risk of violence and aggression by members of the public and staff members. This strategy will support staff to work in a safer and more secure environment which safeguards against abuse, aggression and violence.

Discussion

The Violence Prevention and Reduction Standards employ the Plan, Do, Check and Act approach. This four-step management method will validate, control and achieve continuous improvement processes. This strategy forms part of the initial planning stage and has been ratified by the Health and Safety Committee on the 12th January 2022.

Highlighted within the strategy is data from our Datix incident reporting system and staff survey results which highlights the levels of physical assaults and threatening behaviours aimed at our workforce.

The strategic aims of the strategy are to:

- Identify and respond to incidents better, so that staff feel that reporting is worthwhile.
- Ensure victims are central to the process, and ensure adequate support for those engaging with the criminal justice system.
- Ensure individuals who display unacceptable behaviour are highlighted to the wider trust and actions taken to reduce the risks.
- Gain Trust Board level support and oversight for violence prevention and reduction.
- Ensure all Datix incident data is reviewed, discussed and action plans reviewed accordingly.
- Raise the public's awareness of the issues, along with the action that will be taken.
- Review policies, procedures and resources with the Strategy in mind.
- Ensure each and every member of staff has fit for purpose training.

To achieve these aims the security management team have divided them into six focus areas and documented in the strategy how we are going to deliver on these aims. Examples are provided below:

1) Policies
Update existing policies and introduce new polices in line with current legislations. For example - Management of Lone Working Policy (S1). All policies are managed and ratified through the Health and Safety committee.

2) Staff and Patient Experience
Health and Wellbeing Support – To review all support packages available to staff post incident for example occupational health, support reporting incidents to the police, Employee Assist Programme, Manager training, Staff Training – Clinical Safety Manager and Wellbeing Development Facilitator to review.

3) Training
Breakaway Training – The Education and physical interventions team to deliver Breakaway Training on Child Health and Emergency department monthly mandatory training days.

4) Communication
To ensure the monthly Violent Patient Marker Panel meetings continue to discuss patients who may be of a risk to staff and other patients. The panel ensures all incidents are discussed equally and fairly. Panel members include Clinical Safety Manager, Safeguarding Adults and MCA Lead, Patient Safety and Quality Facilitator.

5) Links to the Community
The Clinical Security Operations Officer to explore links to local schools and academies to start an education programme to help deter anti - social behaviours on all of the hospital sites.

6) Equipment
The Clinical Security Operations Officer to initiate a trail for body worn cameras for the security team and emergency department. Ensuring all data protection principles are followed and training provided on their usage.

The six strategic focus areas are discussed at the monthly Health and Safety Committee meetings.

Conclusion

The Violence and Prevention and Reduction Strategy sits in the “Plan” stage of the management process and the security team are now completing the “Do”. We are working through the six strategic focus areas alongside our workforce. The overall aim is to support staff to work in a safer and secure environment, which safeguards against abuse, aggression and violence.

The strategy will be reviewed formally every six months at the Health and Safety committee.

Recommendation

The board is asked to approve the Violence Prevention and Reduction Strategy.

Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Electronic Patient Record (EPR) Outline Business Case (OBC)			Meeting date: 30 March 2022
Report appendix	n/a		
Report sponsor	Director of Transformation and Partnerships		
Report author	Digital Lead		
Report provenance	The Electronic Patient Record (EPR) Outline Business Case (OBC) has been developed by a small team under the guidance of a Digital Executive Advisory Group consisting of Trust Board members the Director of Transformation and Partnerships; Medical Director; and Deputy Chief Executive and Chief Finance Officer.		
Purpose of the report and key issues for consideration/decision	To provide an update on the EPR OBC		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board of Directors is asked to note the update		

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	X	**Risk score**	25
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**	**X**
NHS England	**X**	**National policy/guidance**	**X**

Report title: Electronic Patient Record Outline Business Case		Meeting date: 30 March 2022
Report sponsor	Director of Transformation and Partnerships	
Report author	Digital Lead	

1. Introduction

An Executive Advisory Group (comprising Director of Transformation and Partnerships, Medical Director and Deputy Chief Executive and Chief Finance Officer) have provided Executive level guidance to the Electronic Patient Record (EPR) Outline Business Case's (OBC) development.

The EPR OBC sets out the case for an integrated EPR and a preferred way forward for a competitive procurement exercise.

2. Governance and proposal

The EPR OBC is part of the Building a Brighter Future (BBF) Programme. Its progress has been provided to the BBF Committee, the Finance Performance and Digital Committee (FPDC), and the Trust Board. Most recently, it was presented to the last Trust Board on the 23rd February.

The outcome from the last Trust Board

Trust Board members approved the EPR OBC, subject to there being no further material changes to the OBC prior to its submission to Region for review at the end of February.

The update for this Trust Board

1. The EPR OBC was successfully submitted to Region for their fundamental criteria review gateway during March. If successful, the business case will move to the second gateway. This stage involves a detailed review of the business case in conjunction with the Department of Health and Social Care (DHSC). At the point of entry to the second gateway, the region will confirm to the Trust, the planned date of the National Joint Investment Committee (JIC).

2. In parallel to the journey of our EPR OBC, the ICS Providers are dedicated to seeking National support for both funding and streamlining national approvals for shared EPR. This means determining the ICS ambition, system-wide benefits, the enabling EPR solution, and costs. PWC has been engaged by the ICS Providers in support of this activity.

3. Conclusion

The EPR OBC has begun a key part of its journey through to securing National approval. Uncertainty on funding remains - the likely final answer will be for funding to be secured through the NHSX 3-year digital investment plan process, in partnership with the ICS, which will be concluded in June 2022.

4. Recommendation

Trust Board is requested to note the update set out above.

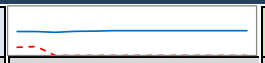
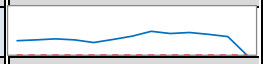
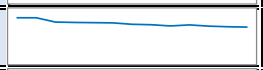
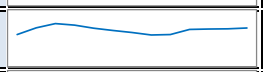
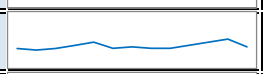
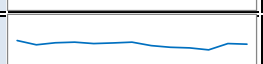
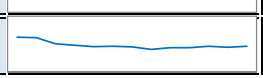
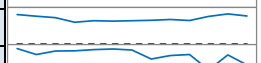
Torbay and South Devon NHS Foundation Trust

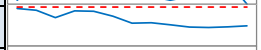
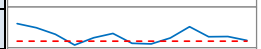
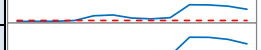
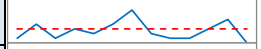
TSDFT Public Board - List of Board Report Attachments

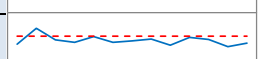
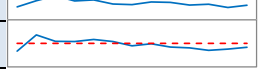
30 March 2022

INDEX

	ISU	Target	13 month trend	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		1	4	0	2	4	2	2	0	1	3	1	4	4	23
Reported Incidents - Death	Trustwide	<1		1	2	0	2	1	2	0	0	1	5	0	2	1	14
Medication errors resulting in moderate harm	Trustwide	<1		2	0	0	1	1	0	0	0	0	0	0	0	0	2
Medication errors - Total reported incidents	Trustwide	N/A		51	54	50	64	57	47	38	47	58	46	59	43	51	560
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		1	1	0	1	0	2	0	0	1	1	0	0		5
Never Events	Trustwide	<1		0	1	0	0	0	0	0	0	0	0	0	0	0	3
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		6	6	5	7	11	8	8	6	1	12	12	6	13	48
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	0	0	0	0	2	0	0	0	2	1	5
Formal complaints - Number received	Trustwide	<60		13	17	10	9	15	18	17	11	11	10	9	16	11	137
VTE - Risk Assessment on Admission	Trustwide	>95%		92.3%	91.9%	92.5%	92.3%	88.6%	94.4%	92.9%	91.9%	91.8%	96.2%	95.1%	94.8%	95.2%	92.9%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		106.8	105.8	102.6	105.5	106.6	108	110.2	108.4	109.6	108.1				86.4
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		85.8%	82.5%	89.0%	90.2%	87.1%	89.5%	87.0%	81.9%	81.9%	89.3%	87.81%	86.8%	88.3%	86.9%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		88.3%	85.4%	90.3%	88.5%	89.4%	93.4%	88.0%	74.6%	74.6%	83.7%	60.32%	77.8%	78.8%	85.0%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		0	23	24	42	381	24	8	42	476	218	285	71	49	1620
Hand Hygiene	Trustwide	>95%		95.3%	92.8%	96.0%	94.8%	97.6%	98.9%	97.1%	96.5%	98.5%	96.2%		99.1%	95.3%	97.7%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		94.4%	78.8%	73.2%	90.3%	84.8%	91.2%	82.1%	81.0%	82.1%	60.0%	68.6%	77.4%	78.4%	84.9%
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		51.6%	77.5%	84.1%	65.9%	66.1%	51.4%	56.3%	69.2%	35.9%	52.8%	50.0%	18.2%	59.0%	56.5%
Follow ups 6 weeks past to be seen date	Trustwide	6400		16986	16950	17118	16713	16323	16967	17651	17789	18231	18069	19797	20026	20496	20496
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		4.1%	4.0%	4.0%	4.0%	4.1%	4.1%	4.2%	4.4%	4.5%	4.6%	4.7%	4.8%		4.1%
Appraisal Completeness	Trustwide	>90%		78.4%	82.4%	85.9%	86.6%	84.7%	81.3%	80.6%	79.7%	77.9%	79.2%	78.6%	76.1%	75.2%	82.4%
Mandatory Training Compliance	Trustwide	>85%		89.5%	89.6%	90.1%	90.1%	90.5%	89.5%	89.4%	89.0%	89.0%	88.8%	88.4%	88.6%	89.2%	89.6%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.2%	10.0%	10.8%	11.0%	11.3%	11.0%	11.7%	11.3%	11.6%	11.5%	12.0%	12.0%	12.0%	

	ISU	Target	13 month trend	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Carers Assessments Completed year to date	Trustwide	40% (Year end)		96.3%	96.3%	93.3%	97.5%	98.3%	100.0%	100.0%	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		207		234	213	201	171	165	147	147					234
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET						117			291						117
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	NONE SET						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		615	616	0	608	629	631	564	546	604	590	628	644	623	604
Intermediate Care - No. urgent referrals	Trustwide	113		146	155	165	155	129	158	191	241	219	229	211	188		1258
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		205	255	282	294	292	297	233	229	243	191	200	202		1870
ADULT SOCIAL CARE TORBAY KPIs																	
Proportion of clients receiving self directed support	Trustwide			73.8%	74.0%	72.9%	71.9%	71.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Proportion of carers receiving self directed support	Trustwide			96.3%	96.3%	93.3%	97.5%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% Adults with learning disabilities in employment	Trustwide			8.3%	8.3%	7.5%	7.4%	7.4%	7.4%	7.1%	7.1%	6.8%	7.0%	6.8%	6.7%	6.6%	6.8%
% Adults with learning disabilities in settled accommodation	Trustwide			80.6%	81.8%	82.6%	82.3%	81.7%	81.3%	81.0%	80.6%	80.6%	81.5%	81.6%	81.6%	81.8%	80.6%
Permanent admissions (18-64) to care homes per 100k population	Trustwide			17.5	16.2	17.5	20.2	23.1	17.7	19.0	17.7	17.7	20.4	23.1	25.8	19.0	17.7
Permanent admissions (65+) to care homes per 100k population	Trustwide			540.8	464.3	499.8	510.8	487.3	498.1	511.5	449.6	422.7	411.9	376.9	487.3	476.5	422.7
Proportion of clients receiving direct payments	Trustwide			21.2%	21.1%	20.1%	19.8%	19.5%	19.6%	19.5%	19.0%	19.4%	19.4%	19.6%	19.4%	19.6%	19.4%
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		79.4%	82.2%	84.4%	78.9%	72.6%	68.6%	67.6%	65.1%	62.5%	59.8%	62.5%	61.1%	60.6%	68.0%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		61.4%	61.4%	62.7%	63.9%	64.4%	61.7%	59.4%	57.4%	57.0%	56.5%	55.6%	54.7%	54.7%	58.7%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		80.9%	64.8%	71.8%	77.9%	68.8%	67.8%	75.0%	73.3%	70.5%	57.0%	61.9%	49.1%	52.1%	65.6%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		40.4%	38.2%	36.3%	30.1%	32.2%	31.7%	32.2%	32.6%	33.8%	32.4%	37.9%	41.3%	38.4%	34.6%
Dementia - Find - monthly report	Trustwide	>90%		98.0%	95.0%	96.7%	96.9%	97.4%	97.8%	97.2%	92.7%	94.4%	95.0%	87.3%	94.8%	89.7%	94.5%

	ISU	Target	13 month trend	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3		1	5	2	5	2	5	8	2	1	2	6	6		39
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		89.6%	85.1%	67.7%	83.9%	83.0%	71.3%	54.6%	55.6%	50.5%	45.2%	44.3%	45.6%	48.1%	58.6%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		96.3%	95.2%	61.9%	54.1%	56.7%	91.0%	77.8%	92.4%	95.1%	79.8%	82.5%	38.6%	71.4%	73.2%
Cancer - 28 day faster diagnosis standard	Trustwide			77.3%	75.0%	75.6%	75.6%	76.0%	76.4%	77.4%	60.6%	58.8%	52.5%	52.8%	55.2%	73.1%	66.3%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		98.8%	99.0%	97.4%	96.7%	98.5%	97.5%	98.8%	99.4%	98.2%	96.7%	96.8%	94.8%	96.5%	97.3%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		100.0%	100.0%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	99.8%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		100.0%	100.0%	98.5%	100.0%	97.0%	98.3%	96.4%	98.6%	98.4%	100.0%	100.0%	97.1%	98.3%	98.4%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		97.0%	84.8%	100.0%	96.7%	97.7%	100.0%	97.3%	100.0%	100.0%	97.1%	100.0%	96.4%	91.7%	97.9%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		83.3%	100.0%	75.0%	73.3%	85.7%	78.6%	92.3%	71.4%	87.5%	82.4%	77.8%	72.7%	85.7%	80.4%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			6	15	15	17	10	10	13	15	29	14	26	27	39	39
RTT 52 week wait incomplete pathway	Trustwide	0		1823	2041	1895	1596	1562	1648	1799	1943	2093	2169	2384	2584	2759	2759
On the day cancellations for elective operations	Trustwide	<0.8%		3.0%	2.4%	1.6%	0.3%	1.2%	1.7%	0.5%	0.5%	1.2%	2.6%	1.3%	1.4%	0.9%	1.4%
Cancelled patients not treated within 28 days of cancellation *	Trustwide	0		6	8	6	11	3	10	17	5	3	30	12	6	8	103
Outpatient virtual appointments (non-face-to-face)	Trustwide	25%		20.4%	20.4%	18.6%	19.2%	19.1%	20.0%	19.6%	20.3%	20.5%	21.1%	19.3%	20.7%	21.3%	
Bed Occupancy	Acute	90.0%		89.0%	85.0%	87.0%	92.0%	95.0%	95.0%	93.0%	94.0%	93.0%	93.0%	93.0%	93.0%	94.0%	97.3%
No Criteria to Reside - daily average - weekday (ICO)	Trustwide	No target							57.8	57.8	56	62	66	88	101	80	
Number of patients >7 days LoS (daily average)	Trustwide			114.2	98.2	97.0	104.5	120.5	129.4	154.4	149.1	148.4	145.7	157.0	183.0	165.0	106.8
Number of extended stay patients >21 days (daily average)	Trustwide			27.8	19.9	15.2	21.3	25.0	26.3	41.5	43.9	43.6	39.9	48.0	64.0	60.6	20.3
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		82	94	90	128	380	421	266	219	285	959	952	889	727	5316
Ambulance handover delays > 60 minutes	Trustwide	0		20	32	19	26	173	165	120	72	125	617	616	559	438	2930
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			27	28	14	46	246	438	534	491	753	788	712	806	364	5192
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		3	5	2	3	32	157	188	69	130	139	162	131	123	1136
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		1	4	1	3	2	4	7	2	1	1	3	5	n/a	29
Number of Clostridium Difficile cases - (Community)	Trustwide	0		0	1	1	2	0	1	1	0	0	1	3	1	n/a	10
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		62.0%	64.6%	60.4%	59.5%	57.5%	60.6%	74.1%	77.3%	74.5%	72.0%	63.0%	69.2%	75.2%	67.2%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		30.9%	41.0%	25.5%	33.1%	32.4%	34.2%	46.6%	46.4%	45.5%	50.7%	39.2%	36.7%	52.8%	39.7%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		95.5%	81.8%	68.5%	62.5%	66.5%	69.8%	69.0%	73.0%	67.7%	67.8%	69.1%	74.6%	67.7%	78.8%

	ISU	Target	13 month trend	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			937	3180		2623	2551	2438	1240	-367	-327	-401	-609	-845	-955	
Agency - Variance to NHSI cap	Trustwide			-0.20%	-0.25%		-1.40%	-1.80%	-2.10%	-2.10%	-2.10%	-2.10%	-2.00%	-2.00%	-1.80%	-1.60%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide											-332	-593	-833	-659	-222	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			11822	2305		2004	3206	4292	5275	9080	12336	16029	19492	20987	15148	
Distance from NHSI Control total (£'000's)	Trustwide			1179	655		2690	2621	2638	1539	7	8	-13	37	153	88	
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			-14.0%	26.8%	-5.3%	-15.9%	0.6%	-20.4%	-14.4%	-4.8%	-19.4%	1.9%	-4.4%	-18.8%	-6.9%	-10.1%
Outpatients - Follow ups	Trustwide			-17.0%	16.8%	-7.6%	-12.9%	-0.9%	-13.1%	-10.2%	-5.9%	-19.1%	-2.7%	-7.0%	-22.3%	-15.0%	-10.9%
Daycase	Trustwide			-23.5%	9.1%	-8.9%	-20.5%	5.1%	-12.2%	-18.4%	-4.5%	-20.7%	-11.7%	-12.6%	-22.3%	-14.7%	-13.1%
Inpatients	Trustwide			-44.8%	-18.8%	1.8%	-19.8%	-15.4%	-33.1%	-35.2%	-24.4%	-25.8%	-37.0%	-33.5%	-47.5%	-37.6%	-28.6%
Non elective	Trustwide			-16.5%	18.0%	4.5%	3.8%	8.1%	3.9%	-5.3%	-0.8%	-7.9%	-9.6%	-15.0%	-12.2%	-8.3%	-3.7%

Mortality Safety Scorecard Appendices 1 - 5

Appendix 1 – Hospital Mortality

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

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

1A The HSMR is based on the *Diagnosis all* Groups using the December 2020 monthly benchmark and analysed by Relative Risk - Trend / Month

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

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

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

The latest month's data, November 2021, has a relative risk of **85.8** (basket of 56 diagnostic groups) and is below the 100 average. The high HSMR recorded May to August is noted for further review.

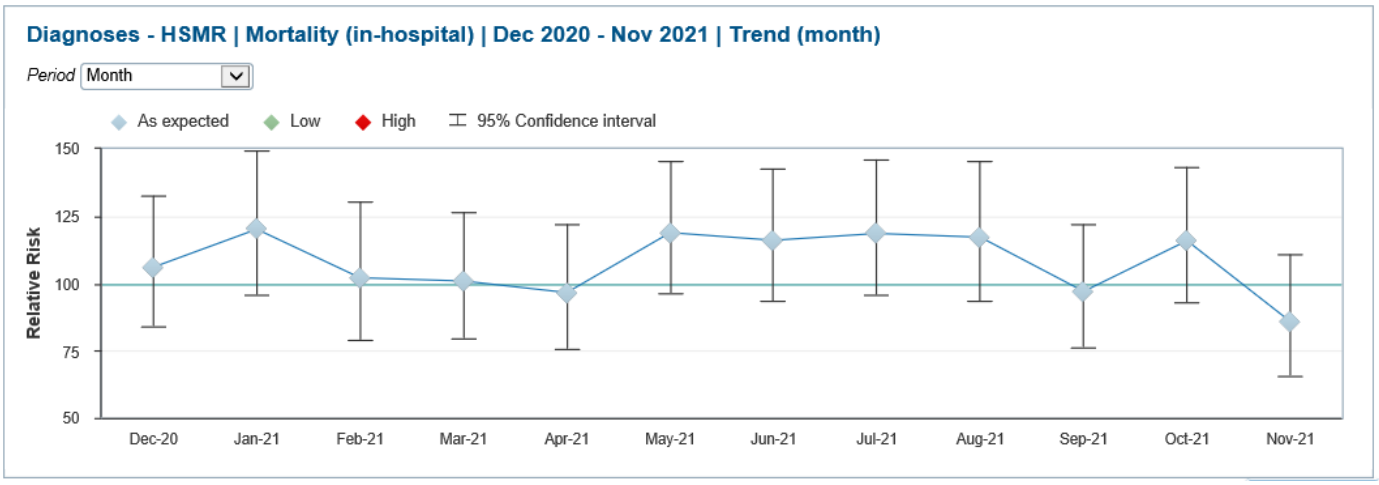


Chart 2, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12-month annual total. The monthly **12-month annual total** is above the 100 line and outside the 95% confidence limits. This measure is being observed via the Mortality Surveillance Group (MSG)

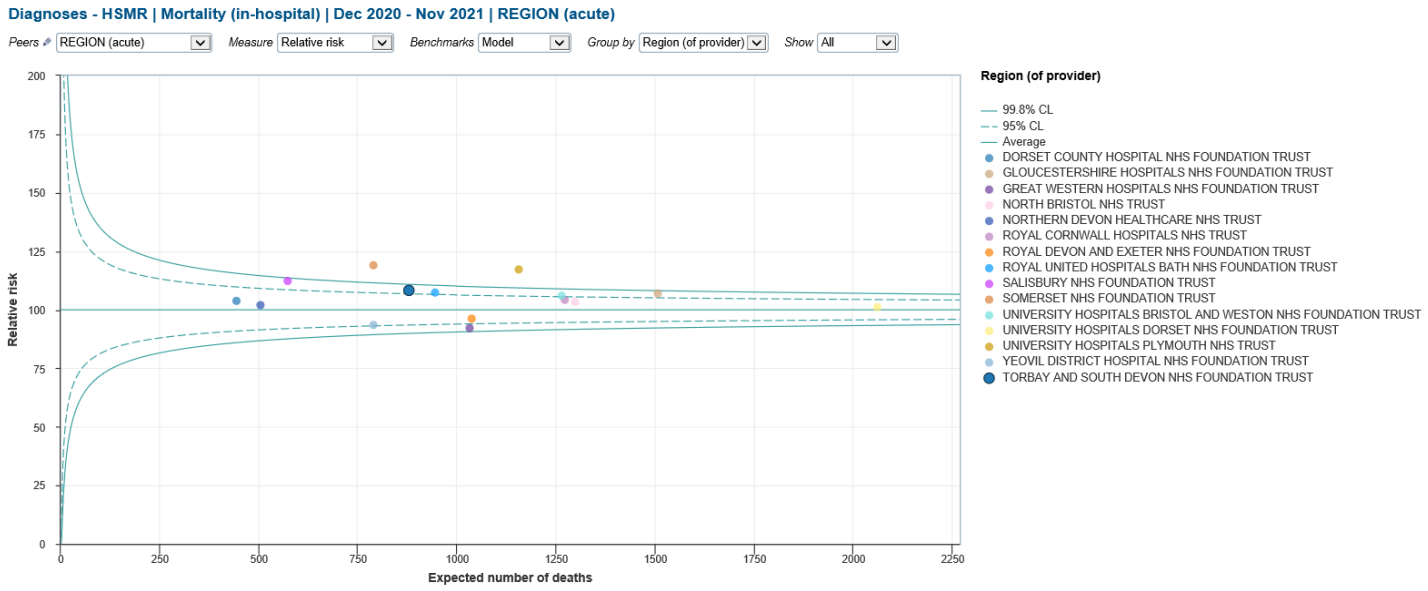
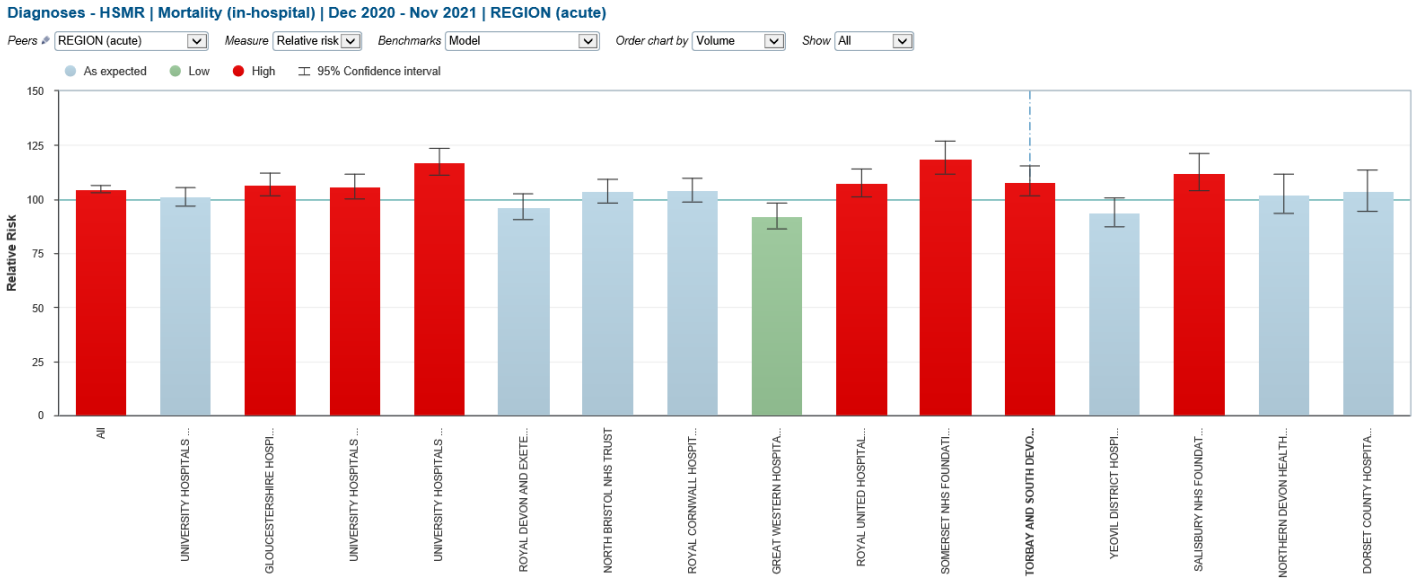


Chart 3 displays the above data as a 'Peer Comparison', and ranked as a bar chart.
The 12-month average HSMR is above the expected rate. Torbay and South Devon is flagged as an outlier during this time period. This is driven by high HSMR in May to August and is subject to further review.



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 reported, Q2 2021/22 (summer 2021), will be subject to further review to confirm factors driving the increase.

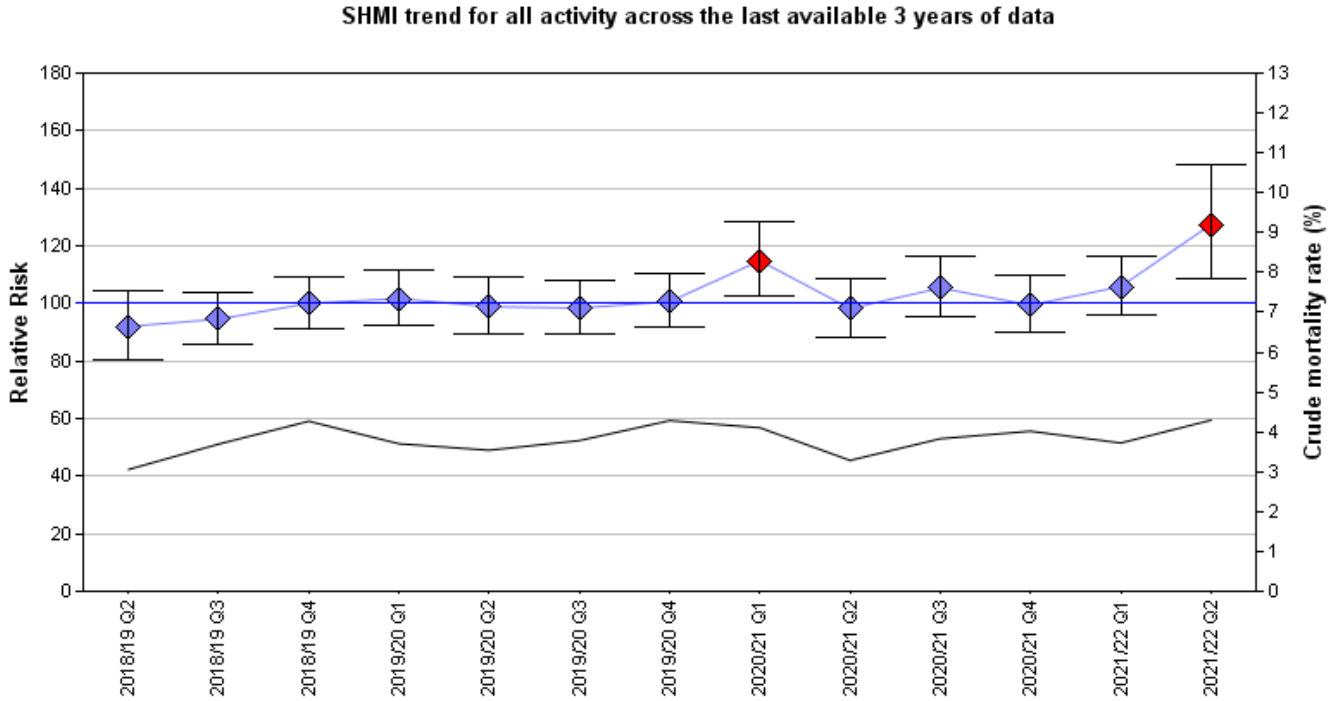


Chart 5 (as below) details - SHMI all deaths, SHMI in hospital deaths, and HSMR comparison, all within normal limits

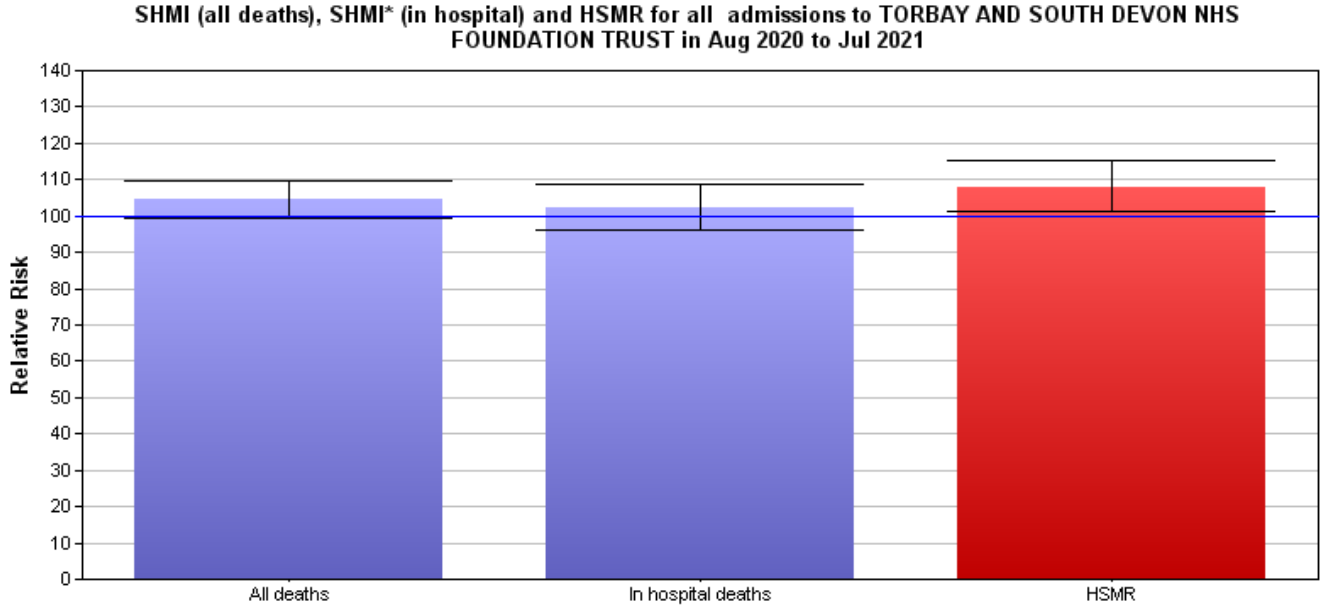
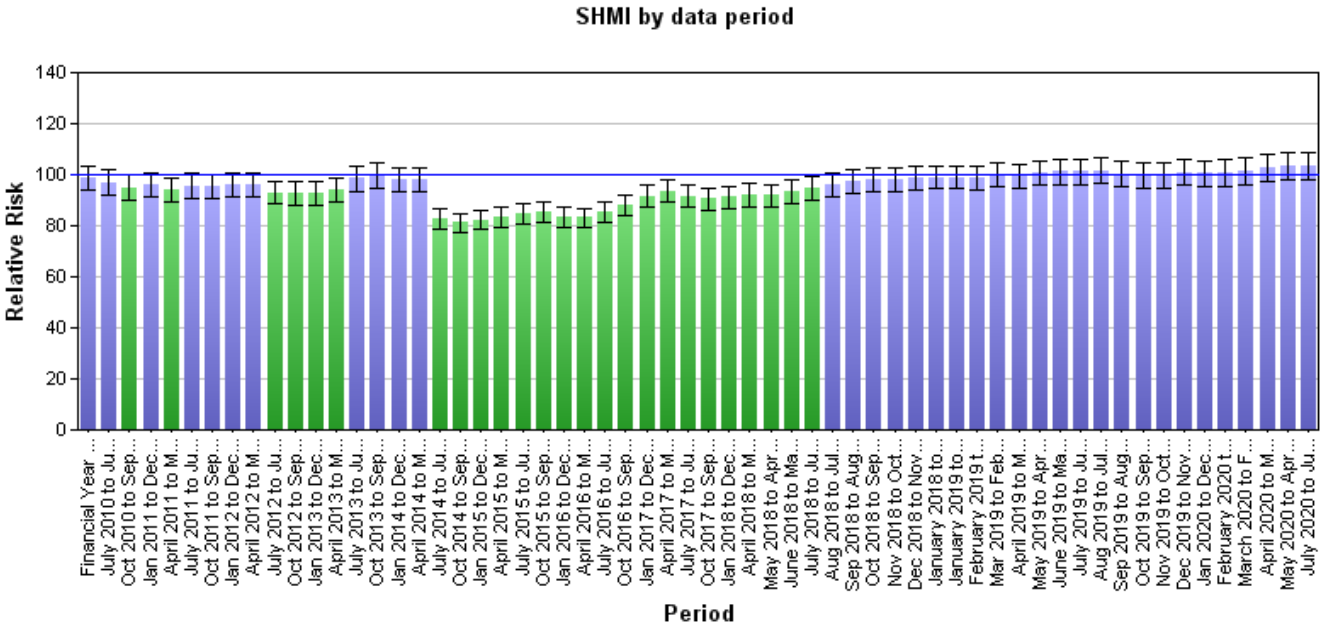


Chart 6, below, expresses the 12-month rolling SHMI data by time period. The mortality index is reporting the expected number of deaths during this time period (July 2020 – June 2021). The increasing trend is noted and will be subject to further review.



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.

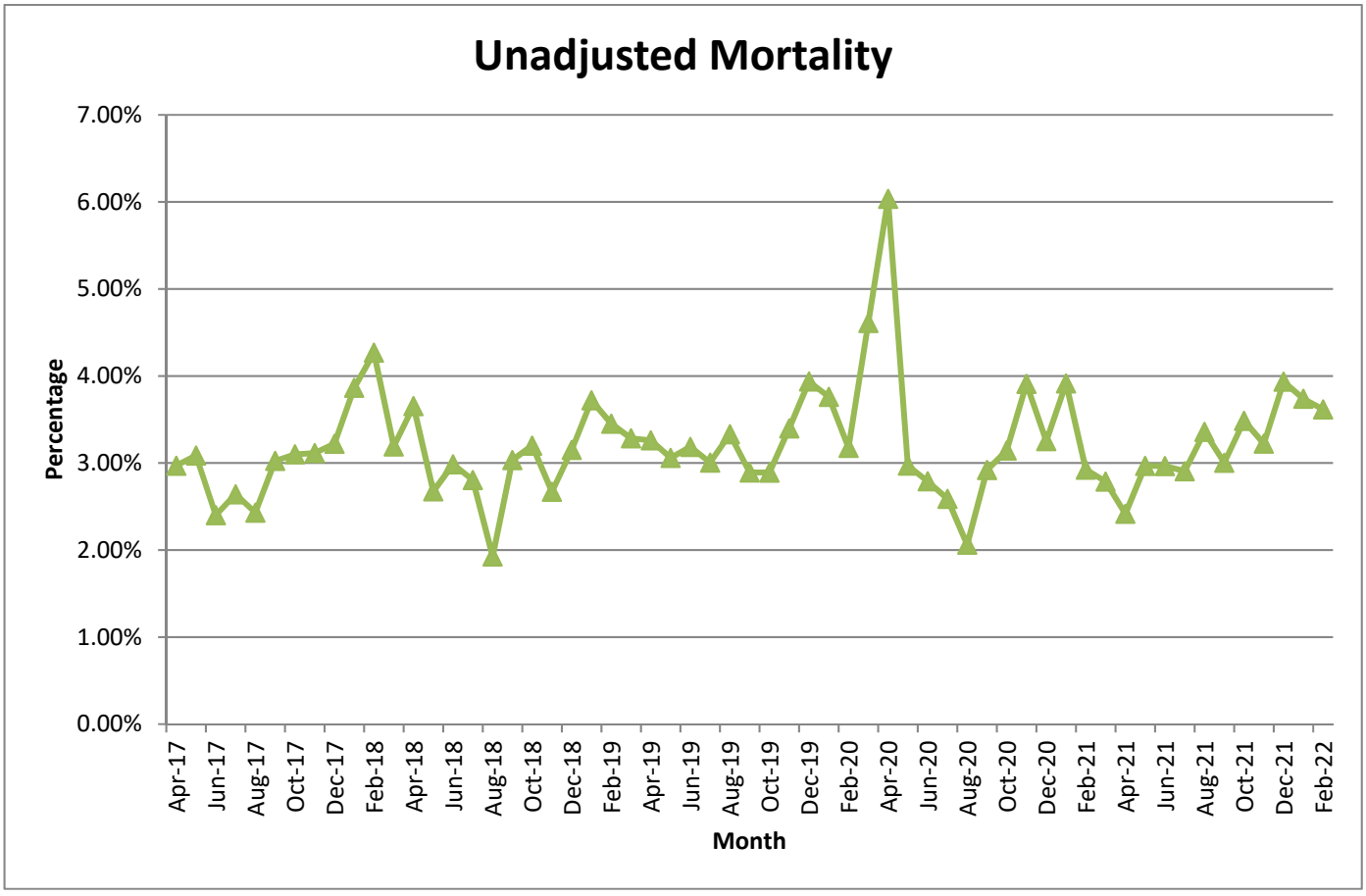


Chart 8 As below, indicates the monthly number of hospital deaths. This shows a rise in March and April 2020 partly due to Covid, before decreasing to comparatively low numbers during Summer 2020. As hospital activity increased following the initial pandemic lockdown, the number of hospital deaths has 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 during winter 2020/21.

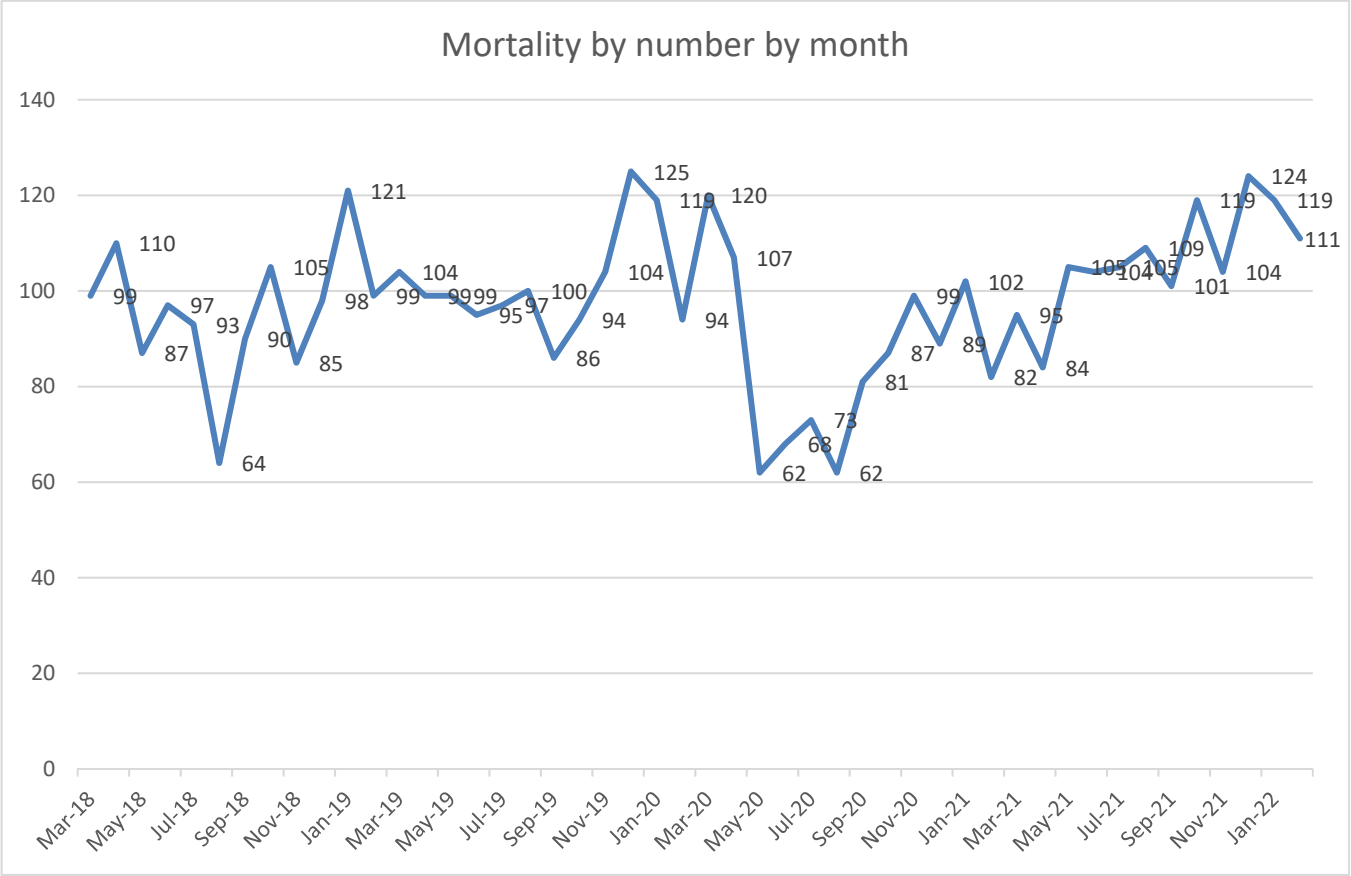


Chart 9, records hospital and community deaths (people's homes) and includes a comparator year, 2019.

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

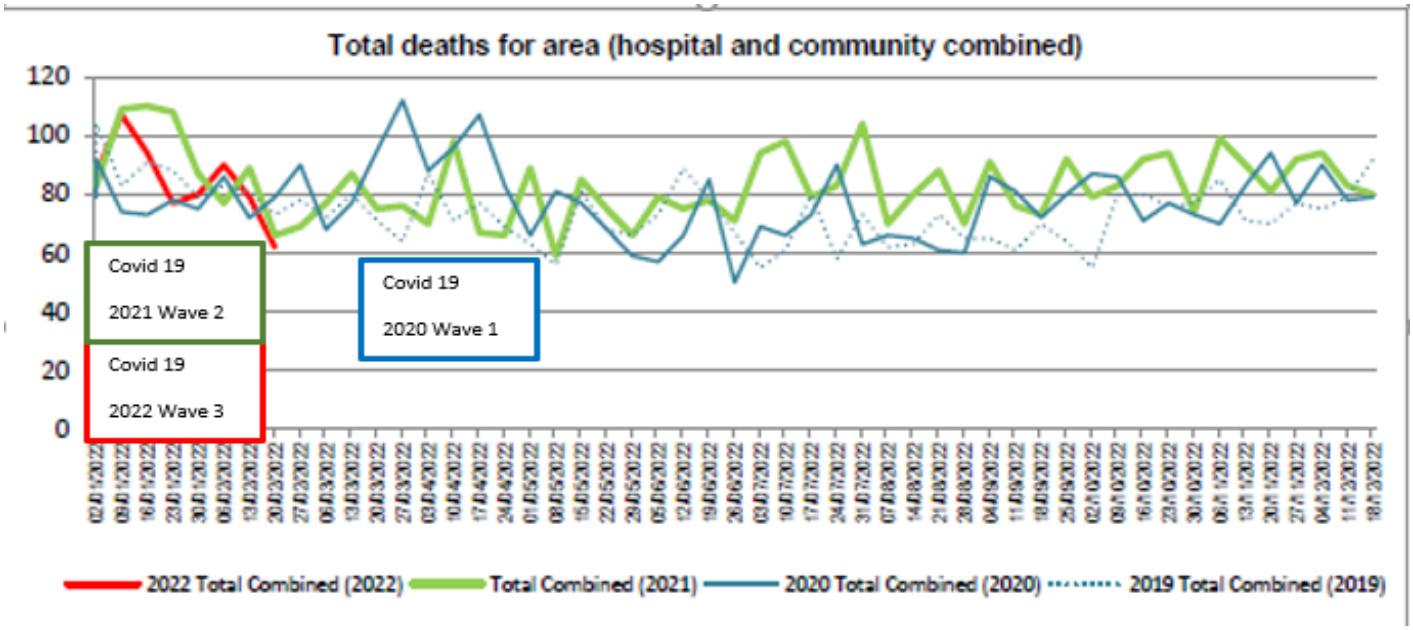
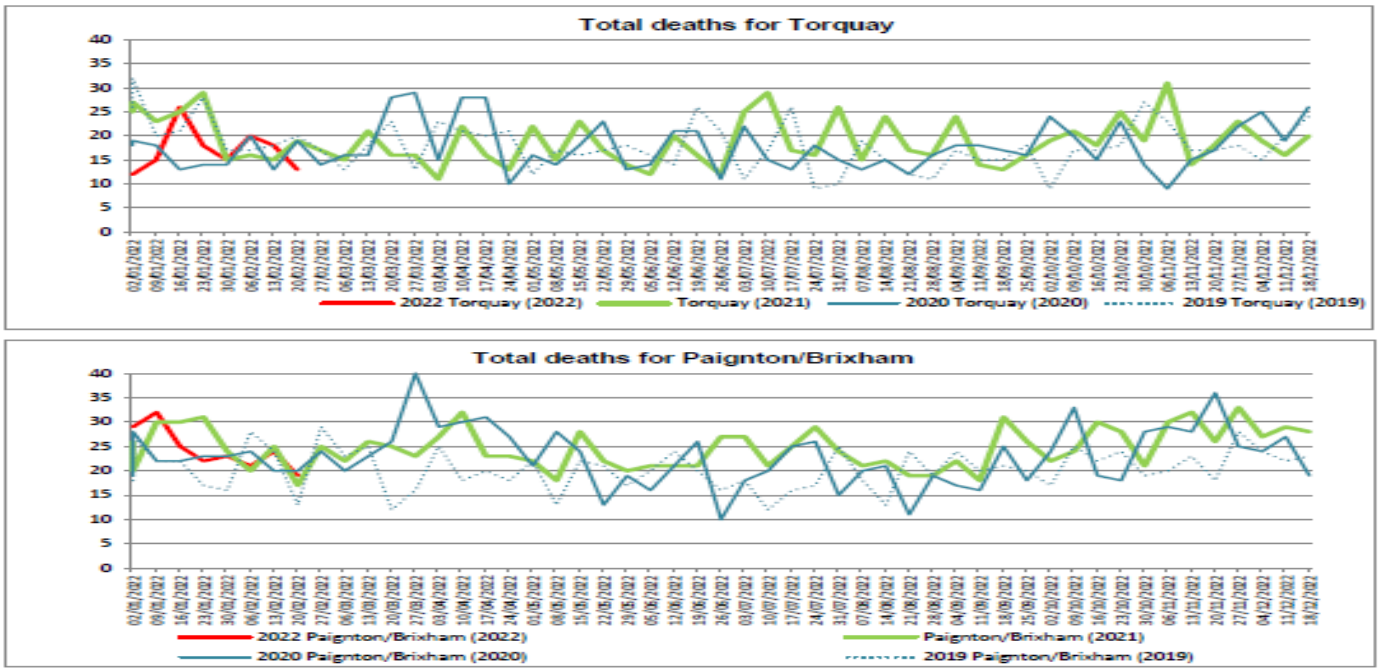
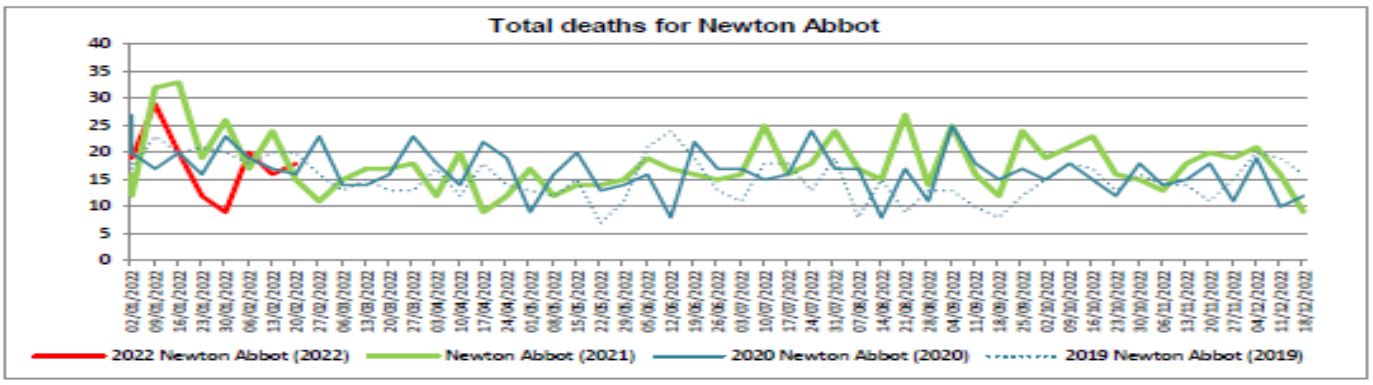
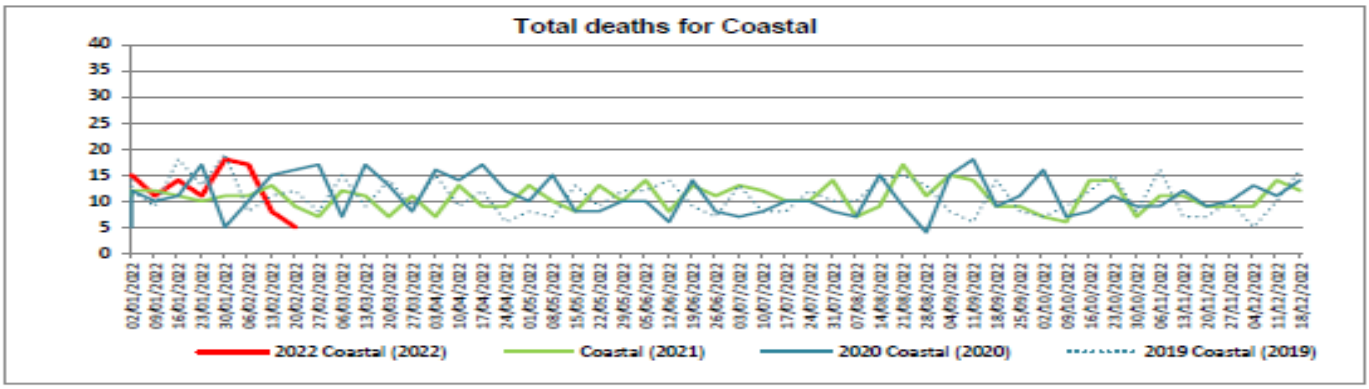
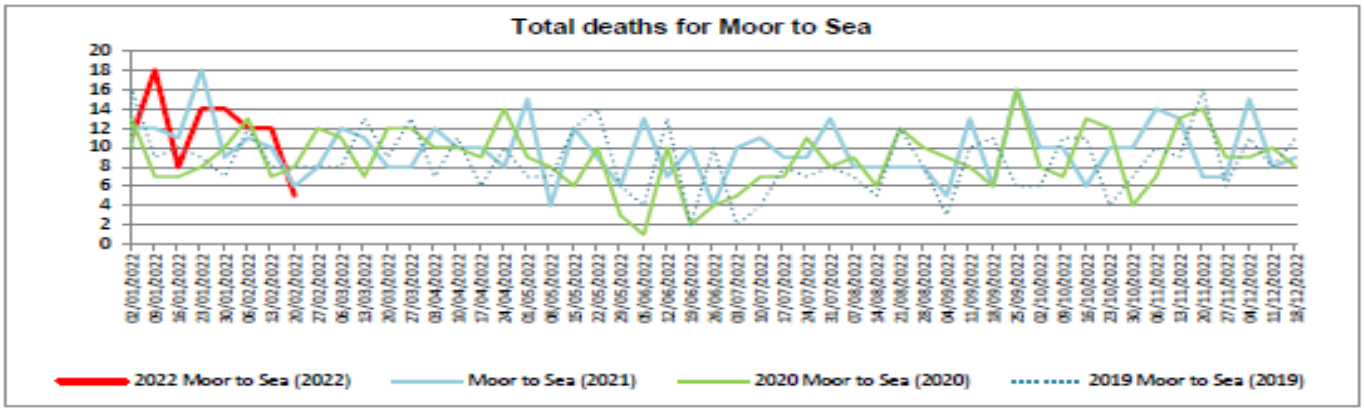


Chart 10 - Total Deaths by ISU locality




Total deaths for Newton Abbot
2022 Newton Abbot (2022)
Newton Abbot (2021)
2020 Newton Abbot (2020)
2019 Newton Abbot (2019)


Total deaths for Coastal
2022 Coastal (2022)
Coastal (2021)
2020 Coastal (2020)
2019 Coastal (2019)


Total deaths for Moor to Sea
2022 Moor to Sea (2022)
Moor to Sea (2021)
2020 Moor to Sea (2020)
2019 Moor to Sea (2019)

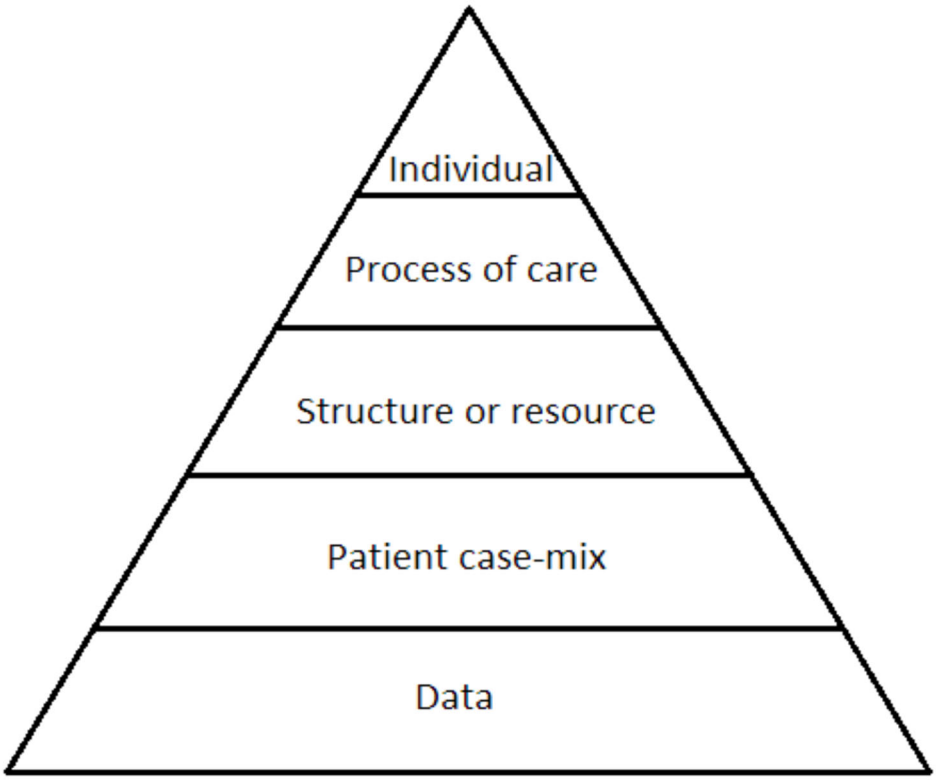
Appendix 3 – Mortality Analysis

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

	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	Jan-22	Feb-22
LOUISA CARY																	
MOTHER AND BABY																	
Paignton and Brixham ISU																	
BRIXHAM	3	4	2	6	4		5	1	1	1	1	2		1	1	2	
CARDIAC CATHETER SUITE									1								1
DUNLOP	2	4	3	4		5	4	3	3	4	8	6	4	7	6	12	3
MIDGLEY	13	10	7	13	16	14	13	18	12	18	16	17	17	15	12	8	14
TORBAY CHEST PAIN UNIT													1				
TORBAY CORONARY CARE BEDS		2	3	1	2	1		2	2	3	4		3	2	3	3	
TURNER	5	2	3	2	3	8		5	6	7	5	5	5	5	7	10	9
ELIZABETH			3	1	3	1	1	1									
WARRINGTON	2	2		2	1	1	2	2	2	2	3	3	4	3	1	1	3
Newton Abbot ISU																	
ACUTE MEDICAL RECEIVING UNIT																	
MEDICAL RECEIVING UNIT							1		3	4	1	3		2	6	4	3
EAU3																	
EAU4	7	7	9	17	10	11	8	9	16	11	11	8	16	9	10	12	5
INTENSIVE CARE UNIT	5	6	12	2	5	4	5	10	16	7	11	3	8	13	12	11	5
RECOVERY INTENSIVE CARE UNIT																	
TEMPORARY INTENSIVE CARE UNIT				1	1												
TEIGN WARD	1	3	2	2	1	2	1	3	2	2		4	2	1	2	2	1
TEMPLAR WARD	3		1		1	2	4		1	1			1		2	2	1
Coastal ISU																	
AINSLIE		2	1	2	1	1	1			4	7	3		1	7	3	6
ALLERTON	7	8	8	2	3	8	4	6	4	3	7	2	8	7	7	8	7
CROMIE	8	8	7	13	6	2	2	7	2	5	5	5	5	3	6	3	8
DAWLISH				4	1	1			1	1		2			3		5
ELLA ROWCROFT	4	3			3		1			2		1				3	1
FORREST				4	5	4				4	5	8	13	7	12	8	6
THEATRES				1							1						1
Moor to Sea ISU																	
CHEETHAM HILL	6	11	11	12	10	11	10	11	7	9	11	12	10	13	6	10	11
DART	1	1				2	3	3		1		1	3		1	2	
GEORGE EARLE	14	16	9	8	4	8	10	8	13	8	9	9	10	6	12	5	8
SIMPSON	6	10	8	5	2	8	9	16	12	8	4	7	9	9	8	7	9
Wards used in Covid surge reponse																	
MCCALLUM																3	2
JOAN WILLIAMS																	2
Grand Total	87	99	89	102	82	95	84	105	104	105	109	101	119	104	124	119	111

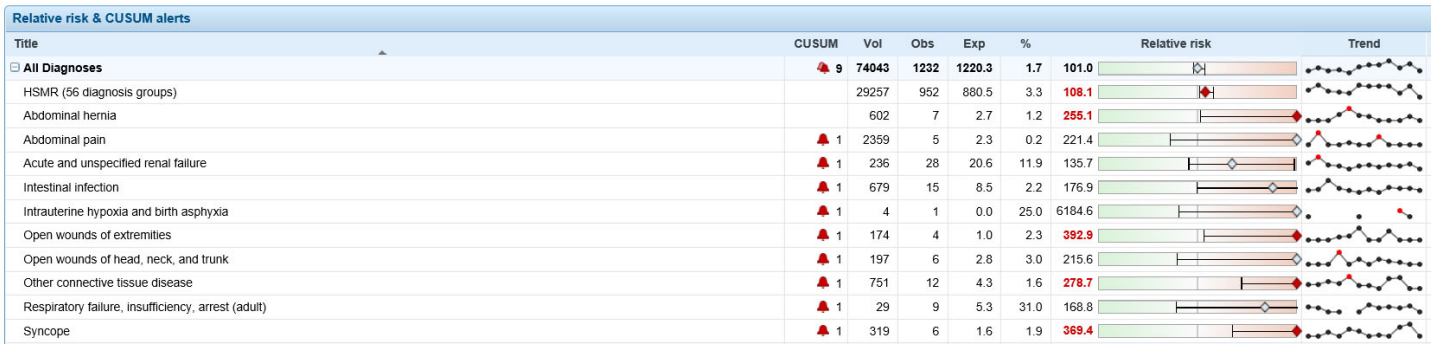
Alerts by Clinical classification

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	9	**74043**	**1232**	**1220.3**	**1.7**	**101.0**	
HSMR (56 diagnosis groups)		29257	952	880.5	3.3	**108.1**	
Abdominal hernia		602	7	2.7	1.2	**255.1**	
Abdominal pain	1	2359	5	2.3	0.2	221.4	
Acute and unspecified renal failure	1	236	28	20.6	11.9	135.7	
Intestinal infection	1	679	15	8.5	2.2	176.9	
Intrauterine hypoxia and birth asphyxia	1	4	1	0.0	25.0	6184.6	
Open wounds of extremities	1	174	4	1.0	2.3	**392.9**	
Open wounds of head, neck, and trunk	1	197	6	2.8	3.0	215.6	
Other connective tissue disease	1	751	12	4.3	1.6	**278.7**	
Respiratory failure, insufficiency, arrest (adult)	1	29	9	5.3	31.0	168.8	
Syncope	1	319	6	1.6	1.9	**369.4**	

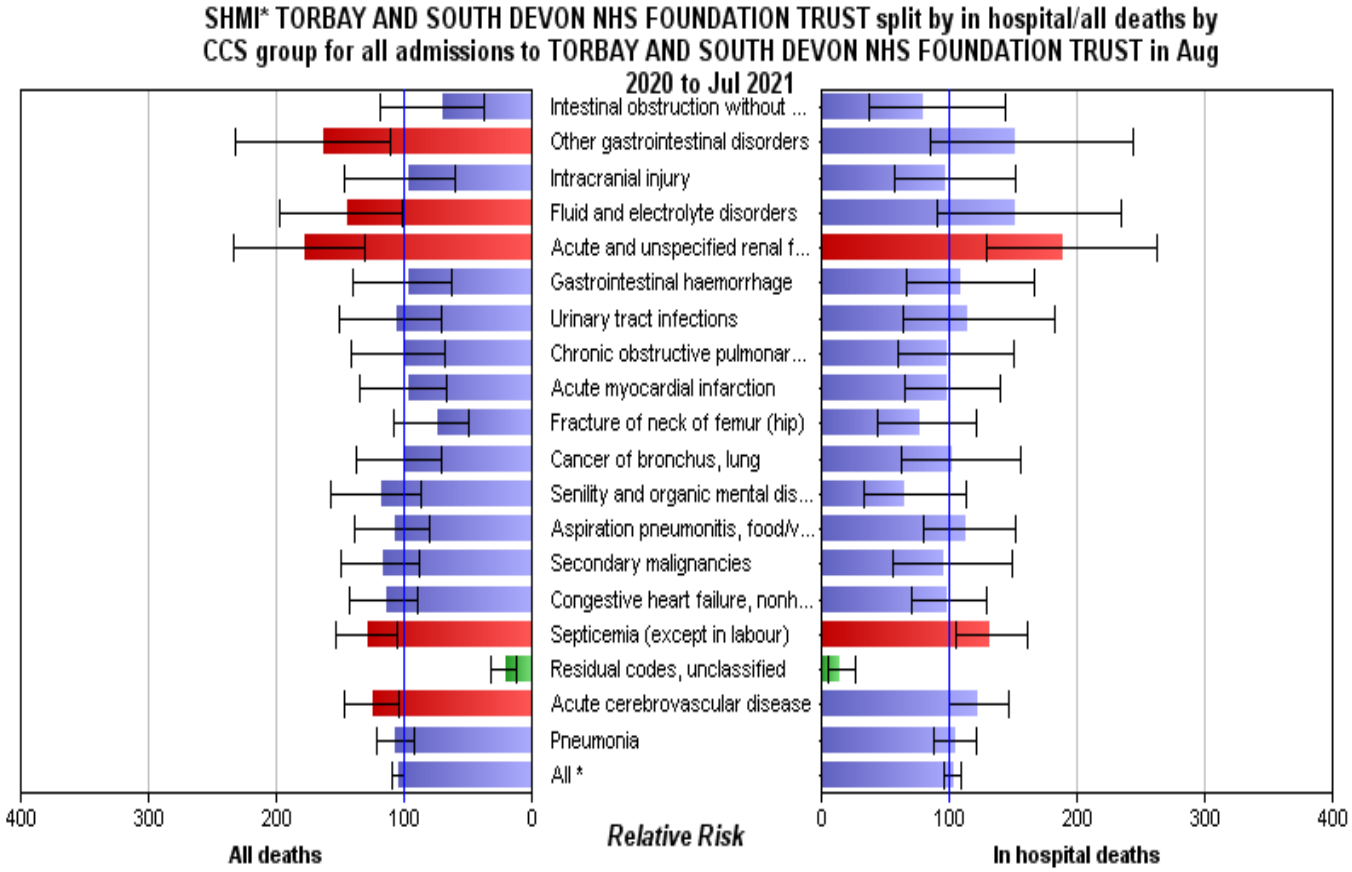
Alerts with observed deaths greater than 10 are currently under investigation:

i) Deaths due to 'Acute and unspecified renal failure' are higher than expected (28 observed v 20.6 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 (15 observed v expected 9.1). This does not appear to be due to coding issues. A review of the case notes is in progress and results to date suggest no lapses in care identified.

iii) Preliminary analysis of deaths due to 'other connective tissue disease' 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 disease' 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.


SHMI* TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST split by in hospital/all deaths by CCS group for all admissions to TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST in Aug 2020 to Jul 2021
Intestinal obstruction without ...
Other gastrointestinal disorders
Intracranial injury
Fluid and electrolyte disorders
Acute and unspecified renal f...
Gastrointestinal haemorrhage
Urinary tract infections
Chronic obstructive pulmonar...
Acute myocardial infarction
Fracture of neck of femur (hip)
Cancer of bronchus, lung
Senility and organic mental dis...
Aspiration pneumonitis, food/v...
Secondary malignancies
Congestive heart failure, nonh...
Septicemia (except in labour)
Residual codes, unclassified
Acute cerebrovascular disease
Pneumonia
All *
400
300
200
100
0
All deaths
Relative Risk
0
100
200
300
400
In hospital deaths

Appendix 4 – Dr Foster Patient Safety Dashboard

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

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

Table 4 – Patient Safety Indicators

Patient Safety Indicators

Period
12 months (Apr 20 to Mar 21)

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

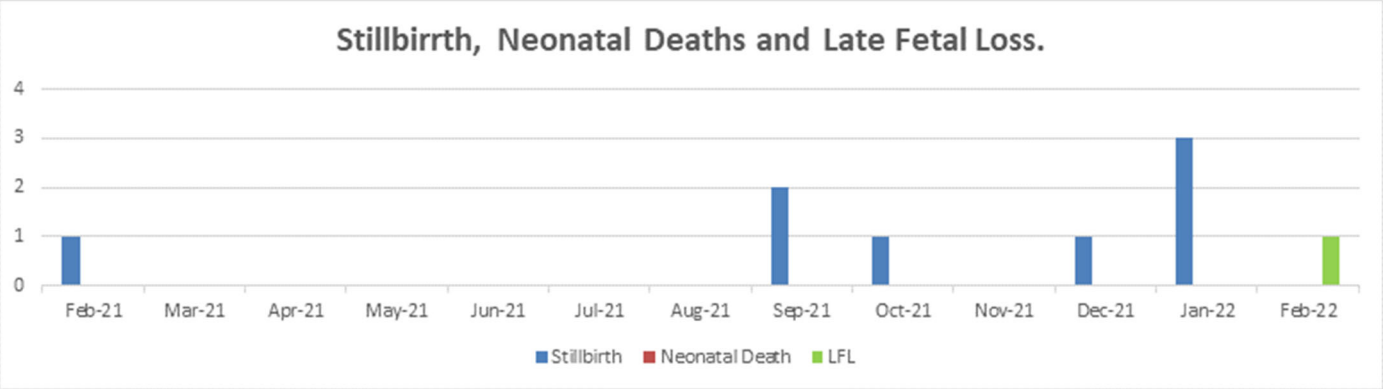
Number of deaths of a patient with a Learning disability

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

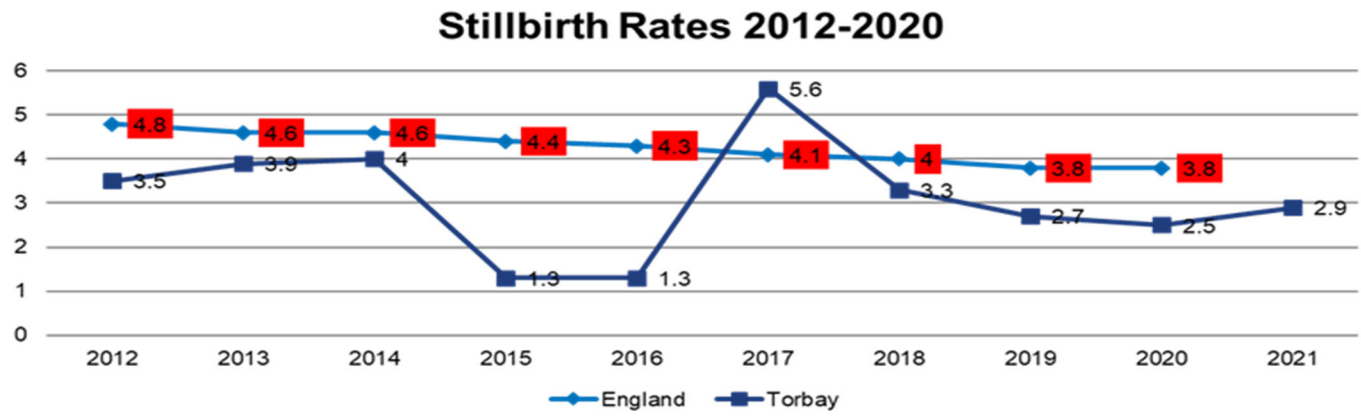
A stillbirth is when a baby born dead after 24 completed weeks of pregnancy. It occurs in around 1 in every 200 births in England. Death of a fetus before 24 weeks gestation is called a miscarriage or late fetal loss. Suicide continues to be the commonest cause of maternal death. Between January and March 2022, we had three stillbirths. These are currently being reviewed using the national pathway however the initial review did not indicate any themes other than two of the Mothers were smokers. The stillbirths were at 36, 36+4- and 40-weeks' gestation.

Chart 12 – Stillbirth, Neonatal Deaths and Late Fetal Losses



The National data for England 2020 remains the same as 2019. TSDFT rates are below the national levels

Chart 13– National Stillbirth Rates



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. 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.

Between January and March 2022 TSDFT had 1 child death (February 2022) -This was a 2yr old with significant congenital heart disease. The child arrested and was successfully resuscitated at Torbay before being transferred to PICU Bristol Children's hospital (BCH). Evidence of severe hypoxia was found on neuroimaging, therefore care was re-orientated and the child died peacefully in BCH. Emotional debrief was organised for staff on 15/3/22.

The Trust has had success with organising Suicide Prevention training. We have worked closely with Pete's Dragon's, local charity who can provide face to face teaching. We have arranged for 6 sessions "5 Steps to Suicide Awareness", 1 per month until September 2022, with space for 23 staff per session (limited due to space available in TREC). This training, has currently been provided free of charge to us by Pete's Dragons. It has been offered to all Paediatric and ED staff, doctors, nurses and allied professionals, and we are planning on opening up to CAMHS staff also. This is a huge step forward to ensuring all staff who work with young people over the age of 10 receive formal suicide prevention training.

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

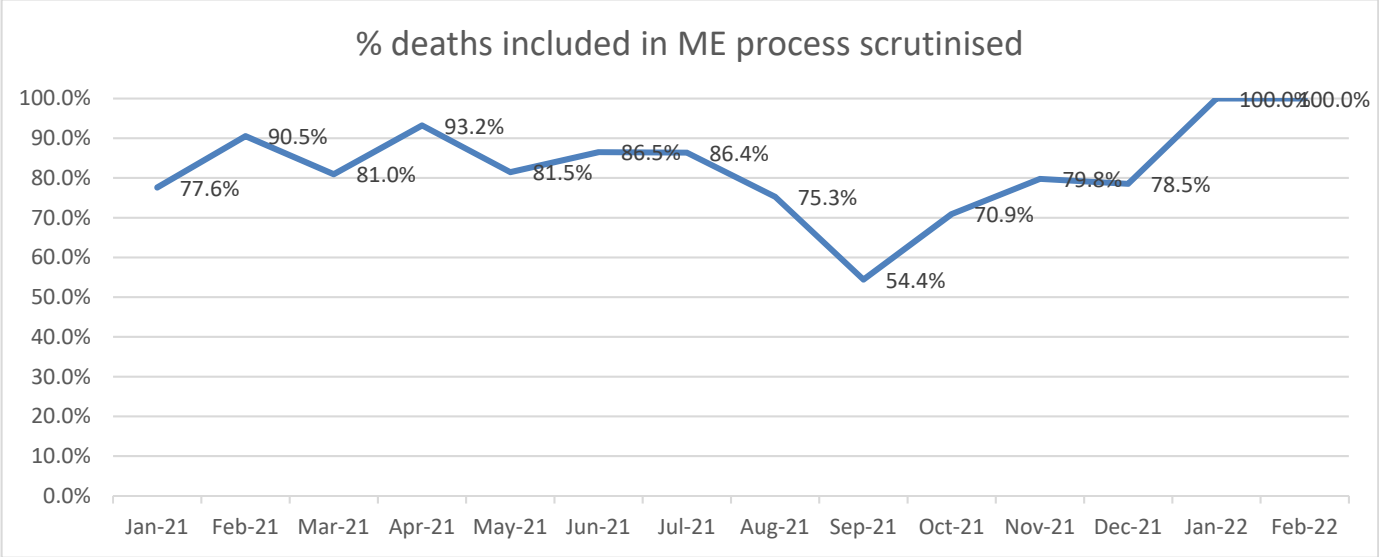
During January and February there have been 9 formal complaints relating to end of life care. Seven of these are currently active and relate to care or medical treatment. There are 2 closed cases one of which related to treatment and the other due to delays in completion of the Medical Certificate of Cause of Death (MCCD).

In addition, there have been 8 concerns and 4 compliments relating to care and / or medical treatment at End of Life.

Medical Examiners

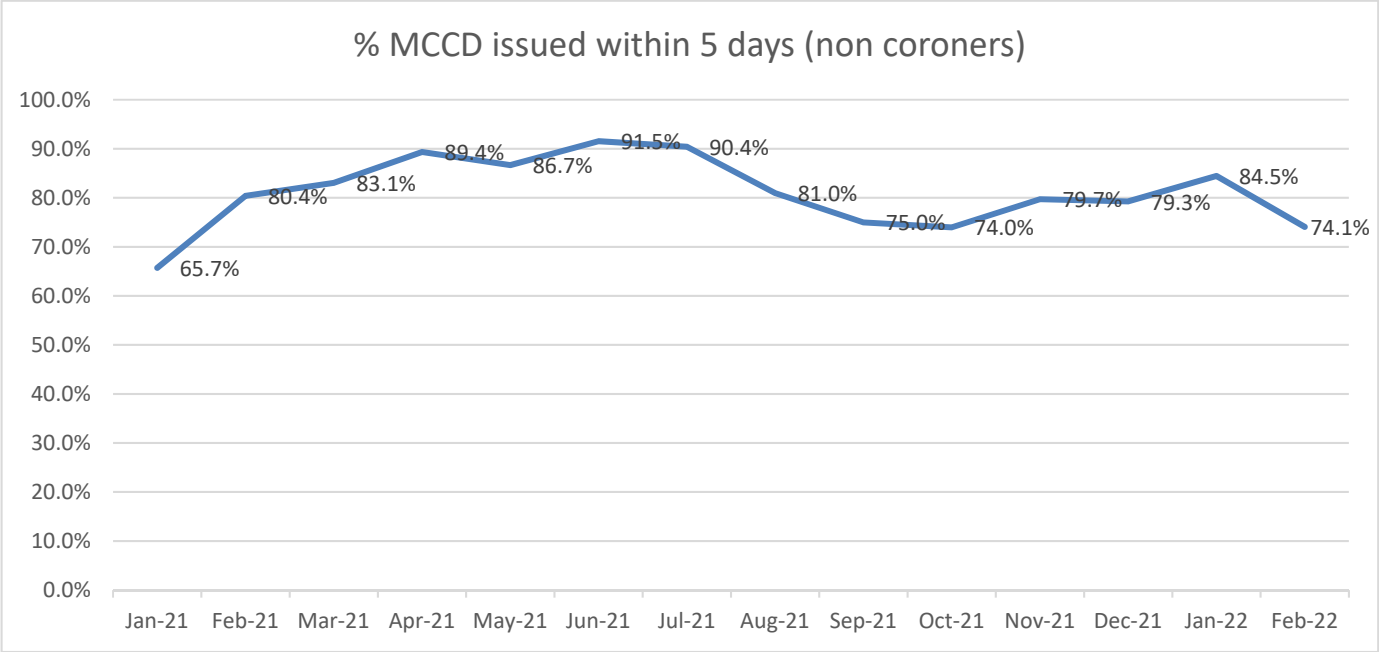
The Medical Examiners are now functioning at full complement and 100% of non-coronial adult inpatient deaths are being scrutinised.

Chart 14 – Medical Examiners Performance Summary



There continues to be delays in the receipt of death referrals and breaches to the completion of the Medical Certificate of Cause of Death (MCCD) within the required 5-day period for registration which is resulting in increased informal concerns being raised by the bereaved and is contributing to the Trusts mortuary capacity issues. There are no apparent patterns or trends to identify a targeted approach for resolution. This is being actively managed on a daily basis vis escalation via Control Room and senior medical leadership team.

Chart 15 – MCCD completion within 5 days



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.

Publication approval reference: PAR807

Maternity services system learning
Maternity self-assessment tool

Version 6, 19 July 2021

Where updates have been made to the content of this document since the previous version was published (version 5, February 2020), they have been highlighted in yellow.

Introduction

This Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

Please use this tool to as a benchmark for your organisation in the core principles of good safety standards within Maternity services.

The tool

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups		
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes		
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined		
		Agenda for change banded at 8D or 9		
		In post		
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate		
		Clinical director to executive medical director		
		DoM to executive director of nursing		
		General manager to executive chief operating officer		
		Maternity services standing item on trust board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		
		There should be a minimum of three PAs allocated to clinical director to execute their role		
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team		
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate		
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area		
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways		
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups		
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly		
		Leadership culture reflects the principles of the '7 Features of Safety'.		
		Trust-wide leadership and development team in place		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Leadership development opportunities	Inhouse or externally supported clinical leadership development programme in place		
		Leadership and development programme for potential future talent (talent pipeline programme)		
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy		
		Organisational vision and values in place and known by all staff		
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]		
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years		
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan		
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.		
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]		
		Maternity strategy aligned with trust board LMNS and MVP's strategies		
		Strategy shared with wider community, LMNS and all key stakeholders		
		Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Non-executive maternity safety champion	Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)		
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]		
Multiprofessional team dynamics	**Multiprofessional engagement workshops**	Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans		
		Record of attendance by professional group and individual		
		Recorded in every staff member's electronic learning and development record		
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority		
		All staff given time to undertake mandatory and job essential training as part of working hours		
		Full record of staff attendance for last three years		
		Record of planned staff attendance in current year		
		Clear policy for training needs analysis in place and in date for all staff groups		
		Compliance monitored against training needs policy and recorded on roster system or equivalent		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Education and training compliance a standing agenda item of divisional governance and management meetings		
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation		
		Compliance with annual appraisal for every individual		
		Professional validation of all relevant staff supported by internal system and email alerts		
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings		
	Multiprofessional clinical forums	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups		
	Multiprofessional inclusion for recruitment and HR processes	Organisational values-based recruitment in place		
		Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures		
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints		
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Schedule of attendance from multiprofessional group members available		
	Multiprofessional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multiprofessional attendance.		
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design		
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users		
	Collaborative multiprofessional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility		
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		
		Identification of the source of evidence to enable provision of assurance to all key stakeholders		
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access		
		Clear communication and engagement strategy for sharing with key staff groups		
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements		
		Weekly/monthly scheduled multiprofessional safety incident review meetings		
	Multiprofessional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS		
		Positive and constructive feedback communication in varying forms		
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]		
		Schedule of focus for behavioural standards framework across the organisation		
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month		
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]		
		All policies and procedures align with the trust's board assurance framework (BAF)		
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance		
		Staff across services can articulate the key principles (golden thread) of learning and safety		
		Staff describe a positive, supportive, safe learning culture		
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support		
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		
		Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales		
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF		
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF		
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board		
		Mechanism in place for trust-wide learning to improve communications		
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication		
		Governance communication boards		
		Publicly visible quality and safety board's outside each clinical area		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Learning shared across local maternity system and regional networks		
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups		
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.		
		Multi-agency input evident in the development of the maternity specification		
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process		
		In date and reflective of local maternity system plan		
		Full compliance with all current 10 standards submitted		
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.		
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance		
		Clear process for multiprofessional, development, review and ratification of all clinical guidelines		
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme.		
		All guidance NICE complaint where appropriate for commissioned services		
		All clinical guidance and quality standards reviewed and updated in compliance with NICE		
		All five elements implemented in line with most updated version		
		SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Saving Babies Lives care bundle implemented	Trajectory for improvement to meet national ambition identified as part of maternity safety plan		
		All four key actions in place and consistently embedded		
	Application of the four key action points to reduce inequality for BAME women and families	Application of equity strategy recommendations and identified within local equity strategy		
		All actions implemented, embedded and sustainable		
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE		
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs		
		Plan in place for implementation and roll out of A-EQUIP		
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team		
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered		
		Service provision and guidance aligned to national bereavement pathway and standards		
	Maternity bereavement services and support available	Bereavement midwife in post		
		Information and support available 24/7		
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities		
		Quality improvement leads in place		
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Recognised and approved quality improvement tools and frameworks widely used to support services		
		Established quality improvement hub, virtual or otherwise		
		Listening into action or similar concept implemented across the trust		
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.		
	MatNeoSip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan		
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)		
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees		
		FTSU guardian in post, with time dedicated to the role		
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post		
	Human factors training available	Human factors training part of trust essential training requirements		
		Human factors training a key component of clinical skills drills		
		Human factors a key area of focus in clinical investigations and formal complaint responses		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.		
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern		
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's		
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date		
		Audit of compliance against above		
		Annual schedule for Swartz rounds in place		
	Trust wide Swartz rounds	Multiprofessional attendance recorded and supported as part of working time		
		Broad range of specialties leading sessions		
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit		
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes		
		In date business plan in place		
Comprehension of business/ contingency plans impact on quality. **(ie Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively**	Meets annual planning guidance		
		Business plan supports and drives quality improvement and safety as key priority		
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups		
		Consultant job plans in place and meet service needs in relation to capacity and demand		
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans		
		Business plans ensures all developments and improvements meet national standards and guidance		
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.		
		Business plans include dedicated time for clinicians leading on innovation, QI and Research		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.		
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.		

Key lines of enquiry	Kirkup recommendation number
Leadership and development	2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18
Governance: Covers all pillars of Good governance	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Quality Improvement: application of methodology and tools	5, 6, 9, 12, 13, 15, 16, 17, 18
National standards and Guidance: service delivery	2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Safety Culture: no blame, proactive, open and honest approach, Psychological safety	2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Patient Voice: Service user involvement and engagement through co-production and co-design. MVP and wider	6, 9, 11, 12, 13, 15, 17, 18

Staff Engagement: Harvard System two leadership approach, feedback and good communication tools	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Business Planning: aligned with LMNS plans and the National Maternity Transformation agenda, Maternity safety strategy and the Long term plan	8, 9, 10, 14, 15, 16, 17, 18

Key supporting documents and reading list

1. NHS England National Maternity review: Better Births. February 2016; https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

2. Royal College of Obstetricians and Gynaecologists Maternity Standards 2016; https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf

3. NHS England NHS Long Term Plan: January 2019; https://www.longtermplan.nhs.uk/

4. Report of the Investigation into Morecambe Bay March 2015; https://www.gov.uk/government/publications/morecambe-bay-investigation-report

5. Royal College of Midwives. Birth-rate plus tools; https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf

6. Royal College of Midwives State of Maternity Services 2018; https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf

7. NHS England. Spotlight on Maternity: Safer Maternity care. 2016; https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf

8. Department of Health Safer Maternity care. The National Ambition. November 2017; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf

9. NHS Resolution. Maternity Incentivisation Scheme 2019/20; https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

10. NHS staff survey. (2018); https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/

11. Maternity Picker Survey. 2019; https://www.picker.org/wp-content/uploads/2014/10/Maternity-4-pager-for-website-ARe-V2-18122018.pdf

12. National Maternity Perinatal Audit. (NMPA) report; https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-nmpa-clinical-report-2019/#.XdUiX2pLFPY

13. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. (MBRACE) report; https://www.npeu.ox.ac.uk/mbrrace-uk

14. Organisations Monthly Maternity Dashboards; https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard

15. Organisational Maternity and Neonatal Cultural Score Survey; https://improvement.nhs.uk/documents/5039/Measuring_safety_culture_in_matneo_services_qi_1apr.pdf

16. NHS England Saving babies lives Care bundle. V2 March 2019; https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

17. 7 Features of safety in maternity services framework; https://for-us-framework.carrd.co/

18. Ockendon Report: investigation into maternity services at Shrewsbury and |Telford NHS hospitals 2020; https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

19. Perinatal Surveillance Model; https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

20. Maternity Incentive Scheme; https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf

CQC Maternity Survey 2021 Improvement Action Plan

Ref	Date created	Issue	*TEPIDCOIL	TSDFT Score 2021	TSDFT Score last Survey 2019	Highest Trust Score in England	Number of Responses	Topic	Action	Lead	Deadline	RAG status	Governance Reporting Route	Monitoring and Evidence	Update
B8	15/03/2022	During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy	Communication	84%	90%	96%	176	Leadership	Review clinic time slots, promote named midwife within CoC framework	Maternity Leadership Team, named midwives, obstetric team	28/09/2022		Maternity CG meeting minutes.	Leadership walk through. Involvement of MVP Friends and Family Questionaire.	
C3	15/03/2022	At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital	Communication	85%	91%	93%	133	Leadership	Review system in place for contacting midwife and labour ward, review impact of introduction of new maternity IT system	Maternity Leadership Team, labour ward co-ordinators	28/09/2022		Maternity CG meeting minutes.	Leadership walk through. Involvement of MVP. Friends and Family Questionaire.	
D7	15/03/2022	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were theyable to stay with as much as you wanted?	Communication	32%	93%	98%	104	Enviromental, Government regulation	Ensure visiting policy reflects current restrictions Governmental guidleines	HoM / ADMPP	28/04/2022		Maternity CG meeting minutes.	Posters, social media, Trust website. Friends and Family Questionaire	
F15	15/03/2022	Were you given information about your physical recovery after the birth?	Communication	66%	74%	79%	177	Leadership	Review postnatal information packs and access to online resources.	Maternity Leadership Team, community team leaders	28/09/2022		Maternity CG meeting minutes.	Leadership walk through. Friends and Family Questionaire.	
F1	15/03/2022	Were you given a choice about where your postnatal care would take place?	Communication	27%	56%	57%	167	Leadership	Review current practice	Maternity Leadership Team, community team leaders	28/09/2022		Maternity CG meeting minutes.	Leadership walk through. Friends and Family Questionaire.	

Risk log

Last updated		Time		Version	

						Risk Scoring						Mitigated Risk Scoring							
Risk ID	Date Raised	Risk Type / Theme / Source	Risk Description	Consequence / type of imapct	Impact (1-5)	Likelihood (1-5)	Rating (Initial)	Rating (Target)	Controls / Mitigation already in place	Mitigations planned if the risks should arise or escalate	Mitigated Impact (1-5)	Mitigated Likelihood (1-5)	Rating (Mitigated)	Rating (Target)	Risk Owner	Next Review Date	Status	Escalation Route
1	05-Jan-22	Operational/EPR/IT	EPR system outdated	low	3	3	9	6	manual audit of notes	business in place for upgrade of system	2	2	4	4	ED leaders	01-Feb-22	open	ISU governance
2	05-Jan-22	Patient feedback/experience	F+F compliance low	low	3	3	9	6	Action in place to improve	healthwatch to support patient audit	2	2	4	4	ED leaders	01-Feb-22	open	ISU governance
3							0						0					
4							0						0					
5							0						0					
6							0						0					
7							0						0					
8							0						0					
9							0						0					
10							0						0					

INSERT NAME Action plan

Last updated		Time		Version	

Ref	Date added to plan	Title	Embedded document
1			
2			
3			
4			
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Violence Prevention and Reduction Strategy

Purpose of Strategy

Torbay and South Devon NHS Foundation Trust (TSDFT) is committed to providing a safe working environment for staff, patients and visitors. The purpose of the violence prevention and reduction strategy is to set out a plan for TSDFT to address the significant and ever-increasing risk of violence and aggression by members of the public and staff members. Please see Appendix 1 and 2. This strategy will support staff to work in a safer and more secure environment, which safeguards against abuse, aggression and violence.

The World Health Organisation defines violence as:

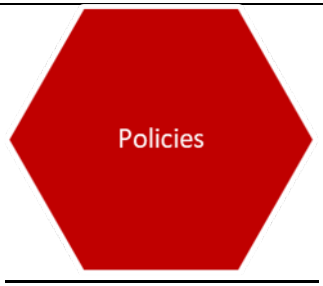
"the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either result in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (Global status report on violence prevention 2014).

The strategy links with the "Violence Prevention and Reduction Standard" produced by NHS England and NHS Improvement which adopts the Plan, Do, Check, Act approach.

Strategic Aims

- Identify and respond to incidents better, so that staff feel that reporting is worthwhile.
- Ensure victims are central to the process, and ensure adequate support for those engaging with the criminal justice system.
- Ensure individuals who display unacceptable behaviour are highlighted to the wider trust and action's taken to reduce the risks.
- Gain Trust Board level support and oversight for violence prevention and reduction.
- Ensure all Datix incident data is reviewed, discussed and action plans reviewed accordingly.
- Raise the public's awareness of the issues, along with the action that will be taken.
- Review policies, procedures and resources with the Strategy in mind.
- Ensure each and every member of staff has fit for purpose training.

Strategic Focus Areas

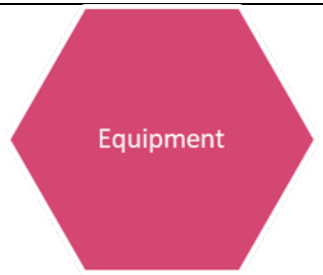
		Responsible
1	**Implement New Policies. Ratified via the Health and Safety Committee.** • Violence Prevention and Reduction Policy • Body Worn Camera Policy	Clinical Safety Manager
2	**Review of all existing policies relating to the Security Team. Ratified via the Health and Safety Committee.** • Management of Violent and Abusive Individuals and Risk of Violence Marker Procedures • Security Procedures • Management of Lone Working Policy (S1) (Jan 2022) • Restrictive Practice Policy (Presently being reviewed by a team led by Corinne Foy, ADNPP) • Supportive Observation Policy (Being reviewed by Rhoda Allison, ADNPP)	Clinical Safety Manager
		
1 A B	**Datix** Security team to place all Datix incident forms to “Being Reviewed” within a week of the forms being completed by our workforce. This will ensure the security management team have viewed the incidents and are able to respond appropriately to the risks highlighted. Healthcare Security Officers to encourage all staff to report a violent or aggressive incident on Datix as soon as possible after an incident.	Clinical Safety Manager/ Security Supervisor Clinical Safety Manager

C	To arrange regular meetings with the clinical coordinators across the ISU's relating to the more complex incidents where Safeguarding, Memory Captures or Witness Statements are required.	Clinical Safety Manager
D	To link in with Patient Safety and Quality Facilitator and Datix Administrator to ensure relevant data relating to violence and aggression is available to be reviewed by the Clinical Safety Manager and presented at the monthly Health and Safety Committee. (Appendix 2)	Patient Safety and Quality Facilitator / Datix Administrator
E	To review Datix incidents quarterly with the Diversity and Inclusion Lead relating to violence and aggression highlight any trends. The senior management will then be informed about any disparity trends for violence and aggression against groups with protected characteristics, and a full equality impact assessment has been developed and will be made available to all stakeholders. Via Health and Safety Committee (AC) / Peoples Committee (DM)	Diversity and Inclusion Lead
F	Datix reports to be sent to clinical safety manager for presentation and discussion at the health and Safety committee, Categories - Disruptive, Aggressive Behaviour – Sub Categories - other disruptive abusive behaviour - Physical Abuse/Assault/Discrimination - Racial Abuse/Assault/Discrimination - Sexual Abuse /Assault/Discrimination - Verbal Abuse/Assault/Discrimination - Security / Crime Related - Sub Categories - Patient / Visitor Monitored by Security - Person Removed from site - Physical Assault Non Clinical - Physical Assault Clinical - Staff Feeling Vulnerable - Threatening / Abusive Behaviour	Clinical Safety Manager / Datix Administrator

G	The Datix team have added a Hate Crime section to the Datix incident forms. This section will appear if staff complete the incident form including, • All Assaults • All Discrimination events • All events of threatening/abusive behaviours and bullying/ harassment.  There is a definition of hate crime and if you were to select the "help" ? you will see further guidance to contact the security team, or go to the Criminal Prosecution Service guidance on hate crimes for more information.	Clinical Safety Manager / Datix Administrator
2 A	**Risk Assessment** Ensure all security site risk assessments are completed on an annual basis and made available for viewing if required. Completion rate presented at monthly Health and Safety Committee.	Clinical Security Operations

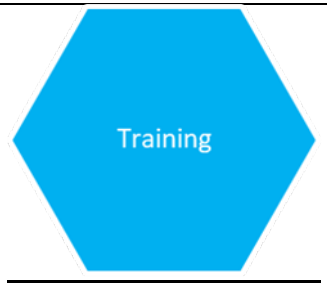
B	Add a staff - based risk assessment form to the security site risk assessments. This risk assessment should include training and lone worker risks.	Officer (CSOO Vacant)
3 A B	**Violent Patient Marker Panel** To ensure the recently restarted violent patient marker panel meetings continue to discuss patients who may be of a risk to staff and other patients. The panel ensures all incidents are discussed equally and fairly. To ensure there is sufficient and suitable attendance from staff at the monthly violent patient marker panel. To link in other local NHS trust security management and the police to ensure patients transitioning across the county are tracked.	Clinical Safety Manager Clinical Safety Manager
4	**Prosecutions** Ensure all staff who are physically assaulted are aware of the importance of reporting these assaults to the police. Staff, patients and visitors can be prosecuted under the Assault on Emergency Workers Act 2018. Physical Assaults will be highlighted via Datix incident forms and the security team will contact staff and managers involved. Implement a plan to improve understanding of, and support for, staff engaging with in judicial processes and inform media of all prosecutions and sentencing.	Security Team / Devon and Cornwall Police
5	**Senior Management Team** Senior Management Team oversight of the performance of this strategy and the associated policy and procedures via board reports and information shared at the health and safety committee (inputs to include incident data, risk assessments, risk registers, governance reports, lessons learned, staff intelligence, HR intelligence and stakeholder engagement).	Clinical Safety Manager
6	**Acceptable Behaviour Campaign linked to Violence Prevention and Reduction** Conduct a staff and public awareness campaign.	CSOO (Vacant)
7	**Acceptable Behaviour** The security management team to ensure that they implement ward- based conversations to individuals who may display behaviours which challenge our services. This may then lead to an acceptable behaviour agreement to be written and signed by both parties.	Security Management Team

		
1	**Devon and Cornwall Police** Improve partnership working with Devon and Cornwall Police to ensure, • Information can be shared about violent patients • Issues of anti social behaviour addresses • Highlight Thefts • Terrorist Threat • Local shared Initiatives	Clinical Safety Manager / Inspector Ian Stevens
2	**Community Safety Accreditation Scheme** Devon and Cornwall Police – Ensure the security team and security officers become accredited with the Community Safety Accreditation Scheme (CSAS). This will provide the security team with limited powers for example "To have access to and share information and intelligence with Devon and Cornwall Police"	Clinical Safety Manager / Security Supervisor
3	**Torbay Anti-social Team** Contact and work alongside the Torbay Anti - Social Team to assist with on going concerns on our community sites.	Clinical Safety Manager / Security Supervisor
4	**Schools and Academy** Explore links to local schools to start an education programme to help deter anti - social behaviours on all of the hospital sites.	CSOO

		
1	**Body Worn Cameras** To initiate a trail for body worn cameras for the security team. Ensuring all data protection principles are followed and training provided on their usage.	CSOO / Security Supervisor
2	**Lone Worker Devices** To invite new companies to tender for the lone worker contract. Ensure there are suitable alternatives to allow each team to decide which device is best suited for them, for example Apps, badges, tracking devices. Once the tender has been agreed ensure sufficient communications are sent to the trust capturing all relevant teams.	Clinical Safety Manager / CSOO
3	**CCTV** To ensure the trust sites have sufficient coverage and signage to deter any incidents. Review current provision of CCTV and complete a business case for funding for any improvements.	Clinical Safety manager / CSOO

		
1	**Health and Wellbeing Support - De Brief** Assist the Wellbeing team and signpost managers and staff to health and wellbeing services offered by the trust JIGSAW is a critical incident stress management service. The JIGSAW team helps, facilitating debriefings after a major incident and support for teams and individuals after a distressing event.	Clinical Safety Manager /

	SIT - Ensures a colleague is supported and listened to when they need it. TriM - Trauma Risk Management	Wellbeing Development Facilitator
2	**Health and Wellbeing Support.** To review all support packages available to staff post incident for example occupation health, support reporting incident to police, EAP, Managers training, Staff Training.	Clinical Safety Manager / Wellbeing Development Facilitator
4	**Security Team** Recruit a Clinical Security Operations Officer and Security Administrator to ensure the team are able to complete all of the relevant workstreams linked to the Violence Prevention and Reduction Standards.	Head Of Operations
5	**New Band 3 – Health Care Assistant Roles** This new role has been developed to work across the stroke and HoP wards to support patients that have behaviours that challenge our service for clinical reasons. This role will take the lead in identifying personalised care, managing meaningful occupation and diffusing behaviours that challenge.	Associate Director of Nursing and Professional Practice (RA)

		
1	**Conflict Resolution** To review and ensure all front- line staff are completing this mandatory training. Ensure the current package meets the aims and objectives set out by the skills for health core skills framework.	Clinical Safety Manager

2 A B	**Supportive Observations and Safe Approaches** Due to COVID we now need to re - introduce this mandatory training to all bank HCA and Nurses. Ensure the aims and objectives meet the needs of our workforce. To achieve this the education physical interventions team will link in with ward managers and Dementia leads to review theory and practical content twice a year. To meet with community matrons and explore delivering this course in their health and wellbeing centres. These workplaces do not have access to full time security officers and are therefore a high-risk area.	Education Department Physical Intervention Team
3	**Physical Interventions** To ensure all healthcare security officers (HSO) are in date with their physical interventions training. To ensure all Physical interventions tutors are in date with their tutor status via the General Services Association and are offered CPD opportunities. For example attending the yearly conference. To update training needs analysis (TNA) linked to all physical interventions training	Clinical Safety Manager
4	**Breakaway Training** Educations Physical interventions team to deliver Breakaway Training on Child Health and Emergency departments monthly mandatory training days.	Educations Physical Interventions Team
5 A B C	**Dementia Education Links** The physical interventions team to link in with the dementia education leads to ensure all training meets the needs of this patient group. Completing work on Cheetham Hill promoting the use of the This Is Me document to find out likes dislikes hobbies and background information to help with engaging the person in conversation and social interaction. This work to progress across the ICO. Identifying meaningful activities, which can help keep someone calm and be a useful distraction if the person is becoming agitated.	Educations Physical Intervention Team Dementia Education Lead Dementia

	As part of the supportive observation policy if a person requires 1 – 1 supervision we are promoting the use of a behaviour chart to document date time of any behaviours that challenge, what was happening at the time and how the situation was de-escalated. This can also aid in identifying any patterns and be used to pre-empt certain situations which can in turn help minimise the risk of behaviours that challenge.	Education Lead
6	**Learning Disabilities** Ensure hospital passports are completed for all individual with learning disabilities. This will ensure we are able to meet their specialist needs and reduce the amount of challenging behaviour.	Senior Learning Disability Nurse /Clinical Safety Manager

Monitoring

The Violence Prevention and Reduction Strategy will be presented to the board and once agreed monitored via the Health and Safety Committee. The efficiency and effectiveness of the violence and reduction plans and process will be assessed and reviewed every six months or following any organisational changes or serious incidents.

Appendix 1

Staff Survey Results 2020

In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?

	2016	2017	2018	2019	2020
Worst	21.1%	22.1%	21.2%	21.7%	20.7%
Your Org	13.2%	15.5%	12.9%	14.5%	14.5%
Average	14.7%	14.8%	14.1%	14.4%	14.2%
Best	7.2%	8.1%	7.3%	7.5%	6.3%

In the last 12 months how many times have you personally experienced physical violence at work from managers?

	2016	2017	2018	2019	2020
Worst	1.9%	2.3%	1.6%	2.0%	2.1%
Your Org	0.2%	0.8%	0.3%	0.4%	0.4%
Average	0.6%	0.7%	0.6%	0.5%	0.5%
Best	0.0%	0.0%	0.0%	0.0%	0.0%

In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?

	2016	2017	2018	2019	2020
Worst	3.5%	4.3%	6.5%	3.8%	4.8%
Your Org	0.9%	1.1%	1.1%	1.0%	1.2%
Average	1.8%	1.8%	1.6%	1.4%	1.4%
Best	0.2%	0.5%	0.6%	0.5%	0.1%

Appendix 2 - October 2020 to October 2021

	Total
Physical Assault - clinical reason	77
Threatening/Abusive Behaviour	446
Physical Assault - non clinical reason	42
Physical Abuse/Assault/Discrimination	11
Physical Abuse/Assault against patient by Staff/Visitor/Public on NHS Premises ONLY	2
Total	578

	HOS. Dawlish Hospital Ward	HOS. Newton Abbot Hospital Teign Ward	HOS. Newton Abbot Hospital Templer Ward	HOS. Torbay Hospital Cromie Ward	HOS. Torbay Hospital Dunlop Ward	HOS. Torbay Hospital EAU 4	HOS. Torbay Hospital ED (A&E)	HOS. Torbay Hospital Forrest Ward	HOS. Torbay Hospital George Earle Ward	HOS. Torbay Hospital Louisa Cary Ward	HOS. Torbay Hospital Midgley Ward	HOS. Torbay Hospital Simpson Ward	HOS. Torbay Hospital Medical Receiving Unit (MRU)	PAT. Patient/Client's own home
Physical Assault - clinical reason	9	2	3	1	5	8	2	0	12	2	1	12	1	2
Threatening/Abusive Behaviour	3	4	8	9	19	22	132	11	48	9	11	41	15	9
Physical Assault - non clinical reason	0	3	0	2	1	2	13	0	3	0	1	8	0	1
Physical Abuse/Assault/Discrimination	0	1	0	0	0	0	1	0	1	0	2	2	0	1
Physical Abuse/Assault against patient by Staff/Visitor/Public on NHS Premises ONLY	0	0	0	1	0	1	0	0	0	0	0	0	0	0
Total	12	10	11	13	25	33	148	11	64	11	15	63	16	13

Contributors

Andrew Chorlton – Clinical Safety Manager

Chris Sparks – Security Supervisor

Debbie Maynard – Diversity and Inclusion

Chris Edworthy – Head of Organisational Development (OD)

Louise Stevens – Safeguarding and MCA Lead / Education Facilitator

Trudi May – Wellbeing Development Facilitator

David Hickman – Patient Safety and Quality Facilitator

Jake Gibbons - Datix Administrator

Inspector Ian Stevens – Devon and Cornwall Police

Trade Unions

Health and Safety Committee Members

Michelle Bell - Associate Director of Nursing and Professional Practice

Rhoda Allisson – Associate Director of Nursing and Professional Practice