Torbay and South Devon NHS Foundation Trust
Public Board of Directors

The Boardroom, Hengrave House/MS Teams

27 July 2022 11:30 - 27 July 2022 14:30

AGENDA

#	Description	Owner	Time
1	Welcome and Introductions Note	Ch	11:30-11:35
2	Preliminary Matters	Ch	
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	Patient Experience Story - Paignton & Brixham Note	CN	11:35-12:00
4	Consent Agenda (Pre Notified Questions)		
4.1	Committee Reports		
4.1.1	Finance Performance and Digital Committee Chair's Report - 27 June 2022 Note 4.01.01 Finance Performance and Digital Commite... 9	P Richards	
4.1.2	People Committee Chair's Report - 27 June 2022 Verbal	V Matthews	
4.2	Reports from Executive Directors (for noting)		
4.2.1	Chief Operating Officer's Report - July 2022 Receive and Note 4.2.1 Chief Operating Officer’s Report.pdf 13	COO	
5	For Approval		

#	Description	Owner	Time
5.1	Unconfirmed Minutes of the Meeting held on the 29 June 2022 and Outstanding Actions Approve 5.01 Unconfirmed Minutes of the Meeting held on th... 25	Ch	12:00-12:05
6	For Noting		
6.1	Report of the Chairman Verbal	Ch	12:05-12:15
6.2	Chief Executive's Report Receive and Note 6.2 Chief Executive's Report.pdf 35	CE	12:15-12:30
7	Safe Quality Care and Best Experience		12:30-13:30
7.1	Integrated Performance Report (IPR): Month 3 2022/23 (June 2022 data) Receive and Note 7.01 Integrated Performance Report Month 3 2022... 47	CFO	
7.2	July 2022 Mortality Score Card Receive and Note 7.2 July 2022 Mortality Score Card.pdf 119	MD	
7.3	Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training Receive and Note 7.3 Report of the Guardian of Safe Working Hours... 141	MD	
7.4	Medical Appraisal and Revalidation Report Approve 7.04 Medical Appraisal and Revalidation Report.pdf 147	MD	
7.5	Annual Infection Prevention and Control Report 2021 22 Approve 7.05 Annual Infection Prevention and Control Repor... 163	DIPC	

#	Description	Owner	Time
7.6	Maternity Governance & Safety Report (1 April 2022 – 30 June 2022) Receive and Note 7.6 - Maternity Governance and Safety Report 1 Ap... 185	CN	
7.7	Complaints, Feedback and Engagement Service Annual Report 2021/22 Receive and Note 7.07 Complaints, Feedback and Engagement Servi... 199	CN	
8	Valuing our Workforce		
8.1	No agenda items		
9	Improved Well-Being Through Partnerships		13:30-13:45
9.1	Children and Family Health Devon – Annual Report Receive and Note 9.1 Children and Family Health Devon – Annual Re... 223	COO	
10	Well-Led		13:45-14:00
10.1	Building a Brighter Future Update Receive and Note 10.1 Building a Brighter Future update.pdf 241	DTP	
10.2	Timeline – health and care in Torbay and South Devon Approve 10.2 Timeline – health and care in Torbay and Sout... 249	DTP	
11	Compliance Issues		
12	Any Other Business Notified in Advance Note	Ch	
13	Date and Time of Next Meeting - 11.30 am, Wednesday 28 September 2022 Note	Ch	

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BOARD CORPORATE OBJECTIVES

Corporate Objective:

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

Corporate Risk / Theme

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

Torbay and South Devon
NHS Foundation Trust

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

Committee meeting date:	27 June 2022
Report author + date:	Paul Richards, Non-Executive Director 21 July 2022
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐

Key issues to highlight to the Board

The Committee received the BAF and CRR, noting that the BAF was currently being reviewed to ensure that it was fit for purpose for the future and a revised format would be presented to the Board of Directors in the near future. The new BAF would also be aligned to the Trust's new strategy.

Investment

The Committee received the Protected Elective Care and Improvement of Day Case Productivity bid, which was submitted under the Targeted Investment Fund opportunity. The Committee was asked to recommend approval to Board to submit the short form business case and noted that, if it was successful, a full business would be brought to the Committee for consideration.

The funding would provide for the construction of two additional modular theatres and, depending on costs, might also cover refurbishment work in existing theatres. The Committee noted that the proposal had been subject to a high-level independent cost review, and a broad letter of support had been received from the Integrated Care System (ICS) to support the application.

The Committee sought assurance on the impact of inflation and funding for revenue costs. With respect to the latter, the funding stream for revenue costs would be tested at business case stage. It was currently assumed that the project would be fully funded, but this would be confirmed in a more detailed letter of support by the ICS, to be requested by the Programme Director.

The Committee also scrutinised the capital charges in light of the wider BBF programme. The Committee also recommended a greater emphasis on the increased throughput the build would provide for Ophthalmology, as the service was currently constrained by the current estate.

The Committee agreed to recommend that Trust Board approves the bid submission.

The Committee also received the TP Packing and Capacity Improvement Plan Business Case. There was a capital expenditure requirement of £4.13m (£0.24m in 2022/23 (covered by TP

budget) and £3.89m in 2023/34) to replace and upgrade equipment to enhance packaging processes, thereby maximising production line utilisation and driving down unit costs. The Net present value (NPV) was £3.46m over five years with payback in 30 months. The Committee scrutinised the sensitivity analysis and requested further information on this prior to the case being presented to Trust Board. The Committee also emphasised that the Trust had a scarce capital resource and there was a need to use leverage to obtain the capital from national sources.

Performance

Quality

The Committee noted the Trust currently had six must do and eight should do Care Quality Commission (CQC) actions outstanding. These related to training; appraisals; and rolling replacement programme.

The Committee also noted three severe incidents and one death: the severe incidents were in Urology and Ophthalmology and the death was due to a lack of Venous thromboembolism (VTE) prophylaxis administration. VTE assessment compliance had reduced from 91.3% to 89.7%. Concern was raised at the deterioration in performance and the action being taken to improve performance was queried.

Workforce

The Committee noted that sickness rates had decreased in May to 4.66% compared to 6.36% in April, but turnover remained high at 13.56% but within normal tolerance of 10-14%. This figure reflected a significant number of staff choosing to return and return (1.7%). Agency spend remained a significant concern, and had increased to £1.3m against a target of £1.1m.

Performance

The Committee noted that Covid numbers had remained static, however it was reported that numbers had now started to increase again. Recovery planning continued to take place with services being moved back to original locations, and Urology to the Paignton Hospital site.

Urgent care remained significantly challenged and under pressure. Four-hour performance was at 57.6%, the lowest performance for 13 months. The number of patients waiting over an hour in ambulances remained high at 514.

The number of patients waiting over 104 weeks for treatment had started to reduce from 245 at the end of March to 173 at the end of May, and was forecast to be less than 100 by the end of June. Focus would now move to patients waiting of 78 weeks for treatment to meet the planned position of 305 by the end of March 2023.

Patient Initiated Follow Up performance was at 21% compared to a target of 25%.

Some cancer specialties remained challenged, particularly dermatology, urology, and lower GI.

The Committee discussed the number of unfilled packages of care (at 242 in May) and has commissioned a deep dive at a future meeting.

Finance

The Trust was reporting a £2.07m deficit, a £1.29m positive variance to plan. This was due to additional inflationary funding having been confirmed by NHSE/I.

The Committee noted that the Trust was in a financially challenged position, with a significant underlying deficit, owing to:

- agency spend, which had increased whilst sickness absences had reduced;
- delays in commencing efficiency programmes, particularly those focused on workforce; and
- delays in Covid cost reductions

The Committee also noted a risk to cash, as borrowing could only take place in line with planned deficits and the Trust no longer had a planned deficit but a planned break-even position. This would be discussed with the regional team.

The Committee also received a more detailed report on the efficiency programme. The Committee reviewed performance to date, noting that that only those projects that had been properly submitted were included in the data. Performance was currently £1.1m behind the required trajectory.

The Committee queried the approach to removing savings from budgets, and was informed that savings were held under management cost centres until they were identified and then allocated to specific budgets.

Governance and oversight arrangements had been changed to support delivery. Performance was reviewed on a weekly basis to ensure plans were being met. The Financial Delivery Group and Transformation and CIP Group had been merged into one group, the CIP Delivery Group, to better oversee and ensure accountability for this work.

The Committee also received the ERIC 2021/22 report, noting that the cost of EFM had increased by £4.26m. This included insurance increases of £0.5m; hard FM costs increases of £1.75m, soft FM increases of £1.6m; and management cost increases of £184,000. Although not part of the EFM function, the return also included increases of £500,000 for medical electronics and £240,000 for medical records.

The Committee sought assurance as to the scope for savings in this area. It was felt there was opportunity to make savings if the Trust was innovative in how it addressed energy efficiencies. This would be supported by the appointment of a specialist Energy and Carbon Manager. Furthermore, a review was taking place of all specialist contracts to ascertain if any savings could be identified.

Short term planning

The Committee received the Capital Expenditure, Cash Plans – Current Position Report. The paper suggested the Trust over-committed capital expenditure by £8.5m, with £5.7m being to progress schemes carried forward into the current financial year, but not contractually committed. A further £2.8m would provide for any potential new schemes.

The Committee noted that impact assessments would be brought to the Committee meeting in July for prioritised schemes, and that a robust prioritisation process had taken place to score schemes, review by the Capital Investment Delivery Group; and cross-disciplinary challenge.

It was envisaged that by over-committing funds it would avoid any capital underspend in the current year.

Other matters.

The Committee also received the following items:

- The updated Trust incident response plan, recommending this to Trust Board for approval
- Changes to the Estates and Facilities Management Leadership Function and Future Delivery of Construction and Engineering Projects
- Emerging risks from IGG (including intermediate care demand, UEC pressures, CIP delivery, clinical cover for escalation)
- Reports from other forums including TP, IM&T group

Key decision(s)/recommendations made by the Committee

Approved:

- Over-programming of capital to a value of £8.5m, to reduce the risk of underspend and to be monitored in year based on delivery of the plan and the outcome of various opportunities to increase the Trust's CDEL
- Proposed changes to the estates and facilities management leadership function and future delivery of construction and engineering projects
- Submission of the Trust's ERIC return
- Updated Terms of Reference for the IM&T Group / Health Informatics Board

Escalating:

- Trust's financial position and ability to break even
- Approval of the TIF bid for elective care and improvement to day case productivity
- TP Packaging and Capacity and Improvement Plan business case
- Incident Response Plan
- Capital Expenditure
- Estates and Facilities Management structure changes
- ERIC Return

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Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report July 2022			**Meeting date: 27 July 2022**
Report sponsor	Chief Operating Officer		
Report author	System Care Group Directors		
Report provenance	The report reflects updates from management leads across the Trusts Integrated Service Units (ISUs) and Children and Family Health Devon (CFHD)		
Purpose of the report and key issues for consideration/decision	The report provides an operational update to complement the Integrated Performance Report (IPR), including some specific performance metrics. The report offers greater visibility of activity not fully covered in the IPR. The Trusts recovery work is explored in more detail in this month's report alongside the urgent work required to support safely reducing length of stay. The report also highlights a number of key developments across the community alongside the key activities, risks and operational responses to support delivery of services through this phase of the recovery and restoration. This includes delivery of high priority cancer, diagnostics and elective services.		
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: 27July 2022**
Report sponsor	Chief Operating Officer (COO)	
Report authors	System Care Group 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 Integrated Service Units (ISU's) and Children and Family Health Devon (CFHD).

2. Introduction

June has proved challenging with a rise in Covid admissions and staff sickness, operational performance across all care groups has therefore been under pressure. The impact of additional Covid workforce absence and rising Covid patient numbers has been seen across organisation.

3. Urgent Care and recovery care group

3.1 System Recovery and Capacity response plan

Focus continues on restoration and delivery across all areas, this has been hampered by the rise in Covid admissions and staff sickness. The Covid impact has required the full utilisation of 2 wards and other areas across the Trust in accordance with the Infection, Prevention and Control (IPC) Covid operational plans. The rise has also been felt across community providers with outbreaks in care homes and domiciliary care providers. Wearing of masks has been reintroduced across all sites during this period. The site operations team is working very closely with the IPC team internally as well as strong links to system colleagues, this is enabling our response to be as agile as possible in our approach to carefully managing the situation.

3.2 Newton Abbot ISU: Urgent & Emergency Care

Attendances during June across all the Trusts Urgent and Emergency care activities are at pre-pandemic levels. Ambulance arrivals averaged 60 a day in June however, despite this lower average we have seen increased delays in offloading the ambulances. Overall attendances to the Emergency Department (ED) were 2% lower in June 2022 (5,733) and 34.3% of these patients were seen and discharged from the ED in four hours. Since April 2021 the ED continues to see increasing numbers of patients with higher acuity requiring treatment and also larger numbers of children requiring urgent care.

The Urgent Treatment Centre (UTC) at Newton Abbot has seen 2,917 attendances and 94.3% of patients were seen and discharged within four hours.

The Medical Receiving Unit (MRU) continues to treat patients directly from GP's avoiding the need to attend the ED. In late October 2022 the MRU will move to its new location, the Acute Medical Unit (AMU).

4. Children and Family Health Devon (CFHD)

4.1 Performance

Three service areas are showing an improvement in referral to treatment (RTT) waits in June, namely the Child and Adolescent Mental Health Service (CAMHS), Physiotherapy and the Autism Assessment Service. Whilst Palliative Care appears to show an improvement, the number of children receiving care at any one time is very low and RTT is 100%, as would be expected, whenever a child is receiving this type of care. 100% RTT is also being maintained by the Children's Nursing Service. There are small deteriorations in RTT across four service areas, namely Learning Disability, Occupational Therapy, Speech and Language Therapy and the Specialist Assessment Centre.

Figure 1: CFHD RTT and Mean waiting times June 2022

Service	Mean Wait	% waiting ≤ 18 weeks	% RTT ≤ 18 weeks compared to last month	% RTT ≤ 18 weeks over the last 12 months
Community Children's Nursing (CFH Devon)	4.1	100.0%	→	
Learning Disability (CFH Devon)	5.0	95.2%	↓	
Mental Health and Wellbeing (CFHD)	19.7	56.5%	↑	
Occupational Therapy (CFH Devon)	13.3	69.0%	↓	
Palliative Care (CFH Devon)	1.0	100.0%	↑	
Physiotherapy (CFH Devon)	12.0	76.8%	↑	
Special School Nursing (CFH Devon)	28.1	10.0%	→	
Specialist Autism Spectrum Assessment Team (CFHD)	41.0	31.0%	↑	
Specialist Children's Assessment Centre (CFHD)	40.6	30.9%	↓	
Speech & Language Therapy (CFH Devon)	34.6	31.2%	↓	

4.2 ASD Waiting Times Improvement Work

The Autism waiting list reduction project is on-going. Since the start of the project in April 2021 2,322 assessments have been undertaken and there has been a steady reduction in the number of children waiting, until February 2022. As previously reported, this has been achieved by re-designing the assessment pathway using Lean principles, achieving a 95% increase in productivity per WTE clinician, increased clinical capacity, using a team of clinicians working remotely, funded by CFHD non-recurrent funding and a simultaneous reduction in demand, during Covid. However, demand began to increase again in Q3 2021/22, since Q1 2022/23 the team has experienced reduced capacity and feedback indicates children being assessed are more complex, requiring additional contacts in order

to complete assessments. These factors have resulted in an increase in the numbers of children waiting this month. Progress of the project is being closely monitored, internally, and in partnership with the ICS and NHSE.

4.3 Transformation

The first stage of the formal staff consultation concluded at the end of May and impressively, 1,760 items of feedback have been received, ranging from single issues to fully developed counter-proposals. This has been themed and is currently under review by the leadership team. Changes are being made to the proposed model in response to feedback from staff and these changes have been subject to further engagement discussions with staff. Staff have responded very positively to the changes being made and have experienced the process as evidence that they are being listened to. Staff engagement has remained a key priority; during the first phase of consultation alone; staff engaged in the launch event, 10 clinical pathway workshops, 11 Q&A sessions, 4 specific group sessions and 127 individual meetings. On the whole, whilst continued uncertainty exists about the future and different views about some areas of the service proposals, staff are also optimistic and enthusiastic about the future direction of the service.

4.4 Children's Services Contracts Review

An interim report, written early in 2022, was presented to the CCG Governing Body in June, as this was the last Board prior to the dissolution of the CCG.

4.5 Devon Special Educational Needs and Disability (SEND) revisit

Ofsted and CQC inspectors spend three days between 23rd and 25th May conducting a re-visit to Devon to assess the degree of progress made by services in addressing weaknesses identified in the SEND inspection of December 2018. The inspection team found that the area had not made sufficient progress in addressing the four significant weaknesses, as follows:

A) Strategic plans and the local area's SEND arrangements are not embedded or widely understood by stakeholders, including schools, settings, staff and parents.
B) The significant concerns that were reported about communication with key stakeholders, particularly with parents and families remains poor.
C) The timeliness of EHC plans and their variable quality, mean that EHC plans are not able to be used as to support the planning and implementation of education, health and care provision to improve outcomes.
D) In 2018, inspectors found weaknesses in the identification, assessment, diagnosis and support of children and young people with autism spectrum disorder (ASD). They found there has been a reduction in the overall number of children and young people waiting for an ASD assessment, but children and young people were still waiting too long.

Decisions regarding the arrangements to ensure improvement in the area's services in relation to children with SEND are currently under consideration by the DfE.

5.0 Planned Care, Care group

5.1 Coastal ISU – Elective Care

Due to the challenged position regarding the number of patients waiting 78 weeks or more

the Trust has been placed in Tier 1 monitoring. This is a national categorisation system, we have joined other Trusts within the ICS who were already in the process. This means there are now weekly review meetings at executive level with the Regional team and the ICS team to maintain oversight of the progress being made.

Total elective activity for June was 93% of our pre-covid levels. Day-case activity was 100% compared to 90% in May whilst inpatient elective activity has dipped to 88% compared to 90% in the previous month.

The 104-week position at the end of June was 93 patients compared to our original plan of 51. This however was an improvement of 7 patients against our position which was re-stated due to high levels of patients choosing to delay treatment (58). Entering July, we were confident that the position would be reduced to only those patients choosing to delay, this has been put at risk by increasing levels of Covid infection amongst staff and patients. A number of long wait patients (10) who were scheduled to be treated this month have cancelled their appointments due to their own positive covid test and 4 have been cancelled as a result of team members testing positive.

Recently submitted plans to reduce the number of patients waiting 78 weeks or more have been followed up by funding applications to deliver:

- Systematic validation of the RTT waiting list
- 7 day working in theatres
- Increased outpatient support and capacity in our “at risk” specialty’s

Implementation of these initiatives will support our ambition to eradicate 78 week waits by March 23 but there remain significant challenges in achieving this despite some early positive indications.

The Trust continues to pursue all opportunities to improve efficiency and effectiveness in our Outpatient and Theatre facilities. This focus will support the delivery of 104% (BAU) activities at reduced cost overall and is being supported by Delloites and 4 Eyes Insight

Paignton and Brixham ISU: Cancer and Diagnostics Update

5.2 Cancer Performance

In addition to being assigned Tier 1 monitoring for the number of patients waiting over 78 weeks, the Trust is also in this category due to the number of cancer patients waiting over 62 days to commence their definitive cancer treatment.

June’s performance against the 62-day cancer standard was 56.8% (85% target) a decline on May’s performance (62.3%). The Trust continues to be challenged to comply with the 62-day cancer performance target with remedial action plans in place. Urology, Skin and Lower GI continue to be the main contributors to this position.

71% of urological cancers are prostate tumours and we continue to have extended waiting times for prostate template biopsies. This position is improving with support from additional sessions by RDUH at Tiverton and Ottery and insourcing – supported by the reopening of Day Surgery. To sustainably maintain this position additional estates work is being finalised to finish a specialist procedure room in Paignton to complete the offering of the new Urology Investigation Unit. Staffing is also a significant factor in recovery, with

consultant and nursing vacancies, these are out to advert.

The colorectal service is heavily reliant on diagnostic colonoscopy procedures and the recovery of this position is focused on the reduction of the current 30 day wait for colonoscopy. From July there is a mobile endoscopy unit arriving at Torbay, this will be commissioned and fully operational in September. The mobile unit provides an additional procedure room and allows building work to commence in January to construct 2 new endoscopy rooms (1 will replace existing an older room and 1 is additional) – this will give provide 4 permanent rooms by Q2 2023/24. There has been extensive modelling, supported by the CCG and Clinical Leads, to demonstrate the backlog clearance (both 2 week wait and Routine) by January 2023.

Colorectal 62-day performance continues to be challenged and currently stands at 27.3%. This is due consistent year on year rise in referrals together with long diagnostic waiting times; 30 days for colonoscopy, 5-6 weeks for CT colonoscopy, plus clinics appointment waits of 5 weeks for face to face appointments and 4 weeks for non-face to face appointments.

The 28-day Faster diagnosis standard performance is currently at 65% in June (75% target). The tumour sites failing this metric are Urology, Colorectal, Gynaecology and Breast. The narrative above describes the key factors in the former two. For Gynaecology a solitary capacity issue in hysteroscopy is the cause. New equipment has now been purchased and completion of Estate's work is required to bring this into use. The Breast Team are being impacted by a shortage of radiology cover for the triple assessment clinics.

Positively, June's 31-day first treatment metric is expected to achieve target at 96%.

Currently the Trust has 239 patients over 62-days, a high percentage of these patients are on Urology and Colorectal pathways. Staffing levels due to sickness and an increase in Covid within the Trust is impacting on our ability to reduce the backlogs as originally planned in the coming months.

5.3 Diagnostics

CT waiting times have remained consistent for June (compared to May), however there remains a strong likelihood this position will deteriorate going forwards due to reduced levels of mobile capacity for CT. There has however been considerable improvement in the waits for CT colonoscopy. MR waiting times have also remained level but should improve in coming weeks as there is increased mobile capacity.

The team can now book CT and MR contrast studies at Nightingale which will allow increased activity, though this is still variable around availability of appropriately trained support staff.

Both MR and CT services lend themselves to additional mobile capacity and space on Trust premises continues to be sought. A potential second site exists at Newton Abbot Hospital; a recent site survey has indicated a significant amount of enabling work to be able to accommodate a second mobile scanner.

Ultrasound has seen an increase in demand for the first time in several months taking the monthly level of demand back to the position at the latter end of 2021. The impact this

increase in demand is having on the waiting list is being compounded by staff sickness and maternity leave at this time.

6.0 Families Community and Home care group

6.1 Torbay SEND

Work continues on the outcomes of the inspection with the 4 sub-groups reporting through to the strategic board, there are health representatives on all these sub groups for Joint commissioning, SEND Strategy, graduated response and culture.

6.2 Child Health / Paediatrics

This month we held our Drumbeat day where we invited colleagues, partners, families and carers to come together and share ideas and visions for the future of child health. We heard from some excellent speakers of innovation and different ways of doing things. The opportunity to come together in person with colleagues was appreciated by everyone after such a long time of having virtual meetings. The ideas and thoughts generated were inspirational and aspirational and will form the basis of our long term plan for child health and our contribution to the Building a Brighter Future plans.

We have started trialling dictation to text for clinic letters using Microsoft Word 365. Early feedback is good and we have been able to produce clinic letters for 5 clinics in the time it usually takes us to do one. This will enable us to free up both clinical and admin time. We will then explore what else admin can do to free up clinician time with an aim of creating more clinical capacity to reduce our waiting list.

A new mental health in reach team from Young Devon are starting work with patients on Louisa Cary ward this month. This is an exciting opportunity which will provide much needed support for our young people while they are in hospital, but also in the community.

6.3 Children's Torbay 0-19 Service

In every stage of a family's life from 0 to 19 the service has created an online information sheet for families to understand what support is on offer to them. This has also been made available in Ukrainian and will soon also be available in Russian.

The service has been working alongside the Healthy Lifestyles team piloting new ways to support local families as part of a Devon wide initiative to improve smoking reduction during pregnancy and generally within families. Initially the team will work with a smaller cohort of families as part of Torbay Promise, which provides additional support during the late stages of pregnancy and postnatally.

6.4 Maternity

SystmOne

Staff are continuing to gain confidence with the system. The project was due for completion 30th June 2022 but was extended until 31st July to provide support for the outstanding project tasks. Confirmation on the start date to rollout BRIGID (electronic observation tool) expected soon.

Concerns remain around ability to report adequate data internally and externally- this could have an impact on ability to provide assurance specifically with regard to the national Maternity Service Data Set (MIS) and Ockenden returns.

Staff engagement and culture

Work continues to address improvements. Maternity staff away days have commenced addressing wellbeing and psychological safety, feedback has been positive so far and all learning will be captured.

Periprem project (Perinatal Excellence to Reduce Injury in Premature Birth)

This is a care bundle of interventions for preterm babies that improve outcomes
We had a visit in May from Dr Sarah Bates clinical lead for the Periprem project to celebrate the work we have done in this area. Torbay rates very highly in respect of optimal cord clamping having only the second-best rate of all Special Care Baby Unit's (SCBUs) in the country.

6.5 Torbay Drug & Alcohol Service

The mobilisation phase of the Multi complex needs (MCN) Alliance including the drug and alcohol service is underway, with the development of key relationships, co-production and "best for people using services" being essential elements of the development of the Alliance principles.

Following the publication of the 10-year Government strategy "From Harm to Hope" further investment has been allocated to the local system. The allocation for this year of c £416k will see some additional funding to support the service and wider community.

A good proportion of this funding c £180k will be allocated to the Criminal Justice Team within the Drug and Alcohol Service to improve care pathways and further integration with the wider criminal justice system. There will also be additional capacity for young people (under 18) to access treatment and support, additional residential rehab and detox funding and expansion of recovery support for people who have been through treatment. Additionally, two new posts have been created, one to work closely with Primary Care Networks around wider physical and mental health to improve integration and pathways and the second post will be closely aligned to the Trust's newly developed alcohol care team.

This local investment will support the recovery of individuals often with complex needs through a trauma informed approach to overcome their addiction and the work of the Alliance as it develops will support a wider system approach for each individual.

6.6 Baywide Independent Sector

The Fair Cost of Care work has mobilised, with 20% of care homes signed up further presentations have been made to the market to demonstrate the modelling tools and how the Trust and Council will support providers. Monthly meetings are conducted with Torbay, DCC, Cornwall and Plymouth to support approach and anomalies as they arise. The two consultants supporting Torbay have proved valuable in their insights and experience.

Supported Living tender evaluations are completed with 23 applicants.

The recent Extra Care Housing procurement altered the model and associated cost. Extensive modelling is underway to understand how this model works and translated into the new schemes in Crossways and Tor Marine. The impact of recruitment challenges, petrol and cost of living increases has impacted providers.

Care Accounts development work continues to progress alongside the identified trailblazers across England. Our colleagues in the Local Government Association (LGA) and Department for Health and Social Care are supporting our communications toolkit for Torbay residents, care providers and TSD staff. The Care Accounts project is also working to improve Torbay's Social Care digital offering and harnessing opportunities to be more efficient.

7.0 Moor to Sea ISU

7.1 Community Services

Adult social care teams continue to experience significant pressures with increasing waiting lists and increases in safeguarding concerns. Short-term services continue to provide backfill into domiciliary care with rates of backfill reaching as high as 80%. Challenges sourcing care continue with increased "hand-backs" of packages experienced particularly in the more outlying areas. However, community physiotherapy have worked hard to reduce their waiting list by 50% and nursing teams are positively engaging with Pathway to Excellence by setting up a staff council.

7.2 Totnes Hospital

Totnes Hospital has achieved its third Gold Award and the Minor Injuries Unit opened as planned and is already very busy. There is ongoing work to bring resilience to the medical cover at Totnes. This is still provided by the Healthcare of the Older Person (HOP) team but with gaps in the consultant workforce this has been challenging. However work is ongoing to develop the future model of care integrating it with HOP and frailty services with the intention to deliver a more resilient model.

7.3 Therapies

Concerns continue within the Speech and Language Therapy Service (SALT) that the community waiting list is growing which has also been impacted by the increase in Covid related absence. Meetings are planned to look in greater detail at the pathway to see how waits can be reduced. The in-patient the Occupational Therapy Team has for several months been managing significant capacity issues by only seeing "medically fit" patients rather than supporting earlier in the pathway; the intention is ow to explore how this can be concerted back to a more normal service delivery both for OT and Physio who are working with wards to identify patients that are most appropriate for them to see and support the ward teams in referring accordingly. Respiratory out-patient clinics have restarted but with significant waiting lists and backlogs – including within the Long Covid Service.

New approaches are being taken to support the significant challenges in recruitment, working with community teams to create more attractive rotations.

7.4 HOP and Frailty

The RTT position has improved due to efforts to address the backlog in waits within the Parkinson's Disease / Movement Disorder Service. The consultant team is challenged due to sickness and planned absence but continue to be committed to their wards, the Frailty Intervention Team and Totnes. Building a Brighter Future meetings are coming up as are frailty development sessions where we are looking to progress the evaluation and future planning for the service. Ward teams continue to work hard. Simpson ward had a "Fantastic Friday" where they celebrated the good work on the ward including 3 members of staff receiving a Daisy Award.

7.5 Stroke and neuro Rehab

The last two months has seen an improvement in SSNAP performance – particularly in the domains relating to therapy where we actually benchmark very favourably both regionally and nationally. The converse applies to our ability to get our patients to the stroke unit, performance in this domain and also in the delivery of thrombolysis within 1 hour has not improved. Performance on these domains is poor nationally but within that we are performing well below the national median. This is a concern not only for patient outcomes but the new Critical Time Standards will be having a "soft launch" on 1st August but are likely to roll out nationally shortly thereafter.

All teams are seeing an increase in Covid related absence as we go into the holiday period giving concern for the cover within services and significant concerns about staff resilience with an increase in both actual sickness and reported concerns related to mental health and wellbeing.

8.0 Conclusion

As described across all care groups, a challenging time for all teams. As we continue on the recovery journey and business as usual work for all our patients, clients and staff our attention must remain on the wellbeing and support agendas`.

9.0 Recommendation

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

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 29 JUNE 2022

Present:	Sir Richard Ibbotson	Chairman
	* Professor C Balch	Non-Executive Director
	* Mr P Richards	Non-Executive Director
	* Mrs S Taylor	Non-Executive Director
	* Mrs J Lyttle	Non-Executive Director
	* Mrs V Matthews	Non-Executive Director
	Mr R Sutton	Non-Executive Director
	* Ms L Davenport	Chief Executive
	Mr D Stacey	Deputy Chief Executive Officer and Chief Finance Officer
	* Mr I Currie	Medical Director
	* Mr J Harrison	Chief Operating Officer
	* 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
	* Mrs S Flavin	Interim Chief People Officer
	* Mrs N McMinn	System Director of Nursing and Professional Practice
	* Ms C Edworthy	Head of Workforce and Organisational Development
	* Mrs J Thomas	Lead Governor
	* Mr D Crawley	Governor

* via Microsoft Teams

123/06/22 **Welcome and Introductions**

The Chairman welcomed all those in attendance to the meeting.

Preliminary Matters

124/06/22 **Apologies for Absence and Quoracy**

No apologies of absence were noted by the Board.

125/06/22 **Board Corporate Objectives**

The Board received and noted the Board Corporate Objectives

126/06/22 **Declaration of Interests**

There were no declarations of interest.

Consent Agenda (Pre-notified questions)

Committee Reports

127/06/22 **Quality Assurance Committee Chair's Report - 23 May 2022**

The Board received and noted the Quality Assurance Committee Chair's Report of 23 May 2022

128/06/22 **Charitable Funds Committee Chair's Report - 15 June 2022**

The Board received and noted the Charitable Funds Committee Chair's Report of 15 June 2022

129/06/22 **Building a Brighter Future Chair's Report - 15 June 2022**

The Board received and noted the Building a Brighter Future Chair's Report of 15 June 2022

130/06/22 **Committee Terms of Reference – Finance Performance and Digital Committee**

The Board approved the Committee Terms of Reference for Finance Performance and Digital Committee

131/06/22 **Committee Terms of Reference – Charitable Funds**

The Board approved the Committee Terms of Reference for Charitable Funds

Reports from Executive Directors

133/06/22 **Chief Operating Officer's Report - June 2022**

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

The Board received and noted the Chief Operating Officers Report.

For Approval

134/06/22 **Unconfirmed Minutes of the Meeting held on the 25 May 2022 and Outstanding Actions**

The Board approved the minutes of the meeting held on 25 May 2022.

Mr Harrison confirmed action 116/05/22 regarding the residual impact of Covid19 and maximisation of diagnostic services would feed through the reports that came to Board.

All outstanding actions were noted as complete.

The Board approved the minutes of the meeting held on 25 May 2022

For Noting

135/06/22 **Parking Lot of Deferred Items**

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

136/06/22 **Report of the Chairman**

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

- The Trust and Community had seen a rise in Covid-19 infections.
- Two Extraordinary Private Boards were held in June:
  1. To discuss and approve the Operating Plan Submission; and
  2. To Approve Annual Report and Accounts
- From the 1 July 2022 the Devon Clinical Commissioning Group would formally become Devon Integrated Care System and Devon Integrated Care Board.
- The first Governor Network Meeting in person since 2020 took place on 9 June 2022.
- The Good Governance Institute were working with Trust Governors who would receive the Good Governance Institute Report on 6 July 2022.
- The Trust had held interviews for Non-Executive Director vacancies and the Council of Governors were in the process ratifying the recommendations.
- The Trust had successful interviewed for a number of Clinical Consultant posts to support the delivery of the recovery plan.
- He was delighted to attend the Chaplaincy Volunteers afternoon tea, with the Chief Executive, acknowledging the importance of their contribution.
- He recognised Mrs Falcao's, Chief People Officer, retirement and reflected on the extraordinary challenges she had faced during her tenure and the positive legacy she would leave.

The Board received and noted the report of the Chairman.

137/06/22 **Report of the Chief Executive**

Mrs Davenport wished Mrs Falcao a happy retirement. She paid tribute to her leadership of the people agenda and ethos of good people management.

Mrs Davenport, Chief Executive, presented the Chief Executive's report, as circulated, highlighting the following key issues:

- She paid tribute to Phill Norrey, Chief Executive and Head of Paid Services, Devon County Council who had signalled his intention to retire in August.
- Tandra Forster, had been appointed as Director for Adult Social Care, Devon County Council. She would be moving from her post as Executive Director for Adults and Communities, Southend Borough Council.
- The importance of the role of carers, including staff who have caring responsibilities and the work that had been undertaken under Mrs Katie Heard's leadership in this area.
- She was delighted to announce the following awards to Trust staff:
  - The Multiple Sclerosis Team in partnership with local GP, Dr Colin Brannen who lived with MS had been received an international award.
  - Dr Mary Stocker, had won the South West NHS Parliamentary Award for Health Care Excellence and was going forward to National Awards.
- A previously reported improved position in respect of Covid-19 admissions and transmission within the community to enable the Trust to stand down IPC arrangements and issue a notice that masks were no longer mandatory. However, an increase in Covid-19 transmissions and hospitalisations had highlighted the need for the review of the Infection Prevention Control policy and wearing of masks had been reinstated within the Trust.
- The 104 week wait list was being reviewed in line with the national zero 104 week by June mandate and with collaboration the Trust would only hold patients who had selected to defer their treatment on the 104 week wait list by the end of July 2022.

Mrs Matthews highlighted the Messenger Review which spoke to the importance of training within any leadership community and sought assurance that the Trust would be building a leadership development offer. Mrs Flavin confirmed the Trust would seek to understand the current internal provision that was offered to internal leaders and would ensure the key findings were shared.

Mrs Matthews had noted the change of tone within the press towards the NHS and asked if the Trust had considered an appropriate approach to responding to negative publicity. Mrs Davenport commented on the importance of presenting the real position to the public. She explained how Dr Harris' approach to communication supported positive relationships with the media by sharing good news and responding to questions openly and honestly.

Mrs Jones reflected on the good engagement the Trust had with its community by having open and honest conversations however, there was acknowledgement of the need to support staff who had contact with members of the public who are influenced by political media narrative.

Prof. Balch Balch asked for an update in respect of the re-opening of the Minor Injury Unit as this would relieve pressure on the Emergency Department. Mrs Davenport explained that Dr Thomas had been working with the local communities to support the re-opening of the Minor Injury Units and potential alternative options. Mr Harrison confirmed taking into account staffing constraints one Minor Injury Unit

should open in the next six weeks; and further communication will be disseminated in due course.

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

Safe Quality Care and Best Experience

138/06/22 **Integrated Performance Report – Month 2, 2022/23**

Dr Watson presented the Integrated Performance Report for month 2, 2022/23, as circulated, and drew the following to the Board's attention:

Quality

- Three severe incidents and one death were reported in the following areas:
  - Urology
  - Two within Ophthalmology; and
  - A death caused by a Pulmonary Embolism
- The stroke target of 80% stroke patients spending 90% of their time on a stroke ward was not met but an improvement had been seen to 67%.
- The Trust had been awarded the NHS Pastoral Care Quality Award.

Mrs Lyttle confirmed the Quality Assurance Committee had held a detailed discussion around harm and risk, and regularly reviewed the processes in place to prevent avoidable harm coming to patients. Mr Currie confirmed there was a Harm Review process in place and reviews took place regularly to identify where harm may occur and support teams.

Workforce

- The rolling annual sickness figure was 5.60% but, for May 2022 a significant decrease in sickness levels had been seen, of 4.66%.

Mrs Matthews asked the Board to note the staff turnover was in the upper tolerance and the implication this would have on teams, with the loss of knowledge and a likely financial impact. Mrs Falcao confirmed work had been commissioned nationally and at system level to look at staff turnover and research was being undertaken. However, this was a key discussion point at People Committee and conversations had been had around the opportunities for staff retiring to return to ensure the Trust could benefit from their knowledge; and whether staff would be more likely to stay if there were clear training opportunities for them. Mrs Flavin explained the value of achievement reviews, as people appreciate recognition; feel valued; and understanding expectation of their line manager. It was confirmed this work would link in with the work being undertaken by the Devon ICS.

Performance

- Covid-19 presentation had changed and the Trust was currently seeing a rise in Covid-19 admissions.
- The recovery plan had enacted and the Day Surgery Unit had been re-established. The Chemotherapy Unit had been scheduled to move back into the Hospital.
- The four hour performance target was reported as 57.6%, the Trust's lowest reported performance for 13 months.

- An improvement in the 'Not Criteria to reside' figures had been seen.
- There had been a decrease in the 104 week wait position, in line with the national mandate.
- Cancer recovery plans were focused on Dermatology, Urology and Lower GI pathways.

Prof. Balch commented on the difficulty with triangulating the operational, quality, workforce and financial metrics within the IPR. As the data showed the Trust had a full compliment of Nurses but could not make significant strides in managing patient flow.

Finance

- The Trust recorded a £2.07m deficit, a £1.29m positive variance to plan. The positive variance to plan was as a result to the additional inflationary funding from NHSEI.
- The Trust reported an adverse to plan position on bank and agency spend of £0.72m.
- Work had been undertaken at the request of NHSEI to submit a breakeven Operating Plan. The plan would be shared with the Senior Leadership Team and taken forward over the coming financial year.

Prof. Balch asked the Board to note the financial position reported for May 2022 was different to the financial position of the Trust now, with the submission of a balanced operational plan on 20 June 2022. Mr Stacey explained the positive impact of inflationary income received on the Trust's finances. Without the inflationary monies the Trust would have been reporting a deficit against the original plan. due to CIP provision, escalation in the Urgent and Emergency Care System; and Covid19 costs not being removed. The Board was asked to note the original operational plan submitted carried a £29.9m deficit and now the Trust's operational plan did not hold any deficit.

Mr Sutton explained the risk in a balanced operational plan and trying to deliver Cost Improvement Plans was heightened due to the fact the Trust was now at the end of the first quarter of the financial year. Mr Stacey agreed and described the link between Cost Improvement Plan delivery and the recovery of financial performance. He confirmed there was weekly oversight of the Operation Plan position at the Executive Meetings; and bi-weekly oversight at the Cost Improvement Plan Delivery Board.

Mrs Davenport explained that the challenge for all organisations was to balance the requirement to maintain patient safety and prioritise patient need whilst balancing best use of resources.

Mr Richards had recently attended the NHS Confederation event in Liverpool where it was articulated there was no further money available for the NHS and there was a need to balance the budgets. He asked what the Trust and Devon ICS were proposing e to ensure the continuation of delivery of safe sustainable services in the longer term. The Chairman counselled there was a need to manage public expectation as the reality was to consider what the Trust could undertake with the financial constraints it was under. He said it was the Trust's duty as a healthcare services provider to manage the public expectations.

Mrs Davenport highlighted the opportunities the Trust had to transform and its aspiration to invest in digital systems to improve access and sustainability within the local population. She described the great history of innovation the Trust had and a workforce that was prepared for the challenge they faced.

Mrs Jones acknowledged the IPR highlighted pressure in all aspects of the Trust but, there was a willingness to respond to the challenge as a group of Executives to deliver safe services to transform the Trust and its partner providers based on economies of scale for the local population. Significant transformational change was being progressed and it was recognised the local communities needed to be involved.

The Chairman stated the Trust was using the resource they received to the best effect and wished to make it clear that the Trust was doing all it could to secure the appropriate funding and resource but, funding was unlikely to increase in the current economic climate.

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

Valuing our Workforce

139/06/22 **Our People Promise and Plan 2021-2024: Celebrating year one and looking ahead to year two**

Mrs Falcao presented the People Promise and Plan to the Board. She confirmed the Trust was initially supporting delivery of the following four key pillars:

- Looking after our People
- Belonging to the NHS
- New Ways of Working
- Growing for the future

With the aim to create the conditions to make changes to enable sustainable services.

The following programmes of work had been undertaken, aligned to the pillars:
- Covid-19 response vaccination programme;
- Staff engagement programme; and
- Staff forums for underrepresented groups.

The focus for year 2 would be:
- Building work into the business as usual agendas;
- Leadership framework; and
- Focus on the Health and Well Being agenda.

She explained feedback had focused on the congruence of language and the need for the Trust to be mindful to celebrate successes.

Mrs Matthews endorsed the People Promise and Plan and the work that had supported it. She outlined the conversation that took place at People Committee, which recognised the context everyone was working in and the need for focus on

teams and people who would feel the benefit of the initiatives. There was recognition of the need to review the plan to ensure it would support the Trust in delivering the balanced operational plan.

Mrs Kelly supported the People Plan and the way it was styled, she said it was an accessible document that staff could relate to. She was in full support of the cultural piece of work and felt it should incorporate patient safety culture. She highlighted the need to test out the meaning of 'key decision making'.

The Chairman commented positively on the style of the paper and reflected on the messages he had heard including the plan to support staff into leadership roles.

The Board approved the priorities for year two of Our People Promise and Plan 2021-2024

140/06/22 **Bespoke Workforce Race Equality Standard (WRES) report overview**

Mrs Falcao, introduced Ms Edworthy, who presented the Bespoke Workforce Race Equality Standard (WRES) report overview as circulated. She confirmed the information had been gleaned from various sources including indicators held within the organisation, staff survey results and engagement. There had been greater engagement with the Black Asian Minority Ethnic (BAME) workforce over the last 18 months, due to the requirements to collect information on staff to inform Covid-19 statistics and Sanita Simadree, commencing in post as Diversity and Inclusion Lead.

Areas of focus for the Trust were:

- Career progression prospects
- Culture including the use of clumsy language and ways to engage
- Bullying and harassment

If the Trust was successful in improving the areas of focus it would drive:

- Learning
- Productivity
- Creative transformation of services

The Trust had formed positive links with the BAME Network who had become critical friends and given the Trust the opportunity to educate and learn from them so we could raise awareness.

Ms Edworthy highlighted the need for cultural KPI's. She also asked that the Equality Diversity and Inclusion programme of work should form part of the Development Programme to enable the broadening of diverse conversations. This would lead to embedding cultural differences throughout the Trust.

Mrs Matthews was in support of an Equality Diversity and Inclusion Development Session. She reflected positively on the contributions of Ms Sanita Simadree since taking on the D&I Lead role.

Mrs Jones agreed with the benefits of a development session focusing on where the Trust might be failing it's BAME staff in an unconscious way.

Mrs Davenport thanked Ms Edworthy for the thought provoking presentation. She said the Trust and the Region had undertaken sessions with Dr Eden Charles to

consider our leadership behaviours and opportunities to lead change across health and care services.

Mr Currie wished to inform the Board the COHORT of trainee Dr's this year had noticed the improvements of BAME culture; and the Junior Dr's were very keen to support leadership programmes but, there was a need to strengthen engagement amongst all staff who were tired due to Covid-19.

The Chairman reflected on Ms Simadree's input and the value she had added; and said if the Trust were committed to taking this work forward effectively there needed to be further resource.

The Board received and noted the Bespoke Workforce Race Equality Standard (WRES) report overview

141/06/22 **Compliance Issues**

There were no compliance issues reported.

142/06/22 **Any Other Business Notified in Advance**

There was no any other business raised for discussion.

143/06/22 **Date and Time of Next Meeting:**

11.30 am, Wednesday 29 July 2022.

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
116/05/22b	Mr Harrison undertook to report to the Board the residual impact left due to Covid19 and opportunities to maximise the growth of diagnostic services.	Mr Harrison	The residual impact of Covid19 and maximisation of diagnostic services would feed through the reports that came to Board. Action closed.	25.05.22
119/05/22b	The approach to policy writing be reviewed.	Mr Raheem	This action has been noted for communication to officers responsible for review of policies. Action closed.	25.05.22

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's Report			**Meeting date**: 27 July 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 19 July 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: 27 July 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

Key issues and developments to bring to the attention of the Board since the last Board of Directors meeting held on 29 June 2022 are as follows:

3.1 Excellent population health and wellbeing

CQC/Ofsted inspection of services for children with special educational needs and/or disabilities in Devon County

A joint report by Ofsted and the Care Quality Commission was published on 07 July 2022 following a recent inspection of health, social care and education services for children with SEND needs in Devon.

This followed Ofsted and CQC re-visit in May this year to assess progress made by services in addressing areas of weakness which were identified in the SEND inspection of December 2018.

In summary, the inspection team found that there had not been sufficient progress in addressing any of the four weaknesses. They found:

- strategic plans and the local area's SEND arrangements are not embedded or widely understood by stakeholders, including schools, settings, staff and parents.
- the significant concerns that were reported about communication with key stakeholders, particularly with parents and families, in 2018, remains poor.
- the timeliness of EHC plans and their variable quality, means that EHC plans are not able to be used to support the planning and implementation of education, health and care provision to improve children's outcomes.
- in 2018, inspectors found weaknesses in the identification, assessment, diagnosis and support of children and young people with autism spectrum disorder (ASD). They found there has been a reduction in the overall number of children and young people waiting for an ASD assessment, but children and young people were still waiting too long.

The report does recognise that there has been progress, but this progress has been insufficient. Inspectors highlight a number of concerns and concluded that Devon's SEND service continues to require significant improvement.

Inspectors also noted in their report that some individuals and services are working well and that together they are improving outcomes for some children and young people with special educational needs and disabilities. Some parents, carers, children and young people talk positively about their experiences, inspectors found though overall parents remain dissatisfied and have reflected on the impact of children and families.

The partnership of the local authority and health services across Devon, led by Devon County Council accept the findings and that fundamental change is needed in some areas. We are absolutely committed to make the changes that are needed to ensure that children, young people and their families are listened to and they are provided with the excellent services they need to support them to thrive.

Totnes Minor Injury Unit reopens

The Minor Injuries Unit (MIU) at Totnes Community Hospital, which closed due to a shortage of staff at the beginning of the pandemic, reopened on Monday 11 July in time for the busy summer.

Currently the MIU is open five days a week from 8am to 5pm, Monday to Friday but it is planned to open seven days a week from August. X-ray facility will be limited to all day Monday, and Tuesday and Wednesday mornings, with people advised to book via 111 if they think they need this service in advance to ensure x-ray is available. X-ray continues to be available 7 days a week, 9am to 5pm at Newton Abbot Urgent Treatment Centre.

We have recruited further staff and following an intensive training programme of up to 12 months they will have the skills required for an MIU. This does mean that we are unable to reopen the MIU at Dawlish at the moment but aim to have it up and running within 12 months when the team are fully skilled. In the

meantime, we are looking at interim options to support local people better. As a key part of this we are working with the local GP practice to see what can be done to provide urgent minor injuries care in the area. It is important to acknowledge the frustrations of the Dawlish Community at the delay in opening Dawlish Minor Injuries Unit.

Building our brighter future together - engagement sessions for our people on our health and care strategy
Earlier this year we brought physical roadshows to a range of our community and acute sites to talk to and listen to our staff about our Building a brighter future programme which is a key enabler for our organisational vision to deliver better health and care for all. While these were really positive events, we recognise that many of our people weren't able to physically join us.

To increase involvement and engagement, we have, this month, run a series of digital (online) roadshows for staff which have focused on discussing our health and care strategy and how we can work together to enable our whole community to live well and independently, managing their own health and wellbeing digitally or as close to home as possible.

Pharmacy announcement for Dartmouth health and wellbeing centre
Wellbeing Pharmacy has been announced as the pharmacy for the new Dartmouth Health and Wellbeing Centre.

Wellbeing Pharmacy, who already have two pharmacies in Devon at Bishopsteignton and Exmouth, will run the pharmacy from the health and wellbeing centre when it opens later this year.

The new centre will bring health and wellbeing services under one roof, for the benefit of the people of Dartmouth and surrounding areas. The purpose-designed centre will give local GPs the facilities they need to support the service into the future, and enable close working relationships and joined up care services with community nurses, therapists, Dartmouth Caring and the pharmacy.

Reintroduction of face masks in our buildings
Due to the rise in the numbers of people both in our communities and in our hospitals with COVID-19, earlier this month we asked all staff and contractors to return to wearing face masks while in work and within 1metre of another person. Anyone working in physical contact with patients in an inpatient or community setting who are known to have COVID-19 or whose COVID-19 status is unknown, are required to wear level 2 PPE.

We are encouraging visitors, patients and the public to wear a mask when visiting our sites if they are able to do so but this is not mandatory.

We are keeping our policy under constant review and will make further adjustments as needed, including stepping down mask wearing as soon as we are confident it is the right time to do so.

Development programme for BAME staff

We have developed and introduced a dedicated leadership programme for our BAME staff to maximise their leadership potential. Beginning in September this year, the programme specifically aimed at BAME staff will provide a 'safe space' to talk freely, and to develop and share learning.

The aims of the programme are to:

- build leadership resilience and confidence through the successful challenging of potential and perceived barriers
- help people improve accountability and engagement among their team
- introduce a coaching style of leadership in line with a wide range of leadership principles and to appreciate a more flexible approach in the new world of virtual leadership
- help people understand their own impact and adjust their style for improved inclusivity and enhanced organisational culture
- give an opportunity to understand self-worth and how best to bring your best self forward in both the workplace and interviews
- empower you to become a role model to help inspire the development and progression of others.

3.2 Excellent experience receiving and providing care

Current pressures

The large rise in the number of people with COVID-19 in our hospitals and our communities has impacted on our services in recent weeks. Staff sickness rates due to COVID-19 have risen significantly which is impacted on both workloads and morale.

While the majority of people with COVID-19 in our hospitals are with us because of other conditions which require medical attention, it is significantly affecting people who are frail and elderly. We currently have no COVID-19 inpatients on intensive care.

We have adapted our infection prevention and control measures to respond to the increase in infections locally – see the separate section below regarding our return to mask wearing.

We have continued to see a high demand for urgent and emergency care which is impacting on our ability to respond as quickly as we would wish. The reopening of Totnes Minor Injury Unit on 11 July should help ease some of the pressure on primary care, Newton Abbot Urgent Treatment Centre and the Emergency Department at Torbay Hospital as well as our medical, surgical and paediatric assessment areas. Ambulance handovers remain a challenge and our teams are working extremely hard with South Western Ambulance NHS Foundation Trust to find sustainable solutions.

We continue to see a significant number of people attending our Emergency Department with issues which require self-care or could be addressed through attendance at a local pharmacy. We are working with system partners to raise awareness of alternatives to the Emergency Department, particularly for those

conditions which are more appropriately treated elsewhere or can be managed safely at home with self-care.

Our partners in the care home sector and domiciliary care continue to work closely with us to support people to stay at home (where they can safely do so) and to get people home from hospital as quickly as we can. We recognise that the face similar challenges to us around workforce and resourcing and we continue to work together to do what we can to address these.

National cancer patient experience survey results 2021
Our cancer services have been rated highly by local adults in the 2021 national cancer patient experience survey.

The survey, overseen by a national Cancer Patient Experience Advisory Group, and commissioned and managed by NHS England, involved 134 NHS Trusts and had a national response rate of 55%.

535 people with a confirmed primary diagnosis of cancer, who received cancer related treatment from us between April and June 2021 gave feedback on the care provided. This was a 63% response rate, which was higher than the national average.

Feedback from local people was very positive with overall care rated at 9.03/10 which placed the organisation 35th out of 134 trusts. The level of involvement patients had in decisions about their treatment and the support and information available to patients and their families were highlighted in particular as great examples of care.

In no areas did the services score below the expected score, however, services are always seeking to improve and are putting in place local action plans.

Quality and safety long-term plan launch
We are committed to delivering outstanding care, ensuring excellence in experience and outcomes for our patients and the wider community we serve. While there is no universal definition of ‘excellent care’, it is important to be clear about what we are aiming to achieve – providing clarity on our purpose enables us to know when we are not delivering against our ambition for patients and staff.

Earlier this month we launched our three-year quality and safety long-term plan which outlines our approach to quality, setting out our ambition for excellence and outstanding care through a set of strategic quality goals and improvement priorities. Key to our success is the requirement to renew and revitalise our approach to quality management and leadership, ensuring that we enable front line clinicians to deliver outstanding care.

Ward accreditations
During June six of our wards underwent the accreditation assessment process. Turner ward and EAU4 both received a bronze award. McCallum ward received

a silver award following their bronze award earlier this year. George Earle ward received a gold award. Brixham Hospital received a gold award, following two previous silver awards. Dart ward at Totnes Community Hospital received their third consecutive gold award – an outstanding achievement.

DAISY awards
The DAISY award winners for May were Lucy Bowser and Ashleigh Godfrey, two ward sisters from Simpson Ward who were nominated for going above and beyond to care for patients and colleagues.

3.3 Excellent value and sustainability

NHS pay award
The government has accepted the NHS Pay Review Body (NHS PRB) and Doctors' and Dentists' Review Body (DDRB) recommendations relating to NHS pay awards for the 2022/23 year.

The pay uplifts announced amount to an additional investment of approximately 5 per cent in the overall NHS pay bill.

In recognition of these updates, the various national teams are preparing new pay advisory notices which will be issued and shared shortly. These will include new national pay circulars and pay charts which we will share with our people as soon as they are available.

We have not yet heard when these increases will be implemented in the payment of colleagues' salaries. As soon as this is confirmed, we will ensure our people are briefed.

Changes to national sick pay arrangements
Following the national decision to withdraw the staff terms and conditions section of the COVID-19 workforce guidance in phases starting from 07 July 2022 we have updated our COVID-19 Frequently Asked Questions for staff.

The main changes from 07 July are:

- normal NHS contractual sick pay arrangements will apply to any new episodes of COVID-19 or long Covid sickness absence after 07 July 2022.
- changes to the way in which COVID-19 and COVID-19 related absences are recorded
- colleagues who are clinically well but who need to self-isolate in line with the UKHSA guidance will be supported to work from home in the first instance, where possible. Where this is not possible, they will be on 'authorised absence' and receive full pay as if at work. This will not be treated as sickness absence and this aligns with how we treat medical suspension in our policy for things such as infection control and hospital acquired infection.

Acute medical unit – progress update
Construction work is entering its final phase on our new £15million Acute Medical Unit (AMU). The progress on the new unit is clearly visible now with the exterior

cladding works and the roof complete. The large crane, which has been in situ for some time, has also been removed.

Internally, the partition walls have been installed and plastering is underway. The heating electrics have also been progressing well and are nearing completion in readiness for the installation of the ceiling grids which will house items such as lighting, wi-fi and safety detection systems. The site is also being prepared for the start of works to the access road and ambulance parking. We anticipate the building works will be completed in the Autumn.

The new facility will have 36 assessment spaces and will support a wide variety of patients requiring varying levels of care. The unit will take referrals from both our Emergency Department as well as direct referrals from the community or other specialties.

The AMU's new location is of particular significance as it will be located alongside our Emergency Department. Having these two units located side-by-side will improve the flow of patients across the two departments allowing for more timely patient reviews and an overall enhanced patient experience.

4. Chief Executive engagement June

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

Internal	External
• Video blog sessions • Staffside • Diversity and Inclusion Lead • Associate Medical Directors Meeting • F1 Quality Improvement presentations • Governor training session with the Good Governance Institute • Quarterly League of Friends Chairs meeting	• Salus Ward visit with Devon Partnership Trust Chief Executive and Chair • National Director of Transformation, NHS England and NHS Improvement (NHSEI) • Integrated Care System for Devon (ICSD) staff launch event • Long Term Plan Programme Director, ICSD • Interim Director of Transformation, ICSD • Locality Director, South & West, Devon ICSD, Devon County Council, Torbay Council • Improvement Director, NHSEI • Director of Finance, University Hospital Plymouth NHS Trust

	• Chief Executive Officer, Royal Devon University Healthcare NHS Foundation Trust • Director of Service Improvement, Royal Devon University Healthcare NHS Foundation Trust • Chief Executive Officer, Devon Partnership NHS Trust • Director of Finance and Strategy and Deputy Chief Executive, Devon Partnership NHS Trust • Medical Director, LiveWell SouthWest • Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust • Kevin Foster MP • Anthony Mangnall MP • South Devon College Apprenticeship Awards ceremony • Meeting with SingHealth

5. Local health and care economy developments

5.1 Partner and partnership updates

5.1.1 Integrated Care System for Devon (ICSD)

Please see the ICSD update for Boards appended to this report.

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

Recent key media releases and responses:

- Multiple Sclerosis team win national award – our MS team have been internationally recognised for setting up an innovative clinic for people with MS
- NHS Parliamentary award winner – release celebrating that Dr Mary Stocker, Consultant Anaesthetist has been recognised in the South West regional NHS Parliamentary Awards

- Torbay Pharmaceuticals help Ukrainian refugees – members of staff at Torbay Pharmaceuticals collected donations to be delivered to refugees in Moldova
- 'Think carer' – during Carers Week 2022, issued a release outlining the support available for those with caring responsibilities for a family member or friend
- Ambulance handover delays – explaining the reasons behind increased delays in ambulance handovers following national data publication

Recent engagement on our social media channels includes:

- National Healthcare Estates and Facilities Day – celebrated the fantastic and varied teams that make up our estates and facilities management teams. They are essential in our delivery of care and support to local people
- Our People Award winners – sharing images from presentations of our most recent Our People Award winners
- Warm weather advice – on the hottest day of the year so far, we shared details of the people most at risk during warm weather and encouraged our followers to check in
- Dr Peter Scott-Morgan – acknowledging the sad news of the death of Dr Peter Scott-Morgan. The care and treatment he received from our clinical teams was highlighted in the 2020 documentary about his motor-neurone disease journey, and his passion for personalised care lives on in our vision and values
- SWAOC shortlisted for national award – the South West Ambulatory Orthopaedic Centre (SWAOC) at NHS Nightingale Exeter has been shortlisted for a patient safety award
- Platinum Jubilee activities – shared fantastic photos of our staff marking the Jubilee with their own events and activities
- Carers Week support awareness – highlighted the information, advice and support available to unpaid carers during Carers Week

Development of our social media channels:

Channel	End of year target	As of 31 March 2021	As of 31 June 2022
LinkedIn	5,000 followers	2,878	4,407 ↑ 1,529 followers
Facebook	15,000 likes	12,141	13,048 ↑ 907 followers
	15,000 followers	12,499	13,577 ↑ 1,078 followers
Twitter	8,000 followers	6,801	7,542 ↑ 741 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

Q1 2022/23 v03

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	20	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	20	12	Amber	Red	
8	Sheridan Flavin Interim Chief People Officer	To implement and continuously review the Trust People Plan, ensuring the Trust is a '*great place to work*'	16	16	Amber	Amber	General updates and target risk score increased to 16 in recognition of the fact that operational and clinical pressures continue to be unprecedented, as are the transformation and Financial pressures. This means capacity continues to be challenged and burnout/pressure experienced, despite mitigations – which help to maintain the current risk score.
9	Sheridan Flavin Interim 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	
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	

Torbay and South Devon NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 3 2022/23 (June 2022 data)			Meeting date: 27 July 2022
Report appendix	M3 2022/23 IPR focus report M3 2022/23 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: 21 July 2022 Integrated Governance Group: 20/21 July 2022 Finance, Performance, and Digital Committee: 25 July 2022		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to bring together the key areas of delivery (including, quality and safety, workforce, operational performance, and finance) into a single integrated report to enable the Trust Board to: • Review evidence of overall delivery, against national and local standard and targets • Interrogate areas of risk and plans for mitigation • provide assurance to the Board that the Trust is on track to deliver the standards required by the regulator. Areas of exception that the Board will want to focus on are highlighted below and detailed in the attached Focus Report.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to **review** the documents and evidence presented.		

Summary of key elements

Strategic objectives supported by this report

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

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

Board Assurance Framework	Yes	**Risk score**	20
Risk Register	Yes	**Risk score**	25

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.

<table>
<tr><td></td><td>BAF Objective 3: To achieve financial sustainability, enabling appropriate investment in the delivery of outstanding care.
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.
BAF Objective 8: To implement and continuously review the impact of the Trust People Plan ensuring the Trust is 'a great place to work'.</td></tr>
<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td>Yes</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>Yes</td><td>Legislation</td><td></td></tr>
<tr><td>NHS England</td><td>Yes</td><td>National policy/guidance</td><td>Yes</td></tr>
</table>

This report reflects the following corporate risks:

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

Report title: Integrated Performance Report (IPR): Month 3 2022/23 (June 2022 data)		**Meeting date:** 27 July 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

The March 2020 action plan continues to be overseen and monitored though the CQCCAG Group. Of the 28 Must Do and 43 Should Do improvements required the Trust remains with 7 Must Do and 8 Should Do actions to complete. The Must Do's can be described in three areas – Staff Training, Staff Appraisals and a Trust wide Rolling Replacement Programme.

As the Training recovery plan is being implemented and the recovery trajectories are being recorded the actions around mandatory training compliance (M3, 6, 10 12 & 25) will be achieved and closed at the July CQCCAG meeting as part of the evidence review.

A review of all the evidence in relation to the Rolling Replacement Programme is underway and will be completed mid-July for the CQCCAG group to assess the evidence for closure or escalation. If closed, governance and oversight will continue through the respective committees.

Compliance with staff appraisal, whilst improving from last month would benefit from a structured recovery plan and the People Directorate have been requested to support.

Incidents

In June there were 2 severe incidents. An inpatient fall resulting in a fractured neck of femur at Brixham Hospital; a baby was transferred to Bristol Hospital following a Cat 1 caesarean section; waiting HSIB recommendations.

Stroke

The percentage of patients who spend 90% of their time on a stroke ward has not met the target of 80% and has decreased to 34.1% from a May position of 67.6%.

7% of patients were admitted to the stroke ward within 4 hours during the month of June 22 which has not met with the national target of 90%.

VTE assessment

VTE assessment compliance demonstrated a slight improvement in compliance from 89.7% in May to 90% in June.

The VTE Steering group continues to meet monthly with a comprehensive Improvement plan having been developed to address the areas of non-concordance and initiatives to be implemented to ensure consistent improvement.

Infection, Prevention, and Control

Bed closures have increased in June from an April position of 12 to a June position of 130.

The number of C. Diff cases have increased with a total of 4 in June, the same number as May.

Maternity

There was 1 stillbirth in June at 40 weeks gestation; will be reviewed via PMRT (Perinatal Mortality Review Tool) process.

On 6th June a new service was launched to help pregnant smokers and people living in same household quit smoking. This pathway is funded as part of LTP and should help to improve compliance with the Saving Babies Lives agenda.

Staffing

We have seen an increase in COVID-19 related sickness absence during the month of June and this has impacted on our ability to ensure our ward leaders are working in a supervisory capacity all of the time. However, we have managed to achieve above 95% fill rate for day shifts and a 90% fill rate for night duty providing assurance that our clinical areas are safely staffed and actions taken to mitigate any risks.

2. Workforce Headlines

The preliminary annual rolling sickness absence rate is 5.62% to the end of June 2022 which is continuing to increase due to the very high figures in 2022 to date. The sickness target rate is 4%. Sickness has now increased slightly in June (from 4.66% in May) with the monthly figure standing at 4.71% which is still a significant drop from 6.36% in April 2022.

June's Achievement Review rate increased again to 75.24% from May's 73.90%.

Continued high absenteeism and system pressures are impacting the ability to perform Achievement Reviews. Our People Business Partners are working with ISUs to plan improvement trajectories.

Whilst the Trust's turnover rate of 13.67% for the year ending June 2022 remains within the normal tolerances of 10-14%, the SPC chart clearly reflects an upward trend since July 21. This in part reflects the significant increase in the number of our colleagues retiring and returning, which accounts for 1.7% of the overall turnover rate. There are significant increases in voluntary resignation relating to a better reward package, promotion, work life balance, health and working relationships. Devon ICS is running a one-year project to support and improve the retention of key staff. The staff groups shown as having the highest turnover are early stage career support to nursing (SN) staff aged 20 – 29 and later stage career RNs aged 50+.

The June overall rate mandatory training figure increased to 90.10% against a target of 85% and this slight increase from the 89.83% figure in May. Information Governance,

Manual Handling and Safeguarding Children are all below the target compliance level for Corporate Mandatory training.

The Trust Agency reported figure for June was £1.173m a decrease from the May figure of £1.335m.

3. Performance Headlines

Covid: The Trust has continued to care for patients with Covid with the numbers remaining low in June. July has seen a steady increase in numbers of covid patients requiring care. The Incident Control Centre (ICC) was reinstated as the number of covid infections impacting service delivery and capacity began to increase. The severity of covid infections remain relatively low with very few patients requiring ITU or oxygen support. There has, however, been a significant impact on staff sickness levels impacting on service continuity.

Recovery Planning: During June, the operation of the Day Surgery Unit and elective inpatient theatre programme has been sustained with activity levels recovering towards pre-pandemic levels in these areas. New insourcing has been contracted in addition to that already in place for Ophthalmology and Gastroenterology using main inpatient theatre lists over the weekend. Urology capacity remain as high risk with ongoing workforce and estate constraints with further capital works required to fully optimise the relocated outpatient services at the Paignton Hospital site.

Urgent Care: Urgent and emergency services continue to be challenged with the Trust operating at OPEL 4, the highest level of escalation, declared on 14 days. The 4-hour performance target for June is reported as 54.5% and the lowest performance for 13 months and being one of the lowest performing Trusts in the South Region. High bed occupancy has continued to impact patient flow leading to delays in ambulance handover, extended waits in ED and assessment areas, and patients bedded in ED and assessment areas overnight. 702 people spent 12-hours or more in the Emergency Department; 832 patients experiencing an ambulance handover delay over an hour once arriving at the Emergency Department this being an all-time high. Overall levels of demand through the ED remain at just below pre-pandemic levels for the time of year. An increase in the number of long stay patients greater than 7 days and 21 days has impacted on patient flow and freeing beds for ED admissions. Bed occupancy remains above the levels needed to have timely flow from ED and assessment areas. Whilst the reduction in No Criteria To Reside (delayed discharges) is showing good progress the average length of stay remains significantly higher than pre-pandemic levels in the same period last year. Further work is being led through the Flow Improvement Group and System Team to understand the drivers for this and further areas for targeted improvement work.

People waiting for care: The number of patients waiting over 104 weeks has started to reduce from 245 at the end of March to 94 at the end of June with 45 of these wanting to further delay to a more convenient date having been offered dates for surgery. The forecast is 75 for the end of July. This is behind the National ambition to have treated anyone waiting over 104 weeks by the end of June. July capacity has been impacted by both patients being unable to proceed as having covid as well as staffing pressures meaning some scheduled theatre lists being cancelled. Progress in reducing the number of 104 week waits continues in addition to the target of treating all patient waiting over 78 weeks by end of March 2023. This still demonstrates good progress since the return of elective capacity and confidence that all patients waiting

this long, who wish to be treated, will be. Whilst this is the aggregated Referral to Treatment position teams are focusing on waiting times across all stages of treatment with a performance review of all areas with long outpatient waits taking place being supported by the Outpatient Transformation Programme.
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. In outpatients, the target is to achieve 25% of consultant led outpatient attendance delivered non-face to face. The current performance is 21% reported in June.
Cancer 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 against the 62-day referral to treatment standard. The backlog over 62 days remains a significant challenge and is not reducing with 250 at end of June against an operational plan trajectory to reduce this to 115 by March 2023. These pathways remain high risk and are receiving weekly executive oversight.

Communication with patients with long waits: The Trust is engaged with the Integrated Care System (ICS) system Waiting Well Programme. Through this work non-clinical validation of long wait patients “yet to be seen” (longer than 52 weeks) is being supported by the Devon Referrals Support Service (DRSS) by contacting some of our longest waiting patients to give assurance and direct to wellbeing and lifestyle support. This Waiting Well Programme is also developing information links through various forms of media for patients to give further advice on waiting times and wider support.

Diagnostic waiting times: MRI, CT**,** Endoscopy, CT, and Echocardiography remain challenged. Overall there has been a small improvement with 30% of patients waiting over 6 weeks for diagnostic tests in the monitored modalities. The use of a mobile scanner, insourcing at weekends, and the use of the Nightingale Hospital facilities continue to be critical to supporting capacity. The national expectation is to plan an increase in diagnostic activity to 120% of 2019/20 levels and to have no more than 25% of patients waiting over 6 weeks by end of March 2023.

Patients in hospital: The number of 7-day and 21-day length of stay patients has increased with the daily average of 173 over 7 days and 43 over 21 days in hospital. The number of longer LOS stay (over 7 days) is partly linked to the number of patients reported as having no criteria to reside waiting for packages of care or placements to nursing and residential home to be commissioned. There has been a reduction in the average number of patients per day recorded as having no criteria to reside from 101 in January to 45.1 in June. A 50% reduction in no criteria to reside from December 2021 levels has been built into the bed modelling for winter 22/23. In support of onward packages of care and complex discharges the retention and recruitment of staff remains a significant challenge for independent sector providers who provide nursing residential and domestic care packages of care.

Community and social care: There continues to be a focus on increased productivity across community teams and recruitment to ensure teams can operate at full establishment. The levels of unfilled packages with “no other formal support” remain a concern with 251 hours outstanding as at 13 June 2022. Daily review and mitigations are in place to prioritise those patients with no other formal support in place and potentially delaying those leaving acute settings of care.

This month, the focus report includes performance against the 2-hour and 2 – 48 Urgent Community Response.

4. Finance headlines

For Month 3 (June), the Trust's adjusted plan was a surplus of £2.4m (in month), and therefore a year to date deficit of £3.1m.

The Trust's underlying performance year to date is a £6.4m deficit. After the release of £3.3m of balance sheet mitigations at month 3, a balanced position was recorded against the re-submitted plan. The Trust is expected to recover the reported deficit throughout the remaining months of the financial year.

The underlying deficit position is primarily due to under-delivery of CIP, significant overspends in the urgent care system (£433k in month) and slower Covid cost reduction than required (cleaning).

Total income for M03 is £0.06m favourable to plan. Key drivers are as follows:

ASC Income (client contributions)	£0.81m
Other Income (inc deferred income)	£0.52m
Pass through drugs & devices	£0.26m
ESRF	£0.13m
Additional CFHD income	£0.09m
Offset by:	
Income recovery actions not yet agreed	(£1.37m)
Covid-19 labs testing	(£0.30m)
R&D Trials income	(£0.10m)
Lower Torbay Pharmaceutical sales	(£0.05m)

Operating expenditure and financing cost in M03 are £0.07m adverse to plan. Key drivers are as follows:

Agency spend	(£0.56m)
Bank spend	(£0.28m)
Provider SLA's	(£0.50m)
Drugs (inc pass through)	(£0.50m)
Offset by	
Substantive pay (incl. movement in reserves)	£0.51m
Non-pay balance sheet accrual release	£0.60m
Supplies and services	£0.30m
Depreciation	£0.34m

In M03 a series of non-recurrent benefits were recognised, including £0.78m released from the annual leave accrual, £0.80m released in respect of adult social care backdated packages, and a further £1.57m through a review of historic accruals. An additional £0.15m of expenditure was reallocated (revenue to capital). The total of these adjustments is £3.3m .

The cash position at the end of June is £21.51m. Other Cashflow Movements £6.0m largely consists of £6.3m of revenue support PDC, which was drawn down in June, in line with the original financial plan for the year. The Trust's working capital position is due to improve from August onwards, following the ICB's agreement to pay block income to the Trust on the 1st day of the month rather than the 15th. This improvement in working capital should offset the ongoing reduction in the Trust's cash position for a

number of months. Revenue support PDC has therefore not been sought for August. The potential need for revenue support PDC for September will be reviewed during August alongside a thorough I&E and cash forecasting exercise.

Spend on capital schemes (CDEL) £7.36m which is behind (£0.81m) the plan value of £8.17m at the end of June.

M03 YTD plan for efficiencies was £5.39m, of which £1.25m has been formally transacted via the financial ledger and a further £1.45m has been marked identified as delivered subject to validation. The Trust has an overall efficiency target of £28.50m for 2022/23, which has been phased throughout the financial year.

A number of the pay related efficiency schemes have yet to commence, but are due to deliver after the end of the first quarter. The Trust's actual financial performance for M03 would suggest a potential shortfall of £2.72m (c. 50%) against the efficiency target, predominantly linked to the position on pay.

The Trust’s final plan re-submitted on 20th June to NHSE/I illustrates a breakeven position for the year as required by regulators. The revised plan has been reflected in the budget from M03.

Looking ahead:

- The plan includes the delivery of an efficiency requirement at £28.5m, through transformation and Covid cost reduction initiatives. At this point in time, delays have already occurred against the original planned phased delivery.
- In addition, a list of targeted measures to breakeven were proposed under the revised plan. The executives have carried out a number of focused briefing sessions with ISU management and set out the requirement for delivery.
- Contract agreement is underway between the ICS and providers with a simplified and compliant approach on marginal contract set-up for ERF, which would include potential mitigation in the first instance via ICS / S256.
- The Hospital Discharge programme is planned to continue supported by S256 funding.
- Capital plans for 2022-23 and beyond have been developed and approved by FPDC in May, detailed schemes level prioritisation continues.
- System agency controls- agency cap to be held to, and diligence is underway in terms of the implications on the plan.
- Year to date ESRF spend is £830k, this may be subject to a claw back risk if the threshold is not achieved for the year. There may be further changes to ESRF funding regime, additional updates will be provided as the position become clearer.

Integrated Performance Focus Report (IPR) Trust Board

Torbay and South Devon NHS Foundation Trust

July 2022: Reporting period June 2022 (Month 3)

	Section 1: Performance
	Quality and safety
	Workforce
	Community and Social Care
	NHSI operational performance with local performance metric exceptions
	Children and Family Health Devon
	Section 2: Finance
	Finance
	Section 3: Appendices
	Statistical Process Control charts – pilot

Quality and Safety Summary

CQC:
The March 2020 action plan continues to be overseen and monitored though the CQCCAG Group. Of the 28 Must Do and 43 Should Do improvements required the Trust remains with 7 Must Do and 8 Should Do actions to complete. The Must Do's can be described in three areas – Staff Training, Staff Appraisals and a Trust wide Rolling Replacement Programme.

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- Compliance with staff appraisal, whilst improving from last month would benefit from a structured recovery plan and the People Directorate have been requested to support.

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In June there were 2 severe incidents.

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Stroke:

- The percentage of patients who spend 90% of their time on a stroke ward has not met the target of 80% and has decreased to 34.1% from a May position of 67.6%.
- 7% of patients were admitted to the stroke ward within 4 hours during the month of June 22 which has not met with the national target of 90%.

VTE assessment:

- VTE assessment compliance demonstrated a slight improvement in compliance from 89.7% in May to 90% in June.
- The VTE Steering group continues to meet monthly with a comprehensive Improvement plan having been developed to address the areas of non-concordance and initiatives to be implemented to ensure consistent improvement.

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- The number of C.Diff cases have increased with a total of 4 in June, the same number as May.

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- On the 6th June a new service was launched to help pregnant smokers and people living in same household quit smoking. This pathway is funded as part of LTP and should help to improve compliance with the Saving Babies Lives agenda.

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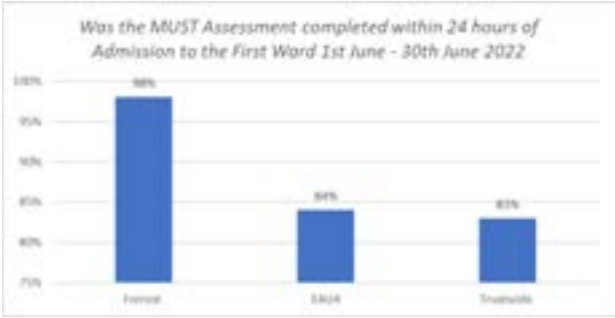
The daily 5 Patient Risk Assessment audits continue to be being recorded electronically and the results can viewed in real time. Daily, weekly, and monthly compliance reports can also be generated and these results are presented by the ADNPPs to the monthly Nutrition & Hydration Steering Group (N&HSG), Integrated Governance Group (IGG) and the Quality Improvement Group (QIG) for oversight and scrutiny.

June - assessments completed within 24 hours at Trust wide level is at 83% with the CQC visited wards which is a slight deterioration from last months of 88.6% :

- Forrest at 98% and EAU4 at 84% in June.
- EAU4 has increased compliance by 16% and this increase is expected to continue with close monitoring and support.
- A significant piece of work continues to strengthen the nursing establishment and leadership in EAU4 to ensure oversight and completion of audits on a daily basis.
- The Trust continues its 'point prevalence' audit capturing of every patient across the organisation.
- A review of the questions, their structure and flow within the audit has taken place and this is now being progressed with the IT developers who will make the changes to the system. Once completed a feed from this data will be taken directly to this IPR report



The 2020 Action plan is monitored through the CQC Compliance Assurance Group and reports to the Quality Improvement Group.

The Trust remains with 7 Must Do and 8 Should Do actions to complete. The Must Do actions have 3 themes: Training, Appraisal, Medical Device Rolling Replacement programme.

At the July CQCCAG it is It is envisaged that 5 improvement actions relating to training will be closed as the group discuss the Mandatory Training Recovery Plan and projected targets. This plan, now approved at the People Committee, will become business as usual and monitored within the ISU and exception reports to IGG.

Appraisal rates are starting to recover slightly but are very subject to and this action would benefit from a recovery plan similar to the Mandatory Training recovery plan and this has been posed to the People Directorate.

A deep dive is underway reviewing the policy and procedure around device replacement and will report back to CQCCAG in July. The aim is to seek to close this action or escalate upwards as necessary.

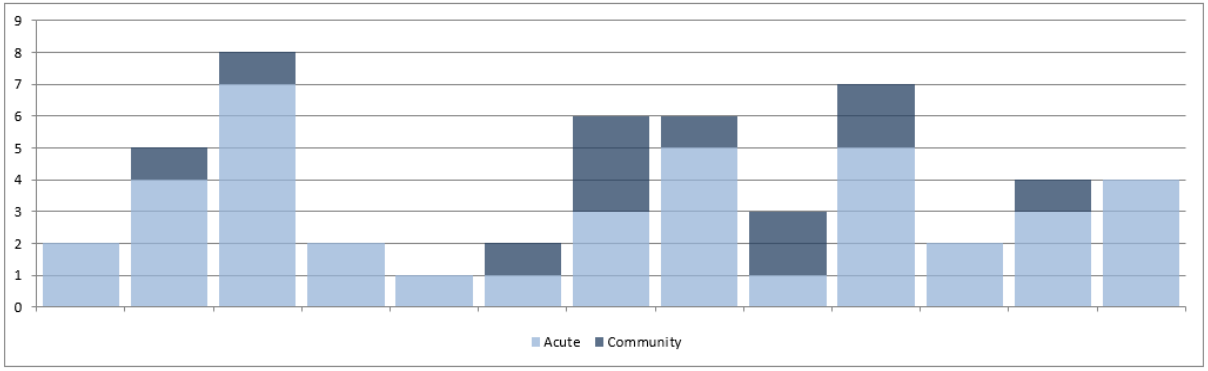
Quality and Safety Indicators

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 – red rated areas		↑
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		↓
Mixed sex accommodation breaches		↔
Follow ups 6 weeks past to be seen date		↑

Number of Clostridium Difficile cases

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



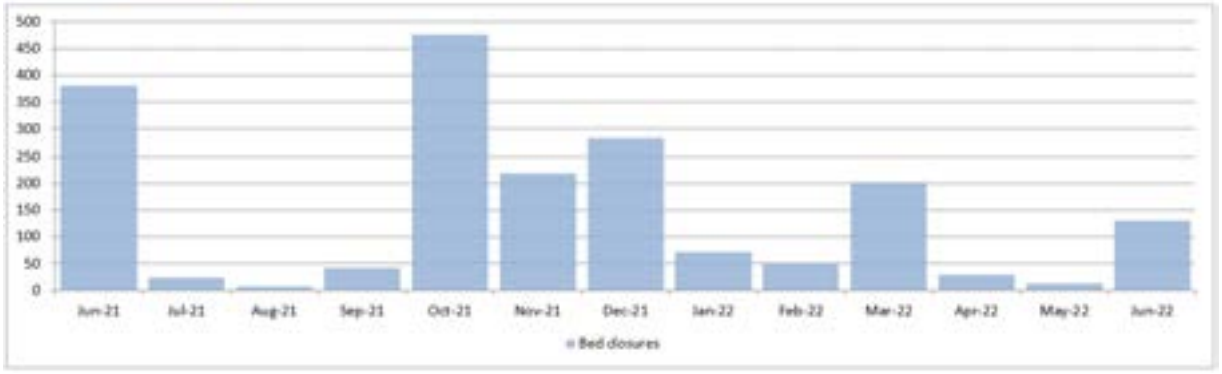
There were 4 reported cases of C.Diff in June:

- 4 hospital onset, of which 3 C Diffs on Simpson 2 different typing 1 not grown
- 0 in the community but have had contact with a healthcare setting in last 28 days.

Themes that are being seen are delay in isolation and giving empirical treatment. None of which, however, led to acquisition of C.Diff.

Infection control - Bed closures (Acute)

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Bed closures	381	24	8	42	476	218	285	71	49	203	30	12	130



June bed closures have seen a significant rise to 130 from the May position of 12.

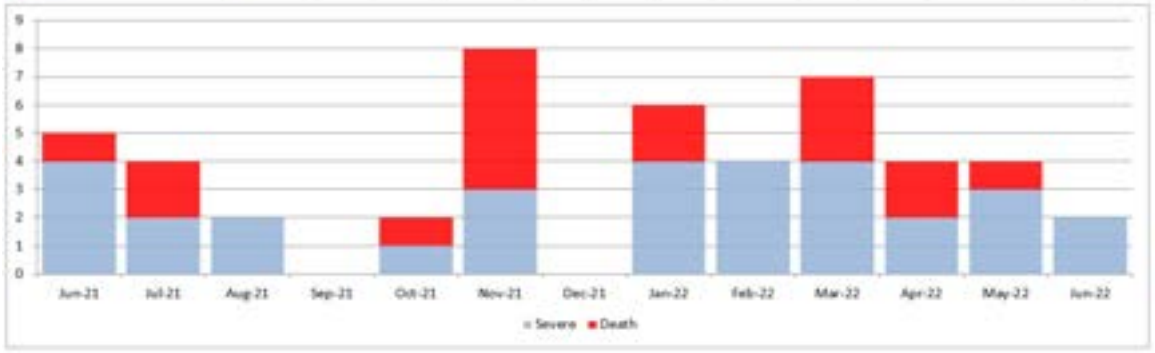
The reason for the closures has mainly been due to;

- Increase in patients testing positive for COVID-19 on admission and outbreaks during admission
- We currently have wards dedicated for COVID-19 patients

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

Reported Incidents - Severe and Death

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



In June there were 2 Severe incidents:

- 1 inpatient fall - fractured hip - Brixham Hospital.
- A baby transferred to Bristol following Cat 1 LSCS.

- No reported incidents causing deaths in June.

Formal complaints

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Formal complaints	15	18	17	11	11	10	9	16	11	12	12	12	7
Target	60	60	60	60	60	60	60	60	60	60	60	60	60

The Trust received 7 formal complaints in June;

Of these 7 complaints;

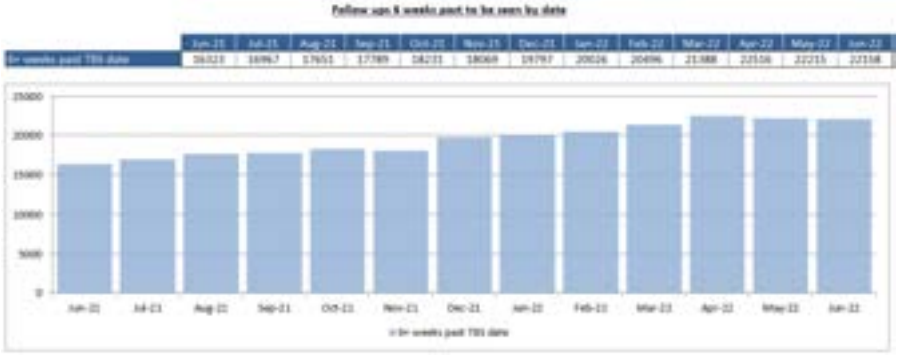
- 3 were in relation to treatment
- 2 in relation to assessment
- 1 in relation to an appointment
- 1 was in relation to a diagnosis

Stroke:

- The percentage of patients who spend 90% of their time on a stroke ward has not met the target of 80% and has decreased to 34.1% in June.
- Only 7% of stroke patients were admitted to the stroke ward within 4 hours which is a slight improvement on the May performancee of 5%, but still well below the national target of 90%.

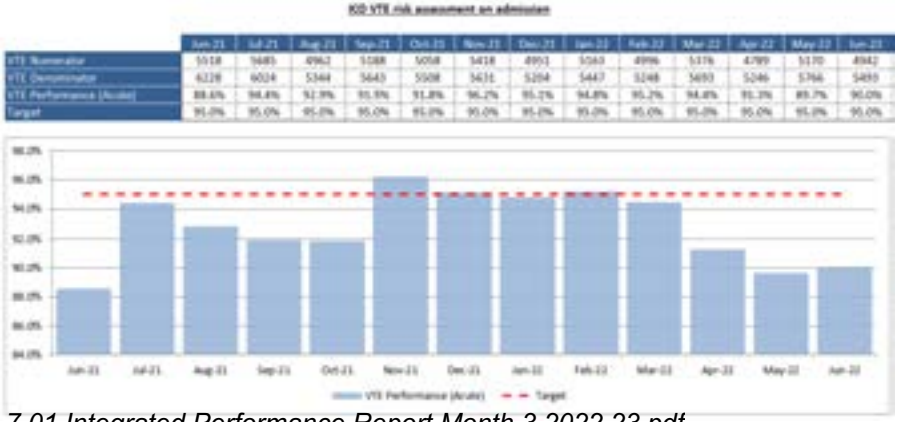
A number of other SNAP stroke targets are, however, being met across the organisation including;

- 97.7% of patients received a scan within 12 hours;
- 100% of patients received a continence assessment;
- 100% of patients received a nutrition screen.



Follow ups:

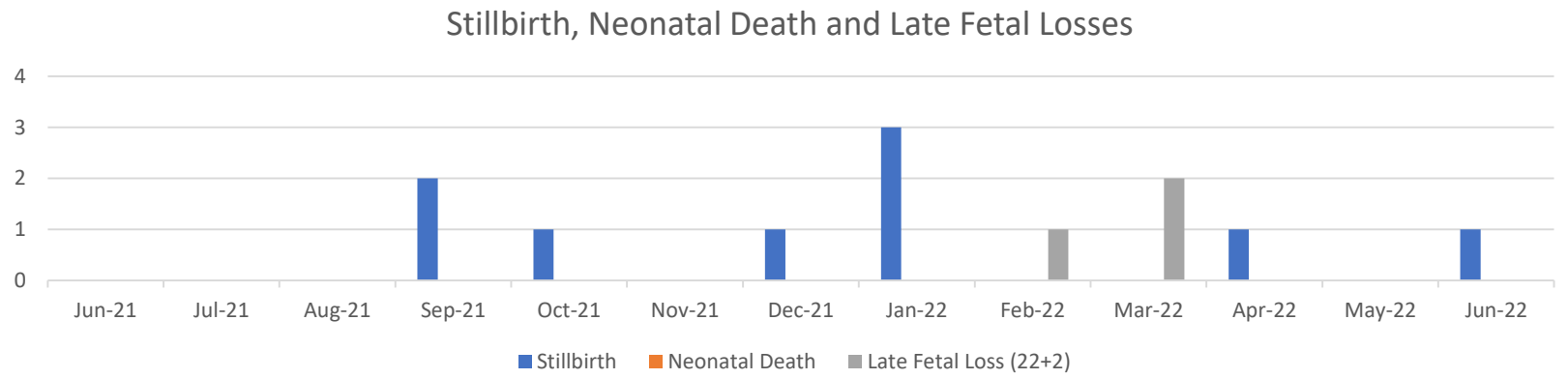
The number of patients waiting for a follow up appointment greater that six weeks past their 'to be seen by date' has decreased in June.
Outpatient Transformation Programme is supporting the adoption of best practice to reduce the demand for follow ups (Target of 25%) including patient Initiated Follow up. It is expected that backlogs will start to reduce as capacity is fully restored and these improvements take effect.
Where long delays continue teams will continue to review and expedite any patients identified as higher risk.



VTE assessment

- VTE assessment compliance demonstrated a slight improvement from 89.7% in May 22 to 90% in June.
- All areas not achieving the targeted 95% compliance are being individually contacted to highlight the risk and concern and to identify improvement strategies to be fed back to the next VTE Steering Group.
- The group continues to review the prescribed medication charts to move the VTE assessment to the front page to improve visibility
- All ISU Associate Medical Directors will be invited to attend the monthly steering group meeting to support this agenda.

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.



- In May 2022, SystmOne, the Maternity EPR was launched. All reporting aspects are now encompassed within the Trust's Data Warehouse Team's project, InView. The InView Project was scheduled to be complete by the end of June 2022, however, due to the change in the EPR and the mechanism by which data is extracted, there will be a delay in the ability to report externally and internally. The external reporting has been prioritised, however, this has resulted in a delay for the internal data reporting elements. This has resulted in being unable to provide the usual data of Robson Group, smoking and breastfeeding rates for May and June 2022. Once the data reports are completed this data will be able to be extracted in retrospect.

- There was 1 stillbirth in June – 40 weeks gestation – will be reviewed via PMRT process.

- Midwifery staffing has improved although short term sickness is continuing to impact. Staffing gaps related to sickness and the remaining vacant posts are being supported with bank and on rare, occasions, agency midwives. We have been able to reduce our staffing risk score to 12 and this has been demonstrated on the risk register.

- Treating Tobacco Dependency service: On the 6th June a new service was launched to help pregnant smokers and people living in same household quit smoking. Advice and support is available on hand through dedicated MSW's to provide advice and support including NRT, e-cigarettes and behavioural support. This pathway is funded as part of LTP and should help to improve compliance with Saving Babies Lives agenda.

Performance exceptions and actions

Staff sickness/absence: RED for 12 months and RED for current month
The preliminary annual rolling sickness absence rate is 5. 62% to the end of Jun 2022 which is continuing to increase due to the very high figures in 2022 to date. The sickness target rate is 4%. Sickness has now increased slightly in Jun (from 4.66% in May) with the monthly figure standing at 4.71% which is still a significant drop from 6.36% in Apr 2022.

Appraisal rate: **Red**
June's Achievement Review rate increased again to 75.24% from May's 73.90%.
Continued high absenteeism and system pressures are impacting the ability to perform Achievement Reviews. Our People Business Partners are working with ISUs to plan improvement trajectories.

Turnover (excluding Junior Doctors): **GREEN**
Whilst the Trusts turnover rate of 13.67% for the year ending Jun 2022 remains within the normal tolerances of 10-14%, the SPC chart clearly reflects an upward trend since July 21. This in part reflects the significant increase in the number of our colleagues retiring and returning, which accounts for 1.7% of the overall turnover rate. There are significant increases in voluntary resignation relating to a better reward package, promotion, work life balance, health and working relationships. Devon ICS is running a one year project to support and improve the retention of key staff. The staff groups shown as having the highest turnover are early stage career support to nursing (SN) staff aged 20 – 29 and later stage career RNs aged 50+.
The primary research and analysis showed that the key retention drivers for these groups are; feeling valued and recognised; having professional development opportunities; having supportive line management and work life balance. The staff survey for our Trust shows that these are important to staff across the organisation.

Mandatory Training rate: **GREEN**
The June **overall** rate mandatory training figure increased to 90.10% against a target of 85% and this slight increase from the 89.83% figure in May. **Information Governance, Manual Handling and Safeguarding Children are all below the target compliance level** for Corporate Mandatory training – Slide 7 has been added to highlight the multi-level training compliance.

Agency Expenditure: The Trust Agency reported figure for June was £1.173m a decrease from the May figure of £1.335m.

Vacancy Rate: N&M vacancies have increased from 62 WTE in May to 66 WTE in June and AHP vacancies have decreased from 91 WTE in May to 84 WTE in June. A&C vacancies have reduced to 109 WTE. Vacancies are higher in this area due to delays in implementing plans. Finance and Workforce are working with Nursing Workforce to validate the vacancies and have established a project group to look at how this should be reported. Of the total vacancies, 50 WTE relate to CFHD and their revised model. It is important to note that vacancies are being covered by agency and bank and are excluded from this report above.

Update of Progress Against Our People Promise and Plan

Reflecting on the KPIs reviewed above, the plans in place to address improvements are built into delivering on Our People Promise; detailed activity is outlined in our strategic People Plan. Progress is described below. Our People plan dashboard includes the national staff survey findings, which has been reviewed nationally to ensure the findings align to the People promise enabling us to robustly measure how effectively we are delivering the People Promise – this is supplemented by the quarterly people pulse survey, which provides a more regular pulse check.
The first year of delivery against out Our people promise and plan has been reviewed; the outcome of which is built into our Year 1 report. This was shared with our People Committee (27th June) and Trust Board (29th June). Priorities for year 2 have now been developed and are being socialised with our people to ensure they are meaningful.

Growing for Our Future

- TV advert campaign now live during July to support recruitment of all roles including volunteers
- Planning underway for next round of recruitment events in September
- A new welcome group has been established to bring together ideas and contributions to create a improved experience for new starters and supporting onboarding and inductions. Part of the output of this group will be to hold new welcome events, revise toolkits and support for local induction, and produce a new Welcome to our Trust interactive booklet.
- ICS Resourcing Pillar – temporary staffing group are meeting with nursing agency supplier to agreement new framework
- New workforce transformation programme is making great progress and improvements planned around Temporary Staffing, e-Rostering, and recruitment. A priority areas is improving the onboarding experience the time to hire of new starters and the procurement t of 2 new modules on TRAC (our recruitment system) has begun.

Looking After Our People

We are excited to have been awarded monies from NHS Charities Together to support our wellbeing activities in the 4 areas below, many of which are already active:

- Looking After me Awareness Campaign
- Mental Health Training for Managers
- Wellbeing Buddies Scheme
- Wellness Activities for Staff

New Ways of Working and Delivering Care

- Work is underway to develop a competency model, rather than role specific model, to support deployment / development of our workforce.
- Investment in our unregistered workforce to develop roles and career pathways - work is underway in this area, our Nursing and Midwifery workforce strategy, competencies based career pathways, the apprenticeship pathway.
- An Advanced practice - steering group has been established to define advanced and extended scope of practice roles within the Trust.
- Continuing Trust Wide job planning review which will provide better understanding of where additional PAs are needed for both DCC and additional responsibility roles. We have completed job planning with over 70% of the organisation, with discussions still continuing and the aim to have all updated job plans on L2P by September 2022.
- The ICS is leading on developing an ICS approach to workforce planning which will align to the ICS Workforce Strategy.
- The third workforce submission has been made to NHSEI as part of business planning for 2022-23.

Belonging

- Through our education programme for international nurses we are beginning to understand the impact of cultural shock and its personal effect on individuals. This also impacts on our ability to retain overseas colleagues and a potential to impact our reputation and ability to recruit. In response the overseas educational programme is being adapted to create time and space for individuals to share their experience before it impacts their ability to perform at work and their health and wellbeing.
- The first EDI creating Inclusive cultures conversation session has been undertaken in theatres and recovery. It generated discussion and self-reflection on own behaviours and attitudes and further discussion groups will be undertaken through July and August and will be followed by evaluation and measurement of impact.
- We are seeing an increase in service managers approaching the EDI team to ask for support in creating more inclusive environments in their teams as a result of the increased visibility of the EDI service.

Creating the Conditions to Enable Transformation

Building Capability:

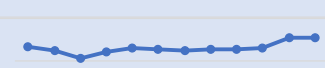
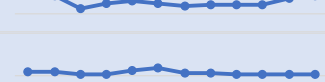
- Cohort 1 of the 4-day QI Practitioner Course completed - early evaluation very positive.
- Cohort 2 merged with Cohort 3 to commence in September (due to rising Covid and workforce issues during the main summer months)
- Cohort 3 – 25 already confirmed to attend.
- Working on improving the course further following this cohort's feedback in preparation for next year.
- Working with People Directorate to align QI learning with new ILM Change & Transformation course
- Developing Improvement calendar to map out key events for the coming year. Will include the establishment of an Improvement & Innovation Community to encourage continual learning, sharing and celebrating of improvement and innovation efforts across our organisation.

Quality & Safety:

- Quality & Safety Long Term Plan launched 6th July
- Monthly programme Board established to manage and support the 2022/23 key deliverables. First meeting 28th July.
- First Improvement Board set up on Simpson Ward
- Mapping exercise arranged for the end of the month to ensure the right patient culture survey is carried out and work is joined up with QI and the People Plan.

iManage has now been live for a couple of months and we are beginning to review the usage and evaluate it's benefits. We are receiving positive feedback from users although want to explore how it can be more widely known about. 2 cohorts of staff have now started a pilot using the a 360 questionnaire based upon the cultural framework and initial responses are informing training offers based around relationships with time and coaching skills.

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

Indicator	Target	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Performance
Month Sickness %	4%	4.63%	4.75%	5.06%	5.41%	5.87%	5.52%	5.46%	6.03%	6.10%	7.44%	6.36%	4.66%	4.71%	
12 Mth Rolling Sickness %	4%	4.04%	4.13%	4.24%	4.36%	4.50%	4.56%	4.67%	4.85%	5.03%	5.34%	5.57%	5.60%	5.62%	
Achievement Rate %	90%	84.73%	81.26%	80.56%	79.69%	77.86%	79.15%	78.57%	76.13%	75.22%	71.87%	71.27%	73.90%	75.24%	
Labour Turnover Rate	10-14%	11.28%	10.95%	11.73%	11.32%	11.57%	11.51%	11.97%	12.60%	12.86%	13.43%	13.15%	13.56%	13.67%	
Overall Training %	85%	90.51%	89.53%	89.36%	88.95%	89.02%	88.75%	88.38%	88.62%	89.22%	89.50%	89.55%	89.83%	90.10%	
FTE Vacancy	N/A	**182**	**255**	**117**	**206**	**340**	**378**	**381**	**373**	**392**	**356**	**352**	**340**	**292**	
Vacancy Factor	<10%	**3.04%**	**4.22%**	**1.93%**	**3.38%**	**5.46%**	**6.05%**	**6.10%**	**5.95%**	**6.23%**	**5.67%**	**5.62%**	**5.43%**	**4.69%**	
Monthly Agency Spend	£698K	**£1,096**	**£1,284**	**£1,090**	**£1,090**	**£1,231**	**£1,373**	**£1,248**	**£1,025**	**£658**	**£1,468**	**£1,148**	**£1,335**	**£1,174**	
Nuring Staff Average % Day Fill Rate- Nurses		87%	90%	87%	82%	86%	89%	88%	87%	88%	88%	89%	96%	96%	
Nuring Staff Average % Night Fill Rate- Nurses		89%	93%	88%	75%	81%	84%	81%	78%	79%	79%	80%	87%	88%	
Safer Staffing- Overal CHPPD		7.71	7.73	7.75	7.55	7.56	7.78	7.93	7.64	7.61	7.56	7.59	7.6	7.55	

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.

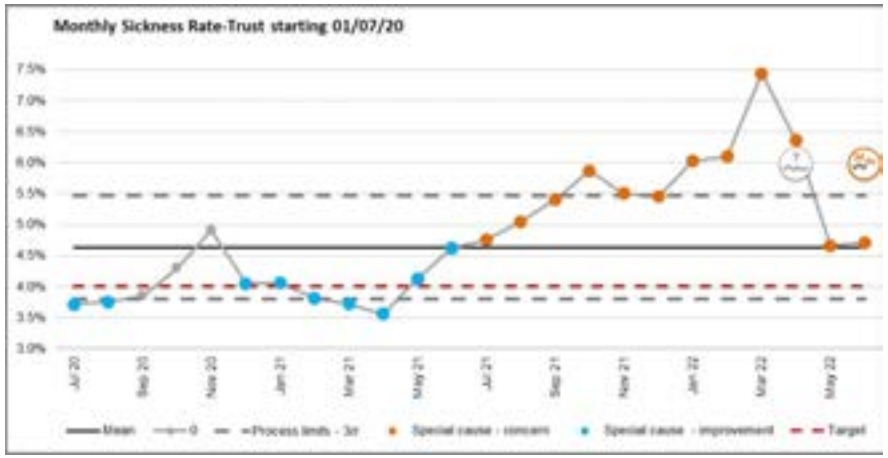
To help you interpret the data a number of rules can be applied.

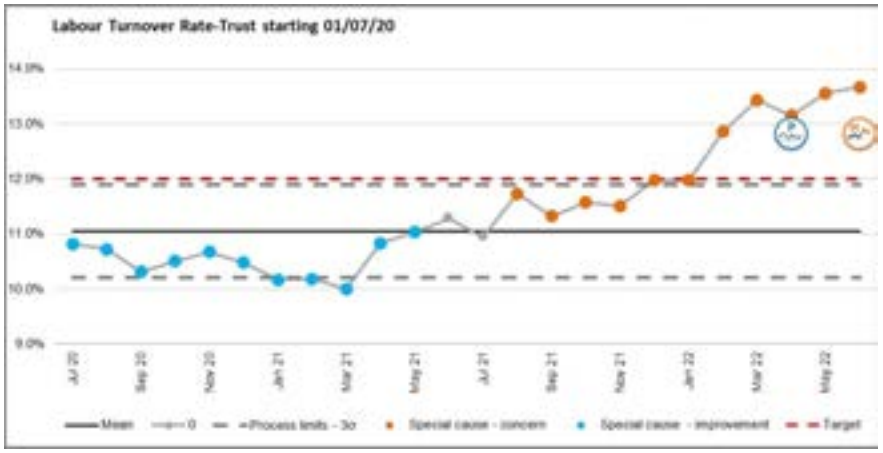
Any single point outside the process limits

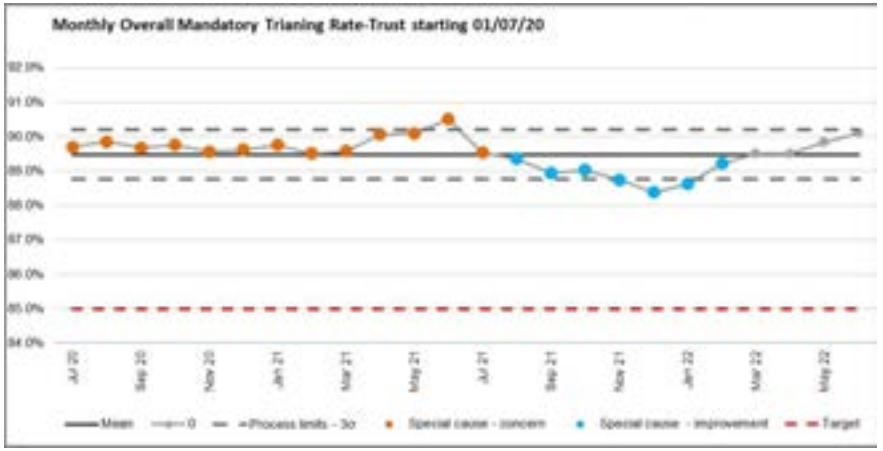
A run of 7 points above or below the mean (a shift), or a run of 7 points all consecutively ascending or descending (a trend).

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 has increased slightly to 4.71% but dropped from over 6% in April / AR has improved slightly in Jun but the trend is still below the mean / LTR shows two trends with the most recent the increase in turnover this has increased slightly again in Jun and does include retire and return / overall

Multiple Level Training Breakdown

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Infection Control L1*	90.87%	91.62%	91.56%	91.52%	91.18%	90.84%	90.58%	90.77%	91.28%	91.69%	91.45%	92.03%
infection Control L2*	82.48%	82.71%	82.30%	82.28%	82.77%	82.00%	81.64%	82.40%	82.41%	82.60%	82.11%	81.85%
Moving & Handling L1*	90.70%	89.96%	90.61%	90.43%	89.85%	90.11	89.52%	89.69%	90.22%	90.80%	90.24%	89.75%
Moving & Handling L2*	66.45%	68.21%	68.54%	68.37%	67.07%	67.93	68.73%	69.31%	69.50%	68.73%	68.47%	69.95%
Safeguarding Adults L1	95.41%	94.60%	94.22%	94.29%	93.85%	93.55%	94.36%	94.47%	94.71%	94.77%	95.14%	95.59%
Safeguarding Adults L2	88.01%	88.33%	87.99%	87.83%	87.68%	87.07%	87.67%	88.04%	88.56%	88.35%	87.86%	89.28%
Safeguarding Adults L3	56.45%	57.26%	57.22%	59.03%	61.76%	62.90%	58.21%	58.47%	57.58%	58.10%	61.56%	61.59%
Safeguarding Adults L4	54.55%	53.49%	65.85%	63.41%	59.09%	65.91%	62.22%	62.22%	65.12%	65.85%	64.29%	76.19%
Safeguarding Adults L5	25.00%	25.00%	25.00%	75.00%	75.00%	80.00%	80.00%	80.00%	100.00%	100.00%	100.00%	100.00%
Safeguarding Adults L6	66.67%	66.67%	77.78%	77.78%	77.78%	77.78%	77.78%	77.78%	87.50%	87.50%	87.50%	87.50%
Mental Capacity Act L1	75.47%	77.77%	79.69%	81.22%	81.87%	83.13%	84.44%	85.35%	86.51%	87.58%	88.27%	89.28%
Mental Capacity Act L2	69.50%	73.82%	74.20%	76.76%	78.39%	79.06%	79.53%	80.52%	81.74%	81.88%	83.72%	84.87%
Mental Capacity Act L3	35.84%	42.30%	44.77%	48.74%	51.91%	54.86%	56.81%	58.42%	59.98%	61.15%	62.62%	64.32%
Mental Capacity Act L4	20.00%	20.00%	20.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%
Mental Capacity Act L5	0.00%	0.00%	0.00%	0.00%	0.00%	33.33%	33.33%	33.33%	100.00%	100.00%	100.00%	100.00%
Mental Capacity Act L6	0.00%	0.00%	85.71%	85.71%	85.71%	85.71%	85.71%	83.33%	83.33%	83.33%	71.43%	71.43%
Safeguarding Children L1	91.82%	91.56%	90.89%	90.98%	89.86%	89.56%	89.09%	89.38%	89.90%	90.21%	90.64%	91.24%
Safeguarding Children L2	80.53%	80.54%	80.29%	80.89%	80.87%	80.52%	80.58%	81.04%	81.38%	81.63%	82.44%	82.82%
Safeguarding Children L3	71.33%	74.04%	70.66%	73.00%	75.96%	73.60%	69.08%	69.12%	73.21%	72.86%	73.31%	72.57%
ABLS L1	96.78%	96.67%	96.61%	96.82%	96.69%	96.87%	98.18%	98.02%	98.17%	98.12%	98.41%	98.51%
ABLS L2	72.87%	74.15%	72.34%	72.87%	72.49%	70.95%	71.57%	70.17%	68.09%	68.80%	68.73%	68.22%
AILS L3	66.67%	65.61%	61.35%	63.49%	64.63%	64.85%	65.49%	61.22%	57.68%	54.58%	57.42%	61.25%
AALS L4	62.59%	34.25%	42.47%	47.22%	46.85%	52.11%	60.36%	60.00%	63.25%	60.49%	65.13%	65.33%
PBLS L2	68.56%	69.15%	69.08%	68.37%	67.96%	66.32%	65.08%	64.38%	63.54%	62.77%	64.56%	65.96%
PILS L3	46.58%	47.83%	52.86%	55.22%	38.10%	39.42%	44.30%	47.20%	43.90%	42.74%	38.52%	35.52%
PALS L4	46.15%	44.12%	41.79%	41.54%	41.79%	37.88%	35.37%	49.23%	50.79%	50.00%	47.54%	49.18%
NBLS L2	81.37%	81.13%	76.13%	67.70%	74.38%	68.75%	71.67%	69.78%	65.41%	61.50%	69.66%	68.54%
NBLS L3									61.29%	61.67%	60.66%	60.66%

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

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Total	Strongly Disagree %	Disagree %	Neither Agree or Disagree %	Agree %	Strongly Agree %	Total
I look forward to going to work	17	41	103	90	19	270	6.30%	15.19%	38.15%	33.33%	7.04%	100.00%
I am enthusiastic about my job	9	19	76	110	57	271	3.32%	7.01%	28.04%	40.59%	21.03%	100.00%
Time passes quickly when I am working	6	16	72	99	77	270	2.22%	5.93%	26.67%	36.67%	28.52%	100.00%
There are frequent opportunities for me to show initiative in my role	20	40	45	106	39	250	8.00%	16.00%	18.00%	42.40%	15.60%	100.00%
I am able to make suggestions to improve the work of my team / department	20	34	42	108	46	250	8.00%	13.60%	16.80%	43.20%	18.40%	100.00%
I am able to make improvements happen in my area of work	20	34	42	108	46	250	8.00%	13.60%	16.80%	43.20%	18.40%	100.00%
Care of patients / service users is my organisation's top priority	9	34	63	128	27	261	3.45%	13.03%	24.14%	49.04%	10.34%	100.00%
I would recommend my organisation as a place to work	32	52	67	95	16	262	12.21%	19.85%	25.57%	36.26%	6.11%	100.00%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	18	30	63	123	27	261	6.90%	11.49%	24.14%	47.13%	10.34%	100.00%

The above table shows the results of the latest quarterly Pulse Survey – future Pulse Survey results will start to include trend data to include the results of the previous Pulse Surveys.

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

N&M FTE in-post has increased by 79 FTE since Jun of last year and M&D has increased by 42 FTE over the same period.

Agency FTE has decreased from last month by 32 FTE and this is reflected in the costs for Agency.

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

NHSI Staff Group	2021/06	2021/07	2021/08	2021/09	2021/10	2021/11	2021/12	2022/01	2022/02	2022/03	2022/4	2022/5	2022/6	Change since June 2021	% Change
Allied Health Professionals	524.64	519.16	524.63	538.34	536.58	528.76	527.30	524.64	522.34	520.82	513.97	517.62	515.85	-8.79	-1.68%
Health Care Scientists	93.71	93.71	94.39	92.69	92.70	93.80	92.40	91.36	92.36	91.76	90.16	89.16	89.16	-4.55	-4.86%
Medical and Dental	527.65	556.82	557.43	561.16	561.56	554.68	553.85	552.38	551.50	559.04	576.93	571.32	569.67	42.02	7.96%
NHS Infrastructure Support	1126.62	1123.82	1121.33	1122.71	1124.58	1133.69	1134.71	1137.89	1147.56	1149.02	1148.34	1146.50	1146.15	19.53	1.73%
Other Scientific, Therapeutic and Technical Staff	341.63	348.60	346.41	345.03	346.02	346.89	342.63	342.09	342.02	346.93	351.10	356.26	347.88	6.25	1.83%
Qualified Ambulance Service Staff	9.33	10.33	10.53	10.53	10.53	10.53	10.53	10.53	9.53	10.53	10.45	10.45	10.25	0.92	9.86%
Registered Nursing, Midwifery and HV staff	1237.77	1248.15	1254.04	1267.34	1266.85	1267.50	1271.48	1287.67	1293.75	1287.20	1306.43	1305.28	1317.37	79.60	6.43%
Support to clinical staff	1902.13	1898.32	1901.54	1904.65	1899.35	1914.09	1908.06	1899.40	1897.31	1912.84	1907.03	1929.11	1928.86	26.72	1.40%
Grand Total	5763.49	5798.91	5810.30	5842.46	5838.17	5849.93	5840.95	5845.95	5856.38	5878.15	5912.46	5925.70	5925.20	161.71	2.81%

Pay Report Summary for the last 12 months

	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
Cost	£	£	£	£	£	£	£	£	£	£	£	£
Substantive	£21,100,577	£21,485,466	£25,412,838	£22,212,036	£22,229,296	£22,000,915	£22,354,848	£22,715,706	£35,278,455	£23,784,603	£22,891,926	£22,092,285
Bank	£1,098,843	£997,363	£1,177,818	£1,105,903	£1,155,652	£1,170,666	£1,090,632	£1,217,561	£1,436,187	£1,342,004	£1,362,536	£1,138,479
Agency	£1,284,092	£1,090,236	£1,191,740	£1,231,573	£1,373,403	£1,247,147	£1,025,186	£658,009	£1,467,363	£1,146,711	£1,335,644	£1,173,389
Total Cost £	£23,483,512	£23,573,065	£27,782,396	£24,549,512	£24,758,351	£24,418,728	£24,470,667	£24,591,276	£38,182,005	£26,273,318	£25,590,106	£24,404,153
WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	5,750.55	5,848.93	5,887.22	5,868.32	5,852.42	5,861.51	5,875.21	5,922.11	5,961.13	5,972.99	5,931.47	5,926.80
Bank	336.05	247.74	313.21	272.84	350.26	343.70	215.37	333.80	348.91	292.62	270.31	304.68
Agency	151.10	148.60	174.75	174.57	182.45	172.07	147.00	140.10	212.24	162.93	194.59	162.83
Total Worked WTE	6,237.70	6,240.27	6,375.18	6,315.75	6,385.13	6,377.28	6,237.57	6,396.02	6,522.28	6,428.54	6,396.37	6,394.31

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

Staff Group	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	Budget WTE	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	Mar-22	Apr-22	May-22	Jun-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	555.27	537.50	536.50	536.49
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	1,412.88	1,384.03	1,373.51	1,377.64
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	2,037.57	1,950.33	1,940.50	1,952.40
Add Prof Scientific and Technic	226.13	226.40	226.40	226.40	226.40	226.40	231.12	231.12	232.12	232.12	246.63	246.63	242.72	242.72	235.22
Allied Health Professionals	699.22	700.07	706.59	713.39	721.79	721.79	722.78	722.31	723.48	723.68	723.68	723.68	738.55	742.55	736.98
Healthcare Scientists	99.60	99.60	100.02	102.19	103.19	103.19	104.19	103.91	104.90	104.90	104.90	104.90	105.64	105.64	105.64
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	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	1,188.27	1,307.23	1,306.43	1,264.93
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	6,276.00	6,272.80	6,254.65	6,216.10

Staff Group	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	Contracted WTE	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	Mar-22	Apr-22	May-22	Jun-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	548.01	551.66	545.79	541.28
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	1,296.64	1,305.03	1,311.17	1,311.79
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	1,917.73	1,919.01	1,920.71	1,937.89
Add Prof Scientific and Technic	227.31	222.33	224.89	224.95	234.72	223.75	227.20	213.43	226.79	227.66	227.99	224.92	228.01	225.38	225.05
Allied Health Professionals	658.92	664.74	664.35	656.84	663.94	671.90	679.91	676.09	671.37	672.78	665.14	665.32	654.49	651.07	653.05
Healthcare Scientists	99.17	100.17	98.72	98.72	99.40	98.16	97.69	99.30	97.80	96.36	96.36	96.77	94.77	94.17	92.49
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	7.61	7.61	7.61	7.41
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	1,163.14	1,159.95	1,158.82	1,155.57
Total Staff Worked WTE	5,794.64	5,774.76	5,807.70	5,780.96	5,942.54	5,881.46	5,888.47	5,864.67	5,873.75	5,893.15	5,894.15	5,920.15	5,920.52	5,914.71	5,924.52

Staff Group	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	Variance WTE	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	Mar-22	Apr-22	May-22	Jun-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	7.26	-14.16	-9.29	-4.79
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	116.24	79.00	62.34	65.85
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	119.83	31.32	19.79	14.51
Add Prof Scientific and Technic	-1.18	4.07	1.51	1.45	-8.32	2.65	3.92	17.69	5.33	4.46	18.64	21.71	14.71	17.34	10.17
Allied Health Professionals	40.30	35.33	42.25	56.55	57.86	49.89	42.87	46.22	52.11	50.90	58.54	58.36	84.06	91.48	83.93
Healthcare Scientists	0.43	-0.57	1.30	3.47	3.79	5.03	6.50	4.61	7.10	8.54	8.54	8.13	10.87	11.47	13.15
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	-0.81	-0.81	-0.81	-0.61
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	25.13	147.28	147.61	109.36
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	355.85	352.28	339.94	291.58

Vacancies: Vacancy data based on Finance Reporting from Unit 4 Agresso. N&M vacancies have increased from 62 WTE in May to 66 WTE in June and AHP vacancies have decreased from 91 WTE in May to 84 WTE in June. N&M WTE has remained consistent. A&C vacancies have reduced to 109 WTE. Vacancies are higher in this area due to delays in implementing plans. Finance and Workforce are working with Nursing Workforce to validate the vacancies and have established a project group to look at how this should be reported. Of the total vacancies, 50 WTE relate to CFHD and their revised model. It is important to note that vacancies are being covered by agency and bank and are excluded from this report above.

The table below shows the agency expenditure by staff Group monthly for the Financial Year 2021-22 and the rolling total for the 22-23 Financial Year.

The Jun figure shows a drop in agency cost compared to May 2022.

Torbay and South Devon NHS Foundation Trust	2021-22 Financial Year											2022-23 Financial Year			
Total Agency Spend	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**2021-22 Total**	**Apr-22**	**May-22**	**Jun-22**	**2022-23 Total**
Registered Nurses	468	584	520	599	557	676	570	432	408	818	6336	546	709	669	1255
Scientific, Therapeutic and Technical	142	122	110	112	162	140	144	147	130	67	1418	93	138	53	231
of which Allied Health Professionals	63	58	65	47	65	70	80	88	86	23	721	52	75	7	127
of which Other Scientific, Therapeutic and Technical Staff	79	64	45	65	96	70	64	59	44	44	696	41	63	46	104
Support to clinical staff (HCA)	-3	7	-8	2	15	19	13	35	31	24	124	32	40	27	72
Total Non-Medical - Clinical Staff Agency	607	713	622	713	734	835	727	614	569	909	7878	671	887	749	1558
Medical and Dental Agency	353	455	328	317	322	390	378	265	-63	370	3621	321	202	331	523
Consultants	281	344	178	171	212	278	245	167	11	250	2554	230	124	204	354
Trainee Grades	72	111	150	146	110	112	133	98	-74	120	1067	91	326	127	417
Non Medical - Non-Clinical Staff Agency	136	116	140	162	174	148	143	146	152	189	1748	156	122	94	278
Total Pay Bill Agency and Contract	1096	1284	1090	1192	1231	1373	1248	1025	658	1468	13248	1148	1335	1174	2483

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

Ward	Day						Night						Total Patients	Day			Night		
	RN / RM		Nursing Associates		Care Staff		RN / RM		Nursing Associates		Care Staff			Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)
	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours							
Ainslie	1725	1812	0	0	1725	1460	1380	1300	0	0	1035	1058	754	105.0%	0.0%	84.6%	94.2%	0.0%	102.2%
Allerton	2833	2103	0	0	1035	1401	1380	1196	0	0	1035	1162	861	74.2%	0.0%	135.3%	86.7%	0.0%	112.2%
Cheetham Hill	1380	1839	345	0	2070	1973	1035	1026	345	0	1380	1839	812	133.3%	0.0%	95.3%	99.1%	0.0%	133.3%
Coronary Care	1380	1478	0	0	0	17	1035	1035	0	0	0	12	378	107.1%	0.0%	0.0%	100.0%	0.0%	0.0%
Cromie	1633	1376	0	0	863	1183	1035	1047	0	0	690	963	735	84.3%	0.0%	137.1%	101.1%	0.0%	139.5%
Dunlop	1380	1373	0	0	1208	1090	1035	920	0	0	1035	1001	718	99.5%	0.0%	90.3%	88.9%	0.0%	96.7%
Forrest	1725	1410	690	0	1380	1391	1725	1381	690	0	1380	1160	719	81.8%	0.0%	100.8%	80.1%	0.0%	84.0%
EAU4	1725	1463	0	0	1380	1631	1725	1414	0	0	1380	1242	756	84.8%	0.0%	118.2%	82.0%	0.0%	90.0%
Ella Rowcroft	1035	1078	0	0	1380	1095	989	839	0	0	690	679	456	104.2%	0.0%	79.3%	84.8%	0.0%	98.3%
Warrington	1035	1156	0	0	690	811	690	736	0	0	690	704	502	111.7%	0.0%	117.5%	106.7%	0.0%	102.0%
George Earle	1380	1654	345	0	2070	1784	1035	943	0	0	1380	1728	813	119.8%	0.0%	86.2%	91.1%	0.0%	125.2%
ICU	3450	2447	0	0	0	389	3105	2219	0	0	0	0	163	70.9%	0.0%	0.0%	71.4%	0.0%	0.0%
Joan Williams	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Louisa Cary	2070	1491	0	0	690	677	2070	1369	0	0	690	749	411	72.0%	0.0%	98.2%	66.1%	0.0%	108.5%
Escalation (McCullum)	690	961	0	0	1035	844	690	679	0	0	1035	960	499	139.3%	0.0%	81.6%	98.3%	0.0%	92.7%
Midgley	1725	1777	0	0	1725	1264	1725	1438	0	0	1380	1360	865	103.0%	0.0%	73.3%	83.3%	0.0%	98.6%
SCBU	1035	885	0	0	345	146	1035	803	0	0	345	173	199	85.5%	0.0%	42.3%	77.5%	0.0%	50.0%
Simpson	1380	1801	345	0	2047	2567	1035	1208	0	0	1380	1841	821	130.5%	0.0%	125.4%	116.7%	0.0%	133.4%
Turner	1035	1381	0	0	1725	1806	690	690	0	0	1380	1189	505	133.4%	0.0%	104.7%	100.0%	0.0%	86.2%
Total (Acute)	*28616*	*27484.09*	*1725*	*0*	*21367*	*21525.5*	*23414*	*20238.04*	*1035*	*0*	*16905*	*17815.5*	*10967*	96.0%	0.0%	100.7%	86.4%	0.0%	105.4%
Brixham	840	948	420	0	1260	1406.75	990	715	0	0	660	889.75	566	112.9%	0.0%	111.6%	72.2%	0.0%	134.8%
Dawlish	840	1060.25	0	0	1050	915.75	720	748	0	0	660	727	474	126.2%	0.0%	87.2%	103.9%	0.0%	110.2%
John Macpherson	1035	917	0	0	541	611	690	778	0	0	690	719	447	88.6%	0.0%	113.1%	112.7%	0.0%	104.2%
NA- Teign Ward	1890	1589	0	0	1890	1724.75	990	990	0	0	990	968	895	84.1%	0.0%	91.3%	100.0%	0.0%	97.8%
NA - Templar Ward	1680	1394.5	0	0	2135	2070.25	990	1001	0	0	1080	962	886	83.0%	0.0%	97.0%	101.1%	0.0%	89.1%
Totnes	840	841.5	0	0	1260	1122	720	662	0	0	660	697	536	100.2%	0.0%	89.0%	91.9%	0.0%	105.6%
Organisational Summary	35741	34234	2145	0	29503	29376	28514	25132	1035	0	21645	22778	14771	95.8%	0.0%	99.6%	88.1%	0.0%	105.2%

- The Registered Nurse (RN) average fill rate for day has be maintained in June 22 at 95.8% from 96.3% in May 22 and the night fill rate has increased to 88.1% in June 22 from 86.5% in May 22. This improvement in fill rate is demonstrates the reduction in Registered Nurse Vacancies.
- The Health Care Support Worker (HCSW) average fill rate for day was 99.6% in June and night was recorded as 105.2% which is an increase for both days and nights but continues to be in line with the safer staffing establishment. The slightly high fill rate at night was to provide supportive observation to patients with complex needs.
- Louisa Cary and ITU reported less than 80% fill rate for days and nights, however mitigations were put in place to reduce any potential risks to patients such as backfilling with HCSW's and redeploying staff from SCBU.

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	7.50	4.10	0.00	3.30	14	9	0	16	46.7%	30.0%	0.0%	53.3%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	6.80	3.80	0.00	3.00	21	30	0	4	70.0%	100.0%	0.0%	13.3%	7.74	4.74	0	2.91
Cheetham Hill	7.39	2.88	0.41	4.11	8.20	3.50	0.00	4.70	6	2	30	2	0.0%	3.3%	100.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.70	6.60	0.00	0.10	3	3	0	0	10.0%	10.0%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.53	3.54	0.00	1.99	6.20	3.30	0.00	2.90	6	21	0	3	20.0%	70.0%	0.0%	10.0%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.10	3.20	0.00	2.90	18	15	0	18	60.0%	50.0%	0.0%	60.0%	7.74	4.74	0	2.91
Forrest	10.12	4.60	1.84	3.68	7.40	3.90	0.00	3.50	30	29	0	21	100.0%	96.7%	0.0%	70.0%	7.74	4.74	0	2.91
EAU4	8.28	4.60	0.00	3.68	7.60	3.80	0.00	3.80	21	27	0	12	70.0%	90.0%	0.0%	40.0%	7.74	4.74	0	2.91
Ella Rowcroft	6.57	3.29	0.00	3.29	8.10	4.20	0.00	3.90	3	4	0	7	10.0%	13.3%	0.0%	23.3%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	6.80	3.80	0.00	3.00	2	1	0	6	6.7%	3.3%	0.0%	20.0%	7.74	4.74	0	2.91
George Earle	7.39	2.88	0.41	4.11	7.50	3.20	0.00	4.30	10	3	30	12	33.3%	10.0%	100.0%	40.0%	7.74	4.74	0	2.91
ICU	24.28	24.28	0.00	0.00	31.00	28.60	0.00	2.40	4	5	0	0	13.3%	16.7%	0.0%	0.0%	7.74	4.74	0	2.91
Joan Williams	0.00	0.00	0.00	0.00					0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
Louisa Cary	9.68	7.26	0.00	2.42	10.40	7.00	0.00	3.50	10	21	0	1	0.0%	70.0%	0.0%	3.3%	7.74	4.74	0	2.91
Escalation (McCullum)	6.76	2.71	0.00	4.06	6.90	3.30	0.00	3.60	12	3	0	20	40.0%	10.0%	0.0%	66.7%	7.74	4.74	0	2.91
Midgley	7.53	3.97	0.00	3.57	6.70	3.70	0.00	3.00	29	19	0	29	96.7%	63.3%	0.0%	96.7%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	10.10	8.50	0.00	1.60	7	7	0	19	23.3%	23.3%	0.0%	63.3%	7.74	4.74	0	2.91
Simpson	7.19	2.88	0.41	3.90	9.00	3.70	0.00	5.40	0	1	30	0	0.0%	3.3%	100.0%	0.0%	7.74	4.74	0	2.91
Turner	10.73	3.83	0.00	6.90	10.00	4.10	0.00	5.90	25	5	0	27	83.3%	16.7%	0.0%	90.0%	7.74	4.74	0	2.91
Brixham	6.95	3.05	0.70	3.20	7.00	2.90	0.00	4.10	14	13	30	1	46.7%	43.3%	100.0%	3.3%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	7.30	3.80	0.00	3.50	7	4	0	15	23.3%	13.3%	0.0%	50.0%	7.74	4.74	0	2.91
John Macpherson	5.18	2.88	0.00	2.30	6.80	3.80	0.00	3.00	1	1	0	5	3.3%	3.3%	0.0%	16.7%	7.74	4.74	0	2.91
NA - Teign Ward	6.40	3.20	0.00	3.20	5.90	2.90	0.00	3.00	25	23	0	21	83.3%	76.7%	0.0%	70.0%	7.74	4.74	0	2.91
NA - Templar Ward	6.50	2.97	0.00	3.53	6.10	2.70	0.00	3.40	24	28	0	18	80.0%	93.3%	0.0%	60.0%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	6.20	2.80	0.00	3.40	20	15	0	20	66.7%	50.0%	0.0%	66.7%	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
	7.54	4.09	0.20	3.25	7.55	4.02	0.00	3.53

- The RN actual CHPPD for TSD has been maintained at to 4.02 in June 22 from 4.04 in May 22, which although consistent remains slightly below the Carter recommendation of 4.7. The CHPPD has seen an improvement over the last 3 months in line with an improved vacancy position.
- The HCA actual CHPPD is at 3.53 which is above the Carter recommendation of 2.91 but above the planned of 3.25
- During June 2022 the operational position deteriorated, with14 days declared at OPEL 4 and 15 days were declared at OPEL 3. Despite this increase in operational demand the total planned CHPPD was recorded as 7.54 and the actual was reported as 7.55 which is encouraging and within our staffer staffing establishment.

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

Children with a Child Protection Plan (one month in arrears)		
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)		⬆
DOLS - Deprivation of Liberty Standard		
Intermediate Care - No. urgent referrals		⬆
Community Hospital - Admissions (non-stroke)		
Urgent Community Response 2 hours		⬆
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)		⬆
% reablement episodes not followed by long term SC support		⬆

Operational update:

The Fair Cost of Care work has mobilised, with 20% of care homes signed up further presentations have been made to the market to demonstrate the modelling tools and how the Trust and Council will support providers. Monthly meetings are conducted with Torbay, DCC, Cornwall, and Plymouth to support approach and anomalies as they arise. The two consultants supporting Torbay have proved valuable in their insights and experience.

Supported Living tender evaluations are completed with 23 applicants. The issue around hourly rates for Supported Living Outreach has been presented in a recommendation paper for Transformation and Performance. While this would incur an increase in cost, delivering this service through Supported Living is around £200k per annum less than through the LW@H framework and they primarily support people with learning disabilities in the community who may otherwise require residential based care.

The recent Extra Care Housing procurement altered the model and associated cost. Extensive modelling is underway to understand how this model works and translated into the new schemes in Crossways and Tor Marine.

We are seeing a lot of requests coming through to Health and Social Care Uplift Panel (HSCUP) for increases in fees and rates from providers. The impact of recruitment, petrol and cost of living has impacted providers. The HSCUP panel has now moved from being a decision making group to recommendations only. Those recommendations will go through to the Transformation & Performance board both recommendations to approve or decline requests.

Care Accounts continues to progress working alongside Trailblazers across England. Our colleagues in the Local Government Association and Department for Health and Social Care are supporting our communications toolkit for Torbay residents, care providers and TSDFT staff. The Care Accounts project is also working to improve Torbay's Social Care digital offering and harnessing opportunities to be more efficient.

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.

Measure	Target 2022/2023	13 month trend	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Year to date 2022/23
SOCIAL CARE SERVICES																
% clients receiving self directed support - Torbay			71.0%	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%
% clients receiving direct payments - Torbay			19.5%	19.6%	19.5%	19.0%	19.4%	19.4%	19.6%	19.4%	19.6%	19.8%	19.5%	19.4%	19.6%	19.6%
% carers receiving self directed support - Torbay			98.3%	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%
% Adults with learning disabilities in employment - Torbay			7.4%	7.4%	7.1%	7.1%	6.8%	7.0%	6.8%	6.7%	6.6%	7.1%	7.3%	7.3%	7.3%	7.3%
% Adults with learning disabilities in settled accommodation - Torbay			81.7%	81.3%	81.0%	80.6%	80.6%	81.5%	81.6%	81.6%	81.8%	81.1%	81.3%	81.2%	80.3%	80.3%
Permanent admissions (18-64) to care homes per 100k population - Torbay			23.1	17.7	19.0	17.7	17.7	20.4	23.1	25.8	19.0	21.7	24.5	29.9	35.3	35.3
Permanent admissions (65+) to care homes per 100k population - Torbay			487.3	498.1	511.5	449.6	422.7	411.9	376.9	487.3	476.5	570.8	576.2	823.8	880.4	880.4
% reablement episodes not followed by long term SC support - Torbay			85.0%	85.9%	87.1%	87.4%	87.9%	87.9%	87.7%	88.0%	87.8%	88.9%	84.5%	86.8%	89.6%	89.6%

Social Care Services: The table above captures the current Torbay Adult Social Care key performance indicators. The targets for 2022_23 have not yet been agreed so no RAG rating has been applied.

Measure	Target 2022/2023	13 month trend	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Year to date 2022/23
PUBLIC HEALTH SERVICES																
% of face to face new birth visits within 14 days *	95.0%															
Children with a child protection plan *			201	171	165	147	147	-	-	-	-	-	-			-
Opiate users - % successful completions of treatment (Quarterly) **	Var															

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.

Community Hospital Dashboard - Summary of Key Measures - June-22

	Act. 21/22 Outturn	Apr-22	May-22	Jun-22	Total
Admissions / Discharges					
Total Admissions (General)	2,499	225	202	179	606
Direct Admissions (General)	152	10	3	6	21
Transfer Admissions (General)	2,347	215	199	173	613
Stroke Admissions	233	17	14	10	41
Transfers from CH to DGH	257	15	15	15	45
Beds					
Bed Occupancy [1]	97.2%	97.6%	97.8%	98.8%	98.1%
Bed Days Lost to Bed Closure	383	0	0	0	0
Length of Stay					
Delayed Discharges		25	8	13	46
Average Length of Stay - Overall (General)	13.6	18.5	16.5	16.7	16.7
Average Length of Stay - Direct Admissions	12.4	12.0	12.1	11.2	11.2
Average Length of Stay - Transfer Admissions	13.7	19.0	16.7	16.8	16.8
Average Length of Stay - Stroke	20.9	10.5	15.3	16.5	16.5
Long LoS (>30 days)	229	15	19	21	60
MIUs					
Total MIU Activity	34,911	2,806	3,053	3,096	8,955
New MIU Attendances	31,634	2,535	2,783	2,819	8,137
All Follow Up Attendances	3,277	271	270	277	818
Planned Follow Up Attendances	2,403	193	169	179	541
Unplanned Follow Up Attendances	874	78	101	98	277
MIU Four Hour Breaches	55	29	51	173	253
Average Waiting Time (Mins) - 95th Pctile	77	104	107	111	0

Operational update:
Community hospital bed occupancy remains high at 98.8%.

Timely discharges from community hospitals continue to be impacted by the availability of domiciliary care and access to residential nursing home beds.

The average length of stay has increase from 13.6 days in 2021/22 to 16.7 days in June 2022.

New MIU attendance in June is 2,819 with 173 4-hour breaches and an average waiting time of 111 minutes.

Totnes Community Hospital MIU re-opened in July with daily attendances back to previous levels.

Community Services – hospital discharge and onward care

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 hospital 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

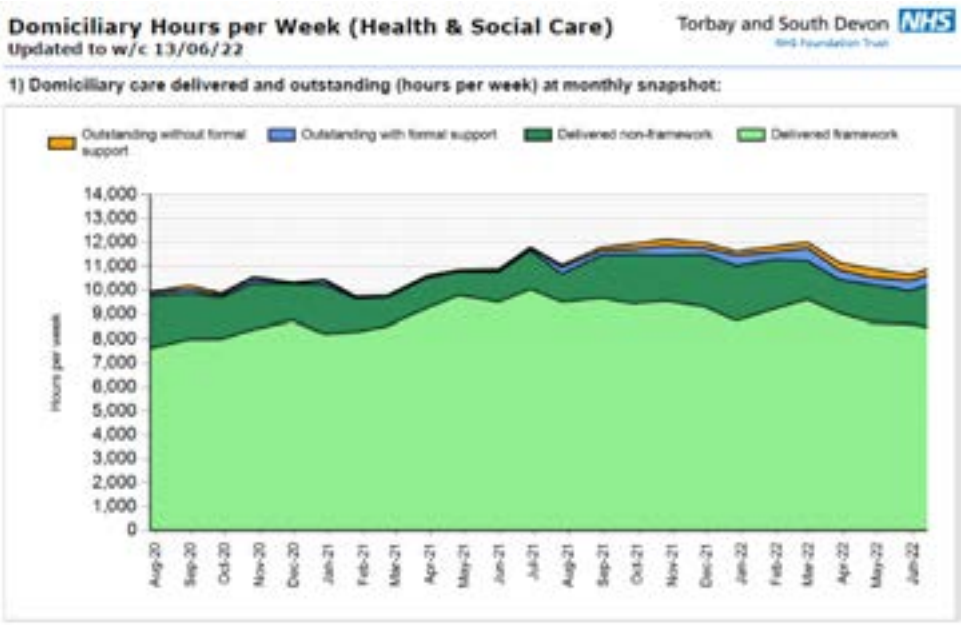


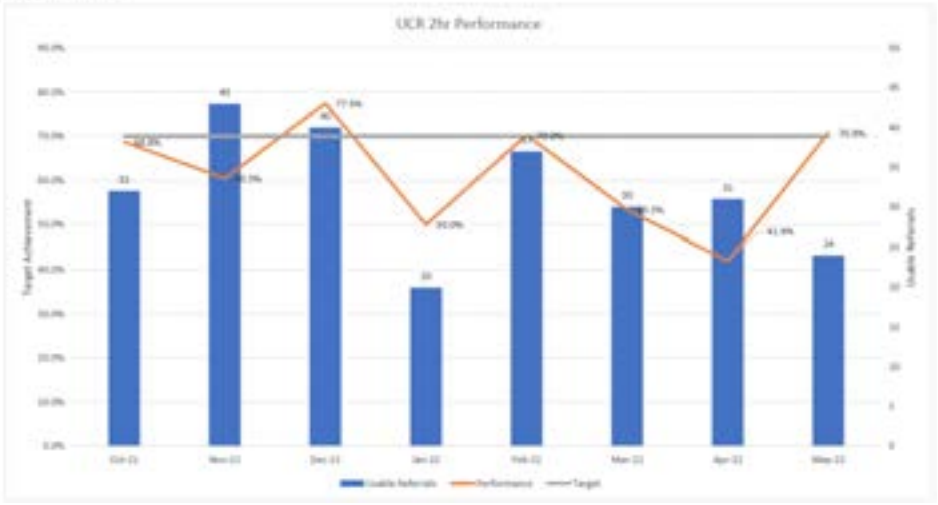
Chart 2 -Unmet packages of care

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. The weekly snapshot in April (362 hours) outstanding decreased to 254 hours without formal support in May. Currently June is reporting 251 outstanding hours (as at 13 June 2022) a further slight improvement.

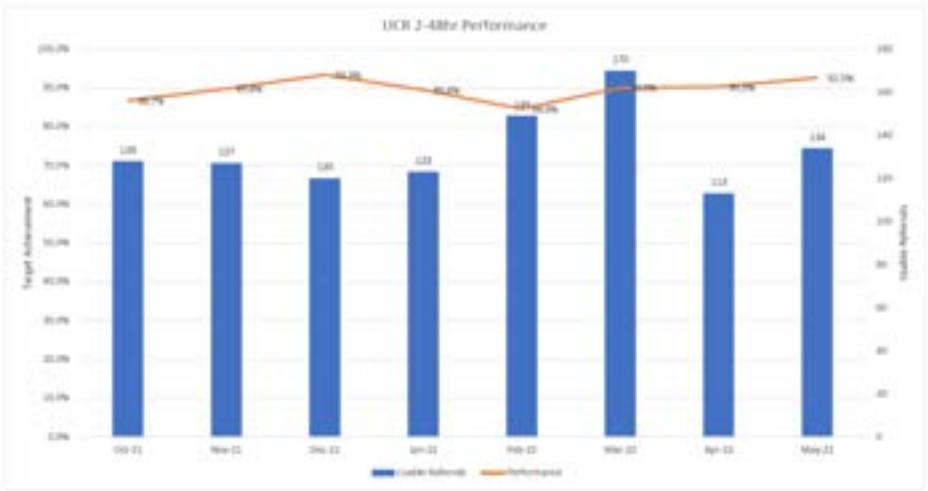
Chart 2- "Unmet packages of care" shows the <u>number</u> of unmet packages of care for South Devon (orange) and Torbay (Green) and where provided by diverting other NHS community provision (Blue). Current levels remain significantly higher than those reported in Q1 2021/22.

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

UCR 2 hour Performance



UCR 2-48 hour Performance



NHS England and NHS Improvement are committed to developing a consistent NHS urgent community response (UCR) offer nationally. As set out in the NHS operational planning and contracting guidance 2022/23, all Integrated Care Systems (ICSs) must ensure Urgent Community Response (UCR) services (that improve the quality and capacity of care for people through delivery of urgent, crisis response support within two hours) are available to all people within their homes or usual place of residence, including care homes. This is a national standard which was introduced in the NHS Long Term Plan and builds on National Institute of Health and Care Excellence (NICE) guidelines.

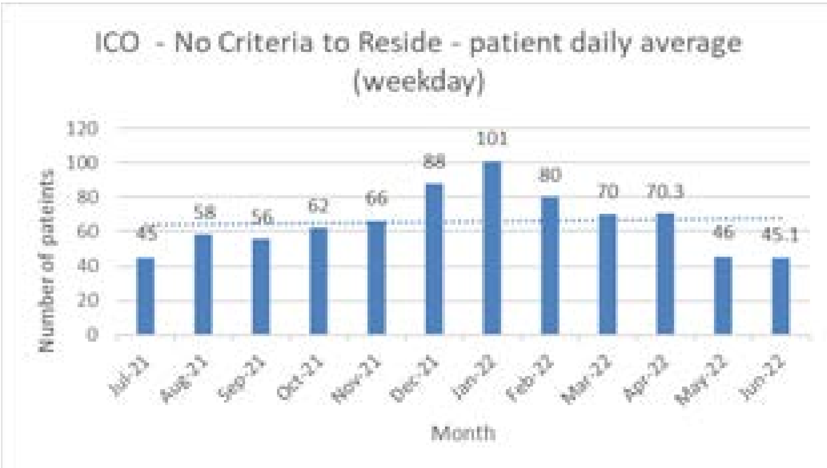
Performance against the target is captured across all ISUs, regularly reviewed with Intermediate Care Leads, and reported monthly to the Intermediate Care Data Task Group and the Home First Group.

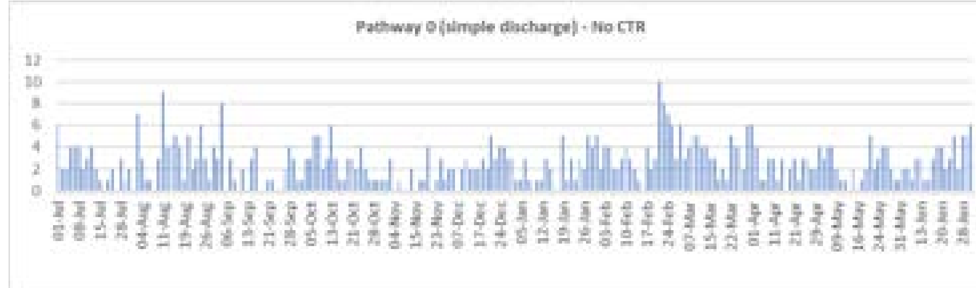
The performance for the May 2-hour target has been achieved at 70.8%, however, a fewer number of patients were referred for this month (a total of 24 2-hour target referrals were received).

134 referrals were received for a response within 2-48 hours and 92.5% were seen within the target time.

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 continues to decrease from the peak seen in January. The Trust has a Complex Discharge Pathway Improvement Plan to support operational bed capacity and flow.

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 an increase in the number of patients waiting for a simple discharge (Pathway 0) and continued improvement for patients delayed waiting for short-term and long-term placement (Pathway 2 and 3). 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 [illegible] / long term placement

Operational Performance Summary – Page 1

Operational performance summary: Chief Operating Officer

Covid: The Trust has continued to care for patients with Covid with the numbers remaining low in June. July has seen a steady increase in numbers of covid patients requiring care. The Incident Control Centre (ICC) was reinstated as the number of covid infections impacting service delivery and capacity began to increase. The severity of covid infections remain relatively low with very few patients requiring ITU or oxygen support. There has, however, been a significant impact on staff sickness levels impacting on service continuity.

Recovery Planning: During June, the operation of the Day Surgery Unit and elective inpatient theatre programme has been sustained with activity levels recovering towards pre-pandemic levels in these areas. New insourcing has been contracted in addition to that already in place for Ophthalmology and Gastroenterology using main inpatient theatre lists over the weekend. Urology capacity remain as high risk with ongoing workforce and estate constraints with further capital works required to fully optimise the relocated outpatient services at the Paignton Hospital site.

Urgent Care: Urgent and emergency services continue to be challenged with the Trust operating at OPEL 4, the highest level of escalation, declared on 14 days. The 4-hour performance target for June is reported as 54.5% and the lowest performance for 13 months and being one of the lowest performing Trusts in the South Region. High bed occupancy has continued to impact patient flow leading to delays in ambulance handover, extended waits in ED and assessment areas, and patients bedded in ED and assessment areas overnight. 702 people spent 12-hours or more in the Emergency Department; 832 patients experiencing an ambulance handover delay over an hour once arriving at the Emergency Department this being an all-time high. Overall levels of demand through the ED remain at just below pre-pandemic levels for the time of year. An increase in the number of long stay patients greater than 7 days and 21 days has impacted on patient flow and freeing beds for ED admissions. Bed occupancy remains above the levels needed to have timely flow from ED and assessment areas. Whilst the reduction in No Criteria To Reside (delayed discharges) is showing good progress the average length of stay remains significantly higher than pre-pandemic levels in the same period last year. Further work is being led through the Flow Improvement Group and System Team to understand the drivers for this and further areas for targeted improvement work.

People waiting for care: The number of patients waiting over 104 weeks has started to reduce from 245 at the end of March to 94 at the end of June with 45 of these wanting to further delay to a more convenient date having been offered dates for surgery. The forecast is 75 for the end of July. This is behind the National ambition to have treated anyone waiting over 104 weeks by the end of June. July capacity has been impacted by both patients being unable to proceed as having covid as well as staffing pressures meaning some scheduled theatre lists being cancelled. Progress in reducing the number of 104 week waits continues in addition to the target of treating all patient waiting over 78 weeks by end of March 2023. This still demonstrates good progress since the return of elective capacity and confidence that all patients waiting this long, who wish to be treated, will be. Whilst this is the aggregated Referral to Treatment position teams are focusing on waiting times across all stages of treatment with a performance review of all areas with long outpatient waits taking place being supported by the Outpatient Transformation Programme.

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. In outpatients, the target is to achieve 25% of consultant led outpatient attendance delivered non face to face. The current performance is 21% reported in June.

Cancer 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 against the 62-day referral to treatment standard. The backlog over 62 days remains a significant challenge and is not reducing with 250 at end of June against an operational plan trajectory to reduce this to 115 by March 2023. These pathways remain high risk and are receiving weekly executive oversight.

Operational Performance Summary – Page 2

Communication with patients with long waits: The Trust is engaged with the Integrated Care System (ICS) system Waiting Well Programme. Through this work non-clinical validation of long wait patients "yet to be seen" (longer than 52 weeks) is being supported by the Devon Referrals Support Service (DRSS) by contacting some of our longest waiting patients to give assurance and direct to wellbeing and lifestyle support. This Waiting Well Programme is also developing information links through various forms of media for patients to give further advice on waiting times and wider support.

Diagnostic waiting times: MRI, CT**,** Endoscopy, CT, and Echocardiography remain challenged. Overall there has been a small improvement with 30% of patients waiting over 6 weeks for diagnostic tests in the monitored modalities. The use of a mobile scanner, insourcing at weekends, and the use of the Nightingale Hospital facilities continue to be critical to supporting capacity. The national expectation is to plan an increase in diagnostic activity to 120% of 2019/20 levels and to have no more than 25% of patients waiting over 6 weeks by end of March 2023.

Patients in hospital: The number of 7-day and 21-day length of stay patients has increased with the daily average of 173 over 7 days and 43 over 21 days in hospital. The number of longer LOS stay (over 7 days) is partly linked to the number of patients reported as having no criteria to reside waiting for packages of care or placements to nursing and residential home to be commissioned. There has been a reduction in the average number of patients per day recorded as having no criteria to reside from 101 in January to 45.1 in June. A 50% reduction in no criteria to reside from December 2021 levels has been built into the bed modelling for winter 22/23. In support of onward packages of care and complex discharges the retention and recruitment of staff remains a significant challenge for independent sector providers who provide nursing residential and domestic care packages of care.

Community and social care: There continues to be a focus on increased productivity across community teams and recruitment to ensure teams can operate at full establishment. The levels of unfilled packages with "no other formal support" remain a concern with 251 hours outstanding as at 13 June 2022. Daily review and mitigations are in place to prioritise those patients with no other formal support in place and potentially delaying those leaving acute settings of care.

This month, the focus report includes performance against the 2-hour and 2 – 48 Urgent Community Response.

Operational Performance Indicators

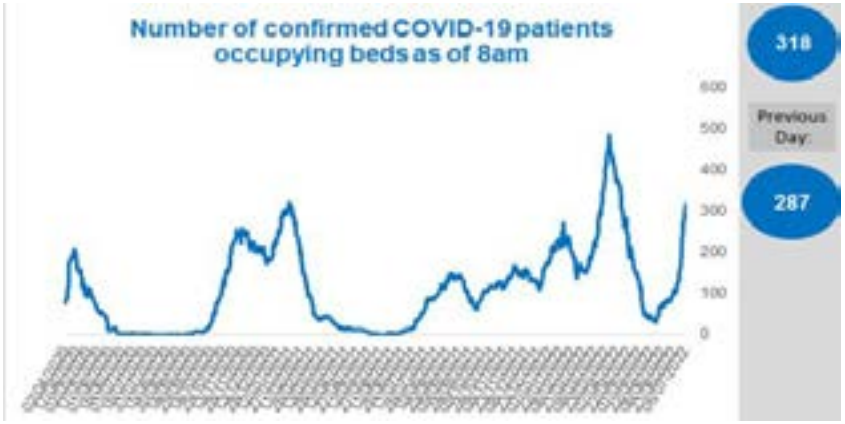
Key									
⬆ = Performance improved from previous month ⬇ = performance deteriorated from previous month ⟷ = no change									
	Not achieved		Under-achieved		Achieved		No target set		Data not available		NHSI Indicator

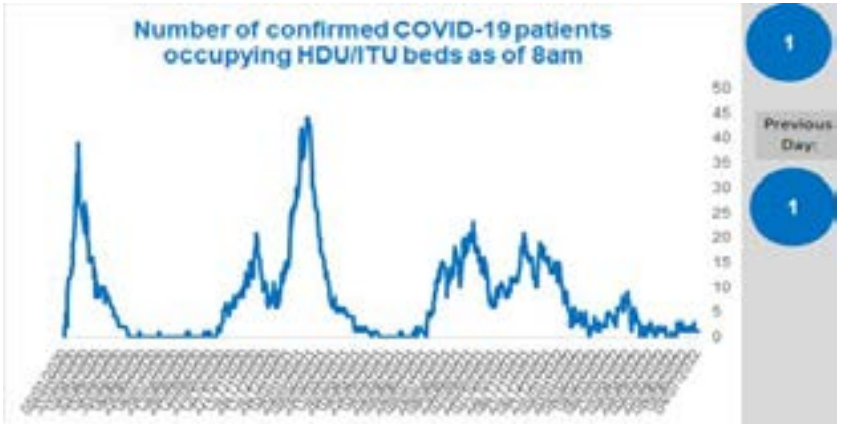
A&E - patients seen within 4 hours (NHSI)		⬇
Referral to treatment - % Incomplete pathways <18 wks (NHSI)		⬇
Cancer - 62-day wait for first treatment - 2ww referral (NHSI)		⬇
Diagnostic tests longer than the 6 week standard (NHSI)		⬆
Dementia Find (NHSI)		⬇
Number of Clostridium Difficile cases reported		⟷
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		⬇
Virtual Outpatient (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		⬆

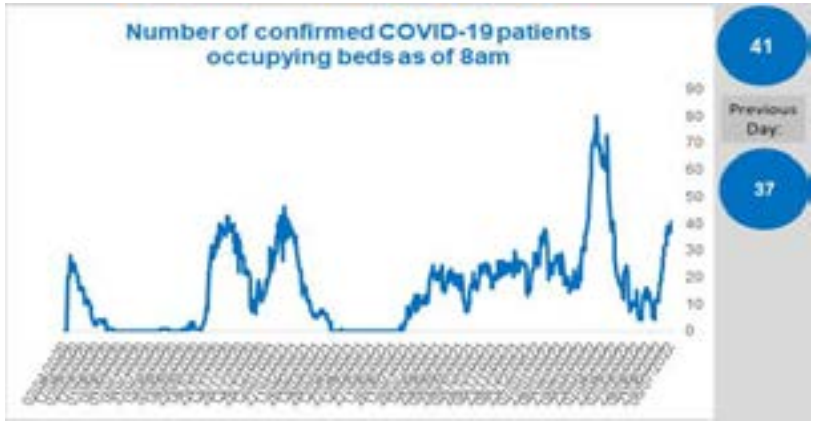
Covid - Hospitalisations

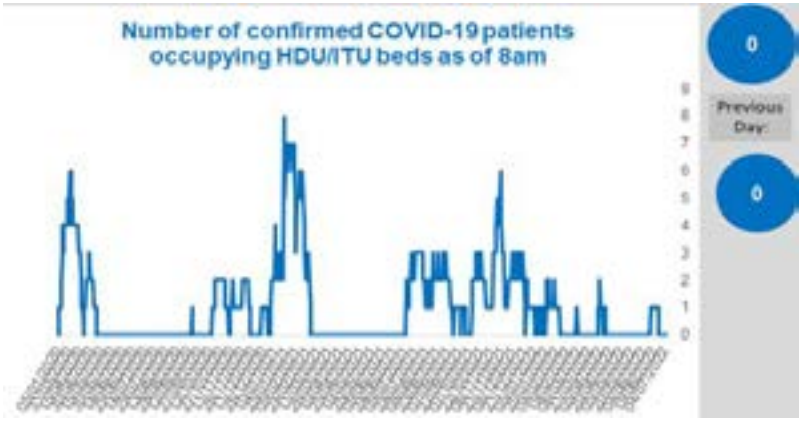
Devon ICS
(as at 7 July 2022)





Torbay and South Devon NHS FT
(as at 7 July 2022)





The level of Covid-19 hospitalisations had remained low through most of June releasing some medical bed capacity for general use, however, in July these numbers have increase significantly with the Trust experiencing a rapid increase in patients in hospital with covid and requiring isolation and associated IPC procedures. The number of covid patients requiring an ITU bed remains low.

The level of covid sickness requiring periods of time off work have increased significantly and is impacting on the ability to maintain staffing levels and continues to be a significant challenge.

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Patients seen within 4 hours in A&E	Performance M3 54.5% Performance M2 57.6% Target 95% Risk level HIGH	The Emergency Department remains challenged with access to inpatient beds continuing to contribute to long stays in the department, overcrowding, and ambulance handover delays. Ambulance handover delays remains high with 832 patients experiencing over 60 minute delay compared to 173 patients last June. 702 patients experienced over 12 hours in the department compared to 246 last June. Across the wider system there continues to be both capacity and workforce challenges to maintain the flow of patients out of hospital.	Streaming GP referred emergencies to the Medical and Surgical Receiving units reduces the potential crowding in ED and can ensure early specialist assessment. Triage is in place to clinically risk assess all handover and ED long waits for medical review. The Discharge Lounge utilisation remains high and is being successful in bringing forward the time that ward beds are released to support flow from ED. Work continues with system partners to support admissions avoidance and reduce delays to discharge patients when medically fit.	
Patients waiting longer that 18 weeks from Referral to Treatment	Performance M3 50.56% Performance M2 52.3% Target 92% Risk level HIGH	The total number of people waiting for treatment has increased by 1,313 from last month. 713 patients are waiting longer that 78 weeks and 94 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. Patients will be booked in-line with clinical prioritisation Treatment capacity to target longest waits will be increased by: • Use of the Nightingale to provide 2 days operating in June (Surgeon permitting) • Insourcing of clinical teams to use main theatres and day unit at weekends has commenced – but ad-hoc. • Teams reviewing plans to identify opportunities to increase capacity and productivity as part of the restoration of services and for 2022/23 business planning. • Mobile endoscopy room – Slight delay – now Sept • Continue existing schemes with insourcing in ophthalmology and endoscopy.	 **Activity variance vs 2019/20 baseline** / **M2** / **M3** Op new / -13.8% / -7.5% OP Follow up / -5.5% / -7.0% Day Case / -10.4% / -0.4% Inpatient / -8.8% / -7.0%

NHSI Performance Indicator Summary

Metric		Risk identified	Management actions	Trend
Cancer 62 day wait for 1st treatment from 2-week wait referral	Performance M3 56.4% Performance M2 61.5% Target 85% Risk level HIGH	June's performance against the 62-day cancer standard was 56.4% (85% target); a decline on May's performance. The Trust continues to be challenged to comply with the 62-day cancer performance target with remedial action plans in place. Urology, Skin and Lower GI continue to be the main contributors to this position. Of the backlog of 250 patients over 62-days, a high percentage of these patients are on Urology and Colorectal pathways. Current staffing levels due to sickness and an increase in COVID patients within the Trust will impact on the ability to reduce the backlogs as originally planned in the coming months. It is therefore forecast that the cancer performance position will deteriorate.	Reinstatement of the Day Surgery Unit has eased some of the capacity pressures of delivering diagnostics and cancer treatments although there remains a backlog of patients to work through. Insourcing of additional clinical capacity remains in place to increase capacity in Urology and lower GI focusing on the diagnostic elements of pathways. The mobile endoscopy room will be on site in August. The Chief Operating Officer and Cancer Clinical Lead are leading the process to review site specific action plans and escalate issues requiring further support. Clinical capacity and recruitment to key roles remain the greatest challenge.	
Diagnostic tests longer than 6 weeks	Performance M3 30.1% Performance M2 32% 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 with backlogs of routine patient over 26 weeks. Having no site for a mobile scanner on the DGH site remains a constraint for bringing in additional mobile scanner capacity. Sickness and recruitment remain critical factors in the current staffing pressures and to fully utilise fixed CT and MRI capacity. Insourcing for endoscopy is needed to maintain capacity, however continued need to medically cover the escalation ward and staff sickness has meant a scaling back of capacity for diagnostic lists.	There remains plans in place for use of insourcing and mobile scanner units to support in- house capacity. Radiology (MRI) are using capacity at the Nightingale Hospital Exeter; currently 2-days a week, 160 patients per month). For endoscopy the mobile unit will be arriving on site however there is now no solution to free up the Gastro consultant workforce from ward medical cover needed to make use of this facility – This is a priority to resolve 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 M3	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.	
	84.1%			
	Performance M2			
	94.6%			
	Target			
	90%			
	Risk level			
	LOW			

NHSI Performance – Referral to Treatment (RTT)

Services with greater than 100 patients waiting over 18 weeks

June 2022 Incomplete 92% Table - National Speciality

	>126			
	Incomplete IPDC	Incomplete OP	Grand Total	%<18wks
Breast Surgery	26	67	449	0.792873
Vascular Surgery	45	65	339	0.681416
Clinical Neuro-Physiology		128	178	0.280899
Clinical Haematology		130	216	0.398148
Nephrology		137	205	0.331707
Rheumatology	42	112	444	0.659153
Pain Management	42	214	524	0.51145
Endocrinology		419	783	0.464879
Neurology	24	717	1299	0.429561
Colorectal Surgery	123	769	1615	0.447678
Respiratory Medicine	3	909	1707	0.465729
Gynaecology	355	572	2701	0.656794
Gastroenterology	405	560	2620	0.631679
Dermatology		1057	2452	0.568923
Upper Gastrointestinal Surgery	413	666	1749	0.381662
Paediatrics	9	1317	2199	0.595349
Oral Surgery	381	1297	3047	0.448296
Cardiology	49	1662	3379	0.493637
Urology	380	1436	3080	0.41039
ENT	171	1647	3310	0.451749
Ophthalmology	346	1653	4871	0.589612
Trauma & Orthopaedics	1304	791	3776	0.455773
Grand Total	4185	16693	42234	0.505659

Referral to Treatment – incomplete pathways

Referral to Treatment: RTT performance in June has deteriorated slightly with the proportion of people waiting less than 18 weeks at 50.56%; 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 42,234 from 40,921, an increase of 1,313 from the May position.

52 week waits: For June 4,137 people will be reported as waiting over 52-weeks and is an increase from 3,795 in May. Overall long waits are increasing, with patients waiting longer than 78-weeks having decreased slightly to 713 in June from 813, 104 weeks waits have continued to decreased to 94 from 173 in May.

Recovery planning: The reopening of Day Surgery and the use of the protected beds on Ella Rowcroft has been maintained since their opening (with only temporary closures on Ella due to COVID) and activity levels continue to build back to pre-Covid levels. The CCG has restarted outsourcing outpatients to Mount Stuart Hospital (MSH) for T&O and Gynae; but not long waiters, with ongoing discussion for long wait T&O hand and wrist surgical patients. Approval has been given to bring a mobile Endoscopy van on-site located at the Annex; this will mitigate the loss of the MSH lists and bolster existing insourcing capacity; planned commencement for September due to drainage issues being identified. T&O continue to use lists at the re-commissioned Nightingale Hospital Exeter with 2 all-day lists per month where we can provide staff. Further insourcing and outsourcing capacity is being sought through the Elective Recovery Fund (ERF) to use theatres on site at weekends for T&O, these continue to be problematic due to surgeon availability from 18 weeks. Weekend insourcing OP Clinics are continuing with Dermatology and Neurology. Cataract operations have commenced at Optimax (privately provided ophthalmic theatre), further lists are being scheduled around surgeon availability. It is noted that the contribution from insourcing is likely to fall short of the anticipated rate built into the operational plan. Approval has now been given for the additional urology rooms at Paignton; a draft capital investment form has been submitted for feedback.

Work continues to transform the outpatient model of delivery with a shift to increased non-face-to-face appointments, current performance is below national expectations and performance of local peers. Transformation programme support is in place to drive these improvements.

Work continues to treat all 104wk patients with the exception of those who make themselves unavailable (P6 patients)– but COVID infections and staff sickness combined with a shortfall in anaesthetic cover continue to impact. All options are being considered by the CCG induding securing out of area independent sector capacity. 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 for 104-week waits and elimination of 78-week waits by March 2023.

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. June has seen an increase in the 06-12 week and 18+ week bandings and reductions in the 12-18 week bandings

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 31.05.2022			
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	825	1420	6008
Rheumatology	178	303	1278
Ear Nose Throat	201	390	1135
Paediatrics	185	206	675
Neurology	162	202	966
Orthoptist	170	312	590
Urology	72	133	309
Gynaecology	43	43	209
Respiratory Medicine (Chest)	67	185	422
Orthodontics	31	61	213
Colorectal Surgery	35	52	410
Orthopaedics	114	157	191
Dermatology	158	218	576
Geriatric Medicine	50	51	147
Cardiac Testing	81	23	25
Gastro-Enterology	91	127	195
Breast Surgery	45	32	314
Cardiology	130	159	227
Pain Management	32	52	44
Oral Surgery	90	86	191
Plastic Surgery	23	62	93
Diabetic	66	102	56
Upper Gastrointestinal Surg	31	52	111
Respiratory Technician	2	56	232
Endocrinology	35	62	33
Grand Total	**2957**	**4569**	**14689**

Specialtities with highest Follow-Up Backlog Passed TBS as at 03.07.2022			
Row Labels	06-12 Weeks	12-18 Weeks	18 Weeks +
Ophthalmology	824	1375	6086
Rheumatology	280	275	1270
Ear Nose Throat	186	299	1271
Paediatrics	196	241	713
Neurology	147	180	843
Orthoptist	167	287	656
Urology	88	127	327
Gynaecology	65	54	182
Respiratory Medicine (Chest)	27	97	381
Orthodontics	32	50	228
Colorectal Surgery	46	51	430
Orthopaedics	118	168	244
Dermatology	176	185	581
Geriatric Medicine	38	61	125
Cardiac Testing	119	22	17
Gastro-Enterology	120	100	82
Breast Surgery	48	61	323
Cardiology	98	146	254
Pain Management	26	42	52
Oral Surgery	73	87	204
Plastic Surgery	52	46	106
Diabetic	59	102	69
Upper Gastrointestinal Surg	27	29	94
Respiratory Technician	2	10	282
Endocrinology	22	55	46
Grand Total	**3079**	**4178**	**14903**

Variance		
06-12 Weeks	12-18 Weeks	18 Weeks +
-1	-45	78
102	-28	-8
-15	-91	136
11	35	38
-15	-22	-123
-3	-25	66
16	-6	18
22	11	-27
-40	-88	-41
1	-11	15
11	-1	20
4	11	53
18	-33	5
-12	10	-22
38	-1	-8
29	-27	-113
3	29	9
-32	-13	27
-6	-10	8
-17	1	13
29	-16	13
-7	0	13
-4	-23	-17
0	-46	50
-13	-7	13
122	-391	214

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

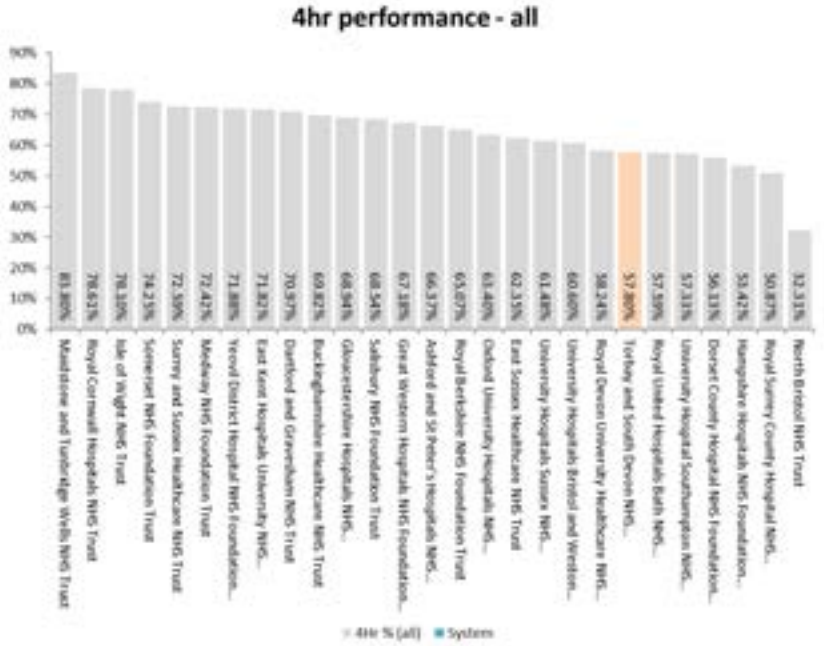
A&E and MIU patients seen within 4 hours

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Patients	9622	9538	9072	8738	8415	7483	6923	7201	6819	7974	8021	8797	8650
4 hour breaches	2698	2990	2935	3052	3155	3010	2596	2800	2690	3318	3370	3732	3934
% seen within 4 hours	72.6%	68.6%	67.6%	65.1%	62.5%	59.8%	62.5%	61.1%	60.6%	58.4%	58.0%	57.6%	54.5%
National target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Local trajectory	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Performance 4 hour standard: Performance has remained a challenge at 54.5%. Access to suitable inpatients beds has contributed to delays at peak times.
12 hour Trolley wait: 178 patients are reported as having a 12-hour trolley wait from decision to admit to admission to an inpatient bed.
Ambulance Handovers: 832 ambulance delays over 60 minutes an increase from 514 in May; and 1081 ambulance handover delays of over 30 minutes an increase from 894 in May.
Patients with a greater than 12-hour visit time pathway: 702 patients had a greater than 12-hour visit time.
Corridor Care: No patients recorded as receiving corridor care.

Operational delivery:
Continued pressure across the emergency department and the assessment areas in June with significant waits for access to inpatient beds. Patients have experienced an increase in 12-hour visit times and extended ambulance handover delays.
We continue to provide compassionate care and maintain safety despite the challenges faced every day.

4-hour performance: provider comparison last 6 weeks - South Region



Escalation status

Opel status	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Opel 1	0	0	0	0	0	0	0	0	0	0	0	0	0
Opel 2	1	0	0	0	0	0	1	0	0	0	7	14	1
Opel 3	21	7	7	5	3	1	4	10	27	13	24	13	13
Opel 4	8	24	24	25	28	29	26	21	1	18	4	2	24
4-hour Performance (ED)	[illegible]												
Bed Occupancy (Acute)	[illegible]												
Ambulance handover delays >1 hour	173	165	120	72	125	617	616	559	458	757	680	554	832
Domiciliary Care - hours outstanding*	467	813	994	1,261	1,357	1,288	468	811	605.75	625.75	538.25	697.5	461
No Criteria To Reside - daily average (weekdays)		45	58	58	62	66	88	101	80	70	70	44	45

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

Jun-21

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

Jun-22

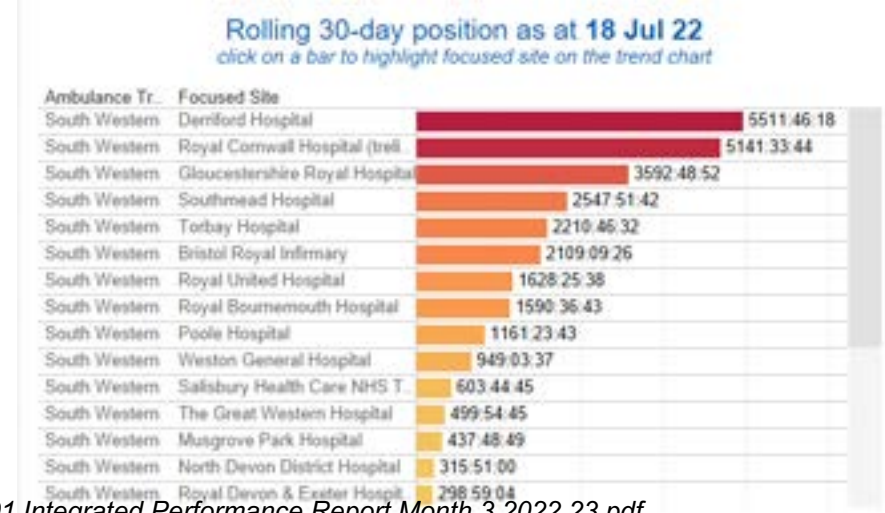
Mo	Tu	We	Th	Fr	Sa	Su
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

South West Ambulance Response Times – Category 1+2

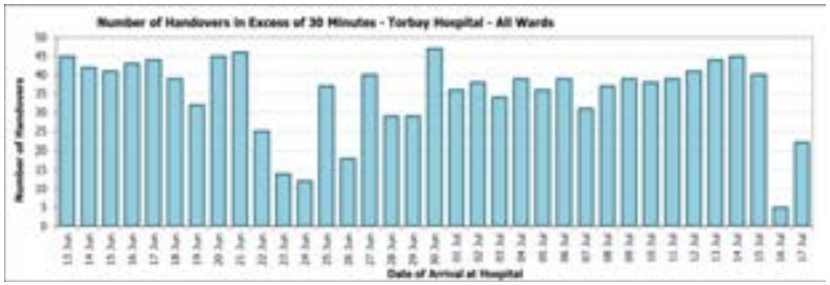
In relation to overall system pressures the above ambulance response time have been included into the performance report to highlight the significant contribution handover delays can have on wider system resources, patient experience and safety. At TSDFT we continue to experience high levels of handover delays so impacting on the capacity for the ambulance service to maintain timely responses to urgent 999 calls and more routine responses. The charts above show the recent performance in the category 1 and 2 ambulance response times for the SWAST headline performance.
Category 1 calls being the 999 highest priority for immediate life threatening conditions with a target response time of 7 minutes
Category 2 calls being serious condition such as stroke or chest pain with a target response time of 18 minutes

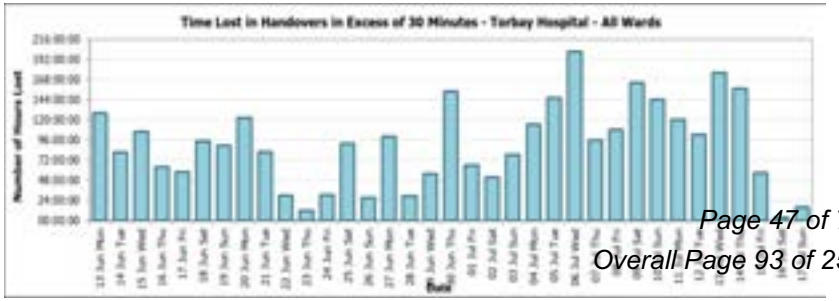
The two charts below show the number of delayed handovers > 30 minutes and the daily hours lost experienced at TSDFT

Delays > 60 minutes by trust (hours lost)



Delays > 30 mins number and hours lost





Cancer treatment and cancer access standards

As at 19/07/2022	2022											
	Q1											
	May				June				July			
target_type	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf
14 day - 2ww Referral	946.0	605.0	1,551.0	61.0%	566.0	1,019.0	1,585.0	35.7%	385.0	1,172.0	1,557.0	24.7%
14 day - Breast Symptomatic Referral	34.0	11.0	45.0	75.6%	15.0	21.0	36.0	41.7%	8.0	43.0	51.0	15.7%
28 day - Faster Diagnosis Standard	1,075.0	531.0	1,608.0	66.9%	977.0	529.0	1,506.0	64.9%	504.0	189.0	693.0	72.7%
31 day - 1st Treatment	166.0	7.0	174.0	96.0%	177.0	10.0	187.0	94.7%	5.0	1.0	6.0	83.3%
31 day - Subsequent Treatment - Drug	59.0	1.0	60.0	98.3%	72.0	0.0	1.0	44.0%	1.0	45.0	1.0	100.0%
31 day - Subsequent Treatment - Radiotherapy	51.0	2.0	53.0	96.2%	42.0	2.0	44.0	95.5%	46.0	1.0	47.0	97.9%
31 day - Subsequent Treatment - Surgery	22.0	1.0	23.0	95.7%	21.0	2.0	24.0	87.5%	26.0	3.0	29.0	89.3%
62 day - 2ww referral	80.0	48.5	128.5	62.3%	57.5	43.5	101.0	56.9%	73.0	36.5	109.5	66.7%
62 day - Screening Referral	8.0	3.0	11.0	72.7%	13.0	1.0	14.0	92.9%	7.0	4.0	11.0	63.6%
62 day - Consultant Upgrade	1.0	1.0	2.0	50.00%					2.0	0.0	2.0	100.00%

Cancer standards The table above shows the position for Q2 (as at 19th July 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: 35.7% (unvalidated) is below the standard of 93%. Skin breaches continue to remain high with waits currently at 2 weeks and 5 days. Urology Waits (4 weeks 1 day - Flexi)) and LGI waits (7 weeks for both F2F and Non-F2F) continue to impact. The most challenged pathways in June are Child (17%) 5 breaches, Breast (23%) 176 breaches, Skin (24%) 433 breaches, H&N (25%) 115 breaches, LGI (26%) 192 breaches, & Urology (41%) 54 Breaches.

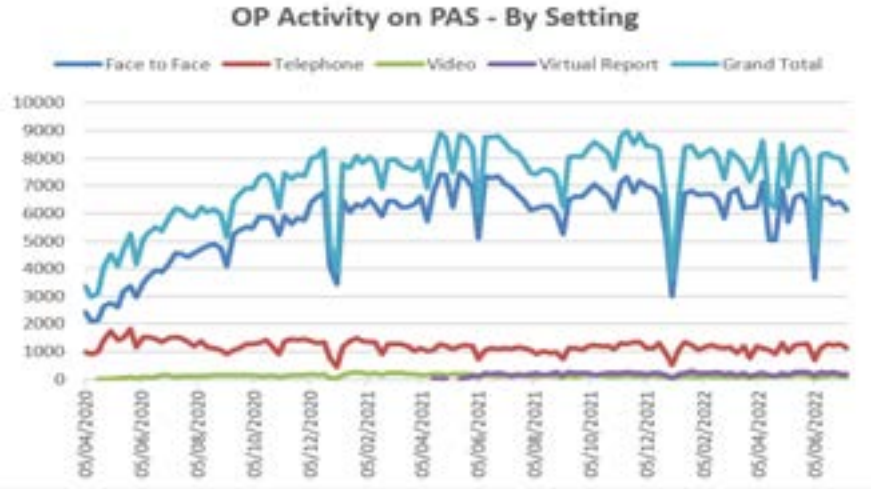
28 days From Referral to Diagnosis: Performance in June is 64.9% (unvalidated) against the target of 75%, this has deteriorated from May (67.0%) and reflects the breach increases for LGI (178), Urology (100), Gynae (56), Breast (84) and Skin (78).

NHSI monitored Cancer 62 day standard: The 62-day referral to treatment standard has deteriorated slightly in June at 56.9%% (unvalidated) against the target of 85% with 57.5 patient being seen within 62 days, however, 43.5 patients falling outside the target time; breaches for Urology account for 17 of the total with 8 LGI, 7 Skin and 4 UGI being 83% of all breaches.

104-day wait: Currently there are 62 (unvalidated) patients with a greater than 104-day wait in June. 23 patients in the backlog having 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 remains the most challenged with 44 patients waiting longer than 104 days, 15 with confirmed cancers.

Virtual appointments (Non-face-to-face)

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
New	14.0%	15.0%	9.0%	14.0%	14.5%	12.4%	11.3%	14.30%	13.5%	12.7%	12.6%	13.1%
Follow-UP	22.0%	21.0%	21.0%	21.0%	23.6%	21.7%	24.0%	23.90%	20.6%	22.0%	23.8%	23.6%
Combined	**20.0%**	**19.6%**	**20.3%**	**20.5%**	**21.1%**	**19.3%**	**20.7%**	**21.30%**	**18.8%**	**19.6%**	**20.9%**	**20.9%**



High Level Milestones	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Virtual Consultation Data - establish accurate recording and range of services.														
Review of current virtual appointments per service- what works and barriers, with particular focus on barrier that services reporting lowest numbers are experiencing and ways to mitigate.														
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.														
[illegible] virtually														

The Trust continues to see virtual appointment performance below the nationally set requirement (25%) achieving 20.6% in June and the lowest across all 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.

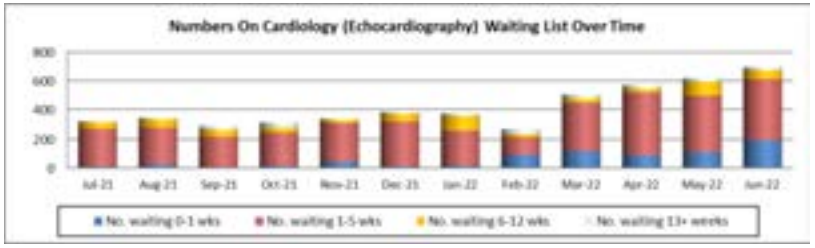
The Patient Centred Outpatient (PCO) Transformation Programme has set out its programme of work (summarised opposite) to deliver improvement for the Virtual appointment targets of 25% from September 2022. One escalated risk is the lack of Information Asset Officer for Attend Anywhere (video appointments system) to support the embedding of this new approach.

The programme of in-depth specialty reviews with operational teams is progressing. This is focusing on adoption of non face to face take up as well as understanding wider capacity and operational constraints that teams are experiencing and require support. Several specialties continue to have reduced outpatient capacity with consultant workforce being redirected to support urgent care escalation. Most social distancing constraints in waiting areas have been lifted and clinic templates returning to pre pandemic profiles we expect to see a recovery to pre covid levels of activity. Waiting times for new appointments and backlogs over overdue follows ups are an increasing clinical risk.

Use of Advice and Guidance, Patient Initiated Follow up and referral optimisation are all part of the strategy for releasing capacity and support the reduction in waiting times and increased productivity.

COMPLETED
IN PROGRESS ON TRACK
IN PROGRESS DELAYED
NOT YET STARTED

NHSI indictor - patients waiting over 6 weeks for diagnostics



All modalities are continuing to see patients with urgent need with appropriate Infection, Prevention and Control precautions. 30% of patients are waiting over 6 weeks.

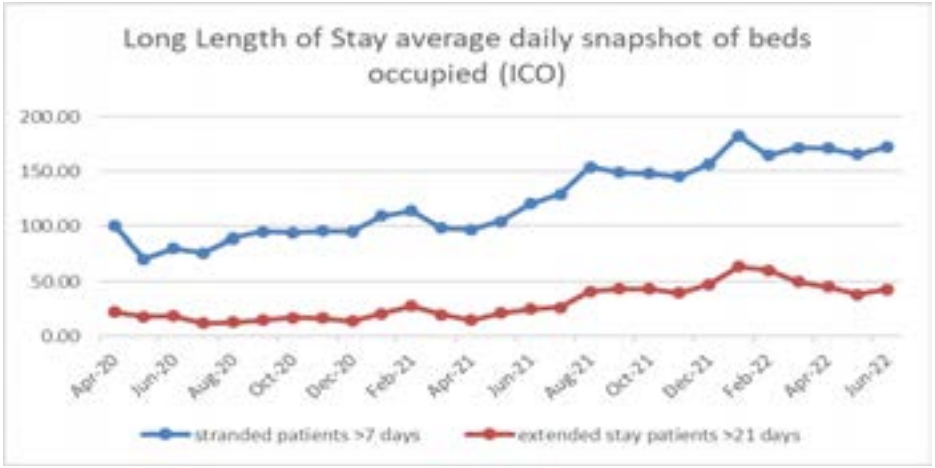
Colonoscopy is now the area of greatest risk**.** The numbers and routine waiting times are increasing with 589 patients waiting over 6 weeks. Weekend insourcing continues but is becoming less effective. A mobile endoscopy unit will be on site to commence in August designed to allow a move away from insourcing with increased capacity for in-house sessions. Staffing, however, is the critical constraint with consultant teams continuing to cover medical inpatient beds so not available to cover increased lists. Recent sickness has also impacted team capacity with the service increasingly under pressure.

MRI waits and total numbers on the list have improved with 546 (732 in April) patients waiting over 6 weeks. Maintaining capacity is reliant on the support of mobile scanner visits and the use of Nightingale as all in-house scanner capacity is 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 improved but remain above target with 127 patients (387 in April) waiting over 6 weeks. Recruitment to vacant posts remains the greatest challenge to increase utilisation hours of in-house scanners, reporting, and vetting of referrals. Insourcing using mobile units will continue to support capacity (will be reducing going forward). Additional capacity is being provided at the Nightingale Hospital Exeter with contrast capability now being available.

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

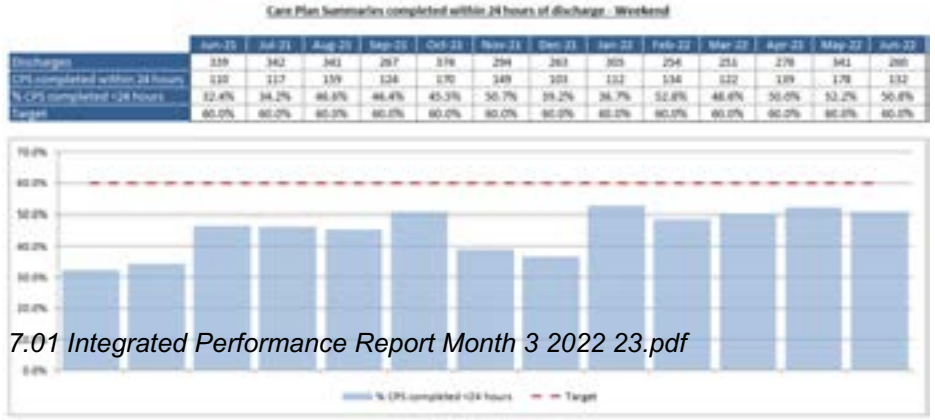


Long Length of Stay (LOS)

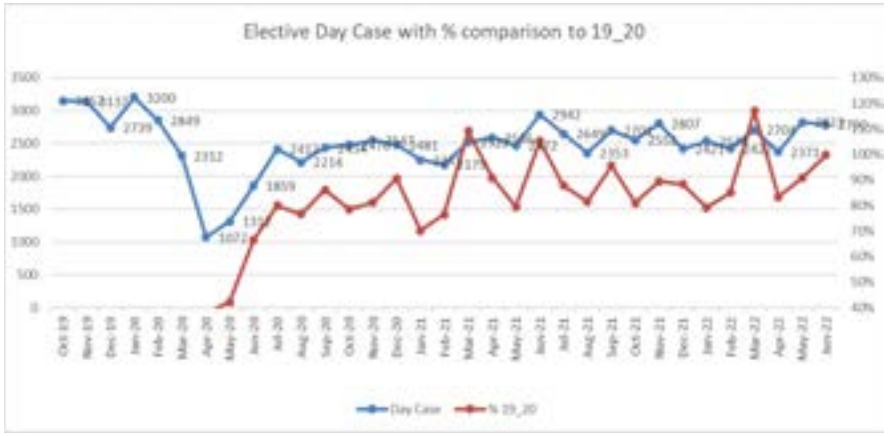
The average number of patients counted as having long length of stay greater than 7 and 21 days as measured in a daily census remains high. The number of patients experiencing long LOS is a critical measure as the Trust is challenged to maintain the flow of urgent patients through a fixed number of beds. 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) so subject to capacity pressures across the wider independent care sector.

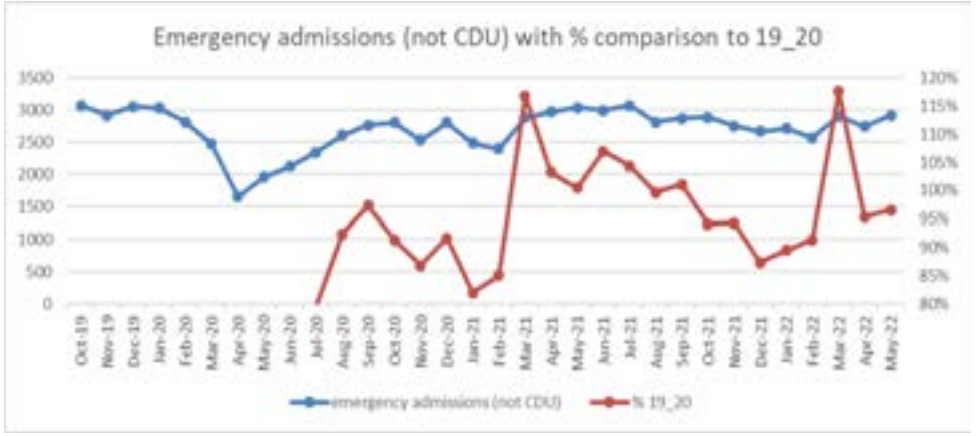
Care Planning Summaries (CPS)

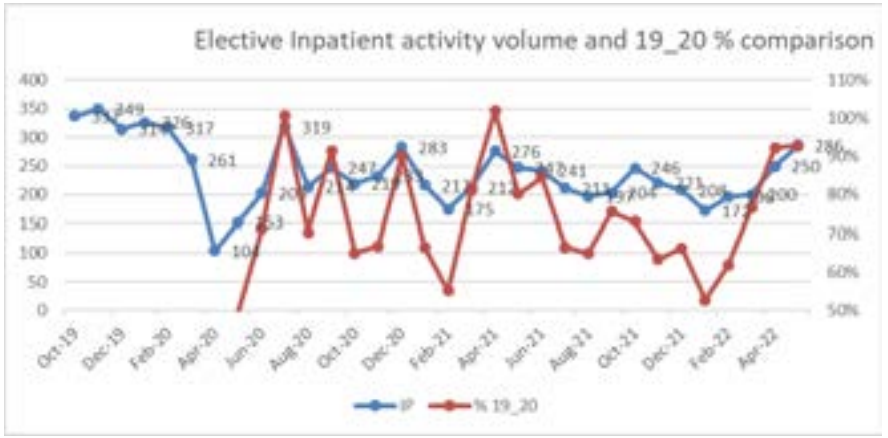
Hospital Care Planning Summaries serve as the primary documents communicating a patient's care plan to the post-hospital care team. CPS completion (within 24 hours of discharge) has improved over the year.

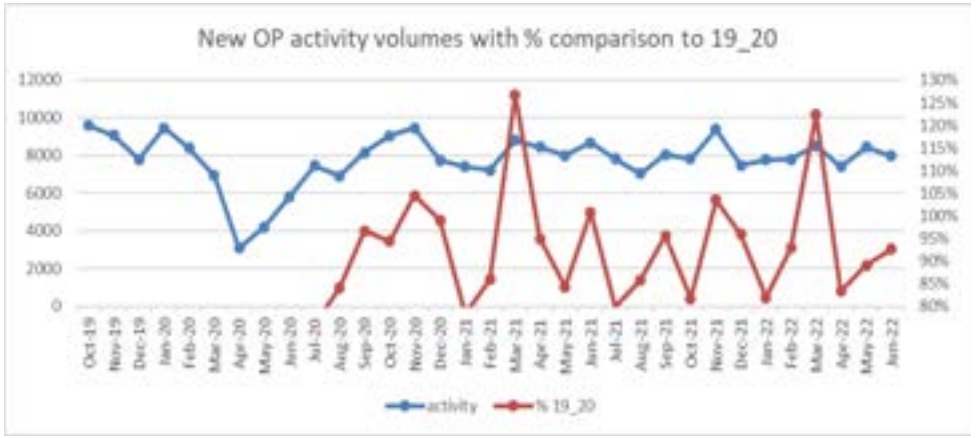


Headline acute activity and comparisons to pre covid 2019/20 activity levels









The charts above show the monthly activity run rate of reported contract activity (Payment by Results & Cost and Volume) to end of June 2022 together with a comparison to 2019/20 levels of activity. Note that the March 22 comparison is skewed as March 20 had reduced activity due to the start of the pandemic.

The reopening of the Day Surgery Unit and return of elective beds has contributed to an increase in both day case and elective activity in Month 3. The Trust is also now utilising capacity and the Nightingale Hospital Exeter and continuing to use insourcing at weekend across ophthalmology and endoscopy day cases. As part of the wider recover plans teams are planning to achieve in excess of 100% of 2019/20 activity levels.

It is noted that whilst the volume of emergency admission remains just below pre-covid levels there has been a focus on admissions avoidance and higher acuity of patients being admitted is being seen.

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.

CFHD

- Internal and external business/governance reporting model now with CFHD assurance for approval before next steps.
- Workforce consultation closed with now 1400 pieces of feedback being reviewed and some feedback being given to the workforce gradually but formally end July/early August. Engagement with the system being planned for late Summer/early Autumn.
- SystemOne discussions ongoing.
- Inter-operability workshop being planned in collaboration with TSD and DPT.
- Leadership and clinical vacancies significant – recruitment underway.
- High Covid sickness across CFHD.

SPA

- Progress made with reducing backlog.
- Need to recruit to several posts prior to mobilisation.

Integrated therapies and nursing

- Early Years and ASD interim lead advertised internally.
- Recovery plans for Autistic Spectrum Disorder (ASD) waiting times progressing – virtual team contracts extended and capacity being sought from lean processes (around private assessment review). Reviewing virtual vs face-to-face waits and demand.

CAMHS

- Vacancy rates in CAMHS appear to have stabilised
- IT networking of the Torbay site has been escalated but not yet resolved.
- Non-complex ADHD commissioning in North Devon is in escalation for resolution.

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.
- Concern around estates plan in Torbay and CFHD not always being included in strategic planning. Recent discussions have progressed this but new estate needs to be sought in the area due to demolishing of some premises to enable BBF work over the coming 1-10 years.

Children and Family Health Devon – Referral to Treatment

	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 May	FY 2022 May	FY 2021 May	FY 2022 May	FY 2021 May	FY 2022 May
Community Children's Nursing (CFH Devon)	0	0	100.0%	100.0%	246	288
Learning Disability (CFH Devon)	0	0	81.0%	100.0%	320	261
Mental Health and Wellbeing	1	16	61.1%	71.0%	3635	4134
Occupational Therapy (CFH Devon)	0	1	46.1%	69.8%	1195	1183
Palliative Care (CFH Devon)	0	0	NA	NA	38	42
Physiotherapy (CFH Devon)	1	0	74.8%	83.7%	431	529
Special School Nursing (CFH Devon)	0	0	100.0%	NA	406	474
Specialist Autism Spectrum Assessment Team (CFHD)	914	1760	20.8%	16.7%	2318	3726
Specialist Children's Assessment Centre (CFHD)	12	128	41.7%	40.6%	627	1030
Speech & Language Therapy (CFH Devon)	44	296	46.1%	43.7%	3994	5229

	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 June	FY 2022 June	FY 2021 June	FY 2022 June	FY 2021 June	FY 2022 June
Community Children's Nursing (CFH Devon)	0	0	100.0%	100.0%	259	288
Learning Disability (CFH Devon)	0	0	76.5%	96.2%	319	263
Mental Health and Wellbeing	6	23	64.7%	69.3%	3591	4170
Occupational Therapy (CFH Devon)	0	1	40.6%	67.0%	1254	1153
Palliative Care (CFH Devon)	0	0	NA	NA	39	43
Physiotherapy (CFH Devon)	1	0	73.9%	81.8%	442	527
Special School Nursing (CFH Devon)	0	0	100.0%	100.0%	441	535
Specialist Autism Spectrum Assessment Team (CFHD)	1008	1726	17.1%	15.3%	2289	3580
Specialist Children's Assessment Centre (CFHD)	16	140	38.2%	36.8%	679	1076
Speech & Language Therapy (CFH Devon)	61	407	39.6%	39.9%	4020	5305

Financial Performance – Month 03 (June)
FY 2022 / 23

Financial Overview – Month 03, June 2022

High Level Summary- Year to Date Position

For Period ended - 30 June 2022, Month 03	Plan £m	Actual £m	Variance £m
Total Operating Income	145.96	146.65	0.68
Total Operating Expenditure and Financing Cost	(149.25)	(149.95)	(0.69)
Surplus/(Deficit)	(3.29)	(3.30)	(0.01)
Add back: NHSE/I Adjustments	0.22	0.23	0.01
Adjusted Surplus/(Deficit)	(3.07)	(3.07)	0.00
CIP	5.39	2.67	(2.72)
Capital (CDEL)	8.17	7.36	(0.81)
Cash & Cash Equivalents		21.51	

Adjusted Surplus / (Deficit)

At Month 3 (June) the adjusted planned deficit is £3.1m, however the Trust's underlying performance is a £6.4m deficit. In Month 3 the Trust recorded a balanced position against the re-submitted plan on 20th June 2022, which includes a £3.3m balance sheet mitigations. The trust is expected to recover the deficit through the remaining months of the financial year.

Operating Income

Operating income for the year to date totals £146.65m, within which income for patient care activities totals £134.21m. Total income for the year to date is £0.68m favourable to plan. Key drivers are as follows: ASC (client contributions) balance sheet release £0.81m, deferred income release £0.84m, other income £0.68m, CFHD variation order £0.19m and pass through drugs and devices £0.20m. The offset being undelivered CIP additional income (£1.37m) adverse variance on pharmacy sales (£0.57m) and Covid-19 top up funding (£0.39m)

Operating Expenditure

Total operating expenditure and financing cost is £149.95m against the budget of £149.25m with a year to date adverse variance of (£0.69m). Key drivers are as follows:

- Employee expenses (£1.53m adverse), substantive posts remain unfilled resulting in disproportionate overspends on agency and bank usage.
- Other operating expenses are broadly in line with plan -but do include a one--off business rates adjustment (£0.51m favourable), other operating expenditure (£1.90m favourable) offset by purchase of health and social care (£1.69m adverse) inpatient/ outpatient drug costs (£0.30m) pass through drugs and devices (£0.20m) and transport costs (£0.22m adverse).
- Remaining variance is due to CIP delivery (see below).

CIP Summary

Year to date CIP target at M03 was £5.39m, of which £1.25m has been formally transacted via the financial ledger. However, £1.45m has been marked identified as delivered subject to validation to transact in M04. The remainder of undelivered CIP has been mitigated via reserves and balance sheet releases.

Balance Sheet and Other

M03 £3.3m was released from the balance sheet YTD (in addition to M02 £0.85m) This includes a review of annual leave carried-forward (£0.78m), adult social care provision (£0.80m) and revenue to capital recharge (£0.15m). A further (£1.57m) of expenditure was released from the balance sheet after a review of historic accruals. All transactions offset the Trust's underlying deficit of £6.4m YTD to a £3.3m reported deficit.

Capital

Capital expenses (CDEL) totalled £7.36m at M03 which is £0.81m behind planned expenditure value of £8.17m.

Cash

The Trust is showing a cash position of £21.51m at the end of M03.

I&E Position – Month 03, June 2022

£m	M03 - In Month		
	Budget	Actual	Variance
Patient Income - Block	32.56	32.65	0.09
Patient Income - Variable	4.67	4.93	0.26
ERF/ERF+/TIF/Capacity Funding	0.57	0.70	0.13
ASC Income - Council	6.04	4.67	(1.37)
Other ASC Income - Contribution	1.10	1.98	0.88
Torbay Pharmaceutical Sales	1.74	1.69	(0.05)
Other Income	4.47	4.58	0.11
Covid19 - Top up & Variable income	0.26	0.28	0.01
Total (A)	**51.42**	**51.48**	**0.06**
Pay - Substantive	(23.46)	(23.23)	0.23
Pay - Agency	(0.61)	(1.17)	(0.56)
Non-Pay - Other	(12.95)	(13.01)	(0.06)
Non- Pay - ASC/CHC	(9.42)	(9.44)	(0.02)
Financing & Other Costs	(2.65)	(2.31)	0.34
Total (B)	**(49.09)**	**(49.16)**	**0.07**
Surplus/(Deficit) pre Top up/Donated Items and Impairment (A+B=C)	**2.32**	**2.32**	**(0.02)**
NHSE/I Adjustments - Donated Items / Impairment / Gain on Asset disposal	0.07	0.08	**0.01**
Adjusted Financial performance - Surplus / (Deficit)	**2.39**	**2.39**	**(0.01)**

In Month Income & Expenditure – Performance versus Plan and run rate

Income

- Overall patient income variance is £0.06m favourable. Variances include £0.09m deferred CFHD income to match expenditure, £0.26m pass through drugs and devices, £0.81m ASC (client contributions) balance sheet release and ESRF income £0.13m matching cost. Various other income includes car parking, release of deferred income and other income £0.52m. This is offset with undelivered CIP for additional income (1.37m), (£0.30m) Covid-19 labs testing to match reduced expenditure, R&D under achieved trial income (£0.10m) and adverse pharmacy sales of (£0.05m)

Pay

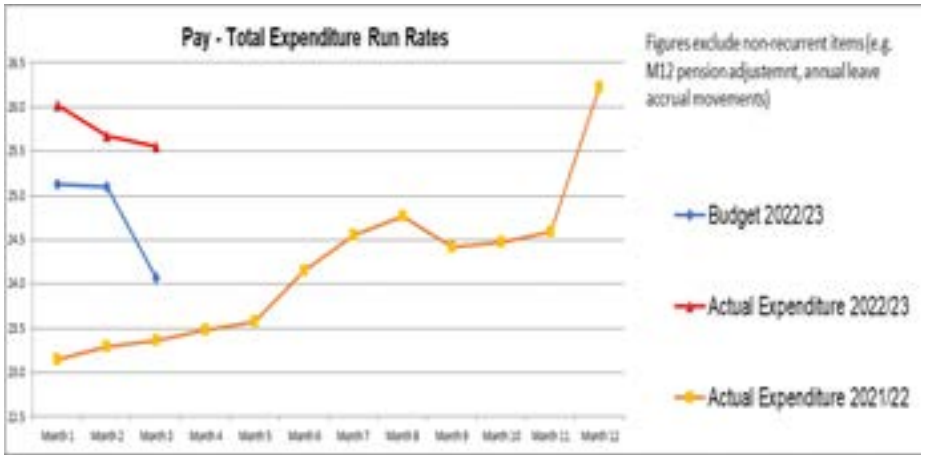
- No pay award had been formally agreed in M03, the position includes the estimated 2% pay accrued for substantive and Bank staff. In M03 overall pay without balance sheet mitigation is overspent by (£1.42m) against the budget of (£24.07m).
- CIP target in M3 is £1.28m, of which £0.28m has been delivered in month
- Substantive staffing is £0.51m underspent and bank usage is overspent (£0.28m).
- Agency cost is (£0.56m) higher than the budget with CIP, however usage has reduced comparing to M2 by £0.16m. The overspend in Agency mainly relates Nursing (£0.38m) and medical (£0.18m) staff groups.
- All of the above was mitigated by £1.09m balance sheet adjustment including the release of annual leave accruals.

Non-pay

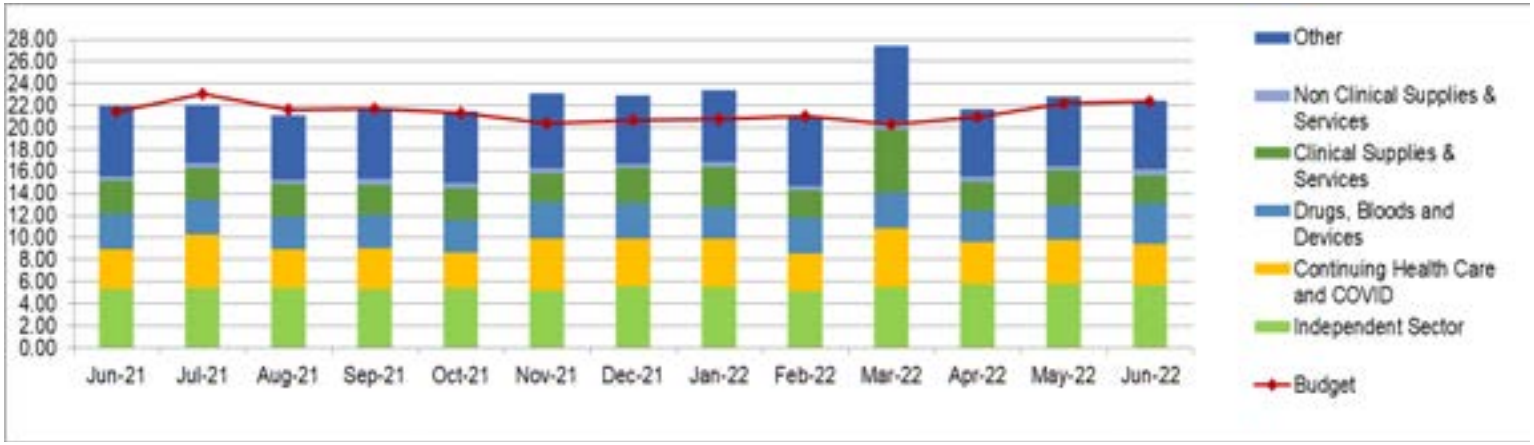
- Non-pay overall is overspent by (£0.08m), this includes cost uplift to provider SLAs (£0.50m) and drugs (including pass through drugs and devices) (£0.50m). Offsetting underspends relate to clinical supplies and services underspend (£0.30m) and balance sheet mitigations (0.60m).
- The non-pay CIP target for M03 is £0.41m of which £0.38m had been delivered transacted.
- ASC/CHC overspend of (£0.02m), mainly due to higher than anticipated costs on residential long stay care price with the same issue impacting nursing long stay.

Income and Expenditure by System				
System Description	Expenditure & Income Category	M03 In Month Budget	M03 In Month Actual	M03 In Month Variance
Children and Family Health Devon (CFHD)	Operating expenditure - Pay	(0.99)	(0.96)	0.03
	Operating expenditure - Non Pay	(1.53)	(1.61)	(0.07)
	Income from patient activities	2.48	2.51	0.03
	Other Operating Income	0.04	0.05	0.01
Children and Family Health Devon (CFHD) Total		**0.00**	**(0.01)**	**(0.01)**
Pharmacy Manufacturing Unit	Operating expenditure - Pay	(0.79)	(0.70)	0.09
	Operating expenditure - Non Pay	(0.99)	(0.84)	0.16
	Misc non-operating items	(0.01)	(0.01)	0.00
	Income from patient activities	0.04	0.03	(0.01)
	Other Operating Income	1.75	1.35	(0.40)
	Finance expenditure	(0.01)	(0.01)	0.00
Pharmacy Manufacturing Unit Total		**(0.03)**	**(0.19)**	**(0.16)**
Shared Corporate Services	Operating expenditure - Pay	(3.35)	(4.10)	(0.75)
	Operating expenditure - Non Pay	(6.30)	(4.50)	1.81
	Misc non-operating items	(0.57)	(0.57)	(0.00)
	Income from patient activities	40.03	34.45	(5.58)
	Other Operating Income	1.81	2.22	0.41
	Finance income	0.00	0.03	0.02
	Finance expenditure	(0.08)	(0.07)	0.01
	Other gains/(losses)	0.00	0.00	0.00
Shared Corporate Services Total		**31.52**	**27.46**	**(4.07)**
Planned Care, Long Term Conditions and Diagnostics	Operating expenditure - Pay	(10.15)	(9.88)	0.27
	Operating expenditure - Non Pay	(4.72)	(5.68)	(0.96)
	Income from patient activities	2.18	7.66	5.48
	Other Operating Income	0.61	0.30	(0.31)
	Finance expenditure	(0.01)	(0.01)	0.00
Planned Care, Long Term Conditions and Diagnostics Total		**(12.09)**	**(7.61)**	**4.48**
Urgent & Emergency Care and Operations	Operating expenditure - Pay	(3.66)	(3.71)	(0.04)
	Operating expenditure - Non Pay	(0.35)	(0.61)	(0.26)
	Income from patient activities	0.72	0.77	0.05
	Other Operating Income	0.05	0.03	(0.02)
	Finance expenditure	(0.14)	(0.14)	0.00
Urgent & Emergency Care and Operations Total		**(3.38)**	**(3.66)**	**(0.28)**
Families, Community and Homes	Operating expenditure - Pay	(5.12)	(5.05)	0.07
	Operating expenditure - Non Pay	(10.30)	(10.74)	(0.44)
	Income from patient activities	1.66	1.92	0.26
	Other Operating Income	0.06	0.20	0.13
Families, Community and Homes		**(13.70)**	**(13.68)**	**0.03**
Grand Total		**2.32**	**2.31**	**(0.01)**

Pay Expenditure Run Rate – Month 03, June 2022



Non-Pay Expenditure – Month 03, June 2022



Risks and Mitigations

In M03 £2.7m CIP had been identified, of which £1.25m had been formally transacted and marked delivered against a year to date target of £5.36m, the additional £1.45m are subject to validation. The balance of undelivered CIP was offset by balance mitigations which is not a sustainable position to be in at M03.

In order to improve grip and control, the bi-weekly CIP delivery board is now in effect and monthly CIP Governance/Grip & Control meetings have been introduced at an individual ISU level. The focus of both of these meetings is on holding SROs/ISUs to account for the identification and delivery of CIP plans, together with alternative schemes where gaps to target exist, and key enabling actions.

ESRF income has been assumed at £0.83m year to date linking in with cost and activity performance. An increase is expected as schemes progress further. There may be changes to the ESRF at national level, further update will be provided as the position become clearer.

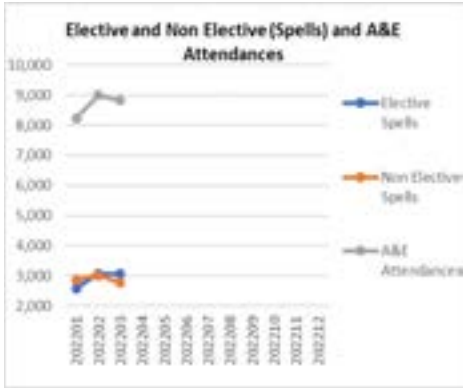
Forward Look

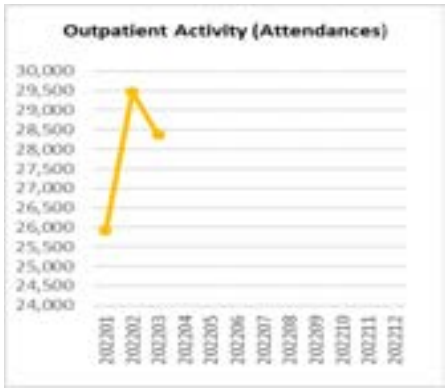
The Trust's final plan re-submitted on 20th June to NHSE/I illustrates a breakeven position for the year as required by regulators. The revised plan has been reflected in the budget from M03.

- The plan includes the delivery of an efficiency requirement at £28.5m, through transformation and Covid cost reduction initiatives. At this point in time, delays have already occurred against the original planned phased delivery.
- In addition, a list of targeted measures to breakeven were proposed under the revised plan. The executives have carried out a number of focused briefing sessions with ISU management and set out the requirement for delivery.
- Contract agreement is underway between the ICS and providers with a simplified and compliant approach on marginal contract set-up for ERF, which would include potential mitigation in the first instance via ICS / S256.
- The Hospital Discharge programme is planned to continue supported by S256 funding.
- Capital plans for 2022-23 and beyond have been developed and approved by FPDC in May, detailed schemes level prioritisation continues.
- System agency controls- agency cap to be held to, and diligence is underway in terms of the implications on the plan.
- Year to date ESRF spend is £830k, this may be subject to a claw back risk if the threshold is not achieved for the year. There may be further changes to ESRF funding regime, additional updates will be provided as the position become clearer.

Change in Activity Performance – Month 02 to Month 03

	Point of Delivery	April 22 Actual	May 22 Actual	June 22 Actual	% YTD vs Plan		Jun-19	Jun 19 v June 22 % change
Activity Drivers	Day Case	2,338	2,797	2,789	100%		*2,795*	100%
	Elective	246	277	252	112%		*285*	88%
	Outpatient New	7,431	8,205	7,991	95%		*8,640*	92%
	Total Elective	**10,015**	**11,279**	**11,032**	**96%**		***11,720***	**94%**
	F-Up	18,468	21,240	20,363	100%		*21,900*	93%
	Non-Elective	2,875	3,006	2,776	88%		*3,170*	88%
	A&E Attendances	8,238	8,991	8,819	100%		*10,227*	86%
	Grand Total	**39,596**	**44,516**	**42,990**	**98%**		***47,017***	**91%**
Bed Utilisation	Occupied beds DGH	10,465	11,188	10,709				
	Available beds DGH	11,164	12,000	11,359				
	Occupancy	94%	93%	94%				





Activity Drivers

- Overall ESRF performance from activity perspective is around 93% of 19/20 activity. The Aim is to achieve 104% of 19/20 value weighted activity levels this financial year with the support of £5.8m ESRF funding.
- The measurement of ESRF payment is based on weighted tariff values, the IT Datawarehouse team is working toward replicating the data script issued by the centre to enable the Trust to track ESRF £ performance on a monthly basis.
- There may be changes to the ESRF funding rules at national level, further update will be provided as the position become clearer.
- A&E Attendances– are slightly above plan but less than the 10,227 from June 2019. Whilst the A&E has been extremely busy, the waits have been long and some of the patients with minor ailments may have subsequently sought alternative sources for a remedy.
- Elective Spells – YTD 112% vs plan but 12% below 19/20 levels. Day case surgery has returned in May providing additional capacity and being successful in increasing capacity. However, to start making good progress against our planned recovery of waiting times, conversely, some of the ESRF programmes are below planned levels e.g. insourcing program.
- Non-Elective Spells – this is 12% below planned/19/20 levels, with ongoing investigations.
- Outpatient Attendance – essentially on plan but lower than 19/20 levels. Lack of capacity with clinical resources being diverted to manage ongoing covid and non-elective pressures, escalation being part of the limiting factor on meeting plan.

Bed utilisation

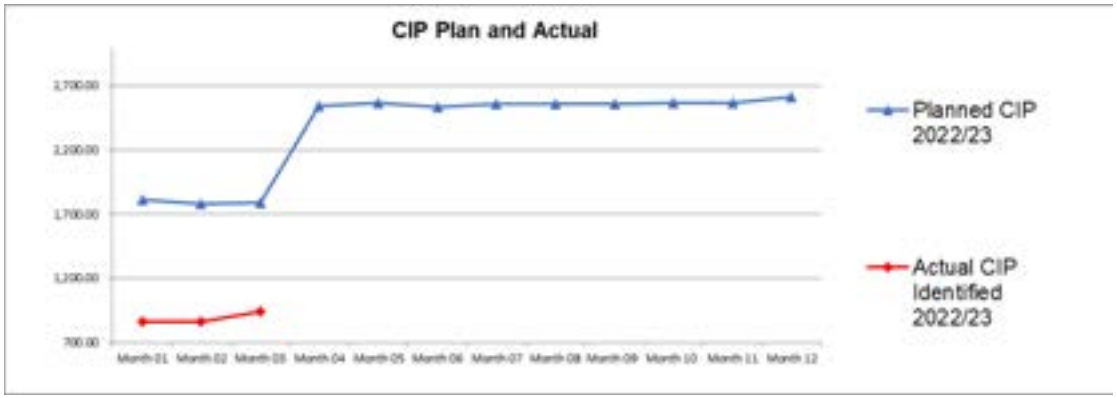
- In June, the overall bed occupancy at 94% remains above required levels to support timely patient flow to avoid emergency care delays. It is noted that the overall available beds have reduced with the closure of the escalation ward (11 beds) that required the decanting of the cancer day unit.
- The level of Covid-19 hospitalisations had remained low through most of June releasing some medical bed capacity for general use however in July we have seen these numbers increase significantly with the Trust experiencing a rapid increase in patients in hospital with covid and requiring isolation and associated IPC procedures. The levels of staff sickness also increasing rapidly putting increased pressure on staffing the available beds and critical clinical areas
- Work has also continued to focus on the number of discharge delays with recent improvements being sustained to manage the number of patients identified as medically fit and having no criteria to reside in an acute hospital bed.
- The ongoing bed pressures has meant timely access to a bed for medical and surgical emergencies has remained a constraint with some patients continuing to experience overnight stays in assessment units and Emergency Department. This also being a major factor in the continued high level of ambulance handover delays and long waits in the Emergency department. Trust has been in OPEL 4 escalation for 14 days and OPEL 3 for 15 days in June.

Key Drivers of System Positions – Month 03, June 2023

System	ISU	Financial Commentary / Key Drivers
Children & Family Health Devon	CFHD	Budget has been set on model option 2 for 2022/23. At M03, the Alliance generated a surplus and after the risk share calculation, TSD is benefiting from £209k surplus to the I&E. The actual expenditure run rate has remained constant. The proposed staffing model and clinical pathways consultation is live, with Senior Teams leading discussions on pathway options; this contributes to a current high level of vacancies which will not change until the consultation is concluded. SystemOne EPR revenue has been budgeted for but there is potential that the project may not commence until 2023/24 due to a change in TSD priorities and unavailability of IT resources; therefore, no costs are currently expected in this financial year.
Torbay Pharmaceuticals	PMU	TP sales in M03 is (£0.42m) lower than plan primarily due to lower contract manufacturer and NHS sales. Overall performance in month shows a profit below budget (£161k)
Corporate	EFM	Overspent at M03 by (£1.06m). Pay is overspent by (£535k) due to the cessation of additional domestic and porters recharged to Covid-19, and increased deep cleaning, escalation, ward opening and clinical demand; with an unachieved vacancy factor target of (£87k). Non-pay is overspent by (£54k) due to increased energy costs (£148k) offset by capital recharges. Income is overachieved by £148k mainly due to increase lease rental on the Level 4 outlets coming back to contractual levels after Covid-19 reductions. There were also increases in patient/visitor car parking charges and meal sales. Unachieved CIP target of (£527k).
	Exec. Directors	Underspent by £133k. Pay is underspent by £261k mainly due to issues in recruitment and retention within HIS of £172k, Education and Training vacancies £113k, including Registered Nursing Degree Apprentices reduced backfill £63k, Director of Nursing & Quality international nurses supernumerary pay costs £38k and £31k pension rebate. Medical Director (£158k) CEA award accrual. Non-pay is overspent by (£64k) mainly due to (£291k) international nurses recruitment costs in the People Directorate, Tableau reporting licences (£25k); offset by underspends in Devon IR Alliance £154k and apprenticeship levy usage £48k both offset in income. Income has overachieved by £298k mainly due to Q1 Health Education England (HEE) income regarding medical training and education £209k, VAT reclaim £102k, Director of Nursing secondment £52k, other secondments/pay funding £96k; offset by reductions in Devon IR Alliance (£154k) and apprenticeship levy usage (£48k) both offset in non-pay. Unachieved CIP target of (£367k).
	Financing Costs	Excluding items outside the NHSE control total, costs are £0.7m favourable to plan. This is principally due to fixed assets being brought into service later than planned, resulting in a reduced depreciation charge.
	Other	Reserves includes plan adjustments, provisions for FNC backlog, legal fees, annual leave accrual, miscellaneous and other small provisions. Year to date balance sheet release for planned breakeven position £4.20m Recovery costs have been allocated to a central budget to allow better analysis of expenditure. In M03 there is an underspend of £330k, budget has now been allocated correctly to the recovery areas. Costs are expected to increase as recovery plans come into place.
Families, Community and Home	Torquay	Against a budget of (£10.70m) there is a YTD overspend of (£202k) which is mainly driven by an overspend of (£209k) on intermediate care placements within the Torbay area caused by a number of highly complex cases requiring care, way in excess of the previous six week maximum.

	Moor to Sea	Against a budget of (£5.9m) there is a YTD overspend at M03 of (£208k). Pay is overspent (£20k) however ward bank and agency costs due to delayed recruitment and care of the elderly senior medical pay costs are overspent by (£318k), offset by underspends in community services vacant posts £297k. Non-pay is overspent (£259k) and is driven by an adverse CIP target of (£258k) to date. There is favourable position of £56k other income partially offsetting pay overspends.
	Independent Sector	Against a budget of (£24.79m) there is a minor YTD overspend of (£84k). Despite a challenging CIP target, a near breakeven position is being achieved by a combination of high number of Direct Payment reclaims (volume & value) combined with a lower level of ASC short stay placements than previously anticipated (short stay placements primarily are processed and paid during / after placement).
Urgent & Emergency Care and Operations	Newton Abbot	Overspent at M03 (£1.527m) against budget. Pay is overspent (£1.115m) due to ongoing cost pressures in ED (£804k) and Acute Medicine (£345k). This is reflected by high Medical Locum, Bank and Nursing Agency spend in these areas including Gen Med Junior Doctors, and is offset with pay underspends due to vacancies. Non-pay overspend (£421k) mainly undelivered CIP (£317k) and ED volume related non-pay costs (£104k). Decreased run rate from previous month, and above average for last quarter in Acute Medicine and ED temporary staffing costs covering further vacancies and absence.
	Shared Operations	Overspent M03 (£72k) against budget. Pay overspent (£23k); unfunded TIF posts due to delayed recruitment. Non-pay overspends (£69k) mainly transport (£60k) and adverse CIP target (£60k), offset with underspends in HSDU £45k. Other income £20k more than planned. Non-pay run rates decreased from previous months mainly due to security services and medical electronics, but broadly consistent with previous quarter average excluding year-end adjustments.
Planned Care, Long Term Conditions & Diagnostics	Paignton and Brixham	Excluding Clinical income there is a YTD overspend of (1.4m). Overspend is primarily driven by not being able to fully achieve the savings target of (£397k) although £324k savings have been transacted, pass through and high cost drug expenditure (£759k) and staffing wards due to agency expenditure (£150k). Overall there is little movement from the previous month's pay run rate, but with some reductions in agency usage offset with an increase in radiography costs. Non-pay run rates have reduced mainly due to lab covid testing.
	Coastal	Excluding clinical income there is an overspend at M03 by (761k) against budget. Pay is underspent £253k which consists of savings due to vacant posts £681k and offset with ward agency costs to cover absence, and Medical locum costs mainly to cover vacant posts (509k). Non-pay is overspent (£37k) mainly due to medical and surgical supplies. Pass through drugs is overspent (£330k) (income adjusted to offset) and there is an adverse CIP variance (£585k) although £100k savings have been transacted. Pay run rates have reduced mainly due to recoding of radiology costs but remain relatively constant compared to an average of the previous quarter. Non-pay costs have increased compare to the previous month in medical and surgical sundries but are also relatively constant based on the previous quarter. ERF recovery schemes are recorded centrally and not within this ISU.
Contract Income	Patient Income	The Trust has received the following income in M03: 1) Income assumed for Elective Recovery Funding in M03 and year to date is £830k. 2) C.£0.276m additional income assumed via the CCG relating to the Hospital Discharge Programme (HDP) and year to date £0.83m. There is a corresponding cost to offset this. 3) Nothing relating to grants has been received or assumed from Torbay Council.

CIP- Month 03, June 2022



CIP

Phased delivery of the efficiency plan for the first quarter is £5.39m. Per the Trust's April planning submission, the split of the £5.39m target as at M03 is:

- Pay related - £3.86m
- Non-pay related - £1.22m
- Income related - £0.30m

A number of the pay related efficiency schemes have yet to commence, but are due to deliver after the end of the first quarter. The Trust's actual financial performance for M03 would suggest a potential shortfall of £2.72m (c. 50%) against the efficiency target, predominantly linked to the position on pay, with delivery to date viewed as:

- Pay related - £1.24m
- Non-pay related - £1.35m
- Income related - £0.08m

Through slippage in other areas of spend, together with non-recurrent benefits, the Trust is able to report a position in line with plan at Month 3. However, it should be noted that it's too early in the financial year to commit to using these to offset the shortfall on CIP, as the flexibilities can only be utilised once and may be required to support/offset other issues during the course of the year.

Based on the Month 3 position, the initial end of year forecast for CIP delivery is estimated at c. £13.1m (c. 46%) against the full £28.5m target. As previously reported, the traditional CIP element of the efficiency programme (£18.1m) is due to be delivered via a combination of cross-cutting (Trust wide) and local ISU/Department schemes. Plans are already in place for a number of the cross-cutting schemes, some of which are due to commence after the end of the first quarter, but of key concern is the delivery of key actions/pace of delivery and the identification of alternative schemes to address gaps to target.

Cash Position – Month 03, June 2022

	Plan £m	M03 Actual £m	Variance £m
Opening cash balance	**39.34**	**39.34**	**0.00**
Capital Expenditure (accruals basis)	(8.23)	(7.36)	0.88
Capital loan/PDC drawndown	0.00	0.00	0.00
Capital loan repayment	(0.82)	(0.99)	(0.17)
Proceeds on disposal of assets	0.00	0.00	0.00
Movement in capital creditor	(11.00)	(9.32)	1.68
Other capital-related elements	(0.79)	(1.13)	(0.34)
Sub-total - capital-related elements	**(20.85)**	**(18.80)**	**2.05**
Cash Generated From Operations	4.67	3.76	(0.91)
Working Capital movements - debtors	(1.04)	(5.97)	(4.93)
Working Capital movements - creditors	(3.77)	(2.10)	1.66
Net Interest	(0.77)	(0.72)	0.05
PDC Dividend paid	0.00	0.00	0.00
Other Cashflow Movements	6.00	6.00	0.01
Sub-total - other elements	**5.09**	**0.97**	**(4.12)**
Closing cash balance	**23.59**	**21.51**	**(2.07)**

Better Payment Practice Code	Paid year to date	Paid within target	% Paid within target
Non-NHS - number of bills	38,924	32,569	83.7%
Non-NHS - value of bills (£k)	87,968	73,696	83.8%
NHS - number of bills	486	306	63.0%
NHS - value of bills (£k)	8,275	6,142	74.2%
Total - number of bills	39,410	32,875	83.4%
Total - value of bills (£k)	96,243	79,838	83.0%

Key points of note:

- Capital-related cashflow is £2.1m favourable to plan. This is largely due to accruals capital expenditure behind plan £0.9m and the capital creditor having been paid down £1.7m less than planned.
- Debtor movements is £4.9m adverse. This is largely due to increased debtors with the ICB, LVA debtors and delayed Covid reimbursement.
- Creditor movements is £1.7m favourable.
- Other Cashflow Movements £6.0m largely consists of £6.3m of revenue support PDC, which was drawn down in June, in line with plan. The Trust's working capital position is due to improve from August onwards, following the ICB's agreement to pay block income to the Trust on the 1st day of the month rather than the 15th. This improvement in working capital should offset the ongoing reduction in the Trust's cash position for a number of months. Revenue support PDC has therefore not been sought for August. The potential need for revenue support PDC for September will be reviewed during August alongside a thorough I&E cash forecasting exercise.

Statement of Financial Position (SoFP) – Month 03, June 2022

	Month 03		
	Plan £m	Actual £m	Variance £m
Non-Current Assets			
Intangible Assets	11.52	11.47	(0.05)
Property, Plant & Equipment	215.93	215.52	(0.41)
On-Balance Sheet PFI	17.52	17.48	(0.04)
Right of Use assets	19.72	20.16	0.44
Other	1.44	1.49	0.06
Total	**266.13**	**266.13**	**(0.00)**
Current Assets			
Cash & Cash Equivalents	23.59	21.51	(2.07)
Other Current Assets	42.28	46.19	3.91
Total	**65.87**	**67.70**	**1.84**
Total Assets	**332.00**	**333.83**	**1.84**
Current Liabilities			
Loan - DHSC ITFF	(3.87)	(3.87)	(0.00)
PFI / LIFT Leases	(1.30)	(1.31)	(0.01)
Trade and Other Payables	(56.68)	(55.98)	0.70
Other Current Liabilities	(11.99)	(14.35)	(2.36)
Total	**(73.84)**	**(75.51)**	**(1.66)**
Net Current assets/(liabilities)	**(7.98)**	**(7.80)**	**0.17**
Non-Current Liabilities			
Loan - DHSC ITFF	(24.39)	(24.22)	0.17
PFI / LIFT Leases	(14.97)	(14.96)	0.01
Other Non-Current Liabilities	(22.05)	(22.28)	(0.23)
Total	**(61.41)**	**(61.46)**	**(0.05)**
Total Assets Employed	**196.75**	**196.87**	**0.12**
Reserves			
Public Dividend Capital	156.66	156.66	0.00
Revaluation	51.54	51.54	0.00
Income and Expenditure	(11.45)	(11.33)	0.12
Total	**196.75**	**196.87**	**0.12**

Key points of note:

- Non-current assets are in line with plan. Capital expenditure is £0.9m lower than plan, offset by depreciation also lower than plan.
- Cash is £2.1m lower than planned, as explained in the commentary to the cashflow statement.
- Other current assets are £3.9m higher than planned. This is principally due to increased debtors with Devon ICB £2.1m (principally due to funding for inflation and risk share), Low Volume Activity (LVA) funding £0.8m and delayed Covid reimbursement funding £0.7m.
- Trade and other payables are £0.7m lower than planned. This is principally due to a decrease in general payables £2.9m following a reappraisal of balance sheet prudence, partly offset by capital creditors £1.7m higher than plan.
- Other Current Liabilities are £2.4m higher than planned, largely due to a delay in the planned unwinding of deferred income, partly offset by £0.3m reduction following review of balance sheet prudence.

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.

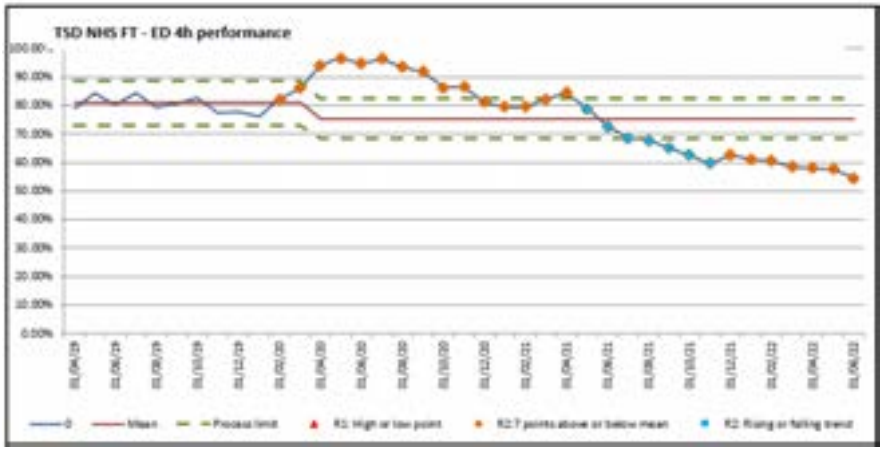
The main aims of Statistical Process Control (SPC) charts is to understand what is 'different' and what is the 'norm'. SPC charts can help to:

- '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.

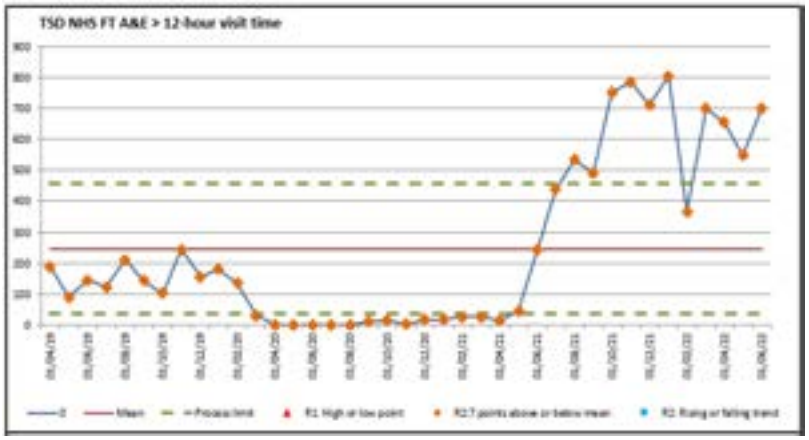
Control limits are the standard deviations located above and below the centre line of an SPC chart. If the data points are within the control limits, it indicates that the process is in control (common cause variation). If there are data points outside of these control units, it indicates that a process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

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

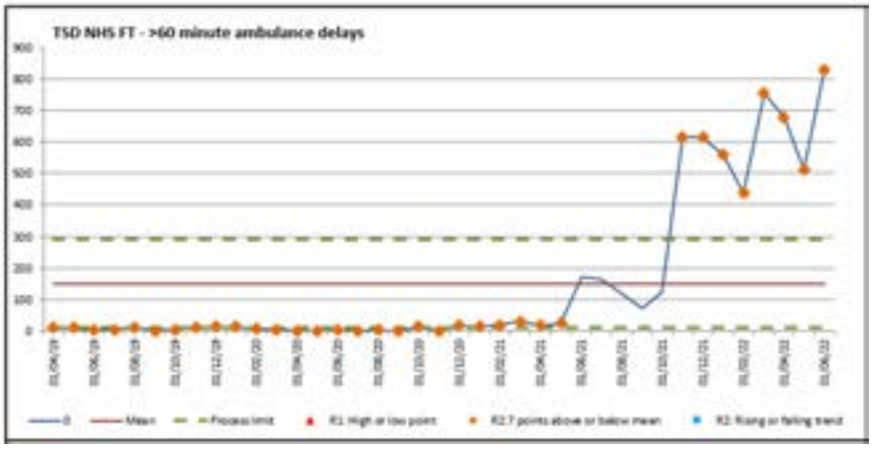
ED 4 hour performance



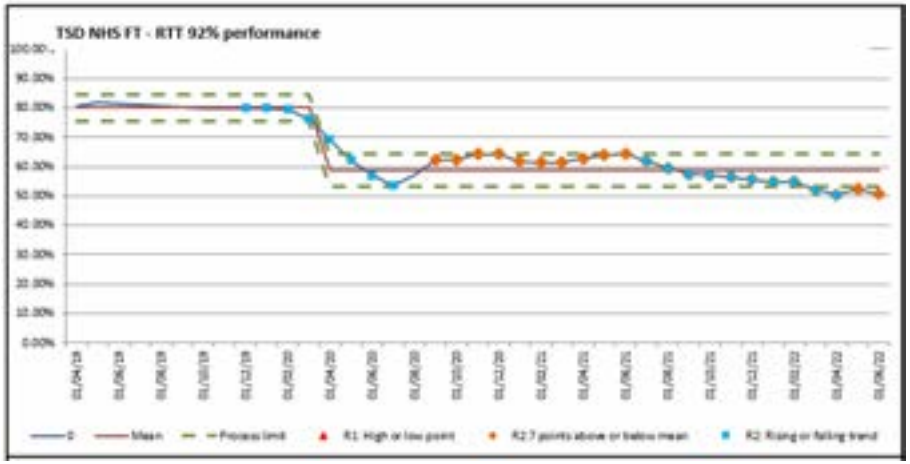
12- hour visit time



Greater than 60-minute ambulance handover delays

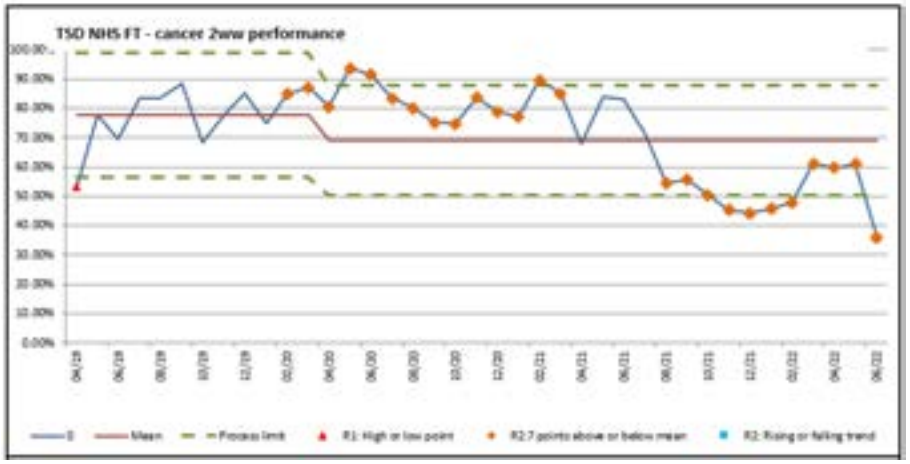


Referral To Treatment

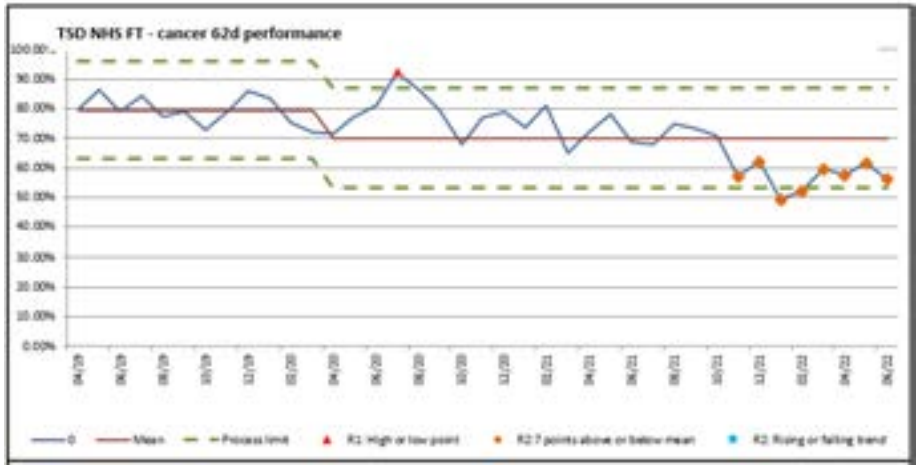


Diagnostics performance

Cancer 2-week-wait performance



Cancer 62-day performance



	ISU	Target	13 month trend	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		4	2	2	0	1	3	0	4	4	4	2	3	2	7
Reported Incidents - Death	Trustwide	<1		1	2	0	0	1	5	0	2	0	3	2	1	0	3
Medication errors resulting in moderate harm	Trustwide	<1		1	0	0	0	0	0	0	1	1	1	1	1	0	2
Medication errors - Total reported incidents	Trustwide	N/A		57	47	38	47	58	46	59	43	56	54	57	62	56	175
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		0	2	0	0	1	1	0	0	0	1	0	0		0
Never Events	Trustwide	<1		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		11	8	8	6	1	12	12	6	13	9	8	10	8	26
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	2	0	0	0	2	1	0	0	2	0	2
Formal complaints - Number received	Trustwide	<60		15	18	17	11	11	10	9	16	11	12	12	12	7	31
VTE - Risk Assessment on Admission (acute)	Trustwide	>95%		88.6%	94.4%	92.9%	91.9%	91.8%	96.2%	95.1%	94.8%	95.2%	94.4%	91.3%	89.7%	90.0%	90.3%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		106.6	108	110.2	108.4	109.6	108.1	107.5	107.3	109.1	112.3				0
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		87.1%	89.5%	87.0%	81.9%	81.9%	89.3%	87.81%	86.8%	88.3%	90.0%	89.0%	96.1%	95.8%	95.8%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		89.4%	93.4%	88.0%	74.6%	74.6%	83.7%	60.32%	77.8%	78.8%	79.3%	79.7%	86.5%	88.1%	88.1%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		381	24	8	42	476	218	285	71	49	203	30	12	130	172
Hand Hygiene	Trustwide	>95%		97.6%	98.9%	97.1%	96.5%	98.5%	96.2%		99.1%	95.3%	98.7%	94.5%	92.3%	94.5%	93.7%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		84.8%	91.2%	82.1%	81.0%	82.1%	60.0%	68.6%	77.4%	78.4%	76.9%	67.9%	65.8%	66.7%	
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		66.1%	51.4%	56.3%	69.2%	35.9%	52.8%	50.0%	18.2%	59.0%	28.1%	35.3%	67.6%	34.1%	46.9%
Mixed Sex Accommodation breaches	Trustwide	0								0	0	0	0	0	0	0	0
Follow ups 6 weeks past to be seen date	Trustwide	6400		16323	16967	17651	17789	18231	18069	19797	20026	20496	21388	22516	22215	22158	22158
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		4.1%	4.1%	4.2%	4.4%	4.5%	4.6%	4.7%	4.8%	5.0%	5.3%	5.6%	5.6%		4.1%
Appraisal Completeness	Trustwide	>90%		84.7%	81.3%	80.6%	79.7%	77.9%	79.2%	78.6%	76.1%	75.2%	71.9%	71.3%	73.9%	75.2%	75.2%
Mandatory Training Compliance	Trustwide	>85%		90.5%	89.5%	89.4%	89.0%	89.0%	88.8%	88.4%	88.6%	89.2%	89.5%	89.6%	89.8%	90.1%	90.1%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		11.3%	11.0%	11.7%	11.3%	11.6%	11.5%	12.0%	12.6%	12.9%	13.4%	13.2%	13.6%	13.7%	

	ISU	Target	13 month trend	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Children with a Child Protection Plan (one month in arrears)	Trustwide	NONE SET		201	171	165	147	147	145	143	154	167	156	0	0	0	0
4 Week Smoking Quitters (reported quarterly in arrears)	Trustwide	NONE SET		110			189	0	0	264	0	0	0	0	0	0	365
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%		4.3%			5.2%			5.4%			6.5%				
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		629	631	564	546	604	590	628	644	623	645	671	664	705	671
Intermediate Care - No. urgent referrals	Trustwide	113		129	158	191	241	222	237	219	195	213	212	175	196	213	214
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		292	297	233	229	243	191	200	202			265	241	213	265
Urgent Community Reponse (2-hour) - Referrals	Trustwide	NONE SET						32	43	40	20	37	30	31	24		55
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	70%						68.8%	60.5%	77.5%	50.0%	70.3%	53.3%	41.9%	70.8%		54.5%
Urgent Community Reponse (2-48 hour)- Referrals	Trustwide	NONE SET						128	127	120	123	149	170	113	134		1064
Urgent Community Reponse (2-48 hour) - Target achievement	Trustwide	NONE SET						86.7%	89.8%	93.3%	89.4%	84.6%	90.0%	90.3%	92.5%		83.1%
ADULT SOCIAL CARE TORBAY KPIs																	
Proportion of clients receiving self directed support	Trustwide			71.0%	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%
Proportion of carers receiving self directed support	Trustwide	94%		98.3%	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%
% Adults with learning disabilities in employment	Trustwide	7%		7.4%	7.4%	7.1%	7.1%	6.8%	7.0%	6.8%	6.7%	6.6%	7.1%	7.3%	7.3%	7.3%	7.3%
% Adults with learning disabilities in settled accommodation	Trustwide	80%		98.3%	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%
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		23.1	17.7	19.0	17.7	17.7	20.4	23.1	25.8	19.0	21.7	24.5	29.9	35.3	24.5
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		487.3	498.1	511.5	449.6	422.7	411.9	376.9	487.3	476.5	570.8	576.2	823.8	880.4	576.2
Proportion of clients receiving direct payments	Trustwide	25%		19.5%	19.6%	19.5%	19.0%	19.4%	19.4%	19.6%	19.4%	19.6%	19.8%	19.5%	19.4%	19.6%	19.5%
% reablement episodes not followed by long term SC support	Trustwide	83%			85.9%	87.1%	87.4%	87.9%	87.9%	87.7%	88.0%	87.8%	88.9%	84.5%	86.8%	89.6%	84.5%
NHS I - OPERATIONAL PERFORMANCE																	
A&E - patients seen within 4 hours	Trustwide	>95%		72.6%	68.6%	67.6%	65.1%	62.5%	59.8%	62.5%	61.1%	60.6%	58.4%	58.0%	57.6%	54.5%	56.7%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		64.4%	61.7%	59.4%	57.4%	57.0%	56.5%	55.6%	54.7%	54.7%	52.0%	50.4%	52.3%	50.6%	50.6%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		68.8%	67.8%	75.0%	73.3%	70.5%	57.0%	61.9%	49.1%	52.1%	59.5%	57.8%	61.5%	56.4%	56.4%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		32.2%	31.7%	32.2%	32.6%	33.8%	32.4%	37.9%	41.3%	38.4%	36.8%	33.9%	32.0%	30.1%	30.1%
Dementia - Find - monthly report	Trustwide	>90%		97.4%	97.8%	97.2%	92.7%	94.4%	95.0%	87.3%	94.8%	89.7%	93.6%	91.6%	94.6%	84.1%	90.3%

	ISU	Target	13 month trend	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Number of Clostridium Difficile cases reported	Trustwide	<3		2	5	8	2	1	2	6	6	3	7	2	4	4	10
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		83.0%	71.3%	54.6%	55.6%	50.5%	45.2%	44.3%	45.6%	48.1%	61.1%	59.6%	60.9%	35.6%	35.6%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		56.7%	91.0%	77.8%	92.4%	95.1%	79.8%	82.5%	38.6%	71.4%	81.0%	76.8%	77.8%	41.7%	41.7%
Cancer - 28 day faster diagnosis standard	Trustwide			76.0%	76.4%	77.4%	60.6%	58.8%	52.5%	52.8%	55.2%	73.1%	75.0%	76.9%	67.6%	64.8%	64.8%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		98.5%	97.5%	98.8%	99.4%	98.2%	96.7%	96.8%	94.8%	96.5%	97.4%	92.6%	90.7%	96.0%	96.0%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	97.3%	98.6%	98.3%	100.0%	100.0%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		97.0%	98.3%	96.4%	98.6%	98.4%	100.0%	100.0%	97.1%	98.3%	93.8%	94.7%	92.6%	95.5%	95.5%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		97.7%	100.0%	97.3%	100.0%	100.0%	97.1%	100.0%	96.4%	91.7%	82.9%	100.0%	95.5%	87.5%	87.5%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		85.7%	78.6%	92.3%	71.4%	87.5%	82.4%	77.8%	72.7%	85.7%	80.0%	70.4%	66.7%	92.9%	92.9%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			10	10	13	15	29	14	26	27	39	39	33	65	61	61
RTT 52 week wait incomplete pathway	Trustwide	0		1562	1648	1799	1943	2093	2169	2384	2584	2759	3199	3374	3765	4137	4137
RTT 78 week wait incomplete pathway	Trustwide	0		330	377	458	580	641	572	477	532	587	649	763	779	813	813
RTT 104 week wait incomplete pathway	Trustwide	0		13	23	42	71	100	116	126	147	182	213	245	192	173	173
On the day cancellations for elective operations	Trustwide	<0.8%		1.2%	1.7%	0.5%	0.5%	1.2%	2.6%	1.3%	1.4%	0.9%	0.9%	1.6%	1.1%	1.3%	1.3%
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		3	10	17	5	3	30	12	6	8	11	12	5	9	26
Virtual outpatient appointments (non-face-to-face) - 1 month in arrears	Trustwide	25%		19.1%	20.0%	19.6%	20.3%	20.5%	21.1%	19.3%	20.7%	21.3%	18.8%	19.6%	20.9%	20.9%	
Bed Occupancy	Acute	90.0%		89.0%	85.0%	87.0%	92.0%	95.0%	95.0%	93.0%	93.0%	94.0%	95.0%	94.0%	93.0%	94.0%	97.6%
No Criteria to Reside - daily average - weekday (ICO)	Trustwide	No target			45.4	57.8	55.6	61.7	66.1	87.8	101.1	80.2	70.4	70.3	46.0	45.1	
Number of patients >7 days LoS (daily average)	Trustwide			120.5	129.4	154.4	149.1	148.4	145.7	157.0	183.0	165.0	172.0	171.6	166.0	173.0	170.2
Number of extended stay patients >21 days (daily average)	Trustwide			25.0	26.3	41.5	43.9	43.6	39.9	48.0	64.0	60.6	50.0	45.6	38.5	43.0	42.4
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		380	421	266	219	285	959	952	889	727	1026	967	894	1081	2942
Ambulance handover delays > 60 minutes	Trustwide	0		173	165	120	72	125	617	616	559	438	757	680	514	832	2026
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			246	438	534	491	753	788	712	806	364	701	656	548	702	1906
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		32	157	188	69	130	139	162	131	123	202	155	68	178	401
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		2	4	7	2	1	1	3	5	1	5	2	3	4	9
Number of Clostridium Difficile cases - (Community)	Trustwide	0		0	1	1	0	0	1	3	1	2	2	0	1	0	1
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		57.5%	60.6%	74.1%	77.3%	74.5%	72.0%	63.0%	69.2%	75.2%	72.1%	71.1%	71.0%	64.7%	68.6%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		32.4%	34.2%	46.6%	46.4%	45.5%	50.7%	39.2%	36.7%	52.8%	48.6%	50.0%	52.2%	50.8%	51.1%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		66.5%	69.8%	69.0%	73.0%	67.7%	67.8%	69.1%	74.6%	67.7%	66.0%	69.5%	65.4%	69.5%	69.5%

	ISU	Target	13 month trend	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			2551	2438	1240	-367	-327	-401	-609	-845	-955	-2025	-187	718	-914	
Agency - Variance to NHSI cap	Trustwide			-1.80%	-2.10%	-2.10%	-2.10%	-2.10%	-2.00%	-2.00%	-1.80%	-1.60%	-1.40%	-2.00%	-2.40%	-2.40%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide							-332	-593	-833	-659	-222	248	-1812	-1873	-2717	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			3206	4292	5275	9080	12336	16029	19492	20987	15148	15919	-57	1977	814	
Distance from NHSI Control total (£'000's)	Trustwide			2621	2638	1539	7	8	-13	37	153	88	-59	-5	1286	-3070	
Risk Share actual income to date cumulative (£'000's)	Trustwide			0	0	0	0	0	0	0	0	0	0	0	0	0	
ACTIVITY VARIANCE vs 2019/20 BASELINE																	
Outpatients - New	Trustwide			0.8%	-20.1%	-14.2%	-4.5%	-19.0%	1.9%	-4.2%	-18.5%	-7.1%	22.4%	-16.3%	-13.8%	-7.5%	-12.6%
Outpatients - Follow ups	Trustwide			-0.8%	-13.0%	-10.1%	-5.8%	-19.0%	-2.7%	-6.9%	-22.2%	-15.2%	19.3%	-13.4%	-5.5%	-7.0%	-8.6%
Daycase	Trustwide			5.3%	-12.1%	-18.4%	-4.5%	-20.6%	-11.7%	-12.6%	-22.3%	-15.8%	17.0%	-17.7%	-10.4%	-0.4%	-9.6%
Inpatients	Trustwide			-15.4%	-33.1%	-35.2%	-24.4%	-25.8%	-37.0%	-33.8%	-47.5%	-38.8%	-23.4%	-9.2%	-8.8%	-7.0%	-8.3%
Non elective	Trustwide			8.2%	4.1%	-5.1%	-0.8%	-7.9%	-9.6%	-14.9%	-12.2%	-10.3%	12.3%	-11.4%	-11.5%	-12.5%	-11.8%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			574	560	472	525	511	537	504	540	554	550	514	541	503	
Intermediate Care GP Referrals	Trustwide			95	94	78	80	78	75	74	64	94	87	89	88	94	
Average length of Intermediate Care episode	Trustwide			12.42	16.36	13.46	14.57	12.19	12.20	14.10	13.60	15.60	15.60	15.70	14.30	14.50	

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: July 2022 Mortality Score Card			Meeting date: 27 July 2022
Report appendix	List any supplementary information as shown below: Appendices 1 to 5		
Report sponsor	Medical Director		
Report author	Medical Director		
Report provenance	The report will go to the next Mortality Surveillance Group meeting 11/08/2022 and Quality Improvement Group Meeting 16/08/2022		
Purpose of the report and key issues for consideration/decision	The report is for bi-monthly assurance to ensure learning from deaths		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	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**	
Risk Register		**Risk score**	

External standards affected by this report and associated risks

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

Report title: Mortality Surveillance Score Card		Meeting date: 27th July 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)		Dr Foster latest benchmark Month	Below the 100 line with an aim for a yearly HSMR ≤90	Mar 2022 106.3 12-month average 112.3
• B. Summary Hospital Mortality Index (SHMI)	Mortality	DH SHMI data		103.2 (Feb 21 – Jan 22) NHS Digital
Appendix 2 • Unadjusted Mortality Rate • By number • By location		Trust Data ONS Data	Yearly Average ≤3%	2.80%
Appendix 3 • Mortality Analysis		Trust Data Dr Foster DH HSMR data	CUSUM alerts greater than 1 in last 12 months	2
Appendix 4 • Mortality Reviews and Learning		Trust Data		

2.0 Trust Wide Summary

The Hospital Standardised Mortality Rate (HSMR) is above the expected level of 100 for our population for March 2022. The rolling 12-month position exceeded the expected range for the 12-months to March 2022 with a relative risk of 112.3 against a 100 benchmark. The rolling 12-month trend shows that the HSMR became statistically higher than expected in July 2021 and has continued to increase since this point. The Trust's HSMR is one of 6 trusts in our peer comparator which are statistically higher than expected out of 15 Trusts.

The Trust's average palliative care coding rate has increased over time and is now only slightly lower than the national rate (4.75% vs a national average of 4.84%). The Trust has a slightly lower than average Charlson co-morbidity upper quartile rate (98 vs national average of 100) and this depth of coding has increased over the last year. Overall the Trust reports a higher percentage of spells in the 'Symptoms and Signs' chapter (12.0% v 7.4% national). This may impact by reducing the overall expected mortality rate.

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

Appendix 1 – Hospital Mortality

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

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

1A The HSMR is based on the *Diagnosis all* Groups using the December 2020 monthly benchmark and analysed by Relative Risk - Trend / Month

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

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

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Chart 1 - HSMR by Month April 2021 to March 2022 (latest month available)
Chart one (as below) shows a longitudinal monthly view of HSMR.

The latest month's data, March 2022, has a relative risk of **106.3** (basket of 56 diagnostic groups) and is above the 100 average. There is a rise in mortality during last summer May to August 2021 and a further rise in winter December 2021 to February 2022.

The rolling 12 month position is shown below showing the cumulative position of the high monthly relative risk reported over the last 11 months

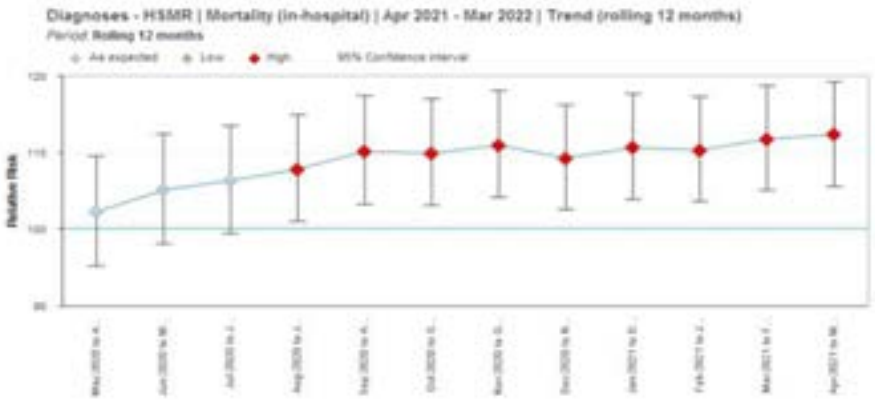


Chart 2 Peer Comparison, as below, highlights HSMR mortality by peer comparison, across the South West, using a 12-month annual total. This shows Torbay and South Devon as having one of the higher rates against peers.

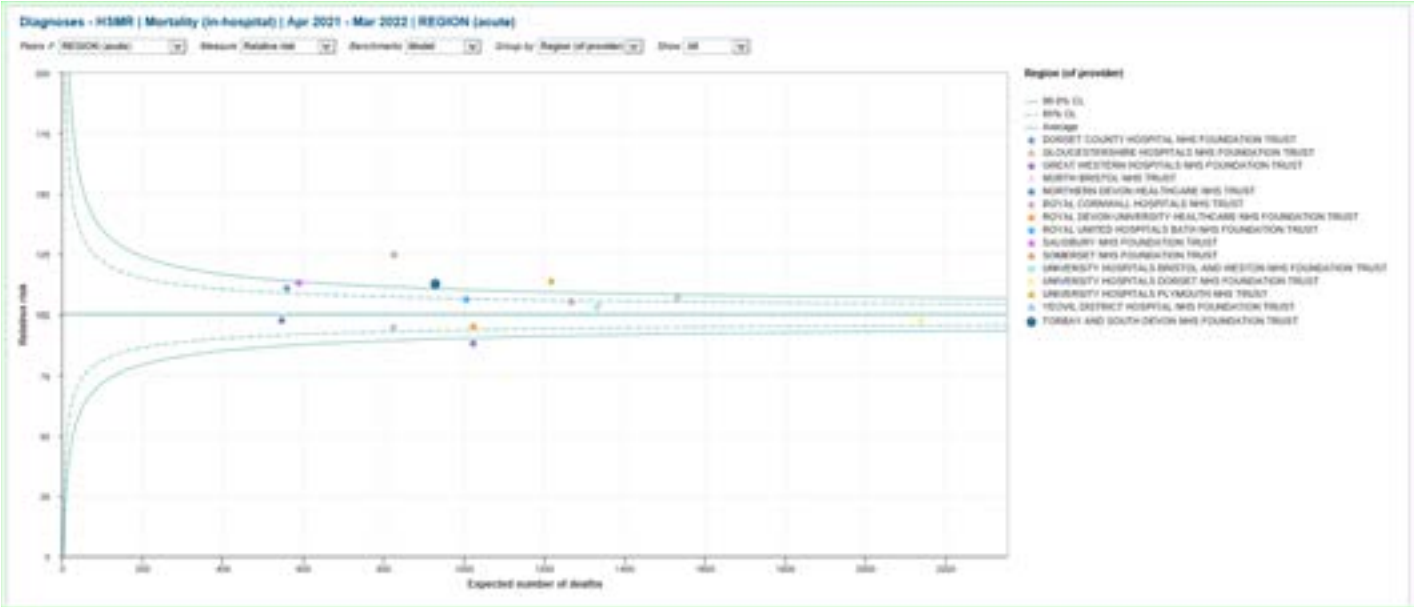
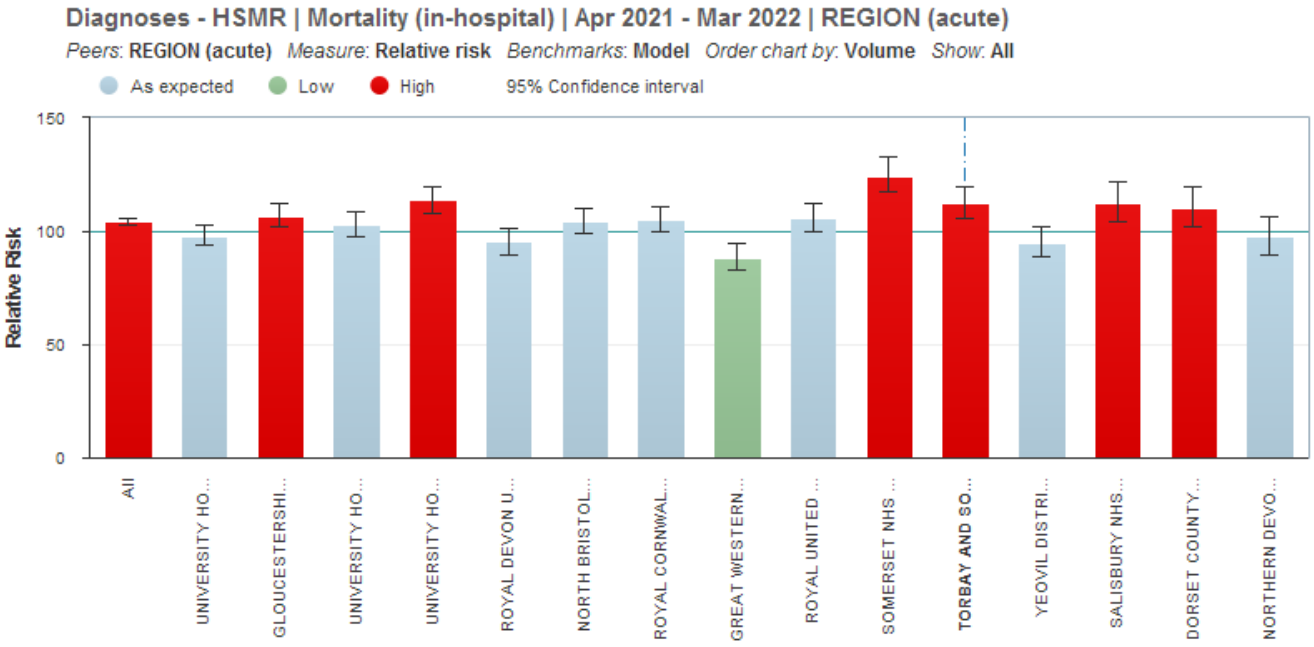


Chart 3 displays the above data as a peer comparison as a bar chart.
The 12-month average HSMR for Torbay and South Devon is flagging red as the lower confidence interval is just above the 100 benchmark.



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* **December 2020 –November 2021** *data period and is different to HSMR.*

Chart 4, as below, highlights SHMI by quarterly periods with all data points and confidence intervals within the expected range except two, which exceeds the average 100 relative risk mark. The first flag is Q1 2020/21 and relates to the first wave of Covid-19. The second flag for Q2 2021/22 with no significant cause identified. No further updates are currently available via Telstra Health.

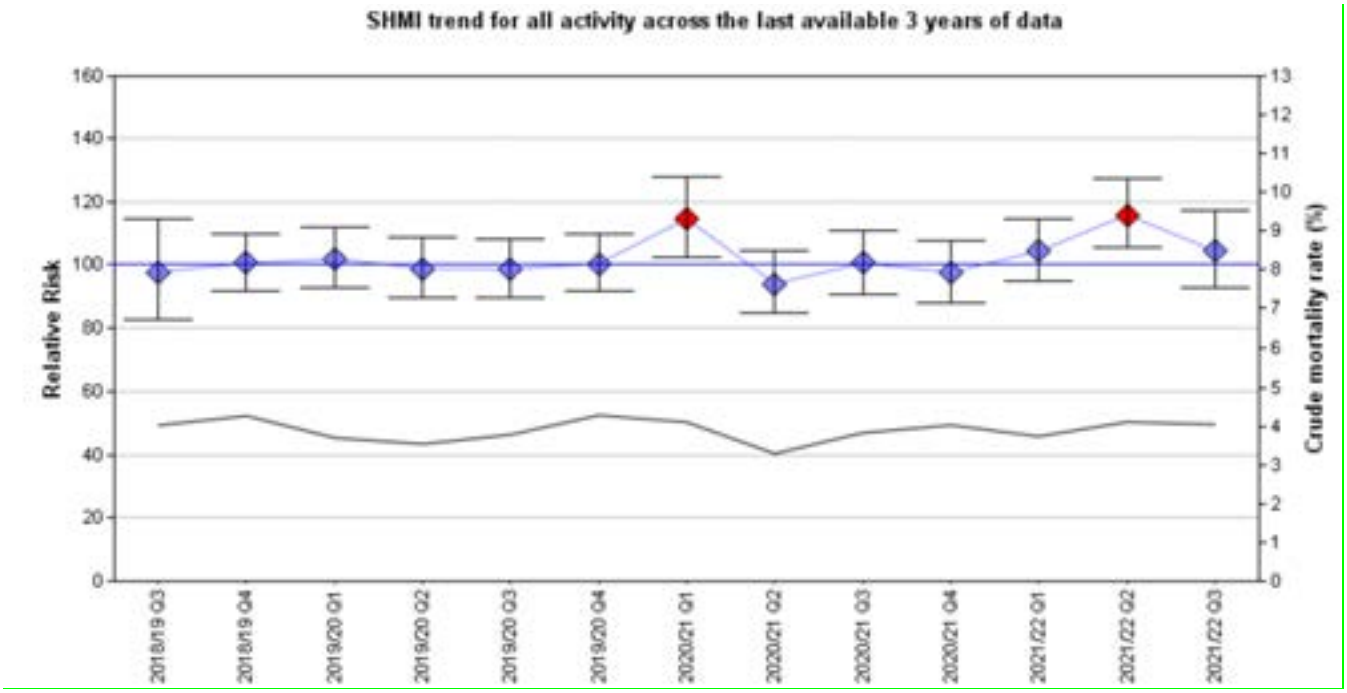


Chart 5 (as below) details SHMI all deaths, SHMI in hospital deaths, and HSMR comparison. The HSMR and SHMI demonstrate a consistent comparison. Confidence intervals are triggering a higher than expected range. No further updates are currently available via Telstra Health.

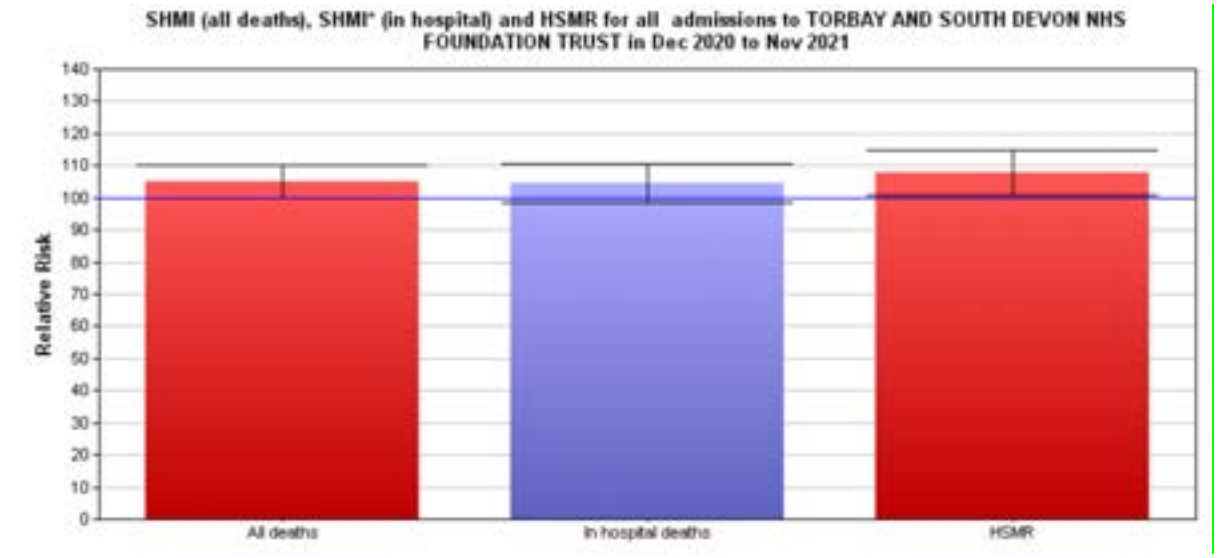
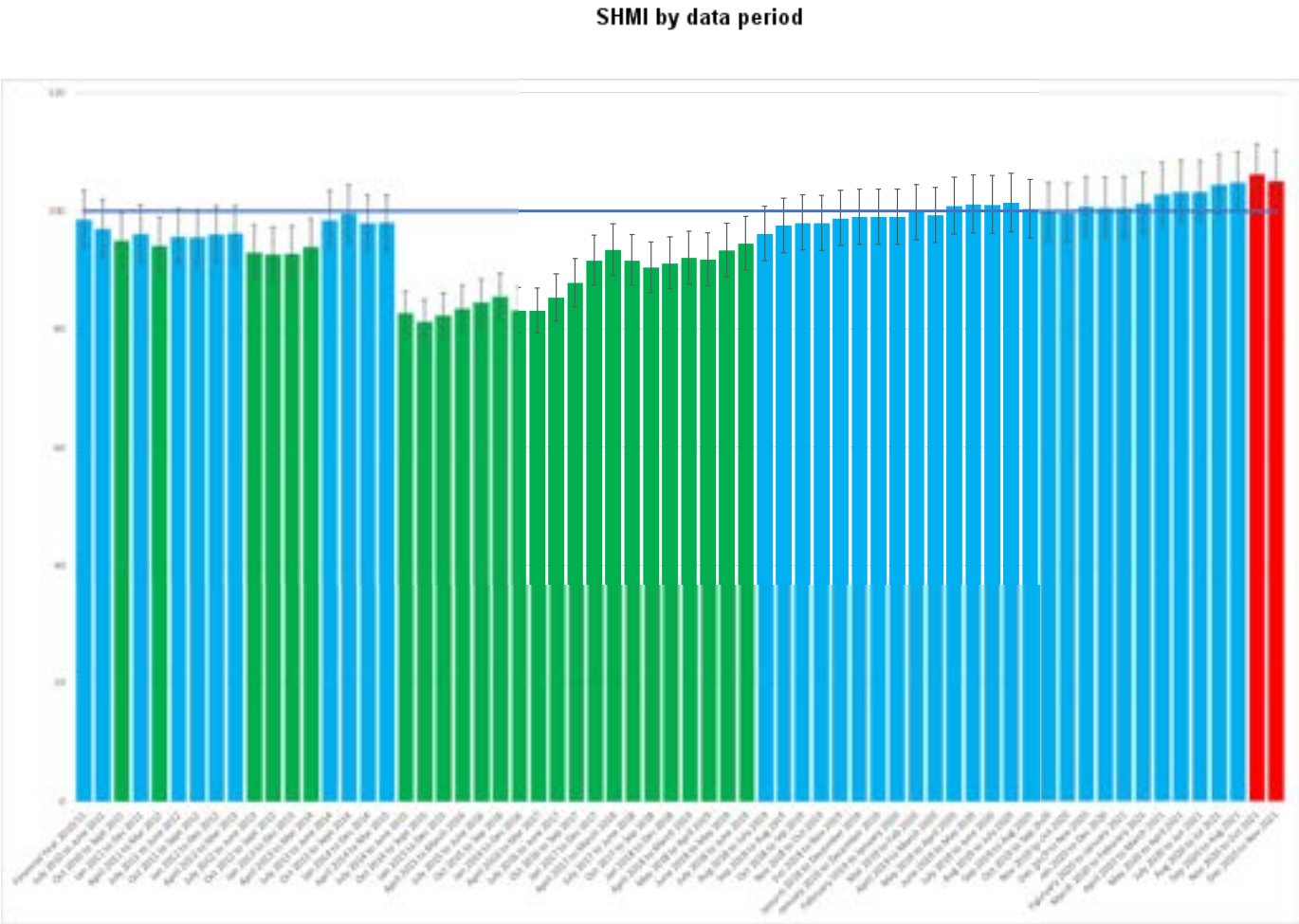


Chart 6, below, expresses the 12-month rolling SHMI data by time period. The mortality index is reporting the expected number of deaths during this time period (December 2020 –November 2021). The confidence intervals for the last two reported periods are just above 100 and will be subject to review. No further updates are currently available via Telstra Health.



Appendix 2 – Unadjusted Mortality Rate

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

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

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

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

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

This chart includes the Covid lockdown period and highlights a rise in deaths in March and April 2020. The mortality rise in March is partly explained by a reduction in activity due to Covid changes. The mortality rise in April is solely down to reduced activity. In April 2019 we had 3036 discharges (the denominator) and in April 2020 this, due to Covid, had reduced to 1773. Unadjusted mortality remains within normal limits for the Trust.

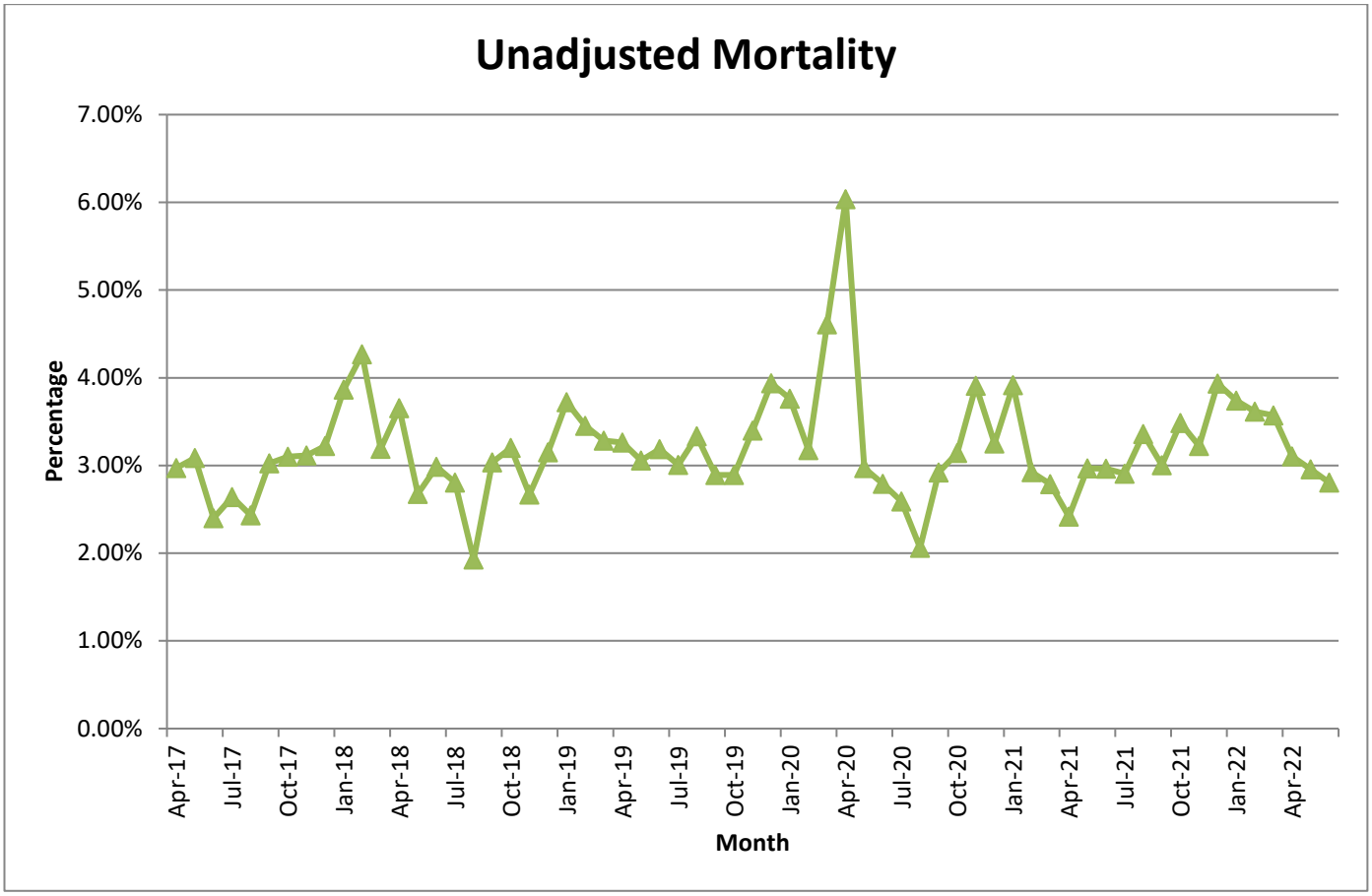
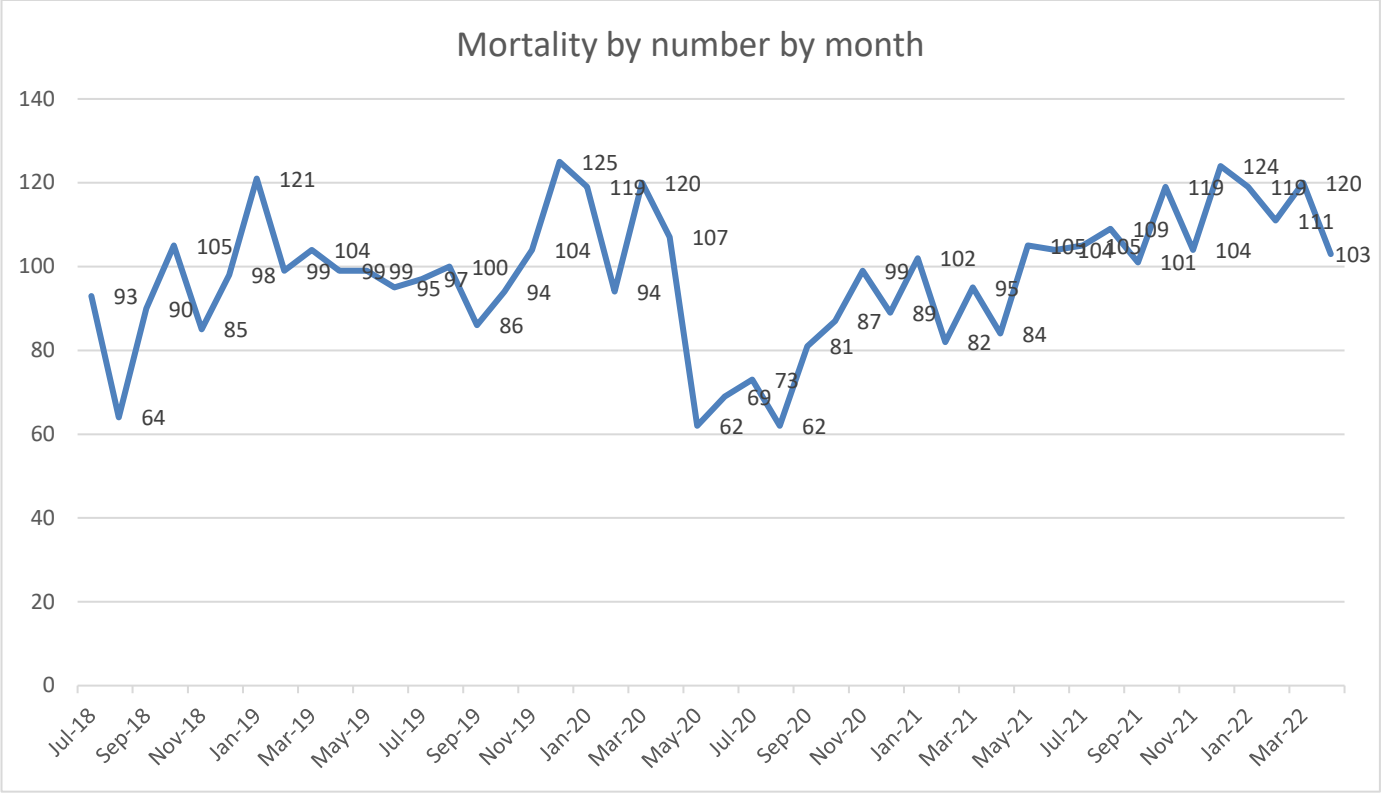


Chart 8 As below, indicates the monthly number of hospital deaths. This shows a rise in March and April 2020 partly due to Covid, before decreasing to comparatively low numbers during Summer 2020. As hospital activity increased following the initial pandemic lockdown, the number of hospital deaths has also increased. The pattern of increased deaths related to winter pressures appears to be re-emerging after a relatively low number of in-hospital deaths last winter.



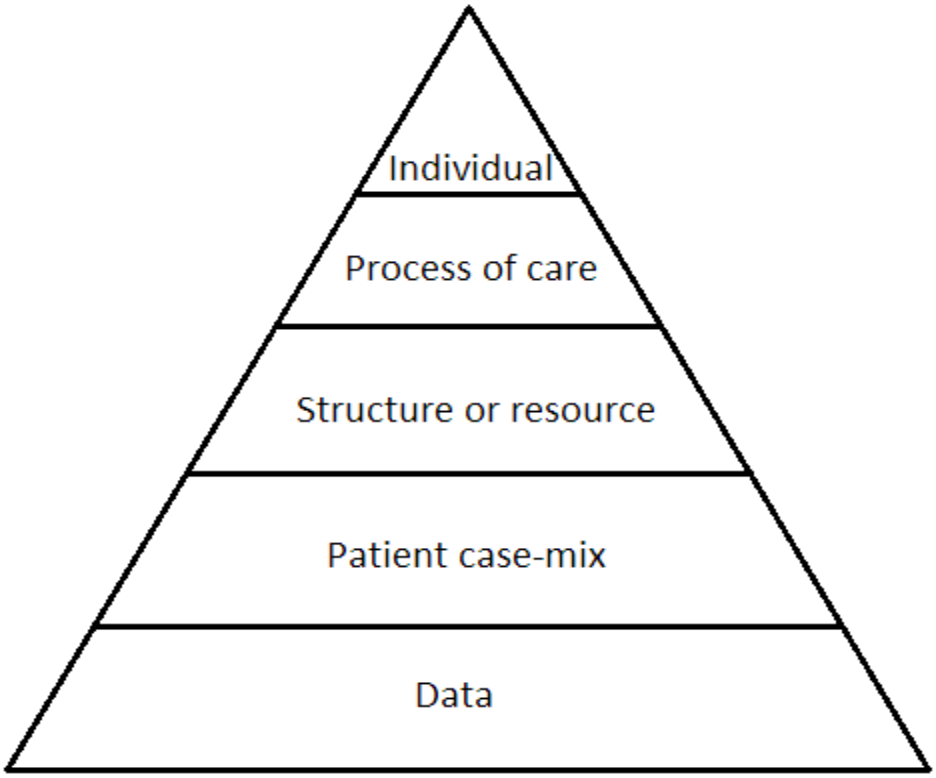
Appendix 3 – Mortality Analysis

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

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Torquay ISU																
DELIVERY SUITE	1															
LCHDU																
LOUISA CARY																
MOTHER AND BABY																
Paignton and Brixham ISU																
BRIXHAM		5	1	1	1	1	2		1	1	2					2
CARDIAC CATHETER SUITE				1								1	1			
DUNLOP	5	4	3	3	4	8	6	4	7	6	12	3	3	5	7	4
MIDGLEY	14	13	18	12	18	16	17	17	15	12	8	14	15	11	7	13
TORBAY CHEST PAIN UNIT								1								
TORBAY CORONARY CARE BEDS	1		2	2	3	4		3	2	3	3			2	4	2
TURNER	8		5	6	7	5	5	5	5	7	10	9	9	4	7	10
ELIZABETH	1	1	1													
VARRINGTON	1	2	2	2	2	3	3	4	3	1	1	3	1	1	2	
Newton Abbot ISU																
ACUTE MEDICAL RECEIVING UNIT																
MEDICAL RECEIVING UNIT		1		3	4	1	3		2	6	4	3	7			
NEW MEDICAL RECEIVING UNIT															3	
EAU3																
EAU4	11	8	9	16	11	11	8	16	9	10	12	5	10	7	10	8
INTENSIVE CARE UNIT	4	5	10	16	7	11	3	8	13	12	11	5	8	13	12	10
TEMPORARY INTENSIVE CARE UNIT																
TEIGN WARD	2	1	3	2	2		4	2	1	2	2	1		1	3	1
TEMPLAR WARD	2	4		1	1			1		2	2	1			3	1
Coastal ISU																
AINSLIE	1	1			4	7	3		1	7	3	6	4	3	2	1
ALLERTON	8	4	6	4	3	7	2	8	7	7	8	7	15	8	3	6
CROMIE	2	2	7	2	5	5	5	5	3	6	3	8	5	6	2	4
DAVLISH	1			1	1		2			3		5	4		2	
ELLA ROVCROFT		1			2		1				3	1	1	2		
FORREST	4				4	5	8	13	7	12	8	6	2	9	8	1
THEATRES						1						1	2		1	
Moor to Sea ISU																
CHEETHAM HILL	11	10	11	7	9	11	12	10	13	6	10	11	10	7	15	7
DART	2	3	3		1		1	3		1	2					1
GEORGE EARLE	8	10	8	13	8	9	9	10	6	12	5	8	9	9	4	7
SIMPSON	8	9	16	12	8	4	7	9	9	8	7	9	11	11	1	5
Wards used in Covid Surge Response																
JOAN WILLIAMS												2	2	1	1	
MCCALLUM											3	2	1	3	1	
Grand Total	**95**	**84**	**105**	**104**	**105**	**109**	**101**	**119**	**104**	**124**	**119**	**111**	**120**	**103**	**98**	**83**

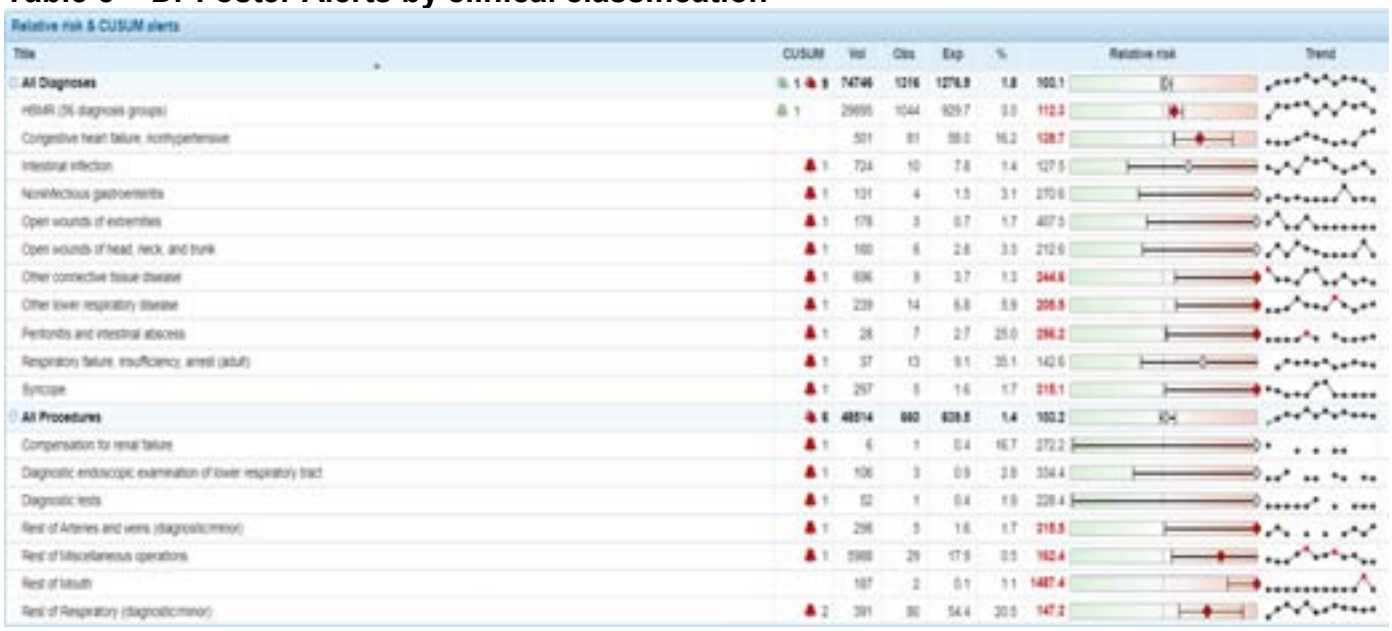
Alerts by Clinical classification

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



Alerts with observed deaths greater than 10 are recommended for further investigation.

i) There are 2 new diagnosis CUSUM alerts – Congestive Heart Failure and Open Wounds of Extremities.
ii) Deaths due to Intestinal infection are higher than expected (10 observed vs 7.8 expected.) Already reviewed, this does not appear to be due to coding issues and has been discussed at Mortality Surveillance review.
iii) Deaths due to other connective tissue disease continue to be higher than expected (9 observed vs 3.7 expected). As reported last month, preliminary analysis of the data suggests the majority of the deaths due to 'other connective tissue disease' occur in the frail, elderly cohort and 8 out of the 14 deaths are coded as having 'a tendency to fall'. Next steps in analysis will be a review of coding in these patients.
iv) Deaths due to liver disease is no longer alerting.

Chart 9 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. Latest available data in Telstra Health Benchmarking Tool (December 2020 – November 2021) highlights alerts for mortality due to acute and unspecified renal failure, and congestive heart disease(non-hypertensive) in deaths occurring in hospital and up to 30 days after discharge. Septicemia (except in labour) is alerting for in-hospital deaths but not alerting for deaths up to 30-days post discharge. No further updates are currently available via Telstra Health.

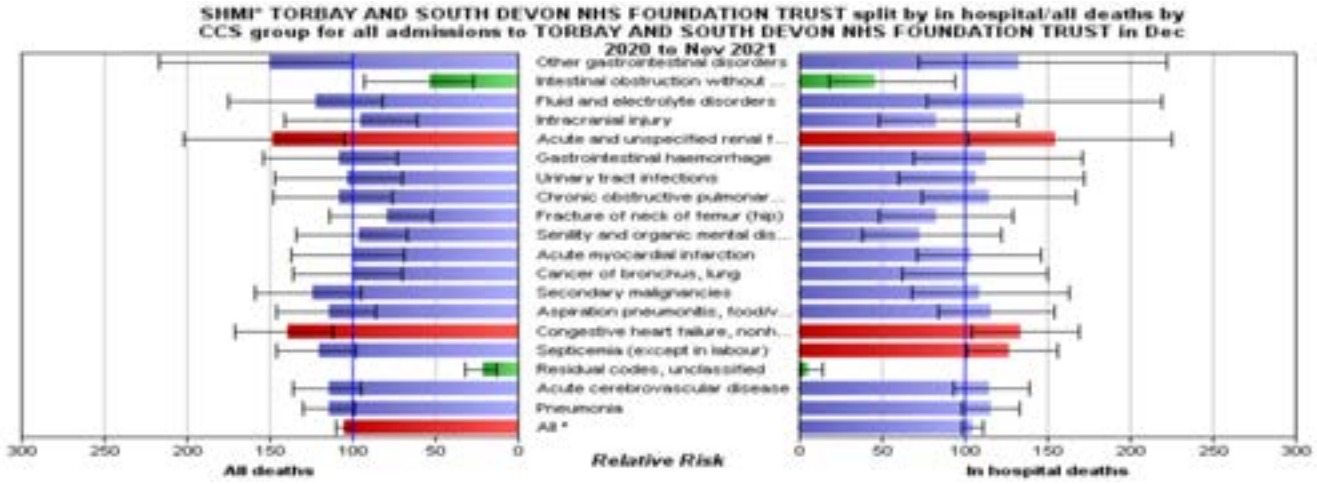
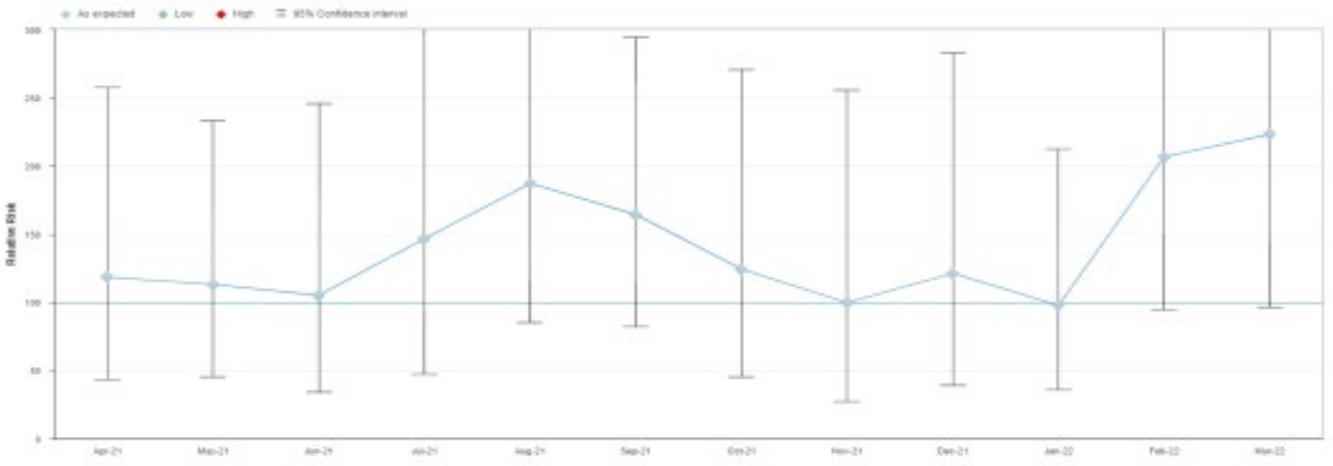
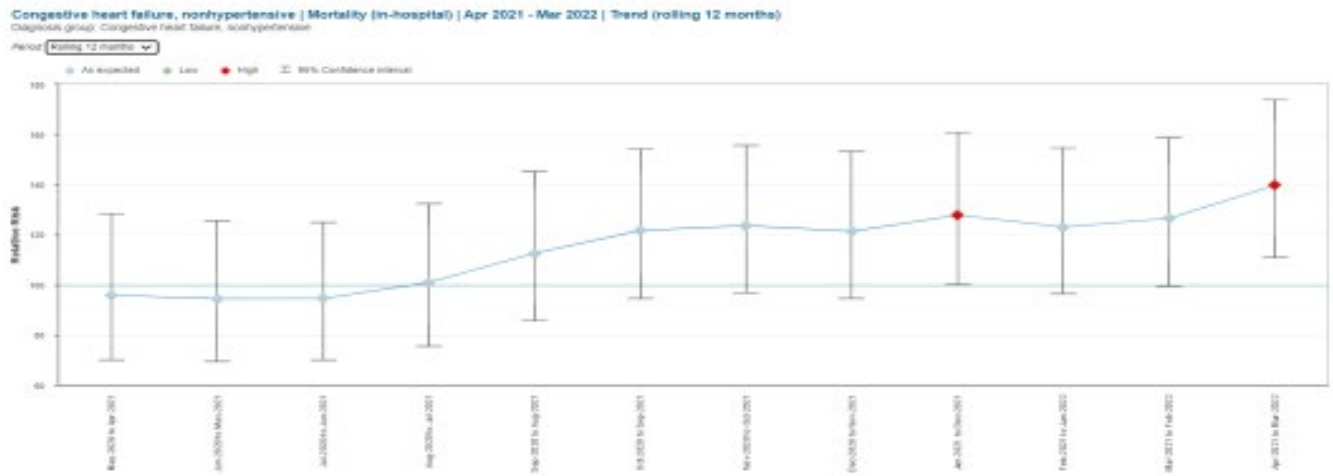


Chart 10 – Congestive Heart Failure

February and March 2022 have seen an increase in relative risk for the diagnostic group of Congestive Heart Failure. No individual month is considered statistically higher than expected however the overall relative risk is statistically higher than expected at 139.7 (110.9 – 173.6)

The rolling 12-month trend data shows the latest data period is statistically higher than expected, the previous 2 data points were 'within' expected' range.

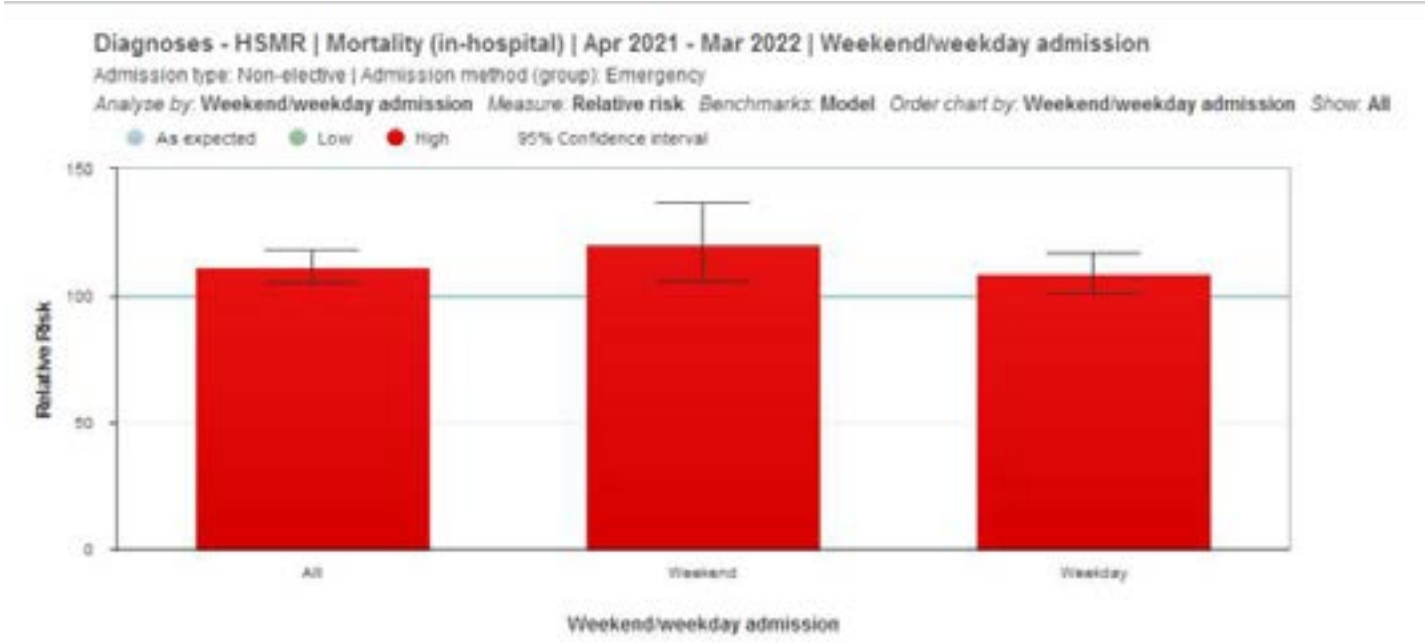




- Within this primary diagnosis group, 27.7% have 1 episode per spell. Of these the spells that have a length of stay more than 1 days are statistically significant. The age range of this group is 63% aged over 80 years
- Spells with 2 episodes per spell account for almost half of the volume of superspells. Understanding the pathway of care for patients with only 1 episode of care and a length of stay of more than 1 day may identify areas where variation may occur and be investigated
- 87.6% of spells are discharged with the same primary diagnosis

Chart 11 - Emergency Weekday / Weekend HSMR

Weekend and weekday HSMR are statistically significantly higher than. This also shows a higher relative risk of mortality at the weekend with a relative risk of 120 compared to 108 for weekday.



Appendix 4 – Focused Mortality Reviews

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. 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.

During the reporting period of May and June 2022 we had one stillborn baby. The Mother was 40+3 weeks gestation. The case has undergone duty of candour and will have a multidisciplinary case review using the national Perinatal Mortality Review Tool for review.

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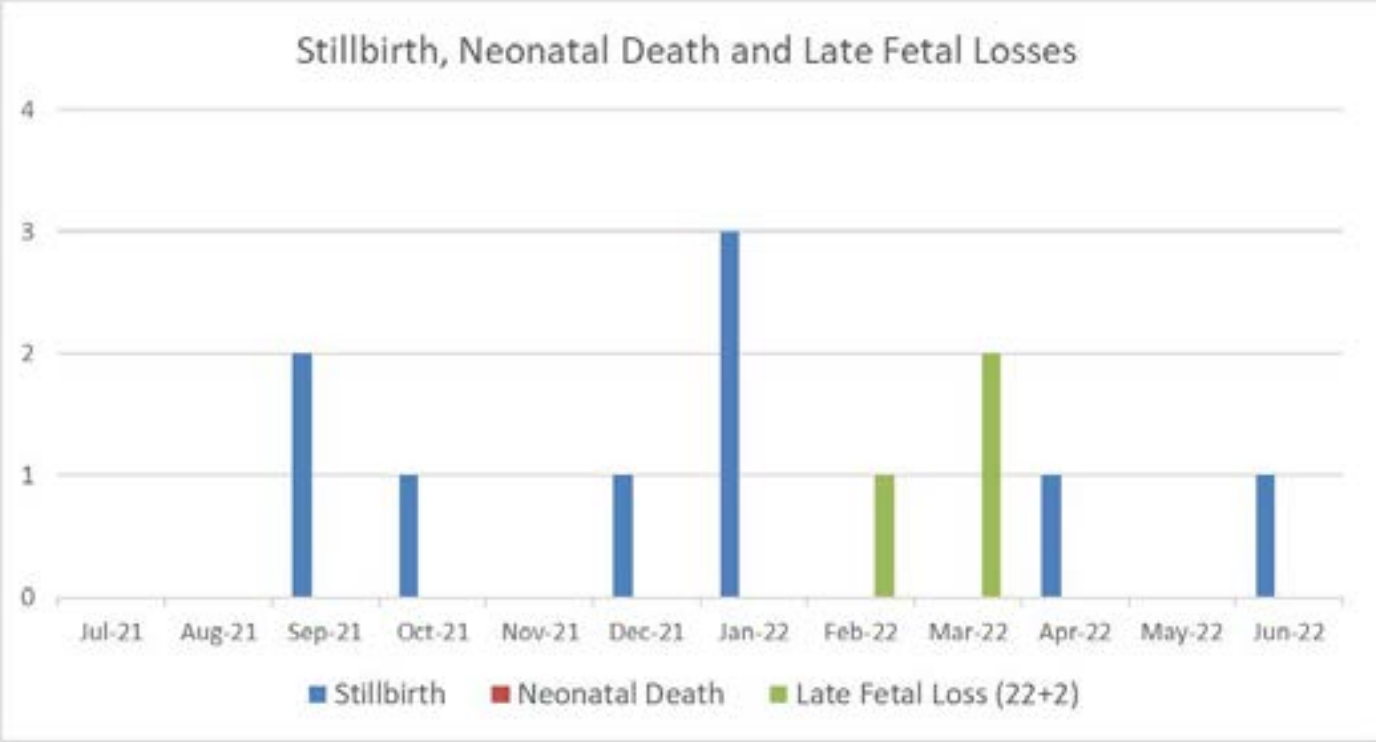
Chart 12 – Stillbirth, Neonatal Deaths and Late Fetal Losses



Number of child deaths
There has only been one Paediatric death since end of May 2022 until current date.

> This was a 12 year old, quadriplegic with Cerebral Palsy, ex 26/40. Post mortem confirmed the cause of death was pneumonia. Some concerns about non-compliance with medically advised treatments/therapies but not this had not reached the Safeguarding threshold.

Training in process:

"5 Steps to Suicide Awareness":

The second of six sessions, (previous two delayed due to speaker having COVID, and limited room availability in TREC) held 14/7/22. Further dates arranged monthly in Sept, October, November and December.

"Medical Examiners and Child death reviews".

13/7/22 a NCMD Webinar will be attended by both the Child Deaths Lead and Lead Medical Examiner to help understand and clarify how these roles are expected to work jointly.

Police walk through Emergency Department

On 19/7/22 we have organised Child Death training on Police request to help understand Child Death process and ensure improved awareness of the hospital environment, processes etc. This will be led by Dr Channer but also involves, ED nursing staff, mortuary and radiographers.

Medical Examiners

The Medical Examiner's Office is now functioning at full complement of both Medical Examiners and Medical Examiner Officers.

Within the Medical Examiners independent role, the office. The previously highlighted issue with 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 continues. This is attributed to staffing shortages and the removal of the COVID death certification amendments which allowed any doctor to complete the MCCD. Whilst this is being actively managed on a daily basis vis escalation via Control Room and senior medical leadership team, it continues to contribute to the Trusts mortuary capacity issues and is resulting in increased informal concerns and complaints being raised by the bereaved.

During May 2022, a total of three of patient deaths were passed without scrutiny to reduce the distress to the bereaved due to the delays in issuing the MCCD's as demonstrated in chart 13.

It has now been confirmed that the medical examiners process will become statutory in April 2023. Work is continuing to support the roll out to the GP practices and Rowcroft Hospice and work is commencing to understand how the service will support child death reviews.

Chart 13 – Medical Examiners Performance Summary

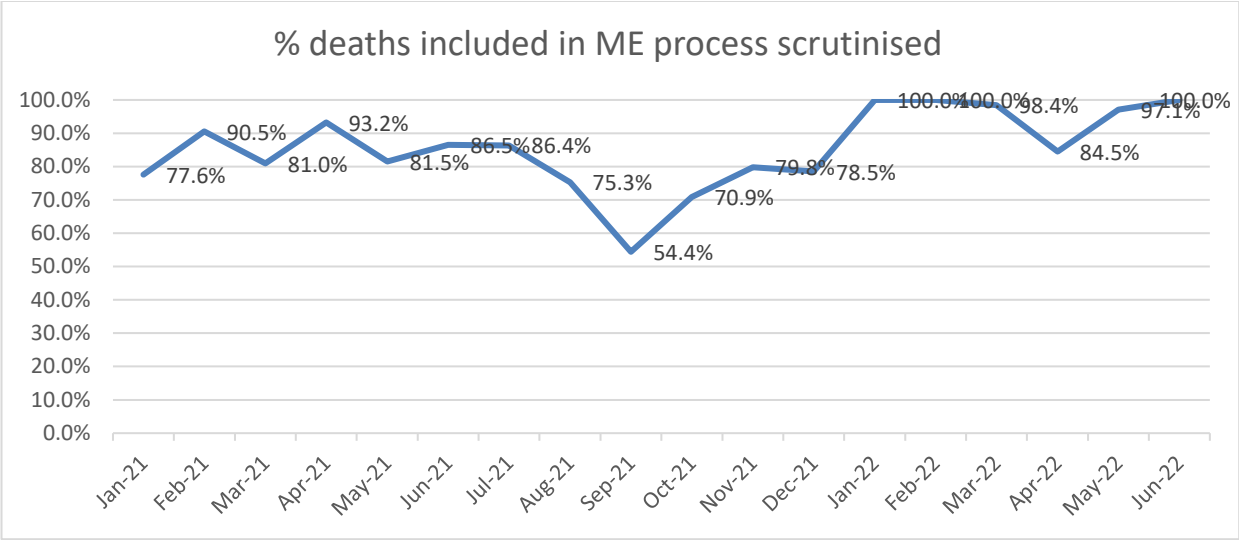
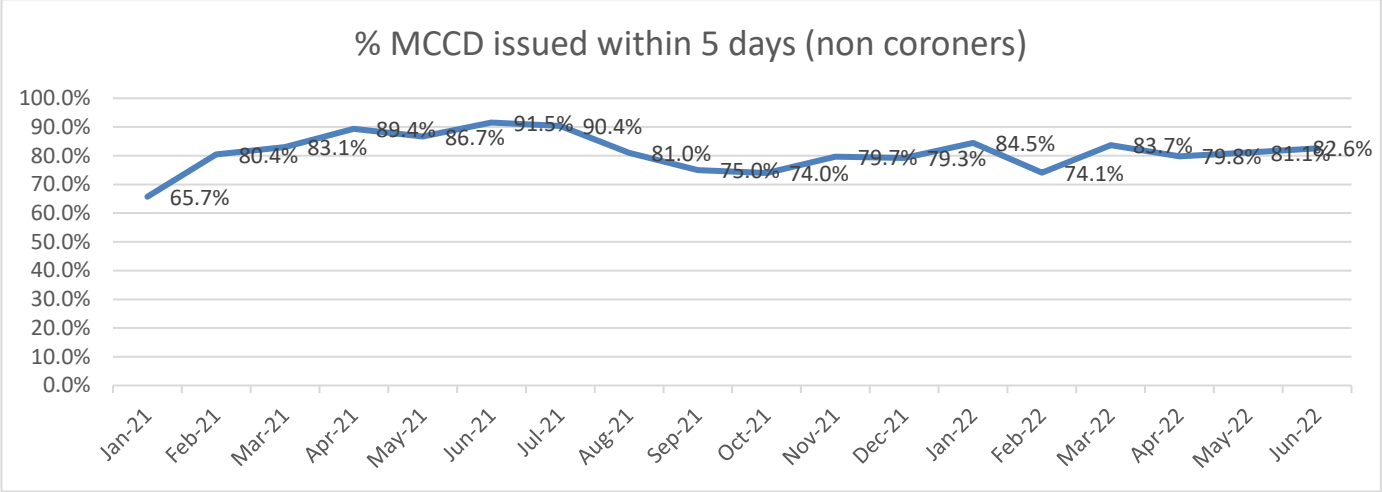


Chart 14– MCCD completion within 5 days



Incidents relating to Care After death

Since January 2022 a total of 35 incidents have been recorded with “Care After Death” as the primary subcategory. Of these it is noted that 18 of the incidents (51%) relate to delays in completion of MCCDs. This issue appears to not be specific to any particular ISU or Clinical Area, but rather a Trustwide issue.

Chart 15– Care after Death incidents

Analysis of Care after Death	Coastal ISU	Moor to Sea ISU	Torquay ISU	Newton Abbot ISU	Paignton and Brixham ISU	Grand Total
Delay in completion of MCCD	4	6	0	5	3	18
Delay in verification of death	0	0	0	0	4	4
Poor Care at EOL	0	1	0	1	1	3
Poor Communication with family	0	2	0	0	1	3
Patient Identification	0	2	0	0	0	2
Privacy & Dignity at EOL	0	1	0	0	0	1
Not identified as a true PSI	0	0	1	0	0	1
Treatment of deceased body	0	0	0	0	1	1
Communication with NOK	0	0	0	1	0	1
Poor communication within team	0	0	0	1	0	1
Grand Total	4	12	1	8	10	35

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

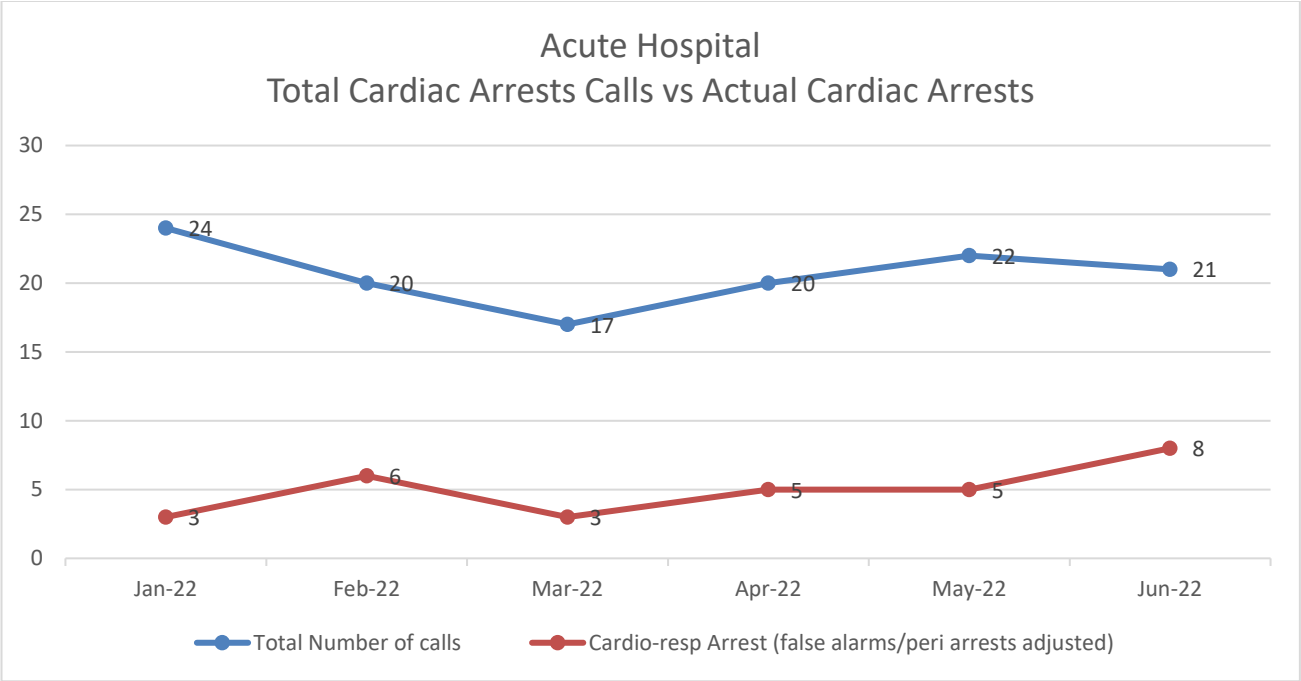
During May and June there have been 8 formal complaints relating to end of life care.
4 of these are currently active and relate of care or medical treatment. There is 1 closed case related to care, 1 closed case related to communication and 2 closed related to delays in the completion of MCCD's.

In addition, there have been 11 concerns and 1 compliment relating to care and / or medical treatment at End of Life

Cardiac Arrest

Numbers of cardiac arrest call and actual cardiac arrests is demonstrating a stable position over the past 6 months.

Chart 16– Acute Hospital – Cardiac Arrests



Appendix 5 – Learning

Learning from Inquests

During May and June 2022 were fifteen inquest reports requested and a total of four inquests held

The Trust has no outstanding Regulation 28 reports.

Trust learning: Serious Adverse Event Group

Key Issues	Learning and actions taken
Treatment / Diagnostic learning The SAE group discussed investigations into 2 deaths in May. No new deaths were discussed in June 2022 1. Presented to ED with GI bleed, fall on ward, further falls in community hospital patient died	Falls assessment process, coroner's inquest awaited

Glossary of Terms

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

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

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

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

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

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training			Meeting date: 27 July 2022
Report appendix	Nil		
Report sponsor	Medical Director		
Report author	Consultant in Emergency Medicine and GOSWH		
Report provenance			
Purpose of the report and key issues for consideration/decision	To provide assurance to the Board that doctors in training under the new terms and conditions of service are working safe working hours and to highlight any areas of concern		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation			

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

Report title: Guardian of Safe Working Hours – Doctors and Dentists in training		Meeting date: 27 July 2022
Report sponsor	Medical Director	
Report author	Consultant in Emergency Medicine and GOSWH	

1. Executive Summary

The following report concerns the time period of 10th of April 2022 to the 11th July 2022 based on the Exception Reports submitted by the Junior Doctor workforce.

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

2. Introduction

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

3. Exception Reports

There have been 185 Exception Reports in the period 28th January 2022 up to the 10th of April 2022. This remains lower than similar periods in 2018 and 2019 but represents an increased number compared to the last three quarters. There is ongoing Quality Improvement (QI) work to discern exception reporting patterns and remedy any issues arising.

Table 1 – Exception Reports by Area

Specialty	No. exceptions raised in reporting period	No. exceptions closed	No. exceptions outstanding	Comment
Acute medicine	3	1	2	
Cardiology	2	2	0	
Gastroenterology	2	0	2	
General Medicine	77	50	27	
General Surgery	36	22	14	

Geriatric medicine	1	0	1	
Haematology	29	2	27	Large number of service provision reports that need investigation.
Obstetrics and gynaecology	4	4	0	
Ophthalmology	5	4	1	
Otolaryngology (ENT)	24	19	5	
Orthopaedics	2	2	0	
Total	185	106 (57%)	79 (43%)	All incomplete less than 28days or pending further information.

Table 2 – Exception reports by Grade

Grade	No. exceptions raised in reporting period
F1	80
F2	58
CT1-3	38
ST 4-9	9
Total	185

Table 3 – Nature of Exception

Additional Hours	131
Service support	46
Educational	8

Table 4 – Outcome of Exceptions

TOIL	12	The high number of outstanding outcomes is due to large volume within the last 28 days.
Payment	84	
Cancelled (no action required)	6	
Agreed no further action required	7	
Outstanding	76	

4. Comment on Exception Reports

The number of exception reports in the quarter is larger than the last 18 months. 57% have been responded to, with 30 (16%) completed by myself. The vast majority of exception reports have been completed by junior members of staff with the majority coming from Acute Medical, General Medical and Acute Surgical rotations. The 43% that are unanswered have been submitted within the last 28 days and will be answered before the next junior doctor rotation change.

There are increased numbers of 'service support' exception reports. These occur when a junior doctor wants to highlight a deficiency of support within their service due to illness, staffing or increased workload. They are likely to be cause by two main issues: the first is that there is widespread understaffing in acute specialities (acute medicine, acute surgery, emergency medicine) which has previously been masked by moving junior doctors around to fill gaps. The second is that the JDRC have made a concerted attempt to improve the notification of these events which allows subsequent investigation. The General medicine and haematology rotas appear to be over represented in this quarter, although it must be noted that 18 of 46 service provision ERs have been filled by a single doctor working in those specialities. This is being reviewed.

The JDRC are running a QI project to try to understand the patterns of Exception Reporting with the aim of removing barriers to completion. The eventual aim is to improve uptake and completion amongst Junior Doctors. There is a feeling that a discrepancy lies between the number of contract breaches and the number of exception reports filed. The QI project will aim to describe this and the factors associated with it. One barrier is that is difficult to interpret patterns of reporting from the number of exception reports submitted. There is a 'small number' bias inherent in the lack of junior Drs reporting and overall, small number regularly completed. Hence the project will mainly draw from qualitative data from JDRC reports, surveys and questionnaires. It is logged with, and being supported by, the QI lead for the hospital.

5. Rota Reviews

Rota reviews have been carried out by Practice Managers Reports working alongside Medical HR on every Junior Doctor rota as mandated by the Junior Doctor Contract. There has been a review of the ENT non-resident on-call rota for junior training grades. The issue was that SHOs were being called overnight to review emergency cases and that this was elongating the length of the shifts whilst affecting rest breaks. The ENT service has provided next-day clinic spaces to allow emergency cases to be stabilized and reviewed in the morning.

The Haematology rota is being reviewed currently as there have been an unusual number of ERs submitted, these pertain to low junior doctor numbers on shift. The result of the investigation will be visible in the next quarter's board report.

There is an ongoing review of staffing numbers in the General Medical junior Dr rotations, with a plan to bolster numbers in the coming rotations. Three doctors have been recruited from abroad and attempts have been made to recruit Trust Grades as well as Allied Health Professionals. Medical HR, the Medical Operational Manager and representatives from the Medical Junior Doctor workforce are currently completing a project to review the number of juniors required per ward/on call, with the aim of improving staffing and generate more resilient rotas.

There is an ongoing review of the surgical hot week rotas. Two rotas approach 70 hours. Whilst in keeping with the Junior Dr contract they are fragile and a potential source for Guardian fines in the future. An alternative rota design has been created by the Surgical rota manager and a Junior Doctor on a surgical placement. This has removed the 70-hour week and will be implemented from the August intake of Juniors. The Obstetric and Gynaecology Junior Rotations are under filled when considering Whole Time Equivalents (WTEs). This has led to current Junior Doctors feeling unsupported as rota organisers work to fill gaps in staffing. The rota remains under discussion and all parties are working to improve compliance.

6. Fines

There have been no Guardian fines for this period.

7. Issues Arising

- My tenure as Guardian of Safe Working Hours finishes in August. The post will be re-advertised shortly. I am very thankful for the opportunity to undertake this role, and for the help of Medical HR and the JDRC throughout my tenure.

8. Actions Taken to Resolve Issues

- Rota related actions are described above.
- Medical HR have been proactive in producing GoSWH/LTFT champion roles and responsibilities, and advertising in preparation for handover in August.

9. Summary

Overall, departments appear compliant and supportive of their Junior Doctors. Departments with high numbers of exception reports appear to be engaged in fixing the rotas but are significantly hindered by the number of available doctors. The Trust benefits from a driven JDRC and a strong theme of co-operation between it and rota managers.

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

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Medical Appraisal and Revalidation Report			Meeting date: 27 July 2022
Report appendix	Nil		
Report sponsor	Responsible Officer and Medical Director		
Report author	Appraisal Lead		
Report provenance	Discussion with Responsible Officer and Appraisal Lead but no other formal presentation prior to this meeting.		
Purpose of the report and key issues for consideration/decision	This is the annual report relating to medical appraisal and revalidation presented by the Medical Director. The report addresses key issues as follows: • Recovery of medical appraisal after the pause for Covid (April to Sept 2020) and the influence of continuing high clinical workload on this. • Appointment of Trust Grade doctor lead to oversee appraisal in this group of doctors • Light touch Appraisal 2020, adopting national guidance • Wellbeing and support of senior clinicians within the Trust		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Trust Board is asked to approve the contents of the Annual Report of the Responsible Officer relating to Medical Appraisal and Revalidation. The monitoring of appraisal and revalidation continues as described and reporting will be undertaken on an annual basis.		
Summary of key elements			

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks	

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

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

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

Contents

Introduction:

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

- **Board Report template:**

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

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

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

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

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

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

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

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

Designated Body Annual Board Report

Section 1 – General:

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

1. The numbers of appraisals undertaken and not undertaken with revalidation data is recorded below:

Date of AOA submission: Not applicable

Action from last year: Not applicable.

Comments: Data for Consultant and SAS doctor appraisals are detailed as follows:

Appraisal data from 1/10/20 to 22/7/22

Since appraisal restarted in October 2020 90% of doctors have had an appraisal (257/286)

37% have had more than one appraisal

80% of doctors (230/286) had an appraisal between 1/4/2021 and 31/3/22

10% of doctors have not had an appraisal since we restarted (29/286)

1 of these doctors has been discussed as non-engagement with the GMC

5 had valid reasons for not having an appraisal such as maternity leave or being out of the country

Of the remaining 23 doctors there was a spread across specialties with slightly higher numbers in care of the elderly, orthopaedics, emergency medicine, paediatrics and anaesthesia/ITU but this could be because these are all large departments with high numbers of consultants and specialty doctors.

Revalidation recommendations to the GMC:

01 April 2021 – 31 March 2022

Recommendations for revalidation: 81

Recommendations for deferral: 46

Recommendations for non-engagement in the appraisal process: 1

Action for next year: Continue to re-engage medical staff with the appraisal process.

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

Action from last year: Not applicable Comments: Mr Ian Currie remains in post as Responsible Officer for Torbay and South Devon NHS Foundation Trust. Action for next year: Continue

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

Action from last year: Not applicable Comments: Due to increasing workload, the requirement for quality assurance and to provide robust support to the Responsible Officer together with succession planning for the Appraisal Lead, a 1 PA Deputy Appraisal Lead appointment would be advisable. Action for next year: Identify source(s) of funding.

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

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

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

Action from last year: Review the Appraisal and Revalidation policy. Comments: Appraisal and Revalidation Policy reviewed and ratified by the Joint Local Negotiating Committee. Action for next year: None required. Next renewal date 2023.

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

Action from last year: Not applicable.

Comments: Higher-Level Responsible Officer Quality Review visits to recommence from 01 September 2022. The visits are not intended to be a formal inspection of Trust process but aim to provide support and education.

Action for next year: Await date of HLROP Quality Review visit.

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

Action from last year: Not applicable.

Comments: Trust Doctor Lead now in post and working closely with the Appraisal Lead and Medical HR to agree an appropriate appraisal format for Trust Doctors and locum doctors.

Action for next year: Finalise a formal appraisal process for Trust and locum doctors with Responsible Officer and Medical Workforce.

Section 2 – Effective Appraisal

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

Action from last year: Continued offer for doctors to use the Appraisal 2020 template rather than the standard one to encourage engagement with appraisal.

Comments: Aim to encourage as many doctors as possible to have a yearly appraisal for personal and professional development.

Action for next year: Introduce the Medical Appraisal 2022 format for appraisal.

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

Action from last year: Not applicable.

Comments: Continue to monitor timelines and encourage doctors to have a supportive appraisal meeting. Missed appraisals to be identified, reasons understood and appropriate action taken.

Action for next year: Continue to monitor and provide support.

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

Action from last year: Not applicable. Comments: The Appraisal and Revalidation Policy has been reviewed and approved by the Joint Local Negotiating Committee. Action for next year: Nil. Next renewal date 2023.

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

Action from last year: Not applicable. Comments: Some appraisers have stepped down due to new roles or other work pressures. We currently have 46 active appraisers for Consultant and SAS doctors. Three new Consultant and SAS appraisers were recruited in 2022 but four longstanding appraisers have left the Trust due to retirement. Some directorates have low numbers of appraisers due to work pressures. Action for next year: Ongoing active recruitment to the appraiser role and support for existing appraisers. Ongoing work to ensure Trust Doctors receive appropriate support and access to appraisal. Explore retention of retired doctors as medical appraisers.

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

Action from last year: Not applicable. Comments: Appraiser Update session held on 10 November 2021 with further refresher training planned for Autumn 2022. MS Teams Appraiser update session held monthly which have included update sessions on the revised GMC Good Medical Practice Guide and coaching skills by the Workforce and Organisational Development team with future planned sessions from the Occupational Health Team. Action for next year: Continue.

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

Action from last year: Not applicable. Comments: New appraisers reviewed after two appraisals to provide support and guidance.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Action for next year: Review of Quality Assurance processes in advance of the Higher-Level Responsible Officer Quality Review visit.

Section 3 – Recommendations to the GMC

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

Action from last year: Not applicable.

Comments: The Responsible Officer has regular meetings with the GMC Employment Liaison Officer to discuss any potential fitness to practice issues.

Action for next year: Continue.

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

Action from last year: Not applicable.

Comments: All revalidation recommendations have been submitted to the GMC prior to the doctor's revalidation date. Two late recommendations were submitted due to administrative error. Revalidation recommendations are communicated to the doctor after submission via GMC Connect. Deferral and non-engagement recommendations are communicated to the doctor before submission to the GMC and an action plan is discussed with the doctor by the Appraisal Lead.

Action for next year: Continue.

Section 4 – Medical governance

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

Action from last year: Not applicable.

Comments: Medical Examiner system now in place. Incidents, complaints and litigation cases recorded in the Datix system. Responsible Officer chairs the Serious Adverse Events Group.

Action for next year: Continue.

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

Action from last year: Not applicable.

Comments: Performance monitored by: annual appraisal; complaints and incidents data via the Datix system; divisional performance data; departmental clinical governance meetings; Dr Foster data, Maintaining High Professional Standards policy; Transfer of Information requests.

Action for next year: Continue.

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

Action from last year: Not applicable.

Comments: Maintaining High Professional Standards and Remediation policies. Close liaison between the Responsible Officer, Appraisal Lead and Medical Workforce team.

Action for next year: Continue.

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

Action from last year: Not applicable.

Comments: Following a Maintaining Professional Standards Investigation the Case Manager will meet with the Case Investigator and Medical Workforce team to debrief and consider any lesson that can be learned. These are communicated to the Responsible Officer. The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No individual will receive less favourable treatment on the grounds of the nine protected characteristics as governed by the Equality Act 2010.

Action for next year: Continue.

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

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

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

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

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

Section 5 – Employment Checks

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

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

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

Section 6 – Summary of comments, and overall conclusion

General review of last year's actions:

- Appointment of new Trust Doctor Lead
- Appraisal and Revalidation system, PReP, due for renewal and currently in negotiations with the supplier, Premier IT
- New Appraiser training held on 11 February 2022 and 30 March 2022 with three consultant/SAS doctors joining the Trust Appraiser group. The training is facilitated by MIAD Healthcare.
- Monthly Appraiser Group updates held via MS Teams
- Annual Organisational Audit stood down due to the ongoing impact of COVID 19 pandemic and recovery planning.
- National guidance received with revised medical appraisal template in place. This template will be incorporated within the electronic toolkit and is designed to be similar to the light touch 2020 template however with more pre-appraisal input required from the individual doctor.
- The Medical Appraisal Guide (MAG) Model Appraisal Form is no longer fit for purpose and will no longer be used for appraisal.

Actions Still Outstanding:

None

Current Issues:

- Challenge of encouraging doctors to have a regular, supportive, appraisal due to ongoing high clinical workload.
- Increased number of deferrals due to lack of supporting information, particularly Colleague and Patient 360 feedback.

Actions:

- Implementation of Medical Appraisal Guide 2022 across the Trust requiring support for appraisers and appraisees.
- Recruitment and retention of enough appraisers to provide timely appraisals for all licensed medical practitioners.
- Continue to work with the Trust Doctor Lead to develop a clear process for support and appraisal for this group of doctors.
- Monitor number of deferrals and understand the underlying reasons.

Overall conclusion:

- Need to continue to develop a robust structure for delivery, oversight and quality assurance of medical appraisal.

Section 7 – Statement of Compliance:

The Executive Board of Torbay and South Devon NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Official name of designated body: Torbay and South Devon NHS Foundation Trust

Name: ---------- Signed: ----------

Role: ----------

Date: ----------

Report to the Trust Board of Directors			
Report title: Annual Infection Prevention and Control Report 2021/22			**Meeting date:** 27 July 2022
Report appendix	a) Table summarising key national policies/guidance & TSDFT responses for managing COVID 19 infections		
Report sponsor	Director of Infection Prevention and Control		
Report author	Director of Infection Prevention and Control		
Report provenance	Quality Assurance Committee		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to provide the Board with information on Torbay & South Devon NHS Foundation Trust's performance across a broad range of infection prevention and control issues relating particularly to hospital acquired infections. The report provides assurance that suitable processes are being employed to prevent and control these.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	For the Board to approve.		

Summary of key elements

Strategic objectives supported by this report

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

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

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

External standards affected by this report and associated risks

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

The Board is asked to note and support IPC work as everyone's business. This work is of central & core importance to our business in health and care, forced into the forefront of work in 2021/22 with the COVID 19 Pandemic.

Infection Prevention & Control Annual Report 2021/22

and Annual Forward Plan 2022/23

Dr Joanne Watson Director Infection Prevention & Control
Dr Selina Hoque Consultant Microbiologist and Infection Control Doctor
Mrs L Kelly Lead Infection Prevention & Control Nurse

Torbay & South Devon NHS Foundation Trust Board July 2022
Ratified through the Infection Prevention & Control Group June 22 and Quality Assurance Committee July 2022

Contents

1. Key Points and Executive Summary

This report demonstrates how the Torbay & South Devon Infection Prevention and Control (IPC) team has engaged in the prevention of health care associated infection (HCAI) prevention and control in 2021/22. The data in this report are for the period 1st April 2021 to 31st March 2022, thus spanning the end of the second COVID 19 wave and the third wave from Autumn 2021 that continued into Spring 2022 with the Omicron variants.

Once again the IPC team has been fully occupied keeping staff and patients safe during the second year of the COVID-19 pandemic though other infections and areas of prevention have also required attention. IPC requires constant vigilance and agile responses. The importance of the infection control standards being delivered to the highest possible level is emphasised in this report as rises in infections pose challenges to our organisation for staff and patients. Section 12 outlines how we have taken the opportunity to reflect and refocus our efforts to prevent as many infections as possible with the continuation of our forward-looking improvement plan.

Highlights:

<u>COVID 19 related</u>

- Covid 19 – our response as a whole ICO is to be commended and recorded. The national Getting It Right First Time (GIRFT) Programme identified that our death rate during the second wave of COVID 19 was lower than expected and a national team from GIFRT met with our clinicians to discuss care at TSDFT.
- The significant changes to our estate to contain the infection, limiting spread etc were inventive and appropriate in the main as demonstrated by a low nosocomial infection rate despite older estates
- Our microbiology laboratory has performed outstandingly well during the whole pandemic and continues with the exemplary performance of 2020/21 e.g. fast and accurate PCR for COVID 19 results.
- Exemplary working with care homes and local public health teams to support colleagues working in these areas who also face similar IPC issues
- Vaccination responses have been at the highest level for us in 2021-22:
    - Flu vaccination achieved >70% for the second year running
    - COVID 19 vaccination rates across staff groups very high >90% Booster (third) dose for staff in Autumn 2021

<u>Standard IPC issues to highlight</u>

- One hospital acquired MRSA bacteraemia reported in 2022. This has been investigated with actions taken to improve the causal factors identified as reflected the high risk of this case
- Gram negative bacteraemia (GNB) overall numbers rose 2021/22 though in all categories infections were under our nationally set trajectories.

- *Clostridium difficile* infections are more common than prior to the pandemic starting. This is in line with the national situation with further work required again. Our cases continued to be lower than national target.
- Antimicrobial resistance surveillance is on-going with lower incidence in our ICO than national picture.
- Workforce in addition has been challenging with only two WTE consultant microbiologists for the majority of the reported year. Successful recruitment of a consultant colleague in March 2022 has improved this situation: 1WTE vacancy remains. Successful recruitment of a physician associate to train as a clinical scientist is a good example of adapting new roles in health care for current need. Further vacancies continue within the IPC team making resources stretched to cover all areas required; recruitment on-going with good appointments, return from maternity leave etc this year too.

Assurance

Policy/ Statutory Responsibility	Annual Performance	Gaps identified with mitigations made
COVID 19 – compliance with national/ regional processes	Review included in section 3; essentially compliant with regulations with COVID 19 inc the IPC COVID BAF which is reviewed, understood and actioned	Ongoing monitoring and adjustments made with further updates and learning on COVID 19
Clostridium difficile – external trajectory	51 attributable cases against a 36 trajectory No internal spread of these cases within the ward environment. After action reviews show low numbers that could possibly have been avoided through more judicious antibiotic use	Improved focus already established on antibiotic prescribing led by consultant microbiologist as increase in colleague numbers supports greater range of consultant activities.
MRSA bacteraemia- NHSE/I 'zero tolerance' approach	1 hospital acquired case in 2021/22 with factors contributing to these identified following post infection review processes	Ongoing surveillance
Reduction in Gram Negative Bacteraemia	Overall GNB infections below the ambition set by NHSE. Rise from 2020/21 which in part relates to increased clinical activity and longer waits for planned care (operations)	This rise demonstrates the importance of 'business as usual' IPC work

2. Requests to the Quality Assurance Committee and Board

2.1 The Committee is asked to note and consider the contents of this report and raise any issues of concern or outline any specific action they request to the Director of Infection Prevention and Control as the Board Member with IPC responsibility.

2.2. The Committee is asked to be asked to be assured of the following:

- The TSDFT Infection Prevention and Control team has engaged constructively and effectively to prevent and/ or control health care associated infection.
- The Annual Report provides an over view of our progress against the criteria of the Health & Social Care Act 2008: Code of Practice on the Prevention & Control of Infections and the COVID 19 Board Assurance Framework first published by NHS England May 2020.

3. COVID 19 Summary of our IPC Responses

The year of 2021-22 continued to pose additional challenges with regards to infection prevention and control measures for the whole of our integrated care organisation due to the viral infection COVID 19. The IPC team and consultant microbiologists have worked hard to embody the principles of what matters within our ICO around both individual and population-wide health care. Work with COVID 19 has consumed most of the team's resources and attention, given the characteristics and frequency of this infection. Our performance in the South West with regard to the level of control achieved is worthy of acknowledgement given that we rarely incurred unexpected positives in the first 48 hours of admission due to one of the fastest turnaround time for a PCR test (average under 4 hours) and our rate of hospital acquired COVID 19 after 15 days of admission (ie definitely an HCAI) was one of the lowest in the region for an acute care provider; particularly good given our reliance on multiple bedded bays at close proximity to each other.

3.1 In-patient COVID Outbreaks: There were circa 250 nosocomial cases recorded at TSDFT during 2021-22 in ~50 outbreaks. Managing these outbreaks represented the majority of the IPC team's resources as we had developed a careful operating procedure which effectively and repeatedly contained the spread of infection to other patients and staff.

3.2 During the course of the year the IPC team responded to the changing patterns of COVID 19 infection. These were due to:

- Changing virulence of the dominant COVID virus variant: Delta became dominant from April 2021 with a higher percentage of people requiring ventilation support; followed by Omicron spreading from South Africa late Autumn 21 with less effect on respiratory system ie less people requiring any form of ventilatory support.
- the success of the vaccine programme. Our local primary care services provided a comprehensive programme for the people of Torbay & South Devon. Our population responded by getting vaccinated with the national average of coverage, higher than average in our elderly population; this continues as demonstrated with ~70% of people over 12 yrs having had three doses of vaccine. Our staff uptake of the vaccine with the Booster dose given in Autumn 2021 was one of the highest in the South-West at over 92%
- The effectiveness of the vaccine. It would appear that the vaccine continues to provide an effective response to COVID 19 after 3 vaccines (3rd dose often referred to as Booster in the non-immunosuppressed group) and an ongoing vaccination programme (4th dose from December 2022) in invited populations.

3.3 In the Annual IPC Report 2020-21 detail was provided as to how TSDFT had responded to the pandemic including the escalation plans of the use of inpatient beds and how we worked. In this the second year of the pandemic, similar approaches were taken. Of note we had more patients with COVID in our organisational bed base than in

the previous year, as this time there was no access to Nightingale Hospital in Exeter for transferring patients. We therefore had circa 80 inpatients in March 2022, with number decreasing rapidly in April.

3.3 We are working with health and safety colleagues on staff acquiring COVID infection at work as these are RIDDOR events. We are investigating 33 cases from the whole pandemic period.

3.4 Included in Appendix A1 is a table summarising key national policies/ guidance around IPC and a description of our response and overall compliance. The COVID 19 BAF is available for oversight and assurance.

4. Performance against alert organisms and infections including antimicrobial resistance

4.1 Clostridium difficile

Healthcare related *C. difficile* infections continue to be a significant safety concern with a renewed focus given the national rise which is being experienced across NHS England providers. This was seen in 2020 and is on-going, still relating to changes made in response to the COVID Pandemic.

The total number of *C. difficile* for 2021/22 was 51 against a threshold set by NHSE of 54. 34 of these were recorded as Hospital onset healthcare associated (HOHA) infections with 17 recorded as Community onset healthcare associated (COHA). It is important to note that the target set is for an acute-care provider and not an ICO with ~25% of the total bed capacity as community hospital beds with an inherent higher risk of *C. difficile* infections for people in these care-settings.

Attributable cases for our ICO are those that have *C. difficile* toxin detected in the stool (enzyme-linked immunoassay or EIA positive) within specific time conditions. The ICO must determine and report to Devon CCG any reportable cases deemed to involve a lapse in care; we are compliant with this and reportable case numbers represented 12% of cases. There were no cases that were identified as spreading within a ward during 2021/22.

Hospital onset healthcare associated (HOHA): cases that are detected in the hospital > 48 hours after admission = 34 cases
After Action Reviews (AARs) are carried out on all *C. difficile* HOHA.

Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks = 17 cases

2019/20 C. difficile target = 36 – this year (2021/22) our total threshold/target (HOHA + COHA) = 54

Our results on *C. difficile* infections and the increased risk noted in current times means that we will be focusing on improving these results in the coming year. We know that antibiotic prescribing can be improved further, steps taken this year have included the review of antibiotic audits and further improvements planned for 2022/23.

There were no cases during 2021/22 where *C. difficile* was cited as a cause of death on the final death certificate.

4.2 MRSA & MSSA Blood Stream Infections (BSI)

MRSA- Meticillin Resistant *Staphylococcus aureus*: NHS England has a 'zero-tolerance' approach to MRSA bacteraemia meaning which we follow. Therefore our objective is for zero attributable cases for us. In 2020/21 there have been 3 MRSA bacteraemia or BSI: 1 of these was a HOHA, the other 2 being identified within 48 hours or admission. We continue to investigate each case of MRSA bloodstream infection via After Action Reviews (AAR) to identify any lessons to learn and share across our ICO. Each of the MRSA blood infections in the reporting year were in people who injected drugs intravenously themselves, a higher risk activity for blood infections.

MSSA- Meticillin Sensitive *Staphylococcus aureus*: Cases of MSSA are reportable to UKHSA but there is no formal objective for the ICO. The ICO has seen a stable incidence of attributable MSSA bacteraemia in 2021/22 compared to the previous year. Up till the end of March 2022, the ICO had a total of 46 MSSA cases, 17 of which were attributable. For the same period in the previous two reporting year the figures were 58 and 13 (2019/20) and 62 and 14 (2020/21); a steady state.

4.3 Gram Negative Bacteraemia

There is a national ambition for England to reduce the healthcare - attributable Gram-negative bacteraemia (GNB) by 50% by 2023/24: this remains in place. For the purpose of this ambitious goal GNB are defined as three organisms: *Escherichia coli* (*E. Coli*), *Klebsiella* (all species) and *Pseudomonas aeroginosa* as these constiture a majority of reported GNB. Of these three, *E.coli* are by far the most numerous, many of which are community onset with health care associations through the GP.

Since 2018, PHE, and now UKHSA, assigned these infections to community or to a provider organisation based on whether the positive culture was indentifed within 48 hours of admission. For 2020/21 the numbers of ICO assigned cases were *E. coli* 34 (2020/21 = 18); *Klebsiella* 8 (2) and *P. aeroginosa* 3 (5). Whilst these infections numbers are higher (except *P. aeroginosa)* than 2020-21 with a total of 38 GNB this year compared to 25 2020/21, the clinical activity was significantly higher with a massive increase. Thresholds were set by NHSE in the National NHS Contract 2021-22 which were for our ICO E.coli 77, *Klebsiella* 27 *and P. aeroginosa* 10. Our results were consistently within these thresholds which are for Trust acquired infections >48 hours after admission. The number of cases has risen nationally. The rise in people waiting for planned procedures such as cholecystectomy and renal stone treatment leads to a rise in GN infections.

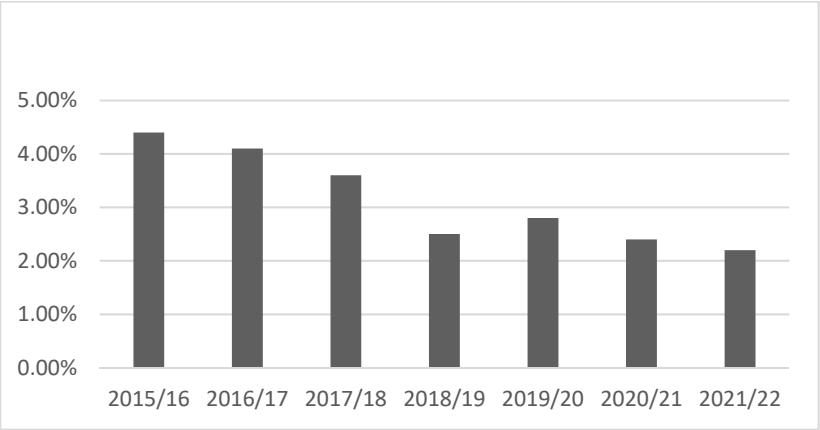
4.4 Antibiotic Resistance

E. Coli BSI

Extended Spectrum Beta-Lactamase (ESBL) producing bacteria *E. Coli* in blood cultures are one of the markers of antibiotic resistance in bacteria and by definition are resistant to 3rd generation cephalosporins.
Below the graph shows the total rate of ESBLs in blood cultures most of the *E. coli* BSI are from admissions from the community which continue to fall – just over 2% in

the reporting year compared to 2.4% and 2.8% the previous two reported years. This also continues to be below the national and regional average incidence as reported in the English surveillance system on antimicrobial usage and resistance 2020-21 report.

ESBL producing E. coli blood stream infections. April 2015 March 2022



Antibiotic Resistance to First line Sepsis treatment

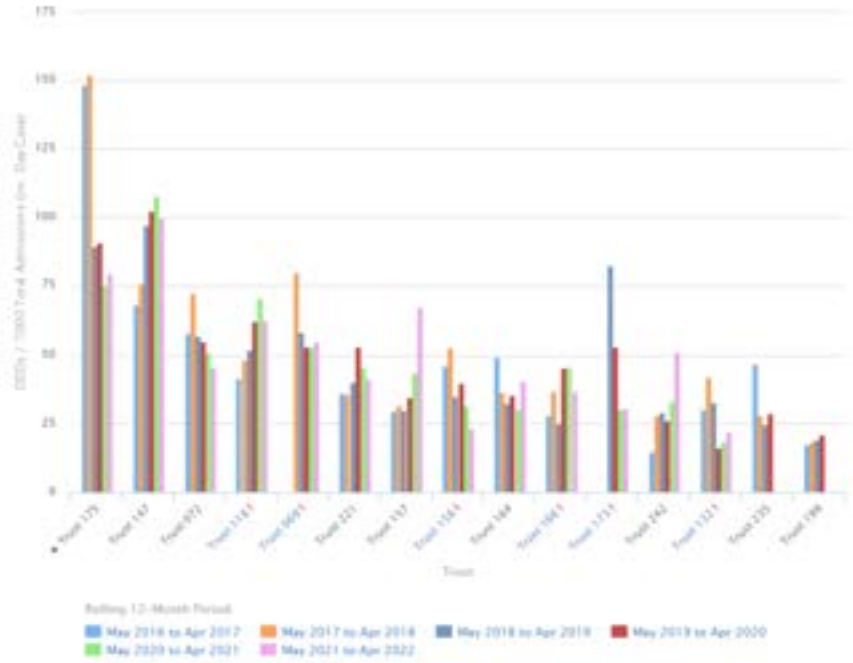
TSDFT's recommendations for first-line sepsis treatment is Tazocin and Gentamicin and the rate of E. coli resistance to this combination is 0.8% in 2020/21. This remains an effective treatment combination for sepsis. In 2020/2021 the rate of resistance of E. coli in blood cultures to both Tazocin & Gentamicin was 0.8%. In 2018/19 and 2019/20 were both 0.7% so there is an increasing trend of resistance which we will monitor but it does not require a change in sepsis prescribing currently.

Carbapenemase Producing Enterobacteriaceae (CPE)

These are bacteria that have resistance mechanisms against the third-line antibiotics. This means that if a patient develops a serious infection with a CPE then treatment is likely to be sub-optimal. In 2020/21 there was zero CPE acquired at TSDFT.

Use Benchmark (DDDs/1000 Admissions) with Trusts in SW

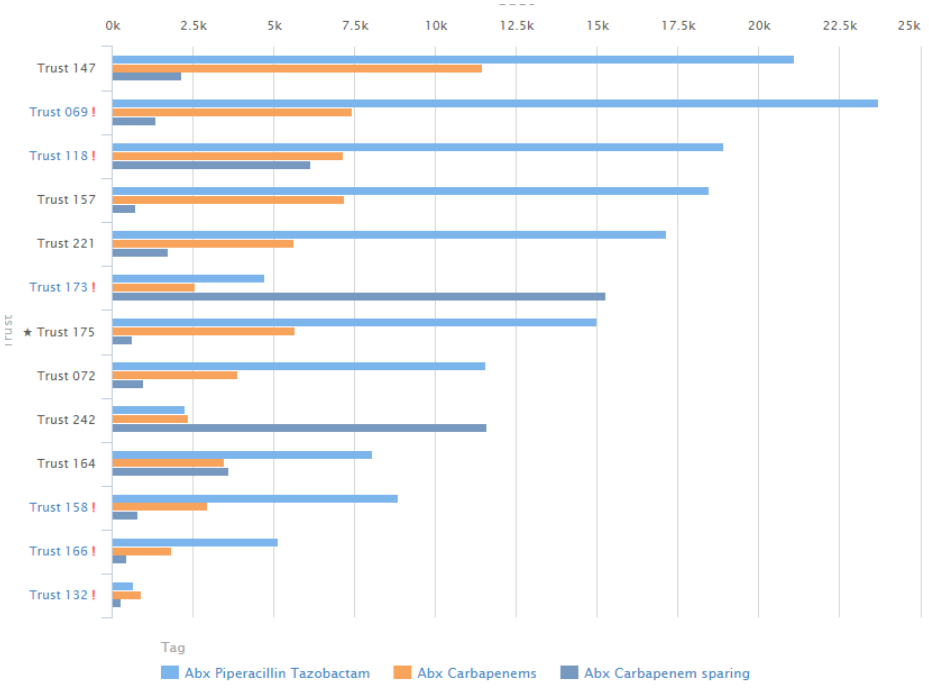
Carbapenems are the 3rd line antibiotics and should be used as sparingly as possible. Below is a plot of Carbapenem use showing TSDFT's use is increasing. The Actions set, to date, are an Antimicrobial Stewardship Group and considering how to de-label penicillin allergy: see next section for more details.



[Report - Define Reports (thirdparty.nhs.uk)](#) TSDFT= Trust 175

Carbapenem Sparing Benchmark (DDDs over 1 year) with Trusts in SW

TSDFT is in a median place for Carbapenem Sparing antibiotic use by using alternative antibiotics.



[Report - Define Reports (thirdparty.nhs.uk)](#) TSDFT= Trust 175

5. Antimicrobial Stewardship

5.1 The prescribing policy is documented in CG1098 and was updated & ratified in 2022. Detailed Antimicrobial Prescribing Guidelines are available for adults (CG0040) updated in 2022, paediatrics (CG1118) and neonates (CG1670) updated in 2022, on the Trust intranet site and the Apple and Android App: called BugBuster3000. The

TSDFT 3-year Antimicrobial Strategy was updated in 2022 and ratified at the Infection Prevention & Control Group Meeting in March 2022 (as Appendix 4 of CG1098).

5.2 The Antimicrobial Team (AMT) consists of a Consultant microbiologist and an Antimicrobial Pharmacist (AP). Due to a combination of vacancy (consultant microbiologist post and long-term leave (pharmacist) team under-power during the reporting year. The AMT reports to the Infection Prevention & Control Group (IP&CG) which now meets quarterly.

5.3 The use of antimicrobial agents safely and effectively is an important safety aspect of care provided. The AP performs monthly, Antimicrobial Saving Lives audits on: allergy status recorded, appropriate cultures taken before antibiotics, indication given, duration specified & evidence of review, on all in-patient wards every month. These results are fed-back to teams each month with an action plan and reported to the IP&CG Meeting as part of the Saving Lives reports. The TSDFT infection Prevention & Control (IP&C) Group has set the Antimicrobial Saving Lives score to be reached at 85%. This was met in 10 out of 12 months in period covered by this report with an improvement of 14 out of 23 areas (60%) complying: compared to 26% in 2020/21. Ongoing work to further improve this includes the Anti-microbial Trust wide Surveillance Group.

5.6 National bench-marking shows that our overall use of antibiotics appears appropriate. We are in line with similar trusts, though direct comparisons are blunt tools as for example, no account of age is included in the PHE Fingertips data and our community hospital use is not included.

<u>The AMT's Antimicrobial Stewardship Annual Forward Plan: April 2021 to March 2022– Actions updated in 2022</u>

Objective	Target	Completed
Establish a system for surveillance of antimicrobial resistance: • Continue to calculate local resistance rates for antimicrobials in current guidelines and monitor annually. • Present results in the Annual Antimicrobial Stewardship Report.	April 2022	May 2022
Establish a Job Plan for the Antimicrobial Pharmacist: • Ensuring that sufficient time is allocated to Antimicrobial Stewardship • Include sending out Saving Lives results with Action plans and check that these are completed.	June 2021	May 2022
Review Trust antibiotic guidelines: • Literature search and review of evidence re efficacy and safety of antimicrobial • Discuss guidelines with stakeholders • Ensure compliance with NICE prescribing guidelines and document the reason for any exceptions • Aim to align with those guidelines of East & North Devon as part of the work towards a SEND Microbiology service.	March 2022	May 2022 Adult (CG0040) and Neonatal (CG1670) Antimicrobial Guidelines rewritten

		and aligned with SEND as far as possible.
Compliance with CQC's Antimicrobial Stewardship Quality Standards: • Discuss with Medical, Surgical, Gynae, Paediatric, T&O, Acute Medicine & Respiratory consultants, interested in Antimicrobial prescribing, the setting up of an Antimicrobial Stewardship Group. • Set Action plans for prescribers to follow so that all areas score 85% in their Saving Lives monthly Antimicrobial Audits.	March 2022	Not completed due to lack of stakeholder engagement
Update Antimicrobial 3 year Strategy and to include Horizon scanning	June 2021	Completed March 2022

The AMT's Antimicrobial Stewardship Annual Forward Plan: April 2022 to March 2023

Objective	Target
Establish a system for surveillance of antimicrobial resistance: • Continue to calculate local resistance rates for antimicrobials in current guidelines and monitor annually. • Present results in the Annual Antimicrobial Stewardship Report.	April 2023
Antimicrobial Pharmacist to fulfil Job Plan • Ensuring that sufficient time is allocated to Antimicrobial Stewardship • Include sending out Saving Lives results with Action plans and check that these are completed.	April 2023
Write a Job Plan for the new Microbiology Physician Associate • Ensure that Antimicrobial Stewardship is included	Dec 2022
Review Trust Paediatric (CG1118) antibiotic guidelines: • Literature search and review of evidence re efficacy and safety of antimicrobial • Discuss guidelines with stakeholders • Ensure compliance with NICE prescribing guidelines and document the reason for any exceptions • Aim to align with those guidelines of East & North Devon as part of the work towards a SEND Microbiology service.	April 2023
Compliance with CQC's Antimicrobial Stewardship Quality Standards: • Discuss with Medical, Surgical, Gynae, Paediatric, T&O, Acute Medicine & Respiratory consultants, interested in Antimicrobial prescribing, the setting up of an Antimicrobial Stewardship Group. • Facilitate Antimicrobial Education	April 2023

• Facilitate Antimicrobial Audits	
Horizon Scanning on Penicillin Allergy De-labelling • Studies show that around 10% of patients labelled with a penicillin allergy are actually allergic to penicillin. De-labelling will reduce TSDFT's Carbapenem use.	April 2024

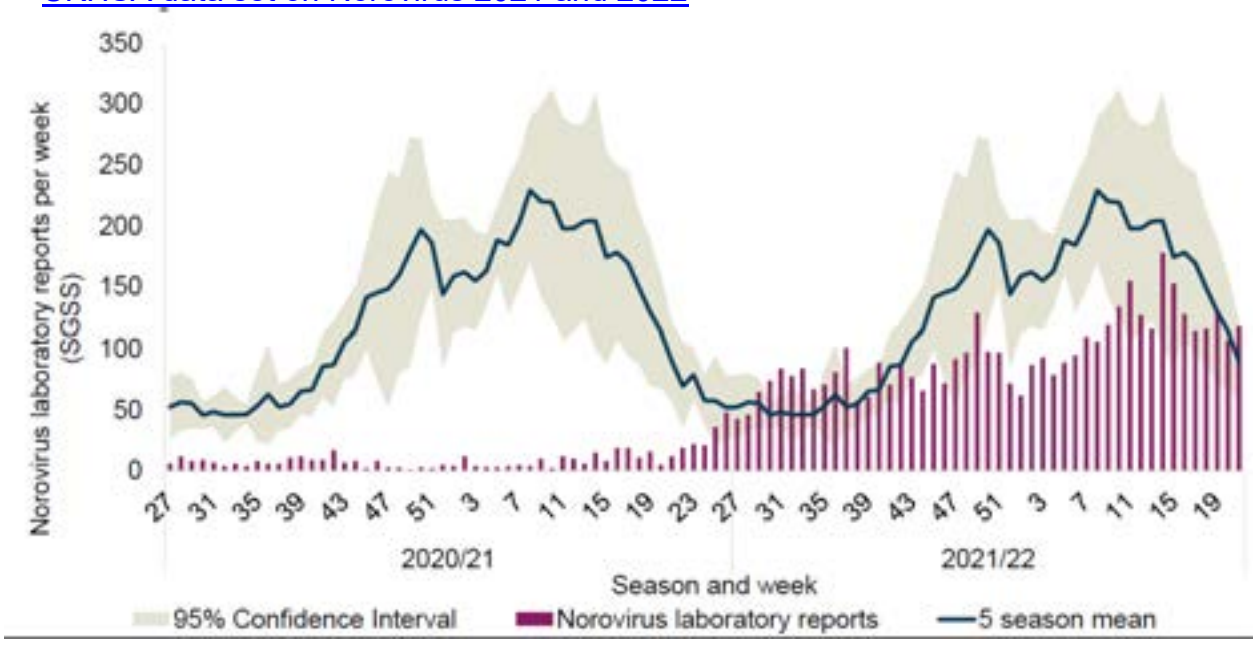
6. Seasonal Viral Infections (not COVID 19)

6.1 Norovirus and other Viral Gastroenteritis

From April 2021 to March 2022 there was four ward closures due to viral gastroenteritis. This is within normal variation seen each year as in the last three years there have been 0-4 wards closed.

An increase on last's Norovirus incidence was expected as there has been nearer to normal (i.e. pre-pandemic) mixing with no school closures in the year. The UKHSA is reporting that case incidence is around or below the rolling 5 year average.

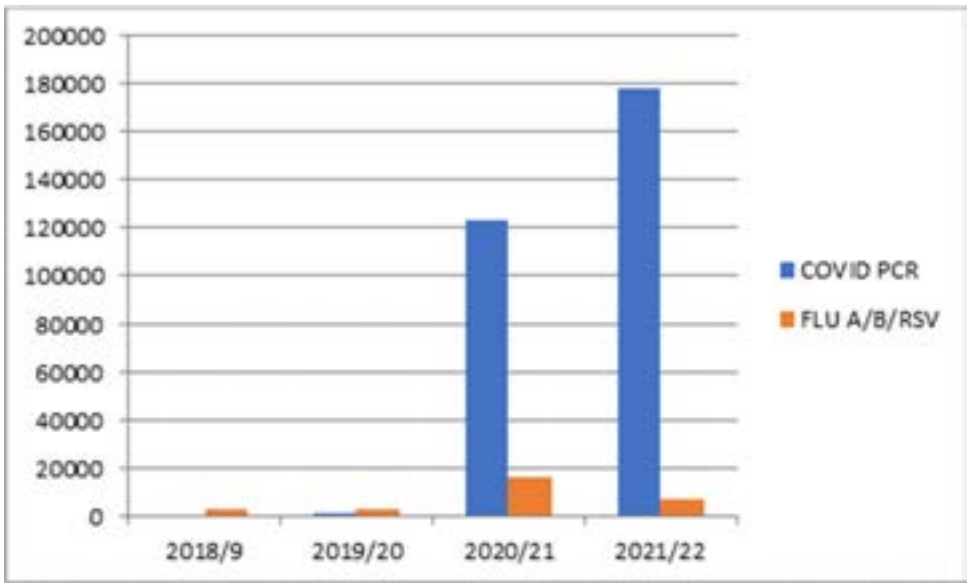
UKHSA data set on Norovirus 2021 and 2022



6.2 Influenza (flu) and Respiratory Syncytial Virus (RSV)

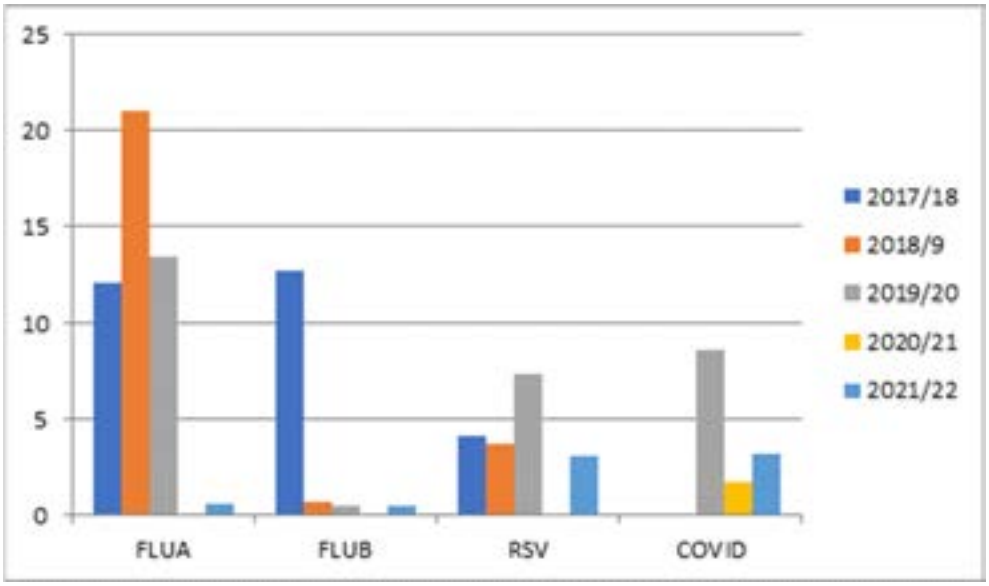
The winter of 2021/22 did not see a rise to pre-pandemic levels of influenza or RSV. The graphs below illustrate this point as well as showing activity relating to COVID as well as these two infections. The large number of COVID tests performed compared to the other respiratory infections, is due to high case numbers from October 2021 onwards as well as the mandated surveillance regimen of all hospitalised patients to pick up nosocomial COVID.

Figure Numbers of Flu/RSV/Covid tests



From the number of tests, the next figure shows the percentage positive for each infection. Numbers remains significantly lower than in pre-pandemic years. As yet there has not been a rebound in these infections. This is expected for flu in the next winter (2022/23).

Figure Percentage positive Flu/RSV/Covid tests from winter of 2017/18 to present reporting year.



6.3 Staff Flu Vaccination Programme

The staff vaccination programme succeeded in vaccinating >70% of frontline staff. The programme ran alongside the COVID 19 Booster vaccination programme with both vaccines being offered at the same time in 2 separate injections. An extensive programme was run along similar lines to previous years with multiple access points for staff to attend. The team ran an exceptional service which won the Chair's Award in Staff Heroes 2021.

7. Surveillance, Audit and Mandatory Training in Infection Prevention and Control

7.1 Monthly Saving Lives Audits & Hand Hygiene Audits

The IPC Team perform these audits for:

- Hand hygiene
- Care of peripherally inserted cannulas,
- Care of centrally inserted lines
- Care of urinary catheters.

Results are emailed to the Ward Managers, Matrons, ADN/PPs and Consultants. The pass score is 95% and the results should be displayed on the ward dashboards. When a pass is not achieved the Ward Manager has to repeat the audit within 15 days. All results are displayed on ICON at the IPC site. The re-audit of Saving Lives when 95% is not reached has become a KPI on the Annual Forward Programme and the results are put on the ward quality performance tool (QUEST).

7.2 Surgical Site Infection Surveillance (SSIS)

The national surveillance is run centrally and every year it is compulsory to report total hip replacement (THR) and total knee replacement (TKR) SSIS.

IPC work with Trauma & Orthopaedics to run a lab-based ward SSIS using internationally recognised definitions and post-discharge surveillance for a year. Elective activity for hip and knee joint were rarely performed in the year of the report by our organisation, thus meaningful data is not obtained. Surveillance will restart in July 2022.

7.3 Mandatory Training

The IPC Team work with the Education & Training Team in the important area of mandatory training for IPC. Across our ICO we have an acceptable level of training compliance averaging throughout 2020/21 86.19%. This is for levels 1 & 2 IPC mandatory training. Level 2 required a focus on it as this level averages 81.25%. In this year, we have looked to set up a new level 2 training for our training doctors joining in August 2022; a virtual reality training programme.

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Infection Control L1*	91.75%	91.00%	90.91%	90.87%	91.62%	91.56%	91.52%	91.18%	90.84%	90.58%	90.77%	91.28%
infection Control L2*	82.15%	82.95%	84.74%	82.48%	82.71%	82.30%	82.28%	82.77%	82.00%	81.64%	82.40%	82.41%

8. Report on Community based IPC Activity

8.1 The IPC team work across our hospitals and out of hospital sites. Since April 2020 our IPC team has been contracted through Devon CCG to provide IPC advice to our local care homes, domiciliary care, supported living and GP surgeries.

Throughout 2021/2022 we have continued to support and advice regarding hospital acquired outbreaks. This has consistently involved either a direct visit or virtual walk around. At the request of Devon CCG, the IPC team presented at their IPC webinar on learning from outbreaks.

A positive development this year has been to extend investigation of causes for community HAI *C.diff* infections. IPC are sending an investigation questionnaire for CDTs identified in GP surgeries. The response has been good and we continue with this throughout 2022, to report after a full year of activity and improvements.

Other Community IPC Work

Community Hospitals all perform and submit the same Saving Lives and Hand Hygiene Audits as detailed in section 7 above. The same monitoring and actions are required in these settings as with Torbay Hospital, our acute site. IPC work closely with QAIT and public health to identify areas that needs input from IPCT.

IPC also contact Care Homes if any residents have an alert organism to offer advice on how to manage in the care home setting. This is most likely to be around urinary catheter care

9. Decontamination

9.1 The Decontamination Lead provides assurance on compliance with the Trust's decontamination policies and National policies from Medicines & Healthcare products Regulatory Agency (MHRA) April 2015 and best practice guidance. The Decontamination Group did not meet in the year due to operational pressures and extended leave, highlighting the vulnerability of the oversight without a Deputy Lead in place. Exception reporting and the risk register have been maintained over the year 2021/22.

9.2 The Hospital Sterilisation & Decontamination Unit's (HSDU) Washer Disinfectors and Sterilisers for surgical instruments have all servicing and testing up to date. The Reverse Osmosis Water Systems that supply the Washer Disinfectors and Sterilisers are also serviced and satisfactory. The HSDU have an annual compliance audit carried out by a Notified Body (Société Générale de Surveillance), appointed on behalf of the MHRA. The successful 2021/22 audit shows that the HSDU continues to be accredited to the UKCA Medical Devices Directive and allows the department to continue to supply sterile medical devices outside of the Trust.

9.3 The Endoscopy Washer Disinfectors' (EWD) servicing and water tests are satisfactory.

9.4 The new Tristel rep took over the South West region in February 2022 and has completed audits for Torbay Head and Neck services and Hutchings Ward and Totnes Outpatient Department on 16th June 2022 he will visit each remaining departments using the high level disinfection with Tristel (chlorine dioxide), Tri-wipe and Tristel Duo Systems to complete the Trust annual audit and training schedule by the end of July 2022.

10. Water Safety

10.1 Water Systems Management Group

This group meets quarterly to review water safety and ensure compliance with HBN 01-04. Positive results for Legionella species or *Pseudomonas aeruginosa* are subject to remedial actions, re-tested until clear and reported to the group and Capital Infrastructure and Environment Group (CIEG).

10.2 Legionella species have been isolated in Paignton Hospital and separately in the Tower Block of Torbay Hospital. Actions taken to successfully eradicate these isolates. Surveillance remains ongoing after containment of these issues. No isolation of pathogenic Legionella species has occurred this year. Flushing in ICU and high-risk areas has been instigated in line with national standards including audits.

11. Ventilation

11.1 All specialist ventilation systems in theatres and other interventional departments have comprehensive maintenance monitoring with reviews by specialist engineering contractors as required. A programme of maintenance, improvement and refurbishment is followed.

11.2 Ventilation is a known to be critical factor in infection prevention and control. Florence Nightingale herself advocated that the windows should be kept open in hospitals. During the course of 2021/22 proxy measurements (Carbon Dioxide level) for the level of ventilation achieved in the Tower and Hetherington have been made under the DIPC's instruction. These measurements have shown that the Tower wards have acceptable level of air circulation, with specific areas being relatively high. Windows can be opened with a specific tool for the higher ones. The Hetherington Wards are still being investigated and whilst reaching acceptable levels of the ventilation further work is underway to review this with solutions being considered. This work is also relevant for the rebuild and refurbishment of Torbay Hospital in the New Hospital Programme build (referred to as Building a Brighter Future within our ICO).

11.3 IPC team has been working closely with Estates in this past year with the Deputy Director of Environment, Jake O'Donovan, taking a special interest in the IPC work and supporting multiple changes. Estates held the first Ventilation Safety Group (VSG) meeting on 16/6/22 with the Authorising Engineer (AE), Authorised Person Ventilation and the consultant Microbiologist also present as stipulated in Health and Technical Memorandum (HTM) 03-01 Specialised ventilation for healthcare premises. The Term of Reference for the Group were agreed at the VSG and a small amendment was made that the reports from the meeting would go to the Infection Prevention and Control Group (IP&CG) but should also go to the trust's Estates governance group- EPCG. Assurances were given that the annual verifications of special ventilation in the trust was on target. A Ventilation Incident log, Action Plan, Ventilation Risk assessment and Ventilation Policy will be developed for future meetings.

12. Infection Prevention & Control Annual Plan for a) current year: 2021/22 and b) looking forwards: 2022/23

Our Vision for IPC in Torbay & South Devon NHS FT:
In our ICO the responsibility of infection prevention and control is everyone's business. Our work is to continuously build the skills and knowledge that keep us safe from infections who ever and where ever we are in our ICO and community.

12.1 Annual Plan for 2021/22:

2020 taught us that IPC is key to keeping ourselves, our people (staff, service users, families) and our community safe. The whole IPC team is committed to building on our core work and achieving even better infection prevention/ control. We recognise that we work within the context of what we need to achieve as an anchor organisation within our community and the wider Devon Integrated Care System. Below is a table with our goals for 2021/22 and how we measured up against these.

Our Goals	How have we done?	Next steps
Excellence in low rates of HAI	• MRSA- with one HOCA we have a never event. We recognise that IV drug use is a major risk factor for these • Below NHSE threshold for all GNB; threshold reduced every year • *C.diff* lower than threshold with no onwards transmission to inpatients • Good performance in COVID HAI esp considering poor quality of estate	• Catheter care focus • Antibiotic usage more targeted
Excellence in staff knowledge and practice in IPC measures	• Improvement in vaccination uptake, led by COVID vaccination programme • Top 3 NHS organisations in SW for staff vaccination uptake	• Training focus to improve clinicians completing level 2 IPC training
Working with the Building a Brighter Future Programme for the re-build & re-furbish work	• Good examples of working with Estates to ensure IPC factors e.g. MRU build, doors on bays and ventilation projects	• Develop relationships further with BBF and estates in

		line with New Hospital Programme's timeline- delayed

12.2 Infection Prevention & Control Annual Plan for 2022/23Our Goals:

- Achieving the national target of decreasing Gram Negative Blood infections by 50% from 2019 baseline: this would be a year ahead of the national objective to do by 2024
- Improve antibiotic prescribing across the ICO to support decreases in HAI, antibiotic resistance and over-use
- Excellence in IPC measures within the Building a Brighter Future Programme as we establish plans for the rebuild/ refurbishment of Torbay Hospital

Our outcome measures continue to be:

- Incidence of HAI
- Attributable HAI to our ICO
- Bed closures due to HAI outbreaks
- Compliance with Saving Lives Audit & Hand Hygiene
- Antibiotic Prescribing standards
- Completion of Mandatory IPC training level 2
- Flu vaccination uptake (may include further COVID vaccinations)

Our Plan

- Working with nursing colleagues on our 'Journey to Excellence' and the QI team on how to develop improvement further. Specific work includes:
  - Developing local IPC leaders/ champions, supported by regional IPC leadership programme opportunity
  - Work on pathway for decreasing *E. coli* (GNB) early infections through understanding increase in these infections secondary to longer waiting lists
  - Improving our green footprint- reducing inappropriate use of gloves where use not contributing to IPC risks
- IPC to be a central development of the Outline Business Case for the Torbay Hospital new build and refurbishment plans in our BBF Programme

13. Concluding Remarks

The Annual IPC Report this year details how we have responded to the COVID 19 pandemic in the second year and demonstrates that our organisation takes IPC measures seriously, dealing with them effectively. Our approach is in line with both national guidance and recommendations set out in the Health & Care Act 2008. We will work in the coming year to improve performance further and step up to challenges which will inevitably come our way.

Appendix A: Covid 19 IPC compliance status with central guidance

In response to the COVID 19 pandemic IPC guidance has been disseminated by various bodies. Most important and relevant have been UK Health and Safety) and national/ regional NHS EI. The guidance has been updated throughout the year with constant attention applied in order to remain current in practice and compliance.

The table below summarises the current iteration of the content of guidance from the above bodies and TSDFT's compliance status.

Content Area	UK HSA[1] (includes previous Public Health England work)	NHS Operating Framework[2]	TSDFT Status
Organisational preparedness	Overview of organisational systems to identify and control Covid 19	Planning testing capacity, medicines supply, consumables and PPE.	Compliant
Reducing the risk of transmission of Covid 19 in the hospital setting	A description of the hierarchy of controls for IPC processes	Follow UKHSA guidance	Compliant
Personal Protective Equipment (PPE)	Descriptions of the two levels of PPE ensemble and where and when to wear them. Includes Fit Testing and reuse and sessional use of PPE and description of the correct use of the range of PPE items.	Follow PHE guidance	Compliant: for cardiac resuscitation level 3 PPE used in line with Cardiac Resuscitation Council Guidance; PHE recommended level 2 PPE. From Spring 2021 TSDFT went to using FFP3 masks in COVID wards, where majority of patients had active COVID i.e. blue wards with EAU4 on 6 (previously Cromie) and others as required.
Occupational Health and staff deployment	Principles of exclusion from work, deployment,	Consistency in staff allocation and avoidance of staff cross over between pathways.	Compliant. RIDDOR process set up and reviewed for staff

	redeployment, risk assessment, training and monitoring.		who may have contracted COVID through work
Planning, scheduling and organisation of clinical activity	Not covered in detail	Principles of patient pathways for planned and elective care, and urgent emergency care. Maximising opportunities for physical and/or visible separation between patients on different pathways. Managing asymptomatic and 'protected' (14 day isolation and test) as well as shielded patients separately from the emergency and urgent pathway. Triage, separation and testing within the emergency pathway.	Compliant. TSDFT also developed using PCR control thresholds to look at infectivity of inpatients as this helped to move people off the COVID wards (blue pathways) at an appropriate time. In March 2022, guidance from NHSEI/ UKHSA formalised new approach
Testing of patients and staff	Not covered	New guidance issued 30 March 2022.	Lateral flow tests recommended for inpatient testing; decision made in April 2022 along with subsequent guidance to set up alternative approach. Approved through Board May 2022 (EBM)

1. UKHSA: COVID-19 infection prevention and control guidance (updated throughout 2021/22)
2. NHS Operating framework for urgent and planned services in hospital settings during COVID-19 (updated throughout 2021)

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Maternity Governance & Safety Report (1 April 2022 – 30 June 2022)			**Meeting date:** 27 July 2022
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	Head of Midwifery and Gynaecology Clinical Governance Co-ordinator Digital & Quality Improvement Midwife Deputy Head of Midwifery		
Report provenance	The content of this report is a summary of the safety improvement activities implemented by the Maternity Governance Group within the Trust to meet the national priority to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025. This is informed by the Safety workstream of the Devon Local Maternity & Neonatal System (LMNS).		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to inform the Trust Board of Directors of the work being undertaken by the Maternity Governance Group. It also informs the membership of recommendations made within the Ockenden Interim Report (Dec 2020). • The paper specifically sets out the Trust position and compliance with the Ockenden Report as of 30th June 2022. • Setting out the Trust position in relation to perinatal mortality and morbidity, specifically reduction in still births. • Progress and next steps with regard to achievement of CNST key safety actions • An update on progress against Maternal Continuity of care (COC) • Evidence of the Trust's position in line with the NHSEI Maternity self-assessment tool An expectation of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme is that a quarterly report will be presented to the Trust Board.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board of Directors are asked to: • Note the progress and compliance position with regard to the priority areas • Note the key quality and safety issues identified in the report • Note progress and next steps with regard to the CNST process		

Summary of key elements	
Strategic objectives supported by this report	

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

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

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

External standards affected by this report and associated risks			

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

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

Report title: Maternity Governance & Safety Report (1 April 2022 to 30th June 2022).	**Meeting date:** 27 July 2022
Report author	Associate Director of Midwifery & Professional Practice/HoM Clinical Governance Co-ordinator Maternity Safety Champion/Deputy Head of Midwifery Digital & Quality Improvement Midwife

1.0 Introduction

Safety, quality and experience is a fundamental priority for the maternity and neonatal services at Torbay and South Devon NHS Foundation Trust. The publication of both the Ockenden Interim Review of Maternity Care at Shrewsbury and Telford, December 2020) and Ockenden Final Report (March 2022) sadly provides all maternity and neonatal providers and commissioners with evidence of the devastating effects and consequences that poor culture and governance can have on families. NHS England & Improvement have set out clear expectations in response to the Ockenden Report for all providers of maternity care.

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

This quarterly report will be constructed to meet the recommendations within the Ockenden report as well as addressing the reporting requirements for MIS. We plan for this to be an iterative process, firstly as the Board and maternity services work to review, amend and strengthen existing reporting mechanisms, and secondly as NHS England & Improvement (NHSEI) provide additional resources to support Trusts in enhancing their safety culture.

This quarterly report will look back at the period 1 April 2022 – 30 June 2022

2.0 Review and monitoring of safety within maternity services

2.1 Ockenden Maternity Review

The Ockenden Interim Report into Maternity Services at Shrewsbury and Telford NHS Trust was published in December 2020. In conjunction with this, NHS England and Improvement set out a series of 7 immediate and essential actions (IEA) and all Trusts were required to provide evidence of assurance against these IEA's.

All outstanding actions for Torbay and South Devon NHS Trust are now completed for all elements of the 7 IEA's.

The final Ockenden Report was published on the 30th March 2022 outlining additional concerns that had been identified at Telford and Shrewsbury NHS Trust. The Board will recall an update in April 2022 about the final report . We are awaiting further direction around the next steps for provider organisations. However, a number of interventions have already been implemented:

- The initiation of a review of maternity governance processes in line with Trust review by the Good Governance Institute
- Listening forums for staff set up with Head of Midwifery and Gynaecology

- Board seminar on the wider Trust implications of report.
- Regional and System Insights visit on 28th July 2022. The all-day visit will focus on progress against the 7 IEA's from the Interim report.

2.2 Perinatal Clinical Quality Surveillance Model

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

Principle one focuses on strengthening trust level oversight for quality, with 6 requirements. Progress against these are detailed in Table 1. The Trust is able to demonstrate full compliance in all areas of principle one.

Table 1: Perinatal Clinical Quality Surveillance Model

PCQS Requirements	TSDFT position
1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.	In place √ Sally Taylor, NED
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.	In place √Maternity metrics included within √Integrated Performance Report (IPR)
3. That all maternity Serious Incidents (SIs) are shared with trust boards and the LMNS, in addition to reporting as required to HSIB.	In place
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.	In place √Dashboard included in IPR. √SI's – as above √Minimum dataset being reported within quarterly report to Board. See Table 3.
5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMNS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.	In Place ✓ Perinatal clinical quality surveillance model reviewed in collaboration with the local maternity system (LMNS) lead and regional Chief Midwife. ✓ Agreement reached to formalise how Trust-level intelligence will be shared to ensure early action and support for areas of concern or need.

	√Standard operating procedure
6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model	In place ✓ Board Level, NED, Obstetric and Midwifery Safety Champions ✓ Monthly Safety walkarounds with Board Level and Midwifery Safety Champion ✓ Bi-monthly safety reports provided for Board Level Safety Champion ✓ NED involvement in Maternity meetings and walkarounds ✓ Key maternity meetings form part of the NED's diary, minutes from meetings emailed to NED Action: • Review NED capacity • Benchmark against safety champion toolkit and how to guides

2.2 Trust Board Reporting – Quality and Safety within Maternity Services-

Table 2 sets out the mandated reporting framework for maternity quality and safety metrics. The Board will note that quality and safety metrics are reported on a monthly basis through the Board IPR. See Table 2 for PCQS minimum dataset information summary for Q1 (April- June 2022) The metrics will continue to be reported through the ISU Safety and Governance routes via QAC and Trust Board.

Table 2: PCQS Minimum Dataset Information Summary

	April	**May**	**June**
Findings of review of all perinatal deaths using the real time data monitoring tool	No reviews undertaken.	Four historic cases reviewed	Two historic cases reviewed
Findings of review all cases eligible for referral to HSIB.	New referral MI-008239	No new referral	New referral: MI – 010616 MI-004774 Completed case. Trust met with family.
Report on: • The number of incidents logged graded as moderate or above and	**4 Moderate incidents reported**	**None**	**2 Moderate Incidents reported**

what actions are being taken • Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training • Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.	-Stillbirth at 27 weeks -Caesarean hysterectomy -Midwifery and Medical staffing concerns. -Baby met criteria for HSIB- therapeutic cooling. **Training –** 95% compliance **Staffing** – Ongoing challenges remain. Full details in section 4	**Training –** 94% compliance **Staffing** – Ongoing challenges remain. Full details in section 4	-Therapeutic cooling - HSIB -Stillbirth at 40+3 weeks **Training** –94% compliance **Staffing-** Ongoing challenges remain. Full details in section 4
Service User Voice feedback	Feedback mechanisms in place.	Feedback mechanisms in place	Feedback mechanisms in place
Staff feedback from frontline champions and walk-about	Completed	Completed	Completed
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Nil	Nil	Nil
Coroner Reg 28 made directly to Trust	Nil	Nil	Nil
Progress in achievement of CNST 10	An update was provided to the Board regarding Element 1 of the SBLCB - reducing smoking in pregnancy with action plan in place	Year 4 scheme relaunched May 6th – Self declaration to Board required -5th Jan 2023	Request submitted to IGG for PMO support to collate evidence required. Some difficulty in the ability to extract data following the change to maternity record to System 1

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

2.3 Serious Adverse Events

2.3.1 Perinatal Mortality Review Tool (PMRT)

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

The maternity service writes to all parents to advise them that a review will take place. They are given the opportunity to provide a perspective about their care and raise any questions that they have.

The team are now using the templates that are provided on the PMRT website, and record all family feedback and questions into the parent engagement section of the PMRT. We have now established a process of inviting external reviewers to the PMRT reviews as set out in the standards.

2.5.1.1 PMRT - Notifications

During April-June 2022 there were two new cases that met the PMRT criteria and were reported. Details of the cases are

- Antepartum Stillbirth at 27+5 weeks gestation
- Antepartum Stillbirth at 40+3 weeks gestation

Both of the cases have undergone duty of candour and will have a multidisciplinary case review using the national PMRT process for review.
The initial Trust review of both cases has not identified any concerns

2.5.1.2 *PMRT – Completed Reviews*

During Q1 we completed six reviews of deaths that occurred prior to Q1.

The learning identified related to the analgesia that is offered to women following the death of a baby. This promoted the Lead obstetric anaesthetist to review and update local guidance around opiate and epidurals for stillbirth analgesia using guidance from SANDS (Stillbirth and Neonatal society), the Royal college of Obstetricians and Gynaecologists (RCOG), TOMMYS, and the Obstetric anaesthetist association.

2.5.2 Healthcare Safety Investigation Branch (HSIB)

2.5.2.1 Referrals to HSIB

In Q1 two new cases were referred to HSIB

Case 1. April 2022- The Mother, laboured spontaneously and delivered at home. Shoulder dystocia was recognised and manoeuvres undertaken to deliver the Baby who

was born in poor condition. The baby was resuscitated at home and transferred to the Maternity unit. Subsequently the Baby was transferred to the regional level 3 neonatal unit for therapeutic cooling.

Initial findings from Trust review:

- Excellent resuscitation from midwives in homebirth setting.
- Review of the local guidance around women choosing to birth outside our recommended guidance to include input from SWAST

Case 2 June 2022- A Mother in her first pregnancy developed meconium staining of the liquor in labour as well as abnormal electronic fetal monitoring of the baby. The Baby was born by an emergency caesarean section and required resuscitation and was subsequently transferred to a level 3 neonatal unit for therapeutic cooling.

Initial findings from Trust review:

- Slight delay in administration of antibiotics in labour although unlikely to have impact on outcome
- Incidental finding of a discrepancy in times recorded in the electronic patient record by midwife and doctor around theatre transfer time. No impact on outcome

2.5.2.2 Finalised investigation reports from HSIB

In Q1 the maternity service received one final report from HSIB, and were advised to put in place two safety recommendations. The Maternity service also developed a further local recommendation.

The recommendations and progress against actions are detailed below.

1. The Trust to ensure that high risk mothers undergoing induction of labour have a customised plan of care, are assessed in line with local guidance and have appropriate fetal monitoring in accordance with local and national guidance

- The lead obstetrician for delivery suite is reviewing and updating local induction of labour guideline to ensure that local policy meets the recommendation with NICE and also the findings of the HSIB report

2. The Trust to implement the direct transfer of women to the obstetric theatre when a bradycardia is identified outside of the delivery suite.

- There has been significant consideration of the operating model for the obstetric theatre by the senior leadership team along with Board discussion. Consultation within the region to ascertain the operating models in similar sized units has also been scoped. The Trust has agreed to move forward to recruit to the surgical theatre team to enable a 24/07 second on site emergency theatre team. Until such time that the team is fully established, significant mitigation has been put in place. This includes a procedure of escalation to support the deployment of theatre staff when required. Further mechanisms to train and aid staff in the recognition of abnormal electronic fetal monitoring have been initiated.

Local recommendation:
3. The Maternity service does not have any written information for women to explain the process of induction of Labour using a cervical ripening balloon.

- A patient information leaflet is being developed for women undergoing induction with this method

The family met with the Head of Midwifery and the Clinical Service lead to discuss the final report and the action plan developed in response to the investigation and were given an update on the progress of the actions.

2.5.2.3 Quarterly Engagement Visit with South West Maternity Investigation Team

There has been no engagement meeting with HSIB in this quarter. A planned review was cancelled by the South West HSIB investigation team.

2.6 Safety Improvement-

2.6.1 Maternity and Neonatal Health Safety Improvement Programme (MATNEOSIP)

The Perinatal Excellence to Reduce Injury in Premature Birth (PERIPrem) project now falls under Mat Neo SIP programme requirements for Maternity.

The most recent MatNeoSIP Patient Safety Network Event, was held on 16 June 2022. The event included a Perinatal Health Equity update, information on the ABC (Avoiding Brain Injury in Children) project, a presentation on maternity data, details of resources provided by the 'Safer Sleep' pilot practitioner (Lullaby Trust) and an update on the optimisation work of the PERIPrem project. At a recent visit in May 2022 the PERIPrem Operational Clinical Lead highlighted that Torbay has the second highest rate of optimal cord clamping of all units in the country. This demonstrates the excellent perinatal collaboration and multi-disciplinary work across maternity and neonatal services.

In addition, the Maternity Safety Champion has attended a 2-day Cultural Competency and Safety workshop, aimed at reducing health inequalities and outcomes in maternity due to race.

2.6.2 Saving Babies Lives Care Bundle

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

At the final SBLCBv2 quarterly report submitted in April 2021 we were able to demonstrate full compliance. We therefore fully met the standard for the CNST safety actions for Year 3.

The Board will recall previous escalation regarding the potential non-compliance around the element pertaining to a reduction of smoking in pregnancy, specifically CO monitoring. We are continuing to monitor and review progress against the associated action plan. Due to the implementation of the maternity electronic patient record in May 2022, there has been difficulty in extracting the data fields for smoking so this is having to be done in retrospect. Therefore, the ability to provide current compliance for Q1 will be slightly delayed

2.6.3 Stillbirth Rate

One of the aims of SBLCB v1 and v2 is to reduce the number of stillbirths. National comparative data for England for 2020 has been published and this remains at 3.8% the same as the previous year. TSD is still below the England rate.

2.6.4 Avoiding Term Admissions into Neonatal Units – ATAIN

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

For this reporting period, 5.1% of term babies were admitted to the Special Care Baby Unit. This is a decrease from 6.5% seen in the last reporting period and is just above the target of 5% or less.

There are a number of constraints that remain with regard to this workstream. Predominately this is due to space and capacity issues within the clinical area. The estates strategy for the Women's Health Unit, which had been approved prior to the COVID-19 pandemic, included provision of dedicated Transitional Care Facilities in the space on Macullum ward. This would enable us to continue our improvement journey to support the on-going care of babies with additional needs, but not requiring SCBU and ensuring mothers and babies are not separated. The team are in the process of reviewing and refreshing the estates strategy.

2.7 Maternity Safety Champions

The Maternity and Neonatal Safety Champions are currently working with the Transformation Midwife to raise the profile of the maternity and neonatal safety champions across the services. The monthly walkarounds with the Board Level Safety Champion (BLSC) and the Non-Executive Director representing Maternity are advertised to staff and provide the opportunity for maternity and neonatal staff to raise any safety concerns directly with the BLSC and NED. This is in addition to the monthly safety drop-in meetings that are held for maternity and neonatal staff.

Concerns that have been raised by staff recently include:

Disabled access on John Macpherson – lack of facilities for disabled women on the ward, no walk-in shower/wet room.
Action: Ward Manager has been asked to meet with the Trust's Equality & Diversity Lead to consider how one of the side rooms could be adapted to provide better facilities and then quotes to be obtained from Estates.

Lack of storage on John MacPherson and SCBU - plus facilities to hold meetings including teaching, meetings with social workers etc.
Action: This has been raised to the Head of Midwifery who will escalate this within the Trust.

Requirement for Trust IT device - to enable women to attend remote court hearings whilst on the ward.
Action: Quote to be obtained for a portable IT device for use by women and birthing people that will support MS Teams.

3 CNST: 10 Key Safety Actions-

Year 4 of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to support the delivery of safer maternity care was relaunched, after a pause in the scheme, on 6th May 2022. Time scales were amended and Trusts must now submit the completed Board declaration form to NHS resolution by noon **5th January 2023**

Potential Challenges/Risks

Since the introduction of the electronic maternity record, System 1, in May there was some concern around the ability to extract data for external reporting as part of the Maternity Services Dataset requirement for CNST. The data warehouse team are confident in the ability to provide this data as required however this has resulted in a delay to the report builds for the internal data reporting elements. This includes quality and safety metrics that form part of the governance reports for the speciality, for the ISU as well as data as part of the monthly IPR for Board. This data includes compliance for smoking rates as well as Continuity of Carer. This is a mandated requirement as part of the Ockenden recommendations.

4.0 Staffing

Following a brief period where staffing levels improved, we are again, at times, facing challenges to maintain optimum staffing levels within Maternity. This is due to an increased rate of sickness caused by Covid-19 as well as other short-term sickness.

Covid-19 absence has also had a significant impact on the medical workforce amongst both consultants and junior doctors.

The roll out of System 1 – EPR impacted on staffing levels due to training and requirement for additional staff to support teams in April and May 2022.

The Birthrate+ acuity data for this quarter demonstrates we were unable to support 4 out of hospital births and there were 12 occasions on which the coordinators were not supernumerary. 1:1 care in labour was maintained 100% of the time throughout this quarter.

Mitigations

On the whole the actions that are put in place enables optimum staffing to be achieved. The actions included to ensure that we meet the standards are:

- Specialist midwives and managers working in clinical roles when acuity high
- Use of registered nursing staff for support mainly on the ante/postnatal ward.
- Daily monitoring of staffing to ensure all actions are taken to maximise staffing levels.

The staffing risk score is regularly reviewed on the risk register, it was reduced from 16 to 12 in May and is on the non-corporate risk register. The rationale for reduction in score was due to the positive results of the local retention and recruitment strategy.

The maternity service had recruited to all posts created by the uplift funding from the Board, however, one member of staff has moved into a pre-existing community midwifery post and one of the international recruits has withdrawn their application.

Whilst the other posts have been recruited to there is a delay in start dates whilst awaiting staff qualification or completion of preceptorship periods. In addition, there are

a number of existing vacancies within some of the community midwifery teams, but 3 external applicants have recently been appointed

The Maternity Service is currently considering supporting two registered nurse applications for the re-introduced shortened midwifery training programmes (18-month course) and, if successful, these would both be offered substantive contracts within the service.

5. Maternal Continuity of Care (MCoC)

We submitted our MCoC plan and an assurance template to the regional team via the LMNS in June. This detailed the plan that was approved by the Trust Board of Directors in April 2022. The regional team are reviewing the plans prior to submission to NHSEI.

The HOM and the transformation midwife are in the process of completing a series of engagement events with all community teams to gather information around ideas to support staff wellbeing and improve the ability to deliver the requirements of the MCoC model. Following these forums, the feedback will be utilised to help shape the required changes. Alongside this, data is being collated and reviewed to evaluate the shift change trial that was initiated following the staff listening events that took place in the latter part of 2021.

We shared our model and plans with the national lead for MCoC in May 2022. She is planning to visit the unit during late summer to provide support with regard to staffing shift /on call patterns.

The newly appointed Deputy Head of the Maternity Transformation Programme from NHSEI is attending as part of the Insights Visit on 28th July. He is planning to speak to some midwives to learn more about the benefits and challenges of MCoC.

5. Maternity Self-Assessment

The Maternity 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, (July 2021), has been further influenced by the findings of the interim Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme, the Kirkup Report (2015) and the areas CQC found to be outstanding in other maternity services across England

The tool is divided into 7 domains which detail areas for improvement. Within the 7 domains are **160** separate evidence requirements, these have been RAG rated to demonstrate compliance. The full tool was presented to the Quality Assurance Committee in July 2022.

Out of the evidential requirements **109 (68%)** have been rated green with the ability to provide supporting evidence. A further **44 (28%)** have been rated as amber with actions required to support the progression of these evidential requirements. **7 (4%)** of the

requirements are rated as Red and will also require additional support and/ or resource to achieve the evidential requirements

The main themes highlighted during the assessment exercise are:

- A need to clarify and strengthen operational management support within the maternity services
- A requirement for a more formalised business and strategic planning plan/strategy
- Trust wide work on sharing the learning around safety
- QI process to be formalised
- Governance oversight

An action plan now needs to be developed by the maternity team in order to work towards all domains becoming compliant. This action plan will be approved and monitored at directorate and ISU governance level

6 Conclusion

The maternity and neonatal teams continue to ensure that systems are in place to provide assurance in relation to safe midwifery care. The team are committed to continuing to work with the LMNS, regional and national team to progress the MCoC model of care. The team will also address the areas highlighted as requiring resource or support as part of the maternity self-assessment tool

7 Recommendations

The Trust Board of Directors are asked to:

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Complaints, Feedback and Engagement Service Annual Report 2021/22			Meeting date: 27 July 2022
Report appendix	List any supplementary information as shown below: Appendix 1: FFT results 2020.21 and 2021.22		
Report sponsor	Chief Nurse		
Report author	System Director for Nursing and Professional Practice (Torbay System) Interim Service Lead for Feedback and Engagement Quality and Experience Lead		
Report provenance	Feedback and Engagement Group.		
Purpose of the report and key issues for consideration/decision	The report provides the Trust Board with assurance that during 2021/22 the Trust has met its statutory accountabilities and provides assurance that as a Trust we put people's experience of our services at the centre. Patient and service user feedback from people about their experience of accessing and using services provided by the trust, are managed and responded to effectively. Where learning is identified and change is required, this is implemented at a local or trust wide level to support continual improvement. The report includes: • An overview of the current Feedback and Engagement services provided across the Trust during 2021/22 • The continued challenges experienced in 2021/22 as the COVID -19 pandemic has persisted. • The work undertaken to develop our "Patient and Service User Experience of Health and Care Strategy – What Matters to You Matters to Us" 2022- 2025 which has been co- designed with our local community.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to: • Note the content of the report and the achievements aligned to feedback and engagement through 2021/22 whilst the global pandemic has continued. • Note the Outcome from the Ombudsman Reviews		

<table>
<tr><th colspan="2">Summary of key elements</th></tr>
<tr><td>Strategic objectives supported by this report</td><td>
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<tr><td>Safe, quality care and best experience</td><td>x</td><td>Valuing our workforce</td><td></td></tr>
<tr><td>Improved wellbeing through partnership</td><td>x</td><td>Well-led</td><td>x</td></tr>
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<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
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<tr><td>Board Assurance Framework</td><td>x</td><td>Risk score</td><td>16</td></tr>
<tr><td>Risk Register</td><td>N/a</td><td>Risk score</td><td>N/a</td></tr>
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BAF Objective 4: To provide safe, quality patient care and achieve best patient experience
</td></tr>
<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td>x</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>x</td><td>Legislation</td><td>x</td></tr>
<tr><td>NHS England</td><td>x</td><td>National policy/guidance</td><td></td></tr>
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Report title: Complaints, Feedback and Engagement Service Annual Report 2021/2022	**Meeting date: 27 July 2022**
Report sponsor	Chief Nurse
Report author	Director for Nursing and Professional Practice (Torbay System)

1.0 Introduction

1.1 This is the Trust Annual Complaints, Feedback and Engagement report for 2021/22 that forms part of our regulatory requirement.

1.2 The aim of the report is to provide oversight of the service provision continued during the on-going Covid-19 pandemic and the areas that have been reinstated over 2021/22 that align to revised national infection prevention and control requirements as the Covid virus has changed. The report also outlines the work undertaken to redesign, relaunch and enhance the Feedback and Engagement service across the Trust during 2021/22.

1.3 Torbay and South Devon NHS foundation Trust have a dedicated small corporate team that oversees and coordinates the feedback and engagement functions of the Trust. The Feedback and Engagement and Patient advice and Liaison Service (PALS) Team work directly with patients/ service user's or their family and carers to provide information, facilitate speedy resolution of concerns and refer patients and their carers to external or specialist support and advocacy services as required. The team works with colleagues across the organisation, together with, external stakeholders, to promote and develop the service and create robust, effective links and working relationships between the Feedback and Engagement Team and other services. The team also liaise with other PALs, advice and advocacy services in both the local health and social care communities in such a way as to ensure a seamless service for patients/clients.

1.4 The Feedback and Engagement Team are based on the Torbay Hospital site, although due to the team capacity, and increase in demand, have not been able to move to a public facing element to the service. The service has continued with a hybrid model of home working and office-based working during 2021/22.

1.5 Throughout the second year of the COVID pandemic, the Feedback and Engagement Team have been able to continue working effectively and were able to manage all queries, concerns and complaints as per Trust policy and in line with the NHS complaints regulations.

1.6 There are a number of routes through which people accessing our services and can submit their feedback including telephone, email, through the public website or in writing. The Feedback and Engagement Team do not currently have a walk-in service available as the team are based off the main site and in a building inaccessible to patients/service users. There is also a lack of appropriate rooms in which to meet members of the public on the main site at present.

The Team are committed to developing a service model which would include a public facing, open access office, thereby raising the visibility of the patient feedback service in

core business hours. This has not been achievable during 2021/22 due to team capacity and funding availability to enable development of this area in the main entrance.

1.7 Over the last twelve months, under the leadership of the System Director for Nursing and Professional Practice (Torbay), we have worked collaboratively with local stakeholders and our local community who access, use and interface with our services to develop our Patient /Service User Experience of Health and Care Strategy – What Matters to You Matters to Us three-year plan.

This has been a three -step process with an initial event in July 2021, with our health and care partners, to reflect and understand what works well, where we can improve and consider what great would look like and develop our vision for our feedback and engagement services into the future.

The second step was a facilitated event led by Healthwatch with local voluntary groups to better understand the experience that a range of groups across our foot print are sharing with their local group. We developed a vision through this work and then progressed with support from Healthwatch and our partners to fully involve our local communities to understand what matters to them, as individuals, families and communities. Step three was a survey of three questions to our local community to enable us to collaboratively co designed a programme of work that underpins what is important to the people we serve.

2.0 Accountability and Responsibility Framework:

2.1 The Chief Executive is accountable for ensuring the Trust complies with NHS complaints regulations. The Chief Executive delegates the responsibility for the effective delivery of the Trust's policy to the Chief Nurse.

2.2 The Trust Board and senior managers have key responsibilities to ensure that the culture of the organisation reflects that the Trust takes feedback and complaints seriously and expects them to be acted on appropriately

2.3 Under the management of the System Director for Nursing and Professional Practice (Torbay), the Interim matron for feedback and engagement is responsible for the operational management of the Feedback and Engagement Team comprising of the Complaints Team and Patient Advice and Liaison Service (PALS) and a small experience team.

2.4 The Feedback and Engagement Team support the Trust in the delivery of the Feedback and Complaints process through the policy that underpins practice. Their roles and responsibilities include:

- ✓ To ensure that feedback is dealt with efficiently
- ✓ To discuss with the person and work with them to resolve their concerns in the best possible way.
- ✓ To promote PALs as an informal, client focused service that deals with problems and concerns as quickly and effectively as possible
- ✓ To ensure people are treated with respect and courtesy
- ✓ To ensure complaints are properly investigated

- ✓ To ensure people receive help to understand the complaints procedure
- ✓ To ensure people receive advice on where they may obtain assistance with the procedure
- ✓ To ensure people receive a response that provides an explanation and response to their complaint and are clear about the outcome of the investigation
- ✓ To ensure that action is taken, if necessary, to ensure the Trust learns from the feedback
- ✓ To ensure that good practice is recognised and acknowledged

2.5 At an Integrated Service Unit (ISU) level, the Associate Directors for Nursing and Professional Practice (ADNPP) or Associate Directors for Operations (ADO) are responsible for ensuring complaints are investigated and responded to in line with the Trust policy. They lead on ensuring, where appropriate, that lessons are learnt and remedial action is implemented, evaluated and embedded in sustainable change.

2.6 The ADNPP or ADO within each ISU are responsible for allocating a lead person for the investigation who will be responsible to update the ADNPP or ADO on the progress of the investigation. The ADNPP or ADO are also responsible for reviewing the relevant investigation documentation and drafting a letter of response. This is reviewed by the System Directors for Nursing and Professional Practice before progressing to the Chief Executive to sign prior to sending to the complainant or their representative.

3.0 The Governance Framework for the Feedback and Engagement Service

3.1 The Feedback and Engagement work across the Trust is overseen by the Feedback and Engagement Group. The Trust Feedback and Engagement Group has a membership that includes trust members, but also the wider health and care community such as the NHS Devon Clinical Commissioning Group that is currently transitioning to NHS Devon Integrated Care System, Advocacy Service, Health Watch, Carers lead and local independent hospital, Mount Stuart and Deputy Director for Adult Social Care in Torbay. The purpose is to provide a forum for staff and wider system members, who are responsible or are involved with the patient / service user experience and engagement of the Trust, to share learning and best practice.

3.2 The main focus of the group is to review the effectiveness of the Trust's response's to complaints and concerns and provide assurance to the Board that the actions taken in response to feedback are completed and where appropriate disseminated across the Trust. The group also reviews all CQC patient experience survey results and monitor action plans for service specific CQC surveys and the wider Adult Inpatient Survey. The sharing of good practice, and continuing to develop a patient-centred culture across the Trust, is pivotal. The Group meets monthly and invites /co-opts specific colleagues when required to enhance the group with additional skills, knowledge and competence.

3.3 The Integrated Service Unit (ISU) governance groups have oversight of the feedback and engagement work within their ISU, and provides a monthly detailed report to the Feedback and Engagement Group. This includes, complaints, concerns, compliments, Friends and Family test and other patient and service user experience and highlights learning being progressed within the ISU and wider trust where applicable.

3.4 The monthly Quality Report, provided to the Quality Improvement Group ensures the scope set out in 3.3 on patient and service user experience as escalated within the corporate governance framework

3.5 The Quality Improvement Group reports to the Quality Assurance Committee which in turn reports to the Trust Board.

4.0 Discussion

4.1 Statutory Regulations

Complaints are managed in line with the Trust's policy and in line with NHS complaints regulations. The Trust are required by NHS complaints regulations to acknowledge all complaints within three working days. During 2021/22, there was only **one** complaint that was not acknowledged within the timeframe, this was a highly complex complaint, involving various services and received initially by the local Council. The Feedback and Engagement Team needed to wait for advice from senior managers and the legal team within the Council before acknowledging receipt.

NHS complaints regulations also require the Trust to investigate and respond to a complaint within six months of receipt. However, the Trust aim to investigate and respond in a much shorter timeframe as delays can both hinder the effectiveness of the investigation and cause increased distress to the complainant.

82% of the complaints received in 2021/22 were extended beyond the original timeframe agreed with the complainant which is an area noted for improvement during 2022/23, considering that extra time is factored in at the start if a complaint is identified as being complex (for example a complaint spanning various organisations, services or Integrated Service Units).

Of the complaints extended, **48%** of complaints were extended once,**30%** of complaints were extended twice, **12%** were extended three times, **6%** were extended four times, **1%** were extended 5 times and **3%** were extended more than 5 times. All complainants were informed of the extensions and the rationale for the extension is shared in an open and transparent manner. The number of complaints that exceeded the six-month time frame for 2021.22 were eight which included five investigated within the emergency department, two that related to safeguarding and one community hospital complaint.

Over 2021/22 a number of factors have resulted in complaints being extended including significant demand on service and clinical staff required to prioritise patient care. Alongside increases in staff absence due to isolation requirements aligned to government guidelines at the time and increases in COVID – 19 infection within staff which saw an increase as the lock down rules were lifted and infection levels rose.

4.2 Learning from Feedback

All staff have a responsibility to acknowledge where care has not been of the required standard and to do everything in their power to learn and to amend practice. Learning from complaints should happen throughout the organisation depending on the issues of

concern. In some instances, the issue may relate to a single department, but the theme may be applicable to other areas. It is the role of the senior staff in the ISUs to ensure that issues and the resulting action plans are appropriately shared. The Feedback and Engagement Team will work with the ISUs to ensure actions are monitored and accurately recorded on the risk management system. Where appropriate staff should incorporate the learning into their annual achievement review with their manager.

The capture and sharing of significant learning from complaints is led by the Trust's Feedback and Engagement Group. Examples of complaints which have identified either learning or good practice to be shared. There is further work required to strengthen our approach to disseminating learning from concerns raised by patients and families. In 2022, the Trust will strengthen how this is undertaken as part of the Patient Experience and Engagement Plan. The examples below illustrate some work undertaken to address issues raised by patients and families.

i. **COM-xxx** This was a complaint about ineffective communication between the patient's husband and both the clinical team on the ward and the receiving Intermediate Care Team on his wife's return home. The complainant attended a Board meeting to share his story and also attended a meeting where improved communication on the wards was being considered. The complainant's story and ideas have been used to design a pilot of a Communication role to be the conduit between the clinical team and family members. The job description is currently undergoing assessment for banding and will fit into the Carer's Service for the pilot.

ii. **COM-xxx** This was a complaint about various items of patient property being lost across successive inpatient stays on different wards, which was distressing for the patient and impacted on her ability to communicate. This complaint (along with other contacts) has led to the implementation of a Task and Finish Group looking at the whole system of property management and policy within the Trust.

iii. **COM-xxx** This was a complaint from a patient who did not feel listened to while on the ward and also had concerns about the care provided to patients with dementia. The outcome was that the feedback was shared with the staff on the ward and live feedback sessions were implemented, where an external member of staff attends the ward and completes a survey with patients on the ward. This helps to ensure that patients have the opportunity to provide feedback and staff can address any identified concerns in real time. With regard to the care provided to patients with dementia, a nurse external to the ward undertook some Observations of Care sessions, which highlighted that some staff did not feel fully equipped to support patients with dementia. A Nursing Practice Educator has been assigned to the ward to provide a rapid education programme to increase skills. In the longer term, the Trust is progressing recruitment for a Dementia Specialist Nurse.

4.3 Ombudsman Cases

The Trust were contacted in relation to 15 complaints between 01/04/2021 and 31/03/2022 by either the Parliamentary and Health Service Ombudsman or the Local Government and Social Care Ombudsman. Of these 15 complaints, 7 were not

investigated by the Ombudsman following an initial review, 2 were not upheld, 1 was partly upheld and 1 was upheld. The remaining 4 complaints are still being investigated.

For the complaint that was upheld (COM-xxx), the Local Government and Social Care Ombudsman found fault because there was a slight delay to direct payments being made. The Trust had also upheld the complaint and apologised to Service User's mother. This was deemed an appropriate remedy by the Ombudsman.

For the complaint that was partly upheld, the Local Government and Social Care Ombudsman found fault because the care home (in a placement commissioned by the Trust), failed to actively monitor the client's fluid intake. The Trust acted to ensure that all staff were reminded that where a client requires their fluid intake to be monitored, documentation is completed, regular oversight of the data is carried out and outcomes are recorded. The Quality Assurance and Improvement Team (QAIT) continue to work closely with the care home to ensure that standards of care that we would expect in a commissioned placement, are provided.

4.4 The feedback and engagement categories and numbers received Q1-Q4 2021/22.

*** Please note that some contacts have more than one issue identified and may therefore span more than one ISU **

Table 1 shows the contacts received in Q1, 21/22

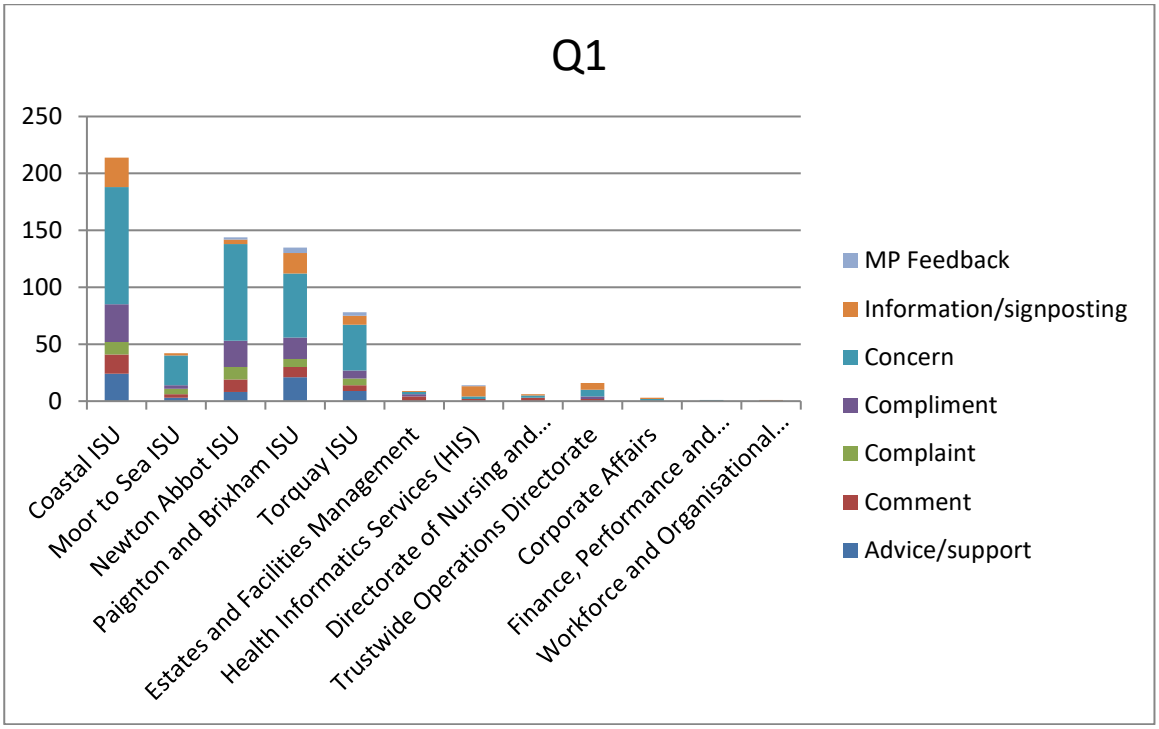


Table 2 shows the contacts received in Q2, 21/22

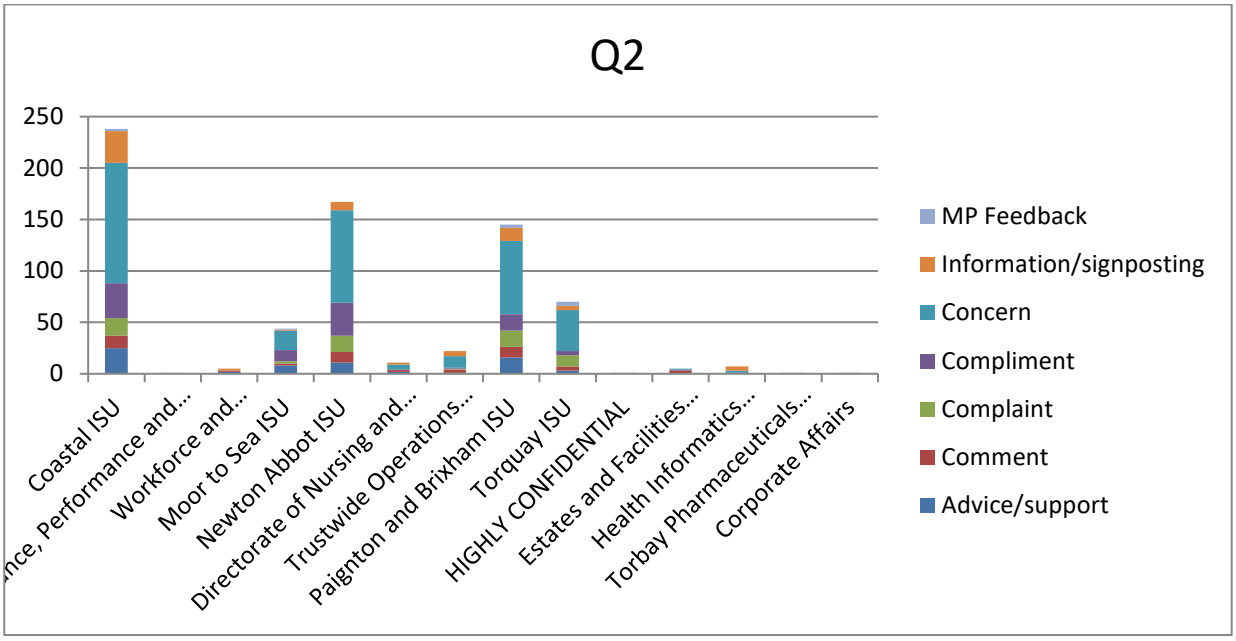


Table 3 shows the contacts received in Q3, 21/22

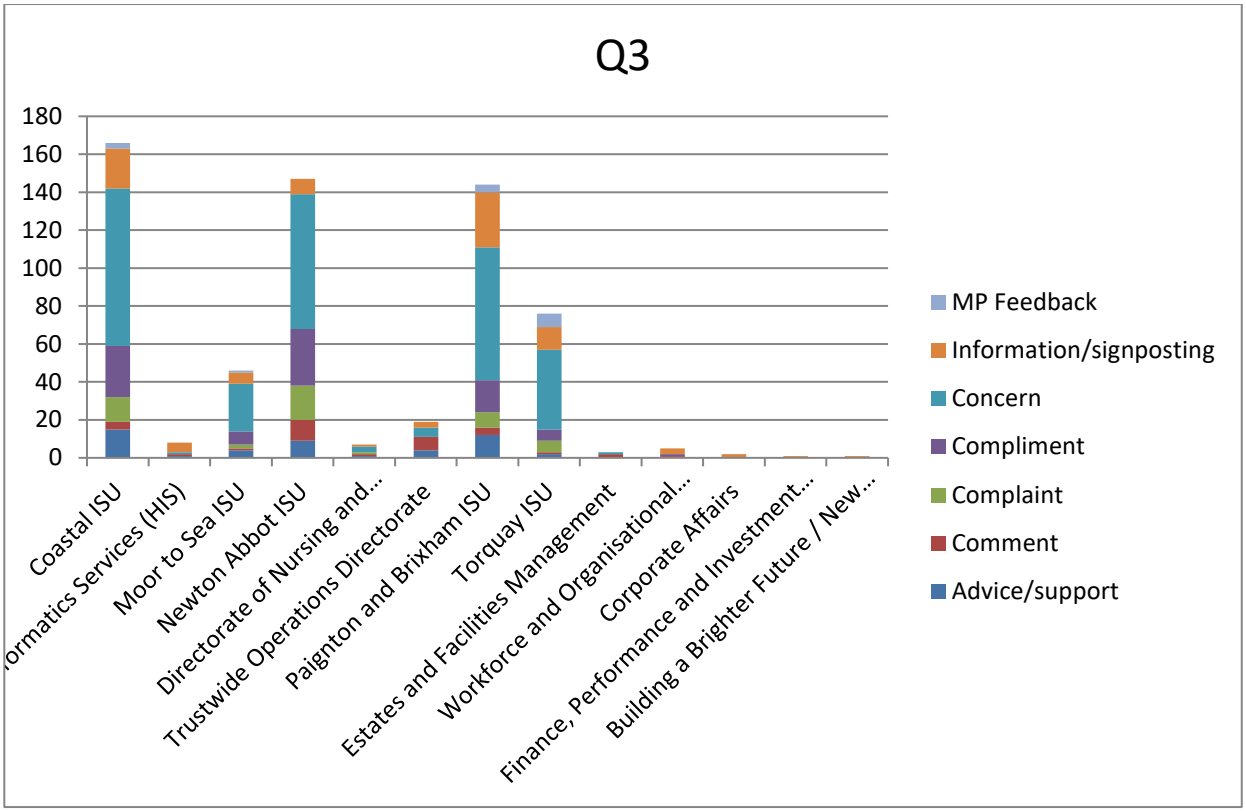
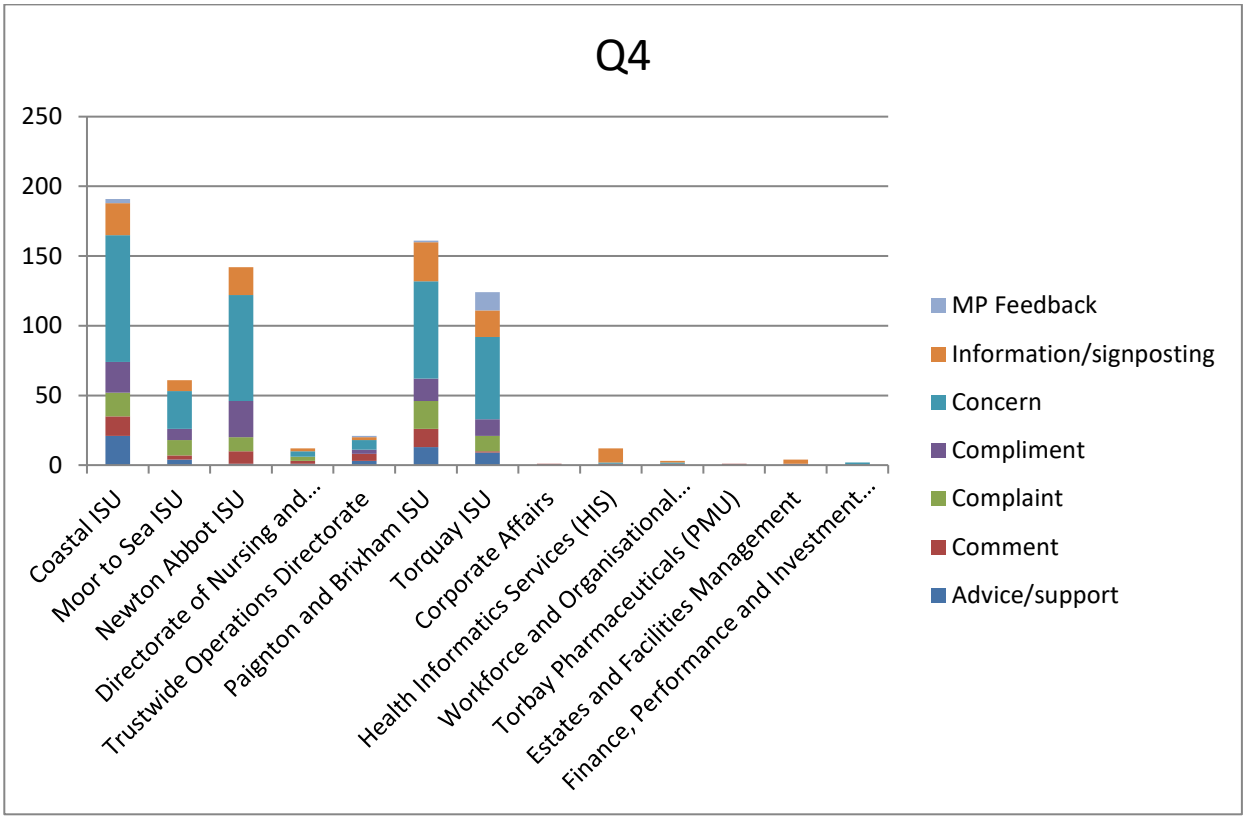
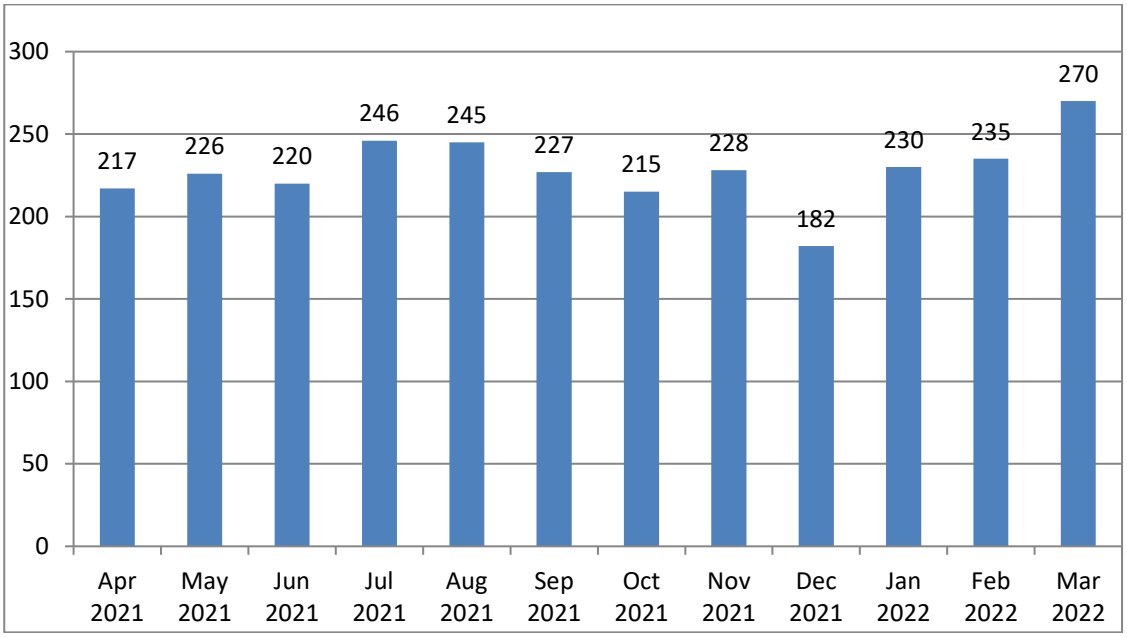


Table 4 shows contacts received in Q4 2021/22



The tables above demonstrate that there was a steady flow of contacts received throughout the year 2021/22. There was a slight decrease in contacts in December 2021 reflecting the Christmas period, increased COVID cases and a noted decrease in contacts when operational pressures on the NHS is shared within the media at a national and local level.

Table 5 shows the contacts received in 21/22 by month.



As a result of the pandemic, there is a significant impact on Due to the impact on increase waiting times for care and treatment, consequently, the Trust anticipates an increase in concerns raised. Further consideration will need to be given to ensure sufficient capacity going forward to effectively and efficiently meet the anticipated increase in demand of complaints and concerns in 2022/23

Table 6: The categories and themes of complaints for 2021/22

	Accessibility	Admission, discharge, transfers	Appointment delays, cancellations	Appropriateness, consent to treat	Attitude of Staff	Availability, Non-Delivery, access to treatment/drugs	Commissioning services	Communication	Alledged Competence, Negligence	Covid-19	Clinical Treatment - Surgery	Effectiveness	Eligibility	End of Life care	Information Handling	Loss, theft, missing items	Privacy, dignity, respect	Procedures, patient care	Timeliness, delays, waiting times	Total
Assessment	2	1	0	0	1	2	0	2	1	0	0	6	1	1	0	0	0	0	2	19
Care	1	0	0	1	4	0	0	3	6	0	0	4	1	3	1	0	0	4	3	31
Referral	4	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Treatment	16	0	0	0	6	5	0	8	31	0	0	48	0	1	0	1	1	5	5	127
Appointment	0	0	2	0	2	0	0	0	1	1	0	0	0	0	0	0	0	0	0	6
Non-Clinical Support	0	0	0	0	0	0	1	0	0	0	0	3	0	0	0	0	0	0	0	4
Discharge	0	0	0	0	0	0	0	4	2	0	0	6	0	0	0	0	0	0	0	12
Record Management	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	2
Diagnosis	0	0	0	0	0	0	0	0	9	0	1	2	0	0	0	0	0	0	5	17
Total	23	1	2	2	13	7	1	18	51	1	1	69	2	5	1	1	1	9	15	223

The majority of the complaints received by the Trust relate to either treatment, care or assessment. In relation to our delivery of the service, effectiveness, alleged competence/negligence and accessibility are the top three complained about themes which is the same as for 2020/21.

The complexity and diversity of services and the range of concerns and complaints result in high level themes that frequently require bespoke service level change.

Please note some complaints have more than one theme and the number of complaints for 2021/22 was **223**. Table 7 demonstrates that since 2018/19 the trust has seen a reduction in the number of complaints received from people who use our services.

Table 7: The last four years numbers of complaints by theme

	2018/2019	2019/2020	2020/2021	2021/2022	Total
Appointment	23	14	3	6	46
Assessment	48	48	30	19	145
Care	44	44	29	31	148
Corporate	1	2	0	0	3
Diagnosis	30	32	24	17	103
Discharge	41	21	10	12	84
Non-Clinical Support	10	8	0	4	22
Nutrition	3	1	0	0	4
Personal Welfare	5	3	0	0	8
Premises	3	0	0	0	3
Record Management	8	8	7	2	25
Referral	7	6	1	5	19
Transport	1	1	0	0	2
Treatment	293	251	113	127	784
Equipment	0	2	2	0	4
Total	517	441	219	223	1400

Throughout 2021/22, a recurrent theme has been communication and the impact on effective communication due to changes in visiting protocols which have all been in line with national COVID -19 pandemic policy. Whilst visiting has remained restricted, we continued to use i-pads on inpatient wards to support communication with family and loved ones for both clinicians and patients to address this challenge. We recognise that although we worked to adopt new models of communication, relatives and loved ones of inpatients experienced difficulty in contacting wards for updates on their loved one's progress. Due to recent changes in visiting we have been able to move to a model of two visitors per patient with no requirement for a negative lateral flow test prior to entering the ward.

The Sending Love Service (led by our Carer's Service), which is a way that relatives, friends and carers can send a direct message and/or photograph to their loved one (on the same working day if submitted by 10am) continues to be incredibly important.

It is important to ensure we review and focus the compliments that services receive (Table 8). We recognise compliments are often spontaneous and some services may not be reporting them into the main system.

It is of note that the number of compliments has decreased slightly in 2021/22, possibly due to the impact of the COVID pandemic and pressures on staff leading to a reduction of the sharing of compliments.

Treatment and care are the main reasons for compliments being received which aligns to our core business as a health and care organisation.

Table 8 The numbers of compliments by theme

	2018/2019	2019/2020	2020/2021	2021/2022	Total
Admission	2	0	1	16	19
Appointment	14	8	12	31	65
Assessment	18	10	24	3	55
Care	214	250	208	163	835
Diagnosis	1	6	3	2	12
Equipment	2	1	3	0	6
Non-Clinical Support	3	6	8	8	25
Personal Welfare	3	1	5	1	10
Record Management	2	1	0	0	3
Transport	1	0	1	1	3
Treatment	204	202	151	133	690
Corporate	0	5	1	0	6
Nutrition	0	3	1	3	7
Referral	0	2	4	4	10
Discharge	0	0	2	0	2
Total	464	495	424	365	1748

4.5 The Trust effectively manages all contacts received by the Feedback and Engagement Team who are proficient in identifying the key issues and managing the contact in line with the enquirer's expectations and this has been achieved through 2021/22 despite the COVID pandemic. However, due to the increased amount of contacts and the increased complexity of the complaints received, the Feedback and Engagement Team are currently unable to answer "live" phone contact, the effect of which is that some contacts will be lost as people may not want to leave an answerphone message or use another form of communication. An increase in capacity into the team is required to reinstate this service and a case to enhance the service has been prepared as additional funding is essential and we hope to achieve this in early in 2022/23.

4.6 Carer Feedback and Engagement

Many people support a family member or friend with health or care needs. Their feedback is obviously essential in determining how services should be run, not just to support them, but also the person for whom they care. More than a third of our staff juggle working with caring for someone, offering valuable insight into how support can be improved in both their professional and personal life.

Torbay's Adult Social Care responsibilities to Carers are delivered by the Trust on behalf of Torbay Council. However, the Trust's Torbay Carers works very closely with a number of partners to ensure the Trust receives feedback from and engages with Carers of any age, with any type of caring role, across its footprint. Two of the Trust's three priorities for 2021/22 in its Commitment to Carers involved extensive engagement and feedback.

Supporting Staff Carers *(Trust Commitment to Carers 2021-22 Priority 1)*
The Trust was awarded Carer Confident Employer Level 2 and used feedback from staff Carers to develop our own 'My Manager Cares' Award, promoting how managers can support staff Carers. Some staff Carers are working with Torbay Carers Service to co-design improved support to staff Carers.

Young Carers Under 25 *(Trust Commitment to Carers 2021-22 Priority 3)*
The inter-agency Strategy for Young Carers under 25 was signed off in March 2022, to link with Young Carers Action Day. Young Carers themselves helped set the priorities for this three-year strategy and action plan, which has co-design and co-production at its heart. Torbay's Services for Young Adult Carers aged 16-25 (YACs) are delivered by the Trust, supported by the YAC Operational Group. This is a group of YACs, two of whom also sit on Torbay's Carers Strategy Steering Group, ensuring good two-way dialogue… *"Another thing that I found really helpful from the Young Adult Carers service was the ability to have my voice heard." (Torbay Young Adult Carer)*

Carer Evaluation of Carers' Direct Payments under the Care Act
The Trust's Torbay Carers has trained Carers / former Carers to undertake evaluations. This year they evaluated the provision of Carers Direct Payments under the Care Act, with very positive results. The key findings were as follows:

- 80% used the payment for a break from their caring role.
- 75% reported an improvement in mental wellbeing.
- 63% reported an improvement in physical wellbeing.
- 75% saw an improvement in family relationships.
- 8% said the break led to the avoidance of a residential care placement.
- 18% said the break prevented a breakdown in their caring role.
- A further 29% said the break may have prevented a breakdown in their caring role.

The personalised nature of this service is valued by Carers and quotes highlighted the value Carers place on the impact of this support, e.g.:

> *"I was very touched that someone was asking after my health and wellbeing rather than focusing on my husband"*

> *"This Direct Payment … has had a massive impact on my emotional wellbeing. [The person I care for] is extremely noisy and this is unrelenting. To be able to get some silence probably saved my sanity."*

National Carers Survey – early results
We are awaiting the national comparators for the National Carers Survey in late 2021, but early signs are encouraging. 71.3% of Carers (up from 70.4%) reported that Adult Social Care (ASC) included / consulted them in discussions about the person they care for, and 45.9% were satisfied with ASC – seemingly higher than many local areas.

Responsiveness to Carers' Concerns
When Carers raised concerns about the end of their free access to national Lateral Flow Tests, Torbay Carers and Torbay Council's Public Health team worked together to enable this to continue, including their distribution across the Bay.

4.7 Friends and Family Test.

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for people to give their view after receiving NHS care or treatment.

The FFT has been a mandatory requirement across all NHS Trusts since 2013 and although every person must be given the opportunity to provide feedback on the service they have accessed, it is optional to respond. In September 2019 NHSE announced changes to the mandatory questions where the key question was changed to ask:

"*Overall, how was your experience of our service "?*

Previously there had been two further prescribed questions and with the changes of the FFT nationally the Trust had an opportunity to develop our own questions. The Feedback and Engagement Group considered this opportunity and made the decision to ask the following questions:

- *Please can you tell us why you gave your answer? (*to the FFT question*)*
- *What one thing could we have done better?*
- *Please tell us what you, your family members and carers think should always happen when you use our services?* (This is to support the Always Events Initiative)

The Revised FFT test was due to commence in April 2020 but due to the COVID 19 pandemic the launch was paused across the country until September 2020. The challenges experienced by the Trust in developing the FFT provision during the COVID pandemic included the paper- based model that had been in place pre-COVID which provided challenges with infection, prevention and control. Pre- populated locations /wards that ensures feedback was accurately attributed was also a challenge as a large number of wards during COVID and beyond, changed configuration in the care they provided, although the name of the ward remained the same.

4.8 The paper- based FFT collection document has been reviewed, and revised, to reflect not only the mandatory question required but also the CQC Adult in-patient questionnaire results received in 2021.

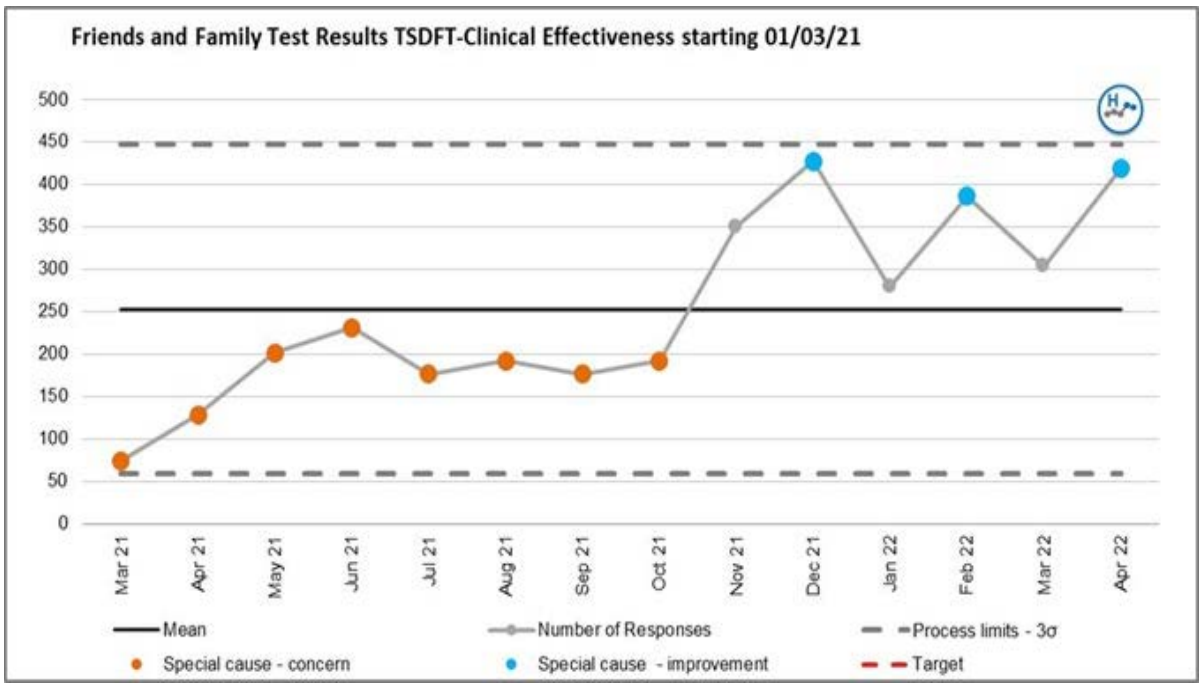
This has been developed by the Feedback and Engagement team, together with input by members of the Working with Us Volunteer group, who support in-patient areas with the FFT agenda, and the wider Feedback and Engagement Group.

The revised FFT/in-patient questionnaire can be used, moving forward, to allow a timely submission of the FFT data and real time feedback for in-patient settings, allowing any issues/concerns raised to be dealt with immediately.

The Feedback and Engagement team are currently working to expand upon the use of a QR reader code, currently used in the Emergency Deportment, for the FFT/In-Patient questionnaire so it can be completed by in-patients without external support.

From **May 2022** it is expected the Working with Us volunteer group will be returning to support in-patients to complete the revised FFT/Inpatient questionnaire which, again, will support the data return moving forward.

The run chart below evidences an increasing trend in FFT submissions with 6 consecutive increasing points from October 21 to April 22 as compared to March 21-October 21. This has a direct correlation to the revised FFT/In-patient questionnaire being put in to practice.

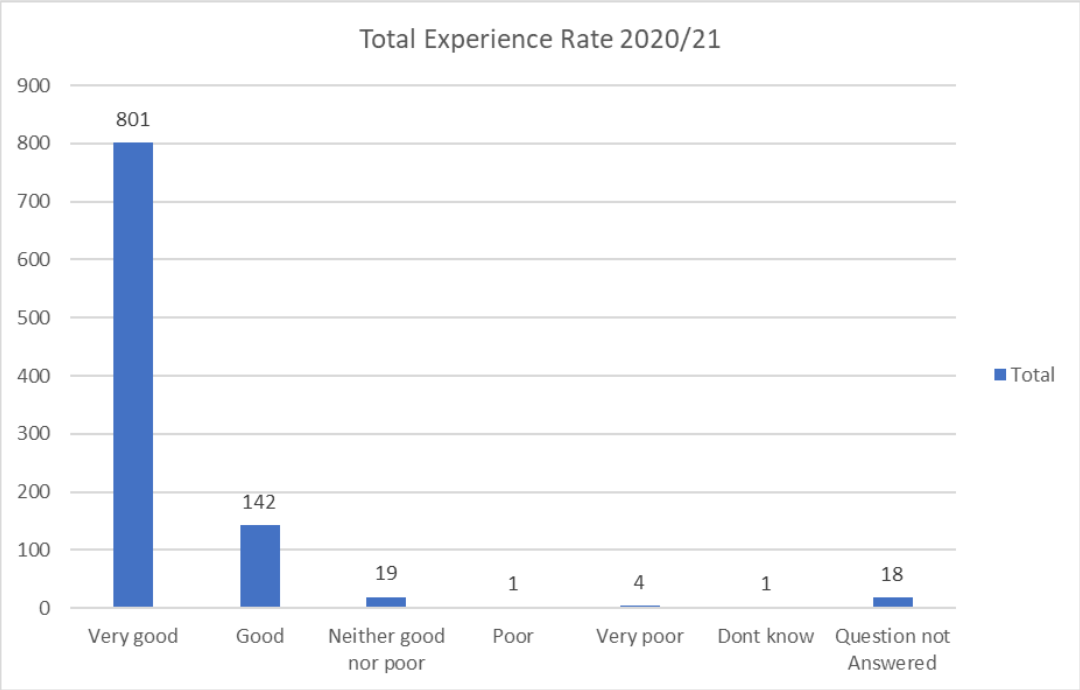


The graphs below demonstrate, at Integrated Service Unit level (ISU), there has been a significant increase in FFT returns from 1st April, 2021- 31st March,2022 compared with 1st April 2020-31st March 2021.

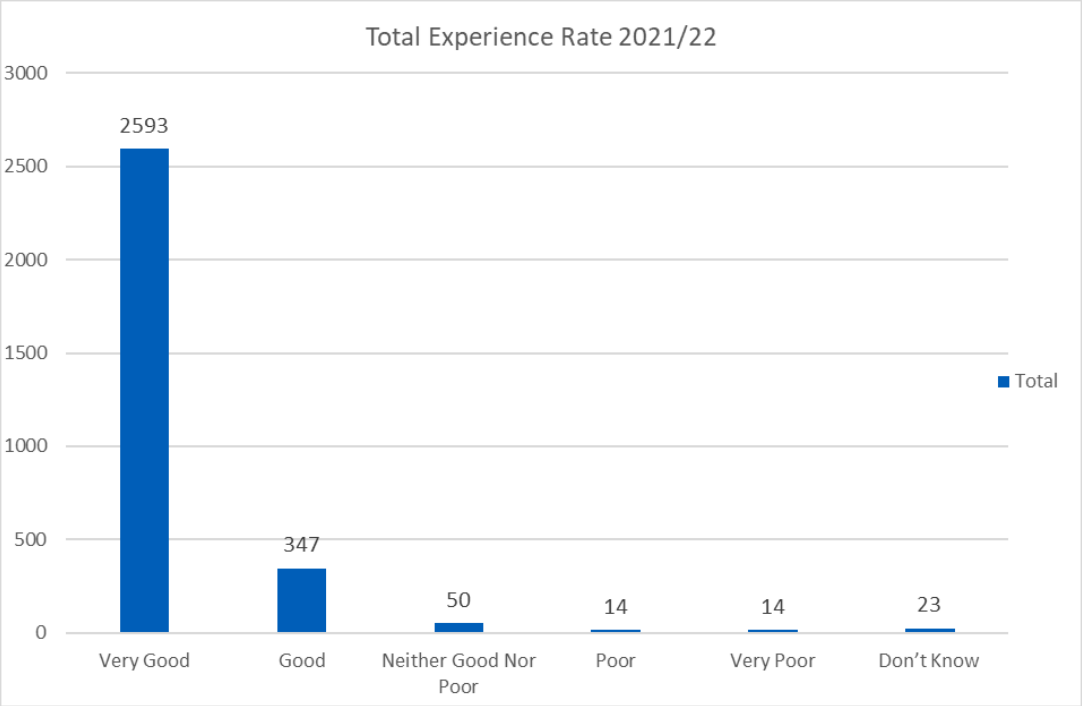
This is evidenced in 2,056 returns in 2021/22 against 985 returns in 2020/21, which is an increase of 208.73%

This has been due to a dedicated Task and finish group that have led the revision of the FFT/In-patient questionnaire, and refocused staff with regard to the feedback and Engagement agenda following the pandemic, Through the Feedback & Engagement group meetings this data is reviewed monthly within performance reports from each ISU.

Table 7: Total Experience Rate from 1/04/2020* – 31/3/2021:



Total Experience Rate from 1/04/2021- 31/3/2022:



To provide assurance that this improvement will be monitored and sustained the FFT/In-patient questionnaire going forward. The results are reviewed through the Feedback and Engagement Group, with a check and challenge approach, to ensure we know what peoples experience has been of our services, what we could do better and how this can

be shared for organisational learning. Alongside are written feedback which is rich and powerful to both celebrate and shape change.

5.0 National Adult Inpatient Survey 2021

Further to the National CQC Adult in- patient survey publication which was reported to the Trust Board in November 2021, all in-patient areas have developed action plans to address the areas identified for improvement which are:

- Noise from other patients: patients being bothered by noise at night from other patients
- Disturbance from hospital lighting: patients being bothered at night from hospital lighting
- Noise from staff: patients being bothered by noise at night from staff
- Help with eating: patients being given enough help from staff to eat meals, if needed
- Feedback on care: patients being asked to give their views on the quality of their care

The action plans are reviewed at the Feedback and Engagement group, from an ISU perspective, with focus on what has gone well over the last month and what can be improved.

As identified in point 4.8 all FFT/in-patient questionnaires now reflect the areas identified
for improvement and the addition of these questions will allow the inpatient wards to address any areas identified promptly.

During 2021/22 the trust has also received the CQC patient experience surveys for the following services:

- Urgent and Emergency Care 2020
- Children and Young People – Inpatient and Day Case 2020
- Maternity 2021.

The results of these surveys and the action plans developed have been shared with the Quality Assurance Committee and Trust Board.

6.0 Conclusion

6.1 Through 2021/22 the Feedback and Engagement team have continued to provide a coordinated service to our local population as the COVID pandemic progressed through wave two and three. The increase in contact relating to delays in access to care are in the main a direct consequence of the pandemic. The feedback and engagement team and wider staff in the organisation who review, investigate and respond to feedback in the form of concerns, complaints, ombudsman and MP enquires as well as compliments demonstrate a commitment to providing comprehensive, compassionate responses and identifying local and trust wide learning.

6.2 As wave three of the COVID pandemic recedes and our full range of services resume across the organisation and many restrictions are lifted, we have an opportunity to enhance our accessibility to patient and service user of our health and care services provide feedback.

6.3 The development of the Patient and Service User Experience of Health and Care Services Strategy has been a journey over the past twelve months as we have adopted an inclusive approach with a wide range of stakeholders including our local community. This three -year strategy has eight key priorities and aligns to the overarching Trust strategy and vision to deliver care closer to home. This strategy aims to raise the profile of the importance of patient and service user experience in developing and delivering high -quality effective services that provide a consistent positive experience for all people.

6.4 The COVID 19 pandemic has impacted on our ability over 2021/22 to receive the breath of proactive feedback from people who use our services. We have seen changes in care delivery going forward that provides a platform for us to further review and modernise our model into 2022/23 and beyond.

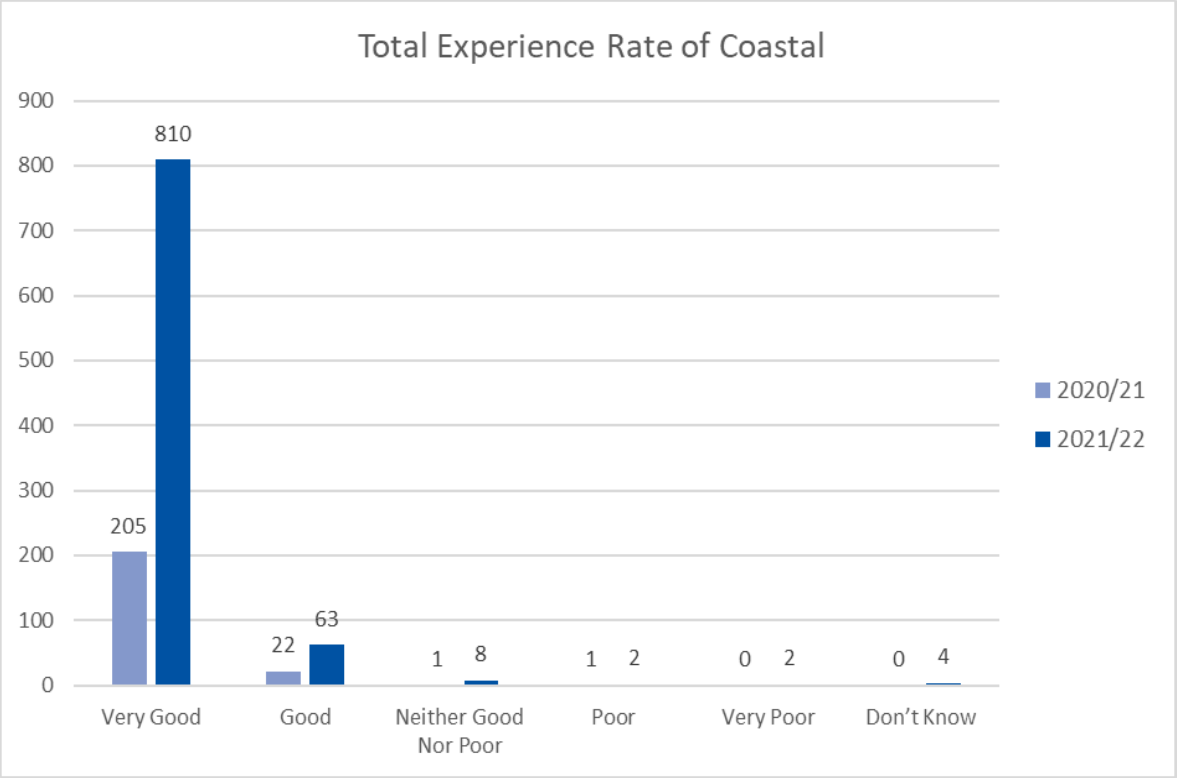
7.0 Recommendations

7.1 To note the content of the report and the achievements aligned to feedback and engagement during the second year of the global pandemic.

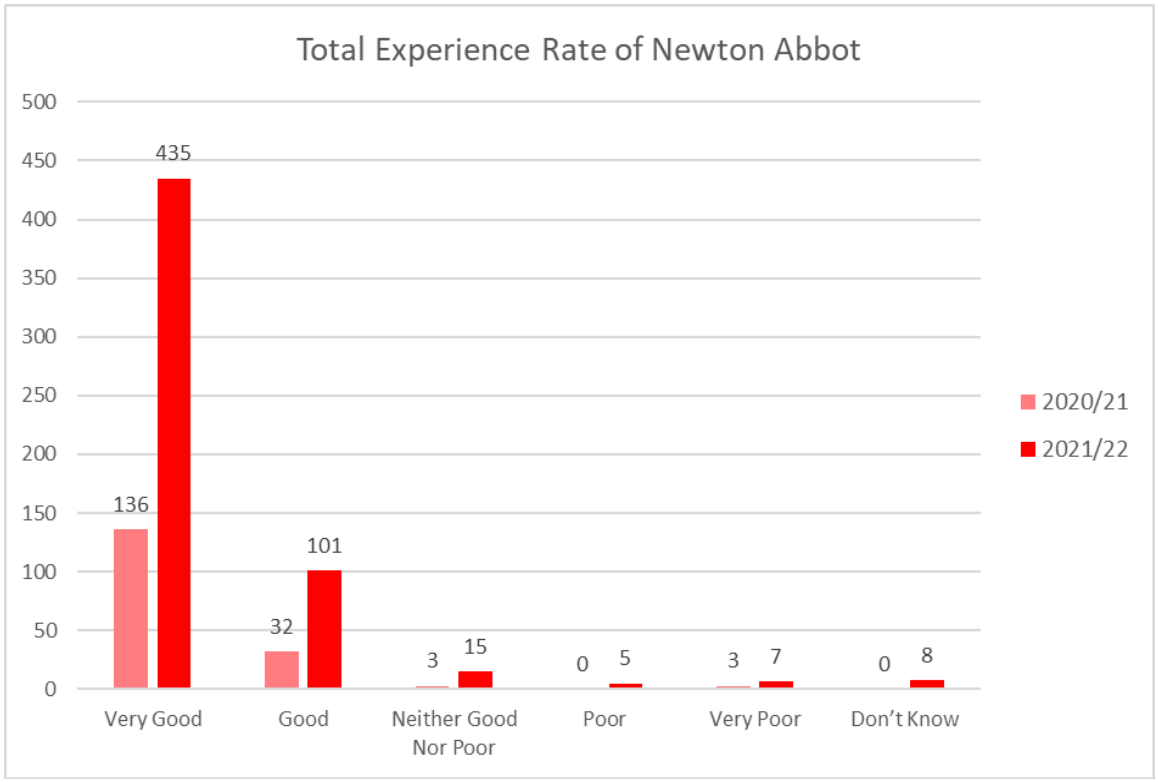
7.2 To support the programme of work set out in the Patient and Service User Experience of Health and Care Services Strategy and Delivery Framework through 2022/25 (separate paper) that will enhance and underpin the provision of high -quality health and care services as we strive to consistently provide an excellent patient experience.

Appendix 1: Friends and Family Test 1 April 2020 - 31 March 2021 by Integrated Service Unit (ISU)

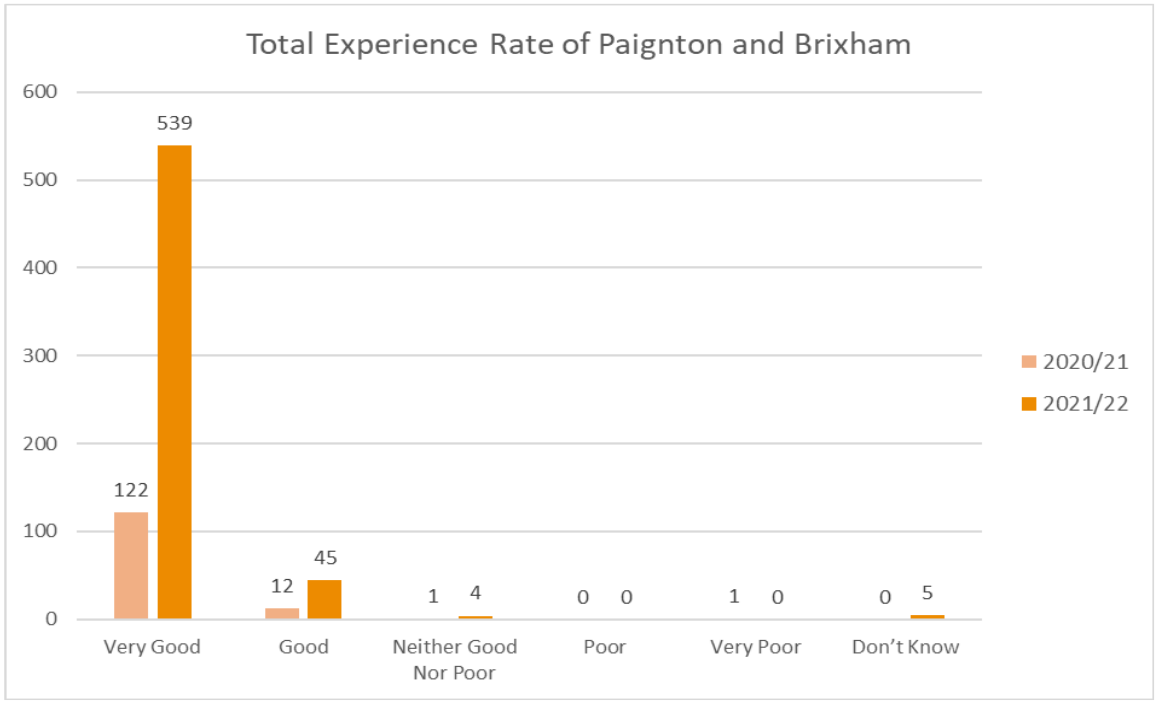
Experience rate per ISU



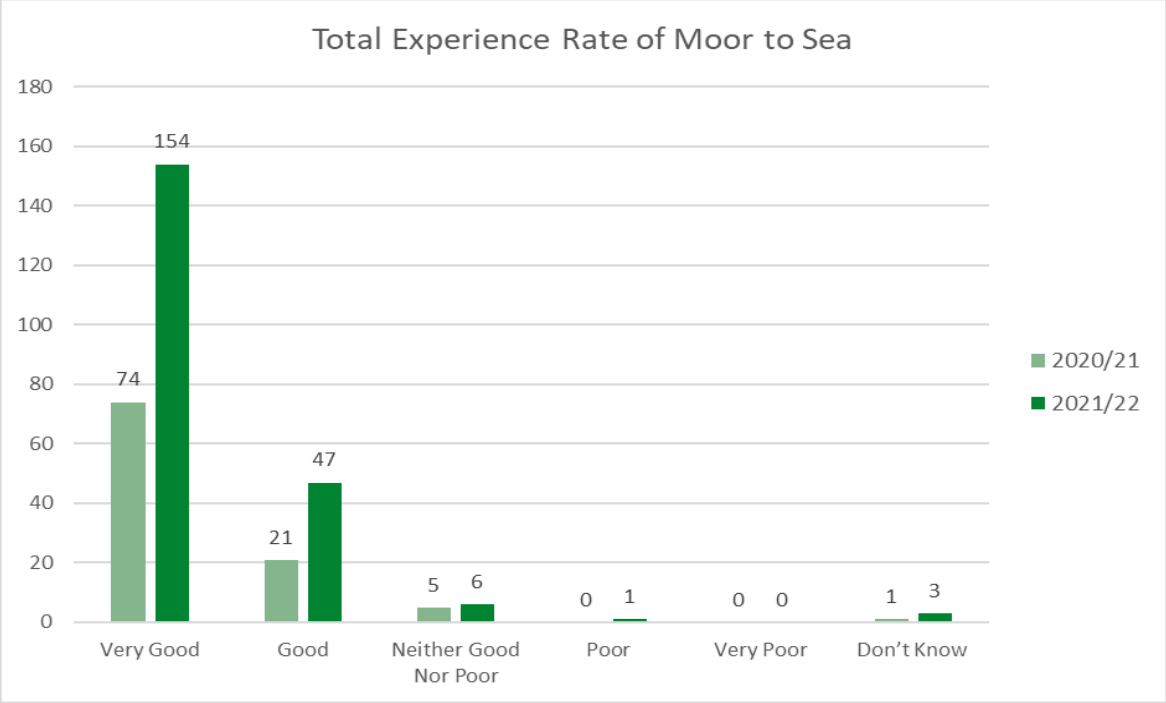
Over the period 2021/22 Coastal received the highest number of FFT responses, with 91% "Very Good" ratings. Over this period, there was an increase in the total number of FFT responses from 2020/21 of 288%. However, over 2021/22 it received 2 "Poor" and 2 "Very Poor" responses; the main reasons given for these were long waiting times and lack of communication.



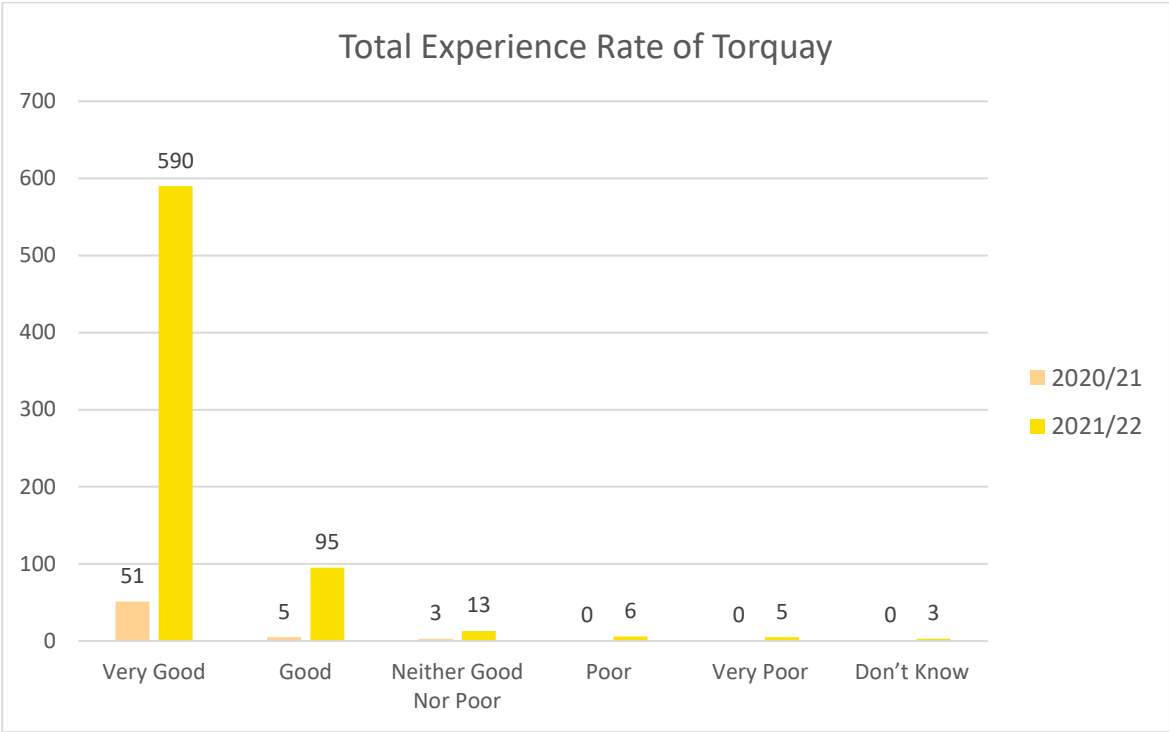
Newton Abbot received the fourth highest number of FFT responses, with a 76% "Very Good" rating. From the previous period it increased its overall responses by 228%. There are 5 responses of "Poor" and 7 of "Very Poor", representing 50% of the total "Very Poor" results recorded across the period 2021/22. The main reasons given for these are lack of communication, long waiting times, and attitude of staff



Over the period 2021/22 Paignton and Brixham received a 91% “Very Good” rating, and did not receive any “Poor” or “Very Poor” ratings. From the previous period it increased its overall responses by 336%.



Moor to Sea received a 73% “Very Good” rating. It received the lowest number of FFT responses over the period 2021/22, but had a 109% increase in responses from the previous period. It received 1 “Poor” rating due to lack of communication



Over the period 2021/22 Torquay received the second highest number of FFT responses, an increase of 1107% from the previous period. In 2021/22 it received an 83% “Very Good” rating, but 6 “Poor” and 5 “Very Poor” ratings. The main reasons for these were the temperature of the wards, and lack of communication.

Report to the Trust Board of Directors			
Report title: Children and Family Health Devon – Annual Report			**Meeting Date:** 27 July 2022
Report appendix	Appendix 1 – Comparison of demand 2019-2021 Appendix 2 – RTT and average waiting times Appendix 3 – NHS Long Term Plan deliverables Appendix 4 - Key workforce metrics 2021/22		
Report sponsor	Chief Operating Officer		
Report author	Children's Alliance Director		
Report provenance	The report has been prepared by the leadership Team of Children and Family Health Devon		
Purpose of the report and key issues for consideration/decision	The report details progress against delivery objectives for 2021/22. Issues for the Board to note: • Demand, capacity and performance • Service developments and progress with the transformation programme • Workforce and the approach to staff engagement • Children's Services Contracts Review • Torbay SEND inspection • Finance • Service objectives 2022/23		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board are asked to receive and note the Child Family Health Devon Annual Report		
Summary of key elements			
Strategic objectives supported by this report	**Safe, quality care and best experience** x; **Valuing our workforce** x **Improved wellbeing through partnership** x; **Well-led** x		
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework** 1,3,8; **Risk score** 20 **Risk Register**; **Risk score** BAF Objective 1: To develop and implement the Long Term Plan with partners and local stakeholders to support the delivery of the Trust's ICO Strategy		

	BAF Objective 3: To achieve financial sustainability, enabling appropriate investment in the delivery of outstanding care. BAF Objective 8: To implement and continuously review the impact of the Trust People Plan ensuring the Trust is 'a great place to work'
External standards affected by this report and associated risks	

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

Report title: Children and Family Health Devon – Annual Report		**Meeting date: 27 July 2022**
Report sponsor	Chief Operating Officer	
Report author	Children's Alliance Director	

1. Introduction

The Annual Report for Children and Family Health Devon covers progress against the delivery objectives for 2021/22. The work to secure the integrated service delivery through the transformation programme has progressed significantly. This was important strategically, providing confidence in the capability of the service and leadership to secure the improved experience of care for young people and families envisaged at the commencement of the contract.

The report outlines demand and capacity in response to Covid 19 and the performance in waiting times across services throughout 2021/22. CAMHS Service developments driven by the NHS Long Term Plan are discussed along with the progress made in the transformation programme. The salient issues relating to workforce are discussed, both in terms of the key metrics and staff engagement. The Children's Contracts Service Review which commenced during 2021/22 is discussed in section 7. A SEND inspection took place in November 2021 and the main findings of the inspection are outlined in section 8. A brief section on finance describes the financial performance across the year. Finally, the service objectives for 2022/23 are listed in section 10 of the report.

2. Demand and capacity

As we continued to live with Covid 19 there was increasing understanding about the adverse impact of the pandemic on children's development, health and wellbeing, in the context of children being deprived of activities essential to their development such as access to education and social contact with peers. Furthermore, it is known that the pandemic exacerbated existing vulnerabilities in individuals and families and children became more susceptible to the vulnerabilities of parents and family life and less able to access protective factors outside of their families.

Across CFHD services the pandemic has disrupted the normal patterns of demand and in some services, has led to significant increases in referrals, such as those across the Children's Nursing Services, CAMHS and Physiotherapy. At the same time, there were changes in how services responded to referrals with an increase in online resources / interventions and self-help guidance being provided. During 2021/22, these activities were not captured as interventions and so the data shows a reduction in the accepted referral rates for some services. See Appendix 1 (page 9) which shows the change in referral rates between the start of the contract and 2021/22.

3. Performance

Minimising waiting times has continued to be a focus across CFHD throughout 2021/22. The table in Appendix 2 shows that the Children's Nursing teams have maintained a highly responsive service throughout 2021/22 with the exception of the

Specialist School Nurses which show an increase in waiting times in recent months. The trend in reducing waiting times has been achieved in the Learning Disabilities Service, Occupational Therapy and the ASD Assessment Service. Five services show a trend in increasing waiting times and there are plans in place for all.

During 2021/22 the Autism Assessment Service embarked on a waiting list reduction programme, which was funded through CFHD non-recurrent funding. This plan was formulated in the context of a legacy of long and voluminous waits over the previous decade and a Written Statement of Action following a DCC SEND inspection in 2018, which required a reduction in the duration of waits and in the number of children waiting. The waits improvement plan had two elements – re-design of the assessment pathway and clinic structure, using Lean principles to achieve greater efficiency and productivity, and an increase in clinical capacity through sub-contracting with our partner Livewell and recruiting a team of agency clinicians who worked remotely, alongside the core team. Over the course of 2021/22, productivity was increased per wte by 95%, 2,080 assessments were undertaken and the number of children on the waiting list was reduced by 31% from 2,756 to 1,905. The pace of the reduction programme was slower than planned, as a result of difficulties in recruiting qualified agency staff and the loss of substantive employees as a result of them being individually targeted by a private provider. However, significant progress was made in reducing the waiting list and there was important organisational learning about deploying a team of clinicians to work remotely to deliver services, thereby broadening the potential workforce pool to a nationwide footprint from which to draw clinical staff.

4. Service Developments

There are a number of service developments relating to children and young people ‘s mental health, Autism and learning disabilities, driven by the NHS Long Term Plan. These include increasing access to CYP mental health care; increasing the Mental Health in Schools teams across Devon to provide greater access to early intervention - evidence based interventions for mild to moderate mental health needs and support for whole school approaches to emotional wellbeing; expanding the Eating Disorders service to enable quicker response times; development of the CYP crisis pathway to enable delivery of crisis assessments in A&E and community settings, brief crisis interventions and home treatment services for young people with acute and emergency mental health needs; services for 18-25 year olds which enable developmentally appropriate care for young adults, working across CAMHS and AMHS; and additional support for children and young people with a Learning Disability and / or Autism (LDAP). See Appendix 3 for details regarding the Long-Term Plan deliverables.

Devon became one of 13 national LDAP Keyworker pilot sites, delivering keyworker functions for children and young people with a Learning Disability and /or Autism who have complex needs and may be at risk of requiring in-patient or residential care. The pilot operates as a system-wide function, ensuring an appropriate level of provision is available, making best use of the Dynamic Support Registers to manage crisis and support community living. Over a period of 18 months, the pilot has prevented admissions which have been reduced for this cohort of young people by 75%.

The South West CAMHS (Tier 4) Provider Collaborative went live during 2021/22, with DPT as the lead organisation. CFHD CAMHS is a partner in the Provider Collaborative (PC) and engaged in its work programmes. The aim of the PC is to work collaboratively to improve the health of the local population, which can be understood through outcomes, experience and delivery of transformation in clinical pathways. The ambition is for patients to experience high quality, specialist care, as close to home as possible, connected to local teams and support networks and for the need for hospital care to be avoided where appropriate. As the PC is able to achieve savings on the baseline Tier 4 spend, there will be opportunities to invest up-stream in community services which improve mental health outcomes for young people.

5. Transformation Programme

The transformation programme to design and mobilise the new integrated service model commenced in January 2021. Throughout 2021/22, the clinical model, operating model, workforce and financial model was completed. Ten needs-based clinical pathways were designed by clinical leaders and their teams. The pathways adhered to a framework of outlining the children in scope, evidence-based pathways, professions required, suite of clinical outcome measures to be used, adherence to the Thrive Framework and interdependencies with other teams and services. The methodology used, produced high quality clinical pathways drawing on the clinical expertise and knowledge of staff. The operating model was developed, offering standardisation and integrity in terms of quality of access and care across Devon whilst being delivered in three localities, making best use of local partnerships to respond to local population needs.

The re-design of the workforce model was a complex process designed to integrate the workforce of CAMHS with Therapies and Nursing so as to enable delivery of care in multi-disciplinary teams which integrated physical and mental healthcare. A matrix model of leadership has been developed which enhances clinical and professional leadership whilst establishing clear operational management structures. The design respected the integrity and professional identities of the many professional disciples within CFHD with greater clarity of roles and responsibilities based on the requirements for delivering high quality care.

As a part of the Transformation Programme, a detailed gaps analysis was undertaken. It became clear that the service specification had been extended to include gaps in service provision, which existed pre-procurement, whilst the contract funding had remained at the pre-existing level. The gaps analysis concluded that there was a significant gap between the scope of the specification. Accordingly, four workforce and financial options were developed. Each adhered to the principles of the service specification but only option 4, delivered the full scope. The proposal to mobilise option 2 was recommended by the leadership team and this was ratified by the Executive teams of DPT and TSDFT and the Partnership Board. This allowed for the protracted uncertainty and insecurity experienced by staff since 2019 to come to an end and enabled mobilisation of a version of the commissioned model within the existing budget. The proposals have been discussed with the CCG.

A formal staff consultation commenced in April 2022 for a period of 8 weeks. Extensive staff engagement has continued throughout this period as we aimed to facilitate

individual agency and involvement. Staff attended the launch event, 10 clinical pathway workshops, 11 Q&A sessions, 4 specific group sessions and 127 individual meetings. Staff have engaged fully in the process providing 1,760 items of feedback, ranging from single questions to detailed counter-proposals. The feedback has been themed and is currently under review; it is evident that changes are being made to the proposals in response to the feedback and this has been helpfully experienced by staff as confirmation that they are being listened to.

6. Workforce

Throughout 2021/22 staff engagement has remained a high priority. A range of different methods of engagement have been used such as weekly whole service Q&As, leadership meetings, Operations Managers meetings, newsletters, leadership email in-box and News-in-Brief bulletins. This has positively impacted the culture of CFHD with a growing identity as an integrated service, with shared ambitions and purpose. It has enabled leaders to be visible, held to account by staff for decisions and built greater collaboration. The approach to staff engagement has also enabled leaders to keep in touch with what matters to our staff and their experience of delivering care.

2021/22 was the third year in which staff worked within the context of uncertainty about their jobs and the future service. Whilst leaders were able to assure staff that we were not planning any redundancies, this undoubtedly adversely impacted on staff morale, and was evident in the staff survey results and in sickness rates / reasons.

The workforce metrics (see Appendix 4) demonstrate improvements in mandatory training including safeguarding training in CAMHS, as a result of significant management focus. The rate of appraisals however, remains low and this should in part, be seen in the context of the forthcoming staff consultation wherein staff did not know which roles they would fulfil until the consultation was concluded. In CAMHS, the vacancy rate increased over the course of 2021/22 because of the growth arising from LTP related investments. However, overall, steady progress was made in recruitment, and retention rates improved, with ‘Stay Interviews’ being operationalised across all services.

Two important substantive appointments were made to the leadership team during 2021/22. Namely, the Associate Clinical Director / Professional Lead for Psychological Therapies and the Deputy Director. There was also evidence of a positive development in the reputation of CFHD as the service began to attract high quality applicants to key posts.

A key aim throughout 2021/22 was to strengthen leadership capability among operational and clinical leaders. To this end, four leaders commenced and two completed the CYP IAPT Leaders Programme and two leaders commenced the Nye Bevan and Rosalyn Franklyn NHS Leadership Academy programmes.

7. Children’s Services Contracts Review

A review of the children’s contracts was commissioned by the CCG, TSDFT (on behalf of the CFHD Alliance) and Livewell SW. The scope of the review is to identify where

services are delivering in line with the contracts, make recommendations on improvements in assurance, test the original commissioning assumptions, identify the likely impact of COVID on demand for children's services, if necessary, refreshing contract specifications, provide insight into the outcomes for Devon children and to provide a baseline assessment to support the establishment of the Devon Strategic Children's Board. The key lines of enquiry related to performance, quality and safety standards being delivered, contract ambitions and a comparison between the two contracts.

An interim report, written early in 2022, was presented to the CCG Governing Body in June, as this was the last Board prior to the dissolution of the CCG. Further work is on-going with Commissioners to finalise the agreed outputs from the report.

8. Special Education Needs & Disabilities (SEND) inspection Torbay

Between 15 and 19 November 2021, Ofsted and the Care Quality Commission conducted a joint inspection of the Torbay local area to judge the effectiveness of the area in implementing the special educational needs and/or disabilities (SEND) reforms as set out in the Children and Families Act 2014. Inspectors determined that a Written Statement of Action (WSoA) would be required to address significant areas of weakness found in the area's practice. The WSoA was submitted, as required, on 14th April 2022 outlining actions that would be taken in relation to the four 'Improvement Pillars' of joint commissioning, inclusion, becoming an adult and quality assurance and community engagement. The numerous elements of the WSoA require actions to be undertaken by individual organisations as well as actions relating to the way in which partners across the system work together.

9. Finance

We have successfully operated within the resources available through the financial regime implemented to support the NHS respond to and be resilient during the pandemic. Our contracted income for 2021/22 was £31.8m and if it were not for the impact of the interim financial framework under which the NHS was working there would be a reported underspend.

During the year the Trust also secured funding for a number of schemes, most notable for Mental Health in Schools, CYP Community & Crisis and Eating Disorders.

In addition to the mental health investment standard minimum uplift the national financial framework provides additional non-recurrent funds for CAMHS to support long term plan implementation for Community, Crisis and eating disorders which provide the organisation with the opportunity to further develop the services that we can offer children and young people.

Once again, our financial performance is a credit to the hard work and professionalism of our staff both on the frontline and in our support functions. In particular I would like to acknowledge the dedication and professionalism of the finance, procurement, estates and digital departments for their significant efforts to meet the additional requirements set out by the national financial framework, delivering significant

programmes of work at short notice and maintaining a high standard of business as usual work.

10. Objectives for 2022/23

Transformation

1. Complete all stages of the consultation process – review staff feedback, finalise the new service and workforce model and complete HR processes

2. Complete internal recruitment process and undertake on-going external recruitment

3. Plan and prepare for mobilisation – co-production by leaders, clinicians and service users - including work to clear waits

4. Engineer solutions to interoperability issues - CFHD aims to deliver an integrated service delivered by staff employed by 2 provider organisations. Accordingly, there are ubiquitous interoperability issues, for which solutions need to be found before the new service model can go live. Risks associated with the interoperability issues relate to reputation, operations, quality, patient safety including children's safeguarding, employment, legal issues, information governance, IT and the regulatory regime.

5. Develop and agree an integrated governance structure involving the two provider organisations

6. Review and agree the Alliance risk share arrangements and objectives of the Children's Alliance, the latter, in light of the transition to the ICS

7. Integrated electronic record system to be developed and operationalised

8. Organisational development work to facilitate transition of staff into integrated multi-disciplinary teams

9. Complete implementation of LTP CAMHS developments in Eating Disorders, Crisis, Mental Health in Schools

Quality

10. Develop infrastructure and undertake training and OD to embed standardised use and reporting of Routine Clinical Outcomes across all clinical pathways

Performance

11. Improve performance – embed productivity standards, creating optimal activity, clarity regarding capacity and demand management; establish and maintain sustainable waiting times

System wide developments

12. Complete actions associate with the Torbay SEND Written Statement of Action

13. Engagement with the ICS ‘Game Changers’ relating to speech, language and communication needs and neurodiversity needs

14. Complete negotiations with the ICB to agree contractual changes in light of the CFHD gaps analysis

Recommendation
The Board is receive and note the report.

Appendix 1
Demand assumptions and calculations

Growth in demand: at the time of procurement, it was assumed that growth in demand would be 0% across the lifetime of the contract. We have therefore identified the current demand (with a Tableau generated predicted FYE for 2021/220), to understand whether this commissioning assumption was appropriate for current provision. See embedded document.

The variance between 2019, the first year of the contract and the current year is summarised below. Of note, the Children's Community Nursing Services show a significant increase in referrals received and accepted along with the CDC for which there has been a 24% increase in accepted referrals. For all other services, with the exception of OT, there has been a decrease in referrals received and accepted. In considering this data it is important to note some key factors:

- The pandemic has altered the volume and pattern of demand across the year, making it difficult to predict future rates of demand
- In the context that in 2021/22 the service has adjusted to delivering care remotely and has been focussing on re-design, in which all services will be delivered in accordance with the Thrive Framework, there have been some important stepped changes to the way services are delivered. Services have developed digital offers and the way in which CYP and their families can be supported without requiring specialist interventions. In so doing, services have begun to expand their 'Getting Advice' offers. However, these are not being captured as 'Getting Advice' but as declined referrals.

Taking the above into consideration, it is not possible to reliably predict at present, the future demand for services.

Summary of variance in referrals received and accepted 2019/20-2021/22

	Service	CCN	Palliative Care	Specialist School Nursing	LD	CAMHS	OT	Physio	SALT	ASD	CDC	Total
Variance 2019/20 to 2021/22[1]	Referrals received	+ 260%	+86%	+46%	- 2.5%	+13%	0%	+12%	-10%	- 15%	+22%	+2.2%
	Referrals accepted	+298%	+86%	+46%	-2%	-4%	- 35%	-14%	-24%	- 40%	+24%	-11%

[1] Tableau predicted referrals data

Appendix 2

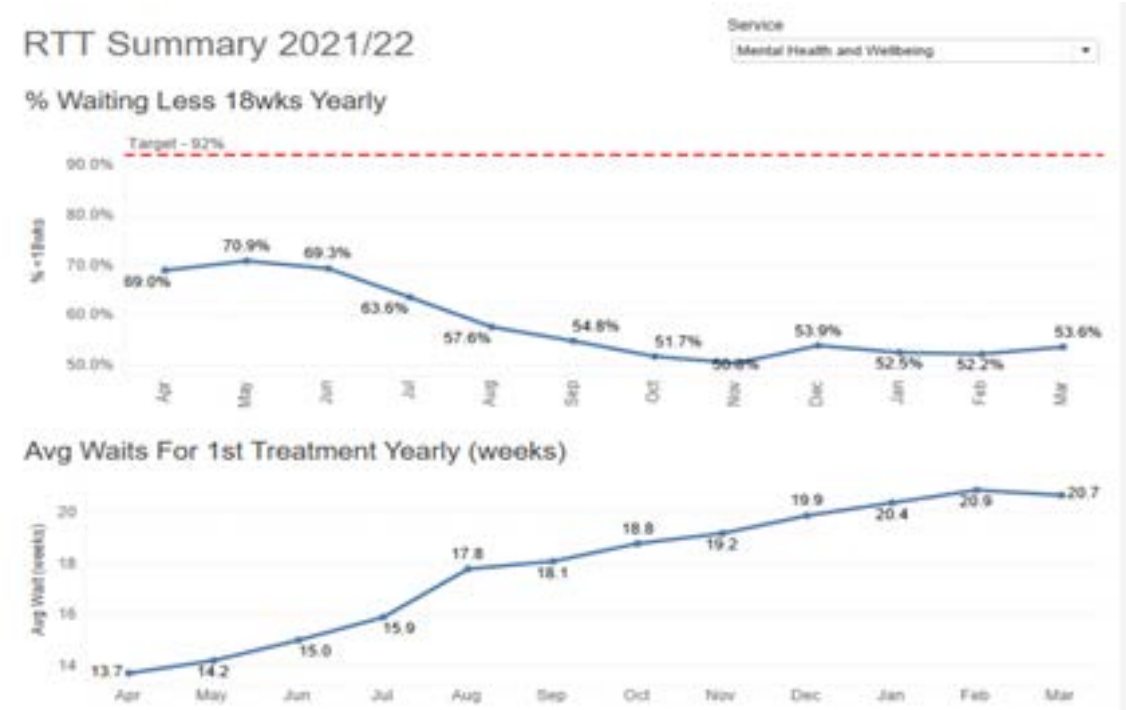
RTT and average waiting times by service 2021/22

Service	RTT Highest	RTT lowest	Average wait in weeks	Trend in weeks waiting
Children's Community Nursing	100%	/	1.8	↔
Palliative Care	100%	/	0	↔
Learning Disability	100% (9 months)	83.6%	4.5	↓
Occupational Therapy	77.3%	59.6%	14.4	↓
ASD Assessment Service	23.1	11.7%	51	↓
CAMHS	70.9%	50.7%	17.9[2]	↑
Physiotherapy	88.4%	64.5%	11.85	↑
Special School Nursing	100% (8 months)	40%	8.5	↑
Children's Assessment Centre	40.5%	31.5%	38	↑
Speech and Language Therapy	43.7%	32.9%	28	↑

RTT and average waits by service by month

[2] Referral to first treatment appointment


RTT Summary 2021/22
Service
Learning Disability (CFH Devon)
% Waiting Less 18wks Yearly
Target - 92%
% <18wks
100.0%
95.0%
90.0%
85.0%
100.0% 100.0% 96.2% 91.3% 94.4% 100.0% 83.9% 94.1% 100.0% 100.0% 100.0% 100.0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Avg Waits For 1st Treatment Yearly (weeks)
Avg Wait (weeks)
8
6
4
2
4.6 4.5 4.1 7.1 8.1 5.1 4.5 3.2 4.2 2.9 3.0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


RTT Summary 2021/22
Service
Mental Health and Wellbeing
% Waiting Less 18wks Yearly
Target - 92%
% <18wks
90.0%
80.0%
70.0%
60.0%
50.0%
69.0% 70.9% 69.3% 63.6% 57.6% 54.8% 51.7% 50.6% 53.9% 52.5% 52.2% 53.6%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Avg Waits For 1st Treatment Yearly (weeks)
Avg Wait (weeks)
20
18
16
14
13.7 14.2 15.0 15.9 17.8 18.1 18.8 19.2 19.9 20.4 20.9 20.7
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


RTT Summary 2021/22
Service
Palliative Care (CFH Devon)
% Waiting Less 18wks Yearly
Target - 92%
100.0%
50.0%
0.0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Avg Waits For 1st Treatment Yearly (weeks)
1.1
0.0

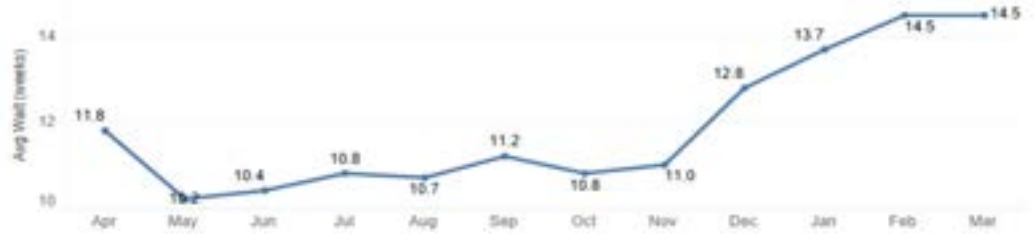

RTT Summary 2021/22
Service
Special School Nursing (CFH Devon)
% Waiting Less 18wks Yearly
Target - 92%
100.0%
66.7%
40.0%
0.0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Avg Waits For 1st Treatment Yearly (weeks)
1.9
6.4
10.8
6.3
12.4
4.9
9.5
13.3
18.0

RTT Summary 2021/22

Service: Physiotherapy (CFH Devon)

% Waiting Less 18wks Yearly

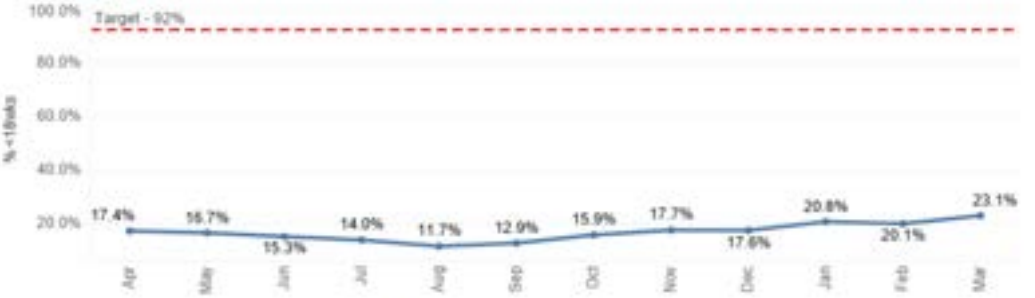
Avg Waits For 1st Treatment Yearly (weeks)



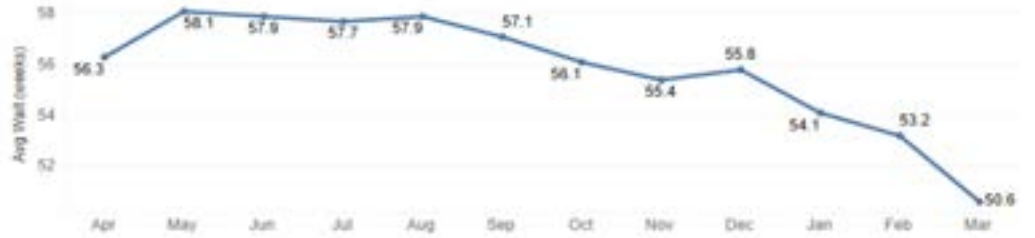
RTT Summary 2021/22

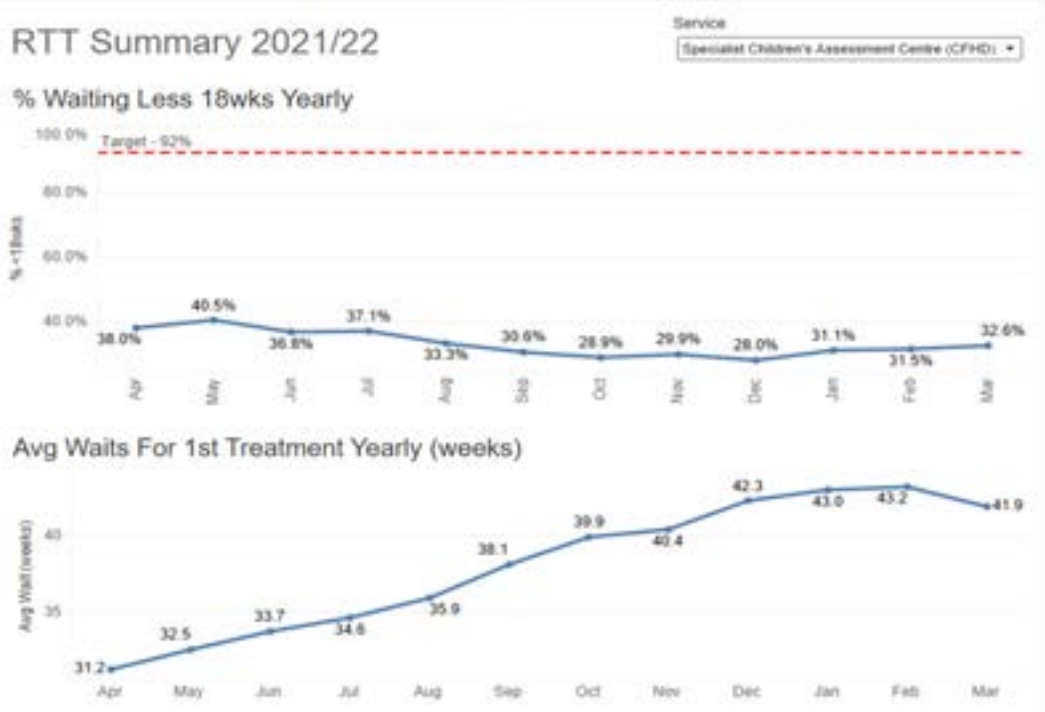
Service: Specialist Autism Spectrum Assessment Team...

% Waiting Less 18wks Yearly



Avg Waits For 1st Treatment Yearly (weeks)




RTT Summary 2021/22
Service
Specialist Children's Assessment Centre (CFHD)
% Waiting Less 18wks Yearly
Target - 92%
% <18wks
38.0%
40.5%
36.8%
37.1%
33.3%
30.6%
28.9%
29.9%
28.0%
31.1%
31.5%
32.6%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Avg Waits For 1st Treatment Yearly (weeks)
Avg Wait (weeks)
31.2
32.5
33.7
34.6
35.9
38.1
39.9
40.4
42.3
43.0
43.2
41.9


RTT Summary 2021/22
Service
Speech & Language Therapy (CFH Devon)
% Waiting Less 18wks Yearly
Target - 92%
% <18wks
42.8%
43.7%
39.9%
41.7%
41.6%
35.5%
34.9%
32.9%
33.7%
36.2%
36.1%
34.6%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Avg Waits For 1st Treatment Yearly (weeks)
Avg Wait (weeks)
24.3
25.5
27.0
25.8
26.7
27.9
28.8
28.6
30.4
30.9
31.3
31.7

Appendix 3:

CAMHS Long Term Plan deliverables

NHS LONG TERM PLAN 3.24.' *Under this Long-Term Plan, the NHS is making a new commitment that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending'*.		
Increasing Access	By 20/21, 35% of children estimated to have a mental health condition will be able to access services. 100% of CYP accessing services over course of the LTP	2022/23 target changed to 1 contact Q1 growth from Q4 is 16% and Q4 22/23 growth from Q4; 21/22 is 21% Recovery Action Plan in place will achieve 69.8% of activity in 22/23
Mental Health in Schools (MHST)	Mental health support for children and young people will be embedded in schools and colleges	Successful in wave 2, 3 & 5 funding – MHSTs now operational in Exeter, Torbay (2 x teams) Teignbridge & North Devon. New funding for 2 x new teams in 2022/23.
Eating Disorders	Over the next five years, we will boost investment in children and young people's eating disorder services and deliver the new waiting time standards for eating disorder services by 2020/21 (7 days urgent, 28 days routine)	Investment being used to increase ED workforce and create county-wide ED pathway. Urgent ED RTT met. Routine ED RTT improvement trajectory in place
Crisis Support	Children and young people experiencing a mental health crisis will be able to access crisis care 24 hours a day, seven days a week.	Currently no provision for MH assessments out of hours beyond 8pm for CYP – plan for Psychiatric Liaison to become all age by Q4 2022/23. CYP calls not currently responded to by FRS – all age plan as above. Development of overnight response part of Urgent Care Board. CYP investment & transformation progressing to deliver crisis response and home treatment until 10pm, 7 days/week in all areas (Go live 05/07/2022).
Development of 0-25 age services	Extend current service models to create a comprehensive offer for 0-25 year olds that reaches	Development of 18-25 services held in AMHS

	across mental health services for children, young people and adults.	

Appendix 4

Key workforce metrics 2021/22

	CAMHS			Integrated Therapies & Nursing		
	April 2021	March 2022	Performance	April 2021	March 2022	Performance
Core training	88%	91%	↑	92%	91%	↓
Safeguarding L3 training	82%	95%	↑	90%	83%	↓
Vacancy rate	32.9 wte	40.2 wte	↓	*	*	
Staff turnover	n/a	1.7%	_	1.5%	5%	↓
Supervision	38%	79%	↑	*	*	
Appraisal	75%	61%	↓	77%	58%	↓

*Data not collected

Report to the Trust Board of Directors			
Report title: Building a Brighter Future update			**Meeting date:** 27 July 2022
Report appendix			
Report sponsor	Director of Transformation and Partnerships, SRO		
Report author	Programme Director		
Report provenance			
Purpose of the report and key issues for consideration/decision	To give members of the Trust Board an update on the latest position regarding the Building Brighter Future Programme		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendations	Members of the Trust Board are asked to note the contents of this report.		
Summary of key elements			

Strategic objectives supported by this report

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

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

Board Assurance Framework	x	**Risk score**	16
Risk Register		**Risk score**	

BAF Risk – 11 To develop and implement the New Hospital Plan (Building a Brighter Future) ensuring that it meets the needs of the local population and peninsula system

External standards affected by this report and associated risks

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

Report title: Building a Brighter Future update		**Meeting date:** 27 July 2022
Report sponsor	Director of Transformation and Partnerships, SRO	
Report author	Programme Director	

1.0 Introduction

This paper has been prepared to give members of the Trust Board an update on the Building a Brighter Future (BBF) programme. There is particular reference to the following aspects of the programme:

- Latest national team briefing – 28th June 2022
- Resubmission of the Strategic Outline Case
- Site Enabling Business Case
- Seed allocation 2022/23
- Timetable

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

2.0 National New Hospital Team briefing – 28th June

The briefing was chaired by Morag Stuart, Chief Programme Officer, and the main issues discussed in the meeting were as follows:

- National Programme Business Case – £3.7bn has now been approved by HM Treasury to allow the New Hospital Programme to proceed with the following elements:

  - Completion of cohort 1 projects.
  - Commencement of construction for cohort 2 projects.
  - Further development of the planning of cohort 3 and 4 projects.

  The next iteration of the programme business case will be presented to HM Treasury in the Autumn which will confirm the funding requirements for all cohort 3 and 4 Trusts. In addition, there is also a national recognition that this phase of the programme business case will also need to include the funding requirements for:

  - 8 additional cohort 5 projects, which have yet to be announced
  - 5 additional Reinforced Autoclaved Aerated Concrete (RAAC) constructed hospitals that are in urgent need of replacement. There are currently 2 RAAC hospitals in the New Hospital Programme (James Paget, Great Yarmouth and West Suffolk Hospital, Bury St Edmunds) but the remaining 5 will also be added into the programme.

- NHP Funding envelopes – it was made clear the national team do not have an audit trial in relation to the indicative allocations that have been made to cohorts 3 and 4. To address this issue, the national team confirmed that they would be looking to review the options of each scheme from July

through to October with a view to confirming both allocations and timetable by the end of calendar year.

- Life Cycle costs – it was explained that the value of schemes was increasingly going to be viewed in terms of the operational and financial efficiency they drive rather than an estates improvement view. The approach being adopted by the National team is to secure the 'minimally viable option' for each Trust within the programme.
- Enabling works – as previously confirmed to the BBF Committee, there is likely to be 2 routes to progress:

  i. For cases under £15m, this is likely to require a short form business case, that will essentially allow smaller enablement measures to progress straight to construction once the short form cases had been approved.
  ii. Torbay and South Devon NHS Foundation Trust will probably fall in to the over £15m category which they said would likely need OBC and FBC or the site enabling programme. This is departure from initial advice as the Trust had received advice to produce one short form case. It was confirmed that the national team would issue more information on the process soon, however the likely implication for the Trust will be the submission of two cases (OBC and FBC) in relation to the site enabling works programme.

3.0 Resubmission of the Strategic Outline Case

The main implication for the BBF programme is that the Strategic Outline Case (SOC) will require resubmission. The revised SOC will include the following changes to the original submission that was made in July 2021:

- Digital – the New Hospital Programme national team confirmed in autumn 2021 that they would not fund the Electronic Patient Record (EPR) element of the programme. Given that this investment has now been secured from another funding source, this element of the original SOC will now be removed.
- Strategic options – It is clear the national team are shifting their terminology away from 'affordable' solutions to 'optimal' solutions. The exact definition of the 'optimal' approach seems to relate to the level of benefit that could accrue from the respective long list of options. (i.e. what level of additional benefit could accrue from additional marginal capital expenditure.) On that basis, the long list of options contained within the SOC will be reviewed to cover the following scenarios:

  - More day case surgical capacity than was in the original scope.
  - More demolition to achieve greater financial benefit in terms of reducing the backlog maintenance burden even further (given that this was a major programme objective from the outset)
  - Greater investment in smart technologies to improve operational efficiency
  - Additional digital investment to improve the economic case e.g. remote monitoring devices.

These revised options were subject to a detailed review at the BBF Committee development session that took place on 20th July meeting. As a result, the BBF programme office is now in a position to present the following short list of options:

- Business as Usual / Counterfactual – which will confirm the level of investment and risk that would exist through investment of Trust capital allocations over the life cycle of the business case.
- Do minimum – the minimum level of investment that would be required to secure the investment objective noted in the business case
- Initial preferred way forward - this option will be the 'minimally viable option' and will include more scope than the original SOC to include more day case surgical capacity and also additional site clearance. It is important to note that the option will exceed the original £350m indicative allocation, though this increase is predominantly due to inflationary pressures and national guidance requirements (i.e. requirement for 100% single rooms)
- Do Maximum – which would be a complete reprovision of the Torbay Hospital site

- Efficiency – the discussion underlines the importance of the finance case part of the Strategic Outline Case in particular. This will require significant development to confirm the capital and revenue affordability of the programme, as the focus of the national team appears to moving from one of capital affordability to the delivery of a sustainable revenue position as a result of the investment being made.
- Digital infrastructure – the SOC will need to include the investment requirements to enable the development of a 'digitally enabled' hospital. Guidance will be required from the national team to specify their exact requirements, however for the purposes of completing the SOC, the Trust's EPR digital team are developing a specification that will address this infrastructure requirement. When national guidance is forthcoming from the national team, this will be included in a more detailed specification that will be included in the Outline Business Case.

The revised Strategic Outline Case will be presented to the Trust Board in September 2022.

4.0 Site enabling business case

As highlighted, the Trust is now likely to have to produce two cases (OBC and FBC) for the site enabling project, and will have to ensure that is complies with the national guidance in this regard. Until this guidance is forthcoming, the impact on timetable is unclear, but will be confirmed to the BBF Committee as soon as possible. The Programme Office are continuing to work on the development of the site enabling business case, however given the requirements in relation to the resubmission of the SOC, it is now likely that this business case will not be submitted until early 2023.

The site enabling project will take two years to deliver and will involve a number of work packages which will result in the site being fully prepared for the main

construction element of the project to commence in 2025. The work packages included in the site enabling project are as follows:

- Modular accommodation – to accommodate clinical accommodation that will require relocation to enable the clearance of the site. The intention is for the construction work as soon as approval is received, and will take up to 50 weeks to complete. The building will be completed by January 2024.
- HV cable diversion – a High Voltage cable in one of the build zones (north) will require diversion, this will take place in mid-2024.
- Site clearance – once the site enablement measure has been completed, 19 buildings on the site will require demolition and clearance. This will site clearance will be completed by the end of 2024.

The business case will include fully tendered packages, and subject to Trust Board approval, the case will then be forwarded to the national New Hospital Programme team for their technical review and subsequent submission to the NHSE/I Joint Investment Committee.

The BBF programme office will be using the period leading up to SOC resubmission to ensure that all the site enabling costs are fully understood and included within the SOC. This will ensure that the Trust does not have any cost pressures when site enabling business case is submitted.

5.0 2022/23 seed allocation submission

The level of 'seed' allocation for 2022/23 was been confirmed at £1.06m. It should be noted that this is a uniform allocation for all cohort 4 Trusts. This has a number of implications for the programme. These are noted below:

- Programme Team costs – the allocation covers programme team costs for 2022/23. It did **not cover** costs associated with:

    - Technical adviser fees – including IBI, Turner Townsend and PwC, which at stage would be required to complete the detailed design phase of the site enabling business case.
    - Strategic transformation and Organisational Development support which is considered important for the Trust to be truly ready to deliver change of the scale required
    - External workforce planning support
    - Recurrent costs of digital programme

The BBF programme office did write to the New Hospital Programme national team asking for further support of £661,000. The Trust is still awaiting confirmation about whether this request has been approved. To mitigate, £200,000 of support has been approved by the Trust Capital investment Delivery Group. This funding will assist the programme team in progressing the development of the site enabling business case in the absence of any further national support at this stage.

6.0 Timetable

The BBF programme office has development a revised level one schedule / timetable for the BBF programme. This timetable is consistently being reviewed to ensure that it reflects the current political, economic and local context. Clearly this programme is subject to change, however the following key dates are still being worked towards by the BBF programme office:

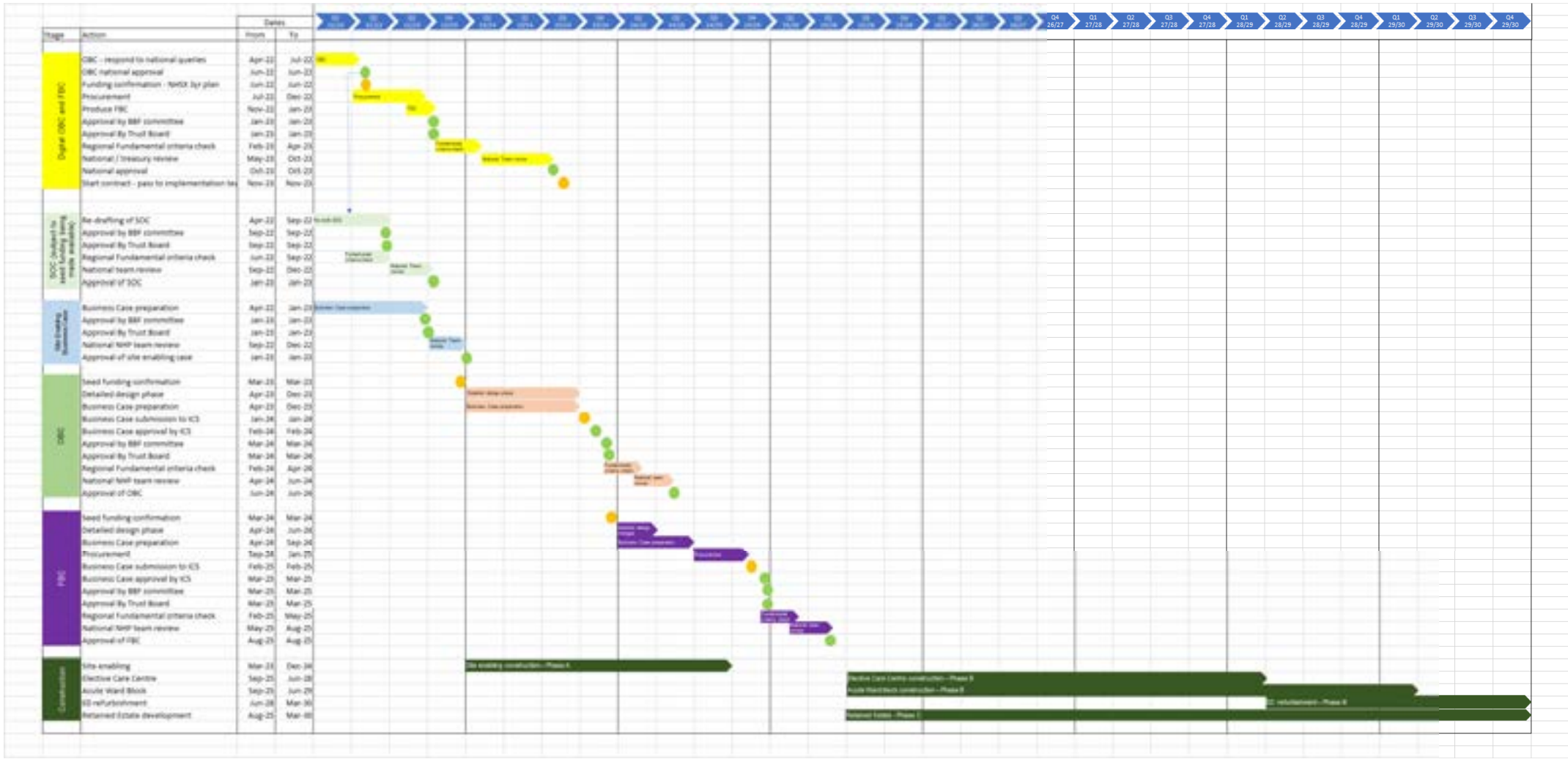
- SOC resubmission – September 2022
- Site enabling business case – January 2022
- Commencement of site enabling works – April / May 2023
- Outline Business Case commencing – April 2023
- Full Business Case commencing – April 2024
- Main construction starts – September 2025
- Completion – December 2029

Appendix A provides the latest timetable for the programme.

7.0 Conclusion

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

Appendix A – Level one schedule Project Timetable



NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Timeline – health and care in Torbay and South Devon			**Meeting date**: 27 July 2022
Report appendix	Draft timeline text		
Report sponsor	Chief Executive		
Report author	Associate Director of Communications and Partnerships		
Report provenance	Reviewed by Executive Directors 19 July 2022		
Purpose of the report and key issues for consideration/decision	To share the draft text for our timeline of health and care in Torbay and South Devon – to be designed and installed on one of the main corridors on level 4 at Torbay Hospital.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board are asked to approve the draft timeline text		

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: Timeline – health and care in Torbay and South Devon		Meeting date: 27 July 2022
Report sponsor	Chief Executive	
Report author	Associate Director of Communications and Partnerships	

1 Our objective

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

We're working on a graphic timeline that will adorn one of our very long corridors at Torbay Hospital. The timeline will tell the history of health and care services in Torbay and South Devon and our vision for the future.
In order to make sure our timeline is reflective of our history (in our various guises and past organisations), who we are as an organisation now, the services we provide and our brighter future we have sought input for the content from:

- Our staff
- Our governors
- Our League of Friends organisations for all our hospitals
- Torbay Hospital staff history group
- Torbay Hospital library
- HeArts
- Nurses League
- Torbay Civic Society
- Torquay Museum
- Torre Abbey
- Torbay Library Services
- Torbay Archive Service
- Rowcroft Hospice
- Torbay Arts and Culture Network
- Healthwatch Torbay, Devon and Plymouth
- Torbay Culture
- Babbacombe and St Mary Church Local History Society
- Galmpton and Churston Local History Group
- Paignton Preservation and History Society
- Brixham Heritage Museum
- Devon History Society
- Torbay Culture
- Undiscovered Torbay (Facebook group)

Once the text is approved we will work with a design company to develop a design that is reflective of the NHS identity guidelines and our own branding and is both engaging and accessible.

We aim to have the timeline installed by October 2022.

2 Recommendation

Board members are asked to **approve** the draft timeline text and plan and **consider** any additions or amendments.

Draft text for timeline

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

Date	Info
1844	Torbay Hospital Provident Dispensary and Eye Infirmary was founded in three rooms in Union Street, Torquay. Prior to this the only free medical care available locally was at Newton Abbot workhouse.
1850	Sir Lawrence Palk and his brother, Lord Haldon, donated a site on Higher Union Street to become the first Torbay Hospital. The foundation stone for the new hospital was laid in 1850 and the building finished in 1853. The hospital was established as a voluntary hospital which meant that it was provided and maintained by voluntary funds. Local people either paid a weekly contribution as a member or paid an entrance fee when they were admitted (and then became a weekly paying member).
1871	The first hospital in Dawlish was opened in this year.
1873	The first hospital in Newton Abbot was opened in this year.
1891	Paignton Community Hospital was built thanks to donations from the Singer Family. In 2015, following a public consultation, the hospital became a health and wellbeing centre. The first hospital in Brixham was opened in this year.
1894	Dartmouth and Kingswear Community Hospital was built.
1899	Ashburton and Buckfastleigh Community Hospital opened. Like Paignton, it became a health and wellbeing centre following a public consultation in 2015.
1900	Opening of Moretonhampstead Hospital. The hospital is now managed by Royal Devon University Healthcare NHS Foundation Trust
1909	We welcomed the first nursing students to Torbay Hospital
1911	The first hospital in Bovey Tracey opened in 1911. The current site, Bovey Tracey Community Hospital, opened in 1932.
11 January 1922	Insulin was first used to treat a person with diabetes. The following year it began to be produced on a mass scale.
25 June 1925	Ella Rowcroft wrote to the President of the Torbay Hospital Committee offering £100,000 to build a new hospital on a site donated by Major Kitson. The site was Hengrave House which was surrounded by 15 acres of land.
23 June 1926	The foundation stone of Torbay Hospital was laid by Ella Rowcroft. Miss Violet Wills, Ella's sister, contributed £13,000 which funded the radiotherapy department.
1928	Brixham Community Hospital opened on its current site. There has been a hospital in Brixham since 1891.
September 1928	Penicillin was discovered by Alexander Fleming.
17 November 1928	The official opening of Torbay Hospital! The celebration event included a ceremony by Lord Mildmay of Flete, Lord Lieutenant of the County of Devon. Over 2,000 representatives from the professional, commercial and social life of Torbay were in attendance, though Ella Rowcroft was unable to attend herself due to ill health.
29 May 1930	His Royal Highness, The Prince of Wales, (the future Edward VIII), visited Torbay Hospital.
12 August 1930	The Chapel at Torbay Hospital was opened and dedicated by the Right Reverend the Lord Bishop of Exeter.

	Ella Rowcroft specified that £6,000 of her generous donation should be allocated to the building of the Chapel and stained-glass window.
1 November 1942	The Beveridge report is published. One of its recommendations was that there should be a free and comprehensive health service available for all. The National Health Service Act was passed in 1946 resulting in hospitals becoming the responsibility of the State.
1945	Torbay Hospital Nurses' League was founded. Set up by trained nurses, for trained nurses, for friendship and support. The League is still going strong today with almost 200 members worldwide.
1946	Penicillin became available for the first time in the UK for public use. It transformed medicine worldwide and ushered in the age of antibiotics.
5 July 1948	The National Health Service is officially launched. The guiding principle was that it would be available to all and free at the point of delivery – financed from general taxation.
1954	Torbay Hospital's League of Friends was formed to raise funds for services and amenities. Over the years it has become one of the most successful Leagues in the country raising millions of pounds.
1954	Teignmouth Community Hospital became the first complete hospital in the country to have been built under the National Health Service. The previous hospital had been bombed and destroyed in 1941 when seven patients and three nurses died. There has been a hospital on the current site since 1925 and a hospital in Teignmouth since the 1840s.
1962	Sir John Charnley performed the first total hip replacement operation at Wrightington Hospital.
1967	Construction work began on a £2.5million hospital expansion which included new wards, an outpatient department, an accident and emergency department, a pharmacy and other clinical offices as well as a nurse training school and residential blocks for junior medical and nursing staff.
1968	The Seebohm Report recommended the establishment of unified social services within each major Local Authority
1970	The hospital expansion at Torbay was officially opened and it was designated a District General Hospital serving a population of 216,000. We proudly opened our school of nursing.
1970	The Local Authority Social Services Act partially introduced the Seebohm recommendations
1970	The Torbay Pharmacy Department formed to service local requirements. Today it is known as Torbay Pharmaceuticals and is the largest NHS-owned contract manufacturer serving global markets.
1972	The first commercially available CT scanner was created by British engineer Godfrey Hounsfield of EMI Laboratories in 1972. He co-invented the technology with physicist Dr Allan Cormack.
1977	Torbay Hospital Radio was founded and started broadcasting within the hospital. TowerSound, Newton Abbot Community Hospital's radio was founded five years later in 1982. Life Care Radio broadcast from studios at Totnes Community Hospital to local nursing and residential homes, hospices and to people receiving long-term care.
9 March 1978	His Royal Highness The Duke of Edinburgh visited Torbay Hospital for the official opening of the new Hydrotherapy Pool and Telecobalt unit. This

	cost approximately £125,000 and the League of Friends contributed approximately £105,000. The Hospital also celebrated its Golden Jubilee and the opening of the John Parkes Children's Unit.
25 July 1978	Louise Brown, the world's first baby to be conceived via in vitro fertilization (IVF) was born at Oldham and District General Hospital in Manchester
18 August 1979	Sir Terence English performed the UK's first heart transplant at Royal Papworth Hospital. The patient, Keith Castle, lived for more than five years post-transplant.
1980	A new catering complex, Bay View restaurant, was built at Torbay Hospital.
1983	The Mental Health Act (1983) introduced the issue of consent in mental health treatment and set out when people can be detained, or "sectioned". It applies in England and Wales, and is still the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.
1984	A new Intensive Care Unit was built on the Torbay Hospital site. A new mental health unit - called the Edith Morgan Unit – was also built on the Torbay Hospital site.
1985	Her Royal Highness, Princess Anne, opened the hospital's new maternity unit - The John MacPherson ward. This was named in honour of Mr John MacPherson, Consultant Obstetrician and Gynaecologist.
1987	The world's first heart, lung and liver transplant was performed. The procedure helped pave the way for other multiple organ transplants.
1988	NHS breast and cervical cancer screening were introduced. Mammograms were offered to women aged over 50, and women aged 20 to 64 were offered cervical cancer screening.
1990	A new pathology and mortuary building was built at Torbay Hospital. Hetherington Unit was officially opened and TREC (Torbay Research and Education Centre) an integrated central library and lecture theatre was constructed.
1991	NHS trusts were set up in the first of several reorganisations of how health services are planned, structured and paid for. Torbay Hospital became one of the first NHS trusts in the country and was known as South Devon Healthcare NHS Trust.
27 August 1992	Devon Air Ambulance flies its first mission – the service operates 5 days a week until July 1997 when it is extended to 7 days a week
1993	Totnes Community Hospital was opened by Katherine, Duchess of Kent. There had been a cottage hospital in Totnes since the nineteenth century.
1994	The NHS Organ Donor Register was launched.
1994	A new Day Surgery Unit and a Cardiology outpatients department was built at Torbay Hospital.
1997	The "CARRIE" project Crisis Assessment and Rapid Reablement for the elderly was rolled out, it was a highly successful service which led to the development of the intermediate care service.
1998	The NHS Direct service for non-emergency health problems was piloted in three areas of England It has since been replaced with NHS 111.
1999	Dawlish community hospital was opened by Her Royal Highness Princess Anne. There has been a hospital in Dawlish since 1871.

2001	A three-storey extension was built to form the Cataract Day Case Unit at Torbay Hospital.
2005	Torbay Care NHS Trust became one of just five integrated health and social care organisations in the country and built its model of care around a fictional character called Mrs Smith which formed the foundation of our current care model. It was responsible for nine community hospitals and for adult social care for the Torbay and South Devon region. Adult social care staff from Torbay Council TUPE'd to the new organisation while adult social care staff from South Devon remained employed by Devon County Council.
2005	Torbay Pharmaceuticals produced over 1million units.
2006	We welcomed our first undergraduate medical students from local medical schools in Exeter and Plymouth.
October 2006	We introduced self-referral into musculoskeletal physiotherapy.
2007	South Devon Healthcare NHS Trust (responsible for Torbay Hospital) was authorised as one of the early NHS Foundation Trusts and became South Devon Healthcare NHS Foundation Trust.
2007	Smoking was banned in restaurants, pubs and other public places.
2007	NHS Choices health advice information website launched.
2009	We opened the Horizon Centre, a new medical training centre at Torbay Hospital with dedicated rooms adapted for clinical training to stimulate full theatre conditions.
2009	The NHS Constitution was published. This was the first summary of what staff, patients and the public can expect from the National Health Service, and what rights you have as a patient.
January 2009	The new Newton Abbot Community Hospital was officially opened. There has been a hospital in Newton Abbot since 1873. The current hospital was awarded "Best Community Care Design" in the Building Better Healthcare Awards in 2009.
2009	The Care Quality Commission (CQC) was launched as a new regulator for health, mental health and adult social care.
2009	NHS Health Checks were introduced to help focus on prevention. This service was set up to assess and help reduce people's risk of developing heart disease, stroke, type 2 diabetes and kidney disease.
2010	We welcomed our first apprentices. We currently offer more than 35 different apprenticeships from GCSE level to masters level across clinical and non-clinical specialities.
2011	South Devon Healthcare NHS Trust won 'Acute Healthcare Organisation of the Year' at the Health Service Journal Awards.
2012	Torbay Hospital League of Friends received the 'Queen's Award' for their continued voluntary service.
2013	Under the Health and Social Care Act, a new NHS structure came into effect, including NHS England and Public Health England. The Act put more focus on public health and was also designed to strengthen the commissioning of NHS services.
2013	The NHS friends and family test was introduced. Since 2013, patients have been asked whether they would recommend hospital wards, A&E departments and other NHS services to their friends and family if they needed similar care or treatment.

2013	Torbay surgeons were the first in UK to trial Google Glass in the operating theatre.
2015	Torbay Hospital introduced a text message reminder service for patients for their outpatient appointments.
2015	Torbay Hospital adapted virtual reality technology to help improve clinicians' understanding of what it is like to be a patient.
July 2015	A groundbreaking ceremony took place to mark the official start of building work on an exciting £14.5m project to deliver a brand new, state-of-the-art critical care unit at Torbay Hospital. The project also included a new main entrance with a café and a shop.
01 October 2015	Torbay Care NHS Trust and South Devon Healthcare NHS Trust merged to became Torbay and South Devon NHS Foundation Trust. By forming our integrated care organisation we became the first NHS organisation in England to join-up hospital and community care with social care. We are proud pioneers in integrating health and social care nationally. As a Foundation Trust we have over 12,000 public members and 33 dedicated governors who represent the views of local people and to help us shape our plans for the future.
2015	The official opening of an enhanced cardiac suite for heart attack patients took place at Torbay Hospital. The project included a new recovery area, a second cardiac catheterisation laboratory and refurbishment of the existing laboratory, making our hospital one of few hospitals nationally to offer the service.
14 April 2016	Following extensive refurbishment the newly named 'Sinclair Oncology Unit' opened.
September 2016	Torbay Hospital League of Friends celebrated reaching its fundraising target of £1.6million in less than two years through its 'This is Critical' campaign for our new critical care unit. It was their second biggest fundraising campaign since their foundation in 1954.
2016	Newton Abbot Stroke Unit became one of the first five in the country to receive an 'A grade' on the National Stroke Audit, demonstrating the standard of rehabilitation provided.
2016	Our volunteer Way Finder service was introduced to help visitors to navigate their way around the Torbay Hospital site.
February 2017	Our new £15m intensive care unit and main entrance officially opened at Torbay Hospital.
July 2017	Torbay Pharmaceuticals opened its brand new £26million manufacturing unit in Paignton with all the latest technology and equipment required to provide a modern, class-leading pharmaceutical facility.
4 July 2017	The first electric cars joined our fleet.
April 2018	An £8million project was completed at Torbay Hospital to provide new state-of-the-art cancer targeting Linear Accelerators otherwise known as LINACs. A LINAC is a machine that delivers specific ionising radiation to kill cancer cells, this is known as radiotherapy – a standard treatment for cancer. Two LINACs were replaced, an additional specialist concrete bunker built and the whole environment for patients improved.
May 2018	We were the first health and social care provider in the world to earn the status of 'Purple Angel dementia-aware.

September 2018	We performed out first day case hip replacement. We were in the first five hospitals in the country to perform day case hip replacements and we were the first hospital to do so in the southwest. This was closely followed by our first day case total knee replacement in 2019 as well as our first day case total shoulder replacement the same year.
February 2019	We began to provide care even closer to home, through the use of video technology by our health and social care community teams.
February 2019	As part of our commitment to NHS zero carbon, we're doing as much as we can to reduce our carbon emissions, including reducing emissions from surgical gases. We took Desflurane off the anaesthetic machines in February 2019 and since then we have saved CO2e 176 Tonnes per annum. We are working on decommissioning our piped nitrous oxide supply. The potential savings are huge – a potential of CO2e 244 Tonnes per annum.
01 April 2019	The Children and Family Health Devon service was launched providing community services for children, young people and their families. We are proud to be the lead partner in the group of organisations which form this important service.
May 2019	Our brand new £800k Friends Centre in Brixham officially opened. We worked in partnership with Brixham Community Hospital's League of Friends and Brixham Does Care to bring together day care, health and wellbeing services in to one place.
October 2019	Torbay Hospital reopened two of its surgical theatres after major modernisation. The £2.3m refurbishment installed up-to-date air handling equipment, among other improvements.
October 2019	The Government confirmed that Torbay Hospital is one of 40 hospitals across the country to receive a share of £3.7 billion in the 'biggest hospital building programme in a generation'. The funding will be used to build hospital facilities to support improved access to diagnostics, improvements to urgent and emergency care environments, and separate planned care units.
January 2020	We started to use the Stericycle system to reduce our use of single use plastics. Since 2020, this has resulted in us saving over 13,000 containers from incineration and saved almost 76,000 kgs of carbon.
March 2020	The COVID-19 pandemic was officially declared. We will never forget the support our communities and people gave us. Torbay Pharmaceuticals began to make hand sanitiser to meet demand.
March 2021	Construction work started on our new £15million Acute Medical Unit at Torbay Hospital. This exciting project will see the hospital receive a modern and fit-for-purpose unit which will be split over two levels. This will allow for patients with different needs to be treated in the most appropriate setting.
June 2021	Building work started on a new £4.8m Health and Wellbeing Centre in Dartmouth.
May 2022	We were successful in securing the Torbay 'Drug and Alcohol Treatment Service' as part of the 'Alliance Agreement for Support Services for Drug and Alcohol Treatment, Domestic Abuse and the Homeless Hostel'.
2022	Devon Partnership NHS Trust's new mental health ward, Salus, opened at Torbay Hospital. The £12.5m project provides a range of facilities, including treatment and therapy rooms, a family room, 16 en-suite bedrooms as well as offices for staff, a main reception and waiting area.

2022	We agreed the sale of the former Dartmouth and Kingswear Community Hospital site to Dartmouth Town Council to fund the building of the new Health and Wellbeing Centre in the town and to support the use of the site to deliver social value to local communities.
Autumn 2022	New Dartmouth Health and Wellbeing Centre opens
Autumn / Winter 2022	New Acute Medical Unit opens.
	Our present…..
	Factoids about 'now' to drop in to the design We support around 500,000 face-to-face contacts with patients in their homes and communities each year. We see over 78,000 people in our Emergency Department annually. We serve a resident population of approximately 286,000 people, plus about 100,000 visitors at any one time during the summer holiday season. We employ over 6,500 people. We have over 800 volunteers who make a difference every day to the people we care for and the services we provide.
	Our opportunity to bridge to our future
	To weave this in to the graphics / story of the timeline We've been given a share of £3.7billion government funding through the New Hospitals Programme for Torbay Hospital. The initial 'seed' funding is enabling us to develop plans for a once in a lifetime opportunity to make a real difference to how we deliver services with, to, and for our people. Parts of Torbay Hospital date back to the 1920s and a significant proportion of the estate will require significant repair or replacement very soon. Our IT infrastructure is also aging with some systems – which are still in use – being over 40 years old. These systems are no longer fit-for purpose. Without significant investment, our estate and digital infrastructure will continue to deteriorate, ultimately resulting in us being unable to continue to deliver safe and effective care to those who use our services, unable to take advantage of the latest developments and innovations in health and care services and unable to provide our workforce with high quality working environments and equipment. Our vision for Building a Brighter Future is not just about building a better hospital in Torquay. It's about exploring opportunities to deliver our services in ways that provide better outcomes for our population and better working environments for our people across all the communities we serve.

	For us it's about 'Building a Brighter Future' together with our people and our communities
	Help us to build our brighter future!
	An investment of this scale in our local health and care system is a once in a lifetime opportunity and we want to work with you to make this a success. Your feedback, ideas, suggestions and comments are hugely important to us and will help to shape our plans to build a brighter future. As our plans progress, we will be holding a range of engagement sessions and activities. Please check our website where we will share the latest news on how to have your say and how you can get involved in shaping our future.