

# Torbay and South Devon NHS Foundation Trust




## Public Board of Directors






The Boardroom, Hengrave House/Microsoft Teams






26 October 2022 11:30 - 26 October 2022 14:00



# AGENDA

#	Description	Owner	Time
1	<p>Welcome and Introductions</p> <p>Note</p>	Ch	11:30-11:35
2	<p>Preliminary Matters</p>	Ch	
2.1	<p>Apologies for Absence and Quoracy</p> <p>Note</p>	Ch	
2.2	<p>Declaration of Interests</p> <p>Note</p>	Ch	
2.3	<p>Board Corporate Objectives</p> <p>Information</p> <p> 2.03 Board Corporate Objectives.pdf 9</p>	Ch	
3	<p>Patient Experience Story - Torquay</p> <p>Note</p>	CN	11:35-12:00
4	<p>Consent Agenda (Pre Notified Questions)</p>		
4.1	<p>Committee Reports</p>		
4.1.1	<p>Finance Performance and Digital Committee Chair's Report - 26 September 2022</p> <p>Note</p> <p> 4.01.01 Finance Performance and Digital Committe... 11</p>	P Richards	
4.1.2	<p>Quality Assurance Committee Chair's Report - 26 September 2022</p> <p>Verbal</p>	J Lyttle	
4.1.3	<p>Charitable Funds Committee Chair's Report - 31 August 2022</p> <p>Note</p> <p> 4.01.03 - Charitable Funds Chair's Report - 31 Aug... 15</p>	J Lyttle	

#	Description	Owner	Time
4.1.4	<b>Audit Committee Chair's Report - 8 September 2022</b> Note  4.01.04 Audit Committee Chair's Report - 8 Septem... 17	S Taylor	
4.2	<b>Reports from Executive Directors (for noting)</b>		
4.2.1	<b>Chief Operating Officer's Report - October 2022</b> Receive and Note  4.02.01 Chief Operating Officer's Report October 2... 21	COO	
5	<b>For Approval</b>		
5.1	<b>Unconfirmed Minutes of the Meeting held on the 28 September 2022 and Outstanding Actions</b> Approve  5.01 Unconfirmed Minutes of the Meeting held on th... 35	Ch	12:00-12:05
6	<b>For Noting</b>		
6.1	<b>Report of the Chairman</b> Verbal	Ch	12:05-12:15
6.2	<b>Chief Executive's Report</b> Receive and Note  6.02 Chief Executive's Report.pdf 55	CE	12:15-12:30
7	<b>Safe Quality Care and Best Experience</b>		12:30-13:30
7.1	<b>Integrated Performance Report (IPR): Month 6 2022/23 (September 2022 data)</b> Receive and Note  7.01 Integrated Performance Report - Month 6.pdf 67	COO	
7.2	<b>Guardian of Safe Working Hours Report</b> Receive and Note  7.02 Report of the Guardian of Safe Working Hours... 135	MD	

#	Description	Owner	Time
7.3	<p><b>Maternity Governance &amp; Safety Report 1 July 2022 - 30 September 2022</b></p> <p>Receive and Note</p> <p> 7.03 Maternity Governance and Safety Report 1 Jul... 139</p>	CN	
7.4	<p><b>Report on Safeguarding Adults, Mental Capacity and Deprivation of Liberty Safeguards</b></p> <p>Receive and Note</p> <p> 7.04 Report on Safeguarding Adults, Mental Capaci... 153</p>	CN	
8	<b>Valuing our Workforce</b>		
8.1	<b>No agenda items</b>		
9	<b>Improved Well-Being Through Partnerships</b>		13:30-13:45
9.1	<p><b>Working together to deliver service transformation in Devon, Cornwall and Isles of Scilly- Peninsula Acute Provider</b></p> <p>Approve</p> <p> 9.01 Working together to deliver service transformat... 173</p> <p> 9.01 Working together to deliver service transformat... 175</p>	CEO	
10	<b>Well-Led</b>		13:45-14:00
10.1	<p><b>Devon Operating Model</b></p> <p>Receive and Note</p> <p> 10.01 Devon Operating Model.pdf 199</p>	CEO	
11	<b>Compliance Issues</b>		
12	<p><b>Any Other Business Notified in Advance</b></p> <p>Note</p>	Ch	
13	<p><b>Date and Time of Next Meeting - 11.30 am, Wednesday 30 November 2022</b></p> <p>Note</p>	Ch	

# INDEX

2.03 Board Corporate Objectives.pdf.....	9
4.01.01 Finance Performance and Digital Committee Chair's Report - 26 Septe.....	11
4.01.03 - Charitable Funds Chair's Report - 31 August 2021.pdf.....	15
4.01.04 Audit Committee Chair's Report - 8 September 2022.pdf.....	17
4.02.01 Chief Operating Officer's Report October 2022.pdf.....	21
5.01 Unconfirmed Minutes of the Meeting held on the 28 September 2022 and.....	35
6.02 Chief Executive's Report.pdf.....	55
7.01 Integrated Performance Report - Month 6.pdf.....	67
7.02 Report of the Guardian of Safe Working Hours – Doctors and Dentists in Tr.....	135
7.03 Maternity Governance and Safety Report 1 July 2022 – 30 September 202.....	139
7.04 Report on Safeguarding Adults, Mental Capacity and Deprivation of Liberty.....	153
9.01 Working together to deliver service transformation in Devon, Cornwall and Is.....	173
9.01 Working together to deliver service transformation in Devon, Cornwall and Is.....	175
10.01 Devon Operating Model.pdf.....	199

## **BOARD CORPORATE OBJECTIVES**

### **Corporate Objective:**

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

### **Corporate Risk / Theme**

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





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

<b>Committee meeting date:</b>	26 September 2022
<b>Report author + date:</b>	Paul Richards, Non-Executive Director 20 October 2022
<b>This report is for:</b> <i>(please select one box)</i>	Information <input checked="" type="checkbox"/> Decision <input type="checkbox"/>
<b>Link to the Trust's strategic objectives:</b> <i>(please select one or more boxes as appropriate)</i>	1: Safe, quality care and best experience <input type="checkbox"/> 2: Improved wellbeing through partnership <input type="checkbox"/> 3: Valuing our workforce <input type="checkbox"/> 4: Well led <input checked="" type="checkbox"/>
<b>Public or Private</b> <i>(please select one box)</i>	Public <input checked="" type="checkbox"/> or Private <input type="checkbox"/>

### Key issues to highlight to the Board

The Committee received the BAF and CRR. A detailed discussion ensued. The Committee noted the Board Development session to agree the new format and content of the BAF has been delayed and was now urgent. In particular, the Committee wanted to ensure adequate coverage of known risks around flow and out of hospital services.

#### **Investment**

The Committee received the draft Winter Plan, which would also be considered by Trust Board. The Committee noted the overarching aim to ensure good flow through the care system over the winter months.

The Committee noted the significant expected bed pressure, as activity was predicted to increase due to Covid waves and 'normal' winter surge. A peak gap of 103 beds was predicted in January 2023 and the Committee endorsed the need to keep 'no criteria to reside' discharge numbers below the baseline number of 54.

Demand modelling suggested the Trust needed to be able to reach between 55-70 acute discharges/transfers per day over winter, which was an ambitious but realistic target.

The Committee noted and recommended to the Board the investment proposals as follows:

- o Acute escalation beds and flow - £3.38m
- o Discharge/capacity - £1.85 m
- o Proposed total beds - 89

The Committee discussed the risks around delivery, notably the ability to staff the additional beds. The Committee was reassured that focused work was taking place to expediate recruitment processes.

The Committee noted wider areas of focus in the winter plan, including pre-planning discharges; carers' support; weekend discharges; and Admiral nurses. In its discussion, the Committee sought assurance that the system as a whole would be able to operate in the way described in

the report without the need to stand down elective care. Reassurance was provided over the plan's adequacy to meet the Trust's ambition to maintain elective services and continue the backlog reduction. The committee sought assurance that further work would be done to plan the detail and ensure further contingency would be built into the plan since there was little detail in the current version to give this assurance.

Finally, the Committee noted that it was not yet clear how much of the funding being provided might be recurrent in future years. It was likely it would be dependent on how successfully the Trust managed the winter period and delivered the required increases in bed and bed equivalent numbers.

### *Performance*

The Committee received the integrated performance report. It was noted that Covid had started to increase, from a low of 3-5 inpatients in August to currently in excess of 20-30 patients (with Covid being incidental to their admission) which had a significant impact on flow. Increases in Covid had also affected staff sickness.

The elective programme continued at pace, and 104 week waiters had reduced to 51 at the end of August. It was expected that this would further reduce in September to below 35.

The forecast numbers of 78 week waiters at the end of March 2023 had increased from 300 to 900. Services that were particularly challenged included urology and colorectal. This also affected the Trust's 62 day cancer standard. The Committee will be receiving further detail on the 78 week and 62 day cancer position.

### *Finance*

The Committee noted the Trust was reporting a year to date deficit of £6m against a plan of £3m. This included £5.4m of non-recurrent mitigations which had supported the position.

The key drivers were £3.9m of CIP slippage; £2.4m overspend in urgent care; increased spend in the independent sector; Torbay Pharmaceuticals sales behind plan by £1.2m; and other cost pressures totalling £700,000.

It was emphasised that the biggest driver of the Trust's position was undelivered CIP performance and assurance was provided that work had commenced to increase focus on this area of work with a robust governance and accountability framework in place.

The Committee queried the relationship between the number of unfilled packages of care and challenges in flow and financial delivery. It was noted that growth in the independent sector included off framework placements for domiciliary care and the need for spot purchasing of intermediate care, all increasing the cost of care. The Committee noted the difficulties in the out of hospital care market.

The Committee also received the Capital Expenditure, Cash Plans – Current Position report, noting a year to date spend of £12.4m against a full year plan of £36.9m. In terms of phasing, the programme was £1m behind plan. The Committee noted a number of large high value programmes were due to commence later in the financial year, and observed significant risk in terms of project resourcing, particularly for digital projects.

Finally, the Committee received the Financial Plan Update paper. The Committee was reminded of the background to the submission of a break-even position and additional funding that would be received if this could be achieved.

The Committee reviewed the original bridge to break even from the draft to the final plan submission. Of the £29.9m of required actions, £13.8m were felt to be green in terms of risk; £7.2m amber; and £8.9m red. As such, further action needed to be taken meet the likely financial shortfall. An increase of grip and control would be required and there was much discussion on plans and processes being put in place by the executives to ensure robust controls and budget managers being held to account.

The Committee was concerned that action was only now being taken to meet the financial gap, alongside the need to start work on the financial plan for 2023/24 in the near future. This was acknowledged and confirmation was provided that work was commencing shortly on a multi-year financial plan at system level.

In the meantime, the CFO provided some reassurance. In particular, the Trust had identified an Interim Delivery Director to support the work to reduce spend and realise efficiencies. The post had been funded by the Integrated Care System. Furthermore, a review of adult social care and continuing health care packages was taking place.

The Committee heard the additional actions that could be taken to reduce spend, including vacancy freeze; discretionary expenditure; closure of 11 ED escalation spaces; and headcount reduction.

***Other matters.***

The Committee also received the following items:

- Update on changes to SFIs and Scheme of Delegation, in line with planned revisions to the Trust's organisational structure and the ICS governance framework
- A review of the Adult Social Care Agreement 2021-22
- Estates matters including the Dartmouth disposal and the Surplus Land Return
- The position against the HFMA Checklist which would be subject to internal audit
- Committee reports, including TP, IM&T Group, Estates, Performance and Compliance Group

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

**Approved:**

- Progression of the Winter Plan to Trust Board

**Escalating:**

- Continued pressures on staff as a result of demand
- Need for increased grip and control to manage the Trust's financial position
- The reliance on system transformation at pace to facilitate the break-even position



## Report of Charitable Funds Committee Chair to TSDFT Board of Directors

<b>Meeting date:</b>	31 <sup>st</sup> August 2022
<b>Report by + date:</b>	Jacqui Lyttle, Committee Chair 4 <sup>th</sup> September 2022
<b>This report is for:</b>	Information <input checked="" type="checkbox"/> Decision <input checked="" type="checkbox"/>
<b>Link to the Trust's strategic objectives:</b>	1: Safe, quality care and best experience <input checked="" type="checkbox"/> 2: Improved wellbeing through partnership <input checked="" type="checkbox"/> 3: Valuing our workforce <input checked="" type="checkbox"/> 4: Well led <input checked="" type="checkbox"/>
<b>Public or Private</b>	Public <input checked="" type="checkbox"/> or Private <input type="checkbox"/>

### Key issues to highlight to the Board:

#### 1. Audit

The committee received and approved the audit plan for 2022/23 from Bishop Fleming..

#### 2. Fundraising strategy update

The committee were pleased to receive a detailed report and noted in particular

- Successful recruitment of a of fundraising and partnership manager who will lead the development and delivery of our fundraising strategy

#### 3. Charitable funds annual report

The committee received and approved the first magazine style report detailing the trusts fundraising activity. The report is has been socialised widely via ICON and Healthy Futures and is available online.

#### 4. Financial Plan

The committee received and approved the 2022/23 financial noting in particular continued and increased financial risks relating to the Nursery.

#### 5. NHS Charities together funding

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

### Key Decision(s)/Recommendations Made:

#### The committee

1. Approved the Audit plan.
2. Approved the Annual report
3. **Asked the Director of Operational Finance to provide a position statement of the risks relating to the Nursery for review and consideration at the next committee meeting**



### Chairs Report AUDIT COMMITTEE MEETING

<b>Committee meeting date:</b>	8 September 2022
<b>Report author + date:</b>	Sally Taylor, Non-Executive Director 3 October 2022
<b>This report is for:</b> <i>(please select one box)</i>	Information <input checked="" type="checkbox"/> Decision <input type="checkbox"/>
<b>Link to the Trust's strategic objectives:</b> <i>(please select one or more boxes as appropriate)</i>	1: Safe, quality care and best experience <input type="checkbox"/> 2: Improved wellbeing through partnership <input type="checkbox"/> 3: Valuing our workforce <input type="checkbox"/> 4: Well led <input checked="" type="checkbox"/>
<b>Public or Private</b> <i>(please select one box)</i>	Public <input checked="" type="checkbox"/> or Private <input type="checkbox"/>

INTERNAL AUDIT
<p>The Committee received the Internal Audit Interim Report. The Committee was asked to note changes that had been made to the Audit Workplan,</p> <p>The report included three limited assurance reports, and three other reports:</p> <p><b>HIS Sirius Review Action Plan (2021-22) (Satisfactory Assurance)</b> In respect of the EPR implementation, the Committee was reminded the report suggested the Trust's Health Informatics team was under-resourced and that there would be a need for additional resource to support the EPR implementation programme. Concern was raised around the whether the Trust's response to the heightened cyber security position should be tested to ensure it was adequate. The Committee noted that IA have a suite or areas that can be reviewed to assess the Trust's cyber security arrangements over a period of time. It was suggested that additional IA days should be allocated to testing cyber security. It was agreed this would be further discussed outside of the meeting.</p> <p><b>Data Security and Protection Toolkit (Moderate Assurance)</b> Recommendations for minor improvements had been suggested around evidence gathering and clarity of evidence presented.</p> <p><b>Torbay Pharmaceuticals (TP) (Satisfactory Assurance)</b> The review focused on TP's governance arrangements in terms of financial performance; risk assessment; progress against strategic objectives; and business continuity readiness and preparedness.</p> <p><b>Emergency Preparedness Resilience and Response (EPRR) Post Incident Debriefs (Limited Assurance)</b></p>

IA had been asked to undertake a review to test the Trust's process of learning from incidents and to test if this was fully embedded throughout the Trust. It had been found that a significant number of areas of learning had not been disseminated throughout the Trust or implemented into business as usual, and there was no audit trail attached to them. A number of recommendations had been made, all of which had been accepted and it was reported the number of outstanding areas of learning had been significantly reduced.

### **Counter Fraud Interim Report and Annual Report 2021-22**

The Committee received the Counter Fraud Interim Report and Annual Report. The committee noted that the Trust's return against the Government CF Functional Standards Return was assessed as Green. One area of the return had been rated as 'amber' around the need for a fraud bribery and corruption risk assessment. It was noted the Trust's risk assessment was nearing full compliance, however the NHS CF Authority were not expecting Trusts to have met full compliance in the reporting year, with an amber rating considered acceptable.

### **Board Assurance Framework and Corporate Risk Register**

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Register noting the work that was taking place to develop a new BAF, which would shortly be reviewed by the Board of Directors with a view to finalising it ready for use. It was felt important the new BAF reflected the impact of flow on the Trust, and the risks presented when patients could not flow through the acute site and into the community, as that was not an area reflected in the current BAF. It was suggested the establishment of Health and Wellbeing Centres would enable the Trust to have some control over the flow of patients from the acute site into the community. The impact to the Trust of the risks around out of hospital services, for example the care home market instability and the pace of change, was acknowledged to be of concern and should be discussed at Board level.

### **Waiver of Standing Orders – April 2022 – June 2022**

The Committee received the Waiver of Standing Orders report, included in the agenda pack. In the reporting period, 39 ICO waivers had been approved, totalling £8.4m.

### **Risk Management Policy and Strategy**

The Committee received the Risk Management Policy and Strategy.

## **EXTERNAL AUDIT**

The Committee received the following reports, presented by External Audit:

Audit Progress Report and Sector Update

Audit Annual Report (The Audit had found that no significant areas of weakness had been identified.)

Final Audit Findings Report

Report to the Council of Governors (CoG)

Following GT's presentation, concern was raised in terms of the Trust's relationship with the District Valuer and the difficulties reported in previous meetings around the District Valuer's office supporting the audit process. It was noted alternative arrangements were being considered for the current financial year.



## **6. CLOSING MATTERS**

### **6.1 Date of Next Meeting**

The Committee was asked to approve the standing down of the meeting due to take place on the 12 October and noted the meeting in January, due to take place on the 11<sup>th</sup> had been moved to the 18<sup>th</sup>.

There being no further business, the meeting was declared closed.



<b>Report to the Trust Board of Directors</b>				
<b>Report title:</b> Chief Operating Officer's Report October 2022		<b>Meeting date:</b> 26 October 2022		
<b>Report sponsor</b>	Chief Operating Officer			
<b>Report author</b>	System Care Group Directors			
<b>Report provenance</b>	The report reflects updates from management leads across the Trusts Integrated Service Units (ISUs) and Children and Family Health Devon (CFHD)			
<b>Purpose of the report and key issues for consideration/decision</b>	<p>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.</p> <p>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.</p>			
<b>Action required (choose 1 only)</b>	<b>For information</b> <input type="checkbox"/>	<b>To receive and note</b> <input checked="" type="checkbox"/>	<b>To approve</b> <input type="checkbox"/>	
<b>Recommendation</b>	The Board is asked to receive and note the Chief Operating Officer's Report.			
<b>Summary of key elements</b>				
<b>Strategic objectives supported by this report</b>	<b>Safe, quality care and best experience</b>	X	<b>Valuing our workforce</b>	X
	<b>Improved wellbeing through partnership</b>		<b>Well-led</b>	X
<b>Is this on the Trust's Board Assurance Framework and/or Risk Register</b>	<b>Board Assurance Framework</b>	X	<b>Risk score</b>	20
	<b>Risk Register</b>		<b>Risk score</b>	
Risk 5 – Operations and Performance Standards				

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

<b>Report title:</b> Chief Operating Officer's Report		<b>Meeting date:</b> <b>26 October 2022</b>
<b>Report sponsor</b>	Chief Operating Officer	
<b>Report authors</b>	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

Despite a continued reduction in demand, urgent care pressures grew throughout the month of September.

Scrutiny of our planned care recovery has intensified and whilst we continue to reduce the numbers of our longest waiting patients, our ambitions to eradicate 78 week waits by April 2023 and improve access to our Cancer services continues to be a very significant challenge.

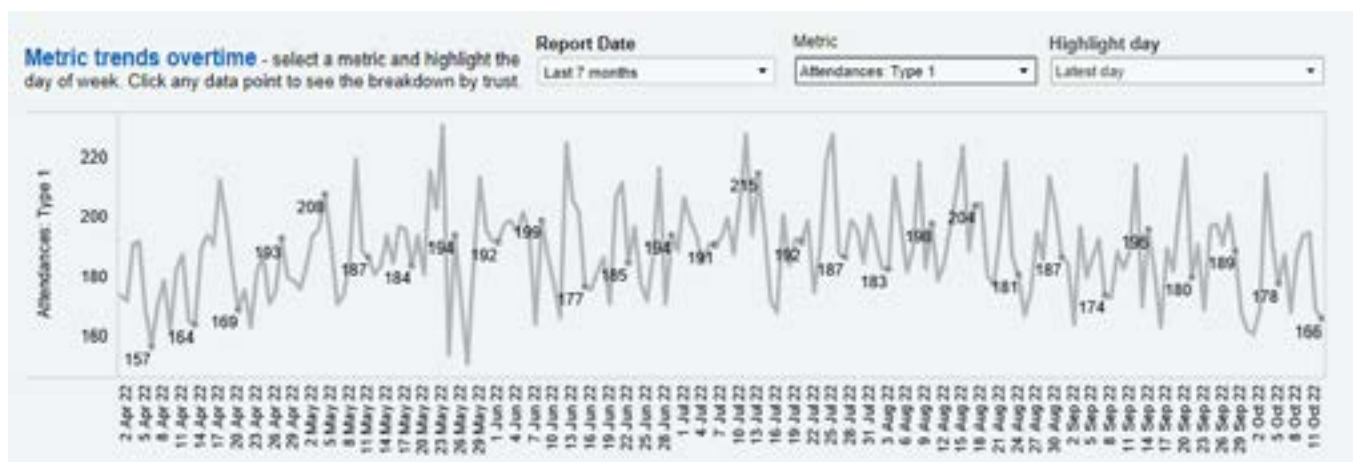
## 3. Urgent Care and recovery care group

### 3.1 System Recovery and Capacity response plan

September saw activity levels in Urgent & Emergency care fall with the end of the Summer holidays.

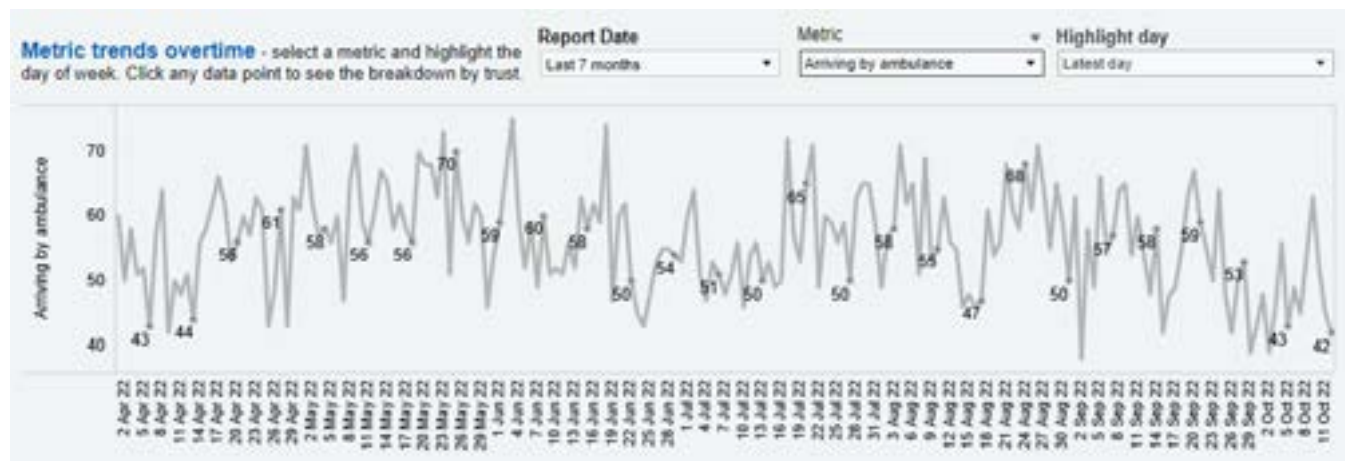
There were 5,592 attendances to the emergency department with 39.8% seen and discharged from the department within four hours. 28% of attendances required admission.

The Urgent Treatment Centre saw 2,393 patients and Totnes saw 661 patients with 97.7% of those seen within four hours.

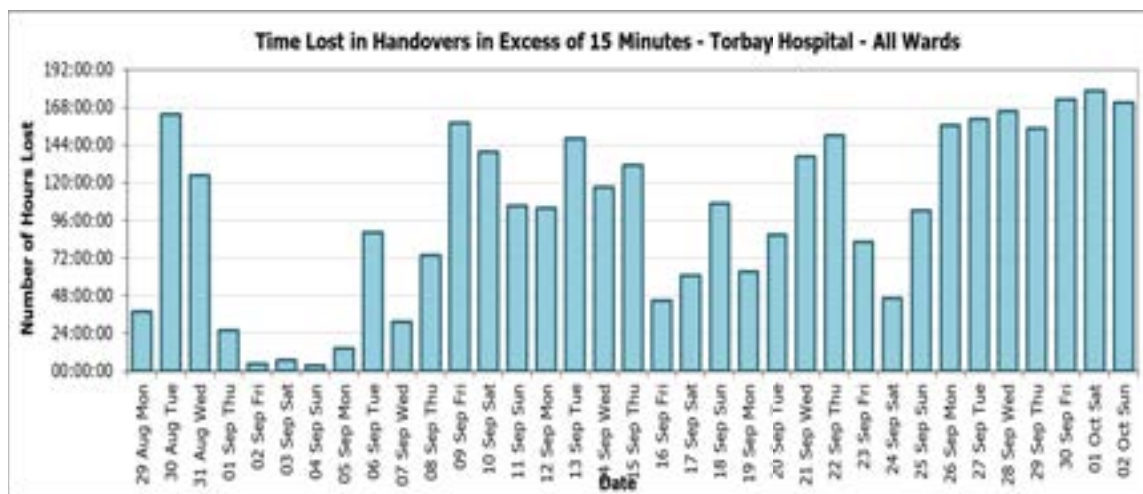


Compared to pre-covid demand for ED majors remains low, demand for ED minors is stable and demand for UTC type 3 attendances has returned to pre-covid levels.

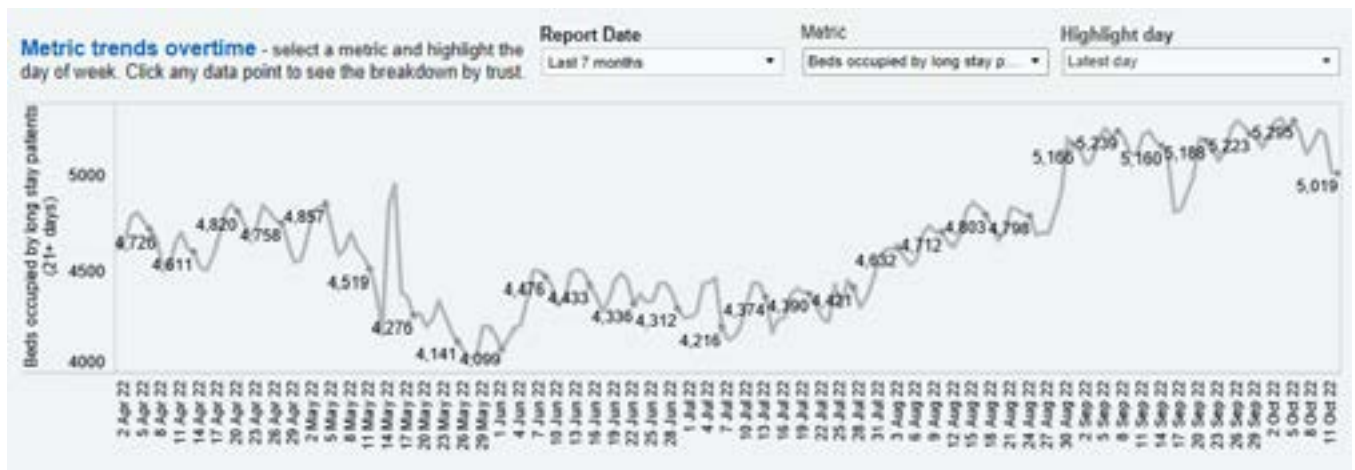
The average number of ambulances arriving were 54 a day with increasing delays to offload the patients into emergency care.



The average time lost per day to ambulance handover was 94 hours and 46 minutes with 22% of ambulances being offloaded within the designated 15 minutes from arrival.



The availability of inpatient beds remains the largest factor to delays. This is driven by an increase in Length of Stay.



The Trust is focussing on the introduction new actions to reduce LOS through earlier in the day discharges (aim 33% before Noon) and more discharges at the weekend (aim 80% of weekday discharge rate).

#### 4. Children and Family Health Devon (CFHD)

##### 4.1 Carenotes Outage

Carenotes supplier (Advanced) suffered a cyberattack around the 4<sup>th</sup> August resulting in a number of services and applications hosted by them to be unavailable. Carenotes continues to be unavailable. Recovery of the CFHD Carenotes instance is currently projected to be 9<sup>th</sup> November (previously 4<sup>th</sup> November). In the interim, access for CFHD staff to the Devon & Cornwall shared record system has been arranged. CarePlus (an alternate clinical system used by CFHD) is in use by Child and Adolescent Mental Health Services (CAMHS) staff.

Once technical recovery has been completed it is expected that a number of tasks will need to be completed before staff are able to use it again. These activities are estimated to take a minimum three to four weeks post system restoration to complete.

This incident remains a corporate level risk for both organisations.

As staff are undertaking their clinical work without access to the clinical notes clinical leaders and managers are ensuring that staff are supported.

##### 4.2 Transformation

The leadership team is working on making the final changes to the final workforce model in response to feedback from staff. We are aiming to make the final adjustments to the model within the next two to three weeks with a final paper presented to Partnership Board in November. This timescale will be dependent upon additional Torbay and South Devon NHS Foundation Trust (TSDFT) HR resources being made available to support the workforce mapping, as we currently have no HR Business Partner within CFHD. We plan to provide a briefing to Executives from Devon Partnership Trust (DPT) and TSDFT prior to the model being presented at Partnership Board for approval.

### **4.3 Workforce**

CFHD people are managing continued uncertainty regarding the final service model and are anxious for confirmation of their roles within the new structure. We have learned from exit interview data that the continued uncertainty has influenced decisions for staff to leave the service. It is therefore important for the consultation process to be brought to an end at the earliest possible time.

### **4.4 Service User involvement**

An engagement event took place during October involving parents and carers from across Devon, who came together to review the Children and Young People's Autism Strategy. The Autism Strategy is informed by current evidence of efficacy in service design and takes a developmental approach to Autism Spectrum Disorder, which we will manage as a long-term condition. The event enabled CFHD leaders to better understand the lived experiences and perspectives of parents/carers, which will be the foundation of our multi-agency Devon-wide offer for families caring for neuro-divergent children. This work also aligns with a system priority – the Neuro-diversity Game Changer.

A young people's engagement event is also due to take place this month which will focus on emotional wellbeing and mental health. A number of CFHD and children's system professionals will attend the event.

## **5.0 Planned Care, Care group**

### **5.1 Coastal ISU – Elective Care (RTT)**

Our elective recovery plans for RTT continue to be monitored through the Tier 1 process at a national level.

The number of 104-week waits reported at the end of September was 49 against a target of zero.

- 40 patients had chosen to delay their treatment beyond August
- 9 patients were complex including 4 pts who had cancelled as a result of Covid infection.

The number of 78 week waits reported at the end of September was 812 against our target of 641. After a prolonged period where the Trust delivered against its 78-week trajectory, we have fallen behind our plan during the summer. This is largely due to a reduction in planned care activities owing to annual leave. We plan to close the gap during the autumn months, as elective activities are increased.

Following the publication of a new national policy initiative, the way we manage our patients who choose to delay their treatment will change in the coming weeks. Patients who have been offered appointments with reasonable notice and choose to delay will be given a status of "active monitoring" and will be removed from the waiting list until they are ready for their treatment. We are establishing the impact of this policy on our reported position but it is expected to be significant.



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

Funding has now been agreed and implementation of these initiatives will support our ambition to eradicate 78 week waits by March 2023. This will be a very challenging undertaking for our operational and clinical teams.

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% (business as usual) activities at reduced cost overall and is being supported by Deloitte and 4 Eyes Insight.

## 5.2 Cancer Performance

Two Week Wait referrals continued to rise through August and September. In September Torbay and South Devon received 1,897 Two Week Wait (2WW) referrals. This equates to an increase of 17.8%, or an average of 280 additional referrals per month, in the first half of this financial year.

Achievement of the 2WW cancer standard was 38.3% in August. This is planned to improve in September. We are also seeing improvements being made in Skin, with performance moving from 20% to 27% in the past month. The improvements in waiting times for Breast and Skin are set to continue, with the services reducing waits for first appointments.

The Trust remains in Tier 1 for Cancer performance. There are four ‘Key Lines of Enquiry’ which are used to benchmark organisations in the Tier 1 group.



## **28-day Faster Diagnosis Standard**

Improvement in performance against the 28-day Faster Diagnosis Standard has been largely maintained over the past 10 months, although we remain below the 75% target. The position for September is 70.8% and our failure to meet the standard is driven by diagnostic delays in Colorectal and Urology.

## **31-day Treatment Standard**

Torbay historically achieve the 31-day standard for treatment (93%), pressures in September within Skin will cause performance to dip below 93% (subject to validation). Currently 11 September breaches are recorded for Skin.

Waiting times for Plastic Surgery appointments and surgery account for the majority of these breaches. This is a service provided by Exeter where there has been a significant reduction in clinical capacity during the summer. This service is being reviewed by Torbay and colleagues at Exeter to agree on the most appropriate model going forward.

## **62-day Referral to Treatment**

September's performance against the 62-day RTT standard is 60.3% (85% target). While acknowledging the Trust's challenged position, this is in line with a deterioration in performance nationally. The average position in England has remained below 65% since April and was 61.6% in July (most recent published figures).

Torbay are currently reporting 48 breaches in September, with 15 in Urology, 12 in Skin and 6.5 in Colorectal. Diagnosis remains the bottleneck in Urology and Colorectal, whilst access to Plastics via our Service Level Agreement (SLA) with Royal Devon University Hospital (RDUH) is driving the skin position.

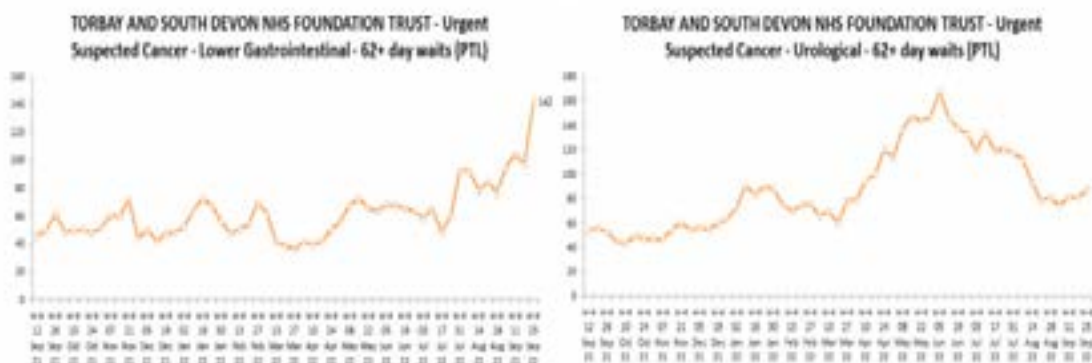
## **Over 62-day Backlog (Open Pathways)**

As of 2<sup>nd</sup> October 2022, there were 333 pathways over 62-days, 13.6% of the total backlog.

The Trust's backlog increased by 89 (3.4%) in the last month. This was due to an increase in referrals eight weeks ago (end of July) and reduced clinical activity over the summer period.

Colorectal accounts for 47% of the backlog. 90% of this Colorectal backlog do not yet have a confirmed cancer diagnosis. This is due to delayed Outpatient waits of over eight weeks and colonoscopy waits of two to three weeks.

In Urology the backlog has decreased from a peak of 160 in June 2022 to 85. The backlog has since remained relatively static in the last four weeks, this is due to biopsy capacity remaining consistent over the summer period. Additional biopsy capacity will be created as we move into the winter period, this will enable further improvements in the Urology backlog position.



## **Recovery**

Taking the themes across the four key lines of enquiry, the key focus of interventions remains on the diagnostic elements of our cancer pathways, particularly targeting the Urology and Colorectal.

## **Cancer Alliance Targeted Support**

The extended waiting times for diagnostic procedures are being seen across the Peninsula and is being prioritised for support by the Cancer Alliance. Torbay are actively engaging in working with the Alliance to finalise a plan for a proposed 'diagnostic support centre'. This initiative is looking at using a local facility (in Torbay) to host key diagnostic procedures, staffed by outsourced medical workforce. The diagnostic tests being considered are Urology Template biopsies, cystoscopies, Gynaecology Hysteroscopies and Dermatology biopsies. While planning is in early stages, the Cancer Alliance have secured funding for this.

## **Urology Template Biopsies**

Torbay are continuing to focus on providing additional capacity for this key test, improvements in access is the key driver in the reduction in our 62-day backlog.

## **Colonoscopies**

There is currently a 16 day wait for this procedure, this is a slight improvement from three weeks reported last month.

The new temporary endoscopy unit continues to be used on the Annexe site. Alongside this the Trust is working to outsource colonoscopy testing capacity to Plymouth (PPG), from 10<sup>th</sup> October.

## **Colorectal Outpatients**

Outpatient waits remain the most pressing risk to Colorectal waiting times. Sustained waits over eight weeks over the past 2 months, has driven the increase in the 62-day backlog.

A further unplanned deficit in colorectal consultant capacity, which is likely to continue into December, has created greater pressure on our Consultant-led activities. However, recent progress has been made to engage the Upper GI consultants in supporting colorectal clinics. This has provided an additional 12 patient slots per week until December 2022, which has led to outpatient appointments now being booked at 4 weeks.

Offers of support from the Regional and National teams as well as colleagues at Plymouth University Hospital and Royal Devon University Hospitals are being actively followed up.

### **5.3 Diagnostics – DM01**

The Trust reported 35.0% referrals waiting more than six weeks for a diagnostic test at the end of September against a March 2023 target of 25%. The DM01 recovery group with the help of ICS support has been focused on cleaning up data set returns and producing recovery action plans, the trajectory for performance improvement will be available within two weeks.

Endoscopy 74% and MRI 52% continue to make the biggest contribution to this position. Echo is on a steep upward trajectory at 40%, up from 12% in June.

The 4<sup>th</sup> Endoscopy (mobile) room is now operational with plans in place to create a 7-day service in Endoscopy by the end of October. A case to provide a permanent pad for mobile MRI will go to the capital prioritisation group on 2<sup>nd</sup> November. Additional Echo capacity has been secured with an outsourcing provider from November and existing locum cover will be extended. Mutual aid has also been agreed within Devon to support recovery of our diagnostic and cancer pathways.

### **5.4 Pathology Services**

There are concerns in Histopathology that capacity will not meet the growing demand being generated by our elective recovery activities. The position is being continuously monitored to ensure service levels are maintained.

## **6.0 Families Community and Home care group**

### **6.1 Child Health / Paediatrics**

Recruitment of medical staff, particularly consultants, remains challenging. We are going into winter with a number of vacancies unfilled, which may have to be managed with locums. Covering gaps and acting down means that our clinic capacity is also compromised. The new rotation of Tier 2 doctors has been smooth, they are settling into the department and already running clinics so that is helping. Nursing is now staffed to establishment. A Medical Support Worker has been welcomed into paediatrics this week and is settling into her new role.

The typing backlogs have further reduced and we are now just two weeks out. There has been a tremendous effort by the whole team to clear this and embrace new ways of working to ensure that it is sustainable going forward.

We have been given provisional approval on a bid to increase Allied Healthcare

Professional (AHP) support within Special Care Baby Unit (SCBU), namely physiotherapy and dietetics. This will have a significant impact on the lives of our youngest patients and is very welcome news.

## **6.2 Children's Torbay 0-19 Service**

The service is working alongside colleagues within Children's Services on developing a project plan to support the Family Hub's bid, although the Council are still awaiting news whether the Trailblazer bid has been successful. A significant element of the bid would be delivered by the service and additional resource required.

The My Health My School survey is being widely promoted amongst the Torbay Schools by both the service and wider Torbay Council commissioning colleagues. This is a pupil perception survey that asks children and young people in years 3, 4, 5, 6, 7, 9 & 11, (as well as separate surveys for Post 16 and provision for children with Special Educational Needs and Disabilities) a number of questions in order to generate vital information on the health and wellbeing of these individuals. The data provided can allow the service to tailor interventions to improve the lives of children and young people for the future. The survey comprises of a range of questions on the eight themes:

- All About Me
- Health Eating
- Physical Activity and Sport
- PE in School
- Drugs, Alcohol and Tobacco
- Social, Emotional and Mental Health (SEMH)
- Sexual Health
- My School/College

These are tailored age-appropriately with year group logins.

## **6.3 Health Lifestyles**

Following the submission of the bid to deliver a Devon-wide structured Diabetes Education programme, it is anticipated that formal notification would be within early to mid-October.

## **6.4 Maternity**

### **Pelvic health bid**

The Devon Local Maternity and Neonatal System (LMNS) have been notified that a recent bid for funding to address a gap in the provision of a service to support women's pelvic health has been approved. A system-wide service will need to be formed with a hub and spoke model of care addressing the needs of those who have sustained pelvic damage during birth. This will require the involvement of specialist midwives, physiotherapists, clinicians and admin staff.

### **Perinatal histopathology**

From 1st August 2022, the capacity for conducting perinatal post-mortems (PM) in the SW region has reduced by 75% due to a lack of specialist pathology staff. All requests to resolve this nationally by mutual aid has been unsuccessful. The only criteria in which a PM will be carried out is: -

- Any unexplained stillbirth >24 weeks gestation without predisposing factors e.g. abruption
- Previously decided post-mortem required by Specialist Fetal Medicine Team antenatally

Attempts are being made nationally to explore more sustainable solutions.

Local guidance has been updated and shared with staff to counsel affected women and families. The issue with the Trust's ability to offer placental histopathology, therefore, also remains unresolved. The risk had been updated to Corporate level.

### **6.5 Torbay Drug & Alcohol Service**

The mobilisation of the TRI partnership and wider Alliance work continues, with the Alliance Leadership Team (ALT) being formed with agreed terms of reference and co-production being at the forefront of the inaugural meeting.

A recent report commissioned by Torbay Community Safety Partnership (CSP) to develop a better understanding of complexity and the system response to individuals with complex needs is being considered in the development of the principles and practice for the Alliance Leadership Team (ALT).

A new role within the treatment service has commenced in September, and funded from the Public Health commissioners to reduce and manage the prescribing of high-risk medications to drug and alcohol users. This non-medical prescribing role will work closely with the Primary Care Networks (PCNs), and wider Public Health and Trust services to support individual's and create safer pathways for prescribing for drug and alcohol users within Torbay.

### **6.6 Community Dental Service**

The service is experiencing recruitment challenges for its specialist dental team. A number of options and approaches are being worked through including improving the job advert and ensuring we are promoting the opportunities in potential relocation and working for the Trust.

### **6.7 Community Sexual Health Service**

The team are currently scoping some small changes to service provision, which includes providing a drop-in clinic at Castle Circus Health Centre and providing bookable appointments from Brixham Hospital.

### **6.8 Baywide Independent Sector**

A transitional supported living service in Torquay is now completed and operational from the end of this month and referrals will be via the Torbay Supported Living Framework and the Torbay Community Mental Health Teams. The service is for

adults with long-term or enduring mental illness, who, have an assessed need for structured and pastoral recovery-oriented support with regaining independence and activities of daily living. The building itself comprises of 10 x 1-bed self-contained flats with 24hr support on site.

As part of social care charging reform and care accounts the work on the Finance and Benefits tools is progressing. The new online tools will support our Torbay population and staff in preparing for their full social care assessments, which is a benefit of the work being undertaken. Teams across social care, IT and the voluntary sector are coming together to deliver better efficiencies and improved access to information.

The Adult Social Care Geomapping Tool, which has been primarily developed to support planning for domiciliary care in our Bay is being further developed to support winter resilience across the health and social care sector. It will also provide valuable information in the event of severe weather, ensuring continuity of care to our at-home clients.

Partnership and collaborative meetings codesigned with our Providers in adult social care are being developed as part of a local initiative to work together on a range of issues such as recruitment. Providers in our markets have struggled with recruitment of staff, an issue faced nationally and here in Torbay, and the collaborative meetings will provide a space to understand concerns and work together for better outcomes.

Managing effective flow across the system is essential for alleviating pressure on front door, patient safety and risk. Currently we have an In-Reach project focused on improving hospital discharge by reviewing patients and ensuring they can return home as soon as possible, reducing the over prescription of care. Evidence collated so far in the 190 patients seen, a significant number of patients have discharged on a lower pathway than initially proposed, with pathway 2 to pathway 1 being most common. In-Reach reviews have also resulted in shorter lengths of stay for multiple patients and the right size care package for their needs.

## **7.0 Moor to Sea ISU**

### **7.1 Community Services**

Activity across the teams remains high across health and social care, with a waiting list of 70 patients and pressures to balance new work with reviews. There have been a number of whole home safeguarding processes and provider of concern support within the locality. This impacts on capacity and has affected the ability to place intermediate care patients and other admissions into placements.

The new Dartmouth Health & Wellbeing Centre progressing with plans for joint working underway.

### **7.2 Totnes Hospital**

The interim medical model remains in place, there continues to be a level of fragility which is being managed. The new out of hours hospital cover system is being monitored.

### **7.3 Healthcare of Older People and Frailty**

Additional appointments have been made to the Frailty Intervention Team (FIT) who continue to develop our acute frailty service.

As reported our next step is to shift to providing short-stay beds for patients with frailty working alongside our Acute Medicine team within a short-stay unit. Meetings developing the processes, training needs and governance are on track.

There has been successful recruitment on Simpson and McCullum wards but Cheetham Hill still holds a high number of vacancies with ongoing concerns for staff health and wellbeing with continued pressures. Despite recent recruitment, due to long-term sickness and maternity leave, the HOP Consultant team remain dependent on locum support.

### **7.4 Stroke and Neuro Rehab**

A new Advanced Clinical Practitioner (ACP) for Stroke Rehabilitation services has been appointed and will commence in November. She will provide clinical leadership to the Stroke Rehab team; the team have also been joined by a consultant stroke physician.

The formal Stroke Peer Review report has been received. We are still working hard to try to maintain the hyper-acute and acute stroke pathway as reported last month. In August 25% of patients got to the Stroke Unit in 4 hours (slightly lower than initially reported in the September COO report due to last minute adjustments) this number dropped slightly to 24% in September; this is still an achievement given the pressures in the System. We do know that the beginning of October has been more challenging due to poor flow, exacerbated by an increase in Covid on our wards. The George Earl staff council is up and running and we hope this will really support us in driving improvement and engagement in the stroke pathway.

### **7.5 Therapies**

Our in-patient therapy teams have been struggling to provide a response service to patients on our acute wards due to significant Covid-related sickness on top of existing vulnerabilities linked to vacancies and our expanded bed-base. Risks have been identified, a detailed plan will be developed with mitigation and actions.

Livewell Southwest and the Integrated Care Partnership have accepted a service transfer for the community Speech and Language Therapy service for patients in South Hams and West Devon.

This work has been in planning for over 12 months but has now entered the consultation phase with staff involved. A date has not yet been agreed for the actual service transfer but will be in the New Year

## **8.0 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 28 SEPTEMBER 2022**

Present:	Sir Richard Ibbotson	Chairman
	* Professor C Balch	Non-Executive Director
	* Mr P Richards	Non-Executive Director
	* Mrs J Lyttle	Non-Executive Director
	* Mrs S Walker-McAllister	Non-Executive Director
	* Mr R Sutton	Non-Executive Director
	* Mrs S Taylor	Non-Executive Director
	* Mrs V Matthews	Non-Executive Director
	* Mr R Crompton	Non-Executive Director
	Mrs 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 D Kelly	Chief Nurse
	* Ms A Jones	Director of Transformation and Partnerships
	* Mrs S Flavin	Interim 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
	*Miss J Doney	Board Secretary
	*Dr J Harris	Associate Director of Communications and Partnerships
	* Mrs J Thomas	Lead Governor
	* Ms Nicola Freeman	Consultant Anaesthetist
	* Mrs Phillipa Hiles	Named Nurse for Safeguarding Children
	*Mr Chris Knight	BBF Programme Director

\* via Microsoft Teams

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168/09/22 **Welcome and Introductions**

The Chairman welcomed all those in attendance to the meeting.

**Preliminary Matters**

169/09/22 **Apologies for Absence and Quoracy**

There were no apologies for absence.

170/09/22 **Declarations of Interest**

There were no declarations of interest.

171/09/22 **Board Corporate Objectives**

**The Board received and noted the Board Corporate Objectives.**

172/09/22 **Patient Experience Story - Organ Donation Service**

Ms Kelly welcomed Ms Nicola Freeman, a Consultant Anaesthetist in the Intensive Care Unit. She also welcomed Lottie Bryon-Edmond, and her father Mr Chris Bryon-Edmond who was an active member of the Trust's Organ Donation Committee. Ms Kelly explained that they had been particularly keen for Lottie to share her personal story as part of Organ Donation Week.

Ms Freeman gave a short presentation to prompt the Board to consider how the organisation could further support organ donation. She informed that despite being a small hospital, the Trust typically had 4 donor's per year who donated 4 organs per patient, which was well above the national average. New ways of caring for patients and their families had been introduced, such withdrawing life support in theatre which helped to preserve the organs for transplant, and they were sharing their practices with Devon partners to help improve their services too.

However, she emphasised that to support this service, investment in staff education and training was vital, and fostering a culture where the topic of organ donation could be spoken about with families. Support from the Board was sought to try and find innovative ways to continue to invest in and educate staff during the current operational pressures.

Lottie, who was now eleven years old, gave her presentation to the Board describing her own personal transplant story which began when she was born prematurely at Torbay Hospital. She explained that soon after she was born, she stopped breathing and was put into an incubator. She was transferred to a number of hospitals, and it was at Birmingham Children's Hospital where her parents were told that she had a rare and potentially fatal disorder and that without a liver transplant she would most likely only survive a few weeks. They were further told that it could be several months before a liver became available. Her parents became very frightened about the poor prospects for her survival.

Fortunately, a liver did become available and Lottie's operation was undertaken at a time when no liver transplant operation had been successfully performed anywhere in the world on such a tiny baby. Sadly, this was not the end of Lottie's transplant story, as her own brother tragically died in an accident when she was very young, but because he had signed up to the organ donation register, some of his organs were donated in line with his wishes. She finished her personal story stating that she

would never forget her brother, nor the stranger who saved her life, or the special people who kept her alive when she was so very poorly.

Lottie sought support from the Board to install a permanent organ donor memorial within the Trust, to celebrate and commemorate donors, and which would provide a focal point to persuade others to consider signing up to be an organ donor. Plans for the memorial had already been in the pipeline for some time, but it now needed support and some extra assistance to get the project completed. Lottie explained that she had already been fundraising and would continue to do so until the memorial was in place.

Ms Freeman added that they had been working with a team of artists who had experience of installing organ donor memorial artworks in hospitals and preliminary plans were being developed to present to the Board, including identifying a suitable place for it to be installed which the Board would be happy and comfortable with.

Mrs Davenport noted that Lottie had presented a number of challenges for the Board to consider including the need to give training and awareness to all staff members on organ donation; and on how staff could support the fundraising campaign and the organ donor memorial project.

The Chairman thanked Lottie for her presentation and inspiring story. The Chairman added that the Board was committed to supporting the memorial project, in the location of a suitable site and in designing something that would be appropriate in the organisation. **ACTION: Ms Kelly**

## **Consent Agenda (Pre-notified questions) Committee Reports**

173/09/22 **Finance Performance and Digital Committee Chair's Report - 25 July and 22 August 2022**

**The Board received and noted the Finance Performance and Digital Committee Chair's Report of 25 July 2022 and 22 August 2022.**

174/09/22 **Quality Assurance Committee Chair's Report - 25 July 2022**

**The Board received and noted the Quality Assurance Committee Chair's Report of 25 July 2022.**

175/09/22 **People Committee Chair's Report - 27 June and 22 August 2022**

**The Board received and noted the People Committee Chair's Report of 27 June 2022 and 22 August 2022.**

176/09/22 **Building a Brighter Future Committee Chair's Report - 17 August and 21 September 2022**

**The Board received and noted the Building a Brighter Future Committee Report of 17 August 2022 and 21 September 2022.**

177/09/22 **Charitable Funds Committee Chair's Report - 14 September 2022**

Mrs Lyttle verbally briefed the Board on the discussions at the Committee held on 31 August 2022 including:

- New auditors Bishop Fleming had been appointed to undertake the Committees' audit for this year, and the Committee received and approved their audit plan.
- The first Charitable Funds Committee Annual Report had been received and was now available online.
- The 2022/23 Financial Plan had been approved, but as it had not been discussed since the last meeting, it was noted that it might have to be amended in light of the current economic climate.
- The Committee had been delighted to be informed of the appointment of a highly skilled and talented fundraising manager to steer the Fundraising Strategy, and work alongside the League of Friends to foster working in partnership.
- Financial risks with regards to some of the funds were reviewed, with the fragility of the nurse being of most concern.

The Chairman thanked Mrs Lyttle for her verbal report.

**The Board received and noted the Charitable Funds Committee Chair's Report of the 14 September 2022.**

178/09/22 **Audit Committee Chair's Report - 8 September 2022**

Mrs Taylor verbally briefed the Board on the discussions at the Committee held on 8 September 2022 and highlighted the following key points:

- A number of internal audit reports had been received, several with satisfactory or moderate assurance. Three required follow ups as only limited assurance had been received, but the Committee noted that good progress had been made on the implementation of the recommendations.
- The Board Assurance Framework and Corporate Risk Register had been considered and it was noted that a new version was still being developed.
- The Waiver of Standing Orders report was received and it was noted that during the quarterly period covered by the report, there were 39 waivers for the Trust totalling £8.4m so a discussion ensued on what should and should not be included in the Waiver of Standing Orders and Mr David Stacey would review this. However, it was highlighted that some of the waivers were continuation of contracts, or related to emergency responses and so were deemed appropriate.
- External Audit presented a number of reports in addition to their Final Audit Findings Report. The main issue they had raised had been the difficulties in working with the District Valuer to agree the valuation of the Trust's properties.

The Chairman thanked Mrs Taylor for her verbal report.

**The Board received and noted the Audit Committee Chair's Report of 8 September 2022.**

- 179/09/22 **Reports from Executive Directors (for noting)**  
180/09/22 **Chief Operating Officer's Report - September 2022**

**The Board received and noted the Chief Operating Officer's Report of September 2022.**

- 181/09/22 **Directorate of Transformation and Partnership Quarterly Report**

The Board received the Director of Transformation and Partnership's Quarterly Report.

Prof. Balch asked if the Trust had sufficient resources to deliver all the 30 or so priorities set out in the report, or alternatively, was focus being given to reduce the number of priorities to match the capacity to deliver. Ms Jones gave detailed explanations on the ongoing efforts to acquire the needed capacity for the transformation agenda. Ms Jones added that the Board had recently approved a business case that sought to improve the capacity and capability of her team. She also gave explanations on the prioritization methods to ensure that resources were directed to areas with the greatest impact.

Prof. Balch confirmed he was assured by Ms Jones responses.

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

**For Approval**

- 182/09/22 **Unconfirmed Minutes of the Meeting held on the 27 July 2022 and Outstanding Actions**

Page 9 of 14 (overall page 59 of 561) the 2<sup>nd</sup> bullet point under item 158/08/22: Change 'local doctors' to 'locum doctors'

The Board approved the minutes of the meeting held on 27 July 2022 subject to the amendment.

On the outstanding actions, the Board noted that the risk mitigation report was due to be presented by Mr Stacey later in the meeting.

Regarding the Board to Board Meeting with Devon Partnership Trust. Mrs Davenport informed that she had a meeting with the Chief Executive of the DPT and they had identified three areas of shared interest that they would like to pursue and the date would be set up shortly.

**The Board approved the minutes of the meeting held on 27 July 2022 subject to the one amendment.**

183/09/22 **Report of the Chairman**

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

- It was the first meeting of the Board since the passing of Her Majesty Queen Elizabeth II, and he thanked Directors, staff and members of the public who had supported the Trust's engagement in the state funeral and mourning period.
- He was delighted to report the recruitment of Dr Michelle Westwood as the new substantive Chief People Officer, and he thanked Mrs Flavin for the superb work she was doing in her interim role.
- He welcomed Mr Crompton and Mrs Walker-McAllister who were now confirmed as new non-executive directors on the Trust Board.
- Mr Anthony Magnall MP had visited Totnes Hospital and had seen the reopened Minor Injuries Unit which he was delighted to see working again. The M had also visited Torbay Pharmaceuticals on 16 August 2022.
- On 13 August 2022, the Chairman had hosted a visit by Dame Shan Morgan, the new Chair of the Royal Devon University Healthcare (RDUH) NHS Foundation Trust during which she gained an insight into the Trust's integrated care organisation delivery. On 21 August 2022, the Chairman had served as an independent member on the RDUH's recruitment panel for a new Director.
- On Monday 26 September 2022 the Trust had hosted a visit from Sing Health, one of the major providers in Singapore. As a consequence of their research, they had flown over a team specifically to gain an understanding of the Trust's approach to delivering integrated care, and all agreed the visit had been very productive.
- He highlighted that the Trust was seeing a distinct increase in the number of patients and staff who were poorly with Covid and as the flu season was also approaching, he expressed that he was commending obtaining the flu vaccine to staff.

**The Board received and noted the report of the Chairman.**

184/09/22 **Chief Executive's Report**

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

- Progress was being made with engaging with the public on the design of the Teignmouth Health and Well Being Centre, and there would be further

opportunities for engagement as Teignbridge District Council moved towards the planning approval process. This development would build on the strategy to build capacity within the community and on the developments at Dartmouth and Brixham.

- Despite the current high operational pressures, progress was being made reducing the number of patients who had been waiting 2 years for treatment and this would continue to be a key focus for the Trust. Further details would be provided in the Integrated Performance Report.
- Focus was now also moving to patients who had been waiting 78 weeks for treatment and she wanted to acknowledge all the hard work of the teams to reduce that position. Activity was now 104% of pre-covid activity which was a significant contributor to that reduction.
- Challenges remained within some specialties, particularly in relation to cancer pathways. As a result, the Trust had been asked to participate in a National Oversight Programme at Tier One, so that it could be supported to address the risks and bring those pathways back into alignment.
- At the beginning of August 2022, a new Alcohol Care Team was launched in Torbay Hospital which would significantly improve outcomes for people by identifying those at risk much earlier.
- Some great work had been done in relation to Ward Accreditations, People Awards and Daisy Awards, and she wished for this to be recorded and noted for the Board's attention.
- The new NHS Pay Award and the introduction of new pension rates was, in some cases, detrimentally affecting staff, by reducing, rather than increasing their income. In light of the increasing indications of industrial unrest, this was posing some risks for the Trust.

Mrs Flavin highlighted some of the steps that had been taken to support the staff members through pension contribution rate changes and increase in cost of living including negotiation with Stagecoach on discounted fares and access to information about Money Advice services.

Mrs Matthews stated that the cost of living was an issue that the Board was incredibly concerned about and of the impact it was having on staff and the local population.

Mrs Davenport, added that she was having conversations with partner organisations in the System, regarding how it responded to the potential impact of the cost of living crisis on the health and well being of the local population and how an approach could be co-ordinated, which was a benefit of being an integrated care system (ICS). The ICS would be using part of a development workshop in October to undertake some of this cross system planning.

Ms Jones informed that the Local Care Partnership would be holding a Cost of Living Summit where partners would come together to set up practical actions to support people through a very difficult time.

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

### **Safe Quality Care and Best Experience**

#### **185/09/22 Integrated Performance Report (IPR): Month 5 2022/23 (August 2022 data)**

Mr Harrison, presented the Integrated Performance Report for month 5, 2022/23, as circulated, and highlighted the key issues in relation to quality, performance, workforce and finance:

Mr Richards, noted that there was an error on Page 3 of 69 (overall page 83 of 561), and so the VTE assessment was more positive than the 89.6% that was stated in the paper. He added that the financial position was discussed at length at the Finance Performance and Digital Committee, and it was pleasing to note the additional grip and control measures that were being put in place to ensure the CIP was receiving a high level of oversight.

Mr Sutton recognised the challenge of the underlying position, but also of the challenge in recovery, the CIP, and of the pressures on front line staff, and so trying to deliver on all fronts was extraordinarily challenging.

Mr Crompton stated that he understood virtual appointments had to be clinically led to ensure patient safety, but as they were an important tool in reducing backlogs he asked for more information as to why the Trust was not attaining the National target, and how quickly could progress be made on the current position.

Mr Currie, responded that it had been felt that all the processes that could be transferred from face to face appointments to non face to face, had been undertaken, and now the entire patient pathway had to be reviewed and addressed to achieve further improvements. One of the issues to contend with was providing adequate physical space for virtual appointments to occur due to the redevelopment of Level 2 of the main hospital building. Also, due to the current pressures, the teams were focused on 2 week waits, or even more urgent cases, and those cohorts were more likely to require face to face appointments. More work was being undertaken to understand the variations between clinical teams and some of the motivation for this was based on well founded concerns.

The Chairman asked if the older demographic of the local population, and its propensity for a lower level of digital literacy, could be having an impact on the Trust's ability to engage with this section of the community and if so, should there be a specific communications campaign?

Mr Currie confirmed this had been raised as a potential issue by an Associate Medical Director. He added that an electronic patient record system would bring together information required for an outpatient's appointment without the need to rely on the physical co-location of clinical and administrative staff and so this could increase the capacity for virtual appointments.

Mrs Lyttle highlighted that in relation to quality, progress against the Care Quality Commission (CQC) Action Plan had been discussed at the most recent Quality Assurance Committee, and whilst there had been some demonstrable improvements



in some areas, such as hydration and nutrition, there were still some areas, such as medical inpatient wards, where the Trust was vulnerable.

Prof. Balch noted that there was no information in the Integrated Performance Report for Children and Family Health Devon (CFHD) relating to performance and standards, and wanted to know the assurances that could be given in the absence of that information.

Mr Harrison responded that this information was still not available in a reportable format due to the recent cyber attack, but staff were working hard to maintain all of the usual oversights and the Integrated Governance meetings with CFHD were still taking place. The CFHD were appraising the clinical risks, as far as they were able, and there was visibility on the activities that were occurring through the business continuity plans, although not as routinely as previous. He noted that staff were to be commended for going over and above, particularly in the CAM service, to keep young people safe, as it was taking longer to prepare consultations and the clinical history was not available as it previously had been.

Mr Harrison added that it was anticipated that the system would be restored in November, but he cautioned that there would be a period of catch up time whilst the business continuity arrangements were retrospectively updated onto the system records.

Mrs Flavin, would like the amount of work being undertaken to promote retention of staff to be noted, and that included social care retention from an integrated care perspective.

Ms Kelly commented on the increase in reporting of falls, and highlighted that she had now taking on chairing of the Falls Group, to provide some executive oversight and leadership.

A number of mechanisms were also in place to enable greater daily monitoring and for early identification of patients who were at risk of falls, so there was a good robust audit framework in place. Two particular measures were monitored, these being i) whether patients were being identified early enough? and ii) whether patients were getting a risk assessment completed with 4 hours?

90% of patients had a care plan in place, and a fail safe bundle of interventions such as appropriate lighting and footwear, were providing further opportunities to reduce falls. She gave assurances that through the Falls Group and the quality improvement work, (as part of the Quality Strategy), that they would work both locally and with national colleagues to determine what further interventions could be introduced.

## **The Board received and noted the Integrated Performance Report – Month 5, 2022/23.**

### **186/09/22 Mortality Surveillance Scorecard - September 2022**

Mr Currie presented the September 2022 Mortality Score Card, as circulated, to the Board. He escalated:

i) Hospital Standardised Mortality Rates (HSMR): For the current month (chart 1) and for the rolling 12 month period (chart 2) the HSMR had increased month on month since June 2021 which coincided with a period of significant pressure for the Trust. The Trust was one of ten Trusts out of fourteen of its' regional peers who had a statistically greater than expected HSMR and the latest available data for June 2022 showed it was now 12 of the 14 regional peers who had a statistically greater HSMR.

Work had been undertaken with Dr Foster data by the Mortality Surveillance Group to try to understand what were the factors that were behind these increases, but it was illustrated (chart 6) that the Trust had a significantly greater number of patients in the most deprived quintiles than the English population, and (chart 7) showed it had a more aged population than the English model, and both of these factors could affect the number of deaths that were occurring.

ii) Clinical Alerts for Diagnosis and Procedures: An alert was raised when the expected number of deaths was significantly exceeded by the actual number of deaths. The new alerts were for Pneumonia and Septicaemia and Mr Currie would be working with the Director of Patient Safety, Dr Chris Manlow to try to understand what was underlying these diagnostic alerts.

iii) Cardiac Arrest Data: The rate of cardiac arrests per thousand hospital admissions (chart 22) illustrated that the Trust had a slightly lower than National average rate and the survival to discharge of patients suffering an in hospital cardiac arrest (chart 23) illustrated a worsening position from previous years with poorer outcomes in Q4 of 2021/22. The Cardiac Arrest Team would be working to understand this.

In reference to Appendix 4 – Focused Mortality Reviews, Mr Crompton queried why, in relation to the number of deaths of patients with a learning disability, current data from the LeDeR process was not available? He further sought assurances that the Trust was undertaking it's own reviews on the death of any patient with learning difficulties whilst in hospital, in the absence of the LeDeR data.

In response Mr Currie informed that the Trust was reliant on referral to the Clinical Commissioning Group (CCG) in carrying out these LeDer reviews and the absence of data had been due to sickness in the CCG. He added that there had been a number of incidents of deaths of patients with learning disabilities which had been referred to the Serious Adverse Event Group for a root cause analysis.

Mrs Walker-McAllister asked, if in the absence of LeDeR data, was the Trust making effective and efficient use of contacts with the Devon and Torbay Safeguarding Partnership, so that any serious incident reports linked in with, and didn't repeat any work being undertaken in relation to any safeguarding adult reviews?

Mr Currie responded that a Quality Team from the CCG provided input to the Serious Adverse Event Group when there had been any incident, particularly involving patients with learning disabilities. Ms Kelly also responded that the Deputy Director for Adult Social Care had the lead responsibility within the organisation for learning disabilities and safeguarding, both in terms of incidents and improving pathways once services were accessed, be they in the acute hospital or in the community. There was an internal Learning Disabilities Reference Group that linked into the Local Learning Disability Partnership Board, and there was complete congruence between these organisations when an incident arose.

**The Board received and noted the Mortality Surveillance Score Card – September 2022.**

187/09/22 **Midwifery Staffing Oversight Report**

Ms Kelly, presented the Midwifery Staffing Oversight Report as circulated, to the Board. She drew attention to the following key points:

- There had been progress in recruitment to fill vacancy rates following the uplift last year as a result of the Ockenden funding and the additional funding approved by the Board.
- A positive position of birth to midwife ratios was being maintained.
- There were continued challenges with the Continuity of Care Model and this was presenting difficulties in terms of the choices available, or not available, to women who wanted a birth at home or in the community.

It was expected that an announcement would be made in the next few weeks in relation to the Continuity of Care Model, which she suspected would relate to the size of teams which was well documented to be impacting on morale, the management of on call, and on the complete and comprehensive delivery of the Continuing Care Model. She would keep the Board informed of the developments.

**The Board received and noted the Midwifery Staffing Oversight Report.**

188/09/22 **Safeguarding Children (Inc. Section 11 Annual Submission)**

Ms Kelly presented the Safeguarding Children (Inc. Section 11 Annual Submission) as circulated, to the Board.

She drew attention to the following key points:

- The arena of safeguarding had continued to be really challenging, and the detrimental impact of the pandemic on the welfare and well being of children and young people was very evident.
- The outcome of the Ofsted inspection of Torbay Council, that had been conducted in March and April 2022, had noted the significant improvements that had been made and the strong partnership working which was resulting in a tangible difference for local children. There was good compliance against KPI's and good performance against meeting statutory responsibilities and obligations.

Mrs Hiles was invited to offer further comment, and she responded that she wanted to pass thanks on behalf of the Safeguarding Team to the Board for its support in additional recruitment which had made a significant difference, particularly in recent months with regards to staff accessing safeguarding supervision. It had received excellent engagement from teams who were under significant pressure or who had a high level of safeguarding children input, such as the Sexual Medicine Service, and the 0 – 19 Health Visitors and School Nurses. Compliance had increased rapidly with their safeguarding supervision.

The Chairman was delighted that the additional recruitment had enabled such positive outcomes, and he expressed the Board's recognition of the valuable service the Safeguarding Team was providing to the local public.

Mrs Matthews referred to one of the concluding statements in the report that the 'Covid-19 pandemic working restrictions' had 'serious repercussions on the safeguarding children's operational activity' and she asked if those repercussions had been really understood or were unforeseen.

In response Mrs Hiles said that nationally, there was a move to redeploy staff, including from safeguarding teams, school nurses and health visitors, into operational teams, but locally, with support from senior leadership, they had retained their staff but modified their working practices to support clinical colleagues to achieve better outcomes.

Mrs Davenport added that there would be more lessons to learn from the early decisions about access to children outside of safeguarding arrangements. She also reflected on the complexities of establishing governance systems in an Alliance Model and so she welcomed that the governance overarching support to safeguarding in Children and Family Health Devon had been resolved as detailed in the report.

Mrs Hiles concluded the discussion by emphasising that there would be safeguarding implications related to patients on waiting lists, who were family members and she urged colleagues to seek safeguarding support much earlier to help families.

### **The Board received and noted the Safeguarding Children (Inc. Section 11 Annual Submission).**

#### **189/09/22 Patient and Service User Experience of Health and Care Strategy 2022-25**

Ms Kelly presented the Patient and Service User Experience of Health and Care Strategy 2022-25 as circulated, to the Board.

She explained that this strategy was aligned to the Quality Strategy and was part of the overarching approach to drive improvements in the experience and outcomes for patients.

This work had been developed over a period of 12 months and had been co-designed with service users and community groups and Healthwatch had provided independent support in enabling colleagues to identify what mattered to patients, and the community. It had been extensively discussed by the Quality Assurance Committee and other groups, both within the organisation and externally.

Six priorities to seek and receive feedback on patients experience underpinned the strategy, and each had an accompanying action plan.

The programme of improvement work was ambitious, yet there was a view that challenged whether it was ambitious enough, but it was felt that the initial focus should be to stabilize and re-establish some of the fundamentals in receiving feedback, with a future aim to build a more dynamic and ambitious partnership with

patients that was more aligned to what the Beryl Institute and the King's Fund was proposing.

Mrs Matthews informed that the Strategy had been given thorough scrutiny at the Quality and Assurance Committee, and the co-creation methodology had been endorsed.

Mrs Davenport also commended the Strategy and noted that the strong level of engagement from the people who used the organisation's services and helped to determine the priorities, confirmed that it had been sufficiently ambitious and she suggested that learning could be taken from the co-creation methodology and applied to other pieces of work being undertaken by the Trust.

Prof. Balch questioned whether a co-creation approach generated an ambitious wish list that set the bar too high which staff, in the context of the pressures they would be facing over the next few years, would struggle to deliver?

Ms Kelly gave assurance that capacity and expertise had been given consideration, both within this and the broader quality agenda and in how the patient's voice was incorporated into every aspect of the organisation's business and in the redesign of services. It was a 3 year plan and the appendix set out what was achievable in the first year to manage expectations with available resources.

Dr Watson stated that she felt the Strategy was important because it linked in with all the improvement work that needed to be undertaken and user experiences would be invaluable in relation to introducing an electronic patient record system, and also integral to the Building a Brighter Future programme.

The Chairman thanked Mrs Kelly for her report.

## **The Board approved the Patient and Service User Experience of Health and Care Strategy 2022-25**

### **Improved Well-Being Through Partnership**

#### **190/09/22 Annual Review of the Audit Social Care Strategic (ASC) Agreement 2021/22**

Mr Harrison presented the Annual Review of the Audit Social Care Strategic (ASC) Agreement 2021/22 as circulated.

He informed that the report represented a review of the 2nd year of the 3 year strategic agreement with Torbay Council for the delivery Adult Social Care. It contained the ASCOF (Adult Social Care Outcomes Framework) measures so there was congruence with the Integrated Performance Reported discussed earlier in the meeting. He drew attention to the list of services provided on behalf of the Council under the Adult Social Care Strategic Agreement which were many and varied.

He drew attention to the following key points:

- The review of the 2nd year (2021-22) was principally focused on covid and the safety of the independent sector and ensuring that all the resources available were fairly deployed.

- There had been a huge increase of 55% in calls for support, equating to approximately three thousand additional requests, so over 8000 in total, which was a significant increase in one year. There was a 74% increase in requests for one off support and the ongoing pressures of providing reablement services to support people back to independence were clearly articulated in the report.
- Work within the Adult Social Care Improvement Plan was also referenced and circa £2.3m savings were made which was 15% over the targeted level.
- The challenge moving into 2022-23 and into future years, was the Social Care Charging Reform, be it the Fair Cost of Care, or the Care Accounts, which would be a significant undertaking for staff, and would be an area of focus for the Board.
- An action had been agreed at the Finance Performance and Digital Committee to work with colleagues in Torbay Council and Devon County Council to ensure alignment of a clear market position statement and in collaborative and strategic level working.

The Chairman asked for further explanation behind the 9.1% decrease in safeguarding concerns raised. It was discussed that this was not necessarily a positive indicator. Mrs Walker-McAllister noted that this decrease was not reflected in other parts of the Country and so she agreed to seek further clarifications outside of the meeting with Mr Harrison. **ACTION: Mrs Walker-McAllister and Mr Harrison**

Mrs Walker-McAllister added that at the recent Quality and Assurance Committee, the issue of provider sustainability and market stability had been discussed, and the need for all elements of the health and care system, including the ambulance service to work together. It was a fragile market area and if patients were to be discharged appropriately from acute and community services, everyone had to aim to work better together. She would very much like to explore this with Mr Harrison and his team. It was agreed that Mr Jon Anthony should also be included in that discussion to provide more detail. **ACTION: Mrs Walker-McAllister, Mr Harrison and Mr Anthony.**

The Chairman asked for his appreciation to be passed to Mrs Machin and her team for the report.

**The Board received and noted the Annual Review of the Audit Social Care Strategic (ASC) Agreement 2021/22.**

**Well-Led**

191/09/22 **Building a Brighter Future Strategic Outline Case**

Mrs Jones presented the Building a Brighter Future Strategic Outline Case as circulated.

She informed that the Strategic Outline Case (SOC) was being presented to the Board for formal approval to submit to the National New Hospital Programme (NHP) team.

The original SOC had been presented in July 2021 but since that time both the National NHP and the Digital Programme had matured and the SOC had been amended in response to some of the strategic changes. The SOC now set out the strategic level requirements to provide the infrastructure improvements that were needed to meet the needs of the population of Torbay and South Devon.

She highlighted the key aspects of the business case which had been produced with a significant level of engagement with the Building a Brighter Future Committee.

The next steps were, following Board approval, to submit the business case to the NHP National Team, and to seek seed allocation to develop the OBC stage which would commence in April 2023 and the Building a Brighter Future programme team would immediately commence work on the site enabling business case.

The Board was asked to approve the SOC at £497.1m and approve its submission to the NHP National Team.

The Chairman acknowledged the enormous amount of work that had been undertaken, including by all the Executive Directors to develop the SOC to this stage of presentation to the Public Board.

Prof. Balch stated that the advantage of revising the SOC was that it had provided the opportunity to rethink key elements of what was required to deliver a minimum viable product. All the options had been thoroughly explored and scrutinised through the Building a Brighter Future (BBF) Committee and it had recommended that the Board approve the SOC for submission to the National NHP team. It was hoped that by the end of the year, a clear indication of the allocation would be given together with the timelines.

Prof. Balch expressed his thanks to colleagues, and to Mr Stacey and the finance team for their support in the preparation of the SOC.

The Chairman also express appreciation of the Board to Ms Jones and her team for their work on one of the most important areas of the future development in health and social care that would be delivered. He also thanked Prof. Balch for his leadership of the BBF Committee and finally he thanked Mr Knight, the Programme Director for his expertise.

**The Board approved:**

- i) The Strategic Outline Case at a value of £497.1m; and
- (ii) The Strategic Outline Case can be sent to the National NHP team for their review.

192/09/22

**Risk Management/Strategy Policy**

Mr Raheem presented the Risk Management/Strategy Policy as circulated.

He explained that the Risk Management/Strategy Policy had been presented at the last meeting of the Board where there had been a request to review some of the language used. The document had been reviewed together with the Associate Director of Communications and there were no further amendments.

Mr Crompton pointed out the need to adequately reflect the Trust's Risk Appetite in the policy. It was noted that Risk Appetite was already referenced at pages 12 and 15 of the policy. Further discussions took place on the need to consider Risk Appetite as part of the new Board Assurance Framework (BAF) which was currently under development. Mr Raheem agreed to take an action to organise Risk Appetite as part of the Executive Development Session on BAF. ACTION: Mr Raheem

**The Board approved the Risk Management/Strategy Policy.**

### **Compliance Issues**

193/09/22 **Any Other Business Notified in Advance**

There was no other business raised for discussion.

194/07/22 **Date and Time of Next Meeting:**

11.30 am, Wednesday 26 October 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
155/07/22	Operation Risk and Mitigation Report to be brought to Board in September 2022	Mr Stacey	The Risk and Mitigation Report would be presented by Mr David Stacey further in the agenda, so this action was considered complete at this meeting. <b>ACTION: CLOSED</b>	27.07.22
162/07/22	A Board to Board with Devon Partnership Trust to be arranged.	Mrs Davenport	Regarding the Board to Board Meeting with Devon Partnership Trust. Mrs Davenport informed that she had a meeting with the Chief Executive of the DPT and they had identified three areas of shared interest that they would like to pursue and the date would be set up shortly. <b>ACTION: CLOSED</b>	27.07.22
172/09/22	Ms Kelly will provide support to Lottie in progressing the Organ Donor Memorial in both suitable design and site location.	Ms Kelly		28.09.22
191/09/22	Mrs Walker-McAllister will seek further clarifications on the 9.1% decrease in safeguarding concerns during 2020-21, with Mr Harrison outside of the meeting	Mrs Walker-McAllister and Mr Harrison		28.09.22
191/09/22	Mrs Walker-McAllister to progress with Mr Harrison and Mr Anthony, further collaborative working to sustain provider and market sustainability in the arena of adult social care.	Mrs Walker-McAllister, Mr Harrison and Mr Anthony		28.09.22

193/09/22	Mr Raheem agreed to take an action to organise Risk Appetite as part of the Executive Development Session on BAF.	Mr Raheem		28.09.22
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<b>Report to the Trust Board of Directors</b>				
<b>Report title:</b> Chief Executive's Report			<b>Meeting date:</b> 26 October 2022	
<b>Report appendix</b>				
<b>Report sponsor</b>	Chief Executive			
<b>Report author</b>	Associate Director of Communications and Partnerships			
<b>Report provenance</b>	Reviewed by Executive Directors 19 October 2022			
<b>Purpose of the report and key issues for consideration/decision</b>	To provide an update from the Chief Executive on key corporate matters, local system and national initiatives and developments since the previous Board meeting.			
<b>Action required (choose 1 only)</b>	<b>For information</b> <input type="checkbox"/>	<b>To receive and note</b> <input checked="" type="checkbox"/>	<b>To approve</b> <input type="checkbox"/>	
<b>Recommendation</b>	The Board are asked to receive and note the Chief Executive's Report			
<b>Summary of key elements</b>				
<b>Strategic objectives supported by this report</b>	<b>Safe, quality care and best experience</b>	X	<b>Valuing our workforce</b>	X
	<b>Improved wellbeing through partnership</b>	X	<b>Well-led</b>	X
<b>Is this on the Trust's Board Assurance Framework and/or Risk Register</b>	<b>Board Assurance Framework</b>	X	<b>Risk score</b>	
	<b>Risk Register</b>	X	<b>Risk score</b>	
<ul style="list-style-type: none"> <li>• 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</li> <li>• 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</li> </ul>				
<b>External standards affected by this report and associated risks</b>	<b>Care Quality Commission</b>	X	<b>Terms of Authorisation</b>	X
	<b>NHS Improvement</b>	X	<b>Legislation</b>	
	<b>NHS England</b>	X	<b>National policy/guidance</b>	X

<b>Report title:</b> Chief Executive's Report		<b>Meeting date:</b> 26 October 2022
<b>Report sponsor</b>	Chief Executive	
<b>Report author</b>	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 28 September 2022 are as follows:

### 3.1 **Excellent population health and wellbeing**

#### **Flu and COVID-19 vaccination programme**

Our COVID-19 booster and flu vaccination programme is well underway. As of 14 October we have given over 2,200 of our people the COVID-19 booster and over 1,800 the flu vaccination. This means that the total number of our people vaccinated is just over 27%.

#### **Teignmouth health and wellbeing centre**

We have submitted a full planning application to Teignbridge District council for a new purpose-built health and wellbeing centre for Teignmouth.

Located on the Brunswick Street site, in Teignmouth town centre, the new £11million state-of-the art facility will bring GP services, and health and care and voluntary sector services under one roof.

GP services provided by the Channel View Medical Group will be based at the new centre together with community nurses, social workers, health and wellbeing teams, therapists, podiatry, audiology, physiotherapy and voluntary sector services.

The purpose built, facility designed by architects [corstorphine-wright](#) will also support the delivery of technology enabled care, helping more people live well within their local communities. Negotiations are continuing with Teignbridge District Council over the acquisition of the site which it owns.

Sustainability is very important and in line with our green plan, the whole building will be built to achieve a BREEAM Environmental Assessment rating of Very Good.

While we recognise that there is still a very long way to go before construction can start on the new centre, with the submission of the full planning application we are one step closer to being able to offer seamless health and wellbeing services for local people in the heart of Teignmouth. We continue to work towards this while acknowledging the potential impact of economic uncertainty.

We know that local people have continuing concerns about the future of the Teignmouth hospital site. We will shortly be inviting key local stakeholders to meet with us to agree how we will involve local people in conversations about the future of the site.

When the new health and wellbeing centre is built, a number of clinical services will move from the hospital into the new building while other clinical services will transfer to Dawlish community hospital or other sites. We will make sure that people are given plenty of notice of the date of any changes and will work closely with partners in Teignbridge District Council and the VCSE sector to address any issues around transport.

The new health and wellbeing centre for Teignmouth is being delivered via a joint venture partnership between gbpartnerships and Torbay and South Devon NHS Foundation Trust, known as South Devon Health Innovation Partnerships (SDHIP).

### **Social event widens smoking cessation support for pregnant people and their loved ones**

In addition to our usual Stoptober activities and the support available from our Healthy Lifestyles team, our Torbay Maternity Services have held a social event in Paignton for anyone who is pregnant and would like help to stop smoking. Our smoke free pregnancy service is available to support pregnant women and their families to stop smoking.

### **Supporting Black History Month**

This year's theme for Black History Month 2022 is [Time for Change: Action Not Words](#). Our BAME staff network have put together a fantastic programme of events including:

A conversation with Dr Peggy Warren on history and experiences of diverse groups in the NHS which is open to all partners in the Integrated Care System for Devon.

A coffee morning with Dr Peggy Warren: Co-creating- Building bridges, what next?

An evening of celebration to mark Black History Month, celebrate Diwali and showcase the diverse tapestry and rich culture we have within our organisations which is open to all partners in the Integrated Care System for Devon.

Our catering teams at Bayview restaurant have put together a fantastic range of menus celebrating different cultures, devised with the support of our international staff.

We have also encouraged colleagues to pledge to be an ally, shared skill boosters videos to raise awareness around racisms and race bias and celebrated and shared stories from our international nurses.

### **Celebrating our Allied Health Professionals**

As a former Occupational Therapist myself, I am passionate about the role Allied Health Professionals play in delivering better health and care for all.

To raise awareness of the contribution of our AHPs and to raise awareness of the different AHP roles our AHPs have organised a trail of 14 AHPs across our hospital and healthcare settings. Launched on AHP day on Friday 14 October, colleagues and patients are being encouraged to track down the figures and find out more about the roles. Those who visit the most figures and scan the QR codes before 02 November will be entered into a prize draw.

### **Wellbeing week – looking after me**

Our wellbeing week was built around world mental health day, raising awareness of the difficulties many of us and those around us face and the importance of looking after ourselves to help us cope with life's ups and downs. Events included sunrise yoga with our Health Lifestyles team, financial wellbeing seminars, live music, workshops by TALKWORKS, stop smoking drop in sessions, men's health and visits from Patrick the pony.

### **Torbay and South Devon Charitable Fund**

Our Charitable Fund is now registered on Amazon Smile:

<https://smile.amazon.co.uk/ch/1052232-0> and will also be the recipient of the Tree of Joy from the Torquay branch of Dunelm this Christmas. We are hoping that patients on 23 of our wards will benefit from the generosity of Dunelm shoppers.

## **3.2 Excellent experience receiving and providing care**

### **Current pressures**

In recent weeks we have seen a significant rise in the number of people with COVID-19 in our hospitals and our communities, reaching over 60 at its peak and now at around 30. Staff sickness rates due to COVID-19 also rose which impacted on both workloads and morale.



In this wave, approximately half of the people with COVID-19 in our hospitals were with us because of other conditions which require medical attention, people who are frail and elderly were significantly affected.

We continue to adapt our infection prevention and control measures to respond to the changes in infection rates locally.

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. Ambulance handovers remain a challenge and our teams are working extremely hard with South Western Ambulance NHS Foundation Trust to find sustainable solutions.

We fully recognise and acknowledge that many people are waiting much longer for care that we (and they) would wish. This is the case across not only urgent and emergency care services but also across our community services, our day surgery and theatres and in adult social care.

Unfortunately, there is no simple answer to many of the issues we face. We are working hard to recruit to our vacancies and to support people to join us quickly, however, for many specialities and professions there are simply not the numbers of people available. Availability of equipment and space is also an issue which we are working to address but the solutions to these issues are neither quick or inexpensive. We are delighted to have received capital funding to increase capacity in endoscopy and day theatres, however, these buildings won't be ready until next winter and we need to continue to work to reducing waiting times while we progress the building work.

We continue to work closely with health and care partners across Devon to maximise opportunities to do things together that provide more robust, sustainable services and help people get the care they need, when they need it. The South West Ambulatory Orthopaedic Centre at the Nightingale Hospital Exeter is an excellent example of this and we are very proud that they have recently received a partnership and integration initiative award from the National Orthopaedic Alliance.

We continue to prioritise reducing waiting lists across our specialities. We are encouraging local people to take up scans, diagnostic tests and operations at the Nightingale Hospital Exeter wherever they are able to do so.

Our mobile endoscopy unit has increased the number of appointments we can offer, however, we are seeing an increasing number of short notice cancellations from patients. Due to the nature of endoscopy appointments it can be difficult to offer these to people who have been waiting at short notice – we have launched a campaign to encourage people who are unable to attend their appointment to give it to someone else who is waiting by contacting us to cancel and giving us at least four days notice where they can.

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 they face similar challenges to us around workforce and resourcing and we continue to work together to do what we can to address these.

### **Trainees give our training programmes the thumbs up**

Our Internal Medical trainees have rated our training programme as the best in the United Kingdom for overall satisfaction. Meanwhile our Radiology trainees have rated our training programme as the best in the south west and the fifth best in the whole country.

Training, supporting and developing our future workforce is so important and it is great to see our people's commitment to this clearly shown in feedback from trainees.

### **Senior House Officer shortlisted for national award**

We are very proud that Dr Jenna Hussain, one of our doctors on Turner ward (oncology Senior House Officer) at Torbay Hospital, is a finalist for the Foundation Doctor of the Year award in the RCGP Inspire Awards 2022.

### **First nursing degree apprenticeships finally get to celebrate their graduation**

The first graduates of our degree nurse apprenticeship finally got to celebrate their graduation from the University of Plymouth last week.

Dawn Clements (Lower Leg Therapy), Charlotte Cole (Dart Ward, Totnes Community Hospital), Nina Henton-Waller (Emergency Department), Chrissy Rugg (Palliative Care Team), Emma Scott (Urgent Treatment Centre, Newton Abbot) and Elaine Wilson (Intensive Care Unit) all graduated in the class of 2020 but due to the pandemic the graduation ceremony only took place last Friday. Not only did all six graduate, but they all gained first class honours which is a true testament to their dedication.

### **Ward accreditations**

One ward underwent accreditation in September. We trialled a new accreditation template that is specific to paediatrics and Louisa Cary Ward achieved a silver award which is a fantastic achievement for the team.

### **DAISY awards**

The DAISY team award has been launched and entries close on 31 October. This is for anyone, staff or public to nominate a team who they truly believe to win nursing or midwifery team of the year. There will be a special ceremony in December to recognise nominees and announce the winner.

## **1.3 Excellent value and sustainability**

### **Changes to our Chief Operating Officer**

John Harrison has joined University Hospitals Plymouth NHS Trust (UHP) for a two-year secondment. John has taken up the role of Programme Director, Clinical Strategy and Peninsula Acute Sustainability Programme for UHP. This is a great opportunity for John to combine his operational leadership skills with his experience and expertise from previous roles in clinical networks and commissioning. We are proud to support John to take this important next step in his career.

John has been part of the Torbay and South Devon family for ten years and I would like to formally acknowledge the significant contribution he has made. I know many of us will miss his skills, leadership and support very much. Some of us will have the opportunity to continue to work with John in his new role as it very much involves working with clinical and operations colleagues across Devon and Cornwall as UHP develops its clinical strategy as our tertiary centre.

We welcome Jon Scott who has joined us as our Chief Operating Officer for an interim period of six months. Jon has worked within healthcare systems since 1995. His most recent role was as Chief Operating Officer for the Bristol, North Somerset and South Gloucestershire Integrated Care Board. Prior to that Jon has been a Chief Operating Officer of 17 Acute trusts of all sizes and make-up including Barts Health, Addenbrookes, Portsmouth and Manchester.

### **Chief People Officer appointed**

Michelle Westwood will join us as our new Chief People Officer on 01 November 2022, following an open and competitive recruitment process.

Michelle is a strategic HR leader, with significant knowledge of workforce matters, including introducing new ways of working, leading retention campaigns, and in the development of programmes to support leadership development and capability and organisational culture. She joins us following a 20-year career with the Royal Navy where her most recent role was the Programme Director for the Royal Navy People Transformation programme.

We look forward to welcoming Michelle to our Torbay and South Devon family and to her first Board meeting next month.

I would also like to formally acknowledge the significant contribution our interim Chief People Officer, Sheridan Flavin, has made during her short time with us and thank her for her hard work and dedication. Sheridan's skills and expertise have supported us to move forward our organisational strategy and our vision for better health and care for all.

### **Expansion of day theatres at Torbay Hospital**

Theatres at Torbay Hospital are set to benefit from around £15million capital investment which will increase capacity and help reduce local waiting lists.

This funding will enable us to create two modular theatres as well as additional preoperative assessment spaces and recovery spaces. This means we will be able to care for 4,500 more people each year, reducing the time that people have to wait for day surgery and improving their experience and outcomes.

Building is scheduled to begin on site in January 2023 and is expected to take eleven months.

### **Supporting international doctors**

Last month we welcomed 18 doctors from overseas who joined us to become NHS doctors through the Medical Support Worker programme.

The Medical Support Worker role provides a gateway for international medical graduates and refugee doctors from overseas who come to live and work in

England being fast-tracked into the health service and supported to become registered NHS doctors, while working under supervision.

Medical Support Workers already have the experience and training that, once registered, means they are well placed to move to more senior positions such as Physicians, Surgeons and Paediatricians.

### **International visit**

Last month we welcomed 11 representatives from SingHealth (Singapore) who spent two days with us as part of their international study trip researching integrated care, population health and financial drivers. They had previously spent time in America and were also visiting Sweden.

During their visit to us, their focus was on our model of integrated care, our experiences and learning from developing our model, how we adapted it during the pandemic and our further developments and future plans. Their interest is very much in taking our learning and experiences to help them respond to similar challenges in Singapore.

We are grateful to our teams who hosted our visitors and shared their work, expertise and experience, particularly the teams at Torbay Pharmaceuticals, Teignmouth, Dawlish, Totnes and teams from our Torquay ISU including our 0-19 service and drug and alcohol teams. We had lots of fascinating discussions and we hope to continue to share and learn from each other in the future.

### **Recruitment event success**

In September we held a recruitment event for healthcare support workers in Torquay and were delighted to be able to recruit 53 new people to join us.

We have also been improving how we work together as a health and care system to recruit people, hosting an online recruitment fair on 18-19 October. The fair was open to anyone looking to start or progress their career and introduced the opportunities available in clinical and non-clinical roles and how to apply. The event included speakers from across a range of areas including the emergency department, oncology, mental health, administration, and corporate.

### **Virtual technology aims to help young people feel more comfortable during hospital visits**

MRes Digital Art and Technology student, Kyra Boyle, has worked alongside academics from the University of Plymouth, and our Digital Futures and Paediatric Mental Health teams to develop a new interactive tool for children and young people.

The tool aims to help reduce anxiety by giving young visitors an awareness of a hospital environment in an enjoyable and engaging way and providing them with an interactive resource to use on the day of their visit.

Currently in prototype form, it is an easy to use and easy to access smart phone application, which young people or families can download before a hospital visit. They can access a range of content such as a 360-degree ward walk and an avatar to help direct them and their families. It aims to address key areas of

concern, signpost to important resources and improve support for those struggling with their mental health.

The project was recently shortlisted in the Digital Service for Children and Young People category of the HETT Unexpected Innovation Awards 2022. It has also been awarded additional funding to enable Kyra to complete focus group testing, evaluation and modification of the app in the hope of it going live within for use in our services within the next four to six months and has the potential to be rolled out across the south west in the future.

Kyra has recently been appointed to the Digital Futures Post Graduate Fellowship in Digital Health.

### **Supporting our local communities**

We continue to work in close partnership with Torbay Council to support local developments including the Torbay Story, community wealth building and Torbay development zone.

#### **4. Chief Executive engagement September**

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
<ul style="list-style-type: none"> <li>• Video blog sessions</li> <li>• Staffside</li> <li>• Diversity and Inclusion Lead</li> <li>• Meeting with Lead Governor</li> <li>• Medical Staffing Committee meeting</li> <li>• Quarterly League of Friends meeting</li> <li>• Horizon Centre delegates visit</li> <li>• Partnership Board</li> <li>• Joint Local Negotiating Committee meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Meeting with Kevin Foster MP</li> <li>• Chief Executive Officer, Integrated Care System for Devon (ICSD)</li> <li>• Long Term Plan Programme Director, ICSD</li> <li>• Interim Director of Transformation, ICSD</li> <li>• Chief Executive Officer, University Hospital Plymouth NHS Trust</li> <li>• Chief Executive Officer, Royal Devon University Healthcare NHS Foundation Trust (RDU)</li> <li>• Director of Transformation, RDU</li> <li>• Chief Executive Officer, Devon Partnership NHS Trust (DPT)</li> <li>• Director of Finance and Strategy and Deputy CEO, DPT</li> <li>• Medical Director, LiveWell SouthWest</li> <li>• Chief Executive Officer, Royal Cornwall Hospitals NHS Trust</li> <li>• Director of Children’s and Young People’s Futures, Devon County Council</li> </ul>

- |   |
|---|
| <ul style="list-style-type: none"> <li>• NHS Devon Integrated Care Board visit</li> <li>• SingHealth visit</li> <li>• NHS Leadership Event</li> </ul> |
|---|

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

#### **Recent key media releases and responses:**

- Chief People Officer announcement – announcing Michelle Westwood as our new Chief People Officer
- Welcoming international doctors – release welcoming 18 new doctors from overseas who have joined us as part of the Medical Support Worker programme
- Horizon Centre redevelopment opening – publicising the opening of our newly redeveloped education spaces in the Horizon Centre, funded by the University of Plymouth’s medical school
- Endoscopy services investment – our endoscopy services at Torbay Hospital will benefit from a £4.99million capital investment which will increase capacity and help reduce local waiting lists
- Diagnostic scan appointments at Nightingale – promoting diagnostic scan resources at the Nightingale Hospital Exeter, and encouraging members of the public to take up the opportunity when offered to receive treatment sooner and help us tackle waiting lists
- Using experience of health conditions to help others – promoting our Health Connect Coaching programme, with opportunities for those with long-term conditions to use their experience to support others to manage their health and wellbeing
- Bank holiday effects on services – responded to a number of enquiries on how the additional bank holiday was affecting services, outlining how we are contacting everyone with an appointment on the Monday to confirm or rearrange

#### **Recent engagement on our social media channels includes:**

- Her Majesty Queen Elizabeth II – sharing the announcement about the sad news of the death of Queen Elizabeth II, and updating followers on the funeral arrangements and effects on our services

- Charitable fundraising review – sharing our annual review of charitable fundraising that our organisation has benefitted from
- Maternity visiting changes – highlighting the updated visiting times and number of visitors allowed in our maternity ward and areas
- Pharmacy bank holiday hours – shared a list of the pharmacies that will be open in our area during the bank holiday
- Recruitment event – promoted our new to care recruitment event for healthcare support workers
- Our People Awards – encouraging members of the public to nominate our amazing staff for the people’s choice award
- Choosing the right service for your need – supporting members of the public to make the right choice for care when they need help, which can include self-care, a pharmacy, GP, a minor injuries unit or our emergency department

#### Development of our social media channels:

Channel	End of year target	As of 31 March 2021	As of 31 August 2022
LinkedIn	5,000 followers	2,878	4,830 ↑ 1,952 followers
Facebook	15,000 likes	12,141	13,347 ↑ 1,206 followers
	15,000 followers	12,499	14,220 ↑ 1,721 followers
Twitter	8,000 followers	6,801	7,636 ↑ 835 followers

## 7. Recommendation

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





<b>Report to the Trust Board of Directors</b>				
<b>Report title:</b> Integrated Performance Report (IPR): Month 6 2022/23 (September 2022 data)			<b>Meeting date:</b> 26 October 2022	
<b>Report appendix</b>	M6 2022/23 IPR focus report M6 2022/23 IPR Dashboard of key metrics			
<b>Report sponsor</b>	Deputy CEO and Chief Finance Officer			
<b>Report author</b>	Head of Performance			
<b>Report provenance</b>	ISU and System governance meetings – review of key performance risks and dashboard Executive Director: 19 October 2022 Integrated Governance Group: 19/20 October 2022 Finance, Performance, and Digital Committee: 24 October 2022			
<b>Purpose of the report and key issues for consideration/decision</b>	<p>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:</p> <ul style="list-style-type: none"> <li>Review evidence of overall delivery, against national and local standard and targets</li> <li>Interrogate areas of risk and plans for mitigation</li> <li>provide assurance to the Board that the Trust is on track to deliver the standards required by the regulator.</li> </ul> <p>Areas of exception that the Board will want to focus on are highlighted below and detailed in the attached Focus Report.</p>			
<b>Action required (choose 1 only)</b>	<b>For information</b> <input type="checkbox"/>	<b>To receive and note</b> <input checked="" type="checkbox"/>	<b>To approve</b> <input type="checkbox"/>	
<b>Recommendation</b>	The Board is asked to <b>review</b> the documents and evidence presented.			
<b>Summary of key elements</b>				
<b>Strategic objectives supported by this report</b>	<b>Safe, quality care and best experience</b>	X	<b>Valuing our workforce</b>	X
	<b>Improved wellbeing through partnership</b>		<b>Well-led</b>	X
<b>Is this on the Trust's Board Assurance Framework and/or Risk Register</b>	<b>Board Assurance Framework</b>	X	<b>Risk score</b>	20
	<b>Risk Register</b>	X	<b>Risk score</b>	25
<p>Risk 1 – Quality and Patient Experience Risk 2 – People Risk 3 – Financial Sustainability</p>				

	Risk 5 – Operations and Performance Standards		
<b>External standards affected by this report and associated risks</b>	<b>Care Quality Commission</b>	<b>X</b>	<b>Terms of Authorisation</b>
	<b>NHS Improvement</b>	<b>X</b>	<b>Legislation</b>
	<b>NHS England</b>	<b>X</b>	<b>National policy/guidance</b>
			<b>X</b>
<p>This report reflects the following corporate risks:</p> <ul style="list-style-type: none"> <li>• failure to achieve key performance standards;</li> <li>• inability to recruit/retain staff in sufficient number/quality to maintain service provision;</li> <li>• failure to achieve financial plan.</li> </ul>			

<b>Report title:</b> Integrated Performance Report (IPR): Month 6 2022/23 (September 2022 data)		<b>Meeting date:</b> 26 October 2022
<b>Report sponsor</b>	Deputy Chief Executive & Chief Finance Officer	
<b>Report author</b>	Head of Performance	

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

## 1. Quality

### 2020 CQC inspection

The Quality Improvement action plan arising from the 2020 CQC inspection is 99% complete and all actions will be moving into business as usual. The Compliance Assurance Group (CQCCAG) is currently reviewing the metrics to determine how we continue to monitor and sustain the improvements. This will include a multifaceted Peer Review program and working with the internal audits to support ongoing monitoring. Patient Safety walkabouts continue weekly across the acute trust to identify opportunities to improve patient safety, to share ideas and provide immediate feedback to the clinical teams. CQC standards are tested and reviewed during the safety walkabouts across the 13 domains of Fundamentals of care. They also identify areas of good practice and provide an opportunity to move towards a reflective approach as opposed to an inspection focused approach.

There remains 1 Must Do and 2 Should Do actions to complete. The CQCCAG were provided with sufficient evidence to enable the closure of the mandatory training related Must Do actions. The Mandatory Training Recovery Plan and agreed projected targets are now accepted and the new policy approved by the People Committee and these will be monitored within the ISU, Mandatory Training Group and exception reported to IGG. The new trajectories have been added to the current Mandatory training policy. The remaining Must Do action is regarding attainment of the staff appraisal achievement rate which has been affected by Covid -19. The trust position has seen August's Achievement Review rate dropped slightly to 75.77% from 77.02% in July. The People Business Partners are working with ISU's to plan improvement trajectories.

### 2021 CQC Focused Inspection

The daily 5 patient Risk Assessment audits continue to be being recorded electronically and the results viewed in real time. The audit covers 43 questions across a number of assessments and daily, weekly, and monthly compliance reports are generated. The 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.

### Incidents:

There were five severe incidents and one incident reported as death in September 2022. One incident was related to staff injury, one related to safeguarding and two related to staff acquiring covid whilst at work

The death incident relates to a patient under the community care team found at home following a possible drugs relapse.

**Stroke:**

Timely access to dedicated stroke units offer the best quality of care and outcomes for patients. In September 54.8% of stroke patients admitted spent 90% or more of their time on a dedicated stroke ward. The quality standard is for 80% of patients to have spent 90% of their time on a stroke ward. For timeliness of admission only 24.2% of patients were admitted to the stroke ward within 4 hours of arrival at hospital. A comprehensive action plan is in place to continue to improve upon this position.

**VTE assessment:**

VTE assessment compliance demonstrated a reduced compliance from 93.6% in August to 92.7% in September. The VTE Steering Group continues to meet with a comprehensive improvement plan in place to address areas of noncompliance and ensure targeted initiatives are implemented to deliver consistent achievements of the target.

**Infection, Prevention, and Control:**

Bed closures have increased to 132 during the month of September due to the increase in COVID-19 outbreaks.

The number of C.Diff cases have increased with a total of 7 in September of which 6 were hospital acquired and 1 community acquired.

**Maternity:**

There was one stillbirth in September at 32 weeks gestation and will be reviewed via the Perinatal Mortality Review Tool process. In May 2022 SystemOne, the Maternity Electronic Patient Record was launched. The safety and quality metrics presented in this report is the first full report detail since May. In September the data demonstrates a slight deterioration in the provision of one-to-one care in labour. Further analysis is being undertaken to understand whether this detail is reflective of actual clinical activity or relating to the inputting of data by the clinical.

**Staffing:**

Despite the increased operational pressures during September 2022 an improved Registered Nurse fill rate for day shifts was reported at 98.5% and a 90% Registered Nurse fill rate for night duty, providing assurance that our clinical areas are safely staffed and actions taken to mitigate any risks.

**Strengthening lens on Quality Priorities:**

Moving forward the above metric will be reviewed in line with our Quality Strategy and further metrics will be reported to the Board against the Quality Improvement Priorities as they are collated and analysed. These include sepsis, deteriorating patient, discharges, falls and nutrition and hydration.

**2. Workforce Headlines**

The preliminary annual rolling sickness absence rate is 5.74% to the end of September 2022. The sickness target rate is 4%. Sickness has now increased slightly in September (from 4.71% in August) with the monthly figure standing at 4.73% which is still a significant drop from 6.36% in April 2022. The high figures of February-April were

predominantly related to high Covid absence, which dropped significantly after April, particularly with people taking less time per episode. Also, the People team have worked with managers to support sickness absence management and team health.

September's Achievement Review rate dropped slightly to 75.77% from 77.02% in August, despite an improving picture from April. Continued high absenteeism and system pressures are impacting the ability to perform Achievement Reviews; indeed, if you map absence onto our achievement review data, there is almost an inverse relationship. There are also a high number of new starters in September, potentially impacting on the data, including managers completing the first year Achievement Reviews. Our People Business Partners are working with ISUs to plan improvement trajectories and deliver training for managers on Effective Feedback and Achievement Reviews.

While the Trust's turnover rate of 13.88% for the year ending September 2022 remains within the normal tolerances of 10 to 14%, the SPC chart clearly reflects an upward trend since July 2021. 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 to 29 and later stage career Registered Nurses 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.

The September overall rate mandatory training figure decreased slightly to 88.70% against a target of 85%. Information Governance, Manual Handling and Safeguarding Children are all below the target compliance level for Corporate Mandatory training – additional information has been added to the Focus Report to highlight the multi-level training compliance.

The Trust Agency reported figure for September was £1.173m, a slight decrease from the August figure of £1.179m.

### **3. Performance Headlines**

The COO report included in these papers gives the headline performance summary. Key areas of performance risks are shown in the Focus Report.

- The Trust remains in the Tier 1 performance regime from NHS England against access targets for cancer and Referral to Treatment (RTT) long waits. This requires weekly executive meetings with South West region performance leads to review progress and gain assurance on agreed action plans. Progress is being made, however, significant risks remain against the cancer backlog and the long-wait RTT backlog clearance. Against cancer backlogs, three areas have significant challenges to provide the capacity needed to target the long waits. These areas are lower GI pathways, Urology, and Dermatology. For RTT the latest forecast shows that the Trust will not meet the original trajectory for the 78-week longest wait standard to clear all

78-week patient waits by 31<sup>st</sup> March 2023. Progress is being made on the cohort of patients requiring admission and treatment with greatest risks across non-admitted pathways in Colorectal, Surgery, ENT, Neurology, Paediatrics, and Urology.

- One Devon Elective Recovery Programme: To support the wider Devon Integrated Care System (ICS) in the delivery of improvements against the Tier 1 performance metrics a dedicated support team has been appointed. This initial focus is on Royal Devon University Healthcare NHS Foundation Trust and University Hospital Plymouth Trusts, however, TSDFT are not being excluded; TSD will be working closely with this improvement programme. This will include the same strategic approach to clarifying actions needed to improve current performance ranging from increasing provider and system capacity to providing increased validation and tracking of individual patient pathways.
- Trust continues to report significant delays across urgent and emergency care pathways. Against the time spent in emergency department the Trust is currently ranked 104<sup>th</sup> out of 116 Trusts. Delays in ambulance handovers, Emergency Department waiting times, and length of stay are covered in the focus report.
- The ICS are setting up provider level integrated performance management meetings to increase wider governance. These meeting will be executive led with NHS England in attendance; the first meeting is scheduled for 31<sup>st</sup> October 2022. The agenda will cover performance against the Strategic Outline Framework (SOF) targets that will include access, workforce and quality.
- The Adult Social Care Performance and Transformation Committee meets monthly with Council and Trust representatives. This committee covers all aspects of performance, service delivery, and financial risks; the Committee reports into the Torquay Integrated Governance Group.

#### **4. Finance headlines**

At Month 6 (September) the planned deficit for the year to date is £2.8m, the actual position shows an adverse variance to plan at £4.0m, giving rise to a total reported deficit of £6.8m.

Following a thorough balance sheet review, £6.3m of non-recurrent mitigations have been reflected in this year to date position.

This gives rise to an underlying deficit for the year to date of c£13.1m, largely due to the gap in CIP delivery, significant overspends in the urgent care system (£2.7m year to date) and slower Covid cost reduction than required (e.g. cleaning). Trends within the independent sector (adult social care & CHC) continue to cause significant concern. The Trust must now rapidly mitigate the position on CIP as an urgent action.

Total reported in month income for M06 is £4.6m favourable to plan. Key drivers are:

Pay award	£4.30m
ASC Income Release	£0.98m
ASC income (client contributions)	£0.15m

Offset by:	
Lower Torbay Pharmaceutical sales	(£0.32m)
Covid-19 labs testing	(£0.23m)
CFHD S75 refund	(£0.16m)

Operating expenditure and financing cost in M06 are £5.64m adverse to plan. Key drivers are as follows:

Substantive pay (incl. back dated pay award, partially offset by income)	(£3.28m)
Agency spend	(£0.56m)
Bank spend (incl. back dated pay award offset by income)	(£0.47m)
ASC/Placed People non-pay	(£1.19m)
Drugs (including pass through)	(£1.15m)
Premises costs	(£0.40m)
Clinical supplies & services	(£0.25m)
Transport costs	(£0.15m)
<i>Offset by</i>	
Provider SLA's	£1.00m
Education and training	£0.35m
Financing & other	£0.33m
Balance sheet provision	£0.10m

The cash position at the end of June is £14.50m. Access to PDC support remains absolutely critical to the Trust's 2022/23 cashflow. The Trust continues to seek £5.9m of emergency capital PDC and will seek revenue support to offset its revenue deficit.

Spend on capital schemes (CDEL) £13.7m which is behind (£1.1m) the plan value of £14.8m at the end of September.

The year to date plan YTD plan for efficiencies was £13.0m at M06, of which £8.6m has been formally transacted via the financial ledger and delivered. The current trajectory indicates a possible CIP shortfall of up to £15.3m for the year, against the £28.5m requirement. It is now critically urgent to identify schemes to close the gap.

Looking ahead:

- Following the national forecasting protocol, the Trust's officially reported forecast position at M06 is a balanced outturn position against plan, however the underlying net in-year risk with mitigations current stands at £18.6m. The Trust will not meet its control total unless further choices are made to reduce the deficit in line with a breakeven plan.
- System agency controls are being developed and the agency cap must be held. Due diligence is underway regarding real-term savings. The Trust has now switched off off-framework providers from 1<sup>st</sup> September.
- Urgent actions are required to rapidly identify further mitigating actions with real commitment through all level of the organisation to close the £15.3m of gap in CIP delivery. The first Trust Management Group (TMG) held on 20th September signed up to a joint commitment change to culture, work across teams and operational boundaries in identifying opportunities, revisit past

decisions to mitigate the savings gap as well as reducing cost pressures as far as possible through Financial Recovery Plan.

- The deadline for divisional Financial Recovery Plan submission was 14th October. Not all services responded within this deadline, the finance team is currently collating the responses, chasing and supporting all services to complete the exercise. It is anticipated that an additional £4m mitigation to CIP delivery would be identified from the Financial Recovery Plan (please see forecast section in the detailed report).
- Year to date gap on the pay award is £0.44m, and full year gap is circa £0.90m. Further work is underway to validate this value in conjunction with other providers to ensure consistency of reporting. Additional funding for the NI increase will be clawed back from M08, when the 1.25% is reversed from employees pay.



# Integrated Performance Focus Report (IPR) Trust Board



Torbay and South Devon  
NHS Foundation Trust

October 2022: Reporting period September 2022 (Month 6)

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

# Quality and Safety Summary

## Quality Priorities

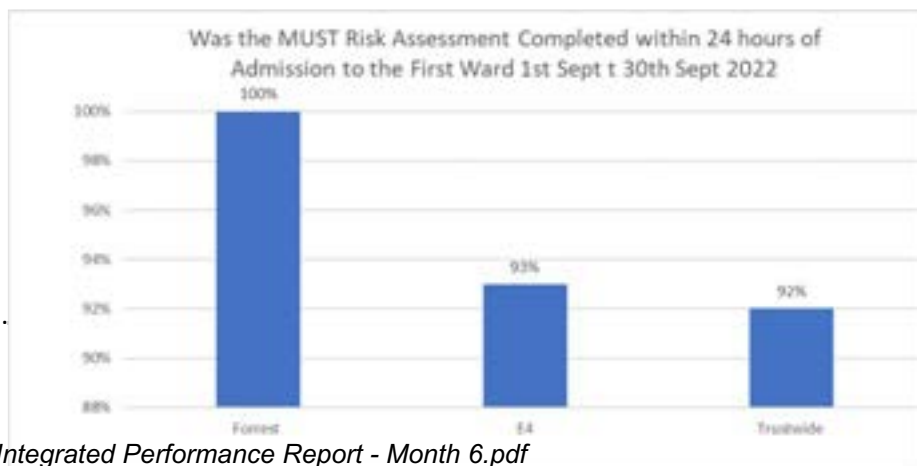
### 2020 CQC inspection

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### 2021 CQC Focused Inspection

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### September 2022

- ✓ Trustwide assessments completed within 24 hrs has improved to 92% although not met the compliance target of 100%
- ✓ Forrest Ward recorded 100% compliance and EAU4 93% compliance.
- ✓ Improvement has been noted in EAU4 but close monitoring and daily senior nurse support is being provided to strengthen this position to meet the target of 100%.
- ✓ A review of the audit process is underway, to align to one data capture methodology. The daily auditing will continue as the main vehicle of assurance and reporting within the Trust

### Incidents:

There were five severe incidents and one incident reported as death in September 2022.

1 incidents was related to staff injury, x 1 related to safeguarding and x2 related to staff acquiring covid whilst at work

The death incident relates to a patient under the community care team found at home following a possible drugs relapse.

### Stroke:

Timely access to dedicated stroke units offer the best quality of care and outcomes for patients. In September 54.8% of stroke patients admitted spent 90% or more of their time on a dedicated stroke ward. The quality standard is for 80% of patients to have spent 90% of their time on a stroke ward. For timeliness of admission only 24.2% of patients were admitted to the stroke ward within 4 hours of arrival at hospital. A comprehensive action plan is in place to continue to improve upon this position.

### VTE assessment:

VTE assessment compliance demonstrated a reduced compliance from 93.6% in August to 92.7% in September.

The VTE Steering Group continues to meet with a comprehensive improvement plan in place to address areas of non-compliance and ensure targeted initiatives are implemented to deliver consistent achievements of the target.

### Infection, Prevention, and Control:

Bed closures have increased to 132 during the month of September due to the increase in COVID-19 outbreaks.

The number of C.Diff cases have increased with a total of 7 in September of which 6 were hospital acquired and 1 community acquitted.

### Maternity

There was 1 stillbirth in September at 32 weeks gestation; will be reviewed via PMRT (Perinatal Mortality Review Tool) process. In May 2022 SystmOne, the Maternity EPR was launched. The safety and quality metrics presented in this report is the first full report detail since May. In September the data demonstrates a slight deterioration in the provision of 1.1 care in labour. Further analysis is being undertaken to understand whether this detail is reflective of actual clinical activity or relating to the inputting of data by the clinical.

### Staffing:

Despite the increased operational pressures during September 2022 an improved Registered Nurse fill rate for day shifts was reported at 98.5% and a 90% Registered Nurse fill rate for night duty, providing assurance that our clinical areas are safely staffed and actions taken to mitigate any risks.

### Strengthening lens on Quality Priorities

Moving forward the above metric will be reviewed in line with our Quality Strategy and further metrics will be reported to the Board against the Quality Improvement Priorities as they are collated and analysed. These include Sepsis, Deteriorating Patient, discharges, falls and nutrition and hydration.

## Quality and Safety Indicators

Key									
<span style="color: green;">↑</span> = Performance improved from previous month <span style="color: red;">↓</span> = Performance deteriorated from previous month                   ↔ = No change									
<span style="background-color: red; color: black;"> </span>	Not achieved	<span style="background-color: yellow;"> </span>	Under-achieved	<span style="background-color: lightgreen;"> </span>	Achieved	<span style="background-color: gray;"> </span>	No target set	<span style="background-color: white;"> </span>	Data not available

Reported Incidents - Severe	<span style="background-color: lightgreen;"> </span>	<span style="color: green;">↑</span>
Reported Incidents - Death	<span style="background-color: lightgreen;"> </span>	<span style="color: green;">↑</span>
Medication errors resulting in moderate harm	<span style="background-color: lightgreen;"> </span>	↔
Medication errors - Total reported incidents	<span style="background-color: gray;"> </span>	
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	<span style="background-color: lightgreen;"> </span>	↔
Never Events	<span style="background-color: lightgreen;"> </span>	↔
Strategic Executive Information System (STEIS)	<span style="background-color: lightgreen;"> </span>	<span style="color: green;">↑</span>
QUEST (Quality Effectiveness Safety Trigger Tool – red rated areas)	<span style="background-color: lightgreen;"> </span>	↔
Formal complaints - Number received	<span style="background-color: lightgreen;"> </span>	<span style="color: green;">↑</span>
VTE - Risk Assessment on Admission	<span style="background-color: red;"> </span>	<span style="color: red;">↓</span>
Hospital standardised mortality rate (HSMR)	<span style="background-color: red;"> </span>	↔
Safer Staffing - ICO - Daytime	<span style="background-color: lightgreen;"> </span>	<span style="color: green;">↑</span>
Safer Staffing - ICO – Night time	<span style="background-color: yellow;"> </span>	<span style="color: green;">↑</span>
Infection Control - Bed Closures - (Acute)	<span style="background-color: yellow;"> </span>	<span style="color: red;">↓</span>
Hand Hygiene	<span style="background-color: lightgreen;"> </span>	<span style="color: red;">↓</span>
Fracture Neck Of Femur - Time to Theatre <36 hours	<span style="background-color: red;"> </span>	<span style="color: red;">↓</span>
Stroke patients spending 90% of time on a stroke ward	<span style="background-color: red;"> </span>	<span style="color: red;">↓</span>
Mixed sex accommodation breaches	<span style="background-color: lightgreen;"> </span>	↔
7.01 Integrated Performance Report - Month 6.pdf Follow ups 6 weeks past to be seen date	<span style="background-color: red;"> </span>	<span style="color: green;">↑</span>

# Quality and Safety- Incident reporting and complaints

Reported Incidents - Severe and Death

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



In September there was five severe incidents and one incident reported with severity of death.

## Severe Incidents

- x1 Staff injury related to moving and handling
- x2 staff developing an infection during the course of completing their work duties (COVID)
- X1 needle stick injury
- X1 Safe guarding incident

## Death

- x 1 Drug and alcohol related death – patient found deceased whilst conducting a welfare check.

Formal complaints

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Formal complaints	11	11	10	9	16	11	12	12	12	7	13	16	10
Target	60	60	60	60	60	60	60	60	60	60	60	60	60



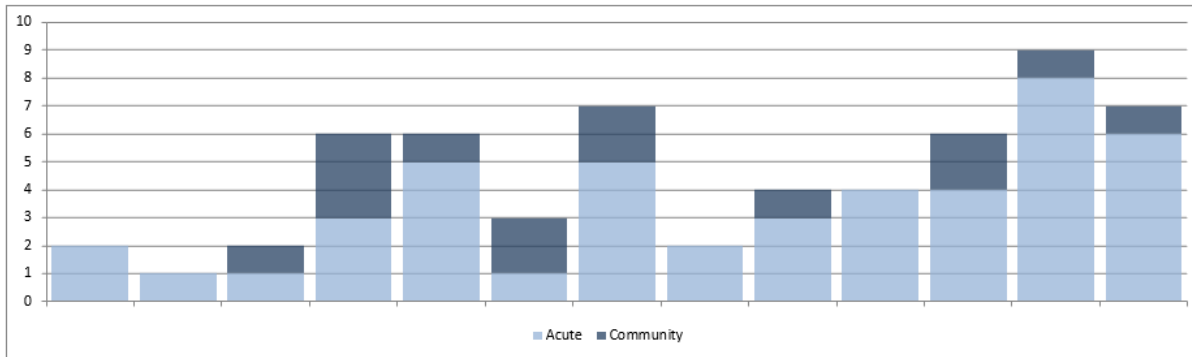
The Trust received 10 formal complaints in September 2022.

Of these:

- 4 were in relation to care
- 4 were in relation to treatment
- 1 was in relation to discharge
- 1 was in relation to assessment (financial)

Number of Clostridium Difficile cases

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Acute	2	1	1	3	5	1	5	2	3	4	4	8	6
Community	0	0	1	3	1	2	2	0	1	0	2	1	1



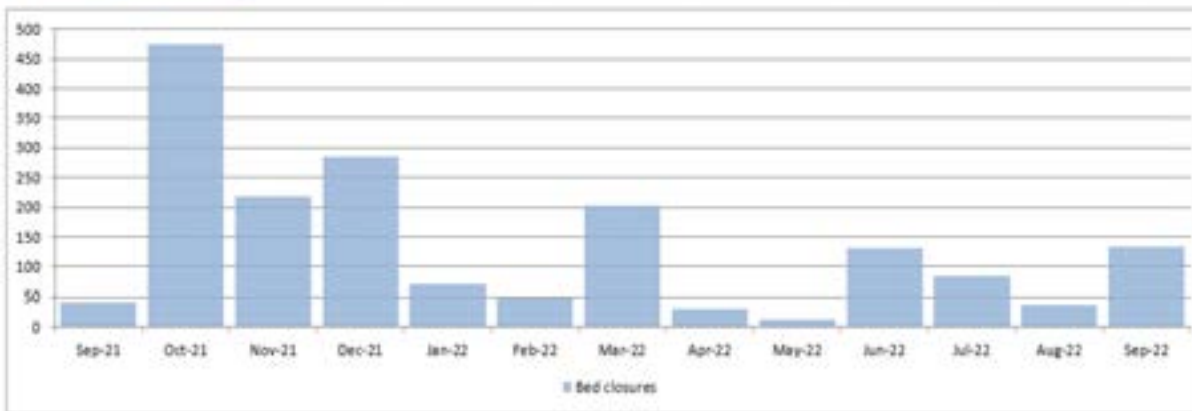
There were 7 reported cases of C.Diff in September :

- 6 hospital onset
- 1 in the community

The IPC team together with consultant microbiologist have commenced weekly ward rounds reviewing these patients. No trends have been noted for this month that could have lead to the acquisition of CDT.

Infection control - Bed closures (Acute)

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Bed closures	42	476	218	285	71	49	203	30	12	130	84	36	132



In September bed closures saw a significant rise to 132 from the August position of 36.

The reason for the closures has mainly been due to;

- Increase in patients testing positive for COVID-19 on admission
- outbreaks during admission of COVID-19

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

# Quality and Safety- Exception Reporting

Stroke



## Stroke:

- The percentage of patients who spend 90% of their time on a stroke ward has not met the target of 80% and decreased to 54.8% in September.
- 24.2% of stroke patients were admitted to the stroke ward within 4 hours in Sept which is a slight deterioration on August position but an overall improvement since Jan 22. This is still well below the national target of 90%. This sustained improvement has been as a result of working collaboratively with the Clinical Site Managers to ensure an emergency stroke bed is available at all times.

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

- 93.9 % of patients received a scan within 12 hours;
- 75.8% of patients received a cognitive screen and mood screen
- 100% of patients received a nutrition screen.

Follow ups 6 weeks past to be seen by date



## Follow ups:

- The number of patients waiting for a follow up appointment greater than six weeks past their 'to be seen by date' has decreased in September.
- 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.

Acute VTE risk assessment on admission

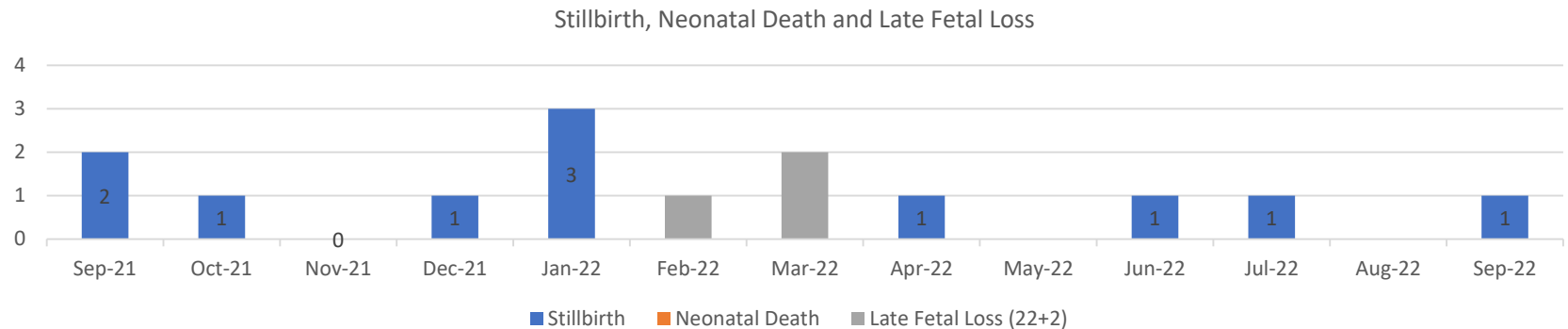


## VTE assessment

- VTE assessment compliance demonstrated a slight decrease in compliance from 93.6% in August 22 to 92.7% in September.
- Due to operational pressures the VTE meeting did not occur last month.
- Junior Drs planning further QI project in ED and MRU to review compliance of risk assessments for VTE
- Medical education to include VTE education for junior doctors to improve learning.

# Quality and Safety- Perinatal Clinical Quality Surveillance September 2022

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 September one stillbirth reported at 32 weeks gestation.

	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Total
Number of Births (TOTAL)	194	172	161	169	140	153	163	152	173	159	153	167	1956
% Robson Group 1	20.0%	24.1%	22.2%	15.4%	10.0%	8.7%	22.2%		22.9%	24.1%	40.9%	37.5%	22.5%
% Robson Group 2	37.8%	51.6%	44.9%	57.1%	58.3%	30.3%	55.3%		40.0%	45.5%	26.1%	48.3%	45.0%
% Robson Group 5	69.0%	78.6%	88.2%	81.0%	79.2%	90.0%	72.2%					90.9%	81.1%
% 1-1 care in labour	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	95.8%	99.28%
% Smoking at Delivery	14.4%	12.2%	13.7%	14.2%	8.6%	10.5%	13.5%		8.7%	6.3%	9.2%	7.2%	10.8%
% Breastfeeding at Delivery	71.0%	80.3%	72.2%	80.5%	78.9%	75.2%	78.0%						76.6%

- In May 2022 SystemOne, the Maternity EPR was launched. The above data is the first time we have been able to present this safety quality information with this detail since May. Work is ongoing to capture all the required information for reporting safety both internally and outside of the organisation. Breast feeding data is still proving difficult to pull from the EPR – work is ongoing to address this.
- The Robson system classifies all deliveries into one of ten groups on the basis of five parameters: obstetric history, onset of labour, fetal lie, number of neonates, and gestational age\* A detailed audit on Robson data has been completed and will be presented at the Obs and Gynae November audit meeting.
- In August and September the data demonstrates a slight dip in the 1.1 care in labour compliance. The mechanism of data capture has changed from the previous method and is now captured from System 1. It is not always completed by the midwives so this is likely to explain the dip in compliance. Further analysis is ongoing by the digital midwife.



## Performance exceptions and actions

### **Staff sickness/absence: RED for 12 mths and RED for current mth**

The preliminary annual rolling sickness absence rate is 5.74% to the end of September 2022. The sickness target rate is 4%. Sickness has now increased slightly in September (from 4.71% in Aug) with the monthly figure standing at 4.73% which is still a significant drop from 6.36% in April 2022.

### **Appraisal rate: Red**

September's Achievement Review rate dropped to 75.77% from 77.02% in August. 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 and deliver training for managers on Effective Feedback and Achievement Reviews.

### **Turnover (excluding Junior Doctors): GREEN**

While the Trust's turnover rate of 13.88% for the year ending September 2022 remains within the normal tolerances of 10 to 14%, the SPC chart clearly reflects an upward trend since July 2021. 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 to 29 and later stage career Registered Nurses 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 September **overall** rate mandatory training figure decreased slightly to 88.70% against a target of 85%. **Information Governance, Manual Handling and Safeguarding Children are all below the target compliance level** for Corporate Mandatory training additional information has been added to this report to highlight the multi-level training compliance.

**Agency Expenditure:** The Trust Agency reported figure for September was £1.173m, a slight decrease from the August figure of £1.179m.

**Vacancy Rate:** Nursing and Midwifery vacancies have decreased from 43 WTE in August to 21 WTE in September and Allied Health Professional vacancies have decreased from 89 WTE in August to 82 WTE in September. Admin and Clerical vacancies have increased to 111 WTE. 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. Workforce and Business Partners are joining Matron meetings to present information in regards to occupation codes and their importance and to discuss the ongoing work in regards to aligning occupational codes to finance data. This includes an overview of the end to end process of how the data is compiled, which has been process mapped by the working group. 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.

# Workforce Summary

## Update of Progress Against Our People Promise and Plan

A review of the first phase of our People Promise and plan, alongside data from our national staff survey and pulse surveys, have informed the development of two clear priorities where we consider we will have the most impact in the next phase. Hence, the delivery of our people promise will be focussed on these two priority areas in order to deliver on our strategic priority :

**“To build a healthy organisational culture where our people thrive”**

- 1. Consistent, compassionate and inclusive leadership that is motivating and empowering**
- 2. Ensuring our people feel safe, healthy and supported by maximising wellbeing through the way we work (i.e. making people’s lives easier and freeing up time to work in a safe and calm way).**

Work is underway and developing in each of these areas, including the Workforce transformation and focussed Retention work. This includes early feedback that there was more to do to increase opportunities for flexible working, which we know is a key retention factor. We have started working with teams on flexible working pilots and to collect case studies that demonstrate the positive impact of flexible working, as well as providing some practical solutions on how the challenges have been addressed.

Engagement has begun to socialise these priorities, including a survey on effective leadership within our organisation.

The following slides summarise progress on work that began under our People Plan pillars, much of which will continue either in the next phase or as part of the work of the People Directorate teams.

### Growing for Our Future

- Our latest face to face Recruitment event took place on 27 September and focused on recruiting new to care HCSW and also promoting other NHS opportunities. The team saw over 80 people on the day, 56 interviews took place and 53 provisional offers were made. 41 offers were for new to care HCSW, 8 were experienced HCSW, and the remainder were to join our temporary staffing bank
- New Welcome To Our Trust handbook is being finalised and during the remainder of October there will be feedback sessions taking place to help finalise content.
- New Managers checklist has been produced and will be issued by the Resourcing Hub as part of improved onboarding support for managers.
- Final conversations are taking place around the new rates for the Devon ICS nursing agency framework and this work will help contribute towards reduce agency costs.
- Our weekly temporary Staffing 'drop in' for our bank workers to meet the team has started and well received. This is now being promoted as part of new starter process and welcome new people to our Trust.
- Devon wide Virtual recruitment fair takes place on the 18<sup>th</sup> and 19<sup>th</sup> October and will promote Devon as a destination of choice and is a collaboration of the Devon partners. This will involve speakers from a variety of disciplines in our Trust to promote areas where we have particular recruitment needs
- The Workforce Transformation Programme remains a core focus for most of the resourcing teams and projects are well underway to progress the activities. This includes supporting improved recruitment, temporary staffing and e-Rostering services

### Looking After Our People

- Last week we celebrated 'Looking after Me' week, funded by NHS Charities, and included the visit of Patrick the Pony to Newton Abbot and Torbay Hospital (and was incredibly well received!), musicians played at Bayview on the same day as the discounted meals (50%) off- which yielded 140 more covers than the same day the previous week, and the well received pensions webinar.
- We now have over 170 Wellbeing Buddies across the organisation, and future training is fully booked for the rest of the year. This role has proved to be incredibly successful within our teams. They range across different specialty areas, different job roles and geography of the organisation.
- Due to the appointment of our Wellbeing and Staff Engagement Administrator, the communications and engagement across the organisation has improved in volume, accessibility and quality, which means that we are much more able to reach our staff who may not ordinarily hear about our wellbeing support.
- Zebra – an external company, are offering reflection sessions for individuals or our teams
- 'Thank you' cards have been extremely popular as our people have used them to show gratitude and recognition to their colleagues.

### 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. This will track the patient through their pathway, which services/staff they access and what skills and competencies are required.
- 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 and the retention project work.
- An Advanced practice - steering group has been established to define advanced and extended scope of practice roles within the Trust.
- The Trust is joining the ICS in a joint adventure, representing 'We are the NHS in Devon' at the annual Acute and General Medical Conference in London in November.
- The Trust is developing a career progression pathway for our Physicians Associates in order to support retention and to develop workforce modelling.
- 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. There may be another submission required in September. We are awaiting confirmation. As part of this there is work ongoing to reconcile Finance and ESR workforce data.
- Organisation wide plan to move to 3 – 5 year planning cycle to support workforce development for BBF, realise longer term cost savings and service transformation. this includes consideration of workforce planner role to support BBF work.
- Funding to support career development i.e. service having to fund development apprenticeship back fill. Pot of money to support skills shortage – targeted approach

### Belonging

- We are endorsing the positive message of inclusion by supporting the induction of the Myanmar intake of doctors by offering pastoral care to and introducing our new colleagues to our BAME network. In addition the EDI Lead was invited by SW HEE to supporting the wider intake across Devon by facilitating a welcome to the UK session.
- Work continues to provide the focus of equality, diversity and inclusion as part of our recruitment process and our EDI lead has been a panel member on two senior panels including the recruitment of the Chief People Officer and System Directors.
- Members of the LGBTQ+ network and allies attended the Totnes Pride event engaging with members of our local community
- Preparations are underway to celebrate black history month during October of which this years theme is 'Action not Words'. There will be a number of activities that will include pledges for anti-racism and allyship. A more detailed plan will be released.
- In collaboration with the Devon system equality, diversity and inclusion leads we are engaging with our workforce to co-design and deliver an anti-racism charter that will demonstrate our commitment to anti-racism.

### Creating the Conditions to Enable Transformation

#### Building Capability:

- Three 'Intro to Improvement' preceptee sessions now completed. Follow up sessions planned with every group in the New Year.
- Intro to Improvement afternoon held for IMT 1&2 doctors
- F1 doctor improvement training due to commence 13.10.22 (one of three planned sessions)
- Understanding and managing change session held with Movement Disorder Nursing Team and HIS Teams.
- Exploring building capability opportunities with NHS Elect and how better to use their resources.

#### Quality & Safety:

- Pathways to Excellence Programme Board held.
- Inaugural Improvement & Innovation Community now to be held on 22<sup>nd</sup> November. This community will bring together like-minded staff from across our organization with an interest in Improvement & Innovation to learn, share and celebrate.
- Work with Sepsis and Deteriorating Patient groups commenced.

#### iManage:

iManage is continually being updated and restructured so as to fit alongside other initiatives more comfortably. The route forward will likely include moving the training packages supplied by skills boost away from iManage to a singular central location. The training will still be signposted to via iManage. The reason for this step is to improve the quality and quantity of data that we can capture.

The iManage handbook is well into development with the majority of the pages started. The pages follow a linear process of development described below.

1. Initial conversation with SME
2. First draft created
3. Draft emailed back to SME for amendments/ changes.
4. Final draft complete
5. Conversation with SME to confirm content
6. Maintenance

Almost all pages have reached step 3. The only exception being that when the conversation is opened, we often explore new thinking and by extension new tools we could develop to improve employee experience.

One such example would be an idea to create an evidence based 'Health and Wellbeing questionnaire' based on our anecdotal 'Health and wellbeing model'. The aim being to not just have model that we do not use, but to create an everyday use for it. Therefore, this has required a redraft of our 'Health and Wellbeing model' to be more robust in its supporting evidence.

Due to the various organisational pressures any acute work has paused with regard to iManage. However, the quality of the offering has led to teams reaching out to co-design training material to an "iManage standard". This is highly encouraging for us. Once organisational needs have settled work will commence with recruitment, payroll, IP&C, Health and safety and emergency planning.

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

Indicator	Target	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Performance
Month Sickness %	4%	5.87%	5.52%	5.46%	6.03%	6.10%	7.44%	6.36%	4.66%	4.71%	4.86%	4.71%	4.73%	
12 Mth Rolling Sickness %	4%	4.50%	4.56%	4.67%	4.85%	5.03%	5.34%	5.57%	5.60%	5.62%	5.63%	5.72%	5.74%	
Achievement Rate %	90%	77.86%	79.15%	78.57%	76.13%	75.22%	71.87%	71.27%	73.90%	75.24%	77.02%	78.03%	75.77%	
Labour Turnover Rate	10-14%	11.57%	11.51%	11.97%	12.60%	12.86%	13.43%	13.15%	13.56%	13.67%	13.79%	13.82%	13.88%	
Overall Training %	85%	89.02%	88.75%	88.38%	88.62%	89.22%	89.50%	89.55%	89.83%	90.10%	89.73%	89.15%	88.70%	
FTE Vacancy	N/A	340	378	381	373	392	356	352	340	292	252	141	183	
Vacancy Factor	<10%	5.46%	6.05%	6.10%	5.95%	6.23%	5.67%	5.62%	5.43%	4.69%	4.04%	2.26%	2.93%	
Monthly Agency Spend	£698K	£1,231	£1,373	£1,248	£1,025	£658	£1,468	£1,148	£1,335	£1,174	£1,023	£1,179	£1,173	
Nuring Staff Average % Day Fill Rate- Nurses		86%	89%	88%	87%	88%	88%	89%	96%	96%	94%	94%	96%	
Nuring Staff Average % Night Fill Rate- Nurses		81%	84%	81%	78%	79%	79%	80%	87%	88%	86%	86%	86%	
Safer Staffing- Overall CHPPD		7.56	7.78	7.93	7.64	7.61	7.56	7.59	7.6	7.55	7.48	7.59	7.53	

# 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.

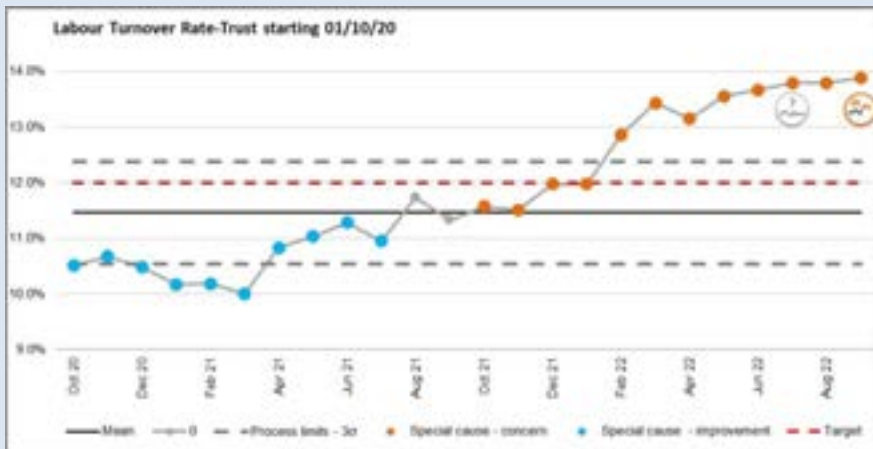
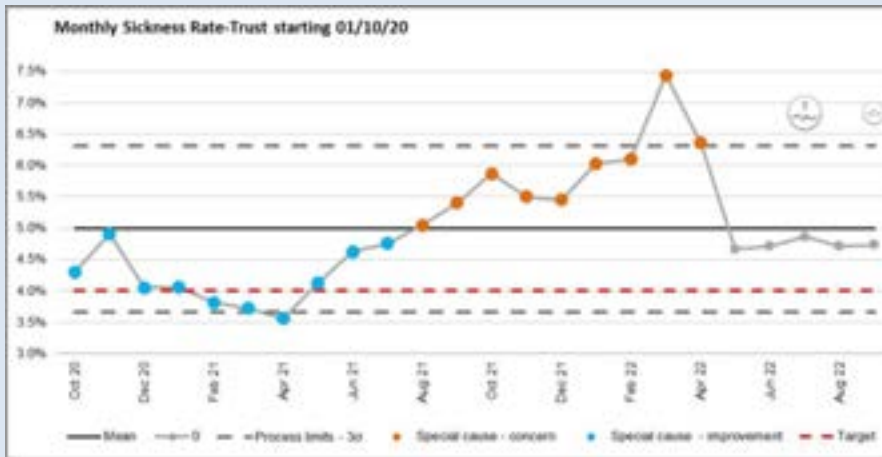
To help you interpret the data a number of rules can be applied.

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 4.73% but dropped from over 6% in April / AR has decreased slightly in Sep 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 Sep and does include retire and return / Overall Performance Report Month 6 of 6

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

## Multiple Level Training Breakdown

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Infection Control L1*	91.52%	91.18%	90.84%	90.58%	90.77%	91.28%	91.69%	91.45%	92.03%	92.14%	91.86%	91.52%
infection Control L2*	82.28%	82.77%	82.00%	81.64%	82.40%	82.41%	82.60%	82.11%	81.85%	81.53%	81.00%	80.02%
Moving & Handling L1*	90.43%	89.85%	90.11	89.52%	89.69%	90.22%	90.80%	90.24%	89.75%	88.50%	87.29%	86.21%
Moving & Handling L2*	68.37%	67.07%	67.93	68.73%	69.31%	69.50%	68.73%	68.47%	69.95%	69.80%	69.66%	68.25%
Safeguarding Adults L1	94.29%	93.85%	93.55%	94.36%	94.47%	94.71%	94.77%	95.14%	95.59%	95.48%	94.80%	94.36%
Safeguarding Adults L2	87.83%	87.68%	87.07%	87.67%	88.04%	88.56%	88.35%	87.86%	89.28%	88.71%	88.39%	88.22%
Safeguarding Adults L3	59.03%	61.76%	62.90%	58.21%	58.47%	57.58%	58.10%	61.56%	61.59%	62.03%	62.73%	56.02%
Safeguarding Adults L4	63.41%	59.09%	65.91%	62.22%	62.22%	65.12%	65.85%	64.29%	76.19%	72.09%	71.11%	66.67%
Safeguarding Adults L5	75.00%	75.00%	80.00%	80.00%	80.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Safeguarding Adults L6	77.78%	77.78%	77.78%	77.78%	77.78%	87.50%	87.50%	87.50%	87.50%	87.50%	100.00%	100.00%
Mental Capacity Act L1	81.22%	81.87%	83.13%	84.44%	85.35%	86.51%	87.58%	88.27%	89.28%	89.78%	89.51%	89.76%
Mental Capacity Act L2	76.76%	78.39%	79.06%	79.53%	80.52%	81.74%	81.88%	83.72%	84.87%	84.72%	84.19%	84.11%
Mental Capacity Act L3	48.74%	51.91%	54.86%	56.81%	58.42%	59.98%	61.15%	62.62%	64.32%	64.76%	65.70%	66.13%
Mental Capacity Act L4	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	80.00%	57.14%
Mental Capacity Act L5	0.00%	0.00%	33.33%	33.33%	33.33%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Mental Capacity Act L6	85.71%	85.71%	85.71%	85.71%	83.33%	83.33%	83.33%	71.43%	71.43%	83.33%	83.33%	83.33%
Safeguarding Children L1	90.98%	89.86%	89.56%	89.09%	89.38%	89.90%	90.21%	90.64%	91.24%	91.30%	90.36%	90.36%
Safeguarding Children L2	80.89%	80.87%	80.52%	80.58%	81.04%	81.38%	81.63%	82.44%	82.82%	82.48%	81.99%	82.04%
Safeguarding Children L3	73.00%	75.96%	73.60%	69.08%	69.12%	73.21%	72.86%	73.31%	72.57%	72.38%	71.60%	69.30%
ABLS L1	96.82%	96.69%	96.87%	98.18%	98.02%	98.17%	98.12%	98.41%	98.51%	98.46%	97.84%	97.59%
ABLS L2	72.87%	72.49%	70.95%	71.57%	70.17%	68.09%	68.80%	68.73%	68.22%	69.82%	70.10%	68.61%
AILS L3	63.49%	64.63%	64.85%	65.49%	61.22%	57.68%	54.58%	57.42%	61.25%	61.86%	56.08%	53.31%
AAALS L4	47.22%	46.85%	52.11%	60.36%	60.00%	63.25%	60.49%	65.13%	65.33%	68.49%	44.00%	62.03%
PBLS L2	68.37%	67.96%	66.32%	65.08%	64.38%	63.54%	62.77%	64.56%	65.96%	66.64%	66.40%	64.18%
PILS L3	55.22%	38.10%	39.42%	44.30%	47.20%	43.90%	42.74%	38.52%	35.52%	36.93%	38.55%	39.20%
PALS L4	41.54%	41.79%	37.88%	35.37%	49.23%	50.79%	50.00%	47.54%	49.18%	54.10%	53.97%	51.47%
NBLS L2	67.70%	74.38%	68.75%	71.67%	69.78%	65.41%	61.50%	69.66%	68.54%	77.01%	75.28%	68.68%
NBLS L3						61.29%	61.67%	60.66%	60.66%	61.29%	59.68%	51.67%



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

Nursing and Midwifery FTE in-post has increased by 96 FTE since September of last year and Medical and Dental has increased by 40 FTE over the same period.

Agency FTE has increased from last month by 14 FTE, although this has not been reflected in the costs for agency which has gone down compared to August.

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

NHSI Staff Group	2021/09	2021/10	2021/11	2021/12	2022/01	2022/02	2022/03	2022/4	2022/5	2022/6	2022/7	2022/8	2022/9	Change since Sep 2021	% Change
Allied Health Professionals	538.34	536.58	528.76	527.30	524.64	522.34	520.82	513.97	517.62	515.85	516.77	519.23	524.88	-13.46	-2.59%
Health Care Scientists	92.69	92.70	93.80	92.40	91.36	92.36	91.76	90.16	89.16	89.16	91.16	91.40	94.40	1.71	1.83%
Medical and Dental	561.16	561.56	554.68	553.85	552.38	551.50	559.04	576.93	571.32	569.67	580.27	595.86	600.97	39.81	7.15%
NHS Infrastructure Support	1122.71	1124.58	1133.69	1134.71	1137.89	1147.56	1149.02	1148.34	1146.50	1146.15	1155.06	1156.47	1163.54	40.83	3.63%
Other Scientific, Therapeutic and Technical Staff	345.03	346.02	346.89	342.63	342.09	342.02	346.93	351.10	356.26	347.88	349.63	343.54	349.97	4.94	1.42%
Qualified Ambulance Service Staff	10.53	10.53	10.53	10.53	10.53	9.53	10.53	10.45	10.45	10.25	11.25	11.25	11.25	0.72	6.94%
Registered Nursing, Midwifery and HV staff	1267.34	1266.85	1267.50	1271.48	1287.67	1293.75	1287.20	1306.43	1305.28	1317.37	1321.15	1340.29	1363.69	96.35	7.72%
Support to clinical staff	1904.65	1899.35	1914.09	1908.06	1899.40	1897.31	1912.84	1907.03	1929.11	1928.86	1952.94	1955.63	1975.21	70.56	3.72%
<b>Grand Total</b>	<b>5842.46</b>	<b>5838.17</b>	<b>5849.93</b>	<b>5840.95</b>	<b>5845.95</b>	<b>5856.38</b>	<b>5878.15</b>	<b>5912.46</b>	<b>5925.70</b>	<b>5925.20</b>	<b>5978.23</b>	<b>6013.67</b>	<b>6083.91</b>	<b>203.37</b>	<b>3.51%</b>

## Pay Report Summary for the last 12 months

	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUGUST	SEPTEMBER
Cost	£	£	£	£	£	£	£	£	£	£	£	£
Substantive	£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	£22,170,277	£23,160,550	£26,163,492
Bank	£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	£1,191,544	£1,367,791	£1,330,659
Agency	£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	£1,023,469	£1,180,278	£1,172,372
<b>Total Cost £</b>	<b>£24,549,512</b>	<b>£24,758,351</b>	<b>£24,418,728</b>	<b>£24,470,667</b>	<b>£24,591,276</b>	<b>£38,182,005</b>	<b>£26,273,318</b>	<b>£25,590,106</b>	<b>£24,404,153</b>	<b>£24,385,291</b>	<b>£25,708,620</b>	<b>£28,666,523</b>
WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	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	5,951.18	6,017.89	6,028.80
Bank	272.84	350.26	343.70	215.37	333.80	348.91	292.62	270.31	304.68	250.66	303.54	309.42
Agency	174.59	182.45	172.07	147.00	140.10	212.24	162.93	194.59	162.83	173.40	119.42	134.13
<b>Total WTE Worked</b>	<b>6,315.75</b>	<b>6,385.13</b>	<b>6,377.28</b>	<b>6,237.57</b>	<b>6,396.02</b>	<b>6,522.28</b>	<b>6,428.54</b>	<b>6,396.37</b>	<b>6,394.31</b>	<b>6,375.25</b>	<b>6,440.86</b>	<b>6,472.35</b>

# 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
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Medical And Dental	551.92	552.62	554.97	555.12	555.27	555.27	537.50	536.50	536.49	536.49	536.49	536.50
Nursing And Midwifery Registered	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	1,378.26	1,377.61	1,378.27
Support To Clinical Staff	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	1,953.27	1,955.49	1,955.74
Add Prof Scientific and Technic	231.12	231.12	232.12	232.12	246.63	246.63	242.72	242.72	235.22	233.62	233.62	233.62
Allied Health Professionals	722.78	722.31	723.48	723.68	723.68	723.68	738.55	742.55	736.98	744.35	744.35	743.96
Healthcare Scientists	104.19	103.91	104.90	104.90	104.90	104.90	105.64	105.64	105.64	105.64	105.64	105.64
Qualified Ambulance Service Staff	6.80	6.80	6.80	6.80	6.80	6.80	6.80	6.80	6.80	6.80	6.80	6.80
Administrative And Estates	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	1,271.09	1,280.59	1,283.41
<b>Total Staff Budgeted WTE</b>	<b>6,228.84</b>	<b>6,242.48</b>	<b>6,255.19</b>	<b>6,266.10</b>	<b>6,285.64</b>	<b>6,276.00</b>	<b>6,272.80</b>	<b>6,254.65</b>	<b>6,216.10</b>	<b>6,229.52</b>	<b>6,240.59</b>	<b>6,243.94</b>

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
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Medical And Dental	551.08	543.11	534.76	538.94	542.01	548.01	551.66	545.79	541.28	536.89	634.71	560.27
Nursing And Midwifery Registered	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	1,323.55	1,334.02	1,356.86
Support To Clinical Staff	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	1,966.05	1,974.62	1,974.51
Add Prof Scientific and Technic	227.20	213.43	226.79	227.66	227.99	224.92	228.01	225.38	225.05	229.23	228.31	228.92
Allied Health Professionals	679.91	676.09	671.37	672.78	665.14	665.32	654.49	651.07	653.05	653.60	654.95	661.89
Healthcare Scientists	97.69	99.30	97.80	96.36	96.36	96.77	94.77	94.17	92.49	95.16	96.16	99.40
Qualified Ambulance Service Staff	10.61	7.61	7.61	8.61	8.61	7.61	7.61	7.61	7.41	8.41	7.41	7.41
Administrative And Estates	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	1,164.97	1,169.55	1,171.92
<b>Total Staff Worked WTE</b>	<b>5,888.47</b>	<b>5,864.67</b>	<b>5,873.75</b>	<b>5,893.15</b>	<b>5,894.15</b>	<b>5,920.15</b>	<b>5,920.52</b>	<b>5,914.71</b>	<b>5,924.52</b>	<b>5,977.86</b>	<b>6,099.74</b>	<b>6,061.18</b>

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
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Medical And Dental	0.84	9.51	20.21	16.18	13.26	7.26	-14.16	-9.29	-4.79	-0.40	-98.22	-23.77
Nursing And Midwifery Registered	136.52	137.78	131.48	126.13	115.19	116.24	79.00	62.34	65.85	54.71	43.59	21.41
Support To Clinical Staff	99.48	115.43	118.03	121.33	138.62	119.83	31.32	19.79	14.51	-12.78	-19.13	-18.77
Add Prof Scientific and Technic	3.92	17.69	5.33	4.46	18.64	21.71	14.71	17.34	10.17	4.39	5.31	4.70
Allied Health Professionals	42.87	46.22	52.11	50.90	58.54	58.36	84.06	91.48	83.93	90.75	89.40	82.08
Healthcare Scientists	6.50	4.61	7.10	8.54	8.54	8.13	10.87	11.47	13.15	10.48	9.48	6.24
Qualified Ambulance Service Staff	-3.81	-0.81	-0.81	-1.81	-1.81	-0.81	-0.81	-0.81	-0.61	-1.61	-0.61	-0.61
Administrative And Estates	54.04	47.38	47.99	47.22	40.52	25.13	147.28	147.61	109.36	106.12	111.04	111.49
<b>Total Staff Worked WTE</b>	<b>340.37</b>	<b>377.81</b>	<b>381.45</b>	<b>372.95</b>	<b>391.50</b>	<b>355.85</b>	<b>352.28</b>	<b>339.94</b>	<b>291.58</b>	<b>251.66</b>	<b>140.85</b>	<b>182.77</b>

Vacancies: Vacancy data based on Finance Reporting from Unit 4 Agresso. Nursing and Midwifery vacancies have decreased from 43 WTE in August to 21 WTE in September and Allied Health Professional vacancies have increased from 89 WTE in August to 82 WTE in September. Admin and clerical vacancies has increased to 111 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

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

The table below shows the agency expenditure by staff Group monthly for the Financial Year 2021-22 and the rolling total for the 2022-23 Financial Year.

The September figure shows a very slight drop in agency cost compared to August 2022.

Torbay and South Devon NHS Foundation Trust	2021-22 Financial Year								2022-23 Financial Year						
Total Agency Spend	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021-22 Total	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	2022-23 Total
Registered Nurses	599	557	676	570	432	408	818	6336	546	709	669	443	414	468	3249
Scientific, Therapeutic and Technical	112	162	140	144	147	130	67	1418	93	138	53	113	95	47	539
of which Allied Health Professionals	47	65	70	80	88	86	23	721	52	75	7	69	59	14	262
of which Other Scientific, Therapeutic and Technical Staff	65	96	70	64	59	44	44	696	41	63	46	44	36	33	230
Support to clinical staff (HCA)	2	15	19	13	35	31	24	124	32	40	27	18	19	14	136
Total Non-Medical - Clinical Staff Agency	713	734	835	727	614	569	909	7878	671	887	749	574	528	529	3409
Medical and Dental Agency	317	322	390	378	265	-63	370	3621	321	202	331	328	455	494	2131
Consultants	171	212	278	245	167	11	250	2554	230	124	204	200	261	291	1310
Trainee Grades	146	110	112	133	98	-74	120	1067	91	326	127	128	194	203	1069
Non Medical - Non-Clinical Staff Agency	162	174	148	143	146	152	189	1748	156	122	94	121	196	150	839
Total Pay Bill Agency and Contract	1192	1231	1373	1248	1025	658	1468	13248	1148	1335	1174	1023	1179	1173	5859

# 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	1523	0	0	1725	1751	1380	1173	0	0	1035	1271	733	88.3%	0.0%	101.5%	85.0%	0.0%	122.8%
Allerton	2833	2043	0	0	1035	1354	1380	1047	0	0	1035	1103	866	72.1%	0.0%	130.8%	75.8%	0.0%	106.5%
Cheetham Hill	1380	1597	345	0	2070	2206	1035	840	345	0	1380	1840	836	115.7%	0.0%	106.6%	81.1%	0.0%	133.3%
Coronary Care	1380	1416	0	0	0	150	1035	1024	0	0	0	35	378	102.6%	0.0%	0.0%	98.9%	0.0%	0.0%
Cromie	1633	1450	0	0	863	1134	1035	1035	0	0	690	1035	749	88.8%	0.0%	131.4%	100.0%	0.0%	150.0%
Dunlop	1380	1311	0	0	1208	1172	1035	943	0	0	1035	1055	710	95.0%	0.0%	97.0%	91.1%	0.0%	101.9%
Forrest	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%
EAU4	1725	1519	0	0	1380	1594	1725	1449	0	0	1380	1241	759	88.0%	0.0%	115.5%	84.0%	0.0%	89.9%
Ella Rowcroft	1035	1090	0	0	1380	1295	989	828	0	0	690	702	434	105.3%	0.0%	93.9%	83.7%	0.0%	101.7%
Warrington	1035	1176	0	0	690	859	690	702	0	0	690	840	504	113.6%	0.0%	124.5%	101.7%	0.0%	121.7%
George Earle	1380	1511	345	0	2070	1739	1035	821	0	0	1380	1576	785	109.5%	0.0%	84.0%	79.3%	0.0%	114.2%
ICU	3450	2483	0	0	0	315	3105	2103	0	0	0	69	163	72.0%	0.0%	0.0%	67.7%	0.0%	0.0%
McCullum	690	1042	0	0	1035	1064	690	702	0	0	1035	917	506	150.9%	0.0%	102.8%	101.7%	0.0%	88.6%
Louisa Cary	2070	1722	0	0	690	762	2070	1454	0	0	690	738	395	83.2%	0.0%	110.4%	70.2%	0.0%	106.9%
John Macpherson	1035	932	0	0	541	637	690	713	0	0	690	638	399	90.0%	0.0%	117.9%	103.3%	0.0%	92.4%
Midgley	1725	2101	0	0	1725	1548	1725	1369	0	0	1380	1219	848	121.8%	0.0%	89.7%	79.3%	0.0%	88.3%
SCBU	1035	800	0	0	345	101	1035	761	0	0	345	196	165	77.2%	0.0%	29.3%	73.5%	0.0%	56.7%
Simpson	1380	1595	345	0	2047	2195	1035	950	0	0	1380	1897	831	115.6%	0.0%	107.2%	91.7%	0.0%	137.5%
Turner	1035	1621	0	0	1725	1569	690	725	0	0	1380	1047	534	156.6%	0.0%	90.9%	105.0%	0.0%	75.8%
COVID-19 Ward	1725	1646	0	0	1380	1796	1380	1461	0	0	1380	1357	707	95.4%	0.0%	130.1%	105.9%	0.0%	98.4%
<b>Total (Acute)</b>	<b>29651</b>	<b>28574.62</b>	<b>1035</b>	<b>0</b>	<b>21907.5</b>	<b>23237.52</b>	<b>23759</b>	<b>20095</b>	<b>345</b>	<b>0</b>	<b>17595</b>	<b>18771.75</b>	<b>11302</b>	<b>96.4%</b>	<b>0.0%</b>	<b>106.1%</b>	<b>84.6%</b>	<b>0.0%</b>	<b>106.7%</b>
Brixham	840	871.5	420	0	1260	1392.5	990	836	0	0	660	682.5	590	103.8%	0.0%	110.5%	84.4%	0.0%	103.4%
Dawlish	840	967	0	0	1050	769.5	720	748	0	0	660	665	474	115.1%	0.0%	73.3%	103.9%	0.0%	100.8%
NA - Teign Ward	1890	1455.25	0	0	1890	1636.25	990	974.25	0	0	990	968	892	77.0%	0.0%	86.6%	98.4%	0.0%	97.8%
NA - Templar Ward	1680	1735	0	0	2128	1894.3	990	1084	0	0	1080	925.5	895	103.3%	0.0%	89.0%	109.5%	0.0%	85.7%
Totnes	840	830.5	0	0	1260	1139.25	720	665	0	0	660	653	533	98.9%	0.0%	90.4%	92.4%	0.0%	98.9%
<b>Organisational Summary</b>	<b>34016</b>	<b>32788</b>	<b>1455</b>	<b>0</b>	<b>28116</b>	<b>28273</b>	<b>26789</b>	<b>22941</b>	<b>345</b>	<b>0</b>	<b>20265</b>	<b>21309</b>	<b>13979</b>	<b>96.4%</b>	<b>0.0%</b>	<b>100.6%</b>	<b>85.6%</b>	<b>0.0%</b>	<b>105.1%</b>

- The Registered Nurse (RN) average fill rate for day has increased in September 22 to 98.5% from an August position of 94.4%, and the night fill rate has increased to 90.1% from an August fill rate of 86.5%.
- The Health Care Support Worker (HCSW) average fill rate for day was 116.5% in September and night was recorded as 108.7% which is an improving position for both days and nights, and continues to be in line with the safer staffing establishment.
- Some specialist areas such as Paediatrics and ITU continue to report a less than 80% fill rate but this was reflective of their patient acuity during the month of September.
- Midgely ward reported less than 80% fill rate for RN's on night duty but this area was supported by other areas during periods of staff absence to ensure safe levels of nurse staffing were maintained.

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

## CHPPD Monthly Summary

Ward	Planned Total CHPPD	Planned RN / RM CHPPD	Planned NA CHPPD	Planned HCA / MCA CHPPD	Actual Mean Monthly Total CHPPD	Actual Mean Monthly RN / RM CHPPD	Actual Mean Monthly NA CHPPD	Actual Mean Monthly HCA / MCA CHPPD	Total CHPPD days not met in month	RN / RM CHPPD days not met in month	NA CHPPD days not met in month	HCA/MCA CHPPD days not met in month	Total CHPPD % days not met in month	RN / RM CHPPD % days not met in month	NA CHPPD % days not met in month	HCA/MCA CHPPD % days not met in month	Carter Median CHPPD All (September 2016)	Carter Median CHPPD RN (September 2016)	Carter Median CHPPD NA (September 2016)	Carter Median CHPPD HCA (September 2016)
Ainslie	7.52	3.98	0.00	3.54	7.80	3.70	0.00	4.10	11	18	0	4	36.7%	60.0%	0.0%	13.3%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	6.40	3.60	0.00	2.80	30	30	0	2	100.0%	100.0%	0.0%	6.7%	7.74	4.74	0	2.91
Cheetham Hill	7.39	2.88	0.41	4.11	7.80	2.90	0.00	4.80	8	10	30	2	10.0%	23.3%	100.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.90	6.50	0.00	0.50	2	3	0	0	6.7%	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	2	19	0	1	6.7%	63.3%	0.0%	3.3%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.30	3.20	0.00	3.10	14	18	0	6	46.7%	60.0%	0.0%	20.0%	7.74	4.74	0	2.91
EAU4	8.63	4.79	0.00	3.83	7.60	3.90	0.00	3.70	28	30	0	17	93.3%	100.0%	0.0%	56.7%	7.74	4.74	0	2.91
Ella Rowcroft	6.57	3.29	0.00	3.29	9.00	4.40	0.00	4.60	2	4	0	2	6.7%	13.3%	0.0%	6.7%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	7.10	3.70	0.00	3.40	1	1	0	2	3.3%	3.3%	0.0%	6.7%	7.74	4.74	0	2.91
George Earle	7.39	2.88	0.41	4.11	7.20	3.00	0.00	4.20	15	13	30	10	50.0%	43.3%	100.0%	33.3%	7.74	4.74	0	2.91
ICU	24.28	24.28	0.00	0.00	30.50	28.10	0.00	2.40	2	5	0	0	6.7%	16.7%	0.0%	0.0%	7.74	4.74	0	2.91
McCullum	6.76	2.71	0.00	4.06	7.40	3.40	0.00	3.90	8	1	0	14	26.7%	3.3%	0.0%	46.7%	7.74	4.74	0	2.91
Louisa Cary	9.68	7.26	0.00	2.42	11.80	8.00	0.00	3.80	5	10	0	0	0.0%	33.3%	0.0%	0.0%	7.74	4.74	0	2.91
John Macpherson	5.18	2.88	0.00	2.30	7.30	4.10	0.00	3.20	1	0	0	2	3.3%	0.0%	0.0%	6.7%	7.74	4.74	0	2.91
Midgley	7.53	3.97	0.00	3.57	7.40	4.10	0.00	3.30	18	12	0	22	60.0%	40.0%	0.0%	73.3%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	11.30	9.50	0.00	1.80	3	2	0	15	10.0%	6.7%	0.0%	50.0%	7.74	4.74	0	2.91
Simpson	7.19	2.88	0.41	3.90	8.00	3.10	0.00	4.90	3	7	30	0	10.0%	23.3%	100.0%	0.0%	7.74	4.74	0	2.91
Turner	8.94	3.19	0.00	5.75	9.30	4.40	0.00	4.90	7	0	0	24	23.3%	0.0%	0.0%	80.0%	7.74	4.74	0	2.91
COVID-19 Ward	7.52	3.98	0.00	3.54	8.90	4.40	0.00	4.50	3	9	0	2	10.0%	30.0%	0.0%	6.7%	7.74	4.74	0	2.91
Brixham	6.95	3.05	0.70	3.20	6.40	2.90	0.00	3.50	22	14	30	7	73.3%	46.7%	100.0%	23.3%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	6.60	3.60	0.00	3.00	20	6	0	27	66.7%	20.0%	0.0%	90.0%	7.74	4.74	0	2.91
NA - Teign Ward	6.40	3.20	0.00	3.20	5.60	2.70	0.00	2.90	29	29	0	26	96.7%	96.7%	0.0%	86.7%	7.74	4.74	0	2.91
NA - Templar Ward	6.50	2.97	0.00	3.53	6.30	3.10	0.00	3.20	17	5	0	22	56.7%	16.7%	0.0%	73.3%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	6.20	2.80	0.00	3.40	19	17	0	23	63.3%	56.7%	0.0%	76.7%	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
	7.02	3.85	0.11	3.06	7.53	3.99	0.00	3.55
Total Planned Beds / Day	527							
Days in month	30							

- The RN actual CHPPD has seen an improvement from 3.66 in August 22 to 4.01 in September 22, which although an improved position remains below the Carter recommendation of 4.7.
- The actual HCA CHPPD is reported at 3.58 which is above the Carter recommendation of 2.91 and the planned CHPPD of 2.94. This is due to the increased need for additional HCSW's to provide 1:1 care for patients with complex needs.
- During September 22 the operational position deteriorated, with 25 days declared at OPEL 4 and 5 days declared at OPEL 3.
- The total planned CHPPD was recorded as 6.74 and the actual CHPPD was reported as 7.59, an increase from August actual of 7.22. This reflects the ongoing use of escalation areas during times of peak capacity.

### Summary from TSDFT Head of Strategic Delivery - Adult Social Care (Torbay)

A transitional supported living service in Torquay is now completed and operational from the end of this month and referrals will be via the Torbay Supported Living Framework. The service is for adults with long-term or enduring mental illness, who have an assessed need for structured and pastoral recovery-oriented support with regaining independence and activities of daily living. The building itself comprises of 10 x 1-bed self-contained flats with 24hr support on site.

Improvement in the Social Care and Finance and Benefits online tools offering progresses well. The implementation will support the Torbay population and staff in preparing for their full social care assessments which is a benefit of the work being undertaken as part of social care charging reform and care accounts. Teams across social care, IT, and the voluntary sector are coming together to delivery better efficiencies and improved access to information.

As we approach winter our teams in the community and adult social care are implementing their Winter Plans. We will improve our demand and capacity monitoring by implementing our Adult Social Care Geomapping Tool which has been primarily developed to support planning for domiciliary care in the Bay but also provides valuable information if Torbay is faced with severe weather as we have done in the past ensuring we can continue to provide support to at home clients.

Partnership and collaborative meetings are being designed alongside Providers in adult social care. This is particularly important as we support each other to ensure care can be provided for clients at home. Providers in our markets have struggled with recruitment of staff, an issue faced nationally and here in Torbay, and the collaborative meetings provide a space to understand concerns and work on improvements together for better outcomes.

Managing Discharge to Access (D2A) efficiently and effectively is essential for alleviating pressure on our short term services and ensuring patient safety. Our Pathway 1 Rapid Project focuses on improving processes within the 4 week health funding window after hospital discharge ensuring social care assessments are completed on time, finance and benefits assessments are also within the window and care packages are right-sized and support enabling and strength-based approaches.

## Community and Social Care Indicators

Key					
<span style="color: green;">↑</span> = Performance improved from previous month <span style="color: red;">↓</span> = Performance deteriorated from previous month <span style="color: black;">↔</span> = No change					
<b>Not achieved</b>	<b>Under-achieved</b>	<b>Achieved</b>	<b>No target set</b>	<b>Data not available</b>	

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		↓
Urgent Community Response 2 to 48 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		↓

## Social Care and Public Health performance metrics - Torbay

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

**Social Care Services:** The table below 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	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Year to date 2022/23
<b>SOCIAL CARE SERVICES</b>																
% clients receiving self directed support - Torbay			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% clients receiving direct payments - Torbay			19.0%	19.4%	19.4%	19.6%	19.4%	19.6%	19.8%	19.5%	19.4%	19.6%	19.7%	20.0%	20.4%	20.4%
% carers receiving self directed support - Torbay			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% Adults with learning disabilities in employment - Torbay	7.2%		7.1%	6.8%	7.0%	6.8%	6.7%	6.6%	7.1%	7.3%	7.3%	7.3%	7.5%	7.5%	7.6%	7.6%
% Adults with learning disabilities in settled accommodation - Torbay			80.6%	80.6%	81.5%	81.6%	81.6%	81.8%	81.1%	81.3%	81.2%	80.3%	79.7%	79.7%	79.6%	79.6%
Permanent admissions (18-64) to care homes per 100k population - Torbay			17.7	17.7	20.4	23.1	25.8	19.0	21.7	24.5	29.9	35.3	28.5	40.8	32.6	32.6
Permanent admissions (65+) to care homes per 100k population - Torbay			449.6	422.7	411.9	376.9	487.3	476.5	570.8	576.2	823.8	880.4	928.8	939.6	931.5	931.5
% reablement episodes not followed by long term SC support - Torbay			87.4%	87.9%	87.9%	87.7%	88.0%	87.8%	88.9%	84.5%	86.8%	89.6%	89.5%	85.4%	85.2%	85.2%

**Public Health Torbay :** The COVID-19 response for patient facing services have had to manage with reduced capacity with only essential services maintained. Teams are making assessments of their recovery plans risks and actions that will be needed to see a return to the capacity needed to meet ongoing demand.

Measure	Target 2022/2023	13 month trend	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Year to date 2022/23
<b>PUBLIC HEALTH SERVICES</b>																
% of face to face new birth visits within 14 days *	95.0%		72.9%	83.8%	82.1%	80.2%	78.8%	84.4%	70.3%	74.7%	78.0%	80.8%	81.4%	72.4%	81.9%	78.0%
Opiate users - % successful completions of treatment (Quarterly) **	Var		5.2%									6.5%			6.8%	6.8%



# Community Services

The table below demonstrates performance against community based services. The nursing activity face to face increase in April 2022 is due to inclusion of South Devon data. The number of intermediate care placements has seen a reduction in the last two months and the average length of stay for an intermediate care placement has increased from 23.9 days in August 2021 to 33.9 days in September 2022.

Corporate Objective	Measure	Target 2022/2023	13 month trend	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Year to date 2022/23
<b>COMMUNITY BASED SERVICES</b>																	
	Nursing activity (F2F)			7,630	7,436	7,187	7,161	6,608	6,411	7,038	11,860	12,600	12,227	13,039	13,806	13,194	76,726
	No. intermediate care urgent referrals			258	222	257	219	195	215	212	190	210	230	205	215	189	1,297
	No. intermediate care placements			31	35	31	47	58	35	40	49	48	46	51	47	32	275
	Intermediate Care - placement average LoS			29.4	23.6	26.1	28.8	32.9	40.7	35.4	31.0	35.5	36.8	32.0	32.8	33.9	33.5

## Community Quality Dashboard

It is noted that the nutritional risk assessment dipped in August and improved in September, there are no significant areas of risk being escalated from the community Quality Dashboard.

Measure	Target 2022/2023	13 month trend	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Year to date 2022/23
<b>QUALITY MEASURES</b>																
No. avoidable grade 3/4 p.u.s within collaborative project *	10		0	0	1	0	0	0	1	0	0	0	0	0		0
% Nutritional risk assessments completed	98.0%		91.7%	82.0%	97.4%	96.9%	95.3%	95.7%	95.5%	95.4%	92.9%	100.0%	98.4%	92.9%	97.0%	96.5%
Community hospital QuESTT - no. red rated teams	0		1	0	0	0	0	0	0	0	0	0	0	0	0	0
Community team QuESTT - no. red rated teams	0		0	1	0	1	2	1	0	0	0	0	1	0	0	0
Friends and Family Test - % Recommendation - C Hospital *	96.2%		97.1%	96.3%	95.0%	100.0%	100.0%	91.4%	94.2%	96.1%	96.2%	92.2%	100.0%	96.8%		95.8%
Friends and Family Test - % Recommendation - MIU *	98.2%		100.0%	-	100.0%	-	-	-	-	0.0%	-	-	-	50.0%		33.3%
No. Clostridium Difficile (C.Diff) HCAIs	9		3	3	4	5	6	6	6	0	1	1	3	4		4
DOLS (Domestic) - Open applications at snapshot			546	604	590	628	644	623	645	671	664	705	700	714	737	737

Corporate Objective Key
Safe, Quality Care and Best Experience
Improved wellbeing through partnership
Well led

**NOTES**  
 \* usually reported 1 month in arrears  
 \*\* usually reported quarterly & 1 quarter in arrears

# Community Services

## Community Hospital Dashboard - Summary of Key Measures - September-22

	Act. 21/22 Outturn	Jul-22	Aug-22	Sep-22	Total
<i>Admissions / Discharges</i>					
Total Admissions (General)	2,499	202	193	167	1,169
Direct Admissions (General)	152	9	8	8	43
Transfer Admissions (General)	2,347	193	185	159	1,132
Stroke Admissions	233	6	5	8	61
Transfers from CH to DGH	257	18	14	12	91
<i>Beds</i>					
Bed Occupancy <sup>1</sup>	97.2%	97.8%	99.1%	99.0%	98.4%
Bed Days Lost to Bed Closure	383	0	0	0	0
<i>Length of Stay</i>					
Delayed Discharges		35	30	60	171
Average Length of Stay - Overall (General)	13.6	15.1	15.5	15.7	16.2
Average Length of Stay - Direct Admissions	12.4	11.5	9.8	14.3	13.2
Average Length of Stay - Transfer Admissions	13.7	15.2	15.7	15.8	16.3
Average Length of Stay - Stroke	20.9	18.8	19.7	23.7	18.1
Long LoS (>30 days)	229	14	19	23	111
<i>MIUs</i>					
Total MIU Activity	34,911	3,557	3,847	3,267	19,626
New MIU Attendances	31,634	3,236	3,574	2,949	17,896
All Follow Up Attendances	3,277	321	273	318	1,730
Planned Follow Up Attendances	2,403	202	170	213	1,126
Unplanned Follow Up Attendances	874	119	103	105	604
MIU Four Hour Breaches	55	118	230	75	676
Average Waiting Time (Mins) - 95th Pctile	77	97	104	101	104

### Operational update:

Community hospital bed occupancy remains high at 99%.

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

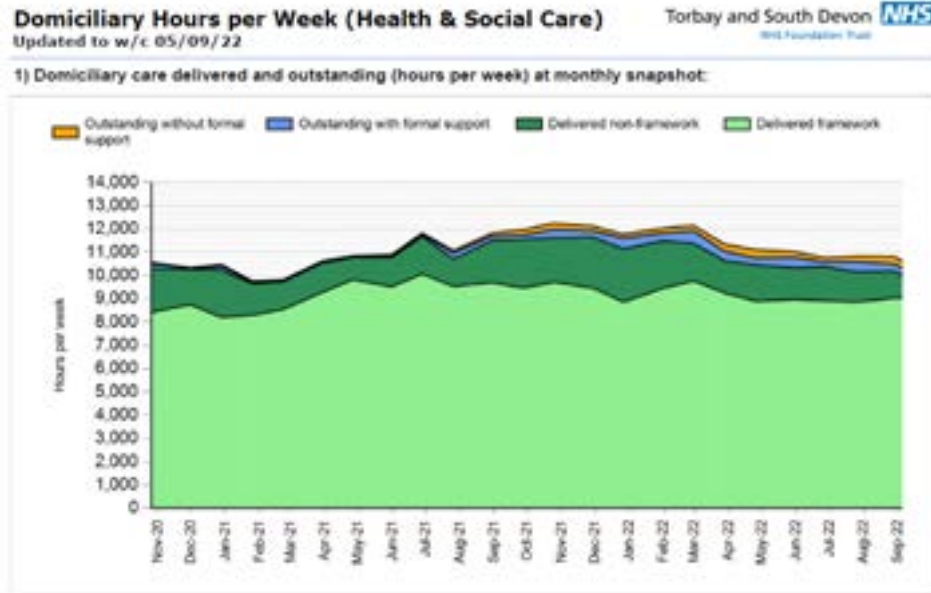
The average length of stay was 15.7 days compared to 13.6 days average in 2021/22.

New MIU attendance decreased to 2,949 with 75 4-hour breaches and an average waiting time of 101 minutes.

# Community Services – hospital discharge and onward care

As a provider of Health and Social Care, The Trust 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**

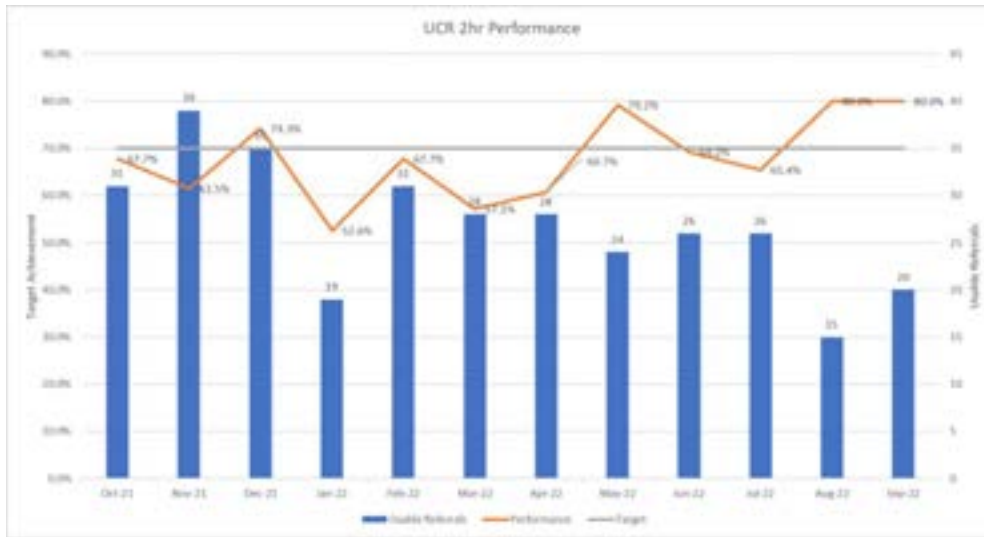


Chart 1 – ‘Hours of care given’ shows the latest data available for total commissioned domiciliary hours by week for Torbay. The amount of care provided is seen along with the outstanding demand; the outstanding hours ‘without formal support’ are of highest concern. Data to week commencing 5 September 2022 recorded 298 hours outstanding without formal support; a decrease from the previous month and a high of 362 in April 2022.

Chart 2- “Unmet packages of care” shows the number of unmet packages of care for South Devon (orange) and Torbay (Green) and where provided by diverting other NHS community provision (Blue). 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.

# Community Services – Urgent Community Response



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 (ICs) 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 Integrated Service Units, 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 September 2-hour target was achieved at 80%; a total of 20 2-hour target referrals were received.

138 referrals were received for a response within 2-48 hours and 91.3% were seen within the target time.

# Community Services – hospital discharge and onward care

ICO - No Criteria to Reside - patient daily average (weekday)



## Criteria To Reside

The Trust records a patient’s Criteria to Reside daily. The graph opposite reflects the ICO bed base, acute and community hospital beds.

The average number of patients with no criteria to reside has increased in September, but remains lower than the peak seen in January.

## Hospital discharge

The ‘Giving patients back their time’ campaign has been running in the Trust to highlight the importance of transferring or discharging a patient to their next destination in a timely and well planned way once a patient no longer needs hospital care.

Importantly the focus is to improve flow with a focus on earlier in the day discharges and maintaining discharge levels over the weekends.

## DISCHARGE DASHBOARD | COMPARISONS



Thursday 1 September 2022 - Friday 30 September 2022

The number of discharges in this period is above or below the baseline  
 Weekday target is 71%. Weekend target is 20%.  
 Pre-Noon target is 33%. Pre-5pm target is 75%.

(Baseline: Tuesday 2 August 2022 - Wednesday 31 August 2022)

Ward Name	Total	Discharges	Transfers to a Community Hospital	Transfers to the Discharge Lounge	Deaths	Pathway 0	Pathway 1	Pathway 2	Pathway 3	Average LoS (Days)	% Pre Noon	% Pre 5pm	% Weekday	% Weekend				
ANSLIE	88	81	4	20	3	0	0	0	0	8.58	14	15.9%	47	53.4%	13	14.8%		
ALLERTON	110	84	8	14	8	0	0	0	0	8.56	14	12.7%	64	58.2%	23	20.9%		
CHEETHAM HILL	83	56	5	16	7	0	0	0	0	8.38	17	25.9%	51	61.4%	11	13.3%		
CROME	136	108	10	15	3	0	0	0	0	6.54	18	13.2%	78	58.1%	32	23.5%		
DUNLOP	82	48	3	7	4	0	0	0	0	10.74	8	9.8%	44	53.7%	11	13.4%		
ELLA ROWNCROFT	162	92	8	3	1	0	0	0	0	5.97	19	18.8%	70	68.8%	13	12.7%		
EMERGENCY ADMISSION UNIT 4	93	89	2	16	8	0	0	0	0	7.45	19	20.4%	48	51.8%	14	15.1%		
FORREST	85	53	8	28	8	0	0	0	0	5.19	22	23.2%	66	68.5%	19	20.8%		
GEORGE EARLE	154	89	14	18	11	0	0	0	0	6.94	15	14.4%	51	49.0%	18	17.3%		
MCCALLUM	48	30	4	12	2	0	0	0	0	11.34	15	31.3%	25	52.1%	4	8.3%		
MIDDLEY	137	86	7	47	17	0	0	0	0	6.17	38	27.7%	87	79.8%	10	7.3%		
SIMPSON	68	39	8	26	3	0	0	0	0	12.82	16	23.5%	41	60.3%	7	10.3%		
TORBAY CHEST PAIN UNIT	38	37	0	1	0	0	0	0	0	4.72	2	5.3%	29	76.3%	8	21.1%		
TORBAY CORONARY CARE BEDS	32	31	0	0	1	0	0	0	0		3	9.4%	18	56.3%	8	28.1%		
TURNER	63	56	1	8	8	0	0	0	0		5	7.8%	29	46.0%	16	25.4%		
WARRINGTON	106	79	8	18	3	0	0	0	0	4.98	25	23.6%	77	72.6%	23	21.7%		
Grand Total	1,385	998	82	227	78	0	0	0	0	7.31	250	18.1%	836	80.4%	1154	83.3%	231	16.7%

Dashboard created and maintained by Torbay and South Devon NHS FT Performance Team

September discharge data shows:

- 18% of discharges took place before 12noon;
- 60.4% of discharges took place before 5pm;
- Average weekdays discharges from main wards = 52 per day / Average weekend discharges = 28 per day.

The Trust has a Complex Discharge Pathway Improvement Plan to support operational bed capacity and flow.

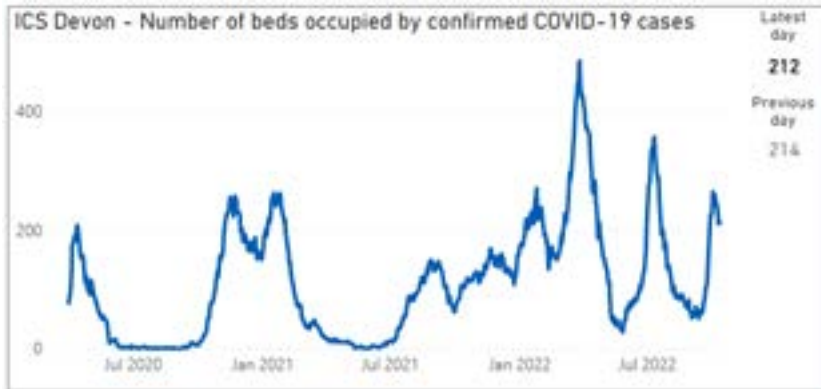
# Operational Performance Indicators

Key										
<span style="color: green;">↑</span> = Performance improved from previous month <span style="color: red;">↓</span> = performance deteriorated from previous month                   ↔ = no change										
	Not achieved		Under-achieved		Achieved		No target set		Data not available	NHSI Indicator

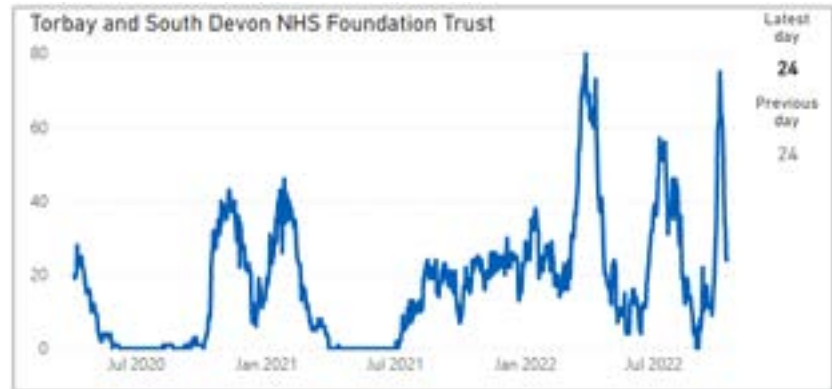
A&E - patients seen within 4 hours (NHSI)		↑	On the day cancellations for elective operations		↑
Referral to treatment - % Incomplete pathways <18 wks (NHSI)		↓	Cancelled patients not treated within 28 days of cancellation		↑
Cancer - 62-day wait for first treatment - 2ww referral (NHSI)		↑	Virtual Outpatient (Non-face-to-face) appointments		↓
Diagnostic tests longer than the 6 week standard (NHSI)		↓	Bed Occupancy (Acute)		↓
Dementia Find (NHSI)		↑	No Criteria to Reside - daily average - weekday (ICO)		↓
Number of Clostridium Difficile cases reported		↑	Number of patients >7 days LoS (daily average)		↓
Cancer - Two week wait from referral to date 1st seen		↑	Number of extended stay patients >21 days (daily average)		↓
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients		↑	Ambulance handover delays > 30 minutes		↑
Cancer – 28 day faster diagnosis standard		↓	Ambulance handover delays > 60 minutes		↑
Cancer - 31-day wait from decision to treat to first treatment		↓	A&E - patients with >12 hour visit time pathway		↑
Cancer - 31-day wait for second or subsequent treatment - Drug		↓	A+E Trolley waits > 12 hours from decision to admit		↓
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy		↓	Care Planning Summaries % completed within 24 hours of discharge – Weekend		
Cancer - 31-day wait for second or subsequent treatment – Surgery		↑	Care Planning Summaries % completed within 24 hours of discharge – Weekday		
Cancer – 62-day wait for first treatment – screening		↑	Clinic letters timeliness - % specialties within 4 working days		
Cancer - Patient waiting longer than 104 days from 2 week wait		↑			
RTT 52-week wait incomplete pathway		↑			
RTT 78-week wait incomplete pathway		↓			
RTT 104-week wait incomplete pathway (Tier 1)		↑			

# Covid - 19 - Hospitalisations

## Devon ICS (as at 13 October 2022)



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



The level of Covid-19 hospitalisations increased in September along with the levels of staff sickness relating to Covid-19 so increasing the operational challenges of finding beds for all admissions and maintaining core workforce numbers. Numbers have since reduced in October however in line with modelling from commissioning colleagues there remains a high risk of further increases in covid and seasonal flu this winter that will impact on staff sickness rates, increased admissions and hospital care IPC.

Staff Covid and seasonal Flu vaccination programme is in place and will help to mitigate the impacts on staff sickness levels and wider community vaccination of high risk groups will also mitigate community levels of infection and requirements for acute hospital care.

### Care Homes Reporting COVID-19 Cases Amongst Residents

Local Authority	Current	Previous	Change
Devon County Council	40	41	-1
Plymouth City Council	9	9	0
Torbay Council	6	7	-1
<b>Total</b>	<b>55</b>	<b>57</b>	<b>-2</b>

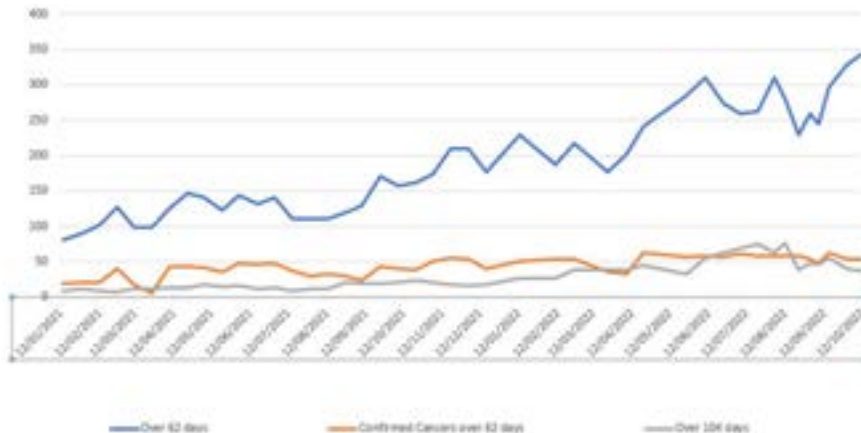
## Tier 1 – Programme of formal support – NHS England

The Trust has been placed in Tier 1 performance support, meaning the highest levels of oversight requiring weekly meetings with regulators with detailed performance monitoring and assurance on recovery plans.

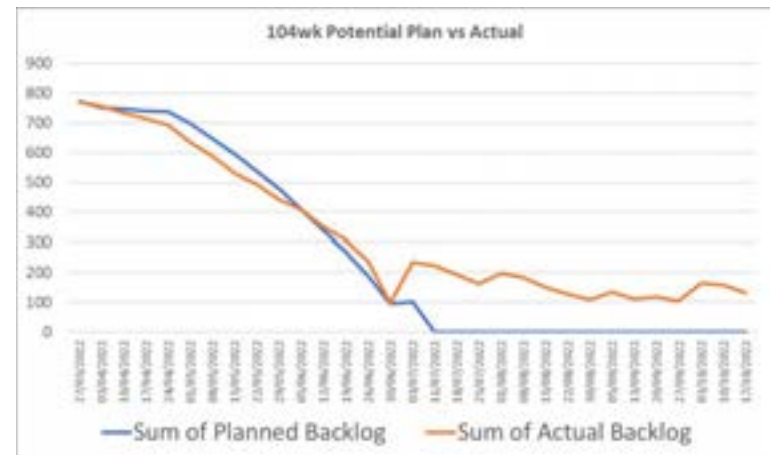
The focus is on reducing the Referral to Treatment waiting times to be in line with minimum national expectations, to have no patients waiting over 78 weeks by 31<sup>st</sup> March 2023 and bringing the backlog of cancer treatments waiting over 62 days from urgent referral, back down to February 2020 levels.

Weekly meetings take place with NHS England and the TSDFT Chief Operating Officer and Head of Planned Care System Director to discuss progress against action plans, challenges, and risks.

### Cancer 62+ backlog:



### RTT 104 week backlog:

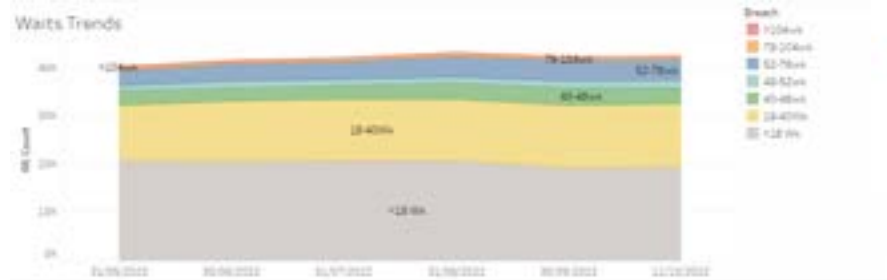


Progress is being made on treating of the longest waiting patients who are already waiting for surgery (admitted pathways). There are patients, however, in the non-admitted RTT lists waiting for new outpatient appointments or decisions at follow up appointment that need to be seen. At the end of September there were 3773 patients waiting longer than 52 weeks on non-admitted pathways and of these 2800 patients are waiting for their first outpatient appointment.



# NHSI Performance – Referral to Treatment (RTT)

## Month Trend - RTT breakdown by long wait band (pre-final validation)



Reporting Date	Total Wait	18wks Break	40wks Break	52wks Break	78wks Break	104wks Break	112wks %	128wks %
21/05/2022	42,272	22,397	9,907	6,002	5,222	782	54.4%	64.4%
18/06/2022	42,149	22,397	12,142	6,977	5,362	812	54.2%	64.8%
15/07/2022	41,222	22,234	9,794	6,278	5,042	794	47.6%	62.4%
12/08/2022	41,985	21,537	9,857	5,794	4,513	582	48.7%	62.3%
09/09/2022	41,392	21,277	8,649	5,953	4,929	776	49.2%	62.9%
06/10/2022	42,094	22,622	9,862	6,939	5,994	842	51.2%	69.2%

## Referral to Treatment



**Referral to Treatment:** The total number of incomplete pathways reduced for the first time in September by 871 to 42,149.

**52, 78, and 104 week waits:** At the end of September 5,060 people will be reported as waiting over 52-weeks this being an increase from 3,765 in May. For over 78 weeks numbers increased slightly to 813 (after validation) from 794 in August. 104 weeks waits have continued to decrease to 50 from 169 in May.

**Recovery planning:** Elective capacity across day case and inpatient elective admissions has been maintained and in September exceeded pre-covid levels for elective inpatient treatments. As we approach winter there will be increasing challenge to maintain protected elective beds.

Trauma and Orthopaedics continue to use lists at the re-commissioned Nightingale Hospital Exeter with two all-day lists per month. In addition a model of providing additional sessions at weekends, 'Glanso', has been trialed and set to be rolled out. This additional capacity is funded through the Elective Recovery Fund schemes and supports the funding of a number of different mechanisms including third party contractors as well as in-house additional sessions. Through mutual aid we are also engaging with the wider Integrated Care System (ICS) to outsource certain urology and colonoscopy diagnostic tests.

Key to the delivery of additional capacity is the optimising of outpatient productivity through adoption of best practice and non face-to-face appointments. Performance for delivery of non face-to-face activity is below national expectations and performance of local peers. Transformation programme support is in place to drive these improvements.

**The Trust and the wider ICS is in the highest tier of performance oversight with NHSE being Tier 1. This entails weekly executive level meetings with NHSE to update progress on plans to meet the national targets.**

**Management action:** Led by the system Director for Planned Care plans are monitored through the Cancer / RTT Performance Risk and Assurance meeting, with any outstanding risk escalated to the monthly Integrated Governance Group (IGG).

## Over 78-week waits at 17/10/22

Specialty	Grand Total
BREAST SURGERY	1
CARDIOLOGY	3
CLINICAL NEUROPHYSIOLOGY	2
COLORECTAL SURGERY	131
DERMATOLOGY	6
DIABETIC MEDICINE	1
ENDOCRINOLOGY	1
ENT	53
GASTROENTEROLOGY	9
GENERAL MEDICINE	4
GYNAECOLOGY	8
NEUROLOGY	11
OPHTHALMOLOGY	42
ORAL SURGERY	12
PAEDIATRICS	88
PAIN MANAGEMENT	1
RESPIRATORY MEDICINE	1
RHEUMATOLOGY	1
TRAUMA & ORTHOPAEDICS	208
UPPER GASTROINTESTINAL SURGERY	62
UROLOGY	137
VASCULAR SURGERY	3
<b>Grand Total</b>	<b>Page 41 of 6885</b>

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

A&E and MIU patients seen within 4 hours

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Patients	8738	8415	7483	6923	7201	6819	7974	8021	8797	8650	9413	9678	8643
4 hour breaches	3052	3155	3010	2596	2800	2690	3316	3170	3732	3934	3907	3961	3437
% seen within 4 hours	65.1%	62.5%	59.8%	62.5%	61.1%	60.6%	58.4%	58.0%	57.6%	54.5%	58.5%	59.1%	60.2%
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%

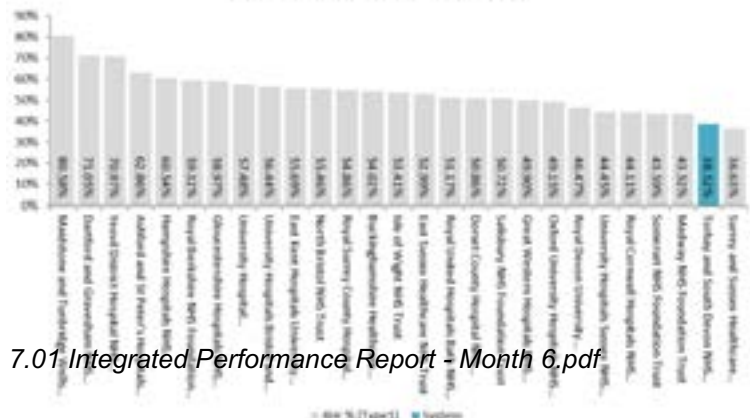


Escalation status	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Open status													
Open 1	0	0	0	0	0	0	0	0	0	0	1	0	0
Open 2	0	0	0	0	1	0	0	0	2	14	1	2	8
Open 3	5	3	1	4	10	27	13	24	15	13	14	22	1
Open 4	25	28	29	26	21	1	18	4	2	14	14	5	21
4-hour Performance (ICO)	65.1%	62.5%	59.8%	62.5%	61.1%	60.6%	58.4%	58.0%	57.6%	54.5%	58.5%	59.1%	60.2%
Bed Occupancy (Acute)	72	125	817	816	556	438	737	680	514	832	694	830	735
Ambulance handover delays >1 hour	1,260	1,357	1,288	468	611	605.75	625.75	338.25	697.5	461	610.75	634.5	623.5
Domiciliary Care - hours outstanding*	54	62	66	88	101	80	70	70	46	45	57	41	55.4

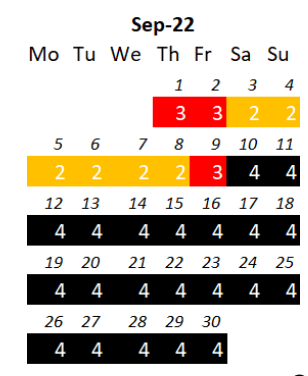
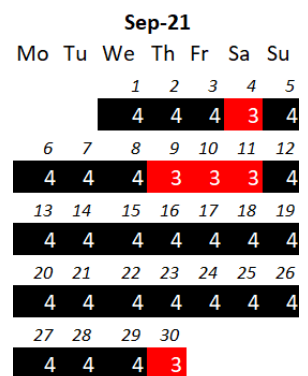
\* December 2021 count changed to only include outstanding hours where client without formal support and client receiving formal support not at home

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

4hr performance - type 1 only

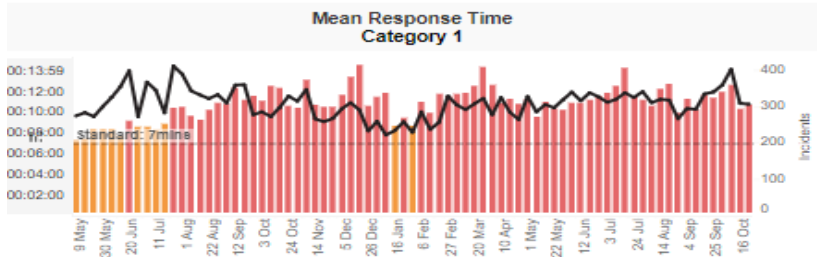


4hr performance weekly rank (Type 1)	
National	Region
104/116	26/28



# Handover delays at TSDFT and South West Ambulance Response Times – Category 1 and 2

## South West Ambulance Response Times – Category 1 and 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 (tables below) so impacting on the capacity for the ambulance service to maintain timely responses for 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 daily hours lost experienced at TSDFT.

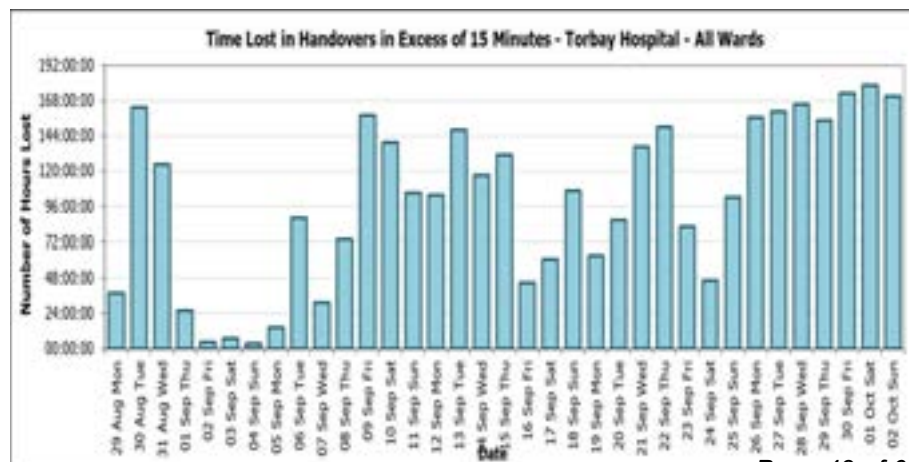
### Delays hours lost by trust

#### Rolling 30-day position as at 16 Oct 22

*click on a bar to highlight focused site on the trend chart*

Ambulance Tr.	Focused Site	Hours Lost
South Western	Royal Cornwall Hospital (Trelivick)	6181:02:59
South Western	Derriford Hospital	4948:39:24
South Western	Torbay Hospital	3188:02:42
South Western	Gloucestershire Royal Hospital	2721:56:11
South Western	Royal United Hospital	2548:06:52
South Western	Bristol Royal Infirmary	2486:14:24
South Western	The Great Western Hospital	1856:06:02
South Western	Southmead Hospital	1846:34:14
South Western	Royal Bournemouth Hospital	1784:48:45
South Western	Poole Hospital	1558:11:17
South Western	Weston General Hospital	651:34:07
South Western	Salisbury Health Care NHS T	651:28:15
South Western	Musgrove Park Hospital	638:26:27
South Western	North Devon District Hospital	463:10:15
South Western	Royal Devon & Exeter Hospit	368:09:33

### Ambulance handovers – hours lost



## Cancer treatment and cancer access standards

As at 13 October 2022		July				August				September			
Target Type	Target	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf	Achieved	Breached	Total	Perf
2 week wait referral	> 93%	596	1,211.00	1,807.00	33.00%	802	1,296.00	2,098.00	38.20%	802	967	1,769.00	45.30%
62-day - 2ww referral	> 85%	78	46	124	62.90%	79	41	120	65.80%	72	46.5	118.5	60.80%
62-day screening referral	> 90%	9	4	13	69.20%	6.5	2	8.5	76.50%	10	1	11	90.90%
14-day breast symptomatic	> 93%	9	43	52	17.30%	31	22	53	58.50%	34	9	43	79.10%
28-day Faster Diagnosis	> 75%	1,187.00	574	1,761.00	67.40%	1,400.00	563	1,963.00	71.30%	1,164.00	481	1,645.00	70.80%
31-day first treatment	> 94%	214	6	220	97.30%	201	3	204	98.50%	180	15	195	92.30%
31-day Sub-Drug	> 98%	77	0	77	100.00%	94	0	94	100.00%	79	1	80	98.80%
31-day Sub-Other	> 94%	20	0	20	100.00%	31	0	31	100.00%	14	0	14	100.00%
31-day Sub-Rads	> 94%	52	0	52	100.00%	65	1	66	98.50%	47	4	51	92.20%
31-day Sub-Surg	> 94%	25	3	28	89.30%	20	1	21	95.20%	30	1	31	96.80%

**Cancer standards** The table above shows the position for Q2 (as at 13<sup>th</sup> October 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.*

The NHSE Tier 1 performance review process has identified the 62 day referral to treatment standard as requiring focused support. The current backlog of patients waiting over 62 days has increased to 319 against the target of 115 by March 2023; Torbay and South Devon have identified 3 key areas of focus targeting the Urology and Colorectal pathways:

Number of patients waiting 63 or more days after referral from cancer PTL		WE-02/10 WE-09/10												October Variance to Plan
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	Plan	200	195	190	185	180	175	165	155	145	135	125	115	64
	Actual	245	273	233	297	244	333	319						

### 1. Urology - Template biopsies

This diagnostic test remains the key cause of pathway delays in Urology: Additional sessions are being completed by our consultant urologists over the next two months with contractual agreement with Nuffield Plymouth to conduct five procedures per week (October – March 2023). This is alongside existing insourcing arrangements with 18-Week Support.

Longer term plans include a) Recruitment for a nurse practitioner (to conduct biopsies) b) Ongoing consultant recruitment; c) Completion of a procedure room in Paignton Hospital Urology Investigations Unit due for completion February 2023.

### 2. Colonoscopies backlog and urgent waiting times

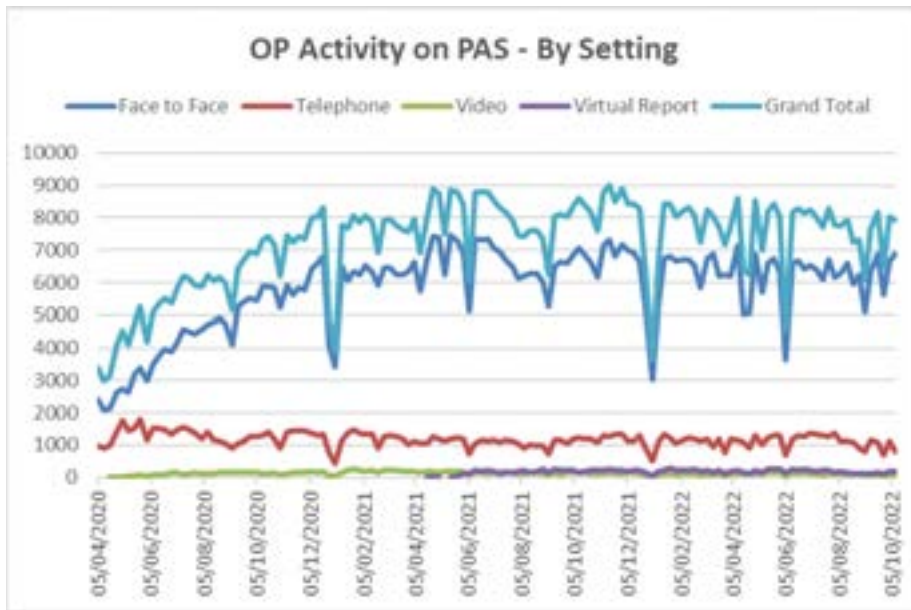
The new temporary Endoscopy Unit is open on the Annexe site, giving Torbay four endoscopy suites until building work for the substantive fourth room commences in January 2023. The Trust has secured capacity for 120 colonoscopies in Plymouth over October and November.

### 3. Colorectal outpatients

Outpatient waits remain at 7 to 8 weeks. Short term solutions are underway seeking the support from insourcing companies, alongside additional sessions from the substantive consultant workforce and mutual aid working with the Devon ICS to explore what support other local and Regional Trusts can provide.

## Virtual appointments (Non-face-to-face)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
New	15.0%	9.0%	14.0%	14.5%	12.4%	11.3%	14.30%	13.5%	12.7%	12.6%	13.1%	12.6%	12.0%	11.5%
Follow-UP	21.0%	21.0%	21.0%	23.6%	21.7%	24.0%	23.90%	20.6%	22.0%	23.8%	23.6%	22.9%	18.6%	18.6%
Combined	19.6%	20.3%	20.5%	21.1%	19.3%	20.7%	21.30%	18.8%	19.6%	20.9%	20.9%	20.2%	16.9%	16.8%



The Trust continues to see virtual appointment performance below the nationally set requirement (25%) achieving 16.8% in September. 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 set out its programme of work to deliver improvement for the Virtual appointment targets of 25% from September 2022. This has not been achieved and in fact the rates have fallen further. This is due in part to the continued escalations and presentations in urgent care which require face-to-face capacity and partly due to slipping back into the routine ways of doing things pre-covid.

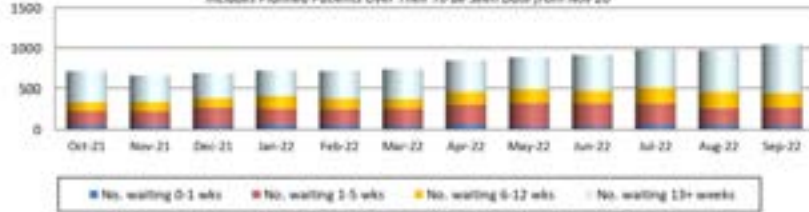
An updated action plan is noted below with the critical enabler being consistent clinical and operational engagement with the implementation plan.

	Description	Expected Benefit	Date Due	Lead
<b>FPDC 6.1</b>	Completion of Attend Anywhere user videos, 80% of admin and clinical staff who use virtual consultations, to access this bite size training via by March 23.	Increased confidence and competence in using Attend Anywhere and increased awareness of opportunities to use within services.	October 2022	Tony Ray
<b>FPDC 6.2</b>	Implementation of Outpatients estates steering group.	To quantify the current space available for services and maximise the utilisation, to include the purchase of a room booking system and identify the urgent must-do's that are significantly impacting on patient safety.	December 2022	Dawn Butler/ Jake O'Donovan
<b>FPDC 6.3</b>	Appointment of Outpatients Leadership	To provide governance and oversight of access and drive service improvements.	January 2023	Kevin Pirie
<b>FPDC 6.4</b>	Regular work with specialty's and community services to focus on their opportunities to increase NF2F and PIFU and what matters to them and their patients.	Build community of practice around doing things differently and be able to demonstrate changes to the performance and clearly evidenced narrative of the issues and barriers.	March 2023	Charlotte Child
<b>FPDC 6.5</b>	Validation of follow up waiting lists	Identify those at risk and those who no longer need and appointment or who would like to be moved to PIFU	November 2023	Charlotte Child
<b>FPDC 6.6</b>	Integrated Performance Report - Month 6.pdf Paediatrics and Gynae	Opportunity to have direct support from the National Team, to refine the concept of Ears On Eyes On Hands on and develop data, evidence and a case story to be included in the new pack	February 2023	Charlotte Child

# NHSI indicator - patients waiting over 6 weeks for diagnostics

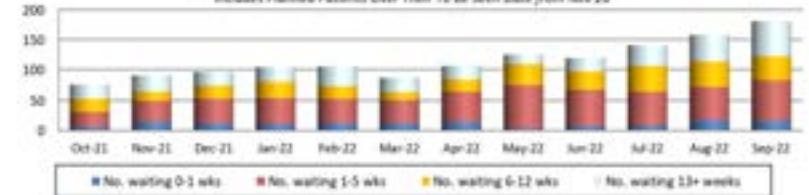
**Numbers On Colonoscopy Waiting List Over Time**

Includes Planned Patients Over Their To Be Seen Date from Nov 20



**Numbers On Flexi Sigmoidoscopy Waiting List Over Time**

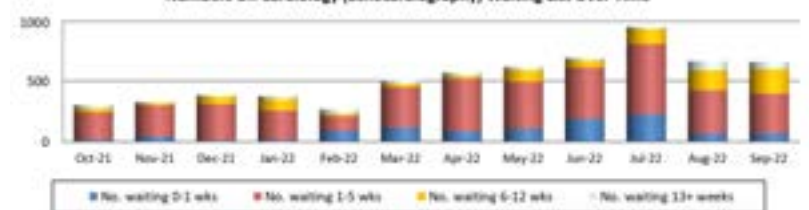
Includes Planned Patients Over Their To Be Seen Date from Nov 20



**Numbers On MRI Waiting List Over Time**



**Numbers On Cardiology (Echocardiography) Waiting List Over Time**



**Numbers On CT Waiting List Over Time**



**Diagnostic tests longer than the 6 week standard**

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Patients	5142	5195	5066	5099	5152	5062	5103	4130	5005	5382	5003	5068	5123
Waiting longer than 6 weeks	1808	1888	1894	2117	2546	2739	2707	2080	1753	1670	1687	1991	2527
% over 6 weeks	35.1%	36.3%	37.4%	41.5%	49.4%	54.2%	53.0%	50.3%	35.0%	30.9%	33.7%	39.3%	49.3%
National target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Local benchmark	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%



All modalities are continuing to see patients with urgent need with appropriate Infection, Prevention and Control precautions. 35% of patients are waiting over 6 weeks.

**Colonoscopy:** remains the area of greatest risk. The numbers and routine waiting times are increasing with 770 patients waiting over 6 weeks of these 366 are waiting longer than 26 weeks. Weekend insourcing continues but is becoming less effective. The mobile endoscopy unit has increased capacity, however, workforce remains insufficient to cover all available lists. Mutual aid agreed with UHP is in place to see 120 colonoscopies.

**MRI:** waits and total numbers on the list have stabilised with 485 (515 in August) 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. Capacity to carry out cardiac scans that require specialist input and reporting make up the bulk of the long waits over 6 weeks.

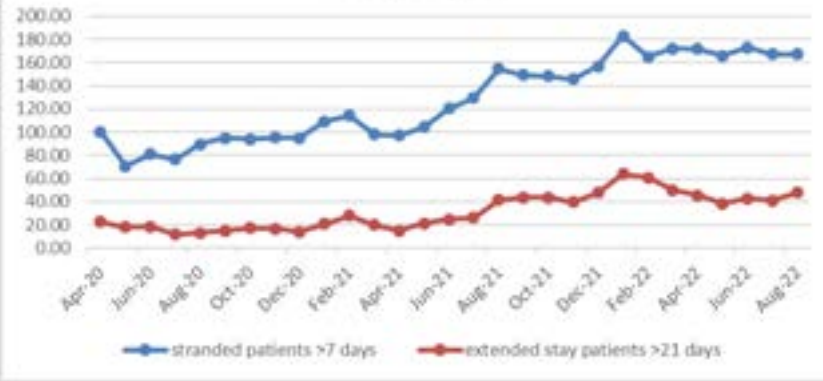
**CT numbers:** waiting times for routine tests have improved. Insourcing using mobile units will continue to support capacity. Additional capacity is being provided at the Nightingale Hospital Exeter with contrast capability now being available.

**Radiology Reporting:** the backlog of scans awaiting reports have continued to increase with delays that can run to several weeks. Plans to support additional reporting capacity are being assessed but will have a cost impact with workforce being a critical constraint.

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 average daily snapshot of beds occupied (ICO)

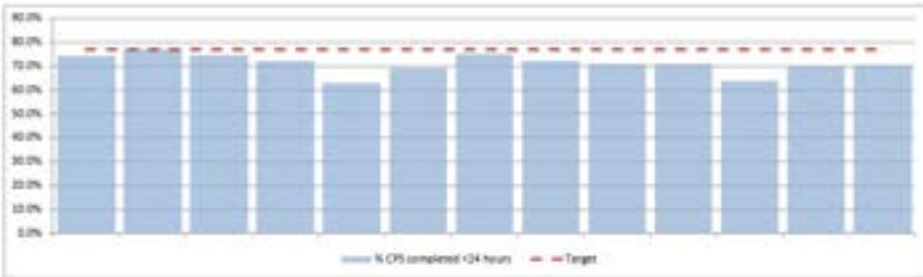


## Long Length of Stay (LOS)

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 Plan Summaries completed within 24 hours of discharge - Weekdays

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Discharges	1386	1434	1268	1347	1289	1024	1052	1175	1271	1468	1741	1329	1531
CPS completed within 24 hours	852	1100	841	870	781	708	791	847	904	1042	1111	926	1081
% CPS completed <24 hours	74.2%	77.8%	74.9%	72.0%	63.0%	69.2%	79.2%	72.1%	71.1%	71.0%	63.8%	69.7%	70.3%
Target	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%



## Care Planning Summaries (CPS)

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

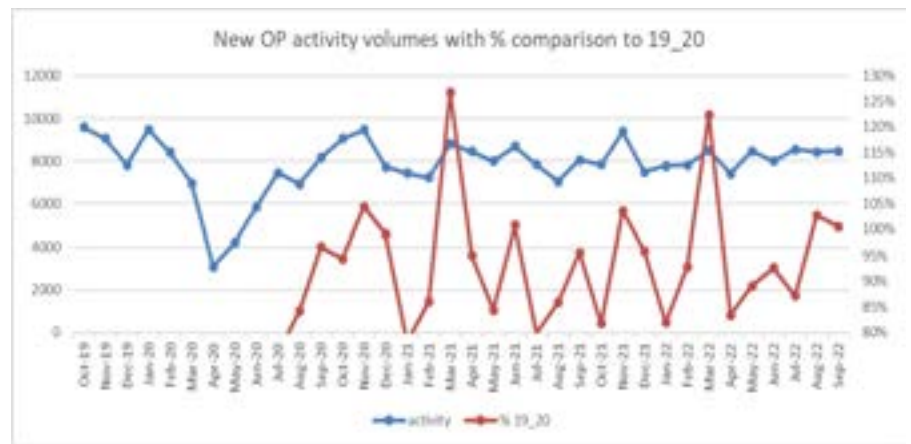
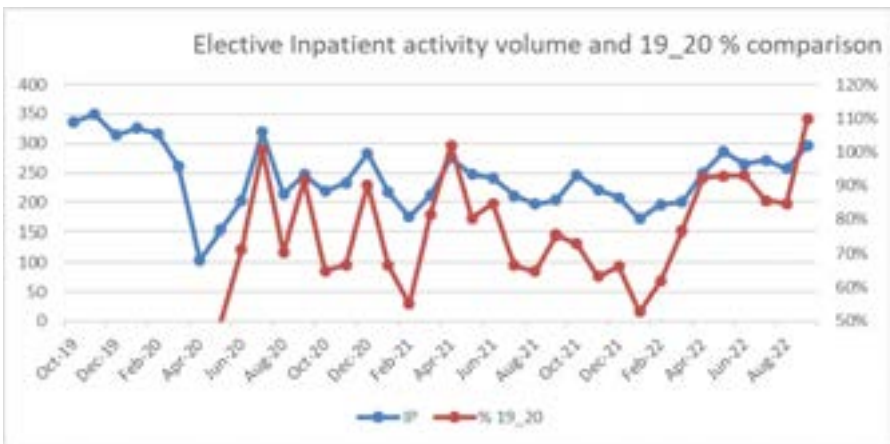
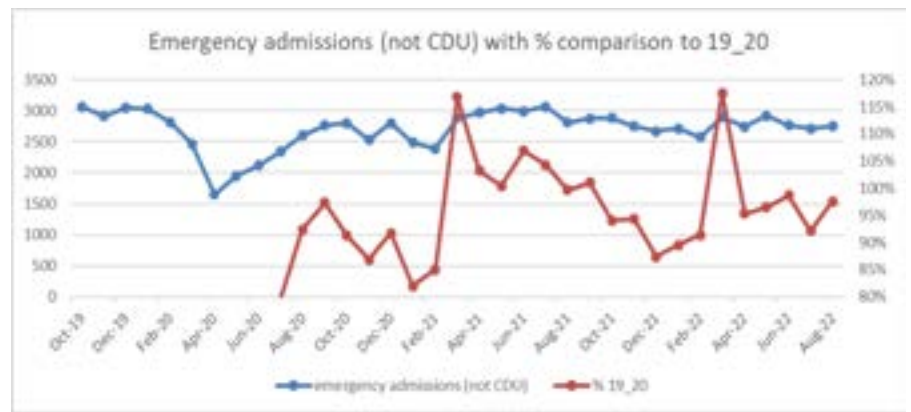
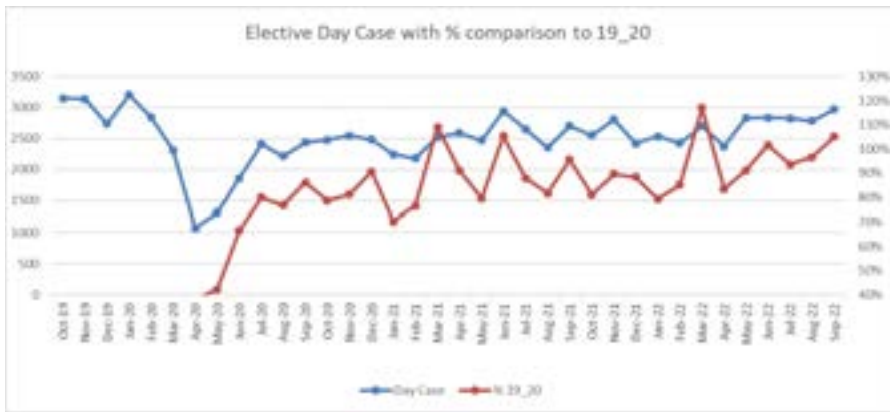
The CPS data for September is not available in time for publication of this report.

Care Plan Summaries completed within 24 hours of discharge - Weekend

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Discharges	841	287	314	294	283	305	254	251	278	841	290	323	242
CPS completed within 24 hours	359	124	170	149	105	112	134	122	139	178	152	155	117
% CPS completed <24 hours	46.8%	46.4%	45.9%	50.7%	39.2%	36.7%	52.8%	48.8%	50.0%	52.2%	50.8%	48.0%	48.3%
Target	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%



# 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 September 2022 together with a comparison (%) to 2019/20 levels of activity. Relative performance improved in September to over 100% for volumes of Day case / Inpatient and new outpatients.

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 5. 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. In August overall New outpatient volumes did return to pre covid levels however is noted that activity remains below pre covid levels in a number of key areas and is a challenge relating to addressing waiting times recovery.

It is noted that whilst the volume of emergency admission remains below pre-covid levels there has been a focus on admissions avoidance however and high occupancy and average length of stay for patients being admitted maintaining high levels of bed occupancy.



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.

## Service Director Overview

### CFHD

- Business and Governance reporting model due for trial from October 2022.
- Workforce consultation feedback due October 2022.
- Inter-operability workshop being planned in collaboration with TSD and DPT; this has been postponed due to lack of TSD/DPT availability.
- Associate Clinical Directors in post from 1 November 22.
- Service development and QI Lead in post 7 November 2022.

### SPA

- Progress made with reducing backlog but impact of CareNotes outage workload impacting and small increases are likely.
- Recruitment underway.

### Integrated therapies and nursing

- Head of IT&N in post 31 October 22.
- Early Years and ASD interim leads now in post (interim).
- Recovery plans for wait times agreed (ASD, OT, SLT and CiC).

### CAMHS

- IT networking of the Torbay site has been escalated but not yet resolved.
- Carenotes impact is significant.

### 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.
- Torbay estate crisis with infestation within The Annexe and lack of notice to move staff from Vowden Hall.

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Financial Performance – Month 06 (September)  
FY 2022 / 23

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## Financial Overview- Month 06, September 2022

### High Level Summary- Year to Date Position

For Period ended - 30 September 2022, Month 06			
	Plan £m	Actual £m	Variance £m
Total Operating Income	293.81	299.60	5.79
Total Operating Expenditure and Financing Cost	(297.03)	(306.85)	(9.82)
Surplus/(Deficit)	(3.22)	(7.25)	(4.02)
Add back: NHSE/I Adjustments	0.44	0.45	0.01
Adjusted Surplus/(Deficit)	(2.79)	(6.80)	(4.01)
CIP	13.03	8.63	(4.40)
Capital (CDEL)	14.67	13.70	(0.98)
Cash & Cash Equivalents		14.50	

At Month 6 (September) the planned deficit year to date is £2.8m. The actual position shows an adverse variance to plan at £4.0m, giving rise to a total reported deficit of £6.8m. In addition, taking into account a sum of £6.3m non-recurrent mitigations in this position, the underlying year to date deficit is c£13.1m, largely due to the gap in CIP delivery. The trust must rapidly mitigate the position on CIP.

### Year-to-date variance Summary



Year to Date Most of the adverse variances to plan relate to CIP delivery (£4.4m). Other areas of significant issues include:

- ASC / CHC cost pressures - £3m YTD
- Intermediate care beds – spot purchases - £0.6m YTD
- Fragile services e.g. maternity – modest YTD but significant in forecast

### CIP Summary

Year to date CIP target at M06 £13.0m, of which £8.6m has been formally transacted via the financial ledger and delivered. **Undelivered CIP £4.4m is contributing to the deficit position, predominantly pay. The current trajectory indicates a CIP shortfall of £15.3m for the year which requires mitigation and the trust continues to identify schemes to close the gap.**

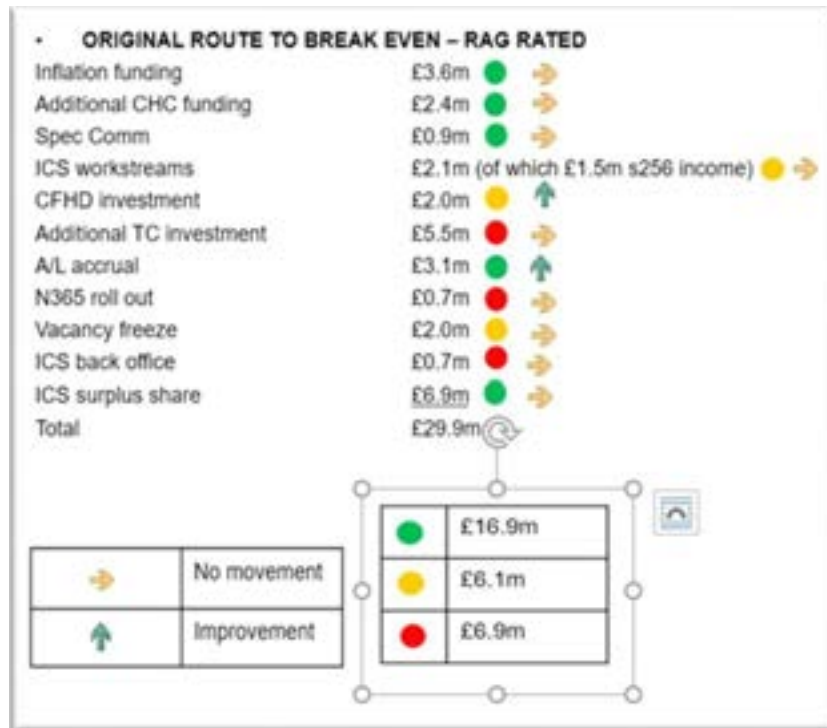
### Non-recurrent Mitigation and Other

**M06 year-to-date £6.3m has been released including non-recurrent mitigations and other revenue adjustments.** M06 includes release of annual leave provision (£0.34m), adult social care provision (£0.98m). These partly offset the Trust's underlying deficit and this is not a sustainable position to maintain and urgent action is underway to identify recurrent solutions.



## Forecast Overview

Following the national forecasting protocol, the Trust's officially reported forecast outturn is in line with plan, however the net underlying risk forecast current stands at 18.6m. Please see below for the detailed risk and mitigations in forecast deficit.



High level Forecast	M6 Forecast	M6 Forecast	M6 Forecast
	£m	Worst £m	Best £m
<b>Plan</b>	<b>0.07</b>	<b>0.07</b>	<b>0.07</b>
CIP Shortfall	-12.60	-16.40	-9.70
ESRF	0.00	0.00	1.14
ASC/CHC	-3.00	-3.00	-3.00
Intermediate Care beds	-1.40	-1.40	-1.40
Excess inflation	-2.50	-5.40	-2.50
TP adverse to plan	-1.00	-1.00	-1.00
Fragile services	-1.77	-1.77	-1.77
Winter demand & capacity	1.57	1.57	1.57
Slippage	0.50	0.50	0.50
Band 2 > 3	0.00	-1.00	0.00
CFHD Risk Share	1.50	0.00	3.50
<b>Forecast (deficit)/surplus</b>	<b>-18.62</b>	<b>-27.82</b>	<b>-12.59</b>

## In Month I&E Position – Month 06, September 2022

£m	M06 - In Month		
	Budget	Actual	Variance
Patient Income - Block	31.41	35.39	3.98
Patient Income - Variable	4.33	4.88	0.55
ERF/ERF+/TIF/Capacity Funding	0.55	0.55	0.00
ASC Income - Council	4.67	5.66	0.99
Other ASC Income - Contribution	1.04	1.19	0.15
Torbay Pharmaceutical Sales	1.96	1.63	(0.32)
Other Income	5.01	4.33	(0.68)
Covid19 - Top up & Variable income	0.26	0.23	(0.03)
<b>Total (A)</b>	<b>49.24</b>	<b>53.87</b>	<b>4.63</b>
Pay - Substantive	(23.75)	(27.50)	(3.75)
Pay - Agency	(0.61)	(1.17)	(0.56)
Non-Pay - Other	(12.75)	(13.24)	(0.49)
Non- Pay - ASC/CHC	(9.30)	(10.49)	(1.19)
Financing & Other Costs	(2.65)	(2.32)	0.33
<b>Total (B)</b>	<b>(49.06)</b>	<b>(54.72)</b>	<b>5.66</b>
<b>Surplus/(Deficit) pre Top up/Donated Items and Impairment (A+B=C)</b>	<b>0.18</b>	<b>(0.86)</b>	<b>(1.03)</b>
<b>NHSE/I Adjustments - Donated Items / Impairment / Gain on Asset disposal</b>	<b>0.07</b>	<b>0.07</b>	<b>(0.00)</b>
<b>Adjusted Financial performance - Surplus / (Deficit)</b>	<b>0.25</b>	<b>(0.79)</b>	<b>(1.04)</b>

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

#### Income

- Overall patient income variance is £4.63m above plan which includes partial funding for the back dated pay award £4.30m and ASC income release £0.98m. Adverse variances include Torbay Pharmaceutical sales (£0.32m), other income which includes Covid lab testing matched to spend (£0.23m), CFHD S75 refund (£0.16m).

#### Pay

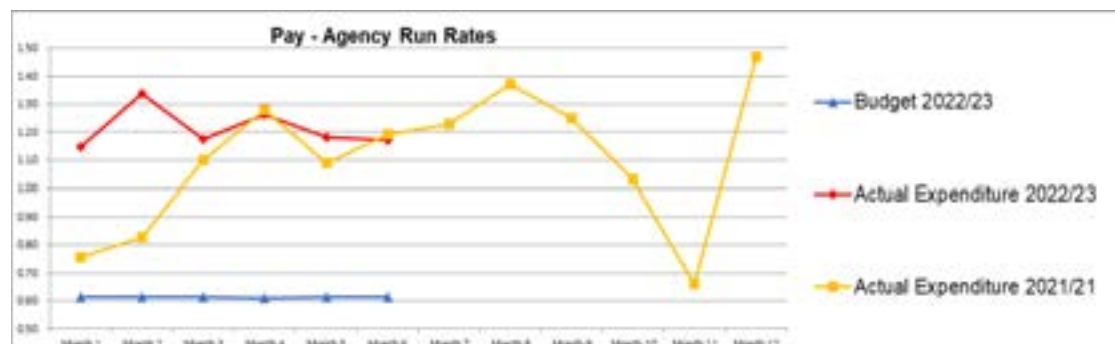
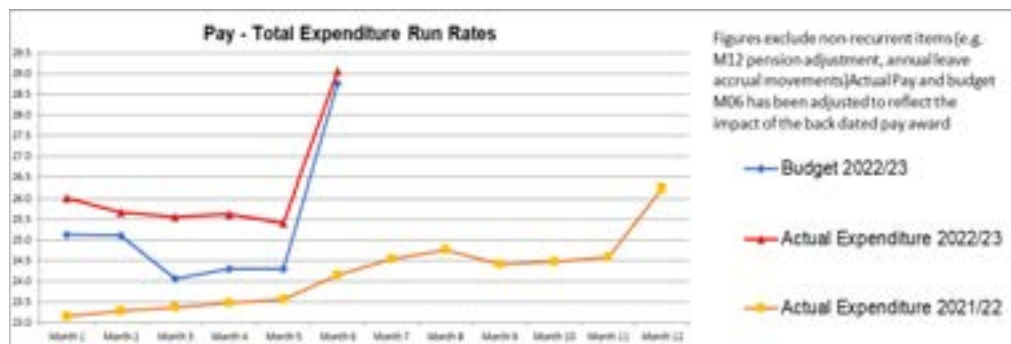
- The net movement in M06 is £3.0m increase compared to M05. The position at M05 included an estimated flat rate of 2% pay award for substantive and bank staff. In M06 the actual pay award was based on agreed sums and backdated to April. This is the main driver for the movement (partially offset by income).
- CIP target in M06 for pay is £1.74m of which £1.41m has been identified and delivered, 68% being non-recurrent vacancy slippage
- Following NHSE/I reporting protocol, substantive staffing budget currently does not reflect the uplift in funding for the pay award at Trust level. Considering the 2% pay award provision and back dated pay award paid, the underlying overspend in month is £0.50m on substantive and bank pay
- The gap on pay award year to date for the Trust is £0.44m
- Agency costs are (£0.56m) higher than the budget with CIP, with no material change from M05. The overspend in Agency mainly relates Nursing (£0.18m) and medical (£0.33m) staff groups.

#### Non-pay

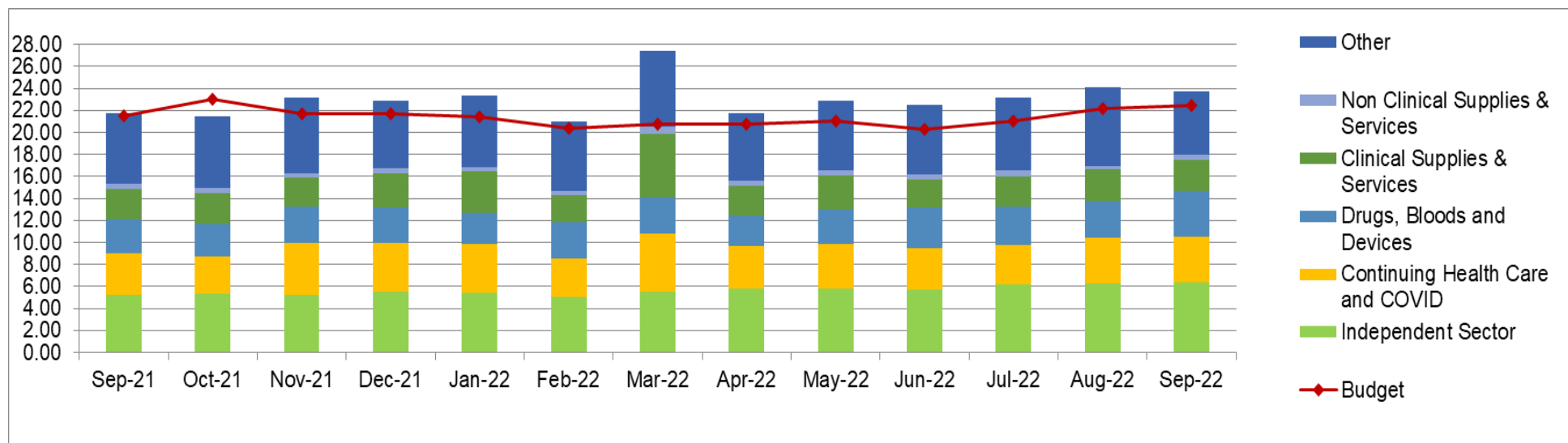
- Non-pay overall is overspent by (£1.66m), this includes clinical supplies and services (£0.25m), drugs (including pass through drugs and devices) (£1.15m) and premises costs including security, estates purchased contracts (£0.40m) and transport costs (£0.15m). Offsetting underspends include provider SLA's £1.00m (main driver being CFHD) education and training £0.35m and £0.10m balance sheet provision release.
- The non-pay CIP target for M04 is £0.69m of which £0.33m had been delivered.
- ASC overspend of (£0.87m) due to an under achievement in savings target combined with higher level of activity pressures (price and complexity), catch up costs and assessment delays. Placed People overspend of (£0.36m) due to an under achievement in savings target, increase in clients and continuing price pressures within adult IPP.

Income and Expenditure by System				
System Description	Expenditure & Income Category	M06 In Month	M06 In Month	M06 In Month
		Budget	Actual	Variance
Children and Family Health Devon (CFHD)	Operating expenditure - Pay	(1.24)	(1.09)	0.14
	Operating expenditure - Non Pay	(1.53)	(0.82)	0.71
	Income from patient activities	2.73	2.68	(0.05)
	Other Operating Income	0.04	0.06	0.02
<b>Children and Family Health Devon (CFHD) Total</b>		<b>(0.00)</b>	<b>0.83</b>	<b>0.83</b>
Pharmacy Manufacturing Unit	Operating expenditure - Pay	(0.94)	(0.84)	0.11
	Operating expenditure - Non Pay	(1.04)	(0.78)	0.26
	Misc non-operating items	(0.01)	(0.01)	0.00
	Finance expenditure	(0.01)	(0.01)	0.00
	Income from patient activities	0.04	0.06	0.02
	Other Operating Income	1.96	1.64	(0.32)
<b>Pharmacy Manufacturing Unit Total</b>		<b>0.00</b>	<b>0.06</b>	<b>0.06</b>
Shared Corporate Services	Operating expenditure - Pay	(0.04)	(5.50)	(5.46)
	Operating expenditure - Non Pay	(6.03)	(4.63)	1.41
	Misc non-operating items	(0.57)	(0.57)	0.00
	Finance expenditure	(0.08)	(0.07)	0.01
	Income from patient activities	37.26	40.68	3.42
	Other Operating Income	1.82	1.97	0.15
	Finance income	0.00	0.06	0.06
	Other gains/(losses)	0.00	0.00	0.00
	<b>Shared Corporate Services Total</b>		<b>32.36</b>	<b>31.95</b>
Planned Care, Long Term Conditions and Diagnostics	Operating expenditure - Pay	(11.87)	(11.14)	0.73
	Operating expenditure - Non Pay	(4.90)	(6.75)	(1.85)
	Finance expenditure	(0.01)	(0.01)	0.00
	Income from patient activities	2.26	3.38	1.12
	Other Operating Income	0.61	0.23	(0.37)
<b>Planned Care, Long Term Conditions and Diagnostics Total</b>		<b>(13.92)</b>	<b>(14.29)</b>	<b>(0.37)</b>
Urgent & Emergency Care and Operations	Operating expenditure - Pay	(4.28)	(4.31)	(0.02)
	Operating expenditure - Non Pay	(0.26)	(0.62)	(0.35)
	Finance expenditure	(0.14)	(0.14)	0.00
	Income from patient activities	0.72	0.75	0.02
	Other Operating Income	0.05	0.04	(0.01)
<b>Urgent &amp; Emergency Care and Operations Total</b>		<b>(3.92)</b>	<b>(4.28)</b>	<b>(0.37)</b>
Families, Community and Homes	Operating expenditure - Pay	(5.98)	(5.79)	0.19
	Operating expenditure - Non Pay	(10.10)	(11.71)	(1.61)
	Income from patient activities	1.68	2.06	0.38
	Other Operating Income	0.06	0.31	0.25
<b>Families, Community and Homes</b>		<b>(14.34)</b>	<b>(15.13)</b>	<b>(0.79)</b>
<b>Grand Total</b>		<b>0.18</b>	<b>(0.86)</b>	<b>(1.04)</b>

Pay Expenditure Run Rate – Month 06, September 2022



Non-Pay Expenditure – Month 06, September 2022



## Risks, Mitigations and Forward Look

### Risks and Mitigations

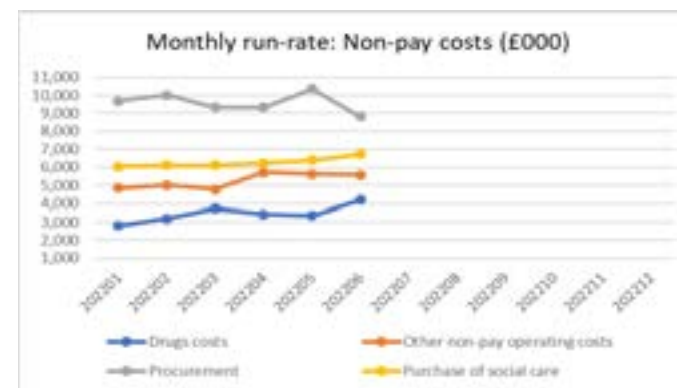
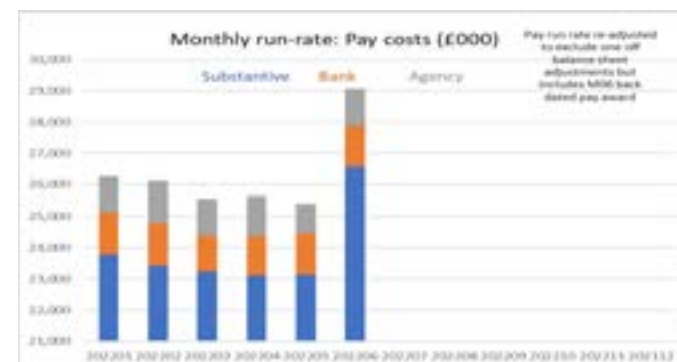
Year to date £8.63m CIP has been identified and transacted against a year to date target of £13.03m. The balance of undelivered CIP is contributing to the reported deficit position, this continues to be an unsustainable position.

ESRF income has been assumed at £2.38m year to date. NHSE/I has stated that there will be no claw back of ESRF income allocation for the full financial year.

### Forward Look

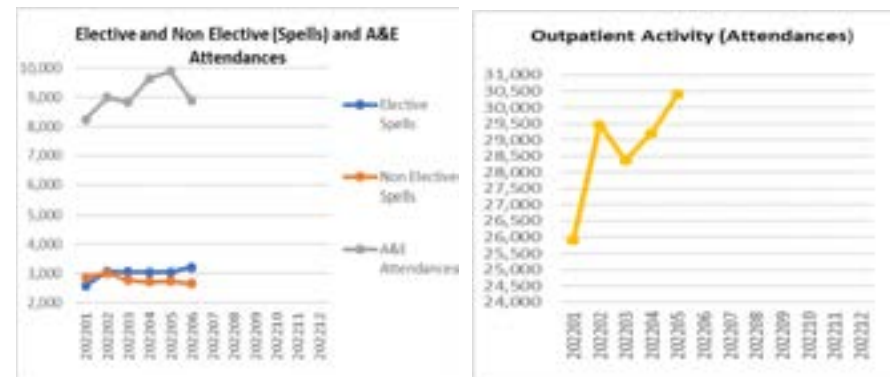
The Trust's final plan re-submitted on 20<sup>th</sup> June to NHSE/I illustrates a breakeven position for the year as required by regulators.

- Included is the delivery of an efficiency requirement at £28.5m, through transformation and Covid cost reduction initiatives. At this point a delivery gap of £15.3m has been forecast, which requires further deliverable schemes to be identified.
- Following the national forecasting protocol, the Trust's officially reported forecast position at M06 is a balanced outturn position against plan, however the underlying net in-year risk with mitigations current stands at £18.6m.
- Other significant risks to achieving the financial plan include increasing inflation beyond the excess inflation funding already received and excessive growth in the independent sector £2.5m
- Urgent actions are required to rapidly identify further mitigating actions with real commitment through all level of the organisation. The first Trust Management Group (TMG) was held on 20<sup>th</sup> September signed up to a joint commitment change to culture, work across teams and operational boundaries in identifying opportunities, revisit past decisions to mitigate the savings gap as well as reducing cost pressures as far as possible through Financial Recovery Plan.
- The deadline for divisional Financial Recovery Plan submission was 14<sup>th</sup> October. Not all services responded within this deadline, the finance team is currently collating the responses, chasing and supporting all services to complete the exercise. It is anticipated that an additional £4m mitigation to CIP delivery would be identified from the Financial Recovery Plan (see forecast section).
- Year to date gap on the pay award is £0.44m, and full year gap is circa £0.90m. Further work is underway to validate this value in conjunction with other providers to ensure consistency of reporting. Additional funding for the NI increase will be clawed back from M08, when the 1.25% is reversed from employees pay.



## Change in Activity Performance – Month 05 to Month 06

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	% YTD vs Plan	Sep-19	Sep 22 v Sep 19 % change
Point of Delivery		Actual	Actual	Actual	Actual	Actual	Actual			
Activity Drivers	Day Case	2,338	2,797	2,789	2,781	2,785	2,917	101%	2,827	3%
	Elective	246	277	252	266	257	296	107%	270	10%
	Outpatient New	7,431	8,205	7,991	8,405	8,429	8,472	100%	8,432	0%
	<b>Total Elective</b>	<b>10,015</b>	<b>11,279</b>	<b>11,032</b>	<b>11,452</b>	<b>11,471</b>	<b>11,685</b>	<b>100%</b>	<b>11,529</b>	<b>1%</b>
	F-Up	18,468	21,240	20,363	20,802	21,585	21,917	102%	22,109	-1%
	Non-Elective	2,875	3,006	2,776	2,716	2,751	2,658	86%	3,186	-17%
	A&E Attendances	8,238	8,991	8,819	9,642	9,885	8,884	102%	9,985	-11%
	<b>Grand Total</b>	<b>39,596</b>	<b>44,516</b>	<b>42,990</b>	<b>44,612</b>	<b>45,692</b>	<b>45,144</b>	<b>100%</b>	<b>46,809</b>	<b>-4%</b>
Bed Utilisation	Occupied beds DGH	10,465	11,188	10,709	10,691	10,756	10,578			
	Available beds DGH	11,164	12,000	11,359	11,588	11,652	11,109			
	Occupancy	94%	93%	94%	92%	92%	95%			



### Activity Drivers

- Overall ESRF performance from an activity perspective for September is around 99% of 19/20 activity. The threshold 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. In H1 (months 1-6) the national rules have enabled ESRF to be paid without reference to the threshold, and this arrangement looks similar for H2.
- A&E Attendances– are slightly above plan but less than the 9,985 from September, this is in part due to the establishment of patient pathways direct to the medical and surgical assessment units following GP referral. A&E waits have been long with associated ambulance handover delays. This is linked to patient flow capacity meaning patients are having to be held in A&E longer than desired once a decision to admit has been made.
- Elective Spells – YTD 107% vs plan but 1% above 19/20 levels. Day case surgery unit has returned in May providing additional capacity. However, to start making progress against our planned recovery of waiting times further increases in capacity will be needed. Some of the ESRF programmes are below planned levels e.g. insourcing program.
- Non-Elective Spells – this is 17% below 19/20 levels. Whilst overall numbers of non-elective spells are below pre covid levels, the acuity and length of stay of patients who are admitted has increased. Winter plans seek to optimise available acute beds, same day emergency care, and target discharge delays for patients in hospital with no criteria to reside.
- Outpatient Attendance – Activity levels for September are performing in line with pre covid levels. Further activity increases are needed however to address the backlog of patients that have accumulated during the pandemic months.

### Bed utilisation

- In September, the overall bed occupancy is 95%. Occupancy against General medical beds for non-elective admissions is much higher and over 98%. This level of bed occupancy remains above required levels to support timely patient flow to avoid emergency care delays from the emergency department and assessment units. The use of the discharge lounge continues to be successful in bringing forward the time of discharge from wards to earlier in the day and aiding patient flow however further improvements to deliver earlier in the day discharges and higher weekend discharges are needed.
- The number of patients occupying a hospital bed with Covid-19 increased in September along with the levels of staff sickness relating to covid. Reductions being seen in October.
- Work continues to focus on the number of patients identified as medically fit and having “no criteria to reside” in an acute hospital bed, with capacity in Adult Social Care and in particular to support patients requiring a domiciliary package of care remaining a challenge.

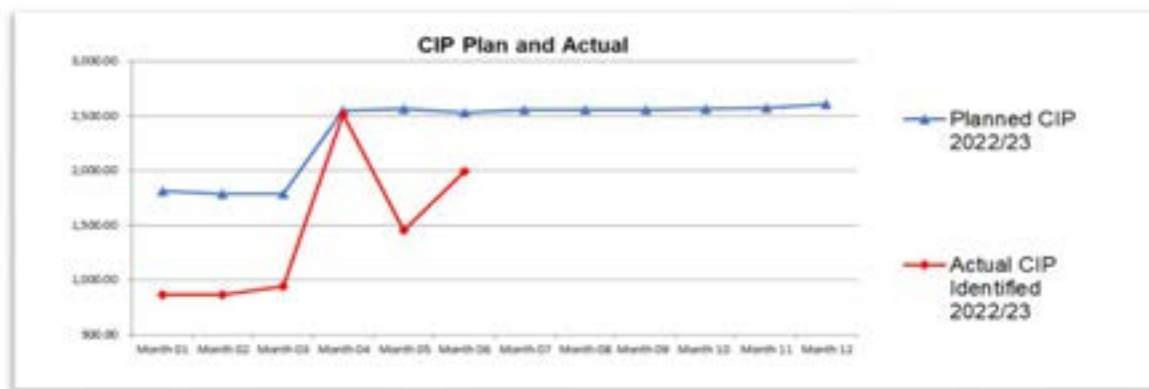


Key Drivers of System Positions – Month 06, September 2023

System	ISU	Financial Commentary / Key Drivers
<b>Children &amp; Family Health Devon</b>	CFHD	Budget has been set on model option 2 for 2022/23. At M06, the Alliance generated a surplus and after applying a risk share calculation, TSD is benefiting from £1,187k 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; the resource and available support are currently being reviewed for implementation commencement in 22/23 – on that basis, with no further information at this stage, 50% of the revenue spend has been included in the month 06 forecast position only.
<b>Torbay Pharmaceuticals</b>	PMU	TP sales in M06 are (£0.32m) lower than plan primarily due to lower contract manufacturer, NHS and export sales. Overall performance in month shows a profit above budget (£58k)
<b>Corporate</b>	EFM	Overspent at M06 by (£2.4m). Pay is overspent by (£831k) 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 (£105k). Non-pay is overspent by (£620k) due to increased energy costs offset by capital recharges. Income is overachieved by £142k mainly due to increase lease rental on the Level 4 outlets coming back to contractual levels after Covid-19 reductions. There are also increases in patient/visitor car parking charges and meal sales. Unachieved CIP target of (£1,078k).
	Exec. Directors	Underspent at M06 by £185k. Pay is overspent by (£102k) offsetting areas are issues in recruitment and retention within HIS of £108k, Education and Training vacancies £196k offset by Medical Director (£375k) LCEA award accrual. Non-pay is overspent by (£141k) mainly due to (£350k) international nurses recruitment costs in the People Directorate; offset by underspends in Devon IR Alliance £137k and apprenticeship levy usage £112k both offset in income. Income has overachieved by £638k mainly due to Health Education England (HEE) income regarding medical training and education £213k, Internal nurses recruitment £257k, VAT reclaim £86k and Director of Nursing secondment £92k; offset by reductions in Devon IR Alliance (£136k) and apprenticeship levy usage (£108k) both offset in non-pay. Unachieved CIP target of (£322k).
	Financing Costs	Excluding items outside the NHSE control total, costs are £1.4m 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 position £6.8m Recovery and Elective Recovery costs have been allocated to a central budget to allow better analysis of expenditure. In M06 there is an underspend of £400k, budget has now been allocated correctly to the recovery areas and further budget re-distributed to support services.
<b>Families, Community and Home</b>	Torquay	Against a budget of (£21.7m) there is a YTD overspend of £0.1m (0.5%) which is entirely driven by an overspend of (£0.4m) 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. This area is under review by operational leads and changes to improve the average length of placement will hopefully be in place late Autumn and ahead of winter which help the limit on going cost pressures in this area. Mitigating some of the above pressures is a £0.1m underspend on JCES and £0.2m of one-off accrual releases.

	Moor to Sea	Against a budget of (£12.0m) there is a YTD overspend of £0.35m (2.9%). This overspend is driven by HOP ward (Cheetham Hill & Simpson) overspends of circa £0.35m, Intermediate Care placements costs within the South Devon area of £0.15m, partially offset by underspends of £0.15m within community teams (linked to vacant positions).
	Independent Sector	Against a budget of (£49.5m) there is a YTD overspend of £1.3m (2.6%) and this is underpinned by three main areas. The target CIP target is not being fully achieved (£1.1m under achievement), volume / prices pressures within the ASC area on Dom Care, Nursing Long Stay and direct payments (£1.2m) and finally there is £0.6m of cost pressures within CHC South Devon locality. These issues are being partially mitigated by releasing accruals across both ASC and Placed People (£1.3m) and application of £0.3m of sustainability funding from Torbay Council.
<b>Urgent &amp; Emergency Care and Operations</b>	Newton Abbot	Against a budget of (£19.3m) there is a material 13.2% YTD overspend of £2.55m. The first main driver behind this is CIP under achievement of £0.6m. In addition to this there is an £1.0m overspend within the nursing Emergency Department area mainly linked to the unfunded 11 escalation beds. Another material overspending area is A&E senior medical costs (0.5m) which is driven again by the escalation beds and locums to cover for sickness in this high-risk area. This area is under review by operational leads with a key focus on winter planning and appropriate application of additional winter planning funding.
	Trust Wide Support Services	Against a budget of (£1.35m) there is a 15% YTD overspend of £0.2m. The first main driver behind this is Transport costs (primarily Patient Transport). Secondly there is a £0.1m overspend on the Forest ward linked to the budget being phased evenly across the financial year. Forecasts assume this ISU will at the very least be back to a break-even position by the end of the financial year once additional winter planning income is applied.
<b>Planned Care, Long Term Conditions &amp; Diagnostics</b>	Paignton and Brixham	Excluding Clinical income there is a YTD at M6 overspend of (£3.1m) against budget. Main overspends are on pay (£0.3m) being locum usage, additional medical sessions and nurse agency costs offset with vacancy slippage in other posts. Also adverse variance against CIP delivery of (£0.3m) although £1.5m savings have been transacted, pass through and high cost drug expenditure (£1.3m), and other non-pay (£1.0m) made up of insourcing overspends and contract maintenance. Overall run rates have been relatively consistent, but with an increase in M6 due to back dated pay award
	Coastal	Excluding clinical income there is a YTD overspend at M06 by (£1.7m) against budget. Pay is underspent £0.4m which consists of savings due to vacant posts £1.5m and offset with ward agency costs to cover absence, and Medical locum costs mainly to cover vacant posts (£1.1m). Non-pay is overspent (£0.4m) mainly due to medical and surgical supplies, drugs (£0.1m), and undelivered CIP variance (£1.0m) although £0.6m savings have been transacted to date. Run rates have remained relatively constant but with an increase M6 due to back dated pay award, ERF recovery schemes are recorded centrally and not within this ISU.
<b>Contract Income</b>	Patient Income	The Trust has received the following income in M06: 1) Income assumed for Elective Recovery Funding in M06 and year to date is £2.38m. 2) We continue to receive CCG income relating to the Hospital Discharge Programme (HDP) for corresponding cost incurred. 3) Nothing relating to grants has been received or assumed from Torbay Council.

## CIP- Month 06, September 2022



### CIP

Phased delivery of the efficiency plan for the first six months is £13.0m. Per the Trust's April planning submission, the split of the £13.0m target as at M06 is:

- Pay related - £9.1m
- Non-pay related - £3.3m
- Income related - £0.6m

The Trust's actual financial performance for M06 indicates a shortfall of £4.4m (c.34%) against the efficiency target, predominantly linked to the position on pay, with delivery to date viewed as:

- Pay related - £6.5m
- Non-pay related - £1.8m
- Income related - £0.4m

Based on the M06 position, the end of year forecast for CIP delivery is estimated at c. £13.1m (c. 54%) 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, but of key concern is the delivery of key actions/pace of delivery and the identification of alternative schemes to address gaps to target. Budget holders have been tasked with establishing Recovery Plans for their areas in order to identify how they intend to deliver a balanced budget. A template has been issued with reports due on 14 October. This will also allow budget holders to identify schemes in respect of 2023/24 too.

## Cash Position – Month 06, September 2022

	Plan £m	M06 YTD Actual £m	Variance £m
<b>Opening cash balance</b>	<b>39.34</b>	<b>39.34</b>	<b>0.00</b>
Capital Expenditure (accruals basis)	(14.80)	(14.47)	0.33
Capital loan/PDC drawdown	6.39	0.75	(5.64)
Capital loan repayment	(2.41)	(2.41)	0.00
Proceeds on disposal of assets	0.00	0.00	0.00
Movement in capital creditor	(11.00)	(9.98)	1.02
Other capital-related elements	(1.59)	(1.60)	(0.02)
<b>Sub-total - capital-related elements</b>	<b>(23.40)</b>	<b>(27.71)</b>	<b>(4.31)</b>
Cash Generated From Operations	12.70	6.92	(5.78)
Working Capital movements - debtors	(1.05)	(4.65)	(3.60)
Working Capital movements - creditors	(7.53)	(1.39)	6.14
Net Interest	(1.54)	(1.29)	0.25
PDC Dividend paid	(3.46)	(2.44)	1.02
Other Cashflow Movements	(0.67)	5.72	6.39
<b>Sub-total - other elements</b>	<b>(1.56)</b>	<b>2.86</b>	<b>4.42</b>
<b>Closing cash balance</b>	<b>14.39</b>	<b>14.50</b>	<b>0.11</b>

Better Payment Practice Code	Paid year to date	Paid within target	% Paid within target
Non-NHS - number of bills	72,579	60,140	82.9%
Non-NHS - value of bills (£k)	161,497	134,508	83.3%
NHS - number of bills	924	548	59.3%
NHS - value of bills (£k)	16,356	12,801	78.3%
Total - number of bills	73,503	60,688	82.6%
Total - value of bills (£k)	177,853	147,309	82.8%

### Key points of note:

- Access to PDC support remains absolutely critical to the Trust's 2022/23 cashflow. The Trust continues to seek £5.9m of emergency capital PDC and to seek revenue support to offset its revenue deficit.
- Cashflow in the first half of each month has improved due to the agreement of the ICB to pay block income at the start (rather than the middle) of each month.
- Capital-related cashflow is £4.3m adverse to plan. This is largely due to capital PDC funding £5.6m not yet received, partly offset by accrued capital expenditure £0.3m behind plan and paying down of the capital creditor £1.0m lower than planned.
- Cash generated from operations is £5.8m adverse, principally due to the adverse I&E position.
- Debtor movements is £3.6m adverse. This is largely due to increased debtors in respect of Dartmouth H&WBC and Torbay Council.
- Creditor movements is £6.1m favourable, principally due to increased NI/pension creditors and HEE deferred income.
- Other Cashflow Movements is £6.4m favourable, due to the early receipt of revenue support PDC.

Statement of Financial Position (SoFP) – Month 06, September 2022

	Month 06		
	Plan £m	Actual £m	Variance £m
<b>Non-Current Assets</b>			
Intangible Assets	11.33	11.56	0.23
Property, Plant & Equipment	218.14	219.19	1.05
On-Balance Sheet PFI	17.43	17.35	(0.08)
Right of Use assets	18.86	18.92	0.06
Other	1.44	1.52	0.09
<b>Total</b>	<b>267.21</b>	<b>268.56</b>	<b>1.35</b>
<b>Current Assets</b>			
Cash & Cash Equivalents	14.39	14.49	0.11
Other Current Assets	42.29	44.89	2.60
<b>Total</b>	<b>56.68</b>	<b>59.39</b>	<b>2.71</b>
<b>Total Assets</b>	<b>323.89</b>	<b>327.94</b>	<b>4.06</b>
<b>Current Liabilities</b>			
Loan - DHSC ITFF	(2.92)	(2.92)	(0.00)
PFI / LIFT Leases	(1.29)	(1.31)	(0.02)
Trade and Other Payables	(53.83)	(58.98)	(5.15)
Other Current Liabilities	(9.32)	(11.50)	(2.18)
<b>Total</b>	<b>(67.36)</b>	<b>(74.71)</b>	<b>(7.35)</b>
<b>Net Current assets/(liabilities)</b>	<b>(10.68)</b>	<b>(15.32)</b>	<b>(4.64)</b>
<b>Non-Current Liabilities</b>			
Loan - DHSC ITFF	(23.75)	(23.75)	(0.00)
PFI / LIFT Leases	(14.65)	(14.68)	(0.03)
Other Non-Current Liabilities	(21.25)	(21.26)	(0.02)
<b>Total</b>	<b>(59.65)</b>	<b>(59.70)</b>	<b>(0.05)</b>
<b>Total Assets Employed</b>	<b>196.88</b>	<b>193.54</b>	<b>(3.34)</b>
<b>Reserves</b>			
Public Dividend Capital	156.73	157.41	0.69
Revaluation	51.54	51.54	0.00
Income and Expenditure	(11.39)	(15.41)	(4.02)
<b>Total</b>	<b>196.88</b>	<b>193.54</b>	<b>(3.34)</b>

**Key points of note:**

- Non-current assets are £1.3m higher than planned. This is principally due to depreciation £1.5m lower than planned, partly offset by capital expenditure £0.3m lower than planned.
- Cash is £0.1m higher than planned, as explained in the commentary to the cashflow statement.
- Other current assets are £2.6m higher than planned. This is principally due to increased debtors in respect of Dartmouth H&WBC £1.4m and Torbay Council, partly offset by reduced Covid reimbursement debtor.
- Trade and other payables are £5.2m higher than planned. This is principally due to increased NI/pension creditor £3.3m due to backdated pay award and increased capital creditors £1.0m.
- Other Current Liabilities are £2.2m higher than planned, largely due to HEE funding received in advance.
- PDC reserves are £0.7m higher than planned, due to revenue support drawn down earlier than planned, largely offset by capital support not yet drawn down.
- I&E reserves are £4.0m lower than planned, due to the adverse I&E position.

## 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:

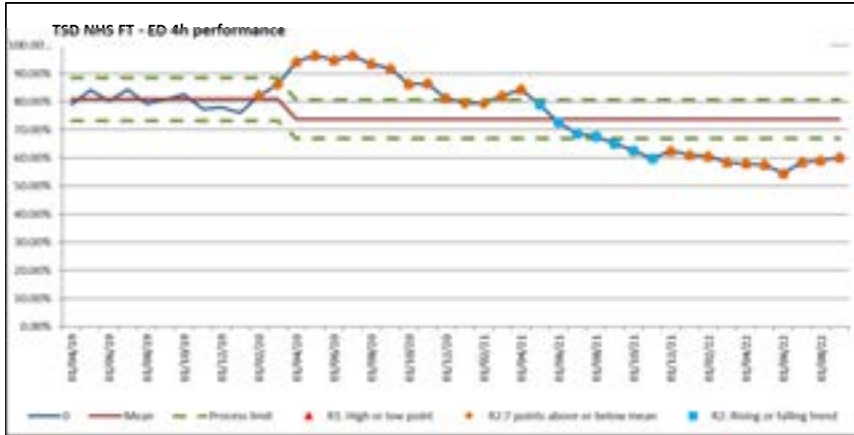
- 'predict' statistically whether a process is 'capable' of meeting a target;
- identify if a process is sustainable - i.e. are your improvements sustaining over time;
- identify when an implemented improvement has changed a process - i.e. it has not just occurred by chance;
- generally understand processes - 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).

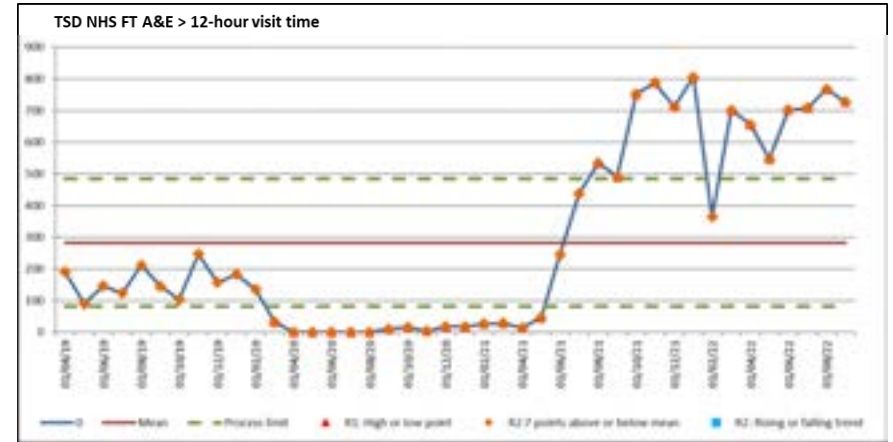
In preparing for fuller roll out, a selection of key metrics are presented below in SPC format.

# Key Indicators - Statistical Process Control (SPC) charts

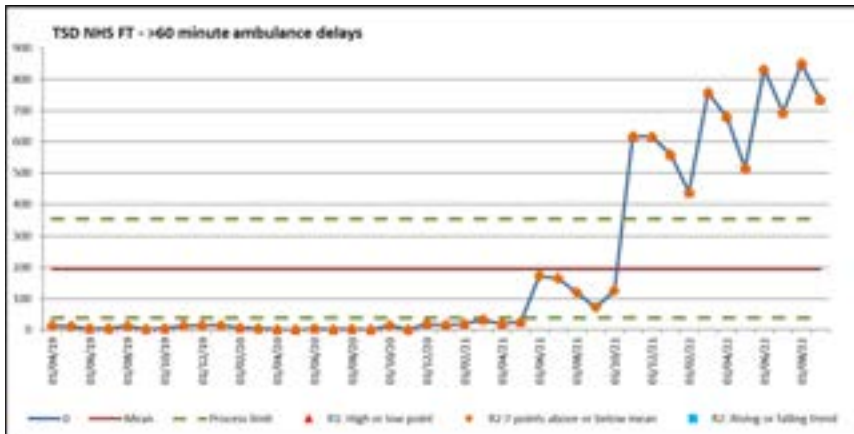
## ED 4 hour performance



## 12- hour visit time



## Greater than 60-minute ambulance handover delays



# Key Indicators - Statistical Process Control (SPC) charts

## Referral To Treatment



## Diagnostics performance



## Cancer 2-week-wait performance



## Cancer 62-day performance





	ISU	Target	13 month trend	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Year to date
<b>QUALITY LOCAL FRAMEWORK</b>																	
Reported Incidents - Severe	Trustwide	<6		0	1	3	0	4	4	4	2	3	2	1	3	5	16
Reported Incidents - Death	Trustwide	<1		0	1	5	0	2	0	3	2	1	0	2	2	1	8
Medication errors resulting in moderate harm	Trustwide	<1		0	0	0	0	0	1	2	1	0	0	0	0	0	1
Medication errors - Total reported incidents	Trustwide	N/A		48	59	45	56	42	58	54	60	61	56	46	58	74	355
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		0	1	1	0	0	0	1	0	0	0	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		6	1	12	12	6	13	9	8	10	8	5	3	2	36
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams)	Trustwide	<1		2	0	0	0	2	1	0	0	2	0	1	0	0	3
Formal complaints - Number received	Trustwide	<60		11	11	10	9	16	11	12	12	12	7	13	16	10	70
VTE - Risk Assessment on Admission (acute)	Trustwide	>95%		91.9%	91.8%	96.2%	95.1%	94.8%	95.2%	94.4%	91.3%	89.7%	90.0%	91.8%	93.6%	92.7%	91.5%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		108.4	109.6	108.1	107.5	107.3	109.1	112.3	113.5	117.4	117				347.9
Safer Staffing - ICO - Daytime	Trustwide	90% - 110%		81.9%	81.9%	89.3%	87.81%	86.8%	88.3%	90.0%	89.0%	96.1%	95.8%	93.7%	94.4%	96.4%	96.4%
Safer Staffing - ICO - Nighttime	Trustwide	90% - 110%		74.6%	74.6%	83.7%	60.32%	77.8%	78.8%	79.3%	79.7%	86.5%	88.1%	85.8%	86.2%	85.6%	85.6%
Infection Control - Bed Closures - (Acute)	Trustwide	<100		42	476	218	285	71	49	203	30	12	130	84	36	132	424
Hand Hygiene	Trustwide	>95%		96.5%	98.5%	96.2%		1	95.3%	98.7%	94.5%	92.3%	94.5%	96.0%	97.7%	96.6%	95.0%
Fracture Neck Of Femur - Time to Theatre <36 hours (1 month in arrears)	Trustwide	>90%		81.0%	82.1%	60.0%	68.6%	77.4%	78.4%	76.9%	67.9%	65.8%	66.7%	56.4%	56.0%	50.0%	
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		69.2%	35.9%	52.8%	50.0%	18.2%	59.0%	28.1%	35.3%	67.6%	34.1%	66.7%	59.3%	54.8%	53.9%
Mixed Sex Accommodation breaches	Trustwide	0					0	0	0	0	0	0	0	0	0	0	0
Follow ups 6 weeks past to be seen date	Trustwide	6400		17789	18231	18069	19797	20026	20496	21388	22516	22215	22158	21504	21797	21693	21693
<b>WORKFORCE MANAGEMENT FRAMEWORK</b>																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		4.4%	4.5%	4.6%	4.7%	4.8%	5.0%	5.3%	5.6%	5.6%	5.6%	5.8%	5.7%		5.7%
Appraisal Completeness	Trustwide	>90%		79.7%	77.9%	79.2%	78.6%	76.1%	75.2%	71.9%	71.3%	73.9%	75.2%	77.0%	78.0%	75.8%	75.8%
Mandatory Training Compliance	Trustwide	>85%		89.0%	89.0%	88.8%	88.4%	88.6%	89.2%	89.5%	89.6%	89.8%	90.1%	89.7%	89.2%	88.7%	88.7%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		11.3%	11.6%	11.5%	12.0%	12.6%	12.9%	13.4%	13.2%	13.6%	13.7%	13.8%	13.8%	13.9%	13.9%

	ISU	Target	13 month trend	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Year to date
<b>COMMUNITY &amp; SOCIAL CARE FRAMEWORK</b>																	
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%		5.2%			5.4%			6.5%			6.5%			6.8%	
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		546	604	590	628	644	623	645	671	664	705	700	714	737	671
Intermediate Care - No. urgent referrals	Trustwide	113		241	222	237	219	195	213	212	190	210	230	205	213	189	214
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		229	243	191	200	202			266	241	215	234	222	196	265
Urgent Community Reponse (2-hour) - Referrals	Trustwide	NONE SET			31	39	35	19	31	28	28	24	26	26	15	20	139
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	70%			67.7%	61.5%	74.3%	52.6%	67.7%	57.1%	60.7%	79.2%	69.2%	65.4%	80.0%	80.0%	71.2%
Urgent Community Reponse (2-48 hour)- Referrals	Trustwide	NONE SET				113	105	98	131	139	98	128	130	106	198	138	1064
Urgent Community Reponse (2-48 hour) - Target achievement	Trustwide	NONE SET				89.4%	97.1%	102.0%	80.2%	83.5%	92.9%	89.1%	88.5%	81.1%	87.9%	91.3%	83.1%
<b>ADULT SOCIAL CARE TORBAY KPIS</b>																	
Proportion of clients receiving self directed support	Trustwide			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Proportion of carers receiving self directed support	Trustwide	94%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% Adults with learning disabilities in employment	Trustwide	7%		7.1%	6.8%	7.0%	6.8%	6.7%	6.6%	7.1%	7.3%	7.3%	7.3%	7.5%	7.5%	7.6%	7.3%
% Adults with learning disabilities in settled accommodation	Trustwide	80%		80.6%	80.6%	81.5%	81.6%	81.6%	81.8%	81.1%	81.3%	81.2%	80.3%	79.7%	79.7%	79.6%	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		17.7	17.7	20.4	23.1	25.8	19.0	21.7	24.5	29.9	35.3	28.5	40.8	32.6	24.5
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		449.6	422.7	411.9	376.9	487.3	476.5	570.8	576.2	823.8	880.4	928.8	939.6	931.5	576.2
Proportion of clients receiving direct payments	Trustwide	25%		19.0%	19.4%	19.4%	19.6%	19.4%	19.6%	19.8%	19.5%	19.4%	19.6%	19.7%	20.0%	20.4%	19.5%
% reablement episodes not followed by long term SC support	Trustwide	83%		87.4%	87.9%	87.9%	87.7%	88.0%	87.8%	88.9%	84.5%	86.8%	89.6%	89.5%	85.4%	85.2%	84.5%
<b>NHS I - OPERATIONAL PERFORMANCE</b>																	
A&E - patients seen within 4 hours	Trustwide	>95%		65.1%	62.5%	59.8%	62.5%	61.1%	60.6%	58.4%	58.0%	57.6%	54.5%	58.5%	59.1%	60.2%	58.0%
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		57.4%	57.0%	56.5%	55.6%	54.7%	54.7%	52.0%	50.4%	52.3%	50.6%	49.5%	48.5%	42.5%	42.5%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		73.3%	70.5%	57.0%	61.9%	49.1%	52.1%	59.5%	57.8%	61.5%	56.4%	60.4%	57.0%	60.8%	60.8%
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		32.6%	33.8%	32.4%	37.9%	41.3%	38.4%	36.8%	33.9%	32.0%	30.1%	29.1%	33.9%	34.9%	34.9%
Dementia - Find - monthly report	Trustwide	>90%		92.7%	94.4%	95.0%	87.3%	94.8%	89.7%	93.6%	91.6%	94.6%	84.1%	92.5%	90.6%	94.1%	91.3%

	ISU	Target	13 month trend	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Year to date
<b>LOCAL PERFORMANCE FRAMEWORK 1</b>																	
Number of Clostridium Difficile cases reported	Trustwide	<3		2	1	2	6	6	3	7	2	4	4	6	9	7	32
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		55.6%	50.5%	45.2%	44.3%	45.6%	48.1%	61.1%	59.6%	60.9%	35.6%	31.9%	38.4%	45.3%	45.3%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		92.4%	95.1%	79.8%	82.5%	38.6%	71.4%	81.0%	76.8%	77.8%	41.7%	17.3%	58.5%	79.1%	79.1%
Cancer - 28 day faster diagnosis standard	Trustwide			60.6%	58.8%	52.5%	52.8%	55.2%	73.1%	75.0%	76.9%	67.6%	64.8%	67.7%	72.1%	70.4%	70.4%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		99.4%	98.2%	96.7%	96.8%	94.8%	96.5%	97.4%	92.6%	90.7%	96.0%	96.7%	98.0%	92.8%	92.8%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	97.3%	98.6%	98.3%	100.0%	97.4%	100.0%	98.7%	98.7%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		98.6%	98.4%	100.0%	100.0%	97.1%	98.3%	93.8%	94.7%	92.6%	95.5%	98.0%	98.4%	92.2%	92.2%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		100.0%	100.0%	97.1%	100.0%	96.4%	91.7%	82.9%	100.0%	95.5%	87.5%	88.9%	95.5%	96.8%	96.8%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		71.4%	87.5%	82.4%	77.8%	72.7%	85.7%	80.0%	70.4%	66.7%	92.9%	69.2%	70.0%	90.9%	90.9%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide			15	29	14	26	27	39	39	33	65	61	67	59	35	35
RTT 52 week wait incomplete pathway	Trustwide	0		1943	2093	2169	2384	2584	2759	3199	3374	3765	4137	4578	5083	5060	5060
RTT 78 week wait incomplete pathway	Trustwide	0		641	572	477	532	587	649	763	779	813	713	686	787	813	813
RTT 104 week wait incomplete pathway	Trustwide	0		100	116	126	147	182	213	245	192	173	96	70	51	50	50
On the day cancellations for elective operations	Trustwide	<0.8%		0.5%	1.2%	2.6%	1.3%	1.4%	0.9%	0.9%	1.6%	1.1%	1.3%	1.7%	3.1%	1.4%	1.7%
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		5	3	30	12	6	8	11	12	5	9	9	13	8	56
Virtual outpatient appointments (non-face-to-face) 1 month in arrears	Trustwide	25%		20.3%	20.5%	21.1%	19.3%	20.7%	21.3%	18.8%	19.6%	20.9%	20.9%	20.2%	16.9%		
Bed Occupancy	Acute	90.0%		93.8%	93.1%	93.2%	93.1%	93.3%	93.9%	95.1%	93.7%	93.2%	94.3%	92.3%	92.3%	95.2%	97.6%
No Criteria to Reside - daily average - weekday (ICO)	Trustwide	No target		55.6	61.7	66.1	87.8	101.1	80.2	70.4	70.3	46.0	45.1	57.2	41.5	55.4	
Number of patients >7 days LoS (daily average)	Trustwide			149.1	148.4	145.7	157.0	183.0	165.0	172.0	171.6	166.0	173.0	167.0	167.0	184.9	171.6
Number of extended stay patients >21 days (daily average)	Trustwide			43.9	43.6	39.9	48.0	64.0	60.6	50.0	45.6	38.5	43.0	40.9	48.0	49.2	44.2
<b>LOCAL PERFORMANCE FRAMEWORK 2</b>																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		219	285	959	952	889	727	1026	967	894	1081	995	1135	983	6055
Ambulance handover delays > 60 minutes	Trustwide	0		72	125	617	616	559	438	757	680	514	832	694	850	735	4305
A&E - patients with >12 hour visit time pathway	Trustwide			491	753	788	712	806	364	701	656	548	702	708	768	727	4109
Trolley waits in A+E > 12 hours from decision to admit	Trustwide	0		69	130	139	162	131	123	202	155	68	178	162	139	241	943
Number of Clostridium Difficile cases - (Acute) *	Trustwide	<3		2	1	1	3	5	1	5	2	3	4	4	8	6	27
Number of Clostridium Difficile cases - (Community)	Trustwide	0		0	0	1	3	1	2	2	0	1	0	2	1	1	5
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		77.3%	74.5%	72.0%	63.0%	69.2%	75.2%	72.1%	71.1%	71.0%	63.8%	69.7%	70.7%		69.0%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		46.4%	45.5%	50.7%	39.2%	36.7%	52.8%	48.6%	50.0%	52.2%	50.8%	48.0%	48.3%		49.9%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		73.0%	67.7%	67.8%	69.1%	74.6%	67.7%	66.0%	69.5%	65.4%	69.5%	69.1%	80.2%		

	ISU	Target	13 month trend	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Year to date
<b>NHS 1 - FINANCE AND USE OF RESOURCES</b>																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-367	-327	-401	-609	-845	-955	-2025	-187	718	-914	-1231	-4412	-5783	
Agency - Variance to NHSI cap	Trustwide			-2.10%	-2.10%	-2.00%	-2.00%	-1.80%	-1.60%	-1.40%	-2.00%	-2.40%	-2.40%	-2.10%	-2.10%	-2.00%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide						-833	-659	-222	248	-1812	-1873	-2717	-2751	-3858	-4403	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			9080	12336	16029	19492	20987	15148	15919	-57	1977	814	1203	1065	975	
Distance from NHSI Control total (£'000's)	Trustwide			7	8	-13	37	153	88	-59	-5	1286	0	0	-2978	-4014	
<b>ACTIVITY VARIANCE vs 2019/20 BASELINE</b>																	
Outpatients - New	Trustwide			-4.5%	-19.0%	1.9%	-4.2%	-18.5%	-7.1%	22.4%	-16.3%	-13.8%	-7.5%	-18.1%	2.4%	0.2%	-9.3%
Outpatients - Follow ups	Trustwide			-5.8%	-19.0%	-2.7%	-6.9%	-22.2%	-15.2%	19.3%	-13.4%	-5.5%	-7.0%	-15.3%	4.0%	-0.8%	-6.5%
Daycase	Trustwide			-4.5%	-20.6%	-11.7%	-12.6%	-22.3%	-15.8%	17.0%	-17.7%	-10.4%	-0.4%	-7.9%	-3.5%	3.2%	-6.2%
Inpatients	Trustwide			-24.4%	-25.8%	-37.0%	-33.8%	-47.5%	-38.8%	-23.4%	-9.2%	-8.8%	-7.0%	-16.1%	-15.5%	9.6%	-8.2%
Non elective	Trustwide			-0.8%	-7.9%	-9.6%	-14.9%	-12.2%	-10.3%	12.3%	0.1%	-11.5%	-1.4%	-8.1%	-2.7%	-6.5%	-3.3%
<b>INTEGRATED CARE MODEL</b>																	
Intermediate Care Referrals (All)	Trustwide			525	511	537	504	540	554	550	514	541	503	512	0	0	
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			14.57	12.19	12.20	14.10	13.60	15.60	15.60	15.70	14.30	14.50	15.70	0.00	0.00	

<b>Report to the Trust Board of Directors</b>				
<b>Report title:</b> Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training			<b>Meeting Date:</b> 26 October 2022	
<b>Report appendix</b>	No appendices			
<b>Report sponsor</b>	Medical Director			
<b>Report author</b>	Medical Workforce Manager			
<b>Report provenance</b>				
<b>Purpose of the report and key issues for consideration/decision</b>	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			
<b>Action required (choose 1 only)</b>	<b>For information</b> <input type="checkbox"/>	<b>To receive and note</b> <input checked="" type="checkbox"/>	<b>To approve</b> <input type="checkbox"/>	
<b>Recommendation</b>	The Board are asked to receive and note the Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training			
<b>Summary of key elements</b>				
<b>Strategic objectives supported by this report</b>	<b>Safe, quality care and best experience</b>	X	<b>Valuing our workforce</b>	X
	<b>Improved wellbeing through partnership</b>	X	<b>Well-led</b>	X
<b>Is this on the Trust's Board Assurance Framework and/or Risk Register</b>	<b>Board Assurance Framework</b>	X	<b>Risk score</b>	16
	<b>Risk Register</b>		<b>Risk score</b>	
Risk Ref. 1 – Quality and Patient Experience				
<b>External standards affected by this report and associated risks</b>	<b>Care Quality Commission</b>		<b>Terms of Authorisation</b>	
	<b>NHS Improvement</b>		<b>Legislation</b>	
	<b>NHS England</b>		<b>National policy/guidance</b>	X

<b>Report title: Guardian of Safe Working Hours – Doctors and Dentists in training</b>		<b>Meeting date:</b> 26 October 2022
<b>Report sponsor</b>	Medical Director	
<b>Report author</b>	Medical Workforce Manager	

## 1. Executive Summary

The following report concerns the time period of 10<sup>th</sup> April 2022 up to the 10<sup>th</sup> August 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 Conditions 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 215 Exception Reports in the period 10<sup>th</sup> April 2022 up to the 10<sup>th</sup> August 2022. This is an increase on the number of exception reports from the previous quarter.

**Table 1 – Exception Reports by Area**

Specialty	No. exceptions raised in reporting period	No. exceptions closed	No. exceptions outstanding	Comment
Gastroenterology	2	2	0	
Acute medicine	8	6	2	
General Medicine	91	52	39	
General Surgery	39	21	18	
Ophthalmology	5	4	1	
Cardiology	2	2	0	

Haematology	37	3	34	21 submitted by 1 trainee. Ongoing discussions with the department
Obstetrics & Gynaecology	4	1	3	
ENT	27	19	8	
Total	215	110 (51%)	105 (49%)	

**Table 2 – Exception reports by Grade**

Grade	No. exceptions raised in reporting period
F1	93
F2	66
CT1-3	47
ST 4-9	9
Total	215

**Table 3 – Nature of Exception**

Additional Hours	150
Service support	50
Educational	15

**Table 4 – Outcome of Exceptions**

TOIL	12
Payment	95
Cancelled (no action required)	4
Agreed no further action required	4
Outstanding	100

#### **4. Comment on Exception Reports**

The number of outstanding actions is due to the role of Guardian of Safeworking Hours currently being vacant. The role has now been recruited to and the new Guardian will be starting in post in January 2023. In the meantime, the Medical Workforce team are reviewing the exception reports on a weekly basis.

## **5. Rota Reviews**

Rota reviews have been carried out by Practice Managers working alongside Medical Workforce on every Junior Doctor rota as mandated by the Junior Doctor Contract. There is an ongoing review of staffing numbers in the General Medical junior Dr rotations, and new rotas have been developed to be implemented for the December rotation.

There is an ongoing review of the surgical F1 hot week rota. 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. The rota manager is attempting to recruit a Junior Dr to help her design an alternative rota which maintains service coverage.

## **6. Fines**

There have been no Guardian fines for this period.

## **7. Qualitative Information**

It is important to appreciate the complexity of the mandated reporting system. In order to receive TOIL or payment the current process requires the Junior Doctor to submit an exception report, have it signed by a clinical supervisor/lead, meet with a rota manager to agree TOIL/payment, submit a timesheet and log back into Allocate (the Exception IT System) to sign off the Exception report as complete. We hope to review this process with the new Guardian.

## **8. Summary**

There has been a huge amount of work undertaken to create a more sustainable rota across general medicine and therefore we hope that following the implementation of the new rota pattern in December 2022 the number of exception reports will decrease as General medicine currently generate the largest number of exception reports.

The National Training Survey Report 2022 for Torbay indicated that the Trust performed well when compared against regional benchmarking. The Trust has improved positively in areas such as teamwork and a supportive environment. However, only 52.69% of trainees reported satisfaction in rota design, this is inline with the national benchmark of 54.28% but as an organisation this is something that we will need to focus on for the year ahead and we hope with the changes made to the General medicine rota's this may have a positive impact.



<b>Report to the Trust Board of Directors</b>			
<b>Report title:</b> Maternity Governance & Safety Report (1 July 2022 – 30 September 2022)			<b>Meeting date:</b> 26 October 2022
<b>Report appendix</b>	None		
<b>Report sponsor</b>	Chief Nurse		
<b>Report author</b>	Associate Director of Midwifery & Professional Practice/HoM Clinical Governance Co-ordinator Maternity Safety Champion/Deputy Head of Midwifery Digital & Quality Improvement Midwife		
<b>Report provenance</b>	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).		
<b>Purpose of the report and key issues for consideration/decision</b>	<p>The purpose of this report is to provide assurance to the Trust Board around key aspects of the maternity safety agenda, specifically relating to:</p> <ul style="list-style-type: none"> <li>• The paper specifically sets out the Trust position and compliance with the Ockenden Report following the Insights Visit</li> <li>• Setting out the Trust position in relation to perinatal mortality and morbidity, specifically reduction in still births.</li> <li>• Progress and next steps with regard to achievement of CNST key safety actions</li> <li>• An update on progress against Maternal Continuity of care (COC)</li> <li>• An update on the progress against the Maternity Self-Assessment tool</li> <li>• To advise on the UNICEF Baby Friendly reaccreditation</li> </ul>		
<b>Action required (choose 1 only)</b>	<b>For information</b> <input type="checkbox"/>	<b>To receive and note</b> <input checked="" type="checkbox"/>	<b>To approve</b> <input type="checkbox"/>
<b>Recommendation</b>	<p>The Trust Board of Directors are asked to:</p> <ul style="list-style-type: none"> <li>• Note the progress and compliance position with regard to the priority areas</li> <li>• Note the key quality and safety issues identified in the report</li> <li>• Note progress and next steps with regard to the CNST process</li> </ul>		

<b>Summary of key elements</b>				
<b>Strategic objectives supported by this report</b>	<b>Safe, quality care and best experience</b>	<b>x</b>	<b>Valuing our workforce</b>	<b>x</b>
	<b>Improved wellbeing through partnership</b>	<b>x</b>	<b>Well-led</b>	<b>x</b>
<b>Is this on the Trust's Board Assurance Framework and/or Risk Register</b>	<b>Board Assurance Framework</b>		<b>Risk score</b>	
	<b>Risk Register</b>		<b>Risk score</b>	
<b>External standards affected by this report and associated risks</b>	<b>Care Quality Commission</b>	<b>x</b>	<b>Terms of Authorisation</b>	
	<b>NHS Improvement</b>	<b>x</b>	<b>Legislation</b>	
	<b>NHS England</b>	<b>x</b>	<b>National policy/guidance</b>	<b>x</b>
	<p>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.</p>			

<b>Report title:</b> Maternity Governance & Safety Report (1 July 2022 to 30 <sup>th</sup> September 2022)		<b>Meeting date:</b> 26 October 2022
<b>Report author</b>	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 has always been a 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) 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 around governance and safety in response to the Ockenden findings 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 July 2022 – 30 September 2022 (Q2)

## 2.0 Review and monitoring of safety within maternity services

### 2.1 Ockenden Maternity Review

An Insight visit to Torbay & South Devon Maternity services was completed on the 28<sup>th</sup> July 2022. The purpose of the visit was to provide assurance against the 7 immediate and essential actions from the first Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice. Overall, the visit team agreed with TSD's Ockenden self-assessment as compliant with all areas. The only area where further clarity was required was around ensuring audits will not be at risk as a result of the SystemOne implementation, particularly in reference to robust risk assessment. The service has put mitigations in place to undertake a manual risk assessment audit which reflects the digital one which is in development on SystemOne.

Strong leadership from the Head of Midwifery was noted as well as a good line of sight to the Trust Board with particular note of the presence of the CEO at the feedback session.

Some of the recommendations identified had been highlighted by the Trust prior to the visit through completion of the Maternity self-assessment tool. This included a requirement to strengthen the Obstetric governance role. An update on progress against the maternity self-assessment is included later in this paper.

The team also highlighted that they felt the environment and organisational logistics were impacting on patient experience. They gave examples of the air conditioning (AC) being broken

and that the footprint on John Macpherson was cramped They recommended that prioritisation needs to be made to fix and maintain AC in the maternity unit.

The team highlighted some exemplars of good practice.

- The work that the retention midwives have done to support the workforce; staff feeling supported was evident throughout the unit. Due to the positive work being done we have been asked to participate in a national service evaluation by a research team based at King's in London.
- The multidisciplinary approach to fetal monitoring education and training. They felt that this was a particular area of strength with active participation of fetal monitoring training on labour ward. They will be sharing this approach throughout the LMNS as an area of best practice.

The full findings of the visit will be shared in full at the Quality Assurance Committee in November 2022

## 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)**

PCQS Requirements	
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
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.	In Place
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
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
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

## 2.3 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.)

**Table 2: PCQS Minimum Dataset Information Summary Q2**

	July	August	September
<b>Findings of review of all perinatal deaths using the real time data monitoring tool</b>	No reviews undertaken.	One case reviewed	Two cases reviewed
<b>Findings of review all cases eligible for referral to HSIB.</b>	No new referral	New referral MI-012927	No new referral
<p><b>Report on:</b> The number of incidents logged graded as moderate or above and what actions are being taken</p> <p>Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training</p> <p>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.</p>	<p><b>1 Moderate incident reported</b></p> <p>-Stillbirth at 24 weeks</p> <p><b>Training – 95% compliance</b></p> <p><b>Staffing</b></p> <p>Full details in section 4</p>	<p><b>3 Moderate Incidents reported</b></p> <p>-Therapeutic cooling, HSIB</p> <p>-Interoperative Complications</p> <p>- PPH – 2.6 Litres</p> <p><b>Training – 98% compliance</b></p> <p><b>Staffing</b></p> <p>Full details in section 4</p>	<p><b>2 Moderate Incidents reported</b></p> <p>-Stillbirth at 32 weeks</p> <p>-Admission to ICU – HELLP Syndrome</p> <p><b>Training –88% compliance</b></p> <p><b>Staffing</b></p> <p>Full details in section 4</p>
<b>Service User Voice feedback</b>	Feedback mechanisms in place.	Feedback mechanisms in place	Feedback mechanisms in place
<b>Staff feedback from frontline champions and walk-about</b>	Completed	Completed	Completed
<b>HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust</b>	Nil	Nil	Nil
<b>Coroner Reg 28 made directly to Trust</b>	Nil	Nil	Nil
<b>Progress in achievement of CNST 10</b>	Data quality concerns escalated to IGG via ISU governance re data quality	Issues raised via IGG around the reporting element for Safety action 2. Poor compliance with CO monitoring – action plan put in place by HOM	Self-declaration date changed to 2/2/23. Compliance for CO monitoring improved with data quality submissions improving
<b>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)</b>			72%
<b>Proportion of specialty trainees in Obstetrics &amp; Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)</b>			100%

## 2.4 Serious Adverse Events

### 2.4.1 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. We have now established a process of inviting external reviewers to the PMRT reviews as set out in the standards.

#### (a) PMRT - Notifications

During July - September 2022 there were two new cases that met the PMRT criteria and were reported. Details of the cases are

- Antepartum Stillbirth at 24 weeks gestation - July
- Antepartum Stillbirth at 32 weeks gestation - September

Both of the cases have undergone duty of candour.

- For the July Case a multidisciplinary case review using the national PMRT process for review has been completed and the review team were unable to determine a cause of death. The family have met with the clinical team to discuss the findings.
- For the September case, the initial case review identified learning regarding electronic fetal monitoring and the interpretation of the Dawes Redman criteria. The electronic fetal monitoring had detected the maternal pulse due to the absence of the fetal heart. This heart rate was lower than would have been expected for a fetus so the midwife did seek a second review. Confirmation of the stillbirth was then made. This learning has been disseminated to all Midwifery and medical staff. .

#### (b) PMRT – Completed Reviews

During Q2 we completed three reviews of deaths that occurred prior to and during Q2. No cause of death was found for the completed cases. Learnings from the cases were:

Placental histology was performed but was not carried out by a perinatal/paediatric pathologist. There are ongoing discussions regionally and nationally around service provision with a nationally led working party set up This action is on the Trust risk register and the Trust have escalated outside to the LMNS. The LMNS are continuing discussions at regional level to maintain the visibility of this gap in service provision. Local guidance has been amended to ensure that placentas requiring examination are set to the pathology laboratory for a basic histological examination.

During a mother's labour, maternal observations, commensurate with her level of risk were not carried out. The Bereavement midwife has met with a member of the clinical team providing care and emphasised the necessity of maternal observations. This did not impact on the outcome and was an incidental finding identified during the review. Audit of maternal observations is carried out as part of a monthly maternal early warning score rolling audit.

A partogram was not completed. This is a tool that summarises overall progress in labour and captures a number of observations and findings such as dilatation of the cervix Presently the

partogram does not form part of the new electronic record therefore the midwives need to complete a paper partogram and maternal observation chart. The observations were performed but just recorded elsewhere in the electronic record. The Bereavement midwife will add to Mandatory training the importance of completing a partogram and we are also planning further bereavement study sessions for clinical teams.

## **2.5 Healthcare Safety Investigation Branch (HSIB)**

### **2.5.2.1 Referrals to HSIB**

In Q2 one new case was referred to HSIB:

This case met the criteria for therapeutic cooling of the baby following birth.

The mother had a category one Caesarean Section (EMLSCS) at 38+2 weeks gestation following an Induction of Labour (IOL) for Gestational Diabetes (GDM), Raised Body Mass Index (BMI) of 53 and Polyhydramnios. The baby was transferred to a level 3 neonatal unit and was subsequently discharged home well.

An initial review of the care was completed and shared with the HSIB.

### **2.5.2. Finalised investigation reports from HSIB**

In Q2 there were no finalised reports completed.

## **2.5 Quarterly Engagement Visit with South West Maternity Investigation Team**

We met with the South West Maternity Investigation Team on 6<sup>th</sup> September 2022. We heard about investigation findings nationally and a review of our local trust referrals was completed. The trust was able to update HSIB on local practice changes in relation to HSIB investigations. These were:

- Trust wide decision to ensure a second emergency theatre and team are available out of hours.
- Latent phase guideline developed.
- A review and update to the Induction of Labour policy
- Handover sheet developed for delayed or cancelled Induction of Labour and Caesarean Sections.
- “Think Pink” Learning for staff on the importance of blood-stained Liquor.
- A review of our triage system has commenced.

The trust also highlighted the ongoing issues regarding placental histopathology and access to post mortems.

## **2.7 Safety Improvement**

### **2.7.1 Maternity and Neonatal Health Safety Improvement Programme (MATNEOSIP) including PERIPrem**

The latest MatNeoSIP Patient Safety Network Event, was held on 28 September 2022. The event included presentations on the collaborative work on EHPIC (Empowering Healthy Pregnancy in Cornwall), which involved Kernow Maternity Voices Partnership & Cornwall Council. An update was provided on the early themes emerging from the current project on Babies Born Before Arrival

in the South West. Data has now been procured from six acute settings and early analysis has begun with aims being to support the reduction of hypothermia and ultimately improve longer term outcomes – disproportionately benefitting under-served groups.

The South West PERIPrem project has won the Best Regional/National Project at the BAPM Gopi Menon Awards 2022

### 2.7.2 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.

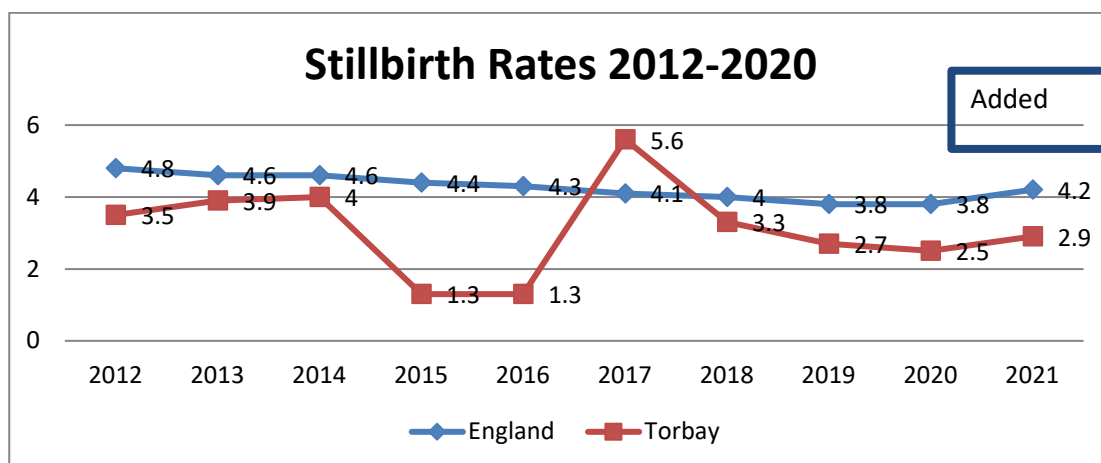
The Board will recall previous escalation regarding the potential non-compliance around the element pertaining to a reduction of smoking in pregnancy, specifically CO monitoring at booking and 36 weeks. Evidence of 80% compliance is required for both. We are continuing to monitor and review progress 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. A CO monitoring dashboard has been developed which provides live data on our compliance in these 2 metrics and is being monitored daily.

For CO readings at booking our figures are August 77% and September 76%  
 For CO readings at 36 weeks our figures are August 82% and September 87%

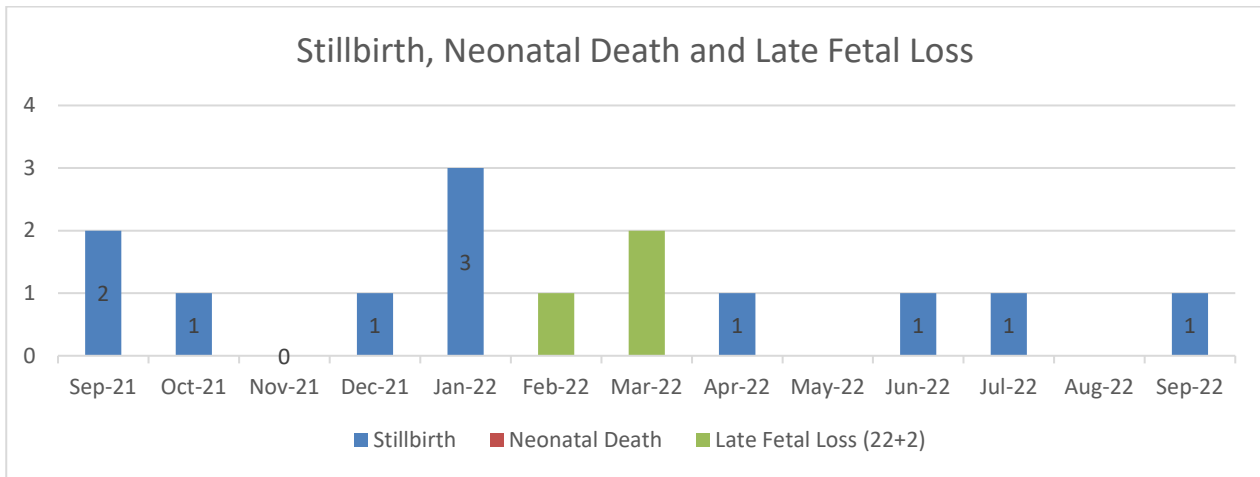
There has been a significant improvements in the compliance rate following targeted intervention led by the Head of Midwifery and team.

### 2.7.3 Stillbirth Rate

One of the aims of SBLCB v1 and v2 is to reduce the number of stillbirths. National comparative data for England for 2021 has been published and has increased to 4.2% (3.8% in the previous year as per chart below). TSD is still below the England rate at 2.9%. It is thought that the national rise in rate is related in some way to the Covid 19 pandemic; either directly by an effect of the virus on the placenta or indirectly due to pressures of NHS or the impact of lockdown.







### 2.7.4 Avoiding Term Admissions into Neonatal Units

The ATAIN collaborative work between the Maternity Service and Child Health is ongoing and is a fundamental part of CNST Safety Action 3. An audit is required of all term babies transferred to the neonatal unit, regardless of the length of stay from July 2022 as a minimum. The findings of this audit inform a live action plan to identify and implement relevant learning. Progress against the action plan is shared with the Board Level Safety Champion.

For this reporting period an average of 4% of term babies were admitted to the Special Care Baby Unit. This is a decrease from 4.7% seen in the last reporting period and remains below the target of 5% or less.

Constraints continue in relation to this workstream. Predominately these issues relate to space and capacity issues within the clinical area. Prior to the COVID-19 pandemic, the estates strategy for the Women’s Health Unit had been approved and included the provision of a dedicated Transitional Care Facility in the space on Macallum ward. This would enable the maternity and neonatal services to support the on-going care of babies with additional needs, ensuring that mothers and babies are not separated, whilst avoiding term admissions into SCBU. Work is underway as part of the capital prioritisation process to review and refresh the strategy for this area.

### 2.8 Maternity Safety Champions

Monthly walkarounds with the Board Level Safety Champion (BLSC) continue and the Non-Executive Director is also undertaking walkarounds within the clinical areas, these provide a mechanism for maternity staff to escalate safety concerns directly to Board level. Monthly safety drop-in meetings also continue for all maternity and neonatal staff and the day and time of these are varied to enable a variety of staff to attend.

A summary of safety concerns and actions taken are provided to staff in the monthly maternity service meeting minutes.

Concerns that have been raised by staff recently include:

**SystemOne** – A number of risks have been raised around the data quality in system one. As part of the Go Live time period, it not unusual for some disruption to data flows which impacts the quality of data. This inhibits our ability to extrapolate data for the purpose of performance and quality surveillance as well as demonstrating compliance against key CNST standards

Over recent weeks confidence has grown with regard to the data flows and although based on our own calculations from the raw data files, we are more confident around achieving full compliance against CNST standards. We will we have asked our Data Warehouse team to make an early submission of July data so that we can receive some immediate feedback on our data quality to see if there is anything that we can rectify. We are able to make multiple submissions up until 31/09 with the last submission being the one that we will be judged against.

## CNST: 10 Key Safety Actions

### 3.1 Process for Submission 2022/23

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. This required the Trust to review evidence compliance and complete a Board declaration to NHS resolution by January 2023. This has now been deferred again to **2<sup>nd</sup> February 2023**.

The team have re-established the 'CNST' task and finish group to ensure that we are able to meet and evidence compliance with the standards. Each year the evidence and assurance requirement become more significant and this impacts on the resources and workload required to facilitate this. This has been escalated through the Torquay ISU with a request for project management support.

Currently, the service is able to demonstrate full compliance with 3 of the safety standards. 4 of the standards are on track and 3 standards are requiring on going oversight to evidence the requirements. The team will need to present their final position at the January 2023 Board meeting with the aim of achieving full compliance in all 10 safety actions. The summary report planned for the January Board meeting will include action plans for some safety actions as required by the CNST technical guidance.

A summary position is included below with details of the actions required to progress the safety actions that are not yet compliant.

#### CNST Maternity Incentive Scheme Year 4: Summary position

Safety Action	Safety action summary	Status
1	Perinatal Mortality Review Tool (PMRT)	Compliant
2	Maternity Services Data Set (MSDS)	Not yet compliant
3	Avoiding Term Admissions	On- track
4	Clinical Workforce (Obs, Anaes, Paed, NN Nursing)	Not yet compliant
5	Midwifery Workforce	On track
6	Saving Babies Lives Version 2	Not yet compliant
7	Service User Feedback	COMPLIANT
8	Multi-Professional Training	On- track
9	Maternity Safety Champions	On- track
10	HSIB and Early Notification Scheme	COMPLIANT

## Potential Risks

### Safety Action 2 – Maternity Service Data Set

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. Following the latest test July MSDS data submission, we have received provisional indicative figures from NHSD for CNST which shows that we are 'meeting expectations' for 10 out of the 11 CQIMS and all of the criteria for Safety Action 2. If this is verified then we will achieve the required standard for this safety action. The work required to progress this safety action is intensive and has impacted on the Digital/QI midwife being able to undertake other elements of her work moving forward consideration must be given on how we sustain the level of support that a digital EPR requires to maintain the level of data quality.

### Safety Action 4 – Clinical workforce

Trusts are required to evidence an effective system of workforce planning for the Obstetric, Anaesthetic and Neonatal workforce. There are some outstanding actions to enable full compliance. These relate to Obstetric and Neonatal Workforce.

Required standard	Technical Guidance	Trust actions
<ol style="list-style-type: none"> <li>1. Commitment to incorporating the principles outline in RCOG workforce document ‘Roles and Responsibilities of the Consultant providing acute care in Obstetrics and Gynaecology’</li> <li>2. Units to monitor compliance of consultant attendance for the clinical situations stipulated. Action plans to be formulated for any occasions of non-attendance and shared with Trust board and LMNS</li> <li>3. The Neonatal Unit meets the British association of Perinatal Medicine (BAPM) national standards of junior medical staffing</li> </ol>	<ul style="list-style-type: none"> <li>• Principles incorporated and discussed at relevant meetings</li> <li>• Mandatory attendance list to be included in escalation policies</li> <li>• Audit of the attendance of Consultants at clinical scenarios</li> <li>• Evidence of the rota demonstrating compliance with standards</li> </ul>	<p>The principles have been embedded into practice.</p> <p>Escalation guideline being reviewed and updated to include the list of mandatory attendance list for clinical situations</p> <p>Audit of attendance is in progress with a plan to address any non-attendance.</p> <p>Confirmation from the Neonatal team BAPM standards and if not an associated action plan to address this in collaboration with the neonatal ODN</p>

## **Safety action 6 – Saving Babies Lives care bundle**

There are 5 elements contained within this safety action. One relates to smoking cessation and requires a number of metrics to be met in relation to CO monitoring. The required standard is 80% compliance as an average over a 4-month period for the completion of CO monitoring at the booking and 36-week gestation appointment. In August compliance was around 36%.

A number of measures were introduced including increasing education and training as well as daily monitoring of performance via a live dashboard which allows any gaps in CO testing to be addressed.

There has been a marked improvement in compliance against this standard.

By the end of September, the position was 82% for booking and 87% for 36 weeks.

The 4-month period for compliance will be 1st September – 31<sup>st</sup> December 2022. It is now anticipated that this standard will be met.

There are also a number of audits associated with the other elements of this safety action that are required to be completed. The results of these audits will impact on the ability to declare compliance in these standards.

### **4. Staffing**

In Q2 sickness due to Covid-19 has significantly reduced resulting in relatively minimal impact on our ability to maintain minimum optimum staffing levels. Shortages continue to be covered by bank midwives and staff working extra hours, with no use of agency midwives. In addition, careful management of annual leave has resulted in optimum staffing levels being maintained on the vast majority of shifts throughout the summer period.

At the present time there are no plans to utilise international recruitment to fill vacancies. This is following a system wide meeting and was a decision due to the challenges experienced nationally associated with the level of support required for these midwives. We remain on track to have filled all of the vacancies created by the uplift of 14.4 WTE by the end of the calendar year.

Obstetric staffing has been impacted by sickness absence leading to a requirement for the Consultant's to cover on calls and clinical work at short notice. This has been particularly challenging over the summer and is more impactful in a unit of this size.

### **5. Midwifery Continuity of Care (MCoC)**

In line with the national debate around challenges and opportunities relating to Midwifery continuity of Care, on the 21<sup>st</sup> September 2022 the Chief Nursing Officer and Chief Midwifery Officer for England sent out a letter detailing a change to the national maternity programme in light of the workforce challenges.

These changes involve the removal of the target date for services to deliver MCoC and local services will instead be supported to develop local plans that work for them. Local midwifery and obstetric leaders should focus on retention and growth of the workforce, and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths.

We plan to review what this means for us as a service and will work collaboratively with our teams as well as the LMNS to continue to develop a sustainable model of continuity.

## 6. Maternity Self-Assessment

The Maternity Safety Self-assessment tool was shared with the Quality Assurance Committee in July 2022. The team are addressing the required actions and are making progress in some areas

- Recruitment processes are in place for an operational manager
- National funding bid approved for additional Consultant PA time to strengthen Governance oversight
- Governance review to be commenced by the SW Internal audit team

## 7. UNICEF Baby friendly reaccreditation

The UNICEF Baby Friendly accreditation programme is recognised and recommended in numerous government and policy documents. Baby Friendly's work to support breastfeeding is based on extensive and resounding evidence that breastfeeding saves lives, improves health and cuts costs in every country worldwide. Services which implement the Baby Friendly standards receive the prestigious Baby Friendly award, a nationally recognised mark of quality care.

Our maternity service achieved full accreditation in 2012. We have subsequently achieved two reaccreditations, the last in 2019. We are being externally reassessed by UNICEF on the 2<sup>nd</sup>-3<sup>rd</sup> of November, this will provide an opportunity to review our service and action plan and how we make improvements to progress towards our goal of achieving gold accreditation. We have a robust audit process and have been able to facilitate a maternity support worker to support the Infant Feeding lead. The COVID-19 pandemic paused some of the initiatives we had underway collaboratively with the community, including our breastfeeding peer support volunteers on the ward. We are planning to reinstate peer support in all settings.

## 8. Conclusion

The maternity and neonatal teams continue to ensure that systems are in place to provide assurance in relation to safe midwifery care. The feedback from the Insights visit will help to shape our continuous improvement journey. The focus in the next quarter will be on achieving full compliance in the CNST standards

## 9. 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 with regard to the CNST process
- Note the next steps and plan with regard to the Maternal Continuity of Care model



<b>Report to the Trust Board of Directors</b>			
<b>Report title:</b> Report on Safeguarding Adults, Mental Capacity and Deprivation of Liberty Safeguards		Meeting date: 26 October 2022	
<b>Report appendix</b>	None		
<b>Report sponsor</b>	Chief Nurse		
<b>Report author</b>	Head of Safeguarding Adults MCA DOLS		
<b>Report provenance</b>	The report has been informed by data collated by TSDFT performance management team for Torbay and Devon Safeguarding Adults Partnership (TDSAP), activity within the TDSAP arrangements, Adult Social Care Outcomes Framework (ASCOF) data, Torbay Council KPI's, Care Quality Commission (CQC) regulated activity Safeguarding Adult and Mental Capacity Operational Group and TSDFT Integrated Safeguarding and Inclusion Group. The report is also informed by regional and national guidance and legislative frameworks.		
<b>Purpose of the report and key issues for consideration/decision</b>	<p>This annual report will inform TSDFT Board members on issues relating to safeguarding vulnerable adults in Torbay and South Devon. The Trust has delegated responsibility for Local Authority statutory safeguarding duties for adults on behalf of Torbay Council. This is governed by The Care Act 2014.</p> <p>Priority considerations within this report are as follows</p> <ol style="list-style-type: none"> <li>1. Implications of the Mental Capacity Amendment Act 2019. Liberty Protection Safeguards. (risk 2692, score 12).</li> <li>2. The current strategic priorities and activity to meet priorities.</li> <li>3. Safeguarding Adult performance data for the period 2021-2022.</li> </ol>		
<b>Action required (choose 1 only)</b>	<b>For information</b> <input type="checkbox"/>	<b>To receive and note</b> <input checked="" type="checkbox"/>	<b>To approve</b> <input type="checkbox"/>
<b>Recommendation</b>	The Board is asked to receive and note the contents of the report on Safeguarding Adults, Mental Capacity and Deprivation of Liberty Safeguards for assurance.		
<b>Summary of key elements</b>			
<b>Strategic objectives supported by this report</b>	<b>Safe, quality care and best experience</b>	x	<b>Valuing our workforce</b>
	<b>Improved wellbeing through partnership</b>	x	<b>Well-led</b>

<b>Is this on the Trust's Board Assurance Framework and/or Risk Register</b>	<b>Board Assurance Framework</b>		<b>Risk score</b>	
	<b>Risk Register</b>	<b>x</b>	<b>Risk score</b>	<b>12</b>
<b>External standards affected by this report and associated risks</b>	<b>Care Quality Commission</b>	<b>x</b>	<b>Terms of Authorisation</b>	
	<b>NHS Improvement</b>		<b>Legislation</b>	<b>x</b>
	<b>NHS England</b>	<b>x</b>	<b>National policy/guidance</b>	<b>x</b>
	<p>The standards and legal frameworks that driving the Safeguarding Adult and Mental Capacity Act agenda are referenced at Para. 5 of this report. These inform our local policies and practice guidance, many of which are co-produced by the Torbay and Devon Safeguarding Adult Partnership.</p>			



<b>Report title:</b> Report on Safeguarding Adults and Mental Capacity Act and Deprivation of Liberty Safeguards		<b>Meeting date:</b> 26 October 2022
<b>Report sponsor</b>	Chief Nurse	
<b>Report author</b>	Head of Safeguarding Adults, Mental Capacity Act and Deprivation of Liberty Safeguards.	

## Introduction

The Safeguarding Adult Annual Report for 2021/2022 provides key information in relation to core messages, performance, legal frameworks, governance and safeguarding activity during this period.

## Discussion

### 1. National and Local Context

National Care Act 2014 statutory guidance continues to direct how organisations work together to safeguarding adults from abuse. It is underpinned by six key principles

- Empowerment. People being supported and encourage to make their own decisions and informed consent.
- Prevention. It is better to take action before harm occurs
- Proportionality. The least intrusive responses to the risk presented
- Protection. Support and representation for those in greatest need
- Partnership. Local solutions through services working with their communities.
- Accountability. Accountability and transparency in delivering safeguarding.

The national Making Safeguarding Personal agenda (MSP) links heavily to the six key principles. Led by the Association of Directors of Adult Social Care (ADASS), Local Government Association and other national partners including health, it is a sector led initiative to develop an outcomes focus to safeguarding practice. The agenda has focused nationally, regionally and locally in evidencing MSP principles in safeguarding responses and performance and improving outcomes in response to safeguarding adult reviews.

### 2. COVID-19

The Local Government Association published its [3rd Report](#) titled COVID-19 Adult Safeguarding Insight Project Third Report in December 2019. The report provided an updated national picture relating to safeguarding adult's activity during the COVID-19 pandemic up to June 2021.

There is some variation in local data when compared to the national insight project outcomes, but the report itself concludes that national variations in safeguarding concern reporting remained high. Some outcomes were identified locally including

- Increased number of safeguarding concerns.
- No change in prevalence of types of abuse but some increases in domestic abuse, self-neglect and complexity.

- Risk of abuse within peoples' homes increased.

### **3. How are we aligned in Torbay and South Devon?**

There are strong partnership arrangements across geographical boundaries such as Torbay and Devon Safeguarding Adult Partnership (TDSAP) and the Torbay and Devon Anti-Slavery and Prevent Partnership Boards. Lead professionals attend and contribute to safeguarding and Mental Capacity forums at a regional level. Partnership networks exist in relation to Liberty Protection Safeguards both in health and social care the newly formed Devon ICB is leading on developing greater consistency in safeguarding systems across health providers. The close partnership arrangements ensure TSDFT systems and processes are informed by local, regional and national drivers.

### **4. Culture and Leadership**

Trust Values, Vision, Objectives and Purpose are aligned to Safeguarding / Mental Capacity Act principles. These key messages directly link to the NHS constitution principles such as

- Protection of human rights. (Principle 1)
- Safe, high quality care which focuses on patient experience. (Principle 3)
- Placing the patient at the heart of everything. (Principle 4)
- Informed consent and the Mental Capacity Act (Rights)

Three examples of how we are putting this into practice include

- Introduction of mandatory Mental Capacity Act Training for all staff
- Best Practice forums
- Placing making safeguarding personal principles at the centre of safeguarding responses.

A zero tolerance of adult abuse is fundamental to our approach alongside principles of equality and non-discriminatory practice.

### **5. Legislation and Guidance**

#### **5.1 Care Act 2014**

The Care Act 2014 sets out provision relating to the care and support for adults and carers. Sections 42-47 of the Care Act relates specifically to Adult Safeguarding. Chapter 14 of Care Act statutory guidance sets out how these duties should be implemented. The Care Act requires that each local authority must:

- Set up an Adult Safeguarding Board (SAB).
- Make enquiries or cause others to do so, if it has reasonable cause to suspect an adult is experiencing, or is at risk of, abuse or neglect.
- Conduct safeguarding adult reviews in accordance with s.44 of the Act (SAB).
- Co-operate with each of its relevant partners as set out in Section 6 of the Act in order to protect the adult.
- In their turn each relevant partner must also co-operate with the local authority.

#### **5.2 The Mental Capacity Act 2005 (MCA 2005)**

This Act provides a statutory framework for

- People who lack capacity to make decisions for themselves, or
- People who have capacity and want to prepare for a time in the future when they may lack capacity.
- Who can take best interest decisions, in which situations, and how they should go about this.

The Act is underlined by 5 key principles –

Principle 1 – A presumption of capacity unless proved otherwise

Principle 2 – Individual's must be supported to make their own decisions

Principle 3 – People have the right to make unwise decisions

Principle 4 – Anything done on behalf of a person who lacks capacity must be undertaken in their best interests.

Principle 5 – Someone deciding or acting on behalf of a person who lacks capacity must do so in a way that is least restrictive.

During 21/22 Audits continued to be undertaken within clinical and adult social care teams. Overall application of MCA is improving but ongoing monitoring and development activity is necessary to meet MCA statutory duties particularly in regulated health services. The quality of recording and completion of MCA assessments was often cited. During this period, there was good evidence of improved recognition of Deprivation of Liberty Applications (DOLS) applications to Supervisory bodies from our regulated services.

### **5.3 Deprivation of Liberty Safeguards (Dols)**

- The Dols legal framework is covered in the Mental Capacity Act 2005 framework.
- It sets out approving the deprivation of liberty for people who lack the capacity to consent to treatment or care, in either a hospital, care home or specified domestic settings.
- The requirements about when and how deprivation of liberty may be authorised.
- The assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

The TSDFT continues to hold a backlog of Deprivation of Liberty Safeguards applications in its delegated Supervisory Body role. This reflects a national picture although during 21/22 our ability to manage backlog was compromised by a long-term vacancy and long-term team sickness. Our capacity was therefore 1/3 of the full staff compliment. Whilst agency Best Interest Assessors were utilised, the Adult Social Care Outcomes Data does benchmark Torbay at a lower than average level of performance than the national average and in previous years. We have also seen an increase in the number of applications from our hospital services (which is a positive), which has added to this pressure from a supervisory body stance. Risk is managed on an ongoing basis through weekly triage of applications against national ADASS guidance. We now have a full compliment of Best Interest Assessors and trained community Social Workers to become Assessors that can be accessed also. Having received the ASCOF data, we

are currently reviewing as an adult social care management team what if anything else can be done to improve performance

#### **5.4 The Mental Capacity (Amendment) Act 2019**

Last year's report highlighted further delays to the implementation of The Mental Capacity (Amendment) Act 2019.

Under the new arrangements NHS Trusts, CCG's and Local Authorities will become responsible bodies and have statutory duties to ensure people who meet threshold, are lawfully deprived of their liberty.

The DHSC national consultation on the draft code of practice closed on the 14<sup>th</sup> July 2022. At the time of writing this report, no further update has been released by the DHSC and it is still unclear on what date the Act will take effect.

A full Business Investment Proposal outlining the operational and financial implications of the Mental Capacity (Amendment) Act 2019 was presented to Board on 21<sup>st</sup> June '22. LPS remains on the corporate risk register (risk 2692, score 12) due to the financial investment required to meet the legal duties of TSDFT.

In total, the number of patients and services users likely to be impacted by these new arrangements is 4098. This excludes a further 3367 patients under the NHS Responsible Body function who may be eligible, but discharged within 72 hours, thus not allowing time for completion of the LPS process. Legally, LPS is still required to be considered and if appropriate activated for these patients.

The Trust LPS Implementation Group is overseeing implementation and will need to continue to plan, prepare and assess risk in readiness for implementation.

#### **5.5 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13**

The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

To meet the requirements of this regulation, the Trust must have a zero-tolerance approach to abuse, unlawful discrimination and restraint.

#### **5.6 Other Key Statutory Frameworks**

- Human Rights Act 1998
- Equality Act 2010
- Modern Slavery Act 2015
- Counter Terrorism and Security Act 2015
- Safeguarding Vulnerable Groups Act 2006

## 6. Strategic Priorities and Driving Improvement.

Strategic Priorities and activities to deliver priorities are described in the SA/MCA Operational Group Workplan. They are informed by Safeguarding Partnership arrangements, internal and external Regulatory and Adult Social Care agendas. The priorities and examples of how we have progressed these are set out below.

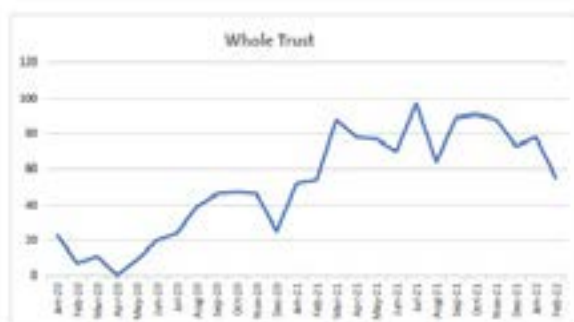
### 6.1 MCA / DOLS

#### Objectives.

1. To achieve compliance levels against agreed MCA training framework (Level 1 90%, All others 85%).
2. To have an MCA legally literate workforce.
3. To have accessible MCA resources available for frontline staff.

#### Key Summary

- ✓ Training compliance trajectory agreed
- ✓ Compliance trajectories on track for all levels
- ✓ 22 bespoke MCA / DOLS training sessions in clinical teams
- ✓ New MCA DOLS resource packs delivered to all clinical areas – inclusive of 7-minute briefings, exemplar templates for MCA assessments, Best Interest Decision checklist, DOLS process map.
- ✓ Liberty Protection Safeguards Implementation Group, LPS GANNT Chart, Local, Regional and National Implementation Group representation, Executive Board Updates and Investment proposal.
- ✓ Key Best Interest Assessor (BIA) Posts x 2 filled (May '22)
- ✓ 8 Community BIA's achieved qualification allowing to practice as BIA's
- ✓ Ongoing Professional Practice Support to Clinical and Adult Social Care Teams
- ✓ 2<sup>nd</sup> LPS scoping project including paediatrics (within 1% accuracy of 1<sup>st</sup> project post pandemic)
- ✓ Overall sustained increase in number of DOLS applications to the Supervisory Bodies although slight drop Dec – March '22



## 6.2 Domestic Abuse

### Objectives:

1. All TSDFT staff understand their roles and responsibilities in response to DASV.
2. TSDFT supports national Pathfinder Project Specialist Health Practitioner recommendation – specialist response for patients who have experienced domestic abuse.
3. All TSDFT have access support in response to DASV.

### Key Summary

- ✓ Overarching Domestic Abuse Policy reviewed to reflect acute and community services.
- ✓ Domestic Abuse Champions identified (to be rolled out).
- ✓ Adult Social Care representation at local Multi-Agency Risk Assessment Conferences (MARAC).
- ✓ New Domestic Abuse Specialist Practitioner to provide specialist advice and support to patients and staff (currently 12 months funding only).
- ✓ New Domestic Abuse Training Framework now available to all staff via the HIVE.

## 6.3 Safeguarding Adults

### Objectives:

1. To achieve compliance levels against agreed Safeguarding training framework (Level 1 90%, All others 85%).
2. To have a Safeguarding legally literate workforce.
3. To have accessible Safeguarding resources available for frontline staff.

### Key Summary

- ✓ Compliance trajectories agreed for all levels of safeguarding adult training.
- ✓ Compliance targets achieved for level 1 and level 2 training (i.e. if you see something say something).
- ✓ Revised TSDFT safeguarding adult policy.
- ✓ Revised TSDFT large scale enquiry policy.
- ✓ Revised TSDFT safeguarding practice guidance.
- ✓ Strengthened monthly (case closure) panels.
- ✓ New quality assurance checker (service user feedback scheme).
- ✓ Contribute to review of key TDSAP partnership policies and practice guidance.
- ✓ Self-Neglect Safeguarding Adult Review learning review seminar.
- ✓ Improved data collation of contacts to Regulated safeguarding adult / MCA leads.
- ✓ Safeguarding Adult Single Point of Contact relocated to new Gateway / Front door adult social care team – increased resilience / more streamlined responses.
- ✓ Attendance at all levels of TDSAP governance and joint leads in Business support arrangements.
- ✓ Contribute to ICB safeguarding workstreams – policy / workforce development programmes – consistency across ICB arrangements.
- ✓ Safeguarding Adult / MCA Newsletter.

Safeguarding Adult Level 3 competency has recently declined despite training availability. A review meeting is scheduled for November 2022 to look at delivery

and action planning and in the interim, teams are being encouraged to monitor compliance and release staff for available dates.

#### **6.4 Audit Assurance**

Objective:

1. Have a clear rolling safeguarding adult and MCA Audit programme with clear action plan responses.

#### **Key Summary – MCA**

- ✓ Audit 6687 completed. Use of MCA on Wards in Torbay Hospital.
- ✓ Bespoke Audit with ED Dept completed.
- ✓ ASC Monthly Peer Audit Programme.
- ✓ ASC 7-minute briefing 'MCA Assessment Audit Learning Outcomes'.
- ✓ ASC Monthly Safeguarding s.42 case closure panels enhanced (legal compliance assurance).
- ✓ Hospital Safeguarding Adult Walkaround completed.

#### **6.5 Prevent**

Objectives:

1. To Meet the Strategic Objectives of the Prevent Partnership Board including Counter Terrorism Local Profile Recommendations.
2. Annually complete the Prevent self-assessment tool referenced in Building Partnerships, Staying Safe, the health sector contribution to HM Governments Prevent Strategy: Guidance for healthcare workers. DOH 2011

- ✓ Contribute to the Health Partnership response to the Counter Terrorism Local Profile.
- ✓ Attendance at local Torbay and Devon Prevent Partnership Board to inform organisational priorities.
- ✓ Attendance at South West Regional Health Prevent Partnership.
- ✓ Monthly attendance at Torbay Channel Panel – standing member.

#### **6.6 Modern Slavery**

Objectives:

1. Adult Social Care staff are legally literate in regard to s. 52 Modern Slavery Act Duty to notify (ASC).
2. All staff have access to training and information resources a) on how to identify those who may be victims of modern slavery and human trafficking b) on how to report concerns

- ✓ Contributed to the development of the Torbay and Devon Anti-Slavery Partnership Modern Slavery Protocol.
- ✓ Corporate sign up to the Protocol.
- ✓ Attendance at Torbay and Devon Anti-Slavery Partnership Board.

## **6.7 Torbay and Devon Safeguarding Adult Partnership (TDSAP) Strategic Priorities.**

TSDFT is a key partner in the Business arrangements and activities of the TDSAP. During 21/22 TSDFT contributed to the creation of a new constitution which sets out the objectives, roles and functions of the partnership. The core objective of the Partnership, set out in section 43(2) of the Care Act 2014, is to help and protect adults in its area in cases where:

- the adult has care and support needs
- they are experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs they are unable to protect themselves from either the risk of or the experience of abuse or neglect.

During 21/22 the Partnership agreed 4 Strategic Plan Priorities for 2021-2024

- ✓ Priority 1 – To embed the learning from Safeguarding Adult Reviews into organisational practice
- ✓ Priority 2 – To improve outcomes for people with needs for care and support by finding the right solution at the right time.
- ✓ Priority 3 – To work with partners to better understand the risk of hidden harm.
- ✓ Priority 4 – Improving and involvement and engagement with people in receipt of safeguarding services.

Our workplan objectives therefore include these 4 priorities of the TDSAP and we continue to support activity to achieve the objectives. The TDSAP Sub Groups are assigned responsibility for completion of specific activities that support the 4 Strategic Priorities.

The Operational Delivery Group holds the Business Activity Plan and reports on progress to each TDSAP Board meeting.

## **6.8 CQC Drivers Regulation 13: Safeguarding Service Users from Abuse and Improper Treatment.**

Regulation 13 states that:

- Service users must be protected from abuse and improper treatment in accordance with this regulation.
- Systems and processes must be established and operated effectively to prevent abuse of service users.
- Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.
- Care or treatment for service users must not be provided in a way that—
  - includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,
  - includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service



user or another individual if the service user was not subject to control or restraint,

- is degrading for the service user, or
- significantly disregards the needs of the service user for care or treatment.
- A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

The overarching priorities sitting within the Safeguarding / Mental Capacity Act TSDFT Workplan provide assurance of activity to meet the TSDFT regulatory requirements.

## 7. Quality Assurance and Governance

### 7.1 Torbay and Devon Safeguarding Adult Partnership

The Devon and Torbay Safeguarding Adults Board (TDSAP) merged in December 2020 to form the Torbay and Devon Safeguarding Adult Partnership. The Partnership oversees and leads adult safeguarding across Torbay and Devon and are interested in a range of matters that contribute to the prevention of abuse and neglect. Safeguarding Adult Boards have three statutory duties -

- It must publish a strategic plan
- it must publish an annual report
- it must conduct any safeguarding adults review in accordance with Section 44 of the Act.

The Trust has been at the centre of creating the new partnership arrangement and has a key role in the business activity of the Board. The governance structure is described below. The TSDFT has membership at all levels of governance, provides data and contributes to local policy and practice development.



**TDSAP Organisational Structure**

## **7.2 Trust Integrated Safeguarding and Inclusion Group (ISIG):**

This is an Executive Led group with a mandate to deliver safeguarding and children statutory functions as a provider of health and social care and priorities of local safeguarding adult boards. The group also maintains oversight of other partnership arrangements linked to themes such as exploitation, domestic abuse and sexual violence. Delivery of priorities are largely connected with the strategic priorities and activities referenced in para 5.

## **7.3 Safeguarding Adults and Mental Capacity Operational Group.**

The purpose of the group is to ensure that clinical teams are leading the delivery of the safeguarding adult's and mental capacity agenda.

The monitoring and quality assurance of Trust wide safeguarding adults processes are reported to this group. This group reports to the Integrated Safeguarding and Inclusion Group, chaired by the Chief Nurse and links to the Quality Improvement Group internally and the Torbay and Devon Safeguarding Adults Board externally. The Trust's Integrated Safeguarding and Inclusion Group have overseen the operational work plan and directly links with the outputs in para 6. During 21/22 a review of membership restructure occurred which has led to ownership of the workplan being driven by Assistant Directors and Community Service Managers rather than operational leads.

## **7.4 Dementia Steering Group.**

The Dementia Steering Group is tasked with embedding national dementia strategy into local systems. This includes having a clear overview and understanding of how staff in TSDFT can support people with dementia within our services.

A member of the safeguarding team attends the quarterly forum meetings

## **7.5 Adult Social Care Operational Oversight Committee**

The committee reports adult social care activity and risk including Safeguarding and MCA DOLS. The committee reports direct to the ASC Performance and Transformation Committee which feeds reports by exception to the Adult Social Care Improvement Board. Reporting into Operational Oversight Committee also feeds into TSDFT IGG.

## **8 Other Areas of Safeguarding Activity**

### **8.1 Modern Slavery**

Slavery is not an issue confined to history; all staff receive modern slavery awareness as part of the mandatory safeguarding adult framework.

The Trust has an ICON site which includes a suite of information to support staff in responding to modern slavery concerns. The Trust contributes to partnership arrangements led by the Torbay and Devon Anti-Slavery Partnership.

## **8.2 Prevent**

Prevent Duty Guidance 2021 is one part of the UK Counter terrorism strategy CONTEST.

A key challenge is to ensure that, where there are signs that someone has been or is being drawn into terrorism, our staff recognise those signs correctly and are aware of and can locate available support, including the Channel programme where necessary.

The Trust is a key partner within the Torbay and Devon Prevent Partnership Board. Prevent awareness is mandatory for all staff and there is an icon page to support staff responding to prevent concerns. The Trust is a standing member of the Torbay Channel Panel and attends Devon Channel Panel as required. The Trust Prevent Policy was updated in February 2020 to reflect updated referral pathways. The Trust has been awaiting a new NHS revised training competency framework which has now been published (9/22). A full review of mandatory Prevent training via the Health partnership is underway to ensure consistency of approach across providers.

## **8.3 Criminal Exploitation**

County Lines remains an increasing problem in Devon which is directly linked to criminal exploitation. County lines, is when gangs and organised crime networks exploit vulnerable adults and children to sell drugs, which originate in major cities. Often these people are made to travel across counties, and they use dedicated mobile phone 'lines' to supply drugs.

It can also involve 'cuckooing' which when those gangs take over the home of a vulnerable adult and use it to sell drugs from. We retain close links with our local safer community partnerships and Devon and Cornwall Police in response to County Lines Concerns.

## **8.4 Domestic Abuse and Sexual Violence**

The Trust is a member of the -

- Torbay Domestic Abuse and Sexual Violence Executive and Operational Groups and there are work plans relating to both groups.
- The Domestic Abuse and Sexual Violence Steering Group.

Both groups have directed many of the activities referenced in 6.2 of this report.

Staff working in specific services receive enhanced training relating to domestic abuse and sexual violence and a new training is now accessible for all staff via the HIVE.

The Trust continues to contribute to Multi-Agency Risk Assessment Conference (MARAC) arrangements to ensure coordinated responses and support mechanisms are in place to people who have experienced or are experiencing Domestic Abuse and Sexual Violence.

## **8.5 Statement from NHS Devon Clinical Commissioning Group**

NHS Devon CCG has continued to support TSDFT in fulfilling their statutory duties under the Care Act through good relationships with both the adult social care teams and the health care teams. This valued relationship is well developed in order to enable the CCG to provide support through the safeguarding process. This includes the provision of an independent health perspective to support the reviewing of concerns to undertaking both large scale and individual enquiries. The CCG is a standing member of the Integrated Safeguarding and Inclusion Committee which supports both TSDFT and the CCG in gaining safeguarding adult assurance. The Designated Nurse for Safeguarding Adults also provides supervision to Nurses within the TSDFT Safeguarding Adult team.

## **8.6 Our Role in Ensuring Quality of Care in Care Homes**

The Trust has statutory responsibility for adult social care and safeguarding for all care home residents in Torbay, and almost half of the residents in these homes are funded this way. There are also people whom are self-funding in these homes, whom we must legally ensure are safeguarded as per our responsibilities under The Care Act 2014.

The Care Quality Commission (CQC) is the overall legal regulator of care homes and is responsible for the monitoring and audit of quality. In Torbay there are currently 64 residential homes registered with CQC and 13 nursing homes. The QAIT team work closely with CQC sharing intelligence and supporting providers to establish a good quality of care.

The NHS England framework for Enhanced Health in Care Homes (EHCH) continues to be rolled out successfully across Torbay. One of the key elements of care detailed is multidisciplinary team (MDT) support for residents with care and support needs. The Quality Assurance and Improvement Team (QAIT) partially provides this MDT from within the team. Where there is a need for more disciplines to be involved the QAIT will signpost, coordinate or work in conjunction with other health/social care professionals to improve the care of people with complex conditions. There have been further community health care professional posts, including the Care Home Visiting Service, established to work within the community and with an expectation that they support care home staff and also to assess and treat care home residents. QAIT staff members are specifically involved in some of the elements of EHCH such as the roll out of NHS emails, management of falls and signposting training specifically set up for care providers on the HIVE.

A weekly huddle which includes membership from safeguarding, QAIT and district nursing teams commenced at the end of August 2022. Whilst in its infancy the huddle has already improved information sharing across teams and encouraged a more robust multi-disciplinary way of working.

## **8.7 The Quality Assurance and Improvement Team**

The QAIT continues to offer care home staff and management the opportunity to develop a long-term relationship with a smaller group of staff and clinicians. Such trusting relationships enable QAIT to work alongside care providers in an open and transparent way to prevent issues becoming serious.

The COVID-19 pandemic has been a challenge that QAIT have heavily been involved in from the start. Care homes, supported living and out-reach services have received extensive support from QAIT and the team have been integral in coordinating support, monitoring risk, escalating concerns and producing a daily COVID report for Gold and Silver command, CCG and Public health. This support was over 7 days a week for large parts of the pandemic. Although this has impacted on the team's ability to carry on with their usual work the frequent contact with providers has strengthened relations and trust. Feedback from providers and CQC with regards to the level and competence of the support given during the COVID pandemic by QAIT, Torbay Care Trust and Torbay Council has been very positive.

QAIT were nominated for a "Chairs Special Award" in April 2022.

Along with other local partners in the South West, Torbay Council has invested in the Provider Assessment and Market Management Solution (PAMMS) system. It's an online audit tool which delivers data collection, analysis and reporting to increase quality of care and mitigate risks of provider failure. The QAIT officers will audit providers from all sectors using a robust question and answer framework. An outcome of the audit will provide a PAMMS rating which will enable the measurement of risk within the market. A small number of providers have been selected to undertake a two phased pilot with the QAIT officers starting towards the end of October 2022, completing at the end of March 2023. If the pilot is successful formal role out of the system will be in Spring 2023.

The QAIT is also involved in monitoring and supporting 24 domiciliary care providers, 12 outreach / enabling services and 25 supported living services, 8 of which have an outreach service attached to them. A QAIT officer post has been established to cover these services and works alongside commissioners to encourage supported living providers to join the Torbay supported living framework. 23 of the 25 supported living providers have now joined the framework.

QAIT have undergone some structural and process changes within the wider context of the Torbay Adult Social Care Improvement Plan. A more robust data system has been developed by QAIT staff to enable easier identification of risk, themes and trends within an overall dash board. This work continues to progress.

The clinical members of the team will be working closely with commissioners to gain better understanding of current capacity and capability across the care home market in Torbay. This will involve detailed review of built environment, management capability, staff skills and training, clinical capability of care home providers.

## **9. Performance**

### **9.1 Concerns and Section 42 Care Act 2014 Enquiries**

There were 998 concerns (1098 - 20/21) reported to Torbay Safeguarding Adults of which 274 (298 – 20/21) proceeded to statutory safeguarding enquiry.

Table 1: Concerns & Enquiries raised, closed & open in period

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend	Total
<b>CONCERNS:</b>														
Raised	102	89	90	102	58	71	62	102	76	89	74	83		998
Closed	79	67	65	127	66	55	52	77	88	49	180	67		912
Open at month end	158	180	205	180	172	188	198	223	211	251	185	201		
<b>ENQUIRIES:</b>														
Raised	43	27	17	19	12	24	22	31	17	27	18	17		274
Closed	15	12	9	22	18	5	11	28	20	6	72	20		211
Open at month end	144	159	167	164	158	177	188	196	193	214	180	157		
% Concerns raised that become enquiries	42.2%	30.3%	18.9%	18.6%	26.7%	33.8%	35.5%	30.4%	22.4%	30.1%	24.3%	20.5%		27.5%

Note: Enquiries are also counted as concerns as per statutory return

## Analysis

ADASS and the LGA led on providing a picture of how safeguarding activity in England and Wales was affected during the pandemic. There were various reports at different stages.

In the early stages of the pandemic there was a trend nationally for safeguarding concerns and enquiries to drop markedly only to return and then exceed normal levels as we came out of the first lockdown. Locally, we did not see this trend, safeguarding reporting remained relatively stable and the number of contacts over the months were slightly higher.

One of the key headlines from the second insight report published in July 21 (completed in May '21), did actually summarise that nationally, rates had been overall higher during 2020. This was subsequently reflected in our 20/21 data which recorded the highest volume of safeguarding concerns received, as referenced in the 1098 figure. This was the highest TSDFT had recorded for a number of years and the number of subsequent enquiries was the highest ever also. Our conversion rates from concern to enquiry were similar Devon County Council. Moving onto 21/22, it's perhaps not surprising that the rates dropped back slightly. They were still high though compared to previous years.

During this reporting period, our safeguarding single point of contact function was redeployed into the Front-End intake team. The rationale for this is we know that a majority of safeguarding concerns reported do not proceed to a formal Care Act s.42 safeguarding enquiry – as mentioned 27.5% of the total proceed to Care Act enquiry and this is comparative with Devon. By redeploying the team into the Front-End system, we have not only given increased resilience and better utilised staff resources, but are able to screen better what is an actual safeguarding concern against what is a welfare concern.

The National Adult Social Care Benchmarking data has been published in September 2022 for the period 2021-2022. Torbay Safeguarding is not an outlier in the number of concerns received per 100k of the population against comparators – for example Torbay is 901 per 100k compared to 866 in Blackpool. Our number of safeguarding statutory safeguarding enquiries per 100k was also average against other comparators.

## 9.2 Making Safeguarding Personal

Table 12: Enquiries closed in period by age band and whether preferred outcomes were asked

Preferred outcomes asked:	18-64	65-74	75-84	85-94	95+	Not Recorded	Total	%Total
Asked & expressed	74	19	25	27	4	1	150	64.4%
Asked & not expressed	12	8	8	12	1	0	41	17.6%
Not asked	4	1	2	3	0	0	10	4.3%
Don't know	3	0	1	1	0	0	5	2.1%
Not Recorded	11	8	4	4	0	0	27	11.6%
<b>Total</b>	<b>104</b>	<b>36</b>	<b>40</b>	<b>47</b>	<b>5</b>	<b>1</b>	<b>233</b>	<b>100.0%</b>
<b>% Total</b>	<b>44.6%</b>	<b>15.5%</b>	<b>17.2%</b>	<b>20.2%</b>	<b>2.1%</b>	<b>0.4%</b>	<b>100.0%</b>	

### Analysis

All Section 42 Care Act 2014 enquiries should as far as possible ascertain an individual's preferred outcomes. In 2021-2022 82% of people were asked about their preferred outcomes with 11.6% not recorded in PARIS. The figure is comparative with that reported to the TDSAP by Devon County Council. Monthly panels are now focusing greater on non-recording with a key target to increase the number of people asked to at least 90% by the end of the 22/33 period.

## 9.3 Outcomes

Table 13: Enquiries closed in period by age band and whether preferred outcomes were achieved (where outcomes were expressed)

Preferred outcomes achieved:	18-64	65-74	75-84	85-94	95+	Not Recorded	Total	%Total
Fully Achieved	33	10	17	20	3	0	83	55.3%
Partially Achieved	32	8	7	6	1	0	54	36.0%
Not Achieved	8	1	1	1	0	1	12	8.0%
Not Recorded	1	0	0	0	0	0	1	0.7%
<b>Total</b>	<b>74</b>	<b>19</b>	<b>25</b>	<b>27</b>	<b>4</b>	<b>1</b>	<b>150</b>	<b>100.0%</b>
<b>% Total</b>	<b>49.3%</b>	<b>12.7%</b>	<b>16.7%</b>	<b>18.0%</b>	<b>2.7%</b>	<b>0.7%</b>	<b>100.0%</b>	

### Analysis

Of those that were asked their preferred outcomes, over 91% of peoples preferred outcomes were either fully or partially achieved. 8% were not achieved but our analysis is that this is likely to be due to external factors.

## 9.4 Risk

Table 11: Enquiries closed in period by source of risk and risk outcome (where risk was identified)

Risk outcome:	Source of risk:				Total	% Total
	SC Support	Other Known	Other Unknown	Not Recorded		
Risk Remained	0	7	1	1	9	5.6%
Risk Reduced	34	56	2	6	98	60.5%
Risk Removed	33	16	0	6	55	34.0%
Not Recorded	0	0	0	0	0	0.0%
<b>Total</b>	<b>67</b>	<b>79</b>	<b>3</b>	<b>13</b>	<b>162</b>	<b>100.0%</b>
<b>% Total</b>	<b>41.4%</b>	<b>48.8%</b>	<b>1.9%</b>	<b>8.0%</b>	<b>100.0%</b>	

## Analysis

94% of individuals had either been reduced or removed as a consequence of a s.42 enquiry response. The number of repeat referrals during the same period (an indicator of ongoing adult abuse concerns) was within agreed KPI range at 8% for the previous 12-month period.

### 9.5 Types of Abuse

The table below reflects the various categories of abuse reported during 2021-2022. The 3 primary types of abuse reflect the national picture. During this period a slightly higher proportion of abuse category was reported in relation to sexual abuse, domestic abuse and self-neglect, despite the slightly lower overall number of enquiries.

Table 9: Enquiries closed in period by source of risk and alleged abuse type

Alleged abuse type:	Source of risk:				Total
	SC Support	Other Known	Other Unknown	Not Recorded	
Discriminatory	3	1	1	1	6
Domestic	1	20	0	2	23
Financial	11	52	2	3	68
Hate Crime	0	3	0	1	4
Institutional	29	9	0	4	42
Modern Slavery	0	1	0	0	1
Neglect	49	30	2	8	89
Physical	21	38	5	4	68
Psychological	19	51	3	6	79
Radicalisation	0	0	0	0	0
Self Neglect	0	24	0	2	26
Sexual	4	14	1	2	21
Sexual Exploitation	0	4	0	1	5
Other	0	3	0	0	3
Not Recorded	0	0	0	0	0
<b>Total</b>	<b>137</b>	<b>250</b>	<b>14</b>	<b>34</b>	<b>435</b>

Note: Multiple abuse types can be recorded per case

### 9.6 Deprivation of Liberty Safeguards (DOLS)

The Trust continues to hold a backlog of Deprivation of Safeguard referrals to the Supervisory Body. The DOLS statutory return was published in September 2022 and identified the following.

- TSDFT has the lowest proportion of granted applications in our comparator group, however we are in line with the South West region.
- We have the fourth highest number of incomplete applications at 31/3/22 in our comparator group, however this is not a rate per population.
- Our estimated time to complete outstanding applications is one of the highest in SW and comparator group.

Analysis is as described at the beginning of this report.

### 9.7 Large Scale Safeguarding Enquiries



There were 2 large scale enquiries during 2021-2022. One related to a community provider service and the other to a residential care home. Each enquiry identified a clear term of reference and required multi-disciplinary and multi-agency approaches to the assessment and management of risk. Such enquiries are a last resort option. They require intense operational responses to safeguard people at risk and support service improvement planning. In both these situations, one provider ceased trading and the other left the market which required transition support to the new provider.

## **10 Performance Quality Assurance**

**10.1 Case Closure Panel Meetings.** All safeguarding enquiries are reviewed within panel meetings prior to closure. This involves a lead safeguarding professional and social work supervisor reviewing safeguarding records to confirm that the Local Authority has satisfied itself that it has met its statutory safeguarding duties. This includes a review of the safeguarding response, records, legal literacy, safeguarding and protection plan as well as the application of best practice principles. Any further activity needed is directly feedback to practitioners by supervisors which also provides opportunity for reflective practice.

**10.2 Multi-agency case file audits** are scheduled within the new safeguarding adult partnership arrangement. This will increase our opportunities to review safeguarding performance within a multi-agency context with assurance provided direct to the safeguarding adult partnership.

**10.3 Provider Quality Assurance Huddles** occurred once every six weeks during this reporting period. The aim of these is to capture intelligence relating to care provider settings and agree responses. In June 2022 these were moved to weekly and redesigned in light of recent large-scale enquiries.

**10.4 Internal Audit.** Terms of reference for a safeguarding adult audit have been agreed and this will be completed by the end of 2022. The audit measures are identified as follows:

- ✓ Decisions on Safeguarding concerns are reached in accordance with national LGA guidance. 'Making decisions on the duty to carry out Safeguarding Adults enquiries' (LGA 2019).
- ✓ The Safeguarding Referral on PARIS evidences defensible decision making with regard to a decision to proceed to a s.42 enquiry.
- ✓ The timeliness of s.42 enquiry.
- ✓ s.42 enquiries clearly reflect the preferred outcomes of adults at risk or their representatives.
- ✓ Recordings in the s.42 assessment tool reflect the progress of the enquiry.
- ✓ Recordings in the s.42 assessment tool reflect defensible decision making.

## **11 Conclusion**

**11.1** Safeguarding activity remained high during 21/22 but with slightly less reporting than in 20/21. Other quantitative data was broadly the same as in previous reporting years although there has been a steady rise in the number of enquiries linked to alleged domestic abuse, sexual abuse and self-neglect. Data was comparative within national benchmarking.

- 11.2** The Torbay and Devon Safeguarding Adult Partnership agreed 4 strategic priorities for 2021-2024. TDSAP has membership at all levels of the partnership structure
- 11.3** Other TSDFT priorities are embedded in the Safeguarding / MCA workplan and captures key areas of safeguarding including Mental Capacity Act.
- 11.4** The Trust has continued to drive forward the safeguarding and mental capacity act agenda throughout this reporting period. Mandatory and Safeguarding Adult Training trajectories have been introduced with all but level 3 safeguarding adult training on track.
- 11.5** The Trust has a strong commitment to local and regional partnership arrangements to ensure our services are informed and we contribute fully to the safeguarding and mental capacity act agendas.
- 11.6** Liberty Protection Safeguards remains a high priority and is likely to have a significant impact on all TSDFT services. A monthly project management group continues to meet to drive decisions relating to implementation ahead of the anticipated go live date of 1<sup>st</sup> October 2023.

## **Recommendations**

The Board is asked to receive and note the contents of the report for assurance.

<b>Report to the Trust Board of Directors</b>			
Working together to deliver service transformation in Devon, Cornwall and Isles of Scilly- Peninsula Acute Provider Collaborative			Meeting Date: 26 October 2022
<b>Report appendix</b>	Appendix 1 - Acute Provider Collaborative Terms of Reference Appendix 2 - Acute Services Sustainability Programme		
<b>Report sponsor</b>	Chief Executive		
<b>Report author</b>	Chief Executive		
<b>Report provenance</b>	The paper has been developed following engagement with the membership of the Peninsula Acute Provider Collaborative and the Peninsula Acute Sustainability Programme Board.		
<b>Purpose of the report and key issues for consideration/decision</b>	<p>The report provides an overview of the work of the Peninsula Acute Provider Collaborative and sets out the rationale for a programme of work aimed at developing a sustainable model of Acute Services across the Peninsula that optimises opportunities afforded through the development of new technologies and new ways of working and addresses the challenges currently faced by our populations.</p> <p>The paper seeks approval to progress to the next phase of the work programme.</p>		
<b>Action required (choose 1 only)</b>	<b>For information</b> <input type="checkbox"/>	<b>To receive and note</b> <input type="checkbox"/>	<b>To approve</b> <input checked="" type="checkbox"/>
<b>Recommendation</b>	<p>The Board is asked to:</p> <ul style="list-style-type: none"> <li>• <b>Note</b> the work undertaken to date by the Peninsula Acute Provider Collaborative and the Acute Sustainability Programme</li> <li>• <b>Discuss</b> and <b>endorse</b> the strategic ambition for the Programme as outlined in <b>Figure 2</b></li> <li>• <b>Discuss</b> and <b>endorse</b> the design principles for the Programme as outlined in <b>Figure 3</b></li> <li>• <b>Discuss</b> and <b>endorse</b> the proposal to conduct a series of clinical workshops, commencing in November 2022, to explore opportunities for sustainable service redesign to deliver better, more equitable, clinical outcomes and make best use of resources across the Peninsula</li> <li>• <b>Agree</b> that regular progress updates on this work will be brought to all member Boards</li> <li>• <b>Note</b> that the governance arrangements and the current work-plan require any further assessment of options for potential service reconfiguration to be specifically mandated to the PAPC by the Trust Boards.</li> </ul>		

Summary of key elements				
<b>Strategic objectives supported by this report</b>	<b>Safe, quality care and best experience</b>	x	<b>Valuing our workforce</b>	x
	<b>Improved wellbeing through partnership</b>	x	<b>Well-led</b>	x
<b>Is this on the Trust's Board Assurance Framework and/or Risk Register</b>	<b>Board Assurance Framework</b>	x	<b>Risk score</b>	20
	<b>Risk Register</b>		<b>Risk score</b>	
BAF Reference: Integrated Care System - To develop and implement the Long Term Plan with partners and local stakeholders to support the delivery of the Trust's ICO Strategy				
<b>External standards affected by this report and associated risks</b>	<b>Care Quality Commission</b>		<b>Terms of Authorisation</b>	
	<b>NHS Improvement</b>		<b>Legislation</b>	
	<b>NHS England</b>		<b>National policy/guidance</b>	

## Working together to deliver service transformation in Devon, Cornwall and Isles of Scilly Peninsula Acute Provider Collaborative

### 1. Introduction

Earlier this year, the Board agreed to the establishment of the Peninsula Acute Provider Collaborative as a vehicle for joint working with other acute Trusts across Devon and Cornwall.

The Terms of reference and membership were previously approved by the Board (Annex 1) together with the establishment of the Acute Services Sustainability Programme (Annex 2) – a clinically-led programme of work that will engage staff and communities in the redesign of acute services to improve clinical, workforce and financial sustainability.

At the same time, the Integrated Care Partnerships of both Cornwall and Isles of Scilly ICS and Devon ICS are each developing their **Integrated Health and Care Strategy**. The strategy aims to set out how, in the future, all partners in the wider health and care system will work together to deliver more joined-up preventative and person-centred care – improving wellbeing, facilitating choice and supporting independent living. This strategy sets a critical context for the delivery of acute services and will be a key determinant of the future shape of healthcare across the Peninsula.

This paper aims to summarise progress to date and seek endorsement of the work-plan that will be implemented over the next 3-6 months with the aim of bringing forward recommendations for change during 2023/24.

### 2. Context

In line with the rest of England, demand is growing for primary and secondary healthcare. Increases in waiting lists, waiting times and ongoing challenges with unscheduled and emergency care activity create significant challenges in balancing demand and capacity. The availability of an appropriately skilled workforce is a major limiting factor impacting directly on the provision of health and social care in the appropriate place according to people's need.

Delivering a high quality, joined-up, sustainable health and care service for the local population is a key priority and expectation of the new Integrated Care Systems across England. This requires partners to work together to:

- Improve population health and care
- Identify and address health inequalities
- Enhance productivity and deliver best value for money across the whole resource envelope
- Address the wider determinants of health including social and economic development

Success will be dependent on organisations taking individual and collective action to drive efficiencies and deliver transformational changes that will generate immediate

improvements and set the foundations for clinical and financial sustainability in the medium to long term.

Back in 2019, local NHS organisations across Devon and Cornwall came together to explore strategic opportunities for transformation that would contribute to longer-term service sustainability. However, progress with the recommendations of the **Peninsula Clinical Services Strategy** was adversely affected by the pandemic.

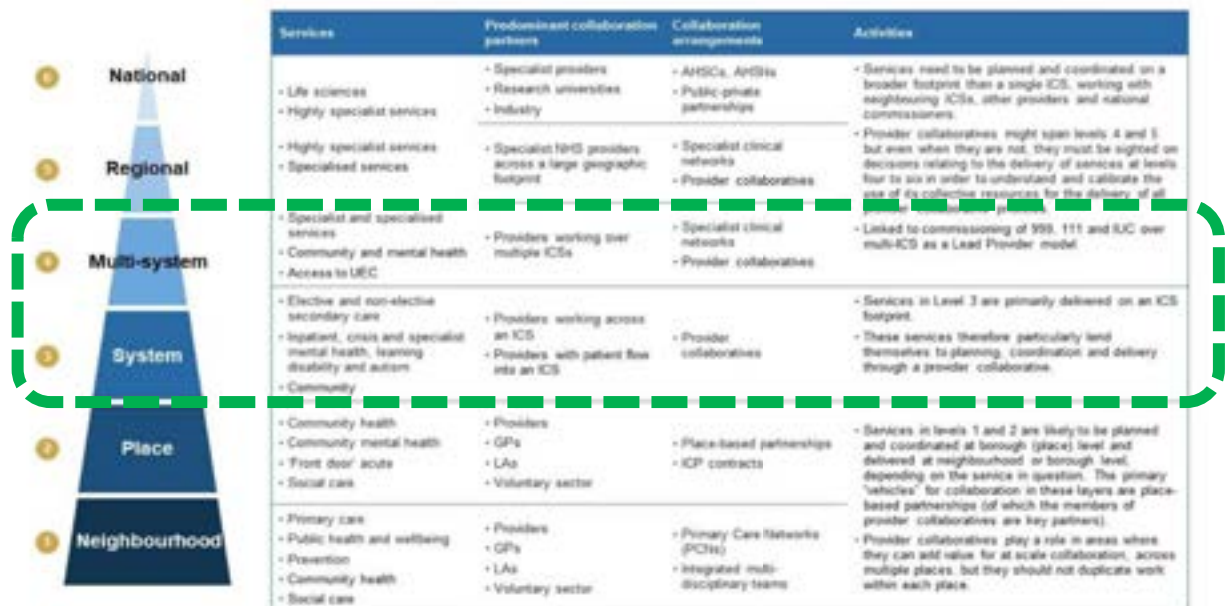
Since then, the strategic context has become even more challenging as demand for care, workforce constraints, and the underlying financial deficit have all increased.

Building on the outcome of the previous joint work, the pace and determination to develop new solutions will need to be much greater which further reinforces the need for leaders and organisations to work more closely together to make decisions to deliver service improvements in the best interest of the whole population of Devon and Cornwall.

### 3. Working together for success

The national framework for provider collaboratives<sup>1</sup> describes a range of levels at which collaborative working is expected to deliver improved services (Figure 1). Joint working in the areas of elective and non-elective secondary care are typically considered at an ICS level but the unique population demographics and flow of patients between boundaries across Devon and Cornwall suggest that collaboration of the acute providers across the whole peninsula population (circa 1.8m) would be in the best interest of local people.

Figure 1: Collaborations and activities that align with typical levels of service planning and delivery

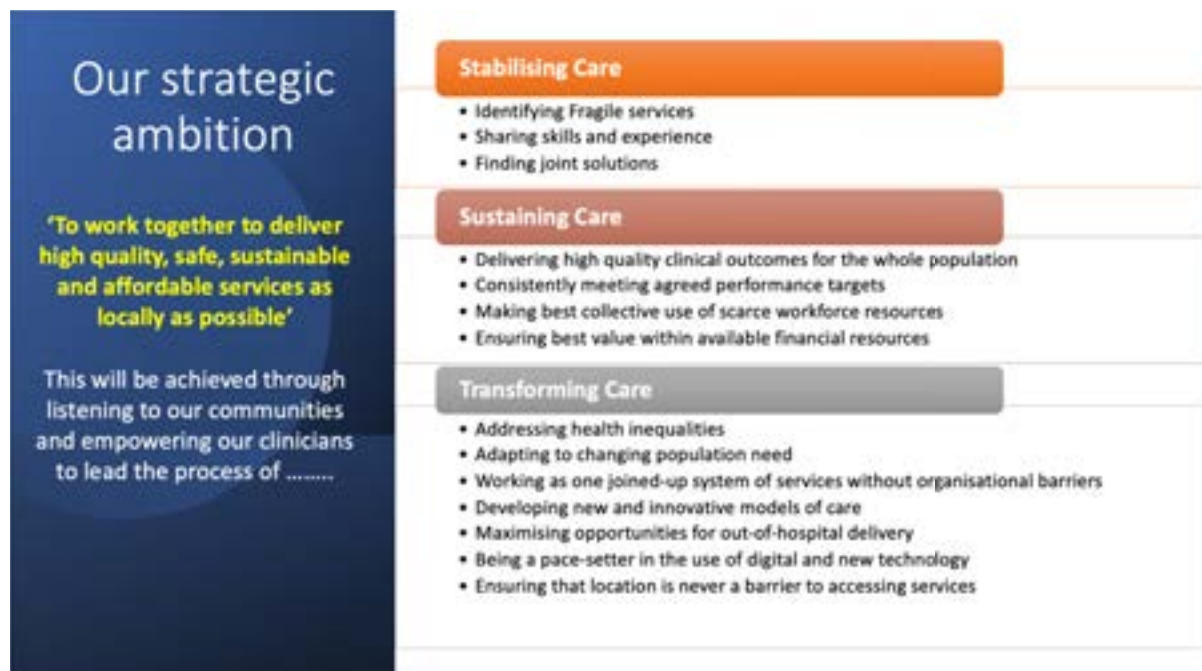


1 <https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf>

On that basis, earlier this year, the Chairs, Chief Executives and Medical Directors of the 4 acute Trusts in Devon (Royal Devon University Healthcare NHS Foundation Trust, University Hospitals Plymouth NHS Trust and Torbay and South Devon NHS Foundation Trust) and Cornwall (Royal Cornwall Hospitals NHS Trust) agreed that they would establish the **'Peninsula Acute Provider Collaborative' (PAPC)**.

The role of the PAPC is to work on behalf of individual Trust Boards to set the direction and provide the strategic leadership across organisational boundaries to stabilise, sustain and transform acute care for the population of Devon and Cornwall. The ambition is summarised in **Figure 2**.

**Figure 2: Strategic ambition of the Peninsula Acute Provider Collaborative**



The principles underpinning the work of the Peninsula Acute Provider Collaborative, previously agreed by the Board, are attached as **Annex 3** and these form the basis upon which members will hold themselves and each other to account for both ways of working and the development of proposals for service improvement.

#### **4. Progress to date**

Over the past 3 months, members of the Acute Services Sustainability Programme have been working to develop an approach and work-plan that will support the redesign of services to address quality, workforce and financial challenges. This has involved several workshop sessions with Medical Directors, other key Executives and subject-matter experts to identify the key factors that will inform the future shape of services and ensure these are fully embedded in the transformation process.

What has become clear is that the emerging Integrated Health and Care Strategies are outlining a direction of travel that strengthens out-of-hospital services and in the longer

term will reduce the need for hospital-based care. With enhanced primary care and community-based services, the ambition is to support people to keep well and maintain their independence.

At the same time, there will always be a requirement for acute care and the evidence base is clear that the right intervention at the right time provided by clinical teams with the right skills has a direct impact on outcomes for the individual. The role of the local District General Hospital will continue to be central to local access and coordination of acute care – providing safe, high quality services as locally as possible.

Advances in medicine mean that treatment options, even for severe injuries and illness, are changing and developing at ever increasing rates. This is extremely positive for patient outcomes but does mean that some clinical staff are, out of necessity, becoming more and more specialist and need a critical mass of patients to maintain their skills.

This is not new – the NHS has a long history of delivering high quality specialist services in specialist centres. For example, Derriford Hospital has served the whole population of the Peninsula well with major trauma, cardiac surgery, neurosurgery and other specialist services for many years. However, new technology, including remote consultation and the ‘real-time’ sharing of information means that the ability to provide significant elements of even the most complex care pathways remotely, closer to people’s homes, is growing at pace. This opens up opportunities for delivering care in new and innovative ways – sharing expertise and extending access across wider populations.

The ability to differentiate people’s care needs quickly and effectively to ensure they are then directed to the right place will become an increasing feature of future health and care services. Growing the capacity and capability of Primary Care and community services will be essential, together with access to high-quality community urgent care and diagnostic services, to enable patients to be directed to the right place according to established need. More robust pathways of care will need to be developed where the ownership, coordination and the vast majority of service delivery is local. If patients need to travel further for specialist interventions, this will need to be supported and kept to a minimum with the use of digital solutions to support remote ‘work-up’ and ‘follow-up’ of patients.

It has therefore been agreed that the starting point for establishing sustainable acute services must be to ensure that there are robust and consistent processes in place for high quality, timely, local assessment of acute care need for all people across the Peninsula, irrespective of where they live. This will then enable joined-up pathways of care to be developed across organisational boundaries supported by new technologies and digital solutions.

It is recognised that any redesign of services will need to be grounded in the reality of:

- Current and future population need including deprivation and an ageing society
- The specific challenges associated with coastal communities and rurality
- Available resources including workforce, buildings and money (capital and revenue)



Considerable work has been undertaken in recent years to explore solutions locally. The learning from these exercises together with an understanding of best practice nationally and internationally will be used to inform this process which will be clinically led.

The agreed design principles are outlined in **Figure 3** below.



Work to date has enabled co-production of a methodology to engage clinicians in a process of exploring new ways of working and models of care. This has included:

- Assessing the best route in to service redesign
- Exploring critical clinical interdependencies
- Identifying the core data requirements to support the process
- Commissioning work to bring together the relevant evidence to support any emerging proposals

Careful consideration has also been given to the need to balance the time commitments of key leaders and clinicians to this process in the context of competing operational pressures.

## 5. Proposal

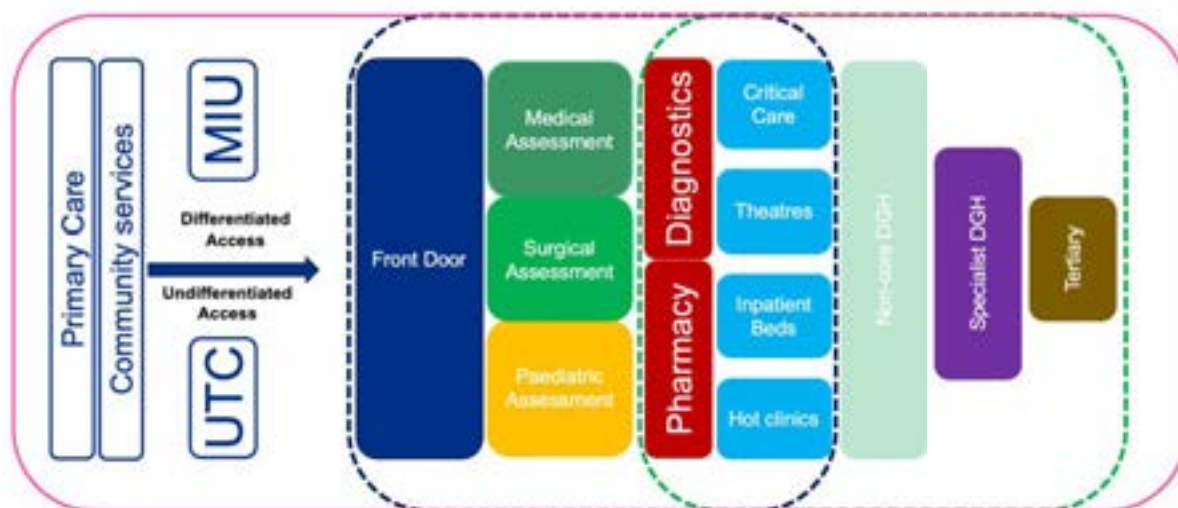
The authentic engagement of staff, stakeholders and citizens in the redesign of health and care services is central to ensuring that any process of change delivers the best possible outcome. On behalf of all Boards, it is imperative that this programme of work fully delivers on this commitment.

Clinical ownership and leadership of the initial work to explore the evidence and opportunities for change is critical to success and early discussions with Healthwatch will be essential to seek advice on the phasing of wider engagement.

A proposed approach has been put forward by the Acute Services Sustainability Programme and endorsed by the PAPC on 10<sup>th</sup> October as follows:

- The 3 index specialties for review will be medical assessment, surgical assessment and paediatric assessment. The rationale for this is that they are the key functions that operate alongside the ‘front-door’ of our hospitals to support the effective differentiation of need (**Figure 4**)

**Figure 4: Building an acute services model**



**Note: Mental Health will also need to be a key consideration in the service models**

- A series of 3 focused workshops (5-6 weeks apart) will be held for each of the index specialties and will involve a wide range of clinicians across the interdependent specialty, subspecialty and clinical support services.
- A series of core questions, co-produced with Medical Directors, will inform the workshop discussions. These will include assessment of critical mass for optimal outcomes, what elements of care pathways must be co-located, the future shape of the workforce and opportunities for better use of digital, technology and artificial intelligence.
- Robust workforce information will be essential to making assessments of how services can be safely and effectively staffed in the future. This will include working with the post-graduate medical Deanery to assess training requirements and optimal configuration of junior and middle grade rotas for both training outcomes and recruitment and retention of medical staff.
- There will be a clear requirement for innovative approaches to role redesign, both in-hospital and in the community, where the focus will be on the skills necessary to support the delivery of team-based care, moving away from traditional professional boundaries. This will create opportunities for new and exciting roles for staff across all professional groups together with the potential for further vocational training opportunities and better, higher skilled jobs for local people.

Following the 3<sup>rd</sup> Workshop, a summary will be produced that outlines:

- An assessment of the challenges associated with the current configuration of services and the ability to sustainably deliver the required outcomes across the whole of the Peninsula
- Opportunities, through shared staff, role redesign and pathway redevelopment, to make best use of the workforce to support the delivery of acute care across Devon and Cornwall
- Options for service redesign which will improve outcomes and make best use of the totality of the resources available (people and finance).

These will be reviewed by the PAPC and resultant recommendations generated for consideration by the Trust Boards.

It is really important that as much scope as possible is given to the teams to bring forward the best solutions. This means keeping to a minimum the number of 'givens' they need to navigate as part of their deliberations. To that end, it is suggested that the assumptions are limited to the following:

- There will continue to be 5 acute hospitals across Devon and Cornwall
- Each acute hospital will continue to have a 'front-door' providing urgent and emergency care
- There will continue to be only one tertiary centre in the Peninsula at Derriford Hospital
- Where services currently delivered in hospital can be delivered just as effectively (or more so) out-of-hospital, this should become the default model (recognising that there may need to be transitional arrangements to support shift of resources in the longer term)

The remit of the clinical workshops will not extend to 'where' services will be delivered in the future. If the outcome of the process is that certain elements of pathways can only be safely and effectively delivered on a smaller number of sites, this will need to be agreed by Boards, in public, before any consideration of where they would be located.

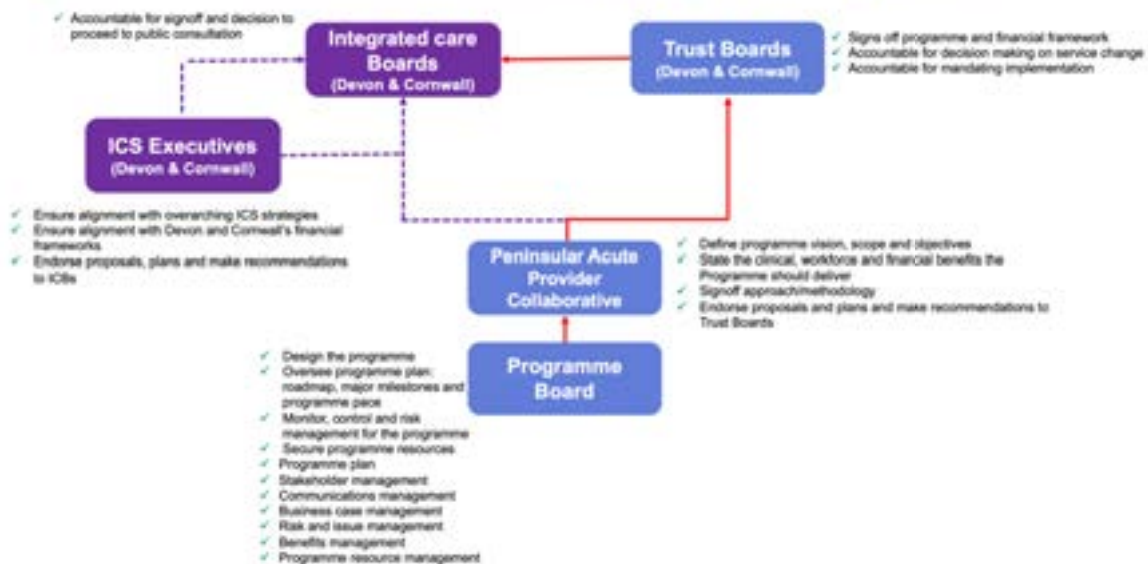
If there is any requirement to consider relocating services, options would need to be generated openly and transparently with wide engagement and consultation as required. Any recommendations would need to take full account of the potential for improved quality and outcomes; the need for clinical co-location; access for patients and their families; the best use of the current estate and any new capital investment; and affordability.

**It is really important to note that the programme would need to report back on the initial workshop findings and seek a further specific mandate from Boards to proceed BEFORE exploring options for service reconfiguration if indicated.**

## 6. Governance and decision-making

The overall governance of this programme of work is summarised in **Figure 5** below.

**Figure 5 : Peninsular Acute Sustainability Programme - governance**



This makes it clear that the decisions on any proposals for future service change and the sign-off of any proposals to proceed to public consultation are reserved for the Trust Boards and the Boards of the two ICBs. The previously agreed decision-making framework aims to limit the risk of different decisions being made by different Boards so that all partners move forward together in the best interest of the whole population of Devon and Cornwall.

## 7. Recommendations

The Board is asked to:

- **Note** the work undertaken to date by the Peninsula Acute Provider Collaborative and the Acute Sustainability Programme
- **Discuss** and **endorse** the strategic ambition for the Programme as outlined in **Figure 2**
- **Discuss** and **endorse** the design principles for the Programme as outlined in **Figure 3**
- **Discuss** and **endorse** the proposal to conduct a series of clinical workshops, commencing in November 2022, to explore opportunities for sustainable service redesign to deliver better, more equitable, clinical outcomes and make best use of resources across the Peninsula
- **Agree** that regular progress updates on this work will be brought to all member Boards
- **Note** that the governance arrangements and the current work-plan require any further assessment of options for potential service reconfiguration to be specifically mandated to the PAPC by the Trust Boards.

## Peninsula Acute Provider Collaborative - Committees in Common Terms of Reference

### 1. Constitutional Obligations

**1.1** The ICB hereby resolve to establish a Committee of the ICB known as the Acute Provider Collaborative Committees in Common (hereafter known as the APC). The Committees in Common is established in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation and the Acute Providers supporting the Devon and Cornwall footprints (see Appendix 1).

i. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into each organisations constitution and standing orders.

ii. As per the ICB's constitution, in the interest of partnership working, this committee will operate as a 'Committees in common' with representatives from each organisation (Appendix 1)

The accountability and decision making of the committee shall remain the responsibility of the individual organisations and its Board(s).

#### Committee in Common

- Each Board delegates authority to the Collaborative to bring forward recommendations for endorsement
- When the recommendation comes forward, each Board meets at the same time, considers the same paper, and makes its own decision
- It is technically possible for there to be different decisions, but any risk would need to be mitigated by the members of the Collaborative

The APC is an assurance committee of the organisations (Appendix 1) and have the ability to execute any powers assigned to them and those specifically delegated in these terms of reference and/or through each organisations constitutional scheme of reservation and delegation.

### 2. Purpose

**2.1** The purpose of the APC is to successfully work together to drive whole system acute services transformational change across the population in Devon and Cornwall – improving outcomes and performance, sharing skills and experience, making best use of scarce workforce resources, and realising tangible financial savings and sustainability.

The APC sits alongside the existing Mental Health Collaborative and will lead the joint planning of acute services for the population of Peninsula. This enables an opportunity to exist for greater devolved accountability for resource allocation and utilisation in future with strong alignment between strategic planning and commissioning functions.

### 3. Responsibilities

The responsibilities of the APC will include:

- Identifying the opportunities for joint working (operationally and strategically)
- Agreeing the acute services transformational priorities and delivery plan
- Commission specific pieces of work
- Receive recommendations and/or business cases
- Make joint decisions within any delegated authority
- Make joint decisions to be endorsed by Trust Boards and ICBs

The work of the ACP will be underpinned by Task and Finish Groups and Technical Advisory Groups (e.g. Finance) as appropriate.

### 4. Membership

The core Membership of the Committee shall be:

<p><b>The following Members have voting rights:</b></p> <ul style="list-style-type: none"> <li>• Acute Trust Chair(s)</li> <li>• Acute Trust CEO(s)</li> <li>• Acute Trust Medical Director(s)</li> </ul>
<p><b>Attendees <u>do not</u> have voting rights and include:</b></p> <ul style="list-style-type: none"> <li>• Independent Chair</li> <li>• APC Manager</li> <li>• ICB Medical Director(s)</li> </ul>
<p>The Chair of the APC may co-opt any non-voting Clinicians, Executive or Managing Directors, nominated deputies and lead managers as appropriate and particularly, when the APC is discussing areas of risk or operation that are the responsibility of that attendee.</p>
<p>Note: When a Committee Member is unable to attend, a named deputy with sufficient authority must attend in their place. Deputies will have the decision making and voting rights of the person he/she is representing.</p>

## 5. Quorum

- 5.1** A quorum of the APC shall be at least two members from each of the organisations (Appendix 1)
- 5.2** With the exception of administrative matters where decisions will be made on a majority basis, decisions will be based on a consensus amongst all Members present. Where consensus cannot be achieved, the agreed decision framework will be invoked by the Chair to reach an outcome in a fair, transparent and timely way.

The decision framework is based on 3 sequential phases designed to be supportive in reaching a decision, and must be adhered to as follows:

- |         |   |
|---------|---|
| Phase 1 | each party formally laying out their concerns and suggested alternatives with the aim of achieving a negotiated outcome   |
| Phase 2 | time-limited independent mediation with those organisations directly affected by the proposals with the aim of either resolving differences or developing an alternative agreed proposal that meets the original aims |
| Phase 3 | independent clinically led panel convened to review all evidence and make a recommendation which is binding on all organisations  |

- 5.3** People invited to attend, or those in attendance at the APC do not have the right to vote.
- 5.4** If the APC Chair is absent then the Members of the APC will select a chair for that meeting from the voting Members present – this will be overseen by the most senior officer responsible for governance as the Chair needs to be an independent representative of the APC

The aim will always be for consensus decisions to be made through a process of mature discussion based on clear and impartial clinical, operational and financial information. Moving to Phase 3 of the decision-making framework should be rarely, if ever, required.

## 6. Register of Interests

- 6.1** The Register of Interest will be reviewed at each meeting of the APC.
- 6.2** Members will be asked by the Chair of the APC to declare any interests at the beginning of each meeting. If a Member feels compromised by any agenda item they should declare a conflict of interest and leave for that agenda item.

## 7. Frequency of Meetings

- 7.1** The APC must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. It is expected that in the first instance meetings will be held monthly, moving to bi-monthly once the workplan is established and agreed.

This will need to be kept under review in line with the scale and pace of changes and decisions required.

## 8. Reporting arrangements

- 8.1** The APC Chair shall report formally to all organisations on its proceedings after each meeting on all matters within its duties and responsibilities.

The report shall be presented to the public meeting of the ICB. The members shall make recommendations to their respective organisations Board(s) on any decisions made and area within its remit where action or improvement is needed.

- 8.2** The APC is authorised by the ICB to investigate any activity within its terms of reference and through the APC Memorandum of Understanding. It is authorised to seek any information it requires from any employee and all employees re directed to co-operate with any request made by the APC.
- 8.3** The APC may require the attendance at its meeting of any officer as required through agreement, and the production of any document that can ensure the APC meets its obligations as set out in these terms of reference.

The APC is authorised through its memorandum of understanding to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Minutes and reports of the meetings will be produced and held by the Administrator of the APC, accessible to the Chair, core Membership and the Director responsible for the administrative function. Extracts from Minutes will be made public as appropriate under the freedom of information act.



## 9. Statutory Functions, Committee Oversight and KPIs (Internal Monitoring)

9.1 The ICB has delegated the following authorities to the Committee:

- |   |
|---|
| <ul style="list-style-type: none"><li>• The Acute Provider Collaboratives Committees in Common has the authority to commission work from the Directors of Finance, Directors of Workforce or Clinical and Professional Cabinet, seeking any advice appropriate for distinct areas of work</li></ul> |
| <ul style="list-style-type: none"><li>• The Acute Provider Collaborative Committees in Common had the authority to establish Task and Finish Groups, drawing on the expertise of Directors and other staff from within the constituent organisations as appropriate</li></ul>                       |

9.2 The APC will undertake an annual review of the performance and effectiveness to ensure that the APC structure, decision making and work plans reflect the current and future needs.

9.3 In addition, the APC will review the work of other sub groups or work streams within the organisations, whose work can provide relevant assurance to the APC's own scope of work. These may include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Public Sector Audit Appointments Ltd, National Audit Office, Financial Reporting Council) or professional bodies with responsibility for the performance of staff or functions (e.g. Royal College, accreditation bodies).

9.4 The reviews will be spread throughout the year with an Annual Report produced by the Committee for the ICB.

## 10. Administration

10.1 The APC and its sub group(s) shall be supported administratively by its Administrator. His or her duties in this respect will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking the minutes and helping the Chair to prepare reports to Board(s)
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair – for example, with the internal/external auditors, or local counter fraud specialists
- Advising the APC on pertinent issues/areas of interest/policy developments
- Ensuring that action points are taken forward between meetings
- Providing appropriate support to the Chairperson

**10.2** Following each meeting, the Administrator will:

- Maintain an attendance log and follow up as appropriate after each meeting to ensure the APC adheres to the required frequency of attendance by Members.
- Maintain a decisions log of reporting arrangements into each formal meeting of the APC and follow up as appropriate.
- Maintain a log of summary written reports provided to ICB from formal meetings.

## **11. Review**

An annual effectiveness review will be undertaken by the Head of Governance as good governance practice and to ensure compliance with the Annual Governance Statement.

These Terms of Reference will be reviewed on an annual basis or sooner if required through the Head of Governance with recommendations made to the Boards for approval.

**END**

## APPENDIX 1

### Member Organisations of the Peninsula Acute Provider Collaborative

Royal Cornwall Hospitals NHS Trust  
Royal Devon University Healthcare NHS Foundation Trust  
Torbay and South Devon Foundation Trust  
University Hospitals Plymouth NHS Trust

#### Membership (updated 17 October 2022)

##### Membership:

Name	Role	Organisation
Nigel Acheson	Chief Medical Officer	NHS Devon
Helen Skinner	Chief Medical Officer	NHS Cornwall
James Brent	Chair	University Hospitals Plymouth NHS Trust
Ian Currie	Medical Director	Torbay and South Devon NHS Foundation Trust
Dave Stacey	Deputy Chief Executive	Torbay and South Devon NHS Foundation Trust
Mark Hamilton	Medical Director	University Hospitals Plymouth NHS Trust
Adrian Harris	Chief Medical Officer	Royal Devon University Healthcare NHS Foundation Trust
Richard Ibbotson	Chair	Torbay and South Devon NHS Foundation Trust
Ann James	Chief Executive Officer	University Hospitals Plymouth NHS Trust
Mairi McLean	Chair	Royal Cornwall Hospitals NHS Trust
Suzanne Tracey	Chief Executive Officer	Royal Devon University Healthcare NHS Foundation Trust
Steve Williamson	Chief Executive Officer	Royal Cornwall Hospitals NHS Trust
Shan Morgan	Chair	Royal Devon University Healthcare NHS Foundation Trust
Allister Grant	Medical Director	Royal Cornwall Hospitals NHS Trust

##### In attendance:

Name	Role	Organisation
Liz Davenport	Programme SRO (& CEO)	Torbay and South Devon NHS Foundation Trust
Allison Williams		NHSE/I

# Peninsula Acute Sustainability Programme Board

## Terms of Reference

### Strategic ambition

The Peninsula Acute Provider Collaborative has endorsed a strategic ambition which will underpin the work of both the Collaborative *and* the Peninsular Acute Sustainability Programme. This lays the foundation for the terms of reference set out in this document. The strategic ambition is as follows:



### Objectives

The objectives of the Peninsula Acute Sustainability Programme Board are to:

1. Secure a **mandate** from the NHS Devon and NHS Cornwall and Isles of Scilly leadership teams to proceed with the development and subsequent implementation of an acute sustainability programme for the Peninsula.
2. Oversee the **design and development** of the programme.
3. Oversee and ensure efficient and **effective management** of the programme.

4. Ensure that the programme defines and delivers **tangible, realisable benefits and outcomes** for the public, patients, and workforce for both the Devon and Cornwall Integrated Care Systems.
5. Ensure programme design and delivery is **aligned with the respective overarching Integrated Care Strategies and 5-year forward plans** for both Devon and Cornwall.
6. Develop a programme and implementation plan which **supports the financial assumptions and commitments** set out in the respective Devon and Cornwall financial frameworks [agreed with regulators].

## Role and responsibilities

### Role

The Peninsula Acute Sustainability Programme Board has the following role, to:

1. Nurture and foster a shared commitment from key stakeholders across the Peninsula to the Acute Sustainability Programme.
2. Ensure key stakeholders across Devon and Cornwall understand “what is the Acute Sustainability Programme?” and “Why we are doing it?”.
3. Define the programme vision, scope, and objectives.
4. Design the programme – ensuring that there is coproduction in the design with appropriate stakeholders
5. Develop and own a financial framework which sits within the wider Peninsula Financial Framework(s).
6. Set out a clear roadmap of the major milestones for the work to be done.
7. Set the pace for the programme.
8. Agree and make proposals to the Peninsula Acute Provider Collaborative, Trust Boards, ICS Executive teams, ICBs and other leadership groups as appropriate.
9. Own and manage the relationship with regulators (e.g., NHSE SW and national teams) – to keep them informed on ambition and progress in relation to the Peninsula Acute Sustainably Programme.
10. Foster a supportive and collegiate Peninsula-wide approach to working together on the programme
11. Ensure that all enabling plans are aligned to support successful delivery of the Peninsula Acute Sustainability Programme and Plan (e.g. Cornwall ICS and Devon ICS: Integrated Care Strategies and associated 5 Year Forward Plans.
12. Formally take stock of progress with the programme every 3 months (to ensure that it continues to achieve its objectives) and seek endorsement of any proposed changes from the Peninsula Acute Provider Collaborative as appropriate.

## Responsibilities

The Peninsula Acute Sustainability Programme Board has the following responsibilities:

1. Define and propose the clinical, workforce and financial benefits the programme should deliver
2. Shape and design the approach to be adopted to carry out the work
3. Ensure all proposals are evidence base
4. Make proposals regarding where business cases are required to proceed
5. Make proposals where there is a requirement to invoke the major service change process because NHSE's 5 key tests for major service change have been met.
6. Ensure that all service change is supported by appropriate involvement and engagement with the public.
7. Ensure programme risk and issues are managed – proactively
8. Task individual members of the Programme Board with stakeholder engagement tasks and activities – as required
9. Ensure oversight and implementation of communications and stakeholder engagement plans
10. Secure resources for the programme
11. Receive regular progress reports from the Peninsula Acute Sustainability Working Group
12. Monitor and control the programme
13. Adopt and embed the principles set out below:

## Principles

The Programme Board should adopt and embed the principles set out below:

- ✓ Collaborative working and decision making
- ✓ Clear and defined goals – shared purpose and a focus on outcomes
- ✓ Whole Peninsula thinking – doing the best thing for Devon & Cornwall
- ✓ Shared accountability to deliver change
- ✓ Role modelling of System behaviour
- ✓ Consistent leadership – setting the right tone
- ✓ Constructive challenge – listening to all voices
- ✓ Assume best intent

## Membership of the Peninsula Acute Sustainability Programme Board

Members of the Programme Board are listed in the table below.

Name	Role	Organisation
Liz Davenport	Chief Executive Officer Programme SRO & Chair of Programme Board	Torbay & South Devon NHS Foundation Trust
Allison Williams	Programme Lead – Expert Advisor (Deputy Chair)	NHSE
Nigel Acheson	ICB Chief Medical Officer	NHS Devon
Helen Skinner	ICB Chief Medical Officer	NHS Cornwall
Simon Gittos-Davies	ICB Chief Finance Officer	NHS Cornwall
Simon Tapley	ICB Chief Transformation & Strategic Planning Officer	NHS Devon
Rachel O'Connor	ICB Director for Inclusion (Commissioning)	NHS Cornwall
Kelvin Grabham	ICB Business Intelligence Lead	NHS Devon
Carolyn Mills	Chief Nursing Officer	Royal Devon University NHS Foundation Trust
Allister Grant	Medical Director	Royal Cornwall Hospitals NHS Trust
Ian Currie	Medical Director	Torbay and South Devon NHS Foundation Trust
Mark Hamilton	Medical Director	University Hospitals Plymouth NHS Trust
Adrian Harris	Medical Director	Royal Devon University NHS Foundation Trust
Colm Owens	Clinical Director	Devon Mental Health Provider Collaborative
Andrew Milward	ICB Chief Communications & Corporate Affairs Officer	NHS Devon
Carol Beckford	Programme Director	NHS Devon

**Note: A Primary Care representative will be added once confirmed**

Each member may nominate a named Deputy to attend and participate with their full authority in their absence. The Chair shall be notified of this prior to the meeting.

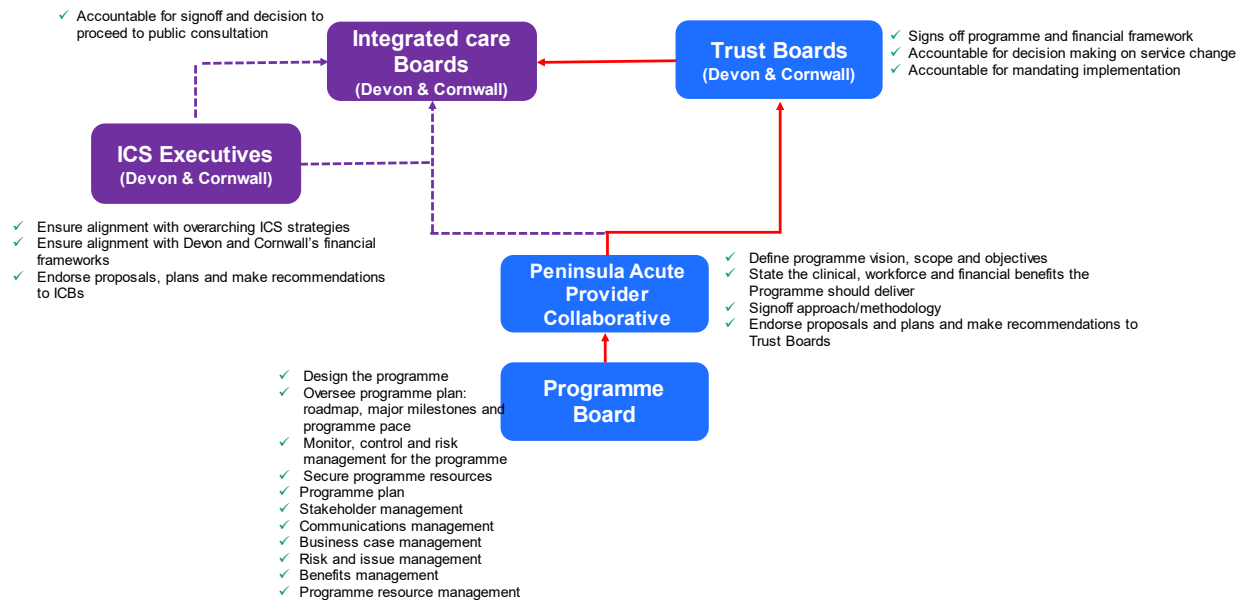
Other individuals may be invited to attend the meeting as appropriate to the agenda item.

For the programme board to be considered quorate the meeting should be comprised of:

- The SRO/Chair or Deputy Chair
- Representatives from both Devon and Cornwall
- At least one representative from Cornwall
- At least two medical directors

## Accountability and reporting

Programme Governance, accountability and reporting is set out the diagram below:



The Programme Board will be directly accountable to the Peninsula Acute Provider Collaborative.

The Peninsula Acute Provider Collaborative will, in turn, secure from Trust Boards:

- Signoff to the programme (i.e., scope, approach and supporting financial framework).
- Decisions, where there a requirement to make a significant service change.
- The mandate for implementation.

Devon and Cornwall's respective ICS Executive forums will be asked to ensure:

- Alignment with their respective overarching ICS strategies and the Peninsula Acute Sustainability Programme Plan
- Alignment with their respective financial frameworks and the Peninsula Acute Sustainability Programme Plan
- They are content to endorse plans and proposals before they are submitted to Devon and Cornwall ICBS

## Administration

The Peninsula Acute Sustainability Programme Board will meet at least monthly. Ideally, meetings will be scheduled for the fourth Thursday each month. The paper deadline for papers to be discussed at the meeting is the third Wednesday each month.



Administration by Peninsula Acute Sustainability Programme – Project Support Officer.

Formal minutes of the meetings will be recorded and will normally be confirmed as accurate at the next meeting of the group.

## **Review**

These terms of reference will be reviewed by the Programme Board and Peninsula Acute Provider Collaborative on receipt of the mandate to proceed with the Peninsula Acute Sustainability Programme - current target date for this decision – November/December 2022.

Current version: updated following comments and feedback from:

- Programme Board – 29<sup>th</sup> September 2022.
- Peninsula Acute Provider Collaborative – 10<sup>th</sup> October 2022

## Guiding Principles Peninsula Acute Provider Collaborative

These guiding principles will form the basis of the working relationships and arrangements for the APC and the mechanism for holding partners to account.

All members of the APC will work together in the best interest of the whole population of Devon and Cornwall.

- The views and opinions of every member of the ACP will be respected even if there is no agreement
- Where System best interests may be considered contrary to the perceived or actual best interests of any one partner, these will be openly declared, constructively discussed and fully considered
- All members will openly share all and any information (financial and non-financial) relevant to the business of the APC
- Prior to local investment in any fragile services, consideration will be given to joint solutions that provide best outcomes and value for money for the whole Devon system
- In arriving at any decisions regarding the disposition of clinical services, the APC will ensure that:
  - There has been full clinical engagement in the process
  - Appropriate staff, stakeholder and public engagement has been undertaken throughout the various stages of the work
  - The underpinning data is robust and objective
  - A comprehensive options appraisal process has been undertaken in line with pre-determined and transparent criteria
  - No one organisation is disproportionately advantaged or disadvantaged by the decision
  - Financial and non-financial risk is fully shared in accordance with the pre-determined framework
  - Where there is a clinical requirement to centralise services on one site, full consideration is given to reciprocal transfer of other

services to make overall best use of staff, estate and other resources

- If a decision is made that has a perceived or real impact on one organisation more than another, all members of the APC will stand jointly with the relevant Board and provide support both internally and externally as required
- Once a decision has been made by the APC, and endorsed by Boards, all organisations will commit to playing their full part in the implementation process
- Decisions that are made by the APC and endorsed by Boards are 'locked-in' unless new evidence becomes available that would question the efficacy of that decision.



<b>Report to the Trust Board of Directors</b>				
Devon Operating Model			Meeting Date: 26 October 2022	
<b>Report appendix</b>	Devon Operating Model Draft Version			
<b>Report sponsor</b>	Chief Executive			
<b>Report author</b>	Chief Executive			
<b>Report provenance</b>	The Operating Model for Devon has been developed through a process of engagement with local stakeholders including representatives from the Trust and was approved by the Devon Integrated Care Board at its meeting on 19 October 2022.			
<b>Purpose of the report and key issues for consideration/decision</b>	The purpose of this report is to ask the Trust Board to receive and note the Devon Operating Model which will support the establishment of the new ICS architecture and build a shared understanding of the roles, accountabilities and responsibilities of each part of the system.			
<b>Action required (choose 1 only)</b>	<b>For information</b> <input type="checkbox"/>	<b>To receive and note</b> <input checked="" type="checkbox"/>	<b>To approve</b> <input type="checkbox"/>	
<b>Recommendation</b>	The Board is asked to receive and note the Devon Operating Model Draft Version report.			
<b>Summary of key elements</b>				
<b>Strategic objectives supported by this report</b>	<b>Safe, quality care and best experience</b>	x	<b>Valuing our workforce</b>	x
	<b>Improved wellbeing through partnership</b>	x	<b>Well-led</b>	x
<b>Is this on the Trust's Board Assurance Framework and/or Risk Register</b>	<b>Board Assurance Framework</b>	x	<b>Risk score</b>	20
	<b>Risk Register</b>		<b>Risk score</b>	
BAF Reference: Integrated Care System - To develop and implement the Long Term Plan with partners and local stakeholders to support the delivery of the Trust's ICO Strategy				

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

# One Devon Operating Model

**DRAFT – Final Version**

# Contents

<b>Introduction and Executive Summary</b>	<b>1 - 6</b>
<b>Context</b>	<b>7 - 9</b>
<b>Vision, Values and Behaviours</b>	<b>10 - 12</b>
<b>Architecture of One Devon</b>	<b>13 - 48</b>
<b>Working Together as a System</b>	<b>49 - 53</b>
<b>Delivering Our Priorities Through the New Operating Model</b>	<b>54 - 57</b>
<b>Adoption Roadmap</b>	<b>58 - 66</b>
<b>Conclusion and Next Steps</b>	<b>67</b>



# This operating model sets out how One Devon will work together to improve health and care for people living in Devon

## Purpose of this document






The One Devon operating model outlines how the Devon Integrated Care System (One Devon) will work to better shape health and social care services around the needs of Devon's population – realising the benefits of integrated care. These benefits include:

- **Improving outcomes** in population health and healthcare
- **Tackling inequalities** in outcomes, experience and access
- **Enhancing productivity** and value for money
- Helping the NHS support wider **social and economic development**

This operating model has been co-designed with involvement from all parts of the health and care system. This document will introduce the new system architecture and Devon's vision for how it will operate. The operating model within this document articulates the future state of the working arrangements in Devon, as well as the roadmap to get there. The model articulated is deliberately flexible to allow for continued development and future iterations.

## What this operating model covers

This operating model...

-  Sets out the vision for the Integrated Care System (ICS) architecture
-  Describes the values and behaviours expected by people working in One Devon
-  Details the roles, responsibilities and functions for each part of the health and care system
-  Sets out the governance arrangements and approach to performance reporting and assurance
-  Outlines the Adoption Roadmap to implement the new operating model, to be supported by a 'learn by doing' approach

## What this operating model does not cover

There are some areas the operating model does not address:

- Team structures or individual roles and responsibilities
- The definitive plan for the development of the operating model – this is a live document and will require further development and iteration

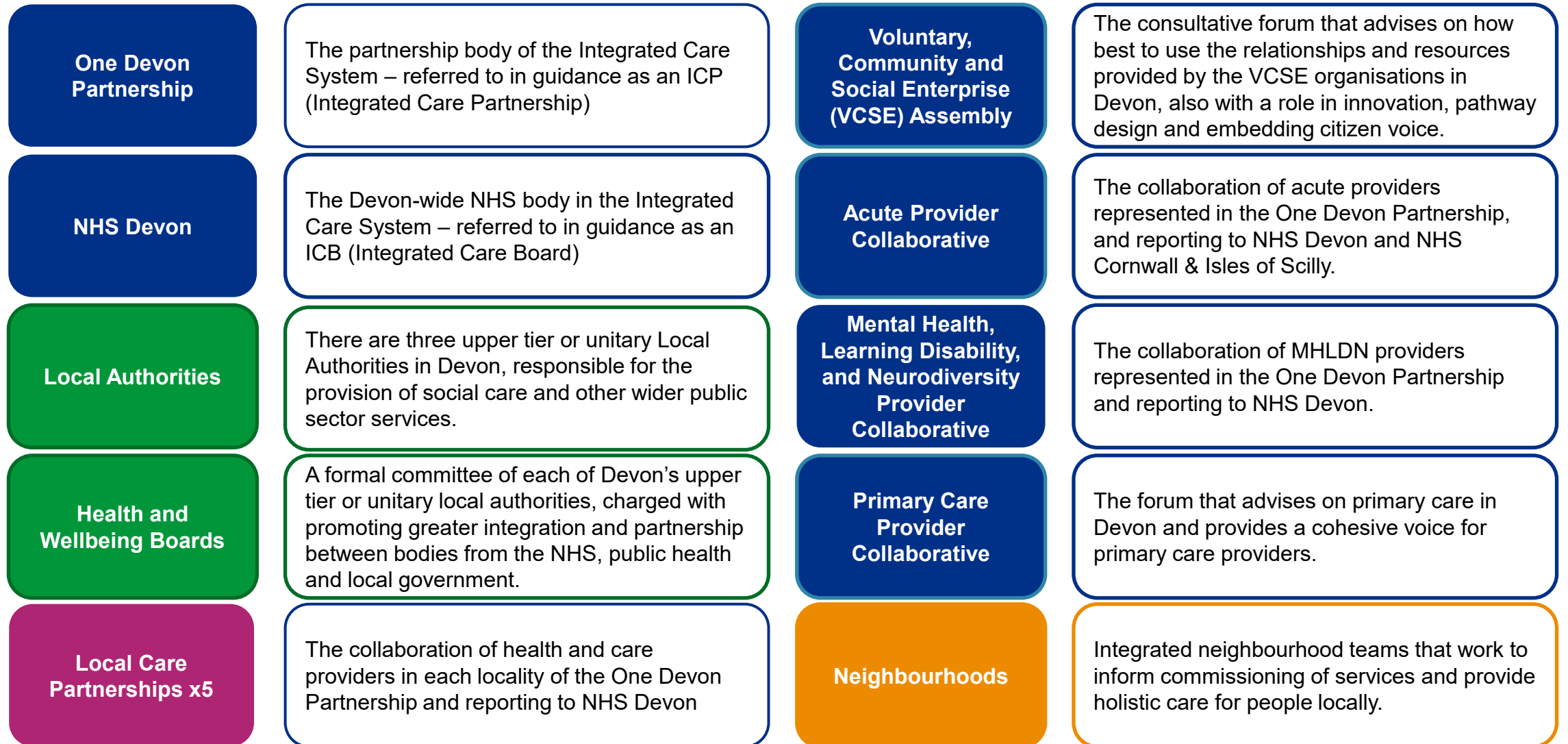
In addition, the implementation of the new system operating model **will not in any way impinge on the statutory duties of the individual organisations** following the **Health and Care Act 2022**

# Executive Summary

# Executive Summary: Overview

- One Devon is a partnership of health, local government and care organisations that are working to provide sustainable, quality health services and improved outcomes for Devon people
- Health and care organisations within Devon are facing growing pressures – these include the significant financial pressures being faced by NHS organisations and Local Authorities within Devon, the cost of living crisis and rising inflation. New collaborative ways of working provide the opportunity to respond to these pressures and improve health and care for people working in Devon
- To support these new ways of working, five values have been outlined to guide how system partners collaborate in One Devon. In One Devon, we will see partners:
  - **Putting Devon’s people first**
  - **Trusting each other and working as one system**
  - **Making best use of the Devon £**
  - **Expanding our scope of collaboration**
  - **Driving innovation**
- To achieve these new ways of working, we must make best use of new collaborative structures in One Devon. These include One Devon Partnership, the Peninsula Acute Provider Collaborative, the Mental Health, Learning Disabilities and Neurodiversity Provider Collaborative, the Primary Care Provider Collaborative, Local Care Partnerships, and Neighbourhoods. Each of these structures have new roles that will draw together system partners and allow for greater integration of services across One Devon, both in 2022/23 and beyond.
- Through the new collaborative structures we can better deliver on our priorities in practice. Via application of this operating model to our Urgent and Emergency Care priority we have illustrated how these new structures might work together and help us to realise the benefits of collaborative working.
- To fully realise the benefits of new collaborative ways of working, development of these new structures is required. Five themes for this development have been identified, further supported by outlining the development journeys of these individual structures. These five themes are:
  - **Learn by Doing**
  - **Prioritise and implement**
  - **Shared Purpose**
  - **Trust and Collaboration**
  - **Moving Towards a system focus**
- The move to the new operating model will be a phased adoption process planned to take place through to 2024/25 and will need to respond to a changing One Devon context. This iterative process will ensure we can best provide for the health and care needs of people living and working in Devon.

# Executive Summary: Overview



# Executive Summary: The Architecture of One Devon

For each of the new structures in One Devon, partners have identified their key roles in 2022/23 and beyond:

<b>One Devon Partnership</b>	<ul style="list-style-type: none"> <li>Leading the co-production, development and agreement of the One Devon’s five-year integrated care strategy, focusing on improving health outcomes and reducing inequalities.</li> </ul>	
<b>NHS Devon</b>	<ul style="list-style-type: none"> <li>The development and agreement of the Joint Forward Plan for Devon and the annual operating plan including revenue allocations, undertaking a strategic commissioning role and outlining the delegation of commissioning responsibilities.</li> <li>Undertaking a performance management role, to ensure services are safe, effective, patient-centred, timely, financially sustainable, efficient and equitable.</li> <li>Ensuring data and intelligence across the entire ICS is collated.</li> </ul>	
<b>Acute Provider Collaborative</b>	<ul style="list-style-type: none"> <li>Planning changes to the provision of NHS services across providers.</li> <li>Undertaking analysis of healthcare usage and population need to provide the basis for evidence based, outcome focused commissioning.</li> <li>Working together to ensure the best use of the totality of resources at their disposal.</li> <li><b>The commissioning of acute services to meet the outcomes set by NHS Devon and NHS Cornwall &amp; Isles of Scilly.</b></li> </ul>	<p><i>Note: This reflects the current Provider Collaboratives operating across One Devon</i></p>
<b>MHLDN Provider Collaborative</b>	<ul style="list-style-type: none"> <li>Planning changes to the provision of services across providers.</li> <li>Undertaking analysis of healthcare usage and population need to provide the basis for evidence based, outcome focused commissioning.</li> <li>Working together to ensure the best use of the totality of resources at their disposal.</li> <li><b>The commissioning of MHLDN services to meet the outcomes set by NHS Devon.</b></li> </ul>	
<b>Primary Care Provider Collaborative</b>	<ul style="list-style-type: none"> <li>Working to provide a coherent primary care delivery model across Devon, which meets the needs of the population and reduces inequality</li> <li>Sharing knowledge and best practice across primary care providers in Devon to deliver a more cohesive and integrated offer of care.</li> <li>Acting as a strong and united voice for primary care in Devon.</li> <li><b>Driving the Devon-wide preventative strategy.</b></li> </ul>	
<b>Local Care Partnerships</b>	<ul style="list-style-type: none"> <li>Supporting the development of the Integrated Care Strategy including articulating provisions that are specific to each locality.</li> <li>Enhancing integration in their LCP, including planning changes to the provision of services in place to deliver improved integrated care and performance.</li> <li>Improving performance of local services where joint working can improve overall performance.</li> <li><b>Procuring and securing health and care services to meet the needs of local communities, commissioning at the level of place.</b></li> </ul>	
<b>Neighbourhoods</b>	<ul style="list-style-type: none"> <li>Using neighbourhood population insight to inform the commissioning of services to improve outcomes and reduce inequalities.</li> <li>Delivering population health management at a neighbourhood level.</li> <li>Taking an asset-based approach across all settings to provide holistic care for people with long-term conditions.</li> </ul>	

*Note: This reflects the current Provider Collaboratives operating across One Devon*

**Bolded** items indicate additional responsibilities beyond 2022/23

# Context

# One Devon is a partnership of health, local government and care organisations that are working to provide sustainable, quality health outcomes for Devon people

## The 2022 Health and Care Act formalised integrated care arrangements

- Integrated care systems have been in development for several years – there are 42 nationally and their aim is to bring together local authorities, NHS organisations and others to take collective responsibility of providing services to improve population health.
- The Integrated Care System in Devon is known as One Devon and includes all health and care partners working throughout Devon.
- The Health and Care Act 2022 transferred statutory powers from CCGs to other organisations, primarily the newly created Integrated Care Boards (ICBs). In Devon, this new ICB is called NHS Devon.
- In recognition of the varying nature of ICSs nationally, in terms of geographies and demographics, this legislation gave significant flexibility on how ICSs can operate.
- This Operating Model sets out how the system will work together to realise the vision for Devon and provides the framework to support delivery of health and care services to the population of Devon.



## Alongside the legislation, national guidance has been released that recommends developing collaborative arrangements to deliver effective integrated care:

- **Provider collaboratives** – bringing together providers to improve pathways and deliver better outcomes, making best use of system resources in areas such as workforce, technology, and estates.
- **Place-based partnership** – called Local Care Partnerships in Devon, place based partnerships bring together a wide range of organisations, including Local Authorities, to deliver integrated health and care services across Devon's localities.
- **Neighbourhoods** – bringing together primary care services, NHS community services, social care and other providers to deliver more co-ordinated and proactive care throughout Devon. They work closely with other partners to deliver improved outcomes across different neighbourhoods.

# We need all partners to draw together and undertake new collaborative ways of working – as outlined in this operating model

Growing pressures within the health and care system, and beyond, are strengthening the requirement for new collaborative ways of working:

- The health and care system nationally is under immense strain. The challenges that have been brought about by the pandemic have placed greater demand on our services, and it is a high priority nationally to ensure that people who had treatment delayed due to the onset of the pandemic are treated promptly.
- In addition, the cost of living crisis is now taking root, and people are feeling the negative impact on their wellbeing. As these challenges persist, One Devon will have to respond to the challenges that our population and staff are facing as a result of the high levels of inflation.
- These high levels of inflation are also an additional financial pressure that our organisations will have to accommodate and mitigate. The financial challenges that NHS organisations across Devon have had over the last few years are well documented, and it is critical that, as we move into the new policy era, our plans and structures work towards achieving a financially sustainable health and care system.
- These challenges impact us all and we are more able to meet them through joined-up, coordinated action. To do this requires a new operating model to guide our new ways of working.

Integrated Care Systems help us to address these challenges by working together more collaboratively:

The benefits of this integrated approach to health and care include:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS support broader social and economic development

**This operating model brings together health and care organisations, local authorities and other partners to outline the structures in which they collectively operate within the One Devon Integrated Care System – these structures include:**

- One Devon Partnership
- NHS Devon
- Consultative forums, including the Clinical and Professional Cabinet and VCSE Assembly
- Peninsula Acute Provider Collaborative
- Mental Health, Learning Disability, and Neurodiversity Provider Collaborative
- Primary Care Provider Collaborative
- Local Care Partnerships
- Neighbourhoods

Source <sup>1</sup> RCP Survey

10.01 Devon Operating Model.pdf



# One Devon Vision, Values and Behaviours

# The operating model should act as an enabler for One Devon's work to achieve our vision



**This Operating Model sets out how the system will work together to realise the vision for Devon and to provide the framework to support delivery of health and care services to the population of Devon**

# Five values have been outlined to guide how all staff throughout One Devon will work together to enable a thriving system

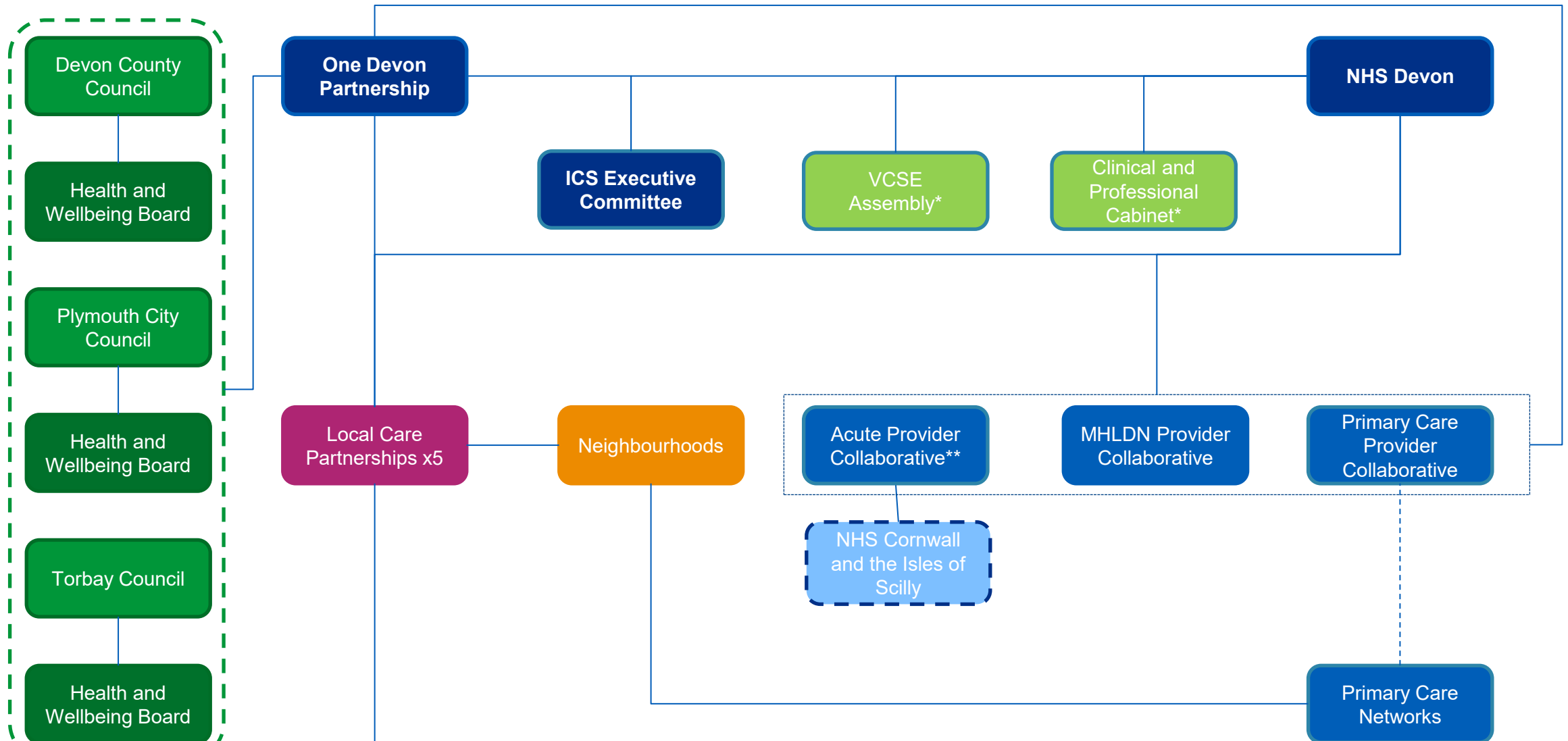
## Values:

## Our ambition for the future:

<p><b>Putting Devon's people first</b></p>	<ul style="list-style-type: none"> <li>• As a system, we will centre our services on the needs of Devon's population and communities. This means listening to local people and our staff, involving them in the decision-making around the services we commission and deliver and being open and transparent about the difficult choices that we have to make. We will engage with communities, patients, Healthwatch and other groups.</li> <li>• In the commissioning and delivery of our services we will reduce inequalities and retain a focus on improving outcomes, driving improvements in everything we do.</li> </ul>
<p><b>Trusting each other and working as one system</b></p>	<ul style="list-style-type: none"> <li>• We will work together as one system to truly put the needs of Devon's population first. As we work together, it is important to take actions on behalf of the system, rather than in pursuit of organisational interest.</li> <li>• We will share resources in working as one system to achieve a shared vision and achieve financial sustainability – building trust between system partners is essential to achieve this approach.</li> </ul>
<p><b>Making the best use of the Devon £</b></p>	<ul style="list-style-type: none"> <li>• We will make the best use of public money across health and care services. This means it is important to invest in services that make the biggest differences to people's health and wellbeing, including preventative care.</li> <li>• We will not be limited by the boundaries of the services we are commissioned to deliver and instead will ensure every contact counts towards meeting the needs of our people.</li> <li>• Aligning financial incentives, distributing and pooling funds and sharing risk across the system will all be necessary to deliver value for money solutions and to ensure that we are providing a sustainable health system into the future.</li> </ul>
<p><b>Expanding our scope of collaboration</b></p>	<ul style="list-style-type: none"> <li>• As well as drawing closer together as One Devon, it is important to consider how we will leverage the full range of partnerships available to us to deliver the best services for our population – including with regional and national teams, organisations and businesses in Devon, and communities.</li> <li>• For those on the borders of Devon, partners in our neighbouring ICSs will contribute to health and wellbeing, whilst regional partners such as the Academic Health Science Network will also be critical to delivering transformation for the benefit of our population.</li> </ul>
<p><b>Driving innovation</b></p>	<ul style="list-style-type: none"> <li>• We will adopt a 'learn by doing' approach and respond flexibly to successes and failures where a change in our approach would benefit people living in Devon.</li> <li>• The requirement for new collaborative ways of working should also empower everyone to adopt innovative solutions, techniques and technologies to drive improvements in resident's health and wellbeing.</li> <li>• More integrated care should expand the range of interventions that can be made to improve the lives of our population and it is critical that we allow everyone to innovate and spread that innovation effectively, wherever possible.</li> </ul>

# Architecture of One Devon

# One Devon Architecture:



\*Consultative forums will also play an advisory role for Local Care Partnerships and Provider Collaboratives as determined by these groups

\*\*The Acute Provider Collaborative spans Devon and Cornwall and the Isles of Scilly

# One Devon Partnership

# The One Devon Partnership (the ICP) is responsible for the co-production of the Integrated Care Strategy for One Devon

## The purpose of an ICP in the 2022 Health and Care Act:

- *Prepare an Integrated Care Strategy setting out how assessed needs in relation to its area are met by:*
  - *NHS Devon, Local Care Partnerships and Provider Collaboratives*
  - *NHS England*
  - *The Local Authorities within Devon*

## Our vision for a thriving One Devon Partnership in Devon:

The One Devon Partnership includes all health and care partners working in Devon and is responsible for the preparation, drafting and co-production of the Integrated Care Strategy, setting out how the needs of people in Devon are to be met by ICS partners. It advises on how arrangements for the provision of health and social care services could be more closely integrated to benefit people living in Devon. System Partners feel that the One Devon Partnership is an inclusive forum, and understand how the views, challenges and priorities of their organisations and our population (eg: via Healthwatch) contribute to a cohesive integrated care plan, and rely on the One Devon Partnership to enable increased collaboration with other system partners.

## Primary responsibilities:

The partnership will adopt the full range of its accountabilities from 2022/23, including:

- Leading the co-design and co-production, development and agreement of One Devon's Integrated Care Strategy, focusing on improving health outcomes and reducing inequalities

# The decisions made by the One Devon Partnership shape the Integrated Care Strategy for Devon

## One Devon Partnership

What decisions does this group make?

### The decisions that the One Devon Partnership makes will involve:

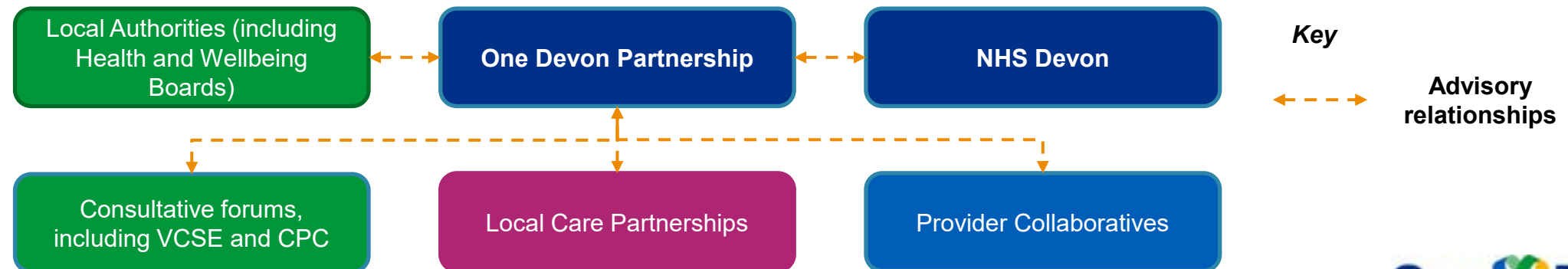
- Leading the co-design and co-production of the content and priorities of One Devon’s Integrated Care Strategy incorporating insights from the Health and Wellbeing Boards and local Joint Strategic Needs Assessments.
- Advising on how arrangements for the provision of health and social care services should be more closely integrated to benefit people living in Devon and reduce health inequalities.
- Advising on the prioritisation of specific population-health focused objectives in One Devon.
- Advising on which services should be prioritised for transformation, savings and investment by NHS Devon, and where new models, tools and ideas should be advanced within the system
- Providing advice to system partners to resolve disagreements with serious implications. Where resolution is not possible through other avenues, the One Devon Partnership can issue a decision.

As the partnership body of One Devon, decisions made by the One Devon Partnership must involve and engage other health and care partners throughout Devon. They will play a key role in the continued development of the integrated care system and new way ways of working.

How does this group support other partners:

### One Devon Partnership Relationships

The One Devon Partnership is the place where system partners including Healthwatch, Local Authorities, Local Care Partnerships, and Provider Collaboratives, come together to determine the strategic direction of One Devon. A cross-body membership with NHS Devon supports alignment in the NHS Devon delivery of the One Devon Strategy:





# The primary responsibility of the One Devon Partnership is defined in the 2022 Health and Care Act

## Responsibilities:

To enable the decisions to take place as articulated on slides 16-17 the following responsibilities need to be held by the One Devon Partnership:

### **Statutory Accountabilities:**

One Devon Partnership holds the statutory accountability to produce the Integrated Care Strategy as outlined in the 2022 Health and Care Act.

*Other responsibilities are advisory in nature and require no formal delegations.*

## One Devon Partnership Structure:

- The One Devon Partnership will work via a core committee in order to be effective in its decision making, and is supported by further committees as necessary.
- This core committee has a broad representation outlined in their terms of reference:
  - Chair
  - ICB Chair
  - ICB CEO
  - ICB Executive Lead for ICP
  - 3 Health and Wellbeing Board Chairs
  - 5 LCP representatives
  - Acute Provider Collaborative Chair
  - MHLDN Provider Collaborative Chair
  - Clinical lead
  - Healthwatch member
  - Health Inequalities and Prevention Programme member
  - NHS Devon Citizen Engagement and Outreach NEM
  - 3 VCSE members
  - Director of Adult Social Care
  - Director of Children's Services
  - Primary Care member
  - District Council member
- Relationships will have to be established with additional partners including: Healthwatch, SWASFT, Citizen Forums and AHSN

## Organisational Governance:

- The responsibilities of the One Devon Partnership are administered via the One Devon Partnership Core Committee, which operates via decision making by consensus
- Cross-body membership between the NHS Devon Board and the One Devon Partnership core-committee supports alignment between these groups, further supported via the ICS Executive Committee

# NHS Devon

# NHS Devon is responsible for developing a system plan in response to the Integrated Care Strategy, commissioning services and allocating budgets

## The purpose of an ICB in the 2022 Health and Care Act:

- *Arrange for the provision of health services to meet the needs of people living in Devon, including the financial duties associated with this*
- *Arrange for the provision of health and care services in an integrated way when this would benefit those living in Devon, including through the reduction of inequalities*

*Source: Health and Care Act 2022*

## Our vision for a thriving NHS Devon:

NHS Devon arranges for the provision of health services to meet the requirements of people living in Devon, and undertake the financial duties associated with this. They take a 'system first' approach, ensuring that services are provided in an integrated way when this would improve the quality of services, reduce inequality of access to services or reduce inequality of outcomes, undertaking an enabling role to support other partners in the commissioning and delivery of integrated care. They work closely with system partners (including SWASFT) and undertake engagement (eg: with Healthwatch and VCSE Assembly) to understand the wants and needs of people living in Devon. Partners understand what their responsibilities are and feel supported in delivering them. They trust NHS Devon and feel able to approach them when they would benefit from collective problem solving or delivery.

## Primary responsibilities:

NHS Devon will adopt the full range of its accountabilities from 2022/23. However, it will progressively delegate elements of these responsibilities in line with the content on the subsequent pages. The phasing of this delegation will also be dependent on the system's progress within the System Oversight Framework, as outlined in the roadmap section of the document:

- The development and agreement of the Joint Forward Plan for Devon and the annual operating plan including revenue allocations, undertaking a strategic commissioning role, and outlining the delegation of commissioning responsibilities.
- The development of strategic change and transformation plans across Devon, working closely with Local Care Partnerships and neighbourhoods to understand the changing need of people living in Devon.
- Working with Local Authorities to identify specific services where commissioning should be joint between the NHS and Local Authorities and supporting the pooling of budgets where appropriate.
- Undertaking a performance management role, to ensure services are safe, effective, patient-centred, timely, financially sustainable, efficient and equitable.
- Ensuring data and intelligence across One Devon is collated, encompassing population health, healthcare and business intelligence to provide a holistic view of performance.
- Working to secure financial sustainability across One Devon.

# The decisions that NHS Devon make will ensure that health services are provided to meet the needs of people living in Devon

## NHS Devon

What decisions does this group make?

**NHS Devon will work with other partners, including Local Authorities, to make decisions on:**

- The long-term financial strategy for the NHS in Devon
- The prioritisation and allocation of NHS capital spend
- The contents and implementation of the 5-year Strategic Workforce Plan
- The annual health and care plan for the NHS element of the One Devon budget
- The framework and quality standards with which to support and monitor outcomes-based commissioning
- Which health and care services across Devon could be best provided by a joint or delegated commissioning agreement
- Joint commissioning of services between the NHS and Local Authorities (in agreement with relevant Local Authorities)
- The delegation of commissioning responsibilities, empowering Provider Collaboratives and Local Care Partnerships to take responsibility
- Enabling delegated commissioning responsibilities
- Budget allocation and responsibility delegation to Provider Collaboratives
- Budget allocation and responsibility delegation to Local Care Partnerships
- The delegated commissioning of specialised services for those with rare and complex conditions (from April 2024)
- Ensuring services are safe, effective, patient-centred, timely, efficient and equitable
- How audits will be undertaken as a response to national guidance
- The NHS in Devon's response to inspection outcomes
- How One Devon will align to the national legal framework and develop a risk management strategy for One Devon's information governance processes
- How data and intelligence is collated across One Devon, and how it can be used across the system to improve and measure performance and impact
- How to better integrate enablers across the system
- Provide advice on how disagreements between two or more NHS partners are resolved, if escalated. In exceptional circumstances, these can be escalated to the One Devon Partnership for wider mediation if required.

How does this group support other partners:



# The primary responsibilities of NHS Devon are defined in the 2022 Health and Care Act

## Responsibilities:

To enable the decisions to take place as articulated on slides 20-21 the following responsibilities need to be held by the NHS Devon:

**Statutory Accountabilities:** NHS Devon holds the statutory accountabilities as outlined in the 2022 Health and Care Act – these are reflected on the previous pages

## Organisational Governance:

The Board of the NHS Devon is responsible for ensuring that NHS Devon meets its duties as outlined in statute. In compliance with national guidance, the Board of NHS Devon consists of the following roles:

- Chair
- Chief Executive
- 1 Partner Member NHS and Foundation Trust
- 1 Partner Member Primary Care Medical Services
- 2 Partner Members Local Authorities
- 1 Mental Health Member
- 6 independent Non-executive Members
- Director of Finance (Chief Financial Officer)
- Medical Director (Chief Medical Officer)
- Director of Nursing (Chief Nursing Officer)
- Chief Transformation & Strategic Planning Officer
- Director of Strategic Workforce
- Chief Communication & Corporate Affairs Officer

## NHS Devon structure:

Legislation provides ICBs with flexibility in how they establish committees, including the ability to appoint individuals from external or partner organisations to be members of a committee. Membership of the specified committees below is informed to balance partnership involvement and effective and efficient governance. NHS Devon works via a series of committees as outlined below:

- Audit and Risk Committee
- Remuneration and Internal ICB Workforce Committee
- Finance Committee
- Quality and Performance Committee
- People and Culture Committee
- ICB Primary Care Commissioning Transition Committee
- Clinical and Professional Cabinet
- LCP Oversight Committee
- ICS Executive Committee
  - Executive Strategy and Transformation Group
  - System Delivery Improvement Group
  - Executive Workforce (People Plan) Group
  - Executive Quality Oversight Group
  - System transformation and Efficiency Committee

These committees ensure links and engagement with individual organisations and clinical and professional forums as required in order to fulfil their functions.

# The Acute Provider Collaborative

# The Acute Provider Collaborative will work together to harness the benefits of scale in the commissioning and provision of acute services

## The purpose of an Acute Provider Collaborative in the ICS Design Framework

- *Provider Collaboratives will work together to harness the benefits of scale in the commissioning and provision of their services*
- The Collaborative will also work to deliver sustainable services, as well as drive service and pathway redesign to improve access, quality and performance, whilst reducing inequalities

*Source: Integrated Care Systems Design Framework 2021*

## Primary responsibilities in 2022/23:

- Planning changes to the provision of NHS services across providers
- Undertaking analysis of healthcare usage and population need to provide the basis for evidence based, outcome focused, commissioning including the voice of people with lived experience and engagement with the population (including Healthwatch)
- Working together to ensure the best use of the totality of resources at their disposal, in the interest of the populations of Devon and Cornwall & the Isles of Scilly

## Our vision for a thriving Acute Collaborative in Devon:

The Acute Provider Collaborative is a partnership arrangement between acute providers in Devon and Cornwall & the Isles of Scilly. They work at scale with a shared purpose, clarity of resource, transparent data and effective decision-making arrangements towards the strategic objectives of the Integrated Care Partnerships, in order to;

- Reduce unwarranted variation in health outcomes, access to services and patient experience
- Improve resilience
- Ensure that specialisation and consolidation occur when this will provide better outcomes and value

The Collaborative builds on existing relationships with all providers feeling valued and respected, regardless of size, and creates new relationships where this would benefit joint working and increased collaboration.

## Additional responsibilities beyond 2022/23

- The commissioning of acute services to meet the outcomes set by NHS Devon and NHS Cornwall & Isles of Scilly, to meet the needs of these populations

# Decisions made by the Acute Provider Collaborative should be sensitive to local needs in supporting the provision of care for people in Devon

## Acute Provider Collaborative

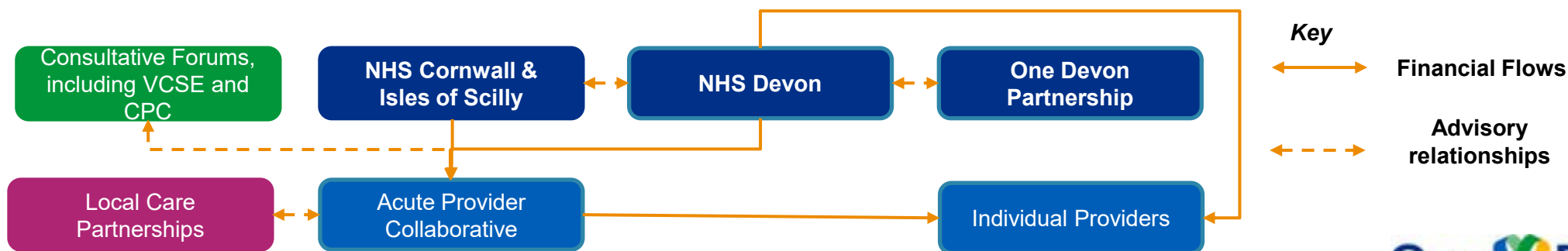
What decisions does this group make?

**For services delivered in Devon, the Acute Provider Collaborative will work on:**

- Deciding on how to deliver on the agreed strategy and priorities for Devon’s acute providers, with reference to the needs of local populations – taking care to engage and consult with residents where appropriate – this may apply to short term acute provision or longer term planning
- Planning changes to the provision of NHS services across the acute providers, informed by LCPs to ensure local needs are met, and enhancing integration with local services
- Determining the model through which acute services are delivered to the population of Devon – escalating disagreements if needed to NHS Devon
- Deciding how to make use of the money allocated to the Provider Collaborative, and the constituent organisations of the Collaborative, by NHS Devon and other sources
- Considering how best to utilise the collective resources at their disposal in order to improve service provision, provide better value for money, improved patient and staff experience and better integrate research and innovation at scale.
- Determining where savings or additional funding is required to implement plans in response to the agreed strategy
- Agreeing on the flexible working arrangements for staff working between member provider organisations working across Devon to allow effective use of staff such as via staff passporting
- Determining how to respond to national initiatives whilst being sensitive to the needs of Devon’s population

How does this group support other partners:

All NHS providers in Devon belong to a Provider Collaborative. Provider collaboratives work closely with LCPs, and may collaborate together where necessary. The Provider Collaboratives influence the direction of One Devon via representation on the One Devon Partnership Core committee.





# The Acute Provider Collaborative is formed as a committee between NHS Devon and NHS Cornwall & Isles of Scilly

## Responsibilities:

To enable the decisions to take place as articulated on slides 24-25, the following responsibilities will need to be delegated to the Acute Provider Collaborative:

### NHS Devon

- Delegated commissioning responsibility for some aspects of the provision of acute care in Devon

### NHS Providers

- Delegated authority to make changes to the provision of acute care in Devon

## Provider Collaborative Structure:

- The Acute Provider Collaborative has elected to use a joint committee model, formed between the NHS Devon and NHS Cornwall & Isles of Scilly
- The following providers are members of the Acute Provider Collaborative:
  - Royal Cornwall Hospitals NHS Trust
  - Royal Devon University Healthcare NHS Foundation Trust
  - Torbay and South Devon NHS Foundation Trust
  - University Hospitals Plymouth NHS Trust

## Organisational Governance:

- The Acute Provider Collaborative is constituted as a committee between NHS Devon and NHS Cornwall and Isles of Scilly. It operates via a 'committees in common' approach, with decisions being made via consensus between provider boards. Where consensus cannot be reached dispute resolution framework will be invoked.



# **The Mental Health, Learning Disability and Neurodiversity Provider Collaborative**

# The MHLDN Provider Collaborative will work together to harness the benefits of scale in the commissioning and provision of MHLDN services

## The purpose of a Provider Collaborative in the ICS Design Framework

- *Provider Collaboratives will work together to harness the benefits of scale in the commissioning and provision of their services*
- The Collaborative will also work to deliver sustainable services, as well as drive service and pathway redesign to improve access, quality and performance, whilst reducing inequalities

*Source: Integrated Care Systems Design Framework 2021*

## Primary responsibilities in 2022/23:

- Planning changes to the provision of services across providers, where integration with other services is required
- Undertaking analysis of healthcare usage and population need to provide the basis for evidence based, outcome focused, commissioning including the voice of people with lived experience and engagement with the population (including Healthwatch)
- Working together to ensure the best use of the totality of the resources at their disposal, in the interest of the Devon population

## Our vision for a thriving Mental Health, Learning Disability, and Neurodiversity Collaborative in Devon:

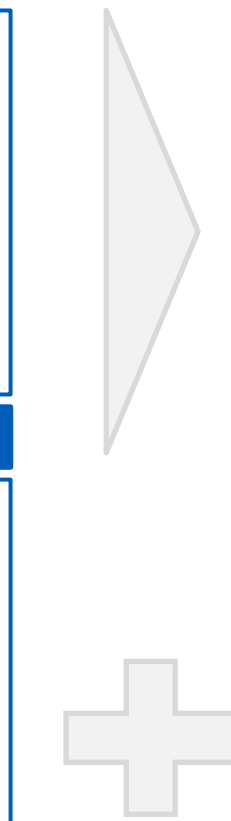
The Mental Health, Learning Disability, and Neurodiversity Collaborative is a partnership arrangement between providers in Devon. They work at scale, with a shared purpose and effective decision-making arrangements to;

- Reduce unwarranted variation in health outcomes, access to services and experience
- Improve resilience
- Ensure that specialisation and consolidation occur when this will provide better outcomes and value

The Collaborative builds on existing relationships, with all providers feeling valued and respected, regardless of size, and creating new relationships where this would benefit joint working and increased collaboration.

## Additional responsibilities beyond 2022/23:

- Commissioning of MHLDN services to meet the outcomes set by NHS Devon to meet the needs of the population



# Decisions made by the MHLDN Provider Collaborative should be sensitive to local needs in supporting the provision of care for people in Devon

## MHLDN Provider Collaborative

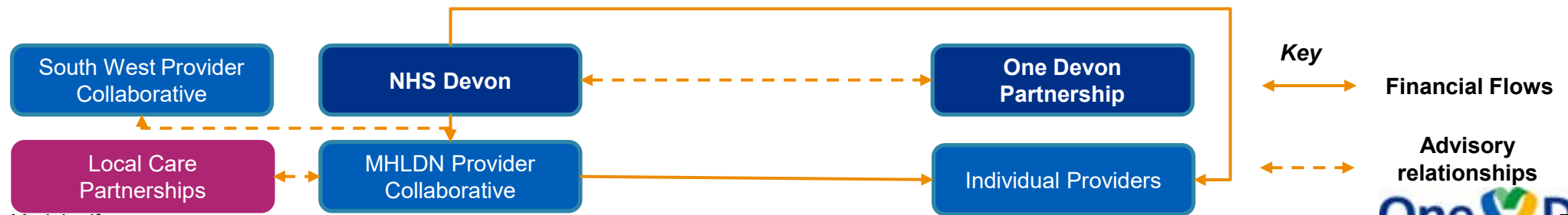
What decisions does this group make?

**In the future state decisions that the MHLDN Provider Collaborative makes will involve:**

- Deciding on how to deliver on the agreed strategy and priorities for Devon’s MHLDN providers, with reference to the needs of local populations – taking care to engage and consult with residents where appropriate – this may apply to short term provision or longer term planning
- Planning changes to the provision of services across the MHLDN providers, informed by LCPs to ensure local needs are met, and enhancing integration with local services
- Deciding how MHLDN services are provided to meet the needs of people living in Devon
- Deciding how to make use of the money allocated to the Provider Collaborative, and the constituent organisations of the Collaborative, by NHS Devon and other sources
- Considering how best to utilise the collective resources at their disposal in order to improve service provision, provide better value for money, improved patient and staff experience and better integrate research and innovation at scale.
- Determining where savings or additional funding is required to implement plans in response to the agreed strategy
- Agreeing on the flexible working arrangements for staff working between member provider organisations working across Devon, to allow effective use of staff such as via staff passporting
- Determining how to respond to national initiatives whilst being sensitive to the needs of Devon’s population

How does this group support other partners:

All NHS providers in Devon belong to a Provider Collaborative. The Provider Collaboratives influence the direction of One Devon via representation on the One Devon Partnership Core committee.



# The MHLDN Provider Collaborative uses a lead provider model, with Devon Partnership Trust as a lead provider

## Responsibilities:

To enable the decisions to take place as articulated on slides 28 - 29, the following responsibilities will need to be delegated to the MHLDN Provider Collaborative:

### NHS Devon

- Delegated commissioning responsibility for MHLDN services in Devon

### NHS Providers

- Delegated authority to make changes to the provision of MHLDN services in Devon

## Provider Collaborative Structure:

- To discharge delegated responsibilities, the Mental Health, Learning Disability, and Neurodiversity Provider Collaborative will use a lead provider model, with Devon Partnership Trust as the lead provider
- The following providers are members of the MHLDN Provider Collaborative:
  - Devon Partnership Trust (DPT)
  - Livewell Southwest
- The MHLDN Provider Collaborative Executive Board has a wide membership, including Local Authority representation

## Organisational Governance:

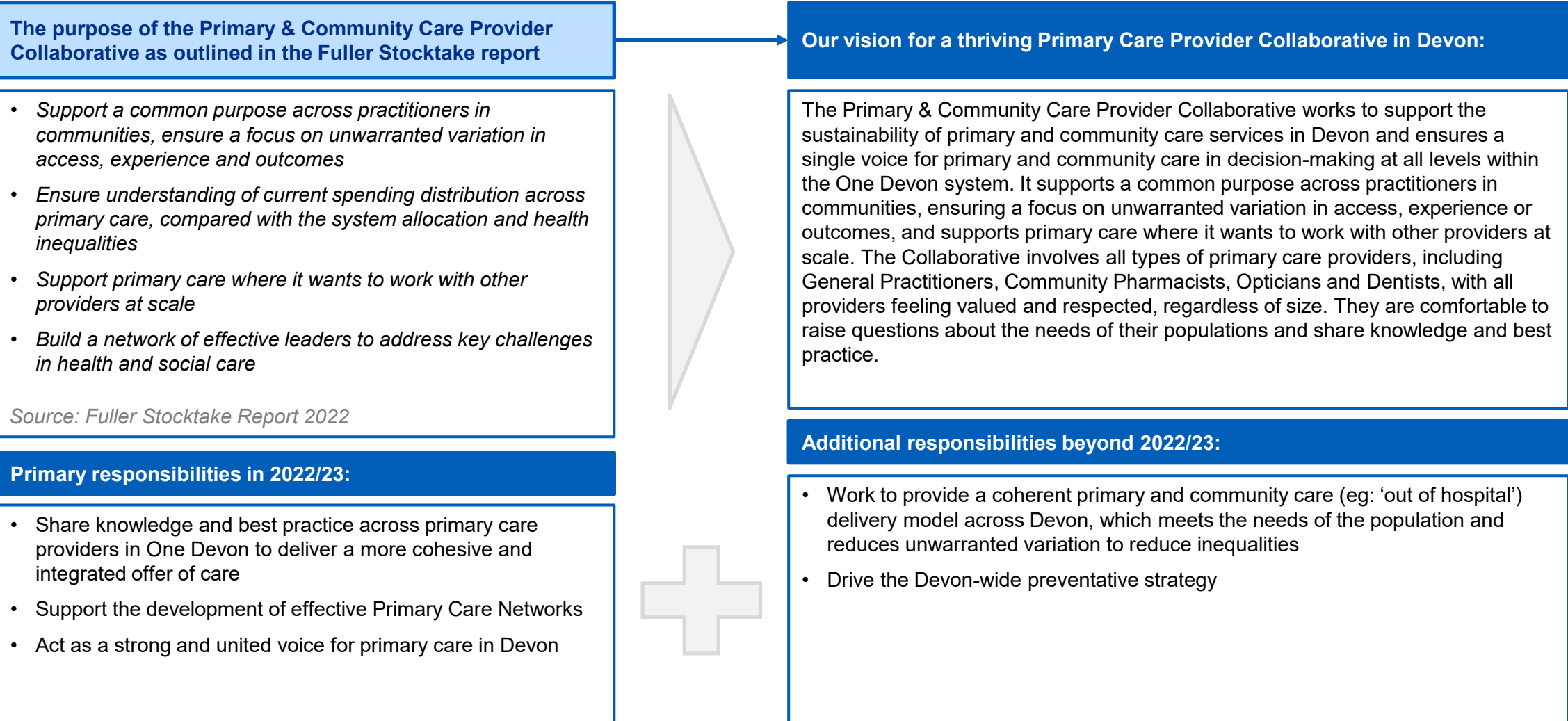
- As lead provider of the MHLDN Provider Collaborative, DPT is accountable to NHS Devon for the delivery of delegated commissioning responsibilities and will also act as the budget holder for the collaborative.
- The Strategic Oversight group is the decision-making body of the collaborative and operates via a principle of consensus. Where consensus cannot be reached, decisions can be escalated to the MHLDN Provider Collaborative Executive Board.



# The Primary & Community Care Provider Collaborative

The establishment of a Primary & Community Care Provider Collaborative will be further co-designed during the Adoption phase

# The Primary & Community Care Provider Collaborative provides a forum to reduce unwarranted variation in outcomes and drive the Devon-wide preventative strategy



# The Primary & Community Care Provider Collaborative will advise on changes to the provision of primary care across Devon to reduce unwarranted variation

What decisions does this group make?

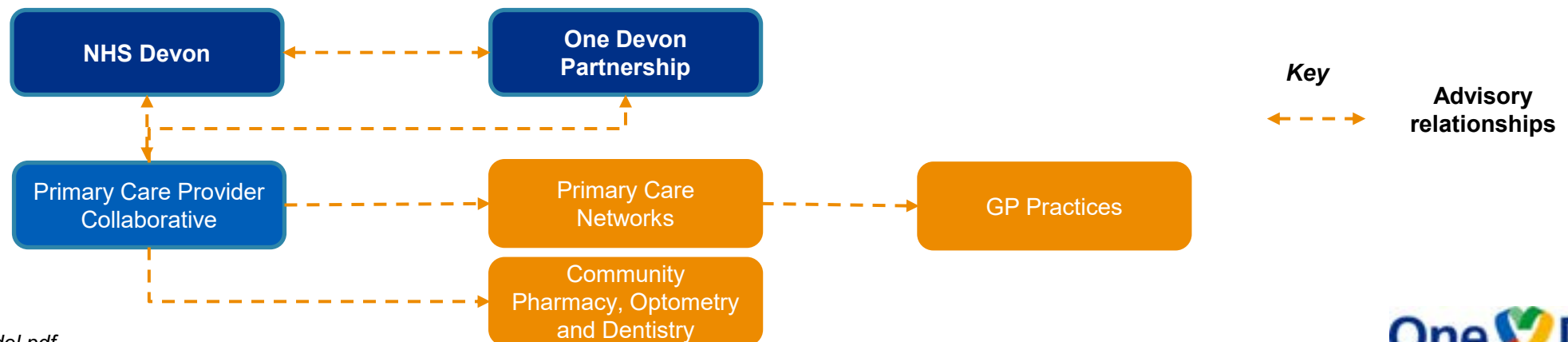
**Primary Care Provider Collaborative**

**In their future state, the decisions that the Primary & Community Care Provider Collaborative make will involve:**

- Advising which services to provide to meet the needs of people living in Devon, with a focus on Devon-wide prevention
- Discussing changes to the provision of primary care across the Provider Collaborative and enhancing integration between local services
- Advising on how to engage the population (including Healthwatch) and what communications to deliver to them
- Support the development of Primary & Community Care Networks across Devon

How does this group support other partners:

The Provider Collaboratives influence the direction of One Devon via representation on the One Devon Partnership.





# Additional development work is required to define how the Primary & Community Care Provider Collaborative will operate

## Responsibilities:

To enable the decisions to take place as articulated on slides 27-28, the following responsibilities will need to be delegated to the Primary Care Provider Collaborative:

### Primary & Community Care Provider Collaborative:

- As a consultative forum, no formal delegations are made

## Provider Collaborative Structure:

- The Primary & Community Care Provider Collaborative will operate as a consultative forum of NHS Devon – additional development work is required to define the membership and structure of the collaborative, including chairing arrangements.
- The precise membership of the collaborative is yet to be determined, but is expected to include representation from each of the Primary Care Networks, optometry, community pharmacy and dentistry

## Organisational Governance:

- The Primary & Community Care Provider Collaborative is constituted as a consultative forum of NHS Devon. Further development work is required to define its terms of reference.



# Local Care Partnerships

# Local Care Partnerships are created in order to serve the health and care needs of people living in their area

## The purpose of the Local Care Partnerships in the ICS implementation framework

- Involve all partners who contribute to health and care in their LCP, including housing, schools, Healthwatch and other Community Groups, employment & training and emergency services, in the co-ordination, planning and delivery of integrated services within localities and alongside communities
- Go beyond strategic planning, including joint commissioning, and integrated service delivery
- Work to reduce inequalities in their LCP

Source: Source:2021 Implementation Guidance

## Primary responsibilities in 2022/23:

The primary responsibilities of the Local Care Partnerships are:

- Supporting the development of the Integrated Care Strategy via One Devon Partnership representation
- Develop and implement demonstrator projects, supported by the One Devon Partnership and NHS Devon to take a learn by doing approach, and embedding innovation throughout LCPs
- Solidify relationships with wider local organisations
- Enhancing service integration in their LCP

## Our vision for a thriving Local Care Partnerships in Devon:

Local Care Partnerships are collaborative arrangements formed by organisations responsible for arranging and delivering health and care services in the 5 localities within Devon. They lead the detailed design and delivery of integrated services in their area, built on a mutual understanding of their local population, trust and a shared vision for the place. Respected as experts on the health and care needs of their population, LCP partners feel supported by the partnership and also feel that the LCP represents their views, opinions, and priorities at larger forums such as the One Devon Partnership, whilst also working to develop the economy in their area. The LCP is constantly engaging with people living and working in its area and people feel able to have an honest conversation about their health and care needs.

## Additional responsibilities beyond 2022/23:

- Improving performance of local services where joint working can improve overall performance
- Planning changes to the provision of services in place to deliver improved integrated care and improved performance
- Delivering relevant strategic priorities for Devon that apply to the local population
- Procuring and securing health and care services to meet the needs of local communities, commissioning at the level of place

# Devon's Local Care Partnerships will make commissioning decisions informed by a detailed understanding of the needs of local people

## Local Care Partnerships

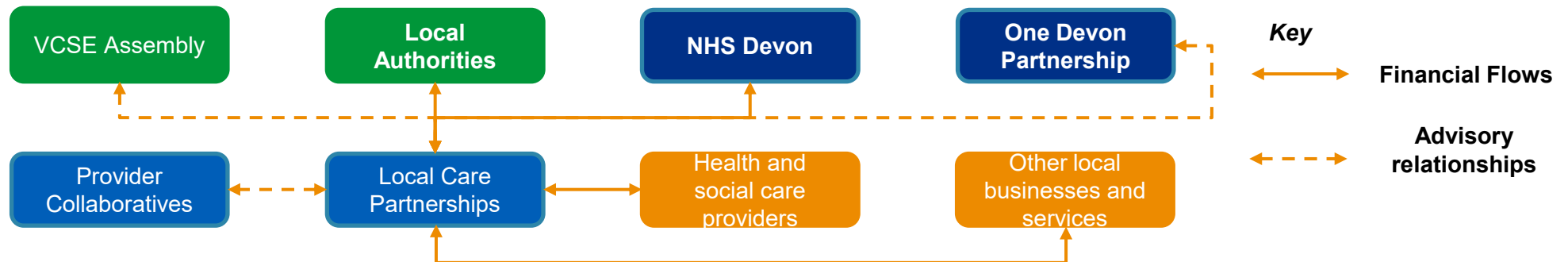
What decisions does this group make?

In the future, the decisions that Local Care Partnerships make will involve:

- Agreeing Local Care Partnership priorities as derived via partnership working with the relevant Health and Wellbeing Boards
- Agreeing the local response to the Integrated Care Strategy, coordinating delivery
- Coordinating services to meet the health needs of local populations
- Planning changes to the provision of services in place to deliver improved integrated care and improved performance –with a particular focus on improvement of preventative and proactive services
- Informing the Provider Collaborative around the needs of the population and ensuring the Provider Collaborative can balance working at scale with a local focus
- Deciding on how to commission services for the local community, where commissioning responsibility has been delegated by NHS Devon or a Local Authority
- Identifying how to optimise use of workforce to manage capacity, including with other partners such as the VCSE
- Identifying how to best make use of existing community groups and forums, transforming community engagement

How does this group support other partners:

There are five Local Care Partnerships in Devon: North Devon LCP, East Devon LCP, South Devon LCP, West Devon LCP, and Plymouth LCP. The LCPs influence the direction of One Devon via representation on the One Devon Partnership Core Committee. The close collaboration between health and care is core to LCPs, including Local Authorities, NHS providers, VCSE sector and other partners.



# The Local Care Partnerships have agreed to work via a consistent governance approach in delivering health and care for their populations

## Responsibilities:

To enable the decisions to take place as articulated on slides 36-37, the following responsibilities could be delegated to Local Care Partnerships by:

### NHS Devon:

- Delegated commissioning responsibility for the provision of community health and care in LCPs

### NHS Providers:

- Delegated authority to make changes to the provision of health and care in LCPs

### Local Authorities:

- Delegated commissioning responsibility for the provision of some agreed services in LCPs

## Local Care Partnerships Structure:

The Local Care Partnerships have agreed to work via a consistent governance approach to commission and co-ordinate health and care services for their population, and will each have:

- **An LCP Executive Group** – responsible for the development of LCP strategy and the representation of the LCP at partnership forums. Where the delivery group cannot reach consensus, decisions may be escalated to the executive group
- **An LCP Delivery Group** – operated by consensus, defining the LCP delivery plan and allocating resource against the workplan
- **LCP Specific Arrangements** – variable between Local Care Partnerships

The staffing of LCPs will include NHS Devon locality teams and agreed commissioning support functions, in addition to staff from partner organisations. They will avoid working in silos, working together with other LCPs and with Provider Collaboratives to share knowledge and resources and avoiding duplication.

## Organisational Governance:

- Initially, LCPs will be formed as consultative forums, advising the LCP Oversight Committee of NHS Devon. Whilst constituted as consultative forums, the LCP Oversight Committee will be accountable to NHS Devon for the delivery of LCP responsibilities.
- As they develop, Local Care Partnerships will become committees of NHS Devon, able to access and hold budgetary responsibilities in their own right.
- Local Care Partnerships will be better placed to align budgets between Local Authorities and NHS. In addition they will be able to access pooled Local Authority funding via Section 75 and 76 agreements made between Local Authorities and NHS Devon as appropriate, in addition of Section 256 agreements and the Better Care Fund.

# Neighbourhoods

# Neighbourhoods enable organisations to deliver more proactive, co-ordinated and tailored care for their communities

## The purpose of Neighbourhoods as in the ICS implementation framework

- Support Local Care Partnerships in establishing a shared understanding of communities' needs
- Support Local Care Partnerships in building relationships with all communities including excluded groups and those impacted by inequalities in access or outcomes
- Undertake engagement with their local population (including Healthwatch) and workforce
- Work with people and communities via a population health management approach

Source: Source:2021 Implementation Guidance

## Primary responsibilities in 2022/23:

The primary responsibilities of the neighbourhoods include:

- Use Neighbourhood knowledge to inform the commissioning of services to improve outcomes, and reduce unwarranted variation and inequalities

## Our vision for a thriving Neighbourhoods in Devon:

As integrated teams, Neighbourhoods bring together teams from Primary Care Networks (PCNs), wider primary care providers, secondary care teams, social care teams, community leaders, voluntary sector and domiciliary and care staff to improve the health and wellbeing of a local community and tackle inequalities. They tap into existing community organisations and forums (including Healthwatch), harnessing ongoing work in promoting a culture of collaboration and pride, creating the time and space to problem solve together, and building relationships and trust between primary care and other system partners and communities. People living in a neighbourhood feel supported in accessing health and care needs, knowing where to get advice and how to be connected to the right services for them.

## Additional responsibilities beyond 2022/23:

- Deliver population health management at a neighbourhood level
- Build teams of primary and secondary care expertise to provide holistic care for people with long-term conditions
- Ensure people are aware of the treatment and non-clinical support options available to them and how to access them
- Support engagement with the Devon health and care workforce
- Undertake engagement with the Devon population
- Deliver health and care campaigns specific to local population needs

# Neighbourhoods provide an in-depth understanding of the needs of their populations, advising Local Care Partnerships on appropriate action

## Neighbourhoods

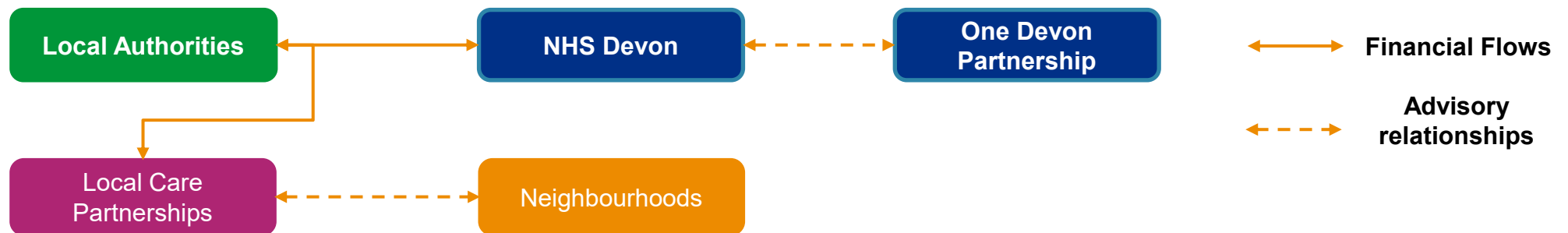
What decisions does this group make?

**In the future, the decisions that Neighbourhoods make will involve:**

- Agreeing the neighbourhood level population health management approach, considering both areas of strength and unmet need
- Identifying opportunities to improve outcomes for the neighbourhood population, with a focus on areas of unmet need
- Agreeing how to provide holistic care for people with more complex and chronic long-term conditions
- Agreeing on proposals to put forward to commissioners, including Local Care Partnerships – to access financial and workforce resource to deliver work where appropriate

How does this group support other partners:

Neighbourhoods influence the provision of care via Local Care Partnerships.





# As consultative forums Neighbourhoods require no formal delegations

## Responsibilities:

To enable the decisions to take place as articulated on slides 40-41, the following responsibilities will need to be delegated:

*Further work is required to define the responsibilities of neighbourhoods, although an initial proposal seeks to establish them as consultative forums of Local Care Partnerships. As consultative forums no formal delegations would be required.*

## Neighbourhood Structure:

- The membership of Neighbourhoods is to be defined, however it is recommended that it constitutes the following:
  - Primary Care Networks
  - Local community and mental health services
  - Local social care providers (Local Authority and Independent Sector)
  - Pharmaceutical services
  - Targeted voluntary sector representation
  - Community champions
- Guidance suggests that Neighbourhoods should be coterminous with the established Primary Care Networks within Devon – further discussion is required to agree the most appropriate footprints for neighbourhoods given Devon’s complex Primary Care Network footprints
- System partners agree Neighbourhoods must build on existing community work

## Organisational Governance:

*Further work is required to define the responsibilities of Neighbourhoods, although an initial proposal seeks to establish them as consultative forums of Local Care Partnerships*

- As consultative forums Neighbourhoods would require no formal organisational governance separate to an agreed membership and Terms of Reference

# Consultative Forums

# There are also consultative forums who bring together and engage with experts in specific areas

## The purpose of Consultative Forums:

### Voluntary, Community and Social Enterprise (VCSE) Assembly

- Operates as a forum for co-production and engagement with the Voluntary, Community and Social Enterprise Sector
- Increase the capacity and capability within the VCSE sector to engage in improving health and care, population health and reducing inequalities
- Provide methods to share information on policy developments and key programmes so that the voluntary and community sector can engage in the delivery of health, care and well-being objectives

*Source: ICS Implementation Guidance 2021*

*These forums have been identified in this operating model due to their being highlighted in published NHS guidance – One Devon will also develop relationships with other consultative forums, such as patient forums, safeguarding forums, and local strategic partnerships*

### Clinical and Professional Cabinet (CPC)

- Bring together a diverse forum of experts across Devon to act as a source of independent, strategic advice and guidance to NHS Devon and the other organisations in One Devon to assist them in making the best decisions about healthcare for the population of Devon
- A representative of Healthwatch is a member within the CPC to ensure that the patient voice is represented and can inform CPC discussions

## Primary responsibilities:

### The VCSE Assembly

- The VCSE Assembly is an open membership assembly representing 6,000 not-for-profit organisations operating within One Devon. This body allows VCSE organisations throughout Devon to engage in, inform and influence strategic partnership discussions.

### The CPC

- The cabinet provides clinical and professional engagement and makes recommendations to NHS Devon with regards to both strategy and delivery. The CPC is made up of senior clinical and professional leads in addition to representatives from the LCsPs.

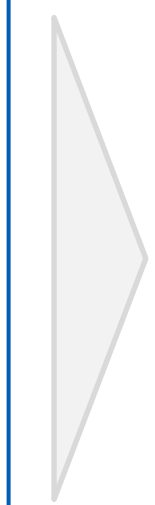
## Our vision for thriving consultative forums in Devon:

Drawing together respected experts, consultative forums provide the foundation for evidence-based decision making throughout One Devon.

Members of the forums feel listened to, and have clarity how their expertise is reflected in the One Devon strategy and policy. One Devon partners, including the One Devon Partnership, Local Care Partnerships, and Provider Collaboratives, feel able to consult with the forums to support their decision making as necessary.

## Additional responsibilities beyond 2022/23:

The consultative forums will fulfil their full role from 2022/23.



# Consultative forums provide essential expertise, check and challenge into the proposals and policies adopted across Devon

What areas will these groups consult on?

## Voluntary, Community and Social Enterprise Assembly

Areas that the VCSE Assembly may be asked to be consulted on/provide advice on:

- Mechanisms and infrastructure for Voluntary, Community and Social Enterprise engagement and integration
- The extent to which system strategies and proposals are supported by evidence effective use of VCSE partners
- The extent to which system strategies and proposals will contribute to the reduction of inequalities and improvement of population health

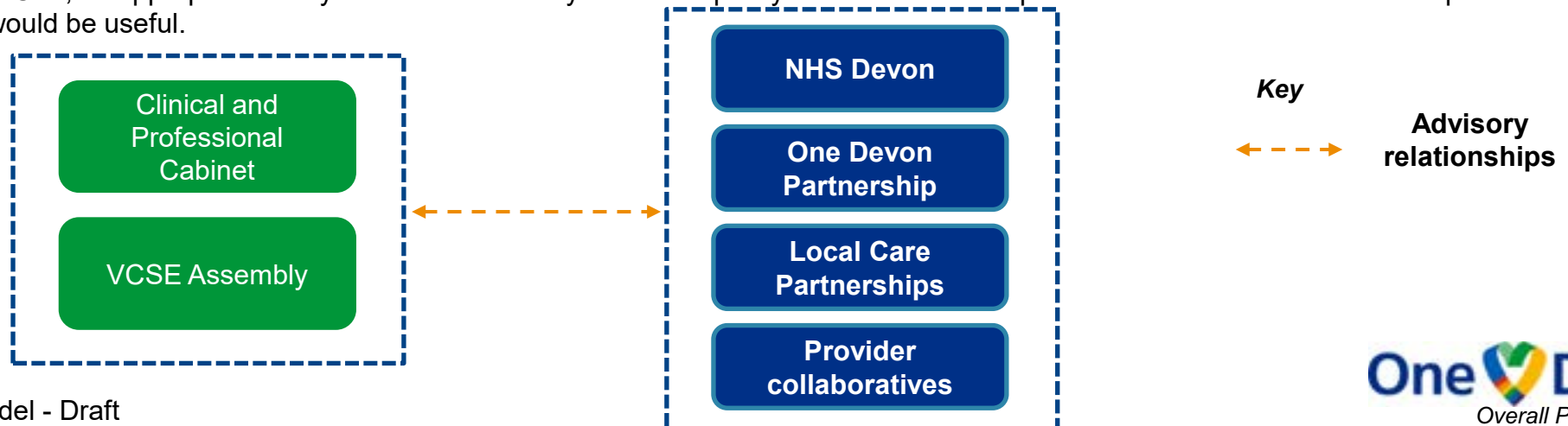
## Clinical and Professional Cabinet

Areas that the Clinical and Professional Cabinet may be asked to be consulted on/provide advice on:

- Mechanisms and infrastructure for clinical and professional engagement
- The extent to which system strategies and proposals are supported by evidence of good clinical and professional practice
- The extent to which system strategies and proposals will contribute to the reduction of inequalities and improvement of population health

How does this group support other partners:

The Clinical and Professional Cabinet and VCSE assembly influence the direction of One Devon via One Devon Partnership representation – and roles within the LCPs, as appropriate. They are consulted on system-wide policy and initiatives and partners feel able to ask for their input where their expertise would be useful.



# External Partners

# NHS Devon will work closely with the existing South West Provider Collaborative in the commissioning of specialised mental health care

What does the South West Provider Collaborative do?

## The South West Provider Collaborative

The South West Provider Collaborative works to commission specialised services for people living in the South West. It includes the following members:

- Devon Partnership NHS Trust (Lead Provider)
- Cornwall Partnership NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
- Avon and Wiltshire Mental Health Partnership NHS Trust
- Gloucestershire Health and Care NHS Foundation Trust
- Cygnet Health Care
- Elysium Healthcare
- Priory Group
- Livewell Southwest

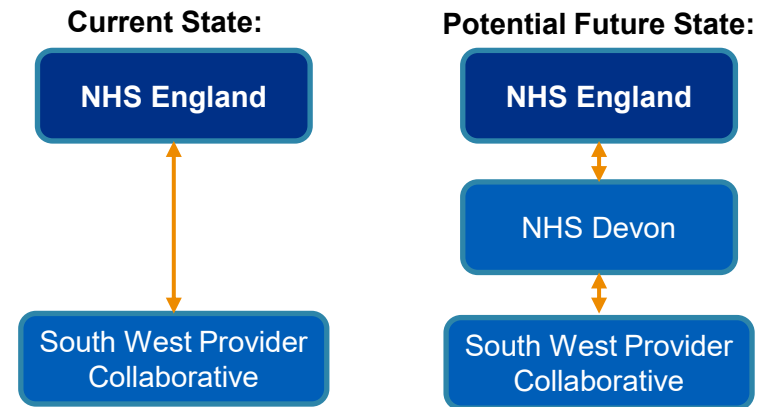
Services currently commissioned by the Collaborative include:

- Adult Low and Medium Secure Services
- Children and Young People’s Mental Health Inpatient Services
- Adult Specialised Inpatient Eating Disorder Services

## How might the South West Provider Collaborative change in the future?

Proposed changes from NHS England may impact how the South West Provider Collaborative commissions care:

- Currently NHS England directly delegates responsibility for the commissioning of specific specialised services to the South West Provider Collaborative
- In the future, NHS England is likely to delegate this responsibility to Integrated Care Boards, including NHS Devon
- There is then a decision to be made in partnership with the other members of the South West Provider Collaborative whether or not there are further delegations to be made to give responsibility for contracting the South West Provider Collaborative to a single ICB



# The new operating model will also provide a more streamlined set of mechanisms to interface with other external partners

## Coordinating ICS Strategies

### In coordinating strategies, other ICSs will interface with:

- **One Devon Partnership** - when advising on matters relevant to the preparation of the Integrated Care strategy
- **NHS Devon** – when advising on or aligning with NHS-specific strategies

## Specialised Commissioning

### Once ICBs have taken responsibility for specialised commissioning, other ICBs will interface with:

- **The South West Provider Collaborative** – supported by DPT as the lead provider, for the provision of specialised mental health care
- **The Acute Provider Collaborative** – for discussions surrounding the provision of specialised acute care

## Clinical and Professional Networks

### Clinical and Professional Networks (assumed to include SW Academic Health Science Network) will interface with:

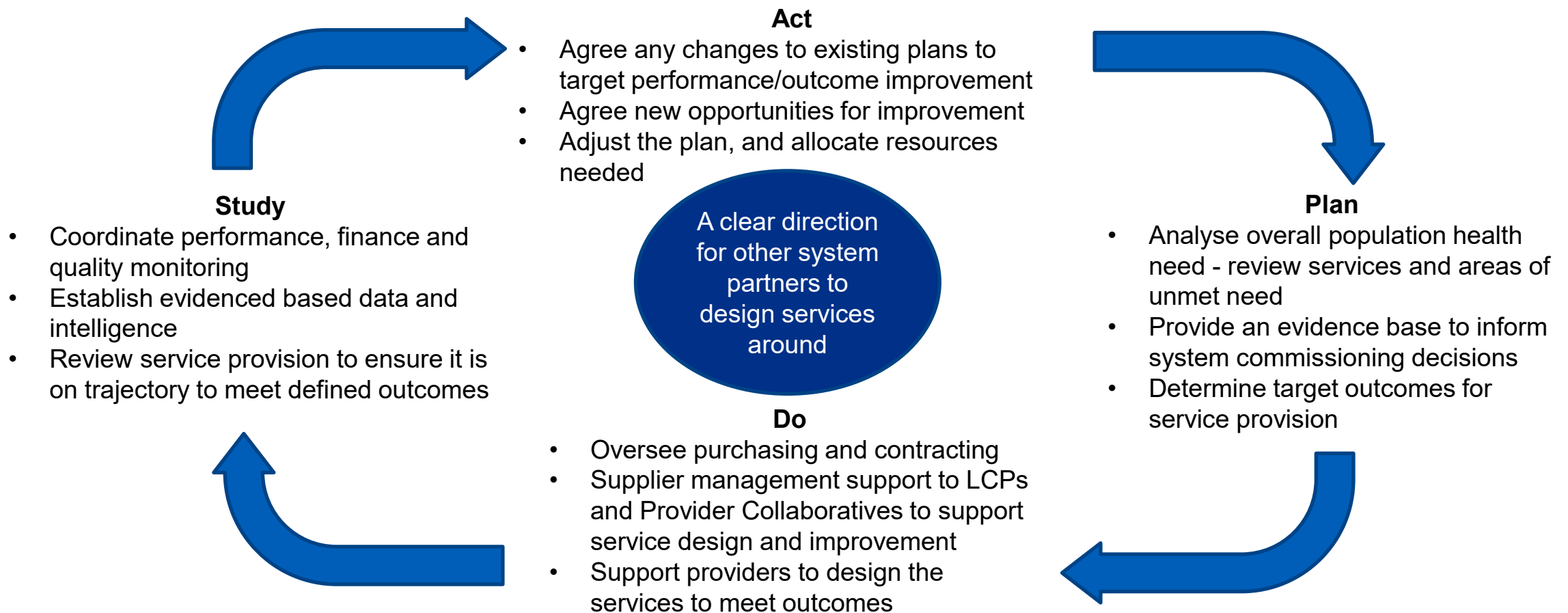
- **One Devon Partnership** – when advising on matters relevant to the preparation of the Integrated Care Strategy
- **Provider Collaboratives** – when advising of the provision of specific acute, MHLDN or primary health care services, as well as the uptake of innovation and the co-ordination of research efforts across the region.

# Working together as a system



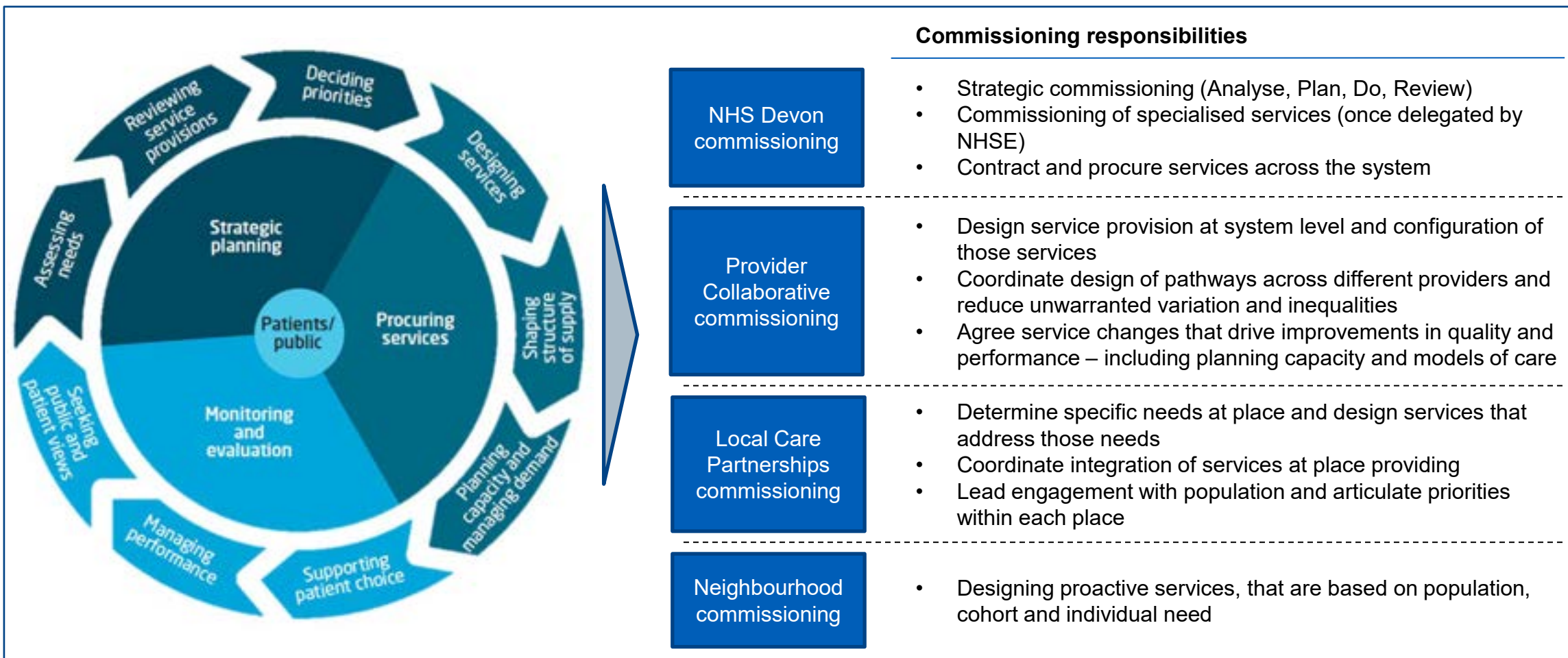
# Under the new operating model, NHS Devon will adopt the role of strategic commissioner

Strategic commissioning places a greater emphasis on determining **what types of services** should be commissioned within the system, but not **how they should be delivered**. The responsibilities of a strategic commissioner can be understood through an 'analyse, plan, do, review' framework



# The full role of commissioning and organising services will be spread across the system and will need close cooperation

Commissioning refers to: “The cycle of assessing the needs of people in an area, designing and then securing appropriate service.” Historically, this has been done by CCGs, but under new arrangements Provider Collaboratives and LCPs will have a role in commissioning services alongside the ICB.



# The operating model will be key to translating system strategic goals into meaningful change and help to bring structure to collaborative action

Mutual accountability describes the way partners in the system challenge and hold each other to account to ensure the delivery of agreed objectives, regardless of statutory accountabilities. By developing strategic objectives and assigning them to system partners, One Devon can embed mutual accountability for the shared objectives that have been co-developed by the One Devon Partnership

## Agreeing strategic objectives through the Devon Plan

One Devon Partnership identifies and agrees the strategic goals to achieve over the next 5 years.

## Aligning metrics to strategic goals

Overarching target metrics are aligned with the strategic goal to allow monitoring of improvement. These metrics should support for outcome based commissioning.

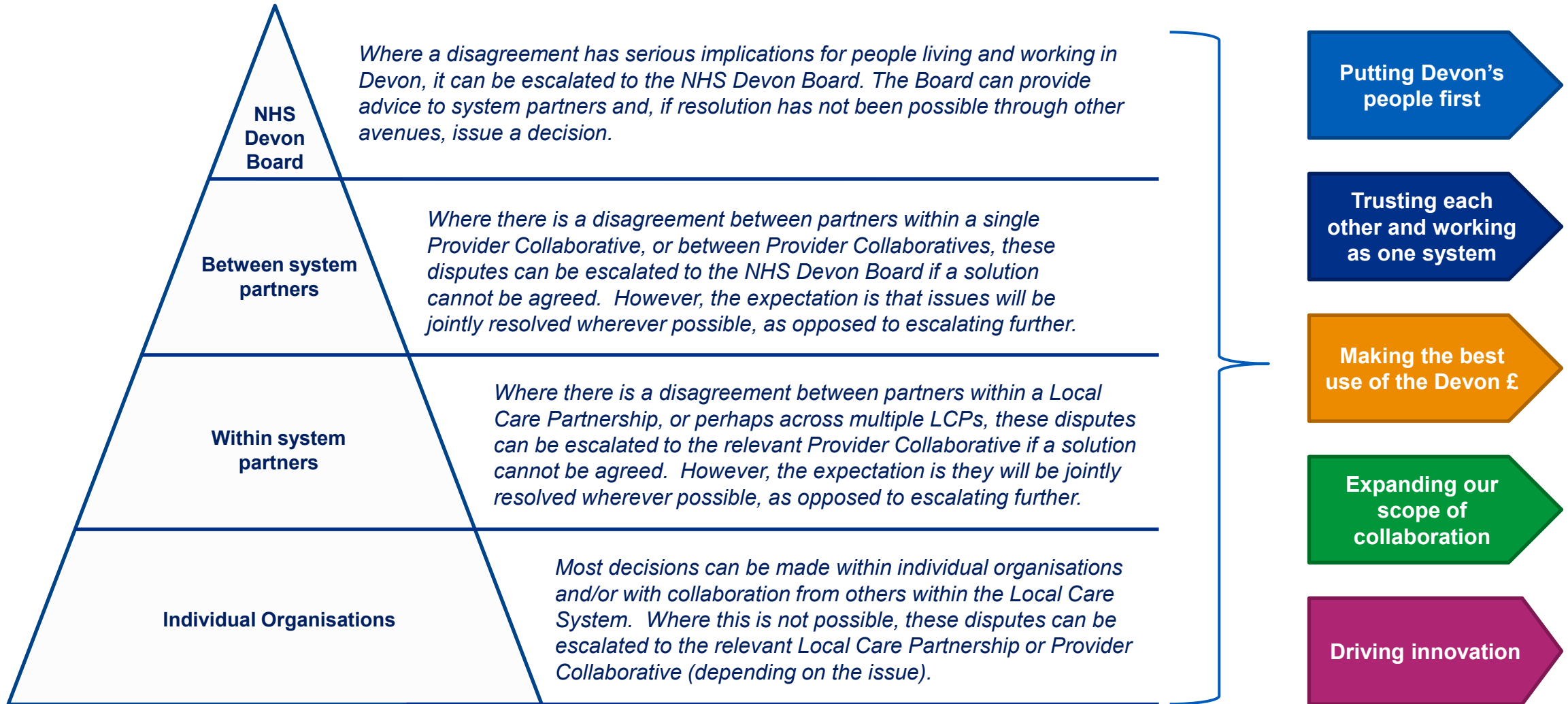
## Distributing metrics throughout partners within One Devon

Supporting metrics are assigned to the collaborative structures within One Devon, including both Local Care Partnerships and Provider Collaboratives – these structures then become responsible for the improvement as evidence by those metrics

## Attaching benefits to the successful delivery of metric improvement

Benefits such as additional allocated funding or greater autonomy are attached to the successful delivery of improvement, in line with agreed metrics

# Any disputes that arise are dealt with at the correct level within the system, with reference to our values and behaviours



# Delivering Our Priorities Through the New Operating Model

# Through the new structures, we can better deliver on our priorities– as shown in the example of Urgent and Emergency Care (UEC) (1/2)

What UEC might look like in One Devon in the future:



## Developing effective prevention

Individuals have an active role in their own health and know what is needed to stay healthy as possible. This is supported by a proactive, integrated set of local services, which are informed by monitoring of population health needs at neighbourhood-level.



## Improving ambulance handovers

Ambulances are directed to the hospital that will most rapidly and appropriately meet the needs of their patient. The handovers are rapid and there are appropriate facilities for patients to be triaged into whilst their needs are fully assessed.



## Creating effective navigation of the system

There is a clear understanding of the range of services that are available for urgent and emergency care. This can be informed by clinical navigation that is easily available through 111 and a single front door to urgent and emergency services, which can arrange and signpost to appropriate care.



## Preventing avoidable admissions

Residents are seen in a setting that best matches their needs. Those at high-risk of admission are known to the system and supported by a nominated representative, who is best placed to meet their primary medical or social requirements.



## Facilitating prompt discharge

Discharge planning begins on admission. The preferred discharge destination is established swiftly and contact is made to assess ability to provide any follow-up care requirements.

If additional support is required, this is arranged in line with the patient's expected 'medically fit for discharge' date.

# Through the new structures, we can better deliver on our priorities– as shown in the example of Urgent and Emergency Care (UEC) (2/2)

The below outlines **an example** of how the system might provide UEC services, under the new operating model but is not reflective of existing plans

## System

- **The One Devon Partnership** will articulate the holistic requirement for UEC services through the Integrated Care Strategy – linking the different elements of the pathway, including the balance of preventative and proactive services with other reactive UEC services.
- **NHS Devon** will coordinate the response to this, primarily by setting an outcome-based commissioning framework and allocating budget to LCPs and Provider Collaboratives. NHS Devon might also directly commission services that will apply system-wide, including ambulance services (SWASFT) and NHS111. The ICB might also commission and manage a digital system that allows for rapid and continuous monitoring of patient need – necessary for adoption of a population health management approach (the necessity for a shared data architecture in UEC has been highlighted by system partners). NHS Devon will also coordinate the creation of a plan that articulates how the NHS workforce will deliver the initiatives outlined in the Integrated Care Strategy.
- Through allocated funding from NHS Devon each **Local Care Partnership** will commission services that support discharge for their population as well as anticipatory services that can support admission avoidance – depending on the needs of the population. This will be informed by key partners in the LCP including social care and housing. LCPs will be responsible to commissioning additional community capacity to help rebalance away from acute services and will also coordinate the involvement of wider public sector and charitable partners.
- The anticipatory services commissioned by the LCP will be informed through consideration of the preventative strategy – these will include services such as care home outreach and long term conditions management, and will be informed via engagement with key LCP partners including housing
- Through allocated funding from NHS Devon, the **Acute Provider Collaborative** will design the services that acute services will deliver. They will also take decisions about policies and protocols, central to maintaining effective patient flow and rapid patient transfer e.g. ambulance handover protocol. They will also feed into the workforce plan developed by NHS Devon.
- Through allocated funding from NHS Devon, the **MHLDN Provider Collaborative** will determine the pathways required for emergency mental health provision and will support effective management of patients in crisis. They will also feed into the workforce plan developed by NHS Devon.
- Each **Neighbourhood** should coordinate different services and support proactive identification of patients who are at risk of admission to hospital – and deliver proactive interventions tailored to their requirements to prevent admission. Neighbourhoods will also identify people who are admitted to hospital through use of data analytics, supporting more proactive discharge planning.

## Neighbourhood

# During periods of intense pressure where closer performance management is required, the new operating model will enable tighter collaborative working

Through the new ways of working, providers will retain their accountability for the delivery of services and achieving constitutional performance standards. However, there will be greater emphasis on shared responsibility for achieving these targets where the system must coordinate to support effective delivery.

Through the performance management system it is crucial that there are sufficiently robust mechanisms that combine with the system values to support improvement at organisational and system level.

## Provide joined-up decision making

For example, when dealing with winter pressures:

- The One Devon Partnership will agree system priorities
- Provider Collaboratives should take decisions about deployment of shared resources
- LCPs can determine initiatives to streamline discharge and coordinate community capacity including services supporting addressing the wider determinants of health
- Neighbourhoods can make joined up decisions about how to manage individuals with complex needs and speed their discharge

## Coordinate system action

For example when needing to make corrective decisions to stay on track with financial plans:

- NHS Devon will retain oversight of the overall programme – tracking progress and identifying areas of poor performance and providing additional support where necessary
- The Provider Collaboratives can determine where there are joint areas of cost and share resources to address these – as well as consolidating efforts, where appropriate
- LCPs can develop alternative models of provision to provide improved and more cost-effective care

## Jointly manage against targets

The Integrated Care Strategy (Devon Plan) will articulate strategic objectives that the system will aim to achieve:

- NHS Devon will contract with target outcomes and will hold others to account in meeting these targets
- Specific metrics will be allocated to system partners to deliver on in support of overall targets
- For example, in support of elective recovery – the acute provider collaborative will focus on reducing long waits and, in support of this, LCPs will focus on reducing stranded patients



# Adoption Roadmap

# Five themes for the development of joint working arrangements have been identified – these will also be applied to adoption of this operating model

## Learn by Doing

Change comes from undertaking real work together and acting upon the learning we generate. One Devon will be able to continually develop if we embed a culture of learning and improvement.

## Prioritise and Implement

Implementing a small number of priority projects and programmes will create the conditions for us to deliver real change together on the journey towards the One Devon vision.

## Shared Purpose

Defining and articulating (and continuously re-articulating) why we are doing what we are doing, and what we hope to achieve from it, thus supporting us as One Devon to collaborate to achieve our common purpose.

## Trust and Collaboration

Increasing levels of trust and collaboration between us will be vital to creating the conditions to progress towards our One Devon vision.

## Move Towards a System Focus

Movement towards our One Devon vision will be enabled by the extent to which we seek to listen to, understand and take into consideration each other's needs and constraints – we will resource system forums effectively to ensure that joint working is impactful and effective.

# To move to this operating model system partners will each need to begin development of their working arrangements in Q3 2022/23

<b>One Devon Partnership</b>	The One Devon Partnership has defined its core committee membership and outlined its Terms of Reference. Initial focus will be on the co-production of the Integrated Care Strategy.
<b>NHS Devon</b>	NHS Devon is currently commissioning health services for people living in Devon. It is accountable for the financial performance of One Devon and is working closely with regional and national colleagues to reach financial sustainability. Looking ahead, a commissioning framework that articulates more detailed delineation of commissioning responsibilities across the system should be developed.
<b>Acute Provider Collaborative</b>	The Acute Provider Collaborative has defined its membership and outlined its terms of reference. Members are beginning to work together to ensure the best use of the totality of resources at its disposal and to plan changes to the provision of NHS services across providers.
<b>MHLDN Provider Collaborative</b>	The MHLDN Provider Collaborative has defined its membership and agreed its Terms of Reference. It is working to establish the required governance including financial due-diligence, creating the provider contract and creating the partnership agreement.
<b>Primary Care Provider Collaborative</b>	In implementing the operating model, the Primary Care Collaborative will work to define its membership and governance. Membership organisations will need to determine the best model of representation that ensures involvement across all parties whilst also creating a plan for primary care that has buy-in across the system.
<b>Local Care Partnerships</b>	Local Care Partnerships have agreed a governance approach and are working to identify their demonstrator projects and the available local and system resource including partners such as those in the VCSE. Initial focus should be upon determining local priorities, in line with the Devon Plan, and creating action plans around delivering on those priorities for the remainder of 2022/23.
<b>Neighbourhoods</b>	There are 31 existing Primary Care Networks (PCNs) in Devon. Development work is required to form Integrated Neighbourhood 'teams of teams' – this should include articulating membership and responsibilities of each neighbourhood by the start of Q4.

# Cutting across the new structures, two enablers have been identified as key to the development of these new ways of working

Engagement undertaken across the system has consistently identified two key barriers to collaborative working in Devon – addressing these barriers will be key to the implementation of these new ways of working



## Clarity of Resource allocation

System partners have identified that clarity surrounding resource allocation is crucial to begin to implement these new ways of working. This includes:

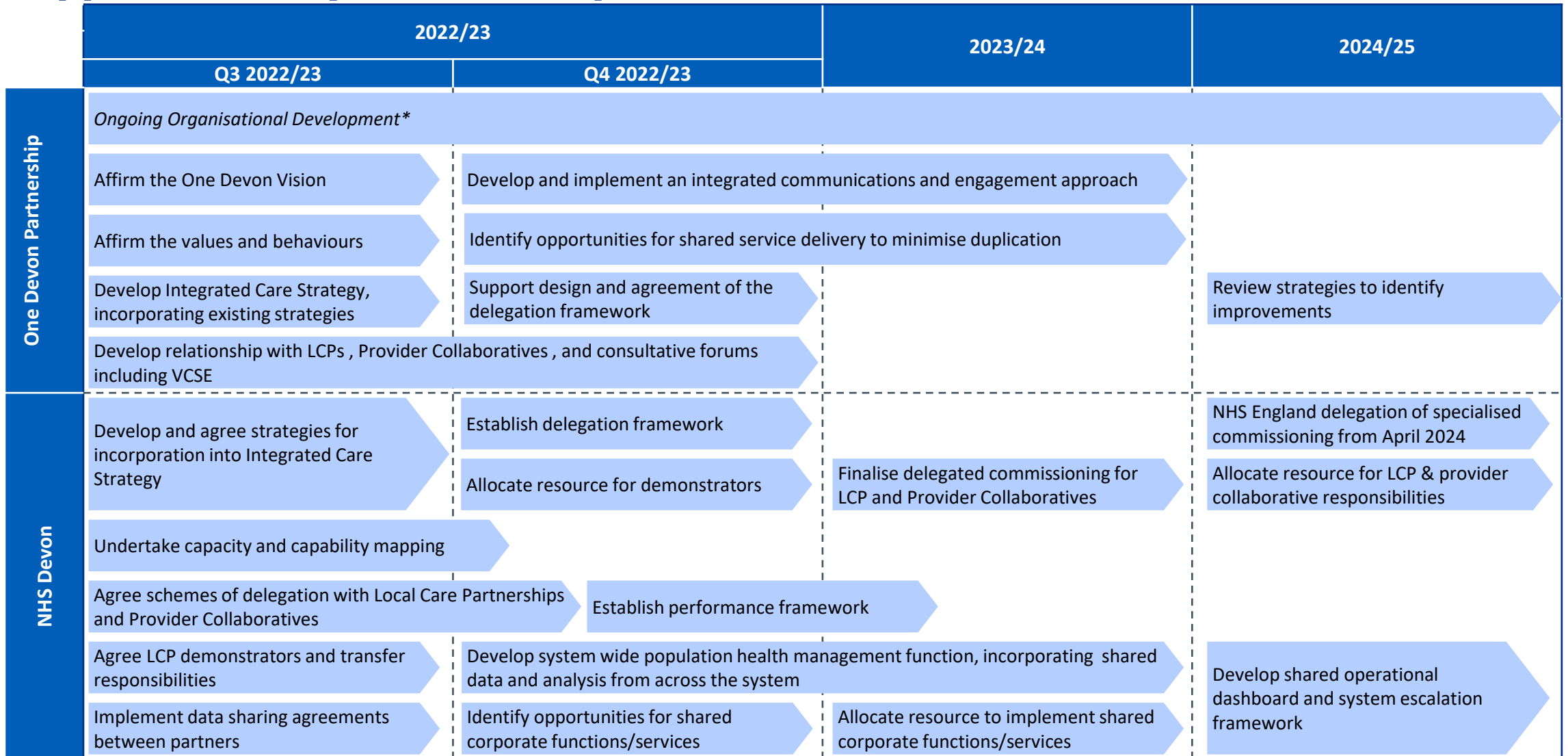
1. Clarity around what staffing will be allocated to Local Care Partnerships, Provider Collaboratives and Neighbourhoods to support the delivery of their new roles and responsibilities.
2. Clarity around the budgetary power that each of these structures will be given. There was general agreement that LCPs and Provider Collaboratives should be given power to spend money, but further work is required to understand how this will be divided up across the system and how this will be balanced with resources allocated directly to organisations.



## Data Architecture

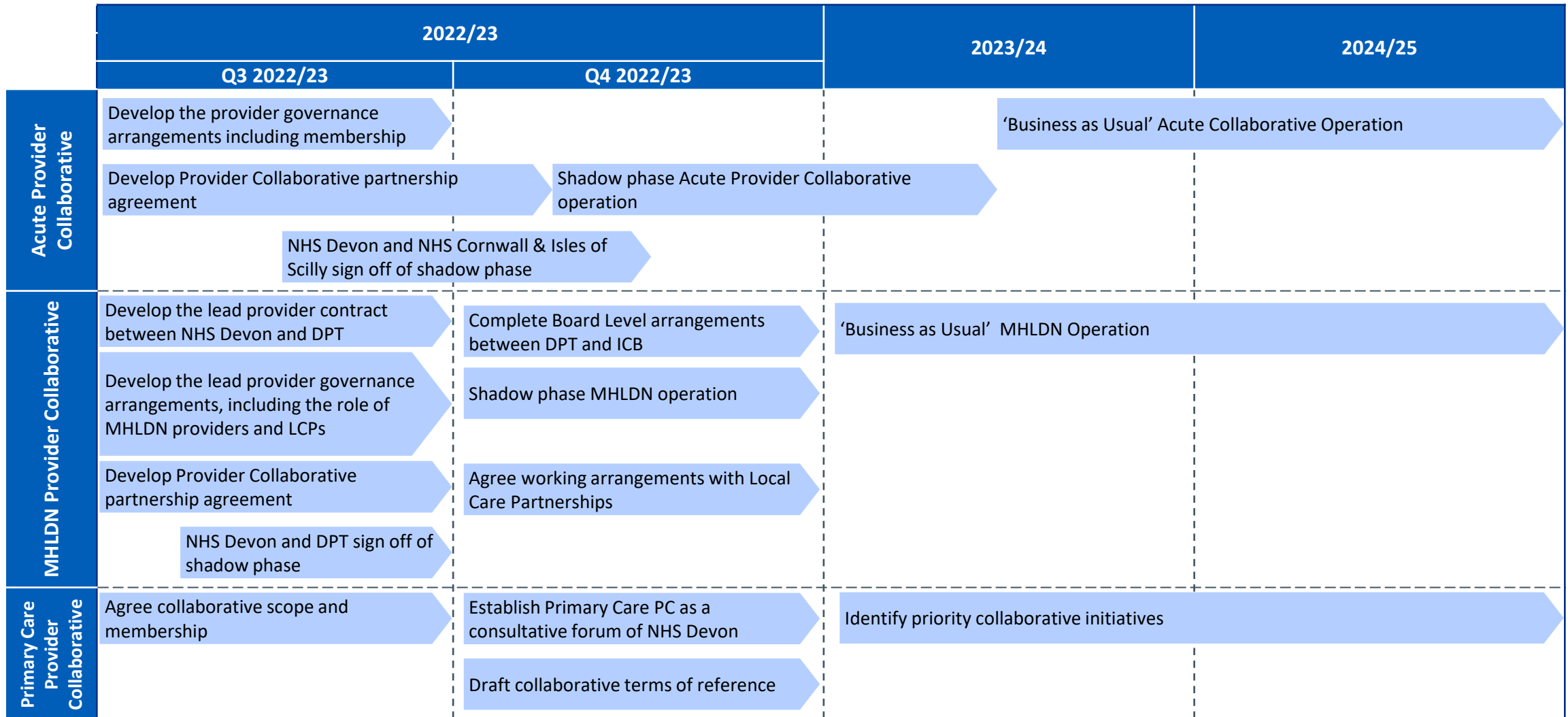
System partners have consistently identified the lack of comparable, accessible data across One Devon as a significant barrier to collaborative working. The commissioning of a shared data architecture, supported by data-sharing agreements between partners in Devon, is a priority in implementing the operating model. Without this, outcome based commissioning, proactive models of care and the implementation of population health management approaches will prove to be challenging. All of these are seen as central to the responsibilities of the new structures.

# One Devon Partnership and NHS Devon will take a coordinating role and support wider system development



10.01 Devon Operating Model.pdf - Roadmap detailing specific OD activities has been separately developed

# The roadmap for the provider collaboratives lays out the trajectory for taking on full responsibilities through to 2024/25



# Local Care Partnerships and Neighbourhoods will also take on additional responsibility as they mature

		2022/23		2023/24	2024/25
		Q3 2022/23	Q4 2022/23		
Local Care Partnerships	Continue to develop mobilisation plans for LCP demonstrator projects		Delivery demonstrator projects		
	Ongoing LCP oversight committee, setting 2022/23 dev't plan		Agree delegation framework	Further development of LCP governance arrangements	
	Develop LCP operating model, including partner roles, contributed resource, and working arrangements with Provider Collaboratives				
	Validate current locality resource aligned to each LCP		Develop a consistent reporting framework for LCPs, with flexibility to include locally agreed outcomes		
	Agree the placement of commissioning support functions/resources to support LCP delivery		Agree a contribution model, identifying what capacity partners can contribute to each LCP	Mobilise contribution model	
	Solidify relationships at place with wider public and voluntary sector		Map LCP OD plans to identify opportunities for OD that is done at scale, defined in an integrated plan	Deliver integrated OD	
			Commence planning for PHM approach in alignment with neighbourhood development		
Neighbourhood	Draft neighbourhood terms of reference		Define neighbourhood boundaries and agree membership		Implement agreed neighbourhood role
			Agree scope of neighbourhood role within individual LCPs, aligned to wider population health management approach		

# Partners must work together to agree the role and governance of the Neighbourhoods in One Devon

Work undertaken to develop neighbourhoods in Devon has thus far reflected national guidance – further work is required to to define the specific role, membership and resources of Neighbourhoods in the Devon context

## What is the role of neighbourhoods in Devon?

- Neighbourhoods should be foundational to integrating care locally and linking health and care services to the wider public sector, volunteer sector and businesses.
- The system should align on how neighbourhoods effectively identify population need – and coordinate action to match this

## What is the membership of neighbourhoods?

- Although national guidance suggests neighbourhoods may be coterminous with Primary Care Networks, work is required to agree whether this is the most appropriate model for Devon
- Work is required to agree the footprint for neighbourhoods and the membership based on those footprints

## How can we ensure we harness the work of existing forums?

- System partners feel strongly that neighbourhoods should build on work already being done by community organisations, building neighbourhoods around these structures ensures their work is harnessed
- This will vary by neighbourhood and should be mapped out for each one

## What is the resource required to deliver their role?

- For Neighbourhoods to be effective there is a need for them to be able to manage their collective resources and to ensure this can be coordinated effectively.
- The scope of this resource is to be defined and it should be clear if this is to be drawn from existing neighbourhood partners or will be in addition to the resources partners currently hold



# Conclusions and Next Steps

# The One Devon Operating Model will be regularly reviewed and updated to ensure it serves the health and care needs of people living in Devon

## Next Steps:

The operating model is part of a wider programme of ongoing development work within One Devon. Following initial approval the operating model will be regularly reviewed and iterated to ensure that it enables those working within the system to best meet the health and care needs of people living in Devon. Following the initial draft, opportunities to formally review and document changes to the operating model in the coming year have been identified:

1. Integrated Care Strategy Draft
2. 5 Year Joint Forward Plan Draft
3. Annual Planning cycle

