Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors

Date: Wednesday 31st May 2023

Time: 12 Noon – 3.15 pm

The Boardroom
Hengrave House
Lowes Bridge
TQ2 7AA

www.torbayandsouthdevon.nhs.uk

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TSDFT Public Board of Directors

31/05/2023 12:00

Torbay and South Devon NHS Foundation Trust

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11. Date and time of Next Meeting - 11.30am, Wednesday 28 June 2023

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OUR STRATEGY AND PURPOSE

Our Purpose (what is our role in society?):

- Our purpose is to support the people of Torbay and South Devon to live well

Our Goals (how do we measure our success?):

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

Our Priorities (what do we need to focus on to achieve our goals):

- More personalised and preventative care: 'What matters to you matters to us'
- Reduce inequity and build a healthy 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

Our Objectives:

- Quality and Patient Experience
- People
- Financial Sustainability
- Estates
- Operations and Performance Standards
- Digital and Cyber Resilience
- Building a Brighter Future
- Transformations and Partnerships
- Integrated Care System
- Green Plan/Environmental, Social and Governance

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MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN POMONA HOUSE
AT 11:30 AM ON 26 April 2023

Present:	Mrs L Davenport	Chief Executive
	Dr P Aitken	Associate Non-Executive Director
	Professor C Balch	Non-Executive Director
	Mr R Crompton	Non-Executive Director/Vice Chairman
	Mr I Currie	Chief Medical Officer
	Ms A Jones	Director of Transformation and Partnerships
	Ms D Kelly	Chief Nurse
	Dr K Lissett	Interim Medical Director
	Mrs E Long	Director of Corporate Governance and Trust Secretary (non-voting Board Member)
	Mrs J Lyttle	Non-Executive Director
	Mr P Richards	Non-Executive Director
	Mr D Stacey	Deputy Chief Executive Officer and Chief Finance Officer
	Mr R Sutton	Non-Executive Director
	Mrs S Walker-McAllister	Non-Executive Director
	Dr J Watson	Health and Care Strategic Director (non-voting Board Member)
	Dr M Westwood*	Chief People Officer

In attendance:	Dr J Harris	Associate Director of Communications and Partnerships
	Mr L Johns	System Director, Planned Care, TSDFT
	Mrs Amanda Lowe	Director of Audit and assurance (ASW)
	Mrs S Byrne	Board Secretary
	Mrs A Hall	Governor
	Mrs J Thomas	Lead Governor
	Mr P Millfield	Governor
	Mrs V Browning	Governor
	Mr A Postlethwaite	Governor
	Mrs C Foy	Associate Director of Nursing and Professional Practice (071/04/23 only)
	Ms Elizabeth Souster	Patient (071/04/23 only)
	Ms Jane Anderson	Volunteer Support Worker (071/04/23 only)

* via Microsoft Teams

067/04/23 **Welcome and Introductions**

The Vice Chairman confirmed he would Chair the Board, in the Chairman's absence and welcomed all those in attendance to the meeting.

Preliminary Matters

068/04/23 **Apologies for Absence and Quoracy**

The Board noted apologies of absence from Sir Richard Ibbotson and Mr Jon Scott who was represented by Mr Lee Johns, System Director, Planned Care.

069/04/23 **Declarations of Interest**

No declarations of interest were received.

070/04/23 **Board Corporate Objectives**

The Board received and noted the Board Corporate Objectives.

071/04/23 **Patient Experience Story**

Ms Kelly welcomed Ms Elizabeth Souster (Elizabeth), her support worker, Ms Anderson and Mrs Foy to the Board, to tell Elizabeth's patient story.

Elizabeth introduced herself and explained how the co-production working of the Torbay Recovery initiative had supported her to regain control over her life, commencing a journey of recovery. She informed the Board that she grew up with complex behavioural problems and severe anxiety which had left her vulnerable. In 2019 she had a mental health breakdown and although the GP saw her regularly, she did not have a strong support network around her and was in a relationship with a coercive partner. At this time in her life she was an alcoholic and her partner had introduced her to his undesirable friends; leading to her becoming a victim of domestic violence and start taking drugs, often with her partners visitors taking drugs in her home.

During the COVID19 pandemic, Elizabeth found herself more isolated, however Devon and Cornwall Police became aware of her situation and supported her rehabilitation through six Multi-Agency Risk Assessment Conferences which involved themselves, the probation service, her GP Surgery and Walnut Lodge.

She informed the Board that her former partner was now serving the second half of his sentence in prison; removing his presence from her life presented an opportunity, with the support of the Multi-Disciplinary Team around her, to remove all other former bad influences from her life and get her life back on track; ensuring Court

fines and bills were paid and she had started to re-build relationships with her son and family.

Due to the co-production of the support she was offered she was able to attend cognitive behaviour therapy, outward bound activities, art therapy as well as accessing other positive support. She believed this enabled her to manage her thoughts and feelings, lead a balanced life and helped her self-esteem immensely. Due to the growth that has been seen in her, she had been appointed as a Peer Mentor.

Elizabeth summed up by saying, “How do you expect a flower to grow when strangled by weeds”.

The Vice-Chair, thanked Elizabeth for sharing her experience and highlighting the importance of Multi-Disciplinary Team working on behalf of the whole Board.

Dr Aitken asked which agencies had visited her home. Elizabeth explained that due to the pandemic and the lock down rules only the police were able to visit her at home and they were the agency to raise concern.

Mrs Davenport recognised the personal strength and courage it took for Elizabeth to talk to the Board and informed her the Trust were looking to shape the services of the future by drawing on knowledge and understanding from those, like herself, with lived experience.

Ms Anderson explained Elizabeth had been considered as a Peer Mentor, as she naturally reached out to her peers; and there was a healthy acceptance of volunteers that came from a lived experience background. Ms Anderson continued, that one former volunteer was now in paid employment as an Alcohol Liaison Worker, which was testimony to the benefits of co-production. However, Elizabeth realised recovery could only happen at a person’s own pace due to the trauma they will have suffered.

Ms Jones confirmed she would be taking Elizabeth’s experience and using it as an example for partner organisations, in particular the Local Care Partnership, to draw on. **ACTION: Ms Jones**

Consent Agenda (Pre-notified questions)

072/04/23 **Committee Reports**

Mrs Long, presented the Committee Reports, as circulated to the Board. It was noted that in place of written Committee reports, which were a duplication of governance as full minutes were written for each meeting, that a link to the Trust’s Diligent Committee Minutes Library had been provided in the covering sheet. In their place, a summary of the meetings held in the period was provided in the Board cover sheet; with Chair’s providing verbal exception reports of specific matters to be brought to the Board’s attention. It should also be noted that a Governor Observer attends each Committee and provides a report to the Council of Governors at each meeting to ensure oversight.

The following committees met in April 2023 and the following derogations made:

- Finance Performance and Digital Committee – No derogations.
- Audit and Risk Committee – Mr Sutton asked the Board to note:
  - A large number of declarations of interest were outstanding;
  - A considerable number of outstanding internal audit recommendations were outstanding; and
  - Clinical Audit and Effectiveness was challenged.
- Building a Brighter Future Committee – Prof. Balch asked the Board to note:
  - Clarification of funding was expected shortly.
- Quality Assurance Committee – No derogations.
- Torbay Pharmaceuticals Board - No derogations.

The Board received and noted the Committee Reports.

074/04/23 **Chief Operating Officer's Report - April 2023**

Mr Johns presented the Chief Operating Officer's report for April 2023, as previously circulated. He highlighted the following:

Urgent and Emergency Care

- A marginal improvement in the Urgent and Emergency Care performance position had been reported. The improved position had been achieved by focusing on discharging early mornings, weekends and before 5pm.Risks which currently affected the recovery position were ambulance delays, bed restrictions and ensuring optimal infection prevention control measures.

Planned Care

- The Trust achieved the nil 104 ww target.
- The 78 week wait position was outperforming the trajectory towards nil.
- The Trust had moved from Tier 1 into Tier 2 based on cancer standards.

The Board welcomed the report and communicated their thanks for the continued hard work in improving the performance position.

Mrs Matthews asked whether the good news within the report was being communicated to staff, it was confirmed that the performance position was shared through a range of mediums and that it had provided the Trust with a sense of buoyancy and staff with confidence.

Prof. Balch challenged that if the Trust had achieved a positive performance position within a period of industrial action would this lead to a challenged position later in the year. Mr Johns explained the teams had seen and acted on the positive learning from the period of industrial action and new practices had been adopted at pace, which had supported the improved performance position. During this period, it had been identified that there was a need for oversight and a forum to drive forward initiatives, therefore an Urgent and Emergency Care Board had been established.

The Vice Chairman asked what other opportunities had been identified to sustain the improved performance position. Mr Johns confirmed the Trust were engaged with

the South Western Ambulance Service Trust; the local care sector; and had identified opportunities within the Same Day Emergency Care pathway.

Mr Richards asked for board oversight in respect of the governance arrangements for Child Family Health Devon. Mrs Davenport confirmed the Trust were currently in year 4 of a 7 plus 3 year contract and given Devon Partnership Trust were part of the contract, it was agreed a Board to Board with Devon Partnership Trust would be arranged to ensure both Boards were briefed. **ACTION: Mrs Davenport**

The Board received and noted the Chief Operating Officer's Report of April 2023

For Approval

075/04/23 **Unconfirmed Minutes of the Meeting held on the 29 March 2023 and outstanding action**

The Board approved the minutes of the meeting held on 29 March 2023.

The Board approved the minutes of the meeting held on

076/04/23 **Report of the Vice Chairman**

The Vice-Chairman verbally briefed the Board on the following:

- The Chairman had taken one weeks' annual leave and would return week commencing the 1 May 2023.
- Torbay and South Devon had now entered the pre-election period, commencing 28 March and ending 5 May.
- The Trust had undergone periods of Industrial Action since November 2023 and he recognised how challenging this was for staff and colleagues.
- The Trust was in the start of its first financial year in System Oversight Framework (SOF) 4. There was a zeal for grip and pace for improvements to be implemented but he counselled, the Trust could only change what was within its control; and reminded the Board of the importance of keeping the Trust's values at the forefront.

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

077/04/23 **Chief Executive's Report**

Mrs Davenport welcomed Dr Kate Lisset to her inaugural Board meeting as Interim Medical Director. She also, welcomed Mrs Amanda Lowe, the newly appointed Director of Internal Audit, Audit South West.

Mrs Davenport briefed the Board on the Chief Executive's report, as circulated and drew attention to the following points.

- An NHSE Leadership Event had taken place on 19 April 2023. There was a strong focus on completion of the operating plans; and for final submission to be signed off by the end of May. When the focus would then be on ensuring the trajectories were met.
- On behalf of NHSE Anne Eden had been commissioned to undertake quality improvement review, which has resulted in the publication of the Quality Improvement Strategy. Ms Jones, was reviewing the strategy on behalf of the Trust and the System.
- The Devon System Operating plan primarily focused on the exit criteria for SOF4, with the plan due for final submission on 4 May 2023. The governance arrangements to deliver against the key milestones had been approved on 25 April 2023 by Devon CEO's.
- The Trust was communicating it's Regain and Renew Plan to staff, she confirmed the plan clearly addressed the operating plan priorities.
- The Elective Care Intensive Support Team were supporting the Trust and its teams.
- The Royal College of Nursing Strike would commence for 72 hours at 8pm on Sunday 30 April 2023. The balance between keeping the organisation safe, whilst minimising disruption to elective care was recognised.
- There had been no resolution to the Royal College of Nursing or Junior Dr's pay dispute; and the British Medical Association was to ballot its members shortly.
- The Trust were formally informed on 26 April 2023 that the CQC would undertake a Well Led Review of the Trust on 14 and 15 June 2023. However, there was an expectation there would be at least one inspection of services ahead of the Well Led Review.
- As part of the clinical governance review, the Trust had established a Quality Board which was empowering staff and teams to own and find solutions whilst balancing quality, safety, performance and finance.
- The Governors had supported the Patient Led Assessments of the Care Environment (PLACE) review and the Trust had been placed in the top five acute trusts for food and cleanliness.

Mr Sutton highlighted the positive outcomes seen by the community dietitians working alongside local care homes and asked how this would be sustained. Ms Jones confirmed the dietitian initiative was a key part of the Enhanced Health in Care Homes agenda and with the support of, Mrs Liz Wardle, lead dietitian the work would continue within care homes.

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

Safe Quality Care and Best Experience

078/04/23 **Integrated Performance Report (IPR): Month 12 2022/23 (March 2023 data)**

Mr Stacey presented the IPR for March 2023 data to the Board, as circulated. He highlighted the following points:

Quality

- Two severe fall incidents had been reported; and
- A cardiac arrest death was reported as an adverse event and the possibility of a change in the outcome if the patient had been admitted directly to the Cardiology Department was under investigation.
- Due to amended Infection Prevention Control measures and new testing protocols a significant improvement to flow had been seen in unplanned care pathways.

Operational performance

Mr Johns had covered the Trust's Operational Performance under the Chief Operating Officers Report, April 2023. However, the following was brought to the Board's attention:

- The 65 week wait position was being remodelled ahead of a verbal submission in recognition it was a higher position than the Trust would like and therefore additional support was being considered such as, Elective Recovery Fund monies, internal productivity schemes and collaborative working.

Prof Balch highlighted the fragile services positions and acknowledged improvement was dependent on the outcome of the acute sustainability review.

Mr Currie explained how against a peer review the Trust performed well in many aspects of stroke care. However, certain areas were currently not within the stroke pathways control, such as bed availability and these risks needed to be addressed as part of the operational plan. He acknowledged some areas of the pathway required collaborative working. He confirmed he had spoken with the Peninsula and West of England clinical leads and would meet with them week commencing 1 May 2023 to develop a 7 day mini stroke assessment service.

Ms Jones confirmed mutual aid for the Urology Service had been agreed; and there was recognition each fragile service required a fragile service delivery plan. She confirmed she was leading the fragile service workstream on behalf of the Peninsula Acute Sustainability Programme and the workstream would link into the SOF4 exit plan to ensure the support of fragile services was embedded.

Mrs Lyttle was aware the Industrial Action may impact those on long waiting lists as it would remove clinical staff away from their normal area of work to the frontline. Mr Stacey confirmed the 65 week wait list was being validated with Operations Managers and the Performance Team to ensure NHSE had the best trajectory for the Trust. With Neurology and Gynaecology services undertaking a forensic capacity review. Mr Johns assured the Board the amended 65 week wait list performance would be reviewed at the Planned Care Board.

Dr Aitken asked what additional support was required to implement additional interventions. Mr Stacey explained he would like the informatics team to support but, the team currently had other pressures, in particular restructuring the IPR to focus on SOF4.

Dr Aitken noted the Trust uses two different languages when it spoke to performance and suggested used one performance language to engage with staff,

other providers and external stakeholders. Mrs Davenport was in support of this suggestion.

Mrs Davenport explained NHS futures were championing the positive outcomes of Trusts who had adequate EPR and information systems.

Workforce

- Staff turnover had stabilised.
- Sickness remained above the 4% target and there was commitment to focus on reducing the Trust's sickness and absence rate.

Mrs Matthews highlighted that although was positive the Trust's turnover rate was stabilising it was still high and the National Staff Survey clearly spoke to the reasons.

Finance

- The Trust reported an end of year deficit of £17.12m, which was £17.19m adverse to the initial surplus plan for the financial year of 2022/23. This was in line with the control total agreed with regulators.
- The month 12 pay spend looked as though it had double in month 12 due to an allowance being made for the pay award and pension top up.
- The District Valuers revaluation had been validated and processed after publication of the IPR, upon validation and comprehensive bottom line was £8.4m lower but, the adjusted comprehensive income position remained unchanged, as annually managed expenditure was below the line. With non-recurrent assets materially unchanged.
- There had been a notable increase in agency run rate among all staff groups.
- In 2022/23 the CIP savings were reliant on non-recurrent spend, for 2023/24 more sustainable saving sources were being considered to ensure the financial deficit was reduced.

Prof. Balch noted there would be no net increase in staffing yet, there was an expectation that productivity increased. Therefore he suggested consideration be given to reallocation of shift resources to support productivity and financial targets.

Mr Stacey explained unplanned escalation capacity would be focused upon in financial year 2023/24 as it had been funded through Urgent and Emergency Care budgets and a review of the use of Elective Recovery Find monies and the impact.

Mr Sutton highlighted that a system approach to finances was important to ensure there was a holistic view of the position. However, it was important to note that it would be a challenge for the Trust to meet its CIP saving forecast and ensure recurrent savings.

The Board received and noted the Integrated Performance Report (IPR): Month 12 2022/23 (March 2023 data)

079/04/23 **National Staff Survey**

Dr Westwood presented the National Staff Survey, which was marked against the People Promise, as circulated to the Board. She explained:

- There was a significant reduction in overall response rate.
- The Trust was above the national average in the following five of nine areas:
  - We are recognised and rewarded;
  - We work flexibly;
  - We are a team;
  - We are compassionate and inclusive;
  - We have a voice that counts.
- The Trust was below the national average in the following four of nine areas:
  - Staff Engagement;
  - Staff Morale;
  - We are safe and healthy; and
  - We are always learning.
- In respect of bullying and harassment the Trust had seen a further decline within BAME and Disability staff cohorts.
- There was a notable decrease in staff feeling safe to raise concerns, the health and safety climate, appraisal process, staff motivation and work pressures.

Dr Westwood confirmed the Trust was undertaking the following:

- A good BAME induction programme had been established; and equality and diversity training would form part of all staff inductions.
- A management training programme was being arranged.
- Triangulation of the Freedom to Speak Up Guardian data was being undertaken.

The Board agreed the National Staff Survey would form part of a Board Development session; and Staff Engagement Updates would come regularly to the private Board. **ACTION: Dr Westwood**

Mrs Davenport informed the Board the staff survey results had a direct link to experience, engagement and outcomes for patients the Trust treats. Therefore the Board and leadership teams needed to listen to what was being said and change its culture to ensure staff felt reassured.

Ms Jones believed to support the Trust's exit out of SOF4 there was a need for managers to receive support so staff felt their voices were heard. She confirmed the Communications Team were developing a Trust meaningful conversations programme.

Prof. Balch highlighted that the Staff Survey results came down to poor behaviours and believed this needed to be discussed at performance reviews and staff needed to feel empowered when they witness poor behaviour. Mrs Walker-McAllister believed there was value in regular 1:1's and the Vice-Chairman acknowledged in a period of intense change and pressure people's behaviour could deteriorate therefore the Trust needed to support staff. Dr Lissett confirmed teams do support staff to challenge poor behaviour.

Dr Westwood acknowledged the staff survey results were complex and there was interconnectivity, she confirmed in May she would present the Leadership and Guidance Training offer to the Board.

The Board received and noted the National Staff Survey

080/04/23 **Annual Report of the Audit and Risk Committee**

Mrs Long presented the Annual Report of the Audit and Risk Committee, as circulated and it was taken as read.

The Board received and noted the Annual Report of the Audit and Risk Committee.

081/04/23 **Register of Directors Interests as at 31 March 2023**

The Board received and noted the Register of Directors Interests as at 31 March 2023

082/04/23 **Compliance Issues**

083/04/23 **Any other business notified in advance**

084/04/23 **Date and Time of Next Meeting:**

11.30 am, Wednesday 31 May 2023

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
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	26.10.22 Ms Kelly is progressing the Organ Donor Memorial. Designs are being finalised, funding was being secured and a space to place the memorial had been identified. 30.11.22 Ms Kelly confirmed two designs and a place for the memorial had been decided upon, the Trust were awaiting costings. 25.01.23 Ms Kelly confirmed the location of the memorial had been agreed but the Trust were awaiting a date for installation. 22.02.23 Ms Kelly confirmed Lottie was engaged with the Organ Donation memorial and site location. 29.03.23 Ms Kelly confirmed engagement with Lottie was ongoing. 26.04.23 Ms Kelly confirmed engagement with Lottie was ongoing.	28.09.22

061/03/23	Ms Kelly and Mr Scott would discuss provision of exception reports for inclusion in the IPR report to highlight what actions were being taken to maintain safety and quality (when relevant – such as long ambulance waits/long waits for elective care)	Ms Kelly and Mr Scott	26.04.23 Ms Kelly confirmed the quality metrics would be amended to create space for greater narrative.	29.03.23
061/03/23	Mr Stacey would ensure the IPR was revamped to make it easier to engage with and less demanding in terms of its volume and content, so that it could be used more frequently and effectively.	Mr Stacey	26.04.23 The revamping of the IPR was in progress with, workforce and quality sections to follow.	29.03.23
63/0/23	Mr Currie to ensure an update on the outcomes of the local investigative work into the higher than anticipated HSMR is included in the next scheduled Mortality Score Care report	Mr Currie		29.03.23
071/04/23	Ms Jones confirmed she would use the patient experience story as an example for partner organisations, in particular the Local Care Partnership, to draw on.	Mrs Jones		26.04.23
074/04/23	A Board to Board with Devon Partnership Trust would be arranged to ensure both Boards were briefed on the governance of Child Family Health Devon.	Mrs Davenport		26.04.23
079/04/23	The Board agreed the National Staff Survey would form part of a Board Development session; and Staff Engagement Updates would come regularly to the private Board.	Dr Westwood		26.04.23

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Report to the Trust Board of Directors			
Report title: Committee Reports			Meeting date: 31 May 2023
Report appendix	n/a		
Report sponsor	Director of Corporate Governance and Trust Secretary		
Report author	Corporate Governance Manager		
Report provenance	n/a		
Purpose of the report and key issues for consideration/decision	The Board are asked to note the following summary of the Committee meetings held in the period. Audit Committee: Chair - R Sutton • 24 May 2023 (minutes yet to be published) Quality Assurance Committee: Chair (J Lyttle) • 22 May 2023 (minutes yet to be published) Finance Performance and Digital Committee: Chair (R Crompton) • 24 April and 22 May 2023 (minutes yet to be published) People Committee: Chair (Vikki Matthews) • 24 April 2023 Building a Brighter Future: Chair - C Balch • 19 April and 17 May 2023 (minutes yet to be published) Minutes of the meetings can be found within the Diligent online library: Hyperlink: Diligent Boards: South Devon Health Information Services: Resource Center Location: Diligent sign-in>Resource Centre>TSDFT Board and Sub-Committee Minutes The Chair of each Committee is asked to escalate any pertinent matters verbally at the meeting, on an exception basis.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board asked to note: • the Committee meetings held since the last meeting; and • any exception reporting of Committee Chairs.		

Summary of key elements	
Strategic goals supported by this report	

Excellent population health and wellbeing		**Excellent experience receiving and providing care**	
Excellent value and sustainability	**X**		

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

Board Assurance Framework	n/a	**Risk score**	
Risk Register	n/a	**Risk score**	

External standards affected by this report and associated risks			

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

Torbay and South Devon NHS Foundation Trust

Report to the Board of Directors			
Report title: Committee Annual Reports			**Meeting date:** 31 May 2023
Report appendix	Appendix 1 - Quality Assurance Committee Annual Report 2022/23 Appendix 2 - NED Nominations and Remuneration Committee Annual Report 2022/23 Appendix 3 - Finance, Performance and Digital Committee Annual Report 2022/23 Appendix 4 – Building a Brighter Future Annual Report 2022/23		
Report sponsor	Director of Corporate Governance and Trust Secretary		
Report author	Corporate Governance Manager		
Report provenance	Quality Assurance Committee – 22nd May 2023 NED Nominations and Remuneration Committee – 22nd May 2023 Finance, Performance and Digital Committee – 22nd May 2023 Building a Brighter Future Committee – 17th May 2023		
Purpose of the report and key issues for consideration/decision	In line with best practice, annual reports are prepared to reflect the work of Board Sub-Committees and to provide assurance that the Committees have carried out their obligations in accordance with their Terms of Reference. The Annual Reports appended to this report summarise the activities of the Trust's Quality Assurance; Finance, Performance and Digital; and NED Nominations and Remuneration Committees during 2022/23.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendations	The Board of Directors is asked to receive and note the Annual Reports of the Quality Assurance; Finance, Performance and Digital; and NED Nominations and Remuneration Committees.		
Summary of key elements			
Strategic goals supported by this report	**Excellent population health and wellbeing**		**Excellent experience receiving and providing care**
	Excellent value and sustainability	**X**	
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework**	n/a	**Risk score**
	Risk Register	n/a	**Risk score**

External standards affected by this report and associated risks	

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

Torbay and South Devon
NHS Foundation Trust

QUALITY AND ASSURANCE COMMITTEE

ANNUAL REPORT

2022/23

1. INTRODUCTION

1.1 The Quality and Assurance Committee (the 'Committee'), in line with best practice, has prepared a report to the Board that sets out how the Committee has met its Terms of Reference.

1.2 This report covers the work the Committee has undertaken at the meetings held during 2022/23. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference.

1.3 The Committee has powers delegated to it by the Board to:

(i) review proposed quality improvement priorities and monitoring performance and improvement against the Trust's quality priorities and the implementation of the Quality Account;

(ii) seek assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified; and

(iii) oversee the ongoing monitoring of compliance with national quality standards and local requirements.

1.4 The purpose of the Committee is laid down in its Terms of Reference, which is to:

(i) provide assurance to the Board that there is continuous and measurable improvement in the quality of services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care; and

(ii) ensure that the risks associated with the quality of the delivery of patient care are identified and managed appropriately.

1.5 The Committee Chair escalates those matters that the Committee considers should be drawn to the attention of the Board when presenting the Committee Chair's Report to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 The Committee receives assurance from the executive director members of the Committee and from the subject matter experts (key senior members of staff) who attend each meeting on a regular basis. This includes the Head of Patient Safety, System Directors of Nursing and Professional Practice, and others who may be required to attend as necessary such as the Safeguarding Adults Lead, Deputy Director of Adult Social Care, Head of Tissue Viability Services, Associate Director of Midwifery and Professional Practice etc.

2.1.2 Assurance is provided through written reports, both regular and bespoke, through challenge by members of the Committee and by members seeking to validate the information provided through a wider knowledge of the organisation, specialist areas of expertise, attending Board of Directors and Council of Governors meetings. The practice of visiting services and talking to staff continued to be restricted during the year due to the ongoing impact of the Covid pandemic.

2.1.3 The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plans are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.

2.1.4 Compliance with a number of the key responsibilities is evidenced by the following areas of work the Committee has received assurance on during 2022/23.

2.2 Quality and Improvement

2.2.1 Monitoring and reviewing the quality of clinical and social care services provided by the Trust. This included review of:

(i) the systems in place to ensure the delivery of safe, high quality, person-centred care;

(ii) quality indicators flagged as 'of concern' through escalation reporting or as requested by the Trust Board;

(iii) an action log evidencing progress toward completion; and

(iv) progress toward delivery of the Trust's clinical strategy.

2.2.2 Reviewing variances against quality and operational performance standards.

2.2.4 Ensuring there is a robust Quality and Equality Impact Assessment process to mitigate any adverse impact of service changes or reconfiguration.

2.2.5 Reviewing the Trust's compliance with the Care Quality Commission essential standards of quality and safety and seek assurance regarding process with action plans in response to quality concerns identified from inspection findings, warning notices and compliance actions.

2.2.6 Receiving, through the reporting schedule, assurance of high quality care provision and compliance with national and local guidelines, standards and requirements.

2.2.7 Overseeing the development of the Quality Account regarding accuracy of data and compliance with timescales for publication and review progress against these.

2.2.8 Establishing, developing and maintaining systems and processes for the regular evaluation and monitoring of compliance against any relevant internal and external assessment, standards or criteria.

2.2.9 Ensuring the Trust learns from national and local reviews and inspections and implements all necessary recommendations to improve the quality of care.

2.3 Governance and Risk

2.3.1 Overseeing how all quality risks are managed across the Trust and that appropriate review and assurance mechanisms are in place, receiving and reviewing quality risks on the corporate risk register and Board Assurance Framework.

2.3.2 Promoting an open culture in which incident and risk reporting is encouraged and supported as part of the delivery of safe and effective healthcare.

2.3.3 Seeking assurance on the process for reviewing and reporting complaints, adverse events and serious incidents and sharing the learning from these.

2.3.4 Seeking assurance against compliance with national clinical standards including NICE guidelines/guidance and any rationale for non or partial compliance.

2.3.5 Overseeing any procedural, policy or strategy document which fall within the remit of the Committee are appropriately written, ratified and monitored for compliance in accordance with any key national standards and best practice.

2.3.6 Establishing an annual work plan which the Committee will review at each meeting.

2.3.7 Producing an annual report against delivery of the terms of reference of the committee.

2.3.8 Undertaking an annual review of the Committee's effectiveness

2.4 Quality and Safety Reporting

2.4.1 Receiving reports from each of the Committee's sub-groups.

2.4.2 Receiving and review submissions to national bodies and make recommendations for sign-off by the Trust Board.

2.4.3 Receiving annual assurance reports in relation to (but not limited to) infection control and safeguarding and medicines management.

2.5 Audit and Assurance

2.5.1 Receiving and review the findings of quality related Internal Audit reports and seek assurance that recommendations are implemented in a timely and effective way.

2.5.2 Approving and oversee delivery of the Clinical Audit Plan and provide assurance to the Audit Committee of delivery.

2.5.3 Receiving by exception information of national clinical audits where the Trust is identified as an outlier or a potential outlier.

2.5.4 Receiving reports from invited service reviews and external visits (as appropriate) and seek assurance regarding delivery of actions.

2.5.5 Receiving reports on significant concerns or adverse findings highlighted by external bodies in relation to quality and safety and the actions being taken.

2.6 Reporting Requirements

2.6.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the business conducted, risks identified, deep dive reviews and issues for escalation.

2.6.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting.

3. RISK MANAGEMENT

3.1 During the year the Committee reviewed the Corporate Risk Register and the Board Assurance Framework ('BAF') in relation to those risks within the scope of the Committee.

3.2 The Committee review of the BAF focussed on quality and safety related risks. Deep-dives in to specific risks were commissioned on a risk-based approach and were as follows:

- Torbay Drug and Alcohol Service
- Stroke Services (two deep dives in the reporting year)
- Support for Patients with Complex Mental Health Needs
- Maternity and Obstetrics

4. MEMBERS AND MEETINGS

4.1 During 2022/23, the Committee met seven times. The meetings were quorate all times. An additional meeting was held in August 2022 to receive information reports on a number of topics and this meeting was not quorate.

4.2 The record of Committee attendance is shown below:

Non-Executive Director	**Number of meetings attended**
Jacqui Lyttle (Chair)	5 (7)
Vikki Matthews	4 (7)
Siân Walker-McAllister (wef 01.09.2022)	4 (4)
Executive Directors	**Number of meetings attended**
Ian Currie	7 (7)
Judy Falcao, Chief People Officer (retired 11.07.22)	1 (1)
Sheridan Flavin, Interim Chief People Officer (wef 12.07.22 until 26.11.22)	1 (3)
Michelle Westwood, Chief People Officer (wef 27.11.22)	3 (3)
John Harrison, Chief Operating Officer (until 17.10.22)	1 (4)
Jon Scott, Chief Operating Officer (wef 18.10.22)	2 (3)
Deborah Kelly	6 (7)

4.3 Senior management representatives also in regular attendance included the Interim Director of Corporate Governance and Trust Secretary and Corporate Governance Manager. The Trust's Vice Chair and Chief Executive also attended some meetings in an observer capacity. A Governor observer was also in attendance at the majority of meetings.

5. COMMITTEE EFFECTIVENESS

5.1 In accordance with the Committee's terms of reference an annual assessment of committee effectiveness was undertaken to ensure continual improvement. Additional areas of focus or development that might lead to further improvement in the effectiveness of the Committee during 2021/22 were reported to the Committee in May 2022 and actioned accordingly.

6. RECOMMENDATION

6.1 The Committee is asked to review and approve the report, subject to any changes agreed in discussion, prior to formal submission to the Trust Board.

Jacqui Lyttle
Chair, Quality Assurance Committee
April 2023

Torbay and South Devon
NHS Foundation Trust

NON-EXECUTIVE DIRECTOR NOMINATION, REMUNERATION AND TERMS OF SERVICE COMMITTEE ANNUAL REPORT

1 APRIL 2022 TO 31 MARCH 2023

1. INTRODUCTION

In line with best practice the Non-Executive Nominations, Remuneration and Terms of Service Committee ('the Committee') should prepare a report to the Board that sets out how the Committee has met its Terms of Reference.

1.1 The purpose of the Committee is laid down in its Terms of Reference. In summary, it oversees:

- strategic portfolio changes relevant to the posts covered by the Committee's remit;
- the performance of and the setting of salaries, terms of service and allowances for the posts covered by the Committees remit;
- the Trust's senior management succession planning arrangements and talent management process;
- senior managerial competence relating to leadership capability; and
- the allowances as may be payable to Foundation Trust Governors.

1.2 The purpose of this report is to provide assurance that the Committee has carried out its obligations in accordance with its Terms of Reference.

1.3 This Annual Report summarises the activities of the Committee for the financial year 2022/23 setting out how it has met its Terms of Reference and key priorities. In particular it addresses various matters for which the Committee has oversight for the Board:

- review the performance development reviews of Executive Directors, Associate Directors and defined Senior Managers.
- keep up to date with relevant national and local developments;
- inform the Committee of changes, both local and national, which may impact on the Committee;
- proactively seek best practice and bring to the attention of the Committee;
- review remuneration policies, including having oversight of those applicable to staff employed on very senior manager terms and conditions;
- consider proposals for changes in terms and conditions of employment;
- consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their employment contract;
- consider any in-year variations of salaries and terms and conditions of employment of Executive Directors and Senior Managers who are subject to the annual review process carried out by the Committee;
- oversee the process for the nomination of the Chief Executive for approval by the Board (and ratification by the Council of Governors);

- oversee the process for the appointment of other Executive Directors, Associate Directors and Director of Corporate Governance and Company Secretary; and
- lead the process for the identification and nomination of the chair of all Board Committees and Board post holders ie Senior Independent Director and Deputy Chair.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 During 2022-23, the Committee has delivered the key responsibilities as set out in the Terms of Reference. Compliance with a number of the key responsibilities is evidenced by the following actions:

- led on executive director appointments for the Chief People Officer and Chief Operating Officer
- reviewed executive director succession planning
- reviewed the composition of the Board of Directors
- reviewed the Chief Executive's and Deputy Chief Executive's responsibilities
- reviewed executive director remuneration
- received report on the output of executive director appraisals
- approved Torbay Pharmaceutical's VSM posts
- received a report on pensions recycling
- received report on organisational structure changes
- reviewed the Trust's Fit and Proper Persons Policy
- approved appointment of a hosted VSM post for NHS Devon to support SOF4 exit

3. MEMBERS AND MEETINGS

3.1 During 2022-23 the Committee met formally on 15 occasions. The meetings were quorate all times apart from one meeting when Committee members gave apologies at very short notice just before the meeting. The meeting was to undertake an executive director longlisting process and due to the timescales involved in the appointment process the decision was made to continue with the meeting and for the Chairman to brief those members not in attendance outside of the meeting.

3.2 The record of Committee attendance is shown below:

Non-Executive Director	Number of meetings attended
Richard Ibbotson (Chair)	14 (14)
Richard Crompton (wef 01/02/2023)	1 (3)
Jacqui Lyttle	7 (14)
Vikki Matthews	8 (14)
Sally Taylor (left 31.12.22)	10 (11)

3.3 Senior management representatives also in regular attendance included: Chief Executive; Chief People Officer; and Interim Director of Corporate Governance and Trust Secretary.

4. COMMITTEE EFFECTIVENESS

4.1 The Committee undertook a self-assessment review during the year, which concluded that the Committee has delivered the majority of its responsibilities as set out in the Terms of Reference, attendance at the majority of meetings has been quorate and the cycle of business has been completed.

4.2 Areas for action identified as part of that self-assessment of the Committee's effectiveness to identify any gaps in the Committee's workings were noted and in the main, addressed.

4.3 The Committee will undertake an annual assessment to ensure continual improvement.

5. RECOMMENDATION

The Committee is asked to review and approve the report, subject to any changes agreed in discussion, prior to its formal submission to the Trust Board.

Richard Ibbotson
Chair, Non-Executive Nominations and Remuneration Committee
April 2023

Torbay and South Devon
NHS Foundation Trust

FINANCE, PERFORMANCE AND DIGITAL COMMITTEE

ANNUAL REPORT

2022/23

1. INTRODUCTION

1.1 The Finance, Performance and Digital Committee (the 'Committee'), in line with best practice, has prepared a report to the Board that sets out how the Committee has met its Terms of Reference.

1.2 This report covers the work the Committee has undertaken at the meetings held during 2022/23. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference.

1.3 The Committee has powers delegated to it by the Board to:

(i) oversee, co-ordinate review and assess the financial, performance and digital management arrangements; including monitoring the delivery of the NHS Long Term Plan and supporting Annual Plan decisions on investment and business cases;
(ii) provide the Board with an independent and objective review of, and assurances, in relation to significant financial, performance and digital risks which may impact on the financial viability and sustainability of the Trust;
(iii) provide detailed scrutiny of financial, performance and digital matters in order to provide assurance and raise concerns (if appropriate) to the Board;
(iv) assess and identify risks within the finance, performance and digital portfolio and escalating this as appropriate;
(v) make recommendations, as appropriate, on financial, performance and digital matters to the Board;
(vi) determine those matters delegated to the Committee in accordance with the Scheme of Delegation and Standing Financial Instructions as set out in the Trust's Standing Orders;
(vii) oversee the development of and approval of the Trust's medium term financial strategy; and
(viii) maintain a watching brief over the strategic direction of the Devon ICS as informed by relevant national policy, and informing the Board of such.

1.4 The purpose of the Committee is laid down in its Terms of Reference, which is to:

(i) advise the Board on all aspects of key performance, financial and investment issues to enable sound decision-making;
(ii) provide assurance in respect of financial, performance and digital related matters along with business planning; and
(iii) provide assurance that corrective action has been initiated and managed where gaps are identified in relation to financial, performance and digital risks.

1.5 The Committee Chair escalates those matters that the Committee considers should be drawn to the attention of the Board when presenting the Committee Chair's Report to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 The Committee receives assurance from the executive director members of the Committee and from the subject matter experts (key senior members of staff) who attend each meeting on a regular basis. This includes the Director of Financial Operations, Director of Estates and Facilities, Health Informatics Service Director, and others who may be required to attend as necessary.

2.1.2 Assurance is provided through written reports, both regular and bespoke, through challenge by members of the Committee and by members seeking to validate the information provided through a wider knowledge of the organisation, seeking specialist areas of expertise, attending Board of Directors and Council of Governors meetings, visiting services and talking to staff.

2.1.3 The Committee is assured that it has the right membership and attendance to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plans are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.

2.1.4 Compliance with a number of the key responsibilities is evidenced by the following areas of work the Committee has received assurance on during 2022/23:

Financial performance

- received and reviewed in detail the Financial Plan for 2022/23 looking at the key financial risks associated with the plan
- received progress reports in regard to the development of the annual plan, including CIP development
- reviewed in detail the financial performance reports at each meeting, noting the underlying deficit and consequential impact on the longer-term financial outlook
- received the year-end financial out-turn prior to being reported to Board
- received progress reports against the Trust's Cost Improvement Plan
- received assurance on the Trust Treasury management arrangements
- received information on Adult Social Care debt
- reviewed the Trust's capital programme
- reviewed financial performance of the Trust's subsidiaries and business divisions
- received progress reports on the capital expenditure and performance against plan
- recommended to the Board approval of the Trust's Capital Plan and Operational Plan
- received reports on the Devon ICS Long Term financial model programme plan and financial risk and escalation framework

Performance

- reviewed the performance section of the integrated performance report at each meeting and reviewed assurance on the actions taken to improve performance related issues
- sought assurance on demand and capacity issues and compliance with national standards
- received reports on the Trust's performance against productivity metrics
- reviewed the Adult Social Care Agreement for 2021-22
- reviewed the Memorandum of Understanding for the Health and Social Care Partnership between the Trust and Devon County Council
- reviewed and approved a number of business cases including: CT scanners; virtual wards; winter planning; protected elective care and improved day case productivity; Torbay Pharmaceuticals packing and capacity improvements; and Torbay Pharmaceuticals machine change parts for plastic vials.

Digital

- sought assurance on the Trust's approach to potential digital risks
- received assurance reports from the Information Management and Technology Group
- received digital related business cases for approval eg Electronic Patient Record OBC
- received a deep dive on Clinical Coding and sought assurance around performance
- received assurance on the CFHD Care Notes reconnection
- received assurance on the Trust's Cyber Security Resilience

Estates

- received reports and business cases relating to the Trust's estate and property eg. Dartmouth, Teignmouth and Dawlish
- received reports on progress of the Trust's Commercial Strategy
- received outcome of the Estates Return Information Collection (ERIC) exercise
- received assurance on the Trust's Incident Response Plan
- received reports on the Trust's Surplus Land Return
- received assurance on the work to review the EFM Leadership Framework
- received reports on the Trust's staff accommodation strategy

Governance

- received business cases for approval in accordance with the Trust's scheme of delegation and where appropriate recommended approval by the Board
- received progress reports on Trust matters
- developed a programme of post implementation reviews and received reports on such
- reviewed the Internal Audit review of the HFMA checklist

- received reports from the Trust's subsidiaries and business divisions ie Torbay Pharmaceuticals
- received risk register reports relating to the scope of work of the Committee
- received the Board Assurance Framework in relation to those risks pertaining to the scope of the Committee
- received reports from Groups reporting to the Committee
- developed a Committee workplan for the year
- reviewed the meetings cycle and agreed a change to the reporting timetable
- undertook a Committee effectiveness self-assessment
- reviewed the Committee's Terms of Reference

2.2 Reporting Requirements

2.2.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the business conducted, risks identified, deep dive reviews and issues for escalation.

2.2.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting.

3. RISK MANAGEMENT

3.1 During the year the Committee reviewed the Corporate Risk Register and the Board Assurance Framework ('BAF') in relation to those risks within the scope of the Committee.

3.2 The Committee review of the BAF focussed on finance, performance and digital related risks. Deep-dives in to specific risks were commissioned on a risk-based approach.

4. MEMBERS AND MEETINGS

4.1 During 2022/23, the Committee met on 13 occasions. The meetings were quorate all times.

4.2 The record of Committee attendance is shown below:

Non-Executive Director	**Number of meetings attended**
Paul Richards (Chair) (until 31.12.22)	10 (10)
Richard Crompton (Chair) (wef 01.01.23)	3 (3)
Chris Balch	13 (13)
Robin Sutton	13 (13)
Executive Directors	**Number of meetings attended**
*Ian Currie, Medical Director	11 (13)
John Harrison, Chief Operating Officer (until 17.10.22)	4 (7)
Jon Scott (wef 18.10.22)	5 (6)
Adel Jones, Director of Transformation and Partnerships	12 (13)
*Deborah Kelly, Chief Nurse	8 (13)
Dave Stacey, Chief Finance Officer	13 (13)

* Joint Membership

4.4 Senior management representatives also in regular attendance included – Interim Director of Corporate Governance and Trust Secretary and Corporate Governance Manager. The Vice-Chair/Audit Committee Chair and Chief Executive attended some meetings in an observer capacity. A Governor observer was also in attendance at the majority of meetings.

5. COMMITTEE EFFECTIVENESS

5.1 In accordance with the Committee's terms of reference an annual assessment of committee effectiveness was undertaken to ensure continual improvement. Committee members were asked in March 2023 to provide feedback on performance. The feedback would be discussed at the April Committee meeting.

6. RECOMMENDATION

The Committee is asked to review and approve the report, subject to any changes agreed in discussion, prior to formal submission to the Trust Board.

Richard Crompton
Chair, Finance, Performance and Digital Committee
April 2023

Torbay and South Devon
NHS Foundation Trust

BUILDING A BRIGHTER FUTURE COMMITTEE

ANNUAL REPORT 2022/23

1. INTRODUCTION

1.1 The Building a Brighter Future Committee ('the Committee') was established as a Board sub-committee in October 2020 as the HIP2 Redevelopment Committee and changed its name in April 2021.

1.2 The Committee was set up in response to the announcement by the Government that Torbay Hospital had been confirmed as "one of 40 hospitals across the country to receive a share of £3.7 billion". The Board considered that the funding quantum and project complexity would require Board oversight and this would be best achieved through a Board Sub-Committee.

1.3 The Committee, in line with best practice, has prepared a report to the Board that sets out how the Committee has met its Terms of Reference.

1.4 In establishing the Committee and agreeing the Terms of Reference, the Committee was mindful of the breadth, scope of work and timescale. The Committee work programme continued to be reviewed to ensure it enables sufficient depth of discussion relevant to the project.

1.5 The purpose of the Committee is laid down in its Terms of Reference, which is to provide assurance to the Board regarding the processes, procedures and management of the BBF Programme and to support the successful achievement of the Programme investment objectives and realisation of the stated benefits.

1.6 The Committee also provides assurance to the Board of the achievement of the objectives set out in the Programme; that approved projects are being effectively managed and controlled; and to confirm that projects are delivering the stated benefits, are value for money, and are ultimately affordable

1.7 The purpose of this report is to provide assurance that the Committee has carried out its obligations in accordance with its Terms of Reference.

1.8 This Report summarises the activities of the Committee for the year ended 31 March 2023 setting out how it has met its Terms of Reference and key priorities. In particular it addresses various matters for which the Committee has oversight for the Board, namely:

- Establishing a programme of independent assurance to ensure the BBF Programme plan and its projects are managed and delivered in a controlled way.
- Receiving reports from the BBF Programme Group that address delivery progress, including, costs; key risks; outcome of assurance activities; and, actions to address recommendations including key decisions with reference to the capital development forward plan.
- Ensuring that prior to formal approval, confirmation that appropriate processes have been implemented and assurance activities completed on key BBF Programme documents, to include:

  - Programme and project delivery plans
  - Strategic Outline Case ('SOC')
  - Outline Business Case ('OBC')
  - Full Business Case ('FBC')
  - Contract and procurement strategies
  - Contract and works procurement documentation
- Ensuring that robust and effective governance arrangements are implemented to oversee the delivery of the BBF Programme and approved projects.
- Ensuring that appropriate internal and external due diligence has been completed prior to appointment of any preferred bidders/contractors in connection with any contract.
- Providing advice and support to the identification and effective control of the BBF Programme and any key project risks.
- Reviewing identified inter-dependencies across the Programme and its approved projects (and external to the BBF Programme) and ensure that controls are established to manage these effectively.
- Ensuring that effective control and risk management arrangements are implemented to manage the delivery of the BBF Programme and the approved projects within its control.
- Reviewing and providing assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee, seeking where necessary further action/assurance.
- Reviewing BBF Programme related risks identified on the Corporate Risk Register and seeking assurance in relation to risk mitigation and future activity/plans.
- Reviewing and advising the Board on the risks associated with any material issues as required from time to time. In preparing such advice, the Committee shall satisfy itself that a due diligence appraisal of the proposition is undertaken and is within the risk appetite and tolerance of the Trust, drawing on independent external advice where appropriate and available, before the Board takes a decision whether to proceed.
- Communicating information about the New Hospitals Programme and approved projects to key internal and external groups, staff, stakeholders, Governors and the general public.
- Actively championing internally and externally, the investment objectives and benefits of the BBF Programme.

1.9 The Chair escalates those matters that the Committee considers should be drawn to the attention of the Board when presenting the Committee Chair's Report to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

2.1.1 During the year the Committee has focussed on delivery of the key responsibilities as set out in the Terms of Reference. Compliance with a number of the key responsibilities is evidenced by the following actions:

- Review of strategic objective contained in the Board Assurance Framework, with appropriate challenge to the proposed gaps, controls and risk scoring.
- Regularly reviewed of risks attached to achieving the strategic objective, including deep dives of individual risks at each meeting.
- Received reports on progress of the Digital Workstream and development of the Digital OBC.
- Received progress reports on the BBF site enabling OBC.
- Received revised expenditure profile information for seed funding.
- Received regular progress reports and updates on timelines, finance, project status, project resourcing etc.
- Received regular reports on engagement and communication, and clinical engagement.
- Received regular updates on the development of the site enabling business case.
- Received report on alignment to the Long Term Plan.
- Received State of Readiness Review report following an external audit review.
- Received regular feedback from national Cohort 4 meetings.
- Received governance reports from those Groups with reporting responsibilities to the Committee.

2.2 Reporting Requirements

2.2.1 The Committee reported to the Board after each meeting. Reports included a description of the business conducted, risks identified, assurance provided and issues for escalation.

2.2.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting, most notably progress against the project timeline/plan.

3. RISK MANAGEMENT

3.1 Since its establishment, the Committee has continued to maintain its review of the Corporate Risk Register ('CRR') and the Board Assurance Framework ('BAF'). The Committee's review of the BAF and CRR focussed on the hospital programme related risks.

4. MEMBERS AND MEETINGS

4.1 During 2022/23, the Committee met formally on 9 occasions. The meetings were quorate all times. Two Committee Development Sessions were also held during 2022/23.

4.2 Committee membership comprised three Non-Executive Directors and three Executive Directors . Chris Balch acted as Committee Chair. Record of their attendance is shown below:

Non-Executive Director	**Number of meetings attended**
Chris Balch (Chair)	9 (9)
Richard Crompton (wef 01.08.22)	3 (6)
Paul Richards	8 (9)
Executive Directors	**Number of meetings attended**
Ian Currie, Medical Director	6 (9)
Adel Jones, Director of Transformation and Partnerships & SRO	7 (9)
Dave Stacey, Chief Finance Officer	7 (9)

4.3 Senior management representatives also in regular attendance included – Programme Director, Deputy Programme Director, Director of Estates and Facilities, Director of Capital Development, Associate Director of Communications and Partnerships, Health and Care Strategy Director, Interim Director of Corporate Governance and Company Secretary and Corporate Governance Manager. The Vice-Chair and Chief Executive attended some meetings in an observer capacity. A Governor observer was also in attendance.

5. COMMITTEE EFFECTIVENESS

5.1 A Committee self-assessment process was undertaken during 2022/23. Areas for improvement were identified as:

- The Committee would benefit from exposure to best practice in new hospital development (action agreed - visits to sites of best practice would be put in place as and when appropriate)
- Concern around the impact of changes in direction at national level on the project (Committee noted that any national guidance that impacts on the project would immediately be brought to the attention of the Committee)
- A suggestion that there might be more engagement and challenge to management and other assurance providers given the current operating environment. (This was in relation to national challenge and the Committee noted that all business cases are subject to regional, national and Treasury scrutiny.)

Chris Balch
Chair, Building a Brighter Future Committee
April 2023

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report			Meeting date: 31 May 2023
Report appendix	N/a		
Report sponsor	Chief Operating Officer		
Report author	System Care Group Directors		
Report provenance	The report reflects updates from management leads across theTrusts Integrated Service Units (ISUs) and Children and Family Health Devon (CFHD)		
Purpose of the report and key issues for consideration/decision	The report provides an operational update to complement the Integrated Performance Report (IPR), including some specific performance metrics. The report offers greater detail not fully covered in the IPR. The report also highlights a number of developments across the community alongside the key activities, risks and operational responses to support delivery of services through this phase of the recovery and restoration. This includes delivery of high priority cancer, diagnostics and elective services.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the Chief Operating Officer's Report.		
Summary of key elements			

Strategic goals supported by this report

Excellent population health and wellbeing	X	**Excellent experience receiving and providing care**	X
Excellent value and sustainability	X		

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

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

Risk Register Number 5 – Operations and Performance Standards

External standards affected by this report and associated risks	

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

Report title: Chief Operating Officer's Report		**Meeting date:** 31 May 2023
Report sponsor	Chief Operating Officer	
Report author	System Care Group Directors	

1.0 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 (ISUs) and Children and Family Health Devon (CFHD).

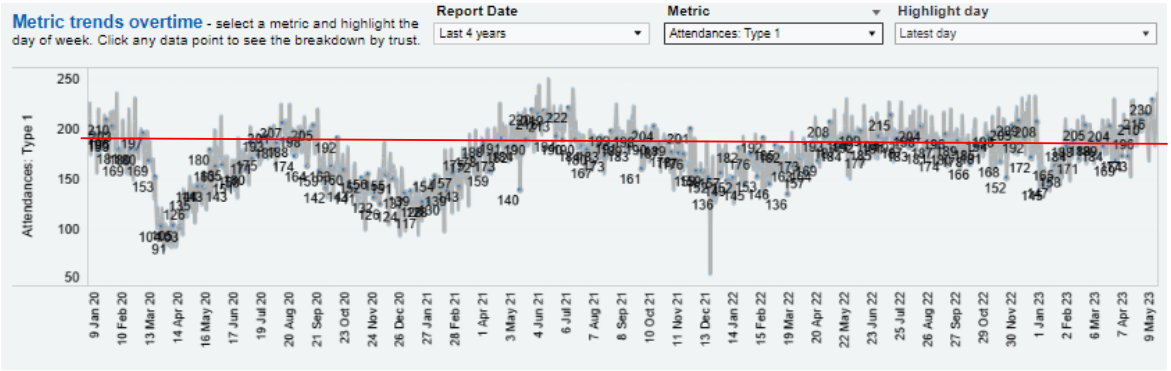
2.0 Introduction

The month of April, with Easter holidays and strike action, has created some challenges to operational delivery, although there is evidence of continued improvement. The discipline of managing the long weekends and strike actions through the creation of a Trust 'Play Book' has enabled clearer planning and cross-organisational engagement to support the safer flow and care of patients.

3.0 Urgent & Emergency Care update

Daily demand to the Type 1 Emergency Department rose from 187.7 in March to 199.2 in April. Overall attendances increased from 5,821 to 5,977. Our Type 3 urgent treatment centre (UTC) and minor injuries unit (MIU) 3 attendances increased in the month from 2,945 to 3,002.

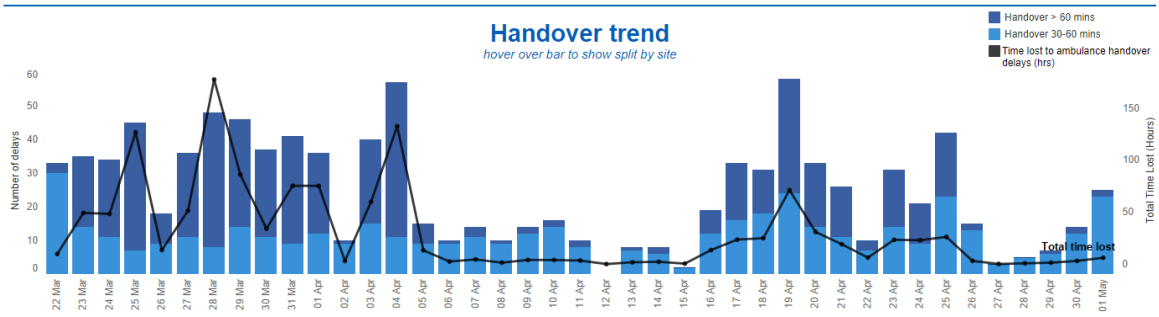
Our demand for Type 1 emergency services has now exceeded pre-covid levels.



Overall our Integrated Care System (ICS) UEC performance was 61.74% compared to 57.59% last month representing an improvement. As a result, the Trust achieved its operational plan trajectory of 60%.

3.1 Ambulance Handovers

Overall the trend in ambulance handovers is one of improvement.



The largest success is in the 60-minute breaches and total time lost (as can be seen above). Our rolling 30-day position has improved against other Trust's performance and we continue to make progress.

Rolling 30-day position as at **11 May 2023**

click on a bar to highlight site on the trend chart

Ambulance Trust	Site	
South Western	Derriford Hospital	3782:30:25
South Western	Royal Cornwall Hospital (treliske)	3689:38:31
South Western	Gloucestershire Royal Hospital	2069:43:04
South Central	Queen Alexandra Hospital	1624:28:23
South Western	Royal United Hospital	1273:38:29
South Western	Bristol Royal Infirmary	1146:26:29
South Western	Weston General Hospital	770:30:33
South Western	The Great Western Hospital	675:43:56
South Western	Royal Bournemouth Hospital	578:02:22
South Western	Royal Devon & Exeter Hospital (w..	537:42:25
South Western	Torbay Hospital	492:38:09
South Western	Poole Hospital	468:02:45
South Western	Southmead Hospital	332:09:51
South Western	Salisbury Health Care NHS Trust	238:05:49
South Western	Musgrove Park Hospital	227:34:06

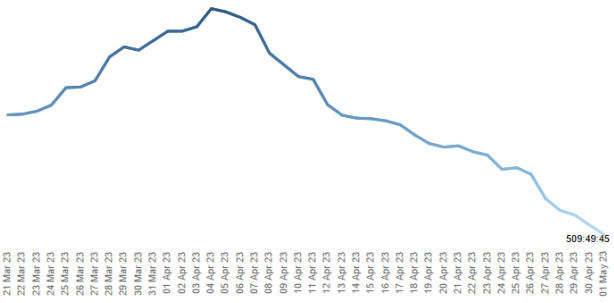
Time lost to ambulance handover delays (hrs)

Rolling 30-day position as at **01 May 2023**

click on a bar to highlight site on the trend chart

Ambulance Trust	Site	
South Western	Torbay Hospital	509:49:45

Rolling 30-day **Trend**



3.2 Inpatient Flow

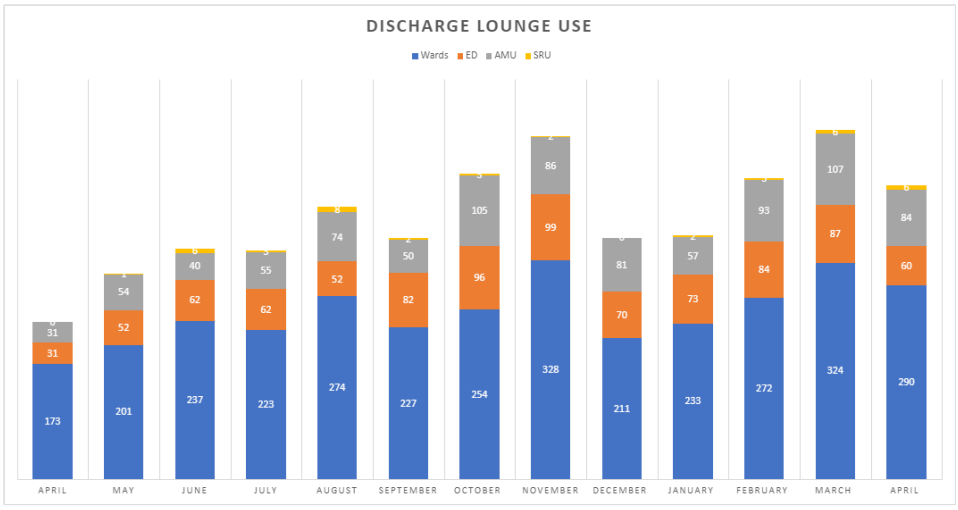
We saw a marginal improvement in our general and acute (G&A) discharges in April. On a number of occasions, we have achieved our pre-5pm discharge target. The flow and ward improvement group (subgroup to Urgent and Emergency Care Board) seeks to continue to drive this improvement, with workstreams to maintain and improve this position and our patient experience.

As mentioned in previous reports we have established a causative relationship between performance and infection control outbreak bed restrictions. In April the number of beds closed due to infection outbreaks was very low with fewer than 78 beds days lost to Covid bed closures.

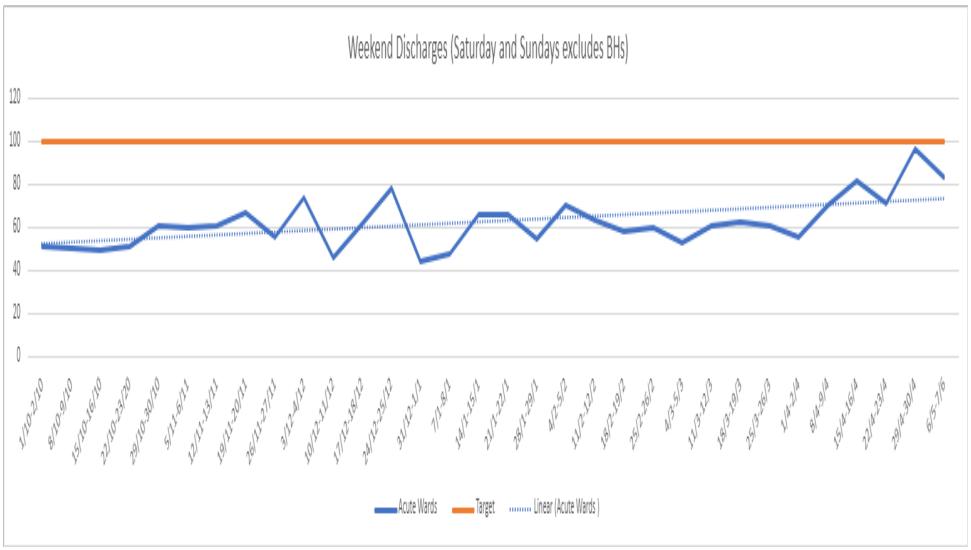
The table below shows the impact of improvement in patient flow with more days at Operational Pressures Escalation Level (OPEL) 2 than at OPEL 4.

DAY	DATE	OPEL	Acute Adult IP bed base - Pre Noon (33%+)	Acute Adult IP bed base - Pre 5PM (75%+)
Saturday	1st	OPEL 4	28.9%	78.9%
Sunday	2nd	OPEL 4	11.1%	44.4%
Monday	3rd	OPEL 4	17.2%	70.3%
Tuesday	4th	OPEL 4	16.4%	53.7%
Wednesday	5th	OPEL 3	21.0%	72.6%
Thursday	6th	OPEL 3	14.1%	59.4%
Friday	7th	OPEL 3	27.0%	85.7%
Saturday	8th	OPEL 3	5.4%	73.0%
Sunday	9th	OPEL 3	26.5%	76.5%
Monday	10th	OPEL 3	20.0%	66.7%
Tuesday	11th	OPEL 3	13.8%	75.9%
Wednesday	12th	OPEL 3	25.0%	83.8%
Thursday	13th	OPEL 2	21.4%	75.7%
Friday	14th	OPEL 2	19.2%%	61.6%
Saturday	15th	OPEL 2	22.4%	69.4%
Sunday	16th	OPEL 2	6.1%	75.8%
Monday	17th	OPEL 3	11.1%	69.8%
Tuesday	18th	OPEL 3	29.5%	77.0%
Wednesday	19th	OPEL 3	23.1%	76.9%
Thursday	20th	OPEL 3	20.6%	76.6%
Friday	21st	OPEL 4	12.0%	56.0%
Saturday	22nd	OPEL 3	20.9%	74.4%
Sunday	23rd	OPEL 3	17.2%	65.5%
Monday	24th	OPEL 3	18.3%	66.7%
Tuesday	25th	OPEL 3	15.9%	73.9%
Wednesday	26th	OPEL 3	23.1%	70.5%
Thursday	27th	OPEL 2	23.5%	73.5%
Friday	28th	OPEL 2	19.0%	55.7%
Saturday	29th	OPEL 2	19.4%	73.2%
Sunday	30th	OPEL 2	9.8%	61.0%

The discharge lounge (DCL) continues to support the generation of timely ward capacity. Although we saw a slight reduction in patient numbers this was due to infection control ward closures. The team are focussed on improving patient experience in the lounge.



Work is underway to review overnight 'bedding' of the DCL and to reduce it. We know this is impacting our pre-noon and 5pm discharges. (as well as the same in same day emergency care (SDEC)). It is expected to identify solutions in early June.



Throughout April we have seen an increase in weekend discharges. Driven by our discharge team and the additional consultant and ward rounds on our short stay ward.

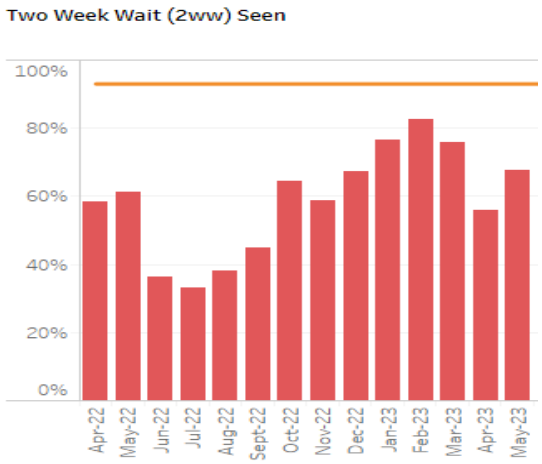
4.0 Cancer Performance

In April, Torbay and South Devon received 1,661 two-week wait referrals (2WW), which is unchanged from the previous year.

4.1 Two-week-wait

The two-week-wait position of the Trust, although not externally scrutinised, is a responsive metric for viewing performance at the beginning of the cancer pathway. For April, this standard dropped to 56%. This was due to two main factors:

- An exceptional month of referrals in March (2,002)
- The loss of activity due to Bank Holidays, Easter school holidays and a 4-day junior doctor strike. Activity in April was 11% down, compared with previous years.



Early indications for May, show an improvement in this position (67%). The recovery of waiting times in dermatology and breast were primary drivers for this improvement; both areas are confident that ongoing capacity is sufficient

4.2 Cancer Recovery

There are four 'Key Lines of Enquiry' which are used to benchmark organisations in the NHS England 'Tiering' system. TSDFT has been in Tier 1 (the highest level) for cancer performance but has improved to Tier 2 provider following a sustained period of operational actions.

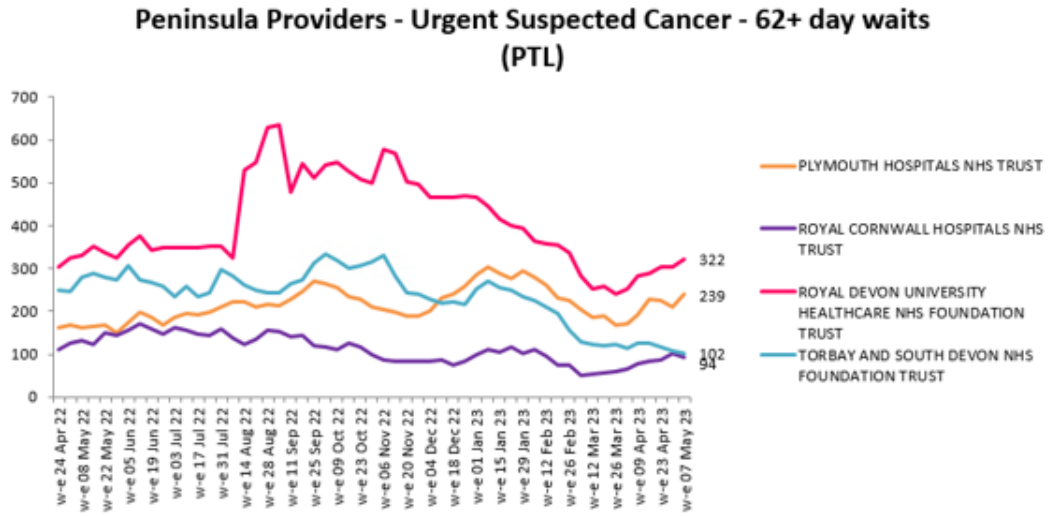
The critical steps have been to reduce our waiting times for diagnosis and our 62-day backlog. For April the 'Faster Diagnosis Standard' is currently at 74.7%. This position is still undergoing validation, with the final position to be confirmed at the end of May. Factors discussed previously regarding April activity levels are a key influence of these changes.

31-day performance in April is expected to be ᶜ90%, against the 96% target. Plastic surgery waiting times are the main reason for this position, accounting for 9 of the 13 breaches.

As a result of our continued improvements in our diagnosis times we continue to see recovery against the 62-day standard. For April, performance is expected to be 75% compared to a National aggregate position of 63.5%.

Over 62-day Backlog (Open Pathways)

As of 7 May 2023, the number of open pathways over 62 days was 102 and represents 6.1% of the total Patient Tracking List (PTL). This is a much-improved position when compared to the >300 that we were reporting pre-Christmas.



Ongoing planned work in endoscopy, with the building of the fourth endoscopy suite and subsequent temporary reduction in capacity, continues to present a risk to this position, this is beginning to materialise in the increasing backlog of patient waiting between 29-62 days but is not yet showing in the over 62-day position. Insourcing and additional lists are being stood up where possible, but physical space limitations have caused a rise in waiting times for these procedures.

Urology and colorectal services remain areas of priority focus, alongside dermatology – especially due to upcoming seasonal demand pressures.

5.0 Referral to Treatment (RTT)

5.1 Long waits (April 2023)

104 weeks –
The Trust reported zero 104-week waits at the end of April, delivering on our planned position.

78 and 65 weeks -
Our 78-week submission for April 2023 is 166 against our forecast of 176. This position was delivered despite the impact of Industrial Actions throughout April.

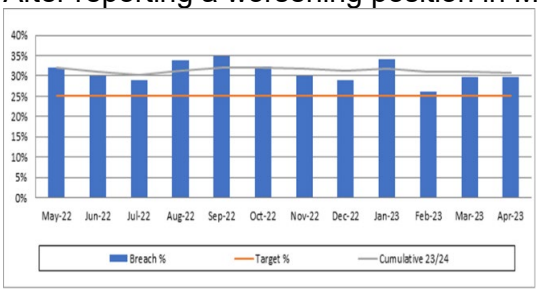
The iterative process of forecasting our 65-week long waits position through 2023/24 continues with the invaluable support of NHSE. The very significant uplift in our long wait position reported in March has been mitigated and re-submitted at a much-improved level. Whilst our long wait cohort remains much higher than in 2022/23, our confidence in delivering the activity to match this growth has increased.

65-week submission	Non-Admit	Admit
Starting position	8,987	473
9th March	3,239	360
23rd March	1,934	421
Current	855	236

- In addition to this we are now forecasting the full clearance of 78-week waiters in 2023/24 although this is dependent on System support to achieve.
- The Trust delivered against our re-stated monthly forecast for 78 and 65 week waits in April and is also on track to deliver our May control totals.

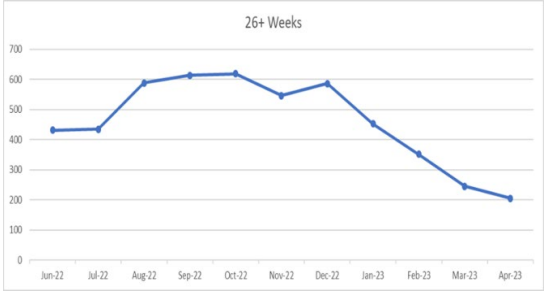
6.0 Diagnostics Performance

After reporting a worsening position in March our performance has stabilised in April.



Our current position is driven by acute staffing shortages in MRI and non-obstetric ultrasound.

Plans are being developed to improve our current performance, including the use of the independent sector



It is encouraging to report that our clearance of long waiters in diagnostics continues at pace

The Trust is fully engaged in the System-wide discussions to develop Community Diagnostic Centres in Devon. This is a very important proposal which presents a range of opportunities to transform and improve elective care pathways for cancer and routine services.

7.0 Children and Family Health Devon (CFHD)

7.1 Carenotes Outage

An impact of the outage reported to earlier Board meetings, affecting all Trusts is that monthly reporting of the Mental Health Services Data Set (MHSDS) is not available in the version put into place to resolve the outage.

The manual data validation exercises on Carenotes are continuing and nearing completion, during which time all clinical data is available and the system fully functional.

7.2 Transformation programme

Following approval by Partnership Board of the future service model, the formal staff consultation was closed on 15 February. HR processes for staff affected by the consultation outcome are being worked through. Recruitment to vacant posts is underway.

The mobilisation plan to prepare for implementation of the new service model is underway. This work includes process mapping, workforce planning for the locality based clinical triage function and caseload and waiting list cleansing. We plan to begin to implement the new pathways in May.

7.3 Revisions to the service specifications

CFHD's clinical pathway leads have drafted the revised service specifications, based on the clinical needs-based pathways in the new model. The ICB and CFHD (Torbay and South Devon NHS Foundation Trust [TSDFT] and Devon Partnership Trust [DPT]) commenced work week commencing 24 April to agree the revised specifications and to identify risks arising from the gaps, first and foremost those relating to population health.

8.0 Families Community and Home Care Group Update

8.1 Child Health / Paediatrics

The team are continuing to carry out validation on the children and young people who have waited the longest. Community paediatrics continues to be the longest wait. A number of initiatives are in place to help see these children in a more timely manner and help them while they wait, our First Steps booklet is now sent to all families, as well as advice and guidance it can help the families record the concerns and hopes for the child.

The Child Health Transformation Programme is underway with many streams of work going on across the directorate all aligned to the Trust's Regain and Renew Plan and with the aim "to deliver safe, timely, high quality care for the children of Torbay and South Devon.

Projects already underway include co-design- establishing a Child Health Participation Panel and engagement with partners, financial planning – including income generation,

cost improvement plans (CIP) and contracting, Patient Safety Incident Response Framework (PSIRF) implementation, workforce strategy, review of medical rotas, pathway reviews and digital opportunities such as Little Journeys and V-Create.

A new mental health leadership / champion role has been developed and funded for the next two years. This will be a strategic-level role to co-ordinate improvements in the way in which Acute Trusts interact and support children's mental health. This role will be supported by the South West Paediatric Mental Health Network.

8.2 Children's Torbay 0-19 Service

The Family Hub workstreams are developing which will shape the service delivery in line with the following core areas:

- Perinatal mental health – mapping service, scoping suitable training to develop the workforce
- Infant Feeding - developing peer support offer across community and maternity
- Parenting support – currently mapping and scoping available support. Longer-term peer support development.
- Early communication / Home Learning Environment – mapping and scoping, and considering shared language and messaging e.g. chat, play, read- info to children's settings e.g. toddler groups
- Start for Life - digital offer – developing the web content, links and uploading, 0-19 part of content

The membership for each group includes representation from Torbay Council Children's Services, Torbay 0-19 and maternity services from the Trust as well as voluntary sector representatives.

There is a planned Ministerial visit on 1 June 2023 from Andrea Leadsom who will be visiting the family hubs and seeing first-hand the developments and progress being made to improve outcomes for our local families.

8.3 Community Dental Service

The service activity levels are stable compared to previous months, though the numbers on the waiting list are growing due to staffing and an increase in referrals since last month, the majority of which are children.

8.4 Maternity

The three-year delivery plan for maternity and neonatal services for England was published on 30 March 2023. This aims to make care safer, more personalised and equitable. It is asking services to focus on four key themes; listening to women with compassion, growing, sustaining and retaining our workforce, developing and sustaining a culture of safety, learning and support and standards/structures that underpin safe, personalised and equitable care. A summary will be presented as part of the quarterly governance report that will be shared with Trust Board in May 2023.

Three members of the maternity team have been shortlisted as finalists in the South West Perinatal awards in the categories of Leadership, Rising star and Innovation. The awards ceremony is being held in Taunton on 22 May.

On 11 March a number of the senior team attended the Mariposa Ball in London to see Anna Stewart receiving a special recognition award for her work as a bereavement midwife. It was a great night out and fabulous to see Anna win.

8.5 Gynaecology
Mount Stuart Hospital have increased the number of general gynaecology weekly referrals that they will accept. They are now accepting 20 patients a week and we have transferred 70 patients so far.

Waiting times for a new outpatient appointment is as follows:

- New – ROUTINE 11 Months
- New – UROGYNAE 10 Months
- New – MIT 12 Months
- New - COLPOSCOPY 12 Months

There are concerns that, as the year progresses, the service will start to fail the 78-week wait target for outpatients. We are currently working with NHSE on a capacity versus demand model. The model demonstrates that the demand is far greater than the capacity.

8.6 Community Sexual Health Service
A new electronic patient record (EPR) "Inform" for Devon Sexual Health (DSH) services is progressing with a planned implementation for Royal Devon University Healthcare NHS Foundation Trust (RDUH) July / August, with TSDFT later this year, as part of the DSH commissioned service. RDUH are currently completing a data impact assessment. An outreach sexual health clinic for the service in Brixham is planned to start in May as a six to nine-month test of change.

8.7 Healthy Lifestyles
The service is currently working as part of a quality improvement (QI) project team looking at inpatient tobacco dependency treatment pathways, this is being supported by the British Thoracic Society (BTS). The project is being led by two pre-reg doctors working in acute medicine.

The team are also developing the Treating Tobacco Dependency (TTD) delivery plan for 2023/24. As part of this plan staffing levels to meet best practice requirements to deliver fully implemented in-house stop smoking provision are being considered. The maternity pathway is now fully live, this ensures that all women identified as smokers during booking in contact with maternity services are routinely referred to tobacco treatment advisers for in-house support.

8.8 Social Care
The Transformation and Sustainability Plan began implementation in April with key work programmes focusing on adult social care strategy, cost improvement, commissioning and market management, and pathway redesign with reablement, adult social care (ASC) Front Door, direct payments and pathway to independence with in learning disability.

Business planning for 2023/24 has been completed and £2.7M cost improvement plan (CIP) identified. Month 1 savings have been completed and reported to finance to be transacted.

8.9 Bay Wide Community Health Services

8.9.1 Therapy

The occupational therapy (OT) and physiotherapy (PT) teams continue to work to reduce the waiting list in Paignton and Brixham (P&B) Integrated Service Unit (ISU). Using the same triage process. OT waiting lists are 96 for P&B ISU and 43 in Torquay (TQ) ISU.

The longest PT wait across the Bay is four weeks for low priority visits. Teams continue to flex across to support the Baywide intermediate care (IC) / urgent community response (UCR) offer by standing down routine work to support an increase in IC referrals. This can impact on the waiting list. Waiting list for physiotherapy in Torquay is 43 with a three-week wait and P&B ISU is 65 with a six-week wait.

8.9.2 Community Nursing

The TQ community nurses (CNs) did 4678 visits last month, (normal numbers are 3800-4100 visits a month). This team has just won the Chair's Special Award in the People's Awards. This is a high functioning cohesive team. A team to be truly proud of.

P&B continue to support their new starters with training to develop community-facing skills and competencies. They recorded 3490 visits last month. They have 2.5 whole time equivalent (WTE) less than TQ and vacancies. South Devon CN teams collectively completed 5819 visits.

The number of insulin-dependent diabetic patients that are being managed by the CN teams are continuing to increase. This is equating in an extra team member having to work at weekends to ensure quality and safety with this cohort of patients.

The Out of hours (OOH) service continues to be managed by the CN Lead in P&B and the Baywide community service manager to providing leadership and management to the team due to long term sickness. A consultation process has started to reduce the team to one base (from two) to increase productivity and cohesion in the team.

8.9.3 Intermediate Care

The IC teams are managing their home-based workloads well and are seeing a reduction in length of stay (LOS). In bedded placements, work is underway to monitor and reduce the length of stay. The teams are managing the 17 extra block pathway 2 rehab beds in care homes to assist with hospital flow. The career promotion of IC lead in Torquay has created the opportunity to redesign and develop a Baywide response. Currently we have 40 patients across the Bay in placement, with an average LOS of 23 days.

8.10 Urgent Care Response (UCR)

The teams are achieving the national target in their response times, meeting the 2-hour response target and exceeding the target for 2-48-hour response. TQ 0 to 2-hour response is 100%. 2 to 48-hour response is 100%. P&B 0 to 2-hour response is 93.1% and 2 to 48-hour is 100%. There are further plans in place for 2023/24 to develop the UCR service and reduce ED attendance and admission.

8.11 Complex Hospital Discharge (Pathway 1-3, excluding community hospital transfers)

Pathway 1 - we have movement and good flow. Time to transfer reduced to on average at 2 days.

Block contract hours to support short-term service extended in Torbay until April 2024. South Devon extended until end of May 2023.

The block contract to support short-term service has been extended in Torbay until April 2024. Torbay residents will be in receipt of 4-week interim health funding (IHF).

South Devon are awaiting confirmation from Devon County Council (DCC) regarding continuation of 4-week IHF for pathway 2 patients and self-funders past May 2023. The Care Act and a financial assessment will need to be completed whilst the patient is an in-patient for all Devon residents.

Pathway 2 - The 17 block beds provided by the demand and capacity monies are being utilised. Senior review multidisciplinary team (MDT) review of all P2 referrals to the Discharge Hub is influencing positively however further improvement of the triage is required to reduce the time to transfer from 7 days to 5.

Pathway 3 - One patient with a very long length of stay remains in hospital on pathway 3 they are managed by the community teams due to their complexities and requiring bespoke support packages. A support package has been sourced and is going through the legal framework process.

Focus on reviewing the no criteria to reside (NCTR) data on Tableau has become business as usual with greater recording accuracy noted. NCTR is at 7% against a 5% end of March 2024 target. NCTR fluctuating between 5% and 9%
Long length of stay (LLOS) for 21-day continues to be monitored by the complex team over 60% are not referred to the Discharge Hub which is being addressed through an improvement plan.

Action plans for improving NCTR is reported to the Operational Recovery Group, UEC improvement plan and the 100-day challenge meetings.

8.13 Continuing Healthcare (CHC)

Torbay and South Devon CHC team are currently achieving 80.6% against a national target for CHC decisions made within 28 days from 85.5% last month. The target is 80%.

There has been a decrease in the number of referrals for assessment received by 29%. However, we have seen an increase in fast track referrals by 16% in April. For South Devon clients the CHC team are responsible for case management, the complexity of needs and availability of support to meet complex needs continues to challenge the team.

Liaison Care have commenced their review work and the data for the first 30 clients has been received. Liaison have committed to review 30 fully funded CHC clients per month, no appointments have been arranged as yet. The process will generate a significant amount of work for the CHC team with both an admin and clinical impact. Under the standing rules the Trust/ICB cannot fully delegate the function for CHC

decisions to a provider. The Trust will still need to validate all decisions made by Liaison and hold full multidisciplinary team (MDT) meetings should clients be deemed no longer eligible by Liaison.

There are currently a number of developments moving forward in relation to nursing home provision. The first is due to open in Dawlish in December 2023. This will have an impact on the team in terms of work with an increase in the number of assessments and also financially. Free nursing care (FNC) is paid in the area the person is resident in, if a person is placed under FNC and they become CHC eligible then responsible commissioner rules apply.

9.0 Community Services

The practical completion date for Dartmouth Health and Wellbeing Centre happened on Monday 24 April with the opening on Tuesday 9 May.

Dartmouth Medical Practice (DMP) will be moving in on Friday 26 May - opening after the bank holiday - and it was anticipated that the Wellbeing Pharmacy would open at the same time. Unfortunately, a delay in the General Pharmaceutical Council (GPhC) inspecting and accrediting the premises means that the unconfirmed opening date is more likely to be the beginning of July.

With only two pharmacies in Dartmouth this has caused concerns for DMP as patients will now have to go into town for their urgent prescriptions.

High levels of sickness absence and vacancies in community therapy and intermediate care are impacting responsiveness for community physiotherapy and the ability to provide consistent therapy input to Dart Ward. As this is a longer-term issue with no clear exit plan, due to significant vacancies within physiotherapy and national challenges with recruitment, there has been a meeting with the head of physio and actions identified to mitigate the risk and develop a longer-term strategy.

A paper is now in draft format and pending a meeting with the finance business partner to describe a proposed approach to reviewing and renewing contracts for our Community Hospitals and the financial risk involved. Once complete it will be sent to the system director for onward sharing and decision making.

10.0 Healthcare of Older People (HOP) and Frailty

We continue to work to better understand our data. We now have QI support for the frailty intervention team and are working on an improvement plan which will start with mapping of our currently frailty pathways.

Scoping for the Frailty Virtual Ward is underway. Dr Mat Fox and Dr Kath Bhatt, both GPs, are working with us to understand the potential and opportunity for models utilising primary care skills and experience in the absence of our ability to recruit consultant workforce. Data is being prepared from existing sources to help understand better where the opportunities lie.

10.1 Stroke and Neuro Rehab

The number of patients admitted with a stroke in April was the highest since June 2021 (and prior to that August 2020). Over Easter, 27 of the 28 beds on George Earl were occupied by stroke patients; this meant maintaining a pathway and access to George Earl for new stroke patients was challenged. We continue to find that during the day the pathway becomes available but then beds are utilised and finding the next two beds to keep clear is incredibly difficult. This also means that meeting the 4-hour target is very challenging and, having achieved 37.5% in March, it fell again to 22.2% in April. Scanning and the percentage of time on the stroke unit also deteriorated in April.
In addition to the actions identified last month to restore the Sentinel Stroke National Audit Programme (SSNAP) administrator post, discussions have taken place and actions identified to protect the stroke specialist nurse role more (it is frequently being used to backfill the ward) and also to develop a standard operating procedure (SOP) with colleagues on Templar that could support the temporary increase in stroke beds on Templar Ward at times of escalation to support the creation of capacity on George Earl. These discussions will be progressed in the next few months.

Time critical Stroke Standards									
	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Number of patients (N)	42	33	46	32	39	34	41	42	56
% Scanned within 1 hour	40.5	45.5	45.7	57.8	48.7	61.8	41.5	57.1	50.9
% Scanned within 12 hours	88.1	93.9	93.5	93.3	92.3	94.1	95.1	100	92.7
% Admitted to Stroke Unit within 4 hours	25	24.2	8.9	26.2	0	15.6	17.5	37.5	22.2
% of patients spending 90% of their time on the Stroke Unit	64.1	54.8	60	76.7	37.1	54.5	70.7	70.7	63
% (No.) Patients that received Thrombolysis	9.5 (4)	15.2 (5)	8.7 (4)	13.3 (4)	7.9 (3)	12.1 (4)	10 (4)	10 (4)	10.9 (6)
% Received Thrombolysis within 1 hr	25	20	50	100	0	50	0	50	50
SSNAP		A	B	C	D	E			

11.0 Recommendation

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Workplace Team Strategic Performance Update			Meeting date: 31 May 2023
Report appendix	Appendix 1: Trust Health & Safety Report Appendix 2: Workplace Compliance Dashboard		
Report sponsor	Chief Finance Officer and Deputy Chief Executive		
Report author	Workplace Director		
Report provenance	Workplace Performance and Compliance Group		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to brief the Trust Board on strategic Workplace Team performance and compliance exceptions for February and March 2023.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To note the current performance and compliance of Workplace Team and headline summary of key exceptions and activities.		

Summary of key elements

Strategic goals supported by this report

Excellent population health and wellbeing	X	**Excellent experience receiving and providing care**	X
Excellent value and sustainability	X		

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

Board Assurance Framework	X	**Risk score**	25
Risk Register	2179	**Risk score**	16

BAF Ref. 4 - Estates

External standards affected by this report and associated risks

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

Report title: Workplace Team Strategic Performance Update		**Meeting date:** 31 May 2023
Report sponsor	Chief Financial Officer & Deputy Chief Executive	
Report author	Workplace Director	

1.0 Introduction

1.1 This report sets out performance and compliance exceptions within the Workplace Team for the months February and March 2023. In addition to this, some strategic updates relating to Workplace activities and business projects are included.

2.0 Discussion

2.1 Corporate Health & Safety

The remaining improvement notice issued to the Trust by the Health and Safety Executive (HSE) relating to the management and use of sharps is nearing close-out. This particular notice was pertinent to some gaps in training relative to the use of sharps across the Trust, the majority of which have been addressed. The revised training materials will be launched as mandatory learning across the organisation at the end of May 2023, which coincides with the HSE's re-inspection to clarify that the theoretical response provided to both improvement notices have been implemented in practice.

The Trust's Authorising Engineer (AE) for fire safety has now concluded his annual two-day audit into the compliance and effectiveness of the organisation's approach to fire safety management. A draft report has been shared with the Workplace Director and Corporate Health and Safety Manager, the final version of which will be included in July's report to Trust Board. Whilst the final version of the report is awaited, the spirit of the AE's feedback was very positive in recognising the significant improvements in relation to the Trust's approach to fire safety management, whilst confirming that opportunities for improvement do still exist and these, along with a series of recommendations, will be included in the final report.

Training for all subjects related to fire safety (i.e. evacuation leads, fire wardens and albac mats) has returned to face to face delivery and the verbal feedback from attendees has been resoundingly positive. The Trust continues to roll out Institute of Safety and Health (IOSH) Managing Safely training for line managers with a total of 50 colleagues having attended to date.

2.2 Compliance and Performance

Appendix two sets out the Workplace Team's operational compliance and performance for the months of February and March 2023.

February and March were exceptionally strong for the Estates Delivery team within Workplace, particularly where pre-planned maintenance (PPM) is concerned having achieved an average of 100% for statutory, mandatory and routine PPM performance in both months. Since the implementation of the Workplace Team's first Target Operating Model (TOM1) in October 2022, with a

specific focus on compliance and performance improvement, there have been demonstrable improvements in the consistently strong delivery of PPM performance.

Whilst progress in relation to reactive performance has seen an overall improvement since the implementation of TOM1, work is required to develop this further which can now be done in a structured and methodical way. Improving PPM performance is key to reducing the causes of reactive failure, meaning reactive performance can be measured and addressed on a realistic basis.

The improvement in fire door compliance across the Trust is also noteworthy with the first significant increase in this area since before January 2022. This is primarily as a result of enhanced focus, collaboration between service teams and the allocation of capital funding. A plan is in place to continue on the trajectory of improvement, with a view to increasing the compliance percentage to 50% by the end of the 2023/2024 financial year.

Additional metrics for review have now been included in the Workplace Performance and Compliance Group, including: site safety walks; community maintenance contract performance; community cleaning contract performance; and the performance of the two special purpose vehicles (SPVs) at the Newton Abbot hospital and Dawlish hospital PFIs. This is a significant development in the level of scrutiny and oversight relating to performance of Workplace Services and demonstrates the enhanced focus in this area.

There are no overarching concerns relating to broader Workplace compliance and performance, which has remained consistent in most areas. The improvement in compliance and performance relative to works under taken by the Clinical Engineering team (formerly known as Medical Device Support Services) outlined in January and March's reports to Trust Board continues.

2.3 Workplace 2023-2024 strategy and re-brand

The Workplace Strategy for 2023-2024 outlined in March's report to Trust Board was launched on the 1st April and has been embraced well by colleagues at all levels. The launch of the strategy will be accompanied by a transformed communications framework with our people. This will include a twice-yearly Workplace Leadership Conference, bringing together line managers at all levels to share strategic updates, discuss key topics and encourage their ownership and accountability for delivering against the strategy, the first of these conferences will be held in early June 2023. In addition to this, Workplace Roadshows have been launched and will take place three times a year, this will be an opportunity for the Workplace Senior Leadership Team (SLT) to give key organisational and strategic updates to frontline colleagues, celebrate outstanding performance and host question and answer sessions with those colleagues in attendance. All Workplace colleagues who are not absent or on annual leave will be expected to attend these roadshows.

Figure One: Workplace Team Strategy – 2023-2024

2.4 Environment and Sustainability

Work is concluding on the specification for locally-sourced solar generated power to be provided to the Torbay Hospital site through a private wire. The opportunity will be placed on the open market for interested bidders in May 2023 with a view to contract award date for the preferred bidder taking place in October 2023. Further updates on the progress of this activity will be presented to Trust Board in future months.

The Trust is currently working towards achieving a Biodiversity Benchmark award from The Wildlife Trust and are in the early stages of engagement with them. The biodiversity benchmark is designed to complement the ISO14001 standard tests the design and implementation of an organisation's management systems to achieve continual biodiversity enhancement and protection.

Much work has been undertaken across the Torbay Hospital site to enhance biodiversity and habitat preservation through the implementation of wildseed meadows, bee and bug hotels, sensory walks and many other initiatives. Attainment of the biodiversity benchmark would be the first of its kind in the National Health Service and would further cement our commitment to the delivery of the Trust Green plan and its environmental protection obligations.

Figure Two: Biodiversity implementation examples – Torbay Hospital

2.5 CIP Delivery and Financial Performance

As at month twelve the Workplace financial position shows a full year adverse variance of £4.3m which is in line with the forecasted number in March's report to Trust Board. The main drivers of overspend are: increased utilities costs (a year on year increase in cost of 20% for electricity and 90% for gas); additional portering, cleaning and catering services to areas which have been expanded or newly-opened in order to support de-escalation; and inflation-linked supplier price increases.

The Workplace CIP target for the 22/23 financial year is £2.8m. As at month twelve, a total of £1.5m CIP has been transacted, £480k of which is recurrent, this exceeds the forecasted CIP position from December 2022 of £1.1m. The reasons for the failure to meet the full allocated CIP target of £2.8m mirror the drivers of the Workplace adverse budgetary position: COVID cost reductions have not been realised due to the provision of unbudgeted services to escalation areas, and energy and supply chain cost saving initiatives have not provided the benefit anticipated due to the significant and unforeseen price increases.

Work on the development of a CIP pipeline, supported by the Trust's Project Management Office (PMO) has begun and various Project Initiation Documents (PIDs) have been submitted and approved. At this stage, the pipeline consists of initiatives relating mainly to organisational re-design and optimisation of frontline teams within the Catering and Cleaning Operations services, and a reduction in utilities spend and consumption with a number of other initiatives at the development stage.

2.6 Our People

Figure three outlines the Workplace Team's performance in relation to people metrics covering its 553 employees, giving a comparison between the directorate's position at the end of February 2023, and the overall Trust performance against each measure.

Compliance for achievement and mandatory training compliance continues to be amongst the strongest across the Trust and the Workplace leadership team remains focussed on sustaining this position.

The directorate's 12-month sickness average has seen an reduction on previous months, and continued improvement is anticipated in this area following a refreshed emphasis on supporting colleagues who have been absent for long periods of time back into the workplace.

The directorate's staff turnover rate is 11.5% which is consistent with previous months. It is anticipated that this number is likely to increase in future months as planned organisational re-designs within the directorate take place.

Metric	February	March	Trust Average
Valid Achievement Review	93.06%	94.84%	76.87%
Mandatory Training	93.97%	95.47%	90.45%
Rolling 12-month sickness average	8.02%	7.88%	5.62%
Rolling 12-month staff turnover	11.77%	11.56%	12.85%

Figure Three: Key People Metrics – EFM Directorate

Work has begun on the soft-launch of the Workplace Team's second Target Operating Model (TOM2) with formal consultation planned for launch on 1st June. This will build on the work achieved through TOM1 in 2022 and the 2023-2024 Workplace Team strategy, focussing on continuing to:

- Strengthen and clarify the operational leadership of the directorate
- Enhance operational resilience
- Improve career progression pathways and get, grow and keep the best people
- Enhance empowerment and accountability and every level
- Increase focus on the quality and compliance of service teams
- Create more capacity for strategic leadership focus on outcomes
- Provide improved communications with our people
- Give our people greater access to leadership
- Support the delivery of the Trust's regain and renew plan
- Enhance customer experience

Further updates on the detail of the new operating model and progress of its implementation will follow in future months.

2.7 Dartmouth and Kingswear Hospital Site Disposal

In the February 2023 Trust Board, it was agreed that the Dartmouth and Kingswear Hospital site should be placed on the open-market for disposal following a breakdown of the previous agreed sale to Dartmouth Town Council (DTC). An extension beyond the completion deadline of 25th March was provided to DTC, however no progress towards completion was made.

The site will be placed on the open market in mid-late May 2023, following the local elections and the opening of the Trust's new Health and Wellbeing Centre in Dartmouth. Further updates on progress will follow in future months.

3.0 Conclusion

February and March have seen strong and consistent levels of compliance and performance across all operational areas of the Workplace Team, particularly in relation to performance and compliance within the Estates Delivery and Clinical Engineering services.

There continues to be significant focus on the roll out and implementation of the Workplace Team strategy and improvements in the team's communication frameworks have been made to support this.

Focus on delivering the basics well remains a key priority, and the improvements this is delivering are clear, particularly in relation to achievement reviews, mandatory training, PPM, reactive performance and estate compliance is concerned.

The Workplace Team did conclude the year financially challenged, though managed to deliver a relatively significant value in relation to CIP. Work on delivering financial transformation in the 2023-2024 financial year has already begun.

Delivering the Trust's Green Plan and meeting its commitment to environmental protection remains a priority and innovation is significant in this space with the work to secure renewable energy sources directly to the Torbay Hospital site and the attainment of the Biodiversity Benchmark from The Wildlife Trust in the planning.

4.0 Recommendations

The Trust Board is asked to note the current performance and key headlines of the Workplace Team.

Report Date	April Committee meeting (reporting period up to 31st March 2023)		
Report Title	Corporate Health & Safety and Fire Monthly Report		
Report Authors	Kevin Wood - Corporate H&S Manager Suzanne Ellis - Senior Compliance Advisor Neil Faulkner - Corporate Fire Safety Advisor Jake O'Donovan - Director of Estates & Environment		
Lead Director	Jon Scott – Chief Operating Officer		
Corporate Objective	Safe, quality care and best experience / Well led		
Corporate Risk/ Theme	Statutory Safety		
Purpose	**Information**	**Assurance**	**Decision**
	✓.	✓.	✓.

Summary of Key Issues relating to Corporate Health, Safety and Fire contained on separate Report

- **Risk register**
  There are a total of 57 Health and Safety open risks on the Trust wide Risk Register of which 29 are currently scoring 12 and above. This is an increase from last month in terms of number and in terms of scoring.

1. Analysis of Performance

Table 1. below, shows the number of incidents reported by month over a rolling 12-month period from 1st April 2022 to 31st March 2023 (inclusive).

Table 1

	Death	Severe	Moderate	Low harm	No harm	Near miss	Totals
Apr 2022	0	19	6	58	133	25	241
May 2022	0	2	4	75	150	23	254
June 2022	0	8	2	54	120	30	214
July 2022	1	8	5	64	148	17	243
Aug 2022	2	6	9	63	148	24	252
Sept 2022	1	7	3	52	116	20	199
October 2022	0	11	2	56	110	29	208
November 2022	0	6	4	58	126	19	213
December 2022	1	1	8	59	133	29	231
January 2023	0	3	7	65	132	21	228
February 2023	0	5	4	64	83	12	168
March 2023	0	3	7	72	105	26	213
YTD Totals	**5**	**80**	**61**	**750**	**1512**	**281**	2689
Averages PM	0.38	6.15	4.69	57.69	116.31	21.61	224

As seen in Table 1. March's figures showed a significant increase in recorded events up from 168 to 213.

Average monthly total recorded events 224, March below average at 213. No deaths, 3 severe, 7 moderate, 72 Low harm, 105 no harm and 26 near misses. March had the second highest month for low harm incidents over the past 12 month period.

The Corporate Safety team wish to seek clarification from the Committee with regards to harm categorisation of patient RIDDOR events on Datix as Trust Incident Reporting and Management Policy, Section 3.6, current states, harm for “any RIDDOR incident” is severe. However, currently patient safety incidents harm is being graded according to the patient safety harm criteria which is different and therefore we have the following events reported under RIDDOR but categorised on Datix as:

- Near Miss x 1
- No Harm x 1
- Low Harm x 1
- Moderate x 4

This is causing a disparity in the figures we are reporting.

Chart 1

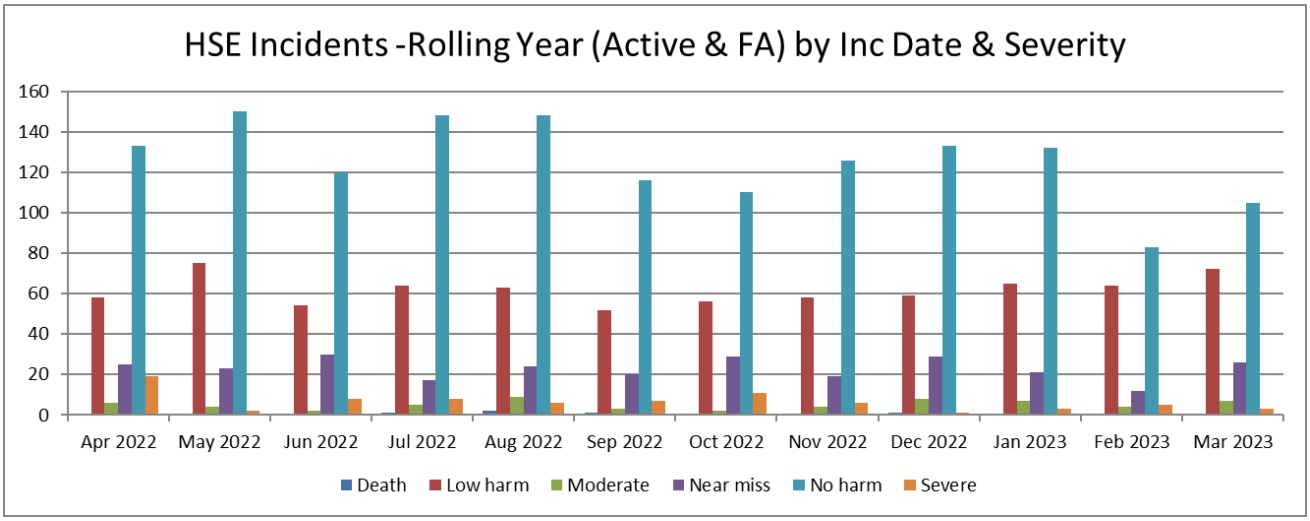
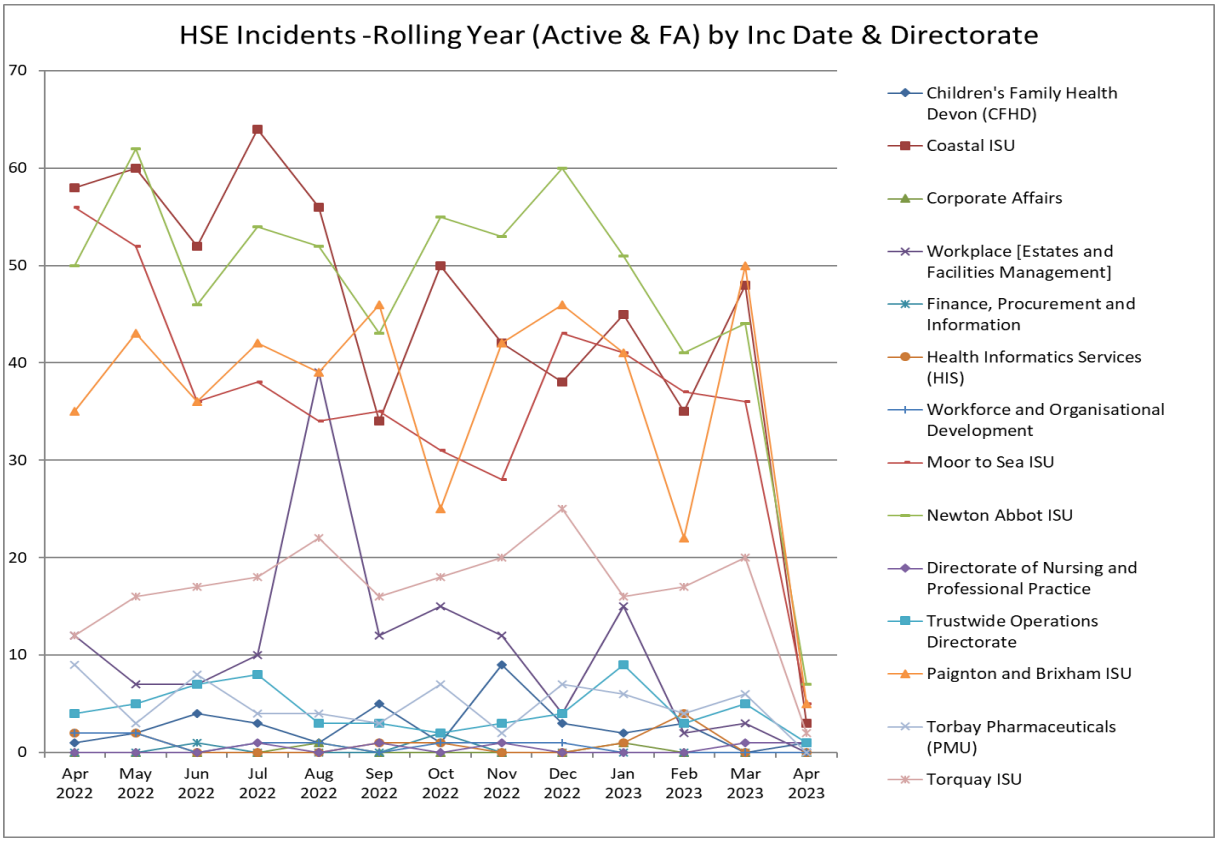


Chart 2



From the 14 directorates, one ISU showed a large increase in incidents, Paignton and Brixham showed an increase from 22 to 50, and the Coastal ISU also increased from 35 to 48.

Chart 3

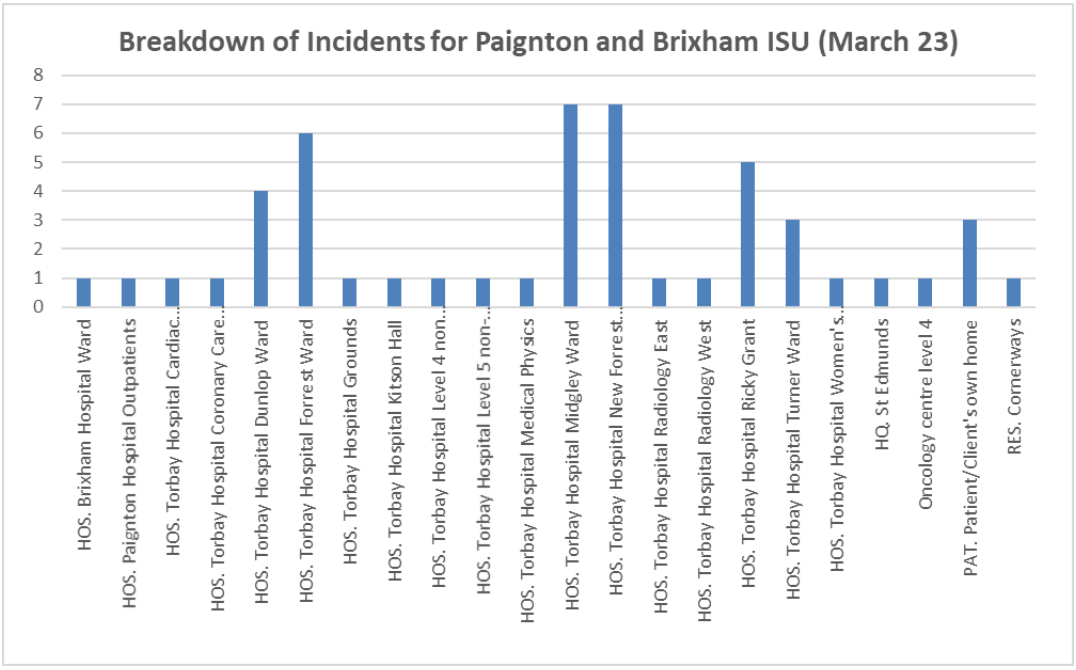


Chart 4

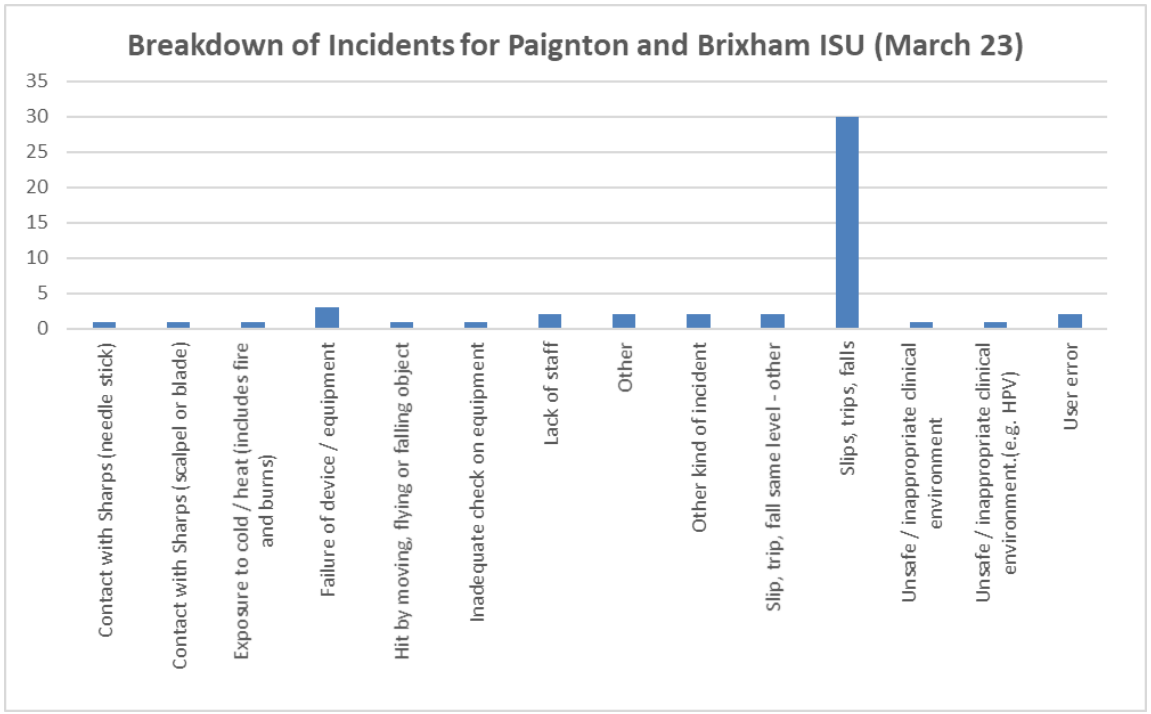


Chart 5

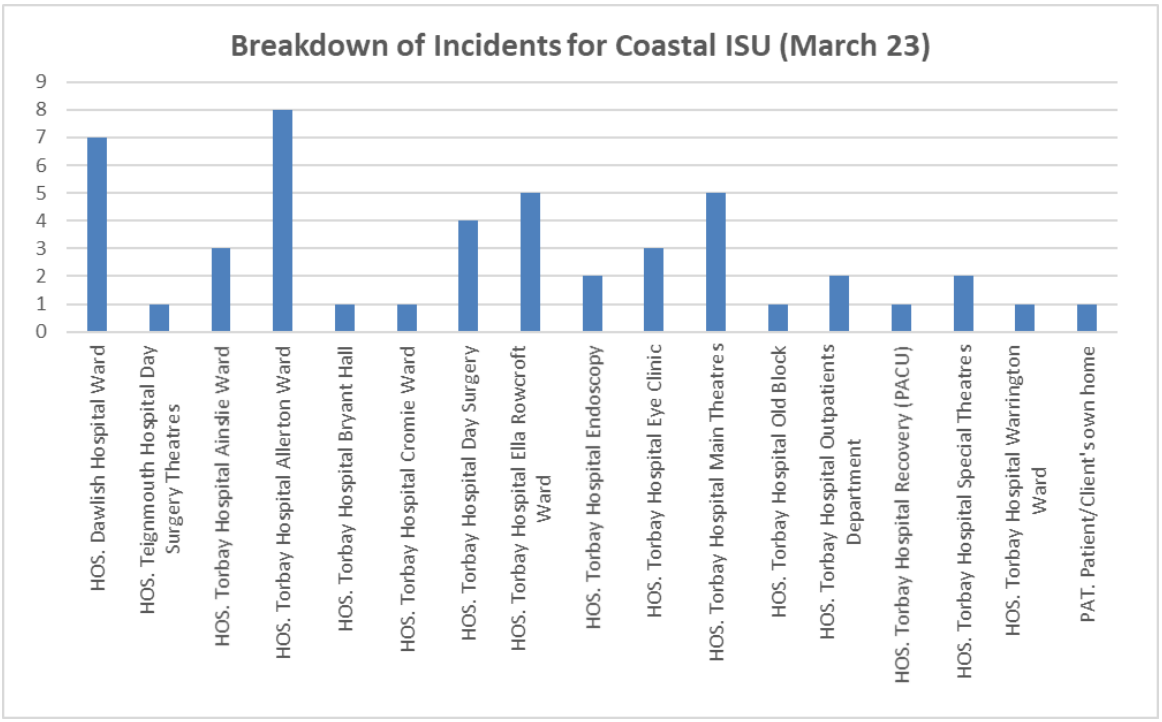
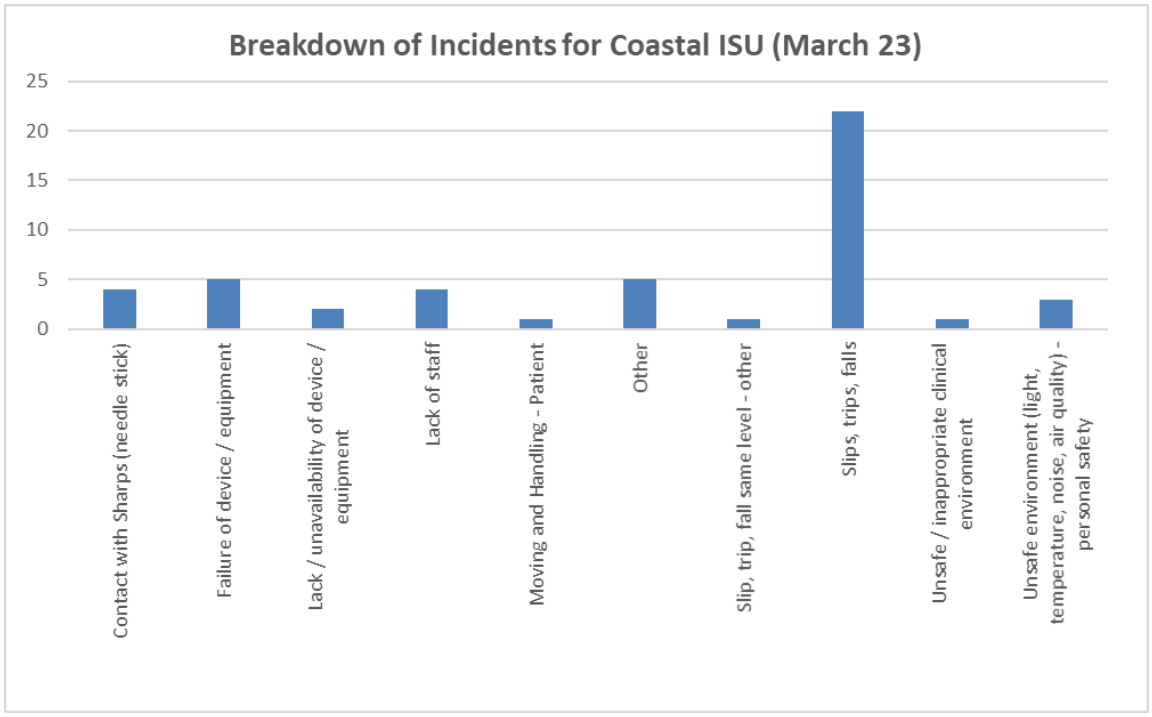


Chart 6

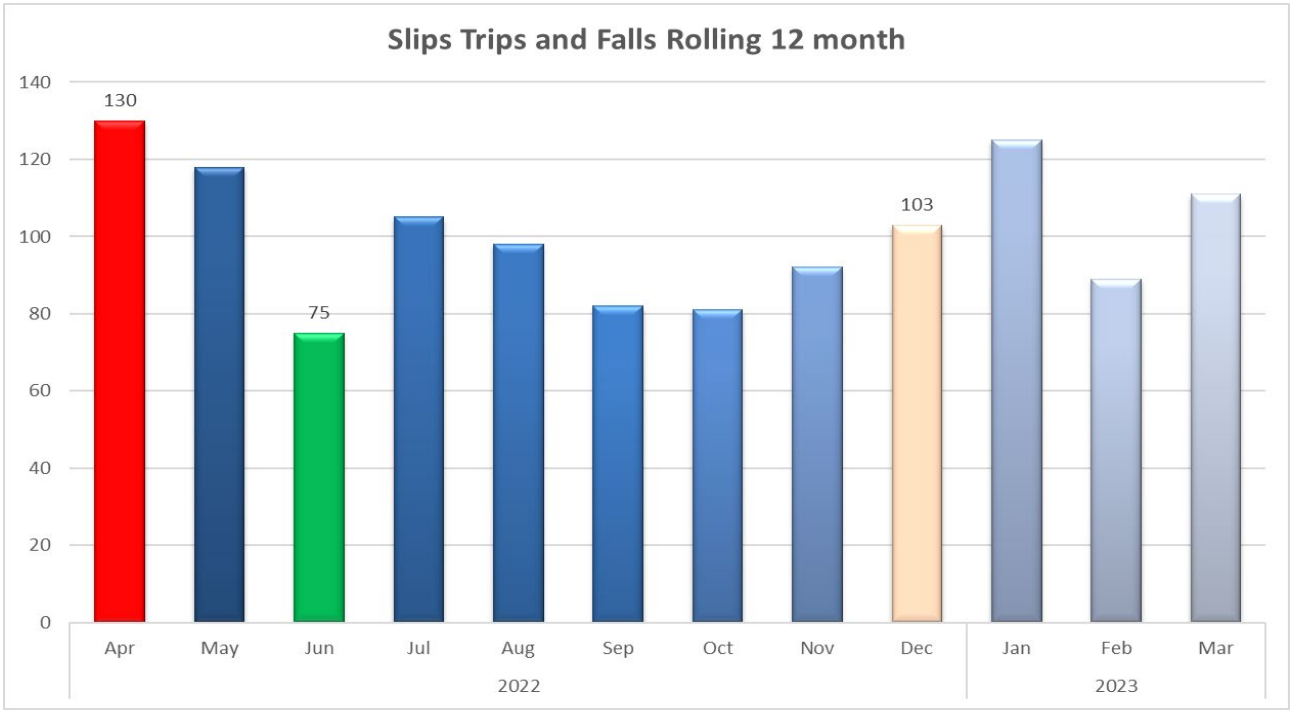


2. Key Issues

2.1 Slips, Trips and Falls (STF)

March had a 12% increase in recorded slips trips and falls. Up from 86 to 111, with a monthly average of 101 incidents.

Chart 7



During March 2023, 55 of these Slip, trip and fall incidents occurred in the top two ISUs, accounting for over half of the incidents recorded. A breakdown by location for each ISU can be seen in the charts below.

Chart 8

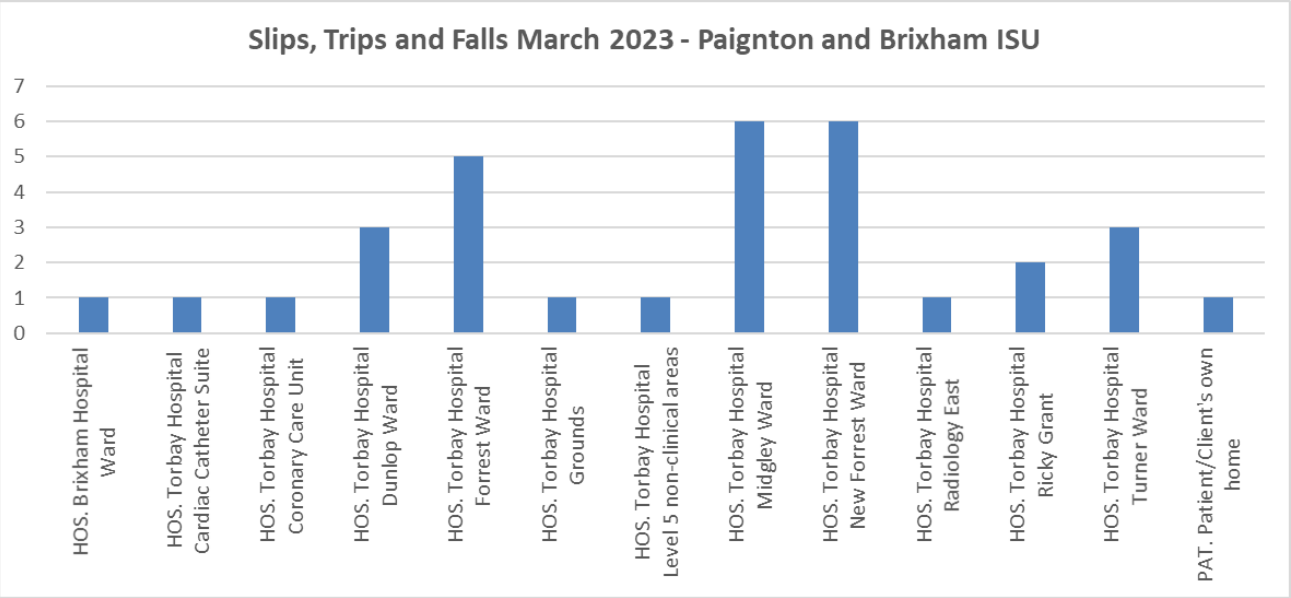


Chart 9

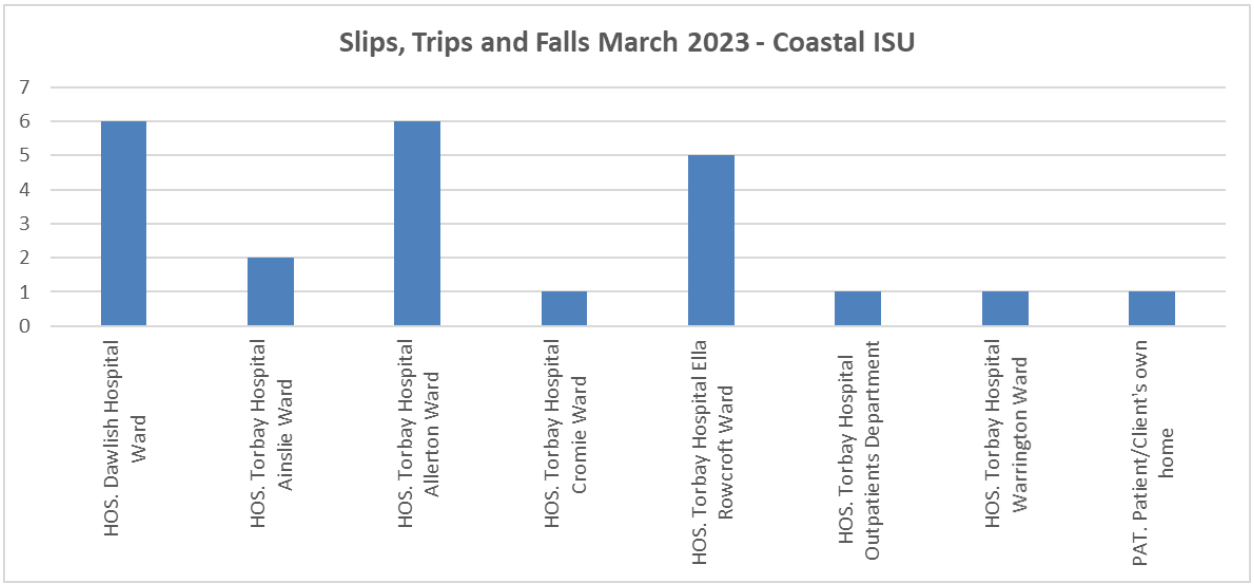


Chart 10

Break down of March's 111 STF incidents

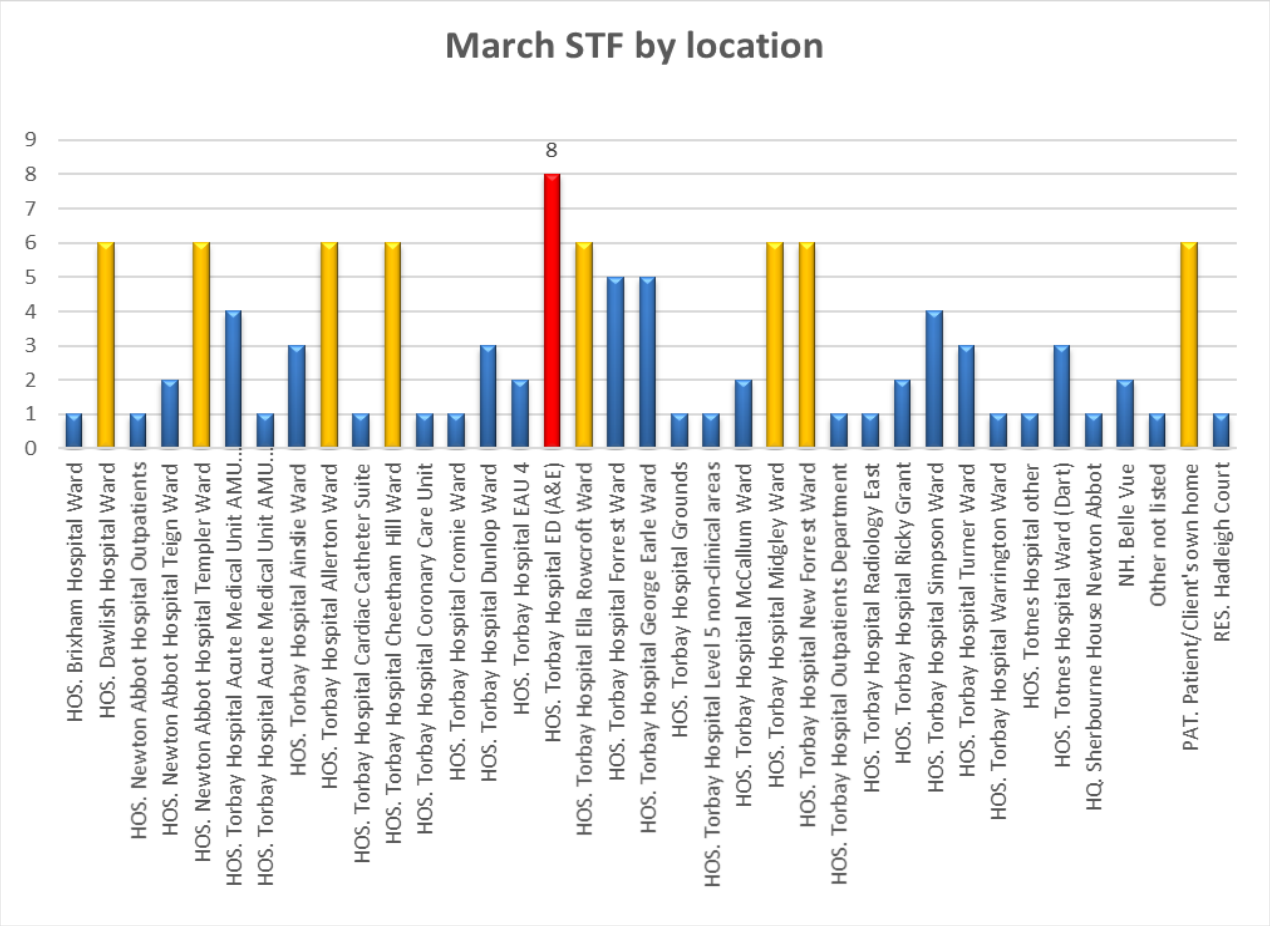


Chart 11

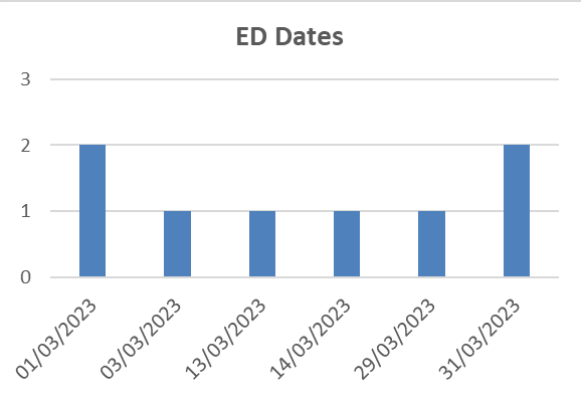
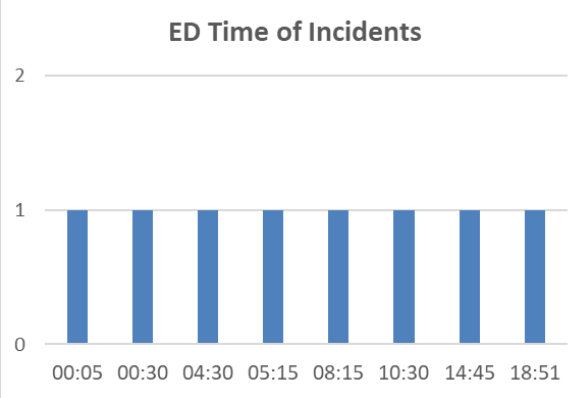


Chart 12



Key location for March, Emergency Department with a total of 8 Incidents, the 1st and 31st showed the largest incidents with 2 recorded each date, no coralation with incident times.

3.0 Manual Handling

March indicated a slight decrease in recorded patient incidents down by 1 from February, non-patient incidents stayed constant for the third month running.

Chart 13

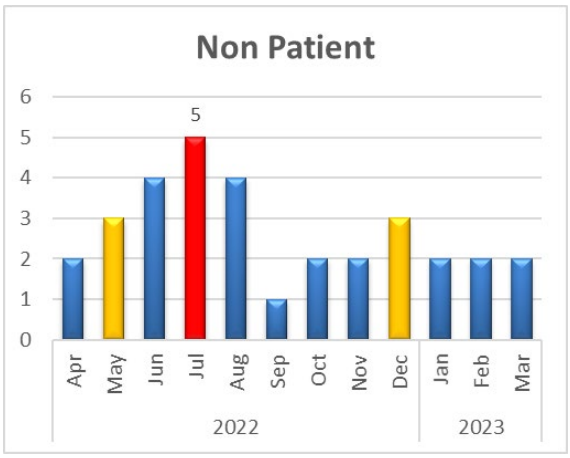
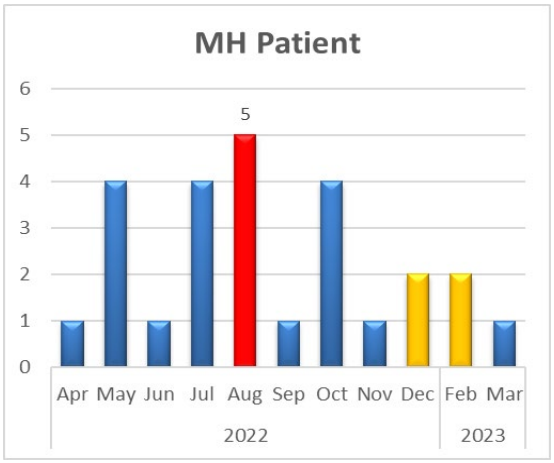


Chart 14



4.0 Sharps

Chart 15

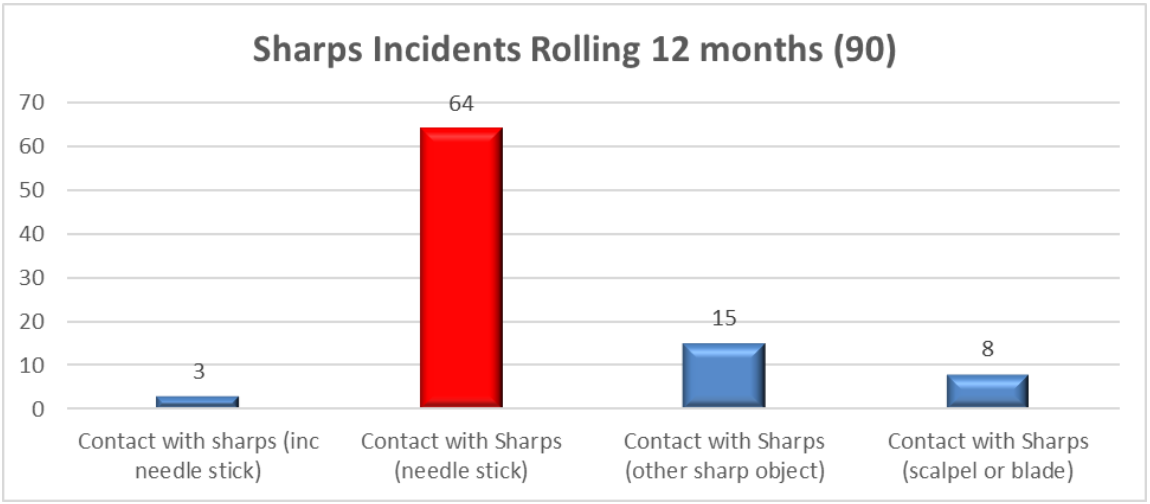
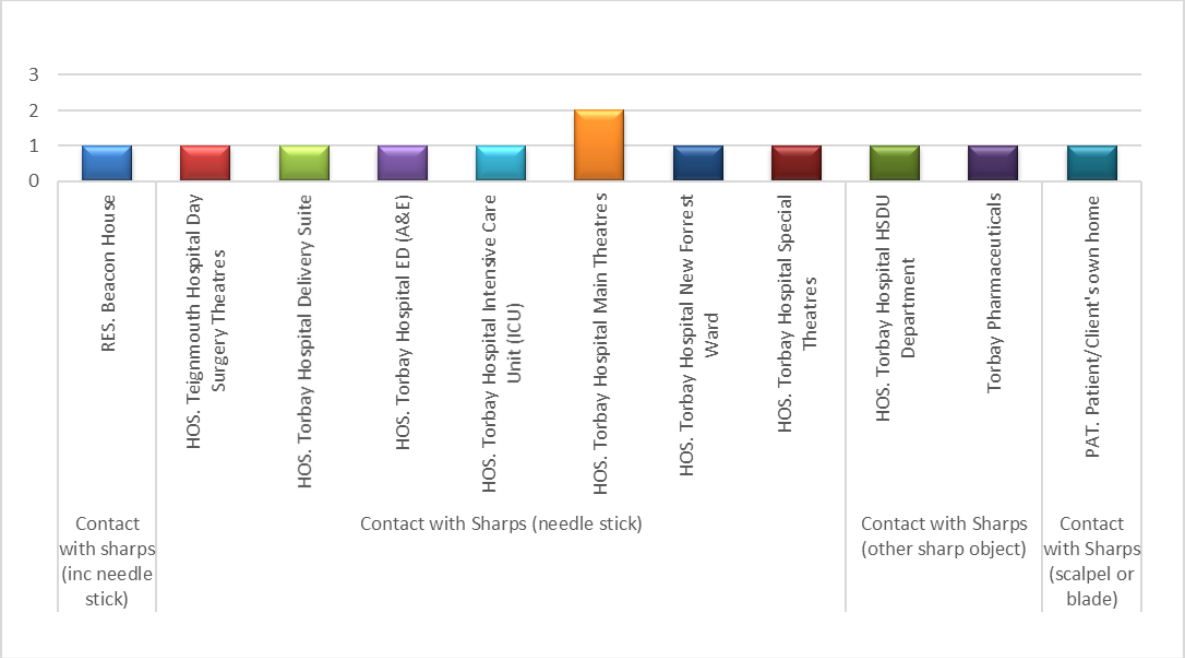


Chart 16

Sharps Breakdown for March



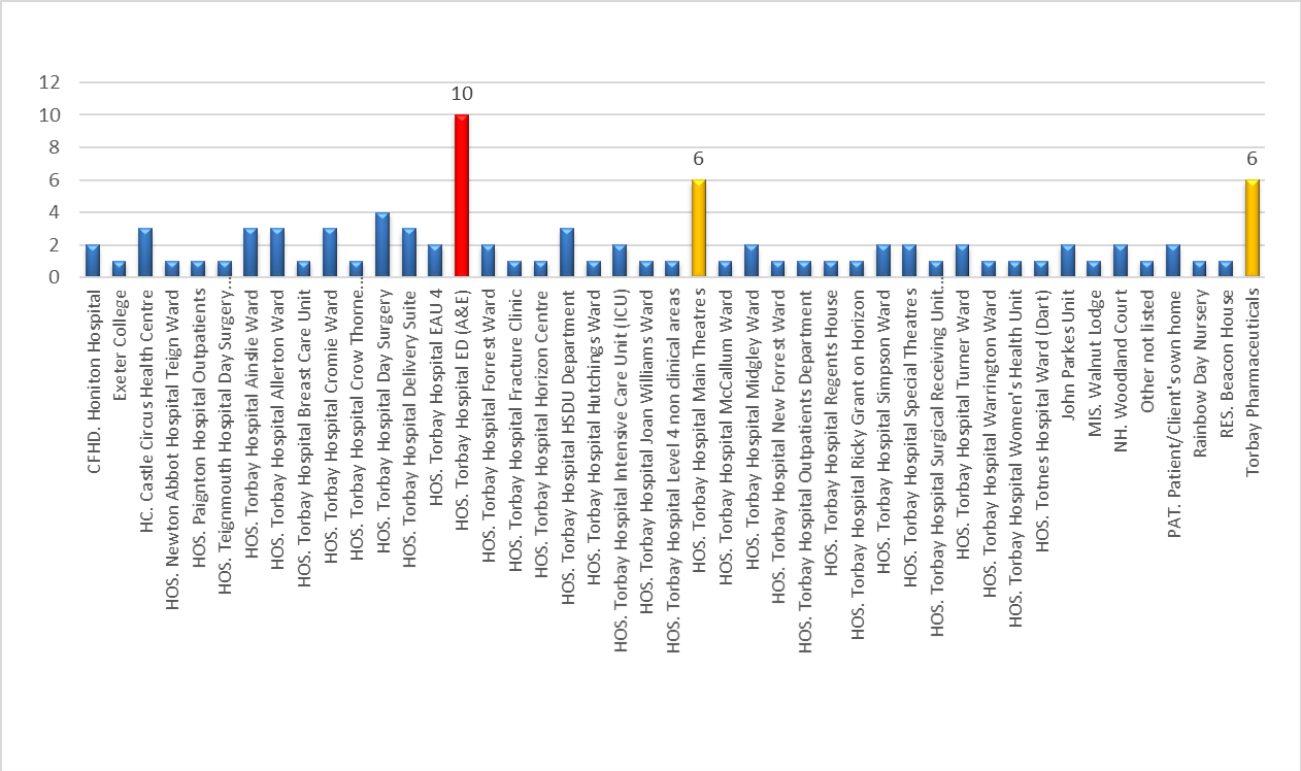
Note: The HSE have agreed to an extension for the second improvement notice relating to Training for the Trust to identify and implement the required changes.

Chart 17

Needle stick Incidents YDT

We are still seeing a high level in recorded events, this is concerning given the HSE involvement and the high profile of the safety sector.

Chart 18
Sharps incident locations YTD



5.0 COSHH

Chart 19

Breakdown YTD incidents – Exposure to a harmful substance

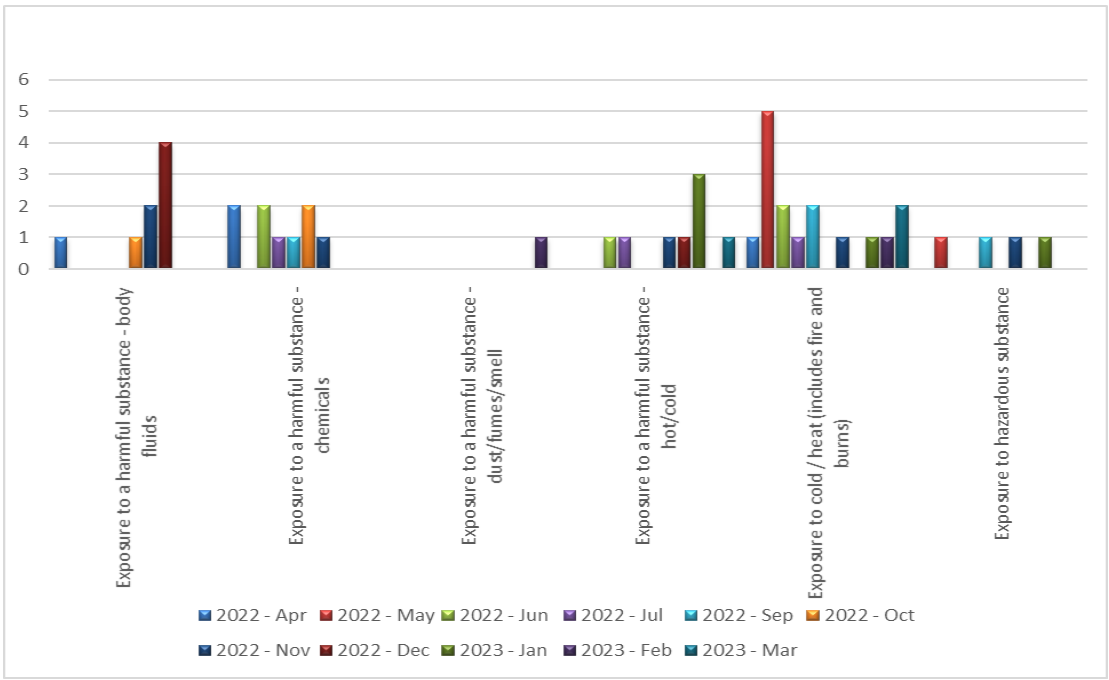


Chart 20

Exposure & Severity figures for March

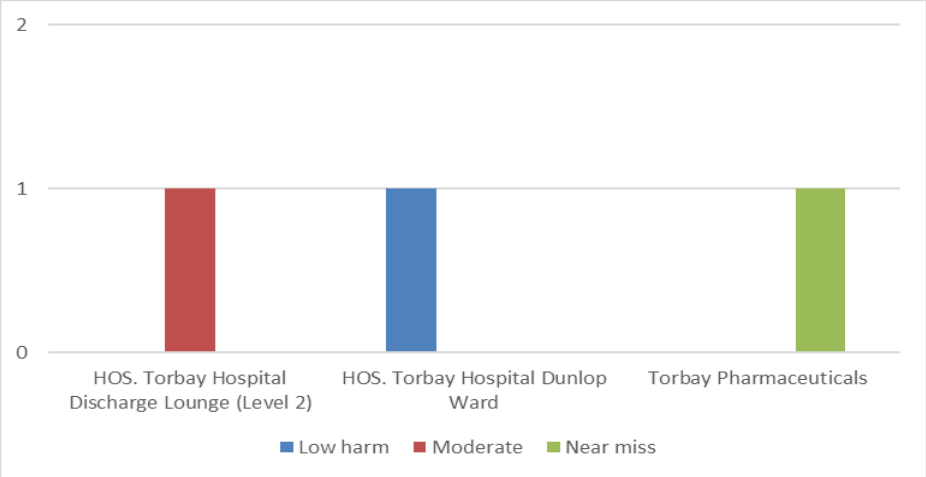
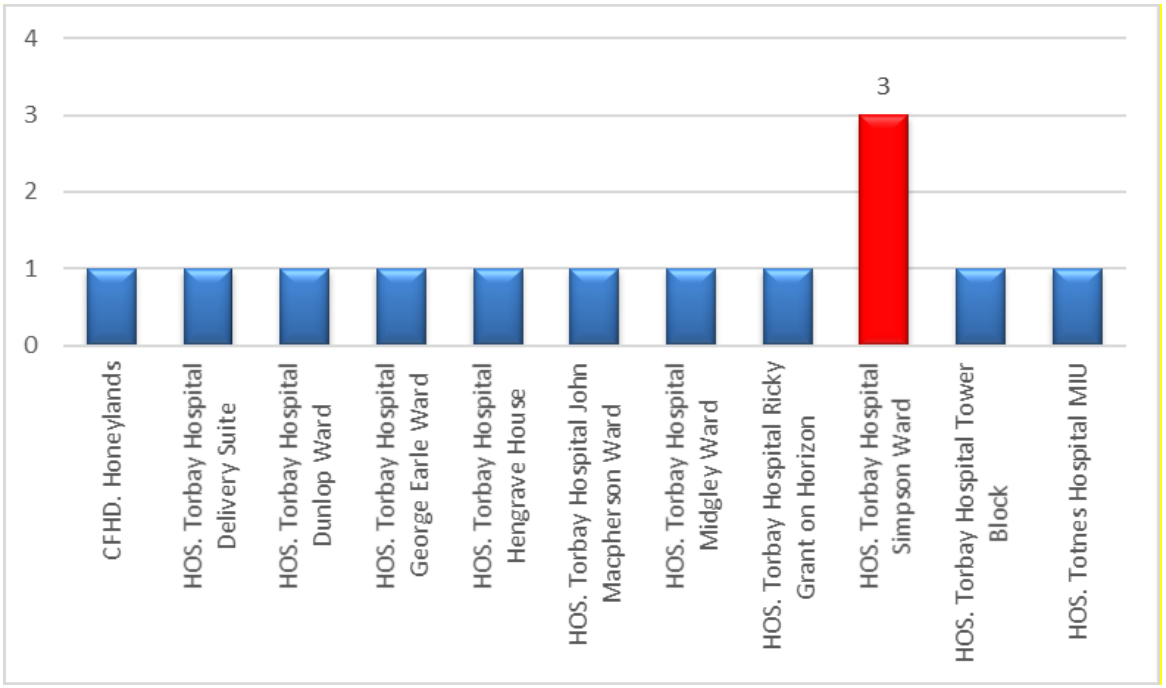


Table 2

Department	Specialty	Location (type)	Category	Sub category	Severity	Description
Discharge Lounge	Inpatient Nursing Adult (ACUTE)	HOS. Torbay Hospital Discharge Lounge (Level 2)	Accident/Injury (Including slips, trips and falls)	Exposure to cold / heat (includes fire and burns)	Moderate	During personal care this morning the HCA noted blistering and red mark son both inner thighs of a patient. On review I assessed that it looked like marks from a burn or scald. The patient had transferred to us yesterday evening. Handover did not say there had been any issue but on looking through the notes it states that whilst she was in the Discharge Lounge she spilled a hot drink and they applied a cold compress to her left leg.
Torbay Pharmaceuticals	Micro Lab	Torbay Pharmaceuticals	Accident/Injury	Exposure to a harmful substance - hot/cold	Near miss	I was sampling water from the POU in Prep1 (sterile manufacturing), when the tubing came away from the metal piping during the 80 degree flush. The tubing had not been secured to the piping with a clamp. The tubing came off when the air was blasted through at the end of the rinse. The water mostly missed me and only caught my leg. No burns or injury
Cardiology	Inpatient Nursing Adult (ACUTE)	HOS. Torbay Hospital Dunlop Ward	Accident/Injury (Including slips, trips and falls)	Exposure to cold / heat (includes fire and burns)	Low harm	Patient in bed 11- called over HCA (Katie) to see to the patient in bed 9. Patient had spilt her hot soup over herself. ? unsure how spilt/ mishandled.

6.0 Stress and working environment YTD

Chart 21



One recorded incident for March:

HOS. Torbay Hospital George Earle Ward	Welfare	Stress (e.g. unable to take break)	No harm	Turned up to the ward to serve short staffing/unsafe staffing numbers in place therefore unable to support patients with high care needs. Unable to take on the job role and fulfil patents needs at meal times too. Paperwork will not be fully done as 14 patients for one HCA is just unreasonable. As a staff member I feel deflated, exhausted and saddened, I would actually not want anyone of my relatives to be a patient at this time. This has to be looked into and fixed before something serious happens.

7.0 RIDDOR Reports

Table 3 - Current status – All assessment has now been reviewed

COVID RIDDOR UPDATE												
	11th April 2022	31st May 2022	30th June 2022	31st July 2022	31st Aug 2022	30th Sept 2022	31st Oct 2022	30th Nov 2022	31st Dec 2022	31st Jan 2023	28th Feb 2023	31st March 2023
2021 Incident Reviews Outstanding	1242	282	0	0	0	0	0	0	0	0	0	0
2022 Incident Reviews Outstanding	1546	579	0	0	0	0	0	0	0	0	0	0
Reports Due / Awaiting Details	70	22	305	218	130	8	4	3	1	0	0	7
Reported RIDDORS to the HSE (COVID)	24	20	35	87	158	12	0	3	0	0	0	0
Outstanding to be reported						44	3	2	1	0	0	7

We have had 4 retrospective incident reports for staff reporting positive for Covid during February and 3 new reports during March.

As reported last committee meeting, due to conflicting reports of staff absences the team began investigating staff sickness reporting (1st Dec 22 to beginning of March 23) to compare information to prevent another backlog to report to the HSE (which previously resulted in a HSE improvement notice to the Trust as per the table above).

The outcome of the investigation has shown that at present we have identified over 540 staff reporting sick due to Covid in this time period and of this 34 so far are known to be attributed to working practices and as such are reportable under RIDDOR but we only have 8 reports on Datix.

The Trust IPC reports daily regarding ongoing Covid updates in Trust locations and we are concerned that the disparity between Covid sickness and management process gaps will lead to HSE action once again.

The Corporate Safety Team is therefore requesting action from the Committee to ensure managers are aware and follow the relevant Management SOP.

8.0 Training February

IOSH – Managing Safely
1 course completed during March held for UHP 7 delegates attended
3 Dates available to book for TSDFT (3-day course): May 18-22; July 13-17; Sept 14-18

Fire Training
Current status - Trust wide:

- 400 Evacuation leads
- 196 Fire wardens
- 99 evacuation chair operatives
- 59 Albac Mat trained operatives
- 49 evacuation lift operators
- 3 Specialists to local area

New training dates for Evacuation Leads and Fire Wardens have been advertised on ICON News and can be booked on the HIVE for the remainder of 2023 – face to face once a month and supported by additional MS Teams courses.

9.0 Lost Working Time.

During March there were 5 recorded DATIX incidents that resulted in time off.

- 2 of the DATIX have no return date included
- The remaining 3 had a combined lost working time equal to 43 Days lost:
    - 1 incident employee off for 29 Days – Patient handling issue - Allerton Ward
    - 1 – 7-day absence incident STF – Simpson ward
    - 1 – 7-day absence – Covid – Cheetham Hill
- YTD Lost working days due to H&S issues 388
- Total of 33 Events, 20 of which are over 7 days which are reportable under RIDDOR

10.00 Key areas of concern - Top 5

Table 4

	Location	**Concerns**	**Assistance Required from Committee**
1	Histopathology	Building condition / extraction / storage of chemicals (DSEAR)	Capital funding identified as part of the BBF project for new build and work being completed currently to improve chemical storage although volumetric control remains an issue and needs to be addressed prior to relocation
2	Paignton Hospital incorporating Fairweather Green	Building condition / fire stopping / use of rooms	Identification of appropriate relocation for Clinical Engineering to complete maintenance and repairs to equipment (workshop)
3	Acute site – wards and corridors breaching fire regulations	Escape routes / use of rooms	Senior management to ensure room changes/refurbishment etc follow correct Trust processes as outlined in Trust Fire Policy Accountability for persistent offenders and enforcement criteria when breaches are identified
4	Hengrave Basement – storage breaching regulations	Building condition unsuitable for use as storage area	Resources allocated to assess records for ownership and relocation/disposal
5	Level 1 Basement office	Unsuitable for current use	Support to SUG for identification and prioritisation of relocation for teams based in this area

11.0 Fire

11.01 Audits / Fire Risk Assessments @ 95 % External Audit booked in for the 20th & 21st April

11.02 Active Fire related Incidents – All sectors indicating a reduction over 20021/22 figures

Chart 22

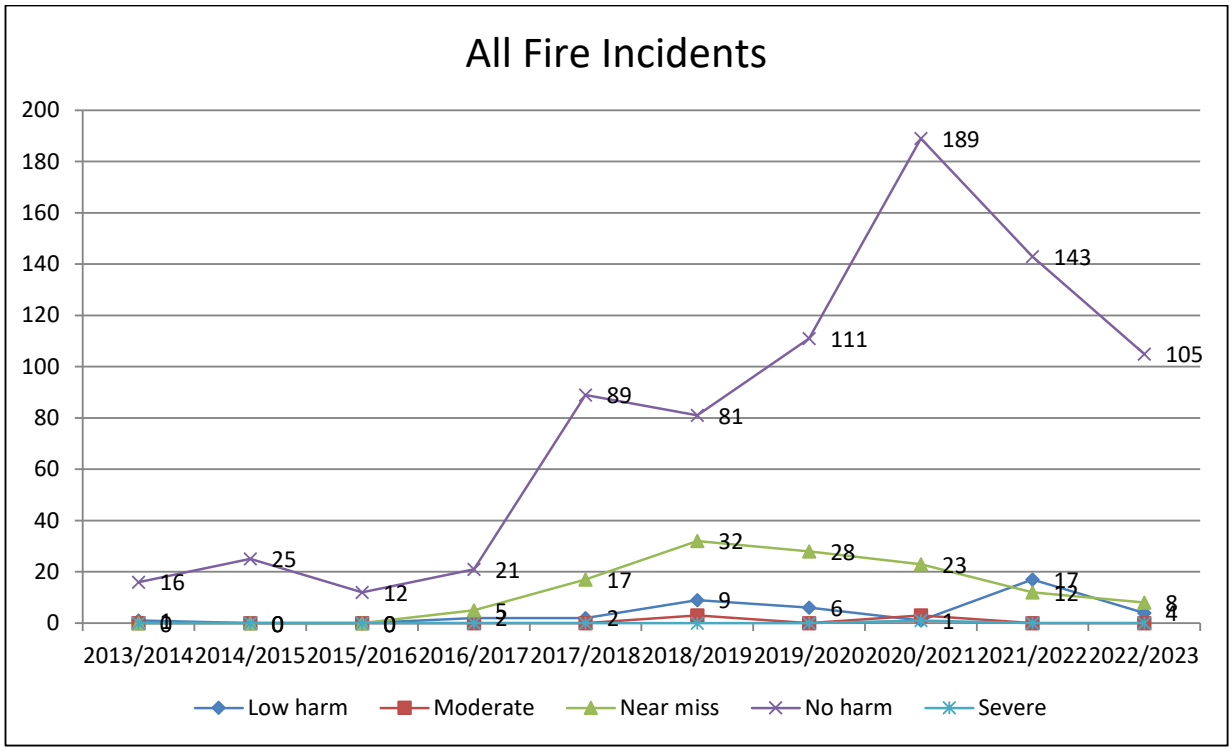


Chart 23 - YTD Breakdown of Fire Incidents

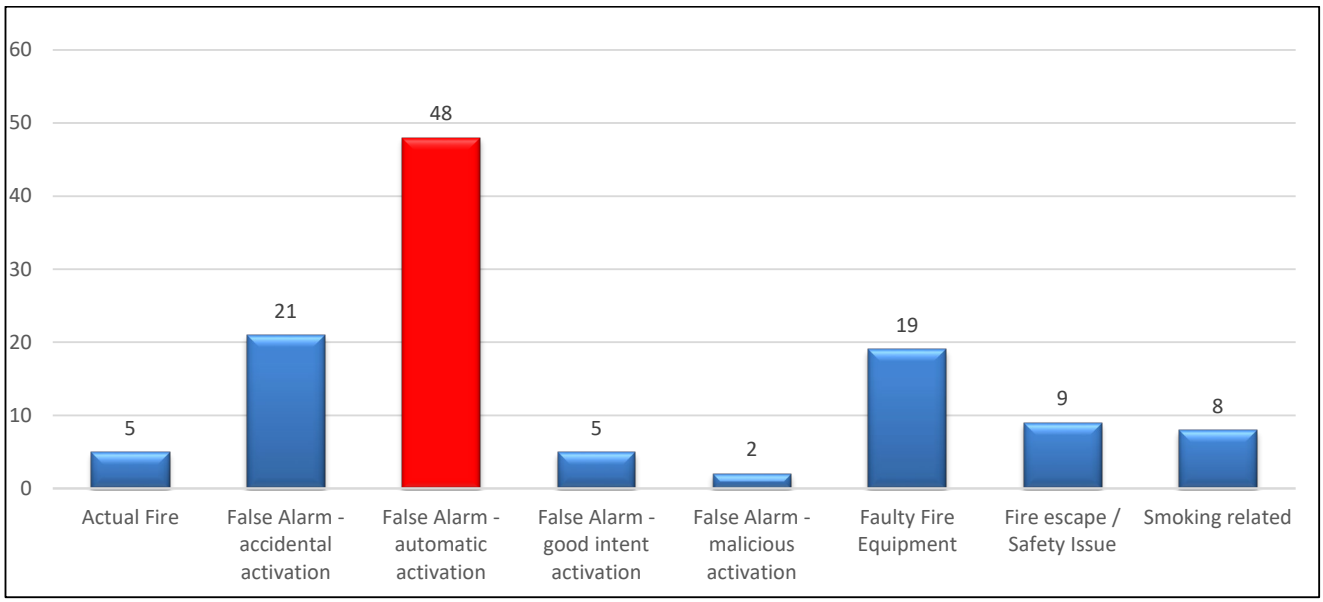


Chart 24 - Breakdown of the 48 False activations – Unwanted signals

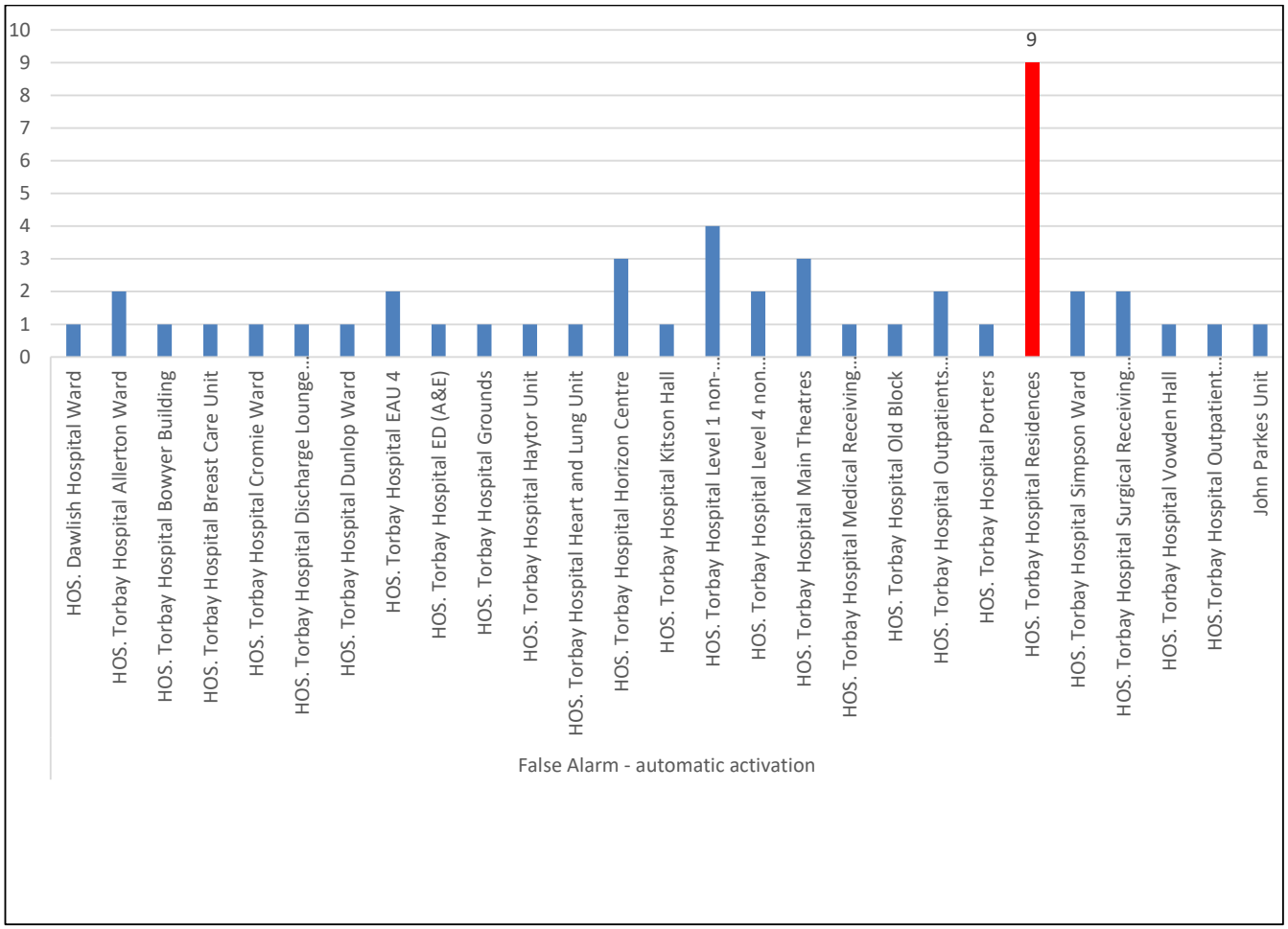


Chart 25 - Breakdown of the 9 Unwanted false activation in Hospital Residencies Time Frames

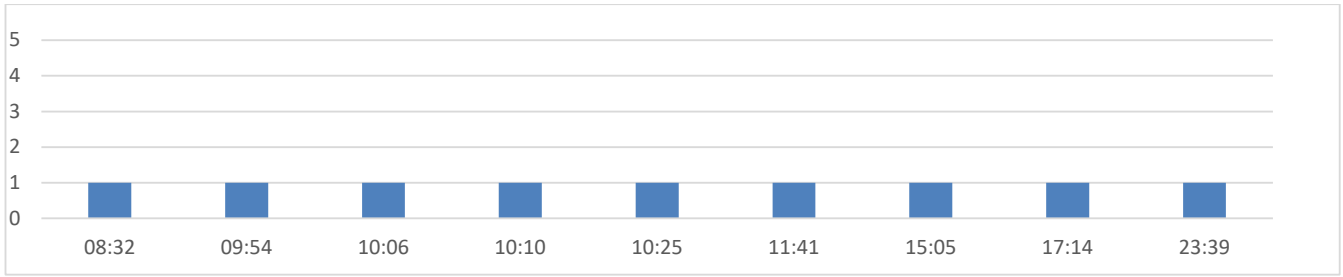


Chart 26 – Breakdown of Locations of fire Related Incidents YTD

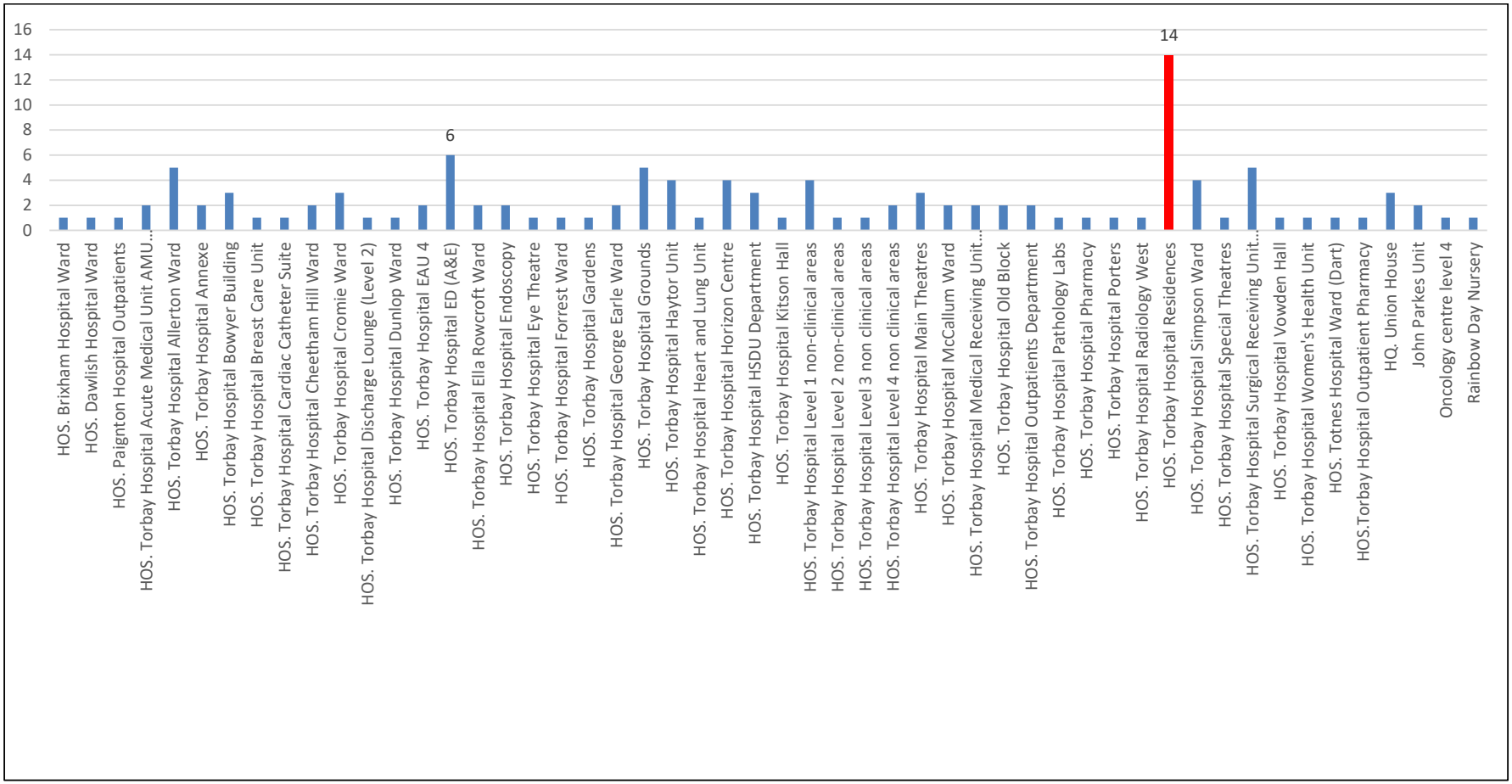


Chart 27 Breakdown of training locations, no change during March

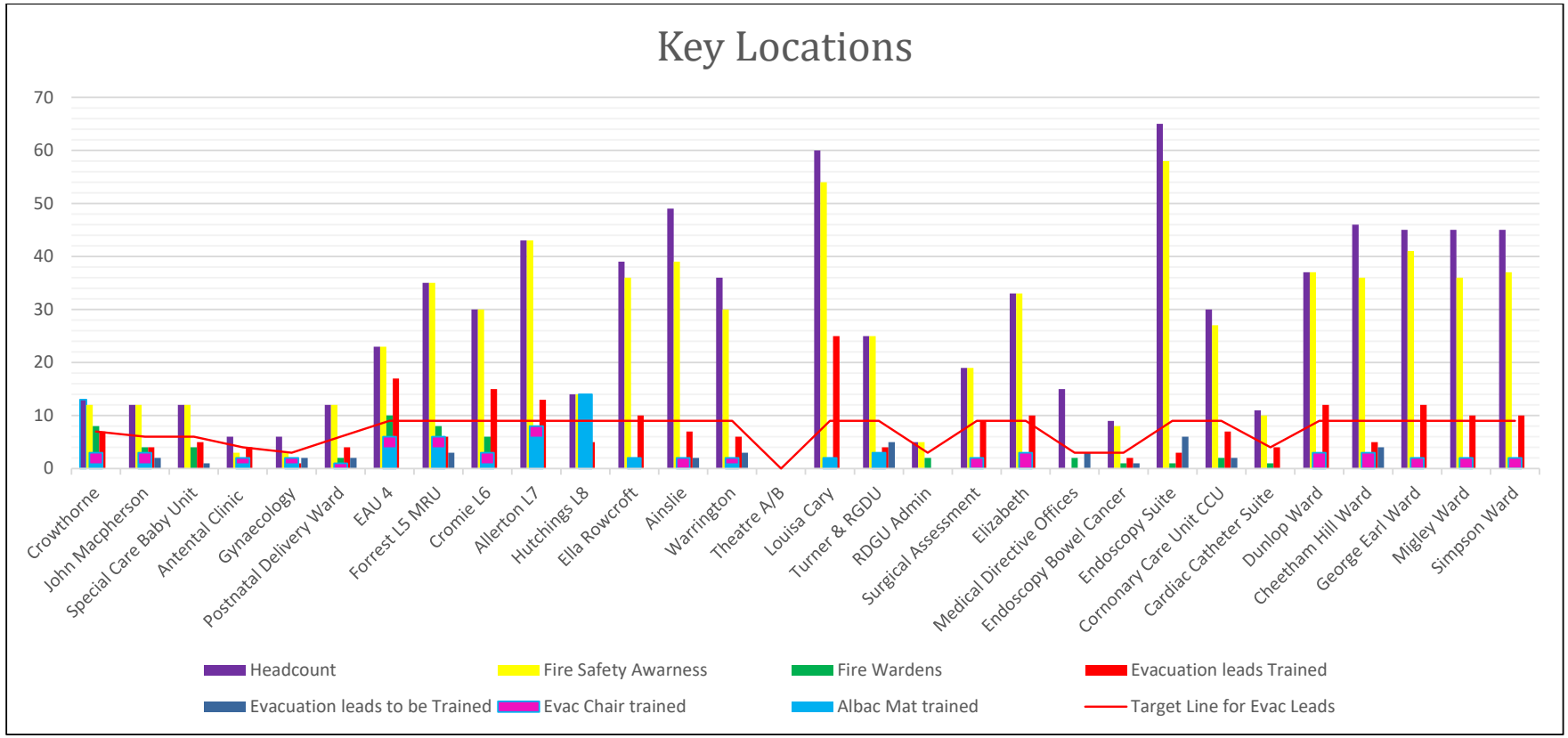
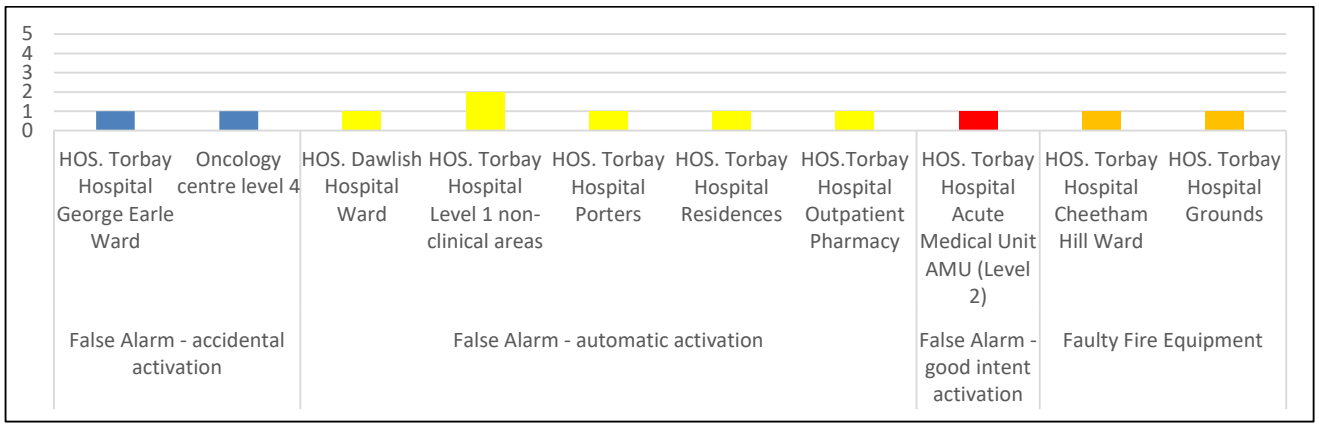


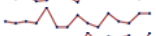
Chart 28 Break down of March fire related incidents



Key Points:

- AMU – Ongoing deviations from Fire Strategy due to operational demands
- Oxygen Bottles remaining on trollies in corridors when not in use
- Excess equipment cluttering corridors and evacuation routes
- Fire Audit 20th/21st April 2023 – all of the above will be picked up as non–compliance

EFM Performance Report

Workplace Services Performance Data March 2023 for April 2023 Report	2021-22 Quarter Four			2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			Trend	Totals to date	Average to date	Target 2022-23	RAG Threshold			Comments
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Total PPMs planned per month (not KPI)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	81	81	69	74	59		364	73	Variable				Not a KPI - an indicator of planned work volumes
PPMs planned per month											25	13	16	21	20		95	19	Variable				*Statutory
Statutory PPM % success against plan											100%	100%	100%	100%	100%			100%	97%	85%	85%	97%	
Routine PPMs planned per month											56	68	53	53	39		269	54	Variable				
Routine PPM % success against plan											100%	100%	100%	100%	100%			100%	90%	60%	60%	70%	
Total Reactive Requests per month (not KPI)	75	65	73	60	62	74	70	58	91	68	88	80	85	65	95		1109	74	Variable				Not a KPI - an indicator of reactive work volumes
Emergency - requests per month	5	4	5	4	12	2	2	8	4	2	9	5	4	9	9		84	6	Variable				Need line for reactive attended/completed on time
Non- Emergency - requests per month	70	61	68	56	50	72	68	50	87	66	79	75	81	56	86		1025	68	Variable				

EFM Performance Report

Workplace Services Performance Data March 2023 for April 2023 Report	2021-22 Quarter Four			2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			Trend	Totals to date	Average to date	Target 2022-23	RAG Threshold			Comments
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Total PPMs planned per month (not KPI)	1043	751	791	900	908	878	898	937	832	961	832	855	887	694	747		12914	861	Variable				Not a KPI - an indicator of planned work volumes
Statutory PPMs planned per month	494	331	354	375	387	372	456	380	338	415	350	397	415	280	307		5651	377	Variable				
Statutory PPM % success against plan	83%	99%	97%	98%	93%	96%	99%	91%	96%	98%	99%	98%	100%	99%	100%			96%	97%	85%	85%	97%	5 not completed
Mandatory PPMs planned per month	284	247	246	262	296	252	258	342	270	322	258	249	217	163	154		3820	255	Variable				
Mandatory PPM % success against plan	80%	78%	92%	99%	84%	97%	94%	87%	83%	85%	99%	99%	100%	100%	100%			92%	97%	85%	85%	95%	
Routine PPMs planned per month	265	173	191	263	225	254	184	215	224	224	224	209	255	251	286		3443	230	Variable				
Routine PPM % success against plan	49%	79%	73%	42%	63%	54%	79%	82%	80%	98%	100%	99%	100%	100%	100%			80%	90%	60%	60%	70%	
Total Reactive Requests per month (not KPI)	876	716	805	806	813	846	797	873	801	841	981	921	1074	837	832		12819	855	Variable				Not a KPI - an indicator of reactive work volumes
Emergency - P1 - requests per month	173	124	108	172	125	137	131	137	125	148	139	170	143	108	83		2023	135	Variable				
Emergency - % P1 completed in < 2hours	89%	95%	86%	100%	92%	100%	98%	96%	98%	99%	96%	99%	99%	99%	93%			96%	97%	90%	90%	95%	low in target completion rate is due to inaccurate data being inputted to the CAFM system by new member of staff.
Urgent - P2 - requests per month	158	161	178	160	170	184	198	170	179	181	205	213	217	163	175		2712	181	Variable				
Urgent – % P2 completed in < 1 - 4 Days	74%	76%	71%	65%	74%	92%	87%	79%	81%	90%	88%	82%	90%	86%	88%			82%	97%	85%	85%	90%	
Routine - P3 - requests per month	463	342	392	373	407	334	352	426	377	399	495	436	525	428	431		6180	412	Variable				
Routine - % P3 completed in < 7 Days	75%	71%	72%	65%	71%	90%	82%	75%	81%	78%	86%	80%	85%	84%	80%			78%	97%	75%	75%	85%	
Routine - P4 - requests per month	82	89	127	101	111	191	116	140	120	113	142	102	189	138	143		1904	127	Variable				
Routine - % P4 completed in < 30 Days	84%	76%	74%	66%	78%	54%	79%	74%	74%	72%	73%	74%	72%	75%				73%	97%	65%	65%	75%	P4 Routine will always be a month in arrears.
Estates Internal Critical Failures per month	2	1	3	1	1	1	0	1	0	1	1	1	0	1	0		14	0.9	0	2	1	0	
Fire Alarm Testing - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	126 Fire Alarm systems
Fire Alarm Remedials Outstanding	323	323	267	267	267	267	267	267	269	269	269	269	263	263	263		4113	274	Variable				Annual inspections completed, defects report to follow RCO is reviewing. Room ID works are in progress
Emergency Lighting - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	139 systems - Tested within month
Emergency Lighting Remedials Outstanding	0	0	0	0	0	0	0	0	30	30	TBC	59	6	9			134	10	Variable				28 Defects recorded - 19 Completed - 9 Outstanding [TBC]
Fire Extinguisher - % In date	99%	99%	99%	99%	99%	99%	99%	99%	99%	98%	99%	98%	99%	99%	99%		Stat	99%	97%	85%	85%	97%	139 Locations - 25 Locations require a test facility (key switch)
Fire Extinguisher Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				Rolling programme. No outstanding items
Fire Dry Risers - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	
Fire Dry Risers Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				Confirmation from Fire Safety Team on requirements with DFRS
Fire Hydrants - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	12 Hydrants
Fire Hydrants Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				
Fire Dampers - % In date	74%	74%	74%	74%	85%	85%	85%	85%	85%	85%	85%	85%	85%	86%	86%		Stat	82%	97%	85%	85%	97%	
Fire Dampers Remedials Outstanding	235	235	235	235	186	186	186	186	175	175	175	167	167	156	156		2855	190	Variable				Access works ongoing, to be completed prior to commencement of inspections
Fire Supression - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	3 Systems
Fire Supression Remedials Outstanding	0	0	0	0	1	1	0	0	1	1	0	0	0	0	0		4	0	Variable				
Fire Doors Inspections - % In date	84%	84%	84%	84%	86%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	95%	97%	85%	85%	97%	127 Locations - Inspections only
Fire Doors Compliance - % In date	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	11%	11%	19%	29%			12%	97%	85%	85%	97%	Updated information on FD replacement and repairs had not been provided at time of this report
Fire Doors Remedials Outstanding	950	950	950	950	950	950	950	950	950	950	950	940	940	853	746		13929	929	Variable				42 FD replaced, 45 FD repaired [61 FD in manjfacture and a further 107 FD's in process of being repaired]
Fixed Wire Testing - % In date	84%	84%	84%	86%	87%	88%	88%	88%	89%	89%	90%	90%	90%	90%	91%		Stat	88%	97%	85%	85%	97%	Enerveo are on-site, confirming programme and commencement date.
Fixed Wire Remedials Outstanding	272	272	272	272	272	272	272	272	895	895	895	895	895	895	895		8441	563	Variable				All C1 remedials have been addressed. C2 391 & FI's 504 [213 completed]
Portable Appliance Testing - % in date	99%	99%	99%	99%	99%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Mand	100%	97%	85%	85%	95%	Year 3 PAT Inspection areas in progress.
Portable Appliance Testing Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				Contract on programme schedule.
HV Equipment Testing - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	HV Substation rolling programme, coinciding with Gen Testing
HV Equipment Remedials Outstanding	0	0	0	0	2	1	1	1	1	1	1	1	1	1	1		12	1	Variable				Sub 3: Tx fins, LV ACB require replacement, programme to be arranged
Generator Service & Load Bank Test - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Mand	100%	97%	85%	85%	95%	Annual Load Bank & Service. On programme.
Generator Service & Load Bank Remedials O/S	0	0	0	0	1	1	1	1	1	1	1	1	1	1	1		11	1	Variable				Gen 7 exhaust stack split - Remedial to be covered under warranty Contractor will address under maintenance visit
Generator Monthly Load Test - % In date	100%	100%	100%	87%	100%	87%	87%	87%	87%	87%	100%	100%	77%	100%	100%		Mand	93%	97%	85%	85%	95%	Monthly Testing - 13 Generator's (Plus 2 PFI) Genset 2 now replaced with new 1650kVA generator.
Generator Monthly Load Test Remedials O/S	0	0	0	1	0	0	0	0	0	1	0	0	0	0	2		4	0	Variable				Auto transfer units for Sub 3 (Haytor); Replacement designed and agreed. Motorised switch for mains return in ICU: Specialist contractor reviewing issue as
Lightning Protection - % In date	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%		Stat	95%	97%	85%	85%	97%	3 Systems to be tested after new building have been completed.
Lightning Protection Remedials Outstanding	1	0	0	0	1	0	0	0	3	3	3	3	3	3	3		23	2	Variable				Specialist Contractor working with KIER expected to complete in March. DPT work has commenced.
Auto Door Inspection - % In date	99%	99%	99%	99%	99%	99%	99%	99%	99%	98%	94%	94%	100%	100%	100%		Mand	98%	97%	85%	85%	95%	Web portal access gained.

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Appendix 2 - Workplace Compliance Dashboard.xlsx

EFM Performance Report

Workplace Services Performance Data March 2023 for April 2023 Report	2021-22 Quarter Four			2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			Trend	Totals to date	Average to date	Target 2022-23	RAG Threshold			Comments
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Auto Door Remedials Outstanding	0	0	0	0	1	0	0	0	1	0	0	0	1	1	1		5	0	Variable				[Last 90 days] 63 maintenance visits, 3 repairs, 24 call-outs. ICU requires part - not resolved.
LEVs Testing - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	All current identified LEV's have been inspected. These sre Due in June 2023 I am in the process of arranging the 2023 inspections
LEVs Testing Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				All satisfactory
Critical Vent Verification - % In date	98%	98%	94%	94%	96%	96%	91%	94%	92%	90%	96%	95%	96%	98%	98%		Stat	95%	97%	85%	85%	97%	Theatres A & B due verification MAT air booked in for April 26th 2023.
Critical Vent Remedials Outstanding	242	242	242	233	221	216	96	96	90	90	87	58	74	55	52		2094	140	Variable				Critical ventilation remedials now 74 decreased from 117
Kitchen + Extract Duct Cleaning - % In date	100%	100%	100%	13%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	94%	97%	85%	85%	97%	This is due in June (quotoation received from Cleaning Concerns for the 2023 clean)
Kitchen + Extract Duct Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				
Gas Protection systems - % In date	88%	88%	88%	88%	88%	88%	88%	95%	96%	100%	100%	100%	100%	100%	100%		Stat	94%	97%	85%	85%	97%	
Gas Protection Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				
Gas Appliance - % In date	100%	100%	97%	97%	100%	97%	97%	98%	100%	100%	100%	100%	100%	100%	100%		Stat	99%	97%	85%	85%	97%	
Gas Appliance Remedials Outstanding	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0		3	0	Variable				
Landlord Gas Appliances - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	Awaiting reports from Lorne Stewart
Landlord Gas Appliance Remedials Outstanding	0	0	0	0	0	0	0	0	0	3	0	18	18	18	18		75	5	Variable				18 Remedial works. - replace 14 ignition probes - 1 x Boiler replacement Flat 18
Pressure Systems inspection - % In date	93%	94%	94%	93%	95%	96%	93%	93%	93%	94%	100%	100%	100%	100%	98%		Stat	96%	97%	85%	85%	97%	J.Bowzen- 3 x CO Detectors Purchase Order beine raised bv MW One steam S/Valve in Heth E plantroom one S/V in HSDU- Awaiting confirmation from Mel Ford regardiong 2 inspection reports from contractors HSDU/Endoscopy
Pressure Systems Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				Allianz PSSR inspector due to carry out in service inspection on Heth E R/Hand
LOLER Lifts Safety Checks - works % in date	100%	100%	97%	97%	100%	100%	100%	100%	97%	96%	100%	100%	100%	100%	100%		Stat	99%	97%	85%	85%	97%	DHW Calorifier
LOLER Lifts Safety Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0		1	0	Variable				
LOLER Lifting Appliances - works % in date	90%	90%	90%	90%	90%	91%	91%	91%	91%	90%	91%	91%	94%	94%	95%		Stat	91%	97%	85%	85%	97%	Manual Checks/records reflect 95% compliance - Prime Portal indicticating 53% this is due to inspection records not being forwarded onto LMP..
LOLER Lifting Appliances Remedials Outstanding	0	0	0	0	0	0	0	0	0	5	0	0	0	0	1		6	0	Variable				Beech unit Bath Lift -Medical Electronics Carry ing out the repair
Water Safety Checks - works % in date	99%	99%	95%	86%	97%	99%	99%	100%	100%	99%	100%	97%	99%	97%	97%		Stat	98%	97%	85%	85%	97%	PPM task failure is in the Community Estate
Water Safety Remedials Outstanding	11	13	73	178	148	221	642	777	578	312	288	296	268	238	317		4360	291	Variable				Acute - All PPM carried out. 18 new remedials this month, 85 completed, 268 outstanding of which 201 are related to cold water failures. remedial completion
Window & Restrictor Insp - % In date	91%	90%	91%	92%	94%	95%	95%	96%	96%	75%	100%	100%	100%	100%	100%		Mand	94%	97%	85%	85%	95%	Inspections only, window condition survey is independent to this functional test
Window & Restrictor Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				
Asbestos Inspections - % in date	98%	97%	97%	97%	97%	97%	98%	95%	95%	98%	100%	100%	100%	93%	88%		Stat	97%	97%	85%	85%	97%	Acute 100% / Community 85%
Asbestos Inspection Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	6	5		11	1	Variable				Outstanding - Albany Street, Kings Ash - Planned for April. Bovey, Union House, Brixham part. Paignton part awaitine dates. Shrublands new buildine to be added to
Edge Protection inspection - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	Edge Protection condition and requirements
Edge Protection Remedials Outstanding	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0		1	0	Variable				Inspections have commenced, a number of recommendations are expected
Fixed Ladder Inspection - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	Fixed ladder Inspections
Fixed Ladder Inspection Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3		6	0	Variable				Carried out by external contractor
Site Safety Audits - % in date														68%	76%		Stat	72%	97%	85%	85%	95%	Added for March 2023
Current Red Status Safety Reports Outstanding														3	1		4	2	Variable				Teignmouth zone 6
Site Safety Audits Remedials Outstanding														118	119		237	119	Variable				Acute and Community Sites
No of Med Devices for Scheduled Service (in month)	1132	993	941	1133	1073	1128	1021	1026	1094	1516	1196	1178	1338	1546	1096		17411	1161	Variable				Included from Oct 2022.
% of COMPLETED Planned Work (in month)	81%	84%	87%	77%	74%	67%	68%	75%	70%	82%	85%	92%	97%	94%	95%		PPM	82%	97%	70%	70%	80%	
PPM not completed / to be done with due date less than 2 months as a percentage of all outstanding PPM	34%	30%	27%	12%	34%	40%	31%	35%	46%	81%	30%	27%	13%	9%	3%		PPM	30%	97%	30%	30%	20%	provides assurance that outstanding Schedule Service Work Requests are monitored & under control within a defined time frame
PPM not completed / to be done over rolling 3 year period as a percentage of all PPM released.	0%	0%	0%	0%	0%	0%	0%	0%	9%	4%	5%	2%	0%	1%	1%		PPM	1%	97%	10%	10%	5%	(over rolling 3 year period)2 - this provides a realistic measure as there are medical devices with a 3 vear schedule service cvcle
No of Devices not found for PPM (for info)	483	456	344	344	344	352	330	415	171	464	484	452	230	230	427		5526	368	Variable				
No of incidents involving Medical Devices (for info)	4	2	1	1	1	1	1	2	20	23	0	5	3	3	2		69	5	Variable				
Total Reactive Requests per month	#N/A	376	745	1356	501	753	681	1497	415	652	1008	900	1048	495	687		11114	794	Variable				Not a KPI - an indicator of reactive work volumes
Emergency - requests per month		6	4	8	8	21	5	1000	1	3	16	5	1	2	1		1081	77	Variable				Aug 22 peak due to large number of devices affected by FSN's being actioned – user/service information uodate
Emergency - % completed in < 1 working day	96%	97%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			99%	97%	85%	85%	95%	
Urgent - requests per month		160	371	288	60	300	117	96	142	370	460	500	344	244	283		3735	267	Variable				Numbers from Nov 22 onwards
Urgent – % completed in < 3 working days	100%	100%	100%	100%	100%	96%	100%	100%	100%	99%	100%	100%	100%	100%	99%			100%	97%	80%	80%	90%	
Routine - requests per month		210	370	1060	433	432	559	401	272	279	532	395	703	249	403		6298	450	Variable				April 22 - large hit on service events due to low valued/simple devices being checked.
Routine - % completed in < 10 working days	98%	98%	97%	98%	100%	95%	100%	100%	100%	99%	100%	100%	96%	98%	98%			98%	97%	80%	80%	90%	

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Workplace Services Performance Data March 2023 for April 2023 Report	2021-22 Quarter Four			2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			Trend	Totals to date	Average to date	Target 2022-23	RAG Threshold			Comments
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
FR1 - Weekly - Torbay Hosp ICU, ED, Oncol, Thtrs				5.00	5.00	5.00	5.00	5.00	4.93	4.97	5.00	5.00	4.90	5.00	5.00			4.98	5	3	3	4	Weekly Audits - Target - 98% completed each week
FR1 - Weekly - Torbay Hosp OPD				5.00	5.00	5.00	5.00	5.00	4.57	5.00	4.98	4.90	4.80	5.00	5.00			4.94	5	3	3	4	Weekly Audits - Target - 98% completed each week
FR1 - Weekly - Newton Abbot Oncology, UTC				5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	4.70	5.00	5.00			4.98	5	3	3	4	Weekly Audits - Target - 98% completed each week
FR1 - Weekly - Totnes Hosp MIU				5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	4.70	5.00	5.00			4.98	5	3	3	4	Weekly Audits - Target - 98% completed each week
FR1 - Weekly - Dawlish Hosp MIU				5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			5.00	5	3	3	4	Weekly Audits - Target - 98% completed each week
FR1 - Weekly - Teignmouth Hosp Theatre				5.00	5.00	5.00	5.00	5.00	5.00	4.99	5.00	5.00	5.00	5.00	5.00			5.00	5	3	3	4	Weekly Audits - Target - 98% completed each week
FR2 - Monthly - Torbay Hosp Wards, CCU, Xray				5.00	5.00	5.00	5.00	5.00	4.69	4.88	5.00	5.00	4.90	5.00	5.00			4.96	5	3	3	4	Monthly Audits - Target - 95% completed each Month
FR2 - Monthly - Torbay Hosp OPD Phrmcy, Eye Cl				5.00	5.00	5.00	5.00	5.00	5.00	4.93	5.00	5.00	4.80	5.00	5.00			4.98	5	3	3	4	Monthly Audits - Target - 95% completed each Month
FR2 - Monthly - Newton Abbot Wards, Maternity				5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	4.30	5.00	5.00			4.94	5	3	3	4	Monthly Audits - Target - 95% completed each Month
FR2 - Monthly - Brixham Hosp Ward				5.00	5.00	5.00	5.00	5.00	4.89	5.00	5.00	5.00	4.10	5.00	5.00			4.92	5	3	3	4	Monthly Audits - Target - 95% completed each Month
FR2 - Monthly - Totnes Hosp Ward				5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			5.00	5	3	3	4	Monthly Audits - Target - 95% completed each Month
FR2 - Monthly - Dawlish Hosp Ward				5.00	5.00	5.00	5.00	5.00	4.78	5.00	5.00	5.00	5.00	5.00	5.00			4.98	5	3	3	4	Monthly Audits - Target - 95% completed each Month
FR2 - Monthly - Paignton H+WBC Oncology				5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	4.70	5.00	5.00			4.98	5	3	3	4	Monthly Audits - Target - 95% completed each Month
FR2 - Monthly - Ashburton Hosp Treatment Room				5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			5.00	5	3	3	4	Monthly Audits - Target - 95% completed each Month
FR3 - Bi-Monthly - Torbay Hosp Dental, Day Units				5.00		5.00		5.00		4.88		4.92		5.00				4.97	5	3	3	4	Bi-Monthly Audits - Target - 90% completed each 2 Month period
FR3 - Bi-Monthly - Torbay Hosp, OPD Pharm,				5.00		5.00		5.00		4.73		4.91		5.00				4.94	5	3	3	4	Bi-Monthly Audits - Target - 90% completed each 2 Month period
FR4 - 4-Monthly - Torbay Hosp - Rms, Audiology				5.00				5.00				4.85		5.00				4.96	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
FR4 - 4-Monthly - Torbay Hosp access wait areas				5.00				5.00				4.95	5.00	5.00				4.99	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
FR4 - 4-Monthly - Newton Abbt access wait areas				5.00				5.00				5.00						5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
FR4 - 4-Monthly - Brixham Hosp access wait areas				5.00				5.00				5.00						5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
FR4 - 4-Monthly - Totnes Hosp access wait areas				5.00				5.00				5.00						5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
FR4 - 4-Monthly - Dawlish Hosp access wait areas				5.00				5.00				5.00						5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
FR4 - 4-Monthly - Teignmth Hosp access wait areas				5.00				5.00				4.95						4.98	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
FR4 - 4-Monthly - Paigntn H+WBC access wait areas				5.00				5.00				5.00						5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
FR4 - 4-Monthly - Ashburton Access Waiting Areas				5.00				5.00				5.00						5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
FR5 - 6-Monthly - Torbay, MDSS, Chapel, PTS Vehs				5.00						5.00								5.00	5	3	3	4	6 Monthly Audits - Target 80% completed each 6 months
FR5 - 6-Monthly - Torbay, OPD				5.00						5.00			5.00					5.00	5	3	3	4	6 Monthly Audits - Target 80% completed each 6 months
FR6 - Annual - Torbay Admin, Training, Stores				5.00														5.00	5	3	3	4	Annual Audits - Target 75% completed each year
FR6 - Annual - Torbay OPD Admin Offices, Stores				5.00									5.00					5.00	5	3	3	4	Annual Audits - Target 75% completed each year
FR6 - Annual - Newton Abbot, Admin Offices, Stores				5.00														5.00	5	3	3	4	Annual Audits - Target 75% completed each year
FR6 - Annual - Brixham, Admin Offices, Stores				5.00														5.00	5	3	3	4	Annual Audits - Target 75% completed each year
FR6 - Annual - Totnes, Admin Offices, Stores				5.00														5.00	5	3	3	4	Annual Audits - Target 75% completed each year
FR6 - Annual - Dawlish, Admin Offices, Stores				5.00														5.00	5	3	3	4	Annual Audits - Target 75% completed each year
FR6 - Annual - Paignton, Admin Offices, Stores				5.00														5.00	5	3	3	4	Annual Audits - Target 75% completed each year
FR6 - Annual - Ashburton, Admin Offices, Stores				5.00														5.00	5	3	3	4	Annual Audits - Target 75% completed each year
HPV Cleans per month	115	74	125	86	49	45	23	25	32	31	14	8	6	6	17		656	44	Variable				From Porter HPV data to 21st Nov 22 then Navenio, back to Backtraq 17th March 23
Deep Cleans per month	1069	785	1267	981	834	1009	973	724	740	873	712	1086	1036	1146	994		14229	949	Variable				From Porter Deep Clean data to 21st Nov 22 then Navenio, back to Backtraq 17th March 23.
EHO Audit Scores - Acute	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5			5.0	5	2	2	4	EHO Audit score back to 5 following audit in January 2022. Routine EHO Audit could be at anv time.
EHO Audit Scores - Brixham Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5			5.0	5	2	2	4	
EHO Audit Scores - Dawlish Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5			5.0	5	2	2	4	
EHO Audit Scores - Newton Abbot Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5			5.0	5	2	2	4	EHO Visit in November - no change
EHO Audit Scores - Totnes Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5			5.0	5	2	2	4	
Catering Audits	20	24	23	21	22	22	22	22	22	22	22	22	22	22	22			22.0	5	19	19	19	
Catering Audit Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				
Total Tonnage all waste streams per month	186.5	210.7	203.3	175.5	170.1	192.5	136.4	161.9	151.8	170.0	158.6	155.4	144.6	140.5	172.1		2530	168.7	Trend				Total tonnage gone down due to decrease in waste disposal.
% of Total tonnage Recycled Waste per month	40.7%	40.7%	40.5%	33.5%	37.3%	35.3%	29.2%	31.1%	33.6%	43.1%	34.9%	31.7%	35.7%	35.3%	36.1%			36%	Aim is ↑	25.0%	25.0%	30.0%	
Tonnage Recycled Waste per month	62.6	65.9	67.6	57.6	63.4	67.9	39.8	46.1	52.6	73.3	55.4	47.1	51.6	49.6	62.1		863	57.5	Trend				

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Workplace Services Performance Data March 2023 for April 2023 Report	2021-22 Quarter Four			2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			Trend	Totals to date	Average to date	Target 2022-23	RAG Threshold			Comments
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
% of Total tonnage Landfill Waste per month	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			0%	Aim is Zero	5.0%	5.0%	2.0%	
Tonnage Landfill Waste per month	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0	0.0	Trend				
% of Total tonnage of Clinical Non-Burn waste per month	20.0%	16.2%	18.3%	17.5%	14.0%	12.2%	18.9%	16.7%	14.6%	14.5%	14.0%	18.2%	18.6%	14.1%	15.6%			16%	Aim is ↓	22.0%	22.0%	18.0%	£435/t - Orange.
Tonnage of Clinical Non-Burn waste per month	30.9	26.2	30.6	30.2	23.8	23.5	25.7	24.7	22.9	24.6	22.1	27.1	26.8	19.5	26.8		385	25.7	Trend				
% of Total tonnage of Clinical Burn waste per month	21.1%	18.5%	21.8%	11.9%	11.5%	9.5%	15.9%	13.5%	17.1%	10.8%	11.5%	11.8%	14.0%	11.4%	12.7%			14%	Aim is ↓	18.0%	18.0%	14.0%	£600/t - Yellow Bags inc Sharps, anatomical, gypsum. DSU, ESU, Theatres.
Tonnage of Clinical Burn waste per month	32.4	30.0	36.4	20.4	19.5	18.3	21.6	19.9	26.9	18.3	18.3	17.5	20.2	15.7	21.9		337	22.5	Trend				
% of Total tonnage of Clinical Offensive waste per month	2.1%	2.7%	2.6%	9.7%	17.0%	13.2%	16.0%	20.0%	15.0%	16.4%	14.1%	16.8%	14.9%	17.0%	15.6%			13%	Aim is ↑	12.0%	12.0%	15.0%	Increased weight in offensive waste due to ward reopening.
Tonnage of Clinical Offensive waste per month	3.3	4.3	4.4	16.6	28.9	25.4	21.8	29.6	23.5	27.8	22.4	24.9	21.6	23.4	26.8		305	20.3	Trend				
% of Total Tonnage Waste to Energy (General Waste)	37.2%	51.9%	38.5%	29.5%	20.3%	29.9%	20.1%	18.7%	16.6%	15.4%	25.5%	19.8%	16.9%	23.3%	20.1%			26%	Aim is ↑	15.0%	15.0%	18.0%	
Tonnage Waste to Energy (General Waste)	57.3	84.2	64.3	50.7	34.5	57.5	27.4	41.7	25.9	26.1	40.5	38.8	24.5	32.2	34.5		640	42.7	Trend				
Statutory Waste Audits - % completed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%	Trend	90%	90%	95%	15 Audits / month
EFM Serious/RIDDOR incidents	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0.0	0	2	1	0	
EFM incidents resulting in moderate harm	1	0	0	0	0	1	0	2	0	0	1	0	2	0	0		7	0.5	0	3	3	1	
EFM incidents resulting in minor harm	3	3	6	5	2	3	2	6	1	2	2	3	3	0	0		41	2.7	0	8	8	5	
EFM incidents resulting in no harm	12	14	12	7	6	6	7	32	7	15	10	7	19	5	6		165	11.0	0	30	30	15	ICU doors - repair due 18 Apr, L2 drain Smells by Dental OPD
EFM Incidents resulting in Near Miss			2	3	1	1	3	0	3	4	3	1	2	1	2		26	2.0	0	10	10	5	Elderly DSU Patient managed to access scaffolding.
EFM Datix incidents open for > 8 weeks				89	81	63	63	63	66	86	68	71	77	53	46		826	68.8	0	70	70	15	
EFM Teams Safety Walks - % Completed								90%	90%	90%	70%	50%	40%	78%	80%			73%	Trend	75%	75%	90%	Reporting started Dec 22. 9 Meetings per month.
EFM Safety Action Group Meetings - % Completed								90%	80%	80%	60%	50%	30%	78%	70%			67%	Trend	75%	75%	90%	Reporting started Dec 22. 9 Meetings per month.
CAS Alerts active and in Progress	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0	Variable				
CAS Alerts Overdue for Completion	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0.0	0	2	2	0	

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Workplace Services Performance Data March 2023 for April 2023 Report	2021-22 Quarter Four			2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			Trend	Totals to date	Average to date	Target 2022-23	RAG Threshold			Comments
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Total PPMs planned per month (not KPI)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	98	82	94	109	73		456	91	Variable				Not a KPI - an indicator of planned work volumes
Statutory PPMs planned per month											27	21	67	27	19		161	32	Variable				
Statutory PPM % success against plan											96%	100%	100%	100%	95%			98%	97%	85%	85%	97%	One outstanding - Dartmouth Hospital fire servicing
Routine PPMs planned per month											71	61	27	82	54		295	59	Variable				
Routine PPM % success against plan											100%	100%	100%	100%	100%			100%	90%	60%	60%	70%	
Grand Total Reactive Work (not KPI)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	199	127	107	108	154		695	139	Variable				
Total Class A Reactive Requests per month (not KPI)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	62	55	38	40	69		264	53	Variable				Not a KPI - an indicator of reactive work volumes
Class A - Emergency - LD1A - requests per month											6	9	3	1	5		24	5	Variable				Note D1A is 1hr response, D1b is 2hr Response
Class A - Urgent - LD2 - requests per month											21	25	17	14	32		109	22	Variable				
Class A - Routine - LD3 - requests per month											28	18	8	22	30		106	21	Variable				
Class A - Routine - P4 - requests per month											7	3	10	3	2		25	5	Variable				

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Workplace Services Performance Data March 2023 for April 2023 Report	2021-22 Quarter Four			2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			Trend	Totals to date	Average to date	Target 2022-23	RAG Threshold			Comments
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Highest Priority Cleaning episodes planned per Month															10		10	10	Variable				
Average % of Cleaning Audit Scores															97%			97%	97%	90%	90%	95%	
Number of Re-audits required															0		0	0.0	0	3	3	1	
Belmont Court															97%			97%	97%	90%	90%	95%	
Castle Circus Health Centre															95%			95%	97%	90%	90%	95%	
Dartmouth Clinic															98%			98%	97%	90%	90%	95%	
Hollacombe CRC															97%			97%	97%	90%	90%	95%	
Kings Ash House															97%			97%	97%	90%	90%	95%	
Sherbourne House															98%			98%	97%	90%	90%	95%	
Teignmouth Clinic															97%			97%	97%	90%	90%	95%	
Union House															98%			98%	97%	90%	90%	95%	
Unit 7															96%			96%	97%	90%	90%	95%	
Walnut Lodge															96%			96%	97%	90%	90%	95%	
Accidents															0		0	0.0	0	3	3	1	
Near misses															0		0	0.0	0	8	8	5	
RIDDORs															0		0	0.0	0	3	3	1	
Health & Safety breaches															0		0	0.0	0	30	30	15	
New starters															0		0	0	Variable				
New starter inductions within 7 days of start date															0		0	0	Variable				
COSHH, RAMS Reviewed/Updated															Ongoing			#DIV/0!	Trend	75%	75%	90%	
Belmont Court															6		6	6.0	0	30	30	15	
Castle Circus Health Centre															3		3	3.0	0	30	30	15	
Dartmouth Clinic															1		1	1.0	0	30	30	15	
Hollacombe CRC															1		1	1.0	0	30	30	15	
Kings Ash House															1		1	1.0	0	30	30	15	
Sherbourne House															3		3	3.0	0	30	30	15	
Teignmouth Clinic															1		1	1.0	0	30	30	15	
Union House															2		2	2.0	0	30	30	15	
Unit 7															1		1	1.0	0	30	30	15	
Walnut Lodge															2		2	2.0	0	30	30	15	

EFM Performance Report

Workplace Services Performance Data March 2023 for April 2023 Report	2021-22 Quarter Four			2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			Trend	Totals to date	Average to date	Target 2022-23	RAG Threshold			Comments
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
PPMs planned per month											50	50	66	43	38		247	49	Variable				
PPM % success against plan											100%	100%	100%	100%	97%			99%	97%	85%	85%	97%	
Total Reactive Requests per month (not KPI)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	35	43	29	20	37		164	33	Variable				Not a KPI - an indicator of reactive work volumes
Emergency - P1 - requests per month											2	3	2	0	3		10	2	Variable				
Emergency - % P1 completed in < 3hours											50%	100%	100%	100%	100%			90%	97%	90%	90%	95%	
Very Important - P2 - requests per month											5	3	3	2	2		15	3	Variable				
Very Important – % P2 completed in <48 hours											100%	100%	100%	100%	100%			100%	97%	85%	85%	90%	
Primary Important - P3 - requests per month											3	8	3	4	3		21	4	Variable				
Primary Important - % P3 completed in < 48 Hours											100%	100%	100%	100%	100%			100%	97%	75%	75%	85%	
Important - P4 - requests per month											25	28	21	14	29		117	23	Variable				
Important - % P4 completed in < 60 hours											100%	100%	100%	100%	96%			99%	97%	65%	65%	75%	
Routine - P5 - requests per month											0	1	0	0	0		1	0	Variable				
Routine - % P5 completed in < 6 Business Days											100%	100%	100%	100%	100%			100%	97%	65%	65%	75%	

Torbay and South Devon NHS Foundation Trust

Report to the Board of Directors			
Report title: Chief Executive's report			Meeting date: 31 May 2023
Report appendix	Integrated Care System for Devon update for Boards		
Report sponsor	Chief Executive		
Report author	Associate Director of Communications and Partnerships		
Report provenance	Reviewed by Executive Team 23 May 2023		
Purpose of the report and key issues for consideration/decision	To provide an update from the Chief Executive on key corporate matters, local system and national initiatives and developments since the previous Board meeting.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board are asked to receive and note the Chief Executive's report.		

Summary of key elements

Strategic goals supported by this report

Excellent population health and wellbeing	X	**Excellent experience receiving and providing care**	X
Excellent value and sustainability	X		

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

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

BAF Risk 1 – Quality and Patient Experience
BAF Risk 2 – People
BAF Risk 4 – Estates
BAF Risk 5 – Operations and Performance Standards
BAF Risk 8 – Transformation and Partnerships
BAF Risk 9 – Integrated Care System

External standards affected by this report and associated risks

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

Report title: Chief Executive's report		**Meeting date: 31 May 2023**
Report sponsor	Chief Executive	
Report author	Associate Director of Communications and Partnerships	

1 Our vision and purpose

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

2 Our strategic goals and our priorities

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

Our strategic goals are:

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

Our priorities are:

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

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

3 Our key issues and developments

Key issues and developments to bring to the attention of the Board since the last Board of Directors meeting held on 26 April 2023 are as follows:

3.1 Excellent population health and wellbeing

Working with Healthwatch to support men's health

Last year we approached Healthwatch to undertake engagement on our behalf to understand what matters to men in Torbay and South Devon, and how we can support them to be better informed about their health and wellbeing.

We are grateful to Healthwatch for undertaking this important work. We have now received its report which reveals the experiences of 132 local men who kindly shared their views.

It revealed, among other things, that many had never been shown how to carry out a testicular examination nor knew what to look for, only half of them who had been provided with a bowel cancer screening test completed and returned it and they would like to understand more about prostate or cancer issues.

This report forms part of our wider engagement project to consider how local health services can be developed and improved to ensure men are better informed about the health issues that affect them now and in the future. We will carefully consider the findings and are grateful to Healthwatch and the men who took part in their survey for their help. You can read the full report online at www.healthwatchtorbay.org.uk

3.2 Excellent experience receiving and providing care

Current pressures

Over the past month we have continued to see improvements in key areas including cancer care and planned care as well as supporting more people to get home from our hospitals earlier in the day and at weekends.

However, a combination of the Easter holidays, industrial action and spikes in COVID-19 and norovirus have affected our ambulance handover times and our emergency care performance times. Demand for our type 1 emergency services is now exceeding pre-pandemic levels, despite this our urgent and emergency care performance was 61.74% last month, a significant improvement against the previous month's performance of 57.59% and ahead of our improvement plan trajectory of 60%. We will have a long way to go to reach our target of 76% by the end of March 2024 and the Devon system has been put into Tier 1 monitoring for urgent and emergency care performance.

Despite pressures, our overall trend in ambulance handover delays is one of improvement and our rolling 30-day position has improved against other trusts performance in the south west.

The number of people in our hospital beds who are medically fit for discharge (no criteria to reside) has further reduced and is now around 7.6% against a year-end target of 5%. Our operational focus remains on improving how we support people to get home earlier in the day (home for lunch) and increasing the number of discharges over the weekends to 80% of a normal week day as well as reducing people's length of stay. We are aiming for 30% of discharges to take place before lunch and in April we achieved 18.9%.

As I shared with you last month, we have no people waiting more than 104 weeks (two years) for treatment. We currently have 166 people who have been waiting more than 78 weeks for treatment (which is ahead of our forecast of 176) and we aim to have no one waiting more than 78 weeks by the end of the financial year (March 2024). This will be delivered with the support of system partners as part of a risk share agreement.

We are currently reporting 29.78% of patients waiting longer than six weeks for diagnostics. Our target is no more than 25% and we are working hard to reduce the number of people waiting. We are fully engaged in the system-wide discussions to develop community diagnostic centres in Devon which offer a range of opportunities to transform and improve the elective care pathways for cancer and routine services.

This month our ophthalmology team undertook a pilot of a high-volume cataract

list at the Nightingale Exeter. This resulted in a 33% increase in the number of patients treated. This is great news for people who have been waiting for eye surgery as we will now be rolling out a weekly high-turnover list from the beginning of June.

The positive progress we have made in cancer care means that we have now exited Tier 1 monitoring for cancer performance. While this is good news and recognises the hard work of our cancer teams, it is critical that we maintain our focus on further reducing the number of people waiting for care.

We have been notified that the Care Quality Commission (CQC) will be undertaking a well-led inspection in June. We welcome the inspection as a conversation about the great care our people provide and how we are addressing our challenges together.

Supporting people to get home safely and quickly
Earlier this month we welcomed Sarah Wollaston, Chair of NHS Devon, on a visit to see the work of our community in-reach team. Created as a pilot post last June, community in-reach lead Becky Gardener has been working with community teams and discharge coordinators to help support more people to get home safely and quickly from hospital and to give them the best chance of regaining their independence.

Working as part of a multi-disciplinary team, Becky and her colleagues have worked together to review the care needs of 696 patients over the past year.

Using community knowledge and resources, from June 2022 to May 2023 Becky has helped reduce hospital length of stays by 48% (331 people), and accelerated helping support 221 people home from hospital with a care package when they no longer had a clinical reason to remain in hospital.

A second post to support this work, funded by NHS Devon, is out to advert.

Our people celebration event
We celebrated the achievements and hard work of some of our incredible people at our annual people celebration at the Riviera International Centre in Torquay on 11 May – our first in-person celebration event since 2019.

It was fantastic to be able to hold the event in person again and celebrate some of our incredible people. Thank you to everyone who attended and made the evening so special, and to our sponsors whose generous donations made the event possible.

The past few years have been challenging for our people, the people we care for and our organisation. It’s so important that we celebrate the incredible work each and every one of our people and our teams do each and every day.

Congratulations to everyone who won an award and a special congratulations to the winner of Our People’s Choice award, the Paignton and Brixham intermediate care team. They were nominated by a family after the support their son received following a serious road traffic collision. The team supported him to recover from his injuries and encouraged every step of the way.

All the nominations for this award were made by people who use our services and finalists were shortlisted before being put to a final public vote. We received close to 1,000 votes overall. Well done to our winners, it is very well deserved. Nominations are open for the next round of Our People awards – colleagues can nominate on ICON or on paper forms while the public can nominate for our People's Choice award on our website or using the paper forms available at our sites.

Ward accreditations
Seven ward accreditations have taken place in the past month using our revised scoring system of white, bronze, silver and gold.

McCallum and Teign wards achieved bronze while Dunlop, Midgley, Dawlish and Allerton achieved silver. Templer ward achieved a fantastic gold – our first gold under the new scoring system. Well done to everyone involved.

Celebrating our nurses
This month we celebrated our amazing nurses and midwives as part of international nurses' day and midwives' day. We are very proud of our nurses and the two awareness days provided an opportunity to recognise their dedication towards providing safe and compassionate care towards our patients, and towards each other.

During the celebrations we invited nurses to plant a sunflower seed, take it away with them and nurture it as it grows. Thank you so much to Glo and Dave Jones who generously donated 10 tree seedlings and two bags of compost.

A tree of inspiration was set up at all of our hospitals and healthcare settings where nurses could write the name of someone who has been instrumental in inspiring them during their career. More than 100 names were attached to the tree, and we are now making plans to recognise our inspirational people.

Guest speaker at South West conference
I was pleased to learn that Christina Harrison, our emergency department clinical senior sister, was a guest speaker at the south west retention event at Sandy Park, Exeter.

More than 200 people attended the event to learn more about how to stop our brilliant people leaving the NHS. Christina shared her learning about the benefits of stay conversations, a coaching initiative aimed to improve staff retention and staff experience by having a conversation before staff begin to contemplate leaving. The emergency department has seen positive outcomes as a result of stay conversations and colleagues from the regional team attended a session with our staff last week to hear first-hand about people's experiences.

Thank you, Christina, for leading the conversation and this important work.

Our maternity services are also receiving recognition for their work on retention. The importance of stay and thrive conversations cannot be underestimated.

Recognising 78 years of our amazing nurses

More than 70 of our nurses – past and present– celebrated the 78th anniversary of our Torbay Hospital nurses' league on 13 May with a lunchtime reunion at St Matthias Church, Wellswood.

Our nurses' league was formed three years before the NHS was founded, and has more than 200 members worldwide, all of whom either trained at Torbay Hospital or worked there for more than two years.

Its members play an active role within the hospital to improve care and experiences of our people and patients, including upgrades to day rooms on George Earle, Simpson and McCallum wards which offer care for older people and those living with dementia. The League also provide handmade syringe driver bags for palliative care patients, memory boxes for patients families, and welcome packs for our newly arrived overseas nurses.

They also hold craft fairs and coffee mornings throughout the year to raise funds to support their work and maintain their living legacy of camaraderie, care and compassion.

Our chaplain, the Reverend Angela Sumner led a short service to celebrate the League's milestone on the theme of love.

Thank you to our nurses for your continued support to help us deliver our vision of better health and care for all. Your kindness, encouragement and commitment is an inspiration to us all and is deeply appreciated by everyone across our sites and services.

Inaugural PRIMROSE award winner
We recently awarded our first PRIMROSE award which recognises the hard work of our healthcare support workers. Anyone working in a healthcare support worker role can be nominated, from podiatry assistants to healthcare assistants and lots of other care supporting roles in between. This new award was the brainchild of our healthcare support worker council.

Our healthcare support workers are a vital part of our Torbay and South Devon family and play a critical role in ensuring our services run smoothly and efficiently, while providing outstanding care to our patients.

We presented the Primrose award to our first winner on 24 May 2023.

Congratulations to Teresa Northcott, Louisa Cary ward. It is fantastic to see her achieve this recognition for her dedication and commitment to caring for people who use our services.

Jane Owens wins DAISY award
Congratulations to Jane Owens, who works on Ricky Grant ward for winning the DAISY award. The DAISY award was created to honour and recognise nurses and midwives for the outstanding work they do providing extraordinary care to patients every day.

Jane was nominated by a colleague who said she: "works so hard even when she is extremely busy, putting other people's needs above her own and often

staying late when her working day is finished. I don't think Jane realises how appreciated she is and I want her to know that her hard work and kindness doesn't go unnoticed."

Thank you, Jane, for providing compassionate care to our patients.

Local nurse attends national service to honour Florence Nightingale
Nina Henton-Waller was invited to attend the 58th annual Florence Nightingale commemorative service at St Paul's Cathedral earlier this month and we were delighted to support her to be able to do so.

Nina, who is the inspiration behind our green plant project, works on our acute medical unit at Torbay Hospital.

Celebrating King Charles III's coronation
Our wards and services decorated their areas to celebrate the King's Coronation on 06 May.

Many of our people also organised events, including our day surgery unit team which held a tea party. It was lovely seeing people getting in the spirit and ensuring our patients could celebrate and have fun too.

NHS 75 – conversations and Westminster abbey service
On 05 July 2023, the NHS will celebrate its 75th anniversary, and we are busy preparing to celebrate this incredible milestone with our people, including arranging a charity fundraising Big Tea. We are also collecting stories of our past, present and future to share with our people, the public and the media as part of a series of NHS 75 editorial opportunities.

We are so proud that some of our people have been invited to attend a special service at Westminster Abbey for NHS staff, volunteers and partners in recognition of their hard work and we look forward to hearing about their experience.

We were asked to support the important NHS Assembly NHS@75 engagement process and have run two listening events where we have recorded a number of staff views on the NHS now and in the future. We will send our findings to the NHS Assembly so it can summarise key learning from the NHS's recent past and highlight future opportunities and challenges. We have been told that this is crucial work that will culminate in a collective statement from the NHS Assembly that will influence where the NHS goes next.

NHS75 service at Westminster Abbey
We have been invited to nominate representatives to attend the NHS 75 service at Westminster Abbey on Wednesday 05 July. We have nominated the following who will all be shortly receiving their official invitations:

- George Averill (F3 doctor)
- Nik Hill (Chair of the Health Care Support Worker Council and a Podiatry HCA)
- Nicholas Pannell (Social worker, over 65s mental health team, Torbay)
- Sarah Davies (Professional Lead OT, Children and Family Health Devon).

3.3 Excellent value and sustainability

Opening of Dartmouth health and wellbeing centre

I was pleased to join our chairman Sir Richard Ibbotson and by David Fursdon, HM Lord-Lieutenant of Devon on 09 May for the official opening of Dartmouth's brand new £5.4million health and wellbeing centre.

The centre is based at the top of town next to the park and ride and marks the completion of the building work which began in 2021. Local people will now be able to access to a broad range of health and wellbeing services in one place by bringing together GPs, community nurses, therapists, Dartmouth Caring and Wellbeing Pharmacy.

The integrated service is part of plans across Devon to bring health and care services and the voluntary sector together to make it easier for people to receive the care they need, in their community. It also allows the clinicians and specialists involved in providing someone's care to work closer together to provide seamless joined-up care for the 21st century.

The ceremony was also attended by representatives from the town and district councils, and a number of local groups including Dartmouth League of Friends, Dartmouth Medical Practice and its Patient Participation Group, and Dartmouth Caring.

It was lovely to welcome so many people to be a part of an incredibly important milestone, which was thanks to the hard work and dedication of so many people during several years.

The building project was led by our strategic estates partner – gbpartnerships – with the building work carried out by West Country building firm Classic Builders, supported by a wide range of contractors, and our architects KTA.

Work begins on expansion of endoscopy and theatre provision at Torbay Hospital to further reduce waiting times

Earlier this month the existing Endoscopy portacabin at Torbay Hospital was removed in preparation for the £4.99million building project to create a fourth endoscopy room and a training facility. This will enable us to see more people and improve their experience and outcomes and is due to be completed by the end of this calendar year.

Together with our new Radiotherapy CT Scanner suite and the expansion of our day theatres, these three projects form our major capital developments for this financial year on the Torbay Hospital site. Building work for the new Radiotherapy CT Scanner suite is progressing well and it should be open to patients by the end of July. We are very grateful to our Torbay Hospital League of Friends who are providing the funding for the new state-of-the-art scanner.

Both our endoscopy expansion and our theatre expansion are being funded through the NHS England Targeted Investment Fund (TIF).

The site enabling works are underway for the theatre expansion which will include two new day surgery theatres as well as additional preoperative assessment spaces and recovery spaces.

A significant programme of work to ensure resilience of vital infrastructure has been completed which will keep them operational for a further two years at which time a full refurbishment can be completed. Around £3million has already been spent to facilitate this significant project and maximise use of surgical space while building work takes place.

The new modular theatres, which should be operational by January 2024, will make a critical and material contribution to our operational and finance plans by delivering an additional 1,400 day case procedures in the last quarter of this financial year, putting us in a better position to meet our System Oversight Framework 4 exit criteria and improve waiting times for local people. Recruitment is underway for the vital clinical and clinical support roles required to support the additional capacity we are creating.

Dartmouth Hospital sale

The site of the former Dartmouth and Kingswear Community Hospital has been placed for sale on the open market again after a bid failed to complete within the agreed timelines. While the community bid to buy and redevelop may still be viable, it had been affected by significant delays in raising the necessary finance.

The former hospital site, which is no longer needed for healthcare, needs to be sold to help fund the recently opened Dartmouth health and wellbeing centre.

We recognise that the former hospital has been a focal point within the town for many years, but we do now need to dispose of the hospital site and are hopeful that a viable bid will come forward through the open market.

Importantly, this does not preclude the sale to Dartmouth Town Council, which remains a unique and innovative community bid.

We would like to thank Dartmouth Town Council for working with us during the past 18 months to explore the viability of a community bid. We have always been clear that if a community bid proved to be impossible we would move to selling the site on the open market, in line with the NHS Estate Code.

Chief Finance Officer/Deputy Chief Executive to take on new challenge

After 10 years in the NHS Dave Stacey, our Chief Finance Officer/Deputy Chief Executive, will be leaving us at the end of July join the University of Exeter as Chief Financial Officer and Executive Divisional Director of Finance, Infrastructure and Commercial Services. In his new role he will be providing strategic financial advice and guidance as well as developing and delivering the University’s capital, estates and commercial strategies.

Dave has been part of our team for three and a half years and has achieved a lot during that time. His contribution to our strategy for better health and care for all has been key and he has been instrumental in attracting people to join us and build the architecture to enable us to deliver on our vision. Through his leadership we have grown our capability in finance, estates and capital

development that not only have set us on the road to regain and renew and deliver against our current challenges but are also building the bridge to our brighter future.

Although we are in system oversight framework 4 both as an organisation and as a system, thanks to Dave we are in a better position and better equipped to face the future, whatever that might bring, and deliver on our commitments to the people and communities we serve.

I know you will join me in wishing Dave well. We will share further information soon on our plans to replace Dave, both in his Chief Finance Officer role and as Deputy Chief Executive.

Welcoming visitors from Kenya

We were pleased to welcome a delegation of five Kenyan academics to Torbay Hospital on 16 May as part of a visit to other NHS trusts across the peninsula.

The group from the University Health Faculties in South West Kenya spent the afternoon learning about our trust and the wider NHS, and explored opportunities to collaborate in research, education, teaching, and service delivery between South West Kenya, and the South West peninsula.

The visit was part of an ongoing collaboration between the UK and Kenya following the signing of the KUKHA (Kenyan UK Health Alliance) last year to strengthen opportunities between the two countries.

We have a significant and valued track record of working in partnership with Kenyan institutions, and several of our people have visited Kisii to share learning and expertise on critical and trauma care, quality and improvement, leadership and maternity.

The visit, which was hosted by Plymouth University, gave us an opportunity to showcase our work and also our workforce development and we hope the visit will lead to many opportunities and mutual benefit between our two countries.

4. Chief executive engagement May

I have continued to engage with external stakeholders and partners both face to face and also 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
• Our people awards celebration • Video blog sessions • Diversity and inclusion lead	• Regional Chief Executive Officer, NHS England and Improvement (NHSEI) • Chief Executive Officer, Integrated Care System Devon (ICSD) • Improvement Director, ICSD

• League of Friends Chairs meeting • Dartmouth Health and Wellbeing Centre opening	• Long Term Plan Programme Director, ICSD • Chief Executive Officer, Royal Devon University Healthcare NHS FT • Chief Executive Officer, University Hospital Plymouth NHS Trust • Chief Executive Officer, Devon Partnership NHS Trust • Chief Superintendent for South West Police

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.

5.1.2 Retirement of Chief Executive of NHS Devon

Jane Milligan, the chief executive of NHS Devon, has announced her decision to retire after a 36-year career in the NHS.

Jane, who led the organisation's evolution from clinical commissioning group to integrated care board, is to step down later this year, ensuring time for a smooth transition.

NHS Devon will shortly begin the process of recruiting Jane's successor. We thank Jane for her service both to Devon over the past few years and to the NHS as a whole.

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 April board report, activity to promote the work of our staff and partners has included:

Recent key media releases, coverage, and responses:

- new 360° virtual tour of special care baby unit to support parents whose babies are born early or need specialist care resulted in coverage on BBC Spotlight and ITV West Country
- annual reunion of Torbay Hospital Nurses' League
- pioneering use of virtual reality to train healthcare staff resulted in coverage on BBC Spotlight and ITV West Country
- work begins on a new radiotherapy planning CT suite at Torbay Hospital as part of a multi-million-pound investment to transform cancer care

- opening of £5.4million Dartmouth health and wellbeing centre
- celebrating our people at our annual awards event
- cleanliness and food rated one of best in country – release celebrating the news that we placed in the top five out of all trusts in England for standards of cleanliness and food in our hospitals was covered by trade press
- care home hydration project cuts hospital admissions – celebrating the success of a dietitian-led hydration project which supports local care homes to encourage good hydration for residents was featured in specialist press
- New Hospital Programme updates – outlining our cohort and current business case position on the New Hospitals Programme funding, following a number of enquiries, including national BBC coverage on 17 May
- ambulance waits, delayed transfers of care and performance ratings enquiries – response issued to a number of media outlets on behalf of Devon's health and care system outlining work to reduce waits and improve performance
- Dartmouth health and wellbeing centre access – dealing with enquiries on the alternative access route to the new health and wellbeing centre, outlining that the informal access was created as an additional route following feedback from residents
- parking charges issue – we supported a BBC Spotlight viewer to successfully rescind their parking charge notice following a hospital admission by working with our car park provider.

Recent engagement on our social media channels includes (figures on reach and views relate to Facebook):

- opening of the new Dartmouth health and wellbeing centre, including video footage of the opening
- details of the nominees and winners at our annual Our People awards celebration, including a video of Our People's Choice winners Paignton and Brixham intermediate care group being presented with their award (1,800 views) and People Partner award winners Josh Clemes and David Strangewood (1300 views) and congratulatory post (reach 7,234)
- time-lapse video of work to build our new radiotherapy suite (1,200 views)
- a range of posts to promote services available at our urgent treatment centre and minor injury units, community pharmacy services, NHS 111, self-care, dental and primary care
- highlights from the Torbay Hospital Nurses' League annual reunion (3,504 reach)
- celebrating DAISY award-winners Jane Owens being presented with her award (7,778 reach) and Leanne who works on Warrington ward at Torbay Hospital
- round up of our nurses' day celebrations including photos of our people (4.837 reach)
- promotion of job opportunities including diabetes and wound specialist podiatrist and Torbay Pharmaceuticals, and theatre recruitment event, and an Allied Health Professionals recruitment event on 07 June at Torbay Hospital from 10am to 4pm
- thank you to Miriam who made and donated a commemorative blanket to the first baby born on our maternity unit on Coronation Day (4,151 reach), and a round up of Coronation events (6,778 reach)
- thank you to Torbay Hospital League of Friends for donating a George Cross print to display as part of the Coronation celebrations

- world immunisation week – reminding families to check what immunisations their child has had and to catch up on any missed doses as part of world immunisation week
- Dartmouth Royal Naval College Easter donation – thanking the Royal Navy for their kind donation of Easter treats for patients on Louisa Cary ward and across Torbay Hospital.

Development of our social media channels:

Channel	End of year target	As of 31 March 2021	As of 30 April 2023
LinkedIn	5,000 followers	2,878	6,027 ↑ 3,149 followers
Facebook	15,000 likes	12,141	13,892 ↑ 1,5751 followers
	15,000 followers	12,499	14,947 ↑ 2,448 followers
Twitter	8,000 followers	6,801	7,863 ↑ 1,062 followers

7 Recommendation

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

One Devon

May 2023

Update from the NHS Devon Board for system leaders

The purpose of this regular report, which is aligned to the public meetings of NHS Devon (the Devon Integrated Care Board), is to:

- **Provide a monthly update for Board and Cabinet meetings across Integrated Care System partner organisations in Devon, Plymouth and Torbay.**
- **Ensure partners are aware of issues discussed by NHS Devon's Board and decisions taken**
- **Ensure consistency of message among One Devon partner organisations.**

This follows the meeting in public of NHS Devon's Board on 3 May 2023.

1. Citizen's Story
2. Reports of the Integrated Care Board Chair and Chief Executive
3. Report of the One Devon Partnership Chair
4. Report of Cornwall and Isles of Scilly Integrated Care Board Chief Executive
5. Integrated Quality, Performance and Finance report
6. Update on the Operating Plan for 2023-34, Finance

1. Citizen's story

June Symes and her husband, Bruce, told the Board of Mrs Symes' wait for a knee replacement. After several years of knee injections, she was referred by her GP to a specialist hospital physiotherapist. Two appointments with further physiotherapists followed but, while all agreed she needed a replacement, no further action was taken. Mrs Symes knew she needed an X-ray but she was not referred and nothing happened.

Mrs Symes described her months of waiting as a time of debilitating pain, where she was unable to join her active husband in any activities or exercise, could not sleep and was unable to visit family, to cook or do anything in the house. Mr Symes looked after her but he could not manage to care for their dog as well, so their pet was re-homed. Mrs Symes became depressed and felt her life was falling apart. Eventually she paid to have her knee replacement done privately.

The Board apologised to both Mrs and Mr Symes and said the established pathway for knee replacements had clearly not been followed: Mrs Symes should have had an X-ray and been added to the waiting list. The NHS in Devon will examine her case to see what went wrong; it will also improve communications for and with waiting patients, and monitor waiting lists to check that already vulnerable or disadvantaged people are not further disadvantaged during the waiting process. Board members also assured the couple that, following the COVID-19 pandemic and more recent industrial action by healthcare staff, intensive work was being done to reduce the lengthened time people have been waiting for planned operations and procedures.

2. Reports of NHS Devon's Chair and Chief Executive

The Chair noted that the first draft of the Joint Forward Plan was being circulated among partners, setting out how strategic goals would be achieved. A further version taking account of partners' observations – including those of Health and Wellbeing Boards - would come to the NHS Devon Board on 7 June, and then be combined with the Integrated Care Strategy for Devon to form the Devon Plan.

The Chair was delighted to attend the launch of the new Interpersonal Trauma Response GP service, in which all GPs in Devon will be trained to ask about violence, trauma and abuse and will have access to a specialist support service for patients experiencing them.

She commended the South West Ambulatory Orthopaedic Centre (SWAOC) at the Nightingale Hospital, Exeter, for meeting top clinical and operational standards and becoming one of eight nationally to be awarded accreditation as part of a pilot scheme.

The Chief Executive updated on the COVID-19 vaccination programme which runs until June, with vaccinations for residents in care homes due to be completed by 28 May. Devon was the highest performer in the country for the number of care homes visited since 3 April.

In March, the Devon system had experienced high levels of pressure, with greater numbers of people in hospital with flu, COVID-19 or norovirus resulting in reduced bed capacity. Action was taken to de-escalate through increased discharges and efforts to reduce demand on emergency departments. Special measures remained in force until 17 April.

3. Report of One Devon Partnership Chair

The Chair noted significant system funding and budget challenges across health, care and beyond. Work was needed to understand the collective impact on people and communities and how any negative effect on health and wellbeing in Devon could be mitigated.

The NHS Devon Board concurred that all system partners should maintain open dialogue about their budget challenges, and that any decisions be made with a view to the best possible outcome for the Devon system as a whole.

4. Report of the Cornwall and Isles of Scilly Integrated Board CEO

The CEO outlined work to redesign the way the ICB works in Cornwall and Isles of Scilly, in the light of the requirement for all ICBs to reduce their running costs. This was being done in partnership with staff and trades unions and would include extensive engagement on the future shape and functions of the organisation.

It was noted that a peninsula-wide Research and Innovation Partnership Board was being established under the auspices of the Academic Health Sciences Network. This includes universities and other research bodies, with the aim of increasing the impact of research and innovation across Somerset, Devon and Cornwall and Isles of Scilly.

5. Integrated Quality, Performance and Finance

Operationally, in February, the ICS remained under great pressure although not at the extreme level seen in late December and the first few days of January. Industrial action in nursing and ambulance services compounded delays in urgent care, ambulance conveyancing and waiting times. A loss of 6,596 ambulance hours due to lengthy handovers was seen in February, down from 13,743 hours in December. Ambulance response times saw a corresponding improvement, with category 2 at an average of 37 minutes for February against the 18-minute target.

The target of people waiting no longer than 4 hours in Emergency Departments to be seen, treated and either discharged or admitted is being reintroduced. Members emphasised that this waiting time was not a reflection on the efficiency of any Emergency Department but rather a barometer of the overall effectiveness of the wider system, including primary and community care, voluntary services and social care. The report was welcomed but members suggested that future reports broaden their range, to monitor wider indicators of wellbeing such as homelessness and drug addiction and that the question of inequalities be built in.

As at the end of February 2023 the financial forecast for the system was a deficit of £49.2million.

6. Operating Plan for 2023-24

Following a meeting with regional and national representatives of NHS England, the Operating Plan was being adjusted, to make minor changes.

These would not involve any change to the financial position, which remained as a forecast deficit of £49.5 million. A recovery plan had been submitted, and it was crucial that all partners were clear about the route to a sustainable position within three years.

To this end, a System Recovery Board had been established, to scrutinise financial performance and ensure early intervention where remedial action was needed.

The System Recovery Board would keep the NHS Devon Board apprised of its work and any deviations from plan but would not – for reasons of expeditiousness – seek approval before taking corrective action where this was needed.

ENDS

NHS
Torbay and South Devon
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Report to Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 1 2023/24 (April 2023 data)			Meeting date: 31 May 2023
Report appendix	M1 2023/24 IPR Dashboard of key metrics M1 2023/24 IPR Focus Report		
Report sponsor	Deputy CEO and Chief Finance Officer		
Report author	Head of Performance		
Report provenance	ISU and system governance meetings – review of key performance risks and dashboard Trust Management Group: 2 May 2023 Executive Director sign off: 19 May 2023 Finance, Performance, and Digital Committee: 22 May 2023		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to bring together the key areas of delivery (including, quality and safety, workforce, operational performance, and finance) into a single integrated report to enable the Trust Board to: • Review evidence of overall delivery, against national and local standard and targets • Interrogate areas of risk and plans for mitigation • provide assurance to the Board that the Trust is on track to deliver the standards required by the regulator. Areas of exception that the Board will want to focus on are highlighted below and detailed in the attached Focus Report.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to **review** the documents and evidence presented.		
Summary of key elements			
Strategic objectives supported by this report			

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

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

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

External standards affected by this report and associated risks

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

This report reflects the following corporate risks:

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

Introduction

The Integrated Performance Report pulls together key metrics and performance exceptions across quality, workforce, performance, and finance.

The report highlights area of risk that have been escalated through the Integrated Service Units and System Care Group Directors. The People Committee provides governance and oversight for workforce and the Quality Assurance Committee for quality and safety metrics.

The purpose of the report is to inform the FPDC and Trust Board of areas to note and provide more granular details against key areas of interest and potential concern.

Operational narrative against key performance metrics are contained in the Chief Operating Officer's report.

1. Performance Headlines

Performance against the system Operating Framework Level 4 exit criteria are summarised in the performance focus report. Where the exit criteria are not being met, exception reports have been created for executive oversight and covers operational update, actions identified, and risks and issues.

Revisions to the 2023/24 Operational Plan were signed off by the Devon ICS in April 2023. This showed a further improvement against Referral to Treatment longest waits trajectory to deliver zero patients waiting against the 78-week target by March 2024 and 1091 patient waits against the 65-week target

Performance oversight with the ICB is in place thorough monthly executive meeting (System Improvement Assurance Group) focusing on delivery of key performance targets.

The Chief Operating Officer's report provides further narrative 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).

<u>Urgent and Emergency Care SOF 4 headlines</u>

	Target	13 month trend	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA															
Urgent and Emergency Care															
Percentage of Ambulance handovers greater than 15 minutes			77.5%	69.6%	80.0%	77.0%	78.3%	77.5%	84.4%	82.2%	87.5%	66.5%	54.8%	73.9%	55.4%
Total average time in ED (hours/minutes)			07:08	06:23	07:22	07:02	07:06	07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57
ED attendances where visit time over 12 hours	0		816	668	871	827	920	906	988	939	1207	823	599	977	568
UEC 4-hour target (RAG against local trajectory to national target)	76%		58.0%	57.6%	54.5%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%
% patient discharges pre-noon	33%								18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%
Percentage of inpatients with No Criteria to Reside (acute)	<5%								11.0%	11.0%	13.0%	13.0%	12.0%	8.1%	7.6%

- Overall the Trust's UEC performance was 61.75% being in line with operational plan trajectory of 60% and an improvement on March performance of 57.6%.
- Ambulance delays reduced in April with 55.4% of handovers over 15 minutes compared to 73.9% in March.
- The Trust has seen another month of improvement against the number of patients reported as having no criteria to reside (delayed discharges) achieving an average level of 7.6% of occupied beds.
- Operational focus remains on improving the discharges earlier in the day before noon (18.2% achieved against the 33% target), increasing the number of

discharges over weekends to 80% of a normal weekday per day, and reducing length of stay.

Elective Recovery SOF 4 headlines

	Target	13 month trend	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA															
Elective recovery															
RTT 104 week wait incomplete pathway	0		192	173	96	70	51	50	47	34	29	22	14	0	0
RTT 78 week wait incomplete pathway	176		779	813	713	686	787	813	829	822	923	708	462	183	166
RTT 65 week wait incomplete pathway	1091						2093	2252	2485	2174	2203	1828	1679	1372	1244
RTT 52 week wait incomplete pathway			3374	3765	4137	4578	5083	5060	5412	5585	6027	5554	5116	4427	4024
Patient waits over 2.5 years	0		18	32	48	54	47	24	24	17	12	9	6	0	0
75% of GP referred patients diagnosed within 28 days	75%		76.9%	67.6%	64.8%	67.7%	72.1%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	74.8%
Number of patients waiting longer than 62 days for treatment	138		245	307	233	283	244	333	331	229	253	225	130	114	107
Percentage of patients waiting longer than 62 days for treatment			11.8%	14.1%	10.2%	11.5%	10.6%	13.6%	15.5%	11.7%	17.1%	16.4%	8.7%	7.0%	6.5%

Elective Referral to Treatment:

- The zero 104-week patient wait target was again achieved at the end of April 2023.
- Against 78-week RTT target the Trust reported further improvement with 166 breaches against a plan of 173 despite industrial action in April.

Cancer standards:
Torbay has achieved the necessary performance metric level to be classified as a Tier 2 provider following a sustained period of improvements.

- 74.8% achieved against the Faster Diagnosis Cancer Standard of 75%;
- Cancer 62-day backlog – the Trust continued to reduce the number of patients waiting over 62 days for treatment with 107 reported against a Trust target threshold of 138. Further detail can be found in the Chief Operating Officer's Report.

Diagnostics: The Trust reported 29.78% of patients waiting longer than 6 weeks against the target of 25%.

2. Quality Headlines

Incidents
In April 2023, one incident of severe harm was verified and reported onto the national StEIS system. This was a patient who experienced a fall that resulted in a fractured neck of femur; an investigation is underway.
Two incidents of death were reported within the Trust and are detailed below:

- One out of hospital paediatric cardiac arrest which is being reviewed under the Child Death review protocol;
- One inpatient death relating to a cardiac arrest; this is being reviewed under an internal incident investigation and has not been reported onto StEIS.

These two incidents will be reviewed through Trust processes to consider if they should be reported onto the StEIS system.

Stroke
Timely access to a dedicated stroke unit improves clinical outcomes for patients and offers improved quality of life outcomes. In April 2023, 22.5% of patients were admitted

to the stroke ward within 4 hours of arrival at hospital which remains below the target of 90%. In April 63% of stroke patients admitted to the Stroke Unit, spent 90% or more of their time on the dedicated stroke ward against a standard of 80%. The target is still not met and there has been a slight decline in these two metrics this month. Further actions to understand the drivers of performance and impact of agreed actions are being undertaken to improve this position.

VTE assessment

VTE assessment compliance demonstrated a conformity for all in patients of 97.7% in April 2023 and the assessment performed within 4 hours of admission was reported at 93%. Those areas that are not achieving the standard required are being supported by the VTE Steering Group.

Infection, Prevention, and Control

Bed closures saw an increase from 164 in March to 217 in April. The reason for the closures has mainly been due to;

- Patients testing positive for COVID-19/Flu A on admission;
- Out breaks of norovirus during admission.

Management of these require adherence with the IPC guidelines and Public Health England guidance.

Maternity

There were no stillbirths or fetal loses in April 2023. The number of women reported to be smoking at birth in April 23 was 5.8% which is well below the national average of 8.6%.

Staffing

The Registered Nurse fill rate for days during April 2023 is reported as 92.4% which is a slight increase from March of 91.3%. The Registered Nurse night duty fill rate has also improved to 91.3% from a March position of 88.4%. The fill rate for health care support workers has increased to 103.7% from March figure of 97.9% and the fill rate has remained stable overnight. Twice daily staffing meetings have continued to ensure risks are assessed and actions and mitigations were put in place to ensure safe staffing levels were maintained.

Feedback and Engagement

This month the Focus Report contains additional information on number of complaints received and the performance management of complaints.

3. Workforce Headlines

Staff sickness/absence

The preliminary annual rolling sickness absence rate is 4.96% to the end of April 2023 from 5.62% in March. The monthly sickness has increased in April at 5.07% from 4.63% in March. Overall the picture for 2022/23 shows improvement compared to the year before, but the spikes in July and December 2022 have meant that it is not showing as an improvement.

Appraisal rate

April's Achievement Review rate increased by 1% to 77.87% from 76.87% in March and is still showing signs of concern and for the last 12 months has been under the mean of

78.17% during that period. However, there has been a 6% increase since April 2022 so the trend is showing an upward rise.

Turnover (excluding Junior Doctors)

The Trust's turnover rate of 12.92% for the year ending April 2023 remains within the normal tolerances of 10-14%. Turnover has now plateaued and in the last six months since September 2022 has dropped significantly from 13.88% to 12.92% and in March 2023 it was the lowest it has been in the last six months.

Mandatory Training rate

The March **overall** rate for mandatory training figure increased slightly to 90.72% against a target of 85%. Overall training compliance is constantly above the target of 85%. There are no signs of concern and the mean over the last two years has been at least 4% above the target. However, a number of the individual subject areas are showing under compliance.

Adult Social Care

The 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

As of April 2023, the financial performance indicated a minor variance to plan.

Our operating income reached **£51.90m**, **£0.5m** lower compared to the projected **£52.41m** plan, reflecting a minimal variance of less than 1%. Similarly, our operating expenditure was a fraction less than our budgeted cost, with the actual expenditure standing at **£56.78m** against the expected **£57.21m**.

This resulted in a favourable expenditure variance of **£0.42m**. However, it's important to note that the operating expenditure includes an unplanned cost pressure of **£0.17m** due to the Junior Doctors Industrial Action. Anticipating that this cost may escalate with further industrial action expected in the coming months, close monitoring and mitigation strategies will be necessary.

The period concluded with an overall deficit of **£4.87m**, marginally better than the forecasted deficit of **£4.89m**, resulting in a positive variance of **£0.02m**.

The opening cash balance was **£19.8m** higher than anticipated. The primary reason for this is that the Mar-23 capital creditor was higher than initially presumed. Similarly, capital cashflow represented a **(£7.6m)** outflow, due to the subsequent payment of capital creditors. The original plan assumed that this repayment would have been made at the end of the prior year.

Creditor movements was a favourable £**14.7m**. The positive change primarily resulted from the scheduling of the Trust weekly payment cycle. Payments totalling **£9.1m** were made a day after the end of the first month. Moreover, the Trust received advance funding from NHSE which added an additional **£3.3m** to our cash position.

Integrated Performance Focus Report (IPR)

NHS
Torbay and South Devon
NHS Foundation Trust

May 2023: reporting period April 2023 (Month 1)

Working with you, for you

System Oversight Framework - Introduction

In December 2022 NHS England rated the Trust at SOF 4 (NHS System Oversight Framework) along with the wider Devon System. The Trust was previously rated as SOF 3. The levels are rated as levels 1 to 4 with SOF 4 being the highest level of oversight. This decision was reached due to our financial performance and delivery against performance targets.

Exiting SOF 4 is the key objective to achieve over the coming months. There is a draft set of exit criteria to be achieved, however, we are awaiting finalisation of these to reflect the changes in the operational planning guidance for 2023/24.

In support of the performance standards relating to Elective Recovery the Trust will have operational recovery plans at specialty level to describe the actions and target milestones that need to be delivered and monitored. Recent support from NHSE has enabled the Trust to develop more robust delivery plans for our long wait cohorts in 23/24 (see IST visit note below)

Tier 1 performance oversight: The Trust remains in the Tier 1 performance regime from NHS England against Referral to Treatment (RTT) long waits but has been downgraded to Tier 2 for Cancer performance following sustained improvements on our KLOE cancer standards The weekly executive meetings with South West region performance leads continue to review progress and gain assurance on agreed action plans.

Intensive Support Team visit: In January, as part of the SOF 4 and Tier 1 oversight the Trust had a planned visit from the Intensive Support Team (IST). This visit reviewed the Trusts governance capacity and plans to deliver against the Cancer Diagnostics and RTT wait times standards.

Further visits have taken place involving our Regional and National colleagues. These visits have been helpful and practical , critical intelligence has been developed to underpin operating plans for 23/24 which show significant improvements against our long wait positions.

System Operational Framework (SOF)
Exiting SOF 4 remains the key Trust objective, therefore, the performance section of this month's IPR focuses on progress against the SOF 4 exit criteria measures. . Where the exit criteria are not being met, exception reports have been created for executive oversight and covers operational update, actions identified, and risks and issues.

System Operational Framework (SOF) monitoring
To support the monitoring of the exit criteria a Tableau dashboard has been created and work is on-going to finalise the data ahead of publication.

System Oversight Framework 4 Exit Criteria – indicative measures

The set of exit criteria below highlights performance levels to be achieved to exit SOF 4, however, we are awaiting finalisation of these to reflect the changes in the NHS Operational Planning guidance for 2023/24.

Each indicative measure has a target to be achieved to exit SOF 4 with local trajectories being agreed in line with Operational Planning submissions. The performance section of this report has been amended to reflect this focus and will build in the details of the SOF 4 exit plans and progress against these plans and milestones as they are agreed.

Exit Criteria Measures

UEC	Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours)
	Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average over 23/24, with plan for further improvements in 24/25
	Improvements in line with agreed baseline and plan, over two quarters, in total average time in ED & 12 hour breaches. (Trajectory to achieve 76% by 23/24)
	Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories
	Achieve and sustain for two quarters a reduction in number of patients who no longer meet the "criteria to reside in hospital" to no more than 5%
	Achieve and sustain for two quarters a reduction in number of patients who no longer meet the "criteria to reside in hospital" to no more than 2019 levels by end of 23/24
Elective Recovery	Reduction in waits over 104 weeks and 78 weeks, inline with agreed plan, against agreed baseline
	Significant reduction in 65 weeks by March 2024, inline with agreed plan, against agreed baseline
	75% of GP referred patients diagnosed within 28 days
	To exit Tier 1: The percentage of patients waiting over 62 days to start cancer treatment across the system is less than double the requirement for March 2023 (≤12.8%) and working towards achieving the national target.
	To exit Tier 1: The weekly number of patients waiting over 62 days decreases over 4 consecutive weeks and remains stable, or improving for 2 out of 3 months for the quarter
Finance	There is confirmation of the underlying run rate from 2022/23 and an improvement in the actual recurrent run rate in the 2023/24 plan
	The 2023/24 plan shows an improvement in productivity compared to 2022/23
	A system-wide shared services programme is developed that has all back office functions within scope and includes accompanying timelines and delivery plans
	The system delivers the financial plan for 2023/24 recurrently for two successive quarters
	The system delivers improvements in productivity in 2023/24 for two successive quarters

System Oversight Framework 4 Exit Criteria – Accountability Framework

	Accountability framework					
Metric:	**Senior Responsible Officer:**	**Clinical Lead:**	**Executive Lead:**	**Reporting forum for review of performance**	**Meeting monthly trajectory**	**Meeting SOF 4 exit target**
UEC 4 hour target 76% by March 2024	System Care Group Director (SCGD) - Urgent Care	System Care Group - Medical Director (SCGMD)	Chief Operating Officer	Operational Recovery Group (ORG) Trust Management Group (TMG)	Yes	No
Ambulance handovers greater than 15 minutes	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	Trajectory TBC	Improvement over 2 Qtrs. – not met
Over 12-hour visit time; and ED (type 1) 4-hour target	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	Trajectory TBC	Improvement over 2 Qtrs. – not met
Increase in pre-noon patient discharges	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	No	No
Reduction in 'No criteria to reside'	SCGD – Families community and place based	Deputy Medical Director	Chief Operating Officer	ORG TMG	yes	No
Patient wait over 104 weeks and 78 weeks	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	Yes	Yes
Patient wait over 65 weeks	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	Yes	No
75% of GP referred patients diagnosed within 28 days	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	Yes	Yes
Cancer longer than 62-day wait	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	Yes	Yes

System Oversight Framework 4 Exit Criteria – Chief Operating Office Highlight Report

Matters of concern/key risks to escalate	Major actions commissioned/work underway
• Ongoing Industrial Action • TIFF Theatre build agreement and delivery of activity required • Infection outbreaks impacting on staff and bed availability	• Establishment of Urgent and Emergency Care Board and Planned Care Board • Review of P1-3 processes about to be completed by Newton Europe. • SOF4 Communications strategy agreed • Support in place from Michael Wilson and NHSE National Team • Updated IPC guidance development
Positive assurances	**Decisions made**
• Operational performance improving • Management of Industrial Action and Bank Holidays resulting in lower numbers of cancellations and improved flow.	• Organisational reshaping agreed

System Oversight Framework 4 Exit Criteria - Performance summary

	Target	13 month trend	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA															
Urgent and Emergency Care															
Percentage of Ambulance handovers greater than 15 minutes			77.5%	69.6%	80.0%	77.0%	78.3%	77.5%	84.4%	82.2%	87.5%	66.5%	54.8%	73.9%	55.4%
Total average time in ED (hours/minutes)			07:08	06:23	07:22	07:02	07:06	07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57
ED attendances where visit time over 12 hours	0		816	668	871	827	920	906	988	939	1207	823	599	977	568
UEC 4-hour target (RAG against local trajectory to national target)	76%		58.0%	57.6%	54.5%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%
% patient discharges pre-noon	33%								18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%
Percentage of inpatients with No Criteria to Reside (acute)	<5%								11.0%	11.0%	13.0%	13.0%	12.0%	8.1%	7.6%

Performance summary: 1 out of 6 urgent and emergency care trajectory targets has been met in April 2023.

Improved performance has been seen this month in:

- percentage of ambulance handovers greater than 15 minutes;
- total average time in ED
- ED attendances where visit time over 12 hours;
- 4-hour ED target.
- percentage of patients with No Criteria to Reside.

A deterioration in performance has been seen in:

- percentage of patients discharged pre-noon.

	Target	13 month trend	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA															
Elective recovery															
RTT 104 week wait incomplete pathway	0		192	173	96	70	51	50	47	34	29	22	14	0	0
RTT 78 week wait incomplete pathway	176		779	813	713	686	787	813	829	822	923	708	462	183	166
RTT 65 week wait incomplete pathway	1091						2093	2252	2485	2174	2203	1828	1679	1372	1244
RTT 52 week wait incomplete pathway			3374	3765	4137	4578	5083	5060	5412	5585	6027	5554	5116	4427	4024
Patient waits over 2.5 years	0		18	32	48	54	47	24	24	17	12	9	6	0	0
75% of GP referred patients diagnosed within 28 days	75%		76.9%	67.6%	64.8%	67.7%	72.1%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	74.8%
Number of patients waiting longer than 62 days for treatment	138		245	307	233	283	244	333	331	229	253	225	130	114	107
Percentage of patients waiting longer than 62 days for treatment			11.8%	14.1%	10.2%	11.5%	10.6%	13.6%	15.5%	11.7%	17.1%	16.4%	8.7%	7.0%	6.5%

Performance summary: 3 of 4 elective recovery exit criteria targets have been met in April 2023.

Improved performance has been seen this month in:

- number of patients waiting 78 weeks for treatment;
- number of patients waiting 65 weeks for treatment;
- number of patients waiting 52 weeks for treatment;
- number of patients waiting longer than 62 days for treatment.

A deterioration in performance has been seen in:

- 75% of GP referred patients receiving a cancer diagnosis within 28 days.

Performance remains the same for:

- number of patients waiting 104 weeks for treatment;
- patients waiting over 2.5 years.

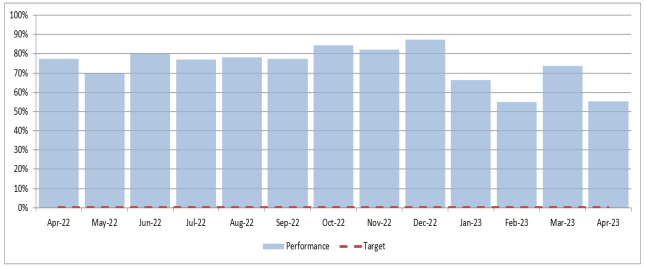
Exception report: Ambulance handovers over 15 minutes: SOF 4 Exit Criteria - Urgent and emergency care

Performance

Ambulance handover delays decreased in April as infection issues subsided and gains were made in early morning and weekend discharges in conjunction with a reduction in NCTR patients.

Percent of ambulance handovers over 15 minutes

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Performance	77%	70%	80%	77%	78%	78%	84%	82%	88%	67%	55%	74%	55%
Target	0	0	0	0	0	0	0	0	0	0	0	0	0



Rolling 30-day position as at **11 May 2023**

click on a bar to highlight site on the trend chart

Ambulance Trust	Site	
South Western	Derriford Hospital	3782:30:25
South Western	Royal Cornwall Hospital (treliske)	3689:38:31
South Western	Gloucestershire Royal Hospital	2069:43:04
South Central	Queen Alexandra Hospital	1624:28:23
South Western	Royal United Hospital	1273:38:29
South Western	Bristol Royal Infirmary	1146:26:29
South Western	Weston General Hospital	770:30:33
South Western	The Great Western Hospital	675:43:56
South Western	Royal Bournemouth Hospital	578:02:22
South Western	Royal Devon & Exeter Hospital (w.	537:42:25
South Western	Torbay Hospital	492:38:09
South Western	Poole Hospital	468:02:45
South Western	Southmead Hospital	332:09:51
South Western	Salisbury Health Care NHS Trust	238:05:49
South Western	Musgrove Park Hospital	227:34:06

Operational update

Operation resilience and grip, resolution of infection issues, forward planning for industrial action and implementing lessons learnt from bank holidays have all contributed to an improved ambulance performance.

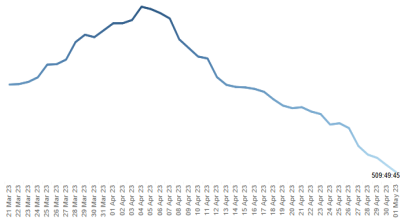
Time lost to ambulance handover delays (hrs)

Rolling 30-day position as at **01 May 2023**

click on a bar to highlight site on the trend chart

Ambulance Trust	Site	
South Western	Torbay Hospital	509:49:45

Rolling 30-day **Trend**



Handover trend

hover over bar to show split by site

Actions to complete next month

We remain committed to improving the two main causes of patient flow imbalance by improving performance by:

1. increasing the number of patient discharges before noon and;
2. Increasing the number of patient weekend discharges.

Risks/issues

- Further Infection issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

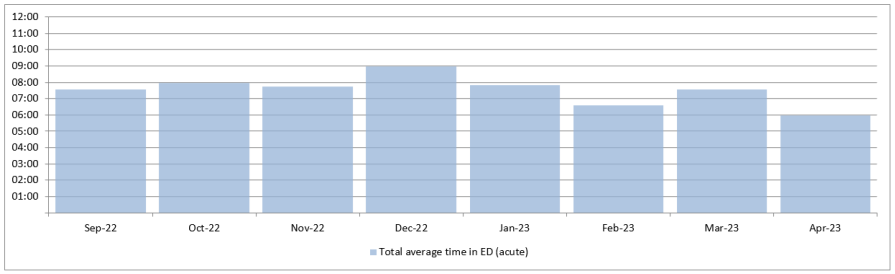
Exception report: Total average time in ED: SOF 4 Exit Criteria - Urgent and emergency care

Performance

April saw a decrease in the total average time in the emergency department to 05.57 down from 07.34 the previous month.

Total average time in ED (acute)

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Performance						07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57
Target	0	0	0	0	0	0	0	0	0	0	0	0	0



Operational update

Throughout April bed capacity and flow was improved as a consequence of minimising infections issues. Further to this early morning flow, an increase in general discharge numbers and weekend capacity increased providing opportunity to reduce occupancy in the emergency department and as a result improve total average time in the department.

Actions to complete next month

We remain committed to improving the two main causes of patient flow imbalance by improving performance by:

1. increasing the number of patient discharges before noon and;
2. Increasing the number of patient weekend discharges.

In additional to the above the following actions are underway:

- Use of the ED escalation area 11 beds - options paper for agreement to improve flow (admitting ward)
- Virtual ward – complete on site mobilisation – data reporting to be implemented
- Focus on quick win non admitted pathways to reduce patient time in the department and ED occupancy

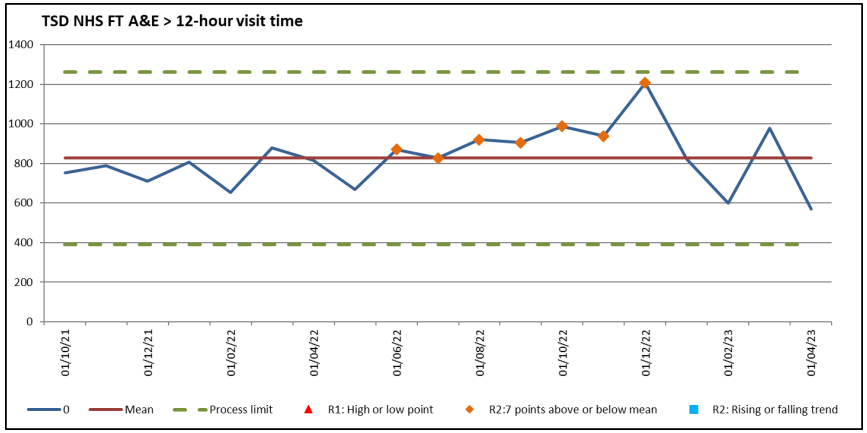
Risks/issues

- Further Infection control issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

Exception report: Over 12-hour visit time: SOF 4 Exit Criteria - Urgent and emergency care

Performance

April 12hr performance mirrored the ambulance delays and total average time in ED with an decrease in numbers as a result of improved patient flow.



Operational update

Early morning discharges, increased weekend discharges and reduced NCTC have all provided the opportunity to reduce occupancy in the emergency department. As a result smaller numbers of patients have been waiting >12hrs in the emergency department. Patient flow has also provided further opportunity to provide specialist beds to patients that have been restricted due to capacity issues e.g. ortho, respiratory and cardiology.

Actions to complete next month

We remain committed to improving the two main causes of patient flow imbalance by improving performance by:

1. increasing the number of patient discharges before noon and;
2. Increasing the number of patient weekend discharges.

In additional to the above the following actions are underway:

- ED escalation area 11 beds - options paper for agreement to improve flow (admitting ward)
- Virtual ward – complete on site mobilisation – data reporting to be implemented
- Further utilisation of the discharge lounge, and early identification of tomorrows discharges (SWIFT, Nerve Centre and Portal alignment)

Risks/issues

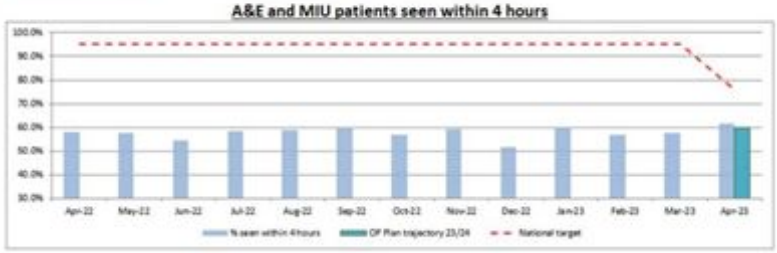
- Further Infection issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

Exception report: 4-hour ED target: SOF 4 Exit Criteria - Urgent and emergency care

Performance

ED Type 1 performance 43.6%
ICO Performance 61.74%

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Patients	8021	8797	8650	9413	9678	8643	8853	8538	9263	7831	7658	8765	8979
4 hour breaches	3370	3732	3934	3907	3981	3437	3805	3464	4464	3131	3299	3717	3435
% seen within 4 hours	58.0%	57.6%	54.5%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%



Operational update

- Daily demand to the Emergency Department (ED) rose from 187.7 in March to 199.2 in April. Overall attendances increased from 5,821 to 5977. We achieved 43.6% against our ED 4-hour target.
- Our type 3 demand (UTC and MIU) increased to 3002 up from 2945 in March. We achieved 97.87% against our Type 3 4-hour target a marginal increase in performance from 97.11 in March.
- Overall our UEC performance was 61.74% up from 57.59 in March.

Actions to complete next month

- Establishment of Urgent Emergency Care Board and 3 workstreams April Meetings – Internal professional standards and measurement to be agreed
- ED escalation area 11 beds - options paper for agreement to improve flow (admitting ward)
- Virtual ward – complete on site mobilisation – data reporting to be implemented
- New (April 2023) UEC funding implementation plan
- Focus on quick win non admitted pathways – specifically paediatrics, minors and walk in patients

Risks/issues

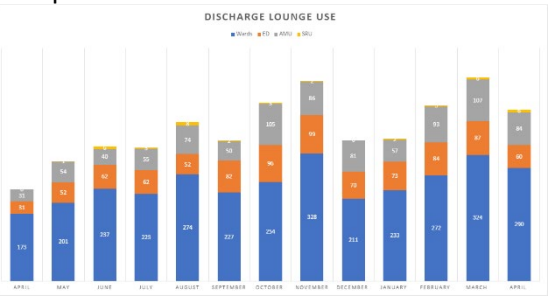
- Further Infection issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

Exception report: Percent of pre-noon discharges: SOF 4 Exit Criteria - Urgent and emergency care

Performance

DAY	DATE	OPEL	Acute Adult IP bed base - Pre Noon (33%+)	Acute Adult IP bed base - Pre 5PM (75%+)
Saturday	1st	OPEL 4	28.9%	78.9%
Sunday	2nd	OPEL 4	11.1%	44.4%
Monday	3rd	OPEL 4	17.2%	70.3%
Tuesday	4th	OPEL 4	16.4%	53.7%
Wednesday	5th	OPEL 3	21.0%	72.6%
Thursday	6th	OPEL 3	14.1%	59.4%
Friday	7th	OPEL 3	27.0%	85.7%
Saturday	8th	OPEL 3	5.4%	73.0%
Sunday	9th	OPEL 3	26.5%	76.5%
Monday	10th	OPEL 3	20.0%	66.7%
Tuesday	11th	OPEL 3	13.8%	75.9%
Wednesday	12th	OPEL 3	25.0%	83.8%
Thursday	13th	OPEL 2	21.4%	75.7%
Friday	14th	OPEL 2	19.2%	61.6%
Saturday	15th	OPEL 2	22.4%	69.4%
Sunday	16th	OPEL 2	6.1%	75.8%
Monday	17th	OPEL 3	11.1%	69.8%
Tuesday	18th	OPEL 3	29.5%	77.0%
Wednesday	19th	OPEL 3	23.1%	76.9%
Thursday	20th	OPEL 3	20.6%	76.6%
Friday	21st	OPEL 4	12.0%	56.0%
Saturday	22nd	OPEL 3	20.9%	74.4%
Sunday	23rd	OPEL 3	17.2%	65.5%
Monday	24th	OPEL 3	18.3%	66.7%
Tuesday	25th	OPEL 3	15.9%	73.9%
Wednesday	26th	OPEL 3	23.1%	70.5%
Thursday	27th	OPEL 2	23.5%	73.5%
Friday	28th	OPEL 2	19.0%	55.7%
Saturday	29th	OPEL 2	19.4%	73.2%
Sunday	30th	OPEL 2	9.8%	61.0%

We saw an improvement in our G&A discharges in April. On a number of occasions, we have achieved our pre 5PM discharge target. The flow and ward improvement group (Subgroup to UEC Board) seek to continue to drive this improvement, with a focus on Pre Noon, with workstreams to maintain and improve this position and our patient experience.



Operational update

The discharge lounge (DCL) remains helpful in generating timely ward capacity. Although we saw a reduction in patient numbers this was due to infection control ward closures.
Work is underway to review overnight 'bedding' the DCL and to reduce it. We know this is impacting our Pre Noon and 5PM Discharges.

Throughout April we have seen an increase in weekend discharges. Driven by our discharge team and the additional consultant and ward rounds on our short stay ward.

Key changes have been developed throughout April to support early morning and weekend discharges

- We have seen an increase in P1 discharges at weekends due to the introduction of a Friday afternoon complex multidisciplinary team (MDT) meeting, and also community teams completing discharge to assess (D2As) to support patients returning home.
- Additional Consultant cover at weekends to EAU4
- Ensuring the weekend discharge SOP is being used and adopting an accountability framework for staff to ensure weekend processes are updated and completed
- Site team focus to support Pre noon and Pre 5PM Discharges.

Actions to complete next month

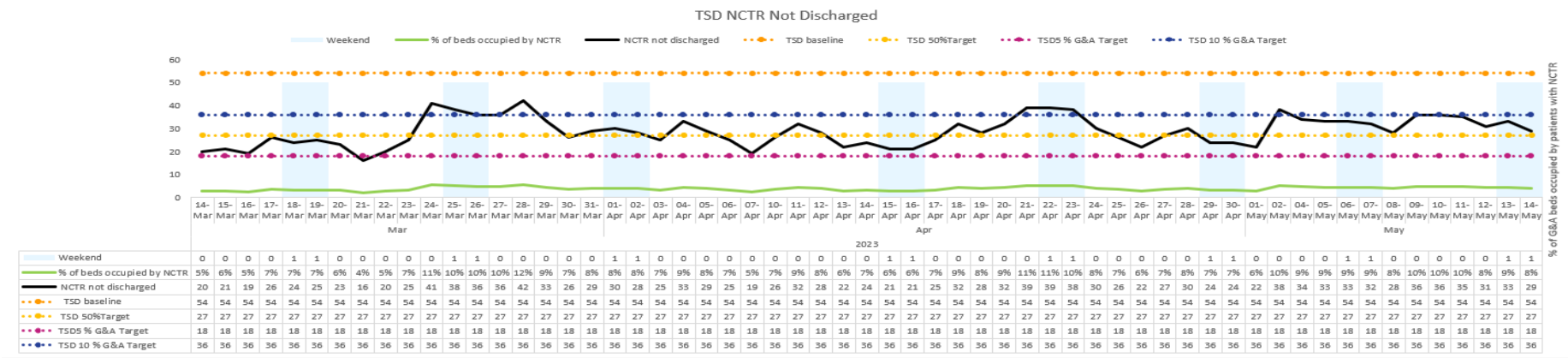
Next Steps/Actions

- New (April 2023) UEC funding implementation plan - winter uplift of workforce in discharge lounge.
- Finalise workstream for Ward and flow improvement sub group.
- Ward Nurse Flow training programme to start in June.
- Develop learning from Industrial action successes – specifically night identification of tomorrows discharges, transport and CPS's.

Risks/issues

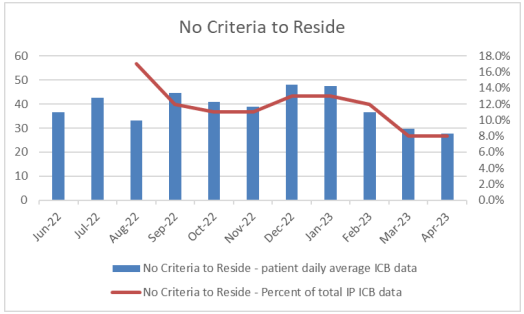
- Further Infection issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Consistent additional staffing support to the discharge team at weekends and senior cover
- Further industrial action

Exception report: No criteria to reside: SOF 4 Exit Criteria - Urgent and emergency care



	14-Mar	15-Mar	16-Mar	17-Mar	18-Mar	19-Mar	20-Mar	21-Mar	22-Mar	23-Mar	24-Mar	25-Mar	26-Mar	27-Mar	28-Mar	29-Mar	30-Mar	31-Mar	01-Apr	02-Apr	03-Apr	04-Apr	05-Apr	06-Apr	07-Apr	10-Apr	11-Apr	12-Apr	13-Apr	14-Apr	15-Apr	16-Apr	17-Apr	18-Apr	19-Apr	20-Apr	21-Apr	22-Apr	23-Apr	24-Apr	25-Apr	26-Apr	27-Apr	28-Apr	29-Apr	30-Apr	01-May	02-May	04-May	05-May	06-May	07-May	08-May	09-May	10-May	11-May	12-May	13-May	14-May
Weekend	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	1	1	0	0	0	0	1	1
% of beds occupied by NCTR	5%	6%	5%	7%	7%	7%	6%	4%	5%	7%	11%	10%	10%	10%	12%	9%	7%	8%	8%	8%	7%	9%	8%	7%	5%	7%	9%	8%	6%	7%	6%	6%	7%	9%	8%	9%	11%	11%	10%	8%	7%	6%	7%	8%	7%	7%	6%	10%	9%	9%	9%	9%	8%	10%	10%	10%	8%	9%	8%
NCTR not discharged	20	21	19	26	24	25	23	16	20	25	41	38	36	36	42	33	26	29	30	28	25	33	29	25	19	26	32	28	22	24	21	21	25	32	28	32	39	39	38	30	26	22	27	30	24	24	22	38	34	33	33	32	28	36	36	35	31	33	29
TSD baseline	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54
TSD 50%Target	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27
TSD5 % G&A Target	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18
TSD 10 % G&A Target	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36

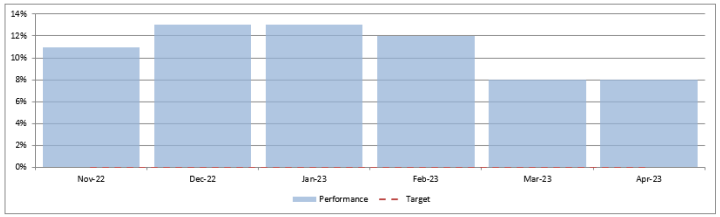
Performance



The average number of patients with no criteria to reside remained static at 8% in April. For noting on the 7th April the Trust dipped to 5%. The Trust have the lowest NCTR across the ICB.

Percent of patients with No Criteria to Reside - ICO

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Performance	0%	0%	0%	0%	0%	0%	11%	11%	13%	13%	12%	8%	8%
Target	0	0	0	0	0	0	0	0	0	0	0	0	0



Operational update

Key actions that have support the improvement in NCTR

- Trusted placement assessor.
- Mobilised block beds.
- OT in reach model – Recruitment of 2nd Post.
- Flexible team and social care services
- Process review of D2A at a senior level to increase capacity and risk.
- Lead DISCO now attending NCTR meeting and taking actions to improve flow and validate patients converted to CTR on day of discharge
- JD review of Lead DISCO to move into a operational manager for inpatient. – Awaiting AFC process to be completed.
- Discharge Hub is competing D2A visits to support discharge when locality lack capacity to meet demand.
- UEC workstreams to be confirmed to include scoping JETS and McCullum delivery model.

Actions to complete next month

- Addressing the influx of referrals on Fridays leading into the weekend
- Internal audit of the processes
- Review of pre-referral patients to the hub
- Awaiting report on 'over-prescription of care' issues from Newton Europe

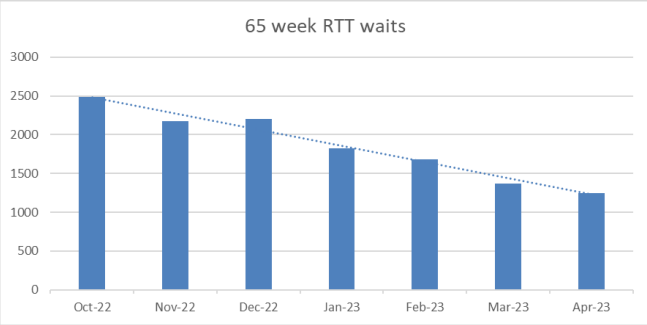
Risks/issues

- Further Infection issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

Exception report: 65 Week Clearance: SOF 4 Exit Criteria – Elective Recovery

Performance

The Trust has reported a reduction in the number of 65 week waiters in recent months.



The predicted position for March 2024 is a reduction in 65 week waits from the end of March position of 1,365 to 1,091. This is split as follows;

- Non-admitted 855
- Admitted 236

April performance was 1,244 against a target of 1,292.
This prediction is made on the basis of the known number of patients who will breach 65 weeks before 31st March 2024 due to capacity issues within the Trust to treat all the patients necessary. Planned additional insourcing and outsourcing has been included in this calculation.

Operational update

Our position was refined during April and May a worse position as follows:

	Non-Admit	Admit	Total
Starting position	**8,987**	**473**	**9,460**
Revised 9th March	**3,239**	**360**	**3,599**
Current forecast	**855**	**236**	**1,091**

As the table shows, the improved prediction is delivered in the non-admitted position and is driven by maintaining or increasing the levels of insourcing activities procured in Q4 of last year. Demand and Capacity work supported by NHSE team has provided further assurance against this improved forecast.

Improvements in productivity and efficiency will also make a contribution to delivery.

Actions to complete next month

Through May we will continue to build on the work done by the NHSE team to provide assurance against all our specialties, particularly where we believe there are delivery risks for outpatient activities or the service is considered “fragile”.

Enhanced reporting (Tableau) of the 65 week cohort will be made available in May and will underpin the discipline and control of our long wait clearance plans

TIF2 clarifications for Business Continuity and activity mitigation have been shared with ICB, we await a response.

Risks/issues

Delivery of the revised plans is dependent on the successful continuation and growth in our use of the Independent Sector. This is not a model the Trust considerers to be sustainable. Plans to be more self sufficient within the Devon System are in discussion.

Managing staff workloads and engagement in delivery of the plan is important and remains the biggest risk to delivery of the 65 week plan.

Quality and Safety Indicators

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

Reported Incidents – Severe (<6)		↑
Reported Incidents – Death (<1)		↑
Medication errors resulting in moderate harm (<1)		↓
Medication errors - Total reported incidents (No target set)		
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears) (9 per year)		↑
Never Events (<1)		↔
Strategic Executive Information System (STEIS) (<1)		↑
QUEST (Quality Effectiveness Safety Trigger Tool – red rated areas (<1)		↓
Formal complaints - Number received (<60)		↑
VTE - Risk Assessment on Admission (>95%) (Acute)		↓
Hospital standardised mortality rate (HSMR) (<100)		↑
Safer Staffing - ICO – Daytime (90% - 110%)		
Safer Staffing - ICO – Night time (90% - 110%)		
Infection Control - Bed Closures - (Acute)(<100)		↓
Hand Hygiene (>95%)		↓
Fracture Neck Of Femur - Time to Theatre <36 hours (>90%)		↓
Stroke patients spending 90% of time on a stroke ward (>80%)		↓
Mixed sex accommodation breaches (0)		↔

Quality and Patient Safety Summary

Incidents
In April 2023, one incident of severe harm was verified and reported onto the national StEIS system. This was a patient who experienced a fall that resulted in a fractured neck of femur; an investigation is underway.

Two incidents of death were reported within the Trust and are detailed below:
- One out of hospital paediatric cardiac arrest which is being reviewed under the Child Death review protocol;
- One inpatient death relating to a cardiac arrest; this is being reviewed under an internal incident investigation and has not been reported onto StEIS.

These two incidents will be reviewed through Trust processes to consider if they should be reported onto the StEIS system.

Stroke
Timely access to a dedicated stroke unit improves clinical outcomes for patients and offers improved quality of life outcomes. In April 2023, 22.5% of patients were admitted to the stroke ward within 4 hours of arrival at hospital which remains below the target of 90%. In April 63% of stroke patients admitted to the Stroke Unit, spent 90% or more of their time on the dedicated stroke ward against a standard of 80%. The target is still not met and there has been a slight decline in these two metrics this month. Further actions are being undertaken to improve this position.

VTE assessment
VTE assessment compliance demonstrated a conformity for all in patients of 97.7% in April 2023 and the assessment performed within 4 hours of admission was reported at 93%. Those areas that are not achieving the standard required are being supported by the VTE Steering Group.

Infection, Prevention, and Control:
Bed closures saw an increase from 164 in March to 217 in April. The reason for the closures has mainly been due to;
- Patients testing positive for COVID-19/Flu A on admission;
- Out breaks of norovirus during admission.

Management of these continue to follow IPC guidelines and Public Health England guidance.

Maternity
There were no stillbirths or fetal loses in April 2023. The number of women reported to be smoking at birth in April 23 was 5.8% which is well below the national average of 8.6%.

Staffing:
The Registered Nurse fill rate for days during April 2023 is reported as 92.4% which is a slight increase from March of 91.3%. The Registered Nurse night duty fill rate has also improved to 91.3% from a March position of 88.4%. The fill rate for health care support workers has increased to 103.7% from March figure of 97.9% and the fill rate has remained stable overnight. Twice daily staffing meetings have continued to ensure risks are assessed and actions and mitigations were put in place to ensure safe staffing levels were maintained.

CQC update 2021 and 2020 Action Plans

2020 CQC inspection

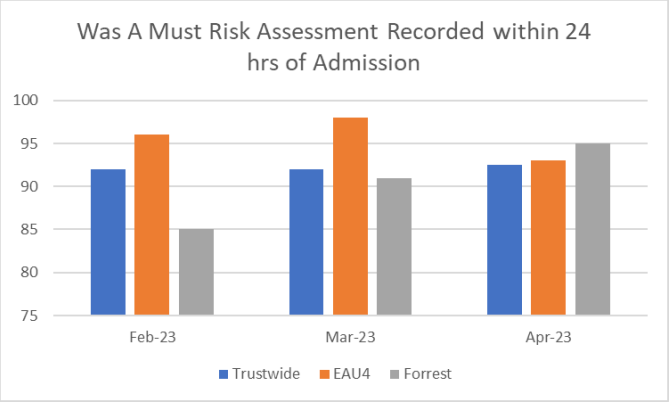
The Quality Improvement action plan arising from the 2020 CQC inspection is nearing completion and all closed actions continue to have oversight through the Integrated Service Units. The Compliance Assurance Group (CQCCAG) have controls in place to ensure the actions are monitored. The Trust has one remaining Must Do action in regard to the Medical Care staff appraisal achievement rate. The Trust position at April 2023 remains at 79%. The People Directorate have created a two phase recovery plan with improvement trajectories to ensure the 85% target is achieved and sustained. This includes clear expectations as set out in Peoples Promise, effective rollout of appraisal training and a transition to electronic records.

2021 CQC Focused Inspection – Quality Improvements

The daily five 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. MUST risk assessment was the most consistently completed within the 24 hour time standard with a compliance rate of 92.5%.

April 2023

- ✓ Audit results report Trust wide nutritional risk assessments completed within 24 hours have improved in April 2023 with a Trust position of 92.5%. It is recognised that there is a variable position on timeliness of the undertaking of patient risk assessments.
- ✓ Forrest Ward recorded continues its improvement from 85.3% in March to 95% in April.
- ✓ EAU4 recorded 93% compliance which is an improved position.



Other nursing risk assessments current compliance rates as follows;

- ✓ Infection Prevention and Control – 98%
- ✓ Waterlow score – 98%
- ✓ Patient Handling and Falls assessment – 99.8%
- ✓ Pain assessments – 97.5%

The above is based on the audit of x5 sets of notes on each ward daily.

Well Led Preparation

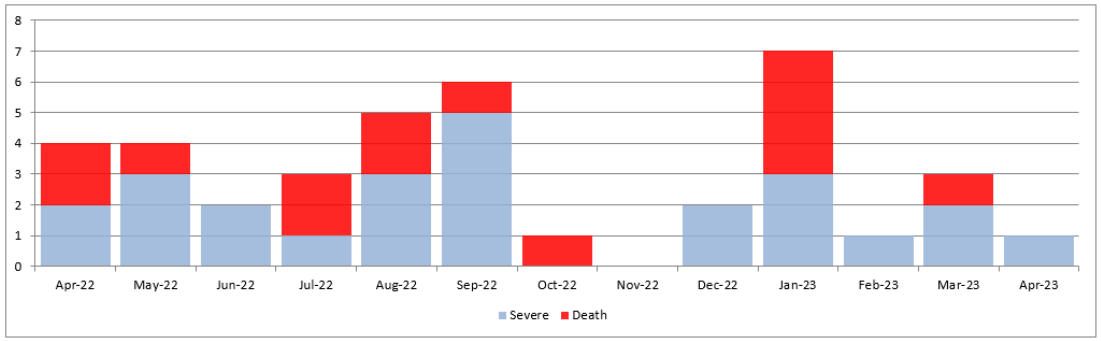
The Trust has been notified of the CQC intention to undertake a Well Led inspection in June 23 and an organisational plan to support staff through the inspection process is underway. This includes;

- ✓ Presentation to Executives, Senior Managers, and further focus groups planned for other staff groups;
- ✓ Detailed communications strategy in place and being implemented;
- ✓ Named executive for each Well Led Key Line of Enquiry;
- ✓ Review self assessment document alongside well lead framework for all services;
- ✓ Evidence Review Panel in place to review evidence weekly;
- ✓ Dedicated project support provided;
- ✓ Weekly exception report to Executives;
- ✓ Governance Framework established.

Quality and Safety exception reports – reported incidents / HSMR

Reported Incidents - Severe and Death

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Severe	2	3	2	1	3	5	0	0	2	3	1	2	1
Death	2	1	0	2	2	1	1	0	0	4	0	1	0

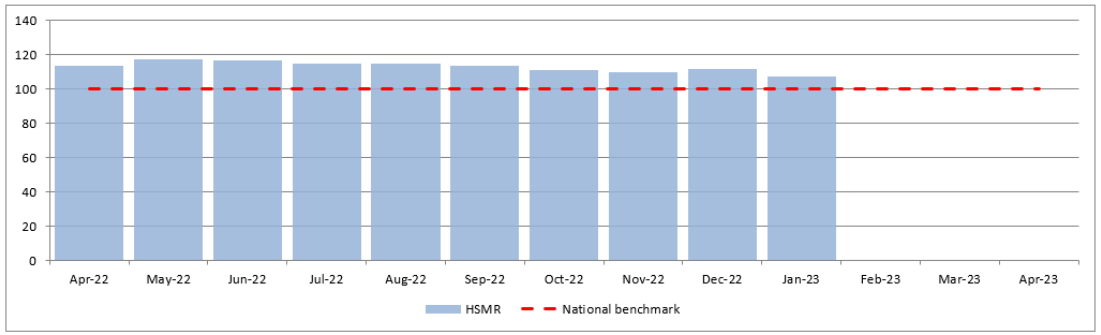


In April 2023, 1 incident of severe harm was verified and reported onto the national StEIS system.

This was a patient who experienced a fall that resulted in a fractured neck of femur; an investigation is underway.

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
HSMR	113.5	117.4	117	115.1	114.7	113.4	111	109.9	111.5	107.1	n/a	n/a	n/a
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



The HSMR is measured from the mortality arising from a standardised group of 56 diagnosis.
This data is always 3 months in arrears due to benchmarking so data is expected next month.
Work continues to focus on understanding our local population in relation to;

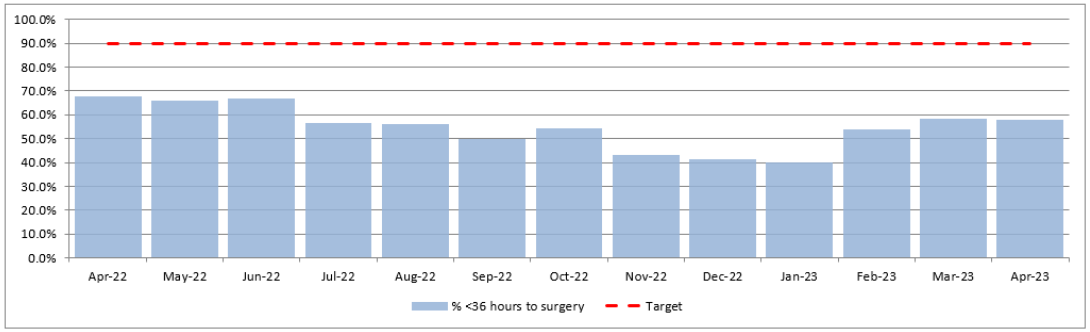
- Age
- Deprivation

Using our local population data the increase in HSMR data over the last 2 years is broadly in line with the trend of increase as seen by our regional peers.

Quality and Safety exception report – fractured neck of femur time to surgery / VTE

Fractured neck of femur - <36 hours to surgery

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
% <36 hours to surgery	67.9%	65.8%	66.7%	56.4%	56.0%	50.0%	54.3%	43.3%	41.5%	40.0%	53.8%	58.3%	58.0%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



58.0% of patients had access to theatre within the recommended time frame in April 2023 against a target of 90%.

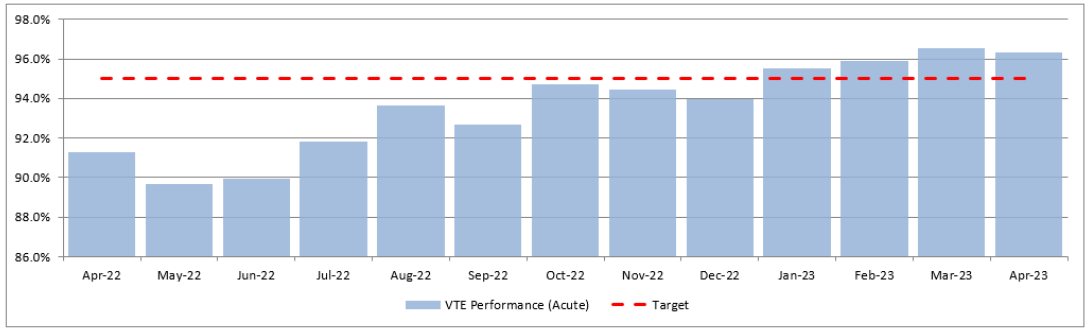
The monthly Hip Fracture Governance meetings are now in place and running frequently to monitor and manage compliance.

Other actions continue such as;

- a commitment to ringfence trauma beds;
- close working with the Emergency Department and SWAST to ensure early x-rays and confirmation of fractures.

Acute VTE risk assessment on admission

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
VTE Numerator	4789	5170	4942	5007	5255	5102	5433	5521	4896	5631	5437	6050	5152
VTE Denominator	5246	5766	5493	5452	5612	5505	5737	5847	5210	5894	5669	6267	5349
VTE Performance (Acute)	91.3%	89.7%	90.0%	91.8%	93.6%	92.7%	94.7%	94.4%	94.0%	95.5%	95.9%	96.5%	96.3%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



VTE assessment

- VTE assessment audit achieved 97.7% in April
- Target of assessments completed within 24 hours of admission was achieved in April.

Area of non compliance for completion with 24 hours;

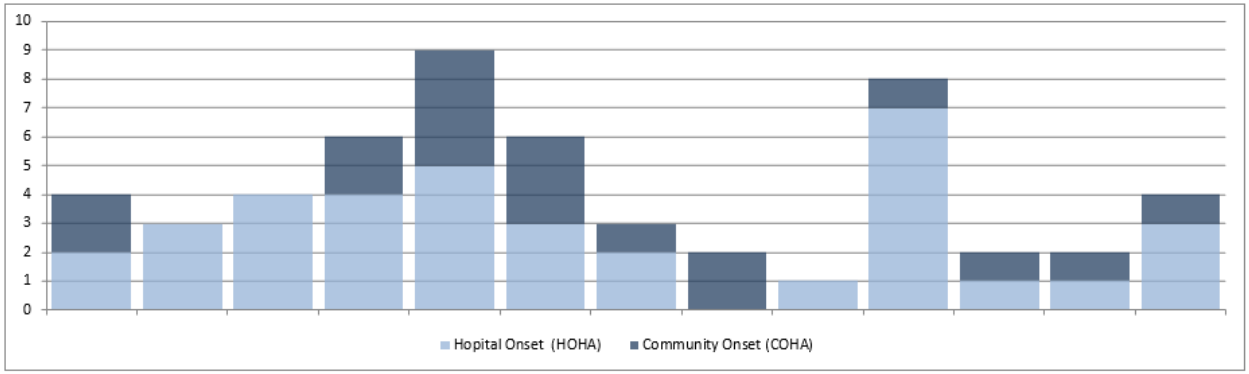
- Ainslie - 68%
- Cheetham Hill – 75%
- Ella Rowcroft – 63.6%
- Louisa Cary – 66.7%.

New Forrest have demonstrated a significant improvement and have increased compliance from 9.1% to 87.0% in April.

Quality and Safety exception report - infection control

Number of Clostridium Difficile cases

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Hopital Onset (HOHA)	2	3	4	4	5	3	2	0	1	7	1	1	3
Community Onset (COHA)	2	0	0	2	4	3	1	2	0	1	1	1	1



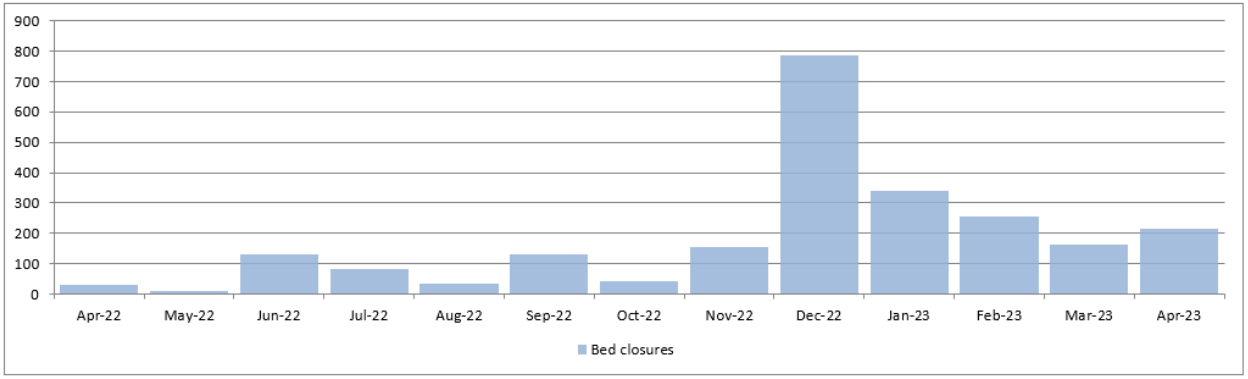
In April 4 cases of C Diff were reported. Themes are as follows:

- not isolating patients once stool sample obtained;
- delay in sending stool sample.

There are no clinical areas that are causing particular IPC practice concerns.

Infection control - Bed days lost (Acute)

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Bed closures	30	12	130	84	36	132	42	156	786	339	254	164	217



Bed closures increased from 164 in March to 217 in April 23.

The reason for the closures has mainly been due to:

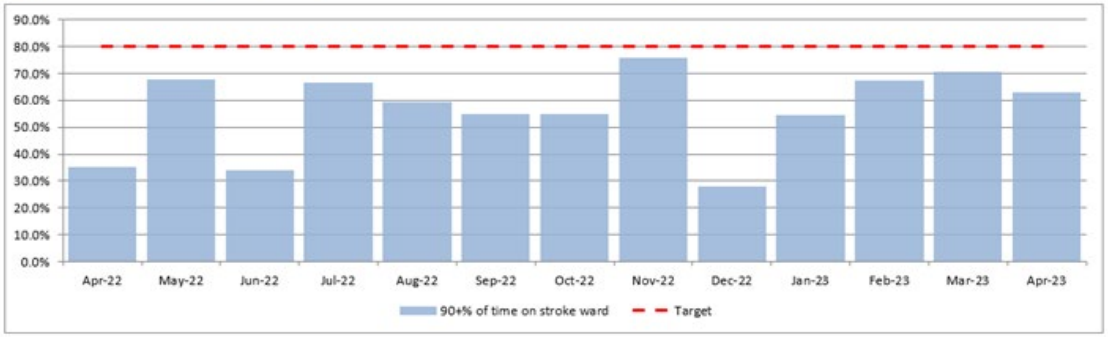
- patients testing positive for COVID-19/Flu A on admission;
- Out-breaks of norovirus during admission.

Management of these have followed Infection, Prevention and Control guidelines and Public Health England guidance.

Quality and Safety exception report – stroke care

Stroke

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
90+% of time on stroke ward	35.3%	67.6%	34.1%	66.7%	59.3%	54.8%	55.0%	75.9%	28.0%	54.5%	67.4%	70.7%	63.0%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



Time critical Stroke Standards									
	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Number of patients (N)	42	33	46	32	39	34	41	42	56
% Scanned within 1 hour	40.5	45.5	45.7	57.8	48.7	61.8	41.5	57.1	50.9
% Scanned within 12 hours	88.1	93.9	93.5	93.3	92.3	94.1	95.1	100	92.7
% Admitted to Stroke Unit within 4 hours	25	24.2	8.9	26.2	0	15.6	17.5	37.5	22.2
% of patients spending 90% of their time on the Stroke Unit	64.1	54.8	60	76.7	37.1	54.5	70.7	70.7	63
% (No.) Patients that received Thrombolysis	9.5 (4)	15.2 (5)	8.7 (4)	13.3 (4)	7.9 (3)	12.1 (4)	10 (4)	10 (4)	10.9 (6)
% Received Thrombolysis within 1 hr	25	20	50	100	0	50	0	50	50
SSNAP	A	B	C	D	E				

Time critical stroke standards

- 63% of patients spent more than 90% of their stay on the stroke unit which is a slightly worsening position;
- 22.2% of patients were admitted to the stroke unit with 4 hours of admission; this metric has seen a deterioration this month;
- 100% of patients received a nutrition screen and a continence plan within 12 hours;
- 50.9 % of patients received a scan within one hour;
- 83.6% saw a stroke nurse within 24 hours.

SSNAP – Sentinel Stroke National Audit programme

The clinical audit programme measures the processes of care provided to stroke patients in inpatient and community settings. Organisational audits measure the structure of stroke services in acute hospital settings (acute organisational audit) and the structure of stroke services in community settings (post-acute organisational audit). The audits measure stroke care against evidence based standards.

Stroke bed ring-fencing

The drive to improve upon the stroke patient pathway continues with recognition that maintaining two beds free for patients on the stroke pathway continues to be a challenge. There has been work to develop a Standard Operation Procedure which will support the ring-fencing of at least one hyper-acute bed on George Earle, including during times of escalation, this will be monitored moving forwards.

Actions have been agreed with the ward co-ordinator, this includes:

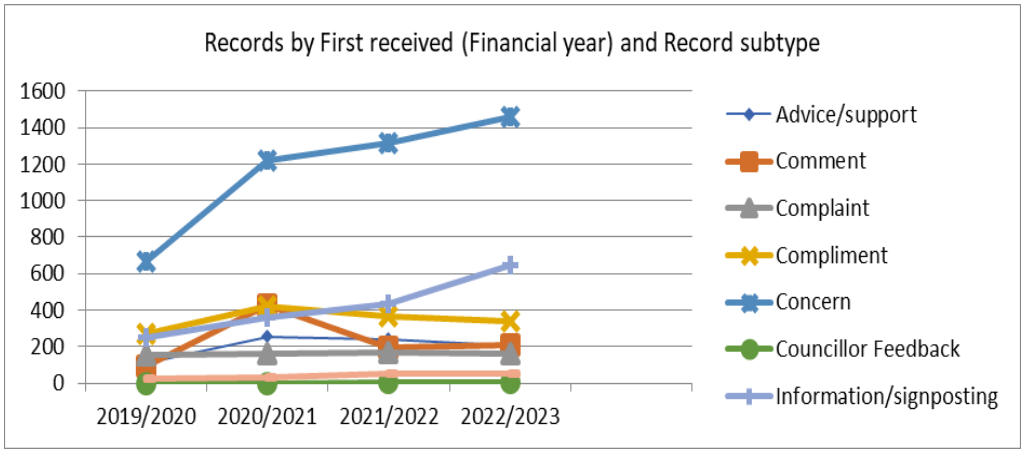
- targeted teaching across all wards, peer reviews, and daily Matron and Associate Director of Nursing – Professional Practice (ADNPP) walk about;
- weekly quality review meetings set up by ADNPP involving Health of Older Person/Stroke leadership team.

Stroke performance governance and oversight

Performance against the time critical stroke standards are reviewed and discussed at the Quality Improvement Group, performance risks and issues are escalated to the Quality Assurance Committee.

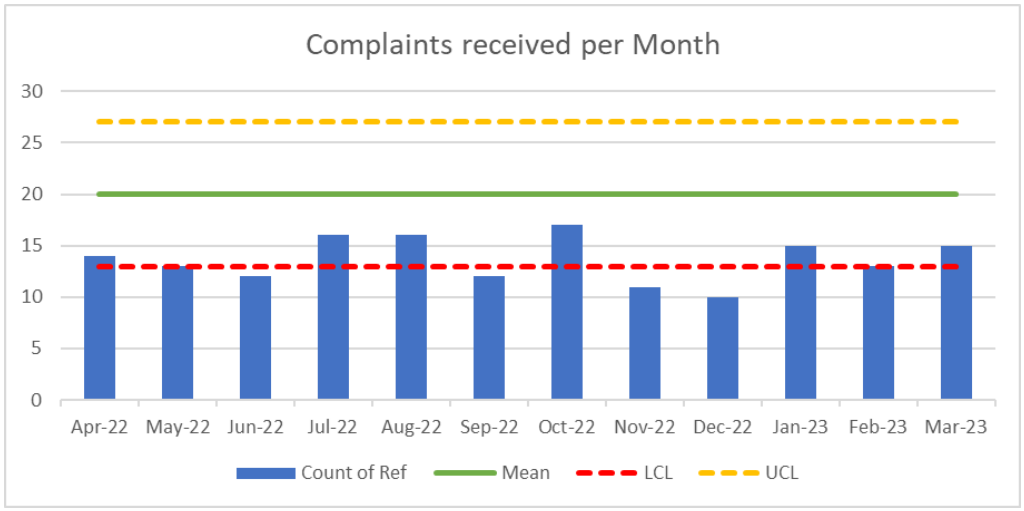
Quality and Safety – Feedback and Engagement - Complaints

Total Number of Complaints, PAL's contacts



In the 22/23 financial year, there were a total of 3,073 contacts to the PALs and Complaints Department recorded on Datix. This is an increase of approx. 600 contacts per financial year [with the exception of 20/21 – likely due to Covid-19].

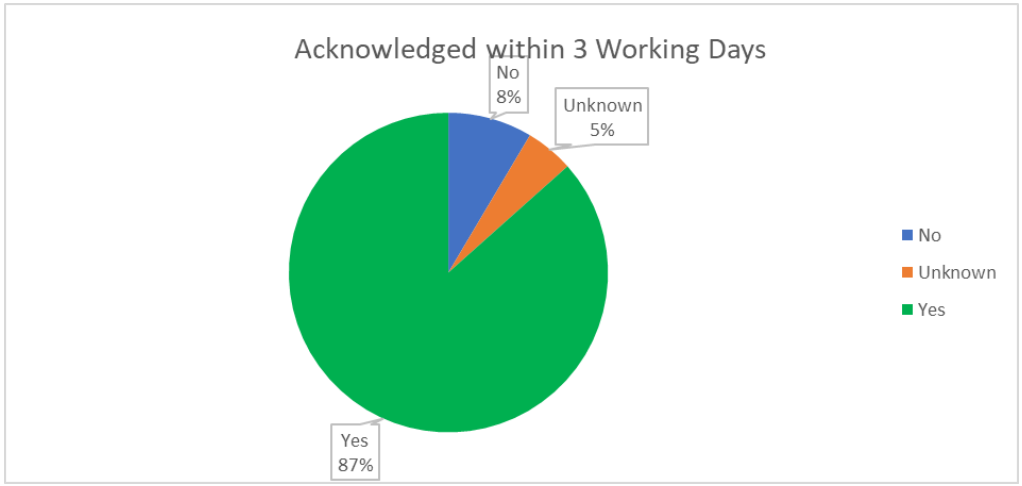
Complaints have remained static across the four years. However, a rise in concerns is related to the impact of Covid-19 and standing down of services. Work is now underway to improve patients access and waits as Covid-19 restrictions are lifted.



The number of complaints received in the 22/23 Financial Year stands at 164 which equates an average of 13 per month. these figures are consistently below the lower control limit of expected volume of complaints per month [Mean = 20 / LCL = 13 / UCL = 27, averages calculated by records received since the Trust integrated circa 2016].

Quality and Safety – Feedback and Engagement - Complaints

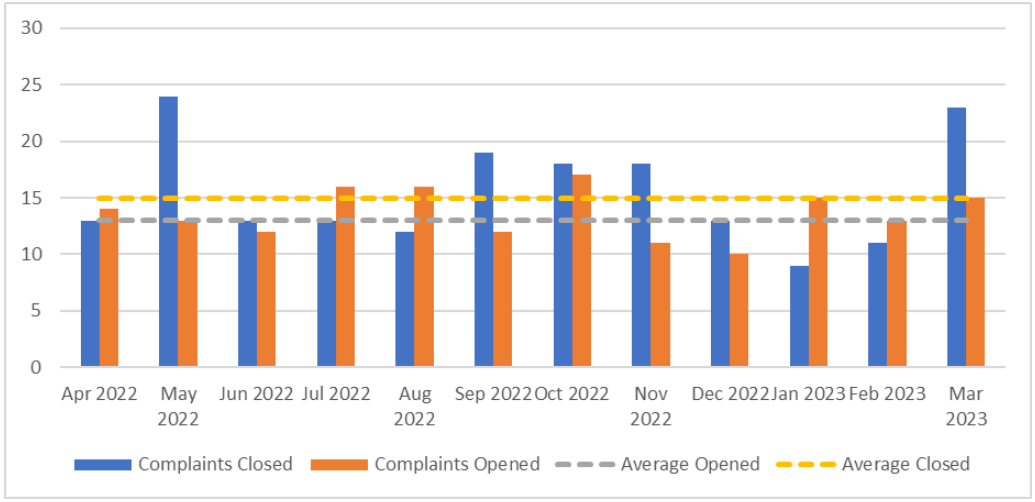
Percent performance against acknowledgement timeframe (3 days)



Within the 164 complaints received in the 22/23 financial year, 87% of complaints received formal acknowledgement within 3 days; please note in 5% [n=8] cases, an acknowledgement date has not been recorded.

The 8% not acknowledged on time will include delays in receiving consent and questions for the complainant. These are then acted on within the 3 day time frame on receipt which isn't reflected due to the data pull.

Percent of complaints closed as a total of complaints received



On a month by month basis, an average of 13 complaints was received per month, and 15 complaints were on average closed per month.

Quality and Safety – Feedback and Engagement – Complaints

Number of Ombudsman 2022/23 to date

	LGSO	PSHO	Joint	Not referred	total referred	% referred
16/17	2	10	0	175	12	7%
17/18	8	23	0	308	31	10%
18/19	3	16	0	295	19	6%
19/20	3	19	0	289	22	8%
20/21	2	8	0	169	10	6%
21/22	4	7	2	161	13	8%
22/23	0	2	0	165	2	1%

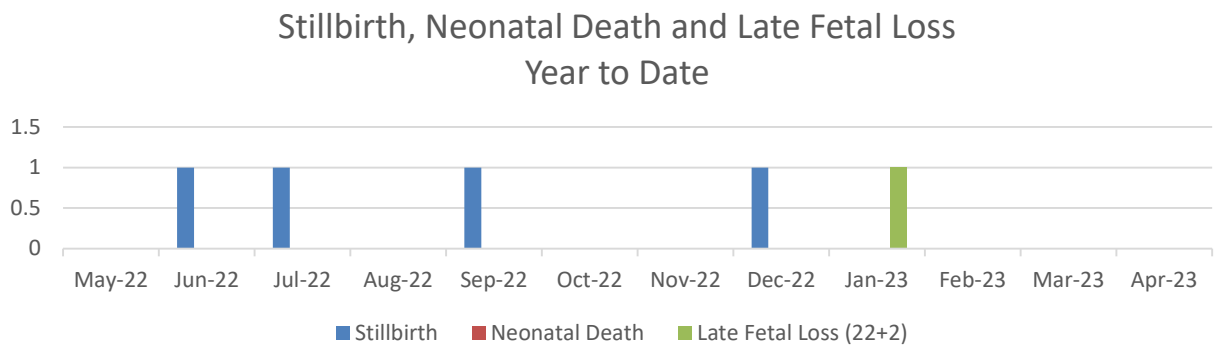
Month referred to Ombudsman	Joint Ombudsman	Local Government and Social Care Ombudsman	Parliamentary and Health Service Ombudsman	Grand Total
Apr-22	0	0	1	1
May-22	0	0	1	1
Jun-22	0	0	1	1
Jul-22	0	0	1	1
Aug-22	1	0	2	3
Sep-22	0	0	0	0
Oct-22	0	0	1	1
Nov-22	0	0	1	1
Dec-22	0	0	0	0
Jan-23	0	0	2	2
Feb-23	0	0	1	1
Mar-23	0	1	1	2
Grand Total	**1**	**1**	**12**	**14**

Two complaints received and closed in the 22/23 financial year were referred to the Ombudsman [Parliamentary and Health Service Ombudsman **(**PHSO) / local Government & Social Care Ombudsman (LGSO)].

In the 22/23 financial year, 14 cases were referred to the Ombudsman, these refer to closed complaints within the last three years but received in year, the majority of these were referred to the PHSO, with one referred to the LGSO and one referred to the Joint Ombudsman.

Quality and Safety- Perinatal Clinical Quality Surveillance March 2023

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 a mandatory requirement required monthly by the Trust Board.



	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	Running Total	
% of women booked for continuity of carer			33.5%*	50.2%*	50.9%	54.9%	52.2%	49.7%	61.0%	62.1%	64.8%	61.8%	57.2%	
Number of Stillbirths	0	1	1	0	1	0	0	1	0	0	0	0	4	
% Robson Group 1		22.9%	24.1%	40.9%	37.5%	12.0%	22.9%	12.0%	19.4%	0.0%	26.9%	5.6%	20.4%	
% Robson Group 2		40.0%	45.5%	26.1%	48.3%	38.2%	36.4%	36.4%	42.9%	42.9%	18.5%	37.0%	37.5%	
% Robson Group 5		*	*	*	90.9%	57.1%	90.5%	90.9%	88.9%	88.9%	87.5%	75.0%	83.7%	* data not accurate
% Breastfeeding at Delivery		*	*	*	70.8%	63.9%	64.7%	63.0%	63.1%	71.8%	71.0%	67.1%	66.9%	concerns re data accuracy

No stillbirths or neonatal deaths were noted in Q4 of 2022-23. There has been no perinatal deaths in April and no new referrals to HIS perinatal deaths in March.

The percentage of women being booked on a continuity pathway of care continues remains stable.

Smoking at time of birth data is at 5.8% this month which is a reduction from last month. This rate is below the current national average for England which is 8.6%. The team have appointed a pregnancy support worker (funded as part of the Treating Tobacco Dependency fund) which will enable even more input and support and advice for pregnant smokers.

Workforce Status

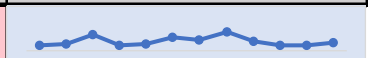
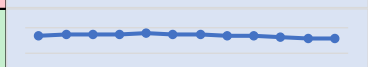
Performance exceptions and actions

Staff sickness/absence: RED for 12 months and RED for current month
The preliminary annual rolling sickness absence rate is 4.96% to the end of Apr 2023 from 5.62% in March. The monthly sickness has increased in April at 5.07% from 4.63% in March. Overall the picture for 22-23 shows improvement compared to the year before, but the spikes in Jul and Dec 22 have meant that it isn't showing as an improvement.

Appraisal rate: **Red**
April's Achievement Review rate increased by 1% to 77.87% from 76.87% in March and is still showing signs of concern and for the last 12 months have been under the mean of 78.17% during that period. However there has been a 6% increase since Apr 22 so the trend is showing an upward rise.

Turnover (excluding Junior Doctors): **GREEN**
While the Trust's turnover rate of 12.92% for the year ending April 2023 remains within the normal tolerances of 10-14%. Turnover has now plateaued and in the last six months since Sept 22 has dropped significantly from 13.88% to 12.92% and in March 23 it was the lowest it has been in the last 6 months.

Mandatory Training rate: **GREEN**
The April **overall** rate for mandatory training figure increased slightly to 90.72% against a target of 85%. Overall training compliance is constantly above the target of 85%. There are no signs of concern and the mean over the last 2 years has been at least 4% above the target. However, a number of the individual subject areas are showing under compliance.

Indicator	Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Performance
Month Sickness %	4%	4.66%	4.83%	6.25%	4.77%	4.90%	5.86%	5.39%	6.54%	5.26%	4.59%	4.63%	5.07%	
12 Mth Rolling Sickness %	4%	5.60%	5.62%	5.63%	5.72%	5.74%	5.71%	5.69%	5.76%	5.69%	5.58%	5.62%	4.96%	
Achievement Rate %	90%	73.90%	75.24%	77.02%	78.03%	75.77%	76.61%	77.96%	76.70%	77.68%	76.71%	76.87%	77.87%	
Labour Turnover Rate	10-14%	13.56%	13.67%	13.79%	13.82%	13.88%	13.66%	13.74%	13.48%	13.33%	13.09%	12.85%	12.92%	
Overall Training %	85%	89.83%	90.10%	89.73%	89.15%	88.70%	88.65%	89.10%	89.70%	89.94%	90.09%	90.45%	90.72%	
Nuring Staff Average % Day Fill Rate- Nurses		96%	96%	94%	94%	96%	99%	99%	92%	92%	91%	93%	92%	
Nuring Staff Average % Night Fill Rate- Nurses		87%	88%	86%	86%	86%	89%	86%	87%	88%	87%	88%	91%	
Safer Staffing- Overall CHPPD		7.6	7.55	7.48	7.59	7.53	7.72	7.75	7.54	7.72	7.83	7.75	7.9	

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

The April **overall** rate for mandatory training increased slightly to 90.72% in April against a target of 85%; overall training compliance is constantly above the target of 85%. The table below highlights a number of the individual subject areas where performance is showing under compliance and requires improvement. The Education Department have developed a Statutory and Mandatory Training Improvement Plan and will track progress against the plan through an oversight governance group through to the People Committee.

Multiple Level Training Breakdown	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Infection Control L1*	91.45%	92.03%	92.14%	91.86%	91.52%	92.37%	92.45%	92.79%	92.53%	92.47%	92.70%	92.23%
infection Control L2*	82.11%	81.85%	81.53%	81.00%	80.02%	79.82%	82.24%	83.04%	83.65%	83.66%	84.31%	85.27%
Moving & Handling L1*	90.24%	89.75%	88.50%	87.29%	86.21%	86.28%	86.63%	87.47%	87.64%	88.11%	88.71%	88.93%
Moving & Handling L2*	68.47%	69.95%	69.80%	69.66%	68.25%	68.77%	68.19%	68.03%	67.03%	66.28%	66.06%	66.35%
Safeguarding Adults L1	95.14%	95.59%	95.48%	94.80%	94.36%	93.86%	94.41%	95.28%	95.33%	95.56%	95.88%	95.86%
Safeguarding Adults L2	87.86%	89.28%	88.71%	88.39%	88.22%	87.74%	88.39%	89.37%	90.80%	91.37%	92.11%	91.94%
Safeguarding Adults L3	61.56%	61.59%	62.03%	62.73%	56.02%	55.69%	47.58%	49.58%	51.87%	50.52%	51.23%	52.10%
Safeguarding Adults L4	64.29%	76.19%	72.09%	71.11%	66.67%	65.85%	59.52%	59.09%	60.47%	56.25%	56.00%	59.57%
Safeguarding Adults L5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	80.00%	66.67%	83.33%
Safeguarding Adults L6	87.50%	87.50%	87.50%	100.00%	100.00%	83.33%	83.33%	71.43%	71.43%	75.00%	75.00%	71.43%
Mental Capacity Act L1	88.27%	89.28%	89.78%	89.51%	89.76%	91.12%	91.13%	91.21%	91.65%	92.30%	93.04%	93.66%
Mental Capacity Act L2	83.72%	84.87%	84.72%	84.19%	84.11%	84.00%	85.38%	85.31%	86.73%	87.75%	89.14%	88.86%
Mental Capacity Act L3	62.62%	64.32%	64.76%	65.70%	66.13%	66.46%	66.78%	68.35%	70.05%	71.18%	72.57%	73.38%
Mental Capacity Act L4	100.00%	100.00%	100.00%	80.00%	57.14%	66.67%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Mental Capacity Act L5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	83.33%	71.43%	71.43%
Mental Capacity Act L6	71.43%	71.43%	83.33%	83.33%	83.33%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	75.00%
Safeguarding Children L1	90.64%	91.24%	91.30%	90.36%	90.36%	89.98%	89.96%	90.69%	90.39%	90.72%	91.40%	91.42%
Safeguarding Children L2	82.44%	82.82%	82.48%	81.99%	82.04%	82.15%	82.62%	82.92%	84.36%	84.79%	85.55%	85.29%
Safeguarding Children L3	73.31%	72.57%	72.38%	71.60%	69.30%	66.62%	64.40%	65.26%	64.17%	65.99%	67.35%	68.55%
ABLS L1	98.41%	98.51%	98.46%	97.84%	97.59%	97.75%	97.93%	98.14%	98.20%	98.35%	98.61%	98.39%
ABLS L2	68.73%	68.22%	69.82%	70.10%	68.61%	69.03%	69.73%	69.67%	67.51%	69.20%	71.77%	71.63%
AILS L3	57.42%	61.25%	61.86%	56.08%	53.31%	57.72%	59.63%	59.57%	63.01%	69.43%	70.31%	72.87%
AALS L4	65.13%	65.33%	68.49%	44.00%	62.03%	78.21%	75.48%	72.26%	69.93%	76.47%	80.28%	77.33%
PBLS L2	64.56%	65.96%	66.64%	66.40%	64.18%	63.88%	64.28%	64.60%	62.97%	63.57%	66.76%	66.48%
PILS L3	38.52%	35.52%	36.93%	38.55%	39.20%	40.00%	43.56%	47.30%	53.85%	57.60%	64.15%	67.45%
PALS L4	47.54%	49.18%	54.10%	53.97%	51.47%	54.41%	53.62%	55.07%	73.91%	75.00%	70.97%	68.75%
NBLS L2	69.66%	68.54%	77.01%	75.28%	68.68%	71.89%	75.68%	69.57%	70.88%	76.11%	80.66%	74.01%
NBLS L3	60.66%	60.66%	61.29%	59.68%	51.67%	53.33%	60.00%	59.18%	60.00%	56.25%	60.42%	57.69%

Safer Staffing – Planned versus Actual

- The Registered Nurse fill rate for days during April was 92.4% which is a slight decrease on March fill rate of 93.1%, and for night duty reported as 91.3% an increase on the previous months fill rate of 88.4%.
- The fill rate for Health care support workers for days is 103.7% for days, which is an increase on March figures of 97.9% and 114.0% for nights which is comparable with March's data.
- The increase in fill rate for Health Care support workers at night is to mitigate any risks associated with the registered nurse fill rate.
- Louisa Cary registered nurse fill rate is reported as 76.7% for has an increased level of health care support staff to support clinical care.

Apr-23

Ward	Day						Night						Total Patients	Day			Night		
	RN / RM		Nursing Associates		Care Staff		RN / RM		Nursing Associates		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		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 (%)
Ainslie	1725	1536	0	0	1725	1901	1380	1314	0	0	1035	1200	718	89.0%	0.0%	110.2%	95.2%	0.0%	115.9%
Allerton	2795	2306	0	0	1035	1094	1380	1219	0	0	1035	1229	863	82.5%	0.0%	105.7%	88.3%	0.0%	118.7%
Cheetham Hill	1725	1435	0	0	2070	2341	1035	949	0	0	1380	2093	785	83.2%	0.0%	113.1%	91.6%	0.0%	151.7%
Coronary Care	1380	1446	0	0	0	3	1035	1035	0	0	0	12	361	104.8%	0.0%	0.0%	100.0%	0.0%	0.0%
Cromie	1610	1356	0	0	863	1290	1035	1067	0	0	690	1047	751	84.2%	0.0%	149.6%	103.1%	0.0%	151.7%
Dunlop	1380	1439	0	0	1208	1186	1035	1070	0	0	1035	1058	727	104.3%	0.0%	98.2%	103.3%	0.0%	102.2%
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	1819	0	0	1380	1375	1725	1449	0	0	1380	1479	709	105.4%	0.0%	99.6%	84.0%	0.0%	107.2%
Ella Rowcroft	1035	1014	0	0	1380	1260	978	805	0	0	690	689	422	97.9%	0.0%	91.3%	82.4%	0.0%	99.8%
Warrington	1035	1293	0	0	690	724	690	868	0	0	690	736	481	125.0%	0.0%	104.9%	125.7%	0.0%	106.7%
George Earle	1725	1511	0	0	2070	2227	1035	965	0	0	1380	1737	798	87.6%	0.0%	107.6%	93.2%	0.0%	125.8%
ICU	3105	2345	0	0	345	206	3105	2277	0	0	0	0	247	75.5%	0.0%	59.8%	73.3%	0.0%	0.0%
McCullum (Escalation)	690	745	0	0	1035	981	690	691	0	0	1035	1001	477	107.9%	0.0%	94.8%	100.1%	0.0%	96.7%
Louisa Cary	2415	1804	0	0	690	739	2415	1507	0	0	690	851	477	74.7%	0.0%	107.1%	62.4%	0.0%	123.3%
John Macpherson	1035	952	0	0	690	631	690	691	0	0	345	329	399	92.0%	0.0%	91.4%	100.1%	0.0%	95.4%
Midgley	1725	1911	0	0	1725	1475	1380	1426	0	0	1380	1328	768	110.8%	0.0%	85.5%	103.3%	0.0%	96.2%
SCBU	1035	900	0	0	345	343	1035	798	0	0	345	209	145	86.9%	0.0%	99.3%	77.1%	0.0%	60.6%
Simpson	1725	1877	0	0	2070	2053	1035	1334	0	0	1380	1997	828	108.8%	0.0%	99.2%	128.9%	0.0%	144.7%
Turner	1380	1346	0	0	1725	1860	690	725	0	0	1380	1265	513	97.5%	0.0%	107.8%	105.0%	0.0%	91.7%
New Forrest Ward	1725	1835	0	0	1380	1582	1380	1426	0	0	1380	1644	861	106.4%	0.0%	114.6%	103.3%	0.0%	119.1%
Total (Acute)	*30970*	*28869.65*	*0*	*0*	*22425*	*23269.32*	*23747.5*	*21612.75*	*0*	*0*	*17250*	*19901*	*11330*	93.2%	0.0%	103.8%	91.0%	0.0%	115.4%
Brixham	840	854.5	420	0	1260	1459	990	979	0	0	660	781	592	101.7%	0.0%	115.8%	98.9%	0.0%	118.3%
Dawlish	840	808.25	0	0	1050	1329.75	720	649.5	0	0	660	998	476	96.2%	0.0%	126.6%	90.2%	0.0%	151.2%
Newton Abbot - Teign Ward	1890	1668	0	0	1890	1612.25	990	990	0	0	990	1001	888	88.3%	0.0%	85.3%	100.0%	0.0%	101.1%
Newton Abbot - Templar Ward	1680	1587	0	0	2100	1962.25	990	1001	0	0	1080	999.5	894	94.5%	0.0%	93.4%	101.1%	0.0%	92.5%
Totnes	840	709	0	0	1260	1608.5	720	649	0	0	660	676	534	84.4%	0.0%	127.7%	90.1%	0.0%	102.4%
Organisational Summary	35335	32661	420	0	28605	29659	26778	24455	0	0	19920	22713	13853	92.4%	0.0%	103.7%	91.3%	0.0%	114.0%

Safer Staffing – Care hours per patient day (CHPPD) and planned versus actual

- The RN actual CHPPD has been reported as 4.12 in April but still remains below the carter recommendation of 4.7.
- The actual HCA CHPPD was 3.78 in April which remains above the carter recommendation of 2.91. This is due to the increased need for HCSW to provide 1:1 supportive observation care.
- During April the Trust was operationally challenged with 5 days in OPEL 4 and 17 days at OPEL 3
- The planned CHPPD total was reported as 6.78 with an actual of 7.90 which reflects an increase in escalation areas due to operational challenges.

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	8.30	4.00	0.00	4.30	1	15	0	0	3.3%	50.0%	0.0%	0.0%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	6.80	4.10	0.00	2.70	24	30	0	6	80.0%	100.0%	0.0%	20.0%	7.74	4.74	0	2.91
Cheetham Hill	7.39	3.29	0.00	4.11	8.70	3.00	0.00	5.60	0	22	0	0	0.0%	10.0%	0.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.90	6.90	0.00	0.00	0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
Cromle	5.53	3.54	0.00	1.99	6.30	3.20	0.00	3.10	3	24	0	0	10.0%	80.0%	0.0%	0.0%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.50	3.50	0.00	3.10	12	11	0	17	40.0%	36.7%	0.0%	56.7%	7.74	4.74	0	2.91
Forrest	0.00	0.00	0.00	0.00					0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
EAU4	8.63	4.79	0.00	3.83	8.60	4.60	0.00	4.00	15	20	0	6	50.0%	66.7%	0.0%	20.0%	7.74	4.74	0	2.91
Ella Rowcroft	8.63	4.31	0.00	4.31	8.90	4.30	0.00	4.60	12	15	0	11	40.0%	50.0%	0.0%	36.7%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	7.50	4.50	0.00	3.00	1	1	0	1	3.3%	3.3%	0.0%	3.3%	7.74	4.74	0	2.91
George Earle	7.39	3.29	0.00	4.11	8.10	3.10	0.00	5.00	3	19	0	3	10.0%	63.3%	0.0%	10.0%	7.74	4.74	0	2.91
ICU	21.85	20.70	0.00	1.15	19.50	18.70	0.00	0.80	14	14	0	21	46.7%	46.7%	0.0%	70.0%	7.74	4.74	0	2.91
McCullum (Escalation)	6.76	2.71	0.00	4.06	7.20	3.00	0.00	4.20	5	1	0	6	16.7%	3.3%	0.0%	20.0%	7.74	4.74	0	2.91
Louisa Cary	10.89	8.47	0.00	2.42	10.30	6.90	0.00	3.30	17	21	0	3	0.0%	70.0%	0.0%	10.0%	7.74	4.74	0	2.91
John Macpherson	5.11	3.19	0.00	1.92	6.50	4.10	0.00	2.40	5	7	0	5	16.7%	23.3%	0.0%	16.7%	7.74	4.74	0	2.91
Midgley	7.96	3.98	0.00	3.98	8.00	4.30	0.00	3.60	15	6	0	25	50.0%	20.0%	0.0%	83.3%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	15.50	11.70	0.00	3.80	0	0	0	6	0.0%	0.0%	0.0%	20.0%	7.74	4.74	0	2.91
Simpson	7.39	3.29	0.00	4.11	8.80	3.90	0.00	4.90	0	3	0	0	0.0%	10.0%	0.0%	0.0%	7.74	4.74	0	2.91
Turner	9.58	3.83	0.00	5.75	10.10	4.00	0.00	6.10	7	7	0	11	23.3%	23.3%	0.0%	36.7%	7.74	4.74	0	2.91
New Forrest Ward	6.74	3.57	0.00	3.17	7.50	3.80	0.00	3.70	3	6	0	2	10.0%	20.0%	0.0%	6.7%	7.74	4.74	0	2.91
Brixham	6.95	3.05	0.70	3.20	6.90	3.10	0.00	3.80	17	14	30	4	56.7%	46.7%	100.0%	13.3%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	8.00	3.10	0.00	4.90	0	21	0	0	0.0%	70.0%	0.0%	0.0%	7.74	4.74	0	2.91
Newton Abbot - Teign Ward	6.40	3.20	0.00	3.20	5.90	3.00	0.00	2.90	26	24	0	25	86.7%	80.0%	0.0%	83.3%	7.74	4.74	0	2.91
Newton Abbot - Templar Ward	6.50	2.97	0.00	3.53	6.20	2.90	0.00	3.30	22	16	0	20	73.3%	53.3%	0.0%	66.7%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	6.80	2.50	0.00	4.30	7	23	0	3	23.3%	76.7%	0.0%	10.0%	7.74	4.74	0	2.91

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
	6.78	3.79	0.03	2.96	7.90	4.12	0.00	3.78
Total Planned Beds / Day	546							
Days in month	30							

Community and Social Care Indicators

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

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)		
Community Hospital average Length of Stay (days)		
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		⬇

Narrative and data to support the community and social care indicators is provided in the Month 1 Chief Operating Officer Report.

Operational Performance Indicators

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

A&E - patients seen within 4 hours (NHSI)		↑
Referral to treatment - % Incomplete pathways <18 wks (NHSI)		↑
Cancer - 62-day wait for first treatment - 2ww referral (Tier 1)		↑
Diagnostic tests longer than the 6 week standard (NHSI)		↓
Dementia Find (NHSI)		↓
Number of Clostridium Difficile cases reported		↓
Cancer - Two week wait from referral to date 1st seen		↓
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients		↓
Cancer – 28 day faster diagnosis standard		↓
Cancer - 31-day wait from decision to treat to first treatment		↓
Cancer - 31-day wait for second or subsequent treatment - Drug		↓
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy		↑
Cancer - 31-day wait for second or subsequent treatment – Surgery		↑
Cancer – 62-day wait for first treatment – screening		↑
Cancer - Patient waiting longer than 104 days from 2 week wait		↑
RTT 52-week wait incomplete pathway		↑
RTT 78-week wait incomplete pathway		↑
RTT 104-week wait incomplete pathway (Tier 1)		↔
On the day cancellations for elective operations		↑

Cancelled patients not treated within 28 days of cancellation		↔
Virtual Outpatient (Non-face-to-face) appointments		↑
Bed Occupancy (Acute)		
No Criteria to Reside - daily average - weekday (ICO)		↑
Percentage of patient discharges pre-noon		↓
Percentage of patient discharges pre-5pm		↑
Number of patients >7 days LoS (daily average)		↑
Number of extended stay patients >21 days (daily average)		↓
Ambulance handover delays > 30 minutes		↑
Ambulance handover delays > 60 minutes		↑
A&E - patients with >12 hour visit time pathway		↑
Time to Initial Assessment within 15 mins – Emergency Department		↑
Clinically Ready to Proceed delay over 1 hour - Emergency Department		↑
Non-admitted minutes mean time in Emergency Department		↑
Admitted minutes mean time in Emergency Department		↑
Care Planning Summaries % completed within 24 hours of discharge – Weekend		↑
Care Planning Summaries % completed within 24 hours of discharge – Weekday		↑
Clinic letters timeliness - % specialties within 4 working days		↑

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Financial Performance Month 01 (Apr-23) FY 23/24

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Executive Summary

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	M01 Plan £M	M01 Actual £M	M01 Variance £M	R.A.G
Operating Income	52.41	51.90	(0.50)	
Operating Expenditure and Financing Cost	(57.21)	(56.78)	0.42	
Surplus / (Deficit)	(4.80)	(4.88)	(0.08)	
Add back: Donated Assets	(0.09)	0.01	0.10	
Adjusted Surplus / (Deficit)	**(4.89)**	**(4.87)**	**0.02**	
Capital (CDEL)	1.44	0.45	(0.99)	
Cash & Cash Equivalents	15.94	41.80	25.86	

Variance Key:

Positive Values = favourable variance

Negative Values = adverse variance

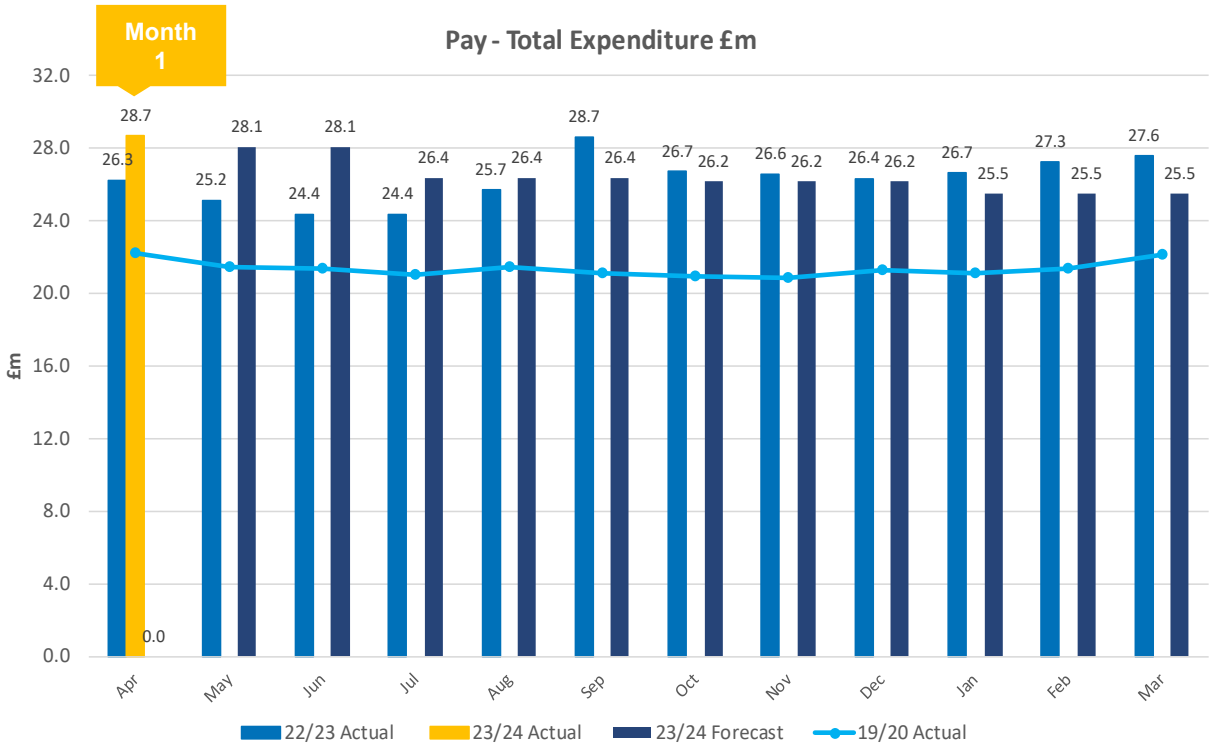
- Favourable variance is greater than £50k
- Adverse or favourable variance is less than £50k
- Adverse variance is greater than £50k

As of April-23, the financial performance indicated a minor departure from the anticipated plan, maintaining overall stability. Our operating income reached **£51.90m**, slightly lower by **£0.5m** compared to the projected **£52.41m** plan, reflecting a minimal variance of less than 1%. Similarly, the operating expenditure was a fraction less than our budgeted cost, with the actual expenditure standing at **£56.78m** against the expected **£57.21m**. This resulted in a favourable variance of **£0.42m**. However, it's important to note that the operating expenditure includes an unplanned cost pressure of **£0.17m** due to the Junior Doctors Industrial Action. Anticipating that this cost may escalate with further industrial action expected in the coming months, mitigation strategies will be necessary.

The period concluded with a deficit of **£4.87m**, marginally better than the forecasted deficit of **£4.89m**, resulting in a positive variance of **£0.02m**. This negligible discrepancy shows the overall financial resilience of the Trust, demonstrating a promising start to the FY23/24.

Pay Expenditure – Run Rate

Torbay and South Devon NHS Foundation Trust



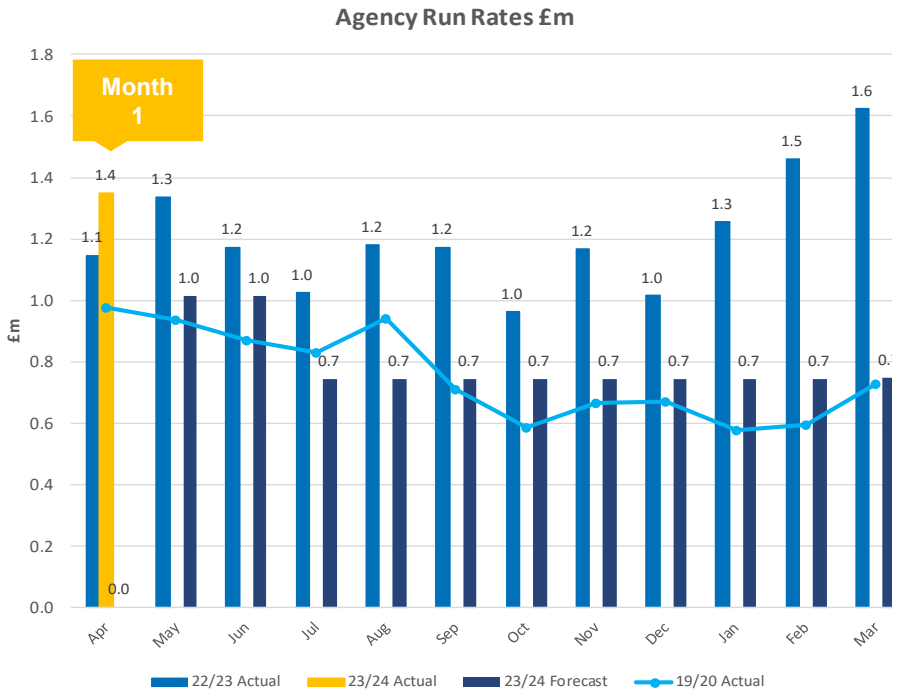
The graph illustrates a comparison of the pay expenditure for April-23, set against previous years, and includes a projection for the current FY23/24, which reflects our financial plan.

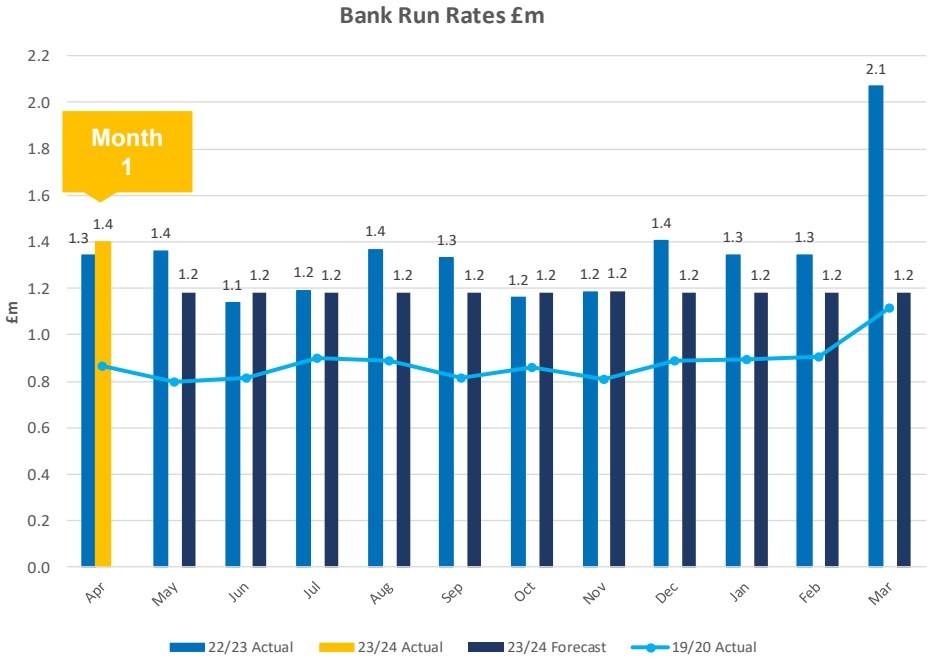
There was a noticeable surge in the expenditure trend in Sep-22, attributable to the processing of a backdated pay award. In line with national directives, we anticipate that the pay award for FY23/24 will be implemented in Jun-23.

Pay expenditure for Apr-23 amounted to **£28.7m**, exceeding the plan by **£0.6m**. This overrun was a consequence of additional agency and bank staff to compensate for existing vacancies, absences due to sickness, and the recent industrial action for Junior Doctors.

Pay Expenditure – Agency and Bank

Torbay and South Devon NHS Foundation Trust

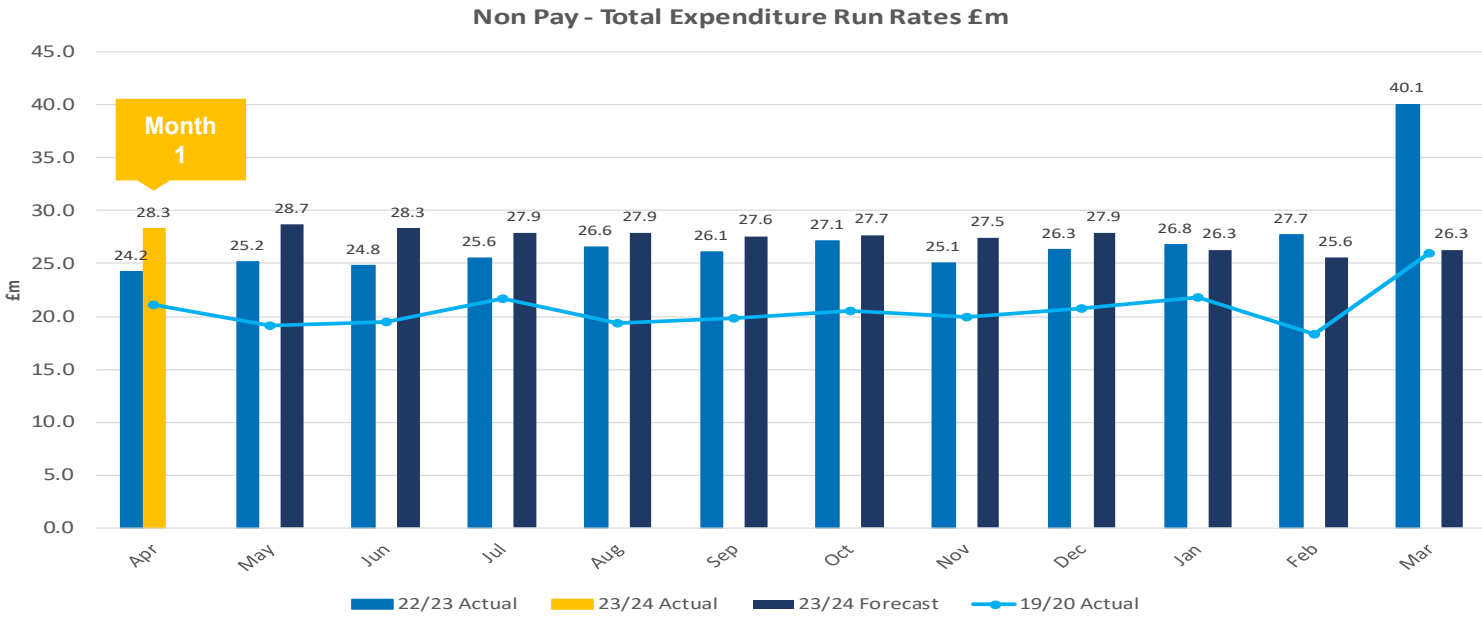




Agency and bank staff have been pivotal in covering vacancies, managing sickness-related absences, and navigating the recent Junior Doctors' industrial action. As can be shown from the charts, there was a marked rise in the deployment of agency and bank staff during the Q4 of 22/23. This surge was triggered by a combination of increased vacancies, sickness, industrial action, and patient activity. Moving forward, for fiscal year 23/24, we are proactively implementing measures to reduce the reliance on agency and bank staff, aiming to remain within our designated plan. This includes adhering to our cumulative agency plan/forecast, which is set at a ceiling of **£9.7m**.

Non-Pay Expenditure – Run Rate

Torbay and South Devon NHS Foundation Trust

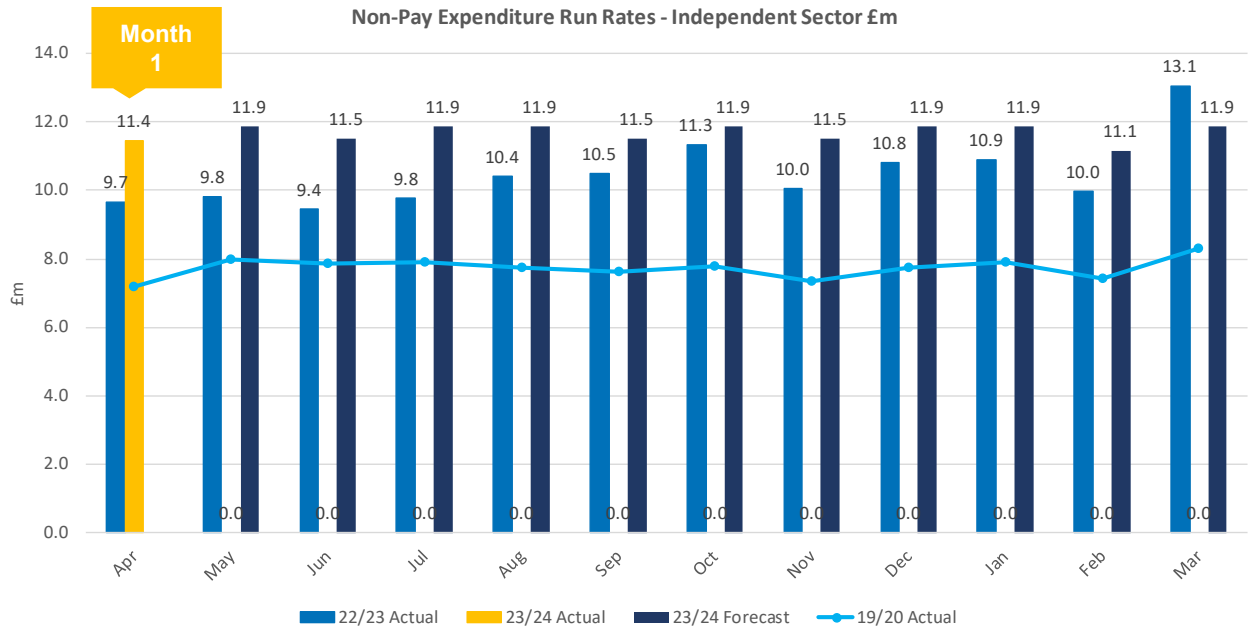


In Apr-23 the Non-Pay expenditure adhered to our plan

Non-Pay expenditure trends in Mar-23 increased due to the revaluation of Trust assets. The revaluation of the Trust assets will be completed again in Mar-24, for which the impact is not known at present.

Non Pay Expenditure – Independent Sector

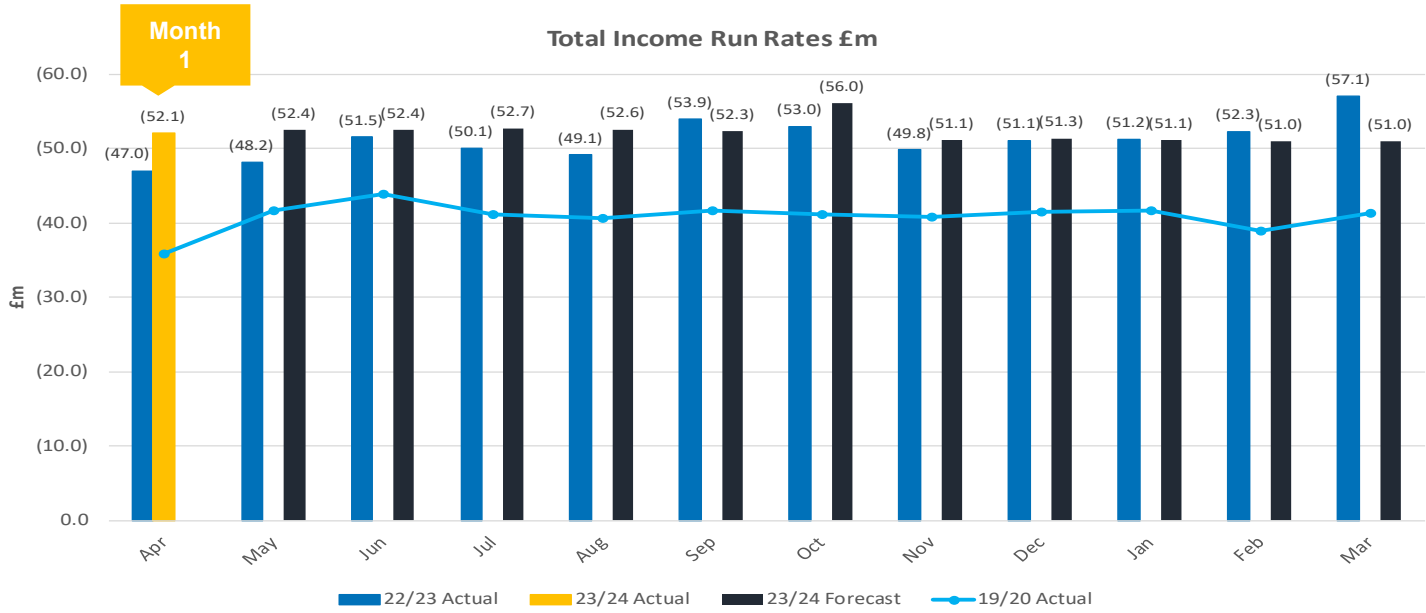
Torbay and South Devon NHS Foundation Trust



Non-Pay expenditure reported in Apr-23 against Independent Sector was in line with plan.
The increase in expenditure in Mar-22 of **£3.1m** was relating to increasing the bad debt provisions and other Adult Social Care expenditure.

Income – Run Rate

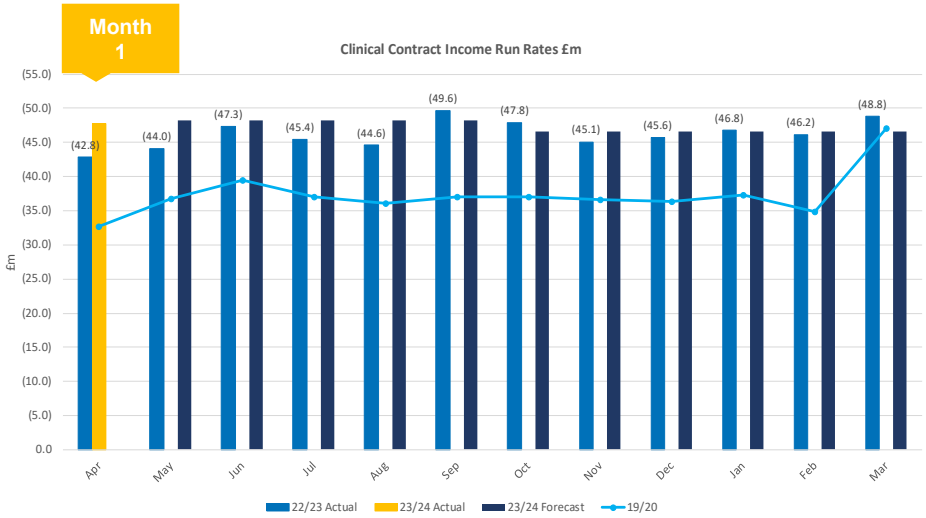
Torbay and South Devon NHS Foundation Trust

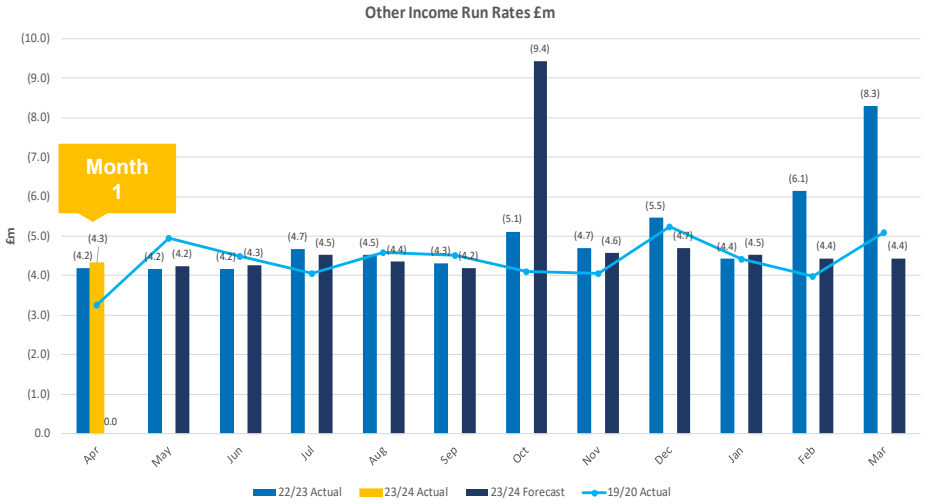


Income was reported in line with the plan in Apr-23.

Income from Patient Activities and Other Income

Torbay and South Devon NHS Foundation Trust

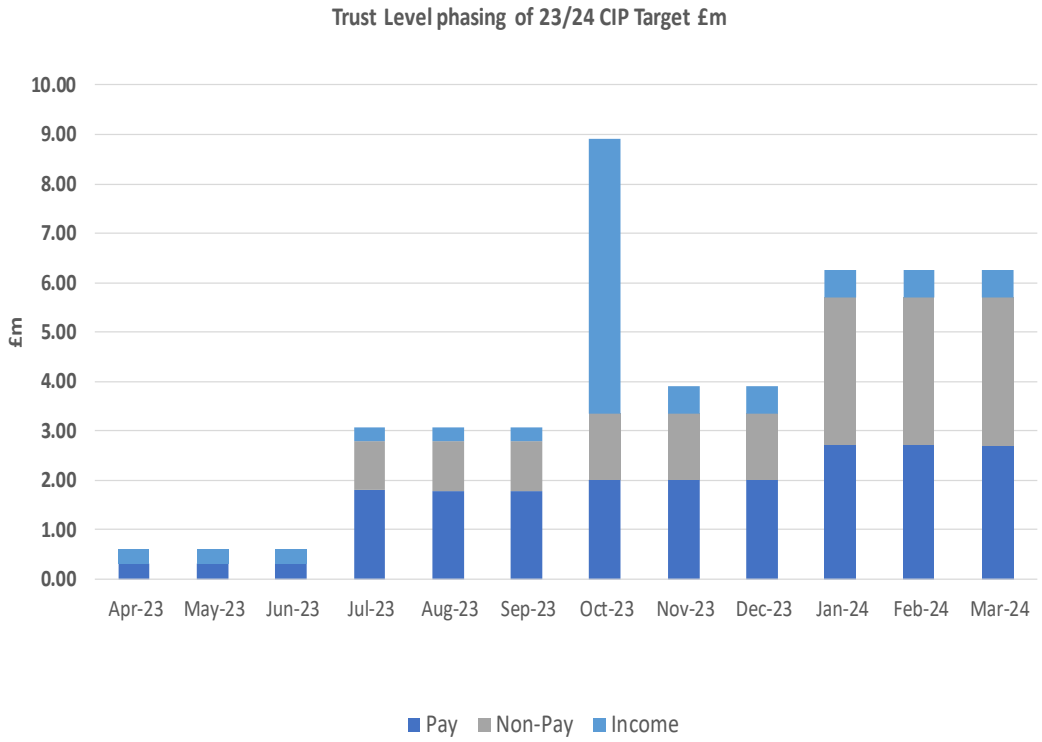




Income reported in Apr-23 was in line with plan. Income trends in previous years were in line with patient activities and other ad-hoc income generation. Income increases in Feb-22 and Mar-22 were the result of additional Education income received at the Trust.

CIP Target 2023/24

NHS
Torbay and South Devon
NHS Foundation Trust



The Trust is required to deliver a savings target of **£46.6M**, which includes **£10.5M** to be delivered through collaborative schemes within the Devon system. CIP requirement has been apportioned between ISU's on the basis of:

- Specific targeted areas identified at time of the submission of the Trust's plan in March
- Underdelivered recurrent CIP from 22/23
- A sharing of the residual balance as a percentage of overall budget.

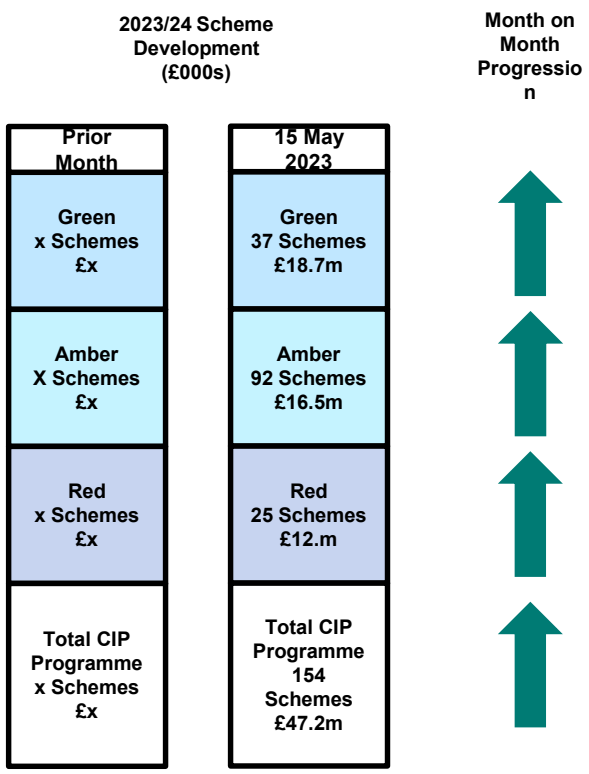
This process has identified our CIP Target split following

- Pay - 44% / **£20.5M**
- Non Pay - 34% / **£15.9M**
- Income - 22% / **£10.01M**

The calculation has been carried out at a specialty level (as held within the finance system structure) to enable adjustments to be made should the structure of ISU's change through the year.

FY23/24 Pipeline Progression

Torbay and South Devon NHS Foundation Trust



The chart is designed to demonstrate a month on month progression tool in order to articulate that the pipeline continues to grow and the 'green' ready for delivery has reached the required target.

Financial year 23/24, the total recurrent CIP delivery requirement is **£46.6m**.

As of 15th May, the 2023/24 CIP programme includes a total of 154 schemes, of which 37 schemes (24%) totalling **£18.7m** are assessed as 'Green' and have been confirmed in the Plan. The schemes are in or ready for delivery and will be managed through PMO governance.

ISU's, pathway workstreams and the PMO are working through 117 new ideas, of which 92 schemes have a high level value of **£16.5m**. The Strategic ICB Collaborative schemes totalling **£10.5m** have been assessed as Amber by the PMO on the basis that although there are signed off PIDs in place, there is not a clear delivery plan for these schemes available, and therefore a substantial focus will be required to accept into the plan.

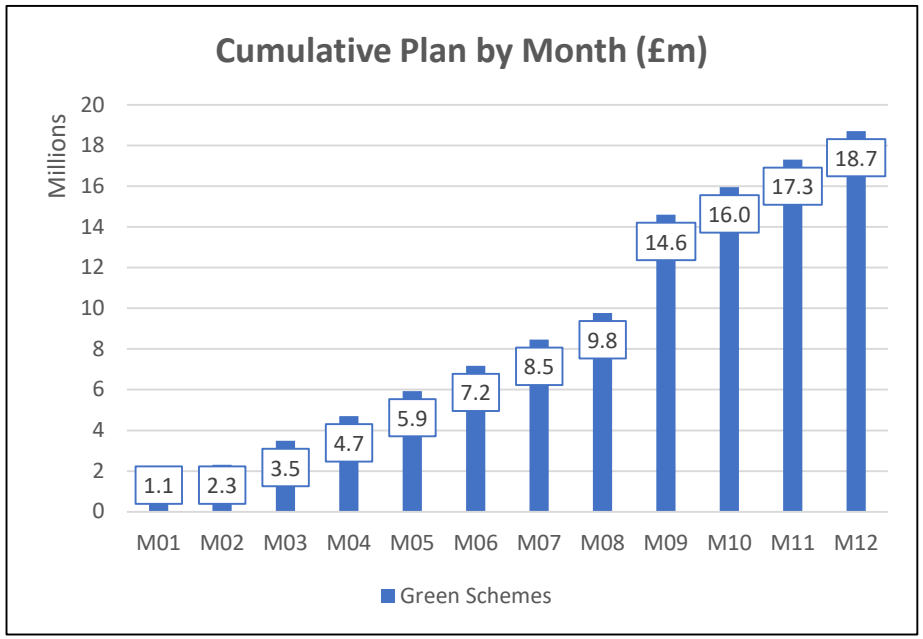
Scoping work continues to be developed whilst maintaining a balance with ensuring the delivery of existing schemes. Considerable focus must be placed on Amber and Red schemes to reach the in-year target.

A risk adjustment will be applied to the green schemes during M2/3, this manages the known deliverability and the 23/24 CIP identified plan will need to be significantly higher in order to actually deliver in year savings of **£46.6m**.

Currently, if all the schemes included in the pipeline were to be developed and pass through the governance process, the total programme would be in the region of **£47.2m** (non risk-adjusted value).

CIP FY23/24 Green Plan – Cumulative (£m)

Torbay and South Devon NHS Foundation Trust



£m	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Plan	1.14	2.30	3.48	4.69	5.93	7.17	8.45	9.76	14.60	15.95	17.31	18.72

- Pay - 12% / **£2.25m**
- Non Pay - 14% / **£2.68m**
- Income - 74% / **£13.79m**

- Recurrent 81% / **£15.22m**
- Non Recurrent 19% / **£3.50m**

The balance to full year effect of the **£18.72m** into 24/25 is **£0.14m**

Cash Position / Better Payment Practice

Torbay and South Devon NHS Foundation Trust

	Plan £M	Actual £M	Variance £M
Opening cash balance	**14.96**	**34.73**	**19.77**
Capital Expenditure (accruals basis)	(1.46)	(0.45)	1.02
Capital loan/PDC drawndown	0.45	0.00	(0.45)
Capital loan repayment principal	0.00	0.00	0.00
Proceeds on disposal of assets	0.00	0.00	0.00
Movement in capital creditor	0.00	(7.88)	(7.88)
Other capital-related elements	0.00	(0.28)	(0.28)
Sub-total - capital-related elements	**(1.02)**	**(8.60)**	**(7.59)**
Cash Generated From Operations	(2.08)	(2.47)	(0.39)
Revenue PDC drawndown	4.80	4.77	(0.03)
Working Capital movements - debtors	(0.19)	(1.23)	(1.04)
Working Capital movements - creditors	0.00	14.72	14.72
Net Interest	(0.21)	(0.01)	0.20
PDC Dividend paid	0.00	0.00	0.00
Other movements	(0.33)	(0.11)	0.22
Sub-total - other elements	**2.00**	**15.67**	**13.67**
Closing cash balance	**15.94**	**41.80**	**25.86**

Better Payment Practice Code	Paid £	Paid within Target £	Paid within Target %
Non-NHS - number of bills	10,445	9,444	90.4%
Non-NHS - value of bills (£k)	25,242	21,762	86.2%
NHS - number of bills	121	88	72.7%
NHS - value of bills (£k)	2,743	2,522	91.9%
Total - number of bills	10,566	9,532	90.2%
Total - value of bills (£k)	27,985	24,284	86.8%

- Access to capital and revenue PDC support remains absolutely critical to the Trust's cashflow. 23/24 planned PDC funding is **£70.8m** (22/23 actual: **£45.3m**).
- Unlike in previous years, the plan has had to be submitted to NHSE prior to the end of the prior financial year. Planned opening balances will not therefore match actual opening balances.
- The opening cash balance was **£19.8m** higher than planned. This is principally due to the March 2023 capital creditor having been higher than assumed.
- Capital-related cashflow is **(£7.6m)** adverse, largely due to the paying down of the capital creditor. The plan assumed that this would have happened at the end of the prior year.
- Creditor movements is **£14.7m** favourable. This is primarily due to the timing of the weekly payments run, with payments of **£9.1m** having been made one day after the end of month 1. NHSE (formerly HEE) funding of **£3.3m** has also been received in advance.

Balance Sheet

Torbay and South Devon NHS Foundation Trust

	M01 Plan £M	M01 Actual £M	M01 Variance £M
Non-Current Assets			
Intangible Assets	11.99	16.42	4.43
Property, Plant & Equipment	247.64	233.25	(14.38)
On-Balance Sheet PFI	17.25	20.27	3.01
Right of Use assets	19.98	21.45	1.47
Other	1.84	1.58	(0.26)
Total	**298.69**	**292.97**	**(5.72)**
Current Assets			
Cash & Cash Equivalents	15.94	41.80	25.86
Other Current Assets	40.85	55.66	14.81
Total	**56.80**	**97.46**	**40.67**
Total Assets	**355.49**	**390.43**	**34.94**
Current Liabilities			
Loan - DHSC ITFF	(2.92)	(2.92)	(0.00)
PFI and Leases	(4.56)	(4.78)	(0.21)
Trade and Other Payables	(53.50)	(87.77)	(34.26)
Other Current Liabilities	(5.27)	(10.78)	(5.51)
Total	**(66.25)**	**(106.24)**	**(39.99)**
Net Current assets/(liabilities)	**(9.45)**	**(8.78)**	**0.67**
Non-Current Liabilities			
Loan - DHSC ITFF	(22.29)	(22.29)	0.00
PFI and Leases	(31.03)	(31.93)	(0.90)
Other Non-Current Liabilities	(4.62)	(4.17)	0.44
Total	**(57.94)**	**(58.40)**	**(0.46)**
Total Assets Employed	**231.30**	**225.79**	**(5.51)**
Reserves			
Public Dividend Capital	199.94	200.38	0.44
Revaluation	61.35	62.09	0.74
Income and Expenditure	(29.99)	(36.68)	(6.69)
Total	**231.30**	**225.79**	**(5.51)**

- Non-Current Assets are **(£5.7m)** lower than plan. This is largely due to 22/23 property revaluation having been **(£7.1m)** lower than planned.
- Cash & Cash Equivalents is **(£25.9m)** higher than plan, as explained in the commentary to the Cash Flow Statement.
- Other Current Assets are **£14.8m** higher than plan. This is principally due to accrued funding **£12.1m** for the 22/23 retrospective pay award.
- Trade and Other Payables are **£34.3m** higher than plan. This is principally due to the 22/23 retrospective pay award £12.1m, annual leave accrual **£3.2m**, provider to provider recharges **£7.7m** and the timing of payment runs **£9.1m**.
- Other Current Liabilities are **£5.5m** higher than planned, principally due to NHSE (formerly HEE) funding of **£3.3m** received in advance.
- The Income and Expenditure reserve is **£6.7m** lower than plan, principally due to below-the-line asset impairment processed late in 22/23.

Risks & Mitigations

NHS
Torbay and South Devon
NHS Foundation Trust

Ref	Risk Description	Risk £'000
R01	Additional cost risk (capacity, pressures, winter)	3,000
R02	High cost drugs growth	2,500
R03	Efficiency risk	23,900
R04	Income risk (excl. ERF)	6,100
R05	Liberty Protection Safeguard	1,800
R06	Diagnostic Cost Pressure	1,000
Total		**38,300**

	Target	13 month trend	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Year to date
SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA																
Urgent and Emergency Care																
Percentage of Ambulance handovers greater than 15 minutes			77.5%	69.6%	80.0%	77.0%	78.3%	77.5%	84.4%	82.2%	87.5%	66.5%	54.8%	73.9%	55.4%	55.4%
Total average time in ED (hours/minutes)			07:08	06:23	07:22	07:02	07:06	07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57	05:57
ED attendances where visit time over 12 hours	0		816	668	871	827	920	906	988	939	1207	823	599	977	568	
UEC 4-hour target (RAG against local trajectory to national target)	76%		58.0%	57.6%	54.5%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	
% patient discharges pre-noon	33%								18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%
Percentage of inpatients with No Criteria to Reside (acute)	<5%								11.0%	11.0%	13.0%	13.0%	12.0%	8.1%	7.6%	7.6%
Elective recovery																
RTT 104 week wait incomplete pathway	0		192	173	96	70	51	50	47	34	29	22	14	0	0	0
RTT 78 week wait incomplete pathway	176		779	813	713	686	787	813	829	822	923	708	462	183	166	166
RTT 65 week wait incomplete pathway	1091						2093	2252	2485	2174	2203	1828	1679	1372	1244	1244
RTT 52 week wait incomplete pathway			3374	3765	4137	4578	5083	5060	5412	5585	6027	5554	5116	4427	4024	4024
Patient waits over 2.5 years	0		18	32	48	54	47	24	24	17	12	9	6	0	0	0
75% of GP referred patients diagnosed within 28 days	75%		76.9%	67.6%	64.8%	67.7%	72.1%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	74.8%	74.8%
Number of patients waiting longer than 62 days for treatment	138		245	307	233	283	244	333	331	229	253	225	130	114	107	107

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - April 2023

	Target	13 month trend	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Year to date
QUALITY LOCAL FRAMEWORK																
Reported Incidents - Severe	<6		2	3	2	1	3	5	0	0	2	3	1	2	1	1
Reported Incidents - Death	<1		2	1	0	2	2	1	1	0	0	4	0	1	0	0
Medication errors resulting in moderate harm	<1		1	0	0	0	0	0	0	1	0	0	0	0	1	1
Medication errors - Total reported incidents	N/A		58	60	50	41	59	64	36	46	47	47	44	61	65	65
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	9 (full year)		1	0	0	0	0	1	3	1	1	0	3	1		0
Never Events	<1		0	0	0	0	0	0	1	0	0	0	2	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	<1		8	10	8	5	3	2	3	0	6	13	3	13	5	5
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	<1		0	2	0	1	0	0	0	0	0	1	0	0	2	2
Formal complaints - Number received	<60		14	12	12	16	16	10	16	11	10	14	12	12	5	5
VTE - Risk Assessment on Admission (acute)	>95%		91.3%	89.7%	90.0%	91.8%	93.6%	92.7%	94.7%	94.4%	94.0%	95.5%	95.9%	96.5%	96.3%	96.3%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	<100		113.5	117.4	117	115.1	114.7	113.4	111	109.9	111.5	107.1				107.1
Safer staffing - ICO - Day time	90% - 110%		89.0%	96.1%	95.8%	93.7%	94.4%	96.4%	99.1%	99.4%	91.6%	92.1%	91.3%	93.1%		0.0%
Safer Staffing - ICO - Nightime	90% - 110%		79.7%	86.5%	88.1%	85.8%	86.2%	85.6%	88.8%	86.4%	87.4%	87.9%	87.0%	88.4%		0.0%
Infection Control - Bed Closures - (Acute bed days in month)	<100		30	12	130	84	36	132	42	156	786	339	254	164	217	217
Hand Hygiene	>95%		94.5%	92.3%	94.5%	96.0%	97.7%	96.6%	94.9%	96.2%	91.2%	94.0%	92.1%	91.3%	92.5%	92.5%
Fracture Neck Of Femur - Time to Theatre <36 hours	>90%		67.9%	65.8%	66.7%	56.4%	56.0%	50.0%	54.3%	43.3%	41.5%	40.0%	53.8%	58.3%	58.0%	
Stroke patients spending 90% of time on a stroke ward	>80%		35.3%	67.6%	34.1%	66.7%	59.3%	54.8%	55.0%	75.9%	28.0%	54.5%	67.4%	70.7%	63.0%	63.0%
Mixed Sex Accommodation breaches	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Follow ups 6 weeks past to be seen date	6400		22516	22215	22158	21504	21797	21821	20806	20257	21452	20030	20048	19979	19618	19618
WORKFORCE MANAGEMENT FRAMEWORK																
Staff sickness / Absence Rolling 12 months (1 month in arrears)	<4.00%		5.6%	5.6%	5.6%	5.8%	5.7%	5.7%	5.7%	5.6%	5.6%	4.7%	5.7%	5.6%		5.6%
Appraisal Completeness	>90%		71.3%	73.9%	75.2%	77.0%	78.0%	75.8%	76.6%	77.6%	76.7%	77.7%	76.7%	76.9%	77.9%	77.9%
Mandatory Training Compliance	>85%		89.6%	89.8%	90.1%	89.7%	89.2%	88.7%	88.6%	89.1%	89.7%	89.9%	90.1%	90.4%	90.7%	90.7%
Turnover (exc Jnr Docs) Rolling 12 months	10%-14%		13.2%	13.6%	13.7%	13.8%	13.8%	13.9%	13.7%	13.7%	13.5%	13.3%	13.1%	12.8%	12.9%	12.9%

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - April 2023

	Target	13 month trend	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	6.95%				6.5%			6.8%			6.5%			6.5%		
DOLS (Domestic) - Open applications at snapshot	NONE SET		671	664	705	700	714	737	751	735	756	755	781	814	784	671
Intermediate Care - No. urgent referrals	113		203	222	234	222	223	205	277	297	299	318	307	298	284	214
Community Hospital - Admissions (non-stroke)	NONE SET		266	241	215	234	222	197	193	203	208	198	200	251	218	265
Urgent Community Reponse (2-hour) - Referrals	NONE SET		26	22	24	25	15	20	26	27	40	34	32	17	22	330
Urgent Community Reponse (2-hour) - Target achievement	70%		0.5385	77.3%	66.7%	88.0%	80.0%	85.0%	100.0%	74.1%	77.5%	79.4%	93.8%	64.7%	95.0%	80.0%
Urgent Community Reponse (2-48 hour)- Referrals	NONE SET				117	103	195	153	195	196	182	177	171	159		1064
Urgent Community Reponse (2-48 hour) - Target achievement	NONE SET				91.5%	78.6%	86.7%	86.9%	85.6%	86.2%	84.6%	92.7%	83.3%	88.1%		83.1%
ADULT SOCIAL CARE TORBAY KPIs																
Proportion of clients receiving self directed support			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	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	7%		7.3%	7.3%	7.3%	7.5%	7.5%	7.6%	7.9%	7.9%	7.8%	7.9%	7.8%	7.8%	7.4%	7.3%
% Adults with learning disabilities in settled accommodation	80%		81.3%	81.2%	80.3%	79.7%	79.7%	79.6%	79.1%	78.7%	78.8%	78.4%	79.0%	79.0%	79.0%	
Permanent admissions (18-64) to care homes per 100k population	14		24.5	29.9	35.3	28.5	40.8	32.6	27.2	29.9	32.6	32.6	28.5	29.9	32.6	24.5
Permanent admissions (65+) to care homes per 100k population	450		576.2	823.8	880.4	928.8	939.6	931.5	861.5	901.9	915.4	840	802.3	826.5	805	576.2
Proportion of clients receiving direct payments	25%		19.5%	19.4%	19.6%	19.7%	20.0%	20.4%	20.3%	20.2%	20.3%	20.0%	20.2%	19.5%	20.1%	19.5%
% reablement episodes not followed by long term SC support	83%		84.5%	86.8%	89.6%	89.5%	85.4%	85.2%	86.0%	85.5%	85.4%	86.6%	86.4%	86.4%	85.3%	84.5%
NHS I - OPERATIONAL PERFORMANCE																
UEC - patients seen within 4 hours (23/24 plan target 76%)	76%		58.0%	57.6%	54.5%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	61.7%
Referral to treatment - % Incomplete pathways <18 wks	>92%		50.4%	52.3%	50.6%	49.5%	48.5%	42.5%	45.5%	45.5%	43.3%	43.9%	44.3%	48.1%	49.7%	49.7%
Cancer - 62-day wait for first treatment - 2ww referral	>85%		57.8%	61.5%	56.4%	60.4%	57.0%	60.8%	64.2%	54.5%	63.1%	47.2%	47.1%	63.2%	66.8%	66.8%
Diagnostic tests longer than the 6 week standard	<1%		33.9%	32.0%	30.1%	29.1%	33.9%	34.9%	32.4%	30.1%	29.0%	34.0%	26.1%	29.7%	29.8%	29.8%
Dementia - Find - monthly report	>90%		91.6%	94.6%	84.1%	92.5%	90.6%	94.1%	87.2%	93.0%	91.6%	87.9%	84.5%	87.1%	83.6%	87.1%

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - April 2023

	Target	13 month trend	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																
Number of Clostridium Difficile cases (COHA+HOHA)	<3		4	3	4	6	9	6	3	2	1	8	2	2	4	4
Cancer - Two week wait from referral to date 1st seen	>93%		59.6%	60.9%	35.6%	31.9%	38.4%	45.3%	63.8%	58.4%	67.4%	76.3%	82.6%	76.0%	55.9%	55.9%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	>93%		76.8%	77.8%	41.7%	17.3%	58.5%	79.1%	87.7%	82.8%	100.0%	93.5%	97.6%	88.9%	87.9%	87.9%
Cancer - 28 day faster diagnosis standard	75%		76.9%	67.6%	64.8%	67.7%	72.1%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	74.8%	74.8%
Cancer - 31-day wait from decision to treat to first treatment	>96%		92.6%	90.7%	96.0%	96.7%	98.0%	92.8%	96.4%	89.0%	98.3%	95.5%	98.3%	95.9%	89.7%	89.7%
Cancer - 31-day wait for second or subsequent treatment - Drug	>98%		98.6%	98.3%	100.0%	97.4%	100.0%	98.7%	100.0%	90.4%	98.6%	100.0%	100.0%	100.0%	98.6%	98.6%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	>94%		94.7%	92.6%	95.5%	98.0%	98.4%	92.2%	94.4%	98.0%	100.0%	85.7%	100.0%	86.9%	100.0%	100.0%
Cancer - 31-day wait for second or subsequent treatment - Surgery	>94%		100.0%	95.5%	87.5%	88.9%	95.5%	96.8%	89.7%	86.8%	89.7%	80.0%	96.2%	83.3%	88.5%	88.5%
Cancer - 62-day wait for first treatment - screening	>90%		70.4%	66.7%	92.9%	69.2%	70.0%	90.9%	100.0%	81.0%	76.9%	100.0%	100.0%	72.7%	100.0%	100.0%
Cancer - Patient waiting longer than 104 days from 2ww (Improvement target 20)			35	59	60	73	37	43	71	62	69	68	53	24	20	20
RTT 65 week wait incomplete pathway	1091		1839	1824	1855	1789	2093	2252	2485	2174	2203	1828	1679	1372	1244	1244
RTT 78 week wait incomplete pathway	178		779	813	713	686	787	813	829	822	923	708	462	183	166	166
RTT 104 week wait incomplete pathway	0		192	173	96	70	51	50	47	34	29	22	14	0	0	0
On the day cancellations for elective operations	<0.8%		1.6%	1.1%	1.3%	1.7%	3.1%	1.4%	1.7%	1.5%	2.1%	1.4%	1.5%	1.5%	0.8%	0.8%
Cancelled patients not treated within 28 days of cancellation	0		12	5	9	9	13	8	7	15	6	11	10	7	7	7
Virtual outpatient appointments (non-face-to-face)	25%		19.6%	20.9%	20.9%	20.2%	16.9%	16.8%	n/a	16.6%	16.1%	16.5%	15.3%	14.6%	15.8%	
Bed Occupancy	90.0%		93.9%	95.1%	93.7%	93.2%	94.3%	92.3%	92.3%	95.2%	94.9%	96.3%	96.2%	96.3%		94.5%
Percentage of inpatients with No Criteria to Reside (acute)	<5%						17.0%	12.0%	11.0%	11.0%	13.0%	13.0%	12.0%	8.1%	7.6%	
% patient discharges pre-noon	33%								18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	
% patient discharges pre-5pm	75%								59.6%	67.2%	63.2%	65.2%	67.9%	67.3%	69.8%	
Number of patients >7 days LoS (daily average)			171.6	166.0	173.0	167.0	167.0	184.9	177.0	162.0	172.6	183.5	166.1	167.0	154.2	154.2
Number of extended stay patients >21 days (daily average)			45.6	38.5	43.0	40.9	48.0	49.2	49.8	32.0	42.3	57.1	40.7	38.6	39.3	39.3
LOCAL PERFORMANCE FRAMEWORK 2																
Ambulance handover delays > 30 minutes	Trajectory		967	894	1081	995	1135	982	1181	1098	1142	802	533	1032	598	598
Ambulance handover delays > 60 minutes	0		680	514	832	694	850	735	907	773	895	561	263	676	277	277
ED - patients with >12 hour visit time pathway				668	871	827	920	906	988	939	1207	823	599	977	568	568
Time to Initial Assessment % seen within 15 mins - Emergency Department				41%	37%	36%	36%	39%	37%	39%	31%	46%	44%	41%	52%	52%
Clinically Ready to Proceed delay over 1 hour - Emergency Department								35%	40%	44%	39%	42%	40%	44%	41%	41%
Non-admitted minutes mean time in Emergency Department (hh:mm)				04:43	05:16	05:06	05:05	04:51	05:21	05:14	06:05	05:02	04:53	05:08	04:24	
Admitted minutes mean time in Emergency Department (hh:mm)				10:18	12:44	12:15	12:15	14:22	14:06	13:14	16:05	13:42	10:06	12:47	09:10	
CDiff - Hospital Onset Healthcare Associated (HOHA)			2	3	4	4	5	3	2	0	1	7	1	1	3	3
CDiff - Community Onset Healthcare Associated (COHA)			2	0	0	2	4	3	1	2	0	1	1	1	1	1
Care Planning Summaries % completed within 24 hours of discharge - Weekday	>77%		71.1%	71.0%	63.8%	69.7%	70.7%	n/a	69.1%	n/a	48.9%	72.3%	65.7%	58.1%	65.0%	65.0%

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - April 2023

	Target	13 month trend	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Year to date
Care Planning Summaries % completed within 24 hours of discharge - Weekend	>60%		50.0%	52.2%	50.8%	48.0%	48.3%	n/a	47.4%	n/a	41.5%	48.1%	45.1%	39.4%	49.1%	49.1%
Clinic letters timeliness - % specialties within 4 working days	>80%		69.5%	65.4%	69.5%	69.1%	80.2%	59.0%	60.0%	62.0%	68.0%	73.9%	69.2%	62.8%	67.7%	
NHS I - FINANCE AND USE OF RESOURCES																
EBITDA - Variance from PBR Plan - cumulative (£'000's)			-187	718	-914	-1231	-4412	-5783	-7140	-10433	-13434	-16118	-19884	-21358	-394	
Agency - Variance to NHSI cap			-2.00%	-2.40%	-2.40%	-2.10%	-2.10%	-2.00%	-1.90%	1.90%	-1.80%	-1.80%	-1.90%	-1.90%	-2.00%	
CIP - Variance from PBR plan - cumulative (£'000's)						-2751	-3858	-4403	-4872	-5005	-5874	-5328	-5512	-3390	-449	
Capital spend - Variance from PBR Plan - cumulative (£'000's)			-57	1977	814	1203	1065	975	1988	2787	3280	4076	944	-18162	-993	
Distance from NHSI Control total (£'000's)			-5	1286	0	0	-2978	-4014	-5022	-7421	-9995	-12182	-15796	-17186	22	
ACTIVITY VARIANCE vs 2019/20 BASELINE* (* March 2023 compared to March 2022)																
Outpatients - New			-16.3%	-13.8%	-7.5%	-18.1%	2.4%	0.2%	-11.7%	3.6%	-2.0%	-5.2%	-0.6%	16.1%	-9.0%	-9.0%
Outpatients - Follow ups			-13.4%	-5.5%	-7.0%	-15.3%	4.0%	-0.8%	-10.1%	4.4%	-4.1%	-6.9%	-2.4%	9.0%	-8.6%	-8.6%
Daycase			-17.7%	-10.4%	-0.4%	-7.9%	-3.5%	3.2%	-4.6%	-3.0%	-5.5%	-1.7%	5.1%	21.7%	-14.3%	-14.3%
Inpatients			-9.2%	-8.8%	-7.0%	-16.1%	-15.5%	9.6%	-16.3%	-19.5%	-21.4%	-18.1%	-16.4%	42.0%	-16.2%	-16.2%
Non elective			-4.7%	-11.5%	-1.4%	-8.2%	-2.9%	-7.1%	-7.0%	-12.7%	-18.1%	-5.7%	-11.2%	-0.2%	-7.1%	-7.1%

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: May 2023 Mortality Score Card			Meeting date: 31 May 2023
Report appendix	Appendix 1 – Hospital Mortality Appendix 2 – Unadjusted Mortality Rate Appendix 3 – Mortality Analysis Appendix 4 – Focused Mortality Reviews Appendix 5 – Glossary of Terms		
Report sponsor	Chief Medical Officer		
Report author	Chief Medical Officer		
Report provenance	Quality Assurance Committee		
Purpose of the report and key issues for consideration/decision	The report is for bi-monthly assurance to ensure learning from deaths . 		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	For the Trust Board to receive and note this report.		
Summary of key elements			
Strategic goals supported by this report	**Excellent population health and wellbeing** X **Excellent experience receiving and providing care** X **Excellent value and sustainability**		
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework** X **Risk score** 16 **Risk Register** **Risk score** BAF Ref. 1 – Quality and Patient Experience		

External standards affected by this report and associated risks	

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

Report title: May 2023 Mortality Score Card		**Meeting date: 31 May 2023**
Report sponsor	Medical Director	
Report author	Medical Director	

1.0 Introduction

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

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

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

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

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

Data Sources

The indicators for this Scorecard have been collated from a variety of data sources using defined methodology. The report is designed to give a top-level view of our mortality data over time.

The report also includes mortality cases reviewed via the Trusts Morbidity and Mortality form based on the Royal College of Physicians Structured Judgement Framework (SJF) looking at any lapses in care as well as good practice.

Data sourced, includes data from the Trust, Department of Health (DH), and Dr Foster. The data in the appendices has, in the main, been displayed as run charts. The report is generated for the Trust Board, Quality Improvement Group, and Mortality Surveillance Group as well as local ISU governance groups.

The run charts used are designed to look for *trends* and *shifts* in the data.

Trends: If 5 or more consecutive data points are increasing or 5 or more consecutive points decrease, this is defined as a trend. If a trend is detected it indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of process starting to err.

Shifts: If 6 or more consecutive data points are all above or all below the median this indicates a non-random pattern in the data which may be a signal of improvement or of a process starting to err.

Table 1: Torbay & South Devon NHS Foundation Trust Data Sources

Safety Indicator		**Data Source**	**Target**	**RAG**
Appendix 1 • A. Hospital Standardised Mortality Rate (HSMR)		Dr Foster latest benchmark Month	Below the 100 line with an aim for a yearly HSMR ≤90	12-month average 111.5
• B. Summary Hospital Mortality Index (SHMI)	Mortality	DH SHMI data		1.0333 ↓ (Nov 21 – Oct 22)
Appendix 2 • Unadjusted Mortality Rate • By number • By location		Trust Data	Yearly Average ≤3%	3.58%
Appendix 3 • Mortality Analysis		Trust Data Dr Foster DH HSMR data	New CUSUM alerts	2
Appendix 4 • Mortality Reviews and Learning		Trust Data		

2.0 Trust Wide Summary

The Hospital Standardised Mortality Rate (HSMR) is above the expected level of 100 for our population. The rolling 12-month position exceeded the expected range for the 12-months to December 2022 with a relative risk of 111.5 against a 100 benchmark. The rolling 12- month trend shows that the HSMR became statistically higher than expected in July 2021. The last 8 data points have remained stable with a slight downward trend. The Trust's HSMR is one of 11 trusts in our peer comparator which are statistically higher than expected out of 20 Trusts. The increase in HSMR over the last 2 years is broadly in line with the trend of increase in HSMR seen by our similar peers.

The factors affecting HSMR have been considered. The Trust has a lower Charlson co-morbidity of 20+ and overall the Trust reports a higher percentage of spells in the 'Symptoms and Signs' chapter (9.0% v 7.5% national). This may impact by reducing the overall expected mortality rate. The Trust has a greater proportion of patients in the higher deprivation quintiles compared to Regional peers. Higher deprivation is known to contribute to poorer health outcomes and shorter life expectancy. The Trusts' patients are older than the peer average which might result in a greater number of observed deaths.

The higher than expected HSMR is subject to a mortality improvement plan to consider all aspects which impact on HSMR including coding, patient mix and process of care.

The Director of Patient Safety has conducted research investigating the association between waits for urgent and emergency care and 30 day mortality which will be presented to QAC in July 2023 once completed. This work is informed by a large observational study of 5 million patients in the NHS from 2016 to 2018 (Moulton, Jones and Swift 2022 'The association between delays to patient admission from the emergency department and all-cause 30 day mortality. *J Emerg Med* 2022;**39**:168-73). The TSDFT audit compared all major and resuscitation patients seen in the emergency department in October 2019 and October 2022 comparing the median waiting times for clinical assessment and 30 day all-cause mortality in the two time periods. The preliminary findings were discussed at the Devon System Mortality Group (15/05/2023) with a view to work collaboratively with other Trusts in Devon on the association between waiting times for emergency patients and 30 day mortality.

Appendix 1 – Hospital Mortality

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

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

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

Our HSMR aim is to reduce and sustain the HSMR below a rate of ≤90
A rate above 100 with a ***high relative risk*** may signify a concern and needs to be investigated

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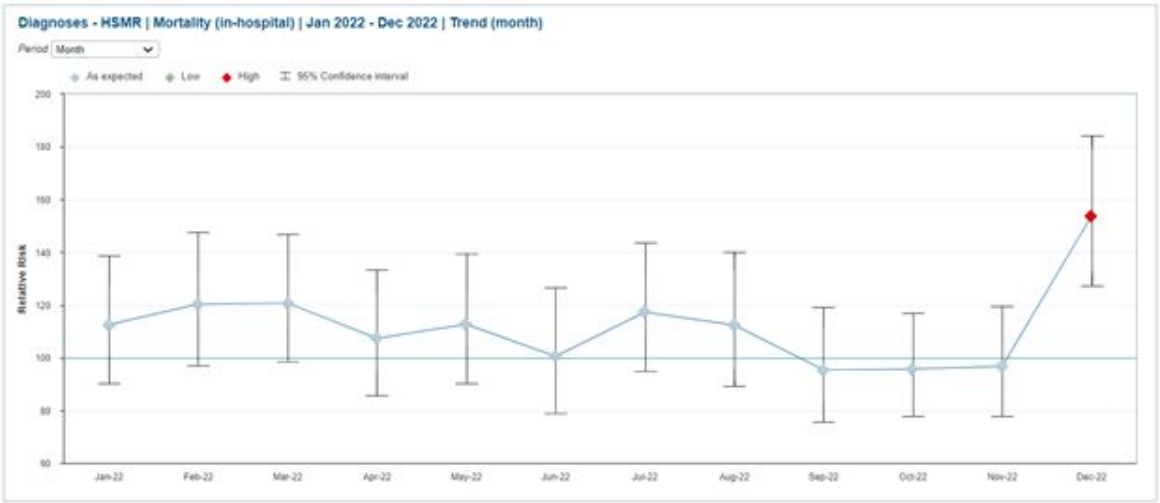
Chart 1 - HSMR by Month January 2022 to December 2022 (latest month available)
Chart one (as below) shows a longitudinal monthly view of HSMR.



The latest month available, December 2022, indicates a relative risk of 153.8 and is statistically higher than expected. A contributing factor is the lower volume of superspells during this month and a high volume of activity within the Residual codes of unclassified group which is not part of the HSMR basket. Once re-coded the diagnosis group and risks will be re-adjusted to provide an accurate figure available in the next report. Unadjusted mortality did see an increase in December 2022 mainly related to winter respiratory illnesses.

The previous three months (September 2022 to November 2022) all demonstrate a relative risk of between 95.3 and 95.7.

Chart 2 -HSMR rolling 12-month position

Rolling 12-month data for January 2022 to December 2022, indicates a relative risk of 111.5 for the 56 diagnostic groups included. The range for the January 2022 to December 2022 is 104.9 to 118.4 which remains statistically higher than the expected range when compared to hospital trusts nationally. The last six data periods show a slight downward trend with an increase in the last period.

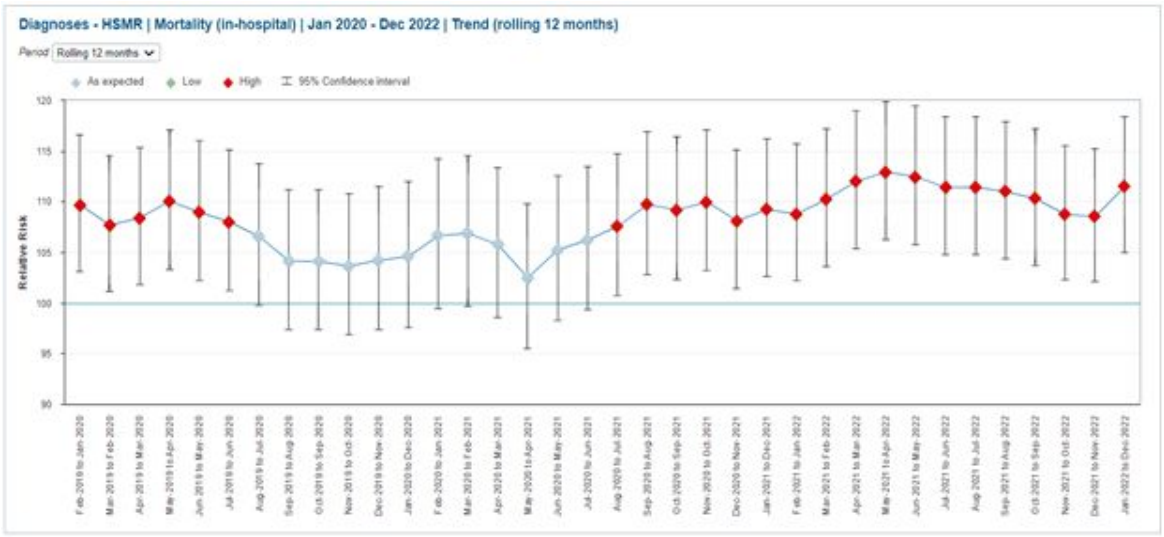


Chart 3-HSMR Peer Comparison – Similar Peers

The chart below highlights HSMR mortality by peer comparison with similar peers, using a 12-month annual total. This shows Torbay and South Devon is 1 of 11 Trusts with a statistically higher HSMR than expected out of 20.

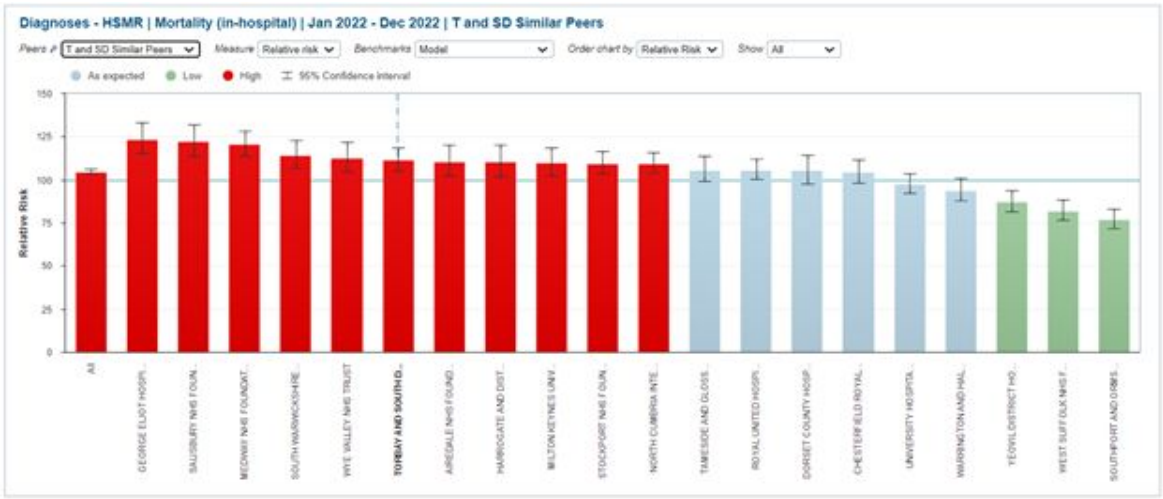


Chart 4- HSMR Peer comparison – Regional Peers

The chart below highlights HSMR mortality by peer comparison with regional peers (Acute non-specialist) , using a 12-month annual total. This shows Torbay and South Devon is 1 of 9 Trusts with a statistically higher HSMR than expected out of 14.

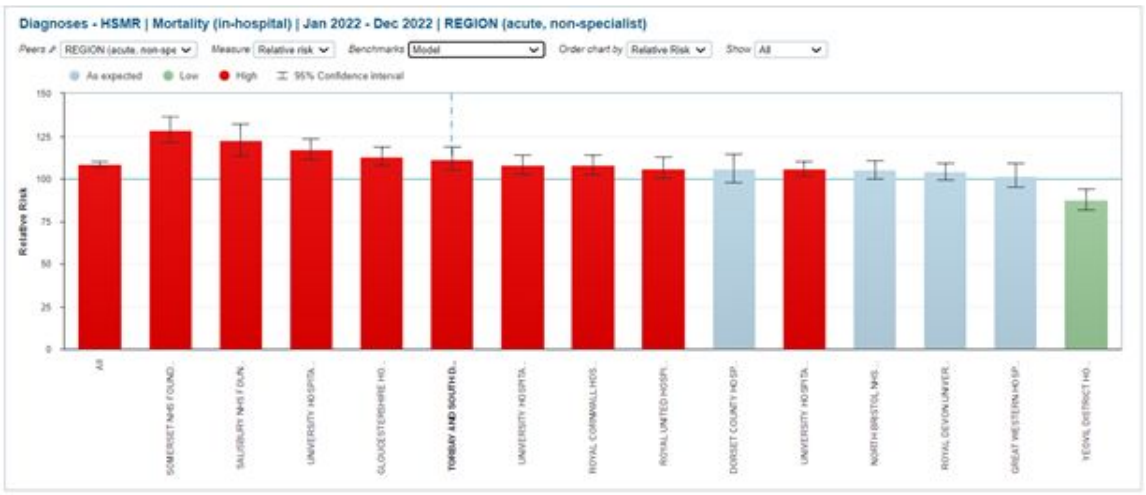


Chart 5- HSMR Expected rate (%) vs National

The expected rates followed a similar pathway to National (but at a lower rate) to the January 22 to December 22 data period, followed by an incremental increase. Whilst the Trust's expected rate has been rising to meet more closely that of national, the rate has remained stable over the last 8 data periods

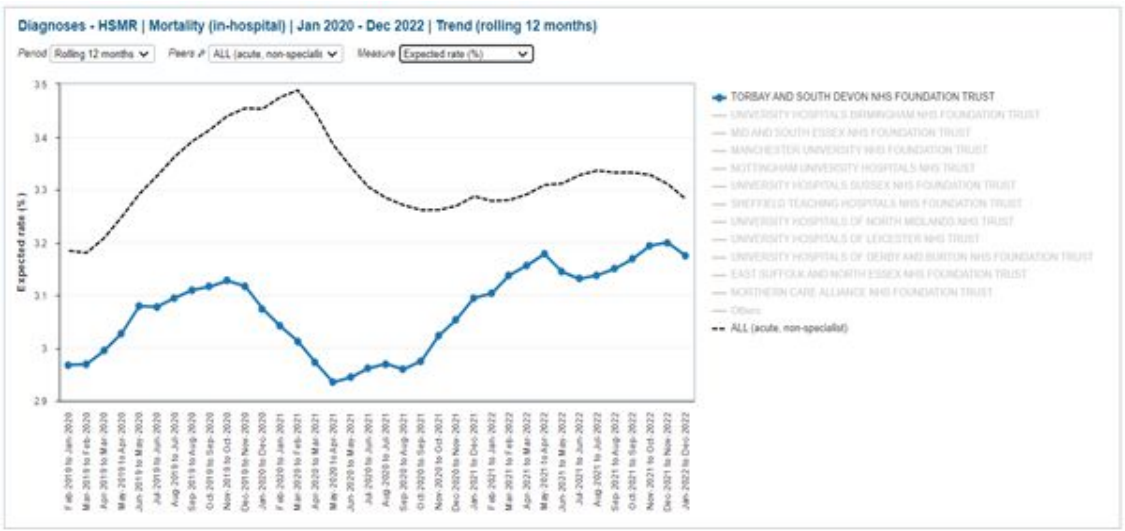


Table 2 – Coding Case Mix Summary

The following table reports a higher percentage of spells in the Symptoms & Signs chapter (9.0%). This is slightly lower than that reported in the last report (9.3%) and is slightly above national and regional peers.

The percentage of spells with the Charlson comorbidity score of 20+ is lower than both the National and Peer average (14.6%). This is higher than in the previous report (14.2%).

Mortality Influencers				
Performance	Site	Trust	Peer	National
HSMR		111.5	108.4	101.2
SMR		102.8	108.5	101.4
Non-elective (HSMR)		111.1	108.4	100.9
Weekday, emergency (HSMR)		107.6	106.6	99.7
Weekend, emergency (HSMR)		121.7	114.4	104.8
Saturday, emergency (HSMR)		123.2	114.5	104.8
Sunday, emergency (HSMR)		120.0	114.7	104.6
Coding/Casemix	Site	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)		44.1%	40.9%	40.5%
% Non-elective spells with palliative care (HSMR)		5.2%	4.8%	5.0%
% Spells in Symptoms & Signs chapter		9.0%	8.9%	7.5%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		40.5%	42.9%	41.4%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		14.6%	15.1%	16.0%
% Non-elective spells in Risk Band (0-10%) (HSMR)		83.4%	84.3%	83.8%

1B Summary Hospital Mortality Index (SHMI) Reporting Period November 2021 – October 2022

SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon inpatient deaths **and** deaths up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is very retrospective, therefore, please note the following data is based on the **November 2021 – October 2022** data period and is different to HSMR.

Chart 6- Trust SHMI compared to National Baseline

The Trust is rated 'as expected' compared to trusts nationally with a SHMI value of 1.0333

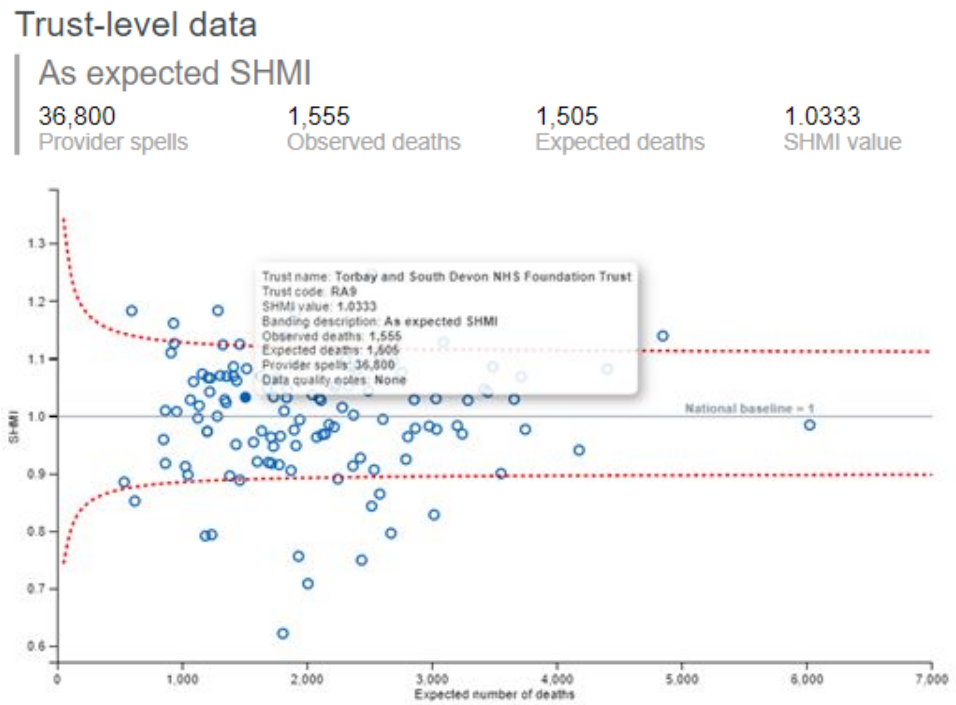


Table 3 – SHMI diagnostic groups

Secondary malignancies continues to remain statistically higher than expected.

Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	SHMI banding
Fluid and electrolyte disorders	37	355	15	25	0.6124	Lower than expected
Secondary malignancies	30	210	55	40	1.3721	Higher than expected
Acute bronchitis	74	560	20	15	1.2096	As expected
Acute myocardial infarction	57	450	40	35	1.2111	As expected
Cancer of bronchus; lung	15	95	25	30	0.9234	As expected
Fracture of neck of femur (hip)	120	485	30	40	0.8468	As expected
Gastrointestinal hemorrhage	96	340	25	20	1.2223	As expected
Pneumonia (excluding TB/STD)	73	1,295	215	220	0.9823	As expected
Septicaemia (except in labour), Shock	2	395	110	95	1.2075	As expected
Urinary tract infections	101	650	30	30	1.0292	As expected

Appendix 2 – Unadjusted Mortality Rate

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

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

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

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

Chart 7, below, highlights the Trust's in hospital unadjusted mortality. The rolling 12-month average is 3.58%. This has to be viewed along with the more in-depth analysis provided by HSMR and SHMI.

This chart below includes the Covid waves as annotated. This highlights a significant rise in deaths in March and April 2020 which is partly explained by a reduction in activity due to Covid changes. December 2022 and January 2023 showed a rise in unadjusted mortality.

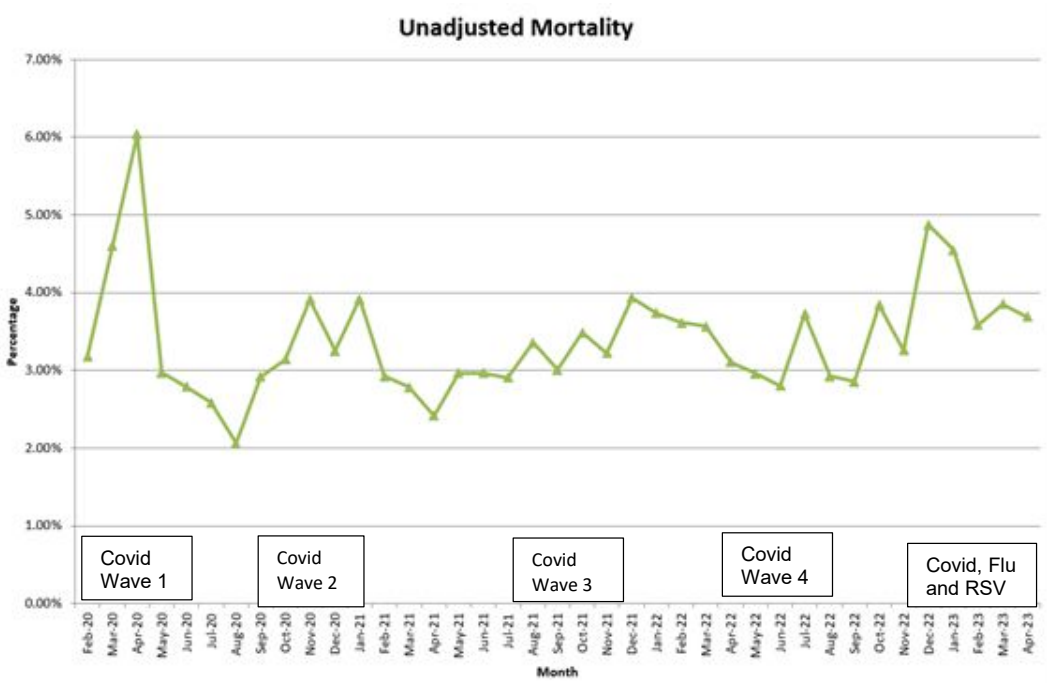
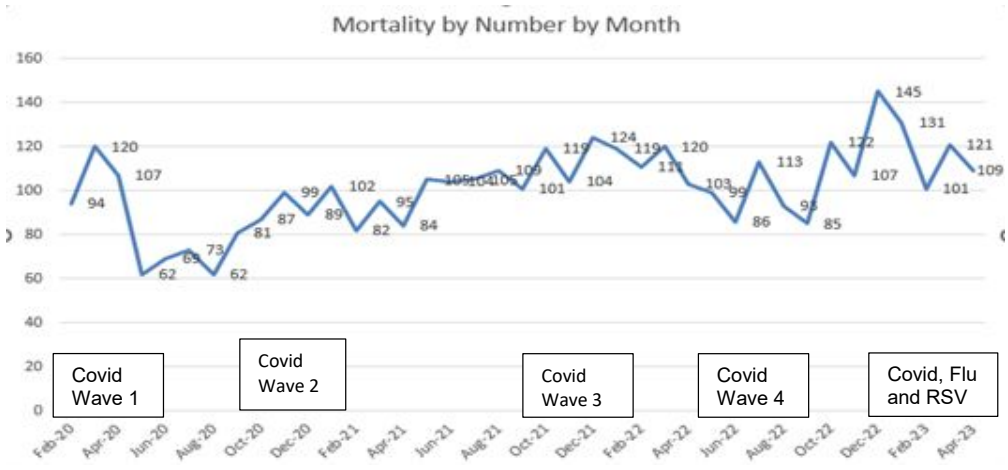


Chart 8 indicates the monthly number of hospital deaths excluding (excluding stillbirths and deaths in A & E).

Key points to note:

- The rise in March and April 2020 is partly due to Covid, before decreasing to comparatively low numbers during Summer 2020.
- As hospital activity increased following the initial pandemic lockdown, the number of hospital deaths has also increased.
- The pattern of increased deaths related to winter pressures appears to re-emerge after a relatively low number of in-hospital deaths during the winter of 2020/2021.
- An increase in deaths is noted in December 2022 and January 2023 which correlates with increased numbers of admissions due to Covid, Flu and RSV.



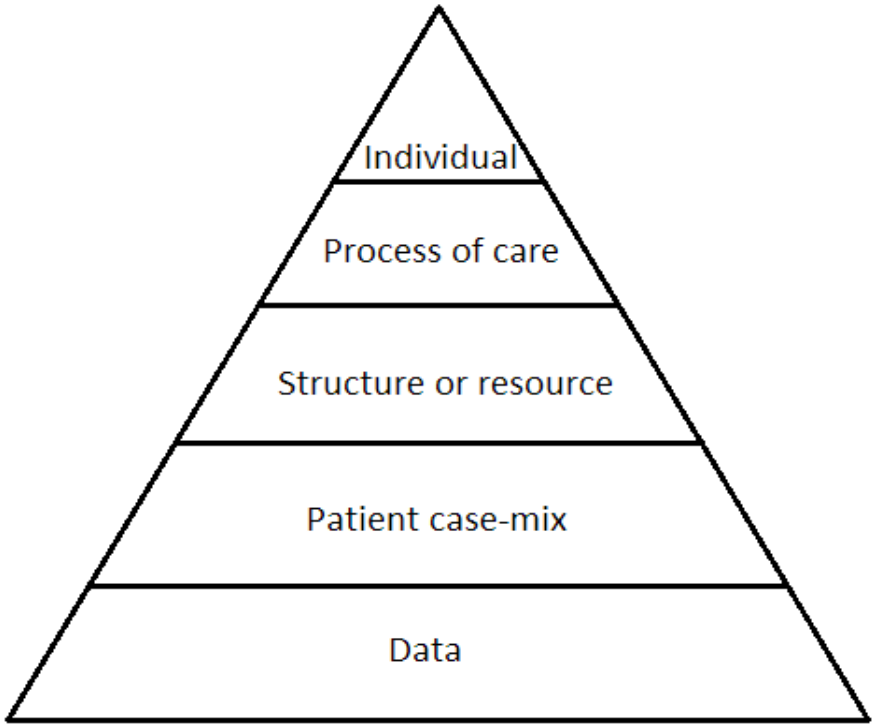
Appendix 3 – Mortality Analysis

Table 4–highlights mortality by ward location by month. Increases in deaths in some wards is attributed to altered case mixes because of the operational responses to infection control and change in specialty.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Torquay ISU													
DELIVERY SUITE													
LCHDU													
LOUISA CARY													
MOTHER AND BABY													
Paignton and Brixham ISU													
BRIXHAM			2	1			2			1		2	2
CARDIAC CATHETER SUITE												1	
DUNLOP	5	7	4	5	7	4	6	1	14	13	6	2	8
MIDGLEY	11	7	13	12	11	17	18	12	17	16	13	17	16
TORBAY CHEST PAIN UNIT									1			1	
TORBAY CORONARY CARE BEDS	2	4	2			1	2	1	5	3	2	2	3
TURNER	4	7	10	6	5	6	4	4	7	5	6	6	4
Newton Abbot ISU													
ACUTE MEDICAL UNIT									5	4	10	6	3
ACUTE SURGICAL UNIT		1											
NEW MEDICAL RECEIVING UNIT		3			1	3	1	2	4				
EAU4	7	10	8	7	6	6	7	9	9	13	3	4	7
INTENSIVE CARE UNIT	13	12	10	11	6	1	6	9	10	13	11	6	6
TEIGN WARD	1	3	1	3	2	3	3	1	4	3	2	5	2
TEMPLAR WARD		3	1	1			3	2	3				2
Coastal ISU													
AINSLIE	3	2	1	3	3	3	3	5	2	1		7	3
ALLERTON	8	3	6	8	5	6	9	8	14	7	4	6	6
CROMIE	6	2	4	6	5	2	4	6	4	3	7	5	2
DAWLISH		2		2	1		2		3	1	2	1	1
ELLA ROWCROFT	2				1	1		1	1		1		
FORREST	9	8	1	8	6	6	11	11	10	12	7	8	8
THEATRES		1							2			1	
WARRINGTON	1	2	3	1	3	3	4	2	2	5	4	1	5
Moor to Sea ISU													
CHEETHAM HILL	7	15	7	7	11	7	11	10	9	5	8	9	8
DART			1	3	1				2		1		1
GEORGE EARLE	9	4	7	17	7	11	14	10	6	9	7	12	11
SIMPSON	11	1	5	8	8	3	10	11	6	8	4	15	8
Wards used in COVID surge / operational escalation													
JOAN WILLIAMS	1	1											
MCCALLUM	3	1		4	4	2	2	2	5	9	3	4	3
Grand Total	**103**	**99**	**86**	**113**	**93**	**85**	**122**	**107**	**145**	**131**	**101**	**121**	**109**

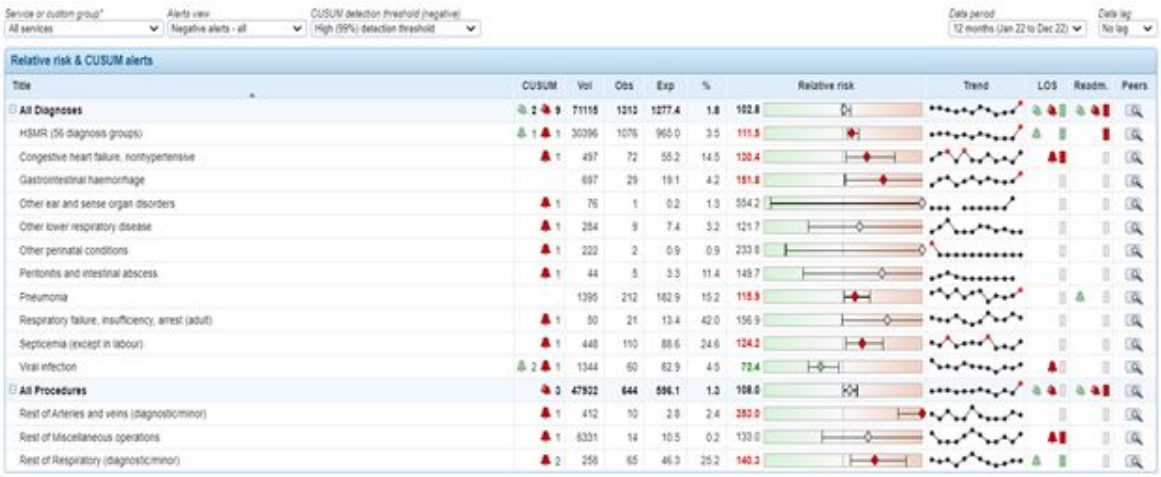
Alerts by Clinical classification

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



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

Table 5 – Dr Foster Alerts by clinical classification



Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	2 9	71115	1313	1277.4	1.8	102.8				
HSMR (56 diagnosis groups)	1 1	30396	1076	965.0	3.5	111.5				
Congestive heart failure, nonhypertensive	1	497	72	55.2	14.5	130.4				
Gastrointestinal haemorrhage		697	29	19.1	4.2	151.8				
Other ear and sense organ disorders	1	76	1	0.2	1.3	554.2				
Other lower respiratory disease	1	284	9	7.4	3.2	121.7				
Other perinatal conditions	1	222	2	0.9	0.9	233.8				
Peritonitis and intestinal abscess	1	44	5	3.3	11.4	149.7				
Pneumonia		1395	212	162.9	15.2	115.9				
Respiratory failure, insufficiency, arrest (adult)	1	50	21	13.4	42.0	156.9				
Septicemia (except in labour)	1	448	110	88.6	24.6	124.2				
Viral infection	2 1	1344	60	82.9	4.5	72.4				
All Procedures	3	47922	644	596.1	1.3	108.0				
Rest of Arteries and veins (diagnostic/minor)	1	412	10	2.8	2.4	353.0				
Rest of Miscellaneous operations	1	6331	14	10.5	0.2	133.0				
Rest of Respiratory (diagnostic/minor)	2	258	65	46.3	25.2	140.3				

Compared to the dashboard previous dashboard there are two new CUSUM alerts and two new diagnosis groups with a relative risk statistically higher than expected.

<u>CUSUM alerts</u>

- Other ear and sense organ disorders – Alert in Nov 22 – 1 observed death vs 0.2 expected
- Other perinatal conditions – Alert in Jan 22 – 2 observed deaths vs 0.9 expected (both P95 – Stillbirth)

The reason for the historic CUSUM alert for Other perinatal conditions which was not apparent in previous reports is due to the change in the benchmark following the recent data refresh. Each month the 10 year benchmark period is re-adjusted (removing a month at the beginning of the period and adding a month to the end) and risks are re-calculated for every group (also affecting the CUSUM threshold) which may sometimes cause an historical alert.

<u>Diagnosis groups</u>

- Gastrointestinal haemorrhage – This will be discussed at the mortality surveillance group
- Pneumonia – This will be discussed at the mortality surveillance group

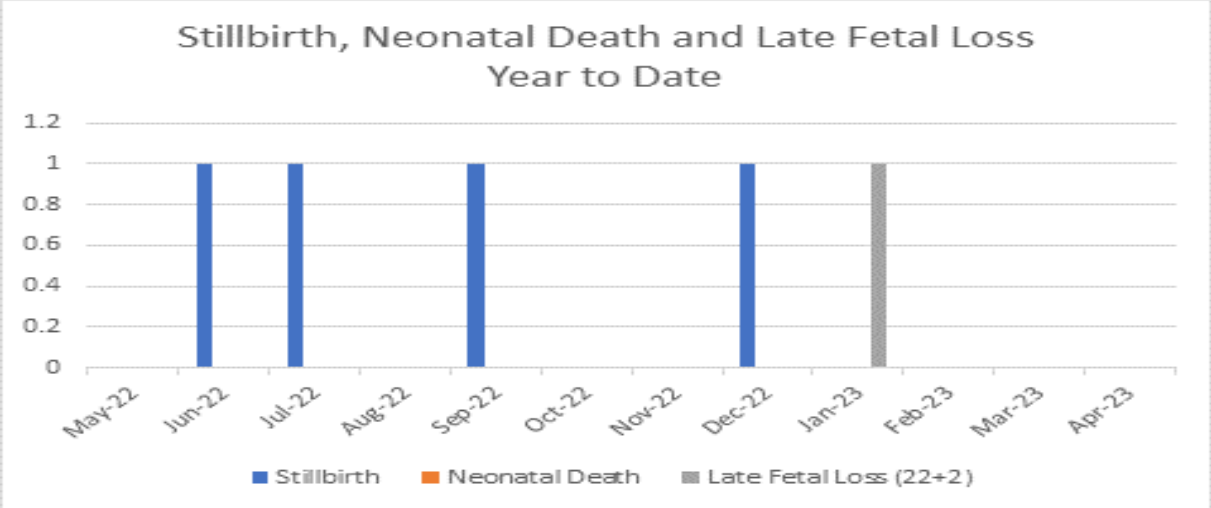
Appendix 4 – Focused Mortality Reviews

Number of Neonatal, Perinatal, and Maternal Deaths

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

During the months of March and April 2023 we had no baby losses, maternal deaths or neonatal losses.

Chart 9 – Stillbirth, Neonatal Deaths and Late Fetal Losses



Medical Examiners

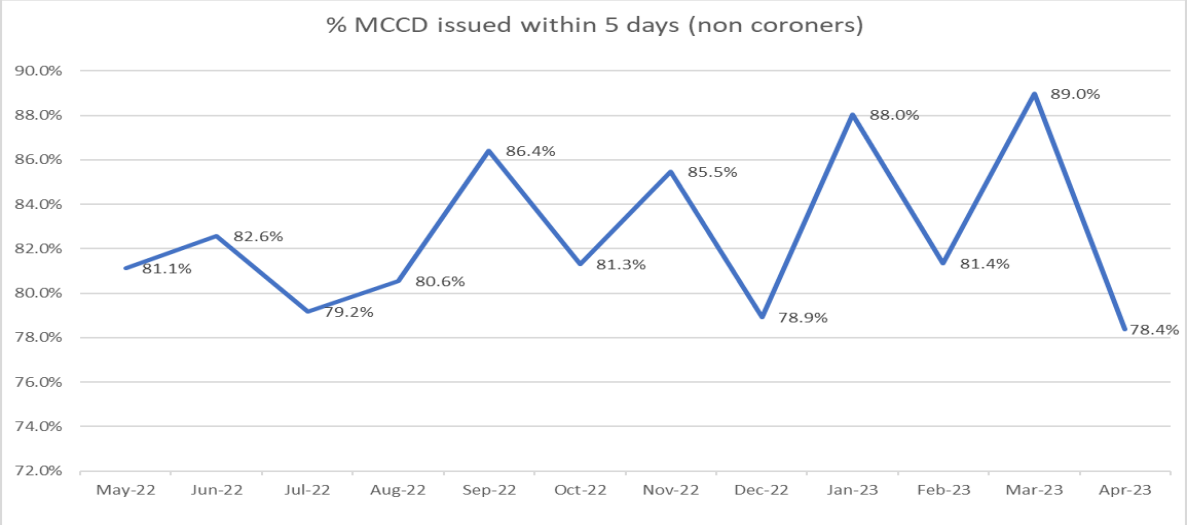
The Medical Examiners service was due to become statutory in April 2023 however the government have now revised this date to April 2024. The service hosted at TSDFT will continue to encourage local GP practices to engage on a voluntary basis.

There have been no areas of concern raised to the Trust during March and April 2023 however the industrial action and bank holidays during these months has negatively impacted on the timescales for completion of MCCD's.

Table 6 – Medical Examiners - Community vs Acute Activity

Month	Number scrutinised by ME	Acute	Community	Number scrutinised referred to coroner
Dec-21	84	84	0	2
Jan-22	107	107	0	4
Feb-22	94	94	0	13
Mar-22	124	124	0	20
Apr-22	93	93	0	9
May-22	101	101	0	11
Jun-22	103	103	0	17
Jul-22	118	114	4	22
Aug-22	93	91	2	21
Sep-22	93	90	3	12
Oct-22	149	126	23	25
Nov-22	130	118	12	20
Dec-22	176	157	19	29
Jan-23	162	143	19	20
Feb-23	140	119	21	22
Mar-23	158	128	30	22
Apr-23	130	110	20	19

Chart 10 – MCCD completion within 5 days



Number of deaths of a patient with a Learning disability or Autism

Patients with learning disabilities currently have a life expectancy at least 15-20 years shorter than other people. The Learning Disabilities Mortality Review (LeDeR) programme requires an independent case review following the deaths of people with Learning Disabilities. All deaths involving patients with a learning disability are reviewed through the LeDeR process. This feeds back any thematic learning to the Trust and our partner organisations.

A new LeDeR process has been created within the Trust establishing close interaction monthly with the Regional LeDeR team. A review of the last two years deaths within the Trust or within the community setting has been undertaken and is summarised in Table 7 below.

Table 7 – Summary of LeDeR referrals

Year	Review undertaken – No formal diagnosis of LD identified. Closed with no outcome	Reviews undertaken – Closed with outcomes and learning provided	Awaiting LeDeR review outcomes
2021 / 2022	4	5	5
2022 / 2023	4	1	7

Of the reviews resulting in outcomes all 5 in 2021 / 2022 resulted in no learning or action plans. Positive feedback was received regarding care and communication.

The 2022 / 2023 case was closed with an action plan to improve awareness training for health professionals with a June 2023 completion date.

Learning from Inquests

In Q4 of 2022 / 2023 the Trust attended 3 inquests. 1 of these was adjourned following evidence from the clinicians and we are still awaiting a further listing date for the Coroner to provide his conclusion. The other 2 inquests are summarised in the table below.

Table 8 – Summary of Inquests attended.

Month of Inquest	Month of Death	Case Outline	Verdict	Learning / actions/ feedback
January 2023	December 2020	Death following embolization procedure	Narrative Conclusion – Known complication of procedure undertaken	NOK contacted Consultant to pass on his appreciation for all the Trust had done for his wife. Whilst he highlighted that there were some mistakes made he also wanted to let her know how grateful he was.
March 2023	May 2021	Unwitnessed fall in community hospital	Accidental Death	Coroner was informed that a review of the policy regarding unwitnessed falls was reviewed and amended accordingly so if a patient has an unwitnessed fall which causes a bang to their head in a community hospital they are taken to the Acute hospital and a scan is undertaken. This was already the policy for falls within the acute hospital setting. The family were grateful that the policy had been amended and we were able to pass on our condolences to them

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

During March and April 2023 there have been 3 formal complaints. All of these are ongoing and relate to end-of-life care and discharges.

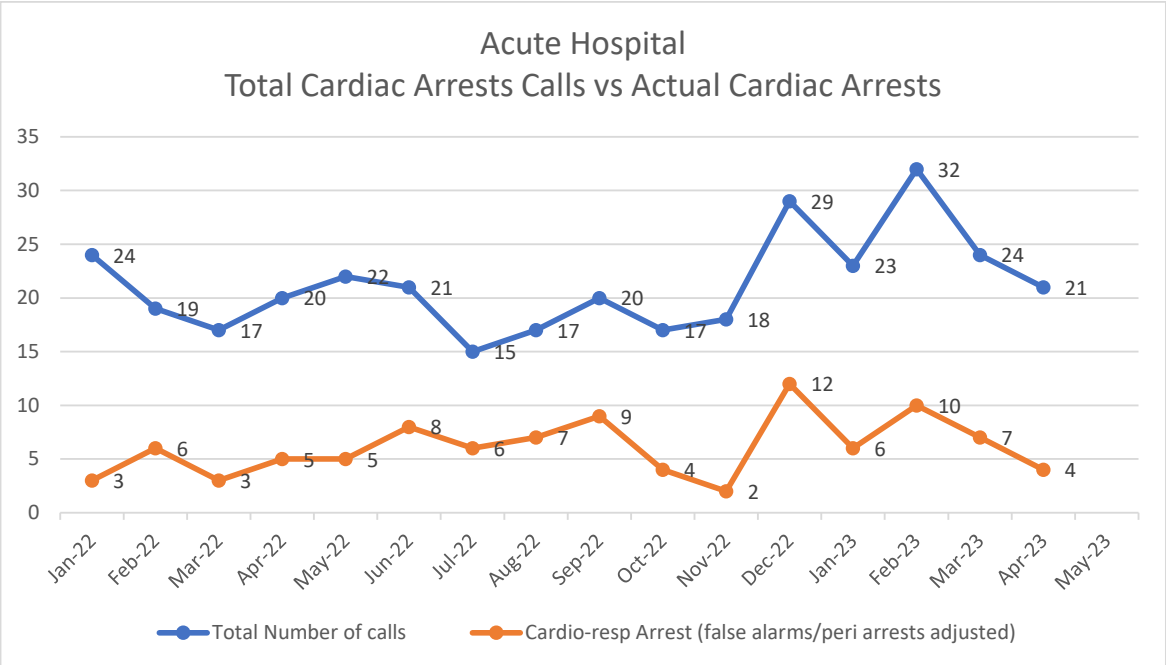
In addition, there have been 18 concerns raised. 3 relating to timeliness of ME referral / MCCD completion / cremation form accuracy, 1 related to diagnosis, 5 relating to communication, 1 related to care home funding and 8 related to care.

There have been 3 compliments received regarding treatment and care.

Cardiac Arrest

Numbers of cardiac arrest call and actual cardiac arrests is demonstrating a stable position since January 2022.

Chart 11– Acute Hospital – Cardiac Arrests



Trust learning: Serious Adverse Event Group
Serious Adverse Event Group 19/4/23 and 17/5/23. A number of incidents were discussed:

Key Issues	Learning and actions taken
Treatment / Diagnostic learning	
• Self presentation of lady to ED. Late diagnosis of myocardial infarction. Underwent coronary intervention but patient died	• Identification of deteriorating patient in the waiting room at times of high acuity. Thematic review of impact of ED waiting times on 30 day mortality to be presented by Director of Patient Safety
• Social admission patient with dementia, fall #NOF, surgery but died post-operative period	• Explore alternatives to admission for social indications. Use of sedatives in elderly patients with dementia

Appendix 5 - Glossary of Terms

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

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

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

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

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Board of Directors			
Report title: Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training			Meeting Date: 31st May 2023
Report appendix	Appendix A - Reasons for ER over last quarter by specialty & grade		
Report sponsor	Medical Director		
Report author	Dr Claire Blandford - Guardian of Safe Working Hours		
Report provenance			
Purpose of the report and key issues for consideration/decision	To provide assurance to the Board that doctors in training under the new terms and conditions of service are working safe working hours and to highlight any areas of concern		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board are asked to receive and note the Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training		
Summary of key elements			

Strategic objectives supported by this report

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

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

Board Assurance Framework		**Risk score**	16
Risk Register		**Risk score**	

BAF objective 9: To ensure management practice, leadership capacity and capability to deliver high-quality, sustainable care for the local population

External standards affected by this report and associated risks

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

Torbay and South Devon NHS Foundation Trust

Report title: Guardian of Safe Working Hours – Doctors and Dentists in training		Meeting date: 31st May 2023
Report sponsor	Medical Director	
Report author	Dr Claire Blandford - GOSWH	

1. Executive Summary

The following report concerns the time period of 10th December 2022 up to the 10th April 2023 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 139 Exception Reports in the period 10th December 2022 up 10th April 2023. This is a decrease in the number of exception reports from the previous quarter.

Table 1 – Exception Reports by Area
I have not been supplied with data in this format by HR, please see comment below as per Table 2.

Table 2 – Exception reports by Grade
I have not been supplied with data in this format by HR, hence I attach an alternative format as Appendix A.

Table 3 – Nature of Exception

Immediate Patient Safety Issue	2
Additional Hours	126
Pattern of Working	3
Service support	3

Educational	5

Table 4 – Outcome of Exceptions

TOIL	41
Payment	213
Work Schedule Review	1
Agreed no further action required	43
Outstanding	49

4. Comment on Exception Reports

The highest proportions of exception reports are coming from general medicine and general surgery with the highest single area being F1s in surgical specialties. 92% of these relate to working additional hours, most frequently this is up to one hour of extra work per report.

Two forms in this period were submitted as Immediate Safety Concerns. On examination of the report details, in both instances there was a high volume of clinical work requiring additional working hours (1 hour/ 1hour 15mins) and/ or support from senior colleagues. In neither situation was patient safety compromised. Both forms were reviewed and assessed by senior medical staff within the required response time frames and were determined as not representing true immediate safety concerns.

5. Rota Reviews

Please see section 8

6. Fines

There have been no Guardian fines for this period.

7. Qualitative Information

Since the last report, Human Resources have led work to alter the claim process for junior doctors whose exception reports are approved for payment so as to streamline the current procedure. Previously, a paper-based form needed to be completed by the junior doctor to request payment. The new system will transfer payments to the electronic system TempRE. A new Exception reporting policy has been drafted to cover this amendment.

8. Summary

When I took over the role at the end of January 2023 there were a significant number of outstanding exception reports (ERs) in the Allocate database. I have undertaken the necessary work to resolve this backlog, Appendix A shows resolved ERs. Previous themes of i) ERs associated with bank holiday work in medical specialties and ii) junior

doctors reporting a lack of service support for oncology patients on Turner ward on seem to have been resolved with the new medical rota introduction and improved senior cover arrangements respectively. The highest single area of exception reports is currently from F1 surgical specialties, most strongly related to additional working hours during ‘hot week’ on-call periods. This has already been highlighted in previous reports as a potentially fragile rota due to its intensive pattern (although compliant within the JD contract terms &conditions). I plan to raise this for discussion at the next Guardian oversight meeting (18.5.23) to seek an update.

The number of ERs in this quarter is notably lower than that of the previous quarter, there is no clearly attributable reason for that (under reporting vs genuine ?). In order to help raise the profile and hopefully improve the general understanding of the exception reporting process and individual’s responsibilities I have, within the last quarter, released a ‘Guardian’ newsletter to the junior doctor body, created additional ‘how to guide’ resources for supervisors and sent all senior medical colleagues an update email communication. I hope this will help highlight exception reporting, clarify the process for all involved and improve the timeliness of resolution of exception reports.

The last two guardian oversight meetings (March 23, April 23) were unfortunately cancelled due to both coinciding with industrial action. I have remained in regular contact with the JDRC during this period. Thank you to the JDRC and HR for assisting me in starting this new role.

Appendix A:

Reasons for ER over last quarter by specialty & grade						
ER relating to:	**Specialty**	**Grade**	**No. ERs carried over from last report**	**No. ERs raised**	**No. ERs closed**	**No. ERs outstanding**
Immediate patient safety issues	General medicine	CT1		1	1	0
	General medicine	Foundation house officer 1		0	1	0
	General medicine	ST1		0	1	0
	Geriatric medicine	Foundation house officer 1		0	1	0
	Paediatrics	CT1		1	1	0
Total				**2**	**5**	**0**
No. relating to hours/pattern	Accident and emergency	CT1		2	2	0
	Accident and emergency	Foundation house officer 2		0	1	0
	Accident and emergency	FY2 *		2	2	0
	Accident and emergency	Specialty registrar in core training 1		0	1	0
	Acute Medicine	CT1		0	1	0
	Acute Medicine	Foundation house officer 1		4	10	0
	Acute Medicine	FY1		3	7	0
	Acute Medicine	ST1		0	2	0
	Anaesthetics	CT3		2	1	1
	Cardiology	FY1		1	1	0
	Gastroenterology	Foundation house officer 1		0	8	0
	General medicine	CT1		16	19	0
	General medicine	CT2		0	1	0
	General medicine	Foundation house officer 1		4	11	0
	General medicine	FY1		16	35	14
	General medicine	FY1 *		0	1	0

	General medicine	FY2		9	9	3
	General medicine	FY2 *		3	27	1
	General medicine	Senior house officer		1	1	0
	General medicine	Specialty registrar in core training 1		0	6	0
	General medicine	ST1		0	2	0
	General medicine	ST2		0	1	0
	General surgery	CT1		0	1	0
	General surgery	CT2		1	1	1
	General surgery	Foundation house officer 1		0	1	0
	General surgery	FY1		3	1	3
	General surgery	FY2		1	2	1
	General surgery	ST7 *		0	0	2
	Geriatric medicine	Foundation house officer 1		0	1	0
	Geriatric medicine	FY1 *		7	5	2
	Haematology	Foundation house officer 1		0	3	1
	Haematology	FY1		0	1	0
	Haematology	FY2		0	1	0
	Haematology	ST1		0	3	0
	Obstetrics and gynaecology	FY2		0	1	0
	Obstetrics and gynaecology	FY2 *		0	1	0
	Ophthalmology	ST2		1	1	0
	Ophthalmology	ST4 *		0	4	0
	Other	FY2		0	1	0
	Otolaryngology (ENT)	FY2		0	2	1
	Otolaryngology (ENT)	FY2 *		0	2	0
	Paediatrics	CT1		1	1	0
	Paediatrics	FY1		1	1	1
	Paediatrics	FY2		0	6	0
	Respiratory Medicine	FY1		3	1	2
	Respiratory Medicine	FY2		0	3	0
	Respiratory Medicine	FY2 *		0	2	0

	Surgical specialties	Foundation house officer 1		0	12	0
	Surgical specialties	FY1		49	60	11
	Surgical specialties	FY1 *		0	1	0
	Trauma & Orthopaedic Surgery	FY1		1	1	0
	Trauma & Orthopaedic Surgery	Specialty registrar in core training 1		0	3	0
	Unknown	FY1		0	1	0
	Urology	FY2		0	1	0
	Urology	ST4		0	1	0
Total				**131**	**275**	**44**
No. relating to educational opportunities	Accident and emergency	FY2 *		1	1	0
	Anaesthetics	CT3		2	0	1
	Anaesthetics	ST4		1	0	1
	General medicine	FY2 *		0	1	0
	General surgery	FY2		0	1	0
	Haematology	Foundation house officer 1		0	2	0
	Haematology	ST1		0	2	0
	Ophthalmology	ST7		0	1	0
	Other	FY2		0	1	0
	Surgical specialties	FY1		1	0	1
Total				**5**	**9**	**3**
No. relating to service support available	General medicine	Foundation house officer 1		0	3	0
	General medicine	FY1		1	0	1
	General medicine	FY2		1	0	1
	General medicine	FY2 *		0	1	0
	Geriatric medicine	Foundation house officer 1		0	1	0
	Haematology	Foundation house officer 1		0	3	0
	Haematology	ST1		0	1	0
	Ophthalmology	ST7		0	1	0
	Surgical specialties	FY1		1	4	0
Total				**3**	**14**	**2**

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Maternity Governance and Safety Report			Meeting date: 31 May 2023
Report appendix	Appendix 1 – LASER templates		
Report sponsor	Chief Nurse		
Report author	Director of Midwifery and Gynaecology Clinical Governance Co-ordinator Digital & Quality Improvement Midwife Deputy Head of Midwifery		
Report provenance	The content of this report is a summary of the safety improvement activities implemented by the Maternity Governance Group within the Trust to meet the national priority to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025. This is informed by the Safety workstream of the Devon Local Maternity & Neonatal System (LMNS).		
Purpose of the report and key issues for consideration/decision	The purpose of this report is to provide assurance to the Board around key aspects of the maternity safety agenda, specifically relating to: • Setting out the Trust position in relation to perinatal mortality and morbidity. • To update the Board following the publication of the three-year single delivery plan for Maternity and Neonatal services • To update on progress against the NHSE maternity self-assessment which was completed 12 months ago		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board 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 the plan with regard to embedding the elements of the three-year Single Delivery plan taking note of theme 3 and specific recommendations for Trust boards. • Acknowledge the progress made against the Maternity self-assessment tool within the last 12 months		

Summary of key elements				
Strategic goals supported by this report	**Excellent population health and wellbeing**	X	**Excellent experience receiving and providing care**	X
	Excellent value and sustainability			
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework**		**Risk score**	
	Risk Register		**Risk score**	
External standards affected by this report and associated risks	**Care Quality Commission**		**Terms of Authorisation**	
	NHS England	**X**	**Legislation**	
	National policy/guidance	**X**		

Report title: Maternity Governance and Safety Report		**Meeting date: 31st May 2023**
Report sponsor	Chief Nurse	
Report author	Director of Midwifery and Gynaecology Clinical Governance Co-ordinator Digital & Quality Improvement Midwife Deputy Head of Midwifery	

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 Review of Maternity Care at Shrewsbury and Telford, (December 2020 and March 2022) as well as the East Kent report 'Reading the Signals' (October 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 these reports for all providers of maternity care.

This quarterly report will be constructed to meet the recommendations within the Ockenden reports as well as addressing the reporting requirements for Maternity Incentive Scheme (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 January 2023 – 31 March 2023 (Q4)

2.0 Review and monitoring of safety within maternity services

2.1 National Maternity Assurance Position – The Single Delivery Plan

2.1.1 On 30 March 2023 NHS England published a three-year single delivery plan for maternity and neonatal services. Following several national plans and reports, including the reports by Donna Ockenden (2020/ 2022) and Dr Bill Kirkup (2022), the plan brings together the key objective's services are asked to deliver against over the next three years.

NHS England has developed this new delivery plan in consultation with service users, healthcare staff, trust leaders and other stakeholders, as well as with the Independent Working Group on maternity chaired by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists (RCOG). This consultation has supported NHS England to triage and review the actions remaining from the Ockenden and Kirkup reports as well as existing NHS England plans for maternity.

The report sets out the 12 priority actions for trusts and systems for the next three years, across four themes or pillars

- Listening to women and families with compassion
- Supporting the workforce
- Developing and sustaining a culture of safety
- Meeting and improving standards and structures

A summary of the recommendations along with a high-level overview of the Trust's current position is set out below.

Theme 1: Listening to and working with women and families with compassion
The plan identifies listening and responding to women and families as an essential component of safe and high-quality care:

The first objective in this theme is for all women to receive compassionate personalised care based on an ongoing dialogue between women and families and their clinicians.

Expectations for Trusts
Training and tools to deliver personalised care
Regular audits of personalised care seeking feedback from women
Consider how to achieve Midwifery continuity of carer in line with safe staffing principles
Achieve Baby Friendly Initiative standards by 2027
Improve equity for mother and babies by addressing health inequalities

Torbay and South Devon position

- Personalised care plans in place with ongoing work as part of LMNS to strengthen these templates and audit processes.
- Audit on personalised care was completed in February 2023. An action from this was to embed a decision-making tool for women to use with the electronic patient record.
- Midwifery continuity of care in place with enhanced maternity support worker roles planned for Torbay teams
- Baby Friendly standards in place – Level 3 reaccreditation process November 2022
- Working with LMNS to address equity and equality plans. Also completed Trust SWOT analysis with Trust lead for Diversity and Inclusion in March 2023 for the NHSE equality delivery system toolkit.

Theme 2: Workforce
NHS England's report acknowledges that the ambitions of the plan "can only be delivered by skilled teams with sufficient capacity and capability" and that currently some services do not have the staff they need.

The Objectives included in this pillar is to grow and retain the workforce as well as succession plan

Expectations for Trusts
Undertake regular local workforce planning, and to meet staffing establishment levels set by Birth-rate Plus by 2027/28

Develop and implement local plans to fill vacancies, including specific support for newly qualified staff and returners

Provide additional administrative support.

Develop retention plan with inclusion of succession planning and leadership pipeline opportunities

Provide a preceptorship programme for newly registered midwives

Invest in skills and make training in line with the core competency framework

Torbay and South Devon position

- Midwifery establishment funded to Birth rate recommended level.
- Retention midwives in post with action plan to address workforce retention
- Leadership programme for band 6 and 7 midwives commenced in early 2023
- Acorn to Oak preceptorship programme and legacy midwife role in place
- Training needs framework encompasses core competency requirements

Theme 3: Developing and sustaining a culture of safety, learning and support
This theme focuses on cultural issues identified in the Kirkkup report including teamworking, professionalism, compassion, listening, and learning. It sets out objectives related to developing a safety culture, learning and improving, and support and oversight.

Expectations for Trusts
Ensuring maternity and neonatal leads have the time, training and development and lines of accountability to focus on developing a safety culture

Supporting senior leaders to engage in national leadership programmes offered by NHS England by April 2024 (Perinatal Quadrumvirate)

At board level, reviewing an implementation plan to improve and sustain culture, aligned with freedom to speak up (FTSU)

Ensuring staff are supported by clear and structured routes for the escalation of clinical concerns

Ensuring staff have access to FTSU training modules and a Guardian who can support them to speak up.

Respond effectively and with candour to patient safety incidents using the patient safety incident response framework (PSIRF)

Good oversight of maternity and neonatal services at Trust Board level with clear escalation processes

Act on outcome data, staff feedback and audits to learn what ‘good looks like’

Torbay and South Devon position

- Continue the support and oversight from Trust board for maternity and neonatal services.
- The perinatal quadrumvirate is part of cohort 3 and is beginning the national perinatal culture and leadership 6-month training programme in July 2023
- Perinatal services are part of the trust-wide programme to implement PSIRF. Bespoke focus workstreams are also planned by ICS and regional team.
- Audit plan in place with mechanism to address and act on feedback (eg matron listening forum., Director of Midwifery – Hear to Here Forums)

Theme 4: Standards and structures that underpin safer, more personalised and more equitable care

This theme acknowledges the need to develop clear standards and structures to support the delivery of the plan, including clinical best practice, the provision of high-quality data, and effective digital tools. The plan stresses that the plan does not create additional standards but seeks the consistent adoption of existing standards.

Expectations for Trust's

Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025, which will be updated by NHS England

Regularly review and act on key local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality

Ensure staff are enabled to deliver care in line with evidence-based guidelines including NICE

Complete the national maternity self-assessment tool and use the findings to inform improvement plans.

Ensure high quality submissions to the maternity services data set and report incidents as appropriate to the relevant national bodies

Develop and implement a local digital strategy

Procure an EPR that complies with national specifications for maternity services

Torbay and South Devon position

- The NEWTT 2 tool will be implemented late in May 2023 and national MEWS parameters will form the future specification for the electronic observation system
- Guidelines updated based on NICE recommendations
- National maternity self- assessment completed in May 2022. Update against progress provided in this paper.
- Ongoing work within trust and with ICS to ensure high quality data submission to national bodies
- Maternity digital strategy in place
- Maternity engagement with CINO with regard to the Trust wide EPR procurement
- Digital midwife completed Foundation course for digital leaders in April 2023

2.1.2 All of the above themes will also be considered by CQC as part of their inspection criteria.

There will also be a follow up “Ockenden Insights” visit with regional and system teams in July 2023. This will review the Trust’s progress and plans to address the recommendations.

2.1.3 Trust boards should pay particular attention to theme 3, creating a positive safety culture in maternity and neonatal services, which contains several actions to be taken forward at board level

2.1.4 Next steps for Torbay and South Devon:

1. Develop local action plan in conjunction with LMNS to address the recommendations within the plan
2. Utilise the recently devised Devon wide LMNS strategy for perinatal services to communicate Torbay’s vision and strategy for the service.
3. Perinatal Collaborative workshop planned for child health and maternity services stakeholders in July 2023 to address the recommendations. This will involve service users

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 (Table 1) focuses on strengthening trust-level oversight for quality, with 6 requirements. 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.
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.
3. That all maternity Serious Incidents (SIs) are shared with trust boards and the LMNS, in addition to reporting as required to HSIB.
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.
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.
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

Trust Board Reporting – Quality and Safety within Maternity Services

Table 2 sets out the mandated reporting framework for maternity quality and safety metrics (The Committee will note that quality and safety metrics are also reported on a monthly basis through the Board IPR.)

Table 2: PCQS Minimum Dataset Information Summary Q4

	January 2023	**February 2023**	**March 2023**
Findings of completed review of all perinatal deaths using the real time data monitoring tool (see 2.3 b for full details)	32-week stillbirth following episode of reduced fetal movements. The PMRT did not identify an obvious cause of death.	None undertaken	38 Week stillbirth review of high-risk mother. The findings of the PMRT were that following post mortem the fetal-placental weight ratio was markedly increased and this suggests a degree of relative placental insufficiency.
Findings of review all cases eligible for referral to HSIB. **We have included as appendix, the LASER Templates developed for families and staff to demonstrate the incident recommendations and learning (appendix 1)**	Please see appendix 1 for details of learning from finalised cases	No eligible cases.	No eligible cases.
Report on: The number of incidents logged graded as moderate or above and what actions are being taken Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.	**1 Moderate** Baby born unexpectedly in poor condition and transferred to Derriford for cooling. MDT case review completed and CTG learning disseminated. **Training –** 93% compliance **Staffing** Full details in section 3	**1 Moderate** Neonatal death at 11 days old following birth at 43+1 gestation. This case is being reviewed by HSIB. **Training –** 94% compliance **Staffing** Full details in section 3	**None reported.** **Training** – 95% compliance **Staffing** Full details in section 3
Service User Voice feedback	Feedback mechanisms in place.	Feedback mechanisms in place	Feedback mechanisms in place
Staff feedback from frontline champions and walk-about	Completed- detail included within this paper	Completed	Completed
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	None	None	None
Coroner Reg 28 made directly to Trust	Nil	Nil	Nil
Progress in achievement of CNST 10 safety actions	Report submitted to the board – declared compliant.	N/A	N/A
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)			59%

Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	N/A

Serious Adverse Events

2.3 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. All of the families have provided feedback. We have now established a process of inviting external reviewers to the PMRT reviews as set out in the standards.

(a) PMRT - Notifications

During Jan – March 2023 there was one case that met the PMRT criteria and was reported. Details of this case are:

- Late fetal Loss at 23 weeks and 6 days gestation – Jan 2023:

The case involved a Mother whose baby was found to have died following an episode of absent fetal movements. This was her third pregnancy and she was considered to be low risk up until this episode. There were no immediate actions or learning that arose from the 72-hour report. A PMRT case review is schedule for May 2023 and any learning from this will be disseminated to all Midwifery and medical staff.

We are also involved in 2 PMRT's assigned to other trusts.

- An unexpected neonatal death following a vaginal delivery that occurred at RDUH(E) where we provided antenatal care – Feb 2023
- A neonatal death that occurred at Derriford Hospital of a baby born at Torbay that was transferred for cooling (See 2.4.1) – Feb 2023

(b) PMRT – Completed Reviews

During Q4 we completed 2 PMRT case reviews.

- A mother who gave birth to a stillborn baby after attending for an elective caesarean section at 38 weeks and was found to have a fetal demise. This mother had increased maternal age, Type 2 diabetes, Hypertension and no issues were found with clinical care.
- A mother who attended with a history of reduced fetal movements at 32 weeks gestation where baby was sadly stillborn. No cause of death was found.

2.4 Healthcare Safety Investigation Branch (HSIB)

2.4.1 Referrals to HSIB

In Q4 one new case was reported to HSIB. This was the case of a baby whose parents chose to birth outside of guidelines, declining induction for a postdate pregnancy. The baby delivered at 43 weeks and 1-day gestation and sadly died at 11 days old in Derriford Hospital.

We are also providing input for a HSIB case reported by RDUH concerning a neonatal death following a vaginal delivery of a woman who received her antenatal care with Torbay but gave birth at RDUH (Exeter).

2.4.2. Finalised investigation reports from HSIB

In Q4 three finalised reports were completed and received from HSIB. The learning from these reports have been circulated via the Maternity Safety and Learning newsletter and summarised in a poster in all clinical area entitled, Learning from Adverse Serious Event Reviews (LASER). **(Appendix 1)**

Additionally, copies of all final HSIB reports and LASER have been circulated for staff learning in all of the Maternity clinical areas.

2.4.3 Quarterly Engagement Visit with South West Maternity Investigation Team

We met with the South West Maternity Investigation Team on 9th March 2023. We heard about investigation findings nationally and a review of the HSIB report on the Assessment of Risk During the Maternity Pathway. This has helped inform us some of the decisions regarding the initiative to launch a telephone triage service for Maternity.

2.5 Safety Improvement

*2.5.*1 Maternity and Neonatal Health Safety Improvement Programme (MATNEOSIP) including PERIPrem

The most recent MatNeoSIP Patient Safety Network Event, was held on 9 March 2023. The event included presentations on:

- Smoking in Pregnancy – Learning from MVP project collaboration,
- SuSTAIN (Supporting Staff Involved in Incidents) – Maternity staff are peer trained in psychological first aid. A reflective space is provided by a psychologist weekly and specific software is used utilised to invite staff to de-briefs.
- PSIRF in Perinatal services overview (including Q&As)
- Maternal Medicine Network
- Fulcrum Project update – this focuses on preceptee midwives and the use of the Maslach Burnout Inventory which is used regularly with these team members in order to assess their wellbeing and to inform care plans which are written to provide targeted individualised support.

2.5.2 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. Version 3 of the care bundle will be launched in the middle of 2023.

The Board will recall previous escalation regarding the potential non-compliance around the element pertaining to a reduction of smoking in pregnancy, specifically carbon monoxide monitoring at booking and 36 weeks. Evidence of 80% compliance is required for both.

There have been significant improvements in the compliance rate following targeted intervention led by the Head of Midwifery and team. Our compliance over 4 consecutive months is now over 80% for both booking and 36 weeks. This met the standard required for the Maternity Incentive Scheme (MIS) Year 4.

As well as the improvement in our CO compliance there has been a marked reduction in the number of women smoking at time of delivery (SATOD). Historically our SATOD data was 13-15%. With the introduction of the Smoke-free Pregnancy team this rate has dropped to 7.3% for the year 2022/23 and for this Quarter was 8.2%

Reducing smoking in pregnancy is a common goal across the whole of the Saving Babies Lives Care Bundle.

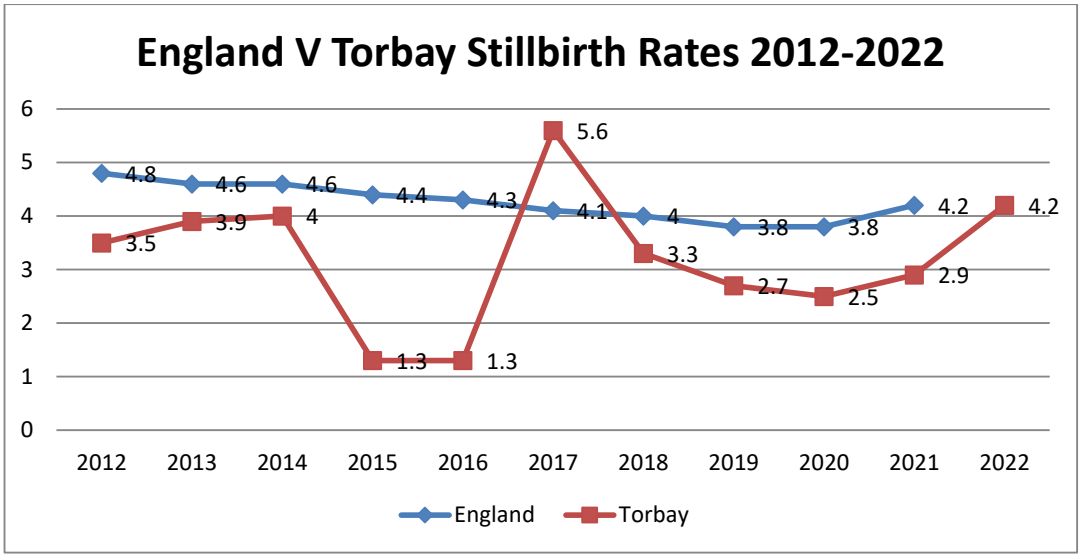
Data from the Perinatal Institute on our detection of small for gestational age (SGA) babies for this Quarter has evidenced that we are still performing above the recommended user average and are one of the Top 10 Trusts in the country for detection of small babies. The Trust detection rate was 69.2% compared to the National average of 43.6%. This links with Element 2 of the Saving Babies Lives Care Bundle.

2.5.3 Stillbirth Rate

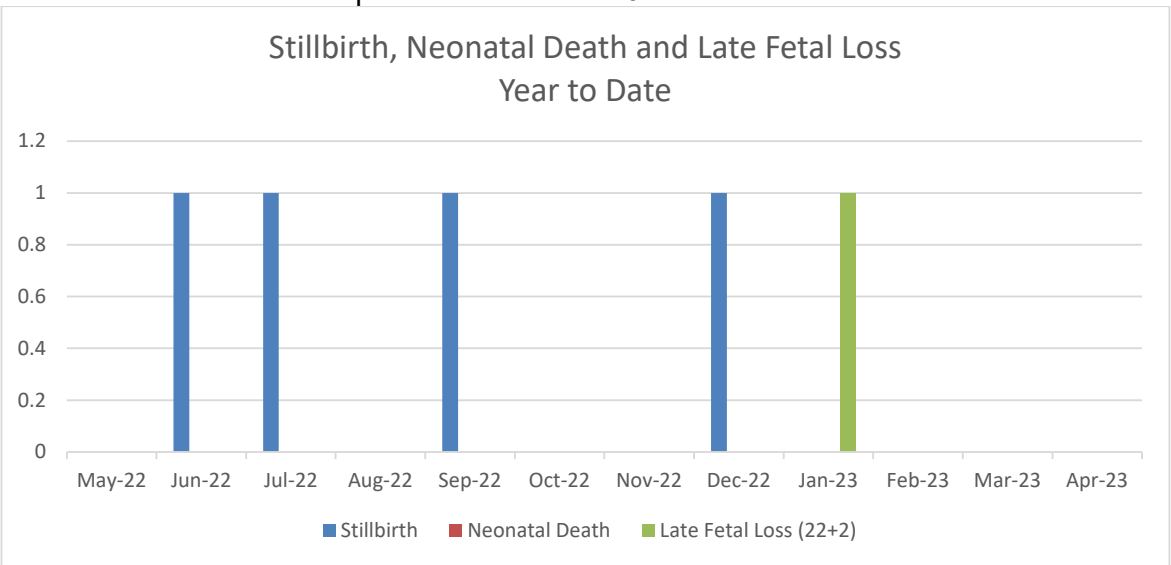
One of the aims of SBLCB v1 and v2 is to reduce the number of stillbirths. National comparative data for England for 2021 has been published and has increased to 4.2% (3.8% in the previous year as per chart below).

TSD data for 2022 is now at the same rate as the England rate for 2021.
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.

We understand the national position for 2022 will be published in May 2023 at which point we will compare our rates with other units of a similar size. We already review each case as part of the PMRT process and although we have not identified any themes or patterns of concern, due to the upward trend, a thematic review of all perinatal deaths was conducted to provide more detailed analysis.



Due to the rise in stillbirths in 2022 a thematic review was undertaken with a summary presented to the Trust Board in March 2023. This review identified no clear themes or issues with care related to perinatal deaths in 2022.



2.5.4 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 MIS Safety Action 3. An audit is required of all term babies transferred to the neonatal unit, regardless of the length of stay. The findings of this audit inform an action plan to identify and implement relevant learning. Progress against the action plan is shared with the Board Level Safety Champion as well as with the LMNS.

For this reporting period an average of **4.7%** of term babies were admitted to the Special Care Baby Unit. This is a decrease from 5.2% seen in the last reporting period and is below the target of 5% or less. 71.4% of the babies that were admitted were due to respiratory factors. The actions to address term admissions to SCBU include relaunching of the 'Warm Care Bundle'. All actions to reduce this rate are captured as part of the overarching collaborative ATAIN action plan monitored via both SCBU and maternity governance groups.

In addition, consideration needs to be given around the development of an estates strategy for Women Health regarding plans for the Transitional Care Strategy.

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.

2.6 Maternity Safety Champions

Monthly walkarounds with the Board Level Safety Champion (BLSC) continue and a new Non-Executive Director for Maternity has been appointed. It is planned that the new NED will join the Board Level Safety Champion and Maternity Safety Champion on the monthly walkarounds. Members of the Maternity Voices Partnership (MVP) will also be invited to join the walkarounds, these are service users who provide feedback and engagement with the maternity service.

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:

- **SystmOne (Maternity IT system) –** issues raised regarding length of time needed to complete sections of the system.
  Action: Staff advised to reboot computers if they are running slow, plus change requests submitted, as required, to ensure that system is running smoothly and providing prompts and additional documents for staff to access which should reduce length of time required on certain processes.

- **Day Assessment Unit/triage update** - Concerns had been raised previously as there is currently no dedicated triage service in DAU/Delivery Suite/John Macpherson ward.
  Action: Work is underway to develop a telephone triage service with the aim that this will be implemented in May 2023

3.0 Staffing

There has been a significant decrease in the number of maternity and medical staff on long term sick leave. Staff have been supported to return to work through carefully planned and adapted phased returns. We continue to use no agency staff. Midwifery staffing levels on all shifts are regularly monitored and any shortages aim to be covered by bank/extra hours and swapping of shifts.

We have been provided with external funding for a number of posts:

- Retention Midwives' role (1.0wte) for a further year until the end of March 2024
- Infant Feeding Support Worker post (0.92wte) continued until October 2024
- Pre-term Birth/Fetal Medicine Specialist Midwife 0.4wte (commenced in post 4 April 2023)
- Pelvic Health Midwife 0.3 wte (recruitment early May 2023)
- Legacy Midwife 0.6wte post has been extended for a further 12 months

N.B. The above roles are all secondments and have been appointed to internally, this in turn, leaves temporary vacancies within the existing midwifery teams

We have been successful in our bid to obtain funding of £27,000 to support Early Career Midwives. This will be used to fund the continuation of the Legacy Midwife post, to provide additional supernumerary time to newly qualified midwives and targeted training in areas such as resourcefulness, adaptability and wellbeing.

We are now planning to provide flexibility with our preceptee midwives posts for the next cohort, who will start in Sept/Oct 2023 we will now be offering 0.8wte posts in addition to full time to support newly qualified midwives who face challenges with working full time. We are also now appointing preceptee midwives to posts in community teams. Each team will take no more than one preceptee and, if they are starting in a community team immediately after qualifying, then they will work for the first 6 months in post on the hospital setting before moving out to the community team.

A service-wide organisational change consultation is currently in progress to address the alignment of shift times across the community and hospital teams. This was in response to significant feedback over the last few years from staff about the on-call shift patterns in community. Consultation meetings have commenced at the end of April 2023, including the offer of 1:1 meeting for all staff members affected.

A review of the Consultant job planning is almost complete. This will consider the requirement to allocate specific roles and responsibilities as required (for example. Obstetric governance lead, fetal monitoring lead) This may lead to a need for additional resource to enable adequate time to complete these roles

4.0 Maternity self-assessment update

The Maternity Safety Self-assessment tool was completed in May 2022. This tool has been designed for NHS maternity services to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the Trust Board and Commissioners aware of their current position.

In May 2022 the evidential requirements demonstrated that of the 160 evidential requirements 109 **(68%)** were rated green with the ability to provide supporting evidence. A further **44 (28%)** were rated as amber with actions required to support the progression of these evidential requirements. **7 (4%)** of the requirements were assessed as Red and will also require additional support and/ or resource to achieve the evidential requirements

The team have been progressing the actions to address the standards and in May 2023 **124 (78%)** rated green, **35(21.4%)** rated amber with only **1 (0.6%)** rated red.
The extensive self-assessment tool provides detailed analysis.

Progress areas

- Job role change of Head of Midwifery to Director of Midwifery
- Operational Manager now in post
- Organisational restructure completed
- Maternity Strategy drafted and in progress

Development Areas

- One remaining red area relates to maternity risk management strategy. The plan is to address as part of the overarching governance review process
- Maternity Governance structure – Internal audit review completed. Action plan to be developed to address recommendations as well as actions from the self-assessment
- Dedicated time for Consultants to undertake required roles and responsibilities

5.0 Maternity Incentive Scheme

Results for year 4 remain embargoed at present. Details of the year 5 scheme are yet to be released. Year 5 is likely to require extensive data resourcing requirements to enable the team to provide the necessary level of information.

Concerns had been raised by the ICB regarding a drop-in data submission for the Trust SUS (Secondary Uses Service) data as well as a missing table for the MSDS submission. SUS data is the repository for healthcare data enabling reporting and analysis and has an impact on performance monitoring as well as clinical coding (income).

The HIS team have resolved the missing MSDS table and are working on validating the process for maternity data (SUS) in the Trust InView program. It is anticipated that migration of the SUS submissions to the new version of InView will take place during Q1 2023/2024. The validation of the SUS data is also reliant on input from ICS as well as from region so we are reliant on other stakeholders to support progression.

6.0 Conclusion

The maternity and neonatal teams continue to ensure that systems are in place to provide assurance in relation to safe midwifery care. They continually review and can evidence progress against a number of trajectories in order to improve the quality of care delivered. The perinatal team will embed the four themes identified within the Single Delivery Plan to ensure that care is personalised and responsive to the needs of women, families and staff.

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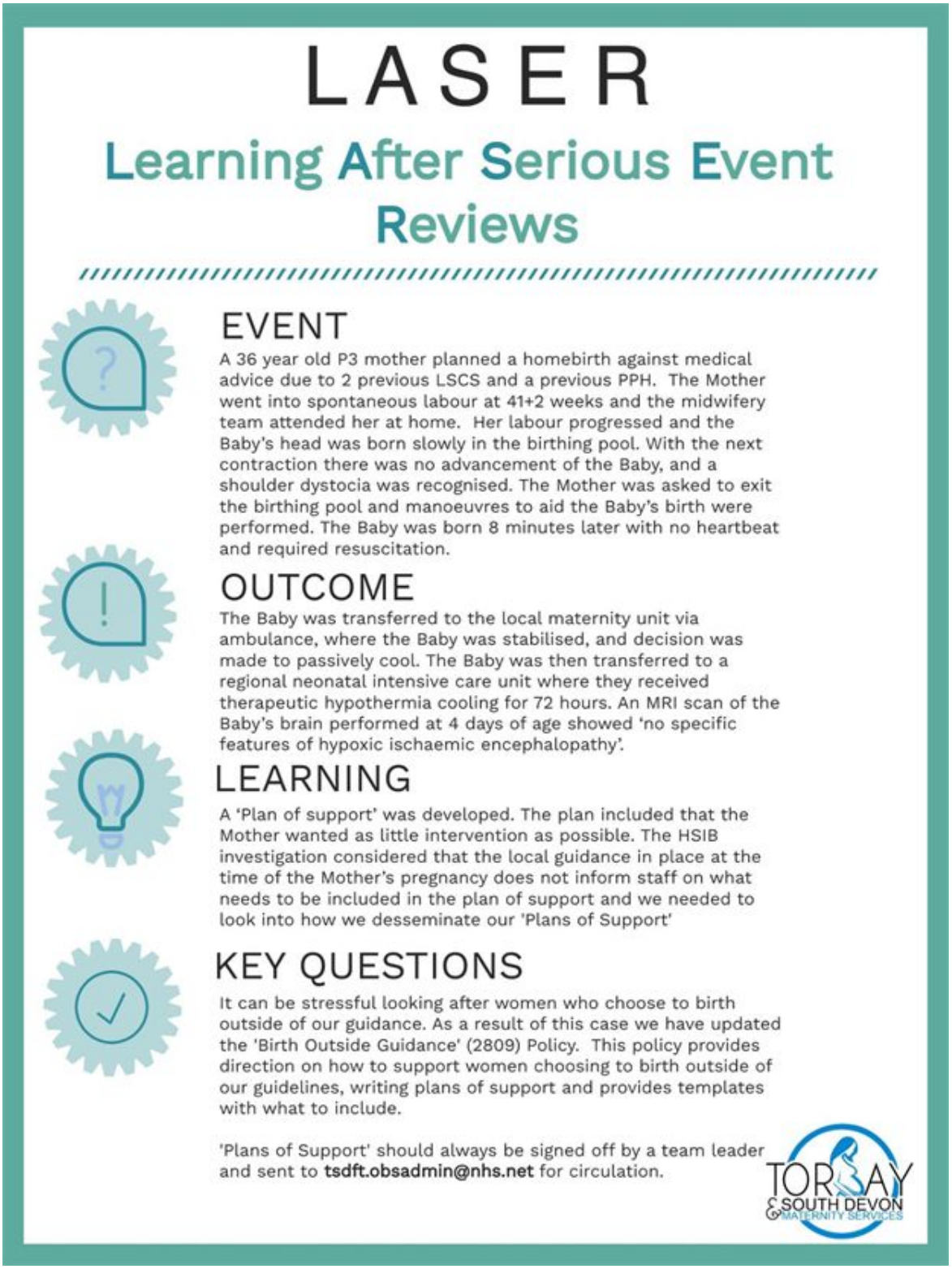
7.0 Recommendations

- Note the progress and compliance position with regard to the priority areas
- Note the key quality and safety issues identified in the report
- Note the plan with regard to embedding the elements of the three-year Single Delivery plan taking note of theme 3 and specific recommendations for Trust boards
- Acknowledge the progress made against the Maternity self-assessment tool within the last 12 months

Appendix 1


LASER
Learning After Serious Event Reviews
EVENT
A 36 year old P3 mother planned a homebirth against medical advice due to 2 previous LSCS and a previous PPH. The Mother went into spontaneous labour at 41+2 weeks and the midwifery team attended her at home. Her labour progressed and the Baby's head was born slowly in the birthing pool. With the next contraction there was no advancement of the Baby, and a shoulder dystocia was recognised. The Mother was asked to exit the birthing pool and manoeuvres to aid the Baby's birth were performed. The Baby was born 8 minutes later with no heartbeat and required resuscitation.
OUTCOME
The Baby was transferred to the local maternity unit via ambulance, where the Baby was stabilised, and decision was made to passively cool. The Baby was then transferred to a regional neonatal intensive care unit where they received therapeutic hypothermia cooling for 72 hours. An MRI scan of the Baby's brain performed at 4 days of age showed 'no specific features of hypoxic ischaemic encephalopathy'.
LEARNING
A 'Plan of support' was developed. The plan included that the Mother wanted as little intervention as possible. The HSIB investigation considered that the local guidance in place at the time of the Mother's pregnancy does not inform staff on what needs to be included in the plan of support and we needed to look into how we desseminate our 'Plans of Support'
KEY QUESTIONS
It can be stressful looking after women who choose to birth outside of our guidance. As a result of this case we have updated the 'Birth Outside Guidance' (2809) Policy. This policy provides direction on how to support women choosing to birth outside of our guidelines, writing plans of support and provides templates with what to include.
'Plans of Support' should always be signed off by a team leader and sent to tsdft.obsadmin@nhs.net for circulation.
TORBAY & SOUTH DEVON MATERNITY SERVICES

LASER

Learning After Serious Event Reviews

EVENT

This case involves a 31 year old, P0 mother with a BMI of 29.5. She was considered low risk until 39+5 when she had was found to have GBS in her urine. The Mother went into spontaneous labour at 41+5. The mother had two episodes of vaginal bleeding, classified as "show" during her labour. Over the course of the Mothers labour care she was cared for by a midwife in training under indirect supervision. Following a Fresh Eyes classification of the CTG as Pathological, and with the mother only being 4cm dilated, a Cat 1 caesarean section was called.

OUTCOME

The baby was born pale with poor tone and no respiratory effort. They were on 61st centile. APGARS at 5 minutes were 4 and cord gasses were low. The baby was resuscitated and transferred to SCBU. As the baby met the criteria for active cooling they were transferred to Derriford. At 9 days old the baby had a normal MRI scan.

RECOMMENDATIONS

There were 4 recommendations we received following this case:

1. Ensure that APH is recognised and escalated to the Obstetric Team.
2. Ensure Clinicians in training are given the correct level of supervision.
3. Ensure when a Cat 1 is called it is prioritised and the baby is born within 30 minutes.
4. Ensure that when a baby is being continuously monitored by CTG one to one care at the mothers bedside is provided.

ACTIONS & LEARNING

We need to escalate all episodes of vaginal bleeding in early and established labour.

Any learners in practice who don't feel supported should escalate their concerns.

We also need to consider if we are not able to be present in the room on delivery suite, to observe the CTG, that we know that someone is watching it for us either in the room or on the centrale until we can return to the room.

TORBAY & SOUTH DEVON MATERNITY SERVICES

LASER

Learning After Serious Event Reviews

EVENT

A 28 year old, P1 mother with a raised BMI of 53, GDM and polyhydramnios. She was admitted at 38 weeks for an IOL. Prior to commencing the IOL there was difficulty in monitoring the fetal heart due to the mothers BMI. She was transferred from the ward to Delivery Suite to have one to one care so fetal wellbeing could be established. A propess was used and 4 hours later the cervix was 3cm dilated and suitable for ARM. Theatres were made aware due to the high risk of cord prolapse. The ARM was performed and an FSE applied.. Baby was found to have a HR of 76 BPM and a Cat 1 caesarean section was called.

OUTCOME

The baby was born pale with poor tone and no respiratory effort. They were on 0.7 centile. APGARS at 5 minutes were 5 and cord gasses were low. The baby was resuscitated and transferred to SCBU. As the baby met the criteria for active cooling they were transferred to Derriford. The baby was found to have a tracho-oesophageal fistula (TOF) and has had surgery 3 times. At 15 days old the baby had a normal MRI scan.

RECOMMENDATIONS

There are examples of good care for this mother, such as transfer to DS when monitoring on the ward was difficult. However, the recommendations are to ensure that if there are ongoing concerns about a fetal heart, staff are supported to expedite the delivery and that high risk ARM's should be performed in an operating theatre. We also need to remember to keep placentas of babies who are unexpectedly transferred to SCBU.

ACTIONS & LEARNING

There is work in progress within the organisation to strengthen the emergency theatre capacity.

Please ensure all placentas of babies who go to SCBU unexpectedly are kept until their outcome is known. If they are transferred for cooling this needs to be sent to pathology.

TORBAY & SOUTH DEVON MATERNITY SERVICES

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Our Leadership Framework: A Compassionate Leadership Approach and Management Development Programme			Meeting date: 31 May 2023
Report appendices	1. Our Compassionate Leadership Approach. 2. Management Induction (MI) and Specialist Skills Sessions (SSS)– topics and roll out timetable. 3. Embedding Our Compassionate Leadership into the Leadership and Management lifecycle. 4. Launch of Our Compassionate Leadership and Management programme – the What and When. 5. Leadership and Management programme – route/method/providers/leads/budget – the How. 6. Forecast time commitment of Board and Leaders within TSD to be inducted Into The Our Compassionate Leadership Approach		
Report sponsor	Chief People Officer		
Report author	Associate Director of People and Associate Director of Education and Workforce Development		
Report provenance	People Committee have reviewed a work in progress paper		
Purpose of the report and key issues for consideration/decision	To present to the Board 'Our Leadership Framework: A Compassionate Leadership Approach'. The paper presents the co-created leadership framework, the plan to embed leadership culture and management training into the organisation, and the resources required, and seeks the Board's approval of the plan, Board commitment to undertake leadership development to enable upholding the leadership framework, committing to leadership and management being integral part of all manager roles, and to be aware of resource commitments for enduring delivery of this framework.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board is requested to approve: - O**ur Compassionate Leadership Approach: We include, we listen, we act.** - The plan to embed the Compassionate Leadership Approach and deliver the aligned management development (Appendices 3-6) - Board commitment to undertake Board and Executive leadership development to enable upholding the leadership framework (Paragraph 23) - Board commitment to leadership and management being integral part of all manager roles, to mandate new managers conduct Manager Induction training), and to commit to releasing leaders and managers (as part of planned training and development) to being developed in Our Compassionate Leadership Approach and management skills. (paragraph 23). - The return to Board with a resource plan for FY 24/25 to continue the with sustainable delivery of leadership and management training as business as usual (Appendix 5, Part 5). -		
Summary of key elements			

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<tr><td>Strategic goals supported by this report</td><td>
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<tr><td>Excellent value and sustainability</td><td></td><td colspan="2"></td></tr>
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<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
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<tr><td>Risk Register</td><td>x</td><td>Risk score</td><td>15</td></tr>
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BAF Ref. 2 - People
</td></tr>
<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td>x</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS England</td><td>x</td><td>Legislation</td><td></td></tr>
<tr><td>National policy/guidance</td><td>x</td><td colspan="2"></td></tr>
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Report title: Our Leadership Framework: A Compassionate Leadership Approach and Management Development Programme		**Meeting date: 31.05.2023**
Report sponsor	Chief People Officer	
Report author	Associate Director of People and Associate Director of Education and Workforce Development	

OUR LEADERSHIP FRAMEWORK: A COMPASSIONATE LEADERSHIP APPROACH. REPORT TO THE BOARD MAY 2023.

Issue

1. The Trust's People priority is to 'build a healthy culture at work where our people feel safe, healthy and supported'. The People Promise focus within TSD, endorsed by the board, committed to co-designing with the workforce what they wish to see in their leaders, and to give managers the essential skills and confidence they need to lead and manage well. This paper presents to the Board the co-created leadership framework 'Our Leadership Framework: A Compassionate Leadership Approach', the proposed management training content, and the roll out plan to embed the leadership framework and management development within TSD, whilst highlighting commitment and resource considerations.

Recommendations

2. The Board is invited **to note**:

a. The People Promise goals within TSD include to define and deliver a consistent, compassionate and inclusive leadership and management approach that is motivating, empowering and encourages accountability.
b. The TSD Learning and Education strategy describes "…a specific need to review our underpinning leadership principles and values as part of a broader leadership strategy, which will then enable us to develop a clear leadership development plan for our people."
c. Good leadership underpins the Trust's Regain and Renew plan, and is vital if the Trust is to successfully navigate its exit from SOF4.
d. The NHS 'Our Leadership Way' sets out the compassionate and inclusive behaviours expected of all leaders in the NHS. Understanding what compassionate and inclusive leadership means to our people, and how this aligns to Our Leadership Way, was an integral part of the process of developing our framework.
e. The Messenger Review, June 2022, recognised the difference good leadership can make in health and social care, and recommended the right leadership is in place at all levels.
f. A King's Fund report on leadership and culture reported increasing evidence that leadership has the most marked influence on organisational culture, which in turn relates to both staff and patient experience and satisfaction.
g. The TSD Our Leadership Way has been co-designed with the workforce and been tested with them. The themes from the engagement feedback have been mapped onto the national 'Our Leadership Way' and considered alongside the Messenger review recommendations.
h. An implementation plan has been designed, and resourcing requirements identified to successfully deliver it.
i. The implementation of Our Leadership Way and aligned Management development, is a core component of creating a healthy and just culture within the

Trust where people feel safe, healthy and supported. It will take time and commitment to introduce and embed, and it's success will be measured and reported on.

and **to approve**:

j. O**ur Compassionate Leadership Approach: We include, we listen, we act.**
k. The plan to embed the Compassionate Leadership Approach and deliver the aligned management development (Appendices 3-6)
l. Board commitment to undertake Board and Executive leadership development to enable upholding the leadership framework (paragraph 23).
m. Board commitment to leadership and management being integral part of all manager roles, to mandate new managers conduct Manager Induction training, and to commit to releasing leaders and managers (as part of planned training and development) to being developed in Our Compassionate Leadership Approach and management skills (paragraph 23).
n. The return to Board with a resource plan for FY 24/25 to continue the with sustainable delivery of leadership and management training as business as usual (Appendix 5, Part 5).

3. **Timings.** On approval, final implementation planning will mature, leadership and management training will be piloted in July and August, before formal launch in September 23.

4. **Risk.** The People section of the BAF articulates a risk level of 20 against a target of 16, particularly highlighting the journey the Trust has to travel to create a culture where people feel safe, healthy and supported. In particular aggravating factor 2.4a highlights the impact of poor leadership and management on workforce satisfaction, and factor 2.10A identifies the upward trend in non-inclusive behaviour within the Trust. The work presented in this paper treats both of these risks. The inability to progress with leadership and management development at this time will exacerbate the likelihood of the risk becoming both operational and reputational issues.

Background

5. Developed by NHS England, co-created with thousands of our NHS people, *Our Leadership Way* sets out the compassionate and inclusive behaviours we want all our leaders at every level to show. It describes three key elements as the Heart, Head and Hands of leadership: 'We are Compassionate, Curious and Collaborative'. Understanding what compassionate and inclusive leadership means to our people, and how this aligns to Our Leadership Way was an integral part of the process of developing our framework.

6. *Messenger Review*. The review, published in June 2022, recognises the real difference that good leadership can make in health and social care and identifies examples that contribute directly to better service. It is clear about the lack of consistency and coordination in the way that leadership and management practice is currently trained, developed and valued across the NHS. The review lays out seven recommendations, aimed at ensuring the right leadership is in place at all levels, covering targeted interventions on collaborative leadership and values, positive inclusive action,

and regional/national actions which include developing consistency in management standards and a simplified and standard NHS appraisal system.

7. *Leadership and Culture* (Michael West, King's Fund). There is increasing evidence that leadership has the most marked influence on organisational culture, which in turn relates to both staff and patient experience and satisfaction. High levels of vacancies, sickness absence and staff turnover have fuelled problems of excess workload, which is a key driver of staff burnout. The King's Fund have proposed key actions for NHS leaders faced with the enormous challenge of addressing these issues. Broadly these comprise a move from traditional individualistic leadership models, to compassionate, inclusive, collective leadership. These recommendations are grounded in a developing evidence base of organisational cultures in healthcare settings. Dixon-Woods (2014) large-scale study of culture and behaviour within the NHS found hospital standardised mortality ratios had an inverse relationship with positive and supportive organisational climates; ie they were lower, the more positive the culture. The recommendations of this study include encouragement for organisations to develop person centred cultures rather than task focused management which work towards an environment of psychological safety, to facilitate attentive listening and open communication. Compassionate leadership may produce psychologically safe working environments and therefore safe, effective and compassionate care. This is reinforced by the work of Covey and colleagues, with the 'speed of trust principle'. High levels of **trust** are correlated with increased efficiency, effectiveness and innovation and drive down error rates.

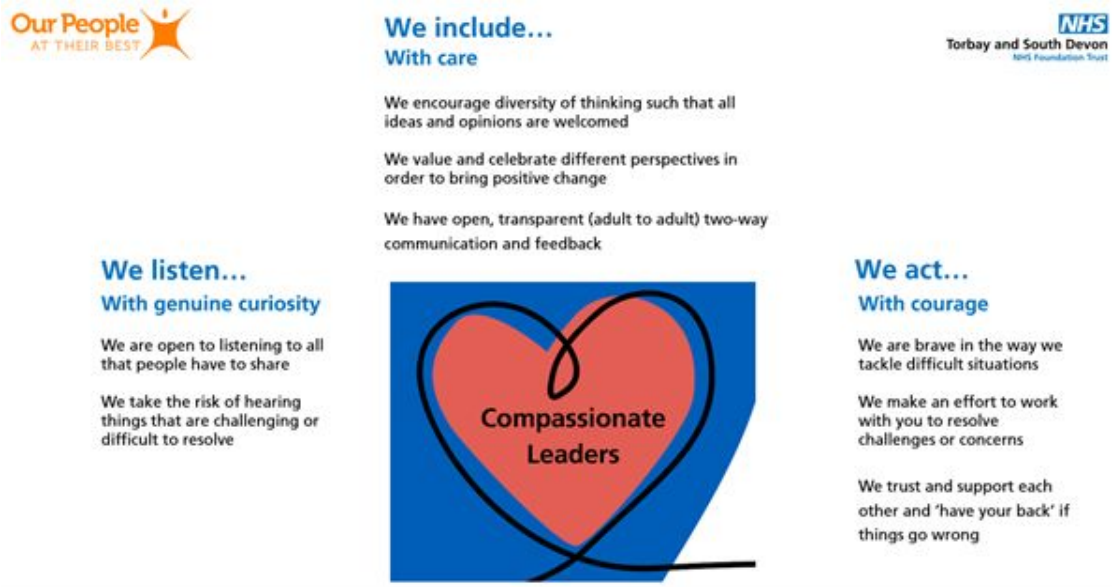
Our Compassionate Leadership Approach

8. In response to the national context, and the People priorities and goals within TSD, the work to develop Our Leadership Approach has been one of collaboration and engagement across the TSD community. In order to include a range of voices to help shape and oversee the development of our leadership framework, a working group was established with a broad representation of our people. Five key questions were developed, which were used to ascertain people's experience of leadership within the organisation; this was used as a survey and to facilitate discussions in focus groups and interviews that were conducted across all levels of the Trust both in the acute and community. The data from the surveys and focus groups were themed and a report produced based on this analysis[1].

9. The resulting themes yielded three key elements which make up **Our compassionate leadership approach:**

- **We Include**
- **We Listen**
- **We act**

[1] The report has not been included in this pack, but is available on request



10. The identified requirement for support that colleagues sought from their leaders fell significantly into the 'on the job' coaching, supervision, feedback, stretch opportunities and coaching/mentoring, rather than formal training. This has been reflected in our approach to development:

Illustration 1: What does a leader need? TSD approach to through career leadership development[2].

[2] Aligned to the framework, there will be specific development frameworks, where required, for key professional groups, such as nursing. A leadership framework for nursing is currently being developed, which will reflect the key leadership themes in this organisation-wide framework - 'Our Compassionate Leadership Approach'.

11. In order to ensure Our Compassionate Leadership approach is recognised and owned within TSD, the draft framework has been shared at a number of roadshows across the organisation, covering both community and acute sites. A key message included the fact that we can all lead at different times, regardless of whether we are in a formal leadership or management role- therefore this framework applies to us all. Questions were asked of participants about whether the draft framework and key elements were meaningful, whether anything was missing, any examples of good practice and what success would look and feel like for people. All feedback was used to finalise the proposed framework[3].

Management Development

12. The Messenger Review highlighted creating consistency in management standards, and feedback from the workforce in TSD has also highlighted the requirement for management development. At present, the offering within TSD is limited and inconsistently accessed and applied. This has led to a gap in knowledge and skills as managers have lacked opportunity to formally develop their management practice and understand what is expected of them.

13. Dovetailing with the leadership framework, the proposed management development offer (Appendix 2) sets out what leaders are expected to know and be competent at as a manager in this Trust, enabling managers to deliver the 'task' or 'activities of work' successfully (this refers to management responsibilities such as people and resource management, not specialist or career specific skills). It provides a suite of development options dependant on the experience of the manager.

14. The offer includes a 2-day Manager Induction programme that newly appointed managers will be automatically enrolled onto once recruited. It can also be attended by existing managers should they wish and they will be able to self-register via The Hive. The launch of the Manager Induction will be aligned with the delivery of the new Corporate Induction package, expected Sept 23.

15. The Manager Induction will provide an overview of the expectations of a manager in TSD, together with specialist topics that are required to be known and delivered in their professional practice as a manager. This includes elements such as people, finance, health and safety, corporate, governance and transformation. These topics have been identified through a manager reference group, self-identified needs, and leadership framework staff engagement and feedback events. In addition, the education practice educators have gained feedback as they roll out their new 'insitu' experiential model of education together. Subject matter experts have also identified organisational risks, e.g. health and safety training and the role of the manager. The people-practice element includes the people management framework recently released by NHS England.

16. There will also be a series of specialist skills sessions by topic that expand on the Manager Induction, providing managers a deeper understanding and knowledge of the topic together with practical application advice, experiential learning and guidance. These will be delivered in a combination of ways including face to face, e-learning and other forms of digital learning.

[3] The report has not been included in this pack, but is available on request

17. Further, a manager's handbook will be available that will provide further tools/techniques and signposting to other support that is designed to increase a manager's capability and competence.

18. To complement the TSD specific management development, the Education and Workforce Development team will work with education providers and partners to develop routes for formal accreditation opportunities in management and leadership.

Embedding Our Compassionate Leadership Approach and management development

19. Embedding the framework into the leadership and management lifecycle will influence leadership practice at all levels, enabling a higher level of consistency of approach, capability and confidence. Throughout the lifecycle, from how TSD attracts, recruits, develops, retains and exits, our leaders will be influenced by the framework. Of particular note:

a. Examples of themes derived from the co-creation and mapping activities will form principles/descriptors, and will be embedded into job descriptions and used to assess/shortlist candidates to judge how well their experience and commitment match these areas.

b. Interviews for leadership/management roles will include questions based on these descriptors and behaviours for both internal and external processes.

c. Onboarding will include an introduction to our leadership framework within the organisational induction.

d. Performance, progression and accountability will include the appraisal process; the descriptors will be built into appraisal conversations. A 360-feedback tool, based on the three key elements and descriptors will support the assessment of leaders and managers against the framework and support targeted development, reviewed at appraisal.

e. An Innocent Bystander programme will support colleagues to 'call it out' – when leaders and managers behave in ways that are inconsistent with these principles-recognising that this can be difficult, but is in line with our key theme of 'we act with courage'. This will rely on creating a culture of psychological safety.

f. Leadership and management development activities and interventions will be built and refined based on the framework. In particular, there will be a management-specific induction, based on explicit expectations of line managers (incorporating the NHS management framework), a compassionate leadership induction, specialist skill sessions, coaching, mentoring and stretch opportunities.

20. Plans for 'what and when' will be launched can be found at Appendix 4, and more detail regarding 'how' the plans will be delivered can be found at Appendix 5 The anticipated launch date is September 2023.

Resources

21. In order to fully commit as an organisation to developing effective, consistent, compassionate and inclusive leadership and management, the commitment of a significant amount of resource is required (planning/preparation/development of materials, releasing time/capacity/headspace to develop, room availability).

22. Appendix 5 provides an overview of further task and finish groups that will finalise the exact delivery methods and resource required to deliver different aspects of the development. It is anticipated that there is sufficient in-house capacity to deliver the development programmes, utilising HRBPs as they partner with their care groups, practice educators, and OD support. This work will be led by the Associate Director of Education and Workforce Development who will ensure that the roll out of all leadership and management development training is managed in accordance in Education best practices, that it can be booked, attendance and progress recorded on HIVE, evaluated and assured, and that time for development is mapped into work plans. Further, that the provision of training and development is managed under the Trust Operational Pressure Escalation Plan.

23. It is however the time that is required for individuals to commit to their own development that requires attention. For example, Appendix 6 articulates the commitment it is anticipated that the Board will require for development. This will be factored into the Board Development plan, but agreement is sought for 3 x 2.5 hour sessions for contracting sessions, along with 2 full day development sessions within a year. Additionally, that over 1,000 of our leaders will need to be released for 1 day each to be inducted into the Compassionate Leadership approach.

24. A commitment is sought from the Board to endorse the time it is recognised will be required for TSD workforce to commit to developing their leadership and management skills and behaviours in order to embed the new culture.

25. Appendix 5 Part 5 identifies that there is current budget to implement the tools and platforms required to enable the delivery of the leadership and management development, however, it is proposed that the Board agrees to a business case for financial year 24/25 be brought to the board at a later date for enduring resourcing of workforce development.

Governance

26. This work is part of the overall People Promise programme that has its own project manager and governance framework, that presents regular updates to the People Committee for assurance. Whilst progress on roll out and attendance at development sessions, evaluation of the delivery of the development, and individual changes in confidence regarding their understanding of leadership and management, will be captured in line with the roll out plan, the culture change will take time to take effect. A longitudinal measure of impact and success will be expected, for example change in People Survey result trends.

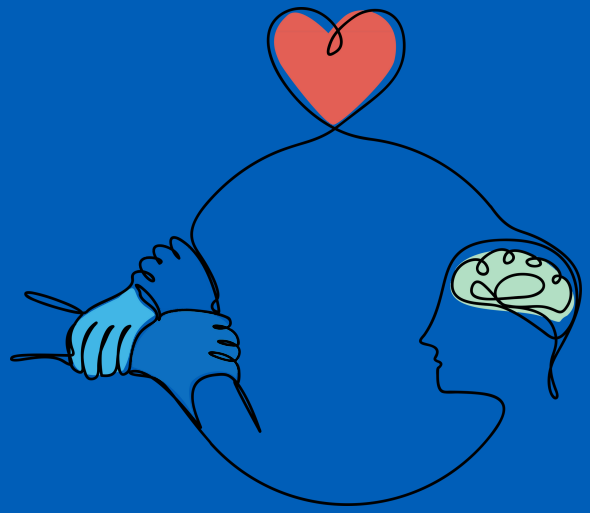
Conclusion

27. The TSD Our Compassionate Leadership Approach, to **Include, Listen, Act**, and the management development programme, have been designed in collaboration with the TSD workforce and in response to rising evidence that TSD leaders and managers are not currently equipped with the skills or consistent behaviours to enable a healthy, safe and supported culture to exist in TSD. Adoption of the recommended approach and development programme will take time and commitment but is essential as part of the Trust's journey to embrace a Just and Learning culture and to become more inclusive.

Our People AT THEIR BEST

NHS
Torbay and South Devon
NHS Foundation Trust

Our Compassionate Leadership Approach



Our People AT THEIR BEST

NHS
Torbay and South Devon
NHS Foundation Trust

Our People AT THEIR BEST

NHS Torbay and South Devon NHS Foundation Trust

We include…

With care

We encourage diversity of thinking such that all ideas and opinions are welcomed

We value and celebrate different perspectives in order to bring positive change

We have open, transparent (adult to adult) two-way communication and feedback

We listen…

With genuine curiosity

We are open to listening to all that people have to share

We take the risk of hearing things that are challenging or difficult to resolve

We act…

With courage

We are brave in the way we tackle difficult situations

We make an effort to work with you to resolve challenges or concerns

We trust and support each other and 'have your back' if things go wrong

Examples of feedback from our people include…

- We foster an environment in which the ideas and opinions of all are welcome and received as valuable - we build each other up - so people feel able to speak up/ask daft questions without feeling silly and do not feel worried about coming to work as a result.
- Leaders role model sharing their vulnerabilities - so we can feel confident that we can share our vulnerabilities and it will be handled in the right way – leading to psychological safety
- If I have a problem, unsure of something or want another opinion, I know I can say it without feeling nervous. If I am nervous, I would rather say nothing.
- Complete two -way trust where there is no blame, we are not afraid to come up with ideas or raise concerns, but are able to learn and improve together...
- Acknowledgement that we are fallible
- Empathy and compassion creates an environment without fear

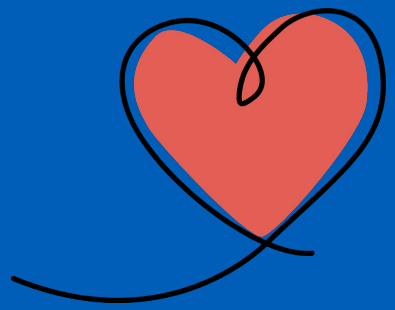
- Transparency- up front, clear, frequent sharing of information (two -way) about the current situation - even if basic
- Inspire shared vision - getting people involved in projects/activities that generates job satisfaction as a result of using their strengths. Makes people feel proud and valued to be included.
- A good leader works with the team not dictates. Check -in with yourself - reflect our tone, culture, behaviour
- Shared a problem within the team and opened up to all for suggestions, then encouraged them to implement, with autonomy in their work. Best problem solving comes from wider team

- Need to create 'connection' and 'belonging '- especially for people working remotely, those working in the community, between senior leaders and the front line

- A genuine heartfelt thank you / recognition of something you have accomplished makes you feel valued and appreciated as a person. Give positive feedback freely

NHS
Torbay and South Devon
NHS Foundation Trust

We Include…
With care



Our People
AT THEIR BEST

Examples of feedback from our people include…

- There needs to be space for a **fresher view of leadership** - more informed, kinder, change in language, more open, honest and frank conversations -ask people what's important and listen. There is an opportunity for new perspectives to bring positive change
- A commanding style all the time will just lead to burnout and moral injury if staff feel abandoned by decisions that are made without them
- Leaders really are interested and ask open -ended questions. Our different perspectives are valued, people feel safe to speak up and leaders pay attention to non verbal cues
- A deep respect for both people who are leading and for the team
- Trust that the team have the capability - leaders need the people in the team more than anything
- Leaders need humility to hear and accept views of others around them, and believe things can change. This way decision -making can be quicker/more dynamic - people feel better and want to change

- Listening requires courage – as when we are open to listening to all that people have to share, there is a risk of hearing things that are challenging or difficult to resolve
- When our concerns and challenges are genuinely heard and understood we feel better, even if our view is not taken on as long as we are listened to

- We need to be able to constructively challenge approachable leaders - training to help people to manage disagreement and criticism rather than dismissing it or becoming defensive. Conflict is a sign that we are heading in the right direction.

- Consult the real experts i.e. those on the ground. Leaders rarely have all, or even the best, ideas - so give space for ideas to be explored without knowing the exact outcome.
- Make an effort to understand the team /our experience and how to get the best out of them
- Listen to our challenges, seek solutions/ideas from us and support those ideas and individuals to a successful conclusion

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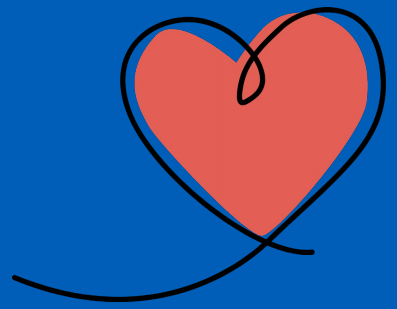
We Listen…

With genuine curiosity



Our People
AT THEIR BEST

Examples of feedback from our people include…

- What I am sharing will be used to make a real difference
- We act - when issues and problems have been shared I see something has happened as a result or I get feedback as to why it hasn't.
- Some of the corporate services need to change processes to make it easier for us.
- A leader delivering thoughtful, intelligent action - engaging front end staff to deliver new ways of working, or acting to remove small obstacles that make everyone's lives that little bit easier.
- I see an effort and action to (work with me to) resolve my challenges or concerns. If a solution is not possible, my leader has a very open and honest conversation with me, explaining why it cannot be resolved
- Being able to see something done as a result of feedback - listening, and then doing something about it or explaining clearly why things can't change

- Listening, being brave, tackling difficult situations and difficult problems
- If people do not have the courage to act, because they do not want to upset people or afraid to tackle issues, this really affects team morale - do more to call out and address bad behaviour.
- When you actually feel able to challenge without reprisal

- If you feel secure in a supportive relationship with your leader (and know this support is available), you are empowered to do your role to the best of your ability and to develop your skills. Knowing 'someone has your back' - support is there if needed in difficult times
- Giving me both autonomy and support over my daily work and to make decisions – great managers let people run with ideas to improve processes in teams
- Leaders have to trust us to delegate to the lowest level they can. This is **safest.**
- Risk-taking needs to be encouraged.

Appendix 2: Management Induction (MI) and Specialist Skills Sessions (SSS)– topics and roll out timetable

	2023/24				2024/25			
	Q1	Q2	Q3	Q4	Q1	Q2	Q34	Q4
People Practice								
Recruitment		MI	SSS					
Onboarding/Inducting		MI	SSS					
Workforce planning		MI	SSS					
Enabling employee performance				SSS				
Developing employees				SSS				
Employee wellbeing			SSS					
Flexible working				SSS				
Employee engagement & experience including stay conversations and career guidance conversations				SSS				
Equality, Diversity, and Inclusion (EDI)		MI	SSS					
Change & Transformation				SSS				
Managing Absence		MI		SSS				
Managing difficult situations		MI		SSS				
Leavers			SSS					
Other general effective management practices					SSS			
Financial Practice								
Budget Management		MI	SSS					
Staff Expenditure			SSS					
Non staff Expenditure			SSS					
Assets			SSS					
Patients Personal Property			SSS					
Charitable Funds			SSS					
Health and Safety Practice								
Managing Safety		MI	SSS					
Risk assessment		MI	SSS					
Reporting		MI	SSS					
Risk Management								
Business continuity		MI	SSS					
Corporate Risk/Register								
Incident Investigation		MI	SSS					
Personal Practice								
Time Management			SSS					
Motivation of self and team			SSS					
Use of IT					SSS			
Effective meetings			SSS					
Business Writing						SSS		
Presentation skills				SSS				
Customer service					SSS			
Social Responsibility					SSS			
Sustainability			SSS					
Press and publicity						SSS		
Performance Reporting			SSS					

Appendix 3- Embedding Our Compassionate Leadership Approach into TSD Leadership & Management Lifecycle

Frameworks and strategies that underpin the model

- Our Leadership Framework
- Regain and renew programme
- Our People Promise

Marketing packages
Redesigned JD & PS
Redesigned adverts focusing on compassionate leadership and includes job details (flexibility, location, etc)
Clear benefits for our prospective leaders
Management roles identified in the pre-recruitment process

Recruitment Process
Interview questions looking at key desirable skills and behaviours
Marking criteria linking back to our Leadership Framework

Retain & Leavers
Stay conversations with all staff
Exit interviews reflecting our Leadership Framework to learn where we can improve
Handovers to be created by outgoing leader/manager

Onboarding
Clear onboarding plan with local and organisational induction
Organisational induction to include our Leadership Framework
After 3 months, meet with manager and review and set objectives

Performance, Progression & Accountability
360 feedback within first 12 months of being within the organisation
Achievement Reviews amended to reflect our Leadership Framework
Career conversations where people have identified their desire to progress
Innocent Bystander Programme

Learning & Development

A personalised development plan looking at:

- **Formal Learning:** via NHS LA, NHS Elect, Apprenticeships, iManage and local modules delivered by TSDFT
- **Reflective learning:** coaching, mentoring, leadership forums and supervision
- **Self-Directed learning:** individuals seeking further development and accountable for the learning

.. and linked to career mapping and career conversations

Reward and recognition
Mechanisms to recognise and reward leaders who role model and live our Leadership Framework

Managing a Team
This section is for those managing a team
- Onboarding – New Managers Welcome focusing on our culture and Leadership Framework
- Management Development with mandatory modules/expectations

Version 2 updated 1702 23/3

Appendix 4: Launch of Our Compassionate Leadership and Management programme – THE WHAT AND WHEN

Leadership and Management Phase/Activity	Due
Phase 1: Planning Phase	
Creation and prepping all products including changing current proformas and restructure iManage Identification of **resources, capacity and logistics/space** (e.g. facilitators, coordinators) Scoping opportunities/resources with national and local partnerships eg South Devon College **Train the trainers** in compassionate leadership ready for delivery **Contract with Executive Team and Board** to ensure they are role modelling what we have designed and that the Trust direction doesn't contradict our cultural aims **Organisational impact measures** identified to assess programme ROI **Executive and Board Team Introduction to TSDFT Compassionate Leadership Session**	Prior to start date
Phase 2: Launch of the Leadership Framework September 2023 (0 – 6 months)	
Communication and Engagement Plans • Roadshows • Bulletin/screen savers • Posters • Social media **Introduction to TSDFT's Compassionate Leadership Induction** for all current leads of: • Band 8A to VSM (>340) • Band 7s (>580) All **new/ new to trust managers** identified and invited to mandatory training prior to start date **6 Month Programme Review** to seek out any lessons learnt, adaptations needed and any successes	 0 – 6 months 0 – 6 months 0 – 6 months 0 – 6 months 1 – 3 months 3 – 6 months 0 – 6 months 6 months
Phase 3.1: Bringing our Current Leaders with Us (6 months – 2 years)	
Continuation of Introduction to TSDFT's Compassionate Leadership roll out **360s** with debrief for line managers and middle/senior leaders • Band 8A to VSM (>340) • Band 7s (>580) **Personal Development Plans** and the **Training and Development Offer** approach launches at 6 months in line with 360s to help bridge gaps. T&D offer will evolve over the next 2 years, including development at different levels and impact measures **1 Year Programme Review** to assess impact to date using agreed impact measures seek out any lessons learnt, adaptations needed and any successes	6 months – 2 years 6 months – 1 Year 1 year – 2 years 6 months – 2 Years 1 Year

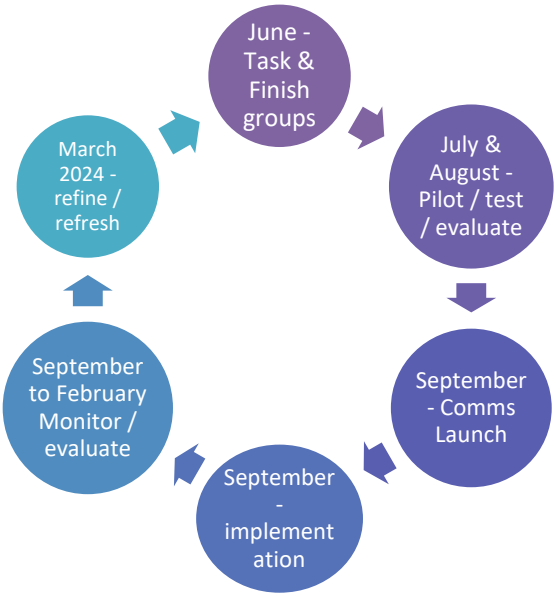
Existing managers able to join induction	6 months
Phase 3.2: Launching our new BAU, see leadership lifecycle (6 months – 2 years)	
Attract, Recruitment & Selection: Marketing Packages and Interview Documentation in place at 6 months	6 months
Onboarding: Compassionate Leadership Module added to organisational induction and new onboarding Programme Review live	6 months
Performance, Progression & Accountability:	
• Innocent Bystander Programme introduced	1 year
• 360 mandated to all new starters at their 1 year of employment	1 year
Retain & Leavers: New stay conversations, career guidance conversations and leavers process in place at 12 months	1 year
Iterative review and development of IManage	1 year
O**ngoing review of courses and content** (see Appendix 5)	6 months
New **Learning & Development** approach introduced	6 months – 2 years
• **Formal Learning:** via NHS LA, NHS Elect, Apprenticeships, iManage and local modules delivered by TSDFT (see appendix 5)	6 months – 2 years
• **Reflective learning:** coaching, mentoring, leadership forums and supervision	
• **Self-Directed learning:** individuals seeking further development and accountable for the learning	
.. and linked to career mapping and career conversations (as part of Management Specialist Skills, Appendix 5)	
1 Year Programme Review to seek out any lessons learnt, adaptations needed and any successes. Track against key impact measures	1 Year
Phase 4: Lessons learnt, Programme Review and adapt (2 – 4 years)	
• Mandate a **360 every 3 years of service** for leaders with line management responsibilities and/or above Band 8A with the option for a debriefer or no debriefer, staggering across three years	2 years
• **2, 3 and 4 Yearly Programme Reviews against key impact measures** to seek out any lessons learnt, adaptations needed and any successes	2, 3, 4 years

Appendix 5: LEADERSHIP AND MANAGEMENT PROGRAMME – ROUTE/METHOD/PROVIDERS/LEADS/BUDGET – THE HOW

DELIVERY PLAN V3

Contents

Lifecycle



PART 1: Induction (Mandated and Essential to role)				
	Route	**Method**	**Provider**	**Next steps / Timescale**
Managers Induction Option 1 for newly appointed managers (First management role)	Corporate Induction – to include Trust Strategy & Values & Leadership framework AND Baseline Induction package for brand new managers AND Networking event to meet colleagues across the organisation	Hybrid F2F & online – The Hive Hybrid F2F & online – The Hive F2F	In house	Task & Finish Group to finalise programme & delivery – arranged for Tuesday 6th June, 1-2pm (invite sent) To implement by September 2023 To pilot with new clinical managers via clinical education team in July/August 2023
Managers Induction Option 2 for experienced and existing managers	Corporate Induction – to include Trust Strategy & Values & Leadership Framework AND Enhanced Managers Induction and resources as self-directed dependant on experience AND Networking event	Hybrid F2F & online – The Hive Hybrid F2F & online – The Hive F2F	In house	Task & Finish Group to finalise programme & delivery - arranged for Tuesday 6th June, 1-2pm (invite sent) To implement by September 2023 To pilot with new clinical managers via clinical education team in July/August 2023

PART 2: Formal Management and Leadership Qualifications / Accredited pathways (Essential to role) *People can combine pathways*				
	Route	**Method**	**Provider**	**Next steps / Timescale**
Apprenticeship Pathway Option 1	Apprenticeships Level 3 (Team Leader) up to Level 7 (Masters Senior Leader)	Hybrid dependant on education provider	Current education providers include: South Devon College NHS Leadership Academy partners BPP University Exeter University Plymouth University	Meeting with Apprenticeship Manager to develop comms and marketing plan – link to overall launch of leadership framework Task & Finish Group set up for Monday 12th June, 1-2pm (invite sent) To implement by September 2023 in line with comms strategy.
Modular Pathway Option 2 Management and Leadership accredited modules	CMI (Chartered Management Institute)	Hybrid dependant on education provider	South Devon College NHS Leadership Academy Open University	Meeting with South Devon College and Leadership Academy to review what is already available and map to framework to identify gaps Task and finish group to review – arranged for Monday 12th June, 1-2pm (invite sent) To implement by September 2023 in line with comms strategy.
Profession specific Pathway Option 3	Depends on regulator e.g. RCN	Hybrid dependant on education provider	Various	Nursing proposal still under review – meeting to be arranged with CNO to agree next steps Scoping AHP specific leadership pathway with AHP leads

				Other professions to be identified as relevant and task and finish groups set up To implement by September 2023 in line with comms strategy.

PART 3: Informal Training and Development / Non-accredited options (Essential to role and self-directed)

People can combine dependant on a persons individual learning needs

	Route	Method	Provider	Next steps
Managers and Leaders Specialist Skills Training	Managers Specialist Skills Platform (The Hive)	Hybrid F2F & online iManage Mix of online resources and training (podcasts, videos, e-learning)	In house TBC South Devon College NHS Elect Open University	Task and finish group to finalise programme & delivery – arranged for 19th June, 11am-12pm (invite sent)
Leadership Masterclasses	Series of leadership masterclasses with internal and external speakers on hot topics	Ms Teams – interactive small group discussion	In house TBC External speakers	Task and Finish Group to review & set programme - arranged for 19th June, 11am-12pm (invite sent)
Managers Grand Rounds	Series of Managers Grand Rounds covering specific management topics	F2F	In house TBC	Currently under review – to form part of overall offer
Lunch & Learn Sessions	Series of facilitated interactive sessions to discuss key challenges / case studies	F2F	In house TBC	Task and Finish Group to set up programme - arranged for 19th June, 11am-12pm (invite sent)
Networking events (with guest speakers)	Regular face to face opportunities for managers and leaders to meet and get together, covering hot topics, guest speakers, meeting peers and socialising / networking	F2F	In house TBC	Task and Finish Group to set up programme - arranged for 19th June, 11am-12pm (invite sent)

PART 4: Complimenting Support & Resources for ongoing reflection, learning and performance (Essential to role & self-directed)				
	Route	**Method**	**Provider**	**Next steps**
Mentorship programme (to be mentored and to be a mentor)	External mentorship programme already available	Online	NHS Leadership Academy	Task & finish group to review current offer to consider how we might be able to expand this
Coaching programme (to be coached and to be a coach)	In house training already available In house coaching service already available	Online & F2F	In house	Task & finish group to review current offer to consider how we might be able to expand this
Mediation	In house service already available	F2F	In house	Task & finish group to review current offer to consider how we might be able to expand this
360-degree appraisals	Currently in-house People Directorate offer Or Via education provider if undertaking an accredited course	Online & F2F	In house The Hive	Task & finish group to be set up to design supportive process for expanding widely 360-degree appraisals across Trust
Appraisal / Achievement review	Currently via in house policy and form	Online & F2F	In house The Hive	Task & finish group to be set up to design supportive process for reviewing and implementing appraisal process via the Hive across Trust – link to Career conversations
Understanding yourself and your teams	Links to appraisal and 360-degree appraisal (see above) Quality Improvement	Online & F2F	In house The Hive TMSDI	Review tool as whole package to support teams
Wellbeing and Pastoral support	Supervision (one to one & Group support) model Wellbeing offer Mental health training	Online & F2F	In house NHS Elect MIND	Link in with pilot being developed through Education and NHS Elect Task & finish group to develop plan for rolling out supervision model and wellbeing support

PART 5: Implementation Costs			
Costs	**Amount**	**Budgeted 2023-24**	**2024 onwards**
NHS Elect	£33k per year	Yes - Education	Yes - Education
CPD (For non-clinical and non-registered individual CPD applications) CPD (For registered clinical staff) CPD (For Medical staff through individual study leave budgets)	£50k per year £500,000 (TBC for 2023-24) Variable	Yes – Education Yes – Education Combination of Medical Dir funding, Education and dept budgets	Need to increase to reflect % of workforce this is supporting and following launch of leadership framework Reviewed annually
Accredited apprenticeship pathway	Fluctuates each year	Yes – Apprenticeship Levy + dept level support for 20% off the job	Yes – Apprenticeship Levy + dept level support for 20% off the job
Accredited module pathway	TBC	No – to negotiate with education providers and through skill mixing within existing budgets	
Non-accredited courses	TBC	No – to negotiate with education providers and through skill mixing within existing budgets	
Hive Perform function *Integrated Talent Management & achievement review*	£8,250 one off set up cost £9,000 annual cost	Yes – Education Yes – Education for one year only	N/A Will need to allocate budget for 2024 onwards
Hive 360-degree appraisal function	£1,650 one off set up cost £12,672 annual cost	Yes – Education Yes – Education for one year only	N/A Will need to allocate budget for 2024 onwards
Supervision Hive function (for all staff)	£10,000 one off cost No annual costs	Yes - Education	N/A

TMSDI	£20,000 per year depending on number we need	Yes – Education (funded from 2022-23)	Will need to allocate budget for 2024 onwards

Appendix 6: FORECAST TIME COMMITMENT OF BOARD AND LEADERS WITHIN TSD TO BE INDUCTED INTO THE OUR COMPASSIONATE LEADERSHIP APPROACH

Phase/Actions	No. of sessions/individuals to go through this process	Days required	Who?
Phase 1: Planning Phase			
Creation and prepping of all products This will include creation of all products across the lifecycle and launch products as well as defining how we monitor and evaluate the products individually and the programme as a whole	TBC	TBC	Leads for areas have been identified. Time required for SMEs to create products – need to release time
Contract with the Executive Team and Board These three sessions will work with the Executive Team and the Board to fully understand the programme, roles, responsibilities and resources required. This stage is crucial to any change programme. Re-contracting at later stages may be required.	3x 2.5 hour contracting sessions	1 day	2x contracting facilitators
Trust Board Team Development We understand that our Trust Board Team play a huge part in our compassionate leadership way. They are the most senior role models in the organisation that our colleagues will be looking to in terms of this approach to leadership. If there is a misunderstanding or lack of synergy regarding what we are promoting and working towards and our leadership team, this cultural journey will not succeed. • 2x full days development sessions within 1 month of each other • Twice annual development sessions	2x full days 2x a year	2 initially and then 2 ongoing	Joint internal and external facilitator
Phase 2: Launch of the Leadership Framework (0 – 6 months)			
Roadshows as a part of our wider comms plan We are proposing 15 Roadshows both virtually and in person across all sites to start promoting the compassionate leadership way. The in-person Roadshows will be approx. 2 hours long and our virtual Roadshow 1 hour long	15 roadshows 10x 2 hours 5x 1 hour	15 days	30 volunteers from various roles and disciplines
Introduction to TSDFT's Compassionate Leadership Induction modules If we want our leaders to feel engaged, gain an understanding of and live by the Compassionate Leadership way we need we will need to equip them with the understanding and tools related to this new leadership approach. One such way is our compulsory **Introduction to TSDFT's Compassionate Leadership**. All leaders are invited to a one-day event to learn about 'Our Leadership Way', to explore how it works in both principle and practice. This will help everyone explore how we can intentionally include with care, listen with increased curiosity and act courageously in our daily working lives and in our interactions with others. In order to manage this transition given the size of the leadership body, we would host these inductions across 6 months starting with our senior most leaders: • Month 1 – 3: Band 8A to VSM including consultants (>341) • Month 3 – 6: Band 7 (>588)	1,000 senior leads over 34 sessions Each session will last 7.5 hours (30 per session)	34 days	Facilitators TBC
Phase 3.1: Bringing our Current Leaders with Us (6 months – 2 years)			
Continuation of Introduction to TSDFT's Compassionate Leadership roll out continued with all staff to continue to embed this work	5,000 individuals over 167 sessions	167	

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Public Board Meeting			
Report title: Freedom to Speak Up Guardian Six Monthly Report			31st May 2023
Report appendix	Freedom to Speak Up Policy for the NHS Freedom to Speak Up Work Plan		
Report sponsor	Michelle Westwood, Lead Executive for Freedom to Speak Up		
Report author	Sarah Burns Lead Freedom to Speak Up Guardian		
Report provenance	NHS National Contract		
Purpose of the report and key issues for consideration/decision	The Freedom to Speak Up Guardian report is submitted every six months to enable the Board to maintain a good oversight of Freedom to Speak Up matters and issues. This report highlights a growing trend of cases brought to the Freedom to Speak Up Guardian, and a lack of capacity to continue to provide a consistent response.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is invited to consider providing additional resource as a priority to deliver the Freedom to Speak Up Guardian role, noting pressures to decrease workforce costs balanced against a rising culture of bullying, harassment and inequality. If the Board agrees that action is required to tackle the growing challenges, it is recommended that the Board be presented with a range of options to consider at the next Board.		
Summary of key elements			

Strategic goals supported by this report

Excellent population health and wellbeing		**Excellent experience receiving and providing care**	x
Excellent value and sustainability			

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

Board Assurance Framework	x	**Risk score**	20
Risk Register	3547	**Risk score**	15

External standards affected by this report and associated risks

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

Report title: Freedom to Speak Up Guardian Six Monthly Report	**Meeting date:31/05/23**
Report sponsor	Michelle Westwood Lead Executive for Freedom to Speak Up
Report author	Sarah Burns Lead Freedom to Speak Up Guardian

Introduction

1. Speaking up protects patients and workers, but is only effective if leaders listen up and follow up with leaders setting the tone from the top. Freedom to Speak Up is about more than the ability to raise concerns about patient safety. It is about being able to speak up about anything which gets in the way of doing a great job. That can be about ideas for improvement, ways of working or behaviours. This routine report highlights the number of Freedom to Speak Up cases that have presented in the past six months, the themes, and also highlights the insufficient capacity of the Freedom to Speak Up Guardian to cope alone with the increasing volume and scope of the cases brought to her.

Cases

2. There have been 50 cases raised to the Freedom to Speak Up Guardian between Oct 22 and Apr 23 – an increase of 16 from the same time 12 months before. 44 of these concerns were raised through the Freedom to Speak Up Guardian and 6 through the anonymous communication platform WorkinConfidence. Four of the anonymous concerns were staff members raising concerns on behalf of their teams located in Coastal, Operations, Child and Family Health Devon and Health Records.

Breakdown of cases:

Bullying and Harassment - 27
Patient Safety - 5
Failure to follow process - 9
Diversity and Inclusion - 2
Staff Safety - 3
Culture of organisation – 3
Fraud – 0
Other - 1

Staff group speaking up:

Medical - 4
Nurse - 13
Midwife - 0
AHP - 7
Senior Manager - 6
HCSW/AP - 5
A&C – 11
EFM – 3
Other -1

3. The highest staff number speaking up were Nurses, followed by Admin and Clerical and Allied Health Professionals. Bullying and Harassment concerns including poor behaviour and

breakdown in relationships remains the main reason staff make contact. The consistent theme from conversations is a lack of interest in trying to find an early resolution. Managers are ignoring the problem rather than addressing it. Failure to follow process is related to recruitment processes, with culture of the organisation relating to lack of flexibility and wellbeing support for teams. Patient safety concerns relate to inconsistences in investigating patient deaths, and competency of international staff. Diversity and Inclusion concerns relate to lack of support for reasonable adjustments in the workplace.

Historic Case numbers

April 21 – Oct21 35 cases
Oct 21 – April 22 34 cases
April 22 – Oct 22 46 cases
Oct 22 - April 23 50 cases

Awareness

4. **The Freedom to Speak Up Policy for the NHS** is provided by NHS England and there is a requirement for this is be adopted by every NHS Trust. The policy is for all workers. It is aligned with the NHS People Promise and commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up and take the time to really listen to understand the hopes and fears that lie behind the words".

5. Feedback from the **National Education Training Survey 2022** highlights that knowledge of the Freedom to Speak Up Guardian is limited within TSD**:**

Do you know how to access support from your local Freedom to Speak Up Guardian?

Hospital	% learners who do **not** know
Torbay And South Devon NHS Foundation Trust	**22%**

Learner groups	% learners who do **not** know
Medicine Postgraduate	17%
Nursing	28%
Allied Health Professional	0%
Medicine Undergraduate	29%
Midwifery	75%
Dental Postgraduate	67%
Pharmacy	50%

Feedback from speaking up

6. These are an example of quotes from individuals who have received support from the Freedom to Speak Up Guardian, demonstrating the positive impact of the role:

"*Thank you so much for everything you have done for me. I will forget many people but not you"*

"I don't trust anyone in this organisation…. only you. Thank you for everything"

"Thank you so much for your time, it is precious I know"

"I would never have made it through this without your support. Thank you."

7. Feedback from those who are aware was positive, but there are key groups of students that I currently don't have access to but will be addressing this moving forward. Improved awareness of my role within the new corporate induction programme will help this, as will training within the management framework.

Just and Learning Culture

8. The Trust is at the start of its journey to embed a Just and Learning culture, which the roll out of the Leadership and Management development programmes will assist, but this will take time. This will include the rewriting of all HR policies so they are less punitive and the adoption of mediation first, grievance second approach, to encourage employees and managers to deal with the problem where possible through mediation. **Resolving** relationship issues is a core part of the Freedom to Speak Up Guardian role. **Incivility** in the workplace has a direct negative impact on the delivery of patient care. The meditative approach is used between individuals and teams with good success.

9. However, to mitigate the gap until this is developed and launched later this year, by using **WorkInConfidence** I have been able to offer managers the use of anonymous surveys to gauge the culture in the team. This is done in partnership with managers so that the action to resolve is held by the manager and not the Freedom to Speak Up Guardian. Further**, E-training for the Well-being buddies' network** is ready to be launched and will give them the information to understand what speaking up is and how to signpost to the Freedom to Speak Up Guardian.

10. The **Just Culture** anonymous survey is being used via WorkinConfidence to support the Patient Safety Incident Response Framework. It is anticipated that feedback from this will give a broad understanding of the culture within teams and departments and provide clear evidence of where there may be significant challenges that require targeted treatment. Expectations regarding speaking up is an integral part of the framework.

11. The NHS guidelines are that every Trust should have at least one Freedom to Speak Up Guardian. For the size of our Trust we are consistent with all Trusts in the south west by having 1 Guardian. With a rising number of cases, I am nervous regarding the capacity I will have to consistently treat them. This nervousness is compounded by Julian Wright, the volunteer Diversity and Inclusion Guardian, stepping down from this role. Torbay and South Devon were the only Trust to implement this forwarding thinking initiative to have a guardian that focused specifically on concerns associated with the protected characteristics. This leaves the Freedom to Speak Up Service with 1.0 WTE for 6000+ staff. There is no cover for annual leave or sickness and concerns are continuing to be responded to during this time. Lack of capacity to support individuals and teams as well as to act proactively to raise awareness of the role, particularly in community settings, is restricted. Supporting the implementation of a Just Culture will also require an increase in capacity. I have established a mutual support arrangement, to share the emotional burden of the topics that I deal with, with the Freedom to Speak Up

Guardian for Plymouth University Hospitals NHS Trust. This is akin to professional supervision and has been formalised with check in sessions held on a fortnightly basis.

Recommendation

12. The Board is invited to consider providing additional resource as a priority to deliver the Freedom to Speak Up Guardian role, noting pressures to decrease workforce costs balanced against a rising culture of bullying, harassment and inequality. If the Board agrees that action is required to tackle the growing challenges, it is recommended that the Board be presented with a range of options to consider at the next Board.

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Report to the Board of Directors			
Report title: Annual Self-Certification: Provider Licence Conditions			Meeting date: 31 May 2023
Report appendix	Appendix 1: Governance Arrangements (Condition FT4 (8)) Appendix 2: Compliance with Condition G6 and CoS7		
Report sponsor	Chief Executive		
Report author	Director of Corporate Governance and Trust Secretary		
Report provenance	Director of Corporate Governance and Trust Secretary		
Purpose of the report and key issues for consideration/decision	For this final year, NHS Foundation Trusts are required to self-certify whether or not they have complied with: 1. Conditions of the NHS Provider Licence; 2. Required resources available if providing commissioner requested services; and 3. Required governance arrangements, providing assurances hitherto. The aim of the self-certification is for providers to provide assurance that they are compliant with these conditions. It is not however a feature of the new Standard Form Licence, effective 1 April 2023. As such, this is the last set of reports of this nature. To support the process for this year it is proposed to follow the previously issued guidance from NHSE, dated March 2019, which has not been updated since. As such, this report has been prepared on the same basis as the previous financial year, with appropriate updates. The Audit Committee met on 24 May 2023, reviewed the certification requirements outlined below alongside the draft annual report and accounts; following such review it was proposed and agreed that the following certifications be considered and approved by the Board; noting the relevant timeframes for such certifications to be complete: • Compliance with Condition G6 and CoS7 - **required by 31 May 2023**. • Compliance with Condition FT4(8) - **required by 30 June 2023**. • Publication of the governance statement **- required by 30 June 2023.** This report sets out assurance for the affirmative self-certification and provides evidence of how the Trust has achieved compliance with the relevant Licence Conditions.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board is asked to note the Audit Committees recommendation and approve the Provider Licence Self-Certifications; FT4 (8), G6 and CoS7.		

Summary of key elements				
Strategic goals supported by this report	**Excellent population health and wellbeing**		**Excellent experience receiving and providing care**	
	Excellent value and sustainability	x		
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework**	n/a	**Risk score**	
	Risk Register	n/a	**Risk score**	
External standards affected by this report and associated risks	**Care Quality Commission**	**x**	**Terms of Authorisation**	**x**
	NHS England	**x**	**Legislation**	**x**
	National policy/guidance	**x**		

Report title: Annual Self Certification: Provider Licence Conditions		**Meeting date:** 31 May 2023
Report sponsor	Chief Executive	
Report author	Director of Corporate Governance and Trust Secretary	

1. Introduction

1.1 NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

1.2 The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions and it is up to providers to how they carry out this process.

2. Discussion

2.1 In previous years, declarations have been made to two deadlines:

(i) Compliance with General Condition 6 and Continuity of Service Condition 7 of the NHS Provider Licence – by 31 May; and
(ii) The provider has complied with required governance arrangements (Condition FT4(8)) – by 30 June.

2.2 Assuming that the deadlines remain the same as in previous years, the Audit Committee and Board are asked to note the timetable for completion and consider the following evidence as assurance that the conditions have been complied with.

Compliance with General Condition 6 and Continuity of Service Condition 7 of the NHS Provider Licence

2.3 To comply with this Condition, the Board must make two declarations, as follows:

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to it in this certificate.

Governance arrangements (Condition FT4(8))

2.4 Under the governance condition, NHS Foundation Trusts must submit a corporate governance statement within three months of the end of each financial year. The governance condition requires Board to confirm:

The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS Provider Licence.

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Process and assurance

2.5 There is no set process for assurance or how conditions are met and how this is done is at the Provider 's discretion. However, what is important is that the Board understands and can sign off the stated compliance. Furthermore, there is no formal requirement now to make a return to NHS England though it may spot check the process followed at selected trusts to ensure they have carried out the self -certification process. Providers will be required to supply the information they have used or provide any documentary evidence, such as Board minutes, papers etc.

2.6 Appendix 1 sets out a detailed self -assessment against the requirements of Condition FT4 which underpin the Trust's overall compliance with Condition G6. From this assessment, it is recommended that the Trust takes assurance that it is operating in line with both Provider Licence Conditions.

2.7 In support of the evidence provided in Appendix 1, and the for the purpose of self-certification against Condition G6 and Condition 7, the Board should take account of the additional following sources of evidence:

- Relevant papers presented to the Board of Directors
- Relevant papers presented to the Board sub-committees: Quality and Assurance Committee, Finance, Performance and Digital Committee, People Committee, Building Brighter Future Committee and the Audit Committee
- The Risk Management Strategy, Board Assurance Framework and Corporate Risk Register
- CQC Registration, and 'GOOD' overall rating
- Accreditation with the NHS Resolution

- NHS Improvement Oversight Framework
- Opinions on assurance from the Trust's Internal Audit Programme

2.8 For the purposes of self-certification for Condition G6 (Appendix 2), the Board should take in to account the following sources of assurance:

- Integrated Performance Report – covering KPIs and workforce plan
- NHSE workforce establishment returns – monthly part of financial reporting

2.9 For the purposes of training, governors participated in the following:

- An externally facilitated governor workshop series on good governance with the Good Governance Institute during 2022, the recommendations of which are being reviewed by the Council of Governors in their meetings, as agreed at their meeting in May 2023.
- Council of Governors - quarterly meetings including presentations by Executive Directors and Non-Executive Directors
- Regular Governor Priority meetings which include presentations and interactive workshops covering areas that have been identified by the Council of Governors as priorities.
- Attendance by Governors at the Governor focus annual online conference.
- Monthly 'Governor Only' meeting which include a briefing by the Chair on the private session of Board meetings. Annual Members Meeting covering the annual report and accounts presented by the Chief Executive, Director of Finance and External Auditor and featuring presentation by clinicians and health professionals on topical health issues

3 Conclusion

3.1 Based on the evidence stated on Appendix 1 and 2 and above, it is proposed that this provides the Board with robust and sound evidence that '*confirmed*' statements against each of the conditions can be declared.

4 Recommendation

4.1 The Board is asked to approve the Provider Licence Self-Certification statements.

Corporate Governance Statement - FT4 NHSE Licence: Provided on 24.05.2023

1.	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	The Board has the following governance arrangements in place to manage its corporate governance arrangements: - - Board and Committee structure - Management and Directorate structure - Arrangements for assessing the Board's performance and effectiveness (including a Board Development Programme) - Quality governance arrangements - Compliance regimes to support regulatory requirements - eg for the Care Quality Commission and NHS England. - Clinical Audit Plan - Quality Improvement Programme - Internal Audit Annual Plan - Counter Fraud Programme - Risk and Control Framework - External Audit scrutiny and support - Information Governance arrangements - Standing Orders, Standing Financial Instructions and Scheme of Delegation The Trust's governance arrangements have been supported by: - The Trust's strategy, vision and objectives, approved February 2022. - The Annual Operational Plan. - The Board having a good balance of skills and experience: Executive Directors have defined portfolios of responsibilities and Non-Executive Directors have lead areas of focus linked to their areas of expertise and the requirements of the Trust. - Succession planning arrangements - the Trust is actively recruiting to Non-Executive Director positions during the financial year 2022/23, as part of a two stage recruitment with NEDs also recruited in 2021/22 to manage succession planning. - Annual self-declaration from all Board members to a Code of Conduct, the Code of Governance and the Nolan principles. This is compliant with the Care Quality Commissions Regulation 5 – Fit and Proper Persons and support the annual declaration from the Board as against its full compliance with this regulation. - Committee Reporting Structure - which enables a focus on and scrutiny of quality and safety issues, workforce matters and financial planning and control. - Reporting and assurance sub-structure of ISU's with triumvurate leadership and clinically led

		- Board Assurance Framework and combined Risk Register which details the risk to the delivery of the Trust's strategic aims. -Internal and external audit reports and opinions. The robustness of the Trust's corporate governance arrangements is validated through the Care Quality Commission's rating of "good" (including an assessment against the Well Led Framework).
2.	The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time.	The Trust responds to all relevant guidance issued by NHS Improvement through the actions of the CEO and the Executive Team. The Chief Executive's Report at every Board meeting also highlights any guidance issued by regulators. Reports are provided to the Board on statutory and regulatory matters as appropriate, notably the new NHS Standard Form Licence and Hewitt Review (April 2023).
3.	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	a. The Trust has Board approved Standing Orders, Standing Financial Instructions and a Scheme of Delegation. These are due to take account of the Trust's role within the Devon ICS and new care group structure, effective 1 July 2023.There are Terms of Reference for each Committee of the Board and effectiveness is assessed annually and following every meeting. Each Committee has a forward plan and cycle of business. b. The Board has a well-established Committee structure that provides for effective review, scrutiny and decision making on the priority areas of the Board's business and a clear focus on and scrutiny of quality and safety issues, workforce matters and financial planning and control. This and an underpinning infrastructure of supporting management meetings enables the Board to discharge its responsibilities and duties effectively and efficiently. c. The composition of the Board is well balanced and has a broad range of skills and experience. Executive Directors have defined portfolios of responsibilities and Non-Executive Directors have lead areas of focus linked to their areas of expertise and the requirements of the Trust. There is a clear reporting and assurance structure within the Clinical Directorates which has a triumvurate leadership team led by a Clinical Director. Job descriptions define duties, responsibilities and accountabilities across the management team and throughout the organisation.
4.	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty	a/b/c The Board ensures that the Trust meets necessary legislative requirements which include Care Quality Commission compliance. Various operational groups ensure that the Board of Directors is assured that the organisation, decisions and business of the trust is monitored effectively. The Trust's SMART transformation programme is testing new ways of delivering care that are more consistent and based upon clinical evidence; it is also looking at more efficient and effective ways of working through digital opportunities. The overarching aim is to

	to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where	make best use of our resources within the current constraints of growing demand and financial challenges. It is an ambitious programme that is driven to improve the care we provide, to enable our staff to spend more time with the people they are supporting and to increase our efficiency as a NHS organisation. The Board has a number of points of assurance which include integrated performance reporting, financial performance, declarations and Annual Accounts, External Audit and Internal Audit reports and statements. d. Our Annual Governance Statement provides a positive statement that we consider ourselves to be a Going Concern. Financial decision making and management and control systems are set out in the Trust's Standing Financial Instructions and Scheme of Delegation. The Trust has a Finance, Performance and Digital Committee which scrutinises financial planning, control and review and approves investment opportunities in accordance with its delegated authority limits and undertakes a pre-Board review of investments in excess of that limit. The ISUs are held to account for their financial performance and cost improvement targets are set for all Units. e. The Board has an agreed governance reporting structure and sequence of meetings though the timing of these is being reviewed to enable timely consideration of relevant and up to date information to make decisions. f. Risks that may affect us in delivering our strategic aims and risk any associated compliance are set out in the Board Assurance Framework which is regularly updated through Executive Director and Committee review. g. The Trust has an annual planning process which is led by the Programme Management Office (PMO); the PMO also supports the delivery of and reporting on Trust Business Plans. h. A range of governance, risk and control processes are in place to ensure that the Trust remains compliant with its legal requirements.

	appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements	
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for	a. The Trust has three Executive Directors who have a clinical background: The Chief Nurse, Medical Director and the Chief Executive. It also has one qualified accountant: The Deputy Chief Executive Officer & Chief Finance Officer. A qualified chartered secretary and governance practitioner who is also a qualified corporate lawyer is in post, supporting the improvement of a range of governance processes and systems. In all, this provides excellent leadership and focus on the quality, safety and effectiveness of services. All Directors are set annual objectives and agree a development plan with the CEO; they are appraised at least annually. b. The Trust has a Quality and Assurance Committee that meets every other month and provides assurance to the Board on matters of quality and safety; it is chaired by a Non-Executive Director. Agendas are informed by standing items, items taken from a forward plan and any topical matters, such as changes in legislation of policy. Governance meetings take place on a monthly basis at ISU level and their focus is on the quality and safety of the operational delivery of services; these meetings are led by the ISU operational director. The Chief Nurse and Medical Director work together on measures to improve patient safety and experience and clinical effectiveness. A comprehensive structure of management meetings looks at a range of specific aspects of quality and safety and are attended by a cross section of multi-professional staff and managers. The Quality and Assurance Committee and ISU Governance Groups consider a range of reports which relate to the quality and safety of Trust services, as well as reviewing relevant risks as detailed within the ISU risk registers. c/d. The overall reporting and assurance framework is based on a sequence of meetings which has recently been reviewed to ensure that the information being considered is timely and accurate. The Trust has a well-established informatics team which assists with performance reporting. Each of the Executive Directors has a defined portfolio of responsibilities which clarifies their accountabilities. There is framework for risk management and a means of escalating concerns about internal control to the Audit Committee. The Trust has significantly invested in its information and IT systems to support the availability of the most timely and accurate data. e. All members of the Board are actively engaged in quality and safety initiatives. As a matter of course, the Trust takes in to account the views of others through the feedback received from complaints, compliments, incident review, ongoing stakeholder meetings and discussions. One

	escalating and resolving quality issues including escalating them to the Board where appropriate.	of the NEDs has been appointed as the NED link to the 'Freedom To Speak Up Guardian' for the Trust. Duty of Candour is a statutory duty that requires the Trust to be open and candid if someone is harmed when in our care. During the year we have continued to provide training for staff about the ways in which we approach someone and apologise when things go wrong. We have provided education via resources on our internal web, information leaflets and regular meetings including our Senior Management and operational governance groups, Quality and Assurance Committee and our public Board meetings where reports are shared across our services to encourage learning. f. This is set out in the systems and processes described above. In addition to formal channels, such as the 'Freedom To Speak Up' service, the CEO and Chair operate an "open door" policy for staff or members of the public. In addition, managers make themselves readily available as a point of contact for concerns or for the speedy resolution of issues.
6.	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Executive Directors have defined portfolios of responsibilities. Non-Executive Directors have lead areas of focus linked to their areas of expertise and the requirements of the Trust. The Chief Executive considers the capacity of the Executive team on an ongoing basis. Regular 1:1 supervision sessions and weekly Executive meetings enable the CEO and the Executives to maintain a focus on delivery priorities. The Senior Leadership Team has been established supported by a Senior Management Team. The Clinical Directorates provide strong clinical and managerial leadership supporting the Executive Team in ensuring service delivery. There is an Annual self-declaration from all Board members to a Code of Conduct, the Code of Governance and the Nolan principles. This is compliant with the Care Quality Commissions Regulation 5 – Fit and Proper Persons and support the annual declaration from the Board as against its full compliance with this regulation.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2022-23

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

While the Trust ended the financial year with a strong cash balance of £34.7m, this is expected to decline over the course of 2023-24 as capital creditors are paid and in light of the Trust's deficit plan. As such, the Trust will be reliant on interim revenue support, which has been applied for but not yet confirmed. The Trust has prepared detailed cash flow forecasts, which were scrutinised by the Audit Committee as part of the Trust's going concern assessment. The Trust is confident that access to interim revenue support will be adequate to ensure continuity of service.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	LIZ DAVENPORT	**Name**	SIR RICHARD IBBOTSON
Capacity	CHIEF EXECUTIVE OFFICER	**Capacity**	CHAIR
Date	24 May 2023	**Date**	24 May 2023

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: **CQC Registration Annual Assurance Report**			Meeting date: 31 May 2023
Report appendix			
Report sponsor	Chief Nurse		
Report author	Deputy Chief Nurse Quality and Compliance Manager		
Report provenance	Quality Assurance Committee		
Purpose of the report and key issues for consideration/decision	To provide assurance to the Trust Board that all sites owned by Torbay and South Devon Healthcare Trust that provide regulated activities, have been registered with the Care Quality Commission as per the Health and Social Care Act 2008.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to note the content of the report.		
Summary of key elements			

Strategic goals supported by this report

Excellent population health and wellbeing	X	**Excellent experience receiving and providing care**	X
Excellent value and sustainability	X		

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

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

External standards affected by this report and associated risks

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

Report title: CQC Registration Annual Assurance Report		Meeting date: 31 May 2023
Report sponsor	Chief Nurse	
Report author	Deputy Chief Nurse Quality and Compliance Manager	

Introduction

This report provides the 2022/23 annual update to the Trust Board on the following:

- Trust's registration status
- Statement of Purpose updates
- Update on future changes to CQC's regulatory approach
- CQC formal Trust inspections and ratings
- CQC's ongoing monitoring of the Trust
- Planned Well Led May 2023

The CQC became fully operational in 2009 as the independent regulator or health and social care in England. Since 2010, all providers of health and social care in England have been legally required to register with the CQC.

From 1 April 2015, the new Health and Social Care Act Regulations came into force, setting out the Fundamental Standards of care all providers must meet and below which the care they provide must not fall. The Key Lines of Enquiry (KLoE) and all CQC activity has its bedrock in these standards. Whilst the CQC is changing the way it carries out inspections, for the next 6 months the KLoE will remain, until the new Quality statements and Single Assessment Framework replace them.

1. Trust's Registration Status

Torbay and South Devon NHS Foundation Trust (T&SDFT) is currently registered with the CQC to provide the following regulated activities, with no conditions or restrictions on its registration:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Personal care
- Surgical procedures
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury.

2. Trusts Statement of Purpose

The Statement of Purpose is a document legally required by Trusts that includes a standard set of information about the services we provide. TSDFT's Statement of Purpose lists the locations and the services provided. The Statement of Purpose now includes the new Dartmouth Health and Wellbeing Centre and services returned to normal, post Covid

3. Update on Future Changes to the CQC's Regulatory Approach

In May 2021 the CQC released its five-year strategy, following extensive public consultation. This remains the CQCs direction but has been delayed in its implication due to Covid. The likely implementation has been put back towards the end of 2023.

The CQC launched the new strategy with the aim of making a positive impact on patient care while regulating providers in a much more targeted and risk-based way. The refocus also reflects the dramatic way health and social care have changed over the past 10 years and the CQC wanted its focus to be people and community centric. To this end they have set out 4 themes, two core ambitions and 12 outcomes.

Themes:

1. People and communities – CQC's regulation will aim to be driven by people's needs and experiences
2. Smarter regulation – the new strategy will focus on deploying a more dynamic and flexible approach by providing up-to-date and high-quality information and ratings
3. Safety through learning – CQC will have a complete focus on safety by requiring a culture that enables people to voice concerns, allowing for shared learning and improvement opportunities
4. Accelerating improvement – lastly, the CQC will encourage health and care services as well as local systems to access support to help improve quality of care.

Core ambitions:

1. Assessing local systems: Providing independent assurance to the public of the quality of care in their area
2. Tackling inequalities in health and care: Pushing for equality of access, experiences and outcomes from health and social care services

CQC outcomes:

People and communities' outcomes

1. Our activity is driven by people's experiences of care.
2. We clearly define quality and safety in line with people's changing needs and expectations. This definition is used consistently by all people, and at all levels of the health and social care system.
3. Our ways of working meet people's needs because they are developed in partnership with them.

Smarter regulation outcomes

4. We are an effective, proportionate, targeted, and dynamic regulator.

5. We provide an up-to-date and accurate picture of quality.
6. It is easy for health and care services, the people who use them and stakeholders to exchange relevant information with us, and the information we provide is accessible, relevant, and useful.
7.

Safety through learning outcomes

8. There is improvement in safety cultures across health and care services and local systems that benefit people because of our contribution.
9. People receive safer care when using and moving between health and social care services because of our contribution.

Accelerating improvement outcomes

10. We have accelerated improvements in the quality of care.
11. We have encouraged and enabled safe innovation that benefits people or results in more effective and efficient services.

Core ambitions: Assessing health and social care systems, and tackling inequalities in health and social care

12. We have contributed to an improvement in people receiving joined-up care.
13. We have influenced others to reduce inequalities in people's access, experiences and outcomes when using health and social care services.

What this means for the Trust

The Hospital ratings system will remain. The CQC will still judge hospitals as being Outstanding, Good, Requires Improvement or Inadequate. However, the days of being rated at physical inspections, according to a set time frame, will be coming to an end. The CQC aim to adopt a continuous assessment approach. Any site-based inspections will likely be reserved for those care providers which cause the CQC's internal systems to alert them to an unacceptable increase in risk, based on the information and data they have gathered.

The complicated and multiple 'key lines of enquiry' will be replaced by one simpler system of questions rooted in what people expect of services. These questions focus on statements which the CQC considers to be more relatable both to providers and the public at large than is the case presently. These will be called quality statements and operate under one Single Assessment Framework (SAF)

The five key questions the CQC use to inspect with remain and any contact/inspection/assessment will still be based on the following;

- Safe
- Effective,
- Caring,
- Responsive
- Well led.

The 12 fundamental standards, (person centred care, dignity & respect, consent, safety, safeguarding from abuse, food and hydration, safe premises, complaints, good governance, safe staffing, fit & proper staff and duty of candour) also remain unchanged. These are the basis of what and how we deliver care and the focus of the Trust in terms of CQC preparedness.

What's next?

The CQC have created a new team structure which will be made up of Assessors, Inspectors, Regulatory Co-ordinators and Regulatory Officers. An operations manager will lead each. There are circa 110 teams, split across 4 Operation areas: London and East of England, Midlands, North and South who will use intelligence gather and apply a risk-based approach to inspection through continual assessment of the Trust. The CQC plan for the changes to be completed and operation by year end

3. CQC Formal Trust Ratings of T&SDFT

The Tables below (1&2) lists the Trusts CQC rating and the ratings of our core Services as of the inspection activity to March 2023.

Please note the Trust has an overall CQC rating of Good

Table 1 Torbay & South Devon CQC ratings – Rated as Good Overall

Torbay and South Devon NHS Foundation Trust

Overall rating	Inadequate	Requires Improvement	**Good**	Outstanding

	Safe	Effective	Caring	Responsive	Well-led	Overall
OVERALL	Requires improvement	Good	Outstanding ☆	Good	Good	**Good**
Community end of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community health services for adults	Good	Outstanding ☆	Good	Good	Outstanding ☆	Outstanding ☆
Community health services for children, young people & families	Good	Good	Good	Good	Good	Good
Community health urgent care services (MIU)	Good	Good	Outstanding ☆	Good	Good	Good
Critical care	Good	Good	Outstanding ☆	Good	Good	Good
Dental services: community (rated Met or Not Met)	Met	Met	Met	Met	Met	Met
Dental services: special care	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
End of life care	Requires Improvement	Good	Good	Good	Good	Good
Maternity	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Gynaecology	Good	Good	Good	Good	Good	Good
Medical care (including older people's care)	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Not rated	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires Improvement	Not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
Patient transport services	Good	Good	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Services for children & young people	Good	Good	Good	Good	Good	Good
St Edmunds	Good	Good	Good	Good	Good	Good
Substance misuse	N/A	N/A	N/A	N/A	N/A	N/A
Surgery	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Urgent & emergency services	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Table 2. Core Services Ratings by CQC as of Year End 2022/23 and areas visited

CQC designation	Core Service	Current rating (date rated)
Acute (Torbay Hospital)	Urgent and Emergency	Requires improvement (2020)
	Medical care (inc older people's care)	Requires improvement (2020)
	Surgical Care	Requires improvement (2020)
	Critical care	Good (2016)
	Maternity Care	Requires improvement (2020)
	Gynaecology	N/A
	Children and young people	Good (2020)
	End of life care	Good (2018)
	Outpatients	Good (2018)
	Diagnostic imaging	N/A
Community health	Community adults	Outstanding (2016)
	Community children and young people	Good (2018)
	Community inpatients	Good (2020)
	Community end of life	Requires improvement (2018)
	Community dental	Outstanding (2016)
	Community urgent care	Good (2016)
Mental health	Substance misuse	N/A
Ambulance	Patient transport services	Outstanding (2016)
Adult social care	St Edmunds	Good (2018)

4. CQC's Ongoing Monitoring of the Trust

The local CQC inspectors and the Trust have continued to engage throughout the pandemic and maintain a good working professional relationship, and in 2022/23 have not carried out any formal inspection activity.

The Trust has continued to receive routine enquiries from the CQC, as part of their ongoing monitoring of the Trust. The local CQC inspectors request additional information on specific concerns relating to services provided by the Trust, such as specific complaints, safeguarding concerns and patient-related incidents. All of these events are routinely managed internally by TSDFT through established processes and governance routes. When the information on the specific events requested becomes available it is passed to the CQC. The CQC also raises enquiries from feedback received directly by the them, in regards to the services provided by the Trust, to which the Trust will provide a timely response.

To monitor this process the Trust meets the CQC inspectors formally, via the monthly Open Enquiry meetings. These meetings are 1 hour long and are carried out via teams. They are an opportunity to formally discuss issues that have come to the Inspectors attention, and review Safeguarding, Complaints and Clinical Incidents they have received and update on the ongoing CQC Must Do improvement action plans.

On a quarterly basis the Trust manages a CQC Engagement meeting. This is a 3-hour meeting and involves presentations from the Chief Nurse, Chief Operating Officer and the Chief Executive on Trust wide issues. It may also include presentation or discussions from distinct teams, for example, Maternity, Safeguarding.

5. Well Led inspection 2023

The Trust is currently preparing for an announced Well Led inspection, between mid to the end of June. Prior to this, the Trust will receive an unannounced inspection on a number of Core Services and plans are in place to manage these visits as we welcome our CQC Inspection colleagues.

6. Conclusion

For assurance, this report has provided an annual update to the Trust Board on the Trust's current registration status; CQC's developing new strategy, Trusts CQC ratings and CQC activity within the Trust 2022/23

7. Recommendations

The Trust Board is asked to note the content of the report.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors		
Report title: Board Assurance Framework and Corporate Risk Register		**Meeting date:** 31 May 2023
Report appendix	Appendix 1: Board Assurance Framework Appendix 2: Corporate Risk Register	
Report sponsor	Director of Corporate Governance and Trust Secretary	
Report author	Corporate Governance Manager	
Report provenance	Reviewed by Board Sub-Committees – People Committee, Quality Assurance Committee, Finance, Performance and Digital Committee, Building a Brighter Future Committee and Risk Group.	
Purpose of the report and key issues for consideration/decision	Please find enclosed the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) for the Board's review. The Board Assurance Framework (BAF) is the key source of evidence that links the Trust's 'mission critical' strategic objectives to risks, controls and assurances, and is the primary tool that the Board uses to discharge its overall responsibility for internal control. The Board has delegated detailed review of a number of risks to Board Sub-Committees. During May Board Sub-Committees have reviewed those risks where they have been designated as the overseeing committee. The Risk Group also reviewed the BAF and Corporate Risk Register ('CRR') at its most recent meeting. You will notice that since the last review that the format of the BAF has changed. In line with the briefing given and comments received at Board we have taken steps to improve "snap shot" assurance, the efficacy of linkages between risk, gaps in assurance and actions. This is the first step in its review and improvement, culminating in a Board development session where we will do a deep dive to also review risk management. In particular, you will see that a risk analysis reference number has been introduced; this can be used to read across each identified aggravating, mitigation and impact area; linking to gaps in assurance to specific actions. This work will support the creation of a "golden thread", which is essential for analysis, audit and mapping of risk management. The BAF will be further updated in future months to provide an analysis of corporate level risks to identify themes for the Board and Board sub-committees to discuss. The Board is asked to consider the proposed target risk score of 16 for the Financial Sustainability objective. This score was discussed by the Finance, Performance and Digital Committee as being appropriate taking into account actions in train to improve the Trust's financial sustainability.	

<table>
<tr><td></td><td colspan="3">The Corporate Risk Register (‘CRR’) is presented alongside the BAF as assurance that the Trust’s risk management system and the risk registers adequately underpin the BAF providing linkage between operational and strategic risks.

Since the last meeting no new risks have been added to the CRR. The following risks have been removed:

2411: Potential Financial Impact Due To Loss Or Reduction Of A Single Product. (10) Owner requesting the risk is closed.

2696: WinPath V5 Incompatibility Risk and Requirement to Reprocure (10) Risk reduced from 25 to 10.</td></tr>
<tr><td>Action required (choose 1 only)</td><td>For information
☐</td><td>To receive and note
☐</td><td>To approve
☒</td></tr>
<tr><td>Recommendations</td><td colspan="3">The Board is asked to:
(i) Review the BAF, and note the updates as described and approve the target risk score for the financial sustainability objective;
(ii) Receive and note the Corporate Risk Register.</td></tr>
<tr><td colspan="4">Summary of key elements</td></tr>
<tr><td>Strategic goals supported by this report</td><td colspan="3"><table>
<tr><td>Excellent population health and wellbeing</td><td></td><td>Excellent experience receiving and providing care</td><td></td></tr>
<tr><td>Excellent value and sustainability</td><td>X</td><td colspan="2"></td></tr>
</table></td></tr>
<tr><td>Is this on the Trust’s Board Assurance Framework and/or Risk Register</td><td colspan="3"><table>
<tr><td>Board Assurance Framework</td><td>n/a</td><td>Risk score</td><td></td></tr>
<tr><td>Risk Register</td><td>n/a</td><td>Risk score</td><td></td></tr>
</table></td></tr>
<tr><td>External standards affected by this report and associated risks</td><td colspan="3"><table>
<tr><td>Care Quality Commission</td><td>X</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS England</td><td>X</td><td>Legislation</td><td>X</td></tr>
<tr><td>National policy/guidance</td><td>X</td><td colspan="2"></td></tr>
</table></td></tr>
</table>

NHS
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BOARD ASSURANCE FRAMEWORK 2022/23

BUILDING A Brighter Future
improving health & care in Torbay & South Devon

Our People AT THEIR BEST

BOARD ASSURANCE FRAMEWORK SUMMARY

Ref	Objective	Executive Lead	Current Risk Score	Target Risk Score	Executive Comment
1.	Quality and Patient Experience	CNO	16	12	
2.	People	CPO	20	16	
3	Financial Sustainability	CFO	25	16	Target risk score of 16 proposed by FPDC
4	Estates	CFO	25	10	
5	Operations and Performance Standards	COO	16	12	
6	Digital and Cyber Resilience	DTP	25	25	
7	Building Brighter Future (BBF)	DTP	15	15	
8	Transformation and Partnerships	DTP	16	9	
9	Integrated Care System	CEO	16	8	
10	Green Plan/Environmental, Social and Governance	DCEO	12	6	

Strategic context:

The Board Assurance Framework ("BAF") is the key source of evidence that links the delivery of the Trust's strategic objectives to risk, control and assurance; and is the primary internal control that the Board uses for strategic oversight and assurance.

The current Trust Strategy was approved in February 2022 and can be found on our website here: https://www.torbayandsouthdevon.nhs.uk/about-us/our-vision-and-strategy/

An Executive Lead is nominated for each BAF Objective, to maintain, review and manage the narrative around each Objective, as well as overseeing the associated risk and controls impacting on delivery. Each Objective is then delegated to a Board Sub-Committee who scrutinise their individual BAF Objectives and undertake a detailed review at each meeting.

The Risk Group also review the BAF and Corporate Risk Register ('CRR').

The Board then undertake a review of the whole BAF, assuring themselves that the narrative and controls contained therein provide sufficient oversight and mitigation of risk as well as noting progress against the Trust strategy; noting the risk position and any exception reporting at their meetings.

Methodology:

In reviewing this document Executives will have regard to the Trust's risk management policies, procedures and methodology, as amended from time to time. Noting the importance of tiered mitigation for controls through the "3 lines of defence" as a matter of good governance:

- First Line Assurance - (assessments undertaken and owned by functions that own and manage the risk) – An example of this could be a local monthly compliance check that is undertaken within a specific function.
- Second Line Assurance - (oversight of functions that oversee or who specialise in compliance or the management of risk) – An example of this could be a system, process or piece of assurance that has been reviewed and assessed by the Risk or Governance Team, independently from the first line. Produced distinct from those who are responsible for delivery
- Third Line Assurance - (objective and independent assurance) An example of this could be an assessment of a system and processes by the Trust's Internal Auditors, External Auditors, or regulatory bodies.

The current policies in place are: Risk Management Policy, approved September 2022 & Risk Management Strategy, approved September 2022. It should be noted that these are to be merged during 2023 ensuring consistency of methodology.

When reviewing the BAF objective risk analysis section it should be noted that a risk analysis reference number will be utilised to read across each identified aggravating, mitigation and impact area; linking to gaps in assurance to specific actions. Creating a "golden thread", which is essential for analysis, audit and mapping of risk management.

BAF Current Risk Score Heatmap

Consequence (Impact) / Likelihood	1 Minimal	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 - Almost Certain	5	10	15	20	25 (6, 4, 3)
4 - Likely	4	8	12 (10)	16 (8, 9, 1, 5)	20 (2)
3 - Possible	3	6	9	12	15 (7)
2 - Unlikely	2	4	6	8	10
1 - Rare	1	2	3	4	5

Risk Summary					
BAF Reference:	**1. QUALITY & PATIENT EXPERIENCE**				
Objective:	To deliver high quality health and care services ,achieving excellence in health and wellbeing for patients and local community				
Internally Driven: ✓ Externally Driven:					
Responsible Executive:	Chief Nurse supported by CMO	**Committee:**	Quality Assurance Committee	**Last Updated:**	May 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jul 22	**Nov 22**	**Jan 23**	**Mar 23**	**April 24**	**May 22**	There are a range of factors that present a risk to delivering high quality health and care .These include the ongoing and accumulate impact of the following: • Demand and Capacity modelling presents a significant gap in terms of TSDFT meeting levels of activity at pace and scale • Unstable operating model and newly emerging structure • Ambiguity around accountability and leadership capacity issues across the Care Group Delays in accessing treatment and care due to waiting list position and harm experienced as a result of significant delays • Continued Pressure on the emergency pathway and patient flow resulting in delays in management of patients in the right place at the right time • Newly emerging clinical governance from April 1st • SOF 4 accelerate pace and scale of service, pathways change which may adversely impact a range of issues around workforce as we progress efficiency, performance and productivity drive • Workforce Challenges in terms of attrition, sickness and moral – to be further impacted by Industrial action over quarters 3 and 4 of 2022/23 • There remains a Moderate risk to the quality of patient care. The likelihood of the risk materialising remains as Likely (x).
Likelihood	5	4	4	4	4	n/a	
Consequence	4	4	4	4	*3*	n/a	
Risk Score	20	16	16	16	12	n/a	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
1.1A	Pace and scale of change required to minimise harm and poor patient experience & meet SOF 4 exit criteria is a significant challenge.	1.1B	Setting out medium to long term plan for reconfiguration of services to meet risk/demand Recovery and Restoration plan with agreed targets as set out in Performance framework and operating plan for planned and emergency Care	1.1C	Inequities and inequalities in access resulting in increase in Mortality& Morbidity across Torbay and South Devon
					Performance and operational resilience remained constrained with ongoing impact of : a) Delays in diagnostics and access to treatment - analysis of harm in key high-risk service areas shows an increase in harm in Ophthalmology, Urology, Cancer Services

			Regular review Mortality and Morbidity through to Board incorporated into overall Harm review framework and through QA Governance framework		b) Failure to achieve recovery and restoration targets set out in the Recovery Plan c) Delayed ambulance handovers d) Adverse Mortality and Morbidity
1.2A	Clinical Leadership Capacity to lead change	1.2B	Acute Service Sustainability Plan in development	1.2C	Failure to deliver fundamental standards of care as set out in regulatory/statuary frameworks
1.3A	Gaps in Leadership Capacity and Capability across new Care Group Structure	1.3B	TSDFT Leadership Strategy Active recruitment to key leadership roles	1.3C	Failure to deliver against Single Improvement Plan targets – Regain and Renew
1.4A	Gaps in expertise and Capacity within the Quality and Patient safety functions across TSDFT	1.4B	Recruitment to Associate Director pf Patient Safety Business Case for Patient Experience lead	1.4C	Delays in delivery against national and regulatory frameworks of Patient safety and Patient Experience
1.5A	Capacity and capability to monitor /interrogate business/clinical Intelligence data including workforce, operational performance, quality and safety immature and sub optimal	1.5B	Quality Metrics being reviewed to ensure focus on appropriate quality and patient safety issues and ensure alignment with risks and SOF 4 criteria	1.4C	Failure to intervene and prevent patient Harm issues and underperformance around SOF 4
1.6A	Maturing quality /governance systems across organisation and within the newly emerging Care Group structure - impacting effectiveness of quality systems – assurance /improvement	1.6B	Broader Corporate Governance Review including strengthened Clinical Governance Framework in line with GGI recommendations	1.6C	Sub-Optimal Quality Assurance framework - Failure to address quality and patient safety risk and to effectively drive up quality improvement a) Continuous review of NICE recommendations and communication of new/changing requirements by the Quality Effectiveness Team. b) Monitoring framework of concerns and feedback from patients and service users c) Embedding key programs of work to ensure fostering of Safety Culture work

Gaps in control/assurance

Internal		**External**	
Risk Analysis reference:		**Risk Analysis Reference:**	
1.3A	Operating structure in transition	1.1C	System /ICS around plans to address inequalities in access and treatment
1.3A	Need to implement and embed new operating structure and CG framework in line with staff engagement and GGI report - Launch 1st July	1.1C	Central government control restricting ability to prioritise local needs
1.3A	Need to strengthen role of Trust Management Group Absence of Executive performance Oversight and monitoring outside Board Sub-Committee	1.1C	Collaboration with Devon system to ensure joined up response to increasing pressures
1.6A	Quality of clinical data variable	1.6A	CQC new regulatory approach not yet tested.
1.3A	Need comprehensive Organisational development plan to support system wide leadership capacity	1.1C	System /ICS around plans to address inequalities in access and treatment

Action Log: (actions identified to achieve target risk score)				
Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
1.2B	Continue acute service collaborative and delivery of the Acute Service Sustainability Plan	CEO	Ongoing 2023	• ICB plan in place - Single Operating Plan for 2023/24 • System approach to service reviews through PASP • Governance and oversight in place • SRO in place – TSDFT CEO
1.1A	Ensure delivery against SOF 4 Exit Criteria in terms of quality and improved performance	COO	April 2024 (to review)	• Improvement Targets agree- set out in SOF 4 • Detailed plans developed with support of recovery • Recovery and Improvement Board established
1.5A	Ensure robust oversight arrangements in place around understanding and monitoring intelligence around harm	CMO	Ongoing monthly group	• Harm Review Group in line with ICB oversight around Clinical Risk and Long Waits assurance Group • Mortality review /process in place to understand recent increase in Mortality – linking with ICS • Review of clinical outcomes for patients delayed in ED
1.6A	Ensure robust measures are in place to compliance with Fundamentals of care and ongoing delivery against the CQC improvement requirements from March 2020 and March 2022 Improvement Plans	CNO	July 2023	• Quality Metrics being reviewed to ensure focus on appropriate quality and patient safety issues and ensure alignment with risks and SOFT 4 criteria • Ward Accreditation Framework in place and strengthened in 2022/23 • Internal audit around compliance against 2020 CQC Action Plan completed in Autumn 2021 • Ongoing Quality and safety walkabout in place Current underperformance around Training a risk - revised assurance submitted to People Committee in June 22 • Consistent Monitoring of the Nutrition and Hydration and risk assessment show good levels of compliance with some areas requiring closer scrutiny – areas known to leadership • Mandatory Training Improvement plan continues to be monitored - ongoing monitoring through Care Group Structure and People Committee to ensure trajectory is met.
1.6A	Develop and implement improvements to the Clinical Governance Framework as set out in GGI	CNO	April 2023	• Revised Structure to go live in July 2023 • Review submitted to QAC March 2023 with launch/go live governance structure from 1st April • Co- Designed Care Group Governance in line with GGI and NHSE Accountability Framework Risks remain around capacity/ capability at corporate and ISU level • AWS to deliver development program
1.3A	Strengthening of quality oversight and assurance at service at Care group level through new operating model	CNO	July2023	• New operating model in place- Launch 1st April • ISU's recording and monitoring all quality meetings where metrics are reviewed and action plans created.
1.6A	Review of current quality metrics reported in the KLOE Dashboard to ensure they are relevant.	CNO	Ongoing 2023	• Phased work program in place led by DoF • KPIS Reviewed for QI Priorities • New Quality Metric introduced in IPR

				• Date being developed with overarching audit framework and digital platform Formic
1.4A	Development of the Patient Experience and Engagement Strategy to strengthen our understanding of patient experience and involvement of patients. Set out specific interventions to enhance experience of patients for 23/2024	CNO	April 2023	• Patient Engagement Strategy launched August 2022 • Plan to be further developed in 2023/24 to be clear about measurable deliverables around priorities

Risk Summary						
BAF Reference:		**2. PEOPLE**				
Objective:		To build a culture where our people feel safe, healthy and supported.				
Internally Driven: ✓ Externally Driven:						
Responsible Executive:		Chief People Officer	**Committee:**	People Committee	**Last Updated:**	May 2023

BAF Risk Scoring

Current Position						**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jul 22	**Nov 22**	**Jan 23**	**Mar 23**	**Apr 23**		**May 22**	SOF4 has highlighted the improvements required in reducing waiting list times and improving financial efficiency. Whilst improvements in processes can alleviate both, people remain the key deliverers of all services, often doing so against competing demands and priorities. Workforce fragility data (sickness, rolling sickness, long term sickness, age profile, holiday taken, overtime hours, bank and agency spend, and turnover) highlights that 6 out of 9 are in red RAYG status. The difficulty in analysing the impact of this is compounded by poor vacancy data quality. All of these categories place growing pressure on workforce to continue to deliver but with less available resource. In addition, organisational culture data from People survey, DES, WRES, EDS, F2SU, and demands on the Employee Relations team, identifies that the Trust has room to build a culture where people feel safe, healthy and supported. The link between this culture and patient safety is actively being investigated, with the full degree of risk to patient safety yet to be understood.
Likelihood	4	4	4	4	5	4	n/a	
Consequence	4	4	4	4	4	4	n/a	
Risk Score	16	16	16	16	20	16	n/a	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
2.1A	Turnover, and difficulties recruiting to critical posts, means there is an increase in services with 15+ risks with staffing factors.	2.1B	Use of interims and agency staff to cover the gaps, as well as exploration of peninsular solutions to addressing fragile services.	2.1C	Loss of ability to deliver some key services; increased agency and interim spend
2.2A	Staff fatigue following covid pandemic, annual leave not being taken due to operational pressure and covering additional shifts is leading to staff burnout. The requirement to improve performance to reduce long waiting lists will likely add mental load to individuals.	2.2B	Suite of wellbeing offers available via Devon Wellbeing, EAP and OH.	2.2C	Increased level of sickness, long term sickness above normal levels, staff turnover, impact on uptake of annual leave, and a decrease in productivity and performance in staff that remain.
2.3A	Lack of strategic business and workforce planning, to identify the workforce needed for the future, with sufficient time for us to develop the appropriate pipeline to deliver the need. Also, a lack of a clear view on how the ICS will work together.	2.3B	Strategic Workforce Planner has been recruited, to start Jul 23.	2.3C	It takes time to recruit and grow patient facing skills and staff – there will be a lag between strategic workforce plan being created and people starting, therefore vacancies will continue to exist in specialist areas
2.4A	Lack of leadership or management framework, development or key accountability expectations, results in workforce expressing dissatisfaction and impact on wellbeing due to poor leadership and management	2.4B	A co-created leadership framework, (Include, Listen, Act) and a management training programme have been designed. Will be presented to Board May 23 with a roll out plan to commence Q2 23. Leadership framework will used to identify leadership expectations, standards & behaviours. Evaluate	2.4C	Continued poor leadership and management behaviours will exasperate an already fragile workforce and reinforce that their concerns are not listened to, further compounding fragility challenges.

			(through a 360 approach), recruit and develop leaders to improve effectiveness and consistency in leadership.		
2.5A	Capacity to deliver services impacted by industrial action	2.5B	Concise industrial action planning involving patient facing and operational teams, supported by reward and recognition where necessary, has enabled most services to continue	2.5C	Further detriment to staff resilience and wellbeing, for those who have cause to strike, and those required to cover services. Staff prevented from participating in CPD due to operational pressures which impact on career pathway work and retention.
2.6A	Operational pressures result in increased time in OPEL 4, that impacts on wellbeing of staff and ability to attend CPD.	2.6B	Clear process and policy to review CPD attendance at times of OPEL 4	2.6C	Staff prevented from participating in CPD due to operational pressures which impact on career pathway work and retention.
2.7A	Unclear career pathways and talent management impacts on retention and wellbeing of workforce	2.7B	People Promise work will design clear career pathways and a trust wide talent management plan. Work to commence Q2 23	2.7C	Impact on recruitment and retention of workforce against an already difficult vacancy picture.
2.8A	Absence and turnover, as well as inconsistent use of rotas, increases use of bank and agency staff	2.8B	Improved recruitment processes, e-rostering roll out, temporary staffing management and an improved triangulation of data with finance and payroll has reduced agency spend for nursing and midwifery.	2.8C	Increased use of bank and agency creates cost pressures, especially when used to cover absence. The cost pressures contributed to declining Trust financial performance.
2.9A	In drive to recover from SOF4 there are an abundance of initiatives underway to improve waiting lists, patient safety, cost improvement and innovation, as well as introducing new leadership and management frameworks, and preparing for a CQC Well Led Inspection	2.9B	Execs are trialling a prioritisation tool to clarify which of competing tasks are actual priority and to understand the dependencies on resources to deliver the priorities. Intent is to provide clarity to workforce to alleviate some pressure. Regain and Renew engagement plans is also asking workforce to focus on what can deliver that offers most impact to recovery.	2.9C	Continued culture of trying to do everything will exasperate workforce fatigue and wellbeing decline, and not aid recovery.
2.10A	An upward trend in EDI related investigations and Employment Tribunals, combined with an in increased reported number of bullying and harassment instances on BAME staff, and an overall decline in experience for our people with LTC (Staff Survey Results 2022), suggests that the workplace culture in TSD is not inclusive.	2.10B	Just and Learning Culture survey, aligned to Patient Safety, currently in circulation to help identify where in Trust there are particular issues in psychological safety. New Leadership framework has inclusivity at its heart. OD team to be renamed as Inclusivity and Culture team to focus on a) culture, inclusion and wellbeing education, rewrites of policies to reflect Just and Learning Culture, and to triangulate data from multiple sources to identify where bespoke interventions may be required.	2.10C	By not treating this risk the Trust will be unable to achieve its objective to build a culture where our people feel safe, healthy and supported. Incidents of incivility impact on staff retention
2.11A	Lack of accurate vacancy data and correlation with financial data	2.11B	Organisational Reshaping project is providing opportunity for all cost centres and ESR to be rebuilt to accurately reflect establishment and new design. Should result in clearer vacancy data	2.11C	Lack of clear vacancy data impacts on a) clear resourcing priorities and workforce planning, b) lack of risk management for shortage of skills, c) unclear financial data regarding cost of certain skills groups

Gaps in control/assurance			
Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
2.1A	Thorough oversight of vacancies and use of agency and interims is required across the Trust		
2.2A	Wellbeing tools only treat symptoms, need to get to cause of symptoms and treat these. Increased perceived workloads to be managed via Regain and Renew call to only focus on key recovery areas; but org culture requires improvement.		
2.10A	1. EDI training is not part of induction 2. Skillset of managers to enforce policy or to investigate is in need of improvement 3. Capacity of People Hub team is stretched against backdrop of current caseload, captured in Risk 3536		

Action Log: (actions identified to achieve target risk score)				
Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
2.1A	New oversight and management of agency and interim spend to be introduced with aim to reduce spend and to meet workforce plans aims of CIP and reduced agency spend	CPO	Mar 24	
2.2A	better management and leadership to be managed via People Directorate. Active culture improvement programme to be launched summer 23	CPO	Sep 23	
2.10A	1&2 New TSD Leadership and Management framework and resources will be launched from Summer 2023 that focus on a leadership responsibility of all to include. Will involve refreshed EDI training,	CPO	Sep 23	
2.10A	3. People Hub capacity under review, uplift of resource and interim support to identify and manage backlog, introduction of prioritisation of projects and dependency management at Exec level should manage demand on People Hub	CPO		

Risk Summary					
BAF Reference:	**3. FINANCIAL SUSTAINABILITY**				
Objective:	To achieve financial sustainability and deliver the ICS three year financial recovery plan, enabling appropriate investment in the delivery of outstanding care.				
Internally Driven: ✓ Externally Driven:					
Responsible Executive:	Chief Financial Officer	**Committee:**	Finance, Performance and Digital Committee	**Last Updated:**	May 2023

BAF Risk Scoring						
Current Position				**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jul 22	**Nov 22**	**Mar 23**	**April 24**	**May 22**	There is a risk that the Trust fails to deliver sufficient improvement in its and productivity to achieve the three year system recovery plan. This will result in regulatory intervention, further financial restriction, leading to issues with access to services, including waiting times, increased health inequalities, and an inability to improve and update equipment and infrastructure for the benefit of patients and staff. Some services may not be viable in the medium term.
Likelihood	5	5	5	4	n/a	
Consequence	5	5	5	4	n/a	
Risk Score	25	25	25	16	n/a	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
3.1A	Inflation outstrips funding available resulting in a deterioration in financial performance	3.1B	Contract negotiation and non-pay controls	3.1C	Deterioration in financial performance and failure to deliver SOF 4 exit requirements
3.2A	Digital and physical environments are not fit for purpose	3.2B	Multi-year capital programme and bids for additional cash-backed external funding	3.2B	Failure to improve productivity therefore not delivering financial nor operational improvements to exit SOF 4
3.3A	Recruitment and retention are difficult for highly skilled clinical staff	3.3B	See workforce risk – people promise, workforce planning, R&R initiatives	3.3B	Unsustainable rotas, fragile services, and failure to delivery SOF 4 exit requirements
3.4A	Failure to comply with best practice guidance such as GIRFT and model hospital	3.4B	Transformation programme and PMO team supporting improvement workstreams	3.4B	Failure to deliver best value (quality / cost) impacting negatively on SOF 4 exit
3.5A	Material differences between income and costs for specific services most notably adult social care	3.5B	Multi-agency recovery and transformation programme supported by external experts	3.5B	Unsustainable provider market and increasing gap between income and cost, resulting in financial deterioration and impacting on SOF 4 exit
3.6A	Capacity and capability of senior budget holders is variable	3.6B	Communication, engagement and training packages, plus business partnering approach	3.6B	Failure to demonstrate sufficient accountability for delivery to assure SOF 4 exit
3.7A	Gaps within the CIP programme	3.7B	Transformation and PMO approach including system-wide saving schemes with appropriate external support	3.7B	Deterioration in financial performance and failure to deliver SOF 4 exit requirements

Gaps in control/assurance			
Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
3.3A	Ongoing challenges with data quality and information availability, driven by limited capability of digital systems and significant capacity issues in data warehousing	3.5A	Slow release of agreed funding through ICB impairs organisational implementation of agreed actions and delays improvements to speed of response to patient need.
3.3A	GIRFT response, has been inconsistent, missing an opportunity to implement best practice		
3.5A	Impact of operational pressures on ability to deliver financial plans.		
3.5A	Reintroduction of activity-based payments on the horizon with limited in-house capacity to support		
3.6A	Productivity has not recovered to pre-Covid levels and recovery funding is often non-recurrent in nature		

Action Log: (actions identified to achieve target risk score)				
Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
3.7A	Establish Recovery Group to oversee key strands of SOF 4 exit	CFO	March 23	Complete
3.5A/3.7A	Efficiency plan for 2023/24	CFO	June 23	In delivery, significant gap with developing mitigations.
3.2A	Systems improvements (Prevero, Tableau, Genesis)	DOpFin	Sept 23	Underway with risk of slippage
3.2A	Ensure full reconciliation of workforce and financial data	DOpFin	Sept 23	Still work in progress – now depends on additional input within Workforce Information Team
3.5A/3.7A	Financial comms campaign	Del Dir	Dec 22	Complete
3.2A/3.5A/ 3.7A	Develop MTFP in line with revised ICS principles and methodology (then informing BBF business cases)	DOpFin	Sep 23	First stage (baseline) complete – now aligned with key business cases. Next steps to overlay strategic interventions, BBF, digital, acute service strategy – external support (ICS level) in place
3.6A	Embed new accountability framework alongside new ops structure	CFO	Sep 22	Delayed – new ops structure to be embedded. Proforma accountability agreements developing through COO
3.4A	SFI refresh taking account of (8)	DOpFin	Jul 23	

Risk Summary					
BAF Reference:	**4. ESTATE**				
Objective:	Provide a fit-for-purpose estate that supports the delivery of safe, quality care.				
Internally Driven: ✓ Externally Driven:					
Responsible Executive:	Chief Finance Officer	**Committee:**	Finance, Performance and Digital Committee	**Last Updated:**	May 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jul 22	**Nov 22**	**Jan 23**	**May 23**	**2030**	**May 22**	Currently, the estate consists of around £60m worth of backlog maintenance (£120m with on-costs included) and the lack of adequate long-term capital funding to ensure this backlog is adequately addressed, is causing a failure to provide a fit-for-purpose estate that supports the delivery of safe, quality care. There are multiple impacts of this, including: unplanned cancellation of clinical services due to failure of aged plant and fabric; potential impact on ability to meet RTT and other contractual clinical standards; increased risk of harm to staff, patients or members of the public; increased estate maintenance revenue costs; and a risk of financial penalties due to clinical breaches and potential claims.
Likelihood	5	5	5	5	2	n/a	
Consequence	5	5	5	5	*5*	n/a	
Risk Score	25	25	25	25	10	n/a	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
4.1 A	The estate is heavily dilapidated with £60m of backlog reported to NHSEI through the Estates Return Information Collection (ERIC) in 2022 (half is high and significant risk)	4.1B	Authorisation of NHP infrastructure monies	4.1C	Increased demand on Workplace Team resources to maintain and improve the overall estate
4.2 A	Engineering infrastructure capacity, capability and resilience to maintain activity and safe environments	4.2 B	Oversight and scrutiny of estates statutory compliance systems by the Workplace Performance & Compliance Group (WPCG) regularly reporting to FPDC and Trust Board (and Risk Group where appropriate) ensuring this supports the Trust's SOF4 exit strategy	4.2 C	Increased demand on capital funding to deal with fundamental capacity and resilience issues, resulting in other issues identified within backlog not being deferred and operated on a run-to-fail basis
4.3 A	Appropriate, proportionate and timely level of funding	4.3 B	Capital investment administered by the Capital Investment & Delivery Group (CIDG)	4.3 C	Increased demand on capital funding to deal with fundamental capacity and resilience issues, resulting in other issues identified within backlog not being deferred and operated on a run-to-fail basis
4.4 A	Delivery of partnership developments (e.g. Health and Wellbeing Centres) with multiple agencies	4.4 B	Devon Plan	4.4 C	Not being able to support effective efficient services may lead to poorer quality patient outcomes and experience, and reduced ability to improve staff wellbeing and working lives.
4.5 A	Inability to improve and reconfigure the estate due to significantly aged infrastructure and insufficient funding impacting the delivery of clinical activity (e.g. lack of suitable clinical rooms to meet demand, insufficient office-accommodation to meet needs of all clinical and non-clinical teams)	4.5 B	Enhanced joint working between the Workplace Team and Clinical Teams to reduce the impact of any issues arising from premises incidents, again ensuring that Workplace Team outputs meet clinical needs to enhance patient experience and ensure SOF4 exit criteria is met where Workplace are an enabler	4.5 C	Not being able to support effective efficient services and meet the basic needs of Trust staff (e.g. through the provision of fit-for-purpose office accommodation) may lead to poorer quality patient outcomes and experience, and reduced ability to improve staff wellbeing and working lives

			Closer collaboration with both Infection Prevention and Control and Health and Safety Colleagues to ensure significant safety risks associated with the inability to improve or reconfigure the estate are mitigated where reasonably practicable		Constrained ability to improve environment at pace to meet clinical, staff and SOF4 exit needs Damage to the Trust's reputation both as a provider of care and an employer Potential for litigation due to claims from employees on the basis that basic, fit for purpose working accommodation is not being provided Constrained ability to effect strategic change and improvements to buildings and environments.
4.6 A	Aging premises, requiring additional servicing and repair	4.6 B	Pre-planned maintenance schedule across a 12-month period to ensure areas at higher risk of failure are proactively inspected, maintained and repaired. Regular oversight and signposting from local Workplace Teams to resolve premises and operational issues	4.6 C	Excess demand on capital programme and project management resource inhibiting the team's ability to deliver both capital programme and strategic projects effectively Increased demand on Workplace Team resources to maintain and improve the overall estate
4.7 A	Premises infrastructure and layout not efficient for modern healthcare needs.	4.7 B	Enhanced joint working between the Workplace Team and Clinical Teams to reduce the impact of any issues arising from premises incidents, again ensuring that Workplace Team outputs meet clinical needs to enhance patient experience and ensure SOF4 exit criteria is met where Workplace are an enabler	4.7 C	Not being able to support effective efficient services and meet the basic needs of Trust staff (e.g. through the provision of fit-for-purpose office accommodation) may lead to poorer quality patient outcomes and experience, and reduced ability to improve staff wellbeing and working lives Constrained ability to effect strategic change and improvements to buildings and environments.

Gaps in control/assurance

Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
4.6 A	Access to undertake essential maintenance is more difficult to plan without causing disruption to clinical services, which are at capacity	**4.1 C**	Insufficient capital funds available to address all high priority risks over a 5-year period
4.6 A	Equipment and plant continue to fail and due to age, cannot always be repaired	**4.3 C**	Insufficient funds available to address all high priority risks over a 5-year period
4.2 A	Due to the scale of potential failures, business continuity plans are unlikely to be able to respond to all eventualities.		

Action Log: (actions identified to achieve target risk score)				
Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
4.1A	Revised Estates Strategy and investment plan to manage aging infrastructure that connects current risk through to the completion of Building a Brighter Future	CFO	01/09/2023	When the revised strategic outline business case (SOC) for NHP is approved the outline business case (OBC) level Estates Strategy will be developed.
4.2 A	WPCG, Workplace Risk Group & CIDG continued prioritising of focus, mitigation and investment in high and significant risk areas	CFO	Ongoing	Ongoing governance in this space. New risk-based approach taken to 5-yearly capital planning process, using a combination of backlog information and known risks to prioritise investment.
4.3 A	Submit bids for capital funding at every opportunity for either Critical Infrastructure Risk funding or clinical specific initiatives that also indirectly reduce backlog and improve the estate and patient environment	CFO	Ongoing	• Endoscopy 4th room (funding approved July 2022) • TIF bid for day surgery theatres (target completion late 2023) • New RT/CT scanners – in progress • 5-year capital plan now agreed – focussed on six-facet survey and BBF as foundation
	Continued development of the approach to Pre-Planned Maintenance to ensure continuous compliance with statutory regulations and enhanced focus on known areas of failure	CFO	05/06/2023	Complete – PPM schedule developed for next twelve months, covers statutory requirements and enhanced maintenance in areas of known risk/increased likelihood of asset failure – 100% completion rate for all pre-planned maintenance activity in January, February, March and April.

Risk Summary					
BAF Reference:	**5. OPERATIONS AND PERFORMANCE STANDARDS**				
Objective:	To deliver levels of performance that are in line with our plans and national standards to ensure provision of safe, quality care				
Internally Driven: ✓	Externally Driven:				
Responsible Executive:	Chief Operating Officer	**Committee:**	Finance Performance and Digital Committee	**Last Updated:**	May 2023

BAF Risk Scoring

Current Position					Target Position	Year on Year	Rationale for Risk Level
	Jul 22	**Nov 22**	**Jan 23**	**Mar 23**	**April 24**	**May 22**	Consequence: Performance Risk - Failure to meet professional standards or statutory requirements. Likelihood: If the activity continues without controls in place, there is a strong possibility the event will occur as there is a history of frequent occurrences.
Likelihood	4	5	5	4	3	n/a	
Consequence	5	4	4	4	4	n/a	
Risk Score	20	20	20	16	12	n/a	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		Mitigating Factors (internal controls):		Impact of risk occurring:	
5.1.A	Imbalance between time of emergency admissions and discharges	5.1.B	Daily Control meetings to align daily discharges with daily admissions. Work programme of transformation improvement team in respect of urgent care recovery plan. UEC Board improvement programmes overseen by Trust Recovery Board	5.1.C	Delays in progressing patient decisions resulting in delays in treating patients both internally and externally (ambulance availability)
5.2.A	Insufficient capacity in Care Home and Domiciliary care market	5.2.B	Work programme of transformation improvement team in respect of urgent care recovery plan. UEC Board improvement programmes overseen by Trust Recovery Board Agreement on funding arrangement to incentivise market development.	5.2.C	Increased number of patients with no criteria to reside and reduced bed capacity for emergency and elective patients leading to an inability to treat patients in a timely way resulting in harm.
5.3.A	Continued infection outbreaks resulting in reduced bed capacity and ability to move patients to the right bed	5.3.B	Daily Control meetings include IPC representatives who work with operational staff to maximise bed capacity while ensuring safe care. Reviews of IPC controls to ensure alignment with national guidance.	5.3.C	Misalignment of bedded capacity resulting in increased LOS and bed occupancy resulting in delays to treatment and harm
5.4.A	Insufficient internal and externally sourced capacity to manage elective demand	5.4.B	Work programme of transformation improvement team in respect of planned care recovery plan. Planned Care Board improvement programmes overseen by Trust Recovery Board. Weekly PLT review meetings to progress patient pathway for Cancers and Electives. Tier 1 Regional Support . Regional Mutual Aid including access to Nightingale Hospital Exeter.	5.4.C	Failure to deliver on SOF4 exit criteria resulting in reduced organisational control

5.5.A	Inadequate information and data analysis to respond to emerging threats.	5.5.B	Information and Performance are members of the Planned Care Board and UEC Board improvement programmes overseen by Trust Recovery Board and engage with requests to deliver required information.	5.5.C	Misalignment of capacity resulting in delays to treatment and harm
5.6.A	Low skill level of staff in managing non-elective and elective demand	5.6.B	Weekly Manager's Grand Round training programme. Restructure of operational and accountability framework	5.6.C	Impaired management capacity to progress improvement and daily operational work resulting in disengagement from clinical staff and poor implementation of agreed actions.

Gaps in control/assurance

Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
5.1.A	Appropriately assessed and agreed job plans are required to ensure resources are directed most effectively at the key areas for operational delivery	5.2.A	An unstemmed decline in available workforce to ensure sufficient capacity for patients no longer needing acute care reduces bed capacity for emergency and elective patient demand.
5.5.A	Inadequate information systems result in poor decision making and difficulties in accurately determining drivers for performance.	5.4.A	Slow release of agreed funding through ICB impairs organisational implementation of agreed actions and delays improvements to speed of response to patient need.
5.6.A	Insufficiently skilled management resource impairs swift analysis of and response to operational issues.		

Action Log: (actions identified to achieve target risk score)

Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
5.1.A	Deliver agreed policies and procedures to facilitate adherence to early discharging and weekend discharging	COO	Jun 23	Earlier weekday discharges occurring but not complete. Weekend Discharges action review and development in place.
5.1.A	Clarification of use of emergency care capacity to facilitate increased ambulatory SDEC	COO	May 23	Space identified. Clinical Discussions planned.
5.2.A	Refining allocation of funding to support development of care home and domically care markets	COO	Mar 23	Complete
5.2.A	Ensure effective partnership working at regional and local level	COO	Mar 23	Complete
5.3.A	Changes to IPC arrangements to be in line with national guidelines	COO	Mar 23	Complete
5.4.A	Establishment of TSD UEC Board and Planned Care Board to focus actions on delivery	COO	May 23	UEC Board TOR agreed. Planned Care Board in development.
5.4.A	Establishment of outsourcing and Insourcing capacity to manage demand	COO	Apr 23	Funding clarified, contracts in train, additional capacity discussions underway
5.5.A	Development of new EPR and data system	DT&P	Jan 25	Funding streams in development
5.6.A	Operational Restructure	COO	Jun 23	Structure completed, plans for implementation in development.

Risk Summary					
BAF Reference:	**6. DIGITAL AND CYBER RESILIENCE**				
Objective:	To provide clinical and administrative IT systems, and supporting digital infrastructure, that efficiently and cost-effectively meet the Trust's clinical models of care and key business needs, and support the confidentiality, integrity and availability requirements of a modern health and care provider delivering 24 * 7 * 365 services.				
Internally Driven: ✓ Externally Driven:					
Responsible Executive:	Director of Transformations and Partnerships	**Committee:**	Finance, Digital and Performance Committee	**Last Updated:**	May 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jul 22	**Nov 22**	**Jan 23**	**May 23**	**April 24**	**May 22**	Current IT systems and supporting infrastructure will not meet the current of future business need. The current likelihood has increased for two reasons, firstly the level of known vulnerability of the PAS / LIMS systems which will cease to be supported from 2024. National security vulnerabilities (such as Log4shell) are significant concerns to IT systems globally, additionally the situation in Ukraine has increased the likelihood of nation-state level cyber-attacks. The current consequence is scored at 5 as the reliance on digital systems in the delivery of business processes and clinical services is high and the impact of a cyber-attack could be catastrophic (for example, extended loss of essential service in more than one critical area)
Likelihood	5	5	5	5	5	n/a	
Consequence	5	5	5	5	5	n/a	
Risk Score	25	25	25	25	25	n/a	

Risk Scoring Analysis					
Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
6.1A	Failure to meet cyber security or information governance standards Cyber-attack – local or global e.g. malware / ransomware / zero-day threats	6.1B	Data Security and Protection Toolkit in place with Standards Met which include compliance to Cyber Essentials Process in place to review and respond to national NHS Digital CareCERT notifications Anti-virus, anti-malware software in place. All devices end user (laptops and desktops) and servers are enrolled in Microsoft ATP (advanced threat protection software) 2022/23 capital plan, including external Frontline Digitisation funding An 'onion layer' of countermeasures and an ongoing investment in refreshing and adding to these to address an ever-evolving threat	6.1C	A shut down of business-critical IT systems would have a significant detrimental impact on patient care and access. Loss of certain IT systems for more than 18 hours would require the Trust to not only stop UEC pathways for new patients, but also displace current inpatients and planned care to neighbouring trusts Not being able to support effective clinical services may lead to poor quality patient outcomes and patient experiences Damage to the Trust's reputation e.g. Loss of local services, IG Breach, Financial loss
6.2A	Computer hardware risks Key infrastructure components failing due to age/lack of support	6.2B	IT Infrastructure Action Plan in place, supported by 2022/23 £8.5m capital funding from Frontline Digitisation IM&T Prioritisation risk matrix in place to ensure that investment is made into the most critical areas	6.2C	A shut down of business-critical IT systems would have a significant detrimental impact on patient care and access. Loss of certain IT systems for more than 18 hours would require the Trust to not only stop UEC pathways for new patients, but also displace current

					inpatients and planned care to neighbouring trusts Not being able to support effective clinical services may lead to poor quality patient outcomes and patient experiences Damage to the Trust's reputation e.g. Loss of local services, IG Breach, Financial loss
6.3A	Failure to secure funding to implement an EPR EPR solution not being sufficiently flexible to deliver level of clinical transformation required	6.3B	EPR business case at OBC stage, with a clear route to national funding Trust has an approved Digital strategy that aligns with the delivery of the Trust Strategy and the ICS digital strategy Regain & Renew/SOF4 Exit transformation priorities being aligned with change/transformation driven by the EPR implementation Clinical pathways being aligned across organisations, enabling standardisation in a shared EPR The Trust Board has undertaken the NHS Providers Digital Boards Programme and has a NED with a specialist expertise in Digital	6.3C	Inability to maintain 'many systems' approach for both technical (complexity) and financial reasons, leading to limited support for business needs Inability to participate in System-level clinical pathways, reducing or eliminating the opportunities to support fragile/inefficient clinical services, and risking fundamental Trust operations
6.4A	End of software product life (e.g. PAS, LIMS)	6.4B	2022/23 capital plan, including external Frontline Digitisation funding Critical systems identified with clinical and corporate colleagues Interim proposal to mitigate short term support concerns for LIMS with longer term solution in discussion with ICS IM&T Prioritisation risk matrix in place to ensure that investment is made into the most critical areas	6.4C	A shut down of business-critical IT systems would have a significant detrimental impact on patient care and access. Loss of certain IT systems for more than 18 hours would require the Trust to not only stop UEC pathways for new patients, but also displace current inpatients and planned care to neighbouring trusts
6.5A	Prohibitive cost of software licensing Increasing change of software licensing to subscription models	6.5B	2022/23 capital plan, including external Frontline Digitisation funding Procurement of an EPR with a high level of functional scope that reduces the number of siloed IT systems required Procurement/implementation of shared IT systems between organisations Maximising use of nationally provisioned IT systems	6.5C	IT to support current or future business needs outstrips the Trust's capacity to finance it
6.6A	Computer infrastructure environmental risks	6.6B	2022/23 capital plan, including external Frontline Digitisation funding System approach to data centre provision being formulated	6.6C	A shut down of business-critical IT systems would have a significant detrimental impact on patient care and access. Loss of certain IT systems for more than 18 hours would require the Trust to not only stop UEC pathways for new patients, but also displace current inpatients and planned care to neighbouring trusts
6.7A	Computer patching risks	6.7B	2022/23 capital plan, including external Frontline Digitisation funding	6.7C	A shut down of business-critical IT systems would have a significant detrimental impact on patient care and access. Loss of certain IT

					systems for more than 18 hours would require the Trust to not only stop UEC pathways for new patients, but also displace current inpatients and planned care to neighbouring trusts

Gaps in control/assurance

Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
6.3A	National funding has not yet been fully secured to deliver the EPR; there is no ICS funding available to fund an EPR	6.3A, 6.4A	The national timetable for securing national investment is currently too lengthy and will lead to interim IM&T risk
6.1A, 6.2A, 6.4A, 6.5A, 6.6A, 6.7A	Longer term capital and revenue investment programmes are required to ensure that digital infrastructure refresh cycles, improvements and maintenance are sustained	6.1A, 6.2A, 6.3A, 6.4A, 6.5A, 6.6A, 6.7A	Inability for the System approach, and the provider-level governance to support it, to a common, single shared IM&T service to be agreed and implemented will reduce ability to mitigate the risk
6.1A, 6.4A	In year reduction in funding for digital will reduce intended progress around cyber-security measures and jeopardise tactical replacement of end-of-life systems		
6.4A, 6.5A	There are a large number of IM&T systems that require developments of procurement, that are highlighted as a significant risk on the digital prioritisation matrix for which there is no current capital or revenue availability		
6.3A	Sufficient capacity within clinical, operational and corporate services to deliver a large scale EPR implementation		
6.1A, 6.2A, 6.3A, 6.4A, 6.5A, 6.6A, 6.7A	Short-term requirement to achieve CIP without real efficiencies deliverable through a shared IM&T service will compromise the ability to mitigate the risk		

Action Log: (actions identified to achieve target risk score)

Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
6.1A, 6.2A, 6.4A, 6.5A, 6.6A, 6.7A	Ensure that all high-risk IM&T investment is programmed into the capital and revenue business planning process at both Trust and ICS level	DTP/CFO	1.4.2023	Secured for 2022/23 with additional external capital.
6.3A	Successfully secure EPR funding from the national team	DTP	1.12.2022	Secured – subject to FBC but all key criteria including affordability now met and process for regional/national OBC approval underway.
6.1A, 6.2A, 6.3A, 6.4A,	Ensure sustainable delivery of all key systems by working in partnership with the ICS Digital Leadership	DTP	1.4.2023	Fully engaged with all ICS partner organisations. A 'system-first' approach is being pursued.

6.5A, 6.6A, 6.7A				
6.4A	Mitigate LIMS support risk by migrating the database onto a supported platform and financing extended support for the servers that are unable to be upgraded. In parallel, initiate a competitive bid procurement, in collaboration with the ICS, for a replacement LIMS as an alternative should it be clear that an EPR and any associated LIMS would not be in place before the end 2024.	DTP	1.2.2023	Progressing to plan.

Risk Summary					
BAF Reference:	**7. BUILDING A BRIGHTER FUTURE (BBF)**				
Objective:	To develop and implement the New Hospital Plan (Building a Brighter Future) ensuring it meets the needs of the local population and the Peninsula System				
Internally Driven: ✓ Externally Driven: ✓					
Responsible Executive:	Director of Transformation and Partnerships	**Committee:**	Building a Brighter Future Committee	**Last Updated:**	May 2023

BAF Risk Scoring

Current Position					Target Position	Year on Year	Rationale for Risk Level
	Aug 22	**Nov 22**	**Jan 23**	**March 23**	**May 23**	**May 22**	
Likelihood	3	3	3	3	3	n/a	The availability of a national funding for cohort 4
Consequence	5	5	5	5	5	n/a	
Risk Score	15	15	15	15	15	n/a	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		Mitigating Factors (internal controls):		Impact of risk occurring:	
7.1A	Availability of central funding and political support to the original programme	7.1B	BBF programme office and capital development team are working through a range of different scenarios should capital funding not be made available at a national level.	7.1C	Should funding not be made available the Trust still requires significant capital investment on its estate infrastructure and as such, would then pursue one of the scenarios previously highlighted.
7.2A	Availability of the specialist support within the BBF programme team to deliver a project of this magnitude and complexity.	7.2B	The Programme office has a well-developed recruitment and retention strategy that highlights requirement for external specialist support in areas such as design, cost advise and legal services. The team will be able to draw on this expertise as required.	7.2C	The costs associated with the external support would be detailed in any 'seed' funding allocation and would be agreed with the national team in advance of the requirement for the specialist support
7.3A	Timeline for programme completion	7.3B	The programme office has developed a range of scenarios associated with the delivery of the programme and these have been shared with the BBF Committee	7.3.C	The inflationary pressures of the programme will continue to increase without the required clarity from the national team on timetable and funding allocation. These costs would be funded centrally.
7.4A	National team resourcing the 'seed' allocation not in line with our timetable	7.4B	This matter is nearing resolution for 23/24 which will confirm the allocation of £1.06m. This figure will need to be supplemented with a further £361,000 from the national team to support the completion of the Site Enabling FBC. The national team are aware of the Trust requirement in this regard.	7.4.C	The Trust would not able to complete the Site Enabling Full Business Case to the required fundamental criteria standards, and the programme would be delayed as a result
7.5A	Planning the clinical and operational support within the Trust to support the delivery of the programme plan from 1/4/23	7.5B	This matter is under review with the SRO and Health and Care Strategy Director and will form part of the 'seed' funding requirements for 23/24.	7.5C	The ability of the Trust team to deliver the BBF programme will be reviewed by the NHP national team, so in order to

					avoid 'step in' it is essential that the programme is able to benefit from the required clinical and operational support.
7.6A	Inflationary cost pressures in preferred option	7.6B	The national team will ensure that the inflationary pressures associated are funded through the 'target cost modelling' review that will be undertaken as part of the approvals process.	7.6C	The impact would be significant as the Trust would be required to reduce the scope of the construction project in order to absorb the inflationary pressure on the project.
7.7A	Alignment of strategic direction with the acute services review in Devon and any associated consultation process.	7.7B	The Programme office is sighted on the requirement for the Outline and Full Business Case(s) to be consistent with the recommendations made within the Provider Acute Sustainability Programme.	7.7C	The business case(s) would not be supported by the One Devon ICB and as a result would not be able to secure approval from the Regional office. The programme would be delayed as a result.
7.8A	Support from the One Devon ICB for the business cases required to secure approval	7.8B	The Programme office will be developed an engagement strategy for ensuring that the business cases are fully supported by the ICB in a timely manner.	7.8C	The business case(s) would not be supported by the One Devon ICB and as a result would not be able to secure approval from the Regional office. The programme would be delayed as a result.
7.9A	Ability to deliver the site enabling and support services elements for the project within the timetable to enable main construction commencing in 2025	7.9B	The Trust are not able to progress the scheme without the required support from the national new hospital team. The national team have confirmed that a funding announcement will confirm both allocation and timetable.	7.9C	The programme office had confirmed that the risk associated with the programme not being able to complete by 2030 are now seen as high.
7.10A	Availability of contractors and materials to complete programmes of work and potential lengthy lead in times.	7.10B	Capacity does need to be developed in order for the scale of the investment to be delivered, and this is being progressed at a national level.	7.10C	The development of the hospital 2.0 concept will mean that this risk is held at a national level. Therefore, the cost and time implications of this issue are being managed centrally

Gaps in control/assurance

Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
7.1A	• Slippage in national programme timeline and the release of seed funding has an implication for the following: ○ Detailed design for site enabling ○ Integrated assurance strategy for programme ○ Workforce planning	7.1B	External • Lack of assurance in relation to NHP cohort 4 capital funding and timetable at a national level • Due to the delays in securing the approval to the National programme Business Case, the NHP timetable subject to regular change.

Action Log: (actions identified to achieve target risk score)

Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
7.1A	Ensure that the ICS can reach agreement by March 2023 on whether there are any requirements for public consultation prior to the presentation of the Outline Business Case	DTP	March 23	Complete
7.2A	Trust to secure a further £661k 'seed allocation' resource for 2022/23 to support the delivery of the site enabling case. This requirement will need to be delivered by January 2023	DTP	January 23	Additional 'seed' funding not received in 2022/23. The BBF team will be able to submit application for further seed funding to complete site enabling FBC

				following the approval of the programme business case
7.3A	Strategic outline case to be completed by August 2022	DTP	August 22	Complete
7.4A	Strategic outline case to be approved by Trust Board in September 2022	DTP	September 22	Complete
7.5A	Strategic Outline Case to be approved at a national level by January 23	DTP	March 23	National Programme Business Case now approved. Position in relation to SOC approval still to be confirmed
7.6A	Site Enabling business case(s) to be completed and submitted for Trust Board approval	DTP	• Outline Business Case – Jan 23 • Full Business Case June 23	The site enabling case have been delayed subject to the approval of the National Programme Business Case. The site enabling OBC business case is now delayed until the national funding allocation and timetable has been confirmed
7.7A	Site Enabling business case to be approved and construction work on this element of the project will have commenced by 31st October 2023	DTP	October 23	This will be dependent on the approval of site enabling works business case(s) which will be determined by the National NHP team. .
7.8A	Seed allocation for 23/24 to be secured with sufficient resource to enable the completion of the OBC in 23/24. The funding will be secured by 31st March 2023	DTP	Mar 23	Complete

Risk Summary					
BAF Reference:	**8. TRANSFORMATION AND PARTNERSHIPS**				
Objective:	To implement Trust plans to transform services, using digital as an enabler, to meet the needs of our local population				
Internally Driven: ✓ Externally Driven: ✓					
Responsible Executive:	Director of Transformation and Partnerships	**Committee:**	Finance, Performance and Digital Committee	**Last Updated:**	May 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jul 22	**Nov 22**	**Jan 23**	**Mar 23**	**March 24**	**May 22**	Significant challenges in Quality, Safety, Performance and Financial performance requires the delivery of a large-scale transformation programme with benefits delivered in 23/24. Recruitment to the Improvement and Innovation team capacity is progressing but there remains a lack of capacity and capability across the Trust and ICS to deliver these changes. A significant and ambitious programme of change is required across the ICS and this is in addition to Trust wide schemes, placing additional pressure on scarce improvement expertise. There isn't a unified and single approach to a standardised and co-ordinated programme of change, implemented reliably across the ICS. Basic IT and estate infrastructure is poor and hampers significant levels of transformation at pace
Likelihood	5	4	4	4	3	n/a	
Consequence	4	4	4	4	3	n/a	
Risk Score	20	16	16	16	9	n/a	

Risk Scoring Analysis					
Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
1.1A	Inadequate improvement and innovation capacity within the Trust	1.1B	Oversight of recruitment through new Transformation Group.	1.1C	Harm to patients arising from services not delivering most effective care
1.2A	Lack of ICS wide improvement capability to create an engine room for system change	1.2B	Peninsula Acute Provider Collaborative Board mandated the development of an investment proposal.	1.2C	Trust does not deliver required improvements at pace to meet SOF4 exit criteria
1.3A	Lack of operational and clinical leadership capacity	1.3B	Oversight of delivery of the outcomes from coaching programme, delivered through Transformation Group and planned to be reported to BBF Committee from July 2023	1.3C	Regulatory action for safety, quality and performance standards
1.4A	IT infrastructure is inadequate for significant transformation	1.4B	EPR Digital business case in approval pipeline with National team, oversight through Exec Advisory Group & BBF committee	1.4C	Low morale and increasing fragility in the workforce as a result of moral injury
1.5A	Estate infrastructure is inadequate for significant transformation	1.5B	FPDC oversight of TIF capital developments and opening of new AMU. BBF committee oversight of NHP programme delivery	1.5C	

1.6A	Too many competing priorities across the ICS and Trust	1.6B	Regain and Renew plan provides a framework for focus on most critical Trust / ICS priorities – monitored by TMG		
1.7A	Operational and Clinical ownership and delivery of all transformation portfolios	1.7B	Executive oversight of delivery of Transformation Programmes within their governance oversight frameworks (e.g Safety and Quality to QIG/QAC) oversight of overall programme of change proposed will sit with new BBF Committee TOR – implementation in July 2023.		

Gaps in control/assurance

Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
1.3A	Deficits in operational management and clinical capacity for improvement, not yet addressed through the full implementation of the new governance and leadership structure	1.3A	ICS PASP programme delivery under-resourced
1.3A	Pace of capability building is consistent with early phase of investment profile, does not provide adequate capacity for significant transformation in 23/24	1.3A	ICS Fragile services delivery under-resourced
1.4A	IT infrastructure investments will not delivery the level of digital capability or business intelligence to drive significant levels of transformation in 23/24 – due to implementation of EPR	1.2A	Clear plan that links ICS recovery and medium term 3 year plan needs to be developed and agreed

Action Log: (actions identified to achieve target risk score)

Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
1.1A	Recruit to full establishment of business case	DTP	Oct 2023	70% of posts recruited to. Further posts advertised.
1.7A, 1.7B	All transformation portfolios led by Executive leads and delivering against agreed milestone actions with robust monitoring	DTP	Sept 2023	
1.3A	Capability programme delivery for 23/24	DTP	Mar 2024	
1.3A	Delivery of new leadership structure and accountability framework	COO	TBC	To be linked to COO/CNO workplan
1.2B	Produce business case for ICS fragile services engine room of capacity	DTP	June 2023	

Risk Summary					
BAF Reference:	**9. INTEGRATED CARE SYSTEM**				
Objective:	Create the conditions for collaborative working and delivery of shared goals in partnership with the ICS				
Internally Driven:	Externally Driven: ✓				
Responsible Executive:	Director of Transformation and Partnerships	**Committee:**	Board of Directors	**Last Updated:**	May 2023

BAF Risk Scoring						
Current Position				**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Nov 22	**Jan 23**	**May 23**	**April 24**	**May 22**	The Trust partnerships across the ICS are critical in securing improvements in the delivery of services for local people. The risk in sustaining the delivery of clinical and back office services, has been a priority for the Trust, however there have been multiple attempts to develop the level of collaborative partnerships that have failed to deliver the appropriate level of transformation. The ICS Acute provider Collaborative Programme has greater level of formal Board sign up and commitment. The Trust is fully engaged in the delivery of this strategic change.
Likelihood	4	4	4	2	n/a	
Consequence	4	4	4	4	n/a	
Risk Score	16	16	16	8	n/a	

Risk Scoring Analysis					
Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
1.1A	PASP programme progress delayed through recent industrial action	1.1B	Proposal for change developed for presentation to Trust Boards agreed by PAPC	1.1C	Unable to influence the direction of change in the local health economy.
1.2A	Internal capacity to ensure that teams are supported to fully engage in the development and delivery of system solutions	1.2B	Oversight through new Transformation Group. Engagement delivered through Trust Strategy Group and TMG	1.2C	Mis-alignment of system changes with the needs of the community and poor-quality outcomes/patient experiences.
1.3A	A transformation plan that outlines a 3 year plan from immediate recovery actions to broader transformational change is not developed and owned by all partners	1.3B	Proposal in development for discussion with Chair of ICB Strategy and Transformation Group,	1.3C	Delays in decision-making.
1.4.A	Leadership and programme management capacity to deliver significant transformational change, including PASP, Fragile Services and back office collaboration	1.4B	PAPC commissioned work to address additional resource requirement	1.4C	Damage to the Trust's reputation.
1.5A	Challenging timelines for engagement to optimise delivery	1.5B	PASP oversight of engagement plan, Trust Strategy Group will oversee implications, wide engagement through TMG, and new BBF Committee provides oversight		
1.6A	Lack of LCP clear mandate and resourcing from the ICB, exacerbated by the ICB restructure	1.6B	Escalated to ICB		
1.7A	Oversight of Partnerships agenda needs to be strengthened	1.7B	Proposal to extend the scope of BBF Committee to provide oversight for ICS partnerships agenda. Intention to seek approval for implementation July 2023		

Gaps in control/assurance			
Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
1.6A	Realignment of capacity for delivery of ICS partnership ambitions	1.6A	ICS governance structures are emerging and decision making at organisation, place and ICS level is ambiguous at times.
1.3A	Plans not of sufficient maturity to understand all implications for the Trust	1.6A	Devon System Health and Care Strategy not mature
1.3A	System planning and delivery arrangements not yet mature	1.6A	Maturity of relationships and collaborative working arrangements developing
1.6A	Lack of capacity	1.7A	Development of formal reporting process through system and organisational governance
		1.7A	Implications of revised governance arrangements on FT governance and decision making
		1.3A	Financial Plan/Devon System Health and Care Strategy

Action Log: (actions identified to achieve target risk score)				
Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
1.1A	Provide system leadership in the development of the PASP proposal	CEO	May 2023	
1.3A	Provide system leadership in the Devon Recovery plan	CEO	Ongoing	
1.4A	Ensure Executive leadership capacity for the system aligns with Trust requirements for internal delivery	CEO	Ongoing	
1.4A	Involvement and influence of outputs from ICS Clinical Leadership Group.	CMO/CN	Ongoing	
1.2A	Continued and regular communication and engagement with staff, CoG and stakeholders (Executive team).	CEO	Ongoing	
1.2A	Regular meetings and relationship building with primary care and ICS leaders to ensure effective communication and influence with regards to ICP.	DTP	Ongoing	

Risk Summary					
BAF Reference:	**10. GREEN PLAN/ENVIRONMENTAL, SOCIAL AND GOVERNANCE**				
Objective:	To deliver on our plans and commitments to environmental sustainability and decarbonisation, as set out in the Trust Green Plan.				
Internally Driven: ✓ Externally Driven:					
Responsible Executive:	Deputy Chief Executive supported by Director of Environment	**Committee:**	Board	**Last Updated:**	May 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jul 22	**Nov 22**	**Jan 23**	**Mar 23**	**Sept 23**	**May 22**	There is a risk that the Trust will fail to meet Green Plan objectives and statutory sustainability targets due to insufficient capital or revenue resources, and lack of prioritisation in decision making. This could lead to: Delay to the decarbonisation of our estate, inability to meet the NHS Net Zero Carbon target deadlines and potential conflict between Trust sustainability commitments and other Trust priorities. Damage to public confidence, statutory non-compliance, regulatory breaches.
Likelihood	n/a	n/a	n/a	4	3	n/a	
Consequence	n/a	n/a	n/a	3	2	n/a	
Risk Score	n/a	n/a	n/a	12	6	n/a	

Risk Scoring Analysis					
Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
10.1 A	Infrastructure across the estate is aged and not environmentally efficient.	10.1 B	Utilisation of capital allocation to replaced assets beyond economical repair. The replacement process considers the opportunity for replacement with environmentally efficient alternatives	10.1 C	Trust will not meet its decarbonisation commitments as outlined in the Green Plan Reputational damage for the Trust
10.2 A	Modern, renewable methods of powering sites across the estate have not been routinely employed	10.2 B	Utilisation of capital allocation to replaced assets beyond economical repair. The replacement process considers the opportunity for replacement with environmentally efficient alternatives Head decarbonisation plan has been developed to determine the optimal decarbonisation pathway	10.2 C	Trust will not meet its decarbonisation commitments as outlined in the Green Plan Reputational damage for the Trust Trust will continue to operate using assets which do not deliver environmental or financial efficiency
10.3 A	The existing infrastructure is aged to a point where assets cannot be easily added or replaced with environmentally efficient ones (due to the condition of the infrastructure on to which they would be attached)	10.3 B	NHP will address some of the underlying issues in relation to the age and capacity of the current infrastructure, allowing for more environmentally efficient ad-ons	10.3 C	Trust will not meet its decarbonisation commitments as outlined in the Green Plan Reputational damage for the Trust Trust will continue to operate using assets which do not deliver environmental or financial efficiency

10.4 A	Sufficient focus and priority is not given to the implementation of the Trust Green Plan as resource availability is limited and focussed on operational delivery and recovery	10.4 B	Trust Green Plan outlines its environmental mission and associated plans and has been shared with Trust staff Sustainability and Wellbeing Group has been setup, led by the Workplace Director focussed on enhancing engagement and input into the green agenda across. This is connected to locality and Devon-wide sustainability plans. Net Zero lead appointed to board	10.4 C	NHS activities are responsible for 6.3% of England's total carbon emissions, and 5% of total air pollution. This has direct consequences for health-related spending Reputational damage for the Trust

Gaps in control/assurance

Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
10.4A	Lack of dedicated resource and integrated working to deliver and identify initiatives in specialist areas, such as supply chain and clinical activities.	10.4A	Uncertain funding to implement decarbonisation initiatives particularly where these may cause a cost pressure.
10.4A	Lack of sustainability awareness at TSDFT from potential new recruits, new starters and existing staff, such as Green Plan objectives and expectations from staff whilst working at the Trust	10.4A	Uncertainty around when and what measures need to be implemented to achieve NHS Carbon Footprint Plus NZC targets, particularly for supply chain emissions.

Action Log: (actions identified to achieve target risk score)

No. Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
10.3A/10.4A	Develop a robust communication plans for staff and embed ownership	CFO	01/08/2023	Sustainability and wellbeing group (SWBG) stood up Green champions currently being appointed 90-day plan as part of SWBG in place
10.4A	Finalise plans for all target actions	CFO	01/05/2023	Will be led by the SWBG
10.3A	Develop dashboard of measures	CFO	01/08/2023	Will be led by SWBG
10.4A	Embed clear sustainability measures across supply chain network	CFO	01/01/2024	Ongoing – further work to engage with procurement team required
10.4A	Climate change impact assessment for Trust owned and leased premises	CFO	01/08/2023	Shortlisting contractors – further updates in July 2023
10.2A	Promote and support the use of electric cars among staff members	CFO	01/03/2024	Forms part of green travel plan and a key focus for SWBG
10.2A	Place opportunity to market for provision of locally generated renewables directly to main hospital site	CFO	01/06/2023	Completed – published to market 18th May 2023.

	Attain Biodiversity Benchmark from The Wildlife Trust in recognition of habitat preservation on site	CFO	01/04/2025	Work to enhance habitat preservation methods has begun (bug hotels, wildseed meadows etc), biodiversity policy under construction and benchmark framework provided

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DATIX RISK MODULE REPORT

(Exceptions highlighted in Yellow.)

ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	Speciality	Risk Location	Title	Description Cause: Effect:	Consequence (Inherent / Initial)	Likelihood (Inherent / Initial)	Rating (Inherent / Initial)	Controls in place	Gaps in Control	Review due date	Consequence (Current)	Likelihood (Current)	Rating (Current)	Risk Progress Notes Last 3 entries minimum.	Consequence (Residual)	Likelihood (Residual)	Rating (Residual)
1083	01/01/2016	Corporate Level Risk	Estates	Karen Robertson	Jake O'Donovan	Chief Finance Officer (David Stacey)	Financial Risk	Estates Mngt	Site Non-Specific	Failure To Provide A Fit-For-Purpose Estate That Supports The Delivery Of Safe/Quality Care.	Cause: Lack of adequate long-term capital funding to ensure backlog maintenance is adequately addressed. Effects: A. Failure of aged plant and deteriorating building fabric, resulting in unplanned cancellation of clinical services. B. Potential impact on ability to meet RTT and other contractual clinical standards. C. Increased risk of harm to staff, patients or members of the public from failing infrastructure. D. Increased estate maintenance costs (revenue and capital) and risk of financial penalties due to clinical breaches. Linked to Risks: DRM ID No 2353 - Cellular Pathology Portacabin No Longer Fit for Purpose. (16) DRM ID No 2542 - Potential Failure of Theatres DSU 3 & Ophthalmology Ventilation Units. (16) DRM ID No 2720 - Leaking Roofs Across Torbay Hospital Site (20) DRM ID No 2718 - Inability To Expand Clinical Services Due To Lack Of Space.(15) DRM ID No 2719 - Chilled Water System Failure (16) DRM ID No 2836 - Telemetry System Upgrade. (Used for looking for causes of collapses & side effects of medication.) (16) DRM ID 3192 - Issues With Inadequate Lighting Sources at Torbay and Newton Abbot for Max Fac Outpatients (15) DRM ID 3193 - Clinic Environment For Max Fac Patients In Alternative Accommodation (15) DRM ID 3473 (20) Mortuary Capacity Consistently Exceeding 100% Standard Capacity DRM ID 2429 Ward Kitchens Environment in Acute and Community Settings in Need of Updating - 26 locations identified.(16)	Catastrophic	Almost Certain	25	1. Risk assessment, prioritisations and approval process in place to manage highest risks. Highest risk elements prioritised in the capital programme, as funding will allow. 2. Increased financial contingency built into capital programme to respond to unplanned critical estates failures. 3. Increased maintenance for key areas. 4. Business continuity plans in place to respond to potential loss of infrastructure. 5. Robust planned preventative maintenance regime in place. 6. Estates Planned Prevenative Maintenance performance and compliance status and critical failures reported and monitored monthly via Capital Infrastructure and Environment Group; Finance, Performance and Investment Committee; Infection Prevention and Control Committee; exceptions to Trust Board meeting. 7. Statutory Estates Roles and Responsibilities appointed and tracked monthly. 8. Annual review of mandatory and statutory systems compliance by externally appointed Authorising Engineer(s). 9. Board has approved annual capital programme based on actively considered risks versus maintaining a cash balance. 10. Trust has submitted Business Case for new acute hospital facilities.	1. Insufficient funds available to address all high priority risks over a 5-year period. 2. Equipment and plant continues to fail and due to age, cannot always be repaired. 3. Due to the scale of potential failures, business continuity plans are unlikely to be able to respond to all eventualities. 4. Access to undertake essential maintenance is more difficult to plan without causing disruption to clinical services, which are at capacity.	30/06/2023	Catastrophic	Almost Certain	25	[05/04/2023 12:57:05 Paul Hayman] Works for new CT_RT scanner commenced and Northcott Hall and Embankment demolished as part of early site clearance works for BBF. [17/01/2023 14:02:52 Paul Hayman] BBF Project aware considering impact of retention of Old Hospital / Podium blocks which are old and require significant refurbishment. 5-10 Year Capital plan will also help to address Backlog elements. AMU completed and scoping work for TIF and Endoscopy units underway to provide 4,500 additional cases per year - (Ophthalmology). Consideration of allocation of funds for patient / colleagues experience and safety. To be reviewed end March 2023. [05/05/2022 08:46:54 Paul Hayman] Significant Capital Project work helping to improve system resilience, however, significant issues remain to be addressed. Backlog Capital Investment overall for 2021-22 at £5.963m, plus a further £1.15m investment in ongoing AMU, MRU and ED Phase 2 works. Provisional Backlog Figure for Acute site now stands at £52.2m. Further bid in train for 2022-23 capital round.	Catastrophic	Possible	15
1159	18/09/2012	Corporate Level Risk	IT Operations and Informatics	Gary Hotine	Adel Jones	Director of Transformation and Partnership (Adel Jones)	Information and Communications Technology Risk	Administration	Site Non-Specific	Current IT Systems And Infrastructure Will Not Meet Future Demands.	Cause: Lack of available capital funding to spend on IT infrastructure and IT Systems. Effects: A. Failure of key IT infrastructure and IT systems resulting in impact on service delivery. B. Lack of cyber security investment may expose the Trust to risk of fines equal to 4% of Turnover or £ capped at £17M following a successful cyber-attack similar to the May 2017 "Wannacry" attack. NHS Digital (for NHS England) are highlighting the number of CareCERTs they have mandated that Trusts have mitigated. C. Inability to meet future statutory or regulatory requirements around reporting. D. Possible impact on clinical systems impacting patients /service users. E. Failure to meet future CQC registration requirements unless the Trust can achieve "minimum digital functionality" as detailed in the Accelerating Digital Healthcare white paper of October 2020. F. Inability to achieve the Government's requirement (2022) of 100% having or implementing EPRs by 2025. Note: Our plans are predicated on an on-going capital investment plan to ensure optimum performance of service. Linked to Risks:	Catastrophic	Almost Certain	25	1. ICT Strategy with supporting policies and procedures e.g. Business Continuity Plans. 2. Well-developed IM&T service, linked strategically with ICS digital delivery strategy/plans. 3. Upgrade current key systems to mitigate effect. 4. IT Projects and Programme governance in place and linked to organisation's executive groups. IM&T Group reports, reports to Finance, Performance and Digital Committee. 5. Investment planning to maintain and develop infrastructure capacity. 6. Continued IM&T Strategic investment. Risk assessment based on need and prioritised accordingly. 7. Continual review of emerging technology and adoption where suitable and funding permits. 8. Minimising critical failure. 9. Management of failure. 10. Internal audit reviews. 11. Actions following Information Commissioners Office visit (Sept 2015 & follow ups in 2018 and 2022). 12. Retention of individuals or contractors with requisite skills and experience to provide tactical software enhancements to plug gaps in legacy systems. 13. PC deployment programme. 14. Replacement data network. 15. Plan to invest significantly in IT linked to digital strategy as a key enabler. Supporting Digital Strategy adopted by Trust Board in September 2020. EPR OBC approved in 2021. FBC approval	Ctrl's 5.6.7.13 & 14 Insufficient funds allocated to reduce risks (2022 example - inability to fund the £1.4m EUD scheme). Ctrl 15 delivery of the key recommendations in the digital strategy	01/10/2023	Catastrophic	Almost Certain	25	[09/05/2023 10:19:44 Gary Hotine] Risk scoring reviewed [26/09/2022 18:40:05 Gary Hotine] Reviewed and updated controls and gaps in controls. [06/09/2022 10:35:49 Joshua Langdon] Network & Server infrastructure is currently in a good state and is supported by both supplier and HIS. Desktop devices (EUD) are now coming up to the end of their warranty period. Capital proposal for £1.4m CapEx has been rejected for FY 2022/23 which will mean that we will be running 'Warranty +1' which introduces additional risk if our devices experience failure. Furthermore, our current Desktop device estate is currently not fit for purpose based on the technical requirements for any future EPR (Electronic Patient Record) system. This risk has been highlighted to BBF and the Capital Planning group.	Major	Possible	12

ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	Speciality	Risk Location	Title	Description Cause: Effect:	Consequence (Inherent / Initial)	Likelihood (Inherent / Initial)	Rating (Inherent / Initial)	Controls in place	Gaps in Control	Review due date	Consequence (Current)	Likelihood (Current)	Rating (Current)	Risk Progress Notes Last 3 entries minimum.	Consequence (Residual)	Likelihood (Residual)	Rating (Residual)
											1168 - National Programme for IT HSCIC. 1174 - Increasingly Software Companies Are Changing Their Licensing. 2019 - Symphony IT System for Emergency Dept not Reliably Sending Safeguarding Referrals to Allocated Drive. 2696 - WinPath V5 Incompatibility Risk. 2781 - Maternity Information System 2830 - Computer Hardware Risks (Replaces 1173 & 2280) 2831 - Computer Infrastructure Risks (Replaces 1164, 2275, 1166 & 1185) 2838 - Potential Failure to Meet Cyber Security and Information Governance Standards Set by NHS Digital. (Replaces 1158 & 1161) 2864 - Failure of the Trust Dell Storage Platform During Routine Patching Maintenance. 3309- Patient Admin System Becomes Unsupported 2161 - Viewpoint System End of Product Life				expected 2023.								
2996	01/02/2021	Corporate Level Risk	Finance	Dave Stacey	Dave Stacey	Deputy Chief Executive Officer - Dave Stacey	Financial Risk	Finance	HQ, Regents House	Financial Sustainability Risk Rating for 22/23 and 23/24	Cause: Lack of Improvement in underlying financial position of the Trust and medium term financial sustainability. Effect: 1. Certain Failure to deliver 2022/23 breakeven financial plan, and risk in delivering the reported £18.6m deficit forecast 2. Failure to address underlying financial performance of the Trust over £50m recurrent, and failure to delivery a no worse than £18.6m deficit plan for year 23/24 3. Reputational risk to the Trust and impact on ICS overall financial sustainability. All provider in the ICB now are under SOF 4 regulatory special measures Linked to Risks: 2997 Overspend On Variable Staffing - 2021/22 Budget Levels. 2402 Increasing Costs Of High Value Drugs & Devices	Catastrophic	Almost Certain	25	1. Tightened internal financial governance and the adoption of the Budget Spending and Investment Protocols adopting a budget envelope approach (Introduced in H2 Oct) 2. Jointly with the ICB to formulate sustainable Medium to long Term Financial Plan (MTFP/ LTFP) and financial recovery strategy and continue to improve 23/24 financial draft plan before final submission to NHSEI in Feb 2023. 3. In-depth discussion on Financial Performance reports at operational governance meetings such as IGG, Executive meetings, Finance Delivery Group (CEO-chaired), System Financial Recovery Board, Finance, Performance and Digital Committee and Board (FPDC). 4. Deep dives undertaken at Finance, Performance and Digital Committee. 5. Programme office and management function established, monitoring and reporting delivery of schemes. 6. Regular updates provided to the system Finance Working Group and system financial recovery board, progression of ICS wide savings initiatives. 7. Exec-led performance monitoring of delivery systems. 8. CIP targets to be established in detail at service level, with Executive sponsors and management leads identified for schemes. 9. External support from Deloitte on drivers of deficit in 2023/24 commissioned by ICB 10. CQC Use of Resources inspection approach 11. Benchmark data such as NCCI, Model Hospital, PLICS 12. the Delivery Director for improvement are no post (Jan 2023)	1. Lack of regular and coherent productivity reviews of clinical services and action plan to address the issues 2. Interruptions to meetings cycles (routine governance) due to operational pressures from the pandemic. 3. Governance and delegation compliance rate following spending protocols requires monitoring and addressing	31/03/2023	Catastrophic	Almost Certain	25	[30/01/2023 13:34:45 Tian Ze Hao] Risk updated for the current and coming financial year (23/24). We are in the process of submitting a joint acceptable operational plan with the ICB in Feb 2023. [20/06/2022 13:31:24 Tian Ze Hao] Risk and gap in controls updated following operational plan resubmission in June. [21/03/2022 12:52:30 Tian Ze Hao] Increased impact to almost certain based on the Trust and the System's draft 22/23 financial plan submission on 17th March. Between now and the final Plan submission towards the end of April, we are working closely with the operational and clinical teams to further improve and reduce the underlying deficit position for 22/23, however the likelihood of a planned deficit at a significant level is almost certain therefore risk has been updated. PS 2021/22 outturn positional will remain balance to plan.	Catastrophic	Likely	20
3309	03/11/2021	Corporate Level Risk	Informatics Systems	Gary Hotine	Adel Jones	Director of Transformation and Partnership (Adel Jones)	Information and Communications Technology	Administration	Other not listed	Patient Admin System Becomes Unsupported	Cause: The PAS is obsolete and support will cease. Effect: The Trust cannot function and deliver its prescribed services and functions without a PAS	Catastrophic	Almost Certain	25	1. Early identification of the issue so that re-procurement and implementation can be accomplished (18 months)	1. EPR business case approval and the funding source identified needs to be achieved by April 2023 to avoid a tactical PAS replacement. 2. HIS resourcing business case approval, or an agreed System solution required to ensure capacity exists to achieve the PAS replacement from April 2022.	03/07/2023	Catastrophic	Almost Certain	25	[04/04/2023 17:14:00 Gary Hotine] No change - EPR OBC progressing but until procurement leads to preferred bidder with clear implementation timescale the risk score will remain the same. [26/09/2022 18:33:34 Gary Hotine] Updated to reflect progress on formal support extension. [15/02/2022 13:22:00 Gary Hotine] Updated the action re: obtaining a support extension	Catastrophic	Rare	5
3274	21/09/2021	Corporate Level Risk	Finance	Dave Stacey	Dave Stacey	CEO (Liz Davenport)	Financial Risk	Finance	HQ, Regents House	Failure to Identify and Deliver CIP	Cause: Operational pressures and historic under-delivery mean that inadequate CIP is identified and delivered on a recurrent basis in order to reduce the underlying deficit and a balance break even plan is achieved for 2022/23 Effect: This could lead to reputational damage, regulatory intervention and hold ups around securing long term strategic capital and revenue funding such as digital and BBF	Catastrophic	Likely	20	1)Transformation and CIP Committee / Finance Delivery g=Group 2)Restructured Integrated Governance Group for care pathways 3)Finance, Performance & Digital Committee 4)System Transformation and Efficiency Committee 5)PMO team in place 6)Regular business planning round table meetings 7)Budgetary control framework 8)External support from Deloitte on savings opportunities identification and delivery had been procured 9)CIP delivery Board meeting biweekly holding ISU to account 10)Planned CIP working group will be in place to support ISUs and corporate in identifying schemes to the Gap in delivery. in 22/23 the gap is forecasted to be £10m in year. 11) ICB level coordination is in progress 12) Delivery Director is now in post (Jan 2023) who will lead on embedding the Trust's single improvement plan	1)Inadequate recurrent CIP identified for 2022/23 and 2023/24 2)Inadequate progress on embedding the requirements of GIRFT 3)Membership of NHS Elect is not owned nor embedded, leading to zero benefit realisation 4)Lack of significant tangible Ideas and system wide solutions	31/03/2023	Catastrophic	Almost Certain	25	[30/01/2023 13:56:37 Tian Ze Hao] The 2022/23 CIP delivery gap is forecasted to be over £10m, in addition, within the delivered CIP in year, over £9m is non-recurrent. 2023/24 detailed CIP plan is still not in place. Delivery Director is now in post (Jan 2023) who will lead on embedding the Trust's single improvement plan [12/09/2022 13:51:34 Tian Ze Hao] CIP delivery Board meeting biweekly holidng ISU to account. Planned CIP working group will be in place to support ISUs and corporate in identifying schemes to close the Gap in delivery (currently at £16m+). In addition, ICB level coordination is in progress [16/02/2022 11:31:15 Tian Ze Hao] External support from Deloitte is now in place under two phases: phase 1 savings opportunities identification was competed in early January and phase 2 support on delivery has commenced to improve in our underlying financial position. Unidentified CIP is projected to be mitigated non-recurrently in 2021/22, however there are significant challenges and risks within the underlying position carried forward into 2022/23. We are working closely with the ICS in the process of formulating our funding position and financial plans for 22/23 and savings delivery requirement, early indication suggests scale of the financial challenge exceeds £40m.	Catastrophic	Possible	15

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Torbay and South Devon NHS
NHS Foundation Trust

ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	Speciality	Risk Location	Title	Description Cause: Effect:	Consequence (Inherent / Initial)	Likelihood (Inherent / Initial)	Rating (Inherent / Initial)	Controls in place	Gaps in Control	Review due date	Consequence (Current)	Likelihood (Current)	Rating (Current)	Risk Progress Notes Last 3 entries minimum.	Consequence (Residual)	Likelihood (Residual)	Rating (Residual)
1070	29/05/2014	Corporate Level Risk	Emergency Services	Joann Hall	Lisa Houlihan	Chief Operating Officer	Performance Risk	Inpatient Nursing Adult (ACUTE)	HOS, Torbay Hospital ED (A&E)	Trust Patient Flow Pressures Resulting in Ambulance Handover Delays, Poor Levels of Care and Performance for 12hr & 4hr Standard	Cause: Patient demand exceeding capacity within the ED department. Effect: Failure of the 95% standard, poor patient experience and possible adverse clinical outcomes as patients not cared for in the correct environment. Linked to other ED CLR: DRM ID No 1095 Overcrowding In Emergency Department.	Catastrophic	Almost Certain	25	1. Good data analysis available - ED dashboard linked with control room - good and accurate weekly data sheets produced to monitor performance. 2. New medical "O" drive - to allow other specialities (Medicine) to be monitored in same way as ED - pressures easier to identify earlier. 3. Escalation policy in place. 4. 3 x daily control meetings with real-time information and appropriate management responses. 5. Ward discharge coordinators have daily meetings to review ward discharges. 6. AMU re-provided on Level 2 from 21/03/16 to divert medically expected patients from ED. 7. "See & Treat" trial in 2017 was successful and is now used during periods of escalation. 8. JET Team now fully operational to provide support for early discharge. 9. Acute Care Model in Bay 5 to accept direct HCP referrals from 10th April 19. Prioritise use of EAU3 as assessment space, additional push from Jan 2020. 10. There are 3 improvement work streams in place with project plans for each; Emergency floor programme, ward processes, and Home First. We also have support from ECIST who are actively supporting a range of improvements. Governance structure in place to support these and currently looking to source additional project support. 11. Increased robustness of internal ED escalation. 12. Improvements to RAR space to enable additional capacity when unit is full. 13. Changes to corridor traffic to prevent thoroughfare use. 14. Creation of an Medical Receiving Unit in DSU as part of the COVID response. 15. Creation of a Surgical Receiving Unit on level 5 opening on 29/06/2020.	1. Linkage of the overcrowding risk score not formally linked to the escalation policy. Need for better OPEL linked escalation. 2. Patient flow out of the ED and other assessment spaces (MRU/SRU)	05/06/2023	Catastrophic	Likely	20	[29/03/2023 11:27:49 Amanda Anders (Risk Officer)] Title changed by COO [22/11/2022 17:30:40 Melody Andrews] Risk reviewed and no change at present [10/06/2022 10:36:11 James Merrell] Risk reviewed and no changes at present.	Catastrophic	Unlikely	10
2416	23/04/2019	Corporate Level Risk	Torbay Pharmaceuticals	Emma Rooth	Emma Rooth	Deputy Chief Executive Officer - Dave Stacey	Financial Risk	Torbay Pharmaceuticals	Torbay Pharmaceuticals	Failure to Meet Financial Compliance with TP's 5 year plan (implemented April 2021)	Cause: Lack of clarity on national review - 18 months since Project Dartmoor paused. Assumptions in existing 5 year plan no longer viable. Effect: Failure to meet financial targets. Significant financial, reputational and people risk.	Catastrophic	Almost Certain	25	1. Annual budgeting process. 2. Five year plan with long term aims. 3. Monthly financial review and presentation at Torbay Pharmaceuticals Board meeting. 4. ERP implemented. 5. Standard costing model applied to all products in business. 6. Horizon scanning of new dosage forms, technologies and changes in clinical practice. 7. Development planning including licensing and product development. 8. Project and Resource planning.	1. Ability of TP to make one-off investments (access to capital). 2. Post Brexit/Covid-19 impacts - inflation on labour and materials. 3. External investment. The entire plan was predicted on basis that significant external financing would be available. 4. Governance. Failure to separate from the Trust presents barriers in acquiring the skills and knowledge required to deliver on the plan. 5. Governance. The TP Board is not currently constructed to lead a global pharmaceutical business at high growth pace.	31/10/2023	Catastrophic	Likely	20	[28/04/2023 09:47:27 Kim Hodder] Action for Clear overseas targets and plan of action closed - Export Manager has clear sales targets. [05/09/2022 14:06:22 Kim Hodder] Actions 10283 and 10287 closed. Action 10282 progress updated. Addition of Action 18722. [05/07/2022 10:14:41 Amanda Anders (Risk Officer)] Risk discussed at July Risk Group. Agreed to add to CRR.	Major	Possible	12
3421	15/07/2022	Corporate Level Risk	Intensive Care	MB2	Derren Westacott	Chief Peoples Officer	Operational Risk	Intensive Care	HOS, Torbay Hospital Intensive Care Unit (ICU)	Consultant Vacancy in ITU (Workforce Risk)	Cause: Vacancy not yet recruited into and due to reduction in hours of two Consultants there is a one slot gap on ITU as from August 2022 Effect: Impact on anaesthetic lists, risk of cancellation, risk of burnout of current staff, financial impact	Major	Almost Certain	20	1. Gaps have been identified and Consultants are covering where possible 2. Anaesthetic sessions are being swapped to ITU sessions 3. Vacancy for 1 further WTE ITU COnsultant to be advertised December 2022 4.	1. Potential sickness 2. inability to rcruit into locum for 1st vacnant post until postholder starts in March 2023 2. Inbility to recruit into 2nd vacant post to be advertised in December 2022 3. Impact on anaesthetic lists can not be mitigated and lists may be cancelled	17/03/2023	Major	Almost Certain	20	[14/02/2023 12:36:00 Mandi Burroughs] Interviews to be held 20 February 2023 - 2 applicants [19/12/2022 14:25:02 Mandi Burroughs] Post placed on Trac to be advertised as soon as approved on TRAC [21/11/2022 16:52:10 Mandi Burroughs] Amendment: Post to be advertised Dece 2022 -updated risk reg	Moderate	Almost Certain	15

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3486	14/11/2022	Corporate Level Risk	All Departments	Liz Davenport	Liz Davenport	CEO (Liz Davenport)	Financial Risk	Administration	HOS. Torbay Hospital Hengrave House	Failure to Deliver Strategies that Supports the Delivery of System Priorities on Finance and Workforce	Cause: Failure to deliver strategies to support delivery of finance and workforce system priorities. Effect: Insufficient financial resources to deliver adequate health and social care services to the population we serve. Lack of skilled workforce to deliver future predicted demand and transformation. Strategic partners do not deliver priority strategic programmes of work	Catastrophic	Likely	20	1. Chair,CEO and Executive engagement with ICS Committess and decsion making groups 3.Development of ICS governance arrangements to include ICB, ICP Local Care Partnerships and Provider Collaboratives 4. ICS Board appointments, Executive Team and Programme Director capacity 5. Provider Collaboratives- Acute, MHLDN and plans for Primary Care and Community 6.Regular TSDFT executive engagement and attendance at ICS Board and Place Based/ICP planning meetings. 7.TSDFT CEO leads the Acute Provider Collaborative and Chair, DCEO and CMO also members 8.Influence at Strategic/Clinical networks: ICS Executive, Finance Working Group and HRD Executive Forum 9.Stakeholder engagement: proactive relationship management at CEO level with ICSs and other Provider CEOs. Focus on primary care leaders and stakeholders, and ensure attendance at key primary care engagement events.	Internal 1.Lack of robust planning arrangements 2.Operational capacity and governance External 3.Financial Plan/Devon System Health and Care Strategy 4.Lack of of engagement from partnership providers to impact positively on pace of change 5.ICS governance structures are emerging and decision making at organisation, place and ICS level is ambiguous at times. 6.Implications of revised governance arrangements on FT governance and decision making	09/05/2023	Catastrophic	Likely	20	[14/02/2023 11:21:26 Amanda Anders (Risk Officer)] Discussed at risk group and approved onto the CRR [09/02/2023 10:12:22 Sophie Byrne] The risk has been updated and an action plan added.	Catastrophic	Possible	15
1697	07/11/2016	Corporate Level Risk	Human Resources	Darran Armitage	Darran Armitage	Chief Peoples Officer	Financial Risk	Human Resources	Site Non-Specific	Difficulty In Recruiting Service Critical Staff And The Scheduling Of Staff (Workforce Risk).	Cause: Lack of strategic workforce planning means we are unable to proactively develop our workforce pipelines to satisfy our current and future workforce need. This is compounded by National shortages mainly due to the deficit between the numbers of trained staff required and the number coming through training providers. Effect: Difficulties in delivering on corporate objectives and national targets. Increase in temporary workforce usage including agency leading to budget overspends. Linked to Risks: DRM 3209 CT Staffing Level (Workforce Risk) DRM 3183 Inadequate Staffing Levels Creating Risk to Patient Safety and Potential to Impede Patient Flow (Workforce Risk) DRM ID No 1432 - Histopathologist Staffing Levels Causing Operational Risk. DRM ID No 1566 - Radiography Staffing Levels. DRM ID No 1603 - Breast Radiology Team reduced availability - Vacancies in Main Radiology. DRM ID No 1830 - Cancer Services Vacancy for Breast and Colo-rectal Clinical Oncology. DRM ID No 1931 - Lack of Resource to Assist with IT Projects & Service Redesign. DRM ID No 2066 - Vulnerability of Medical Take Due to Increases in Last 10 Years. DRM ID No 2528 - Reduced Staffing Numbers Resulting In Inability To Keep Services Open. DRM 1652 Vulnerability Of The Junior Doctors Rota In Medicine. DRM 2928 Inadequate Medical Physics Resources Impacting on Service Provision DRM 2528 Reduced Staffing Numbers Resulting In Inability To Keep Services Open (Workforce Risk). DRM 2602 Recruitment and Retention of Staff. (TP) (Workforce Risk) DRM 2576 Lack Of Anaesthetic Cover To Cover 85% Of Scheduled Lists. DRM 3286 Physiology Workforce (Workforce Risk) DRM 3231 Critical Staff Shortages in Radiotherapy Physics (workforce risk)	Major	Almost Certain	20	1. Recruitment updates are reported to Board bi-monthly as part of Workforce Report. 2. Medical Recruitment is being looked at as part of the Trust's Recruitment Strategy working groups. 3. Performance Report identifies where compliance with RTT/ED/STC impacted by workforce shortage. 4. Nursing workforce strategy in place including capacity plan that identifies demand and supply routes (including overseas nursing, redesign and vocational career pathways) monitored by Workforce and OD group. 5. E-Rostering system in place for nursing staff. 6. Restricted use of agency staff. 7. Use of bank staff wherever possible. 8. Additional support from current staff. 9. Risk discussed at Local level with escalation process for risks. 10. 15+ being linked to this risk. 11. Risk discussed at HR SDU meetings. R+R Groups. Workforce OD Group, Quality & SDU Performance meeting, Nursing working board group meeting, Risk Group meeting, Executive Directors meeting, Audit committee meeting and Trust Board. 12. STP Workforce and Clinical network development. 13. Trust now part of ICS Retention Project for late stage career nurses and early stage career support to improve nursing retention.	Lack of strategic workforce planning capability and capacity. Ctrl 2. Link between requirement to train additional staff and sufficient capacity to deliver placements for students and other trainees. Ctrl 5. E-Rostering system not in place for all staffing groups.	31/07/2023	Major	Almost Certain	20	[03/05/2023 10:11:22 Amanda Anders (Risk Officer)] Risk review by CPO, score increased from 16 to 20 inline with linked risks. [28/02/2023 15:34:01 Sarah Blacoe] emailed manager regarding update [16/02/2023 10:42:23 Sarah Blacoe] emailed manager regarding update	Major	Possible	12

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1815	05/08/2014	Corporate Level Risk	Cancer Services	Alex Atkins	Ria McCoy	Chief Operating Officer	Performance Risk	Administration	Site Non-Specific	Non Compliance With The National Cancer Waiting Time Targets.	Causes: Insufficient capacity to manage demand across some cancer pathways. A. LGI capacity for outpatient clinics, CT colon and colonoscop. Unable to deliver timed cancer pathways through diagnostics to enable achievement of the 62 day pathway consistently. B. Urology capacity for outpatients and DSU diagnostics reduced. Need identified dedicated outpatient space to deliver diagnostics in outpatient setting (Prostate pathway) Significant delays to TP biopsies. c. Consultant vacancies in Dermatology, Urology and Colorectal. Reliant on Locum cover. D. Insufficient capacity in diagnostics - CT, CTC and colonoscopy to achieve the timed pathways for Lung, Urology and LGI. Effects: A. Clinical risk to patients with delays diagnosis and delayed access to treatments. B. Increasing number of patients being reported as potential harm caused by delays to treatment. C. Failing the CWT targets for 14 days referral to first seen. Increasing 62 day referral to treatment breaches. E. Failing to achieve 28 day referral to diagnosis standard across many specialities F. Additional work required to escalate, complete breach analysis and recovery plans. G. Poor Trust reputation and increased scrutiny from regulators.	Major	Almost Certain	20	1. Weekly Cancer Recovery Action Plan meetings with operational leads 2. Weekly Cancer Task and Recovery meetings with Senior Management and Devon ICB 3. Site specific escalation lists on Infoflex for operational managers to access 4. Cancer Clinical Leads meetings to share risks and concerns across the ICO 5. Regular reporting to ICO Risk & Assurance group to escalate risks and concerns 6. Cancer patients are always prioritised when capacity reduced	1. Lack of Consultants to recruit to vacancies. (Substantive and locums.) 2. Clinical space and equipment to provide additional capacity 3. Lack of nursing staff in some areas to support additional clinical activity. 4. Significant increase in demand on services post COVID 5. Fully established CWT team against budget under resourced due to increasein demand and unable to track PTLs daily and escalation where appropriate	30/06/2023	Major	Almost Certain	20	[31/03/2023 16:22:48 Alex Atkins] Torbay remains in Tier 1 for cancer performance, with regular oversight from NHS E and Devon ICB. Whilst the over 62-day backlog is reduced, the current SOF4 and Tier 1 status' and regulatory scrutiny predicate that performance should remain as a significant organisational risk. To be reviewed in 3 months. [14/11/2022 08:51:39 Jacqui Robinson] Significant increase in 2ww referrals, diagnostic capacity, appropriate outpatient space and staffing/vacancies across many services continue to impact on our ability to comply with National Cancer Targets. Main areas of concern continue to be Colorectal and Urology. Lack of appropriately skilled Data Analyst support is also impacting on Cancer Managers' time and causing delays for report request across all cancer sites. Outsourcing and insourcing being widely used across many sites in an attempt to reduce waiting times and overall PTL. [28/06/2022 10:14:39 Jacqui Robinson] COVID, diagnostic capacity, appropriate outpatient space and staffing/vacancies across many services continue to significantly impacting our our ability to comply with National Cancer Targets. Main concerns remain in Urology and Colorectal due to the above. Lack of appropriately skilled Data Analyst support is currently having a huge impact on Cancer Managers' time and delaying reports being created and shared with various internal departments, the CCG or Cancer Alliance which is also a contributing factor to delays and our non-compliance with National uploads.	Major	Possible	12
2412	23/04/2019	Corporate Level Risk	Torbay Pharmaceuticals	Emma Rooth	Emma Rooth	Chief Finance Officer (David Stacey)	Financial Risk	Torbay Pharmaceuticals	Torbay Pharmaceuticals	Insufficient Access to Capital.(TP)	Cause: TP could be requested to reduce its capex budget in order to support the Trusts CDEL. Effect: Inability to invest in items linked to Torbay Pharmaceuticals Strategic Plan and requirements by MHRA if capex is reduced.	Catastrophic	Likely	20	1. Within year Capital plan in place. 2. Reviewed at TP Board meetings. 3. Meetings with Trust FD and TP Chairman. 4. Raised at Trust Board Meetings for assurance.	1. Potential for change in financial requirements of the Trust/NHSE. 2. No long term capital budget visibility (>1 year) from NHSE for Trust/TP.	31/10/2023	Catastrophic	Likely	20	[28/04/2023 09:45:50 Kim Hodder] Following review no updates/changes to risk at this time. [13/12/2022 11:01:29 Amanda Anders (Risk Officer)] Agreed at Risk Group to add to the CRR and Dave Stacey will be the Exec Lead [24/11/2022 15:44:33 Amanda Anders (Risk Officer)] Email from Kim Hodder -I confirm following this afternoons TP Board Meeting changes to TP Risk Register have all been accepted	Catastrophic	Rare	5
1266	01/10/2015	Corporate Level Risk	All Departments	Sandie Heyworth	Derren Westacott	Chief Operating Officer	Performance Risk	Administration	HOS. Torbay Hospital	Failure to Achieve Constitutional Target Regarding RTT Resulting in Poor Patient Experience And Quality Of Care.	Cause: Supply and demand imbalance across most specialities to meet constitutional waiting times, leading to an inability to deliver quality patient experience in relation to waiting times. Effect: Poor patient experience and quality of care, reputational impact for the Trust Linked to Risks: DRM ID No 2307 - Oncology Outpatient Clinic Issues. DRM ID No 2036 - Endocrine Outpatients - Increase on Demand with Limited Consultant Time.	Major	Almost Certain	20	1. Performance reporting and action plans with support of the Performance team, via Risk and Assurance weekly meeting 2. Waiting list management process, weekly PTL meetings 3. Operational teams identifying capacity and maximising all available sessions, also utilising insourcing companies and outsourcing where able. ICB supporting and involved with oversight 4. Support from other specialties creating sense of team working, ie UGI team supporting colleagues within Colorectal to reduce cancer backlog. Greater system working across the region with Urology 5. regular monitoring of demand in services, use of Tableau now integral part of planning	1. Saturday list until the end of the year - dependent on number of theatre and medical staff volunteering. 2. Insufficient training grades resulting in consultants having to action down. 3. Inability to outsource complex patients - patients are deconditioned and higher ASA levels reducing ability to transfer care 4. Funding considerations not supporting recruitment of consultant surgeons. 5. National shortage of urology consultants. 6. Unable to source anaesthetic locums. 7. Heat and humidity issues within theatres - ongoing concerns across both seasons (summer and winter)	24/04/2023	Major	Almost Certain	20	[17/01/2023 13:02:31 Amanda Anders (Risk Officer)] Risk re-written by Nicky Croxon to ensure it is completely up to date. [27/09/2021 09:40:03 Neal Foster] Best week 29th Sept allowing Ella to be use for DSU recovery and ortho patients. Response for OT limited at AfC and LNC rates Approval sought for insourcing of urology diagnostics Sessions at Tiverton and Ottery picked up for TP biopsies. MSH transfers OP/DCIP continue as do 5 endoscopy sessions per week [19/04/2021 10:41:58 Neal Foster] Theatre humidity problems persist with ESU and DSU3. Redrafting of SoP underway to define safe operating limits SRU, DSU and Ella returned to service end of March 21. Forrest now used as MRU, trust wide debate currently on use of Cromie. Theatre project underway with support from SI. Social distancing still impacting of OP productivity.	Moderate	Likely	12

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3030	12/03/2021	Corporate Level Risk	Human Resources	Darran Armitage	Darran Armitage	Chief Peoples Officer	Operational Risk	Human Resources	Site Non-Specific	Staff Fatigue Impacting on Ability to Deliver Services (Workforce)	Cause: Staff fatigue following covid pandemic, annual leave not being taken due to operational pressure and covering additional shifts is leading to staff burnout. The requriement to improve performance to reduce long waiting lists will likley add mental load to individuals. Effect: Increased level of sickness, long term sickness above normal levels, staff turnover, impact on uptake of annual leave, and a decrease in productivity and performance in staff that remain.	Major	Almost Certain	20	1) Investment in health and wellbeing support including high level mental wellbeing. 2) A comprehensive package of health and wellbeing interventions, support and guidance with enhanced measures to be offered via management structures and self referral. 3) An analysis of supporting data on staff sickness, overtime, agency spend and unused annual leave to help identify services that may be vulnerable. 4) Trust leadership to use the data provided to control and mandate the pace and pressure of recovery in vulnerable services. 5) Expanding the number of Wellbeing Buddies across the Trust. 6)Continuing with bespoke listening sessions in particular for teams who are part of the system capacity and recovery plans. 7) roll out Apr 2023 of Regain and Renew plan provides clear priorities and permission to innovate/stop work to focus only on priorities. 8)Roll out of Leadership and Management framework Q2 2023 will enhance managers efficiency and improve staisfaction and reduce burnout. 9) Workforce Transformation programme, focusing on better roster management will improve identification of additional shifts and how they are managed with notice.	1) Scarcity of specialist skills in some areas to fill vacancies, exacerbating problem. 2) Financial envelope available to aid recovery	31/07/2023	Major	Likely	16	[03/05/2023 12:01:50 Amanda Anders (Risk Officer)] (02/05/2023) by CPO: Risk cause and controls updated. Roll out of Regain and Renew engagement plan will help treat this risk, enabling people to understand the priorities, how to focus only on what is required, how to embrace new ideas to improve efficiency, and the roll out of leadership and management development will aid greater understanding of workforce management and pressures and how to better manage them. WIT data 2/5/23 reiterates update from 1/3/23 that remain red for 6 of 9 parameters, but with falling levels of sickness. [01/03/2023 10:10:37 Sarah Blacoe] WIT produce fragility score as part of the ISU workforce information this looks at sickness; rolling sickness; long term sickness; age profile; Holiday taken; overtime; bank and agency and turnover – It highlights the cost centres that are red for 6 or more of the 9 parameters [28/02/2023 15:33:16 Sarah Blacoe] emailed manager regarding update	Major	Possible	12
1603	08/07/2016	Corporate Level Risk	Breast Care	Sandie Heyworth	Derren Westacott	Chief Operating Officer	Performance Risk	Breast Care	Site Non-Specific	Diagnostic Demand and Capacity Constraints	Cause: 1. Insufficient Radiology capacity to meet demand 2. Increase in 2WW referrals 3. 4th Breast Radiologist has left - have appointed replacement but gap until September Effect: 1. The whole Breast Service at risk of falling over without adequate Breast Radiology support and cannot provide a diagnostic service 2. Patients are experiencing a delay to their cancer diagnosis on a 2WW & 14 day symptomatic pathway as one-stop assessment not available for all appointments booked. 3. Surgical patients requiring wires may not be booked within 31/62 day target if radiology capacity is not available on planned date of surgery. 4. Breast screening film reading and assessment breaches. Linked to Risk: CLR DRM ID No 1697 - Difficulty in Recruiting Service Critical Staff. (16)"	Major	Almost Certain	20	1. Micromanagement of radiology, radiography and surgical rotas to optimise the radiology capacity available. 2. Every radiological appointment, if patients cancel, is backfilled with either a symptomatic or screening patient where possible. 3.Advanced Practice Radiographer now trained and providing capacity in clinic 4. Additional reader in training (end April qualify) 5. Additional sessions requested with Radiologists 6. Liaison with Radiology Ops Mgr for priority to be given to Breast if possible when timetables being planned 7. Created additional advanced practice radiographer roles x2 (x1 for biopsies and x1 for film reading) 8. Breast radiology support via additional paid sessions for visiting consultants	1. Referrals are unpredictable 2. The Radiologists may not want to / be able to do additional sessions. 3. Current PT Breast Advance Practice Radiographer has retired and returned and could leave at any time giving 3 months' notice.	30/06/2023	Major	Likely	16	[19/04/2023 14:50:45 Sandie Heyworth] Updated cause and effect, controls and gaps. No change in scoring as risk remains at current levels. [17/04/2023 08:04:53 Sandie Heyworth] Permanent radiologist has left, have appointed but not starting until September. Continue to use locum radiologists from within region on a sessional basis. Advanced Practice Radiographers (2) almost at completion of training. [23/12/2022 14:20:10 Sandie Heyworth] No change. Writing BC in January 2023 to improve resilience - will require commitment from the Trust	Major	Unlikely	8
3372	26/04/2022	Corporate Level Risk	Head and Neck (Including Dentistry)	MB2	Derren Westacott	Chief Operating Officer	Clinical Safety Risk	ENT and Plastic Surgery	HOS, Torbay Hospital Outpatients Department	Continued Reduction of Clinical Activity in ENT Service	Cause: One Clinician currently on LTS (Head & Neck) and One clinician currently on Mat Leave, plus another surgeon leaving May/June 2023 Effect: loss of clinical activity in ENT in emergency cover, Head & Neck cancer speciality and General ENT	Major	Almost Certain	20	1.Remaining Head & Neck Consultant has picked up additional work plus other ENT clinicians are covering where possible and have moved to 1:4 on call rota 2. Using a Consultant from RDUH to cover some sessions approx 2 per month as locum 3. Using insourcing/outsourcing company to provide additional resiliance to reduce backlog in service and assist with 2ww Please see details below of previous Mutual Aid request and details of the agreement by RDUH. Royal Devon University Healthcare NHS Foundation Trust will provide mutual aid with ENT surgical Head and Neck (H&N) services to Torbay and South Devon NHS Trust in response to this request in the short term (expected until 13th June 2022) in the following ways: •Royal Devon will provide consultant telephone advice Monday – Friday on managing specific 2ww ENT patients. •Royal Devon will oversee the management of all new H&N cancers diagnosed at Torbay for the period of the agreement. The majority of this activity will happen at Torbay (delivered by Royal Devon consultants as additional to job plan) wherever possible, but some patient care (inpatient and day case) will need to be transferred to Exeter (see below). Diagnostic scans and outpatient biopsies for these patients will happen at Torbay. •Diagnostic and treatment surgery for ENT H&N patients will be undertaken in Exeter where this cannot be accommodated at Torbay. Torbay will provide theatre time to Royal Devon surgeons on site at Torbay during already planned additional	1. No capacity to cover sickness and to cover A/L 2. Risk of burnout from over works 3. Not sustainable Consultant cover from Locum Consultant 4. Inability to recruit further staffing	17/03/2023	Major	Likely	16	[19/12/2022 14:39:02 Mandi Burroughs] To review stand alone post in new year - Meeting 06/01/2023, to gain agreement for additional shared post from August 2024. Financial agreement has been given. [17/11/2022 16:54:15 Mandi Burroughs] Further post ENT stand alone advertised - has closed 16/11/2022 no suitable applicants. CSL meeting with MD 21/11/2022 to discuss furher mutual aid request for support for Head & Neck Cancer Service [24/10/2022 12:21:29 Mandi Burroughs] No applicants for H&N interviews in September. Have advertised for ENT post (as opposed to Head & Neck post) as at 20/10/2022. Another consultant has now resigned leaving date TBC May/June 2023	Moderate	Possible	9

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															sessions on Tuesdays, to prevent the patients travelling and to reduce the demand on Royal Devon theatre time but this may not be possible for all cases. The OMFS team in Torbay will take over cases from Torbay ENT where this is appropriate due to cross-over between specialties, ie: thyroid and some neck dissections, rather than these being transferred to the Exeter ENT team. The general ENT team in Torbay will cancel less urgent surgery to undertake H&N surgery at Torbay that is within their scope of practice/capability, eg: tonsillectomy, panendoscopy (where patient not a candidate for radical surgery), microlaryngoscopy, lymph node biopsies. •Torbay patients requiring oncological treatment for their H&N cancer will be treated in Torbay. •The histopathology for all surgery done in Exeter on Torbay patients will be transferred to Torbay for analysis. •All relevant scans and notes for Torbay patients having surgery in Exeter need to be made available on Epic in advance of the day of surgery. •Royal Devon surgeons will undertake complex surgical treatments in Exeter – these patients would normally have been treated in Exeter but by a Torbay surgeon. There are already dedicated theatre lists in Exeter for the Torbay surgeons so these will be covered where possible by the Royal Devon consultant team as extra to job plan. This locum cost will be paid for by Royal Devon. •Follow-up H&N clinics in Torbay will be provided by Royal Devon consultants and registrars in addition to job plan, as the										
3195	19/06/2021	Corporate Level Risk	Torbay Pharmaceuticals	Leon Rudd	Emma Rooth	Managing Director Torbay Pharmaceuticals (Emma Rooth)	Financial Risk	Torbay Pharmaceuticals	Torbay Pharmaceuticals	NHS Elective Surgeries Impacting on Sales	Cause: Reduction in NHS elective surgeries due to Covid Effect: Impact to sales	Major	Likely	16	Focusing on alternative business such as Exports and CMO Business	TP has no influence on Hospital Schedules	31/10/2023	Major	Likely	16	[28/04/2023 09:31:21 Kim Hodder] No changes to risk at this time. [17/12/2021 09:20:07 Amanda Anders (Risk Officer)] Risk score increase validated at TP Board [13/12/2021 10:43:21 Kim Hodder] Scoring updated to reflect financial impact.	Moderate	Possible	9
3287	11/10/2021	Corporate Level Risk	Stroke Team	James Hobbs	Shelly Machin	Chief Operating Officer	Clinical Safety Risk	Stroke Service	HOS, Torbay Hospital George Earle Ward	Stroke Services (overarching risk)	Cause: 1) Vulnerability of nursing workforce; high number of new nurses including overseas nurses filling what were previously high number of vacancies. 2) Challenge to ensure all clinical staff gain & maintain stroke competencies; high turnover & large number of new staff plus pressures in system on capacity to give & to receive training. 3) Significant pressure within the system including poor flow; challenges to get patients to the right ward within 4 hour target window Effects: 1) & 2) a) Risk of increased clinical incidents; staff not able to get specialist skills in a timely manner. b) Impact on staff health & wellbeing; experienced staff having to support less experienced staff & trying to train staff in an already pressured system c) Difficulty covering specialist nurse & thrombolysis rotas 3) a) Performance on SSNAP - particularly Domain 2 time to & time spent on a stroke unit - poor & continuing to deteriorate b) Reputational risk; Domain 2 is part of CQC performance metrics This service sits within the category of small and vulnerable services which will only be fully addressed through networking on clinical services across the wider Devon footprint.	Major	Likely	16	1) Training programmes in place 2) & 3)& 4) ADNPP leading Health & wellbeing work across ISU to support all staff 5) a) stroke improvement plan in place detailing actions & supporting the monitoring of progress b) Regular breach analysis & SSNAP meetings to monitor progress c) Assurance that stroke outliers are seen by Stroke team	Control 3) Ongoing challenge to maintain skills Control 5) b) Breaches continue; as few as 2% of patients reaching the stroke unit in 4-hours with consequential impact on ability to get specialist assessment within time, swallow screening etc. NB: Stroke Risk 1069 remains scored at 16 due to inability to get sustained improvement on Domain 2	30/06/2023	Major	Likely	16	[06/03/2023 16:23:55 Lesley Wade] Risk reviewed. Gap in control updated & action updated. Action owner changed. [12/10/2022 13:50:35 Lesley Wade] Risk reviewed & updated. Linked to 1069 which has also been updated & retains same score. Actions reviewed & RO changed to James Hobbs. [01/06/2022 09:36:18 James Hobbs] Risk description and controls updated to reflect that risk 1072 has now been closed. Actions reviewed and updated.	Major	Unlikely	8
3437	09/08/2022	Corporate Level Risk	Torbay Pharmaceuticals	AR3	Emma Rooth	Deputy Chief Executive Officer - Dave Stacey	Operational Risk	Torbay Pharmaceuticals	Torbay Pharmaceuticals	HVAC Cooling Capacity Insufficient During Extreme Hot Weather	Cause: Extreme heat weather conditions. Impact: During extreme heat weather conditions, the temperatures in the GMP manufacturing and equipment preparation areas increase as the cooling capacity of the current air chillers is insufficient to maintain controlled conditions. The consequence of the increasing room temperatures leads to risks to products and revenue. Product risk 1 is caused by operators fully gowned in clean room clothing sweating which negates the barrier created by the clean room clothing and shedding skin in to the environment creating extra viable and non-viable particulates in to the area causing microbial and particulate risk to products and the environment. Product risk 2 is caused as most products should be maintained at 20-25C and there is a risk the upper limit could be surpassed if extreme heat conditions persist creating deviations. Financial risk is created from the possibility of failing batches being manufactured during extreme heat conditions or making the decision not to manufacture during such events.	Major	Likely	16	1.Internal Chiller Units currently run at 100% capacity to maintain GMP manufacturing/prep rooms at 20-25C (regulatory requirement).	1.There is no ability to increase current cooling capacity.	31/10/2023	Major	Likely	16	[28/04/2023 09:30:20 Kim Hodder] No updates/changes at this time [05/01/2023 15:50:29 Kim Hodder] Review date amended to end of March 2023 [06/09/2022 11:32:03 Amanda Anders (Risk Officer)] Risk approved onto the CRR	Major	Possible	12

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3484	14/11/2022	Corporate Level Risk	All Departments	Liz Davenport	Liz Davenport	CEO (Liz Davenport)	Operational Risk	Administration	HOS. Torbay Hospital Hengrave House	Failure of Acute Provider Collaborative to Deliver on Acute Sustainability Plan Programme	Cause: Failure of the ICS to create the conditions for collaborative working and delivery of the shared goals in relation to the acute sustainability plan and community. Effect: No improvement in acute services or outcomes for population served by the Trust. Challenges arising from competing priorities from different partners.	Major	Likely	16	1.Appropriate representation on ICS Board and key committees/governance. 2.Regular TSDFT executive engagement and attendance at ICS Board and Place Based/ICP planning meetings. 3.TSDFT CEO is the ICB Acute Provider Trust Representative and leads Peninsula Acute Provider Collaborative. 4.TSDFT Chairman and MD attend the Acute Provider Collaborative Board 5.Influence at Strategic/Clinical networks: ICS Clinical Leadership Group, Urgent and Emergency Care Network, System Resilience Groups, A&E Delivery Boards. 6.Stakeholder engagement: proactive relationship management at CEO level with ICSs and other Provider CEOs. Focus on primary care leaders and stakeholders, and ensure attendance at key primary care engagement events. 7. Enagagement in ICS Leadership Development Programme.	Internal 1.Planning arrangements not yet mature 2.Realignment of capacity External 3.Devon System Health and Care Strategy not mature 4.Inconsistant engagement from partnership providers to impact positively on pace of change 5.Clarity on population outcomes, prevention plans and specific priorities for change defined within 'place-based plans' is limited. 6.ICS governance structures are emerging and decision making at organisation, place and ICS level is ambiguous at times. 7.Maturity of relationships and collaborative working arrangements	09/05/2023	Major	Likely	16	[14/02/2023 11:25:40 Amanda Anders (Risk Officer)] This risk was discussed at February Risk Group and approved onto the corporate risk register. [09/02/2023 09:59:56 Sophie Byrne] The risk has been reviewed and updated and a comprehensive action plan has been added.	Major	Unlikely	8
3485	14/11/2022	Corporate Level Risk	All Departments	Liz Davenport	Liz Davenport	Deputy Chief Executive Officer - Dave Stacey	Operational Risk	Administration	HOS. Torbay Hospital Hengrave House	Failure of ICS Operating Framework to Support Collaboration in Line with Health and Social Care Policy Requirements	Cause: Failure of the ICS to create operating framework to support collaboration. Effect: Poorly defined shared vision and objectives and no strategic approach to issue of risk, costs and benefits Failure to engage stakeholders Risk of sanctions due to lack of collaboration	Major	Likely	16	1.CE and Executive engagement with PCSS and CE Leadership Groups. 2.Appropriate representation on ICS Board and key committees including NED appointments 3.ICS operating framework in place 4.Regular TSDFT executive engagement and attendance at ICS Board and Place Based/ICP planning meetings. 5.CEO is the ICB Acute Provider Trust Representative 6.Influence at Strategic/Clinical networks: ICS Clinical Leadership Group, Urgent and Emergency Care Network, System Resilience Groups, A&E Delivery Boards. 7.Stakeholder engagement: proactive relationship management at CEO level with ICSs and other Provider CEOs. Focus on primary care leaders and stakeholders, and ensure attendance at key primary care engagement events.	Internal 1.Strengthening of planning arrangements 2.Realignment of capacity External 3.Development of formal reporting process through system and organisational governance 4.Devon System Health and Care Strategy to be finalised 5.Limited to influence the direction of change in the local health economy 6.Lack of engagement from partnership providers to impact positively on pace of change 7.Lack of clarity on population outcomes, prevention plans and specific priorities for change defined within 'place-based plans' is limited. 8.Maturity of relationships and collaborative working arrangements 9.Implications of revised governance arrangements on FT governance and decision making	09/05/2023	Major	Likely	16	[14/02/2023 11:24:38 Amanda Anders (Risk Officer)] This risk was discussed at February Risk Group and approved onto the corporate risk register. [09/02/2023 10:08:32 Sophie Byrne] Risk has been updated and an action plan has been added.	Major	Unlikely	8
3316	12/11/2021	Corporate Level Risk	All Departments	Sandi Clemo	Christopher Knights	Director of Transformation and Partnership (Adel Jones)	Financial Risk	Administration	Site Non-Specific	Failure to Complete the Outline Business Case for the NHP Programme (Overarching Risk)	Cause: The BBF team are not able to complete the Outline Business Case for the NHP programme in a timely manner Effect: Risk in securing funding for the programme Linked to the following risks: 3270 BFF Commissioning - Workforce Risk (closed) 3269 BFF- Business Case Authorship - OBC and FBC (closed) 3268 BFF- OBC and FBC Business Case Authorship -(CIP) (closed) 3267 BFF: OBC Support Services- Lack of Efficiencies (closed) 3266 BFF: OBC - Support Services Not Aligned (closed)	Major	Likely	16	1) The BBF programme office are working through all the requirements of a OBC to ensure that they have the required resource in place to deliver the programme. 2) There is regular dialogue with the National Team and Trust Executive to ensure that the matter is being escalated.	1) The national team are not currently able to confirm definitive timescales associated with the completion of the OBC, but the BBF team are in regular dialogue to ensure that the matter is being escalated.	01/06/2023	Major	Likely	16	[27/03/2023 14:07:20 Sandi Clemo] Risk reviewed, no updates required - rescheduled review date for 01/06/2023 [07/12/2021 10:52:13 Amanda Anders (Risk Officer)] Agreed to add to CRR	Major	Likely	16

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2966	30/11/2020	Corporate Level Risk	Laboratory Medicine	Anthony Lowe	Ria McCoy	Chief Peoples Officer	Operational Risk	Administration	HOS, Torbay Hospital Pathology Labs	Overarching Recruitment Risk in Lab Medicine	Cause: Lab Medicine has a number of very experienced senior members of staff. As these staff members near retirement age the services will struggle to recruit at the same level of expertise that the Trust current employ. Haematology and Histopathology have experienced issues. Microbiology are also now affected. Effect: Without a strong staffing model in place across the services there will be numerous issues associated with this risk: A. Potential delay in turnaround times B. Missed RTT targets, including cancer waiting times resulting in fines C. No time allowance for case reviews D. Unable to meet UKAS Standards in Cellular Pathology E. Reliance on locum cover F. Significant service delivery challenge G. Significant recruitment challenge H. Covid testing placing microbiology under pressure I. Potential for existing staff to relocate for a better work/life balance Linked risks 2131: Consultant Microbiologist Workforce Under Pressure 2807: Additional Staffing Required to Maintain Service Delivery (Microbiology)	Major	Likely	16	1) Reduce non-essential workloads where possible 2) Request staff to reschedule leave 3) Reduce routine quality activities 4) Offer overtime 5) Current Consultants covering additional workloads 6) Locum booked for shifts that can not be covered 7) Request support from SEND network 8) Consider Outsourcing	1) No guarantee that shifts can be covered 2) Backlogs continue to increase 3) National shortage in these specific roles may result in recruitment being unsuccessful 4) Cover provided may not include some key elements of the role 5) Unsuitable workload demand on existing staff 6) Reluctance for extra shifts due to current taxation issue with pensions of senior medical staff. Some departments with SEND Trusts having their own issues. 7)Financial implications to outsourcing	30/04/2023	Major	Likely	16	[08/03/2023 14:43:47 Anthony Lowe] Process to recruit a new Histology manager has begun. Currently at job matching. Risks of recruitment of senior staff is recognised by South 1 Network but any actions could be long term. Unsure mutual aid is possible based on all the Trust positions. [25/01/2023 10:22:04 Anthony Lowe] Histology manager will be leaving in March. Consultant Microbiologist intends to retire in 2023. Locum Microbiologist has returned. Pathology Network has other Histology and Microbiology services with vulnerable staffing, unsure mutual aid is a viable solution. Hence increase in risk [08/11/2022 15:15:41 Anthony Lowe] Biochemistry hoping to appoint two Clinical Scientist Band 7 from latest pool of trainees. Microbiology exploring potential of mutual aid with RDUH.	Major	Unlikely	8
2948	13/11/2020	Corporate Level Risk	Emergency Services	Lisa Houlihan	Nicola McMinn	Chief Operating Officer	Clinical Safety Risk	A and E Majors	HOS, Torbay Hospital ED (A&E)	Delay in MH Patients Being Transferred to Appropriate Placement/Assessment Environment	Cause: Frequent Occurrence's where vulnerable patients are admitted to EAU awaiting Mental Health Beds, or remain in ED for extended periods of time for the same reason. Effects: A. Delays in transferring patients to appropriate units due to bed availability. B. Poor patient experience. C. Huge strain placed on these areas, often requiring extra staffing to support, adding stress/workload for teams.	Major	Likely	16	1. Clinic room at the front of ED converted to provide further ligature free review area. 2. Regular escalation of any long wait patient but MH particular focus to escalate and reduce delay	1. Staffing for appropriate supportive observation being worked through yet not formally agreed therefore whilst every effort will always be made to provide a 1:1 staffing not always available. 3. DPT to provide guidance on supportive 1:1 requirement. 4. Once ED works complete the MH suite will return to its normal function - complete 5. Once ED work complete on the clinic room this will also provide a safer assessment environment.- complete 6. Once points 4 and 5 are complete this will reduce the overall risk.	31/08/2023	Major	Likely	16	[10/06/2022 10:34:58 James Merrell] Risk reviewed and no changes . [08/03/2022 15:16:28 James Merrell] No new changes to the risk. [03/12/2021 09:48:40 James Merrell] No changes to the risk	Major	Possible	12
2957	19/11/2020	Corporate Level Risk	Radiology and Imaging	Nick Rowles	Kevin Pine	Chief Nurse (Deborah Kelly)	Health and Safety Risk	Radiology	HOS, Torbay Hospital Radiology West	Radiation Safety (Staff/Public) : Inadequate Management Controls (Regulatory Compliance)	THIS IS A TRUST WIDE ISSUE AND NOT SPECIFIC TO PAIGNTON & BRIXHAM ISU OR RADIOLOGY. RADIOLOGY HAS BEEN SELECTED AS THE LOCATION SIMPLY AS IT IS THE LARGEST USER OF IONISING RADIATIONS Cause: A significant number of inadequate controls regarding management of radiation safety (Ionising Radiations Regulations 2017-IRR17) have been identified. Effect: These issues affect day to day safety of work with Ionising Radiations and are considered non-compliant with the requirements of IRR17 . Enforcement action in a number of areas is considered highly likely in the event of any inspection by HSE. There is evidence of a poor radiation safety culture in the organisation. Linked risk: 2928: Inadequate Medical Physics Resources Impacting on Service Provision (workforce risk)	Major	Likely	16	1) Radiation Safety Committee 2) Policies / Procedures / Systems for safe work	1) There are widespread gaps in controls across the organisation. 2) Lack of or inadequate radiation risk assessments 3) Lack of effective process and control of Occupational Dosimetry 4) Inadequate training in radiation safety - lack of mandatory training 5) Inadequate Local Rules 6) Local Rules not followed by Staff 7) Lack of Radiation Protection Supervisors for Controlled Areas 8) In adequate numbers of Radiation Protection Supervisors 9) Lack of process of Cooperation between Employers / Outside Workers 10) Inadequate contamination monitoring in Nuclear Medicine 11) Lack of programme for assessment and monitoring of Radon in the workplace 12) Poor overall management of radiation safety	06/06/2023	Major	Likely	16	[06/04/2023 11:14:58 Nick Rowles] I have reviewed this risk today. Whilst there have been improvements in radiation safety and compliance, there are still significant gaps. Risk assessment in key areas of Nuclear Medicine and Radiotherapy are being drafted and identify actions required to improve safety and complaince. These actions will require implementation through Local Rues (instructions for safe work) on completion of the risk assessments. There is still no suitable and sufficient risk assessment in place for cardiac catheter laboraties and there are a number of indicators of concern regarding radiation safety and culture arising in this area. There remain other gaps in risk assessments. In terms of Nuclear Medicine (ref external review), there has been progress around management of radioactive waste, and additional staff in Clinical Nuclear Medicine. Recruitment into the senior medical physics role at 8B however remains challenging and the position remains unfilled after 4 adverts. An alternative solution is being investigated. Actions around this risk warrant review and updating Whilst there has been some progress I feel the overall risk rating should remain unchanged [18/11/2022 13:37:38 Tim Simpson] Action plan reviewed, position agreed. Still outstanding actions that are limited by lack of resource and inability to	Major	Rare	4

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2878	25/08/2020	Corporate Level Risk	Estates	Paul Morgan	Jake O'Donovan	Chief Finance Officer (David Stacey)	Performance Risk	Estates Dvpt	HOS, Torbay Hospital Tower Block	Increased Fire Risk in the Torbay Hospital Tower Block due to Sustained Failure to Meet Statutory Standards	Cause: Due to the age, modifications made and use of the Torbay Hospital tower block it does not meet current statutory fire building standards. Effect: 1. The lift lobby is no longer a sterile location which increases the potential fire risk in this area 2. The current primary evacuation stairwell route is compromised by the fire service attendance leading to a delayed evacuation of staff and patients 3. Death or injury leading to substantial financial penalties. 4. Non compliance with HTM 05-02 and PAS7 leading to an evacuation risk failure and/or inability for the fire service and ambulance service to mount an effective response	Catastrophic	Almost Certain	25	1. L1 detection through the site 2. Fire risk assessments annually assessed 3. Fire wardens and clinical evacuation leads in place 4. 100k capital funding to be targeted in this area for remedial solutions 5. Annual exercise scheduled 6. Regular engagement with the fire service on this risk 7. Fire strategy in place and published 8. Fire training in place for staff. 9. Fire service engaged with and to attend site for planning and liaising on planning. 10. Security officers attending site three times a shift. 11. SSEP team has made contact with each department lead.	1. No firemans lift to support evacuation. 2. No sprinklers to support evacuation. 3. Not enough evacuation equipment to mount and effective evacuation. 4. No third set of evacuation stairwell. 5. Lack of evacuation strategy in relation to the current secondary evacuation stair well. 6. Regular fire drills. 7. Store rooms and offices outside of the main compartment in the lift/escape route. 8. Inpatients housed in the tower block.	31/05/2023	Catastrophic	Possible	15	[05/04/2023 13:02:42 Paul Hayman] Sub station 1 Transformer works now due to complete in April 23 due to delays to accommodate Clinical activity. Lift Motor room work is in progress and due to complete in April 23. IT cabinets Fire Suppression systems to be installed in April 23. [22/03/2023 14:37:03 Amanda Anders (Risk Officer)] Score reduced by Jake O'Donovan from 25 to 15 due to Fire remedials project now completed, bed store stood up so as to reduce clutter and corridor risk, all FRSAs now up to date. [01/03/2023 15:29:53 Paul Hayman] Transformer upgrade due to be completed on 19th March. IT cabinets in 'protected lift lobby' fire suppression systems not connected at present. Confirmation of progress for fire door works within Tower, 3 doors remaining and are scheduled to be replaced by the end of February, from Capital Development team.	Catastrophic	Unlikely	10
2718	03/02/2020	Corporate Level Risk	Estates	Helen Elkington	Jake O'Donovan	Chief Finance Officer (David Stacey)	Operational Risk	Estates Dvpt	Site Non-Specific	Inability To Expand Clinical Services Due To Lack Of Space.	Cause: The Torbay Hospital buildings are too cramped to accommodate further expansion of clinical activity in key areas, the Emergency Department, Radiology, Emergency Department, Outpatients Oncology etc. Effects: A. Inability to respond in a timely manner to emerging Pandemic Threats such as Covid-19, where a need to provide enhanced Red and Green pathways results in having to shut down key diagnostic or elective services B. Inability to provide adequate social distancing within the existing buildings footprint. C. Inability to bid for new clinical contracts or additional services. D. Poor expansion opportunities and significant time pressures involved in any modifications. E. Poor patient experience due to cramped and overcrowded conditions. F. Waiting times increasing and targets not met. Linked to- DRM ID 2234: MDSS Medical Devices Library (MDL), Insufficient Space to Meet ICO's Expectations.(15) DRM ID 1083: Failure To Provide A Fit-For-Purpose Estate That Supports The Delivery Of Safe/Quality Care. DRM ID 2913: Lack of Space Due to Social Distancing/AGP DRM ID 2975: Lack of Provision of IP Pre Assessment DRM ID 3056: Increase UTC Activity Due to COVID Restrictions Lifting Resulting in an Increase in Holiday Makers DRM ID 3207: Appropriate Procedure Room for Vascular Access in Patients and Complex Patients	Moderate	Almost Certain	15	1. Covid Recovery Cell Reviewing opportunities to re-house services off-site to free up acute site capacity. 2. Cross-ISU group in place to review business cases to ensure space consequences are considered as part of future planning. 3. HIP2 seed funding received to scope Strategic Outline Case for new hospital development. 4. Space Group reformed and led by Director of Environment to prioritise strategic requirements across Trust sites.	1. Limited controls possible. 2. Need to manage hospital within current space envelope for next 10 years.	30/06/2023	Moderate	Almost Certain	15	[17/01/2023 14:27:39 Paul Hayman] No Change - review in June 2022 [11/08/2022 13:08:12 Paul Hayman] No Change - review in October 2022. [07/02/2022 15:24:43 Paul Hayman] Building a Brighter Future Outline Business Case not expected before October 2022.	Moderate	Unlikely	6
2920	12/10/2020	Corporate Level Risk	Finance	Neil David Elliott	Dave Stacey	Director of Transformation and Partnership (Adel Jones)	Performance Risk	Finance	HQ, Regents House	Activity Dataset Non-Compliance For Community Setting	Cause: Non compliance in recording activity within the community setting. Effect: Not able to report Activity on SUS, National Cost collection returns, Non compliant with Mandatory NHSE&I requirements. Unable to understand the activity and productivity within the community setting	Catastrophic	Possible	15	1. A Community Data Development Steering Group has been formed that is Chaired by the CFO and will report to CASCIT. 2. The Head of Data Engineering is aiming to get 2 band 6 members of staff recruited to help with resource issues in the team, hopefully some of this resource can be directed to mitigating this risk. 3. In the meantime funding has been agreed for 60 days of agency staff to come in and start work on formulating the dataset. The plan is for this resource to start on Monday 4th October 2021.	No plan to implement the requirements during the role out of the trust wide community system.	30/06/2023	Catastrophic	Possible	15	[03/04/2023 14:24:27 Neil David Elliott] The agency resource that has been submitting our dataset will no longer be available from the end of April 2023. The submission task will be handed to the Data Engineering team, a handover is in progress. With regard to the PARIS system, John Broom is arranging discussions with clinical leads in April 2023 about system changes required to gather the necessary data. [07/12/2022 14:11:49 Neil David Elliott] There has been no change to this risk since February 2022. The organisation is still using agency staff to submit the data that we are able to extract from our systems. We are not able to submit PARIS data until a system upgrade and re-design is achieved. Current estimate is that 60-70% of the data that should form part of this dataset is being submitted. [18/05/2022 10:10:09 Neil David Elliott] The risk score has been reviewed by CASCIT and agreed that Performance risk would score 3 (Moderate - failure to meet national standards) and the likelihood would remain at 5 as the PARIS data would not be able to be included until the system changes had occurred. A score of 15 overall.	Catastrophic	Rare	5

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2965	30/11/2020	Corporate Level Risk	Obstetrics	Jonathan Hindley	Joanna Bassett	Chief Operating Officer	Clinical Safety Risk	Obstetrics	HOS. Torbay Hospital Delivery Suite	Access to an Emergency Theatre for Obstetric Cases	Cause: Due to the nature of obstetrics, urgent access to an emergency theatre is needed. During the planned upgrade to theatres there have been occurrences where treatment has been delayed due to lack of availability of access to an emergency theatre. Effect: 1) Inability to provide care within nationally recommended timescales, eg Category 1 LSCS within 30 mins. 2) Potential delays may result in life threatening harm to a mother. or a baby	Catastrophic	Possible	15	1) Daily morning safety huddle involving obstetrics, anaesthetics and theatre, to include which theatres are available, which lists could be 'crashed' 2) Review of position at each handover 3) Monday and Thursday - Theatre 10 (Griffin Suite) available	1) Still potential that we are unable to go straight to theatre if clinically indicated.	10/05/2023	Catastrophic	Possible	15	[22/03/2023 10:30:05 Anne-Marie Whiting] Maternity Services have had no update on the thatre provision. Gwen Hotine to email Derren Westacott to get an update on the progress. [23/11/2022 10:41:26 Claire Jones] Consultation process ongoing for theatre staff. Awaiting outcome early Jan. [27/07/2022 10:37:01 Anne-Marie Whiting] Trust board have approved funding to recruit additional staff in theaters to support a second theatre provision. SOP produced to provide additional mitigation whilst waiting recruitment of staff.	Catastrophic	Rare	5
3200	01/07/2021	Corporate Level Risk	Paediatrics (Child Health)	Stephen Holman	Shelly Machin	Chief Operating Officer	Clinical Safety Risk	Paediatrics	HOS. Torbay Hospital Outpatients Department	Demand Exceeding Capacity Within The Paediatric Eating Disorder Pathway	Cause: The paediatric team have experienced a 400% increase in referrals over the last year. Effect: This has had a significant impact on both nursing staff and medical staff capacity to provide a comprehensive service which is resulting in an increase of acute/complex and pervasive presentations resulting in long or repeated hospital admissions.	Moderate	Almost Certain	15	1. Cases are prioritised and risk assessed 2. Additional clinic established once a week to review urgent patients for admission avoidance 3. Weekly ward rounds to review patients 4. Dietetic professional lead weekly review of patients	1. Limited Nursing and medical capacity to provide service	07/04/2023	Moderate	Almost Certain	15	[19/01/2023 13:56:53 Natalie Tidball] Demand unchanged. Discussed with ED leads and risk to remain as it is. Discussed monthly with wider Child Health team at Senate. Review date changed [17/10/2022 15:48:34 Rebecca Hudson] Review date extended to end of Month. Risk due to be reviewed by the Child Health team and was flagged at governance meeting on 12/10 that this needs a thorough review to assess if risk remains and narrative is unchanged as it has been on the register for over 1 year. Risk handler changed to N Tidball - interim CGC [18/07/2022 11:31:29 Rebecca Hudson] Demand is unchanged. Interal service review underway. Lead Clinican has been re-allocated and HCA team being upskilled to be able to support to allow more efficient allocation of current resource to support service delivery.	Moderate	Unlikely	6
3293	14/10/2021	Corporate Level Risk	Torbay Pharmaceuticals	David Houghton	Emma Rooth	Deputy Chief Executive Officer - Dave Stacey	Financial Risk	Torbay Pharmaceuticals	Torbay Pharmaceuticals	ITH Pharma- Loss of Future Revenues	Cause: Risk of loss of future revenues as a result of insolvency. Effect: ITH Pharma has been charged with seven counts of supplying a medicinal product which was not of the nature or quality specified in the prescription on 27 May 2014. If the courts find against ITH, there are likely to be substantial fines and penalties which may affect the ability to continue trading.	Catastrophic	Possible	15	1. No controls possible - external factor. 2. TP monitor progress of court case, along with updates from their credit insurance provider.	1. No controls possible - external factor.	31/10/2023	Catastrophic	Possible	15	[28/04/2023 09:20:55 Kim Hodder] Following review no changes/updates and continue to monitor [05/09/2022 10:04:29 Kim Hodder] TP continues to monitor ITH. [25/02/2022 15:08:49 Kim Hodder] Dave Houghton has spoken with Andrew Winstanley (Sales Director) at ITH Pharma. Andrew advised that ITH Pharma have had the full support of their bankers and insurers since the incidents in May 2014, and no restrictions have been placed on them (including the MHRA). He is going to share with Dave a redacted letter between ITH and their bankers that should provide some reassurance of this position.	Catastrophic	Possible	15

Paper as circulated for 26 April 2023 meeting.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Briefing: NHS Standard Form Licence			Meeting date: 31 May 2023
Report appendix	Appendix 1- Current NHS Standard Form Licence Appendix 2 – Revoked NHS Standard Form Licence		
Report sponsor	Director of Corporate Governance and Trust Secretary		
Report author	Director of Corporate Governance and Trust Secretary		
Report provenance	n/a		
Purpose of the report and key issues for consideration/decision	It should be noted that the enclosed report was received by the Board at their meeting on 26 April 2023 in private session as the meeting was held within a pre-election sensitivity period. The paper is being re-circulated in Public session for openness and transparency. It is therefore provided for information only. Brief the Board on the new NHS provider standard form licence issued on 28 March 2023, effective 1 April 2023.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	To receive the report as an information item, having regard to the NHS provider standard form licence appended; noting variances from the previous superseded version.		

Summary of key elements

Strategic goals supported by this report

Excellent population health and wellbeing		**Excellent experience receiving and providing care**	
Excellent value and sustainability	**X**		

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

Board Assurance Framework	n/a	**Risk score**	
Risk Register	n/a	**Risk score**	

External standards affected by this report and associated risks

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

Report title: Briefing: NHS Standard Form Licence		**Meeting date: 31 May 2023**
Report sponsor	Director of Corporate Governance and Trust Secretary	
Report author	Director of Corporate Governance and Trust Secretary	

Introduction

The Board of Torbay and South Devon NHS Foundation Trust (The "Trust") are asked the note the enclosed briefing and newly issued NHS Standard Form Licence conditions, which, together with the updated cover page forms the Trust's provider licence of operation, as issued by NHS England ("NHSE"), together (the "Licence"). The Licence sets out the operational standards and regulatory oversight parameters within which the Trust must operate in the delivery of services, as directed by NHS England.

The new licence was published on 28 March 2023 and effective 1 April 2023, superseding and revoking the previous licence.

This Licence (**Appendix 1**) has been provided with annotations to facilitate the Board's review and interpretation; with newly added sections, deletions and amendments noted with additional commentary provided, where appropriate.

A summary and reflection on those changes can be found below.

Summary: Licence provisions

Enclosed as **Appendix 1** is the Licence, as noted above. Also enclosed as **Appendix 2** is the previous issue, now fully revoked and superseded.

A brief summary of these changes is provided below. Key themes and modifications:
New Condition: WS1 "Cooperation" Integrated care/system working with a positive obligation to engage

- The inclusion of this new condition creates a positive obligation on providers to cooperate and collaborate with System partners, this is a key theme of the new Licence; failure to act and to do so with the best interests of the people of Devon in mind will now fall foul of the prescribed regulatory framework and could therefore theoretically lead to regulatory intervention. Application and learning from other Trusts as the new Integrated Care System ("ICS") system embeds will be our main source of learning here.
- NHSE commentary stated that the Condition *"requires NHS trusts, foundation trusts and NHS controlled providers to consistently cooperate with ICBs, Local Authorities and other organisations that deliver NHS care when developing and delivering system plans, delivering NHS services, improving NHS services, delivering system financial plans and delivering system workforce plans"*
- Furthermore, NHSE reported that "*The condition is intentionally drafted broadly to account for the wide range of services delivered across the NHS and is supported by established good practice and the standard NHS contract; providers and systems are supported in meeting expectations through a number of resources for integrated care and clear guidance addressing health inequalities through Core20PLUS5.*"
- This condition is not extended to independent providers.

New Condition: WS2 the Triple Aim

- A new condition has been created which requires NHS trusts, foundation trusts and NHS controlled providers to have regard for and consider the likely effects of their decisions on the Triple Aim and have regard to related guidance. This aligns with the broader themes of stakeholder engagement now found within the Companies Act 2006 and related reporting (s172 reporting – the duty to act with regard to the best interests of your shareholders whilst having regard to broader stakeholders, demonstrably within decision making).
- The Triple Aim is a key element of the Health and Care Act 2022 ("HCA22") and was intended to ensure the legislative framework supports local health and care organisations to work together in the interests of the populations they serve.
    - The 'Triple Aim' (referred to as the 'duty to have regard to wider effect of decisions' in the Bill for the HCA22) is a common duty for NHS bodies that plan and commission services (NHS England and ICBs) and that provide services (Trusts and Foundation Trusts).
    - It obliges these bodies to consider the effects of their decisions on:
        - the health and wellbeing of the people of England (including inequalities in that health and wellbeing);
        - the quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services); and
        - the sustainable and efficient use of resources by both themselves and other relevant bodies.
    - The aim (taken from supporting commentary from the HCA2022 as a Bill) is "*to encourage these bodies to not only continue a culture of working in the best interest of their immediate service users and organisations, but also on public health, prevention and reducing health disparities for the wider population, and will include working together strategically with other relevant bodies and the public. We hope that the Triple Aim will help align NHS bodies around a common set of objectives, thus supporting the shift towards integrated local health and care systems which have strong engagement with their communities. At report stage in the House of Lords, the government tabled amendments to explicitly include consideration of inequalities in health and wellbeing and the benefits of services in the Triple Aim*."
    - Furthermore, NHSE commentary stated that "*NHS England will keep under review whether developing further guidance would help support progress in this area*." As with many areas of the new Licence, whilst clear direction is set, the boundaries and demonstrable measures of compliance are less clear. We will therefore need to act in the spirit of this and await further clarity. The Board could perhaps consider adding the satisfaction of this principle to their cover sheets, so that as with risk, collaboration and the Triple Aim is in the forefront of our thinking.

New Condition: WS3 Digital Transformation

- This new Condition requires NHS trusts, foundation trusts and NHS controlled providers to comply with the information standards of section 250 of the Health and Social Care Act 2012 and with guidance related to digital maturity as they pertain to cooperation and the Triple Aim. Therefore, this Condition is reinforcing the

aforementioned new principles, aligned with NHS digital strategies. This will need to align with our BBF and transformation strategies. Consideration should be given as to how we meaningfully report against this.

New Condition: IC2 Personalised care

- New Condition creating an obligation to support the delivery of personalised care and offer control and choice to patients. This replaces the Choice and Competition licence conditions within the previous Licence, which focussed on choice of provider.
- NHSE reported that *"ICBs will need to consider how to incorporate personalised care alongside other priorities included in operational planning guidance and the Long Term Plan. The Universal Personalised Care guidance, co-produced with key stakeholders including people with lived experience, can support providers to offer personalised care, including supporting patients to have better control over their own healthcare budget. Furthermore, the Personalised Care Institute has provided a range of quality assured workforce development programmes to support implementation."*
- This crystalises a principle that is likely found within our practices and delivery, consideration will therefore need to be given as to how this is articulated in line with the new Licence terminology and focus; reviewing key strategies, policies and procedures to encourage personalised care.

Amendment to existing Condition: Increased control and ability to intervene to the continuity of services (CoS) licence conditions

- NHSE reported that the intention of amending and reorganising these conditions was "*adding specific quality governance related criteria to the continuity of services (CoS) licence conditions and establishing a category of 'hard to replace' independent providers of NHS services, as designated by NHS England, to whom some of the CoS conditions will also apply*".

- The focus of this section has been to:
  - allow NHSE to define Hard to Replace Providers and apply continuity of service conditions to them;
  - introduce specific quality governance related criteria to the continuity of services (CoS), applicable to the provider and Hard to Replace Providers; and
  - make broader provision for regulatory intervention (previously limited to a provider being a going concern) which enables NHSE to take action should the COS and quality measures not be met; permitting NHSE to inspect information, oversee and appoint management to effectively direct the Trusts activities:
    - Linked closed consultation on Hard to Replace Providers: Consultation on the draft updated risk assessment framework and reporting manual for independent sector providers of NHS services - NHS England - Citizen Space
    - The specific amendments in this regard are highlighted within "*CoS 3: Standards of corporate governance, financial management and quality governance".*
  - The increased power for regulatory intervention linked to quality and system "stress" in the event of a service potentially failing is a significant change in the Licence. Its pertinence should be borne in mind by the Board in seeking risk and assurance information. The lack of a benchmark as to what signifies acceptable "quality" is a gap. Guidance will likely be issued in due course, thought the NHS

System Oversight Framework ("SOF") could provide a mechanism for oversight alongside CQC reporting.

New Sub-Condition(s): Climate and environment

- Trusts must "*have regard to guidance on tackling climate change*" and "*have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health*".
- This is a new focus and reporting against compliance should be considered.

Amendment to existing Conditions (now C1-3& P1): Shifting the focus of the costing conditions to support integration and improvement

- Due to the reshaping of previous provisions it was necessary to restructure this section, as outlined below. Commentary is limited here to allow analysis by finance colleagues in due course, pending further NHSE guidance, as per the *"Response to NHS England's consultation on the provider licence*" Healthcare Financial Management Association guidance on the consultation of the Licence's financial aspects; which identified a need for further clarity. Relevant NHSE extracts copied into the document attached for ease of reference.
- Replace:
  - Pricing Condition 1 with new Costing Condition 1: Submission of costing information
  - Pricing Condition 2 with new Costing Condition 2: Provision of costing and costing related information
  - Pricing Condition 3 with new Costing Condition 3: Assuring the accuracy of pricing and costing information.
- Remove:
  - Pricing Condition 4 (renamed as Pricing Condition 1) – to apply the rules and methods of charging for the provision of NHS services as set out in the NHS Payment Scheme.
- Update:
  - Pricing Condition 5 (local modifications) from the licence.

Streamlining reporting requirements (See NHS2)

- The changes here could have been significant, however, having reviewed the reissued ARM (Annual Reporting Manual) there will be changes in reporting mechanisms, however much of the same information will still need to be produced for the annual report.
  - Remove reporting requirements from General Condition 6 (Systems for compliance), which requires licensees to self-certify against the licence.
  - Remove Foundation Trust Condition 4/Controlled Provider condition 1, which requires foundation trusts to report on past and future compliance with the licence (annual certification) and to prepare a Corporate Governance Statement.
  - As above, the Licence will still need to be referred to and an assurance position confirmed as well as a corporate governance statement being provided, these will simply not be reported additionally and separately going forward.

Amending the Fit and Proper Persons condition (G3)

- Adopting the changes to licence condition G4: Fit and Proper Persons as per the consultation run by Monitor in February-March 2021 and bringing it into line with current law.

Removal of obsolete sections:

- General Condition 3: Payment of fees to Monitor
- Foundation Trust Condition 2: Payment to Monitor in respect of registration and related costs
- Foundation Trust Condition 3: Provision of information to advisory panel.

Further detail of the changes can also be found on the NHSE website, link here: NHS England » NHS Provider Licence: consultation response

Conclusion

The regulatory landscape for the Trust is undoubtably changing, the HCA22, the new Licence, the Hewitt Review 2023 all indicate a change in regulatory intent with the grounding for the Integrated Care System to flourish being laid, with the focus being on the success of the individual systems for the benefit of their populations. There are strong messages of collaboration and cooperation, user experience (physical and digital), our interaction with the physical environment and the quality of service delivered, combined with greater power to take enforcement action – if necessary.

Recommendations

The Board are asked to receive and note this report, giving consideration as to how we as a Trust can embed the key themes of the Licence, illustrating a desire to act in its spirit, awaiting more detailed guidance from NHSE in due course.

It is pertinent to consider how these principles can be distilled and reflected in our decision making, strategy development, risk and assurance mechanisms as we review these in the course of our usual governance activity.

In the interim, the new Licence conditions should be reviewed in accordance with the Business Assurance Framework and Risk Register to ensure that risk based compliance is monitored.

Consideration could also be given to amending the standard Board report template and/or coversheet to encourage the author to consider the core principles of supporting system working, the Triple Aim, quality of service and financial viability and how their proposal incrementally supports one or all of these.

Torbay and South Devon NHS Foundation Trust

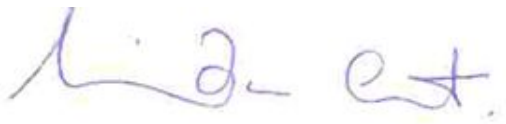
Torbay Hospital

Torquay

TQ2 7AA

Licence number: 110102

Date of issue	**Version number**
1 April 2023	2



Miranda Carter
Director of Provider Development, NHS England

Version History

Version number	Date	Comments
1.0	1 October 2015	Created
2.0	31 March 2023	Modified licence standard conditions

Classification: Official

Publication reference: PR00191

NHS Provider Licence

Standard Conditions

31 March 2023

Version History

Version number	Date	Comments
1.0	26 March 2013	Created
2.0	04 April 2013	Formatting changes
3.0	27 October 2022	Draft updated licence for consultation
4.0	31 March 2023	Updated licence conditions

Contents

NHS Provider Licence Standard Conditions

Previous licence effective to 31/03/23 started at Section 3, meaning sections 1 & 2 are new.

Removal of obsolete sections:
General Condition 3: Payment of fees to Monitor
Foundation Trust Condition 2: Payment to Monitor in respect of registration and related costs
Foundation Trust Condition 3: Provision of information to advisory panel.

Amendments noted in each section.

New condition

NHSE - intention to reframe: IC1 Provision of Integrated Care - as a positive obligation that all providers take steps to integrate services and enable cooperation with other services to improve quality and reduce inequalities of access and outcomes.

Section 1 – Integrated Care

IC1: Provision of Integrated care

1. The Licensee shall act in the interests of the people who use health care services by ensuring that its provision of health care services for the purposes of the NHS:
    i) is integrated with the provision of such services by others, and
    ii) is integrated with the provision of health-related services or social care services by others and
    iii) enables co-operation with other providers of health care services for the purposes of the NHS

   where this would achieve one or more of the objectives referred to in paragraph 2.
2. The objectives are:
    a. improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,
    b. reducing inequalities between persons with respect to their ability to access those services, and
    c. reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.
3. The Licensee shall have regard to guidance as may be issued by NHS England from time to time for the purposes of paragraphs 1 and 2 of this Condition.
4. Nothing in this licence condition requires the licensee to take action or share information with other providers of health care services for the purposes of the NHS if the action or disclosure of the information would materially prejudice its commercial or charitable interests.

New condition.

IC2 Personalised care and Patient Choice - to require providers to support the implementation and delivery of personalised care by having regard for relevant guidance and legislation, offering people control to manage their own health and wellbeing.
ICBs will need to consider how to incorporate personalised care alongside other priorities included in operational planning guidance and the Long Term Plan. The Universal Personalised Care guidance, co-produced with key stakeholders including people with lived experience, can support providers to offer personalised care, including supporting patients to have better control over their own healthcare budget. Furthermore, the Personalised Care Institute has provided a range of quality assured workforce development programmes to support implementation.

IC2: Personalised Care and Patient Choice

1. The Licensee shall support the implementation and delivery of personalised care by complying with legislation and having due regard to guidance on personalised care.
2. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee must ensure people who use their services are offered information, choice and control to manage their own health and well-being to best meet their circumstances, needs and preferences, working in partnership with other services where required.
3. Subsequent to a person becoming a patient of the Licensee, and for as long the person remains a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, the person is notified of that choice and told where information about that choice can be found.
4. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.
5. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.
6. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

New condition.

WS1 "Cooperation" Integrated care/system working with a positive obligation to engage"requires NHS trusts, foundation trusts and NHS controlled providers to consistently cooperate with ICBs, Local Authorities and other organisations that deliver NHS care when developing and delivering system plans, delivering

Section 2 – Trusts Working in Systems

WS1: Cooperation

1. This condition shall apply if the Licensee is an NHS trust NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall carry out its legal duties to co-operate with NHS bodies and with local authorities.
3. Without prejudice to the generality of paragraph 2, the Licensee shall:
   a. consistently co-operate with:
   - other providers of NHS services; and
   - other NHS bodies, including any Integrated Care Board of which it is a partner;
     i. as necessary and appropriate for the purposes of developing and delivering system plan(s).
     ii. as necessary and appropriate for the purposes of delivering their individual or collective financial responsibilities including but not limited to contributing to the delivery of agreed system financial plans in each financial year
     iii. as necessary and appropriate for the purposes of delivering agreed people and workforce plans

   b. consistently co-operate with:
   - other providers of NHS services;
   - other NHS bodies, including any Integrated Care Board of which it is a partner; and
   - any relevant local authority in England
     i. as necessary and appropriate for the purposes of delivering NHS services.
     ii. as necessary and appropriate for the purposes of improving NHS services.
4. The Licensee shall have regard to such guidance concerning co-operation as may be issued from time to time by either:

a. the Secretary of State for Health and Social Care; or
b. NHS England.

For the purposes of this condition, cooperation is considered synonymous to collaboration.

New condition.

WS2 The Triple Aim - which requires NHS trusts, foundation trusts and NHS controlled providers to have regard for and consider the likely effects of their decisions on the Triple Aim and have regard to related guidance.

WS2: The Triple Aim

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. When making decisions in the exercise of its functions which relate to the provision of health care for the purposes of the NHS, the Licensee shall comply with its duty relating to the triple aim.
3. The Licensee shall have regard to the triple aim and to any guidance published by NHS England under section 13NB of the 2006 Act.
4. In this condition, “the triple aim” refers to the aim of achieving:
    a. better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing)
    b. better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services)
    c. more sustainable and efficient use of resources by NHS bodies,

and “duty relating to the triple aim” means, in relation to an NHS trust, its duty under section 26A of the 2006 Act, and in relation to an NHS foundation trust, its duty under section 63A of the 2006 Act.

New condition.

WS3 Digital Transformation - which requires NHS trusts, foundation trusts and NHS controlled providers to comply with the information standards of section 250 of the Health and Social Care Act 2012 and with guidance related to digital maturity as they pertain to cooperation and the Triple Aim. Links to: a new requirement in NHS2: Governance arrangements paragraph 3(c) and CP1: Governance arrangements for NHS controlled providers paragraph 3(c) to have systems and processes in place to meet guidance on digital maturity.

WS3: Digital Transformation

1. This condition shall apply if the Licensee is an NHS trust, NHS foundation trust or NHS controlled provider of healthcare services for the purposes of the NHS.
2. The Licensee shall comply with information standards published under section 250 of the 2012 Act where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).
3. The Licensee shall comply with required levels of digital maturity as set out in guidance published by NHS England from time to time where they pertain to one or more of the requirements set out in the cooperation condition (WS1) and the Triple Aim condition (WS2).

Section 3 – General Conditions

G1: Provision of information

1. The Licensee shall provide NHS England with such information, documents and reports (together 'information') as NHS England may require for any of the purposes set out in section 96(2) of the 2012 Act. This requirement is in addition to specific obligations set out elsewhere in the licence. If requested by NHS England, the Licensee shall prepare or procure information in order to comply with this condition.
2. Information shall be provided in such manner, in such form, and at such place and times as NHS England may require.
3. The Licensee shall take all reasonable steps to ensure that information is:
    a. in the case of information or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested.
4. This Condition shall not require the Licensee to provide any information which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

G2: Publication of information

1. The Licensee shall comply with any instruction by NHS England, issued for any of the purposes set out in section 96(2) of the 2012 Act, to publish information about the health care services it provides for the purposes of the NHS. The Licensee shall publish the information in such manner as NHS England may instruct.
2. For the purposes of this Condition, “publish” includes making available to the public at large, to any section of the public or to particular individuals.

Amendments.

Adopting the changes to licence condition G4: Fit and Proper Persons as per the consultation run by Monitor in February-March 2021 and bringing it into line with current law. Brings in line with reasonable care, skill and expertise obligations of Directors under the Companies Act 2006

G3: Fit and proper persons as Governors and Directors (also applicable to those performing the functions of, or functions equivalent or similar to the functions of, a director)

1. The Licensee must ensure that a person may not become or continue as a Governor of the Licensee if that person is:
   a. a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
   b. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
   c. a person who has made a composition or arrangement with, or granted a trust deed for, that person's creditors and has not been discharged in respect of it;
   d. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on that person.

2. The Licensee must not appoint or have in place a person as a Director of the Licensee who is not fit and proper.

3. For the purposes of paragraph 2, a person is not fit and proper if that person is:
   a. an individual who does not satisfy all the requirements as set out in paragraph (3) and referenced in paragraph (4) of regulation 5 (fit and proper persons: directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (S.I. 2014/2936); or
   b. an organisation which is a body corporate, or a body corporate with a parent body corporate:
      i. where one or more of the Directors of the body corporate or of its parent body corporate is an individual who does not meet the requirements referred to in sub-paragraph (a);
      ii. in relation to which a voluntary arrangement is proposed, or has effect, under section 1 of the Insolvency Act 1986;

iii. which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking;

iv. which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act;

v. which passes any resolution for winding up;

vi. which becomes subject to an order of a Court for winding up; or

vii. the estate of which has been sequestrated under Part 1 of the Bankruptcy (Scotland) Act 1985.

4. In assessing whether a person satisfies the requirements referred to in paragraph 3(a), the Licensee must take into account any guidance published by

Amendments. Detail below.
Adopting the changes to licence condition G4: Fit and Proper Persons as per the consultation run by Monitor in February-March 2021 and bringing it into line with current law.
Brings in line with reasonable care, skill and expertise obligations of Directors under the Companies Act 2006
Consultation extract:
Effect of the proposed modification
Provisions relating to directors
While the proposed modification (as it applies to directors) is a technical amendment, it would have the effect of extending the scope of the fit and proper person test as set out in the licence to include:
qualifications, competence, skills, experience and ability to properly perform the functions of a director
issues of serious misconduct or mismanagement and
disbarment in relation to safeguarding vulnerable groups and disqualification from office.
In practice, licence holders are already required to comply with these requirements under the FPP Regulations. The effect of the modification is therefore simply to ensure consistency of approach in the provider licence.
The modification also removes the requirement for licence holders to ensure that there are contractual arrangements in place for dealing with directors who are unfit. These provisions are no longer necessary since the introduction of the FPP Regulations prohibits licence holders from appointing, or having in office, an unfit director.
The effect of the modification is also to remove provisions which have become redundant and brings provisions in line with current working practices, details of which are set out in paragraphs 15 to 18 below.
Provisions relating to governors
The FPP Regulations do not apply to governors of NHS foundation trusts. The effect of the proposed modification (as it applies to governors) would be limited to bringing the provisions in line with current working practices, as set out in paragraphs 16 to 18 below, and to make minor changes to the wording to provide greater clarity.
Provisions relating to directors and governors
The proposed modification would remove two provisions which are either redundant or have limited application.
The first of these provisions is the reference to Monitor's discretion to authorise any general exception to the fit and proper person requirements for NHS foundation trust directors and governors. This power has limited application because it applies only to fit and proper person requirements that an NHS foundation trust has included in its constitution and which go beyond the legislative requirements. In practice the power has never been used so the modification would simply remove a provision that is already effectively redundant.
The second is the prohibition on holding office as a director or governor for any person disqualified from holding office as a director under the Company Directors' Disqualification Act 1986. As this provision expressly relates to directors' fitness and goes beyond the legislative framework for governors, it is proposed that it is removed in relation to governors.
For directors, the provision can be removed as it is already covered by the FPP test under the FPP Regulations, which would be incorporated into the licence by the proposed modifications.

Brings section into line with law: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/5
Fit and proper persons: directors
5. --(1) This regulation applies where a service provider is a health service body.
(2) Unless the individual satisfies all the requirements set out in paragraph (3), the service provider must not appoint or have in place an individual --
(a)as a director of the service provider, or
(b)performing the functions of, or functions equivalent or similar to the functions of, such a director.

(3) The requirements referred to in paragraph (2) are that --
(a)the individual is of good character,
(b)the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,
(c)the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,
(d)the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and
(e)none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

(4) In assessing an individual's character for the purposes of paragraph (3)(a), the matters considered must include those listed in Part 2 of Schedule 4.

(5) The following information must be available to be supplied to the Commission in relation to each individual who holds an office or position referred to in paragraph (2)(a) or (b) --
(a)the information specified in Schedule 3, and
(b)such other information as is required to be kept by the service provider under any enactment which is relevant to that individual.
(6) Where an individual who holds an office or position referred to in paragraph (2)(a) or (b) no longer meets the requirements in paragraph (3), the service provider must --
(a)take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements, and
(b)if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

G4: NHS England guidance

1. Without prejudice to specific obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS England for any of the purposes set out in section 96(2) of the 2012 Act.
2. In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS England of the reasons for that decision.

Removal of obligation to prepare and submit a certification of compliance with this provision.
Removal of obligation to prepare a corporate governance statement. See NHS2/CP1

G5: Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
    a. the Conditions of this Licence,
    b. any requirements imposed on it under the NHS Acts, and
    c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
    a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
    b. regular review of whether those processes and systems have been implemented and of their effectiveness.

Detail below:
NHSE Consultation & outcome:
To remove reporting requirements from General Condition 6 (Systems for compliance), which requires licensees to self-certify against the licence, and Foundation Trust Condition 4/Controlled Provider condition 1, which requires foundation trusts to report on past and future compliance with the licence and to prepare a Corporate Governance Statement.
Feedback and response
Responses were in favour of these proposed modifications. 79% of respondents agreed or strongly agreed with the proposed removal of paragraphs 3 and 4 from General Condition 6 of the existing licence. No respondents disagreed with the proposal. 73% agreed or strongly agreed with the proposed removal of the Corporate Governance Statement requirements for NHS trusts, foundation trusts and NHS controlled providers, including 81% of trusts and foundation trusts who responded. 10% of trusts and foundation trusts disagreed or strongly disagreed.
There was broad consensus that these proposals would streamline requirements and reduce burden. However, some respondents noted the usefulness of the Corporate Governance Statement in focusing Board attention to governance processes and compliance issues and would continue this process internally.
Many respondents also noted the range of other reporting mechanisms that would continue, such as the annual report, annual governance statements and through any CQC well-led review. These will require Boards to continue to assess their compliance with corporate governance standards, and evidence of this compliance will continue to be considered as part of well-led assessments. However, removing this requirement would mean providers will no longer have to make statements on anticipated future compliance. On balance, there was a consistent view that any reduction in duplication and regulatory burden was welcome.
Independent providers will continue to self-certify through the Risk Assessment Framework, pending consultation.
Outcome
We have removed the reporting requirements from the final modified licence.

Removed text:
3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.
4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

G6: Registration with the Care Quality Commission

1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able to lawfully provide health care services for the purposes of the NHS.
2. The Licensee shall notify NHS England promptly of:
    a. any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or
    b. the cancellation by the Care Quality Commission for any reason of its registration by that Commission.
3. A notification given by the Licensee for the purposes of paragraph 2 shall:
    a. be made within 7 days of:
        i. the making of an application in the case of paragraph (a), or
        ii. becoming aware of the cancellation in the case of paragraph (b), and
    b. contain an explanation of the reasons (in so far as they are known to the Licensee) for:
        i. the making of an application in the case of paragraph (a), or
        ii. the cancellation in the case of paragraph (b).

G7: Patient eligibility and selection criteria

1. The Licensee shall:
    a. set transparent eligibility and selection criteria,
    b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and
    c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.
2. “Eligibility and selection criteria” means criteria for determining:
    a. whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and
    b. if the person is selected, the manner in which the services are provided to the person.

Cross refer to CoS3/6/7
Removal of redundant clauses from General Condition 9 (now G8)
Allow NHS England to determine and apply continuity of service conditions to Hard to Replace Providers (separate consultation on this definition/scope)
Amend relevant CoS conditions to reference Hard to Replace Providers.
This includes a mechanism added to G8 (Application of section 6 (Continuity of Service)) which sets out that the Continuity of Service conditions shall apply to licensees subject to a contractual obligation as CRS, or as determined by NHS England to be a Hard to Replace provider. CoS3 (Standards of corporate governance and financial management), Cos6 (Cooperation in the event of financial stress) and CoS7 (Availability of resources) will also be amended to refer to Hard to Replace Providers.
NHSE - We have included these provisions in the final modified provider licence due to the importance of ensuring that NHS England has regulatory powers to intervene where the loss of a national, multi-regional or large regional provider would significantly reduce capacity across the NHS and impact access to patients.

G8: Application of section 6 (Continuity of Service)

1. The Conditions in Section 6 shall apply:
    a. whenever the Licensee is subject to a contractual obligation to provide a service to a Commissioner which is contractually agreed to be a Commissioner Requested Service,
    b. whenever the Licensee is subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service by virtue of the process set out in paragraph 2,
    c. where the circumstances set out in paragraph 6 apply (expiry of contract without renewal or extension),
    d. where the circumstances set out in paragraph 7 apply (instruction by NHS England that the Licensee must continue to deliver a service as a Commissioner Requested Service),
    e. whenever the Licensee is determined by NHS England to be a Hard to Replace Provider.
2. A service is designated as a Commissioner Requested Service if:
    a. it is a service which the Licensee is required to provide to a Commissioner under the terms of a contract which has been entered into between them, and
    b. the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either
    c. the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or
    d. the Commissioner, not earlier than the expiry of the 28th day after making that request to the Licensee, has given to NHS England and to the Licensee a notice in accordance with paragraph 4, and NHS England, after giving the Licensee the opportunity to make representations, has issued an instruction in writing in accordance with paragraph 4.
3. A notice in accordance with this paragraph is a notice:
    a. in writing,
    b. stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

c. setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service.

4. An instruction in accordance with this paragraph is an instruction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 2(b) is unreasonable.

5. The Licensee shall give NHS England not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

6. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS England issues either:

a. an instruction of the sort referred to in paragraph 7, or

b. a notice in writing to the Licensee stating that it has decided not to issue such a instruction.

7. If, during the period of a contractual or post contractual obligation to provide a Commissioner Requested Service, NHS England issues to the Licensee an instruction in writing to continue providing that service for a period specified in the instruction, then for that period the service shall continue to be a Commissioner Requested Service.

8. A service shall cease to be a Commissioner Requested Service if:

a. all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service, or

b. NHS England has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

c. the contractual obligation pursuant to which the service is provided has expired and NHS England has issued a notice pursuant to paragraph 6(b) in relation to the service; or

d. the period specified in an instruction by NHS England of the sort referred to in paragraph 7 in relation to the service has expired.

9. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

10. Within 28 days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS England in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

11. In this condition, a provider is a Hard to Replace Provider if it has been identified as such by NHS England based on criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing.

12. A provider will cease to be a Hard to Replace provider if it no longer meets the criteria set out and managed through guidance published by NHS England and NHS England has issued a determination in writing that the provider is no longer a Hard to Replace Provider.

13. In this Condition “NHS contract” has the meaning given to that term in Section 9 of the 2006 Act.

Section 4 – Trust Conditions

NHS1: Information to update the register

1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall make available to NHS England written and electronic copies of the following documents:
    a. the current version of Licensee's constitution;
    b. the Licensee's most recently published annual accounts and any report of the auditor on them, and
    c. the Licensee's most recently published annual report,

and for that purpose shall provide to NHS England written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.
3. Subject to paragraph 4, the Licensee shall provide to NHS England written and electronic copies of any document that is required by NHS England for the purpose of NHS foundation trust register within 28 days of the receipt of the original document by the Licensee.
4. The obligation in paragraph 3 shall not apply to:
    a. any document provided pursuant to paragraph 2;
    b. any document originating from NHS England; or
    c. any document required by law to be provided to NHS England by another person.
5. The Licensee shall comply with any instruction issued by NHS England concerning the format in which electronic copies of documents are to be made available or provided.
6. When submitting a document to NHS England for the purposes of this Condition, the Licensee shall provide to NHS England a short written statement describing the document and specifying its electronic format and advising NHS England that the

document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.

Cross refer - WS3
A new requirement in NHS2: Governance arrangements paragraph 3(c) and CP1: Governance arrangements for NHS controlled providers paragraph 3(c) to have systems and processes in place to meet guidance on digital maturity.
A new requirement in: NHS2 Governance arrangements paragraph 3(b) and CP1 Governance arrangements for NHS controlled providers paragraph 3(b) - to ensure NHS trusts, foundation trusts and NHS Controlled Providers have regard to guidance on tackling climate change.

NHS2: Governance arrangements

1. This Condition shall apply if the Licensee is an NHS trust or NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
    a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
    b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
    c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
    d. comply with the following paragraphs of this Condition.
4. The Licensee shall establish and implement:
    a. effective board and committee structures;
    b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
    c. clear reporting lines and accountabilities throughout its organisation.
5. The Licensee shall establish and effectively implement systems and/or processes:
    a. to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
    b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
    c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;

d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Cross refer - WS3
A new requirement in NHS2: Governance arrangements paragraph 3(c) and CP1: Governance arrangements for NHS controlled providers paragraph 3(c) to have systems and processes in place to meet guidance on digital maturity.
A new requirement in: NHS2 Governance arrangements paragraph 3(b) and CP1 Governance arrangements for NHS controlled providers paragraph 3(b) - to ensure NHS trusts, foundation trusts and NHS Controlled Providers have regard to guidance on tackling climate change
Removal of requirement to produce a corporate governance statement.

Section 5 – NHS Controlled Providers Conditions

CP1: Governance arrangements for NHS-controlled providers

1. This condition shall apply if the Licensee is an NHS-controlled provider of healthcare services for the purposes of the NHS without prejudice to the generality of the other conditions in this Licence.
2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a provider of health care services to the NHS.
3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:
    a. have regard to such guidance on good corporate governance as may be issued by NHS England from time to time
    b. have regard to such guidance on tackling climate change and delivering net zero emissions as NHS England may publish from time to time, and take all reasonable steps to minimise the adverse impact of climate change on health
    c. have corporate and/or governance systems and processes in place to meet any guidance issued by NHS England on digital maturity; and
    d. comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:
    a. effective board and committee structures;
    b. clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
    c. clear reporting lines and accountabilities throughout its organisation and to the NHS body by which it is controlled (as defined below).

5. The Licensee shall establish and effectively implement systems and/or processes:
    a. to operate efficiently, economically and effectively;

b. for timely and effective scrutiny and oversight by the Board of the Licensee's operations;
c. to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;
d. for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
e. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h. to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a. that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b. that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
c. the collection of accurate, comprehensive, timely and up to date information on quality of care;
d. that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e. that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

f. that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Cross refer to G8
Removal of redundant clauses from General Condition 9 (now G8)
Allow NHS England to determine and apply continuity of service conditions to Hard to Replace Providers (separate consultation on this definition/scope)
Amend relevant CoS conditions to reference Hard to Replace Providers.
This includes a mechanism added to G8 (Application of section 6 (Continuity of Service)) which sets out that the Continuity of Service conditions shall apply to licensees subject to a contractual obligation as CRS, or as determined by NHS England to be a Hard to Replace provider. CoS3 (Standards of corporate governance and financial management), Cos6 (Cooperation in the event of financial stress) and CoS7 (Availability of resources) will also be amended to refer to Hard to Replace Providers.
NHSE - We have included these provisions in the final modified provider licence due to the importance of ensuring that NHS England has regulatory powers to intervene where the loss of a national, multi-regional or large regional provider would significantly reduce capacity across the NHS and impact access to patients.

Section 6 – Continuity of Services

CoS 1: Continuing provision of Commissioner Requested services

1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.
2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G8(1)(b), NHS England issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.
3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:
    a. with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or
    b. at any time when this condition applies by virtue of Condition G8(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or
    c. if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS England for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.
4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within 28 days of the alteration, shall give to NHS England notice in writing of the occurrence of the alteration with a summary of its nature.

5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery or provision of that service in a manner which differs from the manner specified and described in:

a. the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or
b. if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or
c. at any time when this Condition applies by virtue of Condition G8(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

CoS 2: Restriction of the disposal of assets

1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")
2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.
3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.
4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS England has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.
5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:
    a. with the consent in writing of NHS England, and
    b. in accordance with the paragraphs 6 to 8 of this Condition.
6. The Licensee shall provide NHS England with such information as NHS England may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.
7. Where consent by NHS England for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.
8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:
    a. NHS England has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:
        i. transactions of a specified description; or
        ii. the disposal of or relinquishment of control over relevant assets of a specified description, and the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or
    b. the Licensee is required by the Care Quality Commission to dispose of a relevant asset.

9. In this Condition:

“disposal”	means any of the following: (a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to “dispose” are to be read accordingly;
“relevant asset”	means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee’s ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;
“relinquishment of control”	includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and “relinquish” and related expressions are to be read accordingly.

10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS England regarding:

a. the manner in which asset registers should be established, maintained and updated, and
b. property, including buildings, interests in land, intellectual property rights and equipment, without which a licensee’s ability to provide

Commissioner Requested Services should be regarded as materially prejudiced.

Amend CoS 3 and CoS 6 to include standards of Quality Governance for Commissioner Requested services and Hard to Replace Providers and provide reasonable safeguards against the licensee being unable to deliver services when standards of quality governance have fallen below expectations.
NHSE- We have included these provisions in the final modified licence given the importance of ensuring that NHS England can intervene as a regulator in the interest of patients.

CoS 3: Standards of corporate governance, financial management and quality governance

1. The Licensee shall at all times adopt and apply systems and standards of corporate governance, quality governance and of financial management which reasonably would be regarded as:
   a. suitable for a provider of the Commissioner Requested Services, provided by the Licensee, or a Hard to Replace Provider,
   b. providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern, and
   c. providing reasonable safeguards against the licensee being unable to deliver services due to quality stress.
2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:
   a. such guidance as NHS England may issue from time to time concerning systems and standards of corporate governance, financial management and quality governance;
   b. the Licensee's ratings using the risk rating methodologies published by NHS England from time to time, and
   c. the desirability of that rating being not less than the level regarded by NHS England as acceptable under the provisions of that methodology.

CoS 4: Undertaking from the ultimate controller

1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS England, that the ultimate controller ("the Covenantor"):

a. will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the NHS Acts or this Licence, and

b. will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS England.

2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

3. The Licensee shall:

a. deliver to NHS England a copy of each such undertaking within seven days of obtaining it;

b. inform NHS England immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

c. comply with any request which may be made by NHS England to enforce any such undertaking.

4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

a. directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and
b. that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

5. A person is not an ultimate controller if they are:
   a. a health service body, within the meaning of section 9 of the 2006 Act;
   b. a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;
   c. any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or
   d. a trustee of the Licensee and the Licensee is a charity.

CoS 5: Risk pool levy

1. The Licensee shall pay to NHS England any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.
2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS England.

Amend CoS 3 and CoS 6 to include standards of Quality Governance for Commissioner Requested services and Hard to Replace Providers and provide reasonable safeguards against the licensee being unable to deliver services when standards of quality governance have fallen below expectations.
NHSE- We have included these provisions in the final modified licence given the importance of ensuring that NHS England can intervene as a regulator in the interest of patients.

CoS 6: Cooperation in the event of financial or quality stress

1. The obligations in paragraph 2 shall apply if NHS England has given notice in writing to the Licensee that it is concerned about:
   a. the ability of the Licensee to continue to provide commissioner requested services due to quality stress
   b. the ability of a Hard to Replace Provider being able to continue to provide its NHS commissioned services due to quality stress, or
   c. the ability of the Licensee to carry on as a going concern.
2. When this paragraph applies the Licensee shall:
   a. provide such information as NHS England may direct to Commissioners and to such other persons as NHS England may direct;
   b. allow such persons as NHS England may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and
   c. co-operate with such persons as NHS England may appoint to assist in the management of the Licensee's affairs, business and property.

CoS 7: Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.
3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS England a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:
    a. “After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.”
    b. “After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources”.
    c. “In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate”.
4. The Licensee shall submit to NHS England with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.
5. The statement submitted to NHS England in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform NHS England immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution" includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;

"Financial Year" means the period of twelve months over which the Licensee normally prepares its accounts;

"Required Resources" means such:

a. management resources including clinical leadership,
b. appropriate and accurate information pertinent to the governance of quality
c. financial resources and financial facilities,
d. personnel,
e. physical and other assets including rights, licences and consents relating to their use,
f. subcontracts , and
g. working capital as reasonably would be regarded as sufficient for a Hard to Replace Provider and/or to enable the Licensee at all times to provide the Commissioner Requested Services.

Significant number of amendments. Some movement, some new sections, some deletions. Commentary below for interpretation to assist finance colleagues.

Section 7 – Costing Conditions

C1: Submission of costing information

1. Whereby NHS England, and only in relation to periods from the date of that requirement, the Licensee shall:

    a. obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information,
    b. establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are necessary to enable it to comply with the following paragraphs of this Condition.

2. Licensee should record the cost and other relevant information required in this condition consistent with the guidance in NHS England's Approved Costing Guidance. The form of data collected, costed and submitted should be consistent with the technical guidance included in the Approved Costing Guidance (subject to any variations agreed and approved with NHS England) and submitted in line with the nationally set deadlines.

3. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS England the Licensee shall procure that each of those sub-contractors:

    a. obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and
    b. provides that information to NHS England in a timely manner.

4. Records required to be maintained by this Condition shall be kept for not less than six years.

5. In this Condition:

“the Approved Guidance”	means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs published annually by NHS England.
“other relevant information”	means such information, which may include quality and outcomes data, as may be required by NHS England for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act and material costs funded through other public sector entities which impact on the accuracy of costing information.

Removing the competition condition: Choice and Competition Condition 2: Competition Oversight.

NHSE
Removing the competition condition: Choice and Competition Condition 2: Competition Oversight.
Commentary:
There was strong support for the removal of the competition oversight condition. 91% of respondents agreed or strongly agreed with the proposal, including 97% of trusts and foundation trusts and 79% of independent providers who responded to the question.
The 2022 Act did not transfer enforcement authority for competition oversight to NHS England as part of the dissolution of Monitor, however general competition law will still apply to prevent against anticompetitive practice.
Outcome:
NHSE have removed the competition condition from the final modified licence.

...
Shifting the focus of the costing conditions to support integration and improvement
Proposal
To replace Pricing Condition 1 with new Costing Condition 1: Submission of costing information
To replace Pricing Condition 2 with new Costing Condition 2: Provision of costing and costing related information
To replace Pricing Condition 3 with new Costing Condition 3: Assuring the accuracy of pricing and costing information.
Feedback and response
68% of respondents agreed or strongly agreed with the modifications related to costing conditions 1 and 2.
63% agreed or strongly agreed with replacing Pricing Condition 3 with the new Costing Condition 3. One foundation trust disagreed with the proposals.
Some respondents raised concerns about the resources required to provide accurate and timely costing data. We are working closely with providers to understand how best to support this. Additionally, the new assurance process will provide trusts and foundation trusts with tools and support to improve the accuracy of data before and after it is utilised in the costing process. We understand this is a shift in approach but expect this should improve patient care and outcomes by embedding data reviews into business as usual. This supports the use of quality-assured costing data in ongoing decision-making. We also expect this to remove the burden currently felt when preparing for a specific costing audit once data reviews become part of ongoing practice.
Some independent providers questioned whether they would be expected to meet the same requirements as trusts and foundation trusts. We expect independent providers to meet the same basic costing requirements to achieve value, consistency, and better patient outcomes. Any work to extend the collection of costing information to independent providers will be co-developed. This would include assessing the granularity and complexity of required data to ensure it is reasonable and providers can complete it from their own records as far as possible.
Outcome
Given the need to bring the conditions related to costing up to date, we have included the proposed Costing Condition 1: Submission of costing information, Costing Condition 2: Provision of costing and costing related information, and Costing Condition 3: Assuring the accuracy of pricing and costing information in the final modified licence.

C2: Provision of costing and costing related information

1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall submit the mandated information required per Costing Condition 1 consistent with the approved costing guidance in the form, manner and the timetable as prescribed.
2. In furnishing information documents and reports pursuant to paragraph 1 the Licensee shall take all reasonable steps to ensure that:
    a. in the case of information (data) or a report, it is accurate, complete and not misleading;
    b. in the case of a document, it is a true copy of the document requested;
3. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

C3: Assuring the accuracy of pricing and costing information

1. Providers are required to have processes in place to ensure itself of the accuracy and completeness of costing and other relevant information collected and submitted to NHS England is as per the Approved Costing Guidance.
2. This may include but is not limited to
    a. Regular assessments by the providers internal and/or external auditor
    b. specific work by NHS England or NHS England nominated representative on costing related issues and
    c. use of tools or other information or assessments of costing information produced by NHS England on costing and other relevant information.
    d. Evidence of the assurance process (including work by the internal or external auditor of the provider) should be maintained and submitted as and when requested by NHS England and may be subject to follow up by NHS England. NHS England reserves the right to undertake specific work at a provider where issues are identified which may be undertaken by a nominated representative.

Section 8 – Pricing Conditions

P1: Compliance with the NHS payment scheme

1. Except as approved in writing by NHS England, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the NHS Payment Scheme published by NHS England in accordance with section 116 of the 2012 Act, wherever applicable.

As above.

NHSE:

Amending the pricing conditions to reflect changes to national policy
Proposal
To update Pricing Condition 4 (renamed as Pricing Condition 1) - to apply the rules and methods of charging for the provision of NHS services as set out in the NHS Payment Scheme.
To remove Pricing Condition 5 (local modifications) from the licence.
Feedback and response
Respondents were in favour of these pricing condition changes, noting that the conditions need to reflect changes to policy and legislation to be effective. 63% agreed or strongly agreed with the proposed wording change to Pricing Condition 4 and 70% agreed or strongly agreed with the proposed removal of Pricing Condition 5. The remaining respondents were neutral.
Some independent providers queried whether this may apply to them in the future and others questioned whether there should be more local system input to pricing. Legislation requires NHS England to consult affected providers and ICBs about changes to the NHS payment scheme. There will always be an opportunity for providers to comment on specific proposed pricing changes before this condition would be extended to independent providers.
Outcome
We have included the modified Pricing Condition 4 and this will become Pricing Condition 1 in the final modified licence. Pricing Condition 5 (local modifications) will be removed.

Section 9 – Interpretation and Definitions

Condition D1: Interpretation and Definitions

1. In this Licence, except where the context requires otherwise, words or expressions set out in the left-hand column of the following table have the meaning set out next to them in the right hand column of the table.

“the 2006 Act”	the National Health Service Act 2006 c.41;
“the 2008 Act”	the Health and Social Care Act 2008 c.14;
“the 2009 Act”	the Health Act 2009 c.21;
“the 2012 Act”	the Health and Social Care Act 2012 c.7;
“the 2022 Act”	The Health and Care Act 2022;
“the Care Quality Commission”	the Care Quality Commission established under section 1 of the 2008 Act;
“Commissioner Requested Service”	a service of the sort described in paragraph 2 of condition G8 which has not ceased to be such a service in accordance with paragraph 8 of that condition;
“Commissioners”	NHS England and any Integrated Care Board and includes any bodies exercising commissioning functions pursuant to a delegation from NHS England or an ICB;
“Director”	includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, (ii) an NHS Trust or (iii) a company constituted under the Companies Act 2006;

“Governor”	a Governor of an NHS foundation trust;
“Hard to replace provider”	has the meaning given in condition G8 of the licence; https://www.engage.england.nhs.uk/consultation/draft-updated-risk-assessment-framework-and-report/
“Integrated Care Board”	a body corporate established by NHS England by virtue of section 14Z25 of the 2006 Act;
“the NHS Acts”	the 2006 Act, the 2008 Act, the 2009 Act; the 2012 Act and the 2022 Act;
NHS Controlled provider	An organisation which is not an NHS trust or NHS foundation trust but is ultimately controlled by one or more NHS trusts and/or foundation trusts, where ‘control’ is defined on the basis of IFRS 10;
“NHS England”	the body named as NHS England in section 1 of the 2022 Act;
“NHS foundation trust”	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act;
“NHS Trust”	an NHS trust established under section 25 of the 2006 Act;
“Relevant bodies”	NHS England, Integrated Care Boards, NHS trusts and NHS foundation trusts in accordance with section 96(2B) of the 2012 Act;
“Trusts”	means NHS foundation trusts and NHS trusts.

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.
3. Unless the context requires otherwise, words or expressions which are defined in the NHS Acts shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.

4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

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This publication can be made available in a number of alternative formats on request.

This publication was withdrawn on 27 March 2023.

The new NHS provider licence can be found on the NHS England website.

NHS Provider Licence Standard Conditions

CONTENTS

Section 1 – General Conditions

Condition G1 – Provision of information

1. Subject to paragraph 3, and in addition to obligations under other Conditions of this Licence, the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for any of the purposes set out in section 96(2) of the 2012 Act.

2. Information, documents and reports required to be furnished under this Condition shall be furnished in such manner, in such form, at such place and at such times as Monitor may require.

3. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that:

   (a) in the case of information or a report, it is accurate, complete and not misleading;

   (b) in the case of a document, it is a true copy of the document requested; and

4. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

Section 1 – General Conditions

Condition G2 – Publication of information

1. The Licensee shall comply with any direction from Monitor for any of the purposes set out in section 96(2) of the 2012 Act to publish information about health care services provided for the purposes of the NHS and as to the manner in which such information should be published.

2. For the purposes of this condition “publish” includes making available to the public, to any section of the public or to individuals.

Section 1 – General Conditions

Condition G3 – Payment of fees to Monitor

1. The Licensee shall pay fees to Monitor in each financial year of such amount as Monitor may determine for each such year or part thereof in respect of the exercise by Monitor of its functions for the purposes set out in section 96(2) of the 2012 Act.

2. The Licensee shall pay the fees required to be paid by a determination by Monitor for the purpose of paragraph 1 no later than the 28th day after they become payable in accordance with that determination.

Section 1 – General Conditions

Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)

1. The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of Monitor.

2. The Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of Monitor.

3. The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of Monitor.

4. If Monitor has given approval in relation to any person in accordance with paragraph 1, 2, or 3 of this condition the Licensee shall notify Monitor promptly in writing of any material change in the role required of or performed by that person.

5. In this Condition an unfit person is:

   (a) an individual;

      (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

      (ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

      (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or

      (iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

   (b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

Section 1 – General Conditions

Condition G5 – Monitor guidance

1 Without prejudice to any obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by Monitor for any of the purposes set out in section 96(2) of the 2012 Act.

2 In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform Monitor of the reasons for that decision.

Section 1 – General Conditions

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   (a) the Conditions of this Licence,

   (b) any requirements imposed on it under the NHS Acts, and

   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Section 1 – General Conditions

Condition G7 – Registration with the Care Quality Commission

1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able lawfully to provide the services authorised to be provided by this Licence.

2. The Licensee shall notify Monitor promptly of:

   (a) any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or

   (b) the cancellation by the Care Quality Commission for any reason of its registration by that Commission.

3. A notification given by the Licensee for the purposes of paragraph 2 shall:

   (a) be made within 7 days of:

      (i) the making of an application in the case of paragraph (a), or

      (ii) becoming aware of the cancellation in the case of paragraph (b), and

   (b) contain an explanation of the reasons (in so far as they are known to the Licensee) for:

      (i) the making of an application in the case of paragraph (a), or

      (ii) the cancellation in the case of paragraph (b).

Section 1 – General Conditions

Condition G8 – Patient eligibility and selection criteria

1. The Licensee shall:

   (a) set transparent eligibility and selection criteria,

   (b) apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and

   (c) publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.

2. "Eligibility and selection criteria" means criteria for determining:

   (a) whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and

   (b) if the person is selected, the manner in which the services are provided to the person.

Section 1 – General Conditions

Condition G9 – Application of Section 5 (Continuity of Services)

1. The Conditions in Section 5 shall apply:

   (a) whenever the Licensee is subject to a contractual or other legally enforceable obligation to provide a service which is a Commissioner Requested Service, and

   (b) from the commencement of this Licence until the Licensee becomes subject to an obligation of the type described in sub-paragraph (a), if the Licensee is an NHS foundation trust which:

      (i) was not subject to such an obligation on commencement of this Licence, and

      (ii) was required to provide services, or was party to an NHS contract to provide services, as described in paragraph 2(a) or 2(b);

for the avoidance of doubt, where Section 5 applies by virtue of this subparagraph, the words "Commissioner Requested Service" shall be read to include any service of a description falling within paragraph 2(a) or 2(b).

2. A service is a Commissioner Requested Service if, and to the extent that, it is:

   (a) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or before 31 March 2013, was required to provide in accordance with condition 7(1) and Schedule 2 in the terms of its authorisation by Monitor immediately prior to the commencement of this Licence, or

   (b) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or after 1 April 2013, was required to provide pursuant to an NHS contract immediately before its authorisation date, or

   (c) any other service which the Licensee has contracted with a Commissioner to provide as a Commissioner Requested Service.

3. A service is also a Commissioner Requested Service if, and to the extent that, not being a service within paragraph 2:

Section 1 – General Conditions

(a) it is a service which the Licensee may be required to provide to a Commissioner under the terms of a contract which has been entered into between them, and

(b) the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either

(c) the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or

(d) the Commissioner, not earlier than the expiry of the [28th] day after making that request to the Licensee, has given to Monitor and to the Licensee a notice in accordance with paragraph 4, and Monitor, after giving the Licensee the opportunity to make representations, has issued a direction in writing in accordance with paragraph 5.

4. A notice in accordance with this paragraph is a notice:

(a) in writing,

(b) stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

(c) setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service

5. A direction in accordance with this paragraph is a direction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 3(b) is unreasonable.

6. The Licensee shall give Monitor not less than [28] days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

7. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested

Service, for the period from the expiry of the contractual obligation until Monitor issues either:

(a) a direction of the sort referred to in paragraph 8, or

(b) a notice in writing to the Licensee stating that it has decided not to issue such a direction.

8. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, Monitor issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then for that period the service shall continue to be a Commissioner Requested Service.

9. No service which the Licensee is subject to a contractual or other legally enforceable obligation to provide shall be regarded as a Commissioner Requested Service and, as a consequence, no Condition in Section 5 shall be of any application, during any period for which there is in force a direction in writing by Monitor given for the purposes of this condition and of any equivalent condition in any other current licence issued under the 2012 Act stating that no health care service provided for the purposes of the NHS is to be regarded as a Commissioner Requested Service.

10. A service shall cease to be a Commissioner Requested Service if:

(a) all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and Monitor has issued a determination in writing that the service is no longer a Commissioner Requested Service, or

(b) Monitor has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

(c) it is a Commissioner Requested Service by virtue only of paragraph 2(a) above and 3 years have elapsed since the commencement of this Licence; or

(d) it is a Commissioner Requested Service by virtue only of paragraph 2(b) above and either 3 years have elapsed since 1 April 2013 or 1 year has elapsed since the commencement of this Licence, whichever is the later; or

(e) the contractual obligation pursuant to which the service is provided has expired and Monitor has issued a notice pursuant to paragraph 7(b) in relation to the service; or

(f) the period specified in a direction by Monitor of the sort referred to in paragraph 8 in relation to the service has expired.

11. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

12. Within [28] days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to Monitor in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

13. Unless it is proposes to cease providing the service, the Licensee shall not make any application to Monitor for a determination in accordance with paragraph 10(b):

(a) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(a) above, in the period of 3 years since the commencement of this Licence or

(b) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(b), in the period until the later of 1 April 2016 or 1 year from the commencement of this Licence.

14. In this Condition “NHS contract” has the meaning given to that term in Section 9 of the 2006 Act.

Section 2 – Pricing

Condition P1 – Recording of information

1. If required in writing by Monitor, and only in relation to periods from the date of that requirement, the Licensee shall:

   (a) obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, and

   (b) establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information,

   as are necessary to enable it to comply with the following paragraphs of this Condition.

2. From the time of publication by Monitor of Approved Reporting Currencies the Licensee shall maintain records of its costs and of other relevant information broken down in accordance with those Currencies by allocating to a record for each such Currency all costs expended by the Licensee in providing health care services for the purposes of the NHS within that Currency and by similarly treating other relevant information.

3. In the allocation of costs and other relevant information to Approved Reporting Currencies in accordance with paragraph 2 the Licensee shall use the cost allocation methodology and procedures relating to other relevant information set out in the Approved Guidance.

4. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by Monitor the Licensee shall procure that each of those sub-contractors:

   (a) obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and

   (b) provides that information to Monitor in a timely manner.

5. Records required to be maintained by this Condition shall be kept for not less than six years.

Section 2 – Pricing

6. In this Condition:

"the Approved Guidance"	means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs by reference to Approved Reporting Currencies as may be published by Monitor;
"Approved Reporting Currencies"	means such categories of cost and other relevant information as may be published by Monitor;
"other relevant information"	means such information, which may include quality and outcomes data, as may be required by Monitor for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act.

Section 2 – Pricing

Condition P2 – Provision of information

1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for the purpose of performing its functions under Chapter 4 in Part 3 of the 2012 Act.

2. Information, documents and reports required to be furnished under this Condition shall be furnished in such manner, in such form, at such place and at such times as Monitor may require.

3. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that:

   (a) in the case of information or a report, it is accurate, complete and not misleading;

   (b) in the case of a document, it is a true copy of the document requested; and

4. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

Section 2 – Pricing

Condition P3 – Assurance report on submissions to Monitor

1. If required in writing by Monitor the Licensee shall, as soon as reasonably practicable, obtain and submit to Monitor an assurance report in relation to a submission of the sort described in paragraph 2 which complies with the requirements of paragraph 3.

2. The descriptions of submissions in relation to which a report may be required under paragraph 1 are:

   (a) submissions of information furnished to Monitor pursuant to Condition P2, and

   (b) submissions of information to third parties designated by Monitor as persons from or through whom cost information may be obtained for the purposes of setting or verifying the National Tariff or of developing non-tariff pricing guidance.

3. An assurance report shall meet the requirements of this paragraph if all of the following conditions are met:

   (a) it is prepared by a person approved in writing by Monitor or qualified to act as auditor of an NHS foundation trust in accordance with paragraph 23(4) in Schedule 7 to the 2006 Act;

   (b) it expresses a view on whether the submission to which it relates:

      (i) is based on cost records which have been maintained in a manner which complies with paragraph 2 in Condition P1;

      (ii) is based on costs which have been analysed in a manner which complies with paragraph 3 in Condition P1, and

      (iii) provides a true and fair assessment of the information it contains.

Section 2 – Pricing

Condition P4 – Compliance with the National Tariff

1. Except as approved in writing by Monitor, the Licensee shall only provide health care services for the purpose of the NHS at prices which comply with, or are determined in accordance with, the national tariff published by Monitor, in accordance with section 116 of the 2012 Act.

2. Without prejudice to the generality of paragraph 1, except as approved in writing by Monitor, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the national tariff published by Monitor in accordance with, section 116 of the 2012 Act, wherever applicable.

Section 2 – Pricing

Condition P5 – Constructive engagement concerning local tariff modifications

1. The Licensee shall engage constructively with Commissioners, with a view to reaching agreement as provided in section 124 of the 2012 Act, in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications.

Section 3 – Choice and Competition

Section 3 – Choice and Competition

Condition C1- The right of patients to make choices

1. Subsequent to a person becoming a patient of the Licensee and for as long as he or she remains such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, he or she is notified of that choice and told where information about that choice can be found.

2. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.

3. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.

4. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

Section 3 – Choice and Competition

Condition C2 – Competition oversight

1. The Licensee shall not:

   (a) enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS, or

   (b) engage in any other conduct which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS,

   to the extent that it is against the interests of people who use health care services.

Section 4 – Integrated care

Condition IC1 – Provision of integrated care

1. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services by others with a view to achieving one or more of the objectives referred to in paragraph 4.

2. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of health-related services or social care services by others with a view to achieving one or more of the objectives referred to in paragraph 4.

3. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling it to co-operate with other providers of health care services for the purposes of the NHS with a view to achieving one or more of the objectives referred to in paragraph 4.

4. The objectives referred to in paragraphs 1, 2 and 3 are:

   (a) improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,

   (b) reducing inequalities between persons with respect to their ability to access those services, and

   (c) reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

5. The Licensee shall have regard to such guidance as may have been issued by Monitor from time to time concerning actions or behaviours that might reasonably be regarded as against the interests of people who use health care services for the purposes of paragraphs 1, 2 or 3 of this Condition.

Section 5 – Continuity of Services

Condition CoS1 – Continuing provision of Commissioner Requested Services

1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.

2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G9(1)(b), Monitor issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.

3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:

   (a) with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or

   (b) at any time when this condition applies by virtue of Condition G9(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or

   (c) if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by Monitor for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.

4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within [28] days of the alteration, shall give to Monitor notice in writing of the occurrence of the alteration with a summary of its nature.

5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery

or provision of that service in a manner which differs from the manner specified and described in:

(a) the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or

(b) if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or

(c) at any time when this Condition applies by virtue of Condition G9(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

Section 5 – Continuity of Services

Condition CoS2 – Restriction on the disposal of assets

1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")

2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.

3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.

4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if Monitor has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.

5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:

   (a) with the consent in writing of Monitor, and

   (b) in accordance with the paragraphs 6 to 8 of this Condition.

6. The Licensee shall furnish Monitor with such information as Monitor may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.

7. Where consent by Monitor for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.

8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:

   (a) Monitor has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:

      (i) transactions of a specified description; or

      (ii) the disposal of or relinquishment of control over relevant assets of a specified description, and

   the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or

Section 5 – Continuity of Services

(b) the Licensee is required by the Care Quality Commission to dispose of a relevant asset.

9. In this Condition:

"disposal"	means any of the following: (a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to "dispose" are to be read accordingly;
"relevant asset"	means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;
"relinquishment of control"	includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and "relinquish" and related expressions are to be read accordingly.

10. The Licensee shall have regard to such guidance as may be issued from time to time by Monitor regarding:

(a) the manner in which asset registers should be established, maintained and updated, and

Section 5 – Continuity of Services

(b) property, including buildings, interests in land, intellectual property rights and equipment, without which a licence holder's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.

Section 5 – Continuity of Services

Condition CoS3 – Standards of corporate governance and financial management

1. The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:

   (a) suitable for a provider of the Commissioner Requested Services provided by the Licensee, and

   (b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.

2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:

   (a) such guidance as Monitor may issue from time to time concerning systems and standards of corporate governance and financial management;

   (b) the Licensee's rating using the risk rating methodology published by Monitor from time to time, and

   (c) the desirability of that rating being not less than the level regarded by Monitor as acceptable under the provisions of that methodology.

Section 5 – Continuity of Services

Condition CoS4 – Undertaking from the ultimate controller

1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by Monitor, that the ultimate controller ("the Covenantor"):

   (a) will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the 2012 Act or this Licence, and

   (b) will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to Monitor.

2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

3. The Licensee shall:

   (a) deliver to Monitor a copy of each such undertaking within seven days of obtaining it;

   (b) inform Monitor immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

   (c) comply with any request which may be made by Monitor to enforce any such undertaking.

4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

   (a) directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and

Section 5 – Continuity of Services

(b) that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

5. A person is not an ultimate controller if they are:

(a) a health service body, within the meaning of section 9 of the 2006 Act;

(b) a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;

(c) any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or

(d) a trustee of the Licensee and the Licensee is a charity.

Section 5 – Continuity of Services

Condition CoS5 – Risk pool levy

1. The Licensee shall pay to Monitor any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.

2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by Monitor.

Section 5 – Continuity of Services

Condition CoS6 – Co-operation in the event of financial stress

1. The obligations in paragraph 2 shall apply if Monitor has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.

2. When this paragraph applies the Licensee shall:

   (a) provide such information as Monitor may direct to Commissioners and to such other persons as Monitor may direct;

   (b) allow such persons as Monitor may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and

   (c) co-operate with such persons as Monitor may appoint to assist in the management of the Licensee's affairs, business and property.

Section 5 – Continuity of Services

Condition CoS7 – Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

   (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

   (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".

   (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

4. The Licensee shall submit to Monitor with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to Monitor in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

Section 5 – Continuity of Services

6. The Licensee shall inform Monitor immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution"	includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;
"Financial Year"	means the period of twelve months over which the Licensee normally prepares its accounts;
"Required Resources"	means such: (a) management resources, (b) financial resources and financial facilities, (c) personnel, (d) physical and other assets including rights, licences and consents relating to their use, and (e) working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.

Section 6 – NHS Foundation Trust Conditions

Condition FT1 – Information to update the register of NHS foundation trusts

1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall ensure that Monitor has available to it written and electronic copies of the following documents:

   (a) the current version of Licensee's constitution;

   (b) the Licensee's most recently published annual accounts and any report of the auditor on them, and

   (c) the Licensee's most recently published annual report,

   and for that purpose shall provide to Monitor written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.

3. Subject to paragraph 4, the Licensee shall provide to Monitor written and electronic copies of any document that is required by Monitor for the purpose of Section 39 of the 2006 Act within 28 days of the receipt of the original document by the Licensee.

4. The obligation in paragraph 3 shall not apply to:

   (a) any document provided pursuant to paragraph 2;

   (b) any document originating from Monitor; or

   (c) any document required by law to be provided to Monitor by another person.

5. The Licensee shall comply with any direction issued by Monitor concerning the format in which electronic copies of documents are to be made available or provided.

6. When submitting a document to Monitor for the purposes of this Condition, the Licensee shall provide to Monitor a short written statement describing the document and specifying its electronic format and advising Monitor that the document is being sent for

the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act**.**

Section 6 – NHS Foundation Trust Conditions

Condition FT2 – Payment to Monitor in respect of registration and related costs

1. The obligations in the following paragraph of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. Whenever Monitor determines in accordance with section 50 of the 2006 Act that the Licensee must pay to Monitor a fee in respect of Monitor's exercise of its functions under sections 39 and 39A of that Act the Licensee shall pay that fee to Monitor within 28 days of the fee being notified to the Licensee by Monitor in writing.

Section 6 – NHS Foundation Trust Conditions

Condition FT3 – Provision of information to advisory panel

1. The obligation in the following paragraph of this Condition applies if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall comply with any request for information or advice made of it under Section 39A(5) of the 2006 Act.

Section 6 – NHS Foundation Trust Conditions

Condition FT4 – NHS foundation trust governance arrangements

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

   (a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and

   (b) comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

   (a) effective board and committee structures;

   (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

   (c) clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:

   (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

   (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;

   (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Section 6 – NHS Foundation Trust Conditions

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to Monitor within three months of the end of each financial year:

   (a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and

   (b) if required in writing by Monitor, a statement from its auditors either:

      (i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

      (ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

Section 7 – Interpretation and Definitions

Condition D1 – Interpretation and Definitions

1. In this Licence, except where the context requires otherwise, words or expressions set out in the left hand column of the following table have the meaning set out next to them in the right hand column of the table.

"the 2006 Act"	the National Heath Service Act 2006 c.41;
"the 2008 Act"	the Health and Social Care Act 2008 c.14;
"the 2009 Act"	the Health Act 2009 c.21;
"the 2012 Act"	the Health and Social Care Act 2012 c.7;
"the Care Quality Commission"	the Care Quality Commission established under section 1 of the 2008 Act;
"clinical commissioning group"	a body corporate established pursuant to section 1F and Chapter A of Part 2 of the 2006 Act;
"Commissioner Requested Service"	a service of the sort described in paragraph 2 or 3 of condition G9 which has not ceased to be such a service in accordance with paragraph 9 of that condition;
"Commissioners"	includes the NHS Commissioning Board and any clinical commissioning group;
"Director"	includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, or (ii) a company constituted under the Companies Act 2006;
"Governor"	includes any person who, in any organisation, performs the functions of, or functions equivalent or

	similar to those of, a Governor of an NHS foundation trust as specified by statute;
"the NHS Acts"	the 2006 Act, the 2008 Act, the 2009 Act and the 2012 Act;
"NHS Commissioning Board"	the body corporate established under section 1E of, and Schedule A1 to, the 2006 Act;
"NHS foundation trust"	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act.

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.

3. Unless the context requires otherwise, words or expressions which are defined in the 2012 Act shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.

4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

Paper as circulated for 26 April 2023 meeting.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Briefing: Hewitt review			Meeting date: 31 May 2023
Report appendix	Appendix 1- Hewitt Review		
Report sponsor	Director of Corporate Governance and Trust Secretary		
Report author	Director of Corporate Governance and Trust Secretary		
Report provenance	n/a		
Purpose of the report and key issues for consideration/decision	It should be noted that the enclosed report was received by the Board at their meeting on 26 April 2023 in private session as the meeting was held within a pre-election sensitivity period. The paper is being re-circulated in Public session for openness and transparency. It is therefore provided for information only. Receive the "Hewitt Review", an independent review of integrated care systems, led by the Rt Hon Patricia Hewitt, published 4 April 2023.		
Action required (choose 1 only)	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation	To receive the report as an information item.		

Summary of key elements

Strategic goals supported by this report

Excellent population health and wellbeing		**Excellent experience receiving and providing care**	
Excellent value and sustainability	**X**		

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

Board Assurance Framework	n/a	**Risk score**	
Risk Register	n/a	**Risk score**	

External standards affected by this report and associated risks

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

Report title: Briefing: Hewitt review		**Meeting date: 31 May 2023**
Report sponsor	Director of Corporate Governance and Trust Secretary	
Report author	Director of Corporate Governance and Trust Secretary	

Introduction

The Board are asked to receive and note the "Hewitt Review", an independent review of integrated care systems, led by the Rt Hon Patricia Hewitt, published 4 April 2023 (**Appendix 1**).

Summary

The report, which is supported by a number of recommendations, focuses on six key themes to "*to create the context in which ICSs can thrive and deliver*"; these are: collaboration within and between systems and national bodies; a limited number of shared priorities; allowing local leaders the space and time to lead; the right support, balancing freedom with accountability and enabling access to timely, transparent and high-quality data.

Key recommendations are:

- That the government leads and convenes a national mission for health improvement;
- That target setting is predominately localised within the ICS, with few National targets, rebalancing the relationships between National and Regional system partners;
- That the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years;
- Greater focus on prevention as a means of supporting the population to manage and promote their health; with a community approach, tackling inequality;
- Noting that the government is due to publish a long-term workforce plan for the NHS imminently, that the primary and social care workforce should be supported to promote health, focussing on prevention and the government should produce a complementary strategy for the social care workforce, as soon as possible.; and
- Increased focus on performance and value for money.

Context

This briefing paper supports and builds upon the commentary within the review of the NHS Standard Form Licence, circulated under separate cover, noting the changing legal and regulatory landscape within which the Trust operates.

However, at this time the status of this report is regulatory sponsored comment. The application of these recommendations, in whole or part, would require legal and/or regulatory amendment, as some of the proposals conflict with current law.

The proposals also lack clarity, whilst key themes of supporting the Integrated Care Systems implementation and financial transformation are evident, an increased governance burden on the NHS would also be created, which may or may not add value.
At this time support and granular analysis from NHS England for the proposals is awaited, alongside their proposals to take forward the “Hewitt Review” recommendations in whole or in part.

Conclusion

The Board are advised to note this report and appended “Hewitt Review”, whilst having regard to its current status. Broader NHS England intent and commitment to change either law or regulatory standards would be required to implement much of what is proposed.

Recommendations

The Board are asked to receive and note this report.

The Hewitt Review

An independent review of integrated care systems

Rt Hon Patricia Hewitt

Published 4 April 2023

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Foreword

It has been a privilege to carry out this review. Although the invitation to do so came as a complete surprise, it was an opportunity I could not turn down. As chair of the Norfolk and Waveney NHS integrated care board and deputy chair of its integrated care partnership, and previously one of the first independent chairs of a sustainability and transformation partnership, I have no doubt that the decision to put integrated care systems onto a statutory footing was the right one, widely supported across the political spectrum.

I stepped down as Secretary of State for Health over fifteen years ago. The biggest contribution I helped make to the health of the nation was the smoke-free legislation: an important reminder in the context of this review that we should never mistake NHS policy for health policy. And one of the most creative was the nation-wide public engagement through 'Our health, our care, our say' that confirmed public support for a health and care system that would enable them to be as healthy and independent as possible.[1]

ICSs have been born in difficult times. The answer is not simply more money, although of course that is needed, particularly in social care. Unless we transform our model of health and care, as a nation we will not achieve the health and wellbeing we want for all our communities - or have the right care and treatment available when it is needed.

ICSs bring together all the main partners - local government, the voluntary, community, faith and social enterprise sector, social care providers and the NHS - in a common purpose expressed in 4 main aims: to improve outcomes in population health and healthcare; to tackle inequalities in outcomes, experience and access; to enhance productivity and value for money; and to help the NHS support broader social and economic development.

This report shows how they are already making a difference and explains what needs to happen next to accelerate that progress.

As Secretary of State myself, I was a ‘window-breaker’ rather than a ‘glazier’.[2] Like today’s ministers, I was impatient for change - and rightly so. But my preferred style as a leader remains collaborative: bringing people together to understand each other’s perspective, learning from and challenging each other, and working through disagreements or conflict as honestly and openly as possible to agree the best way forward. That is how I have carried out this review, and as a result I believe that most of my recommendations will command widespread support. But there is a wide range of passionately held views and it would be surprising if there was unanimity on all points. Indeed, an independent review with which everybody agreed would be pointless.

Given the scope of my terms of reference, and the tight timescale, it is hardly surprising that the review has been an intense and sometimes challenging process. I am hugely grateful to the many hundreds of people who have been involved through engagement events, town hall meetings and the 5 review work streams as well as in preparing over 400 submissions in response to the call for evidence. I have also drawn upon the many preceding important reviews and papers, including the work of the King’s Fund, Professor

[1] Our health, our care, our say: a new direction for community services.
[2] Nicholas Timmins, Glaziers and Window Breakers: Former Health Secretaries in their own words, Health Foundation, May 2015

Sir Chris Ham, the Fuller Stocktake and the Messenger Review to name but a few. It has been a privilege to work with so many inspiring colleagues: every conversation has taught me something more. To all of you who have contributed to these rich discussions, thank you.

The time comes, however, when the drafting has to stop. I am painfully aware that it has not been possible to do justice to every insight and recommendation, or work through every issue raised in our discussions. Nonetheless, I hope everyone will feel that their efforts have been worthwhile, and that this report provides all of us committed to the success of ICSs with a platform for the next stage.

Many of my recommendations are designed to shape how we work together in the coming months and years, not only strengthening collaboration at local level but ensuring the breadth of partnership within ICSs is mirrored nationally. Real partnership starts with real work and I have made a number of recommendations for how the way we are learning and creating together within systems, should be embraced and embedded nationally: for instance, with DHSC, DHULC, NHS England, HM Treasury, ICSs and others working in concert on important areas of change including much-needed reform to the financial framework.

This review could never have happened without many people’s exceptionally hard work. I am grateful to the Secretary of State for commissioning this review and his ministers, advisers and departmental officials for their support throughout. I am equally grateful for the active engagement of Amanda Pritchard and many senior colleagues at NHS England. Without them all, the review would not have been possible.

I am particularly grateful to the co-chairs of the 5 work streams: Sam Allen, Rt Hon Paul Burstow, Felicity Cox, Dr Penny Dash, Adam Doyle, Sir Richard Leese, Dr Kathy McLean, Patricia Miller, Cllr Tim Oliver and Joe Rafferty.

I want to thank Matthew Taylor, Annie Bliss, Ed Jones and others at the NHS Confederation whose ICS, primary care, mental health and other networks were invaluable and who provided additional policy and engagement support throughout. My thanks go equally to the Care Providers Alliance, the County Councils Network, the Health and Wellbeing Alliance of VCFSE sector representatives, Healthwatch, the Local Government Association, National Voices, NHS Providers, the Patients Association, the Social Partnership Forum, and the many others who have contributed and facilitated this work. I was also exceptionally fortunate in my DHSC Secretariat: Jason Yiannikkou, Jonathan Walden, Georgina Connah, Laura Bates, Alexandra Kirsima, Haleema Nazir and Thomas Savage, all of whom deserve immense praise.

As the review concludes, and despite the very real challenges that lie ahead, I am even more optimistic about what we can achieve together than I was when this process started. I look forward to working with you all on the next stage of our exciting journey together.

Rt Hon Patricia Hewitt

April 2023

Terms of reference

The review's terms of reference were published on 6 December 2022 and are set out below.

Objectives and scope

The review will consider how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement. It will cover ICSs in England and the NHS targets and priorities for which integrated care boards (ICBs) are accountable, including those set out in the government's mandate to NHS England.

In particular it will consider and make recommendations on:

- how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending
- the scope and options for a significantly smaller number of national targets for which NHS ICBs should be both held accountable for and supported to improve by NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities
- how the role of the Care Quality Commission (CQC) can be enhanced in system oversight

Engagement

The review will draw upon the expertise of ICSs, local government, the NHS, the voluntary sector, patient and service user representatives and other subject experts including in academia, government departments and relevant thinktanks.

Governance and timing

The review will be led by Rt Hon Patricia Hewitt and will be independent of government.

Secretariat support will be provided by the Department of Health and Social Care.

The review will report to the Secretary of State for Health and Social Care, with interim findings by 16 December 2022, a first draft by 31 January 2023 and a final report by no later than 15 March 2023.

Executive summary

Integrated care systems (ICSs) represent the best opportunity in a generation for a transformation in our health and care system. Effective change will require the combination of new structures with changed cultures. Everyone needs to change, and everyone needs to play their part.

The review has identified 6 key principles, that will enable us to create the context in which ICSs can thrive and deliver. These are: collaboration within and between systems and national bodies; a limited number of shared priorities; allowing local leaders the space and time to lead; the right support, balancing freedom with accountability and enabling access to timely, transparent and high-quality data.

From focusing on illness to promoting health

Delivering these principles will require genuine change in how the health and care system operates. While there will always be immediate pressures on our health care system, shifting the focus upstream is essential for improving population health and reducing pressure on our health and care system.

This will require a shift in resources - the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. It will also require cross-governmental collaboration to embed a national mission for health improvement and the establishment of a new Health, Wellbeing and Care Assembly.

Our use of data must also support this mission, with improved data interoperability and more effective use of high-quality data. Alongside this we need to empower the public through greater use of the NHS App and further long-term commitment for the development of citizen health accounts.

Delivering on the promise of systems

ICSs hold enormous promise, bringing together all those involved in health, wellbeing and care to tackle both immediate and long-term challenges. To do this effectively, national and regional organisations should support ICSs in becoming ‘self improving systems’, given the time and space to lead - with national government and NHS England significantly reducing the number of national targets, with certainly no more than 10 national priorities.

We should encourage and deliver subsidiarity at place, system, regional and national levels. We are currently one of the most centralised health systems in the world, and ICSs give us an opportunity to rebalance this.

The most effective ICSs should also be encouraged to go further, working with NHS England to develop a new model with a far greater degree of autonomy, combined with robust and effective accountability.

For every ICS, increased transparency is vital to enabling local autonomy. The availability of timely, transparent and high-quality data must be a priority, and NHS England and the Department of Health and Social Care (DHSC) should incentivise the flow and quality of data between providers and systems. The Federated Data Platform can provide the basis for a radical change in oversight, to replace situation reports (SITREPS), unnecessary and duplicative data requests.

Both the Care Quality Commission (CQC) and NHS England will continue to have a vital role to play in oversight and accountability, but they should ensure that their improvement approaches are as complementary as possible, and complementary to peer review arrangements between systems.

Finally, it will be vital to ensure the right skills and capabilities are available to ICSs as both systems and national organisations manage through a period of challenge for the nation’s finances. There needs to be consideration given to the balance between national, regional and system resource with a larger shift of resource towards systems.

Unlocking the potential of primary and social care and their workforce

In order to make the promise of ICSs a reality, we also need to pull down some of the barriers that currently exist for primary care, social care and the way we train health and care workforce.

Given the interdependence of health and social care, the government should produce a complementary strategy for the social care workforce. More should also be done to enable flexibility for health and care staff, both in moving between roles and in the delegation of some healthcare tasks.

National contracts present a significant barrier to local leaders wanting to work in innovative and transformational ways. I have recommended that work should be undertaken to design a new framework for General Practice (GP) primary care contracts, as well as a review into other primary care contracts.

Work also needs to be done to ensure that there is the flexibility to competitively recruit and train more specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialised analytical and intelligence.

Resetting our approach to finance to embed change

We are currently not creating the best health value that we could from the current investment in the NHS. Instead of viewing health and care as a cost, we need to align all partners, locally and nationally, around the creation of health value.

NHS funding remains over-focused on treatment of illness or injury rather than prevention of them and ICS partners struggle to work around over-complex, uncoordinated funding systems and rules in order to shift resource to where it is most needed.

Instead, it is important to identify the most effective payment models, nationally and internationally, with an aim to implement a new model with population-based budgets, which will incentivise and enable better outcomes and significantly improve productivity. There should also be a review into the NHS capital regime to address the inflexibility in use of capital and the layering of different capital allocations and approvals processes.

NHS England should also ensure that systems are able to draw upon a full range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities.

1. Introduction

1.1 Across the developed world, healthcare systems are facing the challenge of increasing pressures, public expectations and opportunities (including those opened up by new digital and data technologies). As other healthcare systems are finding, no matter how much money is invested in treating illness, unless we transform how we deliver health and care, we will not achieve the health and wellbeing we want for all our communities - or have the right care and treatment available when we need it.

1.2 In England, integrated care systems (ICSs) represent the best opportunity in a generation for that urgently needed transformation of our health and social care system. They provide the opportunity to break out of organisational siloes, enabling all partners to work together to tackle deeply rooted challenges, drawing together their collective skills, resources and capabilities around their 4 core purposes, to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- support broader social and economic development

1.3 If we allow the development of ICSs to become “just another NHS reorganisation”, we will let down patients, the public and everyone working in the health and care system.

Integrated care systems (ICSs) are partnerships that bring together local government, the NHS, social care providers, voluntary, community, faith and social enterprise (VCSFE) organisations and other partners to improve the lives of people who live and work in their area, in line with their 4 core purposes. Each ICS includes a statutory integrated care partnership (ICP) and integrated care board (ICB).

The ICP is a statutory committee jointly formed between the ICB and the relevant local authorities within the ICS area. The ICP brings together the broad alliance of partners and is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

The ICB is the statutory NHS organisation responsible for bringing NHS and other partners together to plan and deliver integrated health and care services and accountable for the finances and performance of the local NHS as a whole.

Why we need a new approach

1.4 There are 3 main reasons why we need a new approach for the health and care system. First and foremost are the immediate pressures upon the NHS and social care, already visible before the pandemic, but greatly exacerbated as a result of it. The public's immediate priorities for the NHS - access to primary care, urgent and emergency care, cancer, other 'elective' care, and mental health services - are just as important to ICSs as they are to ministers and NHS England.

1.5 Second, there is a growing number of people living with complex, long-term physical and mental health conditions, often associated with serious disabilities or ageing.

1.6 Third, as a nation, we are becoming less, rather than more healthy, both physically and mentally. More people spend longer in ill-health and die too young, particularly the least economically advantaged and those most affected by racism, discrimination and prejudice.

> "Against the backdrop of those health challenges, we cannot just keep doing more of the same. The traditional way of operating a health system, where you have your hospitals and your primary care and you have your social care separate, and you have those things relatively siloed, is not a system that works in a world where people are living a long time with multiple health conditions. We know that the determinants of health are much broader than just what happens in a hospital. They include housing, wider care and education. Joining up is an imperative, both for improving health outcomes and for having a sustainable, affordable health system to get what we want."
>
> Helen Whately, MP, Minister of State for Social Care

1.7 ICSs are designed to tackle all 3 problems. As the examples throughout this report illustrate, many are already succeeding in doing so.

1.8 They are already starting to tackle immediate and often intractable problems - including ambulance queues and delayed discharges - which cannot be solved by any one organisation alone or by continuing to work in the same old ways. These problems require close partnerships between many parts of the health and care system - primary care, community health, mental health, acute hospital trusts, local government and social care providers - working together in different ways.

> Dorset ICS has halved the number of A&E and emergency admissions among elderly people through its Ageing Well programme, improving anticipatory, preventative care by integrating community, primary and social care teams at neighbourhood level. ICB investment enabled the anticipatory care programme to undertake upstream interventions for patients with long term conditions. Interventions were developed for specific risk groups

by a multi-agency partnership. The ICS is now using data to predict who might be a frail patient at risk of falling, and intervene to help prevent falls and promote self-care. A digital programme supports an out of hours clinical team to respond to care homes and prevent admissions. The ICS is also expanding the use of virtual wards and is piloting the use of Age Care Technologies which support independence in the home. This is saving approximately £33,000 per person per year in care costs.

1.9 Despite many impressive examples of innovative working, the NHS in general is not yet currently configured to optimise the management of complex, long-term conditions. The result is a system that is fragmented rather than integrated, making it frustrating, inefficient and often challenging for patients and families as well as staff. ICSs, by integrating health and social care services, and working more closely with VCFSE providers, should aim to ensure that services are joined up, pressures are actively managed, and the interests of patients and the public are prioritized.

1.10 It has also long been recognised that the NHS is, in practice, more of a National Illness Service than a National Health Service. Despite important and continuing efforts by NHS England, the reality is that we are a very long way from devoting anything like the same amount of time, energy and money to the causes of poor health as to its treatment. That cannot be done by the NHS alone and ICSs - established as equal partnerships between local government, the NHS, the voluntary, community, faith and social enterprise sector, social care providers and others - are the right vehicle to build on and reinforce existing work.

1.11 Faced with these challenges, but also with many inspiring examples of success, it is not surprising that throughout this review I heard such strong commitment from leaders in ICBs and ICPs, local authorities, providers and national bodies, to the core purposes of ICSs. As so many ICS leaders - both non-executive and executive - said: “This is why I applied for this job.”

1.12 At the same time, however, I heard real concern that the transformational work of ICSs and specifically the opportunity to focus on prevention, population health and health inequalities might be treated as a ‘nice to have’ that must wait until the immediate pressures upon the NHS had been addressed and NHS performance recovers. That is what has always happened before, and must not happen this time.

1.13 Prevention, population health management and tackling health inequalities are not a distraction from the immediate priorities: indeed, they are the key to sustainable solutions to those immediate performance challenges.

1.14 For too long, we have talked about the challenge of moving resources upstream to enable people to live independently for as long as possible, build more resilient communities and reduce health inequalities. This is how we can sustainably tackle

the causes and not just the symptoms of an over-burdened NHS, moving away from the constant cycle of 'winter crisis' management. Furthermore, the partnership working that is at the heart of ICSs is, itself, an essential means to tackle those symptoms of 'winter crisis', including delayed ambulance arrivals, handovers and delayed discharges. These and many other challenges do not just affect one organisation; they can only be effectively tackled by many organisations working together, integrating care across the entire pathway and making the best use of available resources to achieve better, safer outcomes.

Why it can be different this time

1.15 Many of us have talked over many decades about the need to focus on prevention, population health and health inequalities. We have called for a shift from a top-down, centralised system of managing the NHS to a bottom-up system responsive and responsible to local communities and engaging the enthusiasm, knowledge and creativity of staff along with patients, carers and volunteers. The creation of primary care trusts (PCTs) and then clinical commissioning groups (CCGs) were attempts to do exactly that, but each was reorganised and swept away in their turn.

1.16 There are many reasons, however, for believing it can be different this time. There is a welcome, and almost unprecedented, degree of cross-party support for ICSs, both nationally and locally. Although we often hear the plea to "take the NHS out of politics", that is neither possible nor desirable: in any democracy, different political parties will have different views on priorities for public spending as well as how best to fund public services. However, the extent of policy alignment now provides the basis for changes that will last well beyond one parliament, government or minister, giving ICSs the time and space to embed the new model.

> "Local leaders are best placed to make decisions about their local populations… with fewer top-down national targets, missives and directives and greater transparency to help us hold the system to account."
>
> Rt Hon Steve Barclay, Secretary of State for Health and Social Care

> "There is no alternative to health and social care integration. Stakeholders and leaders across health, social care and wider public services know that pressing forward with broad-based integrated care systems and local partnerships in 2023 is the only long-term solution to creating a financially sustainable and successful NHS and social care system; improving the population's health and reducing health inequalities."

Annual report of the Health Devolution Commission, an independent cross-party and cross-sector body.[3]

1.17 By establishing ICSs in statute as broad local partnerships we now have the right structures for change. But there is also a growing understanding that while structures matter, culture, leadership and behaviours matter far more. The failure to recognise that in the past is one of the main reasons why previous attempts have not worked.

"Collaborative behaviours, which are the bedrock of effective system outcomes, are not always encouraged or rewarded in a system which still relies heavily on siloed personal and organisational accountability...the current cultural environment tends to be unfriendly to the collaborative leadership needed to deliver health and social care in a changing and diverse environment...a re-balancing towards collaborative, cross-boundary accountability is a pre-requisite to better outcomes."[4]

Messenger Review

1.18 NHS England has itself recognised the need for change and embarked on an important and welcome transformation in its size, focus and ways of working. The insightful review of NHS leadership by General Sir Gordon Messenger and Dame Linda Pollard, and the follow-up work, will help to accelerate that change. The Messenger Review stressed that although ‘command and control’ is occasionally essential, the most successful organisations need collaborative leadership, good management at every level and clear accountability for defined outcomes. In a similar spirit, when establishing this review, the Secretary of State for Health and Social Care himself stressed the need to reduce ‘top-down national targets, missives and directives’.

“This requires a cultural and behavioural shift towards partnership-based working; creating NHS policy, strategy, priorities and delivery solutions with national partners and with system stakeholders; and giving system leaders the agency and autonomy to identify the best way to deliver agreed priorities in their local context.”

NHS England, new operating framework, October 2022

1.19 The Health and Care Act (2022) has decisively changed the framework of policy and structures. Previous government policies over several decades have encouraged strong sovereign organisations, using competition to drive quality and

[3] Annual Report 'ICSs: a great deal done - a great deal more to do'
[4] Independent report by Sir Gordon Messenger and Dame Linda Pollard “Health and social care review: leadership for a collaborative and inclusive future”

outcomes - most keenly seen in the establishment of foundation trusts. There is no doubt that this has brought benefits: new models of care, greater clinical innovation and the creation of strong boards.

1.20 In many cases, incentives have encouraged leaders to think about their organisation's interests without regard for the wider system. The new, partnership-based structures for statutory ICSs, including the statutory duty to co-operate, recognises that problem and reinforces the need to place the interests of patients and the public first. The 2022 Act also includes significant changes in the procurement framework for healthcare services, giving commissioners more flexibility when selecting providers but retaining the freedom to use competitive processes in the best interests of patients and the public.

1.21 Finally, millions of people are becoming increasingly active in managing and improving their own health and wellbeing, often using ever more sophisticated digital monitoring tools and apps to assist them. This can provide the basis for a very different conversation with the public - including those who are disadvantaged or discriminated against - about what we need to do for ourselves and within our families and communities, and what health and care services can be expected to do for us.

How this review can help

1.22 The creation of ICSs, and the new approach they represent, is the right reform at the right time. But more is needed to enable them to succeed.

1.23 We have created ICSs but not yet the context in which they can thrive and deliver. We have a clear choice - either do what we have done before and create something only to almost immediately undermine its purpose, or back ICSs as part of a commitment to a different model of health policy and delivery.

1.24 This review has given all of us working within and with ICSs the opportunity to consider what needs to be done locally and nationally to create the conditions in which ICSs can succeed.

1.25 Critically, all of us need to change. Local partners within every ICS need to put collaboration and cooperation at the heart of their organisations. NHS England, DHSC and CQC need to support and reflect this new model in the crucial work they do; and central government needs to change, mirroring integration within local systems with much closer collaboration between central government departments and other national bodies.

1.26 In the first stage of this review, we agreed that specific recommendations needed to be based upon clear principles that would command widespread support and form a touchstone for all of us to use in considering how we behave within

systems, within national organisations and in the relationships between them. Six principles emerged clearly from our discussions:

- Collaboration: within each system as well as between systems and national bodies. Rather than thinking about national organisations, regions, systems, places and neighbourhoods as a hierarchy, we should view each other as real partners with complementary and interdependent roles and work accordingly. Subsidiarity within each ICS is therefore vital, recognising that particularly in larger systems, much of the work will be driven by Place Partnerships, building on the work of each Health and Wellbeing Board (HWB) within the wider system, as well as by Provider Collaboratives. Different local partners - notably local government itself, as well as the VCFSE sector - have different accountability and funding arrangements. Only ICSs can create mutual accountability between all partners around jointly agreed outcomes and targets for both the long-term health of the population and for immediate issues such as discharge and tackling the backlog. On the other hand, it is also essential to recognise that, while the role of national organisations should change, some things can only be done effectively and efficiently by them. NHS England's new operating framework and its emphasis on aligned support and collaboration managed by or with the ICS rather than direct to provider organisations is therefore extremely helpful.

- A limited number of shared priorities: the public's immediate priorities - access to primary care, urgent and emergency care, community, mental health and social care services and elective diagnostics and treatment - are priorities for all of us including ministers, NHS England and ICBs. The level of interest in these matters rightly makes them a central part of accountability for all ICBs and their partners in the wider ICS. Evidence-based guidance and best practice examples are, of course, invaluable to local leaders; but it is essential that those local leaders have flexibility about how they apply those lessons to their particular local circumstances.

- Give local leaders space and time to lead: effective change in any system - particularly one as complex as health and care - needs consistent policy, finances, support and regulation over several years. Adding new targets and initiatives, providing small funding pots (often with complex rules and reporting requirements), or non-recurrent funding makes it impossible to plan or even recruit, wastes money and time, and weakens impact and accountability. Multi-year funding horizons, with proportionate reporting requirements, are essential, as is recognising that statutory ICSs are less than a year old.

- Systems need the right support: ICSs require bespoke support geared to the whole system and the partners within it, rather than simply to individual providers or sectors. But there is considerable variety between systems, in maturity as well as size, geography, demographics, NHS configuration and

local government structures, relationships between partners and so on. Support and intervention from NHS England to ICSs, through ICBs, needs to be proportionate: less for mature systems delivering improving results within budget; more for systems facing greater challenges or with weaker relationships and leadership.

- Balancing freedom with accountability: with greater freedom comes robust accountability, including for financial spending and ensuring value for money. That accountability includes the local accountability that is hard-wired into ICSs - through Health Overview and Scrutiny Committees (HOSCs), local government, ICPs, Healthwatch, foundation trust governors and many other forms of patient and public involvement. Peer review, widely used in local government, should also have a much greater role for ICSs as a whole. Within the 2022 Act, accountability for NHS performance and finances within each ICS also involves the accountability of ICBs to NHS England. But the Act also includes a new role for CQC as the independent reviewer of ICSs as a system, as well as their existing functions in relation to social care, NHS and other healthcare providers. CQC is transforming its own working methods to meet these new responsibilities. This will need to be done hand in hand with NHS England's role in overseeing systems. It will also be essential to consider the vital, but different, role of supporting ICSs, ICBs and providers with great challenges to improve, particularly where there are major failings in care.

- Enabling timely, relevant, high-quality and transparent data: we recognize that timely, relevant, high-quality and transparent data is essential for integration, improvement, innovation and accountability. As high performing ICSs are already showing, high quality, integrated data collection and interoperable digital systems can initiate real change. NHS England, working in collaboration with DHSC and local government (including through the Department for Levelling Up, Housing and Communities (DLUHC), the Local Government Association (LGA) and other local government representative bodies or stakeholders) has a key role to play. By defining standards on data taxonomy and interoperability, and coordinating data requests to the system, they can create the conditions for wider transformation.

1.27 In the rest of this report, I set out how these principles can be translated into action.

2. From focusing on illness to promoting health

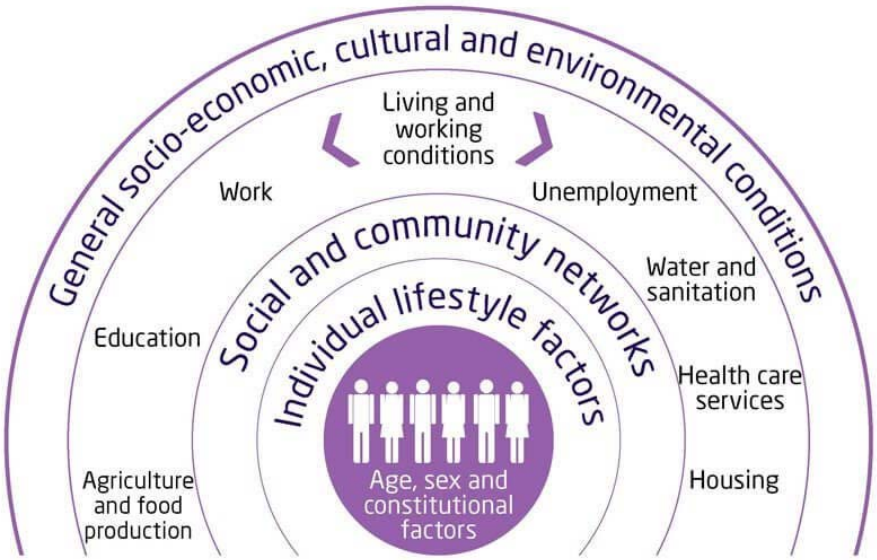
2.1 The review was specifically asked to look at how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending, supported by high quality and transparent data.

2.2 The ultimate objective of health policy is that more people live longer, healthier and happier lives. But too many of our nation's population do not live as long or as healthily as they could, with improvements in life expectancy stalled or even declining amongst some groups, and unhealthy life expectancy increasing, particularly amongst disadvantaged communities. The COVID-19 pandemic starkly highlighted the human cost of health inequalities, with the mortality rates from COVID-19 in the most deprived areas being more than double those in the least deprived areas and death rates being highest among people of Black and Asian ethnic groups.[5]

2.3 In England today, there is a 19-year gap in healthy life expectancy between people in the most and least deprived areas of the country.[6] Those health inequalities, so damaging to the lives of individuals and their families, also impact on our society as a whole.

2.4 Both the Marmot review and the Dame Carol Black review highlighted the huge economic costs of failing to act on the wider determinants of health (see below for an illustration of the wider determinants of health).[7] Even before COVID-19, health inequalities were estimated to cost the NHS an extra £4.8 billion a year, society around £31 billion in lost productivity, and between £20 to 32 billion a year in lost tax revenue and benefit payments.[8]

[5] Public Health England. COVID-19: review of disparities in risks and outcomes. 2 June 2020
[6] Tabor, D. (2021) Health State Life Expectancies, UK: 2017 to 2019, Health state life expectancies, UK - Office for National Statistics. Office for National Statistics.
[7] Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?
[8] Public Health England. (March 2021) 'Inclusion and sustainable economies: leaving no one behind.'



2.5 For too long, however, we have mistaken NHS policy for healthcare policy. In reality, the care and treatment provided by the NHS, vital and often life-saving though it is, only accounts for a relatively small part of each individual's health and wellbeing. Significantly more important are the wider determinants of health. In many parts of the country, partnerships led by local government, the VCFSE sector and residents themselves have been working over many years to create healthier, more resilient communities, often with strong engagement from NHS primary care. The response to the pandemic brought communities, statutory and voluntary partners together to support people in many inspiring ways.

2.6 The creation of integrated care systems (ICSs), with their 4 purposes and a strong statutory framework for partnership working, provides a real opportunity to build upon this approach and suggests a welcome recognition of the need for a more holistic approach to improving the nation's health.

2.7 Indeed, ICS leaders are enthusiastic about maximising the contribution of the NHS to wider economic, social and environmental objectives. From economic regeneration to life sciences, from net zero to local labour markets, the NHS has a crucial role to play in creating thriving places.

2.8 Designing and creating services together with local residents and communities leads to more actively engaged citizens, able to lead and support change within their own lives, with a corresponding reduction in reliance on public services.

2.9 The Wigan Deal - an informal agreement between the council and everyone who lives or works there to work together to create a better borough - is an excellent example of this. In Wigan, the council invested £13 million in a Community

Investment Fund which funded bottom-up prevention ideas from local communities that supported physical activity, addressed social isolation and loneliness and promoted positive mental health. As a result of this sustained approach healthy life expectancy in Wigan bucked the trend and an additional 7 years was added in the most deprived wards.[9]

2.10 Similarly, through PCNs and Integrated Neighbourhood Teams, primary care can play an important leadership role in working with local communities to tackle health inequalities. In Tameside, Greater Manchester, Healthy Hyde PCN employs 34 people across many different disciplines, all working to tackle health inequalities. It has 6 health and wellbeing coaches working in foodbanks, schools, allotments, and providing ESOL lessons to asylum seekers and refugees. The team has clinical leadership, managerial and administrative support, and works together to identify people via clinical systems, local knowledge and working with multiple agencies.

2.11 However, empowering local leaders to work with and through their partners and local communities to improve outcomes for their populations can only happen at scale if the broader environment in which they operate is aligned to enable them to do so - something that is heavily dependent on policies pursued across government.

2.12 Particularly in view of the fourth core purpose of ICSs, to help the NHS support broader social and economic development, all parts of Whitehall should feel they have a stake in the work of Partnerships and Places and should equally strive to replicate the same sense of partnership being forged across the country in ICSs.

Enabling a shift to upstream investment in preventative services and interventions

2.13 There will never be a perfect time to shift the dial toward focusing more on preventative services and interventions. It is easy to argue - especially in the current climate of financial constraints and performance issues - that addressing these issues should be something we consider when the current pressures have died down. But that has always been the case.

2.14 The truth is, unless we make the change, the continual focus on improving flow through acute hospitals will simply channel more and more of an older and increasingly unhealthy population into acute hospitals, which will never be large or efficient enough to cope.

[9] Source: Professor Donna Hall, CBE Chair New Local, Former CEO Wigan Council; and Wigan CCG, ICS Transformation Advisor NHS England, January 2023

2.15 Despite the current pressures, I have also seen through the course of this review a greater appetite to grasp the challenge of shifting our focus to prevention, proactive population health management and tackling health inequalities than at any other time I can remember. It acts as the glue that binds all partners in ICSs. There are many things we can do now - both nationally and at system level - to create the collective conditions for us to capitalise on this.

2.16 In order to achieve a decisive shift ‘upstream’, towards prevention, proactive population health management and tackling health inequalities, we need to establish a baseline of current investment in prevention, broadly defined, within each ICS from which progress can be measured. This baseline would include the £200 million allocated nationally towards tackling health inequalities. This must also be done in a way that enables ICSs to be benchmarked against each other, helping to spread best practice and strengthen both local and national accountability.

2.17 We also need a clear and agreed framework for what we mean by ‘prevention’, broadly defined. We all recognise that ‘prevention’ involves a range of activity including primary, secondary and tertiary prevention, much of it carried out by local government and VCFSE partners as well as within the NHS itself. Furthermore, much ‘prevention’ work is embedded within other services that are also directly concerned with treatment. DHSC should establish a working group of local government, public health leaders, DHSC (including OHID), NHS England, as well as leaders from a range of ICSs, to agree a straightforward and easily understood framework. As part of this work, the group should consider the guidance to local government on the use of the public health grant.

2.18 Once this agreed framework is developed, ICSs should establish and publish their baseline investment in prevention. This should be delivered through the ICP and include both NHS and local government spending on prevention. Especially within larger ICSs, it will also be important to establish the baseline at place level; indeed the ICS view might be built up from place level. Different ICSs will approach baselining in different ways; what matters is that it is done in all systems using a consistent framework.

2.19 By autumn 2023, we should expect the framework to be completed, with all ICSs reporting their prevention investment on a consistent basis by 1 April 2024. Both the initial framework, and the baseline measures, should be reported to and considered by the proposed cross-government arrangements on health improvement I outline below.

2.20 Finally, the government, NHS England and ICS partners, through their ICP, should commit to the aim of increasing resources going to prevention. In particular, I recommend the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. Given the constraints on

the nation's finances, this is my most challenging recommendation; some ICSs will find it more difficult than others, depending on their current financial position as well as the strength of collaboration and common purpose between partners. But an ambition of this kind is essential if we are to avoid simply another round of rhetorical commitment to prevention.

2.21 As public finances allow, the public health grant to local authorities needs to be increased. The most recent government spending review represents the latest in 8 years of real-term squeeze on local authority funding for public health and other essential services. Investment in prevention and early help is essential if we are going to extend healthy life expectancy, reducing the financial burden to health and social care and strengthening local economies.

2.22 In addition, within the NHS itself, every opportunity should also be taken to refocus clinical pathways towards prevention. At the moment, pathways for different conditions often begin with diagnosis and focus on treatment. Instead we must shift the focus and resources towards preventing the condition occurring, diagnosing early and preventing avoidable exacerbation. I welcome the announcement of a major conditions strategy which seeks to address this issue. I also support the recommendation of the recent Health and Social Care Select Committee (HSCC) inquiry into the autonomy and accountability of ICSs that '… the major conditions strategy [should] put prevention and long-term transformation at its heart'. The prevention work done in secondary and tertiary care settings, rightly highlighted by NHS England as receiving increased priority and investment in recent years, must be seen within the wider work of an ICS on prevention. An example of this in action is the work being done under the Core20PLUS5 framework focusing on COPD, which has led to a reduction in unplanned respiratory admissions.[10] Refocusing clinical pathways on prevention will be supported by my points set out below on primary care, which has a particularly important role in embedding prevention.

2.23 ICS leaders should also challenge themselves - and expect to be challenged - to work together to use existing resources as effectively as possible. The Joint Forward Plans (JFPs) that ICBs have been asked to prepare by 30 June 2023, reflecting the system-wide priorities established through the ICP's integrated care strategy, provide an opportunity for ICSs to set out their ambitions to shift the model of care towards prevention. The process for developing JFPs has been underpinned by a much more permissive and collaborative approach from NHS England, compared with previous CCG planning exercises. The collaborative work on the 2024 to 2025 planning guidance provides another opportunity to agree how a further shift on prevention should be achieved, year on year.

[10] Core20PLUS5 (adults) - an approach to reducing healthcare inequalities

Embedding health promotion at every stage

2.24 There is currently no cross-government, national equivalent of the wide partnership involved in an ICS. To enable successful integration in systems, parallel integration across Whitehall is needed. I recommend that the government leads and convenes a national mission for health improvement designed to change the national conversation about health, shifting the focus from simply treating illness to promoting health and wellbeing and supporting the public to be active partners in their own health. To underline its importance, this could be led personally by the prime minister.

2.25 This new mission should be supported by appropriate cross-government arrangements, possibly including a revived Cabinet Committee that includes a senior minister from all relevant departments, as well as DHSC's Office for Health Improvement and Disparities, NHS England and the new Office for Local Government. An early priority should be the creation of a National Health Improvement Strategy, identifying priority areas and actions. I also support the HSCC's recommendation that DHSC should publish, as soon as possible, the proposed shared outcomes framework. This work should develop a small set of clear, high-level national goals for population health, with appropriate timescales and milestones for action. I would expect the government to consider how this framework could be used to consolidate current existing, fragmented outcomes frameworks to enable an aligned set of priorities across health and care.

2.26 These priorities should then be taken into account when setting the mandate for the NHS as well as developing NHS planning guidance and other material for systems.

2.27 It is not for this review to prescribe what this framework would look like, such a framework needs to be developed in collaboration with ICB and ICP leaders, as well as leaders from across the NHS, local government, social care providers and the VCFSE sector. It is vital that there is also full engagement and involvement with the public, patients, service users and carers (including unpaid carers), building upon the important work of Healthwatch, the Patients Association and many other patient and user advocacy groups. We should also learn from international examples, including the Australian Health Performance Framework which reports on the health of Australians, the performance of healthcare and the Australian health system, including health behaviours, socioeconomic factors and wellbeing as well as the safety, accessibility and quality of services. It provides an impressive, interactive online tool that allows the public to obtain information at national, state and local level, disaggregated by demographic and other factors.[11]

[11] The Australian Health Performance Framework (AHPF) is a tool for reporting on the health of Australians, the performance of health care in Australia and the Australian health system

2.28 The NHS Assembly, established by NHS England in 2019, brings together a wide range of partners from within and beyond the NHS, providing an invaluable private forum for advice and challenge to NHS England itself. This should continue and will be complemented by the new arrangements proposed below.

2.29 However, in view of the establishment of statutory ICSs, there is also a clear need for government to have an appropriate forum to engage with integrated care partnerships (ICPs) - the convenors of ICSs as a whole - more widely. This would provide the opportunity for a 2-way exchange between ICP leaders and the relevant government departments and agencies, allowing ICP chairs to raise matters of priority directly with ministers and officials. I therefore recommend that a national ICP Forum is established. This could be convened by government itself, if my recommendation is accepted, or alternatively by the ICS Network and the Local Government Association together. It should include representation from DHSC, DLUHC (including the Office for Local Government) and, in the context of the National Health Improvement mission, the Cabinet Office as well as NHS England.

2.30 To support the shift to a new focus on prevention, population health and health inequalities, I also recommend that the government establish a Health, Wellbeing and Care Assembly, with a membership that mirrors the full range of partners within ICSs, including local government, social care providers and the VCFSE sector as well as the NHS itself. It would also be helpful for the Assembly to be supported by a secretariat drawn from OHID and the Office for Local Government as well as DHSC and NHS England.

ICSs role in embedding population health management

2.31 Improving population health and tackling health inequalities is a complex task. While public health leaders and other experts in the field play and important role, to affect change in all parts of the system requires awareness, knowledge and skills at all levels. Population health, prevention and health inequalities should also be part of the training and continuing development for all professions and embedded in the national workforce plan to help develop the skills needed to improve health equity. ICSs themselves have the opportunity for health and social care professionals to learn from local communities, including VCFSE groups working with disadvantaged and marginalised groups, as West Yorkshire Health and Care Partnership is doing with its health inequalities academy and Cumbria and South Lancashire with their population health and equity academy.

2.32 Giving every child the best start in life, from pregnancy through to late adolescence, is crucial to reducing health inequalities across the life course. Starting with antenatal care, the first 1001 days provide a vital opportunity to support the health and wellbeing of the whole family. Barnardo’s and the Institute

of Health Equity, are partnering to shape the way ICSs improve health and address health inequalities among children and young people. In several parts of the country, local government with responsibility for children's services has led the way in establishing a Strategic Alliance for Children and Young People that brings together all the relevant NHS, education, VCFSE, childcare and other services, partnering with parents and young people themselves to create the most effective and integrated support. Every ICS should ensure that both their ICP's integrated care strategy, and through it their ICB Joint Forward Plan, include a clear articulation of the needs of children and young people within their population, and how those needs will be met through collaboration across the system.

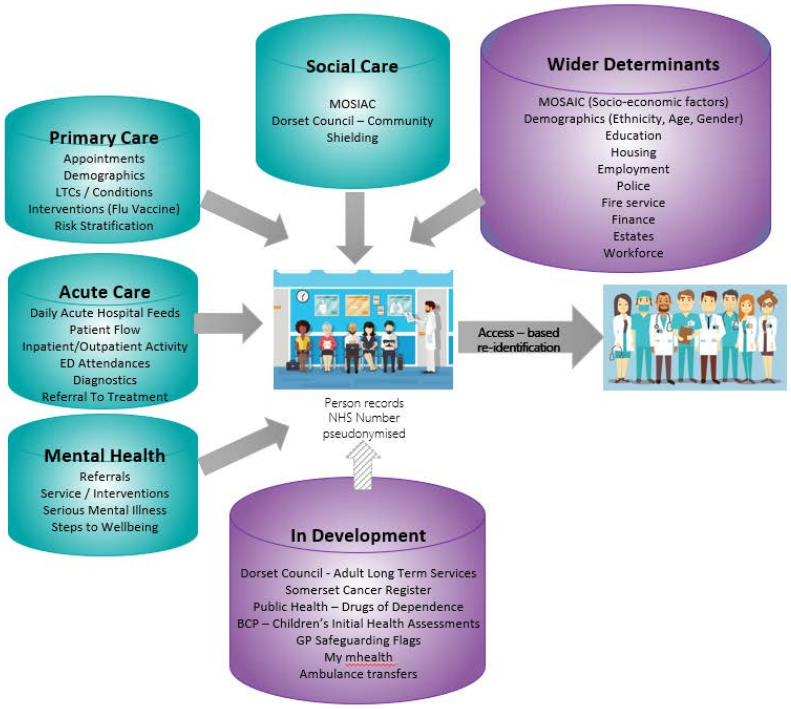
Role of data and digital tools to support the prevention of ill health

2.33 Shifting more of the focus onto prevention - underpinned by whole-system alignment on policy and funding - will radically improve our ability to do much more to tackle the determinants of poor health, with all of the associated health and economic benefits I have described.

2.34 That shift will be more impactful if we enable ICSs to connect data from multiple sources - while, of course, ensuring there are strong safeguards in place for individual privacy and confidentiality. This would transform their ability to accelerate their work around a whole suite of activity including improving individual care and outcomes; improving population health and wellbeing; tackling health inequalities; improving the wellbeing and engagement of staff; and, significantly, improving the productivity of the health and care system.

2.35 Many ICSs and partnerships within them are integrating data from multiple sources as the basis for integrated care and proactive population health management. Dorset ICS, for instance, has worked with its residents and partner organisations to establish a live linked data set, pulling in data from multiple sources, and using it as the basis for screening their fast-growing over-65's population, including for those at high risk of falls, and as a result significantly reducing the number of emergency hospital admissions. Norfolk and Waveney ICS has built on its award-winning COVID Protect approach, establishing Protect NOW, a GP-led collaboration that uses data analytics and risk stratification to

identify people at risk of undiagnosed or poorly managed Type 2 diabetes to improve patient engagement, care and outcomes.



Dorset Integrated Care System[12]

2.36 The North East and North Cumbria ICS is successfully joining up healthcare and social care data, using the OPTICA software, to streamline and simplify processes to effectively support discharge. Staff are using it as the single version of truth in hospital and community settings to help them understand where patients are in the discharge process, highlight blockages and provide actionable intelligence through comprehensive patient tracking and reporting modules. These and many other examples of excellent practice should be used both to support improvement and transformation across all systems and to contribute to work within DHSC and NHS England on wider policy development.

2.37 ICSs and NHS England need to work together to create a single view of population and personal health. To deliver this there needs to be a strong working partnership between ICSs, NHS England, local government, providers, and the VCFSE sector, which will enable systems and organisations locally to collect and utilise high-quality data. A strong partnership between different organisations locally and nationally will be vital for its success.

2.38 We welcome the proposed data framework for adult social care outlined in Care Data Matters, setting out what data the sector needs to collect, the purpose of

[12] Dorset ICS's presentation on a population health management approach to place-based care delivery

those collections and the standard to which it is collected. Adult social care providers should be fully involved in finalising the new framework, reflecting the diversity of the sector, and including those who are already making transformational use of digital and data tools as well as those for whom digitisation will be more challenging. DHSC should work collaboratively with the provider sector, alongside local authorities and other ICS partners to develop the framework, which will set out how we will improve the quality of data and rationalise collections so that we minimise the collection burden.

2.39 Further, building on the Care Data Matters Strategy, I recommend that NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework to be adopted by all ICSs in order to improve interoperability and data sharing across organisational barriers, particularly focusing on GP practices, social care provision and VCFSEs providing health and care services (who will need additional support in this work).

2.40 I also recommend DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, building on the successful change during the pandemic and set out in the Data Saves Lives Strategy (2022). This reform, already agreed in principle, is essential to allow local authorities and the local NHS jointly to plan and deliver support by accessing appropriate patient information.

2.41 The Shared Care Record (ShCR), now established in all ICSs, should be a priority for further development. To support care that is integrated around individuals, there is an urgent need to enable social care providers, VCFSE providers of community and mental health services and local authorities to access the ShCR on an equal basis with NHS partners. As soon as possible, the ShCR should enable individuals (and their carers where appropriate) to access as much as possible of their own data and allow them to add information about their own health and wellbeing. Finally, the ShCR should expand beyond individual ICSs to support people being treated by a provider in a different system or needing care elsewhere in the country.

2.42 As part of the development of shared care records and EPRs, patients should be able to access their hospital as well as their GP record, for instance updating information held on the NHS Spine, checking where they are on an elective waiting list and removing themselves if they have already had their diagnostic test or procedure and so on.

2.43 NHS England has a crucial role in supporting ICSs, particularly smaller systems, with vendor management of large suppliers (including vendors of population health systems) relationships with industry and ensuring supplier accountability for building systems that conform to NHS - and wider ICS - standards including compliant reporting and interoperability with other key national systems including

the Spine. National user-groups should be established with strategic suppliers to leverage and aggregate demand, coordinate any need for changes, and ensure compliance. As part of the national framework, trusts need to adhere to international standards and the data dictionary for nationally mandated metrics and data submissions and ensure coding rules are not open to local interpretation.

2.44 There is a shortage of skilled professionals, including those who are expert at the cultural change that underpins digital transformation. In line with its new operating model, NHS England should therefore develop in-house skilled teams who can be embedded within a provider or system to train front-line staff and grow the new local capability needed to ensure successful digital and data-driven transformation.

2.45 The Data Alliance and Partnership Board, within the Transformation Directorate of NHS England, has a central role in the development of NHS digitisation and will therefore have a significant impact upon the ability of ICSs to succeed. As an immediate measure, I recommend NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs - including from local government, social care providers and the VCFSE provider sector - to join the Board. The aim should then be to develop the Board into an Integrated Data Alliance and Partnership Board, creating a national equivalent of the ICS partnership itself. Both are essential to ensure that integration and the vital shift of effort and resources described in this chapter are not held back by an NHS-dominated view of the world.

2.46 Public support and trust for this approach is essential - without it the real transformation opportunities on offer by digital and data will not be fully realised. It is vital that national and local systems work with and engage the public continually to ensure that we can have a data-literate population that we can draw upon.

Empowering the public to manage their health

2.47 The democratisation and personalisation of data and digital tools has created a population that both expects and is able to use digital tools and data to support their health and manage their care and treatment. Equally, the effort to improve the nation’s health can only succeed if we support people to become active and engaged partners in their own health, wellbeing and care.

2.48 Most people rely on increasingly sophisticated digital devices to support almost every aspect of their lives.

2.49 The nhs.uk website is the UK’s biggest health website, with an average 23 million visits a week and the NHS app is a world leading solution in the hands of over 31 million people in England - nearly 7 in 10 of the adult population. But the public can also tap into multiple sources of information and advice, of varying quality,

reliability and cost, and use increasingly sophisticated wearable and other devices to monitor and support their own health and wellbeing. Increasingly, health and care are ‘high tech’ as well as ‘high touch’.

2.50 At the same time, it is vital to recognise that many NHS patients and social care clients are amongst those least able to use digital solutions, whether because of frailty, economic disadvantage, language issues or physical, cognitive or other disabilities (including dementia). Their voice needs to be heard, within ICSs and nationally, to ensure that the design of digital and data solutions is as inclusive as possible. It is also vital for ICSs to provide digital support to people who cannot self-serve. From a high street pharmacy helping someone into a digital consultation booth and putting digital monitors on them for their remote outpatient consultation, to a dementia day centre supporting a carer to do a digital medicines assessment, digital patient engagement won’t be real until it works for the NHS’s most vulnerable users.

2.51 The response to COVID-19 rapidly accelerated digitisation, particularly in the NHS. The pandemic tapped into a deep sense of civic duty amongst millions of people who were willing to share data through real-time tracking systems in order to reduce the spread of the virus; to report their health status daily as ‘citizen scientists’, enabling faster identification of significant symptoms, the spread of the virus and new variants; and to participate in fast, large-scale and often world-leading clinical research trials to establish the most effective forms of treatment.

2.52 I therefore recommend that, building on the existing work of NHS England, the NHS App should become an even stronger platform for innovation, with the code being made open source to approved developers as each new function is developed. The NHS App is itself an open architecture, with 2 components already being open source. Extending this approach would allow innovators - including those with lived experience - to develop solutions to meet the needs of different communities, whether parents of a child with learning disabilities, adults supporting a parent with dementia or people whose first language is not English and so on. A national user group should be established for the NHS App, including people with lived experience and VCFSE groups supporting marginalized or overlooked groups, to ensure public involvement in future developments. With several ICSs developing ‘carers’ passports’, an electronic version within the app would also be invaluable.

2.53 I also recommend that the government should set a longer-term ambition of establishing Citizen Health Accounts. This should be done by requiring all health and care providers (whether NHS or local authority funded or otherwise) to publish the relevant data they hold on an individual into an account that sits outside the various health and care IT systems and is owned and operated by citizens themselves. This should go further than just EPR data and should become a mechanism to enable people proactively to manage their own health and care.

Such a Citizen Health Account would need to be linked into the NHS app functionality and should receive information from sources such as NICE; it could also be a gateway into clinical trials and improving health outcomes. Digital tools and Apps can play a vital role in enabling ICSs to improve population health outcomes, a point emphasised in my terms of reference. A practical next step would be to trial this proposed approach in a limited format working with the NHS app team and suitable third-party vendors under the oversight of an appropriately recruited citizens' panel.

Chapter 2: recommendations

1. The share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. To deliver this the following enablers are required:

a) DHSC establish a working group of local government, public health leaders, OHID, NHS England and DHSC, as well as leaders from arrange of ICSs, to agree a straightforward and easily understood framework for broadly defining what we mean by prevention.

b) Following an agreed framework ICSs establish and publish their baseline of investment in prevention.

2. That the government leads and convenes a national mission for health improvement. I also support the Health and Social Care Select Committee's recommendation that DHSC should publish, as soon as possible, the proposed shared outcomes framework.

3. That a national Integrated Care Partnership Forum is established.

4. The government establish a Health, Wellbeing and Care Assembly.

5. That NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework to be adopted by all ICSs in order to improve interoperability and data sharing across organisational barriers.

6. DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, building on the successful change during the pandemic and set out in the *Data Saves Lives Strategy* (2022).

7. NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs - including from local government, social care providers and the VCFSE provider sector - to join the Data Alliance and Partnership Board.

8. Building on the existing work of NHS England, the NHS App should become an even stronger platform for innovation, with the code being made open source to approved developers as each new function is developed.

9. The government should set a longer-term ambition of establishing Citizen Health Accounts.

3. Delivering on the promise of systems

3.1 The recommendation to place ICSs on a statutory footing was made following NHS England's engagement and then formal consultation with system leaders, partners and stakeholders, following a period of co-production and engagement in policy development that was widely welcomed. In making that recommendation, DHSC, NHS England and local government representatives all acknowledged that to deliver on the ambition for ICSs, the role of national government and national bodies, and the approach to oversight, assessment and performance management across the health and care system would also need to change.

3.2 I cannot emphasise too strongly the scale of the transformation involved in the establishment of statutory ICSs. Because ICSs are partnerships between all those involved in health, wellbeing and care, we can shift the dial on today's immediate and urgent problems, bringing people together to work in different ways. By doing so, we start to create a new virtuous circle of supporting health and wellbeing, and in the process reduce the pressures on NHS emergency care.

3.3 But the creation of ICSs also requires clarity about where accountability sits. Every partner and sector within an ICS operates within its own financial, regulatory and accountability framework, whether that is local government, a VCFSE organisation, a social care provider, or an individual NHS provider. ICBs and ICPs should - and in many instances already do - create the environment to support 'mutual' or 'collective' accountability: where system partners can, with mutual respect and transparency, support and challenge each other to deliver priorities they have agreed together, irrespective of where their statutory accountability sits. That local accountability can and should be strengthened in the ways described in this chapter.

3.4 The NHS, in particular, sits within a framework of national regulation and accountability that is already changing. The new and welcome NHS England operating framework reflects the move to system-based working, with NHS England expecting ICBs to identify the local shared priorities that sit alongside national NHS commitments and to play a key role in the support and oversight of NHS providers.

3.5 The framework also sets out further changes to NHS England's structure and operating model including the behaviours and values expected of all those within the NHS, with a 'One Team' philosophy and a clear expectation around behaviours - collaborative, trusting and empowering, transparent and honest, inclusive and diverse. Within each ICS, as part of their development, partners are working together to agree the values and behaviours for which they will hold themselves accountable; not surprisingly, they bear a striking resemblance in spirit, if not exact words, to those of the NHS England framework.

3.6 The need for faster, and in some cases further, change in the whole framework of oversight and accountability of the NHS itself and ICSs more widely, was a strong theme in my discussions throughout the review.

3.7 Although much of the following analysis and recommendations involve the NHS, this is not because I (or ICS leaders generally) believe the NHS is or should be the dominant partner in the new model. I believe quite the reverse. Instead, it simply reflects the fact that the necessary national oversight and accountability of the NHS needs to respect and allow space for local accountability within the whole ICS.

3.8 Integrated care boards (ICBs) have a particular position within this wider framework. They are a key partner within the wider integrated care system; with local government, they establish the integrated care partnership (ICP) that brings all partners in the system together to produce the integrated care strategy. As NHS statutory bodies, they have a statutory responsibility for arranging for the provision of health services for their residents; they take the lead in ensuring that all parts of the local NHS work together with each other and with social care and other partners; and they are accountable for the overall performance and finances of the local NHS.

3.9 They are simultaneously part of the 'one system' of an ICS while needing to see themselves - and be seen and treated as - part of the 'one NHS' team. Because ICBs are accountable for around £108 billion of the £150 billion made available annually by parliament for the NHS and for the performance of the local NHS, the need for accountability from the ICB to NHS England, and through NHS England to government, for NHS finances and performance is not in doubt.[13] But the mechanisms for accountability need to be both effective in themselves and also proportionate so that ICB leaders have the space and time to be effective partners and leaders within the wider ICS. The improvement-focused work of NHS England with ICBs needs to take full account of the need for ICBs to be 'great partners' within their ICS and not simply within the NHS itself (see below).

3.10 Where an organisation has a clear responsibility for most or all of an issue and controls the resources to deal with it, accountability sits with them. Many issues are matters for the NHS partners in a system rather than a single organisation and one of the benefits of ICBs taking statutory form is that they can provide clear accountability 'upwards' to NHS England and the government for delivery of those things that are national must-dos and which are wholly or largely the responsibility

[13] Data refers to CCG and NHS England spending for 2021 to 2022 financial year - NHS Commissioning Board Annual Report and Accounts 2021 to 2022 financial year - for the period 1 April 2021 to 31 March 2022 (england.nhs.uk) - to note £108 billion is the amount which ICBs were formally allocated in 22/23 the actual amount ICBs are responsible for is likely to be greater when considering funding streams from delegation or other one off in year funding packets.

of the NHS. It will be important to maintain clarity of accountability on these matters.

3.11 NHS England and the DHSC will continue to focus on the capability of the ICB and the effectiveness of all NHS partners, including the ICB, in ensuring clear accountability for NHS performance. The new role of CQC in relation to ICSs (see below) will include an assessment of how strong the mutual accountability between partners is within a system.

Approach

3.12 Conversations with system leaders towards the start of this review often focused on the need to reduce the top-down management of the NHS that reflects decades of hierarchical NHS management, a culture that NHS England's leaders are already changing. My recommendations build on, and are designed to deepen and entrench, their new approach. As the review progressed, however, the conversation moved from a negative view of autonomy ('freedom from') to a positive vision of self-improving systems ('freedom to') where partners work together, motivated by the common purpose of using the resources available to our communities to achieve the best possible outcomes.

3.13 It also became clear that the principle of subsidiarity must be embedded as part of this, enabling local leaders to make decisions at a level as close as possible to the communities that they affect.

3.14 In this chapter therefore, I set out the conclusions and recommendations I have reached from this review, starting with the need to work on the basis of subsidiarity, through strong, empowered Place Partnerships and neighbourhood teams.

Place

3.15 All ICSs are expected to define a clear role for 'place' level partnerships. As emphasised earlier, however, ICSs vary considerably in size and architecture, with corresponding differences in what 'place' means. At one end of the spectrum, there is a system covering around 750,000 people with a single upper tier local authority and one Health and Wellbeing Board. At the other end, there is a system covering over 3 million people, the ICS includes 13 places, 12 of which align with its own local authority area and Health and Wellbeing Board.

3.16 Although part of the impetus for this review came from concerns about top-down management of ICSs and the need for a new balance between greater autonomy and robust accountability, it is just as important that the principle of collaboration and subsidiarity is lived within systems themselves - and that the partnership

working and integration that is already delivering results locally is supported by further changes in the national framework.

3.17 In many ICSs, place partnerships, aligned with Health and Wellbeing Boards and building on their work over many years, will lead much of the work to transform local services and models of care, support population health and tackle health inequalities.

3.18 Some providers, however, report that they are finding it difficult to navigate between different versions of ‘place’ in different systems. While ‘place’ cannot and should not be defined by the DHSC or NHS England, it should be agreed by partners at system level so that there is visible and accountable leadership at place, underpinned by an integrated governance structure. place-based leaders must be enabled to feed directly into system-wide conversations, plans and funding arrangements. Where provider trusts and foundation trusts provide services within different places or systems, there needs to be close collaboration between providers, place, and system leaders to ensure the best outcomes for residents. As every system establishes its place governance and leadership, taking into account relationships with different providers, this information should be transparent and accessible for their communities.

3.19 The same ‘can do’ culture described in the operating framework should equally apply to ICSs’ relationship with their place partnerships and provider collaboratives. Indeed, we have seen examples through the course of this review where place partnerships are still ‘looking up’ to the ICB for permission and instructions instead of ‘looking out’ to the communities and neighbourhoods they serve. More mature systems are supporting their Place partnerships and provider collaboratives to drive initiatives and define their own priorities within the guardrails of the mutually agreed strategy of the ICB and ICP: this needs to rapidly become the norm across all ICSs.

3.20 In several systems, strong and mature provider collaboratives are an important engine of improvement and transformation. Collaboratives can bring together providers to improve access and reduce wait times, share best practice, staff and resources, and help overcome organisational barriers which can sometimes stop services being designed and delivered around the needs of patients and communities. While provider collaboratives, like ICBs, vary considerably in maturity and strength, they have the potential to become the core NHS delivery arm for achieving key system objectives. ICBs have an important role in convening, supporting and resourcing the development of effective collaboratives to help drive service transformation, increase provider resilience and embed a culture of collaboration across providers. It is also important for the relationship between provider collaboratives and the ICB to be clear within each system, with consistency between system objectives and the priorities of its constituent collaboratives.

Embedding a balance of perspectives

3.21 We have heard frustrations from a range of stakeholders at the limited number of mandated members of an ICB. Many feel it is impossible to have their voices heard if they do not have a seat at the table and that ICBs seem to be largely constituted from parts of the NHS rather than across the wider system; this is particularly felt by social care providers and public health leaders within local government.

3.22 It is important to remember that the 2022 Act created statutory ICSs with 2 separate, complementary bodies: an ICP bringing together the full range of partners through a statutory committee jointly created by the relevant upper-tier local authorities and the NHS, with members drawn from many other organisations and sectors; and an ICB, which is a statutory NHS body accountable for NHS performance and finances.

3.23 Given the variation in ICS constitution and size it was absolutely right that the government chose to be legislatively permissive. It was important to allow ICSs to create the architecture and governance for their ICP and ICB that enabled them best to serve their population. But as ICSs come towards the end of their first year as statutory entities, there is a valuable opportunity for them to learn from each other as well as from their own experience and adapt accordingly.

3.24 Crucially, regardless of membership, collaboration within an ICS should stretch wider than just those who are members of ICB boards. Wider partners, including social care providers, the VCFSE sector, and the independent healthcare sector should be fully engaged and their contribution better understood within the NHS.

3.25 However, I have heard a compelling case that social care providers should have a strong voice in every ICS. I agree, although reflecting the general principle of avoiding top-down directions, I believe that each system should decide how best that is done. Similarly, 20 of the 42 ICB constitutions do not specifically mention a role for public health. While public health is and should remain a crucial role of local government and may have been included through the recruitment of partner members on ICB boards, systems should also consider whether this expertise needs to be better embedded within their structures.

3.26 ICBs have been asked by NHS England to review their governance arrangements over the coming months, after their first year of operation. Each ICB should be encouraged to use this process (as many plan to do in any case) as an opportunity to engage with all system partners to consider how the ICB is operating within the overall ICS architecture. Many ICSs are using a process of self-assessment and mutual peer review to support their own self-development; this process should be actively encouraged while not forming part of any formal assessment. Within the governance review and its own self-assessment, each ICS should consider

whether it needs to do more to ensure that social care providers are involved in planning and decision making, that public health expertise is being effectively deployed within the system.

Local accountability and priority setting

3.27 Just as the care and treatment of individuals must be based on ‘no decision about me without me’, so local communities must be involved through a continual process of engagement, consultation and co-production in design and decision-making about local services. Strong and visible local accountability, recognising the principle of subsidiarity, also plays an important role in promoting legitimacy with the local population through empowering, accountable and transparent decision-making.

3.28 In many ways, local accountability is hard-wired into ICSs - through ICPs themselves as well as Health and Wellbeing Boards, Health Overview and Scrutiny Committees, Healthwatch, foundation trust governors and many other forms of patient and public involvement in system, place, provider and neighbourhood working. Health and Wellbeing Boards enable local councillors, alongside other partners, to set place-based priorities for improving health and wellbeing outcomes, to agree joint strategic needs assessments and health and wellbeing strategies for their residents. Where local government, healthcare and system boundaries do not coincide, it is particularly important that all concerned collaborate in the best interests of residents.

3.29 HOSCs are another important part of the local accountability framework, allowing councillors to scrutinise significant changes or issues in health and care provision and hold local NHS leaders to account. Although (like ICSs themselves) they may vary somewhat in effectiveness and maturity, it is important to the success of ICSs that they provide effective, proportionate scrutiny. In Greater Manchester, the HOSCs in all 10 unitary councils have already delegated this role of system oversight to a Joint Health Overview and Scrutiny Committee; a similar approach could be adopted in other equivalent systems. I therefore recommend recognising HOSCs (and, where agreed, Joint HOSCs) as having an explicit role as System Overview and Scrutiny Committees. DHSC should work with local government - through the LGA, the Office for Local Government and the Centre for Governance and Scrutiny - to develop a renewed support offer to HOSCs and to provide support to ICSs where needed in this respect. In assessing the maturity of ICSs, CQC should consider the effectiveness of system oversight provided by HOSCs or Joint HOSCs, or both.

3.30 In line with its statutory responsibilities, every ICS, through its ICP, has already developed an integrated care strategy, informed by Health and Wellbeing Board priorities (themselves reflecting their system JSNA) and co-developed by the ICP

ensuring engagement and involvement with those with lived experience, the wider local population, different tiers of local government and locally elected leaders, including elected mayors.

3.31 In response to the clearly expressed wishes of local leaders, I recommend that each ICS should be enabled to set a focused number of locally co-developed priorities or targets and decide the metrics for measuring these. These should be co-developed with place leaders and adaptable to complement place level priorities, and should be a natural extension of the ICP health and care strategy. These priorities should be treated with equal weight to national targets and should span across health and social care.

3.32 A mechanism for achieving this recommendation lies with the Joint Forward Plans. NHS England has asked ICBs in their JFPs to reflect local priorities agreed with their ICS partners, ensuring these have equal weight alongside national NHS commitments. Building on the integrated care strategy developed by the ICP, the JFP should describe the outcomes the ICS is aiming to achieve. This should include short, medium and longer-term measures that will be used to track progress as well as how different partners will contribute to these and how they will hold each other to account for doing so.

3.33 NHS England itself consulted with local government and other colleagues to develop the guidance for JFPs; as noted earlier, this was very different in tone and approach from earlier, pre-COVID approaches to local NHS planning. I have heard from several colleagues, however, particularly those in local government, social care and the VCSFE sector, that it is confusing or even inappropriate for guidance relating to ICSs as a whole, and ICPs in particular, to come from NHS England when, by statutory design, the local NHS is only one partner amongst many within the system. Initially, at least, the reference to a ‘joint’ plan prompted some confusion about whether ‘joint’ referred to all local NHS organisations, the local NHS and social care, or the system as a whole. Concerns of this kind underline the need for clearer cross-government arrangements in relation to ICSs as a whole.

Self-improving systems

3.34 In any large, complex organisation, whether national or global, it is essential to find the right balance between ‘national’ and ‘local’. ICSs, of course, are not a single organisation; they are a complex ecosystem. So is the NHS. As I have already described, the cross-sector partnerships of ICSs need to be paralleled by stronger cross-government working. But even for the NHS partners within each ICS, the ‘national centre’ is not a single entity: it includes NHS England, as the leaders and headquarters of the service, as well as DHSC and CQC. It is therefore essential

that the roles of each are clearly defined and delineated, in the way described below.

3.35 We know that high-performing organisations and systems combine high levels of autonomy with high levels of accountability. ICS leaders themselves increasingly want to create a self-improving system - empowered and strong enough to set strategy, agree plans and trajectories and to mobilise the collective time, talent and resource of system partners to realise them.

3.36 System leaders will succeed where they exercise the agency to define the ‘how’ and to deliver against agreed local and national priorities. The operating environment needs to allow system leaders the space to use their time and energy to collaborate, innovate, and tackle the problems their systems face and to determine together how improvement is best achieved in their local circumstances.

3.37 But recognising the considerable differences in maturity, relationships and strength of leadership across ICSs generally, and ICBs in particular, NHS England needs to reinforce the support it offers to the ICBs and other local NHS partners most in need of support. The goal should be to build the right leadership capability and partnership culture while recognising that, as a last resort, regulatory intervention by NHS England will be required.

3.38 I urge ministers, NHS England and ICSs to confirm the principles of subsidiarity, collaboration and flexibility that were set out when ICSs were being established and explicitly commit to supporting ICSs to become ‘self-improving systems’. This clear goal would align all national priorities behind a dynamic, collaborative approach, informed by smart data-driven insights, enabling innovation and imaginative solutions.

3.39 As a system matures and is able to manage a wider range of issues more effectively, it should operate with greater agency. We should not see autonomy as a binary state; as something you do or do not have. For complex organisations in complex systems, the balance between what they do for themselves and what they seek or need further support in achieving is always likely to vary from issue to issue.

3.40 Mature systems and organisations are those which have the shrewdest understanding of where autonomy or support are likely to work best for them. Craving autonomy for its own sake can often be a sign of immaturity. It follows that we should think less in terms of ‘earned’ or ‘assumed’ autonomy and more in terms of a tailored combination of autonomy and support that produces effective agency. As systems mature, far more of that tailoring can be done by the systems themselves, with NHS England playing a stronger role in the less mature systems.

3.41 Inherent in this model, therefore, must be a commitment to organisational and leadership development, with a clear expectation on providers and ICBs in particular to work together and share resources to support the development of the right cultures and relationships.

Accountability relationships at the heart of system working

3.42 In the course of this review, several colleagues stressed the need for clarity within ICSs, and with NHS England, about where accountability lies for NHS organisations and partners. The new NHS England operating framework states clearly that the role of ICBs includes:

- first line oversight of health providers
- to co-ordinate and help tailor support for providers
- assurance and input to regulators' assessment of providers
- liaison or escalation to NHS England

3.43 That remains, in my view, a helpfully clear statement. Building on this, and acknowledging that different systems are at different stages of operationalising these roles and relationships, several principles are clear:

- trust chief executives are accountable for what goes on inside their trust, crucially, the quality and safety of the services they provide to patients. This statutory accountability is to their board (and in the case of FTs, also to their governors and members), as well as to NHS England
- trust chief executives and boards are also accountable to system partners - within a provider collaborative or Place Partnership where appropriate, but also with and through the ICB. They are accountable for their part in agreeing and delivering plans to improve patient outcomes and the quality, safety and accessibility of care, as well as to solve performance and productivity issues (including ambulance handovers and delayed discharges) that can only be solved by multiple organisations working together
- trust chief executives and boards are accountable to partners across the ICS (including the ICB) for their part in shaping and helping to deliver the ICS integrated care strategy and Joint Forward Plan, including their focus on prevention, population health and health inequalities
- as the organisation accountable for the state of the local NHS as a whole, the ICB is uniquely placed to understand the connectivities and inter-dependence

between different providers. They have a crucial role as the convenor of the NHS, as the statutory partner with the upper-tier local authorities that also form the ICP and leader and partner in the wider ICS

- ICBs are accountable for the performance and financial management of the NHS in their area. ICB CEOs are accountable to their boards, to system partners and to NHS England for delivery of agreed priorities and plans - including elective recovery, urgent and emergency care plans and so on. This is different from being accountable for the performance of individual trusts. As set out earlier, ICBs are accountable to both NHS England (through NHSE regions) and to their local communities

- it is the role of all system leaders collectively to challenge and support each other in relation to meeting the agreed objectives. In a growing number of systems, this is realised through a distributed leadership model where different system members at system, place and neighbourhood level all have defined responsibilities and accountabilities within their eco-system and providing appropriate support to enable transformational change

- the ICB has a critical role as the vehicle to coordinate the activities of provider collaboratives and the NHS's contribution to place-based partnerships. ICBs are vital to support and enable these partnership arrangements to deliver faster progress on service transformation, recovery, and wider delivery on long-term plan objectives

- ICBs have a direct interest in and commitment to the success of NHS providers within their system. This is partly because, as 'commissioners', they are properly concerned with quality, safety and productivity within individual providers. More fundamentally it reflects the recognition that none can succeed unless all succeed. Rightly, there is now a clear expectation that ICB chairs will be involved in the recruitment of trust and foundation trust chairs, with ICB CEOs similarly involved in CEO recruitment, helping to ensure that provider leaders understand and are committed to system working

3.44 I hope that these principles will be helpful to ICS leaders as they clarify and operationalise roles and accountabilities between partners across their system, and to NHS England as they support ICBs in making their contribution to shared local priorities.

3.45 NHS England should therefore work 'with and through' ICBs as the default arrangement. ICBs should be the first point of support for providers facing difficulties, supporting (and if necessary, challenging) the trust to agree a plan of action, mobilising system partners to agree action on wider issues that affect the trust and calling in improvement resources if required. As described in the NHS England operating framework, within their 'adult to adult' relationship, the ICB will

want to keep their NHS England regional team (and CQC if appropriate) informed on a ‘no surprises’ basis, and seek their advice on occasion, while retaining the initiative and ‘first line’ responsibility. NHS England should continue to evolve the NHS oversight framework and ensure it is being implemented as intended. There will also be times when an ICB asks the region to intervene directly. In all cases, this must be done collaboratively, with both the ICB and the region ensuring there are ‘no surprises’, whoever is in the lead.

3.46 Many ICBs will need time to develop the capacity and capability to lead all aspects of system risk management, particularly when performance pressures are so apparent in almost every part of the NHS. In less mature systems - for instance where relationships are poor or where the ICB has not yet developed the necessary capability - NHS England, in agreement with the trust and ICB, should take the lead in dealing with a trust facing serious difficulties or catastrophic failure. They should continue to involve the ICB, both so they can build insights into the trust’s difficulties (including those caused by problems elsewhere in the system), and because working in this way will help to strengthen the ICB, improve the chances of success with the trust and help the whole system to develop more effectively.

3.47 Of course, there will be occasions when NHS England needs to communicate directly with providers on urgent or other specific clinical or operational issues. It is essential, however, for NHS England to avoid working directly with providers in a way that weakens or disrupts system working, for instance by bringing in support for a trust on delayed discharges without talking to or taking account of the partnership working tackling exactly the same problem.

3.48 I recommend that, in line with the new operating framework, the ICB should take the lead in working with providers facing difficulties, supporting the trust to agree an internal plan of action, calling on support from region as required. To enable this and recognising NHS England’s statutory responsibilities, support and intervention should be exercised in relation to providers ‘with and through’ ICBs as the default arrangement. Where relationships and leadership are less mature, ICBs will need more active support from NHSE regions.

ICSs develop their own improvement capacity

3.49 ICS leaders have the clearest view of what an ICS does, how it works, the interlinkages between different parts of the system and how best to craft solutions to meet the needs of their communities and resolve the challenges within local health and care services. It therefore follows that they should play a fundamental role in their own improvement.

3.50 Quality improvement should be supported by system leadership and at a system level, including through the adoption of common improvement methodologies across systems. However, this has often been deprioritised by other work and requires investment, capability building and drive amongst partners to accomplish. This will help ensure systems drive a learning culture in all system partners and enable future-focussed thinking.

3.51 The NHS Improvement Approach being developed by NHS England will ensure that the development and adoption of improvement methodologies is prioritised across each ICS. This improvement offer should align with the principle of self-driven improvement by establishing some overarching principles that can be adopted locally, rather than prescribing a 'template' for improvement (outlining the 'what' and the 'why' but not the 'how'). It should also build on, rather than duplicate, the work being done by various improvement focused organisations including the NHS Confederation, NHS Providers, Q Community, the Royal Colleges and Academic Health Service Networks (AHSNs), which should all be seen as leaders in driving and implementing this new approach.

3.52 CQC itself is committed to making its assessment of ICSs an opportunity to support and incentivise improvement, rather than a 'box-ticking' or compliance approach. Given the experience of many provider trusts who in the past have found themselves facing overlapping and sometimes conflicting requirements from CQC and NHS England, I also recommend that NHS England and CQC work together to ensure that as far as possible their approach to improvement is complementary and mutually reinforcing.

3.53 ICSs will naturally take different approaches to improvement - some driving this more directly through provider collaboratives and others in which ICSs are developing in-house capacity to support improvement initiatives or train provider staff. Cross-ICS sharing and learning via peer-to-peer networks and collaboratives will strengthen ICSs' approaches to collectively leading improvement. This work is happening - for example through the NHS Confederation's ICS Network - but there is great potential for the 42 ICSs to think of themselves and be supported to develop as a single learning system.

In West Yorkshire ICS, for example, there are clear arrangements for system improvement agreed between the ICB and the acute provider collaborative, the West Yorkshire Association of Acute Trusts (WYAAT), which leads on certain system priorities on behalf of the ICS including the planned care and diagnostics programmes.

WYAAT collectively has (and will continue to) reviewed and made interventions in specialities with workforce challenges to ensure that equitable access for patients continues. This is clearly led and owned by WYAAT as a collaborative, with ICB involvement for oversight of system risk where required and where changes to protect access may impact the way in which patients access services in the short, medium or

long-term. The oversight approach modelled by the NHS England regional team as well as the ICB is one of improvement support, trust and mutual respect, rather than top-down performance management. By adopting a clear, well-managed structure to facilitate partnership working on health inequalities and prioritising population groups' health at system level, the ICS has ensured it can deliver improved outcomes for key groups and maximise its effectiveness across a large population.

3.54 External peer review can be a powerful tool to incentivise and support improvement. The LGA's well-established local government peer review programme provides the basis for an equivalent ICS process for use by ICSs as a whole. Peer reviews should ensure the appropriate involvement of local populations and services users and have access to bench marking tools such as GIRFT and Model Hospital. I therefore recommend a national peer review offer for systems should be developed, building on learning from the LGA approach.

High Accountability and Responsibility Partnerships

3.55 As part of this work, I have heard a clear desire from ICBs and wider system partners to move towards a model with a far greater degree of autonomy, combined with robust and effective accountability. Such a model will need to balance a high degree of autonomy with the need to sustain and demonstrate both performance improvement and effective financial controls.

3.56 In order to make progress as quickly as possible, and reflecting what I have heard with ICB leaders, I recommend that NHS England works with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024. Reflecting ICB leaders' views, I expect that this new approach will include self-assessment of maturity supported by peer review mechanisms.

3.57 I have already urged all partners, locally and nationally, to commit to the goal of developing 'self-improving systems'. I have also heard a clear desire, both locally and nationally, for systems as a whole to set a high level of ambition, with the most mature systems being enabled to go further and faster in creating the transformation that, as we have argued throughout, is the most sustainable route to solving immediate performance pressures.

3.58 I therefore recommend that an appropriate group of ICS leaders (including local government, VCFSE and other partners as well as those from the NHS) should work together with DHSC, DHLUC and NHS England to create new 'High Accountability and Responsibility Partnerships'. These should start to operate from April 2024. To reinforce the cross-government arrangements needed to parallel the broad partnerships of ICSs as a whole, this working group should report regularly to DHSC and DHLUC ministers together with the chief executive of NHS England.

3.59 The design of HARPs will, of course, depend upon the work of this group. But to give an idea of the scale of ambition that I have heard from colleagues, I suggest that the framework for HARPs should include:

- a radical reduction in the number of shared national priorities and corresponding KPIs
- a collective commitment by HARP systems, including the ICB, NHS providers, and, crucially, local government and other partners, committing themselves to a small number of priorities for which they would be held accountable both locally and nationally; with clear milestones and outcomes, and linked to Joint Forward Plans
- significantly greater financial freedoms to enable partners to make best use of the resources available to them, including the public estate
- an effective data-sharing approach across multiple partners, with linked data sets enabling proactive population health management, significantly improved outcomes for population groups and substantial reductions in demand for emergency and specialist services. These data sets would also, of course, provide appropriate warning systems to departments and regulators in case performance or finances begin to diverge significantly from agreed plans
- a light-touch national accountability framework, for instance with 6-monthly reviews between NHS England, the ICB and other ICS partners
- the process for ICSs to ask for additional support, and the support available to them

3.60 This approach also recognises that not all systems are ready for advanced levels of autonomy and responsibility, while allowing those who can go faster, to do so. It also recognizes that if circumstances change, and a system is struggling, there are processes in place to provide additional improvement-focused support and help.

3.61 Testing this approach in this way will not only provide crucial learning, it will mark out a clear path for all systems, showing what is possible, and what can be expected, from a high-performing system.

3.62 Although it would not be appropriate for this review to recommend how many ICSs should adopt these new arrangements, in order to test the approach, the scale of ambition needs to be clear. I would hope that around 10 systems would be able to work in this way from April 2024.

The right skills and capabilities for ICBs

3.63 This brings me to the capabilities needed for ICBs themselves.

3.64 As this review has confirmed, the 2022 Act gives ICBs a vital new role as convenors and catalysts for change. All ICBs need to work with their partners - including place boards, provider collaboratives and local government - as well as their own staff to establish and develop people in the roles that are needed in the ICB team to facilitate acceleration of and depth of performance improvement and wider transformation across the system - and to fulfil their multiple statutory duties - working in the new, collaborative ways required. ICBs are, of course, at different stages in this process.

3.65 On 2 March, NHS England announced that ICBs' running cost allowance - already frozen in cash terms for 2023 to 2024 financial year - would be further cut by 30% in real terms over the following 2 years, with at least 20% reductions delivered in 2024 to 2025 financial year, with no provision for redundancy payments.

3.66 Everyone I spoke to during this review is acutely aware of the intense pressures upon the nation's - as well as the population's - finances, and the stress upon VCFSE partners, social care providers and local government, as well as the NHS. Local government and NHS partners, including the ICB, need to work together within individual ICSs to share corporate services and other functions, create single teams and make better use of digital tools to improve productivity. Neighbouring ICSs need to consider similar arrangements, such collaboration helps to strengthen ICSs while achieving better value for public funds.

3.67 As the Wigan Deal demonstrates, financial constraints can and should be used as an opportunity for transformation. But the scale and timing of these reductions create a real threat to the successful development of integrated care systems (ICSs), with too much time and energy from all staff, including those most essential to improvement and transformation, diverted into a restructuring that is potentially too extensive and too fast. Instead, we need to focus on striking the right balance of capability between NHS England, NHSE regions and ICBs. As NHS England implements its new operating framework, I encourage a significant move of resource into systems, supported by smaller, more experienced and highly capable NHSE regions. Without that, the restructuring risks creating a new imbalance between the national, regional and ICB teams of 'one NHS', when the original intention was of course to rebalance resources towards ICBs and ICSs as a whole.

3.68 I therefore recommend that during 2023 to 2024 financial year further consideration is given to the balance between national, regional and system resource with a larger shift of resource towards systems; and that the required

10% cut in the RCA for 2025 to 2026 financial year is reconsidered before Budget 2024.

3.69 Finally, delays and complexity with respect to the appointments process for ICB senior leaders have made it difficult for ICBs to build the right capability and governance to fulfil their statutory functions. In some cases, this has led to many months delay in approving the appointment of ICB medical directors, non-executive members and other senior roles. I therefore recommend that NHS England and central government work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.

The role of the regions

3.70 As the chair of an ICB in level 4 of NHS England's oversight framework (SOF4), with considerable challenges in performance, quality and finances, despite many achievements and real progress, I am particularly alert to the value of a senior NHS England regional team who can provide expert advice. Regional teams can help to mobilise, support and resource sustained improvement efforts across the whole system as well as in individual providers and challenge us, in the ICB and working with all NHS providers, to go further and faster. On occasion, of course, they may also need to exercise NHS England's statutory powers of regulatory intervention.

3.71 As 'one NHS', however, we need to make sure that there is the right balance of capability between NHS England, NHSE regions and ICBs. There are a number of fixed points in determining this balance - for example, NHS England will, and should continue to hold statutory regulatory functions in relation to ICB performance. However, there is also a clear need for flexibility - with different areas needing their regions to be structured in different ways, depending on the maturity, size and challenges facing them.

3.72 A region with a small number of large systems with mature relationships and effective, experienced leaders should work in a very different way from a region with several small, relatively immature systems - and both will be different from a region with a wider mix. For the North East and North West, NHS England has already established a single regional director and team in place of the previous 2. As systems mature, the regional arrangements will continue to change, with systems individually or collectively taking on the responsibility for system and regional leadership, with regional teams focusing on their statutory roles rather than on ICSs.

3.73 In other NHSE regions, particularly those with smaller and less mature ICSs, a small number of senior people at the region who know and understand each system (with its particular geography, history, demography, provider configuration and so on) and, crucially, have built strong relationships with the key people within

the system, will remain invaluable. Those NHSE regions should maintain a role as the collective agent for ICBs and the local NHS within ICSs, and should facilitate the resolution of particularly difficult issues, such as the best configuration of vital specialist resources.

3.74 In order to make this approach a reality, NHS England regional teams should work based on a collective set of principles to support systems in translating national expectations to fit local circumstances, brokering national support for ICBs with struggling providers, and supporting less mature systems to develop their own capacity and capabilities. If an ICB requires support or further escalation, or both, then this should be agreed between NHS England Region and the ICB. Only if further escalation is required should national NHS England be involved.

3.75 Improvement rather than 'performance management' should be the dominant approach and priority. NHSE regions should operate as equal partners with ICBs, aligned with the principles as described in its operating framework: "mature, respectful and collegiate, underpinned with effective lines of communication and a 'one team' philosophy".

3.76 There is good practice already of this with examples such as the Northeast and Yorkshire 4+1 scheme and a 'compact' in the South West. Arrangements should be agreed between NHS England and ICBs for the joint governance within NHSE regions.

3.77 Strong relationships and clear oversight arrangements in West Yorkshire are supporting the system to improve care for patients. West Yorkshire ICS has been a partnership since 2016 so has had several years to build up the trust and relationships between Place, providers, the ICB and NHS England regional teams. Within the wider region, they operate on the basis of a 4 ICSs + 1 region model, agreeing regional targets with NHS England regional team and other local ICBs which are then measured at a regional level. This approach helps facilitate peer learning between ICSs to compare local approaches to delivering regional targets. In line with this approach, I would expect all ICSs to continue co-designing arrangements for regional support that best support their continuing development.

3.78 An important part of the support that regional directors can mobilise sits within the many NHS England programmes focused on particular diseases, conditions and so on. The national cancer programme, for instance, is an example of the essential role for NHS England in convening leading clinicians and scientists, national cancer charities and patient advocacy groups to drive and support life-saving changes in prevention, early diagnosis, treatment, patient experience and access. Such work can only be done once, as NHS England's new operating framework explicitly recognises and it is a task for NHS England itself as the headquarters of the service.

3.79 But the multiplicity of national programmes has created real problems, with different national programmes reaching out directly to individual providers and systems, adding to the plethora of meetings, guidance, templates, demands for data and such like. It is helpful that NHS England is significantly reducing the number of national programmes, it is equally important that planning the future support and requests from these programmes will go through NHSE regions rather than directly to providers and systems.

3.80 It will be important for ICS partners themselves, working within NHSE regions, to reinforce this new and welcome way of working; as the Messenger Review underlined, these changes in culture and behaviours take time and sustained effort to bed in.

3.81 There is now an opportunity to build on the new NHS England operating framework to co-design the next evolution of NHSE regions. I recommend that ICS leaders should be closely involved in this work, to ensure that NHSE regions can operate as effective partners, and the collective agent of the local NHS within ICSs.

Organisational development

3.82 Real, lasting change happens because people come together around a common purpose. It is the job of leaders to create the culture and behaviours, backed by the right systems and processes, to enable that to happen. Realising the potential of ICSs - and the neighbourhood teams, place partnerships and other structures within them, including ICBs - needs substantial, sustained investment in organisational development, collaborative leadership and team working across different professions, sectors and organisations.

3.83 Local government and NHS leaders at place and system level can already draw upon the support provided in collaboration between the Local Government Association (LGA), the NHS Confederation and NHS Providers. NHS England has made some organisational development support available for ICBs, drawing upon a variety of change management partners and coaches.

3.84 Depending upon its starting point, each ICS needs to sustain, develop or create its own organisational development programme across the whole of the health and care system. This should include partners from neighbourhood, place and system level arrangements across the NHS, local government, the VCFSE sector and social care providers. Because of the fragmentation and siloed working between the NHS and social care, and within the NHS itself, there is a particular responsibility upon councils with social care responsibilities and NHS leaders - in foundation trusts, trusts and primary care, as well as the ICB - to work together as part of this process of creating a common culture.

3.85 I therefore recommend that NHS England work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer. Investment of this kind is a necessity, not a luxury. But within each ICS, partners need to work together to make the best possible use of limited funds, including the training and development budgets of the ICB, individual NHS organisations and local council partners. The need for such support is echoed in the HSCCs most recent inquiry of ICS autonomy and accountability. Their recommendation calls for government and NHS England to set up and fund an ICS leadership development programme, specifically targeted at supporting leaders of and within ICSs to develop the skills required to be successful system leaders. Statutory partners in ICSs should consider how they support VCFSE and social care provider partners to be fully included in organisational development. Creating shared teams between local councils and the NHS (for instance, a single integrated health and wellbeing communications team) will help to build common purpose and understanding of the very different culture, governance and financial frameworks of different statutory organisations as well as making better use of scarce resources.

3.86 The previously described goal of self-improving systems also requires sustained investment in improvement capabilities. Quality improvement should therefore be supported by system leadership and at system level (or, in very large systems, at place level).

3.87 A few systems or place partnerships have already adopted a common improvement methodology. Others have started bringing together QI leads or teams across different organisations to create a QI community. Mutual understanding, sharing learning and building a common approach will be a powerful driver of improvement and transformation across the local health and care system. When assessing the maturity and effectiveness of ICSs, CQC should take into account the extent of collaboration around organisational development and quality improvement.

3.88 In further recognition of the need to sustain and deepen culture change, I recommend that the implementation groups for the Messenger Review should include individuals with significant experience of leading sustained cultural and organisation change in local government and the voluntary sector as well as the NHS.

National organisations

Relationship between DHSC, NHS England and ICSs

3.89 Consideration now needs to be given to the relationship between NHS England, the department and ICSs themselves. The 2012 Act separated NHS England from the department, placing operational leadership in an arm’s length body. Policy

making, including setting the mandate for NHS England, remained with the department. That arrangement, confirmed by the 2022 Act, reinforced the position that NHS providers, and now NHS ICBs, are accountable to NHS England which is, in turn, is accountable to the Secretary of State and, through them, to parliament. NHS England has also taken on new functions from NHS Improvement, Health Education England and NHS Digital - making clarity of responsibility and accountability even more important than before. It is increasingly clear, however, that these arrangements are not working as intended. From the standpoint of providers and systems the apparently clear distinction between the department and NHS England can feel increasingly blurred in practice.

3.90 Everyone wants ICSs to succeed: the department and its ministers, NHS England and ICS partners and leaders themselves. The fact that all 3 can, at times, have quite different perspectives on the central issue in my terms of reference - the balance between greater autonomy and robust accountability - does not flow from any difference in the outcomes they seek. All want the best outcomes for patients and the public, improved working lives for staff and the most effective use of public funds. Their differences of perspective are driven by differences in position within the health and care system rather than different goals.

3.91 I have therefore sought to understand all 3 perspectives and reflect them here, starting with ICSs.

3.92 I have been directly involved in the development of ICSs over the last 6 years, as independent chair of a sustainability and transformation partnership (STP) and then an ICS, and now as chair of an ICB and deputy chair of the ICP. The views of system leaders are reflected throughout this report, including the clear desire for greater autonomy alongside effective accountability. They want to look outwards, not upwards. ICS leaders themselves recognise ministers' personal commitment to ICSs and welcome their increased interest. It is not only helpful but essential that ministers become as familiar as possible with how different ICSs are working, their real achievements and the challenges they are encountering. Ministerial attention can itself help to reinforce partnership working, highlight and spread excellent practice and innovation and challenge ICS leaders to go further and faster. On the other hand, many ICB leaders are concerned by the growing number of requests for detailed performance data or explanations of exactly what they are doing on a specific performance issue, duplicating or conflicting with clearly established lines of accountability. I am therefore not surprised to hear a growing number of system leaders say that "it feels as if we have 2 centres now."

3.93 In relation to NHS England, from the start of this review, I saw how easy it would be to frame the issue as "ICSs good, NHS England bad". Easy, but wrong. In the announcement of the review itself, I stressed that the review would 'build on the welcome work already done by NHS England to develop a new operating model'. Both before and since 2012, I have worked closely with what is now NHS England.

I value their clinical and operational expertise and have great respect for their many outstanding leaders. It is clear to me that the leaders and staff of NHS England are committed public servants who have a real dedication to supporting the NHS. As both the headquarters for the NHS and as an arm's length body of government they face daily challenges, but it is to the great benefit of the system and to government that they continue to tackle those challenges. NHS England deserve a good deal of credit for the changes they have already made and are continuing to make, referred to in other parts of this report. They themselves initiated STPs in the first place, giving them welcome freedom to develop in response to local circumstances. As the headquarters of our National Health Service, they continue to have a vital role in relation to the NHS as a whole that must be recognised and supported.

3.94 Nonetheless, in matters affecting the success of ICSs, including how they are regulated and held to account, NHS England needs to go further and faster in some respects. They also need to recognise that, as the headquarters of the NHS, they cannot also be the headquarters of ICSs where the local NHS is only part of a far wider partnership.

3.95 Turning to the Department of Health and Social Care: I have been Secretary of State for Health myself, working closely with the many exceptional officials who then formed the ‘department’ team. Both as an ICS leader and particularly through this review, I have leant on the policy expertise, insights and dedication of today’s officials. It is clear that ministers are committed to lightening the load of ‘must dos’ and we have seen, for example, a welcome shortening of the mandate in recent years, a trend I am confident will continue this year. Personally, I have felt the same heavy weight of responsibility for the NHS and the social care system that ministers feel today. I know what it is like, being constantly summoned to the House of Commons to deal with urgent questions or facing media interrogations about serious problems in a particular area. Like ministers today, I held the NHS to account, seeking to understand and support them but also to challenge. I expected to have the information I needed to fulfil my role. For ministers, it can also often feel as if they are in a parallel centre that is being held publicly accountable for performance as well as policy.

3.96 Nonetheless, in matters affecting ICSs, including how they are regulated and held to account, it is essential that there is clarity on roles and responsibilities and clear boundaries between operational management and wider responsibilities. This makes alignment between the department, Secretary of State and NHS England vital. The department needs to accept that provider trusts and ICBs do not report to them, and maintain the distinction between operational performance management on the one hand, and accountability and challenge on the other. And, of course, there needs to be an open, trusting and respectful relationship between NHS senior executives and ministers themselves. Just as we should expect NHS England to work ‘with and through’ ICBs in their relationship with

providers, so we should expect the department to work ‘with and through’ NHS England in its relationship with systems and providers. In both cases that does not preclude direct engagement, but it does set a default expectation for how things should normally work.

3.97 My terms of reference specifically asked me to focus on ‘real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement’. Although I had expected to find a broad measure of agreement on this point, this proved not to be the case. DHSC and its ministers are frustrated by their inability to get data that they want. NHS England itself has changed its stance on sharing data and information with DHSC, with automated data-sharing feeds updated regularly. ICB and trust leaders themselves are increasingly concerned about multiple requests for data and information, often extremely detailed and at very short notice. As the above account illustrates, however, what appears to be a duplicative request for information from one perspective can, from another point of view, be a reasonable action to ensure that parliamentary accountability is done properly. This helps to show why effective alignment can never be found solely in the rulebook or the legislation - it depends on building relationships of trust and on mutual understanding.

3.98 Digitisation of the health and social care system, together with the rapidly growing use of smart data analytics tools, will help to provide the ‘single version of the truth’ that is an essential part of aligning all partners, locally and nationally, around the same purpose and goals. I make recommendations on that and other matters that will help both ICSs and national bodies, including ministers.

3.99 The pandemic itself provides an example of successful data sharing between NHS England, No.10 and DHSC, integrating information from the NHS on cases, symptoms and outcomes as well as population and demographic data to create a ‘single version of the truth’, updated daily and used as the basis for ministerial press conferences as well as policy decisions. And this report provides examples of the impressive results achieved within systems from data-driven approaches to identify people and communities at risk and provide them with the early intervention that is both better for them and relieves pressure on health and care services.

3.100 In order to strengthen the alignment between the department, NHS England and ICSs, I suggest a rapid stocktake - potentially led by the No. 10 delivery unit - to assess data flows for timeliness and usefulness. Its conclusions should be shared with systems, Secretary of State and NHS England as a basis for agreeing actions for using data to further support the work of all 3.

3.101 As an ICS leader remarked to me ‘real change comes from real work’ and the more that systems, NHS England and ministers can do together to make sense of

the key issues and work through practical solutions, the easier it will be for partnership working to be sustained into future challenges. I therefore suggest that DHSC ministers (along with DLUHC colleagues) build on their work with NHS England and systems to undertake shared learning from this winter. This should take the form of shared conclusions and actions during this year, and should report to the Secretaries of State for DHSC and DLUHC and the chief executive of NHS England.

3.102 For the new system we have created to succeed, we need some honest conversations about what is working and what needs to change. There are many unsung examples of effective team working between the department and NHS England and systems in all and every permutation; but there are also examples of tensions, wasted time and needless frictional costs generated by uncoordinated pursuit of organizational goals that do not take account of their wider effects. This also makes it harder for vital partners outside of the NHS - including local government, the VCFSE and social care providers - to collaborate effectively with the NHS. It can often feel to them like looking in on a purely NHS conversation that absorbs enormous amounts of time and energy that could be devoted to joint working. Everyone needs to change, and everyone needs to give a little so that the system as a whole works better.

National planning guidance

3.103 As I've previously made clear the public's immediate priorities - access to primary care, urgent and emergency care, community, mental health and social care services and elective diagnostics and treatment - are priorities for all of us, ministers, NHS England and ICSs. The level of interest in these matters rightly makes them a central part of accountability for ICBs and their partners in the wider ICS.

3.104 However, effective change in any system - particularly one as complex as health and care - needs consistent policy, finances, support and regulation over several years. Adding new targets and initiatives, non-recurrent funding or small funding pots, makes it impossible to plan new services or even recruit staff, wastes money and time, and weakens impact and accountability.

3.105 The government of which I was part introduced national targets as part of a number of measures to improve NHS performance. Although controversial at the time, a small number of targets undoubtedly contributed to significant improvements in performance and productivity. Reflecting on that experience, 4 points stand out to me.

- few targets concentrate minds; the more that are added, the less effective they become

- the higher the performance standards (for instance on emergency department waits), the less they allow room for vital clinical judgement

- the combination of too many targets, performance standards that are not clinically supported and an excessive focus on hitting targets by managers or boards themselves can lead to ‘gaming’ of the targets or even a disastrous neglect of patients themselves[14]

- I also learnt that targets that focus on end-to-end pathways can be particularly powerful in joining up care between siloed organisations, such as the target initially set for patients with suspected cancer to be seen by a specialist within 2 weeks of referral by the GP

3.106 My terms of reference setting out that the review will ‘consider the scope and options for a significantly smaller number of national targets’ reflect the widely-held belief that national targets had become wholly excessive. This is exemplified with the 2022 to 2023 planning guidance expressing national NHS objectives in 133 asks across 10 domains. The 2023 to 2024 planning guidance, developed in close consultation with ICB leaders and this review itself, made welcome and significant progress, summarising national NHS objectives on a single page with 31 asks across 12 domains.

3.107 Further progress should be made in the planning guidance for 2024 to 2025. I recommend that ministers consider a substantial reduction in the priorities set out in the new mandate to the NHS - significantly reduce the number of national targets, with certainly no more than 10 national priorities. Given the need to integrate care around patients themselves, it would also be helpful if the planning guidance could focus on outcomes rather than individual NHS sectors (primary, community, acute and so on). In particular it would be helpful to focus even more rigorously on the ‘what’ and the ‘why’ rather than the ‘how’. I therefore endorse the recommendation of the Select Committee that "Targets for ICSs set by DHSC and NHS England should be based on outcomes". There may be times when greater prescription around how targets are achieved is needed, but we believe this should be done sparingly.

3.108 In turn, we can expect the planning guidance for 2024 to 2025 to reduce further the number of 'domains' and 'asks'. Building on the approach taken last year, NHS England should continue to work closely with ICBs themselves as well as the

[14]The Francis report found that the failures in Mid Staffordshire was ‘in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.' Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary (HC 947). The Stationery Office.

department to produce the new guidance. This focus on a small number of key priorities is particularly important in the current, highly-stressed circumstances.

3.109 I would also strongly urge that the necessary focus on reducing elective care waits be matched by an equal focus on reducing waiting times for acute mental health treatment.

3.110 I understand that the reduction of the number of 'domains' and 'asks' has itself caused concern, particularly amongst those whose area is not included. It is important to stress that national standards for clinical care, including those set by NICE, remain in place and will, of course, continue to guide the care provided to patients with different conditions.

3.111 I would also suggest harnessing the enthusiasm in both NHS England and systems for a more co-productive way of developing policy. In the development of its strategies and plans (for example the UEC strategy or the primary care recovery plan) NHS England works hard to engage a broad cross section of experts and stakeholders, with systems playing an increasingly strong role in the shaping of policy. Both NHS England and ICS leaders should build on this to deepen both the involvement of ICSs in shaping policy and the understanding within ICSs of that involvement. There should be very few ‘degrees of separation’ between an ICS leader and a new policy or strategy: either they or a peer should have had a hand in shaping it.

3.112 Building on the process of engagement used by NHS England in preparing the 2023 planning guidance, NHS England should commit to further deepening this collaborative approach in developing the 2024 planning guidance. Furthermore, where significant new plans and priorities directly impacting systems are added in-year to the planning guidance framework, these plans should also benefit from a process of collaborative co-design with system leaders.

3.113 Finally, I recommend that, to support this, NHS England and ICBs should agree a common approach to co-production, including working with organisations like the NHS Confederation, NHS Providers and the LGA.

Enhanced CQC role in relation to systems

3.114 Greater autonomy for ICSs - including, in particular, a radical reduction in central targets and top-down performance management together with an increase in financial autonomy and flexibility - will enable ICS leaders to deliver both short term performance and longer-term improvements in population health.

3.115 However, greater autonomy must come with more effective accountability to patients and the public as well as to NHS England and ministers.

3.116 Having started the review with a degree of scepticism about CQC, I now strongly support their enhanced role in relation to ICSs. This will build on their core mission to inform patients and the public about the quality of care and the effectiveness of services based on their oversight and inspection of health and social care providers.

3.117 The Health and Care Act 2022 included an important new role for CQC to review ICSs, alongside a further new role to assure local authority commissioning of social care. Once CQC has put in place arrangements to review systems, developing their approach and capability in partnership with a wide range of ICS leaders both from ICBs and ICPs, they should provide clear and transparent ratings on the quality of services within the ICS, across the key domains of care services - including primary care, mental health, community services, social care and both emergency and elective care at acute hospitals. They should also make an assessment of the level of maturity and effectiveness of each ICS as a whole, including a rating of the ICS leadership itself, based on an assessment of how far ICS structures (including of course the ICP and ICB) are adding value and enabling the system as a whole to meet its objectives and improve outcomes. CQC should then use these different ratings and assessments to inform an overall judgement on the achievement, challenges and areas for improvement for each ICS.

3.118 This work - which should be led by a Chief Inspector of Systems - should draw on multiple sources of quantitative and qualitative data, including CQC's existing inspections, as well as NHS England's information on ICB and providers use of financial resources. In its review of the ICS (effectively a 'well-led' review), CQC should assess how the ICS itself (including the ICP, ICP, place partnerships and Provider Collaboratives) adds value, enabling the whole to be more than the sum of its parts. Reporting should focus on helping ICS partners to improve more rapidly, as well as providing a basis for regulatory intervention where required. We know the most effective health and care organisations and systems are those where quality, performance and financial management go hand in hand, and so ratings must take account of all of these elements - and so we would not expect the highest ratings to be given to a system where the financial position is not being well-managed.

3.119 We recognise that this will be a significant shift for CQC, although building on the work that is already underway with ICS leaders to develop the right approach and capability for their new responsibilities. As a result, 2023 to 2024 should be a transitional year, allowing CQC and ICSs to co-design the most effective approach to CQC reviews, sharing learning as both CQC and ICSs embed system working and enabling it to generate ratings that the public, as well as ICS partners themselves, can trust.

3.120 We also recognise that ICSs, and ICBs within them, are at different levels of maturity, and differentiation between them will continue to be both necessary and important. As explained elsewhere, a ‘baseline’ of increased financial autonomy and flexibility should apply in all ICSs, with further freedoms also focussed on the more mature systems and ICBs during 2023 to 2024, so that NHS England can concentrate its improvement work and financial performance management on those ICBs where it is most needed, as well as fine tuning the arrangements for financial autonomy and flexibility.

3.121 CQC have been clear that they do not want to carry out 'compliance' inspections and have seen the opportunity to capture and help scale innovation. It is vital that assessment of ICSs does not become yet another set of tick-box capability and competency requirements but is a useful tool for enabling each system to develop and improve. I welcome CQC’s recognition of that risk and their commitment to understand the very different starting-points of each ICS, how each system stands in relation to its own stated ambitions and focusing on how each ICS is adding value and developing capability as a self-improving system.

3.122 In particular, as recommended in other parts of this review, CQC should include within its assessment of ICS maturity:

- how different partners - local government, the VCFSE sector, social care providers, other ICS partners and the local NHS including the ICB - themselves assess their engagement and relationships within the ICS itself, including the extent to which both public health expertise and the social care provider sector are involved in the leadership of the system

- the strength of the system-wide integrated care strategy with Joint Forward Plans, clear priorities, outcomes and timescales, providing a local outcomes framework against which the system can be held accountable by local residents and others

- the coherence, consistency and impact of arrangements at place and neighbourhood level within the ICS

- how far the system is making progress in shifting resources towards prevention, population health and tackling health inequalities

- how well systems work with and respond to support provided by the NHSE regions within the new operating framework, including the goal of supporting ICSs to become self-supporting systems

- practical examples of ICS partners identifying priorities, agreeing a diagnosis of the problem as well as a plan of action and making progress towards agreed outcomes. This should include looking at specific pathways of care

from a patient and service user perspective. It should also take account of Ofsted's assessment of children's social care services and whether or not system partners have developed an effective strategy for prevention, population health and tackling health inequalities amongst children and young people

- whether system partners are developing a framework of mutual accountability, sharing performance and financial data transparently in order to agree a single version of the truth; developing an ability to learn from mistakes and respond effectively to problems without blame within systems (in other words, focusing on quality improvement and creating a learning and improvement culture, building on peer review, 360-degree feedback, measurement of staff engagement, role of HOSCs and psychological safety)

- whether the system is finding ways of shifting emphasis and resources towards prevention, population health and tackling health inequalities

3.123 Reviews should also share best practice and insight from other systems in suggesting recommendations for improvement and identify good practice to be shared. This would support continuous improvement and stronger relationships. CQC should be mindful to ensure their reviews can help foster stronger relationships and how they can impact fragile relationships in still developing systems.

3.124 CQC has reviewed international experience of integrated care and engaged with a number of ICSs to develop a methodology for ICS inspection. Given the scale of change this represents for the CQC itself, however, at a time when statutory ICSs are in their infancy, CQC and ICSs should work together over the coming year to develop a long-term approach to inspections and ensure that CQC develops the capabilities and skill sets needed to support successful development of ICSs.

3.125 In their first year the focus of CQC should be on calibration of their assessments and supporting improvement and sharing best practice amongst systems within their reports rather than assessment and rating.

3.126 This should be driven by co-design between CQC and systems sharing learning as both CQC and ICSs embed system working. This should include engagement with ICBs in forming a view about the ways in which clinical risk are held and managed within and between providers and other partners, incorporating this into their judgements of registered services.

3.127 I would also suggest investment in training for the CQC workforce to upskill staff and bring in colleagues with experience from systems, including where appropriate other system leaders.

3.128 While I appreciate work is beginning already on CQC's new inspection regime for adult social care and reviews of ICSs, CQC should use this year to work closely with and learn from local authorities and systems while they continue to refine and develop their methods.

The role of data for system accountability

3.129 Transparent, accurate and accessible information enables patients and the public to know whether the services they are receiving are high quality, efficient and effective. Equally, clear and effective engagement with the public builds confidence that individuals' data contributions are creating real benefits for themselves and wider society, thus underpinning further improvement and transformation. Transparent data is a powerful incentive and enabler of improvement, reflected for instance in the work of the National Joint Registry (NJR) over the last decade. Using cutting-edge data analytics, and as a globally recognised exemplar of an implantable medical devices' registry, the NJR has already helped to improve patient outcomes, inform clinical practice, ensure the quality and value of joint replacement surgery and support orthopaedic research.

3.130 To develop integrated care with timely, relevant and high-quality performance data, it is essential to ensure that there is a two-way flow between systems and national bodies.

3.131 The new Federated Data Platform (FDP), currently under procurement, should make a significant difference. The automation of data in real time will drive consistency, free systems from administrative burdens and enable effective benchmarking across providers and systems. Although the first stage of implementation is focused on NHS acute trusts, I recommend that work begins at the same time to build a close partnership between NHS England, the FDP developers, and appropriate colleagues from ICSs, local government and the provider sector including primary care, community and mental health, adult social care providers and VCFSE providers to ensure that the full benefits of the FDP can be realised in future, with all parts of the health and care system involved in its development. The strategic objective should be to create a unifying digital architecture across the entire health and care system, with the FDP itself helping to support local systems to address key challenges while also offering the opportunity to share and scale innovative tools and applications.

3.132 In particular I recommend:

- NHS England and DHSC should incentivise the flow and quality of data between providers and systems by taking SITREP and other reported data directly from the FDP and other automated sources, replacing both SITREPS and additional data requests

- data required in real-time by NHS England and DHSC should be taken from automated receipt of summaries to drive consistency; and where possible without creating excessive reporting requirements, data should enable site-level analysis

- data collection should increasingly include outcomes (including, crucially, Patient Reported Experiences and Outcomes) rather than mainly focusing on inputs and processes

- data held by NHS England (including NHSE regions) about performance within an ICS, including benchmarking with other providers and systems, should be available to the ICS itself and national government

- DHSC and NHS England work with nominated ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, removing requests that are duplicative, unnecessary or not used for any significant purpose. This work should be completed within 3 months

3.133 As I stressed earlier, I understand only too well the need for NHS England and DHSC to get up to date information from systems and providers. But it is essential that information-gathering itself does not distract senior leaders and their teams (including the scarce resource of digital and data experts themselves) from the key priority of actually improving performance. Given the scale of improvement required, the present manual reporting burden placed on providers and partners in ICSs is unacceptable. Notwithstanding the severe performance issues in December 2022, in one instance one ICS received 97 ad-hoc requests from DHSC and NHS England, in addition to the 6 key monthly, 11 weekly and 3 daily data returns.

3.134 Continuing automation of data provision, shared between NHS England, DHSC and No. 10, will itself improve matters. In the meantime, further action is required to reduce the number of uncoordinated, often urgent requests for data that can only be provided through time-consuming manual means.

3.135 Even high quality data needs to be supplemented by experience and insights to understand where investment and energy should best be directed, both within systems and between systems and national bodies. For instance, although data may show the same performance challenges in 2 systems or trusts, the causes may be very different (for instance, in one case a well-led trust or system struggling with a fundamental mismatch between demand and capacity; in the other, a combination of weak leadership, antagonistic relationships and poor culture). The support or regulatory intervention required would also be very different, despite the apparent similarity in performance. Insights from systems themselves, regional teams and CQC are vital in complementing performance and benchmarking data.

The Hewitt Review

Chapter 3: recommendations

10. HOSCs (and, where agreed, Joint HOSCs) should have an explicit role as System Overview and Scrutiny Committees. To enable this DHSC should work with local government to develop a renewed support offer to HOSCs and to provide support to ICSs where needed in this respect.

11. Each ICS should be enabled to set a focused number of locally co-developed priorities or targets and decide the metrics for measuring these. These priorities should be treated with equal weight to national targets and should span across health and social care.

12. In line with the new operating framework, the ICB should take the lead in working with providers facing difficulties, supporting the Trust to agree an internal plan of action, calling on support from region as required. To enable this support and intervention should be exercised in relation to providers 'with and through' ICBs as the default arrangement.

13. NHS England and CQC should work together to ensure that as far as possible their approach to improvement is complementary and mutually reinforcing.

14. A national peer review offer for systems should be developed, building on learning from the LGA approach.

15. NHS England should work with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024.

16. An appropriate group of ICS leaders should work together with DHSC, DHLUC and NHS England to create new 'High Accountability and Responsibility Partnerships'.

17. During 2023 to 2024 financial year further consideration should be given to the balance between national, regional and system resource with a larger shift of resource towards systems; and that the required 10% cut in the RCA for 2025 to 2026 financial year should be reconsidered before Budget 2024.

18. NHS England and central government should work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.

19. ICS leaders should be closely involved in the work to build on the new NHS England operating framework to codesign the next evolution of NHSE regions.

20. NHS England should work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer.

21. The implementation groups for the Messenger review should include individuals with significant experience of leading sustained cultural and organisational change in local government and the voluntary sector as well as the NHS.

22. Ministers should consider a substantial reduction in the priorities set out in the new Mandate to the NHS - significantly reduce the number of national targets, with certainly no more than 10 national priorities.

23. NHS England and ICBs need to agree a common approach to co-production working with organisations like the NHS Confederation, NHS Providers and the LGA.

24. As part of CQC's new role in assessing systems, CQC should consider within their assessment of ICS maturity a range of factors (set out on page 58).

25. ICSs, DHSC, NHS England and CQC should all have access to the same, automated, accurate and high quality data required for the purposes of improvement and accountability. In particular:

a) NHS England and DHSC should incentivise the flow and quality of data between providers and systems by taking SITREP and other reported data directly from the FDP and other automated sources, replacing both SITREPS and additional data requests

b) Data required in real-time by NHS England and DHSC should be taken from automated receipt of summaries to drive consistency; where possible without creating excessive reporting requirements, data should enable site-level analysis

c) Data collection should increasingly include outcomes (including, crucially, Patient Reported Experiences and Outcomes) rather than mainly focusing on inputs and processes

d) Data held by NHS England (including NHSE regions) about performance within an ICS, including benchmarking with other providers and systems, should be available to the ICS itself and national government

e) DHSC and NHS England work with nominated ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, removing requests that are duplicative, unnecessary or not used for any significant purpose. This work should be completed within 3 months

4. Unlocking the potential of primary and social care and building a sustainable, skilled workforce

4.1 The review terms of reference specifically asked to look at how to empower local leaders to focus on improving outcomes for their populations and making ICSs more accountable for performance and spending, much of which can be delivered though primary and social care.

4.2 Strengthening local leaders' ability to have greater and more flexible decision-making in primary and social care, supported through a more joined up national policy approach, will not only better enable them to deliver improvements in immediate performance, it will be key to improving outcomes in the communities they serve.

4.3 In order to enable the kind of integration, collaboration and autonomy we want to see integrated care systems (ICSs) embody, we need to pull down some of the barriers that currently exist for primary care, social care and the way we train health and care workforce. Breaking down these boundaries will be fundamental to unlocking the potential of system working and reinvigorating the much-needed focus on prevention and early intervention.

Primary care

4.4 Dr Claire Fuller's timely stocktake of primary care has already set out a vision and route-map for integrated neighbourhood working where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

4.5 My recommendations build upon the important work and recommendations of the Fuller Stocktake, focusing on what more needs to be done within ICSs to create integrated neighbourhood teams and integrate care across the whole patient pathway. I also make recommendations on the changes needed within primary care contracting (an issue not included within Dr Fuller's terms of reference).

4.6 On 1 April 2023, all ICBs will take on responsibility for commissioning community pharmacy, optometry and dentistry, through delegation of all primary care commissioning for the first time. Instead of each element of primary care being treated as a separate silo, ICBs now have the opportunity - and the responsibility - to work with all elements of primary care to achieve the accessible, high-quality

and integrated services that residents and local communities need. Much of this work, of course, will be led and delivered with local government and VCFSE partners through place partnerships and integrated neighbourhood teams, involving collaboration with community, health and social care services, and specialist acute services as well as primary care itself.

4.7 Despite currently being constrained by nationally negotiated and held contracts with care partners, ICBs through PCNs and place partnerships, as well as system-wide, can still consider the needs of their local population and determine the best use of resources for that population. They can support the joining up of different elements of urgent care, including 111, community pharmacies and walk-in centres and ensure the most effective provision of services to meet population need without focusing solely on one area of primary care when commissioning those services.

4.8 ICSs should also play a greater role in driving primary care transformation. The Fuller Stocktake included many inspiring examples of primary care organisations delivering at scale and through multi-partnership teams; others have emerged during this review, including Medicus in Enfield, North London.

Medicus Health Partners is the second largest primary care practice in England. Working in the London Borough of Enfield, it brings together 15 practices merged into a single PMS contract, with 34 partners, a managing partner, 23 salaried GPs and a multi-professional staff totaling 370. By working at scale to listen and respond to patients, provide development and support for staff and streamline administrative and digital support services, they have been able to improve the working lives of their staff while transforming the quality of care they provide. At a time when A&E attendances and emergency admissions of patients in care homes in other parts of Enfield were rising by around 30%, Medicus worked with care homes to reduce A&E attendances by over 10% and emergency admissions by 16%. Medicus have an estates strategy that consolidates fifteen surgery premises, some of them too small old and not fit for purpose to accommodate staff or patients properly, into 9 modern health and care hubs.

Primary care contracts

4.9 I have heard repeatedly that national contracts present a significant barrier to those within the GP partnership model who want to work in innovative and transformational ways, requiring a great deal of time, goodwill, ingenuity and workarounds from practice partners and ICBs. ICBs also lack effective levers to support and secure the services in practices where practices are facing difficulties in providing a good quality of service in their area.

4.10 With ICBs taking on responsibility for NHS dentistry on 1 April, it is essential that the next stage of dental reforms, which is currently being developed and builds on

the incremental reforms made last year, is implemented as soon as possible. Without this, ICBs are simply being handed the task of improving an unacceptable situation without sufficient tools to address this. The government has already made some welcome changes, giving ICBs some flexibility to create additional services where they are most urgently needed and announcing the first set of contractual reforms in July 2022 to support fairer remuneration for dentists and increase patient access to care.

4.11 Furthermore, the contract held by GP contractors for 'general medical services', which is negotiated nationally between government and the BMA, provides far too little flexibility for ICSs to work with primary care to achieve consistent quality and the best possible outcomes for local people.

4.12 Contracts with national requirements can have unintended consequences when applied to particular circumstances. For instance, the national requirements and funding of Additional Roles Reimbursement Scheme (ARRS) roles for community pharmacists within PCNs, has on occasion exacerbated the problem of a general shortage of pharmacists, with some now preferring to work within primary care rather than remain in community pharmacies or acute hospitals, compounding the problem of community pharmacy closures and delayed discharges. The new responsibilities for ICBs provide an important opportunity, at place or system level, to integrate the whole primary care offer for communities, making the best use of both the staffing resource available and the premises.

4.13 The Quality and Outcome Framework (QOF) points that were an important and useful innovation twenty years ago are now out of date and are seen by GPs as well as ICBs as an inflexible and bureaucratic framework. This needs to be updated with a more holistic approach that allows for variation. The new approach must also recognize that, in order to allow primary care to refocus resources on prevention, outcomes rather than just activity need to be measured.

4.14 As the GP contract is now entering its fifth year of a 5 year agreement, and the government will be shortly considering its intentions for the next iteration of the contract, radical reform is needed, and this is the right time to make it happen.

4.15 I therefore recommend NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts. This partnership group should include a diverse range of GP partnership leaders currently delivering excellence across a range of different regions and demographics, as well as ICB primary care leaders, local government and - crucially - a number of patient and public advocates. As part of this work, NHS England and DHSC should, of course, engage with key stakeholders, including the BMA and the RCGP.

4.16 Although of course the final decision on policy and funding rests with ministers, I would suggest that this framework should enable systems to find the right solutions to fit their circumstances, including building on the partnership model, rather than sweeping it away entirely.

4.17 In particular, I would suggest that the work of this group should consider:

- the outcomes that we want from primary care as a whole. While it is not for this review to specify the outcomes, they should be developed closely with patients and the public over the coming months and include patient reported outcomes and experience as some of the measures for success

- the balance between national specifications and local flexibility and decision making - greater flexibility and appropriate local autonomy within a framework of national standards is needed to improve equity of access and care and to enable PCNs to take a greater role and responsibility in reducing health inequalities and population health management. ICBs, working with primary care partners at neighbourhood and ‘place’ level, need to join up the many different elements of primary care, including urgent care, making best use of clinical and other professional staff as well as premises and budgets, and taking account of the particular needs of their population and its geography and demography, to get the most convenient access and best outcomes for residents

- national standards or specifications should include clear expectations around digital and data, in line with the recommendations elsewhere

- how to incentivise and support primary care at scale. There are many different ways of achieving primary care at scale, within the context of integrated neighbourhood teams and wider place partnerships. These include: practices coming together as a single group; GP provider federations, owned collectively by partners and providing support to all member practices; free-standing practices working together within a PCN, where in future the contract (whether for core GMS services or enhanced services) might be held with the PCN rather than individual practices and partners; GPs working as part of a multi-disciplinary primary care division within a wider NHS trust and so on. The new contract needs to allow for different models, in particular allowing tailoring to local circumstances in the patient facing offer, while ensuring we capture the benefits of an ‘at scale’ model behind the scenes. This work should consider how the system can make it simple for partners who wish to move in this direction to do so, while also encouraging and incentivising others to move in this way

- how best to support struggling practices to improve. Practices that are not delivering at a high enough standard need to be supported to improve and,

where necessary, to be replaced so that residents in every community receive the support from primary care they need. This should include creating a centrally-held fund to buy out contracts or premises, or both, where that is essential to improve access, care and outcomes in a particularly disadvantaged community

Social care

4.18 I have heard a lot throughout the review about the need for social care to be better understood within the NHS. This is critical as appropriately embedding social care is essential for effective integrated working in systems, in particular at place and neighbourhood level.

4.19 Social care at its best can be described in the following terms: “We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing things that matter to us”.[15] This definition is widely supported as describing the diverse range of support that social care offers to enable people to live as well and independently as possible. Social care is an important sector in its own right, employing around 1.5 million people, more even than the NHS, and making a significant economic contribution, estimated in 2021 to 2022 at £51.5 billion.

4.20 While local government has crucial commissioning and market-shaping responsibilities for social care, the provision of social care - both domiciliary and residential - is the responsibility of over 18,000 different organisations, mainly in the private sector, often small and family-owned, but including a small number of very large privately-owned providers as well as a significant number of not-for-profit, charitable and social enterprise organisations.

4.21 The social care landscape is complex. Many people in the UK currently do not know what level of care they are entitled to until they are faced with a family crisis. The government has published plans for social care charging reform, although implementation is currently paused.

4.22 As a society we need to face up to the challenge of providing a decent quality of care for everyone who needs it, including many of the most vulnerable people in our communities. It is not for this review to recommend the shape that any structural or financial reform of social care should take. Instead, we need a national conversation about what we expect from our care; and what we are willing to pay for it.

[15] Routledge, M, Social Care Future, Local Government Association. (Accessed: 17 March 2023).

4.23 It is clear, however, that if health and care are to be effectively integrated and delivered at ICS level, social care needs to be a national priority for investment and workforce development, enabling delivery of the reforms of the 2014 Care Act.

4.24 ICSs also have a vital role in supporting a more sustainable social care sector at system level, by taking an integrated approach to reducing the gap between demand for care and available supply, for example by encouraging the adoption of personalised, preventative and proactive models of care.

4.25 I would therefore urge an acceleration and expansion of existing work on understanding both need and the fair cost of care, before the proposed cap on adult social care costs is implemented. The fair cost of care work, commissioned as part of the government's now delayed implementation of charging reform, is a helpful model to move towards a fairer rate of care paid by local authorities to social care providers, and is helpful to understand the social care market - however, it is currently restricted to the older adults residential care market. While it will be beneficial to see the evaluation and assessment so far, it would also be helpful to expand this work to capture working age adults and potentially children's social care. It is vital we appropriately understand the cost of providing high quality care and support for those who need it. Whether this is paid for privately or through taxes and contributions, there is a clear need for this to be paid at a fair rate that reflects their vital role in enabling the dignity and independence of the people they support and their families.

Workforce

4.26 Further change will only be possible with a strong and supported workforce across both healthcare and social care.

4.27 The government is due to publish a long-term workforce plan for the NHS imminently. Given the interdependence of health and social care, I therefore recommend that the government should now produce a complementary strategy for the social care workforce as soon as possible. This plan should set the strategic direction for a more integrated health and social care workforce. This strategy can then support local authorities, who have responsibility for adult social care provision, and ICSs, who will play an increasingly key role in joined up workforce planning.

4.28 Shared training should be encouraged, together with the development of 'passports' reflecting qualifications and experience that make it easier for people to work within the whole health and care system rather than just one part of it.

4.29 The strategy should include integrated training and continuing professional development for social care and NHS staff, supporting the vital work of multi-

professional, multi-organisational teams and making it easier to integrate care around the needs of an individual. The strategy should also set out practical support for career pathways that include both NHS and social care.

4.30 Investment in workforce development in social care should be longer term, as a minimum based on a 3-year rolling planning cycle to support multi-year investment programmes.

4.31 The example of Derbyshire integrated care system shows the value of collaborative workforce planning:

In Derbyshire the integrated care system workforce team are working with Joined Up Careers, along with the Department for Work and Pensions, Jobcentre Plus and Futures for Business, to boost recruitment to the health and care Sector-based Work Academy Programme (SWAP). The programme, led by the local city council, prepares and places new entrants into the health and social care sector in Derby and Derbyshire, particularly targeting support to increase the employment rate for individuals unemployed and or on Universal Credit who are disabled, people aged 50+, ethnic minorities (BAME) and women. As a result of this programme, 299 participants signed onto the pathways into health and social care employment project, many of whom were previously unemployed or economically inactive.

4.32 Working in this way, at place or system level, ICSs can contribute to wider social and economic development - their fourth core purpose - as well as helping to solve immediate workforce challenges.

4.33 A similar partnership approach has been taken by the Suffolk and North East Essex (SNEE) ICS to the challenge of recruiting and training more NHS dental staff in a region that does not yet have its own university dental school. In collaboration with the ICB, the University of Suffolk have established a Centre for Dental Development, which will enhance local education and training opportunities in dental therapy and hygiene, apprentice dental technicians and post graduate dentists. The Centre will sit alongside a community interest company, created by the university, that will be able to bid for future locally commissioned dental services in line with usual NHS protocol. This initiative has the potential to improve the levels of NHS dentistry provision not only in SNEE but also in neighbouring systems such as Norfolk and Waveney. It is a further example of how an ICS has built an innovative local partnership solution to a major national challenge.

A joint venture community interest community has been established by Suffolk University and the ICB to create a dental training practice, where new recruits train as dental hygienists and dental hygienists can train as dental technicians, upskilling and expanding the existing workforce but also providing badly-needed dental care for local residents

under the supervision of qualified dentists and trainers. As in Derbyshire, the apprenticeship levy is a major source of funding for this work.

4.34 I support the Messenger Review's call for systems to improve mutual awareness and provide opportunities for staff to engage beyond their professional environment, to appreciate the totality of the system, and to value diverse professional approaches. For the NHS (itself a complex system within the larger complex system that is an ICS), there should be a clear expectation that part of the training and development budgets within each NHS entity (that is, primary care practices as well as trusts and foundation trusts) and within social care (at least commissioning and, ideally, provision) should be used for shared training and development of staff with other parts of the NHS and social care. This is an essential part of creating the multi-disciplinary, multi-organisational neighbourhood teams (as well as the coherent system-wide leadership) that are at the heart of effective integrated care.

4.35 Professionals and practitioners should be offered formal and informal opportunities to develop their understanding of other parts of the system as part of their continual professional development.

4.36 Integration also goes beyond training, with a need for clear and standardised policies, governance and frameworks to enable flexibility across health and care roles. Blending some of the tasks of health and care roles can enable a better experience for the patient, increased continuity of care and a more efficient use of resource. Teaching a home carer how to dress a wound is an example of how transferring a healthcare intervention from a clinically registered practitioner to a non-clinically registered individual can potentially improve services by enabling closer alignment of different aspects of a person's care.

4.37 While delegation for certain interventions is becoming more common, it often takes place through informal agreements. This causes challenges for providers (for example around indemnity cover) and complications for regulators. Although published guidelines on delegation do exist, they are disjointed and not applicable across the whole health and care system. Without standardised governance and frameworks, it is challenging for individuals to feel supported and confident in delivering these interventions.

4.38 I therefore recommend that DHSC bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks.

4.39 To speed up the onboarding of health and care staff and enable movement across the system where necessary, commissioners may consider requiring that providers maintain health and care workers DBS certification on the existing online database. This would mean there is no wait time when a person moves job as it is centrally stored and kept up to date, and therefore just minutes for agencies to

check, confirm or print a person's DBS certificate. Consideration should also be given to the passporting of training to reduce duplication and induction times.

The digital and data workforce

4.40 Although much of the focus and investment has been on digital and data systems within acute hospitals, it is essential that we level up basic digital infrastructure in all parts of the system, instead of expecting nurses, healthcare assistants and care workers looking after people with complex conditions and multiple needs to write down essential information on paper and then spend precious time going back to the office to input the data manually.

4.41 The skills needed to deliver data and digital transformation require a professional and highly skilled workforce at the system and provider level. Many health and care staff are well-versed in the use of digital tools; as the digitisation of health and care intensifies, staff at every level need to feel equipped and confident to use the tools available. As I heard frequently from clinical CIOs and other experienced leaders, new systems including electronic patient records are not primarily about technology: they are about transforming clinical and administrative processes to achieve better outcomes for patients, with digital tools enabling but not themselves delivering the necessary transformation. Major 'IT' programmes require substantial time and effort before, during and after implementation in culture, behaviours, and leadership, developing more medical, nursing and AHP CIOs and ensuring that all staff are comfortable with the tools they need to use.

4.42 The health and care system urgently needs to develop, train and recruit more specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialized analytical and intelligence. Unfortunately, the Agenda for Change framework for NHS staff makes it impossible for systems to pay competitive salaries for these skilled professionals, with the result that too many ICBs and providers recruit the necessary staff on short-term contracts. I therefore recommend that ministers and NHS England work with the trade unions to resolve this issue as quickly as possible. National workforce planning needs to include steps to ensure that systems can build digital capability, upskill their current workforce and develop clear pathways for progression. ICSs themselves, working with local schools and further education providers, can create new routes into digital roles along the lines of the local academies that have successfully used apprenticeships to recruit and develop trainee nurse associates. As NHS England completes its own reorganisation, it would also be helpful if skilled staff could be seconded or transferred directly into those ICBs that need most support, with a specific focus on data science, cyber security, and analytical skills.

Chapter 4: recommendations

26. NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts.

27. The government should produce a strategy for the social care workforce, complementary to the NHS workforce plan, as soon as possible.

28. DHSC should bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks.

29. Currently the agenda for change framework for NHS staff makes it impossible for systems to pay competitive salaries for specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialized analytical and intelligence. Ministers and NHS England should work with trade unions to resolve this issue as quickly as possible.

5. Resetting our approach to finance to embed change

5.1 Instead of viewing health and care as a cost, we need to align all partners, locally and nationally, around the creation of health value. That shift is entirely in line with cross-government public spending principles, with their strong focus on public value and the outcomes that are being delivered for citizens.[16] As individuals, there is nothing more valuable than our own health and wellbeing and that of the people we love. But good health also has a wider value to our society and economy. Recent analysis finds that every pound of public money invested in the NHS can generate £4 on average through gains in productivity and increased participation in the labour market.[17]

5.2 Today, however, we are not creating the best health value that we could from the current investment in the NHS. The evidence from other healthcare systems as well as our own demonstrates that there is a proven opportunity, whatever the total spend, to create greater health value by investing in primary and secondary prevention and by shifting care from acute to community and primary care settings ('allocative efficiency'). At the same time, within each element of healthcare, there are multiple opportunities to improve technical efficiency by enabling our most valuable resource - our people - to work more effectively (replacing paper systems with shared digital records, for example, or ensuring that every operating theatre session is fully utilised) and to significantly improve the use of our building and equipment.

5.3 Medicare, the publicly funded programme for people over 65 in the US, provides compelling examples of the improvements in outcomes, quality and value for money that can be achieved at scale through an integrated approach, with a single budget for the healthcare needs of a population group rather than fragmented payments to different providers. Such an approach typically involves earlier screening of older patients, with fewer ED visits and about 30% fewer hospital admissions. One of the Medicare providers demonstrating the value of this 'upstream' approach is the Florida-based group, ChenMed.[18]

Founded in Miami, Florida, ChenMed operates under the Medicare Advantage model, which as part of the wider government-funded Medicare programme specifically provides government funding to support those over 65 with more complex needs or in areas of high deprivation. ChenMed's care model invests heavily in primary care and prevention to

[16] HM Treasury, Managing public money, last updated September 2022
[17] NHS Confederation, Carnall Farrar, Analysis: The link between investing in health and economic growth. 2022.
[18] Commonwealth Fund - Transforming Care: Reporting on Health System Improvement (March 2016)

improve outcomes, experiences and the time patients spend at home. This model uses rigorous risk stratification combined with high intensity proactive care to deliver these outcomes. Prioritising high frequency, longer GP visits enables GPs and core care teams to evaluate patients and conduct risk stratification to ensure they can focus on patients at highest risk of inpatient admission. This approach focusing on primary care and prevention has had remarkable results, generated significant value for those supported by ChenMed and resulted in a 40% reduction in inpatient hospital days compared to the Miami average.

5.4 There are many other examples of the value of this kind of proactive, prevention and outcome-focused care, reflected in the Fuller Stocktake as well as this report and elsewhere. Working at many levels - through place partnerships, integrated neighbourhood teams and provider collaboratives, as well as system-wide, ICSs provide the opportunity for urgently needed improvements in both allocative and technical efficiency.

Financial accountability

5.5 As mentioned earlier, integrated care boards (ICBs) are accountable for £108 billion of the £150 billion made available annually by parliament for the NHS.[19] Ensuring that taxpayers' money is used to the best possible effect is a moral as well as a legal duty. Robust financial accountability, both to local residents and to parliament through NHS England and ministers, is therefore non-negotiable. But the creation of integrated care systems (ICSs) means that ICBs' accountability for NHS finances also needs to sit within a wider framework of local accountability for ICSs (including the mutual accountability of ICS partners to each other for achieving their agreed goals).

5.6 NHS England, DHSC and HM Treasury should therefore work with ICSs collectively, and with other key partners including the Office for Local Government and the Chartered Institute of Public Finance and Accountancy (CIPFA) to develop a consistent method of financial reporting that will give the public the information they need to hold their local systems to account, without creating burdensome new reporting requirements. Obviously much of local councils' budgets are devoted to responsibilities other than health and are therefore outside the scope of ICS-related work. We would also expect this group to review the implementation of recommendations related to greater financial autonomy and encourage proactive management of funds and good financial practice. Working across organisations and with ICSs in this way would provide a further opportunity to build in practice

[19] Data refers to CCG and NHS England spending for 2021 to 2022 financial year - NHS Commissioning Board Annual Report and Accounts for 2021 to 2022 financial year NHS Commissioning Board Annual Report and Accounts 2021 to 2022 financial year - for the period 1 April 2021 to 31 March 2022 (england.nhs.uk) - to note £108 billion is the amount which ICBs were formally allocated in 22/23 the actual amount ICBs are responsible for is likely to be greater when considering funding streams from delegation or other one off in year funding packets.

the collaborative arrangements that are needed at national level to support those within ICSs.

5.7 The aim should be for an ICS to show its residents, local Health and Wellbeing Boards, oversight committees and Healthwatch, as well as national bodies, how much it is collectively spending from all public funds on prevention, population health management and reducing health inequalities; or on supporting mental health as well as treating mental illness; as well as, within the NHS, how effectively money has been spent for instance with respect to rates of operating theatre utilisation. As the financial framework for ICSs develops, this information should be transparent and enable a clear link between spend and health outcomes, as well as between quality, safety and productivity within the NHS itself.

Funding settlements

5.8 One of the main themes in the submissions received in response to the call for evidence was the perverse effects of ‘penny packets’ of funding in particular. Concern has been raised in relation to funding for discharge, and for investment in digital transformation.

5.9 An additional source of frustration and inefficiency is ‘non-recurrent’ money that is in practice ‘recurrent’ but that cannot be properly planned for because it is not in the baseline allocations. For instance, ‘winter funding’ is often provided (in October or November) in order to ramp up community health and social care beds, that will then be stood down in April, before being restored the following winter - when the ‘new’ beds simply return the situation to what it was a few months earlier.

5.10 Instead, funding should be largely multi-year and recurrent. The approach taken by the 2023 to 2024 priorities and operational planning guidance in converting some key non-recurrent funding into recurrent funding has been particularly welcomed in supporting planning over a longer term.

5.11 I therefore recommend ending, as far as possible, the use of small in-year funding pots with extensive reporting requirements. Additional funding pots should be considered only in limited, carefully considered exceptions rather than the rule. If they are required, funding should have:

- a reasonable turnaround time and duration to have a realistic impact. When setting the duration national organisations must consider the length of time needed to mobilise and wind down funding

- restrictions and reporting requirements to be proportionate to the size and duration of the funds, to ensure they are not disruptive to system working, as well as to prevent non-take-up by some systems. In other words, small

amounts of time-limited money require maximum flexibility to get the best results

5.12 Further, the fact that funding settlements for the NHS, social care and public health are announced and allocated at different times throughout the year is a fundamental issue for the integration of services between and within the different parts of the system and impedes the ability of ICBs, ICPs and local authorities to plan effectively at system level. As well as this, differential approaches to funding across local authorities in the same ICB also impact on the system's ability to deliver equitable standards of care across an ICS.

5.13 I recommend that DHSC, DLUHC and NHS England align budget and grant allocations for local government (including social care and public health which are allocated at different points) and the NHS so that systems can more cohesively plan their local priorities over a longer time period.

Financial flexibility for intra-system funding

5.14 In order to facilitate greater self-governance, I recommend that systems should be given more flexibility to determine allocations for services and appropriate payment mechanisms within system boundaries, and the NHS payment scheme should be updated to reflect this.

5.15 Flexibility for intra system funding allocations should include the reduction in hypothecation of funding allocated to systems, either by provision or condition. This will enable local systems to allocate funding to maximise health value for their local populations.

5.16 While the reduction of hypothecation is crucial and should continue, I have heard mixed views over the course of this review as to how far this should be taken. On the one hand some called for an end to all hypothecation including mechanisms such as the Mental Health Investment Standard (MHIS) on the basis that local systems should be able to determine where and how monies should be spent to maximise health and care outcomes. On the other hand, much of the evidence I received identified the MHIS as an effective tool to incentivise spend in an area where there are clear issues in achieving parity of esteem and one which had been long underfunded. As such, at this stage I do not believe systems are in a place where we can remove all hypothecation, particularly the MHIS. However, where hypothecation remains there needs to be a clear focus on delivering outcomes for populations and moving spending upstream towards prevention within hypothecated budgets.

5.17 It is important to recognise the role for consistency, and as such I recommend national guidance providing a default position for payment mechanisms for inter system allocations should be further developed.

5.18 This will also require strengthened local analytical resource to assess what will deliver the greatest value for local populations. For smaller systems this analytical resource could be shared for instance across a regional footprint. This should be supported by national analysis drawing on national and international evidence.

5.19 These proposals do not imply a complete "letting go" by national organisations - rather, a move away from the volume of conditions that so often come with national funding and a move towards greater ICS autonomy, held to account by NHS England.

Simplifying and broadening delegation and pooled budget arrangements

5.20 As part of greater flexibility in managing funding within systems, pooling budgets allows local leaders to make holistic decisions about how best to allocate resources across their health and care systems - both to ensure better use of resources to address immediate needs, but also to support long-term investment in population health and wellbeing.

5.21 Pooled and aligned budgets have been routinely and successfully used across systems for some time; a minimum of £7.2 billion has already been committed to the BCF this year with 90% of local areas consistently agreeing that delivery of the BCF in other years has improved joint working between health and social care.[20] However, we have heard from the system that these methods for pooling budgets can be unnecessarily bureaucratic and narrow and do not allow for effective transparency.

5.22 Section 75 of NHS Act 2006 provides the legal mechanism for creating formal pooled budget arrangements between the NHS and LAs to carry out health and care related functions. I recommend that the government accelerate the work to widen the scope of s.75 to include previously excluded functions, (such as the full range of primary care services) and review the regulations with a view to simplifying them.

5.23 In the medium term reviewing the legislation would be helpful with a view to expanding the range of the organisations that can be part of s.75 arrangements to

[20] Department of Health and Social Care (2022) Better Care Fund Framework 2022 to 2023. (Accessed: 30 March 2023).

include social care providers, VCFSE providers and wider providers such as housing providers.

Ensuring efficient delivery of care

5.24 While there is considerable scope to improve public value through shifting resources “upstream”, there is also scope to improve public value by addressing the costs of delivering care.

5.25 There is an opportunity to address unwanted variation in cost and opportunities to improve ways of working through improvements in technical efficiency. The increasingly urgent need to maximise value for public money is hampered by the continuing difficulty in establishing the real cost of delivering care (for example whether fixed costs are included, how administrative costs are applied and so on.) and the narrow focus on episodes of care, rather than complete pathways that include prevention, early intervention and support in the community (including from the VCFSE sector).

5.26 There are fundamental productivity challenges that systems, if using the appropriate tools, can address. For example, with the exception of the height of the pandemic, performance against the 4-hour A&E target has been declining for a decade, despite the fact that emergency medicine has been the fastest growing clinical specialty in the NHS and, in that time, there’s been a near doubling in the number of (full time equivalent) emergency medicine doctors.[21] This combination of significantly more clinicians but declining productivity emphasises the need to move resources upstream (including by integrating appropriate specialist clinicians within wider neighbourhood teams) as well as rapidly improving productivity within emergency care and acute hospitals themselves.

5.27 Across all parts of the health and care system, there are many opportunities to use digital technologies to reduce administrative burdens on both clinical and other staff (for example moving to real time data dashboards rather than cumbersome paper based data collection); ensure that clinical and other staff are spending the maximum possible time on care and treatment (for example reducing journey times through smart scheduling or optimising theatre scheduling); and to support multidisciplinary working (for example using decision management tools to support a wider range of clinical staff to provide safe and effective care).

5.28 The 7-day-a-week, emergency ophthalmology service provided by Moorfields in partnership with the London Central ICB is a striking example of digitally-enabled, consultant-led transformation that has effectively eliminated waiting times for

[21] Rees, Sebastian, Hassan, Hashmath The A&E crisis: what’s really driving poor performance? Reform, (February 2023)

emergency care in one speciality. Equally, University Hospitals Birmingham has transformed its skin cancer pathway, using telehealth tools in the community and artificial intelligence support for diagnosis, significantly reducing the need for hospital appointments. By connecting primary, community, intermediate care and acute hospital teams through high-speed broadband networks, digital stethoscopes and similar smart diagnostic tools, we can bring the NHS to its patients.

5.29 Systems can play a crucial role in ensuring efficient delivery of care by their partners. Fundamental to this is improved data sharing accompanied by an actuarial approach to data and risk to understand how money is being spent and how effectively it can be spent across a system. The data sharing between NHS England, DHSC, ICBs and providers discussed previously helps to establish a 'single version of the truth' that will allow all concerned to understand the overall performance of the system and its component parts. There is already considerable benchmarking data available (for example GIRFT and Model Hospital Schemes) and this should be expanded to more areas, in particular in areas which are particularly data poor such as mental health, community services and primary care. Given this data, system leaders must feel empowered to work with partner organisations to drive improvements in productivity. Alongside such benchmarking and reflecting the fully integrated approaches of leading systems referred to earlier, it is also essential to adopt clean sheet design approaches or zero-based budgeting to set out what best practice care or processes should look like and calculate what different interventions should cost.

5.30 DHSC and NHS England should undertake work to share examples of pathway redesign where systems are moving to a 'could cost or should cost' funding model rather than what they 'do cost', based on efficient models of care and utilisation of staff or facilities - building on the analysis undertaken by GIRFT and others. These should increasingly look at the whole pathway, including the vital work of the VCFSE sector and local government, rather than individual episodes of care.

5.31 'Should cost' modelling should be indicative rather than compulsory, providing useful input for decision-making within ICSs as well as between ICS partners and helping to create the necessary level of ambition for multi-year transformation.

5.32 Further, to ensure effective and efficient care delivery, there needs to be improvement support for systems and the organisations within them. It is highly encouraging that NHS England's Recovery Support Programme has developed from a provider-facing programme to one that also supports systems facing the greatest challenges. The breadth of that programme - embracing financial challenges but also quality and productivity ones as well - is a very helpful reflection of the appreciation in NHS England and in systems of the interconnectedness of many of the challenges facing the health and care system. NHS England should ensure that systems are able to draw upon a full

range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities. This should include more robust productivity and sophisticated modelling tools which include but go beyond GIRFT and Model Hospital to enable all systems to understand their real productivity challenges and opportunities.

In NW London ICS, the ICB finance team are working closely with finance directors from across NHS trusts to understand the scope of productivity opportunities.

For example, the ICB supported the deployment of external support to quantify current utilisation of operating theatres across all 4 acute trusts and to work with clinicians and managers to realise this significant improvement opportunity. Work has also been funded to support community trusts to count and measure consistently to allow for productivity (costing, inputs and outputs) assessment and comparison beyond the historic approach that has focused mainly on the acute hospital productivity element of patient care. Similar work is being undertaken across mental health trusts and primary care providers. Across all local care providers the ICB is supporting local leaders to identify where the primary, community and mental health real estate could be used more effectively to allow poor quality buildings to be exited.

Across all areas of health and care, the ICB is supporting the wider system to drive consistency of approach by aligning commissioning decisions to standardise service specifications, and to simplify pathways and reduce variation.

Transparency of information enables more effective and consistent comparison and understanding of workforce and other cost inputs to an overall population- based approach to outcomes. This will, in turn, provide the means by which the ICB's ambition to redistribute resources and enable investment in prevention and targeting health inequalities can be realised.

Payment mechanisms

5.33 Financial flows and payment mechanisms can play an important role in ensuring improved efficiency in care delivery. Responses to the call for evidence exposed contrasting views about the use of a payment by results including concerns that it creates perverse incentives for organisations, encouraging overtreatment of patients, discouraging joint-working focused on shifting towards early intervention and undermining efforts to address health inequalities.

5.34 What is clear is that current approaches are not effective in driving value-based healthcare and while payment by results can help drive activity in a particular direction, it is important to recognise that it needs to be adopted in the context of wider system reform, incentivising prioritisation of resources on upstream activity.

5.35 Many health systems in other parts of the world, including those that are entirely or largely taxpayer-funded, are developing payment models that support and incentivise a focus on health. Meanwhile, NHS funding remains over-focused on treatment of illness or injury rather than prevention of them and ICS partners struggle to work around over-complex, uncoordinated funding systems and rules in order to shift resource to where it is most needed. There are lessons from other systems that we should draw on.

5.36 I therefore recommend that NHS England work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, drawing upon international examples as well as local best practice, to identify most effective payment models to incentivise and enable better outcomes and significantly improve productivity. It should consider a number of potential models including:

- incentives for individuals or communities to improve health behaviours
- an incentive payment-based model - providing payments to local care organisations (including social care and the VCFSE sector) to take on the management of people's health and keep people out of hospital
- bundled payment models, which might generate a lead provider model covering costs across a whole pathway to drive an upstream shift in care and technical efficiency in provision at all levels
- payment by activity, where this is appropriate and is beneficial to drive value for populations

5.37 This work should lead as quickly as possible to the testing of new models in practice within a selection of systems, enabling further development and refinement through collaborative learning and action.

Capital expenditure

5.38 The call for evidence repeatedly raised that a lack of capital, inflexibility in use of capital and the layering of different capital allocation and approvals processes from different departments and agencies are major barriers to improvement and productivity.

5.39 While ICS level CDEL allocations have been introduced to give greater ability to direct their operational budget in line with their systems priorities and local needs, there are still some issues around how providers work across system boundaries. In particular, accessing capital to support population need rather than just in their headquartered ICS. For instance, an ICS that urgently needs Tier 4 mental health beds within its own area for patients currently sent out of area finds that its mental

health partner trust is unable to develop the necessary provision simply because the trust is headquartered in a different system.

5.40 To take a different example, even with the hugely important Diagnostic Assessment Centres and Community Diagnostic Centres, some ICBs have found that the configuration that best meets the needs of their particular residents is rejected as not meeting the national specification. The laudable attempt by DHSC ministers to find faster, cheaper ways of creating urgently needed new services have, unfortunately, on occasion added further delays.

5.41 ICS leaders have the perfect opportunity to work together not only within the NHS but with local government partners to make the best possible use of the public estate and scarce public sector capital. I therefore recommend that there should be a cross-government review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024.

5.42 This should build on findings from the independent review of the NHS capital allocation process conducted by Richard Murray in 2021, which I understand NHS England took forward in their planning guidance.

5.43 A cross-government review should consider:

- how government could move towards a 10-year NHS capital plan, with initial freedoms over larger sums for, say, 5 years tested and developed within more mature systems
- reviewing delegated limits and approval processes across HM Treasury Cabinet Office, DHSC, and NHS England with a view to having a simpler more streamlined approval process and giving more mature systems greater responsibility for prioritizing and managing capital expenditure
- how to allow greater year-on-year flexibility to support more efficient use of capital and support invest to save or save to invest
- clarifying the government position in use of private finance and government involvement in primary care capital
- how to enable providers working across systems (particularly mental health, specialised and ambulance providers) to access capital to support population need rather than just in their headquartered ICS
- incentives for more efficient system-wide property management and considering reform of CDEL to enable void space to be filled and co-location across the NHS and local authorities

Strengthening and embedding a culture of research and innovation

5.44 Throughout this review, I have heard about the need to embed innovation throughout the health and care system. As care pathways as transformed across systems, it is essential that ICSs build a culture of importing and exporting "what works", and that they innovate and transform in partnership with academia and industry. Academic Health Science Networks (AHSNs) should be seen as integral to that ambition, with ICBs ensuring that their AHSNs are aligned with local strategic priorities in order that best practice that meets the needs of their populations can be spread and adopted at pace and at scale.

5.45 To give just one example of this in practice, Imperial College Healthcare, itself an AHSN and part of the North West London Acute Provider Collaborative, has worked with primary care partners to transform its entire heart failure pathway. Equipped with a remote heart failure monitoring app to detect any abnormalities, patients are freed from multiple face-to-face follow-up appointments. Costly emergency hospitalisations have been significantly reduced. Above all, health outcomes have been improved.

5.46 Rather than each of the 42 systems to be constantly reinventing the innovation wheel locally, each investing relatively small individual budgets, ICBs can mobilise this expertise as a cost-effective and productive part of their contribution to system infrastructure. Regional AHSNs should work together, and with the national AHSN Network to identify and spread best practice, innovative pathways, enabling each system to import proven interventions including from academia and industry from elsewhere in the country, while ensuring that their own innovative approaches become part of the wider pool. Case studies such as West Yorkshire and South Yorkshire[22] demonstrates how embedding an AHSN to deliver an "innovation hub" for an ICB provides the right expertise for the system, as well as allowing the AHSN to efficiently transfer best practice between systems and regions.

5.47 Systems should feel empowered to engage with AHSNs, National Institute for Health and Care Research (NIHR) as well as regional and national academic communities to proactively draw on their support and skills. This should align and support ICBs with the duty placed on them to facilitate and utilise research for the improvement of health and care services. Therefore, it is vital that we build a thriving research community which can easily access and utilise the wealth of data that systems collect to undertake well-developed and valuable research to support systems to drive transformation and enable wider economic growth.

[22] NHS England Strengthening local partnerships and driving innovative solutions using innovation hubs

Specialised commissioning or tertiary services

5.48 I wanted to note briefly, that during this review, several clinical and other leaders expressed concerns about the place of specialised services within the new landscape of ICSs. Unfortunately, it has not been possible in the timescale of this review to consider this issue in detail.

5.49 Specialist units, whether free standing or within larger trusts, are global leaders within clinical research and care. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS. As such they need to be viewed and supported as national assets within the context of the life sciences strategy and plans for delegation of the commissioning of the services they provide.

5.50 Following extensive engagement over the last 2 years, NHS England is in the process of delegating some of its responsibilities for specialised commissioning to the new ICSs from 2024. I have heard both from some specialist leaders who still have concerns with the new approach, as well as from others who are supportive of the proposed delegation and believe ICB pathways can deliver improved outcomes and more efficient delivery of care.

5.51 During 2023 to 2024 joint committees of ICBs and NHS England are being established to take on a subset of those specialised services. As these new arrangements are put in place, it is essential that they are kept under review to ensure the critical role of these specialist service providers is appropriately maintained through any new arrangements and these provider organisations continue to be engaged.

Chapter 5: recommendations

30. NHS England, DHSC and HM Treasury should work with ICSs collectively, and with other key partners including the Office for Local Government and CIPFA to develop a consistent method of financial reporting.

31. Building on the work already done to ensure greater financial freedoms and more recurrent funding mechanisms, I recommend:

a) Ending, as far as possible, the use of small in-year funding pots with extensive reporting requirements;

b) Giving systems more flexibility to determine allocations for services and appropriate payment mechanisms within their own boundaries, and updating the NHS payment scheme to reflect this; and

c) National guidance should be further developed providing a default position for payment mechanisms for inter system allocations.

32. DHSC, DLUHC and NHS England should align budget and grant allocations for local government (including social care and public health and the NHS).

33. Government should accelerate the work to widen the scope of s.75 to include previously excluded functions (such as the full range of primary care services) and review the regulations with a view to simplifying them. This should also include reviewing the legislation with a view to expanding the scope of the organisations that can be part of s.75 arrangements.

34. NHS England should ensure that systems are able to draw upon a full range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities.

35. NHS England should work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, drawing upon international examples as well as local best practice, to identify most effective payment models to incentivise and enable better outcomes and significantly improve productivity.

36. There should be a cross-government review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024.

6. Annex A: the journey of the review

6.1 In November, during his autumn statement, the Chancellor of the Exchequer announced an independent review to consider the oversight and governance of integrated care systems (ICSs).

6.2 While the Secretary of State for Health and Social Care appointed me to lead this review, the report has only been possible due to the generosity of hundreds of individuals and organisations who have given up their time and engaged with us over the last 5 months.

6.3 During this review, I have engaged with over a thousand leaders from across ICBs, ICPs, local government, NHS trusts and foundation trusts, social care providers, VCFSE groups, academics and others with an interest in the success of ICSs.

6.4 We have also heard from over 400 respondents via our call for evidence - and we are grateful to everyone who responded from across the health and social care sector, patients, the public and wider voluntary sector. Throughout this review, we have been keen to capture the views of all partners involved in the day-to-day business of ICSs and their partners, and their responses has made this process richer and better informed at every step.

6.5 I am especially grateful to the work of colleagues who led and contributed to the 5 workstreams, that produced the majority of my recommendations. Colleagues from patient and service user groups, local government, the voluntary community faith and social enterprise sector and the social care provider sector, as well as the NHS, were included in the work streams, reflecting the partnerships that constitute ICSs.

6.6 Each workstream held a wide range of meetings in order to gather evidence from across the system. They reviewed the call for evidence responses, expert papers and data as well as a range of qualitative information from across the system.

6.7 From late January 2023, each workstreams also held a ‘town hall’ online event in which wider stakeholders were able to hear and contribute to the developing thinking of each workstream.

6.8 The review team also engaged with system partners more widely. This includes but is not limited to, engagement with:

- DHSC, NHS England and CQC
- chairs and CEOs of ICBs and chairs of ICPs

- trust and foundation trust leaders
- social care providers
- primary care providers (including general practise, dentistry, optometry, and community pharmacy) and leaders of primary care networks and partnerships
- a wide range of voluntary, community, faith and social enterprise stakeholders (including organisations representing children, mental health and the role of patient and public voice within health and care services)
- local government, including councillors, CEOs and directors of public health, adult social care and children's social care
- Healthwatch
- national trade union representatives

6.9 In engaging widely, and seeking a range of views, I believe that we have established a number of recommendations that can be widely supported, and which will enable ICSs to succeed.

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