Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors

Date: Wednesday 26th July 2023

Time: 11.30 am – 2.30 pm

The Boardroom
Hengrave House
Lowes Bridge
TQ2 7AA

www.torbayandsouthdevon.nhs.uk

TorbayAndSouthDevonFT
@TorbaySDevonNHS

Working with you, for you

TSDFT Public Board of Directors

26/07/2023 11:30

Torbay and South Devon NHS Foundation Trust

	6.1	Report of the Chairman Receive and Note	Ch	12:00-12:10	
	6.2	Chief Executive's Report Receive and Note	CEO	12:10-12:25	74
7.	Safe Quality Care and Best Experience				93
	7.1	Integrated Performance Report (IPR): Month 3 2023/24 (June 2023 data) Receive and Note	CPO	12:25-12:40	93
	7.2	July 2023 Mortality Safety Scorecard Receive and Note	CMO	12:40-12:55	152
	7.3	Report of the Guardian of Safe Working Hours - Doctors and Dentists in Training Receive and Note	CMO	12:55-13:05	176
	7.4	BREAK		13:05-13:15	
	7.5	Maternity Governance Safety Report Receive and Note	CNO	13:15-13:25	181
	7.6	Complaints, Feedback and Engagement Service Annual Report 2022/23 Receive and Note	CNO	13:25-13:40	196
8.	Valuing our Workforce				215
	8.1	Creating and Embedding a Culture of Inclusion Approve	CPO	13:40-13:55	215
9.	Well Led				232
	9.1	Medical Appraisal and Revalidation Board Report Approve	CMO	13:55-14:05	232
	9.2	Board Assurance Framework and Corporate Risk Register Approve	DCG	14:05-14:15	250
10.	Compliance Issues				
11.	Any other business notified in Advance				
12.	Date and time of Next Meeting - 11.30am, Wednesday 27 September 2023				

NHS
Torbay and South Devon
NHS Foundation Trust

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

Torbay and South Devon NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARDROOM, HENAGRAVE HOUSE
AT 11:30AM ON 28 JUNE 2023

Present:	Sir Richard Ibbotson	Chairman
	Mrs L Davenport	Chief Executive
	Professor C Balch	Non-Executive Director
	Mr R Crompton	Non-Executive Director/Vice Chairman
	Mr I Currie	Chief Medical Officer
	Ms D Kelly	Chief Nurse
	Dr K Lissett	Interim Medical Director
	Mrs J Lyttle	Non-Executive Director
	Mrs V Matthews	Non-Executive Director
	Mr P Richards	Non-Executive
	Mr J Scott	Chief Operating Officer
	Mr D Stacey	Deputy Chief Executive Officer and Chief Finance Officer
	Mr R Sutton	Non-Executive Director
	Ms 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:	Mrs A Bance	CQC Inspector
	Mr J Broad	South West Integrated Personalised Care
	Mrs S Byrne	Board Secretary
	Miss H Dennison	Patient's Daughter
	Mr P Dennison	Patient
	Mr G Hotine	Director of Health Informatics Service
	Mr P Milford	Governor
	Mrs H Milner	Governor
	Mr A Postlethwaite	Governor
	Miss H Rae	Graduate management trainee
	Mrs A Ramon	Governor
	Mrs J Thomas	Governor
	Mr L Thomas	Governor
	Ms L Trout	Specialist Parkinsons Nurse

110/06/23 **Welcome and Introductions**

The Chairman welcomed all those in attendance to the meeting.

Preliminary Matters

111/06/23 **Apologies for Absence and Quoracy**

The Board noted apologies of absence from Ms Jones, Mr Aitken and Mrs Long. Mr Hotine was in attendance on behalf of Ms Jones.

112/06/23 **Declarations of Interest**

No declarations of interest were received.

113/06/23 **Patient Story**

Ms Kelly introduced Mr Dennison, who was diagnosed with Parkinson's Disease in 2018, to the Board. He was supported by Ms Trout, the Trust's specialist Parkinson's Disease Nurse and his daughter Miss Dennison. He made the Board aware his Parkinson's Disease was now medically managed due to the specialist care he had received from Ms Trout and Dr Knight. However, following initial diagnosis and treatment he developed:

- Inability to walk longer distances.
- Dystonia (cramping) of the right foot
- Muscle spasms

Following diagnosis he started medication and this helped physical symptoms but he developed social anxiety, previously having been very outgoing and confident. This was helped by the period of Covid giving him more time to work from home.

However, he then developed Ulcerative colitis unrelated to his Parkinson's. He lost weight, could barely leave the bathroom and ended up with Pneumonia and Uveitis as a side effect from medication. These side effects of his Colitis treatment meant he was unable to have the quality of life he was used to and therefore, he was willing to have a stoma fitted to manage his symptoms and improve his quality of life. However, he was in hospital for five weeks recovering during which time he became dangerously dehydrated and lost weight.

It was highlighted that communication between the Parkinson's Team and the wards on admission was poor however, once Ms Trout was aware he was an inpatient she visited regularly and was able stabilise his Parkinson's medication. Upon his stoma fully functioning he was discharged at eight stone. However he was supported by the gastro team and continued to have regular contact with his Parkinson team also. Eventually when he was better he went to Lancashire to visit his daughter and granddaughter where he contracted Covid19. However, in hindsight, this was for the best as he recovered well, and gave him confidence the Covid19 immunisations did work and felt able to go out socially.

During his recovery he started to put on weight and believed he needed to go on a fruit diet but, this caused unexpected problems with his stoma. He explained upon attending the hospital as, he was leaving he bumped into Dr Johnston, who kindly took the time to listen to his problems and advised him to return to a more balanced diet. He said the advice was much appreciated and solved his stoma problems.

Mr Dennison feels the care he received from the Trust has given him back his life and he is extremely grateful. Ms Trout read Mr Dennison's letter of thanks to

Allerton and Hutchings Wards to the Board. Mr Dennison was unable to read this as it was so emotional, it moved his daughter and board members to tears.

Mr Crompton asked how communication between wards and specialist teams could be improved. Ms Trout replied that she puts her patients into a Parkinson's portal and this sends her an email when they are admitted. However if they are missed or seen by out of area consultants, they will not be flagged. Ms Trout has tried to get IT to change this so the system flags them on admission, but has been told this isn't possible, despite it being the case for other conditions. She tries to ameliorate this by encouraging wards and patients to call her when admitted.

Mrs Davenport said this was a reminder to the Trust that it was important to advocate for people by establishing what is important to them. She asked what he and his daughter would suggest could be improved. Mr Dennison said, he felt all services on the ward were slower and less available at weekends, access to specialists such as his Parkinson's team isn't available at weekends. Miss Dennison explained that her father was in the hospital during a period of Covid19 visitor restrictions and therefore, only one nominated family member could visit her father, which caused her to worry and had she not had colleagues to visit the ward, she would not have had regular updates regarding his condition.

The Board thanked Mr Dennison for the way in which he told his story with compassion, humour and constructive criticism.

The Board received and noted the patient story.

114/06/23 **Board Corporate Objectives**

The Board received and noted the Board Corporate Objectives.

For Approval

115/06/23 **Unconfirmed Minutes of the Meeting held on the 31 May 2023 and outstanding action**

The Board approved the minutes of the meeting held on 31 May 2023 pending the following amendments:

100/05/23
From: *Ms Jones agreed but explained the date was behind the One Devon Data set; and this was about waiting list inequality as opposed to health inequalities.*
To: *Ms Jones agreed and explained that this particular inequalities analysis was focussed on inequity of patients on waiting lists. It was possible using the One Devon Dataset to review wider health inequalities and it was intended that this formed part of the population health management work across the Local Care Partnership.*

In the summary section the letter 'T' be added to 'he board received and noted the waiting list assessment of Trust position'

101/05/23

From: *Dr Westwood presented the Our Leadership and Management Framework: A compassionate Leadership Approach and Management Development Programme, as circulated, which had been co-designed with a focus on culture. She highlighted the focus would be on the following phrases:*

To: *Dr Westwood presented the Our Leadership and Management Framework: A compassionate Leadership Approach and Management Development Programme, as circulated, which had been co-designed with our workforce, and marked the delivery of a key people promise priority. She highlighted the Leadership framework centres on*: …

From: *To enable the programme, collaboration will there would be a change in the name and focus of the People Directorate Departments to:*

- *Inclusivity and Organisational Culture Team;…*

To: A collaborative approach between the following teams will enable the delivery of the development programmes.

- *Inclusivity and Organisational Culture Team (formally called OD team);…*

From:

- *The Just Learning Culture spoke to both the Freedom to Speak Up Guardian work and the Patient Safety Incident Response Framework (PSIRF).*

To:

- *The framework is dependent on the creation of psychological safety, which is central to the Just Learning Culture work that the Inclusion and Organisational Culture team and Freedom to Speak Up Guardian are introducing aligned to the Patient Safety Incident Response Framework (PSIRF).*

The Board approved the minutes of the meeting held on 31 May 2023

Consent Agenda (Pre-notified questions)

116/06/23 **Committee Reports**

Charitable Funds

Mrs Lyttle asked for the Board to note: The Nursery monies would no longer be accounted for within Charitable funds budgets; and, The League of Friends monies would be moved to a separate budget.

The Board received and noted the Committee Reports.

117/06/23 **Ethics Committee Annual Report**

The Board received and noted the Ethics Committee Annual Report.

Reports from the Executive Directors (for noting)

118/06/23 **Chief Operating Officer's Report - June 2023**

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

119/06/23 **Directorate of Transformation and Partnerships Quarterly Report**

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

Reports of the Chairman and Chief Executive

120/06/23 **Report of the Chairman**

The Chairman verbally briefed the Board on the following:

- Odgers Berndtson had been instructed to undertake the NED Recruitment process;
- The Governors were engaged with reviewing the Trust Chairs Job Description; and Personal Specification with a view to the recruitment process commencing in Autumn 2023.
- Trust Chief Operating Officer Interviews would take place with regional and system support tomorrow, 29 June 2023.
- Mr Stacey was formerly thanked by the Chairman and the Board for his time as the Trust's Chief Finance Officer, ahead of his departure to University of Exeter.
- The Trust had appointed an Interim Chief Finance Officer who would commence on 3 July 2023.
- He and Mrs Davenport had met with the new Independent Chair of the Peninsula Acute Provider Collaborative, Mrs Stephanie Elsy.
- Mr Michael Wilson was thanked for the support and guidance he had offered to enable the Trust towards SOF4 exit, with good financial and operational progress being reported.
- He attended Stover School on Monday 26 June 2023, to support the Colour Run arranged by the school and Lottie Bryon-Edmond to fund raise for the Trust's Organ Donation Memorial.

The Board received and noted the report of the Chairman.

121/06/23 **Chief Executive's Report**

Mrs Davenport thanked Mr Stacey for the professionalism, people skills, knowledge and intellect he had brought into the Chief Finance Officer post, Estates, Torbay Pharmaceuticals and into the wider Devon system. She wished him well in his new prestigious role with the University of Exeter.

Mrs Davenport highlighted the following from the Chief Executive's Report, as circulated to the Board:

Interim Chief Finance Officer: Mr Mark Brice, would commence at Interim Chief Finance Officer from 3 July 2023. He had formerly been working with Devon ICS and was therefore familiar with the challenges Devon face and its SOF4 position.

Chief Finance Officer: Further to taking a recommendation to the Non-Executive Director Nominations and Renumerations Committee, the substantive Chief Finance Officer post would be advertised over the summer period.

CQC inspection process: A further CQC Core Service Inspection had been undertaken on the 21 and 22 June 2023 of Diagnostic Imaging Services. Ms Kelly confirmed the feedback was as anticipated and the issues CQC highlighted were on the Trust Risk Register. Some recognised as regional and national challenges, and collaborative working was taking place between the Trust, Royal Devon University Healthcare and University Hospital Plymouth. She confirmed further assurance was being sought around the governance issues raised.

Parliamentary Award: The Health Connect Coaching Team have won the South West Volunteer Award category in recognition of its work to help people in Torbay and South Devon to take control of their health and wellbeing.

Ministerial Visit: Torbay hosted Dame Andrea Leadsom who visited two new family hubs and the incredible work of the trail blazing 0-19 service was brought to her attention.

Industrial Action: The following strikes had been announced:
- Junior Doctors – 7am, Thursday 13 July 2023 to 7am, Tuesday 18 July 2023; and
- Consultants – Thursday 20 July 2023 to Friday 21 July 2023.

Awareness week: Privacy, dignity and respect awareness week took place to enable the Trust to better understand people's experiences and the learning will be reviewed to identify opportunities to improve.

Ward Accreditations: The Coronary Care Unit were awarded a gold ward accreditation, only the second one to be awarded under the new scoring system.

New Hospital Plan: The government confirmed on 25 May 2023 that the Trust remained in the Health Infrastructure Programme, this would allow the Trust to deliver modern day healthcare in the community and ensure staff have better working environments. Prof. Balch confirmed the funding would be received between 2025 and 2030.

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

Safe Quality Care and Best Experience

122/06/23 **Integrated Performance Report (IPR): Month 2 2022/23 (May 2023 data)**

Mr Stacey presented the IPR for May 2023 data to the Board, Month 2, as circulated. He highlighted the following points:

Quality

- 1 severe harm; and 1 death had been reported to STEIS. Investigations were being undertaken to inform the improvement plans around referral management and falls prevention.
- The Trust continued to experience significant delays accessing stroke wards and beds due to operational pressures. However, upon admission to the appropriate ward's patients' outcomes were better than reported since 2021 based on national reporting and targets. However, the Trust continued to focus on recruiting into specialist roles and ring fencing beds.
- There had been an improvement in bed days lost due to revised Covid19 guidance but, bed days were still lost due to another virus'.
- The Maternity team were congratulated on receiving 10/10 for the CNST incentive scheme improvement measures.

Workforce

- Appraisal rates were improving, which had been supported by training of managers.
- Staff turnover was still within tolerance but a decrease had been seen. Ongoing work regarding retention was being undertaken with system partners.

Performance

- Urgent and Emergency Care performance was reported at 60.8% which was under the 65% 4 hour trajectory.
- Unplanned activity had increased between 8 and 12%. Additional bank holidays and Industrial Actions are focussing further attention on pre-noon and weekend discharges, as well as same day emergency care, and internal standards.
- Urgent and Emergency Care had moved into Tier 1 oversight, improvement plans for the Emergency Department escalation area, discharge lounge and Virtual Ward were in place and confirmation of funding was awaited.
- An Emergency Department Perfect Week was being undertaken, with focus on non-admitted pathways and learning from strike periods.
- The 78 and 65 week wait Referral to Treatment Targets, were reported ahead of trajectory.
- The Trust were participating in the national GIRFT Further Faster programme with the focus being on the following services: to Trauma and Orothopaedic, Gynaecology, Neurology and Ophthalmology.
- With a strong position continuing to be reported, cancer services had moved into Tier 2.
- Community activity levels were reported as good, with positive Urgent Community Response times seen, which was driving the No Criteria to Reside position thus supporting flow.

Mr Crompton commented on the need for targets and trajectories to be placed within the IPR to enable the Board to judge effectiveness. He asked if community teams were working at their full potential and, was there a way to get more out of the teams to drive flow. Mr Scott, acknowledged not all teams had clear metrics but within the restructure there was an accountability framework and delivery agreement. He confirmed a review had been commissioned with Newton, to establish what capacity

the Trust had and review how it was being used, as there was thinking the Trust were over-prescribing care in the community.

Ms Kelly confirmed the Trust had quality indicators and the data was collected and monitored; where risk was highlighted it would be brought to the Boards attention, escalated, monitored and reviewed. She explained the Meridian Review was undertaken in 2019, which looked at community nursing caseloads and the Trust had worked in partnership with its community teams due to the changing nature of community care delivery.

Mrs Lyttle spoke to the importance of incorporating 'soft measures' in our review of quality and efficiencies.

Ms Walker-McAllister believed there would be benefit in looking at the social care metrics too. She asked for consideration to be given to social care commissioning that fits the service model; and asked if learning could be sought from other parts of the country.

Mrs Davenport confirmed research had been undertaken with the Trust in partnership with University of Plymouth around patient experience and self-management measures. The Trust's challenge was to ensure the offer added value to the community served and how success could be managed. She explained Newton would be testing efficiencies and she recognised there was a need for greater visibility of this as at present the Trust's reported to the metrics set by the council but it did not have the richness of information the Board would aspire.

Prof. Balch asked the Board to remember the Trust had summer pressures as well as winter pressures, with an additional population of 30% coming to Torbay during the summer and additional pressure being placed on the Trust. Mr Scott said it was unlikely this argument would increase funding as funding was linked to length of stay and holidaymakers tended to be 'walk ins' only.

Finance

- The reported Trust position was £9.6m year to date with a deficit of £0.3m better than plan of £9.9m deficit.
- The pay award was driving pressure but, it was expected this would be remedied in month 3 or 4.
- CIP was ahead of plan but there was a significant uptick in month 4.
- There was a £31.6m risk in the financial plan and this depended on efficiency savings and Elective Recovery Fund claw back. It would be difficult to mitigate due to industrial action causing operational disfunction.

Mr Sutton asked when the Trust would know whether the CIP would be delivered. Mr Stacey explained all identified CIP was rag rated green or amber which therefore made them achievable but, the scale of CIP scheme was due to step up in month 4, which would test its achievability. He also asked the Board to note there were £10.5m worth of system schemes within the Trust's CIP, which could present risk but, the £8.8m work of internal schemes based on workforce controls, should show a demonstrable improvement in position if embedded. He counselled if the Trust could deliver quarter 2 CIP it would improve confidence in Quarter 3 and Quarter 4.

Mr Sutton asked how can the Board be assured the Trust would not overspend on agency staffing threshold. Mr Stacey, could not provide assurance but advised on the detrimental effect aggressive staff reduction could have on the people the Trust

served. However, there were strong rostering programmes of work; and job planning sessions taking place in an attempt to prevent an overspend of agency staff. However, last year the Trust were successful in reducing nursing agency spend and CIP by successfully implementing cultural changes and ensuring controls were in place. These changes needed to be implemented Trust wide.

The Board received and noted the Integrated Performance Report (IPR): Month 2 2022/23 (May 2023 data)

Well Led

123/06/23 **Annual Report 2022/23**

Mrs Davenport presented the Annual Report, as circulated ahead of submission to NHSE by 12 Noon on Friday 30 June. The Annual Report would be layed before Parliament in July 2023. She confirmed: Mrs Vikki Matthews' name would be added in the appropriate section.

The Board approved the Annual Report

124/06/23 **Presentation of the Trust's 2022/23 Financial Statement**

Mr Stacey presented the Trust's 2022/23 Financial Statement, as circulated, to the Board. He confirmed that there had been a clear audit opinion on the financial statements.

The letter of representation was circulated and reviewed by the Board, with one unadjusted audit difference to be appended, on an orthopaedic consumable. Internal checks were undertaken on the rest of the population and this appears to be a one off.

There were two key recommendations regarding financial sustainability:

1. CIP savings Long Term Financial Model; and
2. CIP reporting into Finance Performance and Digital Committee.

There were two improvement recommendations:

1. Standing Financial Instructions and Scheme of Delegation – the work had been planned; and
2. Improve EEE – the IPR and Operational Recovery Guidance was in place.

Mr Sutton sought clarity in respect of the audit adjustment. Mr Stacey confirmed it was £82k against annual accounts of £9.6m found in sampling and therefore grossed up to £1.5m of a non-pay spend of £300m.

The Board approved the Financial Statements and the signing of the letter of representation on behalf of the Board.

125/06/23 **Quality Account 2022/23**

Ms Kelly presented the Quality Account 2022/23 to the Board, as circulated. She confirmed the report had been socialised with Council of Governors, Healthwatch and reviewed at Audit Committee.

The Board approved the Quality Account 2022/23.

126/06/23 **Board Assurance Framework and Corporate Risk Register**

Mr Scott presented the Board Assurance Framework and Corporate Risk Register. He explained conversations had taken place within the Board Sub Committees to restructure the risk matrix to ensure it was aligned.

Prof. Balch confirmed the Board Sub Committees were actively referencing the Board Assurance Framework. Mrs Lyttle confirmed it provided Committees with focus and the opportunity to validate risks when deep dives were being undertaken.

The conversation turned to the need for a system alignment of Board Assurance Frameworks and Corporate Risk Registers. Mrs Davenport said the Devon ICS acknowledged the opportunity to align Risk Registers and Board Assurance Frameworks.

The Board received and noted.

126/06/23 **SID Role Description**

The Chairman presented the SID Role Description to the Board, as circulated. He explained the Trust had never had a description for this role and there was no advice or guidance at NHSE level. However, the Governors believed it was good governance to have the description approved by the Board.

Mr Richards asked how the SID role sat alongside the Vice Chair role. The Chairman said there was a Chair, Vice Chair and SID triumpherate as there were more external commitments. At present, the Chairman was aware there was not a Vice Chair job description but, the natural role of the Vice Chair would be to undertake the Chairman's job description in his absence.

The Board approved the SID Role Description.

127/06/23 **Compliance Issues**

128/06/23 **Any other business notified in advance**

129/06/23 **Date and Time of Next Meeting:**

11.30 am, Wednesday 26 July 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. 28.06.23	28.09.22

			Ms Kelly confirmed a League of Friends funding application had been made to support the memorial.	
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. 28.06.23 Mr Scott confirmed an accountability framework had been prepared for Care Groups and this should ensure there was a triangulated outcomes framework was embedded. Action closed.	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. 28.06.23 Mr Stacey proposed a final review of the IPR take place at September 2023 Board.	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	31.05.23 The report will come to the July Quality Assurance Committee and Board. 28.06.23 Mr Manlow was due to present at July 2023 Quality Assurance Committee. Action Closed	29.03.23

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	31.05.23 Mrs Davenport will report back to the Board with a date for the Board to Board with DPT. 28.06.23 Mrs Davenport confirmed a review between Devon Partnership Trust and Child Family Health Devon was currently being undertaken and a Board to Board was likely to take place by the middle of September 2023.	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	28.06.23 The matters were due to come to Board in July 2023. Action Closed	26.04.23
096/05/23	Dr Aitken raised that he was unable to triangulate the VTE performance data within the IPR. Dr Lissett confirmed the data was reviewed by the VTE Group and with the support of Ms Kelly from next month the IPR would ensure there was a triangulation of the data so trends could be identified by the Board.	Dr Lissett	28.06.23 Dr Lissett would arrange to meet with Dr Aitken.	31.05.23
096/05/23	Mrs Matthews proposed the People Committee reviewed the turnover data as this led to a loss of knowledge for the Trust.	Mrs Matthews	28.06.23 Mrs Matthews confirmed herself and Dr Westwood would work on this and present to the People Committee. Action Closed	31.05.23
097/05/23	Mrs Davenport said there was a need to ensure learning from deaths of those with Learning Disabilities was supported and took an action to enquire whether the Trust could manage the reviews in a timelier way.	Mrs Davenport	28.06.23 Mrs Davenport confirmed she had escalated Learning Disability deaths to the ICS and was awaiting to hear from Naomi Atkin, CNO, Devon ICS	31.05.23
101/05/23	Mrs Kelly explained an immediate response and action plan needed to be developed to address culture issues	Dr Westwood	28.06.23 Dr Westwood confirmed cultural issues had been placed on the People	31.05.23

	that were continually unresolved and an accountability framework needed to be developed.		Committee forward planner. Action Closed.	
101/05/23	It was agreed Dr Westwood would present proposals for additional resource to support the Freedom to Speak Up Guardian role for the Executive Consider proposals for additional resource.	Dr Westwood	28.06.23 Dr Westwood confirmed consideration was being given to integrating existing resource to support the Freedom to Speak Up Guardian role. Action closed.	21.05.23

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Committee Reports			Meeting date: 26 July 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 is asked to note the following summary of the Committee meetings held in the period. Audit Committee: Chair (R Sutton) • 19 July 2023 (minutes yet to be published) Quality Assurance Committee: Chair (J Lyttle) • 24 July 2023 (minutes yet to be published) Charitable Funds Committee: Chair (J Lyttle) • No meetings in reporting period Finance Performance and Digital Committee: Chair (R Crompton) • 24 July 2023 (minutes yet to be published) People Committee: Chair (Vikki Matthews) • No meetings in reporting period Building a Brighter Future: Chair (C Balch) • 19 July 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 is 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**		

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report			Meeting date: 26 July 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 theTrust's Care Groups		
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 several key developments across the community alongside the key activities, risks, and operational responses to support delivery of services through this phase of the recovery and restoration. This includes delivery of high priority cancer, diagnostics, and elective services.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the Chief Operating Officer's Report.		
Summary of key elements			

Strategic 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:** 26 July 2023
Report sponsor	Chief Operating Officer	
Report author	Care Group Directors	

1.0 Purpose

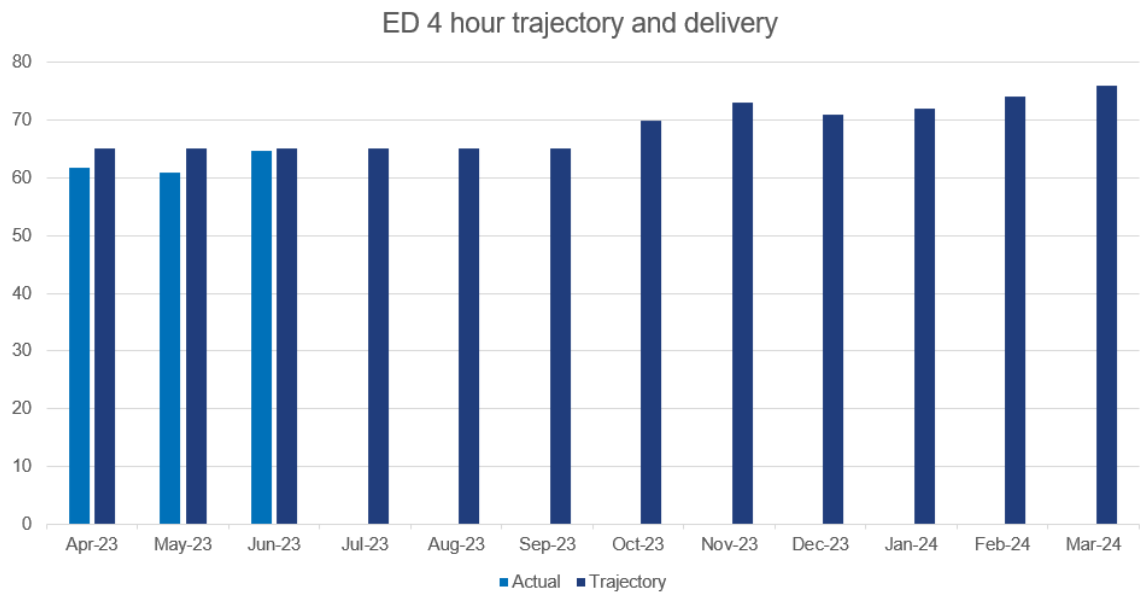
This report provides the Board with an update on progress and the controls in place in relation to operational delivery across the Trust's Care Groups.

2.0 Introduction

Improvements have been evident across several areas; our front door, planned care and our community services. These delivery gains are set against a further backdrop of industrial action throughout June and in some services in particular cancer two week waits a significant increase in referrals.

3.0 Urgent & Emergency Care (UEC) update

June was a month characterised by numbers broadly the same as May, but improved performance across all metrics. The overall ICO attendances for June 23 were 9,991 – on par with the highest ever number in May 23 at 10,009. This is an ICO average of 333.03/day. Against this backdrop of increasing demand, the performance was the highest since September 2021 at 64.61% - the third consecutive month above 60% as a whole ICO.



Type 1 activity was at 6,406 and performance of the ED Department rose again to 45.37%. Changes to the way ED manage the non-admitted pathway in Sept/Oct will improve Type 1 performance. Other metrics are as follows:

- Type 1 non-admitted attendances and discharges totalled 4,507 or an average of 150/day – performance of the 4hr standard was 57.58%
- MIU/UTC performance improved to 98.92%

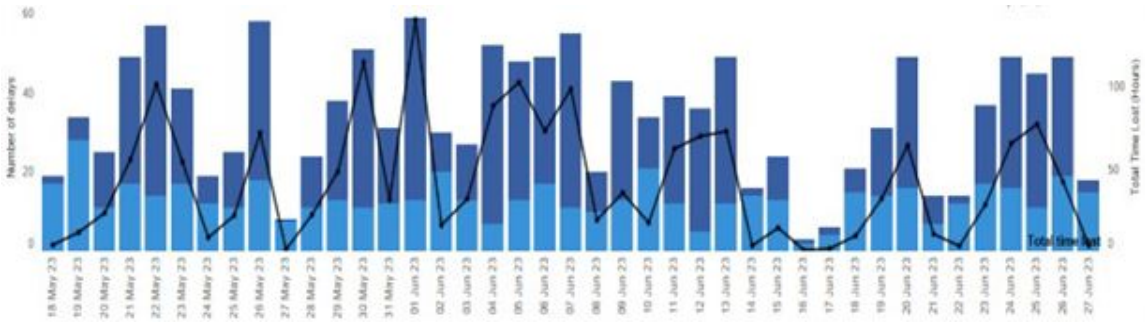
- Ambulance attendances were 2,009 in the month with 23% being off-loaded in 15 minutes or under and the average handover time reduced to 21.2 minutes
- 12hr breaches averaged 4.3 per day

3.1 Ambulance Handovers

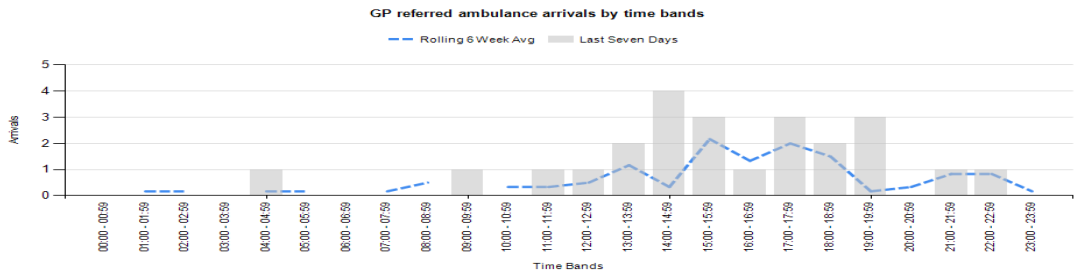
Ambulance arrivals averaged 65.5 per day in June (as at 28 June) – averaging that number for June as a whole would give us 1,965 attendances. Time lost in delayed handovers (above 15 minutes) as a rolling 30-day average up to 28 June is shown in the table below. This is a four hour decrease on the same time last month.

Derriford Hospital	128:30:38
Royal Cornwall Hospital (treliske)	63:16:15
Gloucestershire Royal Hospital	53:22:03
Torbay Hospital	46:21:46
The Great Western Hospital	45:26:26
Royal United Hospital	44:38:28
Royal Devon & Exeter Hospital (w..	18:59:17
Bristol Royal Infirmary	17:57:14
Poole Hospital	13:40:13
Royal Bournemouth Hospital	12:00:33
Southmead Hospital	11:21:13
Weston General Hospital	7:34:51
North Devon District Hospital	7:08:38
Musgrove Park Hospital	5:35:04
Salisbury Health Care NHS Trust	4:52:50
Cheltenham General Hospital	2:21:03
Greenfields Day Centre	2:11:14
Dorset County Hospital	1:05:32
Yeovil District Hospital	0:57:24
Bristol Royal Hospital For Children	0:21:50

The table below shows performance by day of the week up to 27 June and shows a reduction in the middle of the month when there were no infection issues and discharges were high. On these days we saw reductions in 15-30 min handovers, 30-60 and >60-minute handovers.



One area for further review are the late arrivals of GP ordered ambulances (table below shows week commencing 22 June and the dotted line is the 6-week average rolling trend).



Public

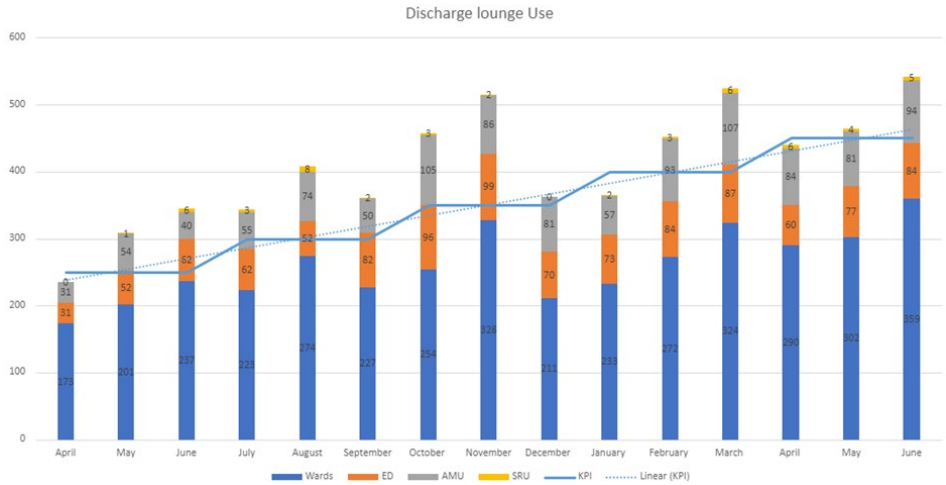
3.2 Inpatient Flow

In June we had 1,742 adult acute ward discharges compared to 1,677 in April. We achieved our pre-5pm discharge target five times but have not yet managed to meet the pre-noon target of 33%. Our average discharge percentage for June was 19.2% by noon and 69.2% pre-5pm. The flow and ward improvement group continue to drive a month on month improvement with a focus on home for lunch and giving patients back our time.

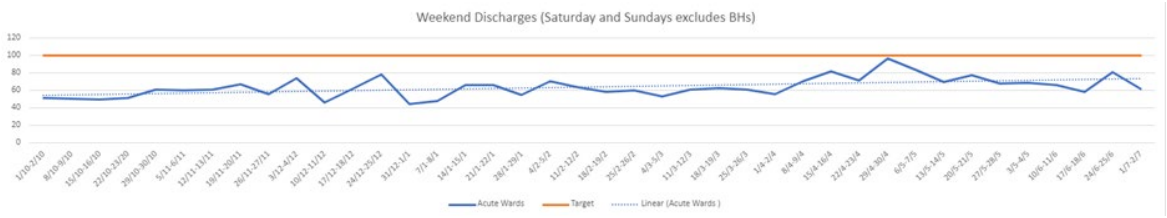
The Trust spent less time at OPEL 4 in June, this makes a difference to our patient and staff experience.

Month	OPEL 1	OPEL 2	OPEL 3	OPEL 4	OPEL 4 + Critical incident
Dec-22	0	1	3	22	5
Jan-23	0	7	6	18	0
Feb-23	0	6	15	7	0
Mar-23	0	0	20	11	0
Apr-23	0	8	17	5	0
May-23	0	7	10	12	2
Jun-23	0	7	17	6	0

The discharge lounge (DCL) supports both our wards, ED and assessment areas to generate capacity earlier. The DCL team supported 542 patents in June, our best month yet. However, we know to support us to achieve 33% of discharges by noon, additional effort is needed to ensure that patients who could use the discharge lounge do so.



We have not been able to sustain the improvement in our weekend discharges we saw in May. This is due to the challenge to secure additional workforce on EAU 4 and senior cover within the weekend discharge team. Following an audit on weekend discharges, the flow and ward improvement team are engaging with speciality teams to review the service offer out of hours, linking the need to improve discharges with virtual ward and reviewing how we collect our information to support the workforce at weekends. We plan that these workstreams will support an improvement in our discharges across the weekends.



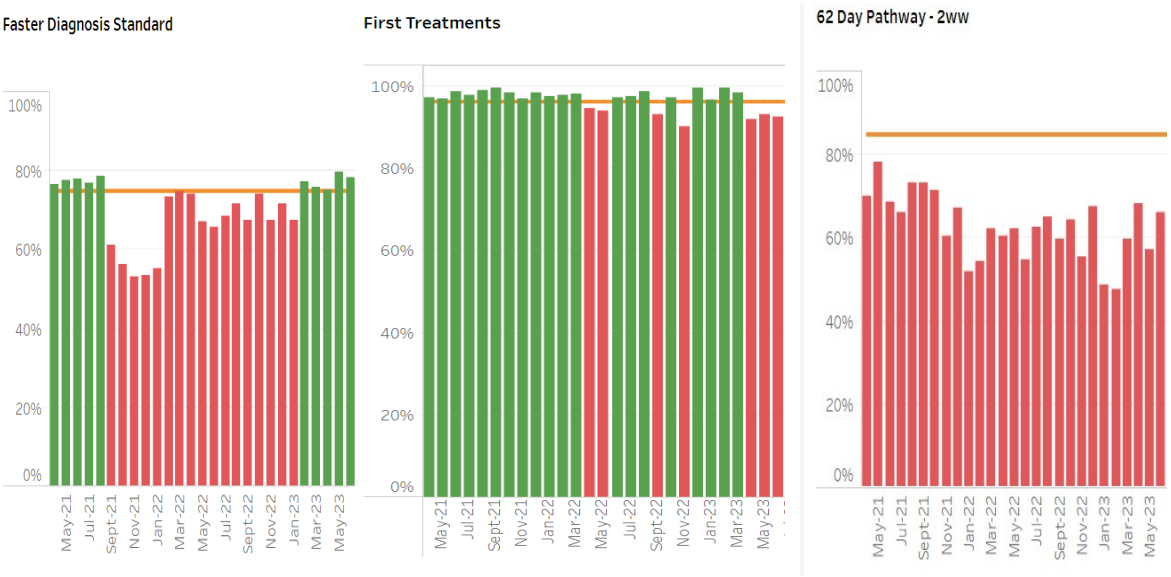
4.0 Cancer Demand

In June, Torbay and South Devon NHS Foundation Trust received 2,213 two-week wait referrals (2WW); this the first time over 2,000 suspected cancer referrals have been received in a single month.

For the first quarter of this financial year there have been 5,719 new referrals, representing a 5.8% increase on last year. Skin, breast, gynaecology and head and neck referrals have seen the greatest rise, with demand growing by over 10% in these sites.

4.1 Cancer Recovery

There are four 'Key Lines of Enquiry', which are the priority measures monitored by NHS England.



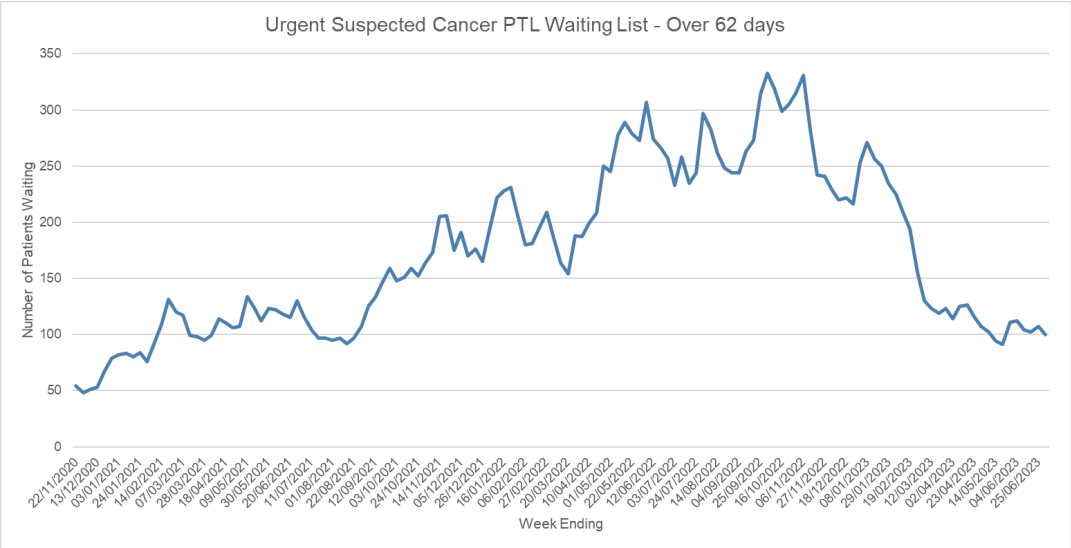
June saw the Trust achieve the 75% Faster Diagnosis Standard for the fifth successive month, with a current performance of 78.4% - this is undergoing final validation.
31-day performance remains challenged in June with 92.5% of patients meeting the standard against the 96% target; of the patients who missed the target, most were by under 10 days. Plastic surgery, a service provided in partnership with RDUH surgeons, delays accounted for the largest proportion of the breaches. Additional weekend sessions continue to be provided and supplementary work from insourcing companies has been provisioned.

The 62-day standard for June is currently at 66.2%, this reflects our improvement, and subsequent sustained position, of the 62-day backlog. Challenges remain across lower gastrointestinal (GI) and urology pathway, with these pathways accounting for 50% of the breaching pathways. Urology has secured a locum consultant from 7 July which will provide more sustainability in the medical team.

Looking ahead, all services are expecting disruption from the junior doctor and consultant strikes at the end of July and beyond. Current indications show that 254 elective appointment and procedures will be rescheduled during the junior doctors strike at the end of July.

Over 62-day Backlog (Open Pathways)

As of 3 July 2023, the number of open pathways over 62-days was 104 and represents 5.8% of the total patient tracking list (PTL). There are only seven patients over 104 days.



Regional position

NHS England benchmark Trusts on their Faster Diagnosis Performance and 62-day backlog position, against their target. For Torbay, as of 3 July 2023, we remain 38 patients below our expected backlog position of 138 and are achieving the Faster Diagnosis Standard. Consequently, Torbay rank 90 out of 122 Trusts; this is a positive position, where the highest-ranking Trusts are the worst performing. As a consequence TSDFT is no longer in Tier 1 or Tier 2 levels of escalation for Cancer care.

Other news

Dr Liz Thomas has been appointed to the role of clinical director for cancer services from 1 August. This post strengthens our leadership team, allowing for the development of a cross organisational strategy to continue the excellent progress Torbay have made in delivering cancer care.

5.0 Referral to Treatment (RTT)

5.1 Long waits (June 2023)

104 weeks – The Trust continues to meet a performance of zero 104-week waits at the end of June, delivering on our forecast position.

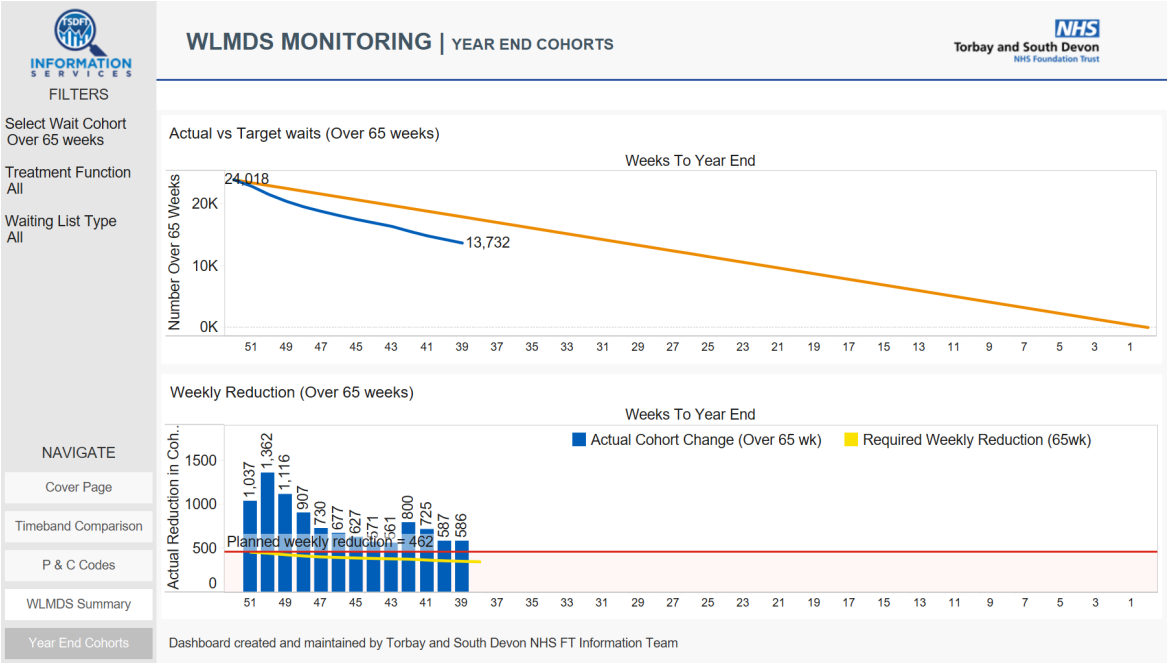
78 and 65 weeks –

The Trust has submitted an updated forecast based on improved clearance rates for our 78- and 65-week cohorts. The Trust is now forecasting that all 65- and 78-week patients will be cleared by 31 March 2024.

Our >78-week submission for June is 125 against our new forecast position of 130.

Our >65-week submission for June is 1,221 against our new forecast position of 1,312.

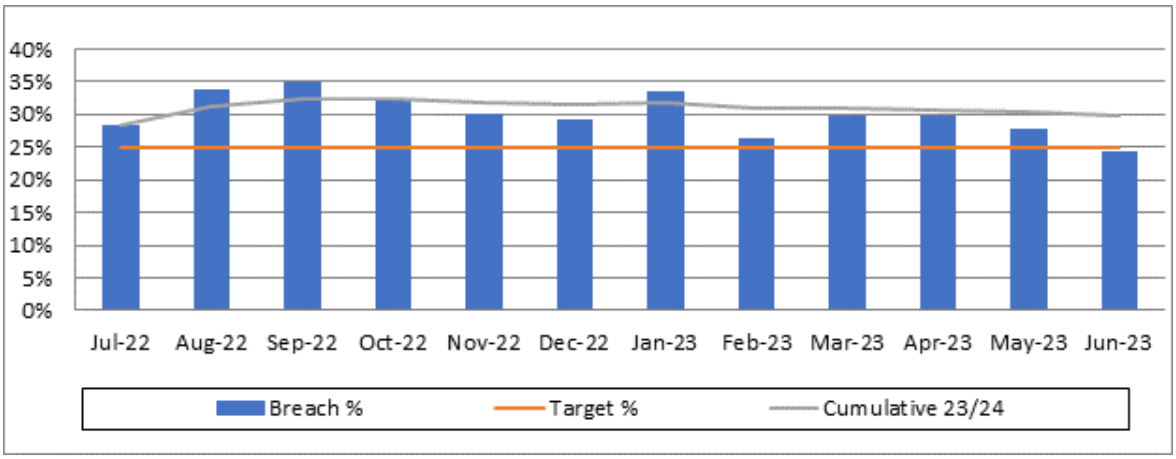
Our strong 65-week clearance rates continue to have a positive impact on our 65-week cohort (see below chart). Whilst the Trust still has specialties that are considered a risk, plans to mitigate these risks are being developed.



Our current position is c4,000 patients ahead of plan for this stage of the year

6.0 Diagnostics Performance

Our diagnostic performance has improved in June. The Trust reported 24.29% of patients waiting longer than six weeks against the end of June target of 25%.



MRI remains a challenge and has remained static at 37% against the target of 25%. Non-obstetric ultrasound has significantly improved from 24% to 19% against the target of 25%.

Of particular note, echocardiograms have improved performance to 15% against the target of 25% - this is improved from the May position of 27%.

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.

Industrial Action by Radiographers in late July is expected to impact our current performance levels. Quantification of this is underway.

7. Children and Family Health Devon (CFHD)

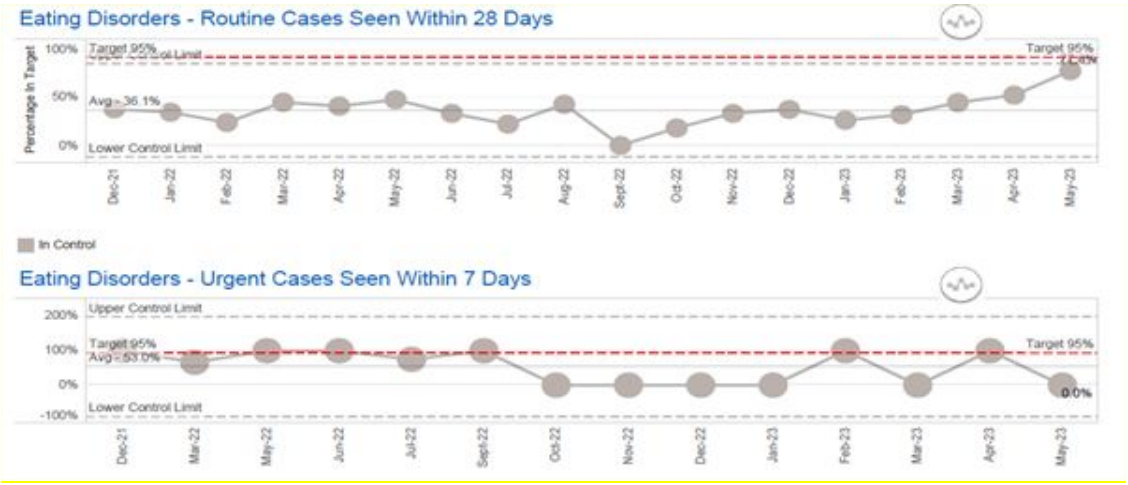
7.1 Performance

Waiting times:
As CFHD services are not consultant-led the RTT position for the Care Group is non-reportable RTT. However, monitoring of these waits and achievement of waiting time reduction remains a high priority. The chart includes a comparison between May and June performance:

	Mean wait wks - May	Mean wait wks - June	Variance in wks	RTT[1] < 18 wks- May	RTT <18 wks- June	% Variance
CCN	13.3	19.9	+6.6	73.0%	59.6%	-13.5%
Learning Disability	4.7	4.9	+0.2	93.8%	95.1%	+1.3%
CAMHS	21.9	20.7	-1.2	55.9%	54.6%	-1.3%
OT	16.6	16.9	+0.3	60.3%	59.3%	-1.0%
Palliative Care	/	/	/	/	/	/
Physiotherapy	8.7	8.9	+0.2	91.9%	90.2%	-1.7%
Special School Nursing	50.9	60	+9.1	36.4%	20.0%	-16.4%
ASD Diagnostics	41.1	41.6	+0.5	30.9%	30.2%	-0.7%
Children's Assessment Centre	51.4	49.9	-4.5	19.7%	29.0%	+9.3%
Speech & Language Therapy	33.7	35	+1.3	36.3%	36.0%	-0.3%

7.2 NHS Long Term Plan Deliverables for CAMHS

Eating Disorders: By 2023/24: 95% children and young people (CYP) eating disorder waiting time standard will be delivered; routine referrals will be seen within four weeks; urgent referrals will be seen within seven days.



The data shows the eating disorders team achieved 77.8% compliance with the 95% target for routine referrals. Work is underway with the team to improve the data capture and we are confident that the 95% target will be achieved. The team consistently achieves the urgent 7-day target. There were no 7-day urgent cases referred in May.

Eating Disorders benchmarking:

England Benchmark (NHS Futures)

82.5% Routine
78.7% Urgent

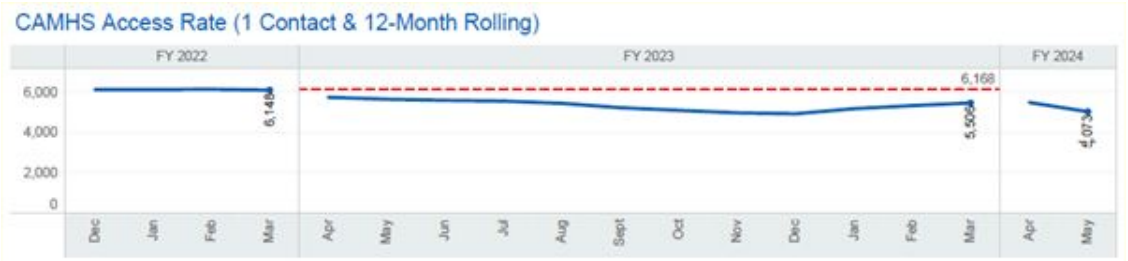
South West Benchmark (NHS Futures)

83.1% Routine
47.2% Urgent

7.3 Child and Adolescent Mental Health Services (CAMHS) Access Target

By 2023/24:
345,000 additional CYP aged 0-25 will have access to support via NHS-funded mental health services and school or college-based mental health support teams (in addition to maintaining the five year forward view for mental health (FYFVMH) commitment to have 70,000 additional CYP accessing NHS Services by 2020/21).

Performance of the CAMHS access target at the end of Quarter 1 was 3,788 contacts against a target of 5,073 contacts.



There is a significant amount of data missing within the CAMHS access numbers owing to the Carenotes outage. Services are currently working to improve data capture and quality to ensure we are capturing all clinically meaningful contacts. Missing data from the cyber incident will be introduced as per the agreed Devon Partnership Trust (DPT) methodology.

8.0 Families Community and Home Care Group Update

8.1 Child Health / Paediatrics

The outpatient waits are currently at 73-weeks and is on trajectory to hit 65-weeks by 31 March 2024. However, the ongoing strikes continue to pose a risk to our ability to deliver this. There is a workforce review underway; currently one consultant post out to advert. Nursing vacancies are proving difficult to recruit to on an ongoing basis. The review will consider further skill mixing and to identify opportunities to improve retention of staff.

The special care baby unit (SCBU) recently scored a bronze for their ward assessment, with a number of areas scoring gold. This is an improvement on their previous accreditation and the team continue to make the necessary improvements. WOW (Well Organised Ward) reviews have taken place in a number of areas and have created an improved environment for patients and staff.

Recent improvement initiatives across child health include:

- Rheumatology pathway and standard operating procedure (SOP) developed for the prescriptions process.
- Discharge posters (for colleagues and for families) have been developed and are being displayed on Louisa Cary.
- Meeting held with team secretary and immediate actions have been identified, including ways in which to improve time management and workload.
- Observation of care held on the short stay paediatric assessment unit (SSPAU).
- Allergies/respiratory project brief and action plan developed and submitted to the specialist clinical nurse.

A key focus now is working up schemes to support the delivery of our cost improvement plans (CIP).

8.2 Children's Torbay 0-19 Service

Torbay Family Hubs now have a logo, brand design and emerging website. The team have designed new signage for the three family hubs and a 'Best Start in Life' leaflet for parents which publishes Torbay's 'Start for Life' offer. This is being printed and distributed to groups, organisations and community venues across Torbay to promote the wide range of help and support available on the website. Family Hub (torbayfamilyhub.org.uk)

As part of continuity of care from maternity into 0-19 services, all new mums are being offered additional support to continue being smoke-free as part of a 'Smoke Free Homes' pilot. This will require carbon dioxide (CO_2) monitoring to take place with all families who receive a contact from the team where a child is one year or under and will allow us to evaluate success at the one-year review.

During conversations the focus will be on the home being smoke free and supporting actions to help families to maintain this.

8.3 Community Dental Service

The numbers on the waiting list are growing in part due to reduced staffing capacity and vacancy, also referrals increased considerably in May, particularly in paediatrics.

8.4 Torbay Recovery Initiatives (Drug & Alcohol Service)

As part of the coproduction development to improve patient experience the service recently held two events at Shrublands House and Walnut Lodge. The purpose was to seek views from people who use the service on how they would like the service to look in the future. This is based upon the service as part of the Multi-Complex Needs Alliance being trauma-informed which includes the environment, which we know can be triggering for individuals.

8.5 Maternity

We are collating a briefing around current workforce challenges in obstetrics and gynaecology. This is related to pressures of balancing the requirements of both specialities within the current budgeted establishment. We have met with the Associate Medical Director and Deputy Medical Director to discuss the issues and to address the next steps.

8.5.1 Brigid Implementation progress

The introduction of the electronic observation recording and escalation system (Brigid) into maternity went live on the 5 June 2023. This was a 'must do' action from the 2020 CQC inspection. Daily support has been provided by the SystmOne team. Initial reports from the team and the staff are that this has gone well with user satisfaction reported as being high. The iPads make documentation quicker and easier thus freeing up time to care as well as improving safety around escalation.

8.5.2 Maternity Incentive Scheme (MIS)

Notification was received of the achievement of 10/10 for year of the MIS. The Trust will receive a full rebate payment as well as a proportion of the monies not paid out to the Trusts that did not achieve 10/10. Only seven South West Trusts achieved full compliance. Year five was published on the 31 May with self-declaration of compliance being required by 2 February 2024. The team are beginning to work through the necessary requirements along with reviewing the recently published 'Saving Babies' Lives' care bundle (v3). A summary of the impact will be presented to the July Quality Assurance Committee and Board of Directors.

8.5.3 SW Perinatal Awards

The team attended the South West perinatal awards on 22 May 2023 and won in three categories:

- Runner up Rising Star – Katie Aston maternity support worker (MSW) for her work as smoke cessation advisor
- Runner up - Leadership – Jo Bassett head of midwifery
- Winner – Innovation – Jacqueline Crow and Josephine Ash - retention midwives

Katie Aston was also presented with a MSW chief midwifery officer (CMidO) silver award by deputy chief midwife for England.

8.6 Gynaecology

The nurse-led colposcopy service has been a huge success.
The next development is the post-menopausal bleeding (PMB) nurse the training wil be completed by the end of July 2023.

The backlogs are cause for concern. A briefing paper which has been prepared which demonstrates the need for additional consultant staff as a result of the increased pressures within obstetrics and increases in all referrals to gynaecology:

Cancer referrals:
20/21 = 1206
21/22 = 1475
22/23 = 1662 - 12% increase

Routine referrals:
20-21 = 7255
21/22 = 7550
22/23 = 8604 (14%) year to date (YTD) to 20 March 2023

We are one of the three Trust services that are failing our 28-day Faster Diagnosis Framework targets in cancer. Workforce capacity and access to treatment room facilities will be imperative to improve this.

8.7 Community Sexual Health Service
The service was rated 'excellent' for the fifth year running at the Foundation Quality panel in April. Responding to feedback the team now include a more structured introductory teaching package for foundation year two junior doctors (F2s) and specialty registrar in general practice (GPST) doctors.

8.8 Healthy Lifestyles & Personalised Care
Health Connect Coaching (HCC) has won the South West NHS Parliamentary Award in the Volunteer category. The NHS Parliamentary Awards launched in 2018 celebrates and recognises the outstanding contribution of staff, volunteers and others working in the health and care sector. The awards represent a chance for MPs to say thank you once again for all the work done to support the NHS in their constituency. The volunteer award recognises the support and commitment of the volunteers on the HCC programme and the incredible power of 'persuasion' and the impact that can have on people living with long-term health conditions. The team are going to the final in Westminster on 5 July.

The team are working with armed forces veterans to co-produce a Health Connect Coaching programme for veterans. There was a successful event held on Torbay Armed Forces Day (17 June) to ask veterans what they need and to recruit peer coaches with over 30 respondents to the questionnaire.

8.9 Social Care
Waiting lists for front-end and complex team services remain high. The highest proportion of cases on the waiting list are those where the funds have dropped below threshold and where there is a request for domiciliary care increases. Staffing shortages are intensifying the pressure on waiting lists in both services in terms of reducing overall productivity. The longest wait for a new front-end social care assessment is approximately 13-weeks, and for complex care 12-weeks. All work is prioritised based on risk and, to support this approach, a risk matrix is being devised for prioritisation of both the front-end and complex care services waiting lists, which will work alongside social work professional practise. Both services operate a duty system to allocate the most urgent work and safeguarding cases continue to be allocated to the complex team within 24 hours. There is an improved approach to monitoring overdue reviews giving more focus to the types of review due, allowing for a targeted approach moving forward.

Permanent admissions of 65+ (ASCOF 2A2) has seen a downward trend in the months since December 2022. This data reflects the active contract data showing reducing overall numbers of clients in long stay residential and nursing placements. As an area of concern raised by TSDFT, improvement activity from both the in-reach project and interim health funding (IHF) project focused on the predetermining factors to permanent admission to care homes, which have supported the overall reduction by ensuring correct pathways are established and hospital discharge and social care assessments are undertaken with a 4-week window.

Whilst weekly adult social care (ASC) expenditure is stabilising the trend is still upwards. Volatility of ASC spend is not comparable to 2022/23, it is indicating that control over the market is increasing. Our client base has increased by +5.2% (+122) which is indicating volume rather than price and is an issue for expenditure alongside no financial provision for growth in client numbers.

ASC contract management policy and procedures have been completed as required by the Local Government Association contract management review. This policy sets out the appropriate processes and procedures for the procurement of services by TSDFT and the contract management relating to these services. The policy aims to ensure compliance with legal and regulatory requirements, promote transparency, accountability and efficiency and support quality services to meet the needs of our service users. The contract management function is now in operation and will be subject to improvement over Q2. Full reporting on contracts held in ASC will be available from July giving greater insight and control over commissioning activities.

Torbay has a lower proportion of outstanding and good market provision than the South West average and a slightly higher proportion than the CIPFA and England averages. Market provision that has a CQC rating "requires improvement" is proportionately higher than the South West average but lower than the CIPFA and England average. Torbay is ensuring all provision which requires improvement have action plans, this work is proceeding well. Our "What good quality looks like" strategic delivery plan will be initiated in July supporting medium and long-term development of markets in Torbay. The project will ensure the strategic commissioning element is supported to shape the market to meet demand and reduce current financial and reputational risks. Our intermediate care reablement and rehabilitation unit (Jack Sears) strategic fit and financial model is to be revisited to validate assumptions made in the original proposal in preparation for the resultant block contract. The revisit is due to the time elapsed between original business case, approved by Devon ICS, and the 18-month delay due to legal issues for the provider.

Independent sector cost improvement plans are progressing well in most areas with £1M saved to date, not including savings through client contributions. CIP resource is no longer available for the Liaison mitigations, which is struggling from the significant and unpredicted deficit of staffing within social care presently. Ongoing plans are in place to mitigate this impact. £400k of Torquay ISU CIP, added to Independent Sector CIP target, is still in planning. From a transformation and sustainability plan perspective, the Pathways delivery partner Newton Europe Ltd is on track to produce a diagnostic report from which TSDFT and Torbay Council must decide on tactical and operational delivery of proposed improvement opportunities. CQC assurance activities are continuing successfully. In terms of budget containment plans the hospital in-reach project performance is indicating 48% reduction in discharge pathway and 38% patients reduced length of stay.

8.10 Social Care South Devon

All three health and wellbeing teams currently hold waiting lists for both the 18-64 client cohort and the 65+ client cohort. Increase in complexity and staff shortages are the main reason for waiting list pressures in South Devon. Currently both the Moor to Sea and Newton Abbot social care teams are impacted by staff shortages due to vacancies and planned sickness absence. All teams operate a prioritisation process to ensure urgent work, including safeguarding, is allocated in a timely way.

South Devon care market follows the same trend as the Devon-wide analysis: The adult social care market in Devon is dominated by small and medium sized enterprises, with care homes often owner-operated and singular or in small groups. Most of these are in converted rather than purpose-built buildings and a comparatively low proportion are of 60 beds or more. A consistently higher proportion (88.8%) are rated 'Good' or 'Outstanding' by the Care Quality Commission than the national, regional or comparator average. Of the 313 care homes in Devon, 64 of them (2,830 beds) are with nursing, 249 (5,359) are without. About half of people in care homes in Devon fund themselves. Occupancy levels are currently as high as at any point in the pandemic or post-pandemic period with around 600 beds vacant at any time.

South Devon has seen a positive improvement in the availability of domiciliary care provision over the past six months. We have moved from having over 14% unmet demand in the South to having only 4%. This improvement is due to a combination of efforts around review need for care provisions, international recruitment, and targeted work with providers to maximise rota capacity. Rural area of South Devon still remains a challenge to provision care to.

Current improvement programmes taking place within Devon Adult Social Care include:

- Improving the front door to reduce telephone hand-offs between public and ASC as our Care Direct Plus team took over adult social care call handling and improved the self-assessment offer.
- Practice improvement programme is in progress around crisis and review work management across all South Teams. Aiming to facilitate targeted planned reviews to increase independence and manage crisis work coming into teams.
- Targeted piece of work taking place within South Devon to map the current market provision for complex cases, focused on supporting living, shared lives and learning disability (LD) residential provision due to market instability.

Devon County Council is currently working with Devon ICB to review their joint hospital discharge funding arrangements for 2023/24. Work is currently underway that aims to launch a new operating model for P1-P3 HD funding (previously known as STS) from September 2023 onwards. Representatives from South Devon and Torbay are present at these workshop sessions.

Current spend in residential and nursing placements, and within the Learning Disability cohort remain the greatest cost pressure on Southern ASC budgets.

In preparation for CQC Assurance, Devon Council has commissioned a Peer Challenge that will be taking place week commencing 17 July. Newton Abbot social care team will be visited by the peer challenge team that week.

8.11 South Devon Community Health Services:
On the 12 June interim joint leadership arrangements for the three South Devon Health and Wellbeing Teams were re-established via a single Assistant Director of health and social care, Southern Devon. Work is currently taking place to produce a consistent set of data reporting for community health services across South Devon.

8.12 Bay Wide Community Health Services

8.12.1 Therapy
The occupational therapy (OT) and physiotherapy (PT) teams both have had a high number of referrals for May. Physiotherapy have seen a 26% increase in referrals with a 19 day wait.

Source: Physio SharePoint Monthly Referrals.xlsx	PN & BX	TQ	Torbay
May-22	93	83	176
Jun-22	63	89	152
Jul-22	91	76	167
Aug-22	43	80	123
Sep-22	58	63	121
Oct-22	60	82	142
Nov-22	73	63	136
Dec-22	45	60	105
Jan-23	59	82	141
Feb-23	95	71	166
Mar-23	66	86	152
Apr-23	69	72	141
May-23	79	99	178

OT referrals also have had an increase in referral rates of 26% with on average a 9-week wait for non-urgent patients.

8.12.2 Community Nursing

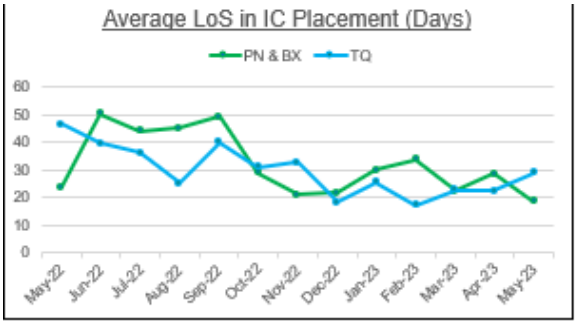
The number of insulin-dependent diabetic patients that are being managed by the Community Nursing (CN)teams are continuing to increase. This continues to be a concern that is actively monitored and managed. All diabetic patients are being reviewed by the CN lead and community matron to check their clinical markers and delegate if clinically able. Torquay CN team complete 50 diabetic visits each day. This reflective in their monthly visit numbers of May. They completed 4,758 visits.

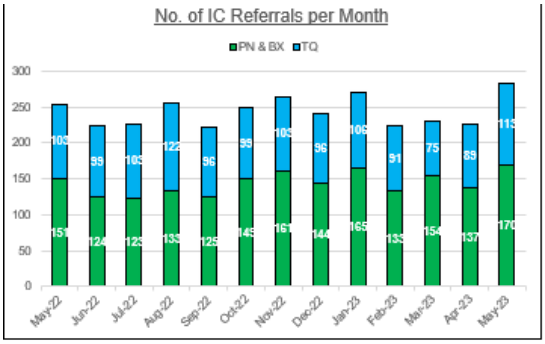
The out of hours (OOH) service CN lead has returned to work following long-term sickness. Meeting weekly with the Baywide Community Service Manager for health once a week for support. A consultation process has started to reduce the team to one base (from two) to increase productivity and cohesion in the team. Initial meeting on 20 June. Letters have been sent to the team members.

HUC have given notice on the management of the OOH CN call handler. Being managed by Shelly Machin.

8.12.3 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.





8.13 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. 0-2hr= 92.86% and 2-48hr 95%.

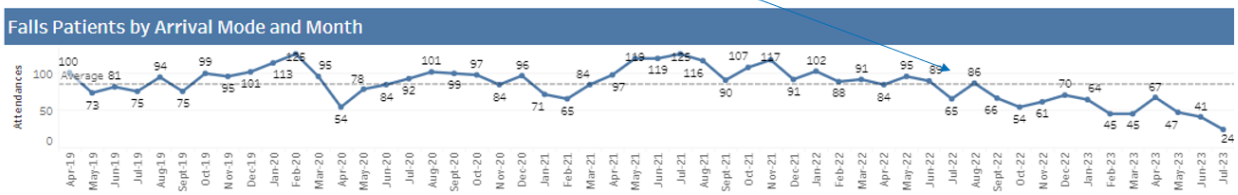
Urgent Community Response

Data source- IC and UCR Summary v4.0 20220930

Urgent Referrals - Up to 2 Hour Response

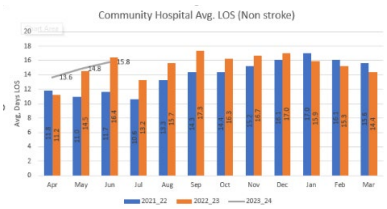
	PN & BX		TQ		Torbay		National Target (%)
	Useable Referrals	Target Met (%)	Useabe Referrals	Target Met (%)	Useable Referrals	Target Met (%)	
Aug-22	2	100.0%	8	75.0%	10	80.00%	70%
Sep-22	5	80.0%	9	88.9%	14	85.71%	70%
Oct-22	7	100.0%	13	100.0%	20	100.00%	70%
Nov-22	10	90.0%	6	100.0%	16	93.75%	70%
Dec-22	11	72.7%	17	82.4%	28	78.57%	70%
Jan-23	10	90.0%	15	86.7%	25	88.00%	70%
Feb-23	6	83.3%	21	85.7%	27	100.00%	70%
Mar-23	13	84.6%	10	100.0%	23	91.30%	70%
Apr-23	13	84.6%	11	100.0%	24	91.67%	70%
May-23	11	72.7%	18	100.0%	29	89.66%	70%
Jun-23	12	91.7%	12	91.7%	24	91.67%	70%

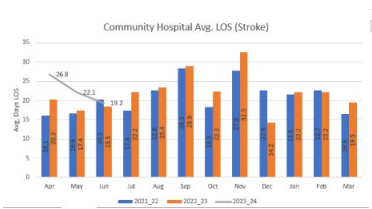
UCR response is reducing community falls arrivals at ED

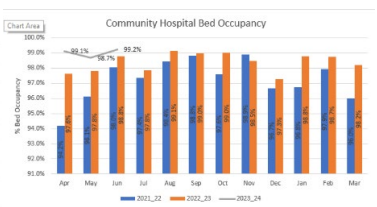


8.14 Community Hospital performance

LOS at the Community Hospitals is improving in Stroke but deteriorating in other areas and increasing the bed occupancy position. Further analysis will be provided in the next COO report.







Public

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

Performance for NCTR continues to improve and has, at the end of June, dropped below the 5% target.

Devon County Council and Devon Integrated Care Board are currently working on revised governance and implementation plans for utilisation of the Hospital Discharge Grant funding 2023/24 to ensure operating models are financially viable for both organisations. Representatives from SD&T are on various working groups looking at this piece of work and a new operating model is anticipated for September 2023.

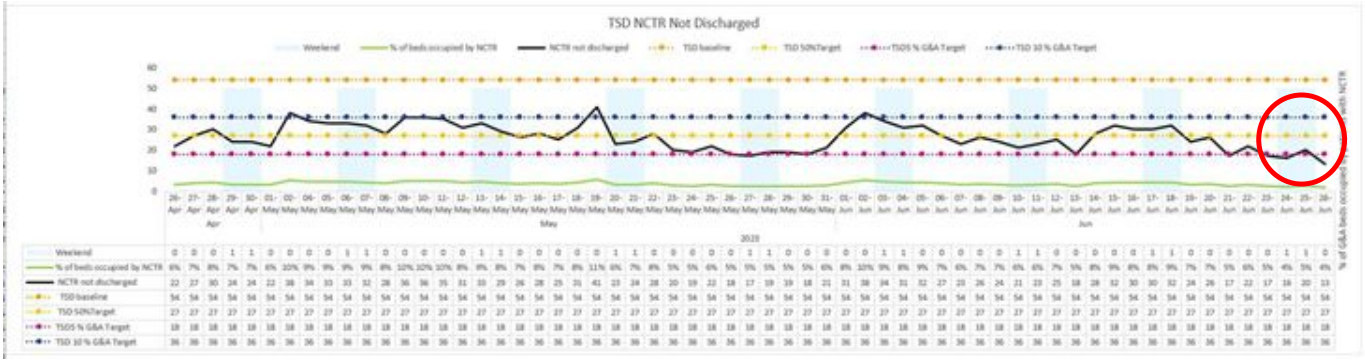
Torbay residents will be in receipt of 4-week interim health funding for the full financial year.

Pathway 1 - we have movement and good flow. The time to transfer has reduced to on average two days.

Block contract hours to support short-term service have been extended in Torbay until April 2024. South Devon collaborative reablement pilot is currently extended until September 2023 with anticipation of funding for full year.

Pathway 2 - The 17 block beds in Torbay 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.
Mapleton in South Devon continues to provide 10 block Pathway 2 beds and provides short term services funding for up to 4 weeks for all spot purchased beds.

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.

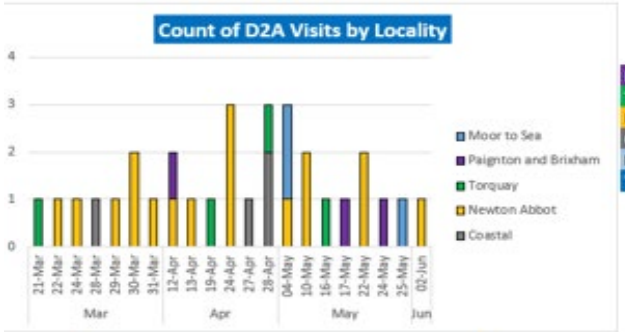


Focus on reviewing the no criteria to reside (NCTR) data on Tableau has become business as usual with greater recording accuracy noted.

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.

The clinicians in the Discharge Hub continue to complete D2A visits to support the community teams. We have commenced capturing the data and the number of bed days saved by the Discharge Hub which will be included in future COO reports.



P & B	3	10%
Tqy	4	13%
NA	17	55%
Cst	4	13%
MtS	3	10%
TOTAL	31	100%

P & B	1	14%
Tqy	2	29%
NA	2	29%
Cst	2	29%
TOTAL	7	100%

8.16 Continuing Healthcare (CHC)
Torbay and South Devon CHC team are currently achieving 87% against a national target for CHC decisions made within 28 days. The target is 80%.

Liaison Care have commenced their review work; they have now received 45 cases for review. So far two have been returned, three have triggered the need for full MDT and 11 have been reviewed and remain eligible. The rest of the cases are currently being booked. All assessments are virtual with no face to face visits.

Trust CHC team continue to review CHC funded clients outside of the Liaison contract and are making progress with CIP. Good progress is being made working with our learning difficulty (LD) team looking at some of the complex LD cases who are overdue reviews.

9.0 Healthcare of Older People (HOP) and Frailty
Over the next two to three months the frailty intervention team (FIT) will undertake a review of their current service provision supported by the quality improvement team. Over the last two years the team has grown but still lacks resilience. Having tried different models of delivery there is a requirement to review the current model, understand the flow of patients with frailty and describe a model that can be delivered within current resource that will have greatest impact on patient care, outcomes and experience.

Previously reported work to develop the frailty virtual ward and the medical model for Totnes Community Hospital continues.

9.1 Stroke and Neuro Rehab

Last month we reported our local Sentinel Stroke National Audit Programme SSNAP results for January – March 2023. The regional results which allow us to benchmark ourselves against our neighbours have now been released. Of the five regional Hyper Acute/Acute Stroke Units four, including TSDFT, are scoring an E on domain 2 (time to and time spent on a dedicated stroke unit) with RDU as the only unit scoring better with a rating of D. This points to continued pressures across the health and care system which are impacting on the ability of all providers to get patients to the stroke unit in a timely manner.

Overall, we score 54 which is fourth in the region. We are also lower than target in Specialist Assessments, Physiotherapy and MDT working. All these areas are monitored and actions have been developed through our fortnightly SSNAP meetings and actions managed through our stroke improvement plan.

SSNAP Scoring Summary:	*Team type*	*Routinely admitting team*	*Routinely admitting team*	*Routinely admitting team*	*Routinely admitting team*	*Routinely admitting team*
	ISDN	SW Peninsula	SW Peninsula	SW Peninsula	SW Peninsula	SW Peninsula
	Trust	Royal Cornwall Hospitals NHS Trust	Royal Devon University Healthcare NHS Foundation Trust	Royal Devon University Healthcare NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust	University Hospitals Plymouth NHS Trust
	Team	Royal Cornwall Hospital	North Devon District Hospital	Royal Devon and Exeter Hospital	Torbay Hospital	Derriford Hospital
Number of records completed:	*Team-centred post-72h all teams cohort*	*253*	*92*	*179*	*178*	*215*
Team-centred KI levels:						
Team-centred Domain levels:	1) Scanning	A	A	B	B	A
	2) Stroke unit	E	E	D	E	E
	3) Thrombolysis	E	C	C	D	D
	4) Specialist Assessments	C	D	A	E	B
	5) Occupational therapy	D	E	A	A	C
	6) Physiotherapy	C	C	A	D	B
	7) Speech and Language therapy	A	E	B	E	B
	8) MDT working	C	C	B	D	C
	9) Standards by discharge	C	D	A	A	C
	10) Discharge processes	B	A	A	B	C
Team-centred KI level	Team-centred Total KI level	C	D	A	D	C
	Team-centred Total KI score	60.0	52.0	84.0	54.0	64.0
Team-centred SSNAP level	Team-centred SSNAP level (after adjustments)	C	D	A	D	C
	Team-centred SSNAP score	60.0	49.4	84.0	54.0	64.0

A scrutiny of thrombolysis scoring within domain 3 is shown below. This shows that, whilst below the national average percentage of patients thrombolysed (those receiving drugs to break down the clot which caused the stroke), we are performing consistent to other Regional units. During the last reported quarter, we thrombolysed 100% of eligible patients. We have plans for improvement in the percentage of patients receiving thrombolysis within 60 minutes; our median time to thrombolysis is at 66 minutes.

Key Indicators *Please note: teams who do not receive either team-centred 72h results or team-centred post-72h all teams results do not receive KI scores* See "Outline of report" for further information about this section of the report See "Technical information" for explanation of 'patient centred' and 'team centred' results			Team type		Routinely admitting team	Routinely admitting team	Routinely admitting team	Routinely admitting team	Routinely admitting team
				SW Peninsula	SW Peninsula	SW Peninsula	SW Peninsula	SW Peninsula	SW Peninsula
					Royal Cornwall Hospitals NHS Trust	Royal Devon University Healthcare NHS Foundation Trust	Royal Devon University Healthcare NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust	University Hospitals Plymouth NHS Trust
The item references show where to find more detail on national and your results in the other sections of the report			*National*	SW Peninsula	Royal Cornwall Hospital	North Devon District Hospital	Royal Devon and Exeter Hospital	Torbay Hospital	Derriford Hospital
Number of patients (72h cohort):									
3. Thrombolysis key indicators See technical information for how calculated									
3.1 Percentage of all stroke patients given thrombolysis (all stroke types)									
3.1B Team centred Item reference: H16.3			11.0	8.6	4.3	19.0	11.8	8.0	7.3
3.2 Percentage of eligible patients (according to the RCP guideline minimum threshold) given thrombolysis									
3.2B Team centred Item reference: H16.55			85.3	93.7	70.0	100.0	100.0	91.7	100.0
3.3 Percentage of patients who were thrombolysed within 1 hour of clock start									
3.3B Team centred Item reference: H16.74			60.1	49.3	10.0	46.7	70.0	46.2	53.8
3.4 Percentage of applicable patients directly admitted to a stroke unit within 4 hours of clock start AND who either receive thrombolysis or have a pre-specified justifiable reason ('no but') for why it could not be given*									
3.4B Team centred Item reference: H16.77.1			41.3	28.7	37.4	11.0	47.7	20.9	14.1
3.5 Median time between clock start and thrombolysis (hours:mins)									
3.5B Team centred Item reference: H16.42			0:54	1:02	1:34	1:04	0:52	1:06	1:00

The May Sentinel Stroke National Audit Programme (SSNAP) DIY results (below) are still the most current with June's results as yet incomplete. However, indications are that the number of stroke admissions remain high as in the previous two months.

Time critical Stroke Standards	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Number of patients (N)	42	33	46	32	39	34	41	42	56	56
% Scanned within 1 hour	40.5	45.5	45.7	57.8	48.7	61.8	41.5	57.1	50.9	65.5
% Scanned within 12 hours	88.1	93.9	93.5	93.3	92.3	94.1	95.1	100	92.7	98.2
% Admitted to Stroke Unit within 4 hours	25	24.2	8.9	26.2	0	15.6	17.5	37.5	22.2	27.8
% 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	80
% (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)	7.1 (4)
% Received Thrombolysis within 1 hr	25	20	50	100	0	50	0	50	50	0
SSNAP		A	B	C	D	E				

The SSNAP meetings have been relaunched in July with attendance from ED and radiology to give the opportunity to discuss challenges and issues as they occur. The ED have identified a stroke link nurse, which means that stronger relationships can be developed with the specialist stroke nurse helping to identify actions which will improve that hyper-acute pathway. In July our trainee advanced clinical practitioner in acute stroke started which will further enhance the service delivery. The Stroke report is discussed at Quality Assurance Committee.

10.0 Recommendation

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

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Workplace Team Strategic Performance Update			Meeting date: 26th July 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 April, May and June 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	4	**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:** 26th July 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 of April, May and June 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 has been satisfied and closed out. The Trust has worked closely with the HSE to ensure the remedial actions identified are appropriately addressed and a level of root cause analysis, and subsequent policy and process adjustment has been carried out so as to prevent recurrence.

On 27th June 2023, road traffic collision (RTC) occurred in Car Park A of the Torbay Hospital site which involved a patient attending appointment experiencing a medical incident whilst driving, causing the RTC which impacted the patient's vehicle and four others which were stationary. Nobody was seriously injured as a result of the RTC, though the patient who experienced the aforementioned medical incident did later pass away as a result of this, not of the RTC. A debrief, led by the Trust's Interim Emergency Planning, Resilience and Response Lead has since been conducted so any lessons pertinent to the incident response can be learned. The general consensus is that the response of Trust teams to the RTC was professional and effective.

Work continues to strengthen the health and safety culture across the Trust, particularly better equipping leaders with an understanding of how to effectively deliver on their responsibilities in this area. This has primarily taken the form of the Institute of Safety and Health (IOSH) Managing Safely qualification which is delivered by the in-house Corporate Health and Safety team at the Trust. In June, two IOSH Managing Safely courses were delivered to a cumulative 18 delegates and further sessions have been planned for July and September of this year, both of which are fully booked.

Further information regarding the Trust's performance in relation to Corporate Health and Safety, and Fire Safety Management can be found in Appendix 1.

2.2 Compliance and Performance

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

April and May continued to be exceptionally strong for the Estates Delivery team within Workplace. The work on delivering a consistently high performance relative to pre-planned maintenance (PPM) activities, which was reported on in May's report to the Trust Board has continued in subsequent months. All PPM tasks across statutory, mandatory and routine categories were fully delivered in accordance with service level agreements for the reporting period. Focus has been placed on delivering a transformation in this space and this has been realised since November 2022.

As intended, this enhanced focus on delivering all PPM activities on time, has resulted in a reduction in the number of equipment and asset failure which has seen a fall in the number of reactive requests being raised. Specifically, the number of reactive requests raised in April and May of 2023 is around 200 less than the same period last year.

Reactive performance has remained reasonably consistent across all categories. Improvements are anticipated in the third quarter of 2023/2024 as a result of what will be the longer-term impact of the refreshed and improved approach to the management of pre-planned maintenance.

The improvement in asbestos inspection compliance across the Trust is noteworthy and is up 10% on March 2023. This is as a result of improved reporting mechanisms opposed to any significant changes in the structure of how asbestos inspections are completed. The previous decline in performance was as a result of slow-moving reporting conclusions from third party suppliers, rather than any intrinsic problem with the timeliness of inspections.

April saw a reduction in the acute site's food hygiene rating from a 'very good' 5, to a 'good' 4. This is specifically as a result of an historic failure to improve the Trust's food safety management plan, dating back a number of years, rather than any specific issues with cleanliness or food quality. This has now been addressed by the newly appointed Catering Operations Manager and it is anticipated that the rating will increase to 5 upon the re-inspection planned for the second half of this financial year.

There are no overarching concerns relating to broader Workplace compliance and performance, including PFI and community delivery contracts, which has remained consistent in most areas.

2.3 Workplace Leadership Conference Launch

June saw the launch of the new Workplace Leadership Conference which is attended by all line managers across the team and will take place once every six months.

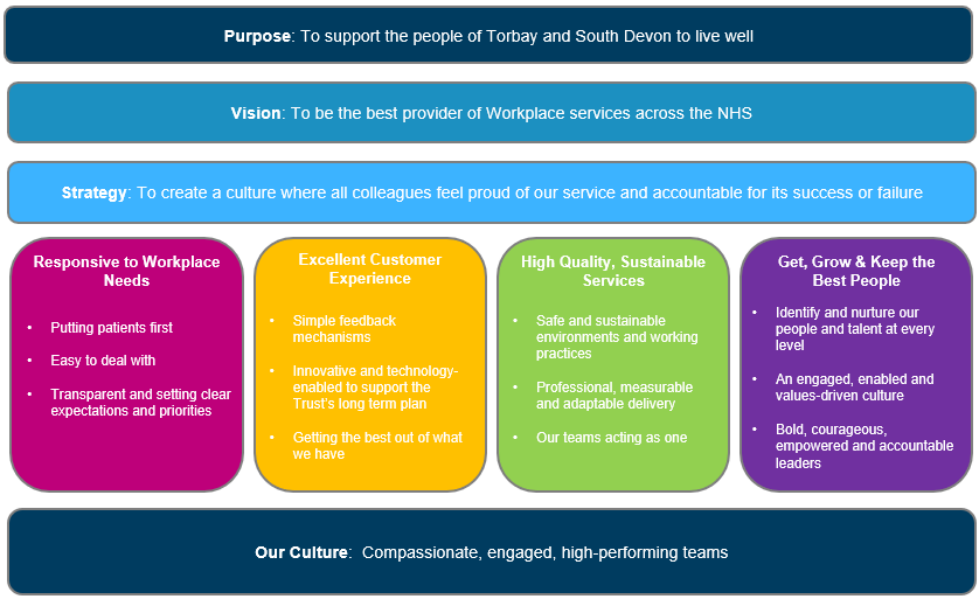
The purpose of the conference is to support the delivery of the Workplace 2023/2024 strategy (figure one) and to provide an opportunity for an open discussion and debate on current and future activity within the Workplace Team.

Headline topics at June's conference were:

- What our people most proud of relative to our safety journey

- The big challenges our people feel we face in improving our safety culture going forward
- Our plan to implement an accreditable Quality Management System within the Workplace Team
- What has worked well relative to the roll out of our new Workplace strategy
- How we make sure our new Workplace Strategy 'lands' with our people and our customer
- How we make our new Workplace Strategy a part of our 'DNA'

The conference was engaging, collaborative and feedback suggests leaders left feeling better informed and clearer on the direction of the team.



Fi

R W

2.4 Environment and Sustainability

Three standard selection questionnaires (SQ) have been answered and submitted in response to the Trust's advertisement of the opportunity to tender for the provision of locally generated renewable energy directly to the Torbay Hospital site through a power purchase agreement. All SQs are now being scored by the Trust's appointed panel and successful applicants will be progressed to the next stage. It is anticipated that contract award will take place in September 2023.

The Trust continues to work towards achieving a Biodiversity Benchmark award from The Wildlife Trust and are in advances stages of engagement with them and undertook a baseline assessment of our current position in June 2023. The results of this assessment, which will be shared in July, will outline the Trust's current performance against the minimum requirements of the benchmark and identify any gaps, suggesting the appropriate course of action. 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.

A substantial number of sustainability initiatives continue to be implemented across the Trust, overseen by the Sustainability and Wellbeing Group which is Chaired by the Workplace Director. These initiatives include: a Bicycle User Group; new electric vehicle charging points (late 2023); a mobile application giving Trust employees a discount 30% on bus fares; an electric bike loan scheme trial; and intelligent travel planning through the Mobilityways platform.

2.5 CIP Delivery and Financial Performance

As at month three the Workplace financial position shows a year to date positive variance of £166k.

The main drivers of underspend are: cleaning operations pay due to a headcount consolidation; clinical engineering non-pay underspend; and overachieved income relative to catering and accommodation charges.

The Workplace CIP target for the 23/24 financial year is £2.8m. As at month twelve, no CIP has been transacted, but it is anticipated that there will be significant movement in the second quarter of the financial year. The Workplace CIP pipeline has identified a number of schemes to the cumulative value of £1.5m. Work continues on identifying a route to cash for each of these schemes and, additional opportunities for CIP to bridge the existing £1.3m gap.

2.6 Our People

Figure three outlines the Workplace Team's performance in relation to people metrics covering its 568 employees, giving a comparison between the directorate's position at the end of May and June 2023, and the overall Trust performance against each measure.

Compliance for achievement reviews and mandatory training compliance continues to be amongst the strongest across the Trust and the Workplace leadership team remains focussed on sustaining this position, which is monitored through monthly Business Unit Reviews with service leads within the team.

There has been a small reduction in the percentage of completed achievement reviews by circa 2%, this is due to some overdue reviews within the Capital Development team which no longer sits within Workplace. The Works Information Team is updating its base data to reflect this and the Head of Delivery within Capital Development has been informed of the overdue reviews.

The directorate's 12-month sickness average continues to see reductions 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.

August's report to Trust Board will outline the work being undertaken to translate feedback from the 2022 NHS staff survey into meaningful action which sustains those high performing areas and delivers on areas which require improvements.

Metric	May	June	Trust Average
Valid Achievement Review	94.91%	92.81%	78.08%
Mandatory Training	97.25%	97.09%	91.74%
Rolling 12-month sickness average	7.40%	7.27%	5.32%
Rolling 12-month staff turnover	11.13%	10.05%	12.46%

Figure Three: Key People Metrics – EFM Directorate

2.7 Dartmouth and Kingswear Hospital Site Disposal

At 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.

May's report to Trust Board stated that the site will be placed on the open market in mid-late May 2023, however it has been suggested by the Trust's appointed agent for the disposal, Montagu Evans, that in order to deliver optimum value, the property should be marketed in September 2023. As such, the Trust will now work with the agent to achieve this timeframe.

A number of off-market enquiries have been received for the property, but it has been agreed that all enquiries should managed through Montagu Evans so as to ensure consistency and remove the commercial risks associated with off-market arrangements.

3.0 Conclusion

April, May and June have seen strong and consistent levels of compliance and performance across all operational areas of the Workplace Team.

There continues to be significant focus on the roll out and implementation of the Workplace Team strategy and communications frameworks, such as the newly launched Workplace Leadership Conference underpin that.

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

Improving the Trust's environmental credentials through its green remains an absolute priority and much needed improvements are being made in this area, in respect of both decarbonisation through activities such as the power purchase agreement for renewables, and sustainable initiatives such as working towards a biodiversity benchmark award, sustainable travel planning and electric bike trials.

4.0 Recommendations

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

Report Date	July Committee meeting (reporting period up to 30th June 2023)		
Report Title	Corporate Health & Safety and Fire Monthly Report		
Report Authors	Kevin Wood - Corporate Safety Manager Suzanne Ellis - Senior Corporate Health and Safety Advisor Neil Faulkner - Corporate Fire Safety Advisor Jake O'Donovan – Workplace Director		
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 59 Health and Safety open risks on the Trust wide Risk Register of which 28 are currently scoring 12 and above.

1. Analysis of Performance

Table 1. below, shows the number of incidents reported by month over a rolling 12-month period from 1st July 2022 to 30th June 2023 (inclusive).

Table 1

	Death	Severe	Moderate	Low harm	No harm	Near miss	Totals
Jul 2022	1	8	4	63	132	17	225
Aug 2022	2	5	9	61	152	23	252
Sep 2022	1	7	3	52	117	20	200
Oct 2022	0	11	2	55	111	28	207
Nov 2022	0	6	4	57	126	20	213
Dec 2022	1	1	7	59	133	29	230
Jan 2023	0	3	5	64	133	21	226
Feb 2023	0	5	4	64	88	10	171
Mar 2023	0	4	7	70	114	22	217
Apr 2023	0	3	2	66	112	19	202
May 2023	1	2	3	78	104	25	213
Jun 2023	1	1	3	79	126	35	245
YTD Totals	7	56	53	768	1448	269	2601
Averages PM	1	5	4	64	121	22	217

June saw a larger increase in incidents overall, making it the second highest over the last twelve month period, including 1 patient death but a larger increase in no harm incidents than most previous months.

Chart 1

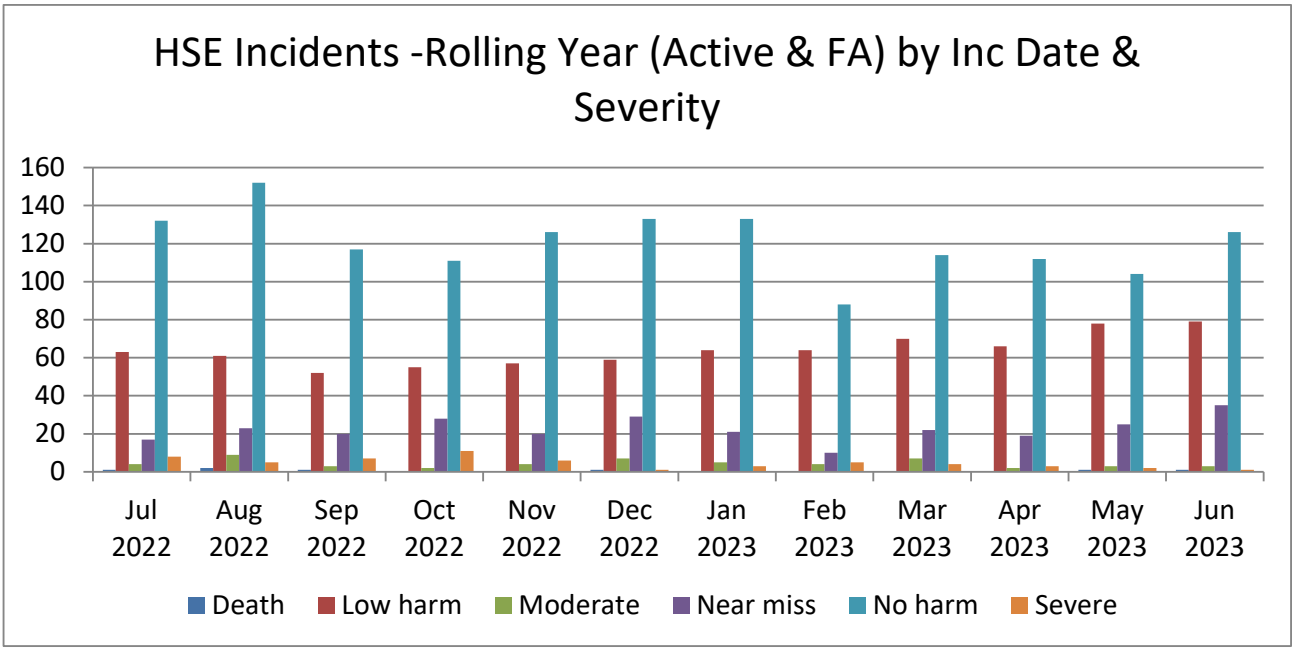
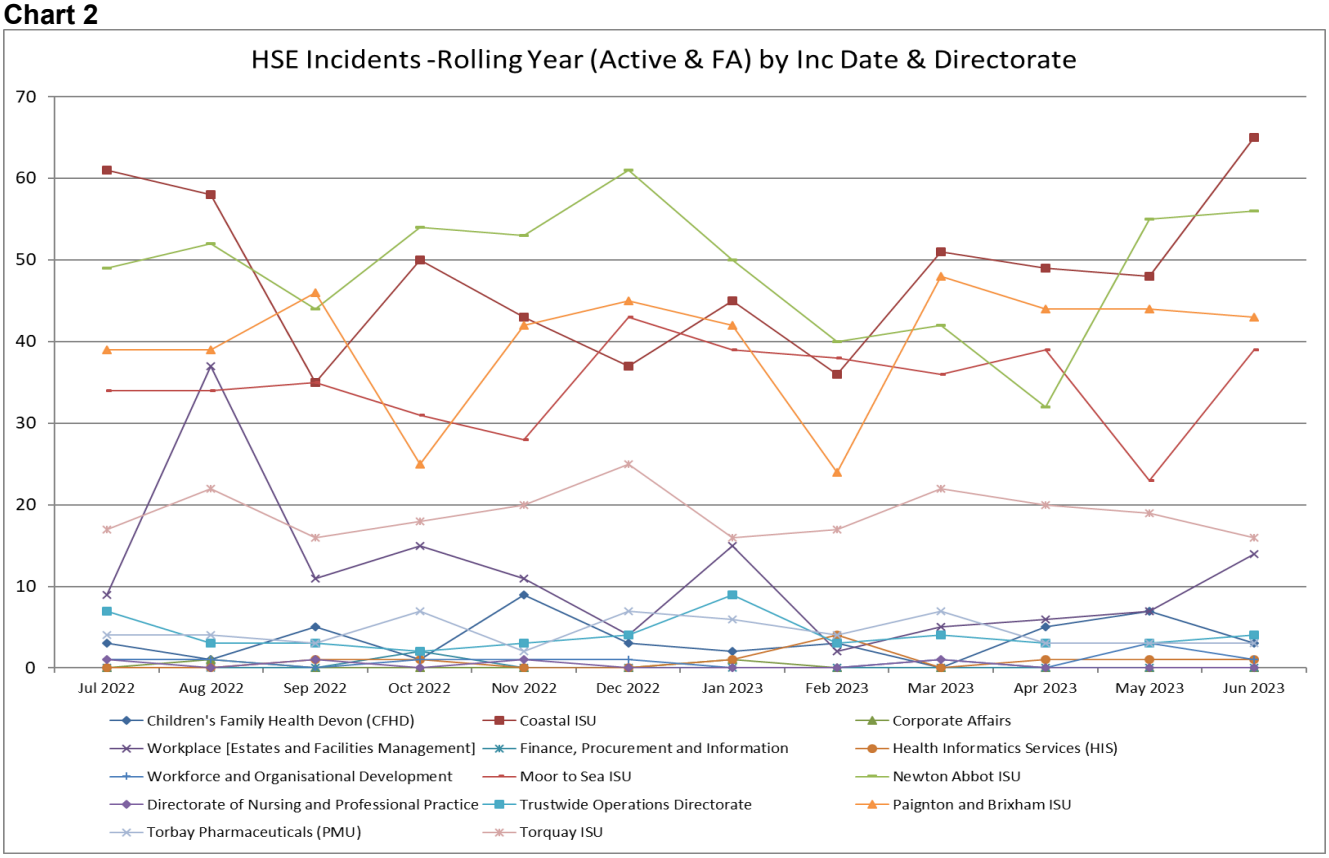


Chart 2



From the 14 directorates, Coastal ISU have the highest recorded amount of incidents for the last month at 65 (see Chart 3 below), with the highest increase (up from 48 reports in the previous month) and have the second highest recorded incidents over the last twelve month period (578). Newton Abbot remain the ISU with the highest incident reports for the year with 588 and Paignton and Brixham ISU remain third with 481.

Chart 3

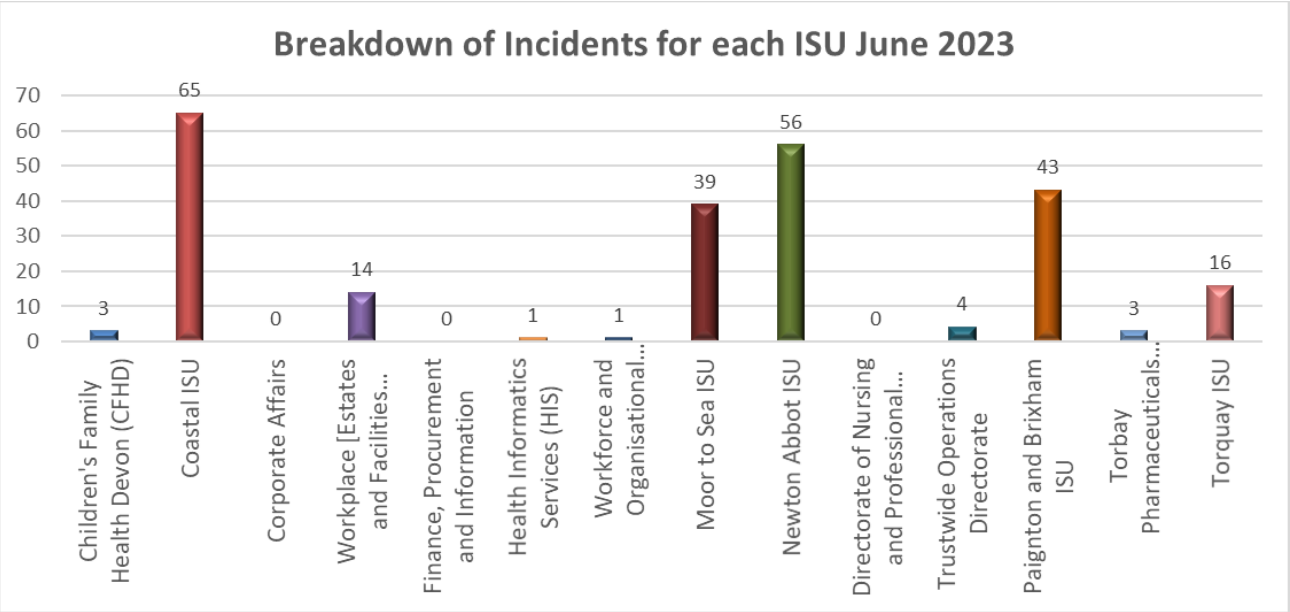


Chart 3.1

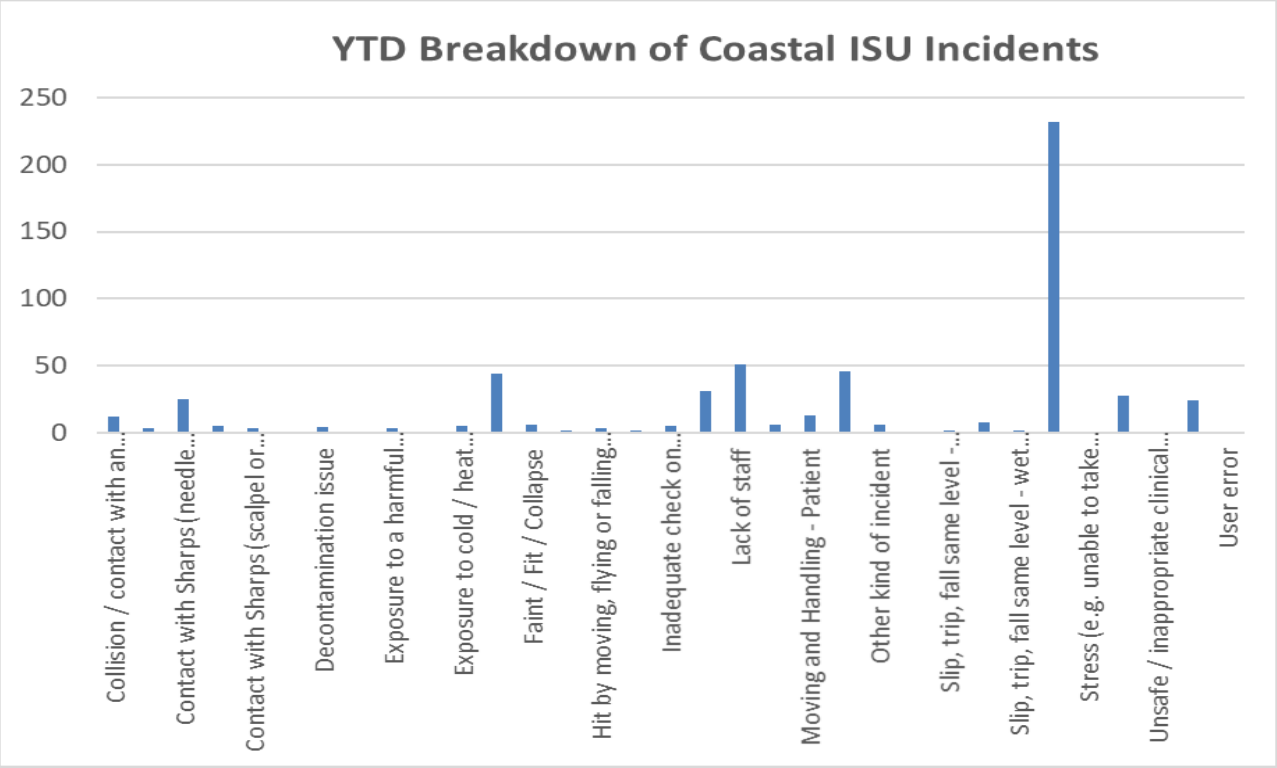
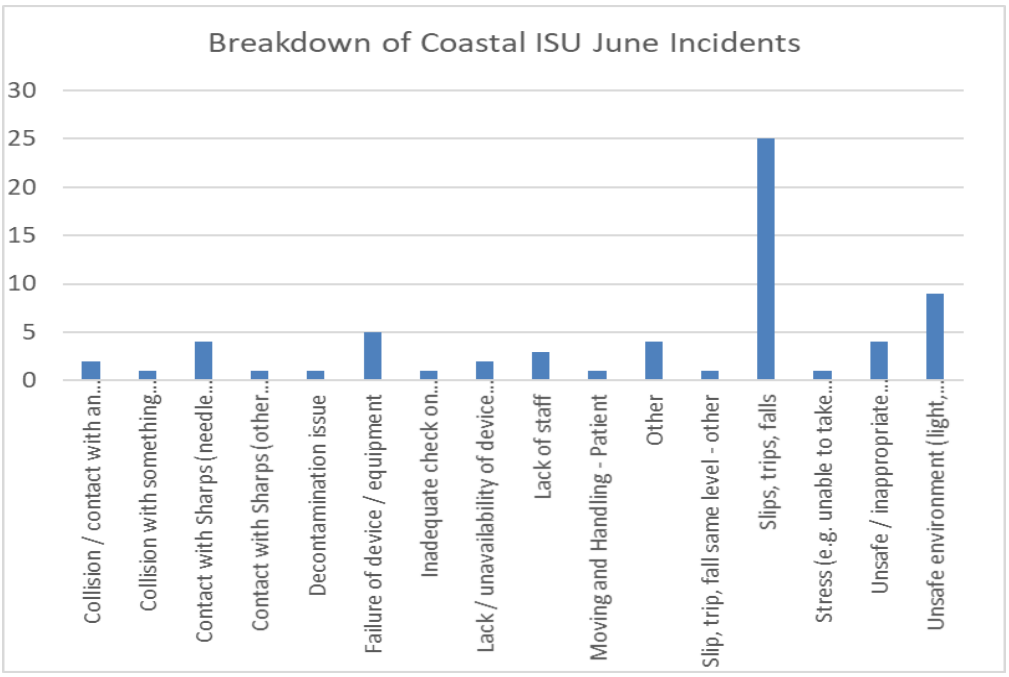


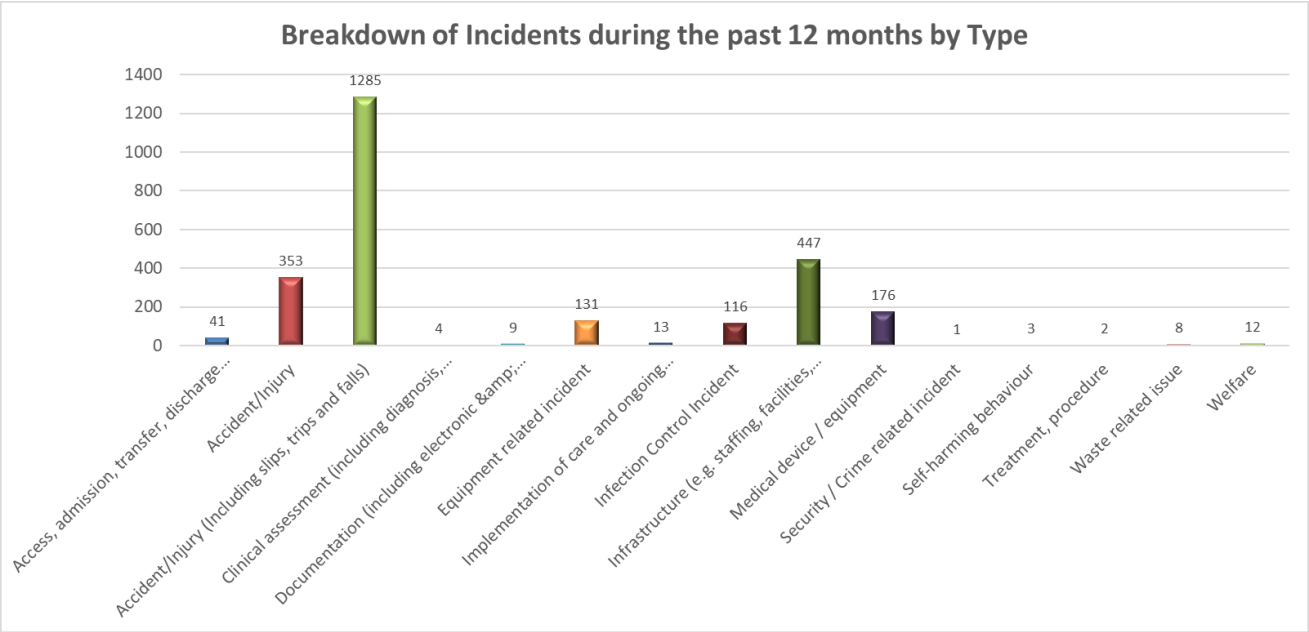
Chart 3.2 Breakdown of Coastal ISU June incidents



Coastal incidents top category for the past year is Slips, trips and falls and this is identical for the month of June 2023. Looking further into the data, over the year of these slips, trips and falls incidents:

- 230 relate to Patients
- 4 relate to visitor/contractor or member of the public
- 10 relate to staff

Chart 4



2. Key Issues

2.1 Slips, Trips and Falls (STF)

June showed another increase in recorded incidents, up from 107 to 114, with a monthly average of 100 incidents (up from 96 last month).

Chart 5

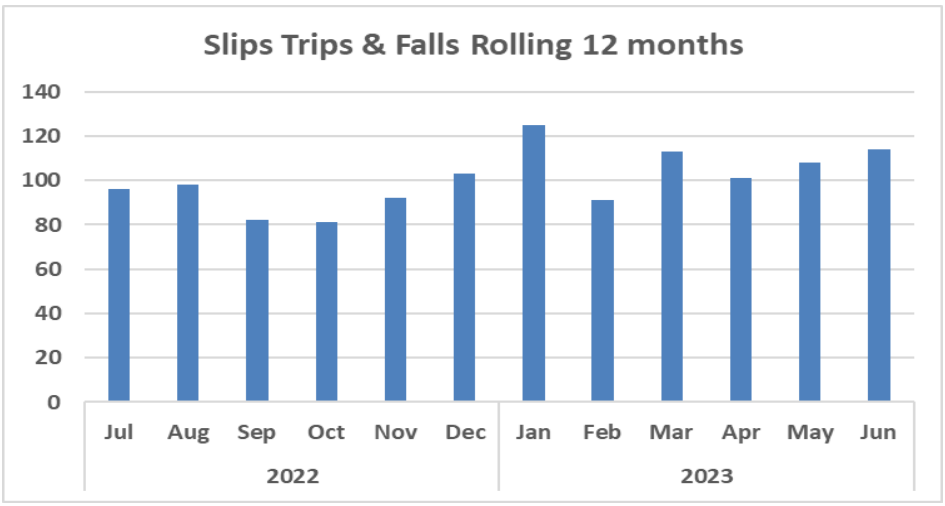
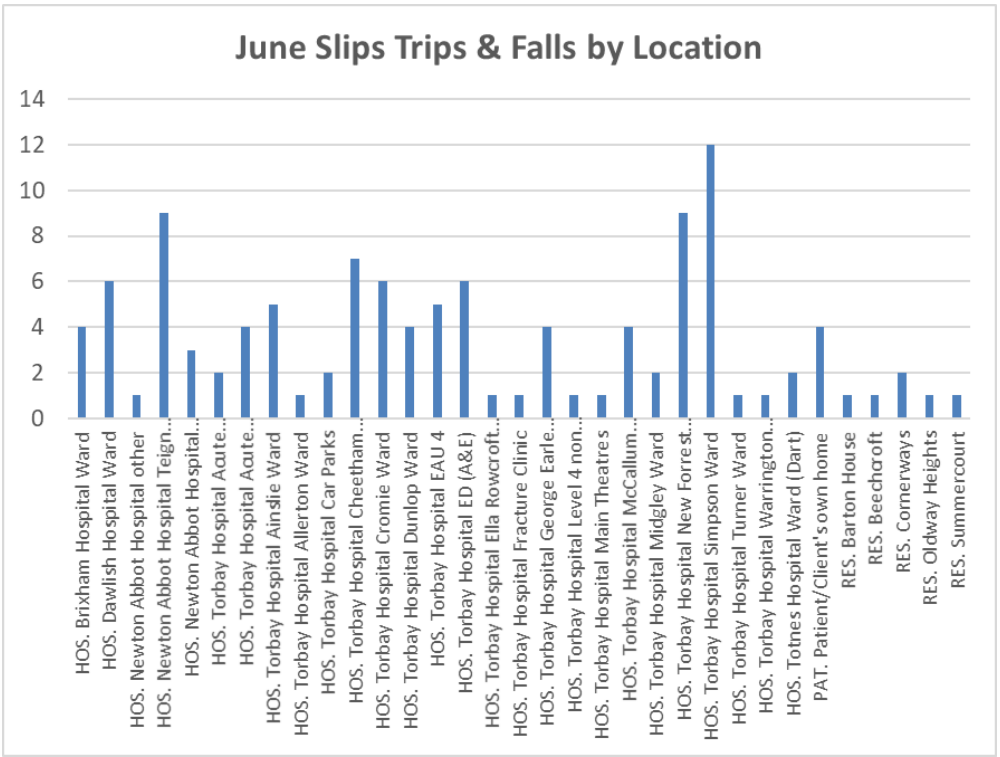


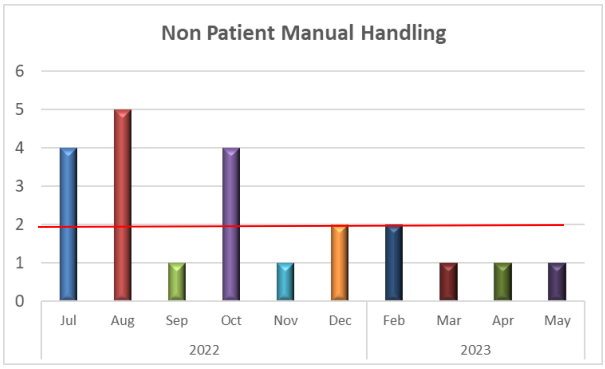
Chart 6

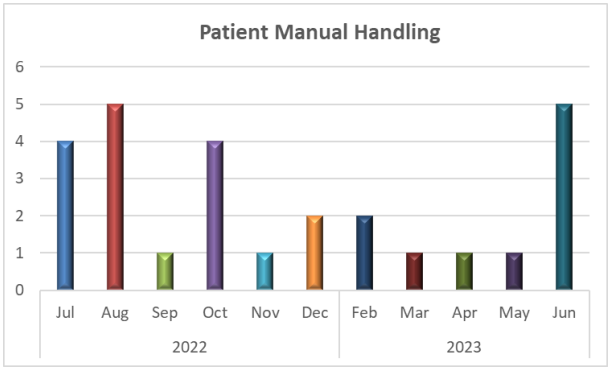
Locations of STF over a 12 month period. 1204 incidents between 54 locations where incidents have been reported, with an average incident rate of 22



3.0 Manual Handling For the first quarter of 2023 Non-patient handling has remained constant and below the monthly average. Patient handling showing good reduction over the twelve-month period.

Charts 7 & 8





4.0 Sharps

There were no trends identified during June.

Chart 9

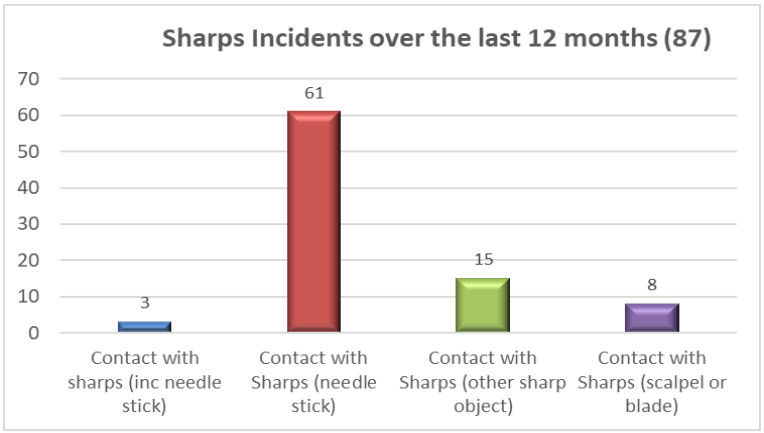
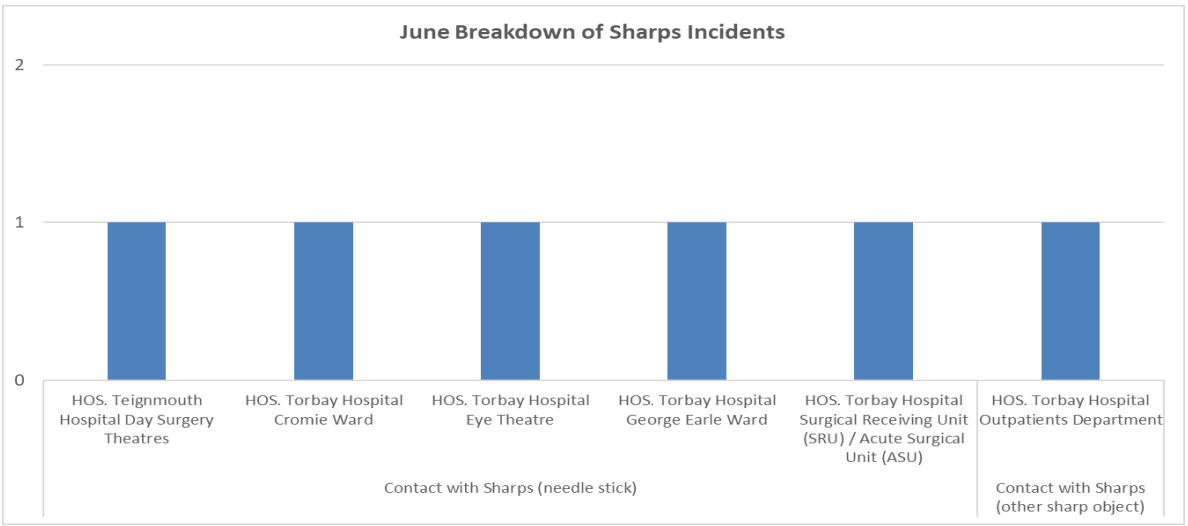


Chart 10



5.0 COSHH

Chart 11

Breakdown YTD incidents – Exposure to a harmful substance

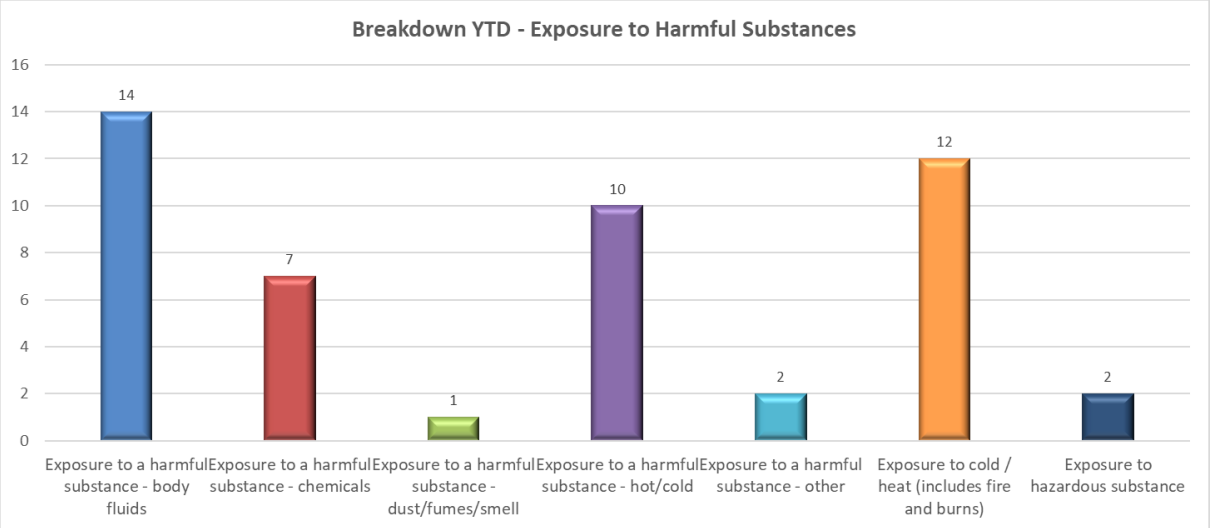
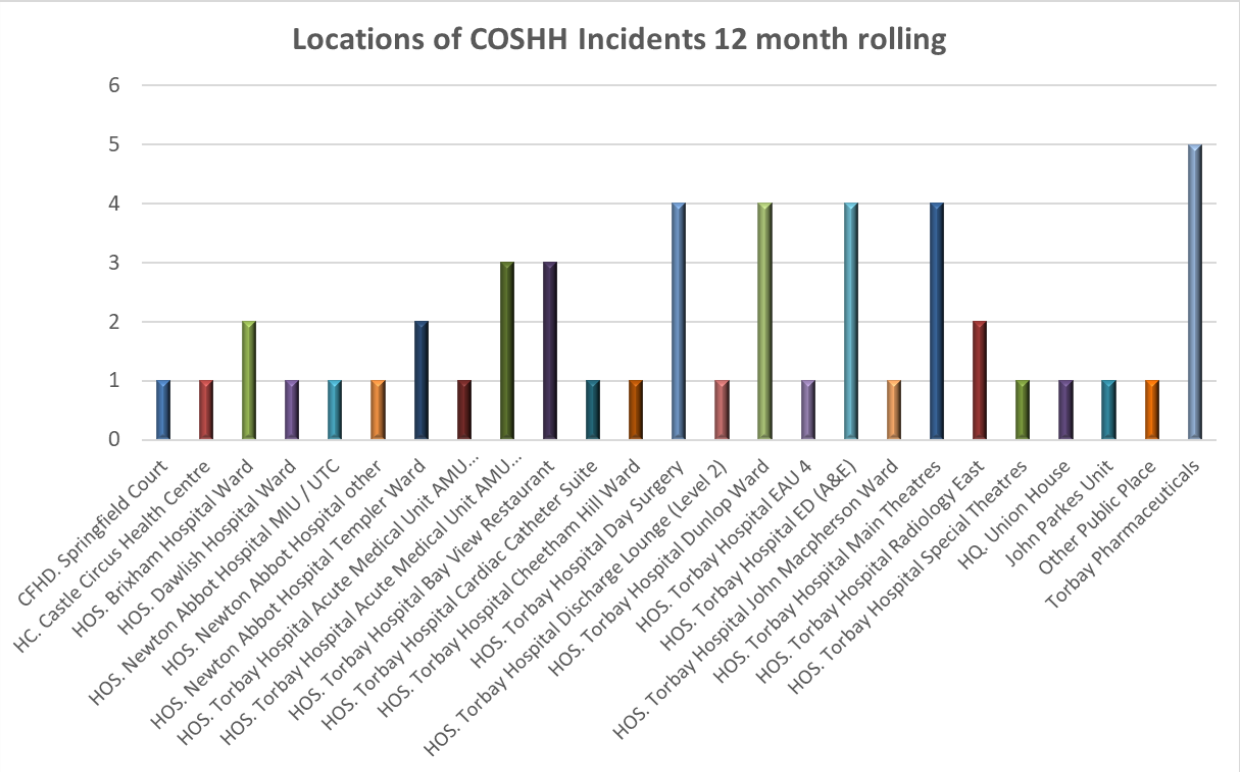


Chart 12

Locations of COSHH incidents

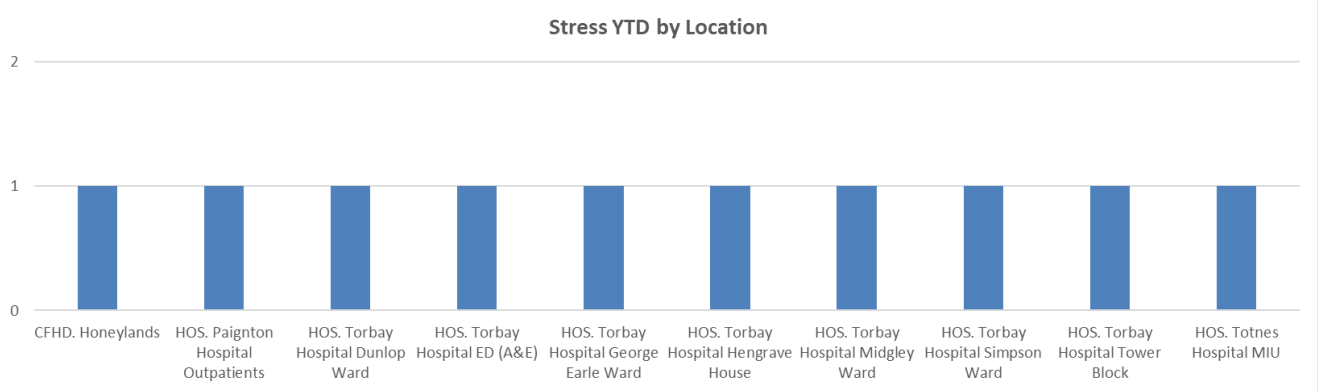


Copy of Datix entries for June 2023:

Water splashed from boiling water dispenser onto staff members hand causing a large blister when making a cup of tea for a patient.
Patient is a red tray and was left soup on her table by the catering staff. The HCA was on her break and the patient was unsupervised and dropped hot soup over chest. 24 hours later the patient has developed a blister to her chest
Patient had been served hot soup at supper time, served in a mug, and spilt this in his lap. Patient alerted staff that he had spilt the soup by shouting out- call bell was in reach but had not been used.

6.0 Stress and working environment YTD

Chart 13



One report for June 2023:

HOS. Paignton Hospital Outpatients	Welfare	Stress (e.g. unable to take break)	No harm	I came into work at 8.15am this morning Wednesday 8th June, to find over 10 piles of consultant and nurse led clinic notes notes from Tuesday 6th and Wednesday 7th June clinic. The piles of notes were left to be sent back to medical records and consultant secretaries. Alongside of this there were 98 outcome forms also from Tuesday 7th and Wednesday 8th Junes clinics , this tray was empty when I left on Monday 6th. A senior member of staff in Urology advised me to to do an incident report form and be copied in to this. This has caused lots of anxiety and stress.

7.0 RIDDOR Reports

Table 2 - Current status – All assessment has now been reviewed

	COVID RIDDOR UPDATE												
	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	30th April 2023	31st May 2023	30th June 2023	
2021 Incident Reviews Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	
2022 Incident Reviews Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	
Reports Due / Awaiting Details	218	130	8	4	3	1	0	0	7	0	2	0	
Reported RIDDORS to the HSE (COVID)	87	158	12	0	3	0	0	0	0	2	0	2	
Outstanding to be reported			44	3	2	1	0	0	7	0	2	0	

Riddors

8.0 Training June

IOSH – Managing Safely
2 course completed during June , undertaken for TP and UH p, 18 delegates attended

Further dates being held for TSDFT (3-day course): July 13-17; Sept 14-18 and are fully booked
Further dates are being organised by the team for additional courses to be held

Fire Training
Current status - Trust wide:

- 458 Evacuation leads (+19)
- 204 Fire wardens (+6)
- 99 evacuation chair operatives
- 59 Albac Mat trained operatives
- 49 evacuation lift operators
- 3 Specialists to local area, identifying specific hazards that need enhanced training
- 12 trained in SALUS

9.0 Lost Working Time.

During June there were 3 recorded DATIX incidents that resulted in lost time, totalling 22 days known absence to date.

- Eye Clinic - 21 days absence Moving and Handling (patient)
- PTS – 1 day Moving and Handling (patient)
- Main Theatres – no return date yet, Slip, Trip and Fall

- YTD Lost working days due to H&S issues 443

10.00 Key areas of concern - Top 5

Table 3

	Location	**Concerns**	**Assistance Required from Committee**	**Update**
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	New container delivered and erected. Awaiting alteration to some infrastructure behind so can settle in final place and add shelving so it can be put into use.
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)	Looking at potential areas with DW
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	Fire AE conducted annual audit – findings to be published.
4	Hengrave Basement – storage breaching regulations	Building condition unsuitable for use as storage area	Resources allocated to assess records for ownership and relocation/disposal	No Progress
5	Level 1 Basement office	Unsuitable for current use	Support to SUG for identification and prioritisation of relocation for teams based in this area	No progress

11.0 Policies and Procedures

Table 4

Title	Review Date	Update
Confined Space Management	Dec-24	
Control of Substances Hazardous to Health (COSHH), The	Apr-24	
Display Screen Equipment (DSE) Eyesight Reimbursement	Feb-25	
Display Screen Equipment (DSE) Procedure	Aug-24	
Display Screen Equipment User Self Assessment Form	Aug-24	
Driving Policy	Feb-23	
Electronic Cigarette Management Policy	Oct-24	
First Aid Management	Dec-25	
Health and Safety Action Plan Template	Feb-25	
Health and Safety Policy	May-24	
Health and Safety Representatives	Apr-24	
Health and Safety Risk Assessment Form- excel	Mar-24	
Health and Safety Risk Assessments	Mar-24	
Hot Desking SOP	Nov-23	
Ladders Checklist- EFM-SO18	Oct-25	
Latex Management	Jan-25	
Latex Product Use Authorisation Form	Jan-25	
Ligature Points, Assessing and Managing	Nov-20	Under review
Ligature Risk Assessment, Environmental Blank Form - Excel	April-24	
Management of Liquid Nitrogen Procedure	Jun-24	
New and Expectant Mothers Risk Assessment Form'	Apr-25	
New and Expectant Mothers Risk Assessment Procedure	Apr-25	
Noise at Work, Management of	Jun-24	
Personal Protective Equipment Management	Jun-24	
Preliminary Noise Assessment Form	Dec-25	
Sharps Management Procedure	Jun-25	
Sharps, Authorisation form for the use of non-safer sharps	Jun-25	
Sharps/Contamination Incident Investigation	Jun-25	
Smoke free Environment Policy	Feb-24	
Working at Height Procedure	Oct-25	
Workplace Health and Safety Audit Procedure	Jun-24	
Workplace Management	Jun-24	
Workplace Slips Trips and Falls Management Procedure	Mar-19	Under review
Young Persons and Work Experience, Management of Health and Safety	May-21	Under review

12.0 Fire

11.01 Audits / Fire Risk Assessments @ 85 %

Completed during June– Ainslie, McCallum, I.C.U. and return visit to Dartmouth HWBC for checks following snagging requirements post-build. FRAs planned for July include Newton Abbott Hospital

External Audit was completed 20th & 21st April and the report findings will be discussed at the next Fire Safety Group and an action plan devised for any improvements.

11.02 Active Fire related Incidents – All sectors indicating a reduction over 20021/22/23 figures

11.03 Low harm incidents down to a to pre-2013 levels

Chart 14

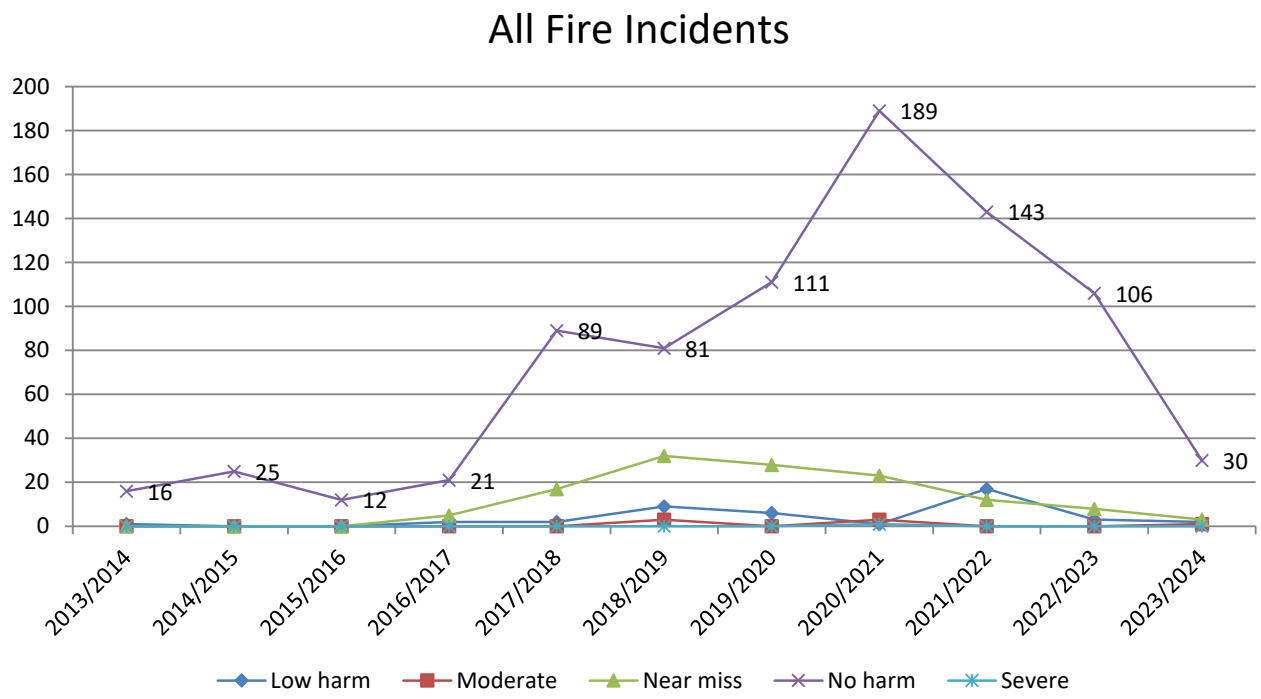


Chart 15 - YTD Breakdown of Fire Incidents

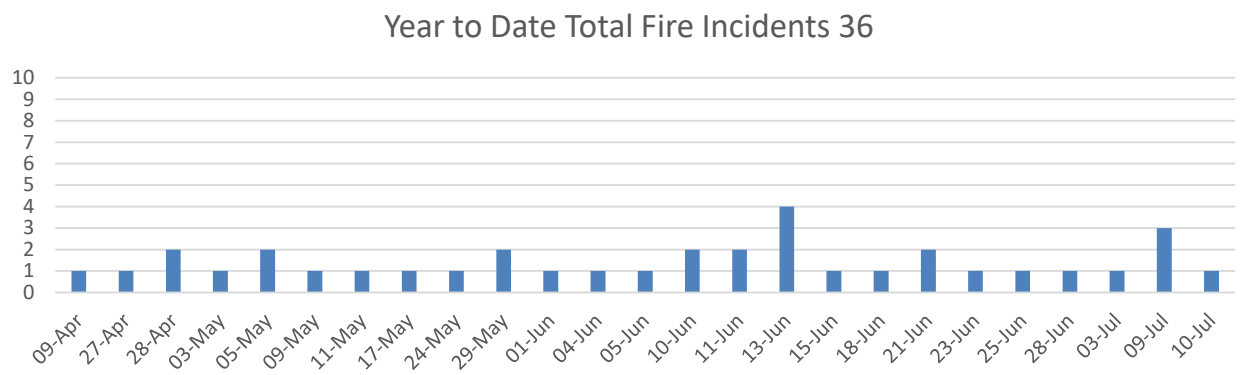
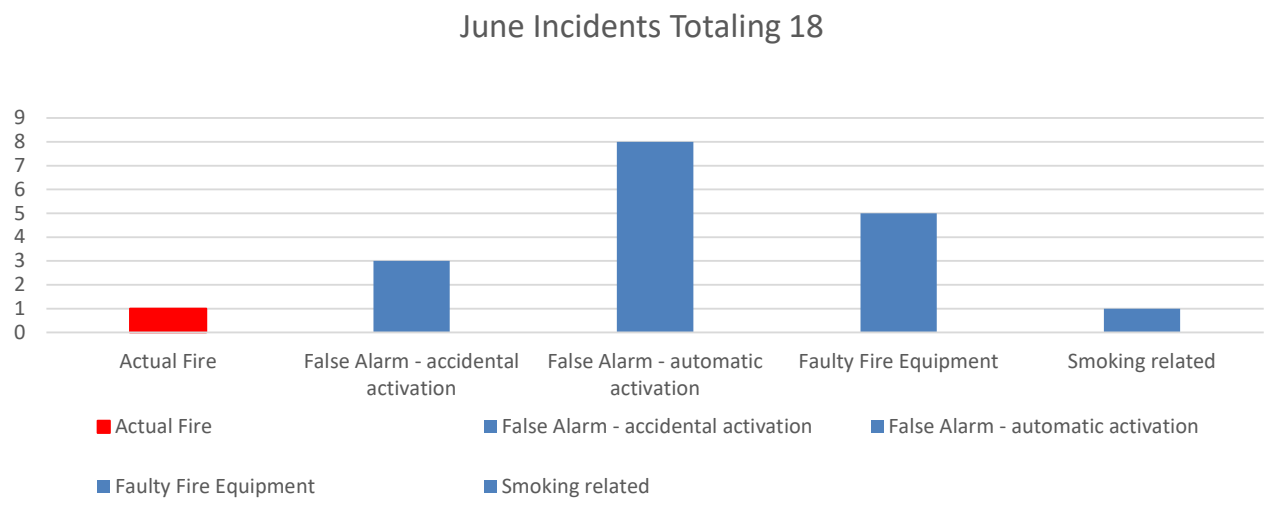


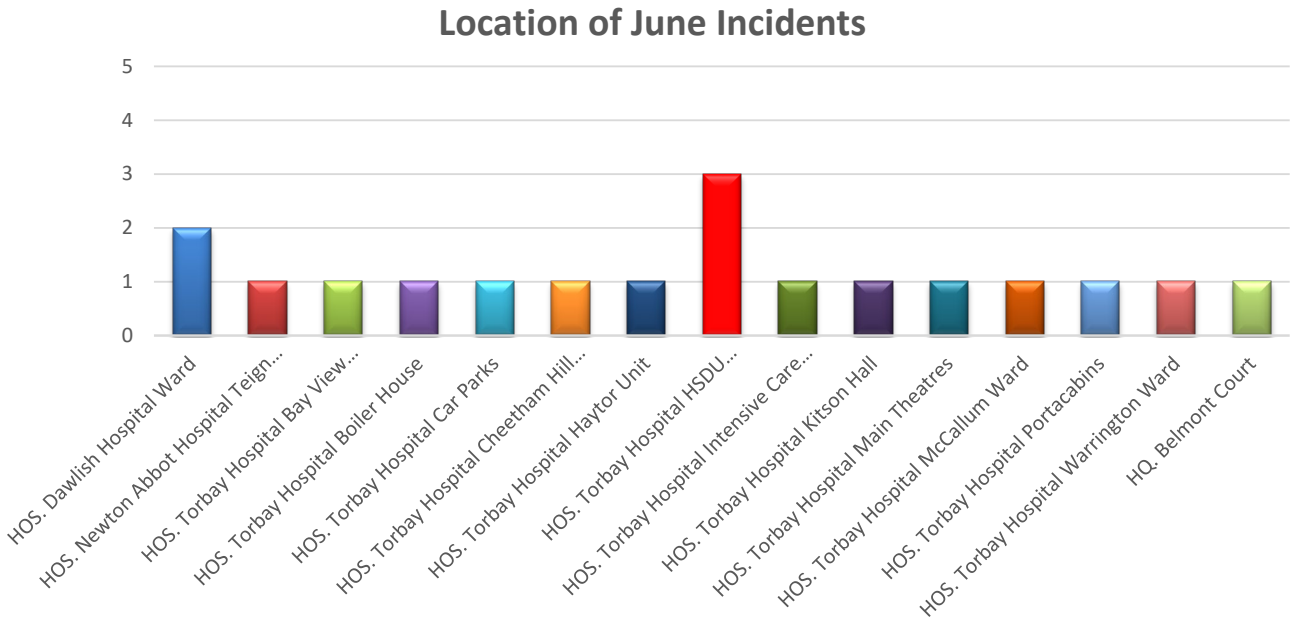
Chart 16



The 1 recorded fire event relates to incident Ref INC-107251

"Security received a call from a member of staff informing us of two homeless men with a shopping trolley with a fire in the woods next to lowes bridge entrance.

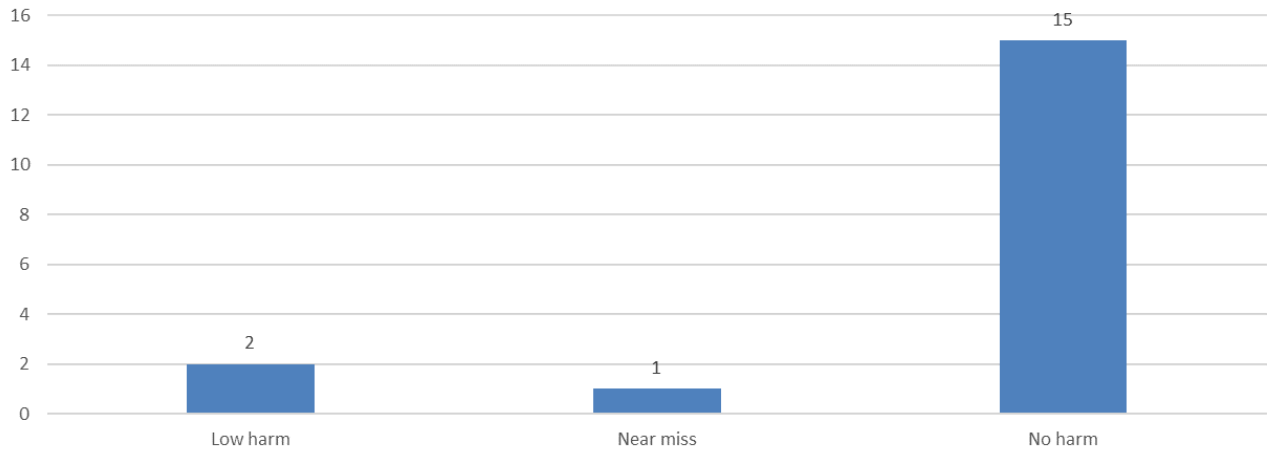
Chart 17



The 3 events to the HSDH Unit relate to:

- Security called by work place team electrician for a code to the HSDU managers office as it contains the fire interface panel that needs to be looked at by a TSDFT on call electrician and a member of Alarm Tec
- We attended and found that there was not a fire alarm activation however the panel was in fault we spoke to switch and asked for them to contact the on-call electrician to attend the job, we were informed that this is an ongoing issue and that Alarmtec had been called to rectify this fault. we stood down at this point as we were not required.
- We attended the HSDU panel and it said fault again we attended with the electrician who said they will call Alarm tec again, we checked the department and could not see any obvious causes for the fire alarm activation so we stood down.

Descriptions of the 18 incidents recorded in June



Low harm

1. Security attended the fire call at HSDU.
2. We were fast paged due to a fire alarm activation at OLD ICU.

Near miss

1. "Security received a call from a member of staff informing us of two homeless men with a shopping trolley with a fire in the woods next to lowes bridge entrance.

No harm

1) at around 04:12 the emergency fire alarm sounded stating fire in zone 15,(FO1 13) aspirator void,
2) Senior staff from neighbouring ward came to assist and fire protocol activated. "
3) Fast Page to HSDU RE: A fire alarm activation.
4) fast paged to Patient transported cabins for a Fire alarm
5) Fire alarm activation at Kitson hall flat 2
6) Fire alarm activation in Warrington ward staff room.
7) Fire alarm activation on Cheetham Hill
8) fire alarm false alarm bottom floor men's toilet's
9) fire alarm sounded panel showed detector in bay 6 however originated from side room 2. patient found to be vaping in the room

10) fire alarm went off .fire board reflecting that fire on area 16 roof of the building of which we had no access .
11) Security called by work place team electrician for a code to the HSDU managers office as it contains the fire interface panel that needs to be looked at by a TSDFT on call electrician and a member of Alarm Tec
12) Security received a call from a member off staff who had been locked inside Belmont court with the intruder alarm going off.
13) Security received a fast page for a pre alarm in the energy room.
14) Security received a fast page from Old ICU for a fire alarm activation.
15) Security received a radio message from switchboard asking us to attend the catering department as estates were down there and could smell a burning smell in the freezer

Full fire report to be delivered at the Fire Safety Group meeting held on the 19th July 2023.

EFM Performance Report

Workplace Services Performance Data May 2023 for June 2023 Report	2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
	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	May-23	Jun-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
Total PPMs planned per month (not KPI)	900	908	878	898	937	832	961	832	855	887	694	747	619	643	#N/A		11591	828	Variable				Not a KPI - an indicator of planned work volumes
Statutory PPMs planned per month	375	387	372	456	380	338	415	350	397	415	280	307	263	229			4964	355	Variable				
Statutory PPM % success against plan	98%	93%	96%	99%	91%	96%	98%	99%	98%	100%	99%	100%	100%	100%				98%	97%	85%	85%	97%	5 not completed
Mandatory PPMs planned per month	262	296	252	258	342	270	322	258	249	217	163	154	171	214			3428	245	Variable				
Mandatory PPM % success against plan	99%	84%	97%	94%	87%	83%	85%	99%	99%	100%	100%	100%	100%	100%				95%	97%	85%	85%	95%	
Routine PPMs planned per month	263	225	254	184	215	224	224	224	209	255	251	286	185	200			3199	229	Variable				
Routine PPM % success against plan	42%	63%	54%	79%	82%	80%	98%	100%	99%	100%	100%	100%	100%	100%				85%	90%	60%	60%	70%	
Total Reactive Requests per month (not KPI)	806	813	846	797	873	801	841	981	921	1074	837	832	748	674	#N/A		11844	846	Variable				Not a KPI - an indicator of reactive work volumes
Emergency - P1 - requests per month	172	125	137	131	137	125	148	139	170	143	108	83	111	107			1836	131	Variable				
Emergency - % P1 completed in < 2hours	100%	92%	100%	98%	96%	98%	99%	96%	99%	99%	93%	98%	96%	97%				97%	97%	90%	90%	95%	
Urgent - P2 - requests per month	160	170	184	198	170	179	181	205	213	217	163	175	164	166			2545	182	Variable				
Urgent – % P2 completed in < 1 - 4 Days	65%	74%	92%	87%	79%	81%	90%	88%	82%	90%	86%	88%	88%	88%				84%	97%	85%	85%	90%	
Routine - P3 - requests per month	373	407	334	352	426	377	399	495	436	525	428	431	357	317			5657	404	Variable				
Routine - % P3 completed in < 7 Days	65%	71%	90%	82%	75%	81%	78%	86%	80%	85%	84%	80%	79%	77%				79%	97%	75%	75%	85%	
Routine - P4 - requests per month	101	111	191	116	140	120	113	142	102	189	138	143	116	84			1806	129	Variable				
Routine - % P4 completed in < 30 Days	66%	78%	54%	79%	74%	74%	72%	73%	74%	72%	75%	71%	75%					72%	97%	65%	65%	75%	P4 Routine will always be a month in arrears.
Estates Internal Critical Failures per month	1	1	1	0	1	0	1	1	1	0	1	0	1	0			9	0.6	0	2	1	0	Sewage leaks affecting level 2
Fire Alarm Testing - % In date	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	267	267	267	267	267	269	269	269	269	263	263	263	263	263			3726	266	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%			Stat	100%	97%	85%	85%	97%	139 Locations - 25 Locations require a test facility (key switch)
Emergency Lighting Remedials Outstanding	0	0	0	0	0	30	30	TBC	59	6	9	0	0	6			140	11	Variable				12 Defects recorded - 6 Completed - 6 Outstanding
Fire Extinguisher - % In date	99%	99%	99%	99%	99%	99%	98%	99%	98%	99%	99%	99%	99%	99%			Stat	99%	97%	85%	85%	97%	
Fire Extinguisher Remedials Outstanding	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%			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	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%			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	Variable				
Fire Dampers - % In date	74%	85%	85%	85%	85%	85%	85%	85%	85%	85%	86%	86%	86%	86%			Stat	85%	97%	85%	85%	97%	inspection completed in June 2023 awaiting reports from supplier
Fire Dampers Remedials Outstanding	235	186	186	186	186	175	175	175	167	167	156	156	156	156			2462	176	Variable				Access work completed. Still have dampers obstructed by infrastructure that will have to be relocated.
Fire Supression - % In date	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	1	1	0	0	1	1	0	0	0	0	0	0	0			4	0	Variable				
Fire Doors Inspections - % In date	84%	86%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			Stat	98%	97%	85%	85%	97%	127 Locations - Inspections only
Fire Doors Compliance - % In date	10%	10%	10%	10%	10%	10%	10%	10%	11%	11%	19%	29%	10%	10%				12%	97%	85%	85%	97%	New PRIME system will give accurate whole asset survey within 12 months i.e. by 03/24)
Fire Doors Remedials Outstanding	950	950	950	950	950	950	950	950	940	940	853	746	0	8			11087	792	Variable				No of doors requiring works. - not replacement level
Fixed Wire Testing - % In date	86%	87%	88%	88%	88%	89%	89%	90%	90%	90%	90%	91%	92%	93%			Stat	89%	97%	85%	85%	97%	Enerveo are on-site, confirming programme and commencement date. Shrublands, Castle Circus & Union House recently completed.
Fixed Wire Remedials Outstanding	272	272	272	272	272	895	895	895	895	895	895	895	895	895			9415	673	Variable				All C1 remedials have been addressed. C2 391 & FI's 504 [213 completed]
Portable Appliance Testing - % in date	99%	99%	99%	100%	100%	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	Variable				Contract on programme schedule.
HV Equipment Testing - % In date	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	2	1	1	1	1	1	1	1	1	1	1	1	1			14	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%			Mand	100%	97%	85%	85%	95%	Annual Load Bank & Service. On programme.
Generator Service & Load Bank Remedials O/S	0	1	1	1	1	1	1	1	1	1	1	1	1	1			13	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	87%	100%	87%	87%	87%	87%	87%	100%	100%	77%	100%	100%	100%	100%			Mand	93%	97%	85%	85%	95%	Monthly Testing - 13 Generator's (Plus 2 PFI) Genset 2 now replaced with new 1650kVA eenerator.
Generator Monthly Load Test Remedials O/S	1	0	0	0	0	0	1	0	0	0	0	2	2	2			8	1	Variable				Auto transfer units for Sub 3 (Haytor); Replacement designed and agreed. Motorised switch for mains return in ICU: Soecialist contractor reviewing issue as
Lightning Protection - % In date	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	0	1	0	0	0	3	3	3	3	3	3	3	3	3			28	2	Variable				Specialist Contractor working with KIER expected to complete in March. DPT work has now commenced and will be complete for June's figures.
Auto Door Inspection - % In date	99%	99%	99%	99%	99%	99%	98%	94%	94%	100%	100%	100%	100%	100%			Mand	99%	97%	85%	85%	95%	Web portal access gained.
Auto Door Remedials Outstanding	0	1	0	0	0	1	0	0	0	1	1	1	1	0			6	0	Variable				[Last 90 days] 62 maintenance visits, 7 repairs, 25 call-outs. Endoscopy outer door arm damaged.
LEVs Testing - % In date	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 are due in June 2023, currently arranging the 2023 inspections
LEVs Testing Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0	0	Variable				All satisfactory

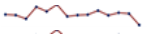
EFM Performance Report

Workplace Services Performance Data May 2023 for June 2023 Report	2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
	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	May-23	Jun-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
Critical Vent Verification - % In date	94%	96%	96%	91%	94%	92%	90%	96%	95%	96%	98%	98%	100%	100%			Stat	95%	97%	85%	85%	97%	
Critical Vent Remedials Outstanding	233	221	216	96	96	90	90	87	58	74	55	52	50	48			1466	105	Variable				
Kitchen + Extract Duct Cleaning - % In date	13%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			Stat	93%	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	Variable				
Gas Protection systems - % In date	88%	88%	88%	88%	95%	96%	100%	100%	100%	100%	100%	100%	100%	100%			Stat	96%	97%	85%	85%	97%	
Gas Protection Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0	0	Variable				
Gas Appliance - % In date	97%	100%	97%	97%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%			Stat	99%	97%	85%	85%	97%	
Gas Appliance Remedials Outstanding	0	1	1	1	0	0	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%			Stat	100%	97%	85%	85%	97%	
Landlord Gas Appliance Remedials Outstanding	0	0	0	0	0	0	3	0	18	18	18	18	18	11			104	7	Variable				11 Remedial works. -
Pressure Systems inspection - % In date	93%	95%	96%	93%	93%	93%	94%	100%	100%	100%	100%	98%	98%	98%			Stat	97%	97%	85%	85%	97%	
Pressure Systems Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	1			1	0	Variable				DSU heating calorifier tube nest failure
LOLER Lifts Safety Checks - works % in date	97%	100%	100%	100%	100%	97%	96%	100%	100%	100%	100%	100%	100%	100%			Stat	99%	97%	85%	85%	97%	
LOLER Lifts Safety Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	1	0	0	0			1	0	Variable				
LOLER Lifting Appliances - works % in date	90%	90%	91%	91%	91%	91%	90%	91%	91%	94%	94%	95%	95%	95%			Stat	92%	97%	85%	85%	97%	Manual Checks/records reflect 95% compliance - Prime Portal indicticating 56% this is due to inspection records not being forwarded onto LMP..
LOLER Lifting Appliances Remedials Outstanding	0	0	0	0	0	0	5	0	0	0	0	1	1	1			8	1	Variable				Beech unit Bath Lift -clinical engineering carry ing out the repair
Water Safety Checks - works % in date	86%	97%	99%	99%	100%	100%	99%	100%	97%	99%	97%	97%	100%	100%			Stat	98%	97%	85%	85%	97%	PPM task failure is in the Community Estate. Acute at 100%
Water Safety Remedials Outstanding	178	148	221	642	777	578	312	288	296	268	238	317	284	136			4683	335	Variable				Acute - 99% PPM carried out. 35 new remedials this month, 172 completed, 81 outstandine of which 0 are related to cold water failures. remedial comoletion
Window & Restrictor Insp - % In date	92%	94%	95%	95%	96%	96%	75%	100%	100%	100%	100%	100%	100%	100%			Mand	96%	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	Variable				
Asbestos Inspections - % in date	97%	97%	97%	98%	95%	95%	98%	100%	100%	100%	93%	88%	98%	98%			Stat	97%	97%	85%	85%	97%	Acute 100% / Community 95% (information from Safety Group)
Asbestos Inspection Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	6	5	5	2			18	1	Variable				Some areas outstanding at Castle Circus, Walnut Lodge
Edge Protection inspection - % In date	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	1	0	0	0	0	0	0	0	0	0	0	0	10			11	1	Variable				Inspections have commenced, a number of recommendations are expected. Potentiallv £100k capital budget required
Fixed Ladder Inspection - % In date	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	3	3	2	2			10	1	Variable				Carried out by external contractor
Site Safety Audits - % in date											68%	76%	82%	92%			Stat	80%	97%	85%	85%	95%	Added for March 2023
Current Red Status Safety Reports Outstanding											3	1	0	0			4	1	Variable				
Site Safety Audits Remedials Outstanding											118	119	113	113			463	116	Variable				Acute and Community Sites
No of Med Devices for Scheduled Service (in month)	1133	1073	1128	1021	1026	1094	1516	1196	1178	1338	1546	1096	1111	934			16390	1171	Variable				Included from Oct 2022.
% of COMPLETED Planned Work (in month)	77%	74%	67%	68%	75%	70%	82%	85%	92%	97%	94%	95%	88%	91%			PPM	83%	97%	70%	70%	80%	
PPM not completed / to be done with due date less than 2 months as a percentage of all outstanding PPM	12%	34%	40%	31%	35%	46%	81%	30%	27%	13%	9%	3%	9%	13%			PPM	27%	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%	9%	4%	5%	2%	0%	1%	1%	1%	1%			PPM	2%	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)	344	344	352	330	415	171	464	484	452	230	230	427	564	341			5148	368	Variable				
No of incidents involving Medical Devices (for info)	1	1	1	1	2	20	23	0	5	3	3	2	2	4			68	5	Variable				
Total Reactive Requests per month	1356	501	753	681	1497	415	652	1008	900	1048	495	687	669	817		#N/A	11479	820	Variable				Not a KPI - an indicator of reactive work volumes
Emergency - requests per month	8	8	21	5	1000	1	3	16	5	1	2	1	0	3			1074	77	Variable				Aug 22 peak due to large number of devices affected by FSN's being actioned – user/service information update
Emergency - % completed in < 1 working day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	97%	85%	85%	95%	
Urgent - requests per month	288	60	300	117	96	142	370	460	500	344	244	283	241	205			3650	261	Variable				Numbers from Nov 22 onwards
Urgent – % completed in < 3 working days	100%	100%	96%	100%	100%	100%	99%	100%	100%	100%	100%	99%	100%	100%				100%	97%	80%	80%	90%	
Routine - requests per month	1060	433	432	559	401	272	279	532	395	703	249	403	428	609			6755	483	Variable				April 22 - large hit on service events due to low valued/simple devices being checked.
Routine - % completed in < 10 working days	98%	100%	95%	100%	100%	100%	99%	100%	100%	96%	98%	98%	98%	97%				99%	97%	80%	80%	90%	

EFM Performance Report

Workplace Services Performance Data May 2023 for June 2023 Report	2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
	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	May-23	Jun-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
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	4.90	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	5.00	5.00				4.95	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	4.80	5.00				4.96	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	5.00	5.00				4.98	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	5.00				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	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	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	5.00	5.00				4.95	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	4.50	5.00				4.89	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	5.00				5.00	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	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	5.00				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		5.00	4.00				4.85	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		5.00					4.95	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		5.00	5.00				4.98	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		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					5.00	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					5.00	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					5.00	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				5.00					4.99	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
FR4 - 4-Monthly - Paignth H+WBC access wait areas	5.00				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					5.00	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	5.00				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					5.00	5	3	3	4	Annual Audits - Target 75% completed each year
FR6 - Annual - Torbay OPD Admin Offices, Stores	5.00									5.00			5.00					5.00	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 - 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	86	49	45	23	25	32	31	14	8	6	6	17	31	12			385	28	Variable				From Porter HPV data to 21st Nov 22 then Navenio, back to Backtraq 17th March 23.
Deep Cleans per month	981	834	1009	973	724	740	873	712	1086	1036	1146	994	852	938			12898	921	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	4	4				4.9	5	2	2	4	EHO Audit score back to 5 following audit in January 2022. Routine EHO Audit could be at any time
EHO Audit Scores - Brixham Hospital	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				5.0	5	2	2	4	
EHO Audit Scores - Newton Abbot Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5	5				5.0	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				5.0	5	2	2	4	
Catering Audits	21	22	22	22	22	22	22	22	22	22	22	22	22	22				21.9	5	19	19	19	
Catering Audit Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0	0	Variable				
Total Tonnage all waste streams per month	175.5	170.1	192.5	136.4	161.9	151.8	170.0	158.6	155.4	144.6	140.5	172.1	128.2	146.5	#N/A		2204.2	157.4	Trend				We have implemented bigger skips so the collections are less frequent resulting in decrease in tonnage figures for general waste. As well as the site
% of Total tonnage Recycled Waste per month	33.5%	37.3%	35.3%	29.2%	31.1%	33.6%	43.1%	34.9%	31.7%	35.7%	35.3%	36.1%	34.5%	42.8%				35%	Aim is ↑	25.0%	25.0%	30.0%	
Tonnage Recycled Waste per month	57.6	63.4	67.9	39.8	46.1	52.6	73.3	55.4	47.1	51.6	49.6	62.1	44.2	62.7			773	55.2	Trend				
% 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%	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	Trend				
% of Total tonnage of Clinical Non-Burn waste per month	17.5%	14.0%	12.2%	18.9%	16.7%	14.6%	14.5%	14.0%	18.2%	18.6%	14.1%	15.6%	17.0%	11.6%				16%	Aim is ↓	22.0%	22.0%	18.0%	£435/t - Orange.
Tonnage of Clinical Non-Burn waste per month	30.2	23.8	23.5	25.7	24.7	22.9	24.6	22.1	27.1	26.8	19.5	26.8	21.8	17.0			336	24.0	Trend				

EFM Performance Report

Workplace Services Performance Data May 2023 for June 2023 Report	2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
	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	May-23	Jun-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
% of Total tonnage of Clinical Burn waste per month	11.9%	11.5%	9.5%	15.9%	13.5%	17.1%	10.8%	11.5%	11.8%	14.0%	11.4%	12.7%	12.3%	6.2%				12%	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	20.4	19.5	18.3	21.6	19.9	26.9	18.3	18.3	17.5	20.2	15.7	21.9	15.8	9.1			263	18.8	Trend				
% of Total tonnage of Clinical Offensive waste per month	9.7%	17.0%	13.2%	16.0%	20.0%	15.0%	16.4%	14.1%	16.8%	14.9%	17.0%	15.6%	16.0%	19.9%				16%	Aim is ↑	12.0%	12.0%	15.0%	Increased weight in offensive waste due to ward reopening.
Tonnage of Clinical Offensive waste per month	16.6	28.9	25.4	21.8	29.6	23.5	27.8	22.4	24.9	21.6	23.4	26.8	20.5	29.2			342	24.5	Trend				
% of Total Tonnage Waste to Energy (General Waste)	29.5%	20.3%	29.9%	20.1%	18.7%	16.6%	15.4%	25.5%	19.8%	16.9%	23.3%	20.1%	20.3%	19.5%				21%	Aim is ↑	15.0%	15.0%	18.0%	
Tonnage Waste to Energy (General Waste)	50.7	34.5	57.5	27.4	41.7	25.9	26.1	40.5	38.8	24.5	32.2	34.5	26.0	28.6			489	34.9	Trend				
Statutory Waste Audits - % completed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	Trend	90%	90%	95%	15 Audits / month
Workplace Serious/RIDDOR incidents	0	0	0	0	0	0	0	0	0	0	0	1	0	1			2	0.1	0	2	1	0	Trip on internal stairs - momentary inattention. Note - RIDDOR from Mar 2023 added - fell over wooden bench o/s Eye Clinic.
Workplace incidents resulting in moderate harm	0	0	1	0	2	0	0	1	0	2	0	0	0	0			6	0.4	0	3	3	1	
Workplace incidents resulting in minor harm	5	2	3	2	6	1	2	2	3	3	0	0	2	4			35	2.5	0	8	8	5	Catering Colleague scald, Trip inot cages by L4 access to Heth
Workplace incidents resulting in no harm	7	6	6	7	32	7	15	10	7	19	5	6	4	13			144	10.3	0	30	30	15	8 Security Incidents,
Workplace Incidents resulting in Near Miss	3	1	1	3	0	3	4	3	1	2	1	2	0	5			29	2.1	0	10	10	5	Food Contam, Porter jobs, Water leak.
Workplace Datix incidents open for > 8 weeks	89	81	63	63	63	66	86	68	71	77	53	46	42	38			906	64.7	0	70	70	15	
Workplace Teams Safety Walks - % Completed					90%	90%	90%	70%	50%	40%	78%	80%	80%	90%				76%	Trend	75%	75%	90%	Reporting started Dec 22. 10 Meetings per month.
Workplace Safety Action Group Mtgs - % Completed					90%	80%	80%	60%	50%	30%	78%	70%	70%	90%				70%	Trend	75%	75%	90%	Reporting started Dec 22. 10 Meetings per month.

EFM Performance Report

Workplace Services Performance Data May 2023 for June 2023 Report	2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
	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	May-23	Jun-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
Total PPMs planned per month (not KPI)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	98	82	94	109	73	156	131	#N/A		743	106	Variable				Not a KPI - an indicator of planned work volumes
Statutory PPMs planned per month								27	21	67	27	19	38	45			244	35	Variable				
Statutory PPM % success against plan								96%	100%	100%	100%	95%	100%	100%				99%	97%	85%	85%	97%	
Routine PPMs planned per month								71	61	27	82	54	118	86			499	71	Variable				
Routine PPM % success against plan								100%	100%	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	199	127	107	108	154	113	120	#N/A		928	133	Variable				
Total Class A Reactive Requests per month (not KPI)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	62	55	38	40	69	47	63	#N/A		374	53	Variable				Not a KPI - an indicator of reactive work volumes
Class A - Emergency - LD1A - requests per month								6	9	3	1	5	4	2			30	4	Variable				Note LD1A is 1hr response, LD1B is 2hr Response
Class A - Urgent - LD2 - requests per month								21	25	17	14	32	22	15			146	21	Variable				
Class A - Routine - LD3 - requests per month								28	18	8	22	30	21	37			164	23	Variable				
Class A - Routine - P4 - requests per month								7	3	10	3	2	0	9			34	5	Variable				

EFM Performance Report

Workplace Services Performance Data May 2023 for June 2023 Report	2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
	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	May-23	Jun-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
Number of Cleaning Audit Scores												10	11	8			29	10	Variable				
Average % of Cleaning Audit Scores												97%	95%	97%				96%	97%	85%	85%	95%	
Belmont Court												97%	80%	98%				92%	97%	85%	85%	95%	
Castle Circus Health Centre												95%	88%	92%				91%	97%	85%	85%	95%	
Dartmouth Clinic												98%	98%	98%				98%	97%	85%	85%	95%	
Dartmouth H+WBC														98%				98%	97%	85%	85%	95%	Added from May 2023
Hollacombe CRC												97%	98%	97%				97%	97%	85%	85%	95%	
Kings Ash House												97%	96%	97%				97%	97%	85%	85%	95%	
Sherbourne House												98%	98%	97%				98%	97%	85%	85%	95%	
Shrublands												96%	97%	97%				97%	97%	85%	85%	95%	
Teignmouth Clinic												97%	97%	95%				96%	97%	85%	85%	95%	
Union House												98%	98%	96%				98%	97%	85%	85%	95%	
Unit 7												96%	96%	98%				97%	97%	85%	85%	95%	
Walnut Lodge												96%	98%	98%				97%	97%	85%	85%	95%	
Number of Re-audits required												0	2	0			2	0.7	0	3	3	0	
Belmont Court													97%					97%	97%	85%	85%	95%	
Castle Circus Health Centre													91%					91%	97%	85%	85%	95%	
Dartmouth Clinic																		#DIV/0!	97%	85%	85%	95%	
Dartmouth H+WBC																		#DIV/0!	97%	85%	85%	95%	
Hollacombe CRC																		#DIV/0!	97%	85%	85%	95%	
Kings Ash House																		#DIV/0!	97%	85%	85%	95%	
Sherbourne House																		#DIV/0!	97%	85%	85%	95%	
Shrublands																		#DIV/0!	97%	85%	85%	95%	
Teignmouth Clinic																		#DIV/0!	97%	85%	85%	95%	
Union House																		#DIV/0!	97%	85%	85%	95%	
Unit 7																		#DIV/0!	97%	85%	85%	95%	
Walnut Lodge																		#DIV/0!	97%	85%	85%	95%	
Accidents												0	0	0			0	0.0	0	3	3	1	
Near misses												0	0	0			0	0.0	0	8	8	5	
RIDDORs												0	0	0			0	0.0	0	3	3	1	
Health & Safety breaches												0	0	0			0	0.0	0	30	30	15	
New starters												0	0	2			2	1	Variable				Not a KPI - for info only.
New starter inductions within 7 days of start date												0	0	2			2	1	Variable				

EFM Performance Report

Workplace Services Performance Data May 2023 for June 2023 Report	2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
	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	May-23	Jun-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
PPMs planned per month								50	50	66	43	38	44	44			335	48	Variable				
PPM % success against plan								100%	100%	100%	100%	97%	100%	100%				100%	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	35	43	29	20	37	22	21	#N/A		207	30	Variable				Not a KPI - an indicator of reactive work volumes
Emergency - P1 - requests per month								2	3	2	0	3	5	3			18	3	Variable				
Emergency - % P1 completed in < 3hours								50%	100%	100%	100%	100%	80%	100%				90%	97%	90%	90%	95%	Parts required
Primary Important - P2 - requests per month								3	8	3	4	3	5	1			27	4	Variable				
Primary Important - % P2 completed in < 24 Hours								100%	100%	100%	100%	100%	80%	100%				97%	97%	75%	75%	85%	Parts required
Very Important - P3 - requests per month								5	3	3	2	2	1	5			21	3	Variable				
Very Important – % P3 completed in <48 hours								100%	100%	100%	100%	100%	100%	80%				97%	97%	85%	85%	90%	
Important - P4 - requests per month								25	28	21	14	29	11	12			140	20	Variable				
Important - % P4 completed in < 60 hours								100%	100%	100%	100%	96%	100%	100%				99%	97%	65%	65%	75%	
Routine - P5 - requests per month								0	1	0	0	0	0	0			1	0	Variable				
Routine - % P5 completed in < 6 Business Days								100%	100%	100%	100%	100%	100%	100%				100%	97%	65%	65%	75%	

EFM Performance Report

Workplace Services Performance Data May 2023 for June 2023 Report	2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
	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	May-23	Jun-23					Constant Review	Cause for Concern	No Concerns	
Metrics	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3								
Total PPMs planned per month (not KPI)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	81	81	69	74	59	79	91	#N/A		534	76	Variable				Not a KPI - an indicator of planned work volumes
Statutory PPMs planned per month								25	13	16	21	20	18	21			134	19	Variable				*Statutory
Statutory PPM % success against plan								100%	100%	100%	100%	100%	100%	100%				100%	97%	85%	85%	97%	
Routine PPMs planned per month								56	68	53	53	39	61	70			400	57	Variable				
Routine PPM % success against plan								100%	100%	100%	100%	100%	100%	100%				100%	90%	60%	60%	70%	
Total Reactive Requests per month (not KPI)	116	112	146	138	108	178	134	167	155	166	121	181	167	116	#N/A		2005	143	Variable				Not a KPI - an indicator of reactive work volumes
Emergency - requests per month	4	12	2	2	8	4	2	9	5	4	9	9	3	8			81	6	Variable				
Emergency - % completed in < 24hours														100%				100%	97%	90%	90%	95%	
Non- Emergency - requests per month	56	50	72	68	50	87	66	79	75	81	56	86	82	108			1016	73	Variable				
Non-Emergency – % completed in < 1 - 5 Days														100%				100%	97%	85%	85%	90%	

Workplace Services Performance Data
May 2023 for June 2023 Report

Policies and Procedures

TITLE	Procedure	Lead	Group Developing Doc	Pre-ratification Route	Ratification Group / Committee	Date to begin next review	Next Review date	Notes & Target Date for completion
Water Safety Policy	Policy	Rae Callcut	Water Safety Group	DIPC	Infection Control Committee	Mar-24	May-24	Ratified by Infection Control Committee 28th Sep 2021.
Water Safety Plan	Procedure	Rae Callcut	EFM Senior Leadership Team	Dir E&F Operations	EPCG	Oct-22	Jan-23	Water Safety Plan completed in January 2022. RCa reviewing SOPs as next step.
Management of Fire Safety and Evacuation Including Trust Fire Safety Policy Evacuation Including Trust Fire Safety Policy	Policy	Jake O'Donovan / Kevin Wood	Fire Safety Group	EPCG	Health and Safety Committee	Jul-24	Oct-24	Reviewed annually, first draft review being undertaken by JOD and external technical author.
Medical Gases	Policy	Paul Morgan	EFM Senior Leadership Team - Medical Gas Committee	Head Pharmacy . Dir E&F Operations	H&S Committee	Jun-23	Sep-23	Issued to Medical Gas Committee members for review.
Electrical Safety	Policy	Paul Morgan	EFM SMT	AE	H&S Committee	Apr-23	Jul-23	Commenced review
Electrical Safety	Procedures	Richard Coombes	Electrical Safety Group	AE	EPCG	Apr-23	Jul-23	Commenced review
Ventilation Systems Policy	Policy	Paul Morgan	EFM Senior Leadership Team	AE	H&S Committee	Jan-24	Apr-24	Ratified - update header sheet
Lifting Operations & Lifting Equipment Management	Policy	Paul Morgan	EFM Senior Leadership Team	Manual Handling Group	H&S Committee	Aug-24	Nov-24	Ratified - update header sheet
Lift Management Plan	Procedure	Rae Callcut	EFM Senior Leadership Team	Dir E&F Operations	EPCG	Sep-19	Dec-19	Draft lift management plan in progress, to be compllleted by 1st May 2023
Pressure Systems Policy	Policy	Paul Morgan	EFM Senior Leadership Team	AE	H&S Committee	Jan-24	Apr-24	Ratified - update header sheet
Asbestos Policy	Policy	Paul Morgan	EFM Senior Leadership Team	Dir E&F Operations	H&S Committee	Jun-24	Sep-24	
Asbestos Management Plan	Procedure	Ian Hackney	EFM Senior Leadership Team	Dir E&F Operations	EPCG	May-23	Jun-23	Commenced review
Cleaning Policy	Policy	Tony Hopkins	Environment Gp	DIPC	Infection Prevention Control Gp	Jan-24	Apr-24	
Linen & Laundry Policy	Policy	Tony Hopkins	EFM Senior Leadership Team	DIPC	Infection Prevention Control Gp	Jan-24	Apr-24	
Waste Management Policy	Policy	Tony Hopkins	Environment Gp	DIPC	H&S Committee	Dec-24	Mar-25	
Food Safety Policy	Policy	Tony Hopkins	EFM Senior Leadership Team	Nutritional Steering Gp	Infection Prevention Control Gp	Jan-24	Apr-24	
Confined Space Management	Policy	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Sep-24	Dec-24	
Control of Substances Hazardous to Health (COSHH), The	Policy	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Jan-24	Apr-24	
Display Screen Equipment (DSE) Eyesight Reimbursement	Procedure	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Jan-19	May-19	under review - ratified at H&S Committee 8 Feb 2023.
Display Screen Equipment (DSE) Procedure	Procedure	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	May-24	Aug-24	
Display Screen Equipment User Self Assessment Form	Form	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	May-24	Aug-24	
Driving Policy	Policy	Andrew Knowles, Transport Services Manager		Corporate Health and Safety Lead	H&S Committee	Nov-22	Feb-23	
Electronic Cigarette Management Policy	Policy			Corporate Health and Safety Lead	H&S Committee	Jul-24	Oct-24	
First Aid Management	Policy	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Sep-25	Dec-25	
Health and Safety Action Plan Template	Form	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Nov-17	Feb-18	under review - ratified at H&S Committee 8 Feb 2023.
Health and Safety Policy	Policy	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Feb-24	May-24	
Health and Safety Representatives	Policy	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Jan-24	Apr-24	
Health and Safety Risk Assessment Form- excel	Form	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Dec-23	Mar-24	
Health and Safety Risk Assessments	Form	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Dec-23	Mar-24	
Hot Desking SOP	Procedure	Health and Safety Committee		Corporate Health and Safety Lead	H&S Committee	Aug-23	Nov-23	
Ladders Checklist- EFM-SO18	Form	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Jul-25	Oct-25	
Latex Management	Policy	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Oct-24	Jan-25	
Latex Product Use Authorisation Form	Form	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Oct-24	Jan-25	
Ligature Points, Assessing and Managing	Procedure	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Aug-20	Nov-20	awaiting CQC update on requirements
Ligature Risk Assessment, Environmental Blank Form - Excel	Form	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Aug-21	Nov-21	awaiting CQC update on requirements
Management of Confidential Waste	Policy	Environment and site Services Manager		Corporate Health and Safety Lead	H&S Committee	Jun-21	Sep-21	Was under Data Protection on the system now moved to Workplace. To Emma davies for IGSG for ratification in May 23
Management of Liquid Nitrogen Procedure	Procedure	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Mar-24	Jun-24	
New and Expectant Mothers Risk Assessment Form'	Form	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Jan-25	Apr-25	
New and Expectant Mothers Risk Assessment Procedure	Procedure	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Jan-25	Apr-25	
Noise at Work, Management of	Policy	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Mar-24	Jun-24	
Personal Protective Equipment Management	Policy	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Mar-24	Jun-24	
Preliminary Noise Assessment Form	Form	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Dec-18	Mar-19	with Kevin Wood for review Completed 23.01.2023
Sharps Management Procedure	Policy	Kevin Wood	Sharps Committee	Corporate Health and Safety Lead	H&S Committee	May-21	Aug-21	Under review by new Sharps Group as of 16th Jan 2023
Sharps, Authorisation form for the use of non-safer sharps	Form	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Dec-20	Mar-21	Under review by new Sharps Group as of 16th Jan 2023
Sharps/Contamination Incident Investigation	Policy	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	N/A	No date given	Under review by new Sharps Group as of 16th Jan 2023
Smoke free Environment Policy	Policy	Medical Director		Corporate Health and Safety Lead	H&S Committee	Nov-23	Feb-24	
Working at Height Procedure	Procedure	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Jul-25	Oct-25	
Workplace Health and Safety Audit Procedure	Procedure	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Mar-24	Jun-24	
Workplace Management	Policy	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	Mar-24	Jun-24	

Workplace Slips Trips and Falls Management Procedure	Procedure	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	**Dec-18**	**Mar-19**	under review - ratified at H&S Committee 8 Feb 2023.
Young Persons and Work Experience, Management of Health and Safety	Policy	Kevin Wood		Corporate Health and Safety Lead	H&S Committee	**Jan-21**	**May-21**	under review - ratified at H&S Committee 8 Feb 2023.
Medical Devices Management Policy	Policy	Darren Russell		Medical Devices Management Group	Quality Improvement Group	**Feb-25**	**May-25**	
Non-Ionising Radiation Policy	Policy	Darren Russell		Radiological Safety Committee	H&S Committee	**Jun-23**	**Sep-23**	
Business Continuity Plan MDSS Assets Management System	Procedure	Darren Russell		Information Asset Support Team	Information Governance	**Jan-20**	**Apr-20**	HIS Lead to be identified.
107 Planning Tool - Staff	Procedure	Darren Russell		not given	not given	**Oct-23**	**Jan-24**	To be aligned with Workplace Services Strategy.
MDSS Flexible Working Procedure	Policy	Darren Russell		not given	EPCG	**Jan-24**	**Apr-24**	
Medical Device Procurement Process	Procedure	Darren Russell		not given	EPCG	**Apr-24**	**Jul-24**	Aug 2021 version 2 - no leads, ratification route / no review date given. From Clin Eng / Procurement procedure webpage
S001 Safety Requirements and Safety Notes for Contractors	Policy	Darren Russell				**t b c**	**DRAFT**	
G0564 Medical Device Education and Training Policy	Policy	Darren Russell		EPCG	Medical Devices Committee	**Dec-23**	**Mar-24**	
Medical Devices Management Procedure	Procedure	Darren Russell		Medical Devices Management Group	Quality Improvement Group	**Jan-23**	**May-23**	
Business Continuity Plan	Procedure	Darren Russell				**Jan-24**	**Apr-24**	
MDSS BC All Contacts Details	Procedure	Darren Russell				**May-23**	**Aug-23**	
Medical Devices Risk Management for PPM	Procedure	Darren Russell		Medical Devices Operational Group	EPCG	**May-24**	**Aug-24**	
Policy for use of Mobile Communication Devices within Hospital Buildings	Policy	Darren Russell		Radiological Safety Committee	H&S Committee	**Jun-24**	**Sep-24**	

Workplace Services Performance Data
May 2023 for June 2023 Report

Roles and Responsibilities

Compliance area	Authorising Engineer	Responsible Persons	Authorised Persons	Competent Persons / Other Competent Persons	Other Key Personnel	Notes
Water	Neil Edmonds	Rae Callcut	John Armstrong Emma Hughes	Churchill Services, PFI Contractors	Trust DIPC – Dr Joanne Watson	
Fire	Darren Kirk	Fire Safety Manager – Jake O'Donovan.	Fire Safety Advisor - Kevin Wood/ Neil Faulkner	Suzanne Ellis, Keith Pascoe Neil Faulkner	Estates Team - Weekly Testing AlarmTec - Periodic Maintenance Chubb - Periodic Maintenance, Hydrant & Dry Riser Inspections Westcountry Fire Alarms - Fire Extinguisher Maintenance	
Medical Gases	Malcolm Thompson		Paul Morgan Tim Coysh Sophie Archer (Mat Leave)	Gary Jones Mark Fahy Medical Gas Pipelines Ltd M&M Medical – Newton Abbot PFI. Quality Controller (MGPS) Accredited External Contractor as required. Porters - Cylinder Handling Mechanical Team - First Response and Cylinder Handling	Designated Medical Officer (MGPS) and Designated Nursing Officer (MGPS) to be appointed.	
Electrical Systems	Alex Bray (HV/ LV)		Paul Morgan (HV/ LV) Richard Coombes (HV/ LV) Mark Wykes (HV/ LV)	Steve Thompson (HV Res/ LV), Richard O'Reilly (HV Res/ LV), Andy Maddock (HV Res/ LV), Ross Chandler (HV Res/ LV), Dave Callan (HV Res/ LV), Mark Hodges (HV Res/ LV), Declan Pearson (HV Res/ LV), Richard Hicks (LV - Gas safe) Contractors: Enerveo, HV Power Services (HV/ LV), Addicott Electrics, Bender, Starkstrom.	External Specialist Consultants (ETA Projects Ltd)	
Ventilation Compliance	Graham Powell		Sophie Archer (Mat Leave) Tim Coysh	Mechanical Team trained in November 2021. D&S - Steve Wallis, Howorth Air Technology Ltd Camfil ltd Medical Air Technologies	Trust DIPC – Dr Joanne Watson	
Lifts / LOLER	Mottram Associates (Competence for Lift systems but not AE)		Mottram Associates Ltd	Lift Release DEL Staff (Lifts) Specialist contractor - Kone Lifts	LmP (examination systems), Allianz Insurance Inspectors for Lift and Fixed / Portable hoist and Lifting beams LOLER. Declan Pearson, Emma Hughes to Lift AP level for day to day management Paul Morgan, Richard Coombes (Electrical)	
Pressure Systems	LmP - Corporate AE		Tim Coysh - (AE has assessed) Paul Morgan - (AE has assessed)	CP Examination is Allianz CP Written Schemes prepared by LmP Technical Services Mechanical Team	Mark Wykes - Operational Support	
Decontamination Engineering Systems	Jim Tinsdale		Richard Coombes Paul Morgan	Ben Armstrong (Weekly Testing) Serve Medical MMM Limited Lancer		
Asbestos	N/A	Asbestos Coordinator – Ian Hackney		All EFM Staff trained in Asbestos Awareness Contractors as appointed. (Tony Mayne for Environmental Services)	Asbestos Removal Projects - Controlled by Capital projects	
Cleaning	N/A	Infection Control – Tony Hopkins, Cleaning in IPC – Rachel Russell		Alan Stephens, Lynn Northcott, Matt Acton Lucy Woodward – Community Inpatient Norse Cleaning - Community Non-Inpatient	Norse Cleaning – Non-Inpatient Areas, managed by Emma Hughes	
Waste Management	N/A	IPC - Rachel Russell		Tony Hopkins, Matt Acton, Ryan Evans	Catalyst	
Catering	N/A	Tony Hopkins	Nathan Simms Kathryn Sherlock			
Medical Devices Safety	N/A	Medical Director - ICO Responsible Person for Medical Devices		Medical Devices Safety Officer - Darren Russell wef 3 May 2023.	Lead Medical Device Advisor - Darren Russell	Medical Devices Safety Officer (MDSO) is the single point of contact for Alerts or information impacting patient safety from government agencies.
Laser Safety	N/A			Laser Safety Officer (LSO)/ Laser Protection Adviser/Laser Safety Manager - Darren Russell	Support: Peter Mead	Co-ordinate laser safety arrangements across the organisation to ensure that adequate radiation protection arrangements are made to prevent exposure to potentially harmful laser radiation.
Non-ionising Radiation Protection	N/A			Non-ionising radiation Protection Advisor - Darren Russell	Support (Optical/RF): Rob Wilson Support (EMF/RF): Peter Mead	Co-ordinate optical and Non-ionising Radiation safety arrangements were possible across the organisation to ensure that adequate radiation protection arrangements are made to prevent exposure to potentially harmful sources.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Executive's report			Meeting date: 26 July 2023
Report appendix	Devon Integrated Care Board Update		
Report sponsor	Chief Executive		
Report author	Associate Director of Communications and Partnerships		
Report provenance	Reviewed by Executive Team 18 July 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 is 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: 26 July 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 28 June 2023 are as follows:

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

Torbay aims to become exam centre for south of England for anatomical pathology

Currently trainee anatomical pathology technicians (APTs) undertake their examinations in North Tees. This has a significant impact in terms of travel and cost for trainee APTs in the south of the country.

Our mortuary manager, Simon Hughes, has successfully led an initiative which has resulted in Torbay hosting ATP exams last month. The feedback has been overwhelmingly positive. We are in discussions with Public Health England and the ATP education provider and are hopeful that Torbay will become the APT exam centre for the south of England. The first exams took place in early June.

I would like to take this opportunity to formally recognise the compassionate leadership Simon evidences in all aspects of his role and the great work he and his team do to care for the deceased and their families. They provide an extremely high-quality service and show exceptional levels of care and respect for the deceased.

NHS75 celebrations
On 05 July 2023, the NHS celebrated its 75th anniversary. We were delighted to host BBC Radio Devon's breakfast show from the main entrance at Torbay Hospital and BBC Spotlight's evening news programme from the Acute Medical Unit at Torbay Hospital. The BBC Spotlight programme also included stories from our MS Service about how we are using virtual reality HoloLens to support people with MS in their homes as well as a live panel interview which featured Dr Matt Halkes, Consultant Anaesthetist.

Our Bake Off (baking) and Cake Off (cake decorating) competitions took place in the Bayview restaurant at Torbay Hospital while our #ThankYouTree tour took in fifteen sites over four days. We have hundreds of messages from our people, patients and carers and we are currently exploring how best to preserve and share these messages. Local poet Harula Ladd offered three-minute poems to our people and wrote a NHS75 poem for us which we shared with our people on the day. Harula is making some final amendments to the poem which we will then make available across our sites. Lauren Bradley-Foster (health care support worker) won our NHS75 quiz, closely followed by the podiatry team in second place and Maria Dowling (administrator, Torbay Drug and Alcohol Team) in third place.

Our representatives at national events
Dr George Averill (F3 doctor), Nik Hill (chair of our health care support worker council and podiatry health care support worker), Nicholas Pannell (social worker, over 65s mental health team) and Sarah Davies (professional lead occupational therapy, Children and Family Health Devon) attended the NHS75 service at Westminster Abbey as our representatives while Katie Aston and Hannah O'Sullivan represented Devon at the No. 10 Downing Street NHS 75 event. Katie and Hannah were recognised for the Treating Tobacco Dependency Service, launched to support people to stop smoking during pregnancy.

Our Health Connect Coaching team attended the NHS Parliamentary Awards ceremony on the NHS birthday. While they didn't win the national award, we are really proud of their achievements in winning the south west regional award for NHS volunteers and we are grateful to Torbay MP, Kevin Foster, who took them on a tour of the Palace of Westminster.

Parkrun for the NHS
I was delighted to be invited to start the Teignmouth promenade parkrun on Saturday 08 July and it was fantastic to see so many people getting active and supporting the NHS. Parkrun for the NHS also took place at Torquay Velopark (supported by our breast care clinicians who last year set up the first 5k your way in the peninsula for those living with and beyond cancer), Haldon Forest, Sharpham estate, Park and Bolberry Down.

NHS Big Tea
More than 12 NHS Big Tea parties took place across our community, adult social care and acute services to celebrate the NHS birthday and raise funds for our Torbay and South Devon NHS Charity and more than £1,500 was raised.

We are grateful to Morrisons, Totnes, for supporting the NHS Big Tea from 04 to 18 July and to Morrisons Totnes community champions Liz and Val for their fantastic support.

NHS@75 conversations and report
In May, we supported the NHS Assembly's NHS@75 conversations with our people – across the country more than 700 conversations took place not only in health organisations but with patient groups, charities and partners in health and social care.

Here in Torbay and South Devon we held a number of focus groups with colleagues from different professions and services and asked seven questions about the NHS' past, present and future. Ahead of the NHS' 75th birthday, the NHS Assembly published an independent report which found that NHS should now focus on three key areas:

- preventing poor health
- creating more personalised care which better responds to patients views
- coordinated care closer to home, including by strengthening General Practice.

In the report entitled, *The NHS in England: Priorities For The Future*, the Assembly says the health service faces significant workforce and estates challenges, but it should be "emboldened by the resolve and agility it showed during the pandemic." Co-authored by Professor Dame Clare Gerada and Professor Sir Chris Ham, the analysis notes the demands on the health service are far greater now than when the NHS was founded with almost 3.5 million more people older than 75 compared to 1948. It also noted that there was a greater need for prevention of ill health through wider societal change that falls outside of the NHS remit with the Assembly noting that 80% of health outcomes are determined by other factors such as incoming, housing education and employment. The report calls for capital investment and a long-term infrastructure plan to tackle backlog maintenance and modernise primary care where a third of the estate was built before the NHS was founded (just like many of our buildings in both Torbay and South Devon).

Both the findings of the full report (which is available here) NHS Long Term Plan » The NHS in England at 75 (NHS@75) and our own NHS@75 conversations will be fed into the ongoing review of our organisational strategy.

Devon annual public health report 2022-3
I welcome the Devon annual public health report from Steve Brown, Director of Public Health, Communities and Prosperity which is available here.

The annual report focuses on the importance of prevention in tackling poor health and premature mortality in Devon. It considers the four key approaches to prevention, providing the case for investment within in each approach and examples of the preventative work taking place within Devon, along with a

number of recommendations. We will carefully review the report and the recommendations will be fed into the ongoing review of our organisational strategy to ensure alignment with this and the Devon five year forward plan.

Other milestones this year
2023 also marks 150 years since the first hospital opened in Newton Abbot Community Hospital as well as the 95th anniversary of Brixham Community Hospital opening on its current site. There has been a hospital in Brixham since 1891. This November will see the 95th anniversary of the official opening of Torbay Hospital on its current site.

Honorary director's colour run for organ and tissue donation memorial
Our honorary director, Lottie Bryon-Edmond, organised a colour run at her school and raised £6,453 towards our organ and tissue donation memorial. The colour run was started by Sir Richard Ibbotson, Chair, and was covered by BBC Spotlight and ITV West Country. Lottie also joined us in our NHS75 celebrations to promote organ and tissue donation at Torbay Hospital.

Cricket and rounders match results are in
Mr Sinha and Becky George organised a cricket and rounders match at Barton Cricket Club at the end of June. It was a fantastic family event enjoyed by all. Both winning teams received trophies, with the medics losing to the rest of the hospital by three wickets in the cricket. In the rounders, the A team snuck a hard-fought victory and the trophy was collected by the captains Darcey and Oliver. We are grateful to Mr Sinha and Becky George for organising such a great event.

More accurate information for patients thanks to physio spinal team research
Our physiotherapy spinal team have contributed to a national study which aims to help clinicians provide more accurate information to people with sciatica.

The team have been taking part in the POiSE research study. Led by Dr Siobhan Stynes at Keele University, the study looks at factors which indicate what the outcome will be for people with sciatica after they receive an epidural spinal injection.

This research will mean clinicians can offer better, more accurate information about treatment options and identify who is more likely to benefit from these injections.

The team have been celebrating after recently reaching their recruitment target. This was the first study undertaken by the team, led by Associate Principal Investigator (API), Martin Fancutt. Martin recently spoke to NIHR about his experience with the NIHR scheme.

Growing our library resources for our people
I want to formally recognise the work of our librarians at Torbay Hospital. They are a small team but have a big impact. Our library not only supports our students with their training and development but also helps to improve the quality of patient care.

The library has recently been refurbished and the feedback from people who use the library has been overwhelmingly positive. To further improve the aesthetics of the environment a staff photography competition has been held on the theme of 'what makes you happy' and the winners photographs will be framed and hung in the library.

Last autumn we recruited our first clinical librarian to search the evidence base on behalf of our clinicians to help them make evidence-informed decisions. Several case studies of the positive impact from evidence searches have been included in the NHSE database including enhancing care in patients with chronic fatigue, treatment and management of trigger finger and volunteer peer health coaches.

In addition, our library has also been part of national pilots to improve library services while their pioneering work on enabling single sign-on to OpenAthens via organisational logins has resulted in other trusts adopting our approach.

Workforce plan for NHS in England published
I welcome the publication of the first workforce plan for the NHS in England which is available here. We are currently carefully reviewing and analysing the plan and will bring a paper to September's meeting which will give detail on our next steps, ensuring alignment with our strategy and our system plans.

3.2 Excellent experience receiving and providing care

Current pressures
Over the past month we have seen further improvements across several areas: our front door, planned care and our community services. These are set against a further backdrop of industrial action throughout June and July.

For the third consecutive month our urgent and emergency care performance was above 60%. While we still have more to do to reach our target of 76% by the end of March, in June our performance was 64.61% (our highest since September 2021).

We have exited tier monitoring for our cancer care due to the sustained improvement work put in place by the teams. We achieved the Faster Diagnosis Standard for the fifth successive month. In June, for the first time, we received over 2,000 suspected cancer referrals in a single month which reflects the increasing need and demand for our services.

Our performance in planned care services has remained strong and we have maintained our improvement trajectory despite ongoing industrial action which resulted in a small number of planned appointments and procedures being postponed.

We are currently ahead of plans to hit our improved position on 78-week and 65 week waits. We are ahead of target to have no one waiting more than 65-weeks by 31 March 2024. While we still have some specialities that are considered a risk, plans to mitigate these risks are being developed.

Care Quality Commission visit
Our two day well-led inspection visit took place on 12-13 July. While we have received some initial feedback which highlighted how honest and open our people have been with the inspectors, we do not expect to receive the draft report until the end of the summer. A number of further interviews will take place over the next few weeks and we will also be responding to a number of data requests.

Industrial action
Services have been affected this month by continuing industrial action by junior doctors and new industrial action by consultants and radiographers. Junior doctors took five days of action between 13 and 18 July; consultants took action between 20 and 21 July (with further action scheduled for 24-25 August) and radiologists took industrial action between 25 and 27 July.

We have well-rehearsed plans in place to mitigate the impact of industrial action as much as possible. Whiles issue around pay are a matter between government and unions and we fully support everyone's right to make an individual decision on what action to take, we continue to ask our people to share their plans with us so we can maintain patient safety.

The biggest impact of continuing industrial action is on elective activities which is particular challenge when all teams are working so hard to reduce waiting times and waiting lists to ensure people can be seen as quickly as possible.

Improving how we care for our children and young people
Our paediatric department is leading the development of the south west paediatric mental health network (SWPHMN). The network is focused on supporting teams looking after children and young people with mental health difficulties, collaborating together to learn from and share good practice and advocating and amplifying children and young people's voices locally and regionally. Dr James Dearden (Consultant Paediatrician) is paediatric clinical lead for the network and we are hosting the network administrator role, which has been funded by NHSE for this year and next year. The SWPHMN has been hugely successful at linking up professionals involved in children and young people's mental health across the seven south west integrated care systems and has built the basis for extensive trans-regional and inter-professional collaboration that overcomes the traditional boundaries created by different regions, professions and organisational structures.

We are proud to be one of the first acute trusts to actively invest in mental health leadership by allocating consultants time to address the strategic and ingrained problems and to support our people to lead the way in this field. Our paediatric mental health leadership role is being used as one of the key examples of how the role can influence change at the coal face and at systems level. In the last twelve months Dr Dearden has been invited to share his experiences of his role at regional and national level through RCPCH annual conference, webinars and podcasts including the paediatric mental health association webinar, NHSE children and young peoples regional groups in the south west and the north west and the Great Ormond Street Hospital conference.

Our mental health paediatric work within our services has also allowed us to harness and learn the most from projects such as the in-reach youth worker programme being run by Young Devon, We Can Talk training modules and Maudsley ARFID training to ensure that our people remain highly skilled, informed and connected.

And perhaps most importantly, the work we are doing has opened the doors to rebuilding our participation and engagement work with children, young people and their families. Dr Dearden and Rebecca Hudson have been working closely with our engagement manager, Eli McCutchion, to understand active participation groups in our community, how best to engage and learn from them, and how we can use this to shape and direct how we deliver healthcare for children, young people and their families locally.

Royal College of Nursing awards 2023 nursing support worker finalist
Tara Johnson, health care support worker in our Emergency Department at Torbay Hospital has been shortlisted as a finalist for the nursing support worker category in the RCN nursing awards 2023. We are delighted for Tara who is passionate about caring holstically for children and young people who are in need of urgent or emergency care.

Nursing Times awards 2023 theatres and surgical nursing finalist
Our acuity based patient allocation work has been shortlisted as a finalist in the 2023 Nursing Times awards. We are very proud of the work our theatre teams are doing to improve how we care for our people.

Congratulations to our latest PRIMROSE and DAISY award winners
Our latest PRIMROSE award winner is Samantha Edmunds, midwifery support worker in the Torview midwifery team. Sam’s prompt response to concerns raised by a family about their newborn baby’s health identified a bleed on the brain and resulted in potentially life-saving treatment. Sam has supported the family throughout providing excellent clinical care as well as emotional and breastfeeding support.

Our latest DAISY award winner is Verity Martin, a registered nurse who is part of our bank team. Verity was nominated by a family for the fantastic clinical care she provided to a baby with heart issues and the training and emotional support she gave to their parents.

We were also delighted to be able to give Helen Cant, registered nurse, Templar ward, her DAISY award from December. Helen was nominated for the compassionate care and sensitivity she showed to a carer which led to a supported safeguarding referral.

Members of the public and colleagues can nominate a nurse or a midwife who has provided outstanding care for a DAISY award. Health care support workers who provide outstanding care can be nominated for a PRIMROSE award.

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

New Forrest achieved white while Ella Rowcroft and Cromie achieved bronze. George Earle achieved a silver award. Well done to everyone involved.

3.3 Excellent value and sustainability

Appointment of Chief Operating Officer
We are delighted to have appointed Arun Chandran as our new Chief Operating Officer (COO) following a competitive recruitment process.

Arun is currently the Divisional Director of Operations at Oxford University Hospitals NHS Foundation Trust and will join us in the autumn.

Arun began his NHS career as a nurse and has held a variety of leadership roles in NHS trusts including London North West Healthcare Trusts, Royal Surrey Country NHS Foundation Trust and Gloucestershire Hospitals.

Arun will join us in the autumn and brings with him a passion for equality and inclusion which aligns with our compassionate leadership framework and our vision to deliver better health and care for all.

His input will be key to further developing our care model and transforming our clinical services so that they meet the needs of our communities now and in the future.

I would like to take this opportunity to formally thank our interim Chief Operating Officer Jon Scott for his leadership and continued support.

Executive leadership changes
Dave Stacey, Chief Finance Officer/Deputy Chief Executive, left us this month to take up a new role at the University of Exeter. Dave has been part of our team for three and a half years and has achieved a significant amount 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.

I would like to take this opportunity to formally thank Dave on behalf of the Board for his leadership, vision and dedicated service and to wish him well in his new role.

We are delighted to have welcomed Mark Brice as our interim Chief Finance Officer. Mark brings with him a wealth of senior leadership experience and financial expertise.

We will shortly begin the recruitment process for a substantive Chief Finance Officer and, due to the retirement of Ian Currie at the end of this year, Chief Medical Officer.

Strengthening our governance and reshaping how we are organised
At the start of July, we implemented our new operational and governance structures which organised clinical services into divisions which will sit in one of our four care groups. This work has been undertaken in partnership with our clinical, corporate, operational and professional teams to build on what has worked well in our previous structure and address the issues we have identified together.

Our four care groups are:
- Families and communities
- Planned care and surgery
- Medicine and urgent care
- Children and Family Health Devon.

This change to our structure:
- makes better use of the capacity, capability, experience and expertise we have to improve the quality of care we provide to people who use our services
- better reflects how our clinical teams want to work together to deliver care
- creates clear lines of governance and accountability which will reduce duplication, bureaucracy and confusion.

We fully recognise that there is no perfect structure for any large complex organisation such as ours. The very act of creating a structure draws lines through different areas – we have developed clear bridges that will link areas together to minimise any potential negative impact or inequity for people who use our services by establishing 10 clinical pathway groups that will work across care groups.

Our regain and renew plan – addressing our challenges
Through our regain and renew plan we are making meaningful conversations real, building a shared consciousness of our vision and purpose, building trust, visibility and connection between our people while giving support and direction that will help us exit Single Oversight Framework 4.

Our aim is that everyone in the organisation knows what contribution they are making to our regain and renew plan, they are given the opportunity to identify areas to improve from their knowledge of their own services and are supported to do so.

The conversations we are having with our teams enable us to better understand their concerns and challenges while also directing and targeting our teams' improvement activity to meet the targets we have set to improve the quality of the care we provide and deliver best value (improving productivity and effectiveness).

To date 94 initial meetings have taken place (or are planned to take place) – just over 52% of our target of meeting all 179 teams across all services.

Our people really value the conversations we are having, however, we need to ensure that this becomes embedded in the way that we work so that meaningful conversations are part of the way that we do things around here (in line with our communications and engagement strategy).

While we are at an early stage in the process, we need to ensure that the commitments we have made are sustained and maintained, with effective meeting notes shared and recorded, SMART objectives developed and progress against these effectively tracked. Otherwise, we risk this becoming another false dawn which has the potential not only to negatively impact our ability to exit SOF4 but to undermine the trust we are trying to build with our people.

Our executive and senior leader buddies have a responsibility to underpin and support the improvement action the teams identify. Through Trust Management Group executive leads will be asked to consider the outputs of all conversations and commission support from professional and corporate services (for example, workforce, finance, improvement and innovation) to support activity where this is felt to be needed.

Our work is closely aligned to and congruent with our compassionate leadership framework through which we will support our people to build confidence, capability and capacity to engage in meaningful conversations with teams and individuals while building the just and learning culture that will enable us to provide safe, effective care, drive improvement and innovation and create a great place to work.

NHS Homes Alliance

We are proud to be a founding member of NHS Homes Alliance – a collaboration of representatives from public and private sector organisations including NHS Trusts, pension funds, financial, legal and real estate experts, housing associations, architects and developers.

Earlier this month, the NHS Homes Alliances launched a White Paper ‘A people driven approach: delivering NHS homes’ which sets out a vision for using the NHS estate to build affordable, high-quality, and sustainable homes near to hospitals and clinics. Thus, boosting NHS and social care staff retention and recruitment, ultimately improving the quality of care and providing better services for all.

Our Director of Capital Development, Caroline Cozens, has not only contributed to the development of the white paper but was also one of the sector experts on the panel at the launch event.

Following the launch, the government announced a joint ministerial taskforce which will take the White Paper’s recommendations forward and help find solutions to the urgent need for decent, affordable housing for our talented NHS and social care workforce.

Our staff tell us that they often struggle to find affordable housing in our local communities and this affects about ability to attract and retain people in our local NHS. We are passionate about supporting our people to live well and this includes doing what we can to ensure there is suitable, safe, affordable housing available to them close to their work.

The full White Paper can be read here: www.nhshomesalliance.co.uk

Work begins on theatre expansion
Building work has begun for our two new modular theatres as well as preoperative assessment and recovery rooms on our Torbay Hospital site. This means we will be able to care for 4,500 more people each year, reducing the time that people have to wait for day surgery and improving their experience and outcomes.

The building work will continue until early next year. Due to the building works, the way that some people access services will change temporarily.

The new entrance to access outpatients reception including Heart and Lung services is along our Acute Medical Unit. New signage is in place to help with directions and our volunteer Wayfinders are on hand to assist people as and when they need it.

Once the building work is complete there will be a new entrance for heart and lung, outpatients and theatres. We thank everyone for their patience while building work is ongoing. While we are delighted that people will benefit from the new facilities we appreciate the disruption that building work causes and are doing our best to mitigate any negative impact.

New Radiotherapy CT scanner coming online
Our new extension for our replacement Radiotherapy CT scanner has been completed and the commissioning process for the scanner is now underway. We hope to be able to start welcoming patients in the next few weeks. The state of the art scanner has been kindly funded by Torbay Hospital League of Friends. The extension provides a much better environment for both staff and patients and specialist light boxes have been installed on the wall and ceiling of the scanner room to improve the patient experience.

Peninsula Acute Sustainability Programme
Through the Peninsula Acute Sustainability Programme we are working together with other NHS organisations in Devon, Cornwall and Isles of Scilly to improve hospital services for local people and staff.

Together with Healthwatch we are undertaking a series of focus groups and interviews to understand the experiences and priorities of:

- people who have been unwell in the last two years which meant they had to go to hospital urgently or their carers (people who have used urgent and emergency NHS hospital services)
- children, young people (under 16) and their families who have been admitted to an acute hospital for unscheduled care.

People’s insights will directly inform how we shape and develop our programme.

Fundraising for our charity
Thanks to funding from NHS Charities Together we are putting in place the infrastructure needed to grow our Torbay and South Devon NHS Charity. A customer relationship management system will be implemented in the next few months, the new branding is being rolled out and new assets to support fundraisers are on order.

We have an increasing number of people fundraising for our charity and we are very proud to support them. One of our fantastic fundraisers is Marco Jimenez, Charge Nurse on Templer ward at Newton Abbot Community Hospital, who will be bravely jumping out of a plane to raise funds for additional equipment, which will support the rehabilitation of stoke and neuro patients on the ward.

The funds will be raised for our Torbay and South Devon NHS Charity, set up to help improve and enhance patient care by funding equipment and services that can't be funded by the NHS.

Templer ward operates a wish list of items to support patient care which includes beach balls for use in group sessions, mirror boxes which help retrain the brain after a stroke to build up mobility, jigsaws, and innovative special gloves which help to retrain hands and feet after a stroke or for people with a neurological impairment.

Marco is undertaking his skydive at Dunkeswell airfield near Honiton on 30 July. For anyone who would like to donate and help enhance care for people needing stoke and neuro rehabilitation, Marco has a Just Giving page.

Celebrating our workplace colleagues

Our professional and corporate services are a vital part of how we care for our patients and carers. Last month we celebrated estates and facilities day with executives and senior leaders visiting our workplace teams to say thank you and recognise their contributions. I want to note here a few of the highlights and successes of the team from the past year:

- rebranded as 'workplace' to better reflect the work and support the teams provide with a new strategy, purpose and vision
- scored in the top five trusts in the country for both food and cleanliness in the Patient-Led Assessments of the Care Environment (PLACE)
- opening of our Acute Medical Unit at Torbay Hospital and Dartmouth Health and Wellbeing Centre were two significant highlights of the incredible projects that our capital development team are involved with
- redesigned ward facilities services and introduced bespoke ward catering assistants
- grounds and gardens colleagues have done a fantastic job towards enhancing our green spaces and improving our outdoor environments for people to enjoy
- Matthew Neil, our first ever estates delivery mechanical apprentice, successfully completed his apprenticeship last month.

4. Chief executive engagement July

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

Internal	External
• Video blog sessions • Staffside • Health and care support worker welcome • Junior Doctor corporate induction • Maternity insights visit • Lead discharge nurse • Lead head and neck/thyroid cancer clinical nurse specialist • Quarterly League of Friends meeting • Long service awards	• Chief Executive Officer, Integrated Care System Devon (ICSD) • Chief Finance Officer, ICSD • Medical Director, ICSD • Chair, Royal Devon University Healthcare NHS Foundation Trust (RDUH) • Deputy Chief Executive Officer, RDUH • Chief Finance Officer and Deputy Chief Executive Officer, Devon Partnership NHS Trust • Director of Children's Services, Torbay Council • Director of Adult Social Services, Torbay Council • Director of Integrated Adult Social Care • NHS Parliamentary Awards • Ministerial Round Table • Park Run Teignmouth promenade • Interview panel - Divisional Director Adult Social Care Commissioning

5. Local health and care economy developments

5.1 Partner and partnership updates

5.1.1 Integrated Care System for Devon (ICSD)

The Integrated Care Board update is attached.

6 Local media update

6.1 News release and campaign highlights include:

We continue to maximise our use of local and social media as well as our website to ensure that the people of Torbay and South Devon have access to timely, accurate information, to support them to live well and access services appropriately when needed.

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

Recent key media releases and responses:

- health matching programme receives parliamentary award – celebrating the news that our Health Connect Coaching programme, which matches people who

may be struggling with their health and wellbeing to a trained peer coach who has experience of the same condition or challenges, won a regional parliamentary award as part of the NHS 75th birthday celebrations
- NHS Homes Alliance founding member – promoting the NHS Homes Alliance, a collaboration to provide houses for NHS people, of which we are a proud founding member
- parkrun for the NHS – encouraging people to take part in their local parkrun as part of celebrations for the NHS' 75th birthday
- local nurse takes on skydive challenge – Marco, a nurse on Templer ward at Newton Abbot Community Hospital, is taking part in a charity skydive to raise funds for additional equipment on the ward
- new county-wide service to support people affected by cancer – promoting a new service provided by Macmillan and Citizens Advice which offers money and benefits advice to people affected by cancer and their families

Recent engagement on our social media channels includes:

- national healthcare estates and facilities day – thanking the amazing people working across our workplace teams, as senior leaders and members of the executive team visited different departments
- #Red4Research – celebrating the work of our research and development teams and people working in research across the country, as our teams wore red to show their support and appreciation
- Nurses League garden furniture donation – thanking our Torbay Hospital Nurses League who donated garden furniture for our Acute Medical Unit team's outside space
- DAISY award representative presentation – we welcomed Melissa Barnes from the international DAISY Foundation who presented two of our latest DAISY award winners with their certificates during her visit
- charity fundraising donation for Louisa Cary – thanking the fabulous 11-year-old Akashnil Dey who raised £440 to fund books and toys for children on Louisa Cary ward by running 20k over four weeks
- HeArTs gallery exhibition – promoting the latest exhibition at our HeArTs gallery at Torbay Hospital; 'Above us only Sky' by Steve Manning
- Lottie's colour run – Lottie, organ donation campaigner and honorary director, organised a colour run at her school to raise funds towards an organ donor memorial at Torbay Hospital
- virtual work experience – promoting our brand new virtual work experience software and programme
- hospital cricket and rounders match – thanking people for attending and supporting the medics vs rest of the hospital cricket and rounders matches at Barton Cricket Club

Development of our social media channels:

Channel	End of year target	As of 31 March 2021	As of 30 June 2023
LinkedIn	8,000 followers	2,878	6,318 followers ↑ 3,440 followers
Facebook	15,000 likes	12,141	14,015 ↑ 1,874 followers

Twitter	8,000 followers	6,801	7,940 followers ↑ 1,139 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

July 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 5 July 2023

1. NHS 75th anniversary
2. Devon 5-year Joint Forward Plan
3. Board Assurance Framework
4. Safeguarding Annual Report 2022-2023
5. Integrated Quality, Performance and Finance report
6. Specialised acute provision, people with learning disability or autism
7. Finance report

1. NHS 75th anniversary

Members of the Board heard staff tributes to the NHS to mark the 75th anniversary of its founding. They also contributed their own stories and watched a film in which clinicians and management staff told of the changes they had witnessed during their careers and spoke of their predictions for the future.

GP Dr Tom Debenham, for example, said he expected a wholesale transformation in healthcare through epigenetics, which will allow treatment to be tailored specifically for each individual patient.

The Board chair, Dr Sarah Wollaston, spoke of the "everyday miracles" seen each day in the NHS and thanked all staff for making the service one to be proud of.

2. Devon 5-Year Forward Plan

The Board approved the Devon 5-Year Joint Forward Plan, hearing of the extensive engagement that had been carried out in its drafting. All three local authority Health and Wellbeing Boards had endorsed it as consistent with their strategies.
The chair endorsed comment that as the plan is developed over the course of its lifetime, it will need to pay due regard to its duties under the Armed Forces Act which covers healthcare for those who are serving, veterans, reserves and families.

3. Board Assurance Framework

The Board noted that risks included in the 5-Year Forward Plan had been mapped across to the Board Assurance Framework, reflecting risks in both the delivery and enabling programmes of the plan.

It approved a recommendation that risks pertaining to inequalities and population management should be kept separate rather than merged, to give the new Population Health Committee the opportunity to review them.

It also approved the inclusion of a new risk concerning the need to embed a new culture to allow changes to the current system ways of working in order that healthcare provision for the Devon population be improved. The risk was rated at 16, with a potential major impact but with little likelihood of materialising.

4. Safeguarding Annual Report

The Board approved the Safeguarding Annual Report, after discussion about the onerous current governance arrangements which see NHS Devon staff needing to attend 37 different meetings. The Chief Executive, Jane Milligan, said work was under way to streamline these reporting mechanisms, with the goal of NHS Devon and its partners agreeing on the right attendance at the right meetings.

Members also noted that services to support the emotional health and wellbeing of children in care or leaving care need to be given high priority. Actions resulting from a recent national-level visit will be circulated to members and discussed in detail at the next Board meeting.

5. Integrated Quality, Performance and Finance

Operationally, prolonged industrial action by frontline staff had had an impact on performance, albeit not on the safety of care. The recovery period after these spells of industrial action also needed to be understood by members. Nonetheless, performance in unscheduled care was now just short of the planned trajectory of improvement, and there had been better performance in elective (planned) care as well. The proportion of those remaining in hospital when they had no medical need to be there had fallen to 9%, even given a reduction in the care market.

6. Specialised acute provision, people with learning disability or autism

A business case for new specialised acute provision was approved for people who find it hard to access existing services – mainly those with learning disability or autism. Currently, this group may need to use services outside the region. With national funding, two appropriate units are proposed for the southwest, one in the north of the region and the other in Devon, providing 10 beds at the Langdon Hospital site near Dawlish. This was an opportunity to develop an innovative model to help people avoid long-term residential care.

The Finance Committee had approved the business case after considering risks to the budget and finance, particularly as there would be double running costs for the first two years. It had been satisfied that these risks could be mitigated.

Local authorities, particularly Overview and Scrutiny Committees, had been engaged over the proposal.

7. Finance report

In financial performance, NHS Devon ICB in month two of the financial year had shown a position very slightly adverse to plan, and the programme for a cost reduction in the

year of £150 million was well on track. As a Devon system, more than £30 million of the required £60 million saving had been identified, with project initiation plans and plans on a page drawn up.

Trusts in Devon were also showing a modest adverse variance from plan, mostly due to industrial action.

One area for imminent attention would be the Devon Referral Support Service, which supports GP practices in securing the most appropriate care and services for their patients. This was described as an effective but traditional services which operated on a call-centre model and allowed room for innovation, including use of AI.

The Board heard that the spend on mental health services in Devon was proportionally higher than in other integrated care boards; this did not exempt it from the requirement to increase its spend as a proportion of budget.

The focus in finance for the next three months would be on delivery, to curb costs and provide a better position for next year. The goal remained to exit national direction measures (NOF4) by the end of quarter one in 2024/25.

The Board welcomed the report and agreed it gave cause for cautious optimism.

ENDS

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 3 2023/24 (June 2023 data)			Meeting date: 26 July 2023
Report appendix	M3 2023/24 IPR Dashboard of key metrics M3 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: 4 July 2023 Executive Director sign off: 20 July 2023 Finance, Performance, and Digital Committee: 24 July 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	X	**Valuing our workforce**	X
Improved wellbeing through partnership		**Well-led**	X

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

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

External standards affected by this report and associated risks	

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

This report reflects the following corporate risks:

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

Report title: Integrated Performance Report (IPR): Month 3 2023/24 (June 2023 data)		**Meeting date: 26 July 2023**
Report sponsor	Deputy CEO and Chief Finance Officer	
Report author	Head of Performance	

Introduction:

The Integrated Performance Report pulls together key metrics and performance exceptions across quality, workforce, performance, and finance.
The report highlights areas of risk that have been escalated through governance meetings 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.

Quality Headlines:

Incidents
In June 2023, one incident of severe harm and one incident of death were reported onto the national StEIS (Strategic Executive Information system). The incident resulting in death was an inpatient fall which resulted in a large acute subdural haematoma. There was a delay in confirming diagnosis via CT scan. Subsequently the patient deteriorated and passed away shortly after. The severe incident was an inpatient fall which resulted in an acute on chronic subdural haemorrhage as well as fractured ribs and a fracture at the base of the skull. Reducing falls remains a Trust priority and we are now significantly above the national average for completing lying and standing blood pressure, as part of the Falls Safe Bundle.

Stroke
The Sentinel Stroke National Audit Programme (SSNAP) results have now been published covering the period Jan to March 2023. The score was the services highest SSNAP score since 2021, with George Earle ward retaining a grade of D. Improvement against all 6 of the target indicators was achieved in the Specialist Assessment domain. However, collectively the score remained an E with median time to see a stroke nurse and a stroke consultant being 2 indicators which remain a challenge.

VTE (Venous Thromboembolism) Assessment
VTE assessment compliance demonstrated a conformity for all in patients of 96.5% in June 2023 which is a slight improvement from the May position. The VTE Steering Group are currently reviewing the frequency of its meetings due to the trust-wide sustained meeting of the 95.0% national targets with a consideration of reducing to bi-monthly. Those areas that are not achieving the standard required are being supported by the VTE Steering Group.

Infection, Prevention, and Control:
Bed closures saw a decrease from 120 in May 23 to 99 in June 2023. The reason for the decrease was mainly the change in national guidance for patients who test positive

for COVID-19. Management of these patients continue to follow IPC (Infection Prevention and Control) guidelines and Public Health England guidance.

Maternity
There were no stillbirths or fetal loses in June 2023.

Torbay and South Devon NHS Foundation Trust was successful in achieving 10 out of 10 safety actions for year 4 of the Maternity Incentive Scheme, which supports the delivery of safer maternity care through an incentive element to trust contributions to the Clinical Negligence Scheme for Trusts.
In the South West region only 7 Trusts achieved full compliance. The Year 5 Maternity Incentive Scheme was launched at the end of May 2023. Evidence of Trust compliance, via self-declaration, is required to be submitted by the 1st of February 2024.

Safer Staffing
The Registered Nurse fill rate for days during June was 99.8% which is an increase on the May fill rate of 97%, and the night duty fill rate was reported as 87.5%, a slight decrease on the previous months fill rate of 91%.
The fill rate for Health care support workers for days is 102% for days, which is an increase on May figures of 100.7% and 118% for nights which is comparable with May figures of 119.0%.

Workforce Headlines:

Progress in delivering the workforce implications of the Operational Plan
Whilst the Trust achieved the workforce plan in May for substantive Whole Time Equivalent (WTE), in June the position is over plan by 18 WTE. The Trust has not achieved the WTE targets for bank and agency, with bank currently standing at 115 WTE above plan and agency 134 WTE over plan. As part of the recovery controls process enhanced vacancy and scrutiny measures have been established.

Local workforce factors affecting NOF4 exit criteria and mitigating actions
Workforce is one of the key factors affecting specialties that are challenged in delivering RTT performance targets. Substantive clinical and consultant vacancies are seen across several of the most challenged areas of ENT, Urology, Gynae Colorectal and Neurology. A number of actions are being taken in mitigation, these include the development of marketing materials, workforce modelling and collaborating with other Trusts.

Overview of workforce metrics
The turnover and sickness rates for June are higher than those forecasted in the operational plan, however, significantly lower than the same time last year.

Mandatory training compliance continues to perform well overall at 91.74%. At a topic level we remain challenged in Manual Handling at 78% and Information Governance at 87% compliance.

Whilst improving marginally each month since February, we remain challenged around Achievement Review compliance at 78% against the target of 90%. Visibility of this data at cost centre level, as well as through Care Group and assurance meetings, remains in place to support improvement plans.

Performance Headlines:

The Chief Operating officer report gives a detailed account of current performance against Planned Care, Unscheduled Care, Families, Community, and Home Care Groups including Adult Social Care, and Children and Family Health Devon (CHFD).

The IPR provides the performance oversight against the National Operating Framework performance targets.

There has been a change in terminology relating to the System Operating Framework (SOF); this is now the National Operating Framework (NOF). It is noted that in all respects there are no other changes.

The Trust remains in level 4 performance against the National Operating Framework (NOF). Level 4 exit criteria are summarised in the Performance Focus Report. Where the exit criteria is not being met, exception reports have been created for executive oversight and covers operational update, actions identified, and risks and issues.

Extensive performance oversight and scrutiny with the ICB and our regulators, is in place through monthly executive meetings, including the System Improvement Assurance Group (SIAG) and other key weekly groups focusing on delivery of key performance targets.

Urgent and Emergency Care NOF 4 headlines:

	Target	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Operational Plan trajectory June 2023
SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA															
Urgent and Emergency Care															
Percentage of Ambulance handovers greater than 15 minutes		80.0%	77.0%	78.3%	77.5%	84.4%	82.2%	87.5%	66.5%	54.8%	73.9%	55.4%	72.1%	72.1%	No trajectory
Percentage of Ambulance handovers greater than 3 hours		19.8%	16.7%	19.5%	23.8%	27.0%	18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	No trajectory
Total average time in ED (hours/minutes)		07:22	07:02	07:06	07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	No trajectory
ED attendances where visit time over 12 hours	0	871	827	920	906	988	939	1207	823	599	977	568	891	797	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	54.5%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	65%
% patient discharges pre-noon	33%					18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	33%
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%	6.0%	7.0%	10.0%

2023/24 RAG indicator

Meeting monthly trajectory

Not meeting monthly trajectory

- Overall, the Trust's Urgent and Emergency Care (UEC) performance was 64.6% against the trajectory of 65%.
- Ambulance handover improved in June which is notable against the reported total hours lost. The percentage of patients waiting over 15 minutes remained unchanged at 72% with a reduction in longer delays contributing to the reduction in total hours lost.
- The Trust has continued to meet the trajectory for the percentage of beds occupied with No Criteria To Reside with 6% of occupied beds in June reported as No Criteria To Reside.
- Operational focus remains on improving the discharges earlier in the day. 19.9% of discharges were achieved before noon. against the 33% target.

Elective Recovery NOF 4 headlines:

	Target	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Operational Plan trajectory June 2023
SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA															
Elective recovery															
RTT 104 week wait incomplete pathway	0	96	70	51	50	47	34	29	22	14	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	713	686	787	813	829	822	923	708	462	183	166	167	123	130
RTT 65 week wait incomplete pathway	0			2093	2252	2485	2174	2203	1828	1679	1372	1244	1168	1221	1814
RTT 52 week wait incomplete pathway	Reduction	4137	4578	5083	5060	5412	5585	6027	5554	5116	4427	4024	3926	3938	5982
Patient waits over 2.5 years	0	48	54	47	24	24	17	12	9	6	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	64.8%	67.7%	72.1%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	75.5%	78.0%	77.7%	75%
Number of patients waiting longer than 62 days for treatment	138	233	283	244	333	331	229	253	225	130	114	107	111	100	152

2023/24 RAG indicator
Meeting monthly trajectory
Not meeting monthly trajectory

Elective Referral to Treatment (RTT)

- The zero 104-week patient wait target was again achieved at the end of June 2023.
- Against the 78-week RTT target the Trust reported 123 breaches against a plan of 130.
- Against 65-week RTT target the Trust reported 1196 against a plan of 1312.

Cancer standards

NHS England benchmark Trusts on their Faster Diagnosis Performance and 62-day backlog position, against their target. For Torbay, as of 3 July 2023, we remain 38 patients below our expected backlog position of 138 and are achieving the Faster Diagnosis Standard. Consequently, Torbay rank 90 out of 122 Trusts; this is a positive position, where the highest-ranking Trusts are the worst performing. As a result, TSDFT is no longer in Tier 1 or Tier 2 levels of escalation for cancer care.

Diagnostics

The Trust reported in June 24.3% of patients waiting longer than 6 weeks against the target of 15% by March 2024.

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.

Finance headlines

As at Month 3 the Trust reported an overall favourable variance to plan of **£0.3m**. This consists of a **£1.33m** Year to Date (YTD) favourable variance for operating income (0.8% of budget), partially offset by an adverse variance of **£1.10m** in operating expenditure, mainly due to pay award being agreed and adjusted on both income and expenditure.

It is important to note that our Cost Improvement Plan (CIP) target is phased comparably light in Q1 which had contributed to the overall favourable variance at

this stage of the year, however the forecast position will be closely monitored, and associated risks continuously reported.

The YTD operating expenditure also includes an unplanned cost pressure of **£0.6m** due to industrial actions, anticipating that this cost will escalate further with industrial actions planned in July and August, additional risks have been included in the risk and mitigation schedule and shared with ICB and NHSE/I.

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 **(£14.5m)** adverse, largely due to further pay down of the capital creditor. The plan assumed that this would have happened at the end of the prior year.

Debtor movement is £11.0m favourable, which is principally due to the 22/23 pay award. Working capital variance mainly relates to payment for DPT CFHD and pay award.

Integrated Performance Focus Report (IPR)

Torbay and South Devon NHS Foundation Trust

July 2023: reporting period June 2023 (Month 3)

Working with you, for you

National 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.

From June 2023 this is now known as the National Outcomes Framework (NOF).

Exiting NOF 4 is the key objective to achieve over the coming months and measured against a set of exit criteria for key performance measures, based on the Operational Planning Guidance for 2023/24.

In support of the performance standards relating to Elective Recovery the Trust has received support from NHSE intensive support team to review plans to treat the cohort of longest wait patient in 2023/24. This work has culminated in increased assurance that the Trust will meet the National target to have no patients waiting over 65 weeks by March 2024.

Tier 1 performance oversight:
The Trust remains in the Tier 1 performance regime from NHS England against Referral to Treatment (RTT) long waits. In June, the Trust met the exit criteria to be removed from NHSE oversight Cancer performance monitoring, following sustained improvements on our Key Lines Of Enquiry cancer standards. The weekly executive meetings with the Southwest region performance leads, continue to review progress and gain assurance on agreed action plans.

National Operational Framework (NOF)
Exiting NOF 4 remains the key Trust objective, therefore, the performance section of this month's IPR (Integrated Performance Report) focuses on progress against the NOF 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 NOF governance and reporting – System Improvement and Assurance Group (SIAG)
Monthly meetings are in place to review system progress and Trust level reports against NOF exit criteria. This meeting is attended by all provider CEO's and ICS system leads.

National Oversight Framework 4 Exit Criteria – Indicative Measures

The set of exit criteria below will be used to monitor the Trusts performance levels required to exit NOF 4.

Each indicative measure has a target to be achieved to exit NOF 4 with local trajectories 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 NOF 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

National 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 NOF 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)	No	No
Ambulance handovers greater than 15 minutes	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	No trajectory	No
Over 12-hour visit time; and ED (type 1) 4-hour target	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	No trajectory	No
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	Yes
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 Officer Highlight Report

Torbay and South Devon NHS Foundation Trust

Matters of concern/key risks to escalate	Major actions commissioned/work underway
• Ongoing Industrial Action • TIFF Theatre delivery of activity, recruitment of workforce. • Infection outbreaks impacting on staff and bed availability • Seasonal uplift in activity – specifically walk in attendances • Medical workforce gaps and the availability of locums to support	• Development of space and process changes within ED for non-admitted patient performance improvement • Review of Pathway 1-3 processes report completed and under review • ECIST support to Frailty pathway
Positive assurances	**Decisions made**
• Planned care performance improving • UEC 4hr performance above 60% for third month in a row and on track to improve. • ECIST highlighting good UEC performance • Management of Industrial Action and Bank Holidays resulting in lower numbers of cancellations and improved flow. • Establishment of Urgent and Emergency Care Board and Planned Care Board • TIF funding letter received	• NOF4 Communications strategy agreed • Organisational reshaping implemented • ED Focus week completed. Analysis underway. • Ringfencing of AMU level 2 to protect capacity for SDEC

National Oversight Framework (NOF) 4 Exit Criteria – Urgent and Emergency Care Performance Summary

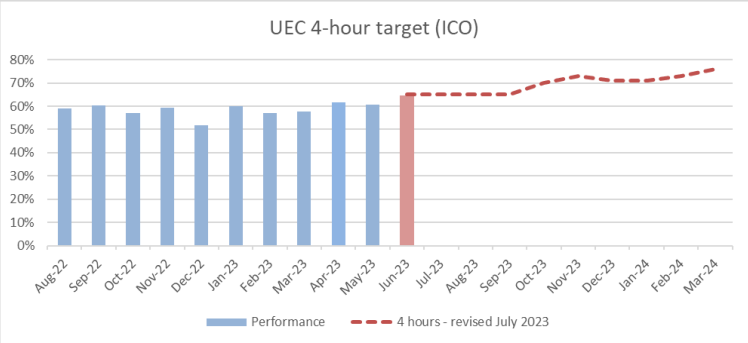
Torbay and South Devon NHS Foundation Trust

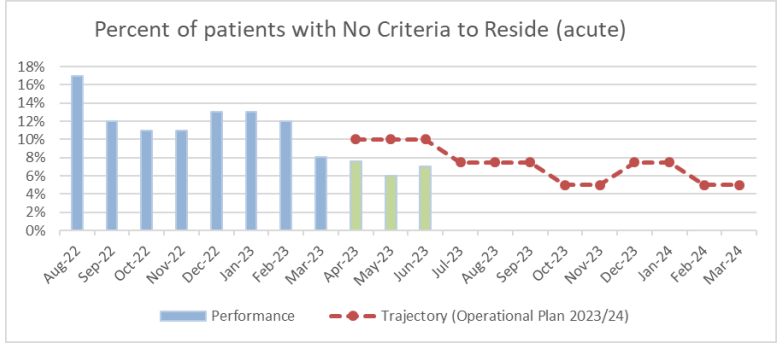
	Target	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Operational Plan trajectory June 2023
SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA															
Urgent and Emergency Care															
Percentage of Ambulance handovers greater than 15 minutes		80.0%	77.0%	78.3%	77.5%	84.4%	82.2%	87.5%	66.5%	54.8%	73.9%	55.4%	72.1%	72.1%	No trajectory
Percentage of Ambulance handovers greater than 3 hours		19.8%	16.7%	19.5%	23.8%	27.0%	18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	No trajectory
Total average time in ED (hours/minutes)		07:22	07:02	07:06	07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	No trajectory
ED attendances where visit time over 12 hours	0	871	827	920	906	988	939	1207	823	599	977	568	891	797	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	54.5%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	65%
% patient discharges pre-noon	33%					18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	33%
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%	6.0%	7.0%	10.0%

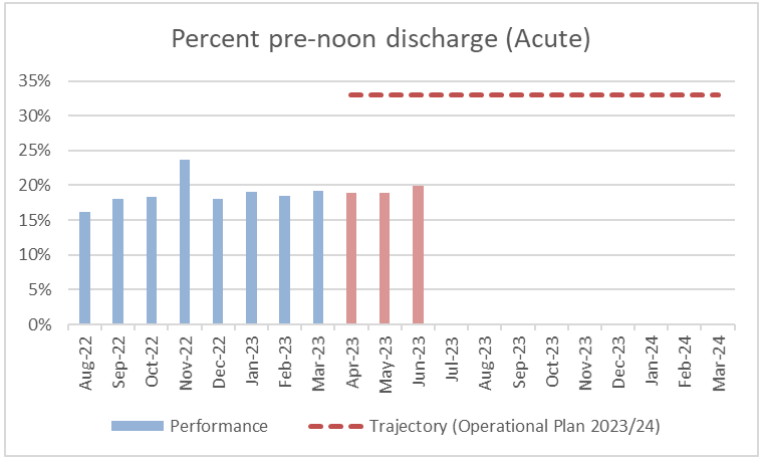
Trajectories have been agreed across a number of indicators as part of the 2023/24 Operational Plan submission. The latest month trajectory, where applicable, is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories.

2023/24 RAG indicator

- Meeting monthly trajectory
- Not meeting monthly trajectory







1 of the 7 indicators has met the agreed monthly trajectory. Exception reports have been completed where the trajectory / target has not been met.

This month exception reports are included for:

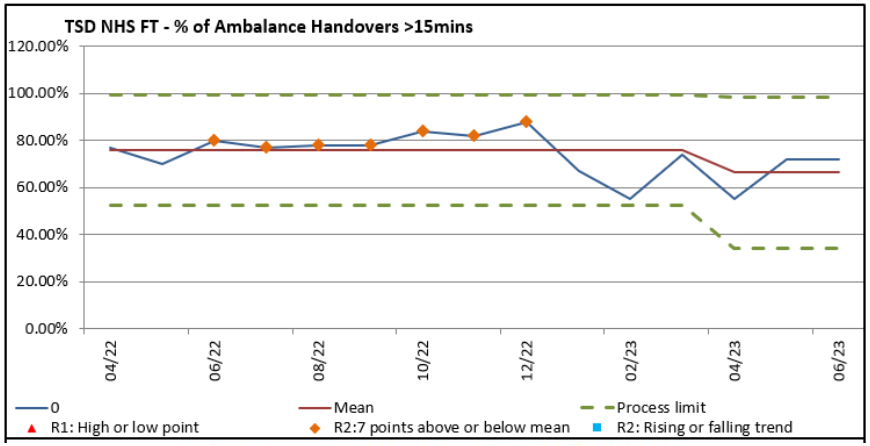
1. Ambulance handover times
2. Total average time in ED
3. ED attendances over 12 hours
4. UEC 4-hour target
5. Patient discharges pre-noon

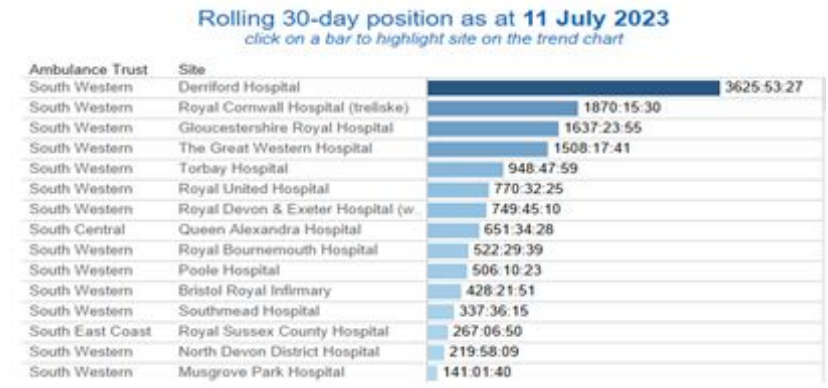
Exception report: Ambulance Handovers over 15 minutes: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

Ambulance 15mins handover delays remained the same for June as May with 72.1% breaching the standard. The 30-day rolling average, however, for time lost to ambulance delays has improved from 60hr at the start of June to 38hrs at the end of June. July already show further improvement down to 27hr lost per day.





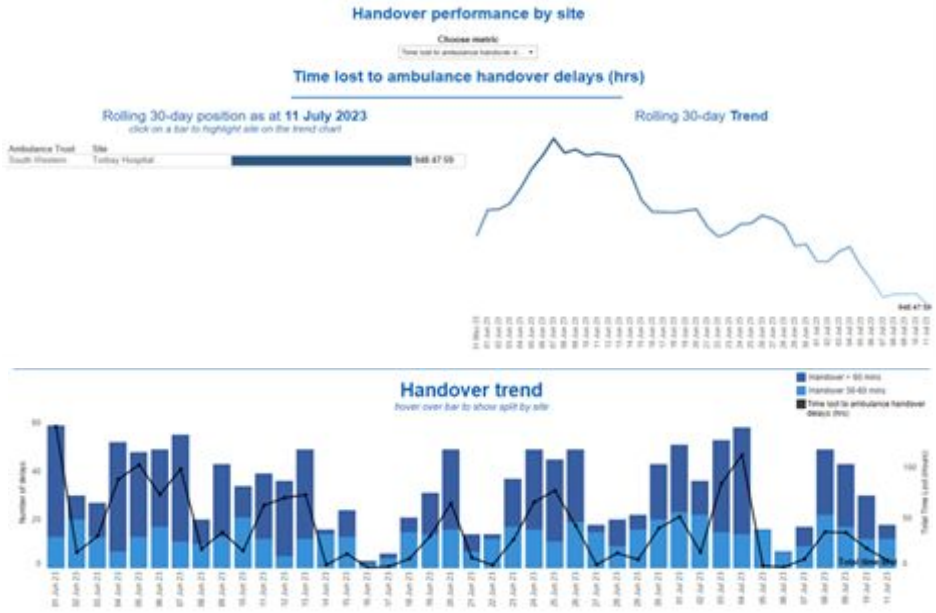
Operational update

The Trust continues to make progress on ambulance handover delays. Comparing this year with last – average ambulance attendances are up from 59 to 68.

Despite the increase in activity handover breaches over 15 mins have decreased from 80% June 22 to 72.1% June 23. Ambulance handovers exceeding 3hrs have likewise mirrored this improvement with 19.8% performance in June22 compared with 7.5% June 23.

A combination of high occupancy and flow out of the department were the contributing factors adding to the delays in conjunction with a period of industrial action.

Further improvements are already being realised in July – see below.



Actions to complete next month

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

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

Risks/issues

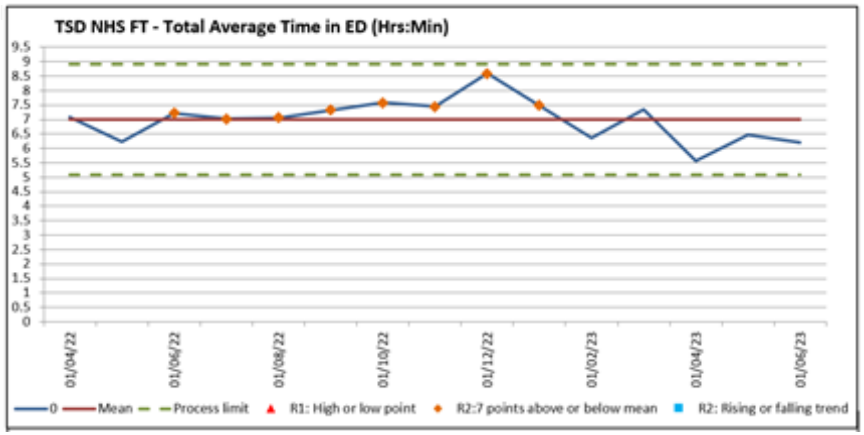
- Further infection control issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

Exception report: Total average time in ED: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

May saw a decrease in the total average time in the Emergency Department to 06.20hours hours from 06.48hours the previous



Operational update

Progress is being made on the average time in department despite growing attendances numbers.

Higher attendances contributed to longer waits, specifically in delays to see patients in the waiting area, where space is at a premium to manage patient flow.

Comparing the previous year, activity to the emergency department is up from 5733 in June 22 to 6406 June 23. Despite the increase average time in the department has decreased from 7hr 20 June 22 to 6hr 20mins June 23.

Actions to complete next month

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

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

In addition to the above, the following actions are underway:

- Confirmation of SDEC, JETS, Frailty and AMU Level 2 configuration to support ED Escalation bed reconfiguration to support the non-admitted pathway.
- Virtual Ward – plan currently above trajectory therefore sustaining increased activity
- Focus on quick win non-admitted pathways following learning from the Emergency Department improvement week.

Risks/issues

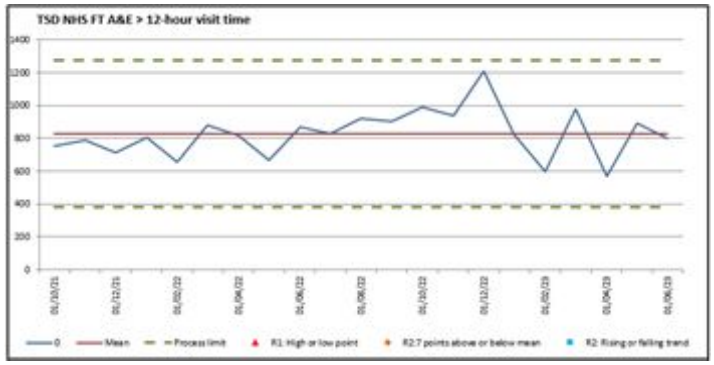
- Further infection control issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

Exception report: Over 12-hour visit time: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

June 12 hour performance improved from the previous month and mirrored ambulance delays and total average time in ED. In June 797 patient attendances exceeded 12hrs compared with 891 in May.



Operational update

Progress is being made on 12hr performance in department despite growing attendances numbers.

Higher attendances contributed to longer waits, specifically in delays to see patients in the waiting area, where space is at a premium to manage patient flow.

Comparing this period with last year 12hr breaches have moved from a position of 871 in June 22 to 797 June 23.

Actions to complete next month

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

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

In addition to the above, the following actions are underway:

- Confirmation of SDEC, JETS, Frailty and AMU Level 2 configuration to support ED Escalation bed reconfiguration to support the non-admitted pathway.
- Virtual Ward – plan currently above trajectory therefore sustaining increased activity
- Focus on quick win non-admitted pathways following learning from the Emergency Department improvement week.

Risks/issues

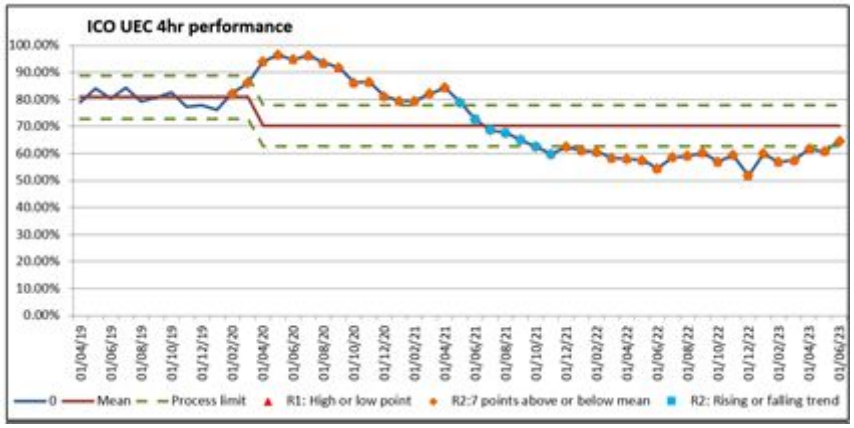
- Further Infection issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action

Exception report: 4-hour ED target: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

ED Type 1 performance 45.9%
ICO Performance 64.6%



Operational update

- Overall attendances decreased from 6488 to 6409. We achieved 45.9% against our ED 4-hour target.
- Our type 3 demand (UTC and MIU) increased from 3521 to 3585 in June. We achieved 98.91% against our Type 3 4-hour target an increase in performance from 98.35 in May.
- ICO attendances saw a reduction from 10009 to 9991 in June
- Overall, our UEC performance was 64.63% up from 60.83% in May.
- This is the third consecutive month where ICO (Integrated Care Organisation) performance is above 60% since February 2022. Performance for June is at a level higher than any month since Sept 2021.

Comparing this year with last – performance in June 22 was 54.5% following 8650 ICO attendances.

Actions to complete next month

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

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

- In addition to the above, the following actions are underway:
- Confirmation of SDEC, JETS, Frailty and AMU Level 2 configuration to support ED Escalation bed reconfiguration to support the non-admitted pathway.
- Virtual Ward – plan currently above trajectory therefore sustaining increased activity
- Focus on quick win non-admitted pathways following learning from the Emergency Department improvement week.

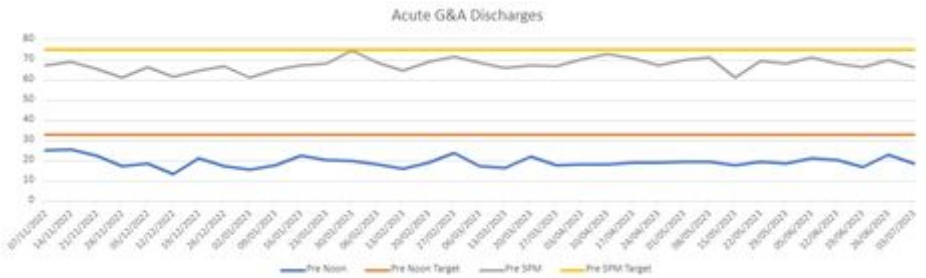
Risks/issues

- 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: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance - May

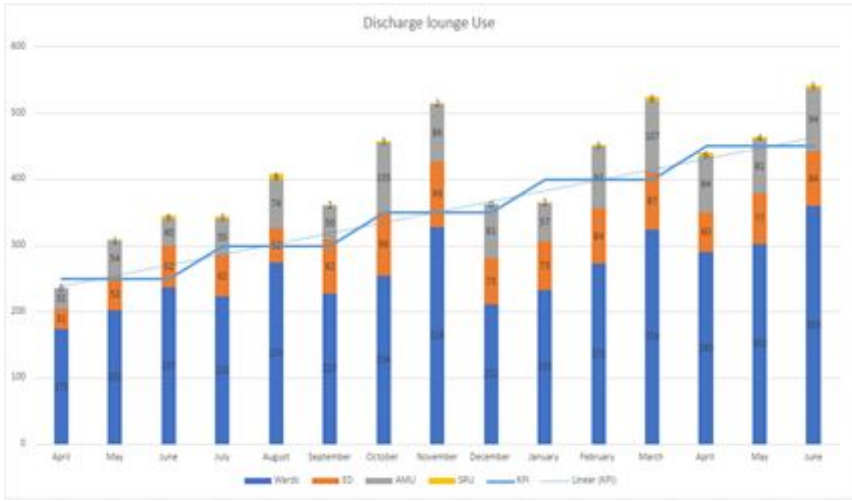


We saw an improvement in our overall general and acute discharges in June totalling 1751 compared with 1697 in May. The percentage discharges pre 5pm improved and the total numbers discharged before 5pm increased. Pre –noon discharges increased in month supporting flow and performance. The Flow and Ward 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

	Pre-noon	Pre 5PM
May	18.9%	69.8%
June	19.9%	69.2%

Operational update

The Discharge Lounge (DCL) remains a key part of the strategy for generating timely ward capacity. June saw 542 patients attend the discharge lounge - the highest number since records started back in April 2022.



Actions to complete next month

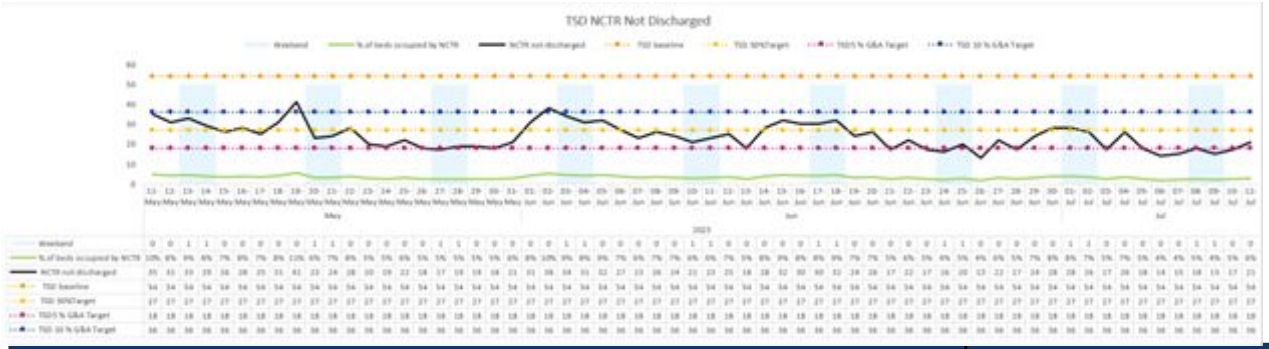
- Secure UEC funding - winter uplift of workforce in discharge lounge.
- Ward Nurse Flow Training Programme.
- Develop learning from industrial action successes – specifically overnight confirmation of tomorrows discharges, Transport, and Care Planning Summaries.
- Discharge Audit – review
- Pre-noon discharge comms drive.
- Home for lunch.
- Patient transport and TTA monitoring via the Control Room

Risks/issues

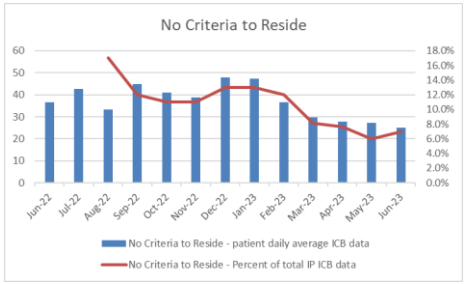
- Further infection issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Consistent additional staffing support to the discharge team at weekends and senior cover

Exception report: No criteria to reside: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust



Performance - May



The average number of patients with No Criteria To Reside (NCTR) was 7% for June. **Achieving 5% for 8 days in the month.** We continue to have the lowest NCTR across the ICB.
July has already further progress with 4% NCTR days.

Operational update

Key actions that have supported the improvement in NCTR

- Trusted placement assessor.
- Occupational therapy in reach model – recruitment of second post.
- Flexible team and social care services
- Process review of Discharge to Assess (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
- Job description review of Lead DISCO to move into an 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 working up trials of change for JETS and McCullum ward

Actions to complete next month

- Addressing the influx of referrals on Fridays leading into the weekend
- Internal audit of the processes of Discharge Team - scoping improvements
- Review of pre-referral patients to the hub.
- Improvement x2 weeks of McCullum ward becoming a central hub for NCTR Patients

Risks/issues

- Further infection control issues
- Uplift in activity as a result of bank holiday and seasonal activity
- Further industrial action linked to the bank holidays
- Local Care Market to support patient discharges

National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

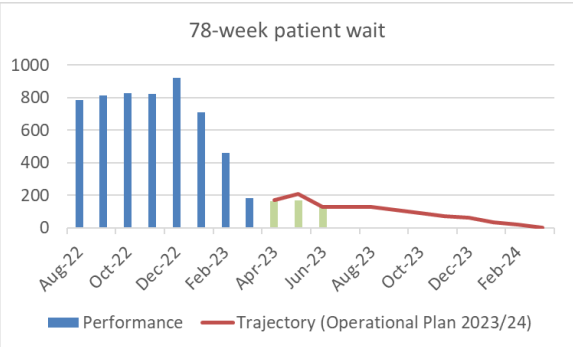
Torbay and South Devon NHS Foundation Trust

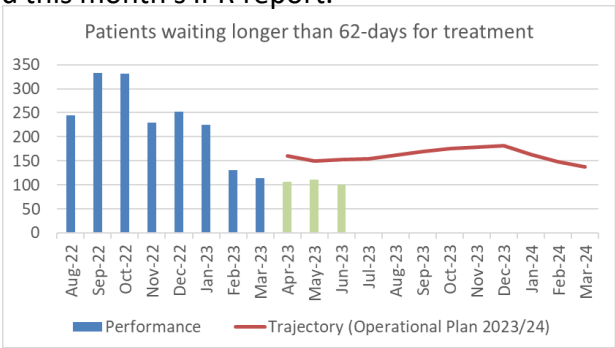
	Target	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Operational Plan trajectory June 2023
SYSTEM OVERSIGHT FRAMEWORK EXIT CRITERIA															
Urgent and Emergency Care															
Percentage of Ambulance handovers greater than 15 minutes		80.0%	77.0%	78.3%	77.5%	84.4%	82.2%	87.5%	66.5%	54.8%	73.9%	55.4%	72.1%	72.1%	No trajectory
Percentage of Ambulance handovers greater than 3 hours		19.8%	16.7%	19.5%	23.8%	27.0%	18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	No trajectory
Total average time in ED (hours/minutes)		07:22	07:02	07:06	07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	No trajectory
ED attendances where visit time over 12 hours	0	871	827	920	906	988	939	1207	823	599	977	568	891	797	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	54.5%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	65%
% patient discharges pre-noon	33%					18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	33%
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%	6.0%	7.0%	10.0%

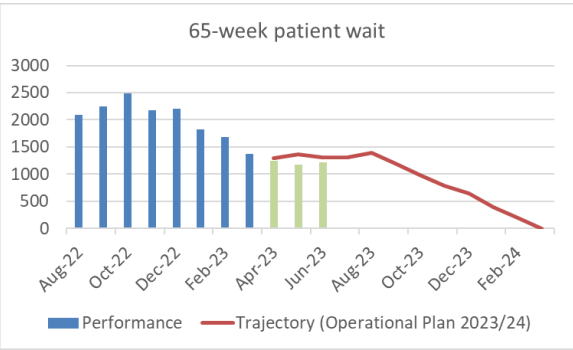
Trajectories have been agreed across a number of indicators as part of the 2023/24 Operational Plan submission. The latest month trajectory, where applicable, is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories.

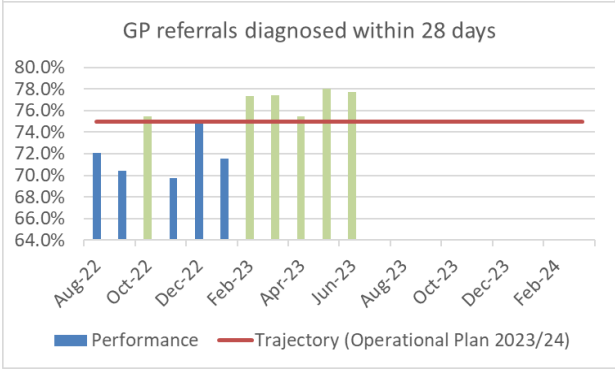
All the Elective Recovery indicators have been met in June against the agreed monthly trajectories. No exception reports are included this month's IPR report.

2023/24 RAG indicator
- Meeting monthly trajectory
- Not meeting monthly trajectory









Actions on-going this month

- Engagement with "Further Faster" work programme;
- Targeted Investment Fund (TIF) day case theatres - remains on track;
- Surgical and Outpatient Transformation programmes on track;
- Insourcing to support most challenged long-wait specialties;
- Continued utilisation of the Nightingale elective centre – orthopaedics / cataract surgery and diagnostics.

Risks and Barriers

- Industrial action – some loss of capacity will impact on long wait clearance trajectories; mitigations in place to minimise impact;
- Workforce – clinical, nursing, admin – insourcing supporting clinical gaps in clinical workforce capacity - HR programme to support recruitment and retention with ICS system support.

Quality and Safety Indicators – dashboard of key metrics

Torbay and South Devon NHS Foundation Trust

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 (<20)		⬆
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%)		⬇
Number of Clostridium Difficile cases (COHA+HOHA)		⬌
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 June 2023, one incident of severe harm and one incident of death were reported onto the national StEIS (Strategic Executive Information system). The incident resulting in death was an inpatient fall which resulted in a large acute subdural haematoma. There was a delay in confirming diagnosis via CT scan. Subsequently the patient deteriorated and passed away shortly after. The severe incident was an inpatient fall which resulted in an acute on chronic subdural haemorrhage as well as fractured ribs and a fracture at the base of the skull.

Stroke

The Sentinel Stroke National Audit Programme (SSNAP) results have now been published covering the period Jan to March 2023. The score was the services highest SSNAP score since 2021, with George Earl ward retaining a grade of D. Improvement against all 6 of the target indicators was achieved in the Specialist Assessment domain. However, collectively the score remained an E with median time to see a stroke nurse and a stroke consultant being 2 indicators which remain a challenge.

VTE (Venous Thromboembolism) Assessment

VTE assessment compliance demonstrated a conformity for all in patients of 96.5% in June 2023 which is a slight improvement from the May position. The VTE Steering Group are currently reviewing the frequency of its meetings due to the trust-wide sustained meeting of the 95.0% national targets with a consideration of reducing to bi-monthly. Those areas that are not achieving the standard required, are being supported by the VTE steering group.

Those areas that are not achieving the standard required, are being supported by the VTE Steering Group.

Infection, Prevention, and Control:

Bed closures saw a decrease from 120 in May 23 to 99 in June 2023. The reason for the decrease was mainly the change in national guidance for patients who test positive for COVID-19. Management of these continue to follow IPC (Infection Prevention and Control) guidelines and Public Health England guidance.

Maternity

There were no stillbirths or fetal loses in June 2023.

Torbay and South Devon NHS Foundation Trust was successful in achieving 10 out of 10 safety actions for year 4 of the Maternity Incentive Scheme. (The scheme supports the delivery of safer maternity care through an incentive element to trust contributions to the Clinical Negligence Scheme for Trusts (CNST))

In the Southwest region only 7 Trusts achieved full compliance. The Year 5 Maternity Incentive Scheme was launched at the end of May 2023. Evidence of compliance via self-declaration by Trusts is to be submitted by the 1st of February 2024.

Safer Staffing

The Registered Nurse fill rate for days during June was 99.8% which is an increase on May fill rate of 97%, and for night duty reported as 87.5%, a slight decrease on the previous months fill rate of 91%.

The fill rate for Health care support workers for days is 102% for days, which is an increase on May figures of 100.7% and 118% for nights which is comparable with May figures of 119.0%.

CQC Update 2020 and 2021 action plans

Torbay and South Devon NHS Foundation Trust

2020 CQC inspection

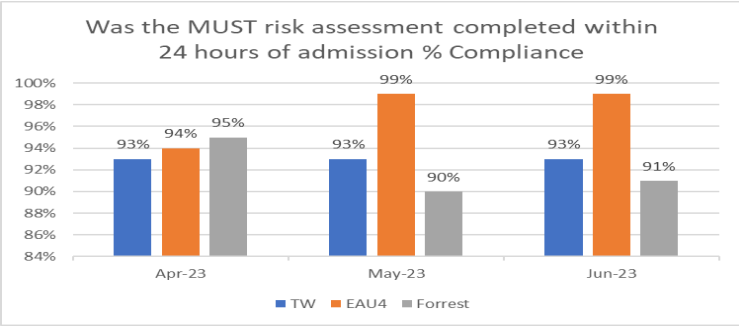
The action plan arising from the 2020 CQC inspection is nearing completion, and all closed actions continue to have oversight through the ISU's. The Trust has one remaining Must Do action regarding staff appraisal achievement rate. The Trust position in June 2023 was reported as 78.2%. The People Directorate 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 5 patient Risk Assessment audits continue to be being recorded electronically and the results viewed in real time. The audit covers 43 questions across several assessments and daily, weekly, and monthly compliance reports are generated. Malnutrition Universal Screening Tool (MUST) risk assessment completion within the 24-hour time standard, has a trust wide compliance rate of 93%.

June 2023 Data

- ✓ Trust wide nutritional risk assessments completed within 24 hours was 93% in June which has been consistent across the last 3 months.
- ✓ Forrest Ward continues to demonstrate a high compliance rate of 91%
- ✓ EAU4 recorded 99% compliance



16

CQC 2023 Inspections

Torbay and South Devon NHS Foundation Trust

CQC Well Led Inspection

Radiology & Imaging

The CQC undertook the 4th Core Service inspection as part of the Well Led review on June 21st and 22nd June. This was an unannounced inspection of the Radiology & Imaging Services. This review included X-Ray, Ultrasound, Interventional Radiology, Cardiac Cather Lab, MRI and CT departments. The team observed practice, reviewed policies, maintenance records and met with the staff and patients within these departments.

Immediate feedback included

exceptional staff who care deeply about their services

- Staff are actively looking to improve and innovate where they can.
- patients were very happy with the service they received
- all staff interactions they observed were extremely polite, courteous, and respectful.

Areas to focus on include:

- the use of Planned Group Directives (PGDs),
- reviewing Standard Operating Procedures (SOPs),
- Diagnostic Reference Levels (DRLs),
- cleaning schedules

The final report will be sent through early September.

Two-day Well Led Inspection

The CQC also carried out their Trust Well Led inspection on the 12th & 13th July. During this process they interviewed several staff.

The immediate feedback included:

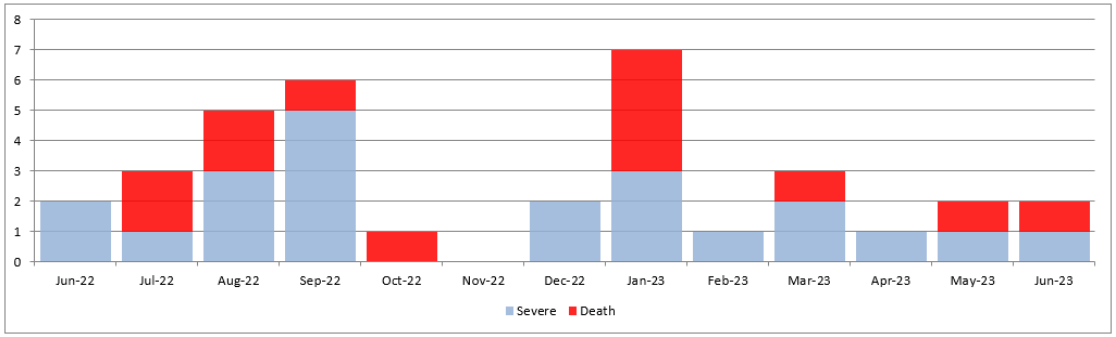
- Work is needed on the Equality, Diversity and Inclusion (EDI) agenda
- Staff were open and honest in their discussions, felt listened to but did not always see the actions or solutions they required
- Strengthened governance systems in operation, however these were heavily acute focused and needed to incorporate the whole Trust
- Leaders were involved & invested in being system players and were forward thinking and utilised a system approach in seeking solutions
- There are the right skills among the Board Executives and Nonexecutives and there is a collegiate unitary board in operation in delivering the objectives
- There have been great appointments to the leadership team and succession planning is evident

Quality and Safety exception reports – reported incidents / HSMR

Torbay and South Devon NHS Foundation Trust

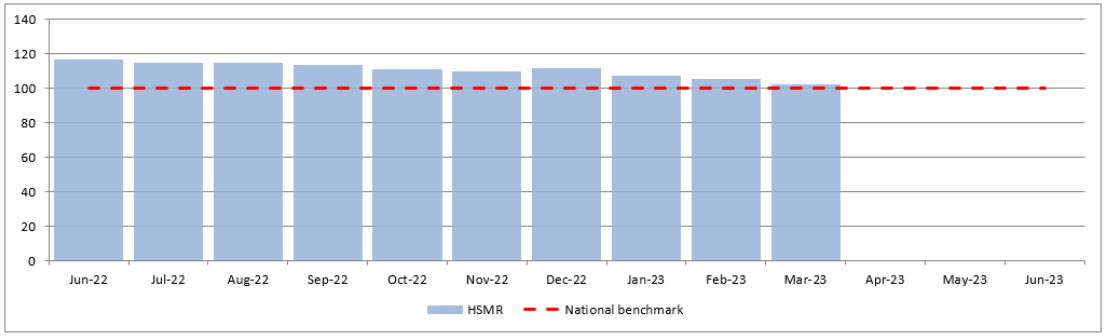
Reported Incidents - Severe and Death

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



Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
HSMR	117	115.1	114.7	113.4	111	109.9	111.5	107.1	105.5	102.4	n/a	n/a	n/a
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



In June 2023, one incident of severe harm and one death reported onto the national StEIS system.

The incident resulting in death was an inpatient fall which resulted in a large acute subdural haematoma. There was a delay in confirming diagnosis via CT scan. Subsequently the patient deteriorated and passed away shortly after.

The severe incident was an inpatient fall which resulted in an acute on chronic subdural haemorrhage as well as fractured ribs and a fracture at the base of the skull.

The latest HMSR for March 2022 - February 2023 is 103.6 (97.5 – 109.9); this is within the expected range compared to hospital trusts nationally.

The rolling twelve-month picture for weekday emergency HSMR shows a downward trend over the last seven data periods and a shift in banding from statistically higher than expected to within the expected range.
Weekend emergency HSMR is statistically higher than expected compared to trusts nationally

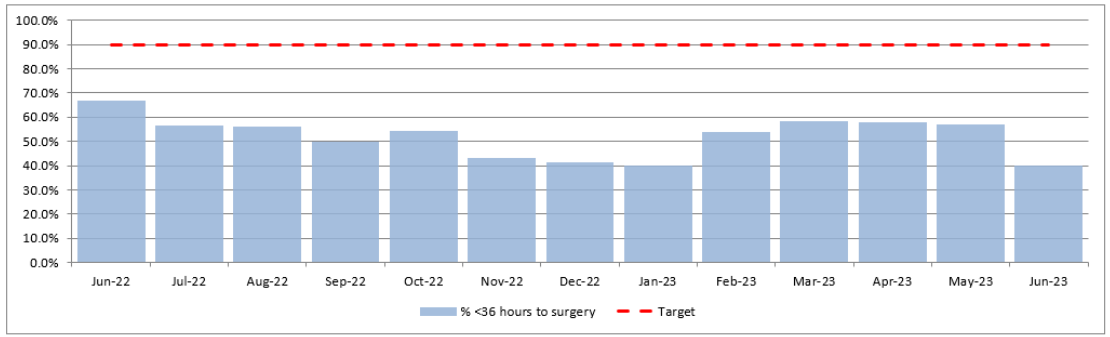
Previous work has demonstrated that at the weekend there were more individuals in the >75 age group, a higher comorbidity index, greater deprivation, and higher frailty. Whilst the national picture reveals similar themes, the Trust has a higher proportion of these individuals than national peers.

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

Torbay and South Devon NHS Foundation Trust

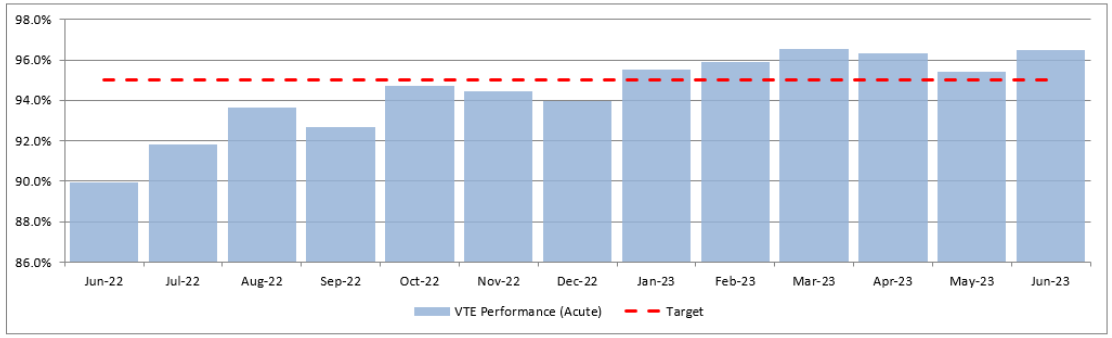
Fractured neck of femur - <36 hours to surgery

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
% <36 hours to surgery	66.7%	56.4%	56.0%	50.0%	54.3%	43.3%	41.5%	40.0%	53.8%	58.3%	58.0%	57.1%	40.0%
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%



Acute VTE risk assessment on admission

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
VTE Numerator	4942	5007	5255	5102	5433	5521	4896	5631	5437	6050	5152	5104	2563
VTE Denominator	5493	5452	5612	5505	5737	5847	5210	5894	5669	6267	5349	5349	2656
VTE Performance (Acute)	90.0%	91.8%	93.6%	92.7%	94.7%	94.4%	94.0%	95.5%	95.9%	96.5%	96.3%	95.4%	96.5%
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%



40.0% of patients had access to theatre within the recommended time frame in June 2023 against a target of 90%. This deterioration is mainly due to;

- Increase in other trauma admissions
- Workforce challenges to run a second trauma theatre list
- Increased elective activity to manage long waiting patients as part of the recovery programme.

The monthly Hip Fracture Governance meetings are now in place and running frequently to monitor and manage compliance. There continues to be a commitment to ringfence beds

VTE assessment

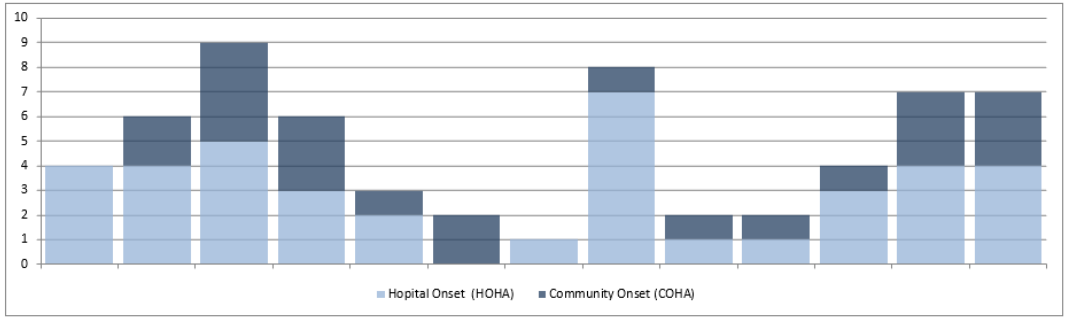
- VTE assessment audit achieved 96.5% in June, this is an improved position on May's position.
- Those areas that are not achieving the standard required are being identified and supported by the VTE Steering Group.
- For the past three months a total of 29 VTE incidents were submitted. This falls within the expected average of 10-20 positive VTEs per month

Quality and Safety exception report - infection control

Torbay and South Devon NHS Foundation Trust

Number of Clostridium Difficile cases

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



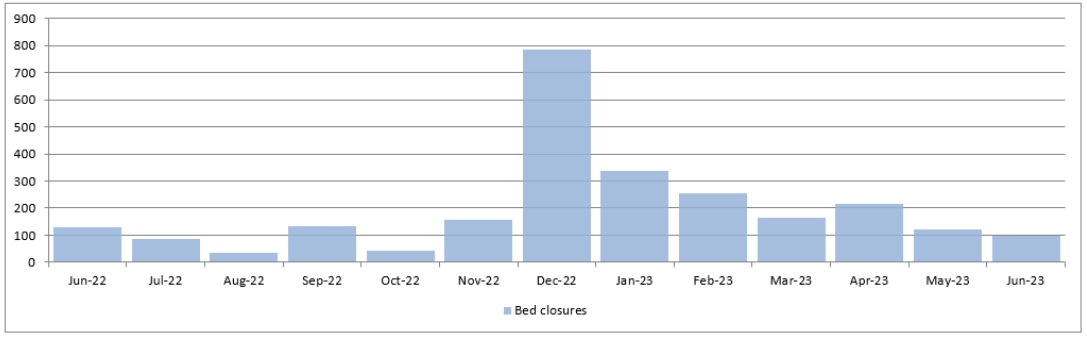
In June, 7 cases of Clostridium Difficile were reported.

The deep cleaning programme of all wards in now underway to support the reduction in Hospital associated infections.

Wards are deep cleaned in order of priority which is based on the number of infections associated with that ward.

Infection control - Bed days lost (Acute)

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Bed closures	130	84	36	132	42	156	786	339	254	164	217	120	99



Bed closures decreased from 120 in May to 99 in June 2023.

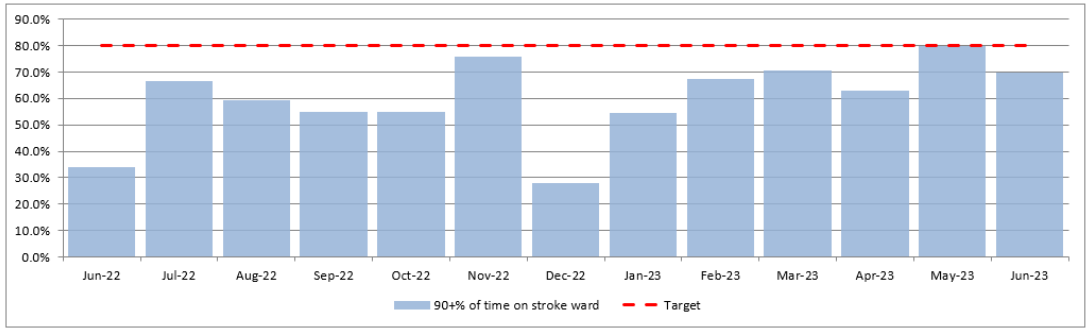
Bed closures were all related to patients in the affected bays having diarrhoea and vomiting.
None of the samples obtained there were no definite infections identified and bays were reopened.

Quality and Safety exception report – stroke care

Torbay and South Devon NHS Foundation Trust

Stroke

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
90+% of time on stroke ward	34.1%	66.7%	59.3%	54.8%	55.0%	75.9%	28.0%	54.5%	67.4%	70.7%	63.0%	80.0%	70.0%
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

- 70% of patients spent more than 90% of their stay on the stroke unit which is a slightly worsening position from May 23
- 27.5% of patients were admitted to the stroke unit with 4 hours of admission; this metric is consistent with last month;
- 100% of patients received a nutrition screen and a continence plan within 12 hours;
- 58.5% of patients received a scan within one hour;
- 90.6% of patients received a scan within 12 hours
- 79.3% saw a stroke nurse within 24 hours.

Stroke performance governance and oversight

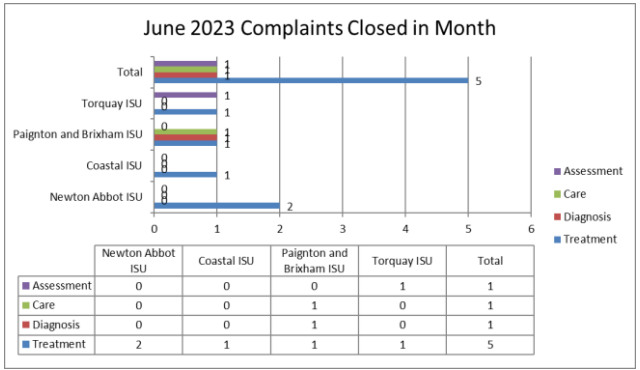
Actions identified from a review of the latest SSNAP data will be added to the Stroke Improvement Plan and managed via the Stroke Governance and SSNAP meetings.

Whilst we are addressing several of the issues raised locally some of the concerns raised require a System response.

The Trust are playing an active part in reviewing the current workforce availability across the Peninsula to look at developing a way to ensure there is shared knowledge and skills and equity of access to the SW population for all stroke presentations, at any time in any location.

Additional stroke information can be found in the Chief Operating Officer's report.

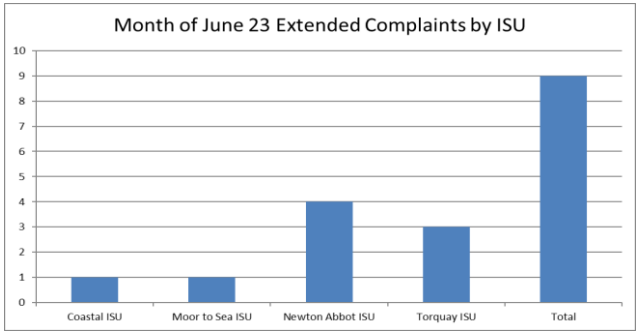
Total Number of Complaints and PAL's contacts during May 2023



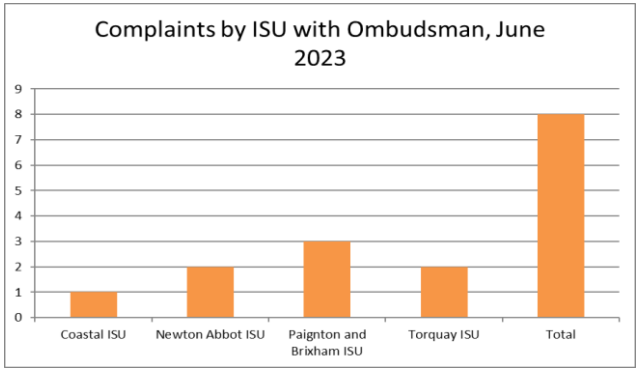
	Newton Abbot ISU	Coastal ISU	Paignton and Brixham ISU	Torquay ISU	Total
Assessment	0	0	0	1	1
Care	0	0	1	0	1
Diagnosis	0	0	1	0	1
Treatment	2	1	1	1	5

In the month of June 2023, 8 complaints were closed, which included 3 from P&B, 2 each from Newton Abbot and Torquay and one from Coastal.
The largest theme related to complaints

- Treatment, which included access to treatment.



In June 2023 9 complaints where extended due to their complexity and the need for extensive investigations.



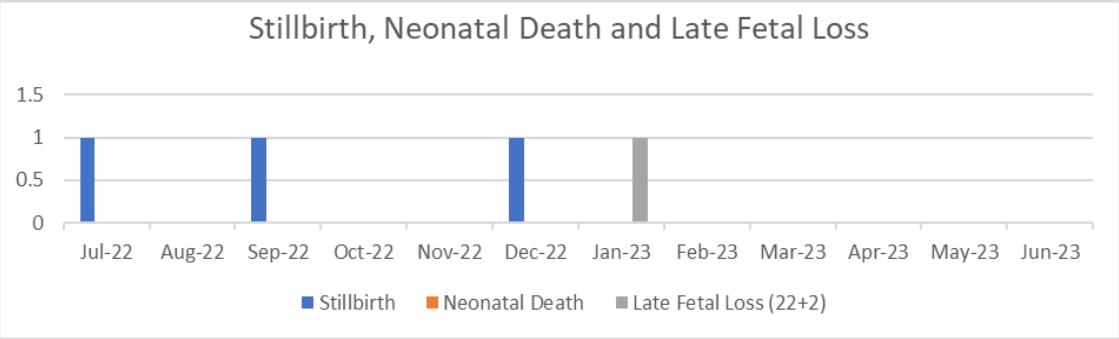
For the month of June 2023, 8 complaints were active/ongoing with the Ombudsman.

Not all of these referrals will be investigated or upheld. The Trust is waiting for reviews and subsequent updates from the Ombudsman.

Quality and Safety- Perinatal Clinical Quality Surveillance May 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 required monthly by the Trust Board.

The Trust had no perinatal deaths in June; there was also no new referrals this month to Healthcare Safety Investigation Branch.



National Perinatal Culture and Leadership training programme (Quadrumvirate)

Four members of the Perinatal team attended the first part of this programme in July in Birmingham. The team is made up of the Director of Midwifery, Obstetric Consultant, Operational Manager, and Neonatal Matron. Ongoing work over the next six months will include action learning sets as well as participation in the SCORE culture survey. It is an expectation of year 5 Maternity incentive Scheme that a monthly update on progress of the programme is provided to the Board.

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	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%	74.4%	75.7%	57.6%	60.3%
Number of Stillbirths	1	0	1	0	0	1	0	0	0	0	0	0	3
% Robson Group 1	24.1%	40.9%	37.5%	12.0%	22.9%	12.0%	19.4%	0.0%	26.9%	5.6%	17.6%	22.7%	20.1%
% Robson Group 2	45.5%	26.1%	48.3%	38.2%	36.4%	36.4%	42.9%	42.9%	18.5%	37.0%	22.2%	28.0%	35.2%
% Robson Group 5	*	*	90.9%	57.1%	90.5%	90.9%	88.9%	88.9%	87.5%	75.0%	76.5%	81.3%	82.8%
% Breastfeeding at Delivery	*	*	70.8%	63.9%	64.7%	63.0%	63.1%	71.8%	71.0%	67.1%	71.7%	69.9%	67.7%

- The provisional Clinical Negligence Scheme for Trusts (CNST) scorecard for April data shows that the Trust is passing all the required data and data quality fields for Safety Action 2. July is the assessment month for CNST Year 5.
- Ongoing data quality issues this month, highlighted in the continuity of carer data, show antenatal care plans are not being completed – these contain the information for that metric. The maternity management team are taking steps to address this.
- The BRIGID electronic observation module has now been introduced into the patient record (System One) which closes a must do CQC action. This provides clinicians with an overview of key patient information.

Workforce Status

As part of the review and development of the IPR, the workforce elements of this report has been completely reviewed and is on an iterative process of on-going improvement. The report provides an update on progress in delivering the Trust-wide workforce implications and mitigating actions of the:

- operational plan
- local workforce factors impacting NOF4 exit criteria and

A revised format for the overview of workforce metrics via a new dashboard, endorsed by the People Committee, which will support the new organisational governance structure to highlight specific risks and actions.

Performance exceptions and actions

The table below provides a high-level overview of the exceptions and actions to mitigate, further detail can be found in the subsequent slides.

Exceptions		Actions to mitigate
Workforce implications of the operational plan		
Substantive WTE	June 2023 18 WTE over plan	• enhanced vacancy and scrutiny measures have been established
Bank WTE	June 2023 115 WTE over plan	
Agency WTE	June 2023 134 WTE over plan	
Local workforce factors affecting NOF4 exit criteria		
Workforce is one of the key factors affecting specialties that are challenged in delivering RTT performance targets. Substantive clinical and consultant vacancies are held across several of the most challenged areas.		• workforce modelling • the development of marketing materials • enhanced collaboration with local Trusts within the Devon system
Trust Level workforce KPI's		
Sickness, month % (target 4%)	June 2023 4.88%	• visibility of cost-centre level data is being shared and discussed with Care Groups, as well as Care Group governance and assurance meetings to develop and support improvement plans
Sickness, 12m rolling % (target 4%)	June 2023 5.32%	
Achievement review rate (target 90%)	June 2023 78.08%	

Trust Level Operational Plan – Workforce Implications

Torbay and South Devon NHS Foundation Trust

Local and system level operational plans are required to meet the requirement for 0% total workforce growth (substantive, bank and agency). The table below demonstrates how we are currently progressing against our overall plan, the associated headlines are as follows:

- The Trusts **substantive** workforce is **18 WTE** over plan in June 2023, having increased by **28 WTE** from the May position
- Use of **bank** workforce currently stands at **115 WTE** above plan, and represents an increase between May and June of **73.14 WTE**, an increase of 25%
- **Agency** workforce figures are **134 WTE** over plan in June, this represents a 12% (**25 WTE**) increase in comparison to the use of agency in May

To mitigate these increases, and support the Trust to achieve its substantive, bank and agency plans, we have increased our vacancy and agency scrutiny controls. The new Interim Vacancy Scrutiny Group now meets weekly to scrutinise;

- All clinical areas operating at band 6 and higher
- All corporate service and non-clinical roles (non-patient facing)
- Interim and Agency Requests

These controls support the financial sustainability 6-point plan and continued work between the PMO and services to identify and deliver cost improvement. Further work is been progressed to ensure there is a single and co-ordinated governance process around workforce Cost Improvement Plan (CIP) within the Trust.

		Plan - As at the end of June 2023															
	Baseline: Staff in post 31-Mar-23	Plan Apr 23	Apr 23 Actual	Plan May 23	May 23 Actual	Plan Jun 23	Jun 23 Actual	Plan Jul 23	Plan Aug 23	Plan Sep 23	Plan Oct 23	Plan Nov 23	Plan Dec 23	Plan Jan 24	Plan Feb 24	Plan Mar 24	Growth
	Total WTE	Total WTE	*Total WTE*	Total WTE	*Total WTE*	Total WTE	*Total WTE*	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	%
Total Workforce	6710.23	6,498	6636.15	6,508	6662.09	6,520	6788.34	6,522	6,531	6530	6,552	6,579	6,609	6,619	6,622	6,644	-1%
Total Substantive	6189.91	6,170	6188.1	6,170	6168.33	6,178	6196.22	6,180	6,184	6,190	6,197	6,199	6,212	6,222	6,225	6,241	1%
Total Bank	319.4	237	282.02	243	289.44	247	362.58	246	251	249	251	270	281	280	282	281	-17%
Total Agency	200.92	91	166.03	95	204.32	95	229.54	96	96	91	104	110	116	117	115	122	-34%

Service Level – Workforce Implications affecting NOF4 exit

Referral to Treatment Time (RTT) and Fragile Services

The following specialties face significant challenges in delivering the activity needed to reduce long waiting times.
The table below summarises the workforce risks and actions that are being taken.

Speciality	Workforce issues and actions
ENT	**Issue:** Currently have 2 consultant vacancies meaning they are operating 1:4 consultant rota which is unsustainable and poses risk to burnout. **Mitigating action:** A bespoke recruitment video has been developed to enhance marketing and attraction.
Urology	**Issue:** Continue to have 2 consultant vacancies being filled by locums. **Mitigating actions:** Currently part of the fragile services review this will enable collaborative working to find sustainable solutions to workforce challenges. Developing a clinical model with Royal Devon for out of hours cover.
Gynae	**Issue:** Gynae clinic demand profiles and Okenden requirements require additional clinical capacity. **Mitigating actions:** Currently undertaking workforce modelling to help identify capacity opportunities.
Colorectal / Upper GI	**Issues:** Consultants moved to a 2nd on-call rota during COVID which has impacted job plans and the delivery of elective capacity. There have been 3 SpR gaps on the general surgery rota over the last 2 years. **Mitigating actions:** Job plans are currently being signed off to increase elective activity. One SpR has been appointed and will commence in role in Sept 23. An SHO has been appointed for next 8-12 months and will also support ST3 on-call (to make the on-call rota compliant). August 23 is first time we have had a full quota of Junior Doctors starting for 18 months.
Interventional Radiology	**Issue**: Since April 23, the 24/7 Interventional Radiology (IR) service has not been able to provide out of hours (OOH) cover due for Exeter and Torbay as there has been insufficient substantive IR Consultants in post. **Mitigation**: In July 2023 a 10-week trial, established by the Peninsular Acute Sustainability Programme, for a 24/7 IR on call service covering North Devon, Taunton, Yeovil, Torbay and Exeter. During the trial, the on-call service will be provided at a single centre, with patients transferred to Musgrove Park Hospital (MPH), Taunton for emergency IR treatment.
Operating Department Practitioners	**Issue:** Local and national shortage of Operating Department Practitioners (OPD), which is impacting on elective recovery and coverage of emergency obstetric theatre service out of hours. **Mitigation:** Active and on-going recruitment campaigns to support the filling of ODP vacancies, and the use of ODP agency is being explored. A business case has been submitted to support a rolling programme of apprenticeships for ODPs.

Trust Level Workforce – KPI's

Torbay and South Devon NHS Foundation Trust

Indicator	Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Performance
Month Sickness %	<4%	6.25%	4.77%	4.90%	5.86%	5.39%	6.54%	5.26%	4.59%	4.63%	5.07%	4.46%	4.88%	
12 Mth Rolling Sickness %	<4%	5.63%	5.72%	5.74%	5.71%	5.69%	5.76%	5.69%	5.58%	5.62%	4.96%	5.29%	5.32%	
Achievement Rate %	>90%	77.02%	78.03%	75.77%	76.61%	77.96%	76.70%	77.68%	76.71%	76.87%	77.87%	78.12%	78.08%	
Labour Turnover Rate	10-14%	13.79%	13.82%	13.88%	13.66%	13.74%	13.48%	13.33%	13.09%	12.85%	12.92%	12.74%	12.46%	
Overall Training %	>85%	89.73%	89.15%	88.70%	88.65%	89.10%	89.70%	89.94%	90.09%	90.45%	90.72%	91.24%	91.74%	
Nuring Staff Average % Day Fill Rate- Nurses		94%	94%	96%	99%	99%	92%	92%	91%	93%	92%	96%	100%	
Nuring Staff Average % Night Fill Rate- Nurses		86%	86%	86%	89%	86%	87%	88%	87%	88%	91%	90%	89%	
Safer Staffing- Overall CHPPD		7.48	7.59	7.53	7.72	7.75	7.54	7.72	7.83	7.75	7.9	8.05	7.99	

Sickness – The operational plan trajectories reflects revised KPI's for sickness absence based upon the previous 5 years trend data. Whilst we have seen a slight increase in the 12 months ending June to **5.32%**, this is still below our plan of 5.63% and considerably lower than the same last year. Sickness at these levels carries an estimated cost of £11.8m

Turnover – There is a downward trend in turnover since the start of the calendar year and we continue to perform well against our plan of 13.11% in June with an actual turnover of **12.46%**, which again is significantly lower that the same time last year. Actions as part of the ICS Retention project are showing a positive impact e.g. stay interviews, legacy mentors, 5 high impact measures

Mandatory Training - Overall training continues to show a steady upward trend in compliance over the last 12 months. The June overall rate for mandatory training figure increased slightly to **91.74%** against a target of 85% and is the highest it has been for the last 12 months. However, at a topic level we remain challenged in Manual Handling at **78%** and Information Governance at **87%.**

Achievement Review – There is an improvement in compliance since February. However, at **78.08%** Junes Achievement Review rate remains below the target of 90%. To aid improvement the data is made available to cost centre managers as well as through ISU and IGG governance meetings.

Safer Staffing – planned versus actual

Torbay and South Devon NHS Foundation Trust

Jun-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	1655	0	0	1725	1754	1380	1218	0	0	1035	1237	722	96.0%	0.0%	101.7%	88.2%	0.0%	119.5%
Allerton	2833	2377	0	0	1035	1320	1380	1128	0	0	1035	1312	866	83.9%	0.0%	127.5%	81.7%	0.0%	126.8%
Cheetham Hill	1725	1749	0	0	2070	2364	1035	999	0	0	1380	2239	840	101.4%	0.0%	114.2%	96.5%	0.0%	162.2%
Coronary Care	1380	1525	0	0	0	2	1035	1047	0	0	0	12	369	110.5%	0.0%	0.0%	101.1%	0.0%	0.0%
Cromie	1633	1817	0	0	863	1319	1035	1057	0	0	690	1127	739	111.3%	0.0%	152.9%	102.1%	0.0%	163.3%
Dunlop	1380	1413	0	0	1208	1125	1035	1035	0	0	1035	1018	725	102.4%	0.0%	93.2%	100.0%	0.0%	98.4%
EAU4	1725	1846	0	0	1380	1279	1725	1380	0	0	1380	1336	716	107.0%	0.0%	92.7%	80.0%	0.0%	96.8%
Ella Rowcroft	1035	1028	0	0	1380	1182	989	794	0	0	690	713	411	99.3%	0.0%	85.6%	80.2%	0.0%	103.3%
Warrington	1035	1294	0	0	690	871	690	873	0	0	690	828	490	125.0%	0.0%	126.3%	126.5%	0.0%	120.0%
George Earle	1725	1726	0	0	2070	1965	1035	968	0	0	1380	1576	816	100.1%	0.0%	94.9%	93.6%	0.0%	114.2%
ICU	3105	2655	0	0	345	81	3105	2254	0	0	0	0	169	85.5%	0.0%	23.3%	72.6%	0.0%	0.0%
McCullum (Escalation)	690	911	0	0	1035	950	690	713	0	0	1035	1114	509	132.1%	0.0%	91.8%	103.3%	0.0%	107.6%
Louisa Cary	2415	1794	0	0	690	817	2415	1407	0	0	690	833	450	74.3%	0.0%	118.4%	58.2%	0.0%	120.7%
John Macpherson	1035	1022	0	0	690	573	690	634	0	0	345	340	353	98.7%	0.0%	83.0%	91.8%	0.0%	98.6%
Midgley	1725	1921	0	0	1725	1386	1380	1383	0	0	1380	1464	774	111.3%	0.0%	80.3%	100.2%	0.0%	106.1%
SCBU	1035	882	0	0	345	284	1035	783	0	0	345	253	153	85.2%	0.0%	82.2%	75.7%	0.0%	73.3%
Simpson	1725	1795	0	0	2070	2436	1035	1037	0	0	1380	2049	833	104.0%	0.0%	117.7%	100.2%	0.0%	148.5%
Turner	1380	1429	0	0	1725	1855	690	690	0	0	1380	1533	518	103.5%	0.0%	107.5%	100.0%	0.0%	111.1%
New Forrest Ward	1725	2122	0	0	1380	1324	1380	1391	0	0	1380	1529	864	123.0%	0.0%	95.9%	100.8%	0.0%	110.8%
Total (Acute)	*31031*	*30958.39*	*0*	*0*	*22425*	*22884*	*23759*	*20788*	*0*	*0*	*17250*	*20511.83*	*11317*	99.8%	0.0%	102.0%	87.5%	0.0%	118.9%
Brixham	840	1137	420	0	1260	1439	990	965	0	0	660	856.75	589	135.4%	0.0%	114.2%	97.5%	0.0%	129.8%
Dawlish	840	855	0	0	1050	1054.75	720	674.5	0	0	660	993	477	101.8%	0.0%	100.5%	93.7%	0.0%	150.5%
Newton Abbot - Teign Ward	1890	1834.75	0	0	1890	1503.75	990	1001	0	0	990	1056	896	97.1%	0.0%	79.6%	101.1%	0.0%	106.7%
Newton Abbot - Templar Ward	1680	1594	0	0	2100	1851	990	994.5	0	0	1080	1089	895	94.9%	0.0%	88.1%	100.5%	0.0%	100.8%
Totnes	840	784.5	0	0	1260	1419.5	720	649	0	0	660	660	536	93.4%	0.0%	112.7%	90.1%	0.0%	100.0%
Organisational Summary	37121	37164	420	0	29985	30152	28169	25072	0	0	21300	25167	14710	100.1%	0.0%	100.6%	89.0%	0.0%	118.2%

- The Registered Nurse fill rate for days during June was 99.8%, which is a slight increase on May fill rate. Night duty reported as 87.5% a slight decrease on the previous months fill rate. These fill rates are reflective of bed occupancy rates within our Paediatric wards during June.

- The fill rate for Health Care Support Workers (HCSW) for days is 102% for days, which is an increase on April and 118% for nights which is an increase on April

- The increase in fill rate for Health Care Support Workers at night is to mitigate any risks associated with the Registered Nurse fill rate.

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

NHS Torbay and South Devon NHS Foundation Trust

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	8.10	4.00	0.00	4.10	8	14	0	3	26.7%	46.7%	0.0%	10.0%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	7.10	4.00	0.00	3.00	20	29	0	1	66.7%	96.7%	0.0%	3.3%	7.74	4.74	0	2.91
Cheetham Hill	7.39	3.29	0.00	4.11	0.00	3.30	0.00	5.50	30	11	0	0	3.3%	40.0%	0.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	7.00	7.00	0.00	0.00	0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.75	3.68	0.00	2.07	7.20	3.90	0.00	3.30	0	7	0	0	0.0%	23.3%	0.0%	0.0%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.30	3.40	0.00	3.00	16	13	0	15	53.3%	43.3%	0.0%	50.0%	7.74	4.74	0	2.91
EAU4	8.63	4.79	0.00	3.83	8.20	4.50	0.00	3.70	26	24	0	12	86.7%	80.0%	0.0%	40.0%	7.74	4.74	0	2.91
Ella Rowcroft	8.63	4.31	0.00	4.31	9.00	4.40	0.00	4.60	11	12	0	9	36.7%	40.0%	0.0%	30.0%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	7.90	4.40	0.00	3.50	0	1	0	0	0.0%	3.3%	0.0%	0.0%	7.74	4.74	0	2.91
George Earle	7.39	3.29	0.00	4.11	7.60	3.30	0.00	4.30	9	15	0	9	30.0%	50.0%	0.0%	30.0%	7.74	4.74	0	2.91
ICU	21.85	20.70	0.00	1.15	29.50	29.00	0.00	0.50	1	1	0	23	3.3%	3.3%	0.0%	76.7%	7.74	4.74	0	2.91
McCullum (Escalation)	6.76	2.71	0.00	4.06	7.20	3.20	0.00	4.10	6	3	0	11	20.0%	10.0%	0.0%	36.7%	7.74	4.74	0	2.91
Louisa Cary	10.89	8.47	0.00	2.42	10.80	7.10	0.00	3.70	16	22	0	3	0.0%	73.3%	0.0%	10.0%	7.74	4.74	0	2.91
John Macpherson	5.11	3.19	0.00	1.92	7.30	4.70	0.00	2.60	1	5	0	4	3.3%	16.7%	0.0%	13.3%	7.74	4.74	0	2.91
Midgley	7.96	3.98	0.00	3.98	7.90	4.30	0.00	3.70	11	3	0	22	36.7%	10.0%	0.0%	73.3%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	14.40	10.90	0.00	3.50	3	3	0	5	10.0%	10.0%	0.0%	16.7%	7.74	4.74	0	2.91
Simpson	7.39	3.29	0.00	4.11	8.80	3.40	0.00	5.40	1	12	0	0	3.3%	40.0%	0.0%	0.0%	7.74	4.74	0	2.91
Turner	9.58	3.83	0.00	5.75	10.60	4.10	0.00	6.50	2	5	0	5	6.7%	16.7%	0.0%	16.7%	7.74	4.74	0	2.91
New Forrest Ward	6.74	3.57	0.00	3.17	7.40	4.10	0.00	3.30	4	1	0	14	13.3%	3.3%	0.0%	46.7%	7.74	4.74	0	2.91
Brixham	6.95	3.05	0.70	3.20	7.50	3.60	0.00	3.90	6	5	30	0	20.0%	16.7%	100.0%	0.0%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	7.50	3.20	0.00	4.30	1	15	0	0	3.3%	50.0%	0.0%	0.0%	7.74	4.74	0	2.91
NA - Teign Ward	6.40	3.20	0.00	3.20	6.00	3.20	0.00	2.90	25	13	0	26	83.3%	43.3%	0.0%	86.7%	7.74	4.74	0	2.91
NA - Templar Ward	6.50	2.97	0.00	3.53	6.20	2.90	0.00	3.30	23	14	0	21	76.7%	46.7%	0.0%	70.0%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	6.60	2.70	0.00	3.90	12	22	0	8	40.0%	73.3%	0.0%	26.7%	7.74	4.74	0	2.91

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
	7.50	4.19	0.03	3.29	7.99	4.23	0.00	3.76
Total Planned Beds / Day	520							
Days in month	30							

- The RN actual CHPPD is reported as 4.23 in June but remains below the Carter Recommendation of 4.7. Although the RN CHPPD is below the Carter Recommendation it is reflective of safer staffing establishment reviews.
- The actual HCA CHPPD was 3.76 in May 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 June, the Trust was operationally challenged with 6 days in OPEL 4 and 17 days at OPEL 3.
- The planned CHPPD total was reported as 7.50 with an actual of 7.99 which reflects an increase in patient acuity and demand.

Community and Social Care Indicators - dashboard of key metrics

Torbay and South Devon NHS Foundation Trust

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 quarter 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		⬆
Permanent admissions (18-64) to care homes per 100k population (ASCOF) (14)		⬆
Permanent admissions (65+) to care homes per 100k population (ASCOF) (450)		⬆
Proportion of clients receiving direct payments (ASCOF) (25%)		⬇
% reablement episodes not followed by long term SC support (83%)		⬆

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

Operational Performance Indicators - dashboard of key metrics

NHS Torbay and South Devon NHS Foundation Trust

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		↑
Referral to treatment - % Incomplete pathways <18 weeks		↑
Cancer - 62-day wait for first treatment - 2ww referral		↑
Diagnostic tests longer than the 6-week standard		↑
Dementia Find		
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 65-week wait incomplete pathway		↓
RTT 78-week wait incomplete pathway		↑
RTT 104-week wait incomplete pathway		↑
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 – percentage - (acute)		↓
Percentage of patient discharges pre-noon		↑
Percentage of patient discharges pre-5pm		↑
Number of patients >7 days length of stay (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		↓

NHS
Torbay and South Devon
NHS Foundation Trust

Monthly Financial Performance Report

M03 (Period ended 30/06/2023)

Contents Page

NHS
Torbay and South Devon
NHS Foundation Trust

Working with you, for you

Executive Summary

NHS
Torbay and South Devon
NHS Foundation Trust

Description	YTD Bud £000	YTD Act £000	YTD Var £000	YTD Var %	YTD R.A.G	Forecast Bud £000	Forecast Exp £000	Forecast Var £000	Forecast Var %	Forecast R.A.G
Operating Income	159,449	160,782	1,333	0.8%		635,220	639,889	4,669	0.0%	
Operating Expenditure and Financing Cost	(174,400)	(175,504)	(1,104)	(0.6%)		(667,795)	(672,464)	(4,669)	0.0%	
Surplus / (Deficit)	(14,951)	(14,722)	229	(1.5%)		(32,575)	(32,575)	0	0.0%	
Add back: Net Donated Assets	183	254	71	39.1%		2	2	0	0.0%	
Adjusted Surplus / (Deficit)	(14,768)	(14,468)	301	(2.0%)		(32,573)	(32,573)	0	0.0%	
Capital (CDEL)	7,241	5,626	(1.615)	(22.3%)		56,755	47,608	(9,147)	(16.1%)	
Cash & Cash Equivalents	17,044	18,288	1,244	7.3%		14,975	14,975	0	0%	

As at Month 3 the Trust reported an overall favourable variance to plan of **£0.3m**. This consists of a **£1.33m** Year to Date (YTD) favourable variance for operating income (0.8% of budget), partially offset by an adverse variance of **£1.10m** in operating expenditure, mainly due to pay award being agreed and adjusted on both in come and expenditure.

It important to note that our CIP target is phased comparably light in Q1 which had contributed to the overall favourable variance at this stage of the year, however the forecast position will be closely monitored, and associated risks continuously reported.

Please also note that the YTD operating expenditure includes an unplanned cost pressure of **£0.6m** due to Industrial Actions, anticipating that this cost will escalate further with industrial actions planed in July and August, additional risks have been included in the risk and mitigation schedule and shared with ICB and NHSE/I.

In Month Position by Category

NHS
Torbay and South Devon
NHS Foundation Trust

	M03 Bud £000	M03 Act £000	M03 Var £000
Patient Income – Block incl. Torbay Council	44,464	43,727	(737)
Patient Income - Variable	3,876	3,828	(48)
ASC Client Contribution	1,322	1,658	336
Other Patient Income incl. Private Patient	726	303	(423)
Torbay Pharmaceutical Sales	1,710	1,862	152
Other Income	2,507	2,905	398
Total Income (A)	**54,604**	**54,282**	**(322)**
Pay – Substantive and Bank	(29,189)	(28,251)	938
Pay - Agency	(1,012)	(1,165)	(153)
Non-Pay - Other	(14,049)	(14,836)	(787)
Non- Pay - ASC/CHC	(11,448)	(11,788)	(340)
Financing & Other Costs	(3,742)	(3,170)	572
Total Expenses (B)	(59,440)	(59,209)	230
Sub-Total Surplus/(Deficit) (A+B)	**(4,835)**	**(4,927)**	**(92)**
Adjustments - Donated Items / Impairment / Gain on Asset disposal	(1)	85	85
Adjusted Surplus / (Deficit)	(4,836)	(4,843)	(7)

Overview - In month planned financial deficit for Jun-23 was **(£4.84m)**. The actual net expenditure reported was **(£4.84 m)**, showing a favourable variance to the plan of **£0.07m** in month.

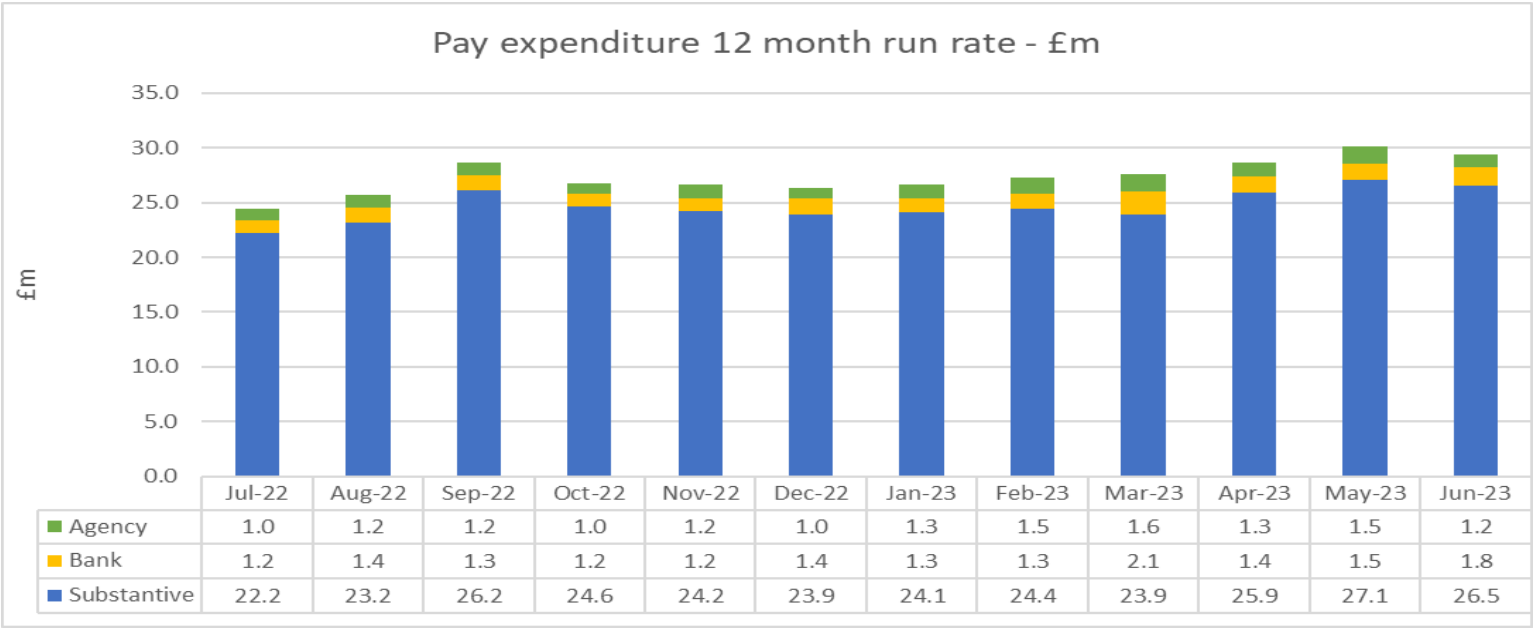
Income - Total in month patient and Other Income shows a variance of **£0.32m** adverse to plan. Patient block income is lower than anticipated in month and for the year due to the treatment of non-recurrent ICB income received at year-end 22/23 after plans submission, mitigating agreement is in place via balance sheet. The £423k adverse variance in other patient income mainly relates to provider-to-provider income and Private patient income.

Pay – In month pay cost is favourable to plan, however it is worth noting the phasing of Pay CIP target is from M4 onwards. Within the Expenditure position, pay award of 5% uplift had been applied.

Non-pay - Total Non-Pay expenditure position was **£0.56m** adverse to plan. This mainly relates under-achievement of CIP and higher than plan costs in Adult Social Care (ASC) and Continuing Health Care (CHC) due to client complexity

Pay Expenditure – Run Rate

Torbay and South Devon NHS Foundation Trust



	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Agency	1.0	1.2	1.2	1.0	1.2	1.0	1.3	1.5	1.6	1.3	1.5	1.2
Bank	1.2	1.4	1.3	1.2	1.2	1.4	1.3	1.3	2.1	1.4	1.5	1.8
Substantive	22.2	23.2	26.2	24.6	24.2	23.9	24.1	24.4	23.9	25.9	27.1	26.5

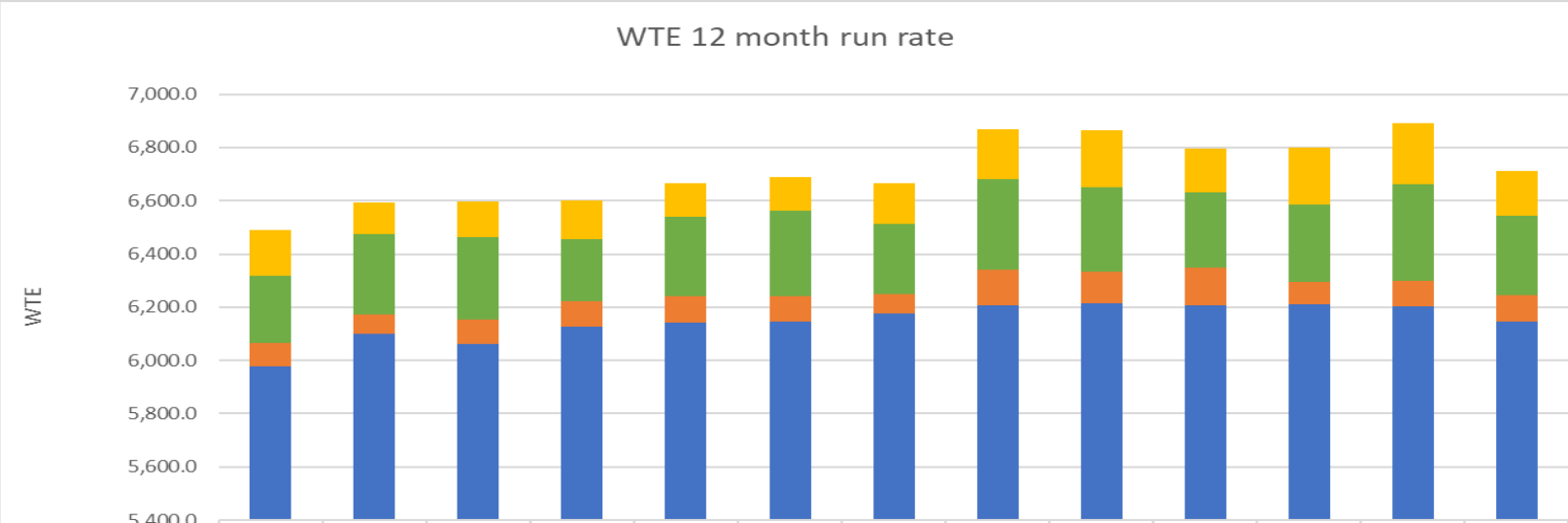
The graph above shows the last 12 months run rate for overall pay expenditure (please note 22/23 pay value is at 22/23 rates, no inflation had been applied). The figures in the run rate include bank, agency and substantive pay including overtime worked. There were significant increases in bank and agency in recent months partly due to Industrial actions. Expectations are that further Industrial Action may result in additional increases to cost in July and August 2023. For WTE movements please see next slide.

Bank and agency run rates continue to above £1m due to coverage of vacancies across the Trust and the impact of ongoing Industrial Action.

Please note nearly 50% of the agency limit set by NHSE/I had been consumed in Q1 alone, immediate remedial actions are required to control agency spend. This will be done via the agency control panel.

WTE Worked - Run Rate

Torbay and South Devon NHS Foundation Trust



	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	12 month average
Agency	173.4	119.4	134.1	145.5	126.1	125.8	151.9	185.3	213.3	166.0	212.5	229.5	165.2
Bank	250.7	303.5	309.4	233.2	298.7	320.9	265.8	340.8	320.2	282.0	289.4	362.6	298.1
Overtime	89.2	71.9	91.2	95.3	99.5	96.8	71.7	133.1	115.7	143.2	87.0	96.0	99.2
Contracted	5,977.9	6,099.7	6,061.2	6,126.8	6,140.9	6,144.4	6,176.2	6,208.3	6,216.1	6,205.1	6,209.2	6,203.4	6,147.4

The table above provides a summary of Whole-Time Equivalent (WTE) run rates for the last 12 months. This include bank, agency and substantive WTE which includes contracted as well as overtime worked. (please note this may slightly vary from the information presented under the workforce pack due to the inclusion of overtime here).

Significant increases in overtime, bank and agency occurred due to coverage of vacancies across the Trust and the impact of ongoing Industrial Action.

Non-Pay Expenditure – Spend Category

Torbay and South Devon NHS Foundation Trust

Non Pay Category	In Mth			YTD			R.A.G
	Bud £'000	Act £'000	Var £'000	Bud £'000	Act £'000	Var £'000	
CNST	783	723	61	2,350	2,275	75	
Drugs costs	3,932	3,647	285	11,797	11,268	528	
Excluded - Donated depreciation	78	85	(7)	261	254	7	
Non-executive directors	17	16	1	50	49	2	
Other operating costs	5,362	5,956	(594)	16,063	16,752	(688)	
Other Non-pay contract	11,137	10,832	305	33,478	31,997	1,480	
Purchase of social care	7,029	7,796	(767)	21,297	22,483	(1,186)	
Total Non Pay	**28,338**	**29,054**	**(717)**	**85,296**	**85,078**	**218**	

In Month Non-Pay expenditure at M3 was £0.72m adverse to plan. This was primarily due to additional Purchase of Social Care and Other non-pay operating costs.

Year-to-date expenditure was £0.22m favourable to plan, mainly due to over achievement of CIP bearing in mind the phasing of CIP is light in Q1. This was partially offset by significant additional expenditure against Purchase of Social Care and Other non-pay operating costs.

YTD Position by Care Group

Please note naming conventions to new Org structure will be changed from M4 onwards

NHS
Torbay and South Devon
NHS Foundation Trust

The table below provides a snapshot of our year-to-date (YTD) financial position at the end of Month 3 at Care Group Level, with commentary on key variances that have material impact on our overall performance.

Care Groups	YTD Bud £000	YTD Act £000	YTD Var £000	R.A.G	Commentary
Shared Corporate Services and Reserves / Other Income	90,450	94,589	4,139		Due to phasing of reserves, lower than planned depreciation and increase in interest income on cash balance
Pharmacy Manufacturing Unit	18	60	42		Slightly higher than planned in sales revenue
Children and Family Health Devon (CFHD)	146	427	281		Service is currently carrying a significant number of vacancies up to 60+ WTE
Families, Community and Home	(49,053)	(49,987)	(934)		Adverse variance is driven by increase in volume and complexity in Adult Social Care (ASC) clients
Planned Care, Long Term Conditions and Diagnostics	(42,696)	(43,639)	(943)		Due to premium Costs incurred, mainly Bank, agency and locum usage to cover key vacancies and fragile services.
Urgent & Emergency Care and Operations	(13,634)	(15,919)	(2,284)		Due to additional Agency Nursing and Medical Staffing costs to meet demand and the lack of UEC funding. The bids for UEC funding are currently going through the triple lock process with the ICB.
Total	**(14,768)**	**(14,468)**	**300**		

Provisional ESRF Income Position

NHS
Torbay and South Devon
NHS Foundation Trust

Setting	YTD Elective 19/20 Activity	YTD Elective 23/24 Activity	YTD Elective Activity Var	YTD Elective Activity Compared to 19/20 %	YTD 19/20 Elective Inc at 23/24 Tariff £'000	YTD Elective 23/24 Inc £'000	YTD Elective Inc Var £'000	YTD Elective Inc Compared to 19/20 %
Day Cases	7,512	6,831	(681)	91.9%	6,190	5,820	(369)	94.0%
Electives	858	765	(93)	89.2%	3,354	2,869	(485)	85.5%
APC TOTAL	**8,370**	**7,596**	**(774)**	**90.8%**	**9,544**	**8,689**	**854**	91.0%
Firsts	22,140	21,546	(594)	97.3%	4,272	4,379	107	102.5%
First Procedures	4,596	5,373	777	116.9%	803	924	121	115.1%
Follow-up Procedures	12,532	13,085	553	104.4%	1752	1961	210	111.9%
OPA TOTAL	**39,268**	**40,004**	**736**	**101.9%**	**6,826**	**7,265**	**438**	106.4%
Total ERF Performance	**47,638**	**47,600**	**38**	**99.9%**	**16,370**	**15,954**	**(416)**	**97.5%**

The original target for 23/24 was to meet 103% of the 19/20 baseline, however due to the Industrial Action, NHSE/I has reset the target to 101% taking into account its impact. This is yet to be formally communicated. Once this is confirmed we will adjust the baseline from 100% of 19/20 to101% for comparable purposes and risk of income analysis. The potential income risk estimation will be recalculated in M4.

Please note M1&2 are based on SUS freeze submission and M3 is at Flex Submission.

M3 is showing an increase in performance however there are a list of specialties are significantly behind targets, these include Trauma & Orthopaedics, Upper GI and ENT which would require some focused support. We will also be working with the ICB to ensure there is consistency in reporting across the system and with NHSE/I.

Bed Utilisation

NHS
Torbay and South Devon
NHS Foundation Trust

Point of Delivery	Jun 22 Act	Jul 22 Act	Aug 22 Act	Sep 22 Act	Oct 22 Act	Nov 22 Act	Dec 22 Act	Jan 23 Act	Feb 23 Act	Mar 23 Act	Apr 23 Act	May 23 Act	Jun 23 Act
Occupied beds DGH	10,709	10,691	10,756	10,578	10,810	10,590	10,939	11,221	9,992	11,195	10,576	11,044	10,625
Available beds DGH	11,359	11,588	11,652	11,109	11,388	10,994	11,375	11,598	10,376	11,559	11,092	11,460	11,125
Occupancy	94%	92%	92%	95%	95%	96%	96%	97%	96%	97%	95%	96%	96%

In June 2023, the overall bed occupancy for Acute beds is **96%**. Occupancy below **95%** is considered a minimum to support timely patient flow. In June 2023, this was achieved on 5 occasions.

Improvement initiatives are being supported by the Transformation and Improvement team reporting through the Unscheduled Care Board meeting every 2 weeks.

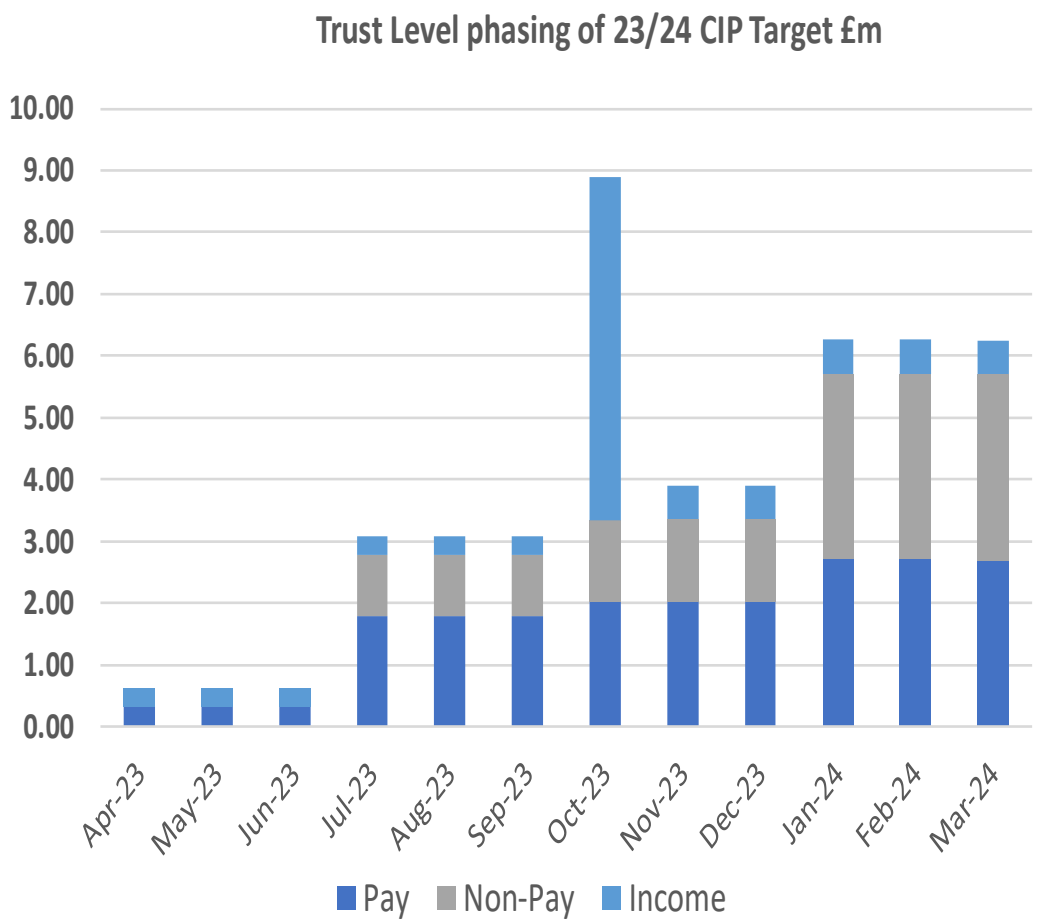
The key areas of improvement are:

- Implementation and roll out of Virtual ward,
- Optimising Same Day Emergency Care (SDEC) to reduce number of patient transferred to main inpatient wards,
- Patient flow and inpatient ward delivery focusing on ward processes and timely discharge – key areas being the use of the discharge lounge, earlier in the day discharged (before noon **33%**) and to increase the number of patients discharged at weekends (Target **80%** of average weekday),
- Emergency Department clinical pathway improvement,
- Supporting out of hospital capacity including access to packages of care and intermediate care placement.

Work continues to focus on the number of patients identified as medically fit and having “No Criteria to Reside” in an acute hospital bed. In June 2023 the Trust reported **6%** of occupied as "No Criteria to Reside". This is against the May 2023 plan trajectory of **10%** and overall plan to achieve less that **5%** of occupied beds by March 2024.

CIP Target 23/24

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 FY22/23
- 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% / **£16.0M**
- Income - 22% / **£10.1M**

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.

23/24 CIP Pipeline

NHS
Torbay and South Devon
NHS Foundation Trust

For the financial year 2023/24, the total recurrent CIP delivery requirement is £46.6m. As of 17th July, the 2023/24 CIP programme includes 166 schemes, of which 88 schemes (53%) totalling £25.6m are assessed as Green and have been confirmed in the Plan.

Divisions and workstreams are working through 88 new ideas, of which 23 schemes have a high-level value of £10.65m.

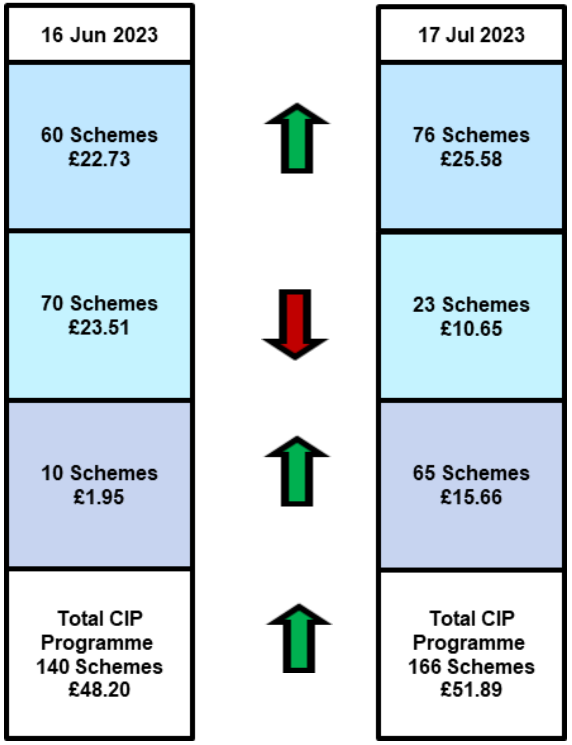
The Strategic ICB Collaborative schemes totalling £10.5m have been assessed as £9.9m Red and £0.6m Amber by the PMO on the basis that although there are signed off PIDs in place, there is not a clear delivery plan for these schemes available and there has been little progress, and therefore a substantial 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.

It is highly likely that with risk adjustment of the CIP plan of £46.6m, that the full value of schemes required to be implemented for 2023/24 will need to be significantly higher (a minimum of £51m) to 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 £51.9m (non-risk-adjusted value).

2023/24 Scheme Development (£m)



Cash Position / Better Payment Practice

Torbay and South Devon NHS Foundation Trust

	YTD Bud £000	YTD Act £000	YTD Var £000
Opening cash balance	14,961	34,734	19,773
Capital Expenditure (accruals basis)	(7,375)	(5,625)	1,750
Capital loan/PDC drawn down	4,183	0	(4,183)
Capital loan repayment principal	(824)	(990)	(166)
Proceeds on disposal of assets	0	0	0
Movement in capital creditor	0	(11,921)	(11,921)
Other capital-related elements	(563)	(571)	(8)
Sub-total - capital-related elements	**(4,579)**	**(19,107)**	**(14,528)**
Cash Generated From Operations	(6,567)	(7,317)	(750)
Revenue PDC drawn down	14,768	4,768	(10,000)
Working Capital movements - debtors	(573)	10,457	11,030
Working Capital movements - creditors	(17)	(4,697)	(4,680)
Net Interest	(629)	(221)	408
PDC Dividend paid	0	0	0
Other movements	(319)	(328)	(9)
Sub-total - other elements	**6,662**	**2,661**	**(4,001)**
Closing cash balance	**17,044**	**18,288**	**1,244**

Better Payment Practice Code	Paid	Paid within Target	Paid within Target %
Non-NHS - number of bills	32,382	28,335	87.5%
Non-NHS - value of bills (£k)	81,042	64,573	79.7%
NHS - number of bills	350	241	68.9%
NHS - value of bills (£k)	5,092	4,692	92.1%
Total - number of bills	32,732	28,576	87.3%
Total - value of bills (£k)	86,134	69,265	80.4%

- Access to capital and revenue PDC support remains critical to the Trust's cashflow. FY23/24 planned PDC funding is **£61.6m** (FY22/23 actual: **£45.3m**). This represents a **£9.2m** reduction compared to plan due to a delay with national capital schemes.
- 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 **£14.5m** adverse, largely due to pay down of the capital creditor **£12.0m**. The plan assumed that this would have happened at the end of the prior year. PDC capital drawn down **£4.2m** adverse due to delays in capital expenditure requirement.
- Debtor movement is **£11.0m** favourable, which is principally due to the 22/23 pay award.
- Working capital variance mainly relates to payment for DPT CFHD and pay award.

Balance Sheet

Torbay and South Devon NHS Foundation Trust

	YTD Bud £000	YTD Act £000	YTD Var £000
Intangible Assets	11,757	17,221	5,464
Property, Plant & Equipment	250,438	234,830	(15,608)
On-Balance Sheet PFI	17,209	20,178	2,969
Right of Use assets	19,507	20,837	1,330
Other	1,843	1,498	(345)
Non-Current Assets Total	**300,754**	**294,564**	**(6,190)**
Cash & Cash Equivalents	17,040	18,288	1,248
Other Current Assets	41,234	44,092	2,858
Current Assets Total	**58,274**	**62,380**	**4,106**
Total Assets	**359,028**	**356,944**	**(2,084)**
Loan - DHSC ITFF	(2,917)	(2,918)	(1)
PFI and Leases	(4,400)	(4,797)	(397)
Trade and Other Payables	(54,871)	(67,184)	(12,313)
Other Current Liabilities	(5,267)	(8,776)	(3,509)
Current Liabilities Total	**(67,455)**	**(83,675)**	**(16,220)**
Net Current Assets/(liabilities)	**(9,181)**	**(21,295)**	**(12,114)**
Loan - DHSC ITFF	(21,468)	(21,301)	167
PFI and Leases	(30,553)	(31,445)	(892)
Other Non-Current Liabilities	(4,615)	(4,581)	34
Non-Current Liabilities Total	**(56,636)**	**(57,328)**	**(692)**
Total Assets Employed (Assets + Liabilities)	**234,937**	**215,941**	**(18,996)**
Reserves			
Public Dividend Capital	213,645	200,383	(13,262)
Revaluation	61,351	62,093	742
Income and Expenditure	(40,059)	(46,535)	(6,476)
Total	**234,937**	**215,941**	**(18,996)**

- Non-Current Assets are £6.2m lower than plan. This is largely due to FY22/23 property revaluation having been lower than planned £4.7m. In year capital expenditure is £1.7m behind plan, which is partially offset by reduced depreciation £0.6m due to delays in bringing assets into service.
- Cash & Cash Equivalents is £1.3m higher than plan, as explained in the commentary to the Cash Flow Statement.
- Other Current Assets are £2.9m higher than planned. This is principally due to charitable funded capital projects £0.9m, ASC debtors £0.9m and assets held for sale £1.4m for Dartmouth.
- Trade and Other Payables are £12.3m higher than plan. This is principally due to HMRC PAYE costs (£7.2m) for the FY22/23 pay award being paid retrospective in 23/24, and pension costs associated with the 23/24 pay award £1.2m. The residual value is due to an increase in general accruals.
- Other Current Liabilities are £3.5m higher than planned, mainly due to deferred income not reducing as quickly as anticipated.
- PDC reserves are £13.3m lower than planned, due to PDC support being drawn down later than planned.
- The Income and Expenditure reserve is £6.5m lower than plan, principally due to below-the-line asset impairment processed late in FY22/23 for finished Acute Medicine Unit.

Risks & Mitigations

Torbay and South Devon NHS Foundation Trust

Ref	Risk Description	M02 Risk £'000	M03 Risk £'000	R.A.G	Mitigation
R01	High Cost Drugs Growth	2,500	2,500		
R02	Income Risk Income Risk (Incl. ICB ASC funding Shortfall & ESRF)	6,100	6,100		Potential partial mitigation via new uplift from NHSE/I to support Local Authority spend (ICB allocation TBC)
R03	Liberty Protection Safeguard	1,800	1,800		Awaiting parliament approval, impact may fall under 24/25
R04	Additional Cost (Capacity/ Winter Pressure mainly UEC staffing costs)	3,000	3,000		
R05	Industrial Strike Action	0	654		
R06	Efficiency risk System strategic efficiencies risk	10,477	10,477		Need to find local mitigations
R07	Efficiency Schemes	13,423	13,423		Need to accelerate progress from ideas identified to concrete plans
R08	Diagnostic Cost Pressure	1,000	1,000		
Total		**38,300**	**38,955**		

Highlighted above are the Risks to the Trust's financial position.

An Efficiency Risk of £23.9m has been identified relating to forecast undelivered CIP across the Trust for the year of which £10.4m relates to ICS wide strategic schemes. Actions are being put in place to ensure the overall target of **£46.6m** is delivered in line with plan this would need identification of local possible schemes to mitigate.

An Income Risk of £6.1m largely relates to potential ICB funding gap for ASC.

Integrated Performance Report - Dashboard of key metrics - June 2023

	Target	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Operational Plan trajectory June 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA															
Urgent and Emergency Care															
Percentage of Ambulance handovers greater than 15 minutes		80.0%	77.0%	78.3%	77.5%	84.4%	82.2%	87.5%	66.5%	54.8%	73.9%	55.4%	72.1%	72.1%	No trajectory
Percentage of Ambulance handovers greater than 3 hours		19.8%	16.7%	19.5%	23.8%	27.0%	18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	No trajectory
Total average time in ED (hours/minutes)		07:22	07:02	07:06	07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	No trajectory
ED attendances where visit time over 12 hours	0	871	827	920	906	988	939	1207	823	599	977	568	891	797	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	54.5%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	65%
% patient discharges pre-noon	33%					18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	33%
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%	6.0%	7.0%	10.0%
Elective recovery															
RTT 104 week wait incomplete pathway	0	96	70	51	50	47	34	29	22	14	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	713	686	787	813	829	822	923	708	462	183	166	167	123	130
RTT 65 week wait incomplete pathway	0			2093	2252	2485	2174	2203	1828	1679	1372	1244	1168	1221	1814
RTT 52 week wait incomplete pathway	Reduction	4137	4578	5083	5060	5412	5585	6027	5554	5116	4427	4024	3926	3938	5982
Patient waits over 2.5 years	0	48	54	47	24	24	17	12	9	6	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	64.8%	67.7%	72.1%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	75.5%	78.0%	77.7%	75%
Number of patients waiting longer than 62 days for treatment	138	233	283	244	333	331	229	253	225	130	114	107	111	100	152

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - June 2023

	ISU	Target	13 month trend	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		2	1	3	5	0	0	2	3	1	2	1	1	1	3
Reported Incidents - Death	Trustwide	<1		0	2	2	1	1	0	0	4	0	1	0	1	1	2
Medication errors resulting in moderate harm	Trustwide	<1		0	0	0	0	0	1	0	0	0	0	1	2	3	6
Medication errors - Total reported incidents	Trustwide	N/A		50	41	59	64	36	44	48	47	44	62	68	72	76	216
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		0	0	0	1	3	1	1	0	3	1	0	0		0
Never Events	Trustwide	<1		0	0	0	0	1	0	0	0	2	0	0	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		8	5	3	2	3	0	6	13	3	13	5	7	8	20
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	1	0	0	0	0	0	1	0	0	2	1	2	5
Formal complaints - Number received	Trustwide	20		12	16	16	10	16	11	10	14	12	12	5	7	6	18
VTE - Risk Assessment on Admission (acute)	Trustwide	>95%		90.0%	91.8%	93.6%	92.7%	94.7%	94.4%	94.0%	95.5%	95.9%	96.5%	96.3%	95.4%	96.5%	96.0%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		117	115.1	114.7	113.4	111	109.9	111.5	107.1	105.5	102.4				102.4
Safer staffing - ICO - Day time	Trustwide	90% - 110%		95.8%	93.7%	94.4%	96.4%	99.1%	99.4%	91.6%	92.1%	91.3%	93.1%	92.4%	96.0%	100.1%	100.1%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		88.1%	85.8%	86.2%	85.6%	88.8%	86.4%	87.4%	87.9%	87.0%	88.4%	91.3%	90.0%	89.0%	89.0%
Infection Control - Bed Closures - (Acute bed days in month)	Trustwide	<100		130	84	36	132	42	156	786	339	254	164	217	120	99	436
Hand Hygiene	Trustwide	>95%		94.5%	96.0%	97.7%	96.6%	94.9%	96.2%	91.2%	94.0%	92.1%	91.3%	92.5%	92.9%	91.3%	92.2%
Number of Clostridium Difficile cases (COHA+HOHA)	Trustwide	<3		4	6	9	6	3	2	1	8	2	2	4	7	7	18
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		66.7%	56.4%	56.0%	50.0%	54.3%	43.3%	41.5%	40.0%	53.8%	58.3%	58.0%	57.1%	40.0%	40.0%
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		34.1%	66.7%	59.3%	54.8%	55.0%	75.9%	28.0%	54.5%	67.4%	70.7%	63.0%	80.0%	70.0%	71.2%
Mixed Sex Accommodation breaches	Trustwide	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Follow ups 6 weeks past to be seen date	Trustwide	6400		22158	21504	21797	21821	20806	20257	21452	20030	20048	19979	19618	19609	18738	18738
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.6%	5.8%	5.7%	5.7%	5.7%	5.6%	5.6%	4.7%	5.7%	5.6%	5.0%	5.3%		5.3%
Appraisal Completeness	Trustwide	>90%		75.2%	77.0%	78.0%	75.8%	76.6%	77.6%	76.7%	77.7%	76.7%	76.9%	77.9%	78.1%	78.1%	78.1%
Mandatory Training Compliance	Trustwide	>85%		90.1%	89.7%	89.2%	88.7%	88.6%	89.1%	89.7%	89.9%	90.1%	90.4%	90.7%	91.2%	91.7%	91.7%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		13.7%	13.8%	13.8%	13.9%	13.7%	13.7%	13.5%	13.3%	13.1%	12.8%	12.9%	12.7%	12.5%	12.5%

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - June 2023

	ISU	Target	13 month trend	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%		6.5%			6.8%			6.5%			6.5%				
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		705	700	714	737	751	735	756	755	781	814	784	804	817	671
Intermediate Care - No. urgent referrals	Trustwide	113		234	222	223	205	277	297	299	318	307	298	287	321	371	214
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		215	234	222	197	193	203	208	198	200	251	224	218	224	265
Urgent Community Reponse (2-hour) - Referrals	Trustwide	NONE SET		24	25	15	20	26	27	40	34	34	30	26	32	34	349
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	70%		66.7%	88.0%	80.0%	85.0%	100.0%	74.1%	77.5%	79.4%	94.1%	90.0%	92.3%	90.6%	85.3%	81.7%
Urgent Community Reponse (2-48 hour)- Referrals	Trustwide	NONE SET				195	153	195	196	182	177	171	160	136	155	144	1064
Urgent Community Reponse (2-48 hour) - Target achievement	Trustwide	NONE SET				86.7%	86.9%	85.6%	86.2%	84.6%	92.7%	83.3%	86.3%	87.7%	87.3%	87.5%	83.1%
ADULT SOCIAL CARE TORBAY KPIs																	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		35.3	28.5	40.8	32.6	27.2	29.9	32.6	32.6	28.5	29.9	32.6	27.2	24.5	24.5
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		880.4	928.8	939.6	931.5	861.5	901.9	915.4	840	802.3	826.5	805	748.5	729.6	576.2
Proportion of clients receiving direct payments	Trustwide	25%		19.6%	19.7%	20.0%	20.4%	20.3%	20.2%	20.3%	20.0%	20.2%	19.5%	20.1%	20.1%	20.0%	19.5%
% reablement episodes not followed by long term SC support	Trustwide	83%		89.6%	89.5%	85.4%	85.2%	86.0%	85.5%	85.4%	86.6%	86.4%	86.4%	85.3%	88.3%	88.9%	84.5%

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - June 2023

	ISU	Target	13 month trend	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		35.6%	31.9%	38.4%	45.3%	63.8%	58.4%	67.4%	76.3%	82.6%	76.0%	55.9%	74.1%	76.3%	76.3%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		41.7%	17.3%	58.5%	79.1%	87.7%	82.8%	100.0%	93.5%	97.6%	88.9%	87.9%	76.7%	69.6%	69.6%
Cancer - 28 day faster diagnosis standard	Trustwide	75%		64.8%	67.7%	72.1%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	75.5%	78.0%	77.7%	77.7%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		96.0%	96.7%	98.0%	92.8%	96.4%	89.0%	98.3%	95.5%	98.3%	95.9%	89.7%	92.3%	93.3%	93.3%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		100.0%	97.4%	100.0%	98.7%	100.0%	90.4%	98.6%	100.0%	100.0%	100.0%	98.6%	100.0%	100.0%	100.0%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		95.5%	98.0%	98.4%	92.2%	94.4%	98.0%	100.0%	85.7%	100.0%	86.9%	100.0%	96.9%	80.8%	80.8%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		87.5%	88.9%	95.5%	96.8%	89.7%	86.8%	89.7%	80.0%	96.2%	83.3%	88.5%	87.5%	89.7%	89.7%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		56.4%	60.4%	57.0%	60.8%	64.2%	54.5%	63.1%	47.2%	47.1%	63.2%	66.8%	54.7%	65.6%	65.6%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		92.9%	69.2%	70.0%	90.9%	100.0%	81.0%	76.9%	100.0%	100.0%	72.7%	100.0%	100.0%	77.4%	77.4%
Cancer - Patient waiting longer than 104 days from 2ww (Improvement target 20)	Trustwide			60	73	37	43	71	62	69	68	53	24	20	11	7	
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		50.6%	49.5%	48.5%	42.5%	45.5%	45.5%	43.3%	43.9%	44.3%	48.1%	49.7%	49.8%	51.2%	51.2%
RTT 65 week wait incomplete pathway	Trustwide	1091		1855	1789	2093	2252	2485	2174	2203	1828	1679	1372	1244	1168	1221	1221
RTT 78 week wait incomplete pathway	Trustwide	178		713	686	787	813	829	822	923	708	462	183	166	167	123	123
RTT 104 week wait incomplete pathway	Trustwide	0		96	70	51	50	47	34	29	22	14	0	0	0	0	0
On the day cancellations for elective operations	Trustwide	<0.8%		1.3%	1.7%	3.1%	1.4%	1.7%	1.5%	2.1%	1.4%	1.5%	1.5%	0.8%	1.4%	1.8%	1.4%
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		9	9	13	8	7	15	6	11	10	7	7	10	14	31
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		20.9%	20.2%	16.9%	16.8%	n/a	16.6%	16.1%	16.5%	15.3%	14.6%	15.8%	15.2%	15.0%	
Bed Occupancy	Acute	90.0%		93.7%	93.2%	94.3%	92.3%	92.3%	95.2%	94.9%	96.3%	96.2%	96.3%	95.3%	96.4%	95.5%	95.5%
Percentage of inpatients with No Criteria to Reside (acute)	Trustwide	<5%						11.0%	11.0%	13.0%	13.0%	12.0%	8.1%	7.6%	6.0%	7.0%	
% patient discharges pre-noon	Acute	33%								18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	
% patient discharges pre-5pm	Acute	75%								63.2%	65.2%	67.9%	67.3%	69.8%	66.7%	67.7%	
Number of patients >7 days LoS (daily average)	Trustwide			173.0	167.0	167.0	184.9	177.0	162.0	172.6	183.5	166.1	167.0	154.2	159.8	156.2	156.7
Number of extended stay patients >21 days (daily average)	Trustwide			43.0	40.9	48.0	49.2	49.8	32.0	42.3	57.1	40.7	38.6	39.3	33.2	35.2	35.9

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - June 2023

	ISU	Target	13 month trend	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Year to date
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		1886	1476	1156	1012	1208	1112	1232	865	534	1043	598	1025	1002	2625
Ambulance handover delays > 60 minutes	Trustwide	0		1458	1078	871	764	933	787	983	623	263	687	277	595	615	1487
UEC - patients seen within 4 hours (23/24 plan target 76%)	Trustwide	76%		54.5%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	0.0%
ED - patients with >12 hour visit time pathway	Trustwide			871	827	920	906	988	939	1207	823	599	977	568	891	797	2256
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute				36%	36%	39%	37%	39%	31%	46%	44%	41%	52%	53%	55%	55%
Clinically Ready to Proceed delay over 1 hour - Emergency Department	Acute								44%	39%	42%	40%	44%	41%	40%	29%	29%
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute				05:06	05:05	04:51	05:21	05:14	06:05	05:02	04:53	05:08	04:24	04:42	04:22	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute				12:15	12:15	14:22	14:06	13:14	16:05	13:42	10:06	12:47	09:10	11:15	10:55	
Diagnostic tests longer than the 6 week standard	Trustwide	<1%		30.1%	29.1%	33.9%	34.9%	32.4%	30.1%	29.0%	34.0%	26.1%	29.7%	29.8%	27.7%	24.3%	24.3%
CDiff - Hospital Onset Healthcare Associated (HOHA)	Trustwide			4	4	5	3	2	0	1	7	1	1	3	4	4	11
CDiff - Community Onset Healthcare Associated (COHA)	Trustwide			0	2	4	3	1	2	0	1	1	1	1	3	3	7
Dementia - Find - monthly report	Trustwide	>90%		84.1%	92.5%	90.6%	94.1%	87.2%	93.0%	91.6%	87.9%	84.5%	87.1%	83.6%	90.7%	85.2%	90.7%
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		63.8%	69.7%	70.7%	n/a	69.1%	n/a	48.9%	72.3%	65.7%	58.1%	65.0%	61.5%	71.7%	66.2%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		50.8%	48.0%	48.3%	n/a	47.4%	n/a	41.5%	48.1%	45.1%	39.4%	49.1%	55.5%	52.7%	52.2%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		69.5%	69.1%	80.2%	59.0%	60.0%	62.0%	68.0%	73.9%	69.2%	62.8%	67.7%	64.4%	63.7%	

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - June 2023

	ISU	Target	13 month trend	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-914	-1231	-4412	-5783	-7140	-10433	-13434	-16118	-19884	-21358	-394	-4478	-6555	
Agency - Variance to NHSI cap	Trustwide			-2.40%	-2.10%	-2.10%	-2.00%	-1.90%	1.90%	-1.80%	-1.80%	-1.90%	-1.90%				
Agency - Spend in month against budget value	Trustwide													38.22%	55.00%	-22.78%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide			-2717	-2751	-3858	-4403	-4872	-5005	-5874	-5328	-5512	-3390	-449	17	-1873	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			814	1203	1065	975	1988	2787	3280	4076	944	-18162	-993	3619	1616	
Distance from NHSI Control total (£'000's)	Trustwide			0	0	-2978	-4014	-5022	-7421	-9995	-12182	-15796	-17186	22	307	300	
ACTIVITY VARIANCE vs 2019/20 BASELINE* (* March 2023 compared to March 2022)																	
Outpatients - New	Trustwide			-7.5%	-18.1%	2.4%	0.2%	-11.7%	3.6%	-2.0%	-5.2%	-0.6%	16.1%	-12.2%	9.4%	6.1%	3.0%
Outpatients - Follow ups	Trustwide			-7.0%	-15.3%	4.0%	-0.8%	-10.1%	4.4%	-4.1%	-6.9%	-2.4%	9.0%	-6.9%	6.2%	10.3%	2.4%
Daycase	Trustwide			-0.4%	-7.9%	-3.5%	3.2%	-4.6%	-3.0%	-5.5%	-1.7%	5.1%	21.7%	-8.1%	4.1%	4.4%	-3.7%
Inpatients	Trustwide			-7.0%	-16.1%	-15.5%	9.6%	-16.3%	-19.5%	-21.4%	-18.1%	-16.4%	42.0%	-11.7%	-3.8%	-7.9%	-6.0%
Non elective	Trustwide			-1.4%	-8.2%	-2.9%	-7.1%	-7.0%	-12.7%	-18.1%	-5.7%	-11.2%	-0.2%	-7.1%	-8.9%	1.2%	-5.0%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			503	512	0	0	0	0	0	0	0	0	#N/A	#N/A	#N/A	
Intermediate Care GP Referrals	Trustwide			95	94	78	80	78	75	74	64	94	87	89	88	94	
Average length of Intermediate Care episode	Trustwide			14.50	15.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#N/A	#N/A	#N/A	

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: July 2023 Mortality Score Card			Meeting date: 26 July 2023
Report appendix	**Appendix 1 – Hospital Mortality** **Appendix 2 – Unadjusted Mortality Rate** **Appendix 3 – Mortality Analysis** **Appendix 4 – Focused Mortality Reviews**		
Report sponsor	Medical Director		
Report author	Medical Director		
Report provenance	Mortality Surveillance Group		
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	The Board is asked to receive and note the July 2023 Mortality Score Card.		

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

Report title: July 2023 Mortality Score Card		**Meeting date: 26 July 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 103.6 ↓
• B. Summary Hospital Mortality Index (SHMI)	Mortality	DH SHMI data		1.0343 ↑ (Jan 22 – Dec 22)
Appendix 2 • Unadjusted Mortality Rate • By number • By location		Trust Data	Yearly Average ≤3%	3.65%
Appendix 3 • Mortality Analysis		Trust Data Dr Foster DH HSMR data	New CUSUM alerts	0
Appendix 4 • Mortality Reviews and Learning		Trust Data		

2.0 Trust Wide Summary

The Hospital Standardised Mortality Rate (HSMR) is above the target level of 100 for our population but is now within the expected range compared to hospital trusts nationally. The rolling 12-month position exceeded the targeted range for the 12-months to February 2023 with a relative risk of 103.6 against a 100 benchmark. The rolling 12- month trend shows that the HSMR became statistically higher than expected in July 2021. The last 10 data points have remained stable with a slight downward trend resulting in the last 2 data periods falling within the expected range. The Trust's HSMR is one of 6 trusts in our peer comparator statistically within the 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.

Appendix 1 – Hospital Mortality

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

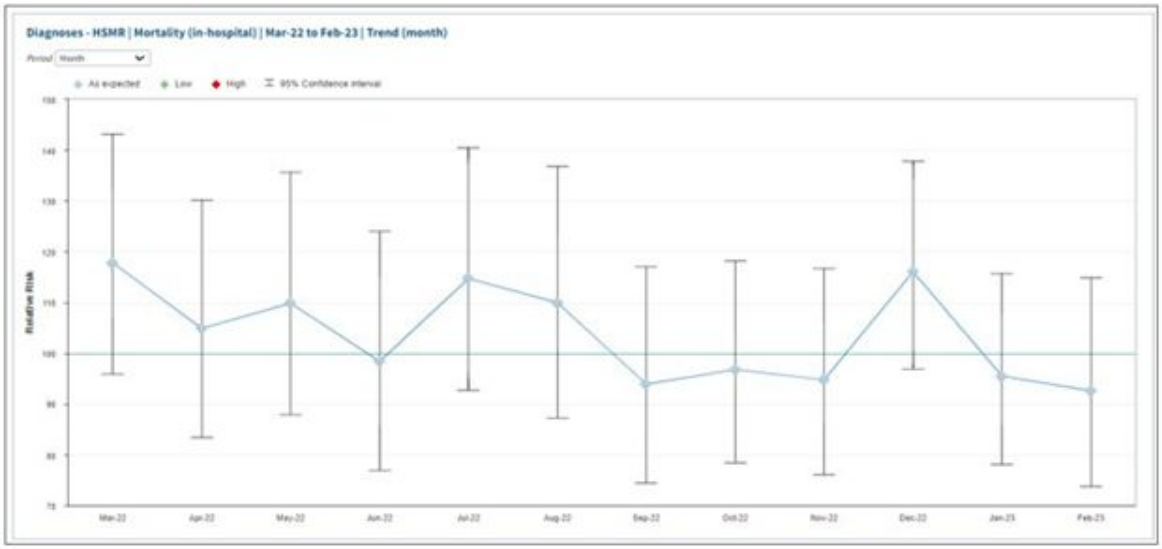
- 1A – Dr Foster's Hospital Standardised Mortality Rate (HSMR) and,
- 1B – Department of Health's Summary Hospital Mortality Index (SHMI)

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

Our HSMR aim is to reduce and sustain the HSMR below a rate of ≤90
A rate above 100 with a ***high relative risk*** may signify a concern and needs to be investigated

---

Chart 1 - HSMR by Month March 2022 to February 2022 (1 month lag applied due to residual coding data lag)
Chart one (as below) shows a longitudinal monthly view of HSMR.



A one month lag has been applied to the data due to the high volume of super spells within the Residual codes, unclassified group in the last month of data in the extract (March 23) which are still to be coded with a more robust diagnosis.

The latest HMSR for March 22 - February 23 is **103.6** (97.5 – 109.9), this is within the expected range compared to hospital trusts nationally. (↓). There were 31,628 super spells recorded in the time period and 1096 deaths. All individual months are also within the expected range.

Chart 2 -HSMR rolling 12-month position

The rolling 12 month trend shows that the HSMR became statistically higher than expected in the Aug 20 to Jul 2021 period and remained so until the January to December 22 data point. There has been a steady decline however and the HSMR has been within the expected range for the last two data periods.

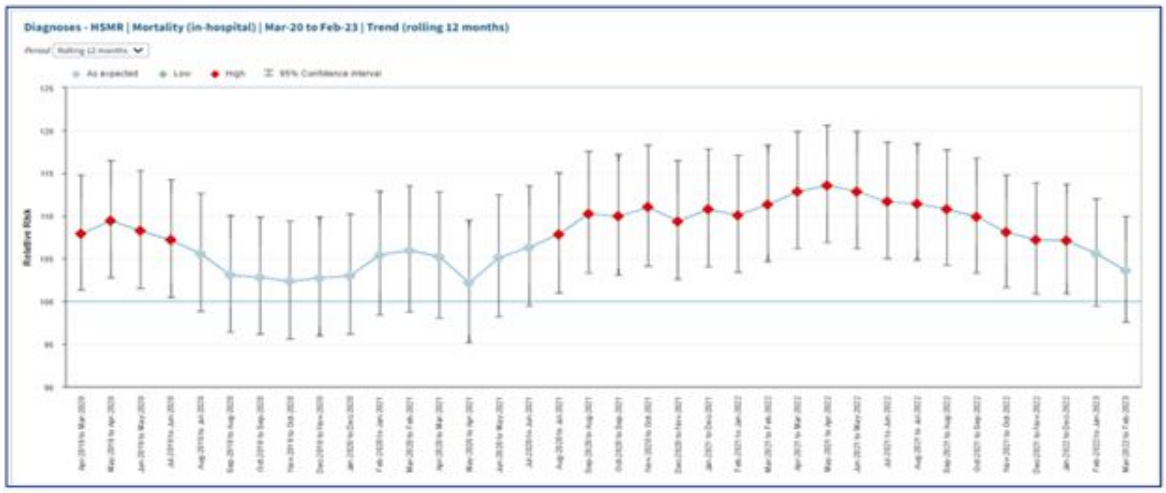


Chart 3-HSMR Peer Comparison – Similar Peers

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 6 Trusts within the expected range out of 20.

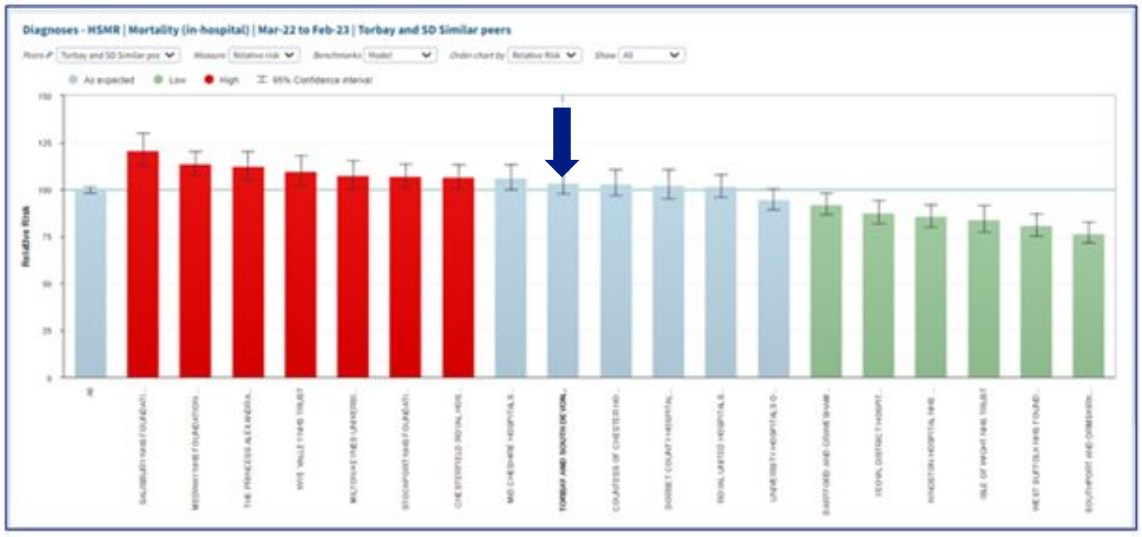


Chart 4- HSMR Peer comparison – Regional Peers

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 6 Trusts that are within the expected range (out of a total 14).

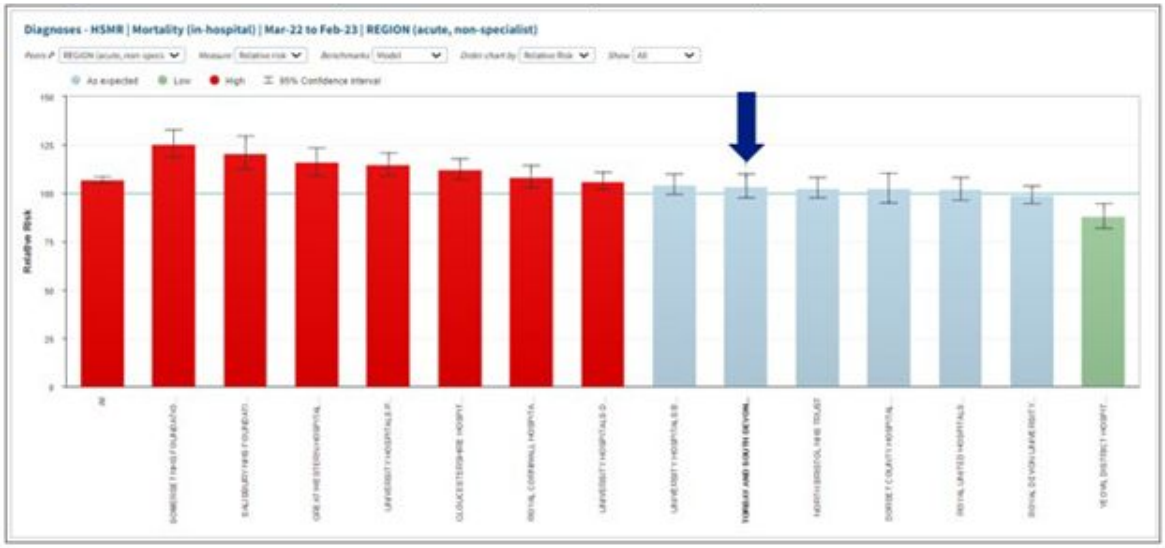


Chart 5- HSMR Expected rate (%) vs National

The expected rates followed a similar pathway to National (but at a lower rate) followed by an incremental increase. The Trust's expected rate has now risen to meet more closely that of national in the last 2 data periods.

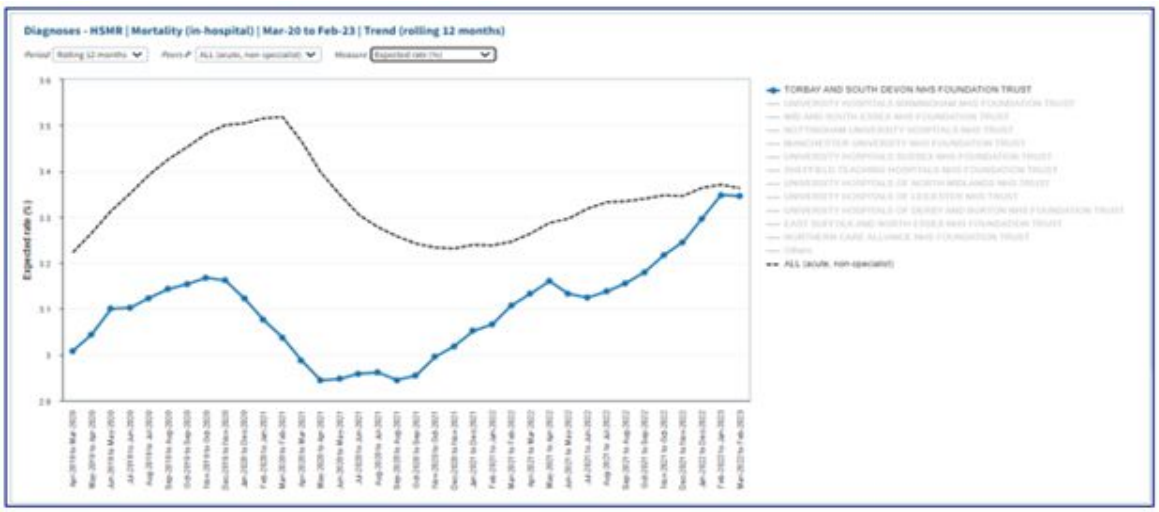


Table 2 – Coding Case Mix Summary

The following table reports a higher percentage of spells in the Symptoms & Signs chapter (7.3%). This has improved to that reported in the last report (9.0%) but is still 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 remains the same as the last report.

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		103.6	107.0	99.7
SMR		98.5	105.9	99.5
Non-elective (HSMR)		102.9	106.9	99.4
Weekday, emergency (HSMR)		99.5	104.8	98.1
Weekend, emergency (HSMR)		114.6	113.7	103.6
Saturday, emergency (HSMR)		119.4	114.1	103.2
Sunday, emergency (HSMR)		109.5	113.5	103.9
Coding/Casemix	Site	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)		48.7%	41.2%	41.1%
% Non-elective spells with palliative care (HSMR)		5.6%	4.8%	5.0%
% Spells in Symptoms & Signs chapter		7.3%	6.7%	6.1%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		40.6%	43.1%	41.5%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		14.6%	15.0%	15.9%
% Non-elective spells in Risk Band (0-10%) (HSMR)		83.2%	84.2%	83.5%

Chart 6- Emergency Weekday / Weekend HSMR

The emergency weekday HSMR has moved banding and is now statistically within the expected range. However, the emergency weekend HSMR remains statistically higher than expected.

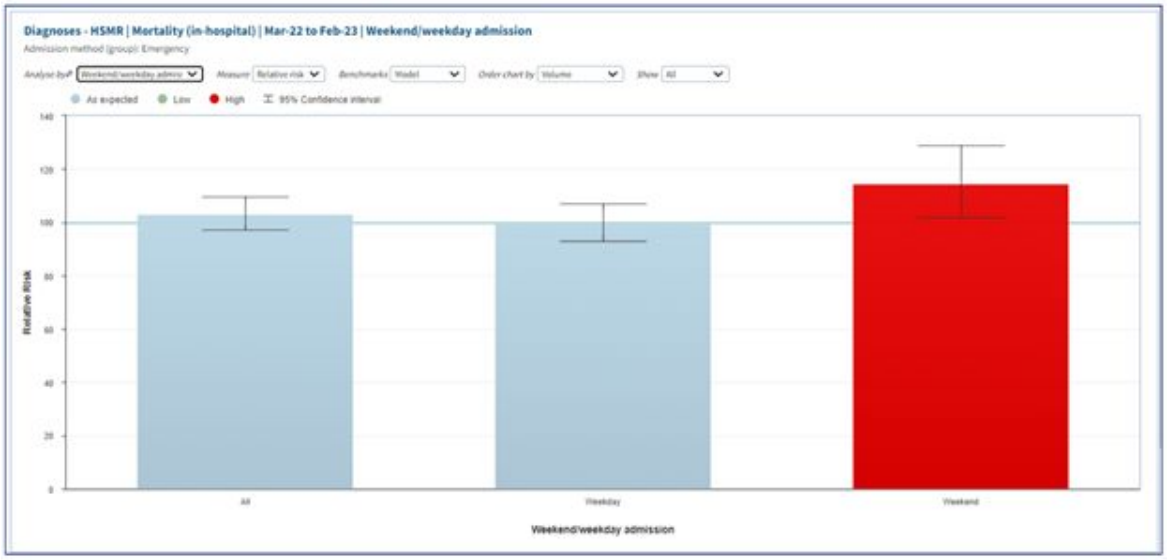


Chart 7- Emergency Weekday HSMR

The rolling twelve month picture for weekday emergency HSMR shows a downward trend over the last seven data periods and a shift in banding from statistically higher than expected to within the expected range

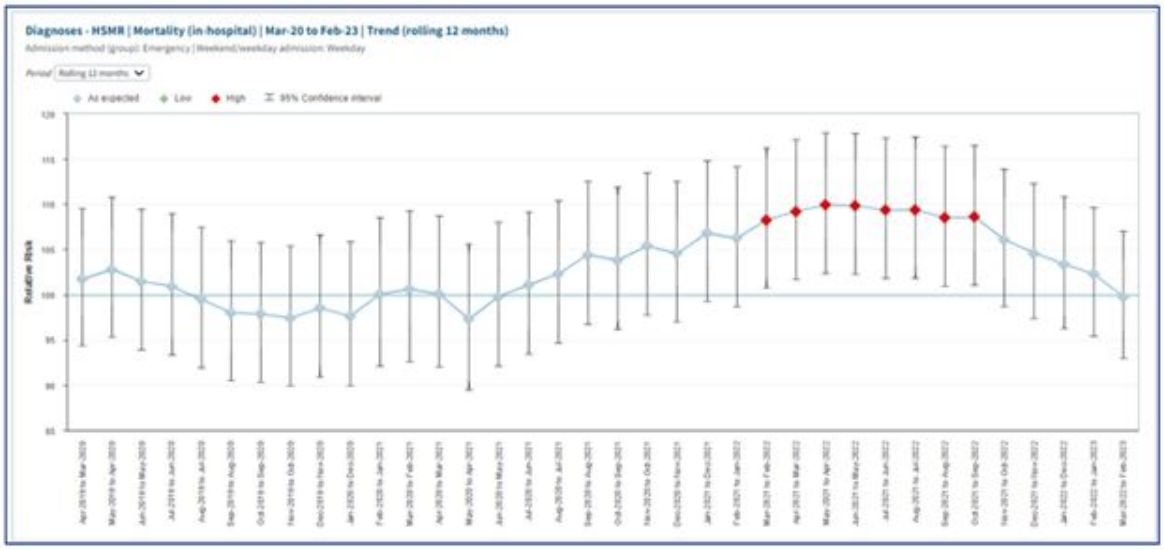
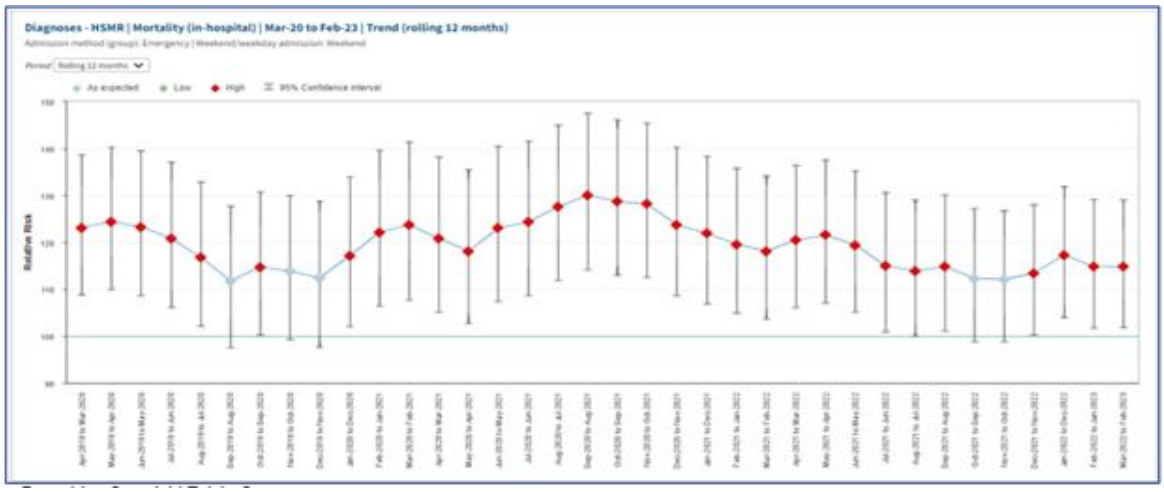


Chart 8- Emergency Weekend HSMR

Weekend emergency HSMR is statistically higher than expected compared to trusts nationally, for the majority of periods. A more stable trend can be seen in latter periods.



1B Summary Hospital Mortality Index (SHMI) Reporting Period January 2022 – December 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 **January 2021 – December 2022** data period and is different to HSMR.

Chart 9- Trust SHMI compared to National Baseline

The Trust is rated 'as expected' compared to trusts nationally with a SHMI value of 1.0343

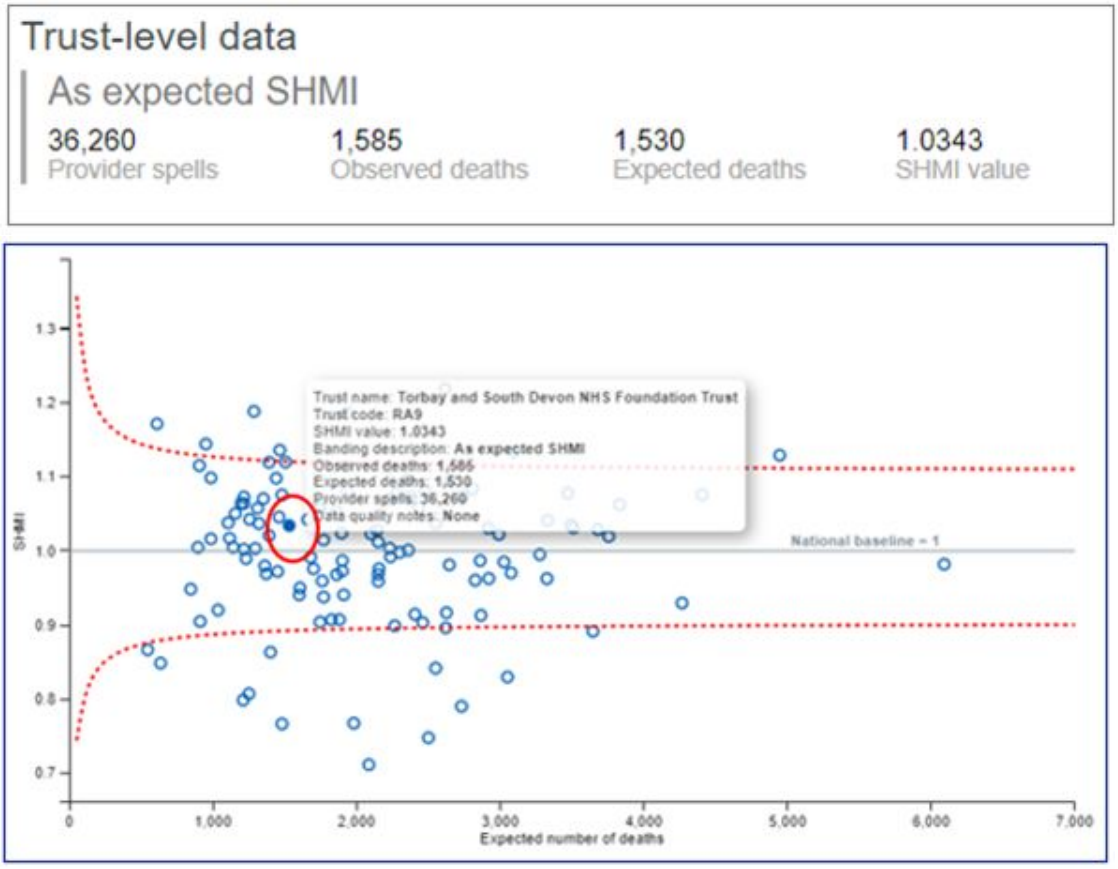


Table 3 – SHMI diagnostic groups

Secondary malignancies continue to remain statistically higher than expected.

Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	SHMI banding
Secondary malignancies	30	220	60	40	1.3848	Higher than expected
Acute bronchitis	74	675	20	15	1.1732	As expected
Acute myocardial infarction	57	435	35	35	1.0408	As expected
Cancer of bronchus; lung	15	90	25	25	1.0175	As expected
Fluid and electrolyte disorders	37	355	15	25	0.7387	As expected
Fracture of neck of femur (hip)	120	510	35	40	0.9537	As expected
Gastrointestinal hemorrhage	96	330	30	25	1.2841	As expected
Pneumonia (excluding TB/STD)	73	1,355	225	225	0.9929	As expected
Septicaemia (except in labour), Shock	2	415	115	100	1.1634	As expected
Urinary tract infections	101	625	35	30	1.1645	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 10, below, highlights the Trust's in hospital unadjusted mortality. The rolling 12-month average is 3.65%. 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. December 2022 and January 2023 showed a rise in unadjusted mortality greatly attributed to increased admissions with Covid, Flu and RSV infections.

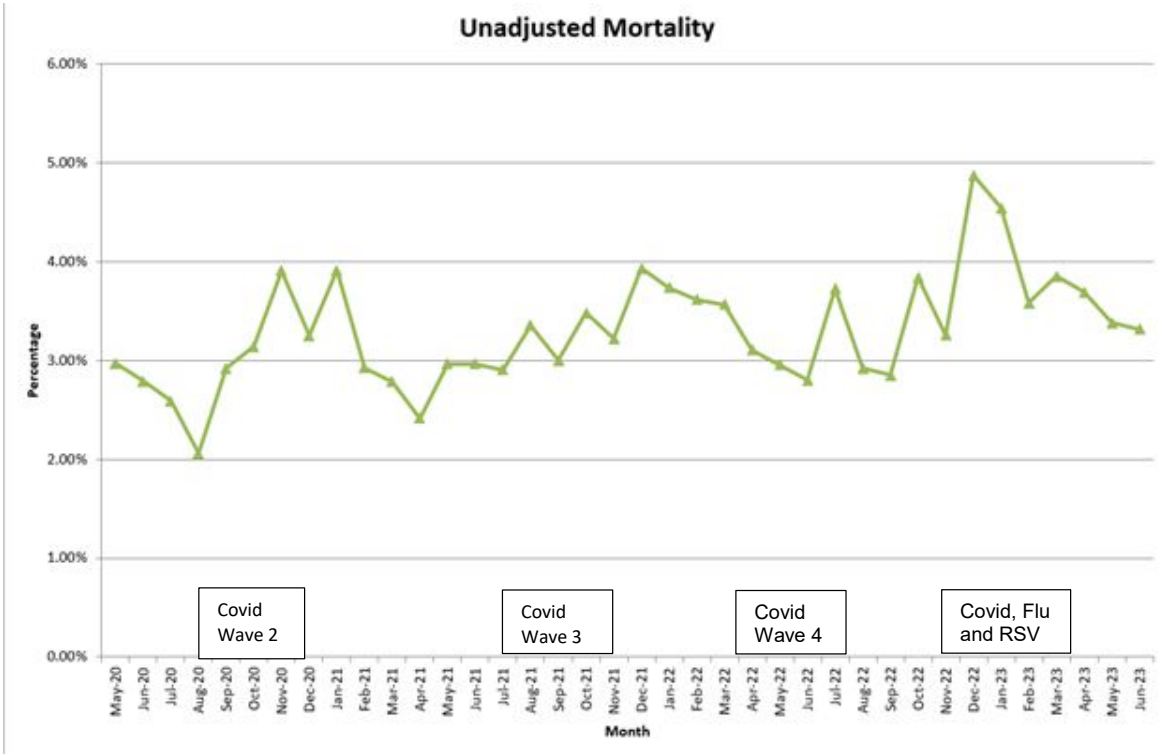
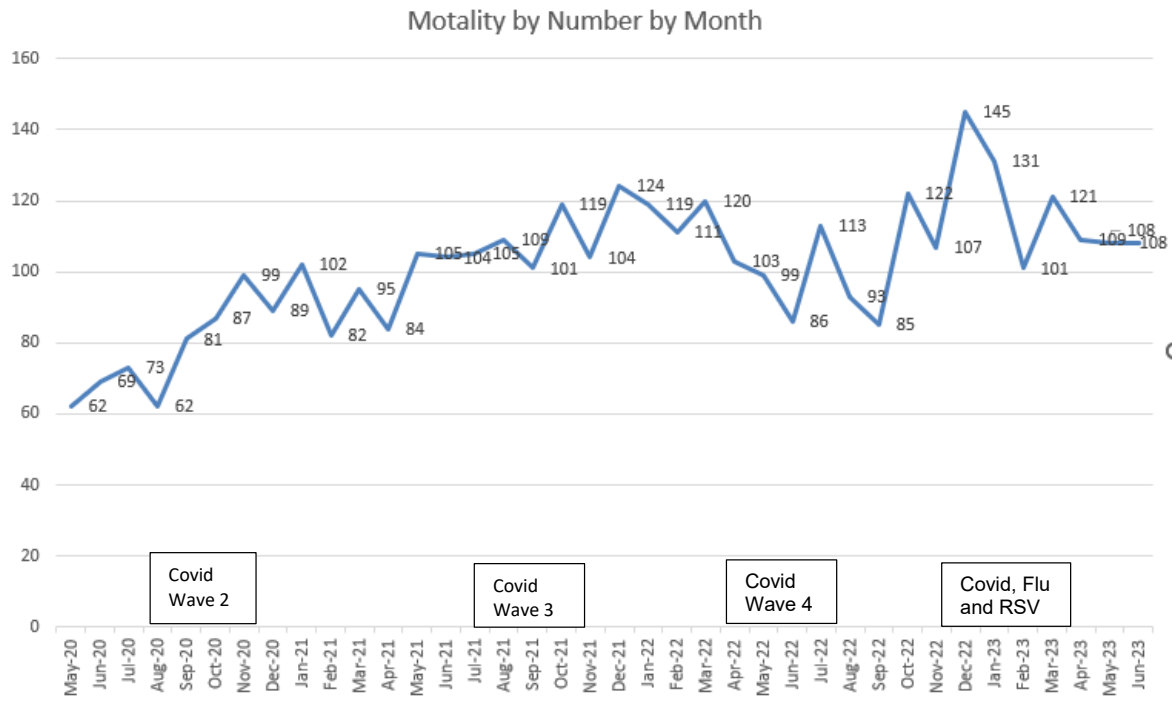


Chart 11 indicates the monthly number of hospital deaths excluding (excluding stillbirths and deaths in A & E).

Key points to note

- The comparatively low numbers during Summer 2020 are due to the reduction in hospital activity due to the initial Covid pandemic lockdown.
- 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.



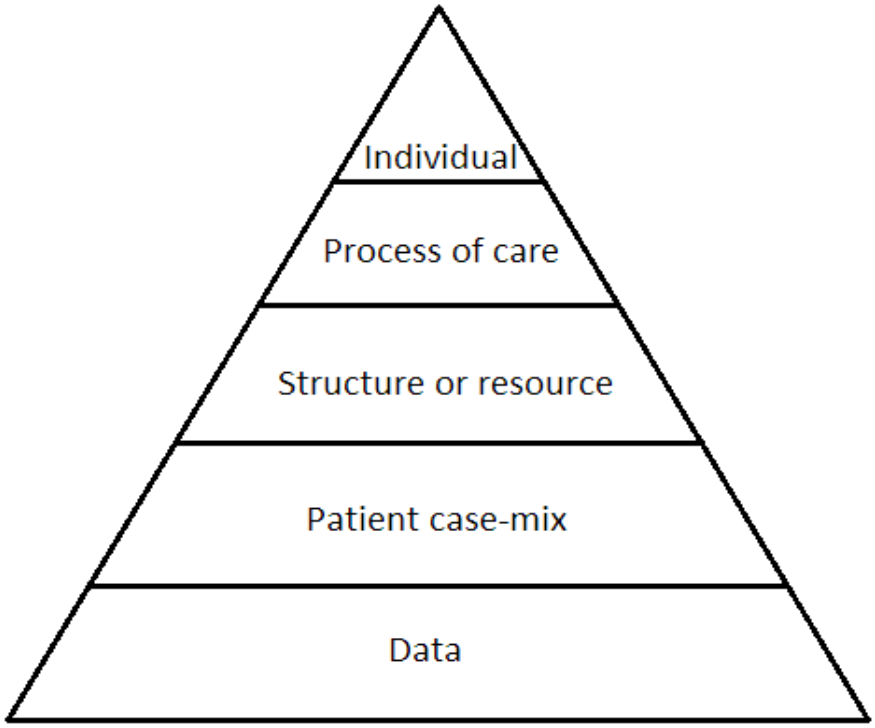
Appendix 3 – Mortality Analysis

Table 4–highlights mortality by Care Group 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.

	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Care Group - Families and Communities													
BRIXHAM	2	1			2			1		2	2		
DART	1	3	1				2		1		1		1
DAWLISH		2	1		2		3	1	2	1	1	2	1
DELIVERY SUITE													
LCHDU													
LOUISA CARY													
MOTHER AND BABY													
TEIGN WARD	1	3	2	3	3	1	4	3	2	5	2		1
TEMPLAR WARD	1	1			3	2	3				2		
Care Group - Planned Care													
AINSLIE	1	3	3	3	3	5	2	1		7	3	5	
ALLERTON	6	8	5	6	9	8	14	7	4	6	6	7	4
CROMIE	4	6	5	2	4	6	4	3	7	5	2	4	6
ELLA ROWCROFT			1	1		1	1		1			1	1
INTENSIVE CARE UNIT	10	11	6	1	6	9	10	13	11	6	6	8	7
THEATRES							2			1		1	
WARRINGTON	3	1	3	3	4	2	2	5	4	1	5	1	
Care Group - Medicine and Urgent Care													
ACUTE MEDICAL UNIT							5	4	10	6	3	5	2
CARDIAC CATHETER SUITE										1			1
CHEETHAM HILL	7	7	11	7	11	10	9	5	8	9	8	8	12
DUNLOP	4	5	7	4	6	1	14	13	6	2	8	1	3
EAU4	8	7	6	6	7	9	9	13	3	4	7	12	7
FORREST	1	8	6	6	11	11	10	12	7	8	8	10	4
GEORGE EARLE	7	17	7	11	14	10	6	9	7	12	11	12	14
MCCALLUM		4	4	2	2	2	5	9	3	4	3	1	3
MIDGLEY	13	12	11	17	18	12	17	16	13	17	16	13	18
NEW MEDICAL RECEIVING UNIT			1	3	1	2	4						
SIMPSON	5	8	8	3	10	11	6	8	4	15	8	8	11
TORBAY CHEST PAIN UNIT							1			1			
TORBAY CORONARY CARE BEDS	2			1	2	1	5	3	2	2	3		2
TURNER	10	6	5	6	4	4	7	5	6	6	4	9	10
Grand Total	**86**	**113**	**93**	**85**	**122**	**107**	**145**	**131**	**101**	**121**	**109**	**108**	**108**

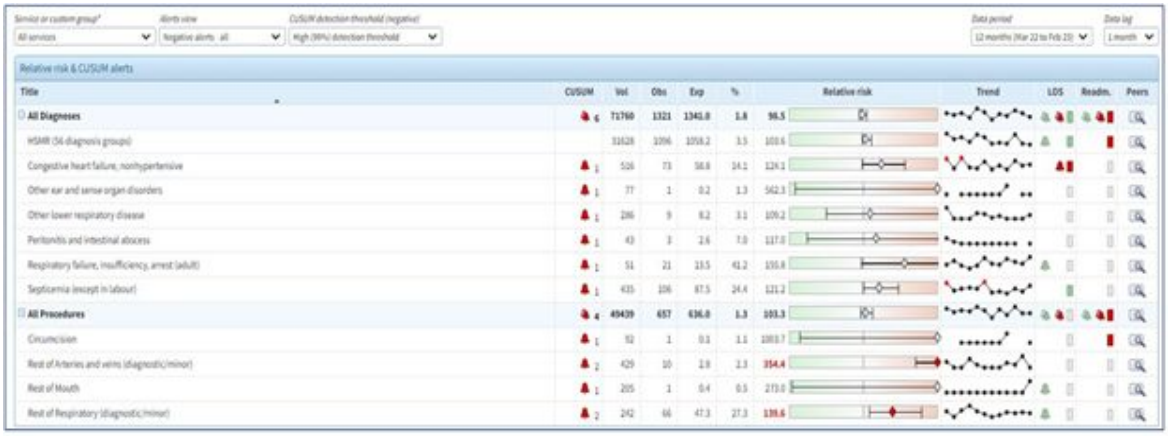
Alerts by Clinical classification

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



Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	6	71790	1321	1341.0	1.8	98.5				
HSMR (56 diagnosis groups)		31628	1096	1058.2	3.5	103.6				
Congestive heart failure, nonhypertensive	1	516	73	58.8	14.1	124.1				
Other ear and sense organ disorders	1	77	1	0.2	1.3	562.3				
Other lower respiratory disease	1	286	9	8.2	3.1	109.2				
Peritonitis and intestinal abscess	1	43	3	2.6	7.0	117.0				
Respiratory failure, insufficiency, arrest (adult)	1	51	21	13.5	41.2	155.8				
Septicemia (except in labour)	1	435	106	87.5	24.4	121.2				
All Procedures	4	49439	657	636.0	1.3	103.3				
Circumcision	1	92	1	0.1	1.1	1003.7				
Rest of Arteries and veins (diagnostic/minor)	2	429	10	2.8	2.3	354.4				
Rest of Mouth	1	205	1	0.4	0.5	273.0				
Rest of Respiratory (diagnostic/minor)	2	242	66	47.3	27.3	139.6				

Compared to the dashboard previous dashboard there are no new CUSUM alerts or new diagnosis groups with a relative risk statistically higher than expected.

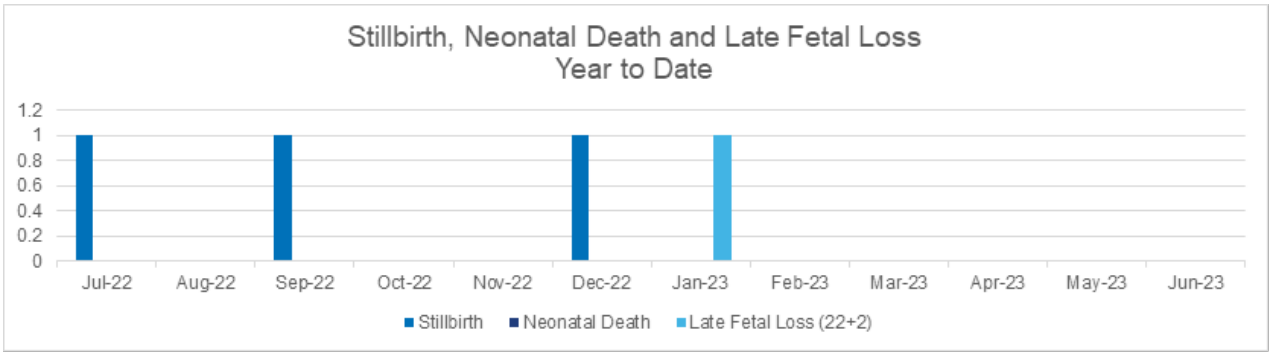
Appendix 4 – Focused Mortality Reviews

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 May and June 2023 we had no baby losses, maternal deaths or neonatal losses.

Chart 12 – Stillbirth, Neonatal Deaths and Late Fetal Losses



Child Death Review

Under statutory guidelines, issued October 2018, a child is defined as a person under 18 years of age, and a child death review must be carried out for all children regardless of the cause of death, both expected and unexpected, including death of a live-born baby, and birth of a baby not attended by a healthcare professional determined was born alive (it does not include stillbirths, late foetal loss or termination of pregnancy (of any gestation) carried out within the law).

Reviews can be in the form of an Early Response meeting (ERM) and Child Death Review Meeting (CDRM), both chaired by the Named Doctor for Child Death. Reviews may also be informed by hospital-based mortality meetings, perinatal mortality review, serious adverse event (SAE), root cause analysis (RCA) or other investigatory bodies, including Healthcare Safety Investigations Branch (HSIB). All deaths reviewed require an analysis form to be completed, identifying any learning and recommendations, both locally and nationally. This form is uploaded to the NCMD (National Child Mortality Database).

In November 2022 following meeting with lead medical examiner, it was agreed that all child deaths, including coronial unexpected, be referred to the Medical Examiner by submission of the online Medical Examiner Referral Form on the intranet by the attending Consultant Paediatrician. The medical examiner teams would also be invited to all Early Response Meetings and final Child Death Review Meetings. All flowcharts and SOPs were amended, including information on intranet to reflect this.

The child death review process is supported by two posts within the Trust:

- Named Doctor for Child Death review (Clinician)
- Child Death Review Coordinator (Admin)

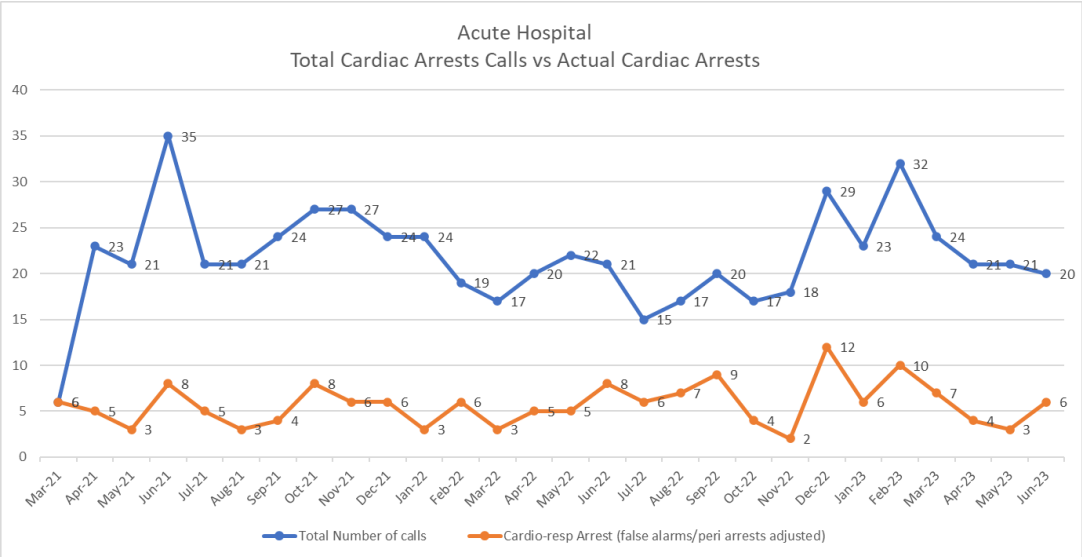
Table 6- Child Death Review activity 2022/2023

Reported Deaths 2022-2023	**Under 1s**	**1-17**	**Learning Disabilities Mortality Review (LeDeR) cases**	**Early response /strategy meetings**	**Staff well-being debrief sessions**	**Child Death review meetings**
Unexpected	2	6	2	7	4	3
Expected	3	4	3	2	2	4

Cardiac Arrest

Numbers of cardiac arrest call and actual cardiac arrests is demonstrating a stable position since March 2021.

Chart 13– Acute Hospital – Cardiac Arrests



Medical Examiners

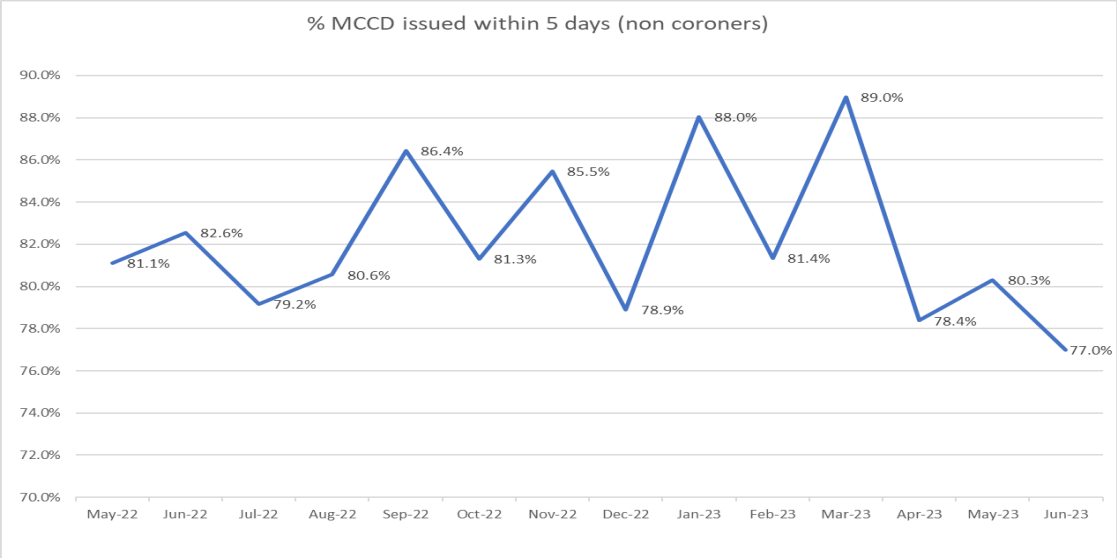
The Medical Examiners service was due to become statutory in April 2023 however the government have nor revised this date to April 2024. The service hosted at TSDFT will continue to encourage local GP practices to engage on a voluntary basis.

Table 7 – 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
May-23	150	126	24	23
Jun-23	146	128	18	20

Chart 14 – MCCD completion within 5 days

The industrial action and Bank Holidays during these months has negatively impacted on the timescales for completion of MCCD's.



As part of the Mortality Improvement Programme a new process was introduced on 16th June 2023 to provide a robust way to flag any issues identified by the Medical Examiner's Office and facilitate investigation and collation of centralised learning from deaths. A Datix incident is now being recorded with a recommendation that an SJR or Mortality review is undertaken by the appropriate team for the following circumstances:

- Severe mental Illness
- Bereaved have raised significant concerns about the care
- Staff have raised significant concerns about the care
- ME raised concerns about the care
- Patient not expected to die – e.g. elective procedures
- In addition - If any causes of deaths / specialities are identified by the Mortality Surveillance Group as requiring specific short term focus

During the period of 16th June to 30th June a total of 8 Datix's have been submitted - 4 relating concerns highlighted by the Medical Examiner and 4 related to concerns raised by the Bereaved family.

In addition, during the months of May and June a total of 13 bereaved families were signposted to PALS by the Medical Examiner Office.

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. This process encompasses the regional LeDeR policy change, communicated in June 2023, that deaths of children with learning disabilities or autism do not need to be referred to LeDer from July 2023 as they are included in the established child deaths review process.

During May and June 2023 three (3) LeDeR reviews have been completed for referrals made in October and December 2022. No specific learning has been identified and the outcomes will inform the general themes feedback provided by the Regional team.

During these months a total of six (6) LeDeR referrals have been made – One (1) community death and five (5) hospital deaths. Structured Judgement Reviews have been undertaken on all the hospital deaths which have not identified any issues in care. Formal LeDeR outcomes awaited.

Learning from Inquests

In May and June 2023 there were a total of 5 inquests. The Trusts did not attend 3 of these where a conclusion of suicide was returned.

The other 2 inquests attended by the Trust are summarised in the table below.

Table 8 – Summary of Inquests attended.

Month of Inquest	Month of Death	Case Outline	Verdict	Learning / actions/ feedback
May 2023	July 2021	Fall at home	Narrative conclusion	Ambulance delay of 7 hours PEG feed not commenced for 60 hours after admission. Note keeping – wording ambiguous and lack of clarity regarding PEG feeding and TEP with DNR in place however resuscitation was attempted as clinicians unaware.
June 2023	August 2021	Elective and subsequent emergency surgery – Perforated bowel and serious infection not caused by surgery	Misadventure	Delay in getting patient back down to surgery for 2nd operation – requested less than 2 hours but took 4 hours.

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

During May and June 2023 there has been 1 formal complaints. This is ongoing and relates to care across multi-agencies in July 2021.

In addition, there have been 12 concerns raised. 3 relating to timeliness of MCCD completion, 1 relating to treatment, and 8 related to care and communication.

There have been 3 compliments received regarding treatment and care.

Trust learning: Serious Adverse Event Group

Key Issues	Learning and actions taken
The wrong medication was used for the anaesthetic block: levomepromazine was used instead of levobupivacaine in ED	Medication incident to be included in the newsletter Adjustment/changes to the storage of the drug to reduce risk
Risk of hospital admission: there were a number of cases in which patients admitted to the hospital fell and experienced significant harm (for example Sub arachnoid (brain) haemorrhage, or fractured neck of femur.	Whilst falls in hospital are reducing (6.1 to 4.2 per 1000 bed days) hospital admission is not risk-free. There is a perception that this is not well understood by the wider population. **Action: discussion at execs on 18/7/23 re whether is there a role for using storytelling to share this more widely with our staff and population.**
Consequences of delays in ED on patient mortality, morbidity and quality.	**Separate paper to be brought to QAC this month.**

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 Trust Board of Directors			
Report title: Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training			Meeting Date: 26 July 2023
Report appendix	No appendices		
Report sponsor	Medical Director		
Report author	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	X	**Risk score**	16
Risk Register		**Risk score**	

BAF Ref. 2 - People

External standards affected by this report and associated risks

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

Report title: Guardian of Safe Working Hours – Doctors and Dentists in training	**Meeting date:** 26 July 2023
Report sponsor	Medical Director
Report author	Guardian of Safe Working Hours

1. Executive Summary

The following report concerns the time period of 11th April 2023 up to the 10th July 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 66 Exception Reports in the period 11th April 2023 up 10th July 2023. This is a decrease of 73 on the number of exception reports from the previous quarter.

Table 1 – Exception Reports by Area

Specialty	No. exceptions raised in reporting period	No. exceptions closed	No. exceptions outstanding	Comment
Anaesthetics	1	1	0	
Acute medicine	9	7	2	
General Medicine	32	14	18	
General Surgery	8	7	1	
Opthalmology	0	0	0	
Cardiology	0	0	0	
Respiratory	2	1	1	

Surgical Specialities	4	1	3	
Geriatric Medicine	10	9	1	
Haematology	0	0	0	
Obstetrics & Gynaecology	0	0	0	
ENT	0	0	0	
T&O				
Total	66	40 (61%)	26 (39%)	

Table 2 – Exception reports by Grade

Grade	No. exceptions raised in reporting period
F1	54
F2	5
CT1-3	7
ST 4-9	0
Total	66

Table 3 – Nature of Exception

Additional Hours	55
Service support	4
Educational	7

Table 4 – Outcome of Exceptions

TOIL	3
Payment	27
Work Schedule Review	0
Agreed no further action required	10
Outstanding	26

4. Comment on Exception Reports

The number of exception reports is lower than numbers seen on previously reports. On observation of this trend, given this is my first year as GOSW I discussed with HR who advised that is was a commonly seen annual pattern. JDRC felt that this reflected that most Post Graduate Doctors in Training / Locally Employed Doctors (PGDiT/LED) had by this time of the year been settled in their posts for several months and had more

established familiarity with working practices/processes and hence had likely built up greater efficiency.

The spread of ERs reflects previous reports of the highest proportions being from F1 doctors and from within General medicine.

Additional hours account for over 83% of exception reports submitted and from observation the majority of these additional hours are 30-60minutes additional work at the end of a normal working day or oncall shift. These typically fall between the hours of 17.30 and 19.30 depending on the individual's rostered shift pattern. There are a small number of service support and education reports. The DME/Assoc Director Med Ed for Quality has oversight of the education submissions. The minority of service support forms make it challenging to draw and trends/ conclusions with such low numbers.

No immediate safety concern ERs reported.

5. Rota Reviews

Nil triggered rota reviews this period.
As GOSW I received several enquiries from the PDGiT/LED body regarding the delayed release of generic work schedules for the coming August 2023 work period – timescales around the release of generic work and personalised work schedules are covered within the terms of the Junior Doctors Contract 2016 . I was informed that these difficulties arose due to a workforce shortage in HR and also that some departments received different numbers of PGDiT than they were anticipating from HEE hence meaning some rotas had to be completely re-written at short notice. This release delay did create some unhappiness & anxiety within the PGDiT/LED body.

Throughout the delay HR kept myself and JDRC abreast of progress and diverted as much of their workforce resource as was possible to address this. I also escalated knowledge of the delay to the medical director.

6. Fines

Nil levied this period

7. Qualitative Information

See section 8

8. Summary

I have no specific concerns from exception reporting to raise for this period.

Previous alterations to medical rotas appear to have had a positive effect on exception reports. Surgical F1 'hotweek' rota remains a recognised area of high intensity workload for which strategies are currently being explored by HR to try and address.

We continue to highlight via JDRC and direct messaging to the PGDiT/LED body the importance of exception reporting and this will be emphasised at the forthcoming junior doctor inductions. Ongoing work promoting the importance of timely responses to submitted exception reports by the PGDiT/LED's responsible educational or clinical

supervisor. There are still a significant proportion where the review does not occur within the timeframes specified within the junior doctors contract. Any support from the trust board in championing these two aspects would be of value.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Maternity Governance & Safety Report (1April 2023 – 30 June 2023)			Meeting date:26th July 2023
Report appendix			
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). It is also required as part of the maternity reporting framework for NHS England (NHSE)		
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 Committee on any areas of risk with compliance for Maternity Incentive Scheme (MIS) in year 5 • To provide an update on progress following the publication of the three-year single delivery plan for Maternity and Neonatal services		
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 potential areas of risk and mitigation to full compliance with Maternity Incentive Scheme year 5.		
Summary of key elements			

<table>
<tr><td>Strategic goals supported by this report</td><td>
<table>
<tr><td>Excellent population health and wellbeing</td><td>x</td><td>Excellent experience receiving and providing care</td><td>x</td></tr>
<tr><td>Excellent value and sustainability</td><td></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>
<table>
<tr><td>Board Assurance Framework</td><td></td><td>Risk score</td><td></td></tr>
<tr><td>Risk Register</td><td></td><td>Risk score</td><td></td></tr>
</table>
</td></tr>
<tr><td>External standards affected by this report and associated risks</td><td>
<table>
<tr><td>Care Quality Commission</td><td></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>
</table>
</td></tr>
</table>

Report title: Maternity Governance & Safety Report (1st April 2023 – 30th June 2023- Q1)		**Meeting date: 26th July 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. It will also provide a mechanism to evidence progress with the three-year Single Delivery plan for Perinatal care.

This quarterly report will look back at the period 1 April 2023 – 30 June 2023 (Q1)

2.0 Review and monitoring of safety within maternity services

2.1 National Maternity Assurance Position – The Single Delivery Plan-

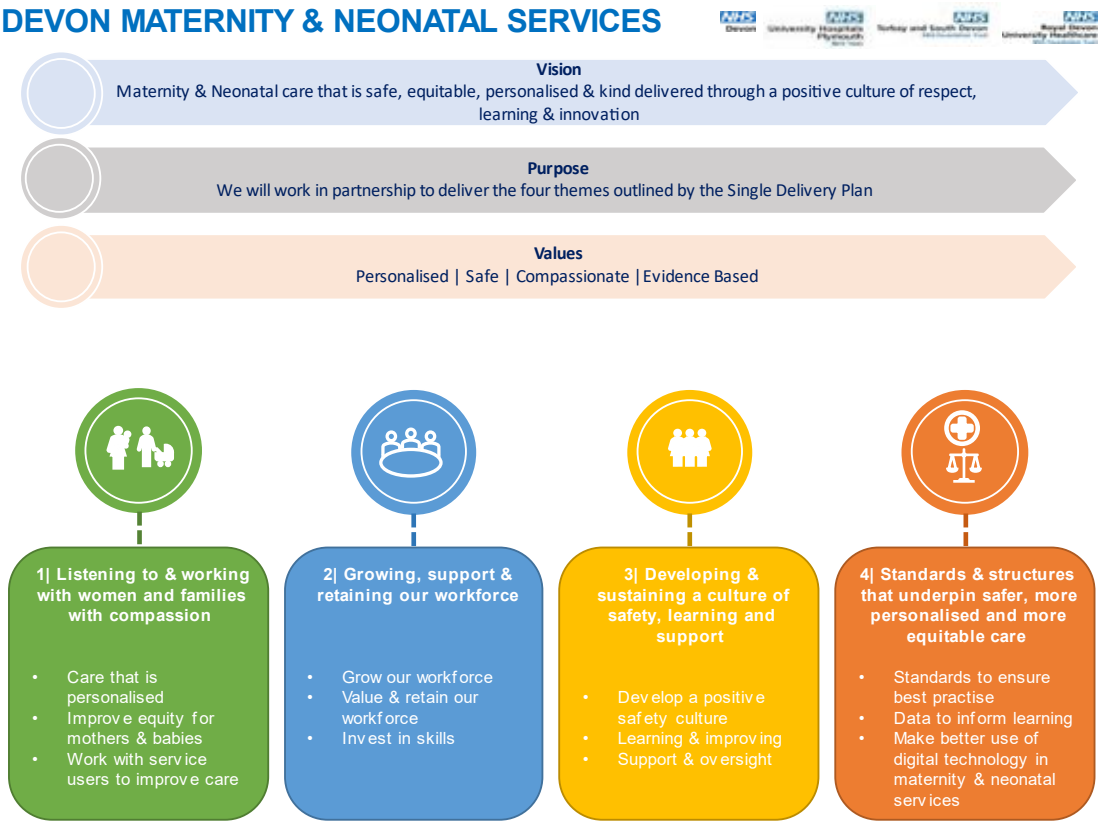
2.1.1 On 30 March 2023 NHS England published a three-year single delivery plan for maternity and neonatal services. Following several national plans and reports, including the reports by Donna Ockenden (2020/ 2022) and Dr Bill Kirkup (2022), the plan brings together the key objective's services are asked to deliver against over the next three years.

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.

2.1.2 Devon LMNS has developed a maternity strategy that aligns to the three-year Delivery Plan. This was devised in conjunction with the Directors/Heads of Midwifery of

the three provider Trusts, the Senior LMNS team as well as by representatives of the MVNP. This strategy will formalise and shape operational planning for the service.



2.1.3 There is an “Ockenden Insights “visit with regional and system teams on July 7th, 2023. This is an opportunity to demonstrate progress as well as highlight challenges and opportunities. Feedback from the visit will be shared in the next quarterly report.

2.2 Perinatal Clinical Quality Surveillance Model

As part of the Ockenden Review and the NHSEI 12 urgent actions, a model has been proposed to improve oversight of safety metrics within Maternity and Neonatal Services. The Perinatal Clinical Quality Surveillance (PCQS) Model is based on three principles, with principle one relating to trust level, principle two at system level and principle three at regional level. Principle one (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 Q1 2023

	April 2023	**May 2023**	**June 2023**
Findings of completed review of all perinatal deaths using the real time data monitoring tool (see 2.3 b for full details)	None Undertaken	23+6-week stillbirth following episode of reduced fetal movements. The PMRT did not identify an obvious cause of death.	43+1 Week neonatal loss review. The findings of the PMRT were that following post mortem the cause of death was defined as Persistent Pulmonary Hypertension with HIE and prolonged gestation.
Findings of review all cases eligible for referral to HSIB.	No eligible 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	**1 Moderate** Baby born unexpectedly in poor condition and transferred to Derriford for cooling. MDT case review completed and CTG learning disseminated.	**1 Moderate** Neonatal death at 11 days old following birth at 43+1 gestation. This case is being reviewed by HSIB.	**None reported.**
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	**Training –** 93% compliance	**Training –** 94% compliance	**Training** – 95% compliance
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.	**Staffing** Full details in section 3	**Staffing** Full details in section 3	**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	HSIB investigation Started for 43+1 Neonatal Loss staff interviews completed.	None	None
Coroner Reg 28 made directly to Trust	Nil	Nil	Nil
Progress in achievement of CNST 10 safety actions	N/A	CNST confirmed as met and award given	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

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 April – June 2023 we had no cases that met the PMRT criteria.

We are 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
- An unexpected stillbirth following an APH that occurred at RDUH(E) where we provided the antenatal care - April 2023

(b) PMRT – Completed Reviews

During Q1 we completed 2 PMRT case reviews.

- A neonatal death that occurred at Derriford Hospital of a baby born at Torbay that was transferred for cooling (See 2.4.1) – Mar 2023 – Completed June 2023
- A Stillbirth of a baby at 23+6 – Jan 2023 – Completed May 2023

2.4 Healthcare Safety Investigation Branch (HSIB)

2.4.1 Referrals to HSIB

In Q1 there were no new cases reported to HSIB.

2.4.2 Ongoing HSIB Cases

We have one ongoing HSIB investigation. 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. All staff interviews have taken place for this investigation.

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). All staff interviews have taken place for this investigation.

We are awaiting draft reports for both these cases for sign off.

2.4.3. Finalised investigation reports from HSIB

In Q1 we have had no finalised reports received from HSIB.

2.4.3 Quarterly Engagement Meeting with South West Maternity Investigation Team

The Quarterly engagement meeting for this quarter was postponed to early July by the HSIB team. An update will be provided in the next quarterly review.

2.5 Safety Improvement

*2.5.*1 Maternity and Neonatal Health Safety Improvement Programme (MATNEOSIP) including PERI Prem

The most recent MatNeoSIP Patient Safety Network Event, was held on 13 June 2023 in Exeter. The event provided stakeholders with the opportunity to learn about the 2 main clinical priorities of the national programme:

- ❖ Optimisation and stabilisation of the pre-term infant
- ❖ Early recognition and management of deterioration of women and babies

Presentations were given on:

- The findings around the Babies Born Before Arrival project and identified areas for improvement
- Update on the Emergency Role Allocation System (ERAS) project which is looking at improving safety in maternity settings by supporting teams to respond efficiently to obstetric emergencies
- Birmingham Symptom Specific Obstetric Triage System (BSOTS) presentation and question & answer session, including update from UHP on how they are planning to implement this system

2.5.2 Saving Babies Lives Care Bundle V3

Saving Babies Lives Care Bundle Version 3 (SBLCB v3) was launched in May 2023. This continues to build on the existing bundle expanding each element, and adds a sixth element (management of pre-existing diabetes in pregnancy) for implementation. Version 3 is required to be fully implemented by March 2024

Providers should use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and ICB.

A summary of the maternity service's areas of current position against the 6 elements is provided in the table below, including areas of risk, mitigations and potential investment/actions required: (Table 3)

(Table 3) Element	Areas of risk	Action required
Element 1: **Reducing Smoking in Pregnancy** Currently Torbay & South Devon maternity service runs a fully in-house	Currently we hold separate telephone booking appointment followed by face-to-face appointment. This can impact on data accuracy and ability to confirm	Explore combined booking clinics by MSW and Community midwives.

tobacco dependence treatment service.	smoking status with CO reading.	
	Data recorded on 2 digital platforms which don't interface, impacting on data required for outcome indicator	Team have requested that data from second digital platform is reported to them monthly
Element 2: Fetal Growth	BP recordings should be taken with a digital monitor. Currently manual monitors used in clinic and community	Cost up and purchase digital BP monitors for community & clinic.
	Further expansion of capacity required for women needing growth scans.	Review of sonography staffing and skills required & consideration of revisiting bid for fourth scan room
Element 3: Raising awareness of reduced fetal movements	Fully compliant	
Element 4: Effective fetal monitoring during labour	Structured risk assessment required re: fetal monitoring at onset of labour – currently no structured risk assessment on maternity IT system	Once structured risk assessment has been created, change request will be submitted to add to maternity IT system
Element 5: Reducing preterm births and optimising perinatal care	Preterm Birth Midwife and Perinatal Pathway Optimisation Lead should be in post.	Specialist Preterm birth Midwife currently in post (0.4WTE) but funding only provided until March 2024 at present. Consideration of permanent funding for Preterm Birth

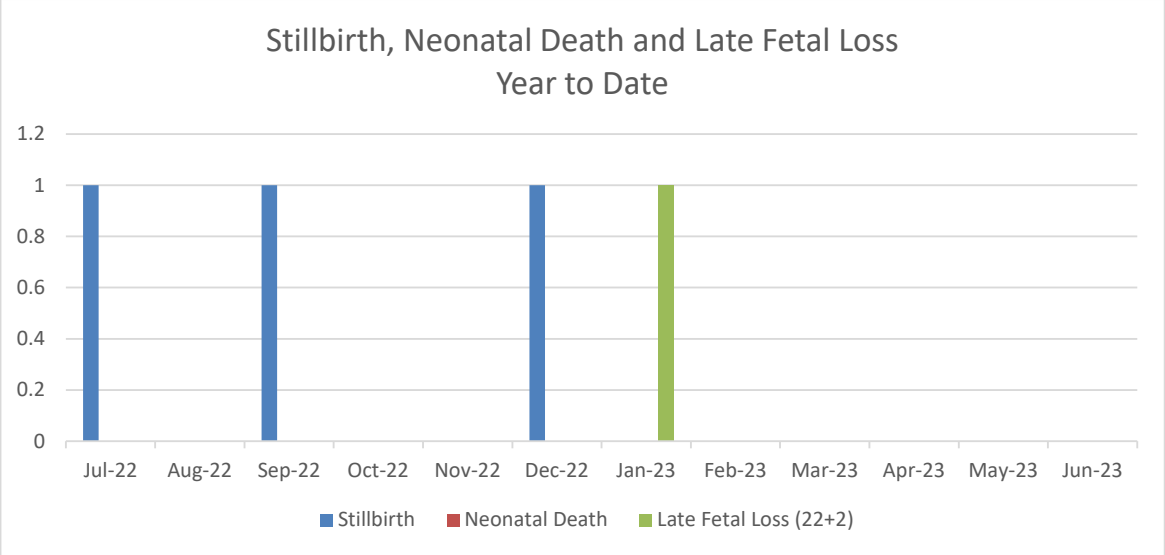
		Specialist role as well as reviewing responsibility and role of Perinatal Optimisation Lead
Element 6: (NEW) Management of pre-existing diabetes in pregnancy	Women with pre-existing diabetes should be seen in one stop multi-disciplinary clinic which includes a diabetes midwife – there is currently no diabetes midwife.	Consideration of creation of specialist Diabetes Midwife role from within antenatal clinic establishment.
	Agreed pathway which provides holistic care planning & pathway for provision of additional public health support – fully holistic care planning is not currently provided.	Joint working needs to be planned to enable attendance in the clinic of Public Health midwife.
	Agreed pathway for management of women with DKA (Diabetic Ketoacidosis), including clear escalation pathway	Trust wide policy for DKA in place. Maternity specific policy to be written.

There has been a continued improvement in our CO compliance with an ongoing significant 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 7% which is below the national average of around 8.7%
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 79.1% compared to the National average of 43.8%. This links with Element 2 of the Saving Babies Lives Care Bundle.

2.5.3 Stillbirth

During Quarter one there has been no stillbirths or perinatal deaths.



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 Special Care Baby 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 **6.7%** of term babies were admitted to the Special Care Baby Unit. This is an increase from 4.7% seen in the last reporting period and is above the target of 5% or less. Ongoing audit by the team has identified no themes around the increase in admissions this quarter. The actions to address term admissions to SCBU that included relaunching of the 'Warm Care Bundle', has resulted in a reduction in the number of babies admitted with hypothermia. 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.

Constraints continue in relation to this workstream. Predominately these issues relate to space and capacity issues within the clinical area. Prior to the COVID-19 pandemic, the estates strategy for the Women's Health Unit had been approved and included the provision of a dedicated Transitional Care Facility in the space on McCallum ward. This would have enabled 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 reducing the likelihood of term admissions into SCBU. The Perinatal team are continuing to address alternative ways to facilitate this within the current footprint.

2.6 Maternity Safety Champions

The new Non-Executive Director for Maternity is now in post and has commenced regular walkarounds within the Maternity Unit, in addition to the Chief Nurse, in their roles as Board Level Maternity Safety Champions.

The role of the Midwifery Maternity Safety Champion is currently held by the Deputy Head of Midwifery & Gynaecology, but this will be transferring to the Inpatient Maternity Matron later this year.

Drop-in meetings for maternity staff continue on MS Teams to provide medical and maternity team members further opportunities to raise any safety concerns they have. An explanation of the Maternity Safety Champions roles is provided to all new members of maternity staff during their induction, including information on the variety of ways in which they can raise concerns, including anonymously if they wish.

Updates on concerns that have been raised by staff include:

- **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: A new telephone triage service is now progressing. Office space has been identified and a new telephone call service is in the process of being upgraded within the NetCall platform. Education (including customer service training) will be provided for all members of the triage team and specific SOPs (Standard Operating Procedures) and guidelines are being developed. Implementation date will be dependent on the Telephony workplan to support the project work for telephone changes. The proposed date is September 2023

- **No central monitoring system for CTGs (Cardiotocographs) on John Macpherson Ward –** concerns raised regarding capacity of midwives to enter side rooms to check CTG monitoring (CTGs record the unborn baby's heart rate and frequency/presence of any contractions).
  Action: Business case to have a central monitoring system installed in both John Macpherson and Day Assessment Unit is nearing completion and new quotes for this work have been requested. It is hoped that finances received from achieving the Maternity CNST standards last year may fund this work,

3.0 Staffing

Issues regarding medical staff on long term sick leave have now resolved and we continue to see a decrease in sickness rates within the maternity service also. Sickness rates for April 2023 (most recent data available) demonstrate a significant fall in sickness levels for maternity this calendar year:

Jan 23 = 8.67%
Feb 23 = 5.75%
Mar 23 = 3.65%
Apr 23 = 3.29%

3 community midwifery teams out of 6 had 0% sickness in April and one had only 0.31% sickness. There has also been a notable fall in sickness rates in Meridian (core hospital-based team) also. We continue to use no agency staff to cover midwifery shifts.

In order to support our ongoing recruitment efforts, we have increased our establishment of preceptee midwife posts (12-month fixed term preceptorship post) again this year and will be offering 5 posts at 0.8 to 1.0wte (0.8wte posts now being offered to support work/life balance). Posts will commence in September/October 2023.

Our recruitment efforts continue to be focussed on the community midwifery teams and we have seen a notable rise in the number of preceptee midwives applying for community midwifery posts. Only one preceptee post is offered within each of the 6 community teams, ensuring that an appropriate skill mix is provided in each team. Preceptees who are appointed to community teams will work within the hospital setting for the first 6 months, in order to provide additional support before moving out to the community team. Further support is being provided for newly qualified staff through the Retention Midwives, Legacy Midwife and PMA service (Professional Midwifery Advocates). The PMA service is also providing additional support to junior doctors within the service through the provision of restorative clinical supervision.

A new 8a Maternity Matron (Inpatient Maternity Services) has been appointed to replace the current post holder who is retiring in July. The new appointee is currently working in a similar role within the South West and has experience of working in several maternity units within the area.

The service-wide organisational change consultation is nearing conclusion, with all maternity staff being offered the chance to vote on the new proposed shift system within maternity. The aim of the consultation has been to address the alignment of shift times across the community and hospital teams. There has been a very high degree of staff involvement and engagement with the consultation progress, which has been commended by the Partnership Forum at their last meeting in May.

Finalisation of the Consultant's job planning is almost complete, and this has highlighted a shortfall in the required number of programmed activity (PA's.) The additional PAs are required to enable the team to meet the requirements outlined by NHS England / Health Education England as well as those detailed as part of the Maternity Incentive Scheme (Year 5).
An options appraisal briefing paper has been drafted and has been shared with the Associate Medical Director for the Care Group as well as with the Deputy Medical Director. This options appraisal will be discussed with the Care Group's triumvirate team for further review and action.

4.0 Maternity Incentive Scheme (MIS) (Year 5)

4.1 Torbay and South Devon NHS Foundation Trust was successful in achieving 10 out of 10 safety actions for the year 4 of the MIS. Th full rebate was issued to the Trust in June 2023, and we are also awaiting confirmation of a further rebate as a proportion from other Trusts that were unsuccessful. In the Southwest region only 7 Trusts achieved full compliance.

4.2 Year 5 scheme was launched at the end of May 2023. Evidence of compliance via self-declaration by Trusts is to be submitted by the 1st of February 2024. Additional requirements have been added to the scheme this year which may impact on the ability to achieve compliance in all the ten safety actions. The service has reviewed the

requirements for each of the safety actions. A high-level summary of any areas of risk and mitigation is provided.

4.2.1 – **Areas of Risk**

Safety Action 2 – MSDS data
Action –

1. Ensuring that there is more than 1 data analyst registered as a data submitter within the organisation.
2. Robust data quality is required to enable accurate submission. This requires resource from digital midwife as well as adequate support from Inview team.

Mitigation –

1. Working with Informatics team to ensure adequate personnel for this task.
2. Utilisation of another digital midwifery champion to support data entry including providing some more training and support to the staff on optimisation of the EPR.

Safety Action 3- Transitional Care services
Action - Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.

Mitigation
Child Health is working in conjunction with the maternity team and the Neonatal Network to review pathways of care; this includes consideration of a Neonatal Outreach service.

Safety Action 4 – Clinical workforce planning
Obstetric Workforce
Action - Trusts should implement RCOG guidance on compensatory rest for consultants working on call out of hours. Assurance of evidence is required or an action plan to address any shortfalls in compliance should be shared with Trust Board and LMNS.
Mitigation – Audit being conducted on number of occasions that Consultants are utilised out of hours. Options appraisal drafted (as per section 3.0) to reflect the potential shortfall and impact.

Neonatal Workforce

Action - The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing.
Mitigation – This standard was met previously. Assurance required that this has not altered and if it is likely that this standard is not going to be met, an action plan is required to address deficiencies.

Safety Action 6- Saving Babies Lives – see 2.5.2 for more detail.
Action - Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.
2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available

Mitigation - To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. The maternity service is confident that it will meet this target for compliance however the compliance metrics have to be captured via the new implementation tool which is yet to be published in full. This tool will provide a definitive response to all the required elements.

Safety Action 8- In house Training
Action – A local plan is in place for implementation of Version 2 of the Core Competency Framework (V2 – released June 2023) This increases the requirement for perinatal training especially in relation to fetal monitoring training. Consideration will need to be given to additional training requirements for midwives and obstetricians to ensure compliance rates of 90% It is estimated that an additional 7.5 hours of training time will need to be allocated.

Mitigation – The service already includes a significant proportion of the training that is outlined in the Core Competency framework. The education team are in the process of calculating the additional requirement and the impact this could have on the workforce establishment.

Safety Action 9 – Board assurance on safety and quality
Action- Alongside the Board review of maternity and neonatal quality, the Trust's claims scorecard must be reviewed.
Mitigation – A quarterly meeting to be held with Litigation team and maternity Governance team to review triangulation of complaints, claims and incidents. An update from this meeting will be shared within the quality reporting framework within the organisation.

4.3 The MIS enables the Trust to demonstrate continual improvement in the safety actions detailed. This may require further resources or investment to address and enable full compliance. The service would escalate any requirements via the governance route of the Family and Communities care group structure.

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 strategic aims of the Devon LMNS to ensure that care is personalised and responsive to the needs of women, families, and staff.

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 potential areas of risk and mitigation to full compliance with Maternity Incentive Scheme year 5.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Complaints, Feedback and Engagement Service Annual Report 2022/23			Meeting date: 26th July 2023
Report appendix	None		
Report sponsor	Chief Nurse		
Report author	Interim Deputy Chief Nurse		
Report provenance	Feedback and Engagement Group.		
Purpose of the report and key issues for consideration/decision	The report provides the Trust Board with assurance that during 2022/23 the Trust has met its statutory accountabilities. This report sets out how we as a Trust hear the voice of our patients and put people's experience of our services at the centre. Patient and service user feedback from people about their experience of accessing and using services provided by the Trust are managed and responded to effectively. Where learning is identified and change is required, this is implemented at a local or Trust wide level to support continual improvement. The report includes: • An overview of the current Feedback and Engagement services provided across the Trust during 2022/23 • The continued challenges experienced in 2022/23 • Review of services through the voice of the patient in 2022/23		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board is asked to: • Note the content of the report and the achievements aligned to feedback and engagement through 2022/23 • Note the Outcome from the Ombudsman Reviews		
Summary of key elements			
Strategic objectives supported by this report	**Safe, quality care and best experience** x **Valuing our workforce** ☐ **Improved wellbeing through partnership** x **Well-led** x		

<table>
<tr>
<td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td>
<td>
<table>
<tr><td>Board Assurance Framework</td><td>x</td><td>Risk score</td><td>16</td></tr>
<tr><td>Risk Register</td><td>N/A</td><td>Risk score</td><td>N/A</td></tr>
</table>
BAF Ref. 1 – Quality and Patient Experience
</td>
</tr>
<tr>
<td>External standards affected by this report and associated risks</td>
<td>
<table>
<tr><td>Care Quality Commission</td><td>x</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td>x</td><td>Legislation</td><td>x</td></tr>
<tr><td>NHS England</td><td>x</td><td>National policy/guidance</td><td></td></tr>
</table>
</td>
</tr>
</table>

Report title: Complaints, Feedback and Engagement Service Annual Report 2022/2023		Meeting date: 26th July 2023
Report sponsor	Chief Nurse	
Report author	Interim Deputy Chief Nurse	

1.0 Introduction

1.1 This is the Trust Annual Complaints, Feedback and Engagement report for 2022/23 that forms part of our regulatory requirement.

1.2 The aim of the report is to provide oversight of the service provision and key insights into the experience of patients. The report also outlines the work undertaken to redesign, relaunch and enhance the Feedback and Engagement service across the Trust during 2022/23.

2.0 Context

2.1 Torbay and South Devon NHS Foundation Trust have a dedicated small corporate team that oversees and coordinates the feedback and engagement functions of the Trust. The Feedback and Engagement and Patient Advice and Liaison Service (PALS) Team work directly with patients, service user's or their family and carers to provide information, facilitate speedy resolution of concerns, and refer patients and their carers to external or specialist support and advocacy services as required. The team works with colleagues across the organisation, together with external stakeholders, to promote and develop the service and create robust, effective links and working relationships between the Feedback and Engagement Team and other services. The team also liaise with other PALS, advice, and advocacy services in both the local health and social care communities in such a way as to ensure a seamless service for patients and clients.

2.2 Throughout 2022/23 and the Covid-19 pandemic, the Feedback and Engagement Team were able to continue working effectively and were able to manage all queries, concerns, and complaints as per Trust policy and in line with the NHS complaints regulations.

2.3 There are several routes through which we hear the voice of the patients, including

i. telephone, email, through the public website or in writing
ii. formal complaints process
iii. Friends and Family Test
iv. Executive Walkabouts including 15-step programme
v. National CQC surveys
vi. Carer feedback

2.4 The Trust is working to establish a more patient-facing system with the team. Currently the team do not have a walk-in service available to the public due to the team being based in a building inaccessible to patients/service users. This is currently under review with the aim of providing a contact point within the main reception of the acute site as per the Patient and Service User Experience of Health and Care Strategy – What

Matters to You Matters to Us three-year plan aligned to priority four. This commitment of development from the team will provide a service model which would include a public facing, open access office, working closely with carers and volunteers to raise the visibility of the patient feedback service in core business hours. This has not been achievable during 2022/23 due to team capacity but is a focus for 23/24.

2.5 Over the last twelve months, under the leadership of the System Director for Nursing and Professional Practice (Torbay) and more recently the Interim Deputy Chief Nurse, collaboration has taken place with local stakeholders and our local community who access, use and interface with our services to begin the embedding of the codesigned Patient and Service User Experience of Health and Care Strategy – What Matters to You Matters to Us three-year plan.

3.0 Accountability and Responsibility Framework:

3.0 The Chief Executive is accountable for ensuring the Trust complies with NHS complaints regulations. The Chief Executive delegates the responsibility for the effective delivery of the Trust's policy to the Chief Nurse.

3.1 The Trust Board and senior managers have key responsibilities to ensure that the culture of the organisation reflects that the Trust takes feedback and complaints seriously and expects them to be acted on appropriately.

3.2 Under the management of the System Director for Nursing and Professional Practice (Torbay), and now the Interim Deputy Chief Nurse the Feedback and Engagement Manager is responsible for the operational management of the Feedback and Engagement Team comprising of the Complaints Team and Patient Advice and Liaison Service (PALS) and a small experience team.

3.3 The Feedback and Engagement Team support the Trust in the delivery of the Feedback and Complaints process through the policy that underpins practice. Their roles and responsibilities include:

- ✓ To ensure that feedback is dealt with efficiently.
- ✓ To discuss with the person and work with them to resolve their concerns in the best way possible.
- ✓ To promote PALS as an informal, client focused service that deals with problems and concerns as quickly and effectively as possible.
- ✓ To ensure people are treated with respect and courtesy.
- ✓ To ensure complaints are properly investigated.
- ✓ To ensure people receive help to understand the complaints procedure.
- ✓ To ensure people receive advice on where they may obtain assistance with the procedure.
- ✓ To ensure people receive a response that provides an explanation and response to their complaint and are clear about the outcome of the investigation.
- ✓ To ensure that action is taken, if necessary, to ensure the Trust learns from the feedback.
- ✓ To ensure that good practice is recognised and acknowledged.
- ✓ To signpost individuals who are seeking advice and support.

3.4 The Associate Directors for Nursing and Professional Practice (ADNPP) or Associate Directors for Operations (ADO) are responsible for ensuring complaints are investigated and responded to in line with the Trust policy. They lead on ensuring, where appropriate, that lessons are learnt and remedial action is implemented, evaluated, and embedded in sustainable change.

3.5 The ADNPP or ADO within each Care Group are responsible for allocating a lead person for the investigation who will be responsible for updating the ADNPP or ADO on the progress of the investigation. The ADNPP or ADO are also responsible for reviewing the relevant investigation documentation and drafting a letter of response. This is reviewed by the Deputy Directors of Nursing and Professional Practice before progressing to the Chief Executive to sign prior to sending to the complainant or their representative. In 2023/24 we will be enhancing now this is embedded within the revised governance framework.

4.0 The Governance Framework for the Feedback and Engagement Service

4.0 The Feedback and Engagement Group oversee the feedback and engagement work undertaken across the Trust. The group has a membership that includes Trust members, but also the wider health and care community such as the NHS Devon Integrated Care System, Advocacy Service, Health Watch, Carers Lead, local independent hospital, Mount Stuart and Deputy Director for Adult Social Care in Torbay. The purpose is to provide a forum for staff and wider system members, who are responsible for or are involved with the patient, service user experience and engagement of the Trust, to share learning and best practice.

4.1 The main focus of the group is to review the effectiveness of the Trust's responses to complaints and concerns, providing assurance to the Trust Board that the actions taken in response to feedback are completed and, where appropriate, disseminated across the Trust. The group also reviews all CQC patient experience survey results and monitor action plans for service specific CQC surveys and the wider Adult Inpatient Survey. The sharing of good practice and continuing to develop a patient-centred culture across the Trust is pivotal. The Group meets monthly and invites /co-opts specific colleagues when required to enhance the group with additional skills, knowledge, and competence. In September 2022 the group introduced a change to the monthly meetings whereby alternative months the meeting has a focus on lessons learned and quality improvements as a result of patient feedback. These have been successfully attended by staff from across the Trust.

4.2 In 2022/23, the ISU's/Care Groups retained oversight of the feedback and engagement work within their ISU/Care Group, and this is provided through a monthly report by the ADNPP's to the Feedback and Engagement Group. This includes complaints, concerns, compliments, Friends and Family test, survey action plans where appropriate and any other service user experience and highlights learning being progressed within the ISU/Care Group and wider Trust where applicable.

4.3 The monthly Quality Report, provided to the Quality Improvement Group ensures the scope set out in 3.3 on patient and service user experience is escalated within the corporate governance framework.

4.4 The Quality Improvement Group reports to the Quality Assurance Committee which in turn reports to the Trust Board.

5.0 Discussion

5.1 Statutory Regulations

Complaints are managed in line with the Trust's policy and in line with NHS complaints regulations. The Trust are required by NHS complaints regulations to acknowledge all complaints within three working days. During 2022/23, **95%** of complaints were acknowledged within the 3-day timeframe. Of the remaining 5%, no date was recorded on the system, we are therefore unable to confirm if these met the 3-day acknowledgement standard. As a result, an action taken by the Feedback and Engagement Team is to ensure acknowledgement dates are captured for all contacts moving forward.

NHS complaints regulations also require the Trust to investigate and respond to a complaint within six months of receipt. However, the Trust aim to investigate and respond in a much shorter timeframe of six weeks as delays can both hinder the effectiveness of the investigation and cause increased distress to the complainant.

In 2022/23, **74%** of complaints were responded to within the 6-week timescale set by the Trust, whilst **26%** of the complaints received were extended beyond the original six-week timeframe agreed with the complainant which is an area noted for improvement during 2023/24. Figure 1 illustrates that of the 164 complaints received 21% were extended once, 16% were extended twice, 10% were extended three times, 1% were extended four times, 3% were extended five times, and a further 2% were extended on more than 5 occasions. These delays were caused by the level of complexity and multi-agency involvement and the need and the commitments to a robust investigatory process to provide the complaint with a thorough review. Whilst we recognise there has been several extensions through 22/23 the Trusts compliance for closure against the National six-month target was **90%.** Given the level of complexity and commitment to robust investigatory processes, the Trust is considering revising the six-week timescales to be more aligned with the National Standards.

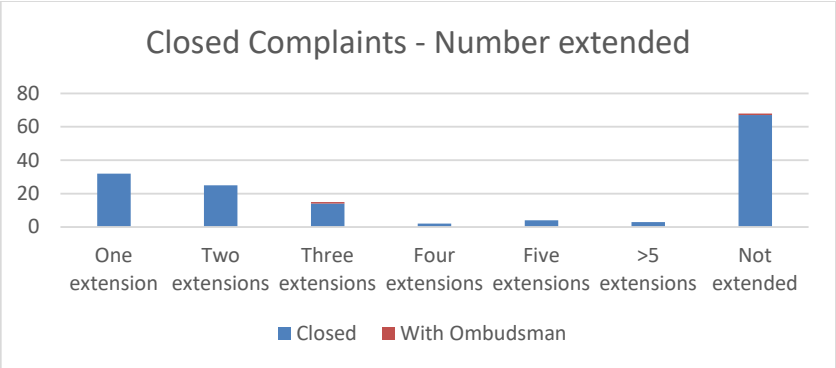


Figure 1: Close complaints number of extensions for 22/23

The number of complaints that exceeded the six-month timeframe for the 22/23 financial year was eight, all these cases were extended at least twice citing the Trust's 'Operational Pressures OPEL Level' as the primary reason for the extensions. The complaints where complex often involving multiple services. Themes related to assessment, diagnosis and treatment and its impact on individuals through cancellations of appointments, alleged delay in diagnosis and alleged competence, negligence around the care individuals received.

5.2 Ombudsman Cases

The Trust were contacted in relation to 15 complaints between 01/04/2022 and 31/03/2023 by either the Parliamentary and Health Service Ombudsman or the Local Government and Social Care Ombudsman.

- 6 cases where not investigated by the Ombudsman
- 3 cases have been investigated and closed, none of which were upheld
- 6 cases remain open and under investigation to which we await the outcome and any learning to be identified

5.3 Contact Analysis

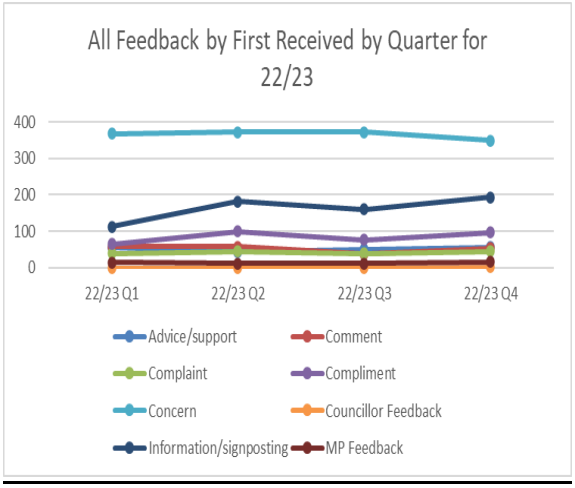


Figure 2: All feedback received by quarter in run chart 22/23

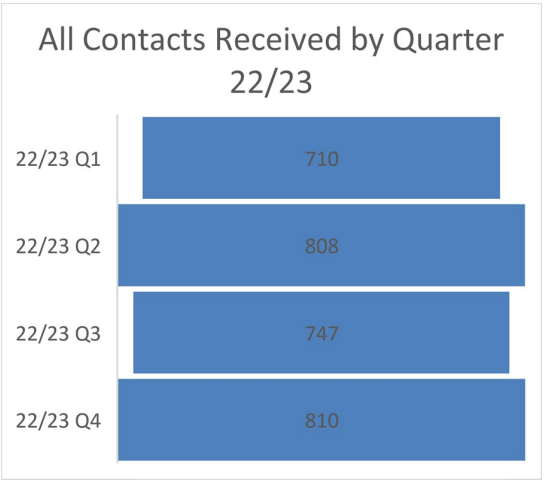


Figure 3: All feedback received by quarter by number 22/23

In total, there were 3,075 contacts received, which equates to an average 59 a week in 2022/23.

Figures 2 and 3 demonstrate that there were fluctuations in numbers received across each quarter however it is noted that there was an increase of contacts received in Q2-Q4 from Q1 throughout the year of 2022/23. Q2 saw a 38% increase in signpost contacts as the Trust stood back up some activity previously stood down as part of the Covid-19 pandemic which generated enquires relating to surgery wait and appointment times.

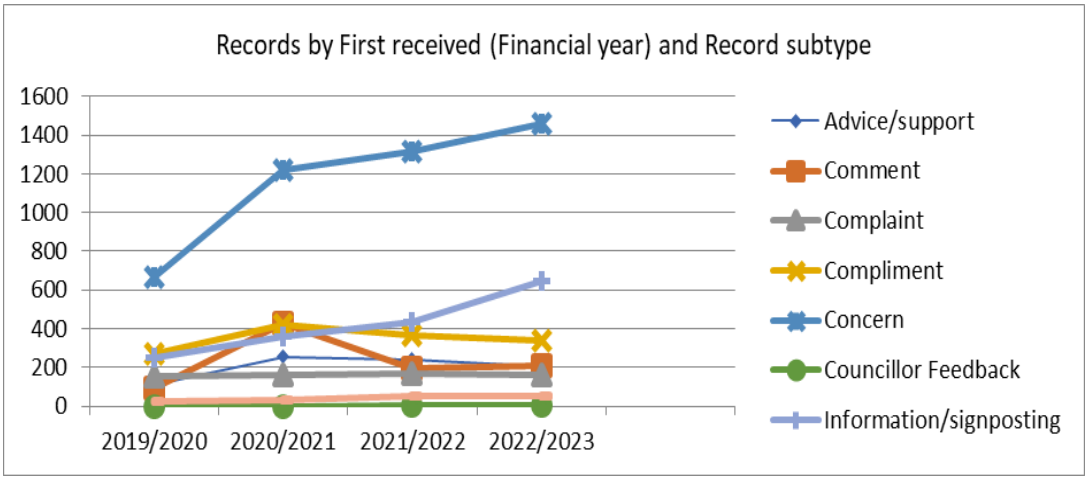


Figure 4: All feedback received by financial year

Figure 4 provides an overview of all the feedback received across the last four financial years, to which concerns and signposting contacts are on the increase:

1. There were a total of 3,075 contacts made to the PALS and Complaints Department recorded on Datix for financial year 22/23. This is an increase of approx. 600 against the 2020/21 position. It should be noted this increase was anticipated since the decrease in contact in wave 1+2 of Covid-19.

2. 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 have been lifted.

To further understand people's experiences around discharge, a task and finish group was set up in February 2023 looking at gaining real time feedback. The group reviewed incidents, complaints, concerns and feedback from patients though Friends and Family Test (FFT), National and Local Surveys that related to poor experiences on discharge. Identified themes are:

- Patients not being sent home with enough information on next steps, delays in care or equipment arriving.
- Medication being supplied but not explained or medication not being provided at point of discharge.
- Patients felt at times there was a lack of information shared with themselves and next of kin around planning for discharge and the discharge process.
- Some concerns were also identified relating to transport regarding time of discharge and discharge destination not being correct.

As a result, the group have redesigned the discharge checklist which has been piloted and due to go live with an updated policy to support in Summer 2023. Alongside this to strengthen a positive experience on discharge and to understand where the Trust needs to place a focus an audit has been launched in July 2023 based on the National CQC Inpatient Surveys 10 questions related to discharge. The first of each month 10 patients are randomly select via our digital platform who were discharged the previous week

against a set criteria. This audit is to take place every month, based on the inpatient national survey questions, their experience related to discharge to further support the Trust in improving patient's outcomes and experiences.

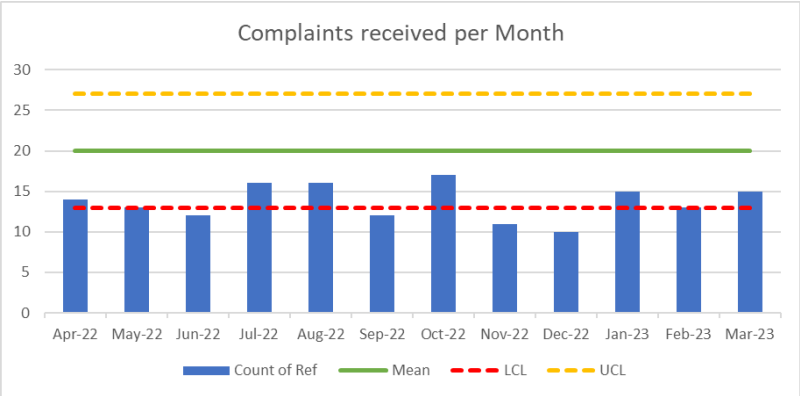


Figure 5: All complaints received by month over the financial year 22/23

The number of complaints received in the 22/23 Financial Year stands at 164 which equates to an average of 13 per month illustrated in figure 5. These figures are consistently below the mean control limit of 20 expected volume of complaints per month and 50% of the year under the lower control limit. This control limit is set based on the data received since 2016, whilst as a Trust we would like to see a zero tolerance to complaints this would be an aspirational target. Therefore, the Trust is currently reviewing what would be an appropriate and achievable trajectory.

Please note, not all complaints received in the 22/23 financial year have been closed; 19 cases remain under internal investigation and moved into 23/24 for ongoing investigation.

Figure 6 illustrates that the trends relating to the highest level of concerns and complaints reported for 22/23 are within the following three services:

1. General Surgery – waiting times for surgery/clinics, information on waiting times, PACS – booking system, multiple pathways, attitude of staff.

2. Emergency Services – long waits, environment, lost property, management of patient's expectations.

3. General Medicine – delay in access to appointments, communication, attitude of staff.

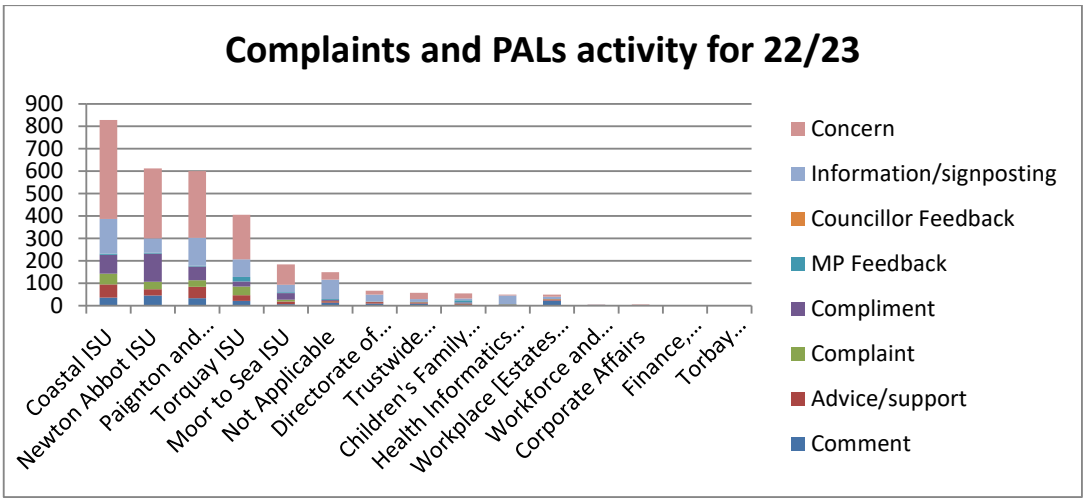


Figure 6: Complaints and PALS activity for 22/23

The ADNPP's for the ISU's/Care Groups manage these concerns and complaints and where themes and trends are identified, these are worked on in conjunction with staff and patients (where appropriate) to develop local action plans to improve patients/service user's outcomes. Where appropriate and where further learning can be undertaken these outcomes will be shared wider than just the relevant ISU/Care Group.

The majority of the complaints received by the Trust in the 22/23 financial year relate to Treatment, Care or Assessment, a full picture is displayed in Figure 7. The top three themes in relation to our delivery of service are:

- Effectiveness,
- Alleged competence/negligence
- Communication

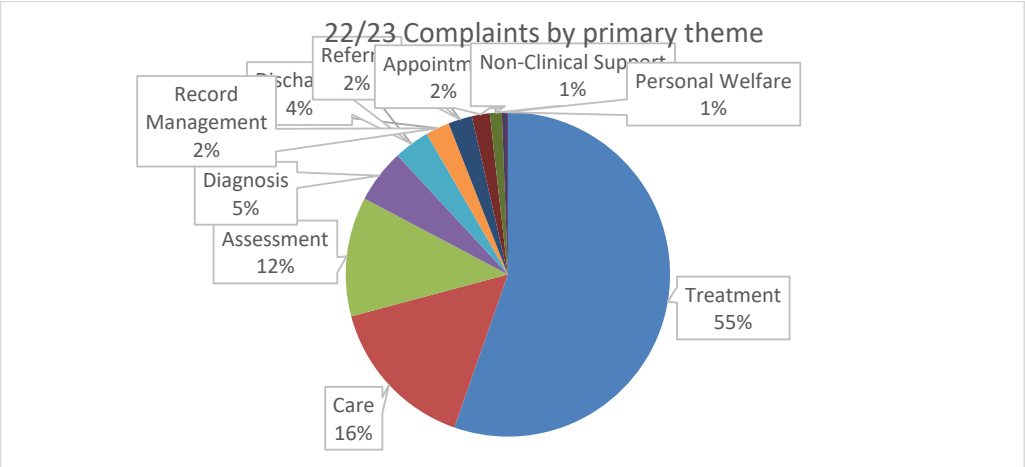


Figure 7: Themes of complaints received in 22/23

The complexity and diversity of services and the range of concerns and complaints result in high level themes that frequently require bespoke service level change. This is explained further in section 7.0.

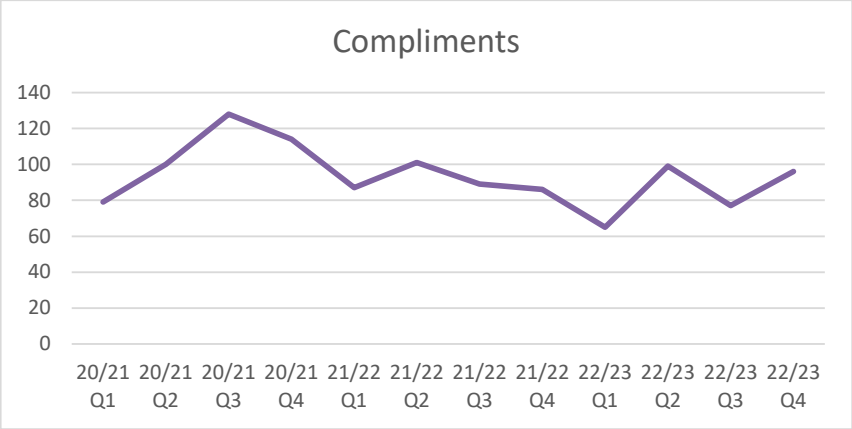


Figure 8: Compliments Received 20/21 - 22/23

It is important to ensure we review and learn from the positive experiences expressed through compliments that services receive (Figure 8). We recognise compliments are often spontaneous and some services may not be reporting them into the main system. However, the Trust received 337 compliments for 22/23. This is a slight increase on 21/22 overall total but less than previous years. This is possibly due to the impact of the Covid-19 pandemic and pressures on staff leading to a reduction of the sharing of compliments.

Treatment and care are the main reasons for compliments being received which aligns to our core business as a health and care organisation. Section 7 goes into more detail around what people are telling us.

5.4 Carer Feedback and Engagement

Many people support a family member or friend with health or care needs. Their feedback is obviously essential in determining how services should be run, not just to support them, but also the person for whom they care. More than a third of our staff juggle working with caring for someone, offering valuable insight into how support can be improved in both their professional and personal life.

Torbay's Adult Social Care responsibilities to Carers are delivered by the Trust on behalf of Torbay Council. However, the Trust's Torbay Carers work very closely with a number of partners to ensure the Trust receives feedback from and engages with Carers of any age, with any type of caring role, across its footprint.

As a result of Carer feedback, George Earle Ward implemented a pilot in Q4 looking at how to better communicate with family and carers. The pilot is supported by a worker on the ward dealing directly with patients and their families. Early indications are that this post has been well received by patients, their families and staff. Autumn of 23/24 should provide the Trust with the pilot outcomes which will support next steps regarding if the role needs to be embedded across a wider footprint.

- Supporting Staff Carers (Trust Commitment to Carers 2022-23 Priority 1)
  Based on feedback from Staff Carers, there is now 'on-request' support to all staff Carers. Wellbeing buddies are being trained in Carer Awareness, and those who

either are or have been Carers are offering support to other Staff Carers in their department. The hope is that this network will then be expanded to all staff areas.

- Young Carers Under 25 (Trust Commitment to Carers 2021-22 Priority 3)
  After significant work with Young Carers under 25, the inter-agency Strategy for Young Carers under 25 was formally launched by Young Carers under 25 at an event for Carers' Rights Day in November 2022.

- Update web- and paper-based information (Trust Commitment to Carers 2022-23 Priority 3).
  Carers have been involved in improving both web- and paper-based Carers information, both in the original design, and accessibility review.

- Carer Evaluations
  We have a number of Carers / former Carers who are trained in evaluation techniques. In 2022-23 they completed an evaluation of Carer Support for Carers of adults with learning disabilities, the results of which were very positive and have now been built into the tender for the ongoing service.
  https://www.torbayandsouthdevon.nhs.uk/uploads/learning-disability-carers-survey-2022.pdf

They also completed an evaluation of the pilot to support Carers with technology enabled care. As the results indicated a significant positive impact on Carers health and wellbeing, the pilot has been now been built into the standard Carers' Service. https://www.torbayandsouthdevon.nhs.uk/uploads/carers-technology-enabled-care-pilot-evaluation-summer-2022.pdf

5.6 Friends and Family Test (FFT)

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for people to give their view after receiving NHS care or treatment.

The FFT has been a mandatory requirement across all NHS Trusts since 2013 and although every person must be given the opportunity to provide feedback on the service they have accessed, it is optional to respond. In September 2019 NHSE announced changes to the mandatory questions where the key question was changed to ask:

"*Overall, how was your experience of our service "?*

Previously there had been two further prescribed questions and with the changes of the FFT nationally, the Trust had an opportunity to develop our own questions. The Feedback and Engagement Group considered this opportunity and made the decision to ask the following questions:

- *Please can you tell us why you gave your answer? (*to the FFT question*)*
- *What one thing could we have done better?*

- *Please tell us what you, your family members and carers think should always happen when you use our services?* (This is to support the Always Events Initiative)

The Revised FFT test was due to commence in April 2020 but due to the Covid-19 pandemic the launch was paused across the country until September 2020. The challenges experienced by the Trust in developing the FFT provision during the Covid-19 pandemic included the paper- based model that had been in place pre-Covid-19 which provided challenges with infection, prevention, and control. Pre- populated locations /wards that ensures feedback was accurately attributed was also a challenge as a large number of wards during Covid-19 and beyond changed configuration in the care they provided, although the name of the ward remained the same.

5.7 The paper- based FFT collection document has been reviewed and revised to reflect not only the mandatory question required but also the CQC Adult in-patient questionnaire results received in 2021.

This has been developed by the Feedback and Engagement team, together with input by members of the Working with Us Volunteer group, who support in-patient areas with the FFT agenda, and the wider Feedback and Engagement Group.

The revised FFT/in-patient questionnaire can be used, moving forward, to allow a timely submission of the FFT data and real time feedback for in-patient settings, allowing any issues/concerns raised to be dealt with immediately.

The Feedback and Engagement team introduced QR codes to overcome the paper issues but also to align feedback with more interactive digital technology. Throughout 22/23 a large proportion of our clinical areas have moved to a QR code process by including this in discharge packs, to visible QR codes on walls and tables with good effect. Work continues in 23/24 to promote those in use and look to expand the work across the Trusts community footprint.

The Working with Us volunteer group was paused while Covid-19 pandemic was present, however this has since returned to support in-patients to complete the revised FFT/Inpatient questionnaire which, again, will support the data return moving forward.

The run chart above in Figure 9 identifies an increasing trend in FFT submissions with the last 6 consecutive months falling above the mean calculation as compared to the previous 6 months where the FFT feedback fell below the mean on two occasions. This has a direct correlation to the revised FFT/In-patient questionnaire being put into practice supported with QR codes.

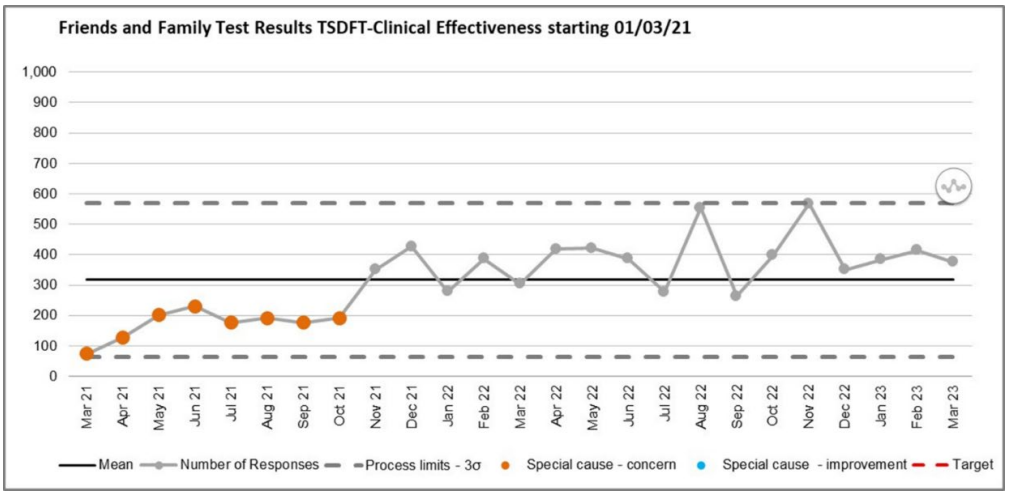


Figure 9: Friends and Family Test compliance rate Mar 21 – March 23

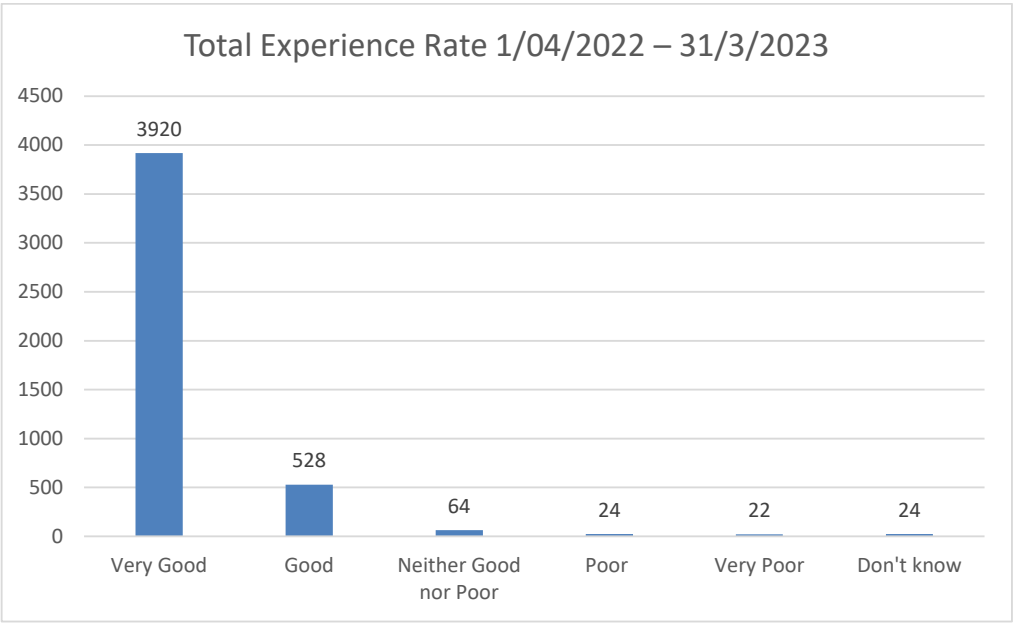


Figure 10: Friends and Family Test category response Mar 21 – March 23

To provide assurance that this improvement will be monitored and sustained results are reviewed through the Feedback and Engagement Group, with a check and challenge approach. This is to ensure we understand the experience of our people and the services we provide. It allows a review of what can be done better and how this can be shared for organisational learning. Figure 10 illustrates the positive feedback received through the FFT with an overall compliance of 97% of feedback falling into the category 'very good/good' combined. Alongside this written feedback is shared which is rich and powerful to both celebrate and shape change going forward. Some examples of what people are telling us are:

"I felt heard and seen. I have been put forward for a scan, which is what I asked for"

"The nurse was very clear in her explanation and attentive to my answers. Very caring!"

"Very Poor - Waited 13 hours before my wife saw a senior consultant. Had to return next day for scan. Also cost £20 parking charge"

6.0 National Survey Results 2022/23

Throughout 22/23 there were a range of surveys undertaken in year which are identified as below.

6.1 Inpatient Survey Results

Further to the National CQC Adult in-patient survey publication, which was reported to the Trust Board in November 2022, all in-patient areas have developed relevant action plans to address the areas identified for improvement which are:

- Length of time patients felt they were waiting on a list before they were admitted to hospital.
- Length of time patients felt they had to wait to get a bed on a ward after arriving at hospital.
- Patients felt at times they were prevented from sleeping at night by noise of other patients.
- Patients didn't feel that they were always given the opportunity to give their views on the quality of their care.
- Patients felt they weren't always given the opportunity to discuss their treatment or condition with hospital staff without being overheard.

The action plans are reviewed at the Feedback and Engagement group, from a ISU/Care Group perspective, with focus on what has gone well over the last month and what can be improved. Further work is also taking place to address these concerns through Building a Brighter Future around the Trusts estate, real time patient feedback, investment into the Feedback and Engagement Team along with flow improvement works.

6.2 Maternity CQC Survey 2022

The results of this survey and the action plans developed have been shared with the Feedback and Engagement Group, Quality Assurance Committee and Trust Board. In summary findings where:

Areas for improvement
- Delay in discharge
- Limited visiting due to Covid-19
- Some feedback felt help wasn't accessible
- More help support needed with infant feeding

Areas that Maternity performed well in
✓given enough information at start of pregnancy
✓offered choice of where to have your baby
✓appropriate information shared before induction

✓given enough information in where to have your baby
✓able to speak to midwife as much as needed

6.3 Emergency Department CQC Survey 2022

The Trust is awaiting the published Emergency Department report, but early indications are of areas requiring a focus for improvement as shown along with actions taken to mitigate while we await the full report are shown in Table 2 below:

Ref	Issue	TSDFT Score 2022	TSDFT Score last Survey 2020	Action
Q6	Were you given enough privacy when discussing your condition with the receptionist?	62.5%	77.9%	1) Installation of e-Triage to allow patients, where able to detail their condition electronically. 2) Re-design of reception and triage space to promote privacy, dignity and improve flow
Q7	How long did you wait before you first before you first spoke to a nurse of doctor? (This does not included staff screening for COVID at the entrance to ED)	38.0%	72.6%	1) Two nurses at triage and an escalation tool to highlight rising pressure to the silver Team.2) Re-design of reception and triage space to promote privacy dignity and improve flow
Q 13	Did you have enough time to discuss your condition with the doctor or nurse?	76.0%	84.0%	Discussion at Nursing and medical handover to highlight performance. Refresh “It's ok to ask" campaign. Arrange QI audit to check effectiveness
Q 23	Were you given enough privacy when being examined or treated?	83%	88.70%	Re-design of reception and triage space to promote privacy, dignity and improve flow. Conversion of lab space to provide privacy for discussions with patients in fit to sit.

Table 2: CQC Survey - Emergency Department 2022 embargoed summary

7.0 Learning from Feedback

7.1 What matters to patients

All staff have a responsibility to acknowledge where care has not been of the required standard and to do everything in their power to learn and to amend practice. Learning from complaints should happen throughout the organisation depending on the issues of concern. In some instances, the issue may relate to a single department, but the theme may be applicable to other areas. It is the role of the senior staff in the ISU/Care Groups to ensure that issues and the resulting action plans are appropriately shared. The Feedback and Engagement Team will work with the ISU/Care Groups to ensure actions are monitored and accurately recorded on the risk management system. Where

appropriate, staff should incorporate the learning into their annual achievement review with their manager.

The capture and sharing of significant learning from complaints is led by the Trust's Feedback and Engagement Group. Examples of complaints which have identified either learning or good practice will be shared. There is further work required to strengthen our approach to disseminating learning from concerns raised by patients and families and how we capture the actions required on the electronic database. In 2023, the Trust will strengthen how this is undertaken as part of the Patient Experience and Engagement Plan. The examples below in Table 3 illustrate some work undertaken to address issues raised by patients and families.

Themes to what our patients are telling us	What actions have we taken as a result
Emergency Services – - **long waits,** - **environment,** - **lost property,** - **management of patient's expectations**	✓ The Trust are reviewing the Lost Property Policy to include ED flow chart to reduce the risk of property being lost within the department. ✓ Ongoing work with the ADNPP's working with their teams around how and what we communicate to better manage people's expectations. ✓ Implementation of a Standard Operating Procedure for Boarding and Escalation to expedite transfers. ✓ Implementation of long stay book to ensure patients are offered food and fluids when in the Emergency Department for greater than eight hours. ✓ Exploring reconfiguration of the Emergency Department footprint to move Paediatrics out of main waiting room.
General Medicine – - **delay in access to appointments,** - **poor communication,** - **attitude of staff**	✓ ADNPP working with Matrons and Teams around professional behaviours and targeted learning for individuals ✓ Clinic capacity review
General Surgery – - **waiting times for surgery/clinics,** - **information on waiting times,** - **PACS – booking system, multiple pathways,** - **attitude of staff**	✓ Work taking place to ensure pre assessments are in time and valid. ✓ Review of themes related to cancellations of surgery on the day to minimise impact to patients. ✓ Golden Patient Implementation, a review of the list utilisation, allowing more patients to be added to a list and reduce wait times. ✓ Investment in the PAC Team has improved retention resulting in a better experience for patients. ✓ Targeted intervention across roles and services regarding individual learning

Table 3: What patients are telling us

7.2 Awards and Recognition

2020 saw the launch of the DAISY award with the ambition and focus of rewarding and recognising those extraordinary Nurses and Midwives. The DAISY Award commenced in 1999; it is steeped in emotional prestige originating from a family's grief and appreciation of the care that their son Patrick Barnes was given at the end of his short life from exceptional nursing teams. Patricks family, inspired by the care Patrick received set up the DAISY Foundation, to commemorate the care and compassion shown to him and his family. The DAISY Award therefore has a meaningful back drop for all registered Nurses and Midwives winners and nominees. In 2022 the Trust saw the launch of The Primrose Award to mimic The Daisy Award but for Health Care Support Workers to which November 2022 saw its launch.

Since 2020 as an Integrated Care Organisation, we have had a total of 227 DAISY award nominations and 17 Primrose award Nominations. Of these nominations 89 have

been from colleagues and the remaining 155 from patients and families. In total we have awarded twenty-four DAISY awards and May 2023 was the first Primrose award. Figure 11 and 12 shows how the nominations have been received over the last three years for The Daisy award and for The Primrose since November 2022.

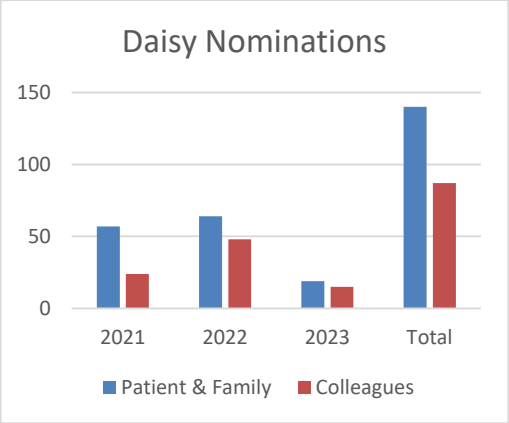


Figure 11: Daisy nominations

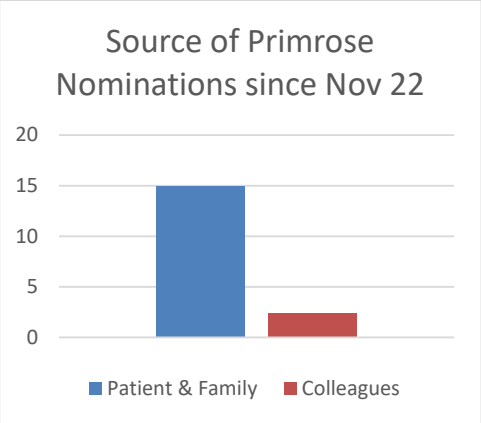


Figure 12: Primrose nominations

This provides confidence that family and patients are receiving positive experiences as they nominate teams and individuals for the outstanding care they or their family have received. The following provides some examples of the experience where individuals have been nominated for the outstanding care they have delivered.

*"This morning my 6-year-old needed to complete a drugs challenge for several hours which we were both extremely nervous about. Despite the team being extremely busy, ***** made us feel welcome, listened to, safe and happy within our 7 hour stay. We were give factual information but at the same time ***** went above and beyond to make us feel comfortable, safe and happy, including myself as a Mum; she was so kind and nurturing, she completely reduced our anxiety. My daughter received prizes between each medication and this was such a wonderful touch. Thank you so much."*

*"***** was working as on a call manager for the hospital during the weekend that I became unwell. Although she was not working on the Surgical Receiving Unit, she stepped in to recognise that I was deteriorating after my operation and stayed on to lead and advocate for my care. She went above and beyond on that day, the worry and concern she showed me will stay with me forever. ***** was a member of staff who was leading an entire hospital that Saturday. She showed me individual care and compassion. She demonstrated leadership on another level, one that is inspired."*

*"I would like to do a huge shout out and a big thank you to a lovely lady named *****, working on turner ward at Torbay hospital. After having to go for a bone biopsy this morning (Tuesday 18th), she was an absolute breath of fresh air at such a difficult time. Her care and compassion was outstanding and made me feel so at ease… ***** is an absolute credit to turner ward and Torbay hospital as a whole. I just wanted you to know you're doing an amazing job and I very much appreciate everything you did for me."*

The testimonials illustrate that our workforce feel valued and recognised for their daily work. The schemes have added meaning to our nominees and winners' roles and we

have often seen this during presentations which regularly results in them beaming with emotion and pride. This has a positive effect on workforce culture and well-being and the care that is delivered.

8.0 Conclusion

8.1 Through 2022/23 the Feedback and Engagement team have continued to provide a coordinated service to our local population as the Covid-19 pandemic progressed. The increase in contact relating to delays in access to care are in the main a direct consequence of the pandemic. The feedback and engagement team and wider staff in the organisation who review, investigate, and respond to feedback in the form of concerns, complaints, Ombudsman and MP enquires as well as compliments demonstrate a commitment to providing comprehensive, compassionate responses and identifying local and Trust wide learning.

8.2 As wave three of the Covid-19 pandemic ceased and our full range of services resumed across the organisation with restrictions being lifted, we have an opportunity to enhance our accessibility to patient and service user to provide feedback.

8.3 The development of the Patient and Service User Experience of Health and Care Services Strategy has been signed off by the Trust Board and work is now underway to implement the six priorities which aligns to the overarching Trust strategy and vision to deliver care closer to home. This strategy aims to raise the profile of the importance of patient and service user experience in developing and delivering high-quality effective services that provide a consistent positive experience for all people by putting people's experience of our services at the centre.

8.4 The Covid-19 pandemic has impacted on our ability over 2022/23 to receive the breadth of proactive feedback from people who use our services. However, as we move away from the restrictions this will provide a platform to further review and modernise our model into 2023/24 and beyond.

9.0 Recommendations

9.1 To note the content of the report and the achievements aligned to feedback and engagement during the third wave of the global pandemic.

9.2 To support the programme of work set out in the Patient and Service User Experience of Health and Care Services Strategy and Delivery Framework through 2022/25 that will enhance and underpin the provision of high-quality health and care services as we strive to consistently provide an excellent patient experience.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Creating and Embedding a Culture of Inclusion			Meeting date: 26 July 2023
Report appendices	1. The Plan to Create and Embed a Culture of Inclusion at TSD		
Report sponsor	Chief People Officer		
Report author	Head of Inclusion and Cultural Development		
Report provenance	Executive Directors – 20th June 2023 People Committee – 26th June 2023		
Purpose of the report and key issues for consideration/decision	To present to the Board the plan to create and embed 'a culture of inclusion' throughout TSD, in a way that is systematic and designed to have maximum positive impact for our people.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board is invited to note that the TSD Plan to create and embed a culture of inclusion, has the following objectives: a. For all managers to role model leading with compassion, demonstrating inclusive behaviours and creating an environment that encourages feedback and where staff feel able to speak up. b. To create an environment free of discrimination, where difference and diversity is encouraged and celebrated, giving people a sense of belonging and ability to perform at their best. c. To create an environment where our people are able to be healthy and well (physically and mentally), to be themselves and perform at their best. d. To introduce Just and Learning HR polices, systems, processes and practices. e. To embed inclusion throughout the employee lifecycle: onboarding, induction, training, talent management, appraisal (via Leadership Framework Include, Listen, Act). f. To be recognised as an inclusive and equitable employer committed to ensure our workforce reflects the community it serves and recognise and works to eliminate pay gaps. g. To develop staff networks to gain confidence in sharing their lived experience to inform organisational decision making and improvements and creating a sense of belonging.		

	h. To create and utilise cultural dashboards for TSD, to identify areas requiring cultural development to improve workforce lived experience and patient safety. and that the plan: i. requires action from all of the workforce – particularly via the completion of updated EDI training available through the HIVE in the autumn of 2023. It is recommended that everyone will be expected to complete the new training within 6 months of its launch (plan section 2.1) j. will require commitment from the Board to sign statement of commitment towards an inclusive charter (incorporating anti-racism and anti-disabilitism charters) (plan section 2.2) h. will, iaw NHS EDI Improvement Plan 2023, require Board members to have and be reported on in the BAF, measurable objectives regarding EDI (plan section 5.2).
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** 20 **Risk Register** x **Risk score** 15 Board Assurance Section 2: People Risk 3547: Upwards Trend in EDI related investigations
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: Creating and Embedding a Culture of Inclusion		**Meeting date:** 26 July 2023
Report sponsor	Chief People Officer	
Report author	Head of Inclusion and Cultural Development	

Creating and Embedding a Culture of Inclusion within Torbay and South Devon NHS Foundation Trust (TSD)

Issue

1. The Trust's People priority is to 'build a healthy culture at work where our people feel safe, healthy and supported'. This paper and its Appendix present to the Board the systematic plan to create and embed 'a culture of inclusion' throughout TSD. It is designed to have maximum positive impact for our people so that feel safe, healthy and supported. The timelines and dependencies within the detailed action plan (Appendix 1) are to be matured and managed via the project manager for the People Promise. The Board is invited to note the intent and content of the plan ahead of delivery commencement, and to approve the recommendations. The People Committee has assured the intent and content.

Recommendations

2. The Board is invited to note that the TSD Plan to create and embed a culture of inclusion, has the following objectives:

a. For all managers to role model leading with compassion, demonstrating inclusive behaviours and creating an environment that encourages feedback and where staff feel able to speak up.
b. To create an environment free of discrimination, where difference and diversity is encouraged and celebrated, giving people a sense of belonging and ability to perform at their best.
c. To create an environment where our people are able to be healthy and well (physically and mentally), to be themselves and perform at their best.
d. To introduce Just and Learning HR polices, systems, processes and practices.
e. To embed inclusion throughout the employee lifecycle: onboarding, induction, training, talent management, appraisal (via Leadership Framework Include, Listen, Act).
f. To be recognised as an inclusive and equitable employer committed to ensure our workforce reflects the community it serves and recognise and works to eliminate pay gaps.
g. To develop staff networks to gain confidence in sharing their lived experience to inform organisational decision making and improvements and creating a sense of belonging.
h. To create and utilise cultural dashboards for TSD, to identify areas requiring cultural development to improve workforce lived experience and patient safety.

And to approve that the plan:

i. requires action from all of the workforce – particularly via the completion of updated EDI training available through the HIVE in the autumn of 2023. It is recommended that everyone will be expected to complete the new training within 6 months of its launch (plan section 2.1)
j. will require commitment from the Board to sign statement of commitment towards an inclusive charter (incorporating anti-racism and anti-disabilitism charters) (plan section 2.2)
h. will, iaw NHS EDI Improvement Plan 2023, require Board members to have and be reported on in the BAF, measurable objectives regarding EDI (plan section 5.2).

Context

3. TSD is in the midst of a challenging time: as a Trust and local system this is mirrored against a backdrop of SOF4, the most ever challenging financial climate, a need for operational productivity to increase to decrease waiting times, a very tired workforce, and increasing levels of incivility, bullying, harassment and discrimination. Nevertheless, this presents us with opportunities to galvanise our resources and create a culture where our people can be their best, perform at their best, to deliver the best possible patient care. Creating a culture at work where our people feel safe, healthy and supported is within our gift.

4. The detailed plan to create and embed a culture of inclusion throughout TSD can be found at the Appendix. It sets out the key actions required during 2023/24 to build the solid foundations for an inclusive culture, which enables our organisational goals to be delivered, and our people to enjoy being at work motivated to be their best selves and to perform at their highest level. The plan is an amalgamation of existing key elements of work and considers the need to comply with statutory reports, address themes identified in existing data sources and enact improvement plans:

- Workforce Disability Equality System (WDES)
- Workforce Rae Equality Delivery System (WRES)
- National Staff Survey (NSS)
- Equality Deliver System (EDS2)
- NHS EDI Improvement Plan
- Devon 5 Year Joint Forward Plan EDI Objectives
- Just and Learning Culture (JLC)
- Just Culture survey (related to PSIRF)
- Freedom to Speak Up Guardian report
- CQC Well Led W1 and W4
- Employee Assistance Programme (EAP)
- Recent engagement through developing ‘our leadership way’ and leadership framework
- Themes from triangulating data sources between Business Partners, OD and Employee Relation cases.
- NHS Health and Wellbeing self-assessment tool

- Selenity Employee Relations case management system
- Fragility score as part of the ISU workforce information

5. The Plan recognises the need to be holistic in approach, and reflects improvements for marginalised groups, whilst prioritising aims and being realistic with available resource. The learnings from the pioneering Mersey Care Trust in relation to implementing JLC have also been included.

6. The plan is deliberately designed to be delivered through collaboration; every single person in the Trust has a contribution to make. For example, how every individual behaves, performs at work and contributes to how they make others feel, creates 'the culture' at TSD. It also includes the design of a cultural dashboard that measures ‘how it feels around here’. Afterall, ‘the real culture is what happens when no one is watching’[1]. This dashboard will help identify where targeted interventions may be required to address cultural challenges.

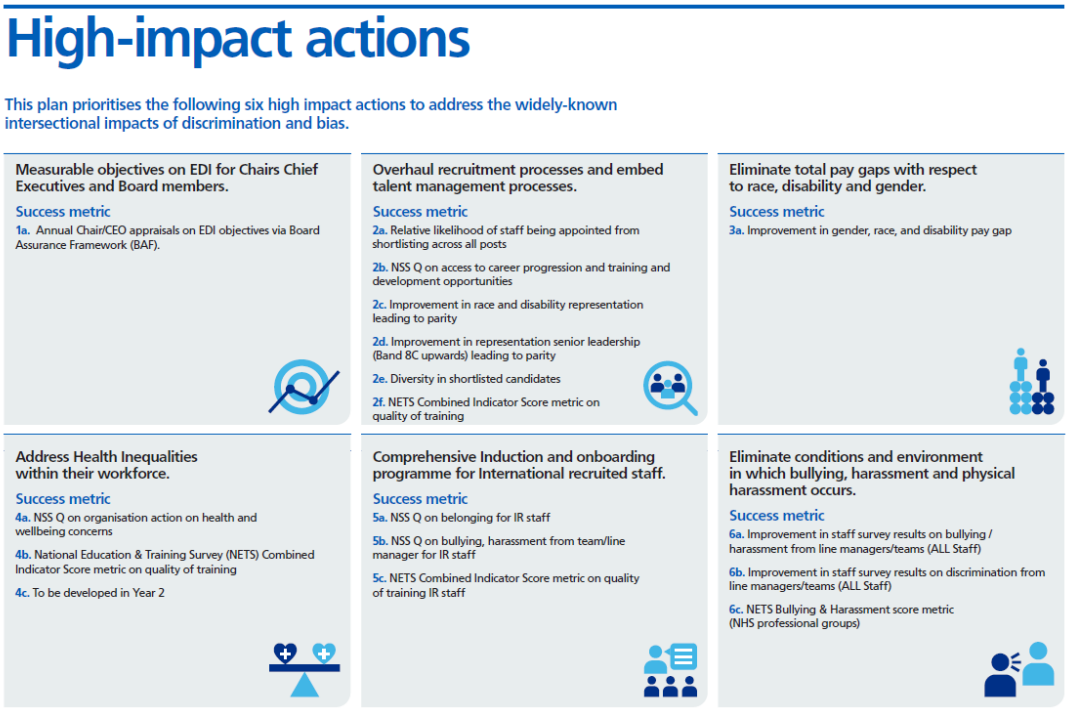
Background

7. The plan responds to the NHS Long-term Plan and subsequent NHS People Plan that says “The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms.” It builds on the people plan work already undertaken within the Belonging Pillar from 2020 at the inception of our local People Promise and Plan. This was last shared with the People Committee in 2022.

8. The plan is integral to the Trust’s People priority to ‘build a health culture at work where our people feel safe, healthy and supported’. It dovetails with the co-created leadership framework ‘Our Leadership Framework: A Compassionate Leadership Approach’ and management training due to commence roll out from September 2023.

9. The NHS equality, diversity and inclusion improvement plan[2] released in May 2023 is incorporated within the plan and addresses the six high impact actions as illustrated overleaf.

[1] Various
[2] NHS England » NHS equality, diversity, and inclusion improvement plan



TSD Culture: Findings and Themes

10. The national picture through the NSS, WDES and WRES shows there is much more to be done before we can say we have an inclusive work environment. Although this relates to all staff, the data shows a worsening picture for colleagues in marginalised groups. The NHS EDI improvement plan reflects the main areas of concern that require attention across the NHS; this mirrors the findings within the TSDFT data sources, as summarised in the following headlines.

11. **Incivility, Bullying, Harassment, and Discrimination.**

The findings of TSD's National Staff Survey, that incorporated findings from the WDES and WRES, and the data from the F2SUG report May 2023, identify the increasing trend of incivility, bullying and harassment. Too many staff (particularly those of marginalised groups) are experiencing incivility, bullying, harassment and discrimination, which it is anticipated shows correlating increases in increased sickness absence, employee turnover, diminished productivity, sickness presenteeism, governance and employee relations costs. Empirical evidence[3] [4]identifies that workplace bullying adversely impacts patient safety:

- Safe, effective patient care is intimately linked to good staff health, wellbeing and engagement.
- doctors who feel more engaged are significantly less likely to make mistakes
- a study of nursing practice found that higher staff engagement was linked to improved patient safety.

[3] Royal College of Physicians report into Work and wellbeing in the NHS: why staff health matters to patient care, 2015;
[4] Links between NHS staff experience and patient satisfaction: analysis of surveys from 2014 and 2015. Jeremy Dawson, University of Sheffield, 21 February 2018

- better staff wellbeing is associated with reduced MRSA infection rates and lower standardised mortality figures.
- The Keogh review of 14 trusts with high levels of patient mortality found that these trusts tended to have high rates of sickness absence, particularly among doctors and nurses.
- the higher the work pressure felt by staff, the less satisfied patients were.
- The more staff believe their Trust provides equal opportunities for career progression or promotion, the more satisfied patients will be on average.
- The higher the effectiveness of team working reported by staff (in terms of the clarity of objectives, interdependence of team members, and reflection by the team), the more satisfied patients were.

12. The plan to address incivility, bullying, harassment, and discrimination is multifaceted. The delivery of the leadership framework and management development from September plays a central part. This will set out what compassionate and inclusive leadership looks like and the expectation of all of us, irrespective of whether we are a leader or manager, to include, listen, and act and to be accountable for our culture. Raising awareness of our own behaviours and how we all contribute to the culture of the organisation will be highlighted through improved EDI and cultural awareness training via the HIVE, that has been designed around the civility and respect and the Civility Saves Lives campaigns. Our staff will be introduced to and invited to reflect on behaviours via evidence that links the devasting impact and ripple effect on those at the receiving of uncivil behaviour and their outputs in clinical environments.

13. The plan provides action to address the experience of our internationally recruited colleagues. TSDFT data sources evidence an increasing experience of racism by our staff. Whilst practice educators in the clinical environment are working with TSD's EDI lead to develop education packages for managers to understand and manage the the cultural differences between staff members, more needs to be done to support managers and teams who welcome our international colleagues.

14. **Inclusive recruitment processes leading to a more diverse workforce.**
Whilst we have made some positive changes to the way we recruit, the data suggests that we still have some way to go to see diversity at all levels throughout the organisation. From the introduction of an inclusivity representative on some interview panels, including executive and very senior manager posts, we are starting to see habitual approaches to recruiting be challenged leading to appointments being made from more diverse backgrounds, particularly relating to ethnicity. However, to improve this further we need to focus more on how and where we advertise and how we shortlist. Currently a person is 3 times less likely to be shortlisted if they are from an ethnic minority background and 2 times less likely if they have a disability[5]. Members of our networks are key to us gaining a better understanding of barriers to recruitment and improving our approach to shortlisting processes.

15. **Career pathways and personal development.**

[5] Nationwide, not TSD specific, evidence.

Over the last 18 months we have focused heavily on engagement to gain trust in order to understand the experience of our ethnic minority colleagues. As a result, we now know the barriers to career progression and development, and work has commenced in particular to:

- Support colleagues develop interview skills and techniques
- Develop leadership skills (through inaugural BME leadership programme)
- Develop inclusive recruitment practices
- Signposting to personal development opportunities

However, we now need to widen our focus on colleagues from other minority groups by way in the first instance of understanding their experiences and barriers to career and personal development. The staff networks are key to this; focus this year will be a focus on developing the networks, increasing the membership and amplifying their voices to focus on opportunities for improvement of polices and processes throughout the Trust.

16. **Physical Health and Wellbeing of staff.**

Covid 19 led to particular focus on the mental health of our staff. There are now a plethora of offers to support staff that are becoming embedded throughout the organisation[6]. In line with the NHS Health and Wellbeing plan, a focus must also be applied to the physical health of our people. Through the staff survey, year on year, staff are reporting musculoskeletal issues impacting their ability to work. The plan to Create and Enable a Culture of Inclusion addresses this in a number of ways, whilst also focusing on the importance of diet and nutrition that will support the ability to stay well during the winter months.

Approach

17. The approach to the delivery of the plan is threefold:

    a. At a People Directorate level key workstreams will work collaboratively, maximising the opportunities and ability to make impact, reducing duplication of work and cost. This has seen the creation of the Inclusion and Culture Team, which brings together the EDI and Health and Wellbeing Team. The intention does not dilute the importance of these areas in their own right but strengthens the ability to deliver programmes of work together. Further, a closer working relationship between teams within the People Directorate has been welcomed, to ensure that inclusivity and culture become the business as usual approach for HR professionals. This is reflected by the collaboration between the Employee Relations and Inclusivity and Culture team, and the identified requirement for service leads from across the Directorate and the Practice Educator teams to routinely meet to align activity, to respond to data that highlights where targeted cultural or leadership development opportunities may be required.

    b. Culture is everyone's business and therefore there is the requirement to review the format of workforce performance reports and dashboards to ensure

[6] EAP, Devon well-being hub, TSD Well-being team and well-being buddies.

that at a local level teams can understand what data is signifying, and that teams feel confident to demonstrate ownership and improvement of localised culture. The People Directorate will work closely with Care Groups to identify what workforce information exists and assist in growing instinctive confidence in interpreting and acting on it.

c. The plan deliberately connects with other enablers and programmes of work that can drive the delivery and messages required for a culture of inclusion. For example, the launch of PSIRF in September 2023 is underpinned by a Just and Learning Culture and will bring cultural change directly to patient facing staff.

18. There is further potential to look to system solutions, sharing learning and mutual benefits from work that has already been undertaken across Devon. An example of this is using policies that have been re-framed through a JLC lens, for example, adopting the HR policies and training packages recently implemented by Royal Devon University Hospital. This also supports the ICS agenda to standardise process where opportunity presents.

Resource

19. Consideration to managing costs has been given through the bringing together of key strands of work to maximise the use of our existing workforce resources, and to ensure that the mechanism of delivering cultural change is largely behavioural change brought about in the workplace rather than in classrooms. In addition, the intent is to maximise the ability to share and learn from other organisations and across teams to avoid 're-inventing the wheel'. The creation of the Inclusion and Cultural Development team, through rebranding what the previous EDI and Health and Wellbeing teams did, is the first step. Further alignment needs to mature between this team and the Freedom to Speak Up Guardian: many of the key themes the Guardian is presented with[7] will be treated by an improved culture, however there it is predicted that there is a risk that the number of complaints to the Employee Relations (ER) team, and the number of issues raised to the Guardian, will increase within the first year of the cultural change programme as a symptom of realising how one should be or have been treated.

[7] F2SUG Report May 2023 identified the majority of issues presented are bullying and harassment.

20. The increase in demand for the ER team has been mitigated through the recruitment of an additional band 6, who also provides the capacity to rewrite the HR policies in line with Just and Learning Culture, however additional resource to support the Guardian is recommended and will be presented through the Executive Committee in a separate paper: the People Directorate risk report will be updated to reflect these concerns.

Risk

21. 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. Risk 3547 scores at 15, articulating that 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. The plan to create and embed a culture of inclusion within TSD directly treats this risk.

Governance

22. 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, 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.

23. The impact measures will largely be demonstrated through the year-on-year findings through credible sources, which include:

- NSS
- WDES
- WRES
- EDS2
- Quarterly people pulse
- F2SUG Report

24. Although the measures are in the main annual, lead measures will be designed that can be routinely reviewed by the People Directorate, and via care group and corporate governance arrangements. These will ensure improvement is continuously tracked and trends of concern are spotted early and treated, therefore avoiding potential negative impact and harm. The impact measures will also require improved triangulation of people, performance and patient safety data to identify hotspots where targeted support maybe required. The creation and utilisation of Cultural dashboards will underpin the ability to proactively identify hotspots.

25. As part of the review of appraisals, it will be explored how everyone's attitude and behaviour to inclusivity is measured and people held to account. This is in addition to, but aligned with, the requirement of the NHS EDI Improvement Plan

2023, for Board members to have and be reported on in the BAF, measurable objectives regarding EDI (plan section 5.2).

Conclusion

26. The creation and embedding of a culture of inclusion within TSD is key to delivering the People priorities of the TSD Strategy. The plan to deliver this cultural change creates a holistic approach to incorporating inclusion, just and learning culture, and health and well-being, is significantly intertwined with the TSD Compassionate Leadership Approach to Include, Listen and Act, and the PSIRF programme, and relies upon a collaborative approach from across the Trust to embed changed behaviours.

Draft Plan to Create a Culture of Inclusion 2023/24

Objective	Action Required	Draft Timeline for launch (to be confirmed with dependencies)	National timelines for completion (where appropriate)	Lead	Impact Measure	Informs	Protected Characteristic Supported
1. All managers role model leading with compassion, demonstrating inclusive behaviours creating an environment that encourages feedback and where staff feel able to speak up	**1.1** Launch Leading with Compassion Framework and commence introduction workshops including 360 and feedback	Sep-23		Associate Director of People	· Attendance figures for all managers · Year on year increase in NSS: - My immediate manager values my work - My immediate manager gives me clear feedback on my work · Year on year decrease of staff reporting feeling bullied and harrassed by line manager ? discriminated against? · Year on year improvement WRES indicators · Year on year improvement on WDES indicators ***Aiming to close the equality gap for marginalised groups and improving the experience for all staff***	NSS WRES WDES	All
	1.2 Board Development on compassionate leadership, inclusive behaviours and culture	Jul 23 first session		CPO	attendance figures for board - reflection of use of behaviours and language as evidenced in board papers	EDS	All
	1.3 Launch new managers induction and essential skills for managers programme that include principles of creating a compassionate, fair and inclusive management practice	Sep-23		Head of Inclusion and Culture Development	Attendance figures for managers who are: - new to the Trust - newly promoted - existing managers	NSS WRES WDES	All
2. To create an environment free of discrimination, where difference and diversity is encouraged and celebrated giving people a sense of belonging and ability to perform at their best	**2.1** Bolt on EDI mandatory training package is developed and launched which reflects required attitudes and behaviours. To be delivered via HIVE.	Sep-23		EDI Lead	· Numbers of staff undertaken bolt on training - will need to be completed within 6 months of launch · Year on year decrease of all staff reporting feeling bullied and harrassed by line manager and colleagues ***Aiming to close the equality gap for marginalised groups and improving the experience for all staff***	NSS WRES WDES	All
	2.2 Launch anti-racism charter that sets out a zero tolerence towards racism Launch anti-disibility charter that sets out a zero tolerance towards disabilitism Signpost staff to how they can report any kind of discrimination, where to go to get support if witnessed together with how to be an active bystander Board and Trustwide Statement of commitment towards an inclusive culture.	Aug 23		EDI Lead Staffside CPO	· Reduction of staff reporting B&H from managers/teams and public · Numbers of staff reporting racism through ER cases (may increase in the first instance) Increased numbers of staff reporting they have reasonable adjustments in place · Increased numbers of staff reporting development opportunities	NSS WRES WDES	Race Disability

	2.3 Commence systematic delivery of comprehensive campaign of kindness and respect together with a comms plan. Embed the principles into induction, appraisal, leaderhip framework, managers induction and specialist skills development	Sep-23		Health and Wellbeing Lead	· Year on year reduction in formal grievance/disciplinary cases. · Year on year decrease of all staff reporting feeling bullied and harrassed by line manager and colleagues · Reduction in work stress absence · Potential increase in requests for mediation	NSS WRES WDES JLC	All
	2.4 Ensure principles of compassion, kindness and respect are built into essential skills for managers programme of topics	Sep-23		Head of Inclusion and Culture Development	· Reduction of staff reporting B&H from managers	NSS WRES WDES	All
	2.5 Create a diverse network of inclusion champions (replacing B&H advisor role) providing a confidential space to seek advice for staff when they experience incivil / B&H behaviour. Providing champions with training/time and a comprehensive comms plan to raise visbility and access.	Oct-23		EDI Lead	· Number of inclusion champions representative of the diversity in the Trust · Number of contacts made to inclusion champion network · Potential increase in staff reporting incivility, B&H · Number of contacts made to mediation service · Number of mediation cases undertaken	NSS WRES WDES JLC	All
	2.6 Visible calender of events across H&W and EDI	Jul-23		Health and Wellbeing Lead	· Number of events arranged Attendees at any group (all to be booked onto the HIVE)		All
3. Creating an environment where our people are able to be healthy and well (physically and mentally) to be themselves and perform at their best	**3.1** Increase visiblity of financial and bereavement support available	Aug-23		Health and Wellbeing Lead	· Numbers of staff taking utilisng EAP	H&W framework	All
	3.2 Increase visibility of reasonable adjustment policy and provide proactive training and support for all staff and managers Increase number of staff supported with a reasonable adjustment. Identify ability to track, record and audit specific equipment purchased as a reasonable adjustment (currently very costly as each dept purchases own).	Nov 23 Oct 24 Nov 23		ER Team Manager Health and Wellbeing Lead Health and Wellbeing Lead	· Numbers of staff going through training · Increased number of staff reporting supported with reasonable adjustments at work Database to record purchase and location of reasonable adjustement equipment	NSS WDES	Disability
	3.3 Upskill all staff and managers to improve their own physical or MSK wellbeing by raising awareness of importance and proactive promotion of physiotherapy. Promote importance of MH&L training through Education Team Promote preventative options eg desk exercises	April 24 April 24 December 23		Health and Wellbeing Lead Head of Clinical Education Health and Wellbeing Lead	· Increased numbers attending OH physio · Increased compliance with MH&L mandatory training · Reduction in MSK related sickness absence	NSS	All
	3.4 Review DSE process raising awareness OH support. staff have completed a DSE risk assessment for desk space.	Mar-24		Health and Safety Manager	· Increased numbers of staff referred to OH · Increased number requesting equipment · Reduction in work place injuries?		All
	3.5 Line managers and supervisors should have regular effective wellbeing conversations with their teams, utilising resources such as NHS health and wellbeing framework	Oct-23		Health and Wellbeing Lead	· Organisation action on staff health and wellbeing	NSS	All

	3.6 Support people to make healthy lifestyles choices food and drink and accessibility Raise awareness of importance and impact of a healthy lifestyle through seminars on HIVE	Dec 23 Dec 23		Catering and Retail Manager Health and Wellbeing Lead	· Availability of a healthy menu choices including out of hours · attendance number of seminars through the HIVE		All
	3.7 Deliver flu and COVID vaccination campaign as part of a holistic health and wellbeing 'getting winter ready' programme	Sep-23		Health and Welbeing Lead	Numbers of staff received flu / COVID vaccination		All
4. Introduction of Just and Learning HR polices, systems, processes and practice.	**4.1** In partnership with staff side colleagues identify key policies to review and reframe through a JLC lens	Jul-23		Head of Inclusion and Culture Development	· Identified policies, re-framed and agreed through joint partnership forum · policies published · number of attendees on policy train ng sessions · reduction in formal ER cases for disciplinary	HIVE Selenity	All
	4.2 Implementation of roll out plan for key policies identified, guidance written and training plan embedded for ER team and into managers induction, managers development	Sep-23		ER Team Manager	· policies published · number of attendees on training sessions · reduction in formal ER cases for disciplinary		All
	4.3 Increase visibility and pro-activity of mediation network	Sep-23		Mediation Lead	· Increased number of mediation requests before formal process intigated · Decreased numbers of formal investigations related to grievance and disciplinary		All
	4.4 Commence JLC awareness and training within key teams in the People Directorate to ensure consistent approaches are used and translating into practice through expected impact measures	Sep-23		ER Team Manager	· number of team members attended training · number of cases referred for mediation		All
	4.5 Embed ER learning reviews into business as usual practice developing a learning framework to ensure wider People Directorate and organisational learning	Sep-23		ER Team Manager	· number of learning reviews undertaken · evidence of changes to practice and policy · potential reduction in ET claims · potential cost in legal firm costs		All
	4.6 Review disciplinary and ER processes. This may involve obtaining insights on themes and trends from Trust's solicitors. There should be assurances that all staff who enter into formal processes are treated with compassion, equity and fairness irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve	Sep 23		Associate Director of People (ER)	· Improvement in staff survey results on bullying and harrassment from line managers · Improvement in staff survey results on discrimination from line managers/teams · Bullying and harrassment score metric	NHS EDI Improvement Plan progress report	All
	4.7 Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence. Support should be available for those who need it and staff should know how to access	Jan-24		Health and Wellbeing Lead	· Improvement in staff survey results on bullying and harrassment from line managers · Improvement in staff survey results on discrimination from line managers/teams · Bullying and harrassment score metric	NSS NHS EDI Improvement Plan progress report F2SUG Report	All
	4.8 Create an environment where staff feel able to speak up and raise concerns, with steady year on year improvments. Boards should review this by protected characteristic and take steps to ensure parity for all staff	Jan 24		Head of Inclusion and Culture Development	· Improvement in staff survey results on bullying and harrassment from line managers · Improvement in staff survey results on discrimination from line managers/teams · Bullying and harrassment score metric	NSS NHS EDI Improvement Plan progress report F2SUG Report	All
	4.9 Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harrassment, discrimination or violence	Sep 23		Health and Wellbeing Lead	· Improvement in staff survey results on bullying and harrassment from line managers · Improvement in staff survey results on discrimination from line managers/teams · Bullying and harrassment score metric	NSS NHS EDI Improvement Plan progress report	All

	4.10 Have mechanisms to ensure staff who raise concerns are protected by their organisation.	Oct-23		Head of Inclusion and Culture Development	· Improvement in staff survey results on bullying and harrassment from line managers · Improvement in staff survey results on discrimination from line managers/teams · Bullying and harrassment score metric	NSS NHS EDI Improvement Plan progress report	All
5. To embed inclusion throughout the employee lifecycle: onboarding, induction, training, talent management, appraisal (via Leadership Framework Include, Listen, Act)	**5.1** Through engagement understand the barriers to career progression for marginalised groups in particular disability and LGBTQ+	Aug 23		EDI Lead	· Increased numbers of staff in a marginalised group reporting positively about access to career development · Increase in staff reporting a positive experience of AR	NSS WDES NHS EDI Improvement Plan progress report	All
	5.2 Measureable objectives on EDI for Chairs, Chief Executives and Board members	Oct 23		Chief People Officer	Annual Chair/CEO appraisals on EDI objectives Annual report	NHS EDI Improvement Plan progress report	All
	5.3 Refresh achievement review (AR) paperwork in line with JLC approach to include and EDI objective for all	Jul-23		Health and Wellbeing Lead	· Increase in compliance of AR numbers · Increase in staff reporting a positive experience of AR	NSS WDES NHS EDI Improvement Plan progress report	All
	5.4 Systematic roll out of AR training for managers to be incorporated into the management training including accountablity	Sep-23		Health and Wellbeing Lead	· Increase in staff reporting a positive experience of AR · Increase in compliance of AR numbers	NSS	All
	5.5 Create and implement a talent management plan to improve the diversity of executive and senior leadership teams	Jan 24	Jun-24	Associate Director of People	· Relative likelihood of staff being appointed from shortlisting across all posts · Access to career progression, training and development opportunities · Year on year improvement in race and disability representation leading to parity over the life of the plan · Year on year improvment in representation of senior leadership (Band 8c and above) · Diversity in short listed candidates	WRES WDES NHS EDI Improvement Plan progress report NSS	Race Disability
	5.6 Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety	Jun 23	Mar-24	Head of Inclusion and Culture Development	· Sense of belonging for IR staff · Reduction in instances of bullying and harrassment from team/line manager (IR staff)	NSS WDES NHS EDI Improvement Plan progress report	Race
	5.7 Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams particularly international staff to access training and development opportunities.	Jun 24	Mar-24	Head of Clinical Education	· Sense of belonging for IR staff · Reduction in instances of bullying and harrassment from team/line manager (IR staff)	NSS WRES NHS EDI Improvement Plan progress report	Race

6. To be recognised as an inclusive and equitable employer committed to ensuring our workforce reflects the community it serves and eliminates pay gaps	**6.1** Review recruitment processes to ensure an inclusive and equitable approach from application to appointment. This will include reviewing: - Advertising - Shortlisting processes for marginalised groups including BME, Disability and LGBTQ+ - Panel composition to include inclusivity reps in key areas/roles - Grow numbers of inclusivity rep pool providing training and time to undertake acitviity - Inclusion interview questions - Recruiting managers training	Oct 23	Mar-24	Head of Resourcing	· increased places / new methods of advertising · year on year increased number of people shortlisted representing marginalised groups (BME, Disabled, LGBTQ+) · Increasing numbers of panels where an inclusivity rep is part of · Increasing numbers of a diverse pool of inclusivity reps · Year on year increased number of BME, Disabled, LGBTQ+ recruited	WRES WDES NHS EDI Improvement Plan progress report	Race Disability LGBTQ+
	6.2 Implement a plan to widen recruitment opportunities within local communities aligned to LT WF plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes, Grad schemes	Jan-24	Oct-24	Associate Director of Education Head of Resourcing	Access to career progression, training and development opportunities Year on year improvment in race and disability representation leading to parity relative likelihood of staff being appointed from shortlisting across all posts Progression towards achievement of Devon 5 Year Joiny Forward Pland D&I workforce targets - 20% disability, 3% LGBTQ+, 8% race and ethnicity.	NSS WRES WDES NHS EDI Improvement Plan progress report	All
	6.3 Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce	xxx	Mar-24	Head of Medical Workforce	Year on year reductions in gender, race and disability pay gaps. Meeting of NHS E set target:, plans should be in place for sex and race by 2024, disbility by 2025 and other protected characteristics by 2026.	Pay gap reporting	Sex
	6.4 Analyse data to understand pay gaps by protected characteristic and put in place and improvement plan (do for whole workforce). Implement an effective flexible working policy including advertising flexible working options on organisations recruitment campaigns (whole workforce)	Dec 23 Sep 23	Sex and Race 2024 Mar 24	Associate Director of People (ER) Head Inclusivity and Culture	Year on year reductions in gender, race and disability pay gaps. Meeting of NHS E set target:, plans should be in place for sex and race by 2024, disbility by 2025 and other protected characteristics by 2026.	Pay gap reporting EDI Improvement Plan progress	All
	6.5 Improve the capture of data on protected characteristics of whole workforce, to include the diversity at Board level	Jul 23	Mar-24	Head of Inclusion and Culture Development	· Increased representation of protected characteristics across workforce and Board	NSS WDES WRES	All
7. To develop staff networks to gain confidence in sharing their lived experience to inform organisational decision - making and improvements and create a sense of belonging.	**7.1** Using national EDI network toolkit engage with each network to: - review purpose of current networks - identify/recruit a chair and provide relevant training - develop a progressive plan for each network - Ensure each chair and co-chair has required protected time and reflected in policy - increase membership	Jul-23	Feb-24	EDI Lead	· Re-established disability network · Identified network chairs and co-chairs (where necessary) · Identified workplans for each network dependent on the needs of each network -evidence of closed-loop feedback to networks following input to organisatioanl decision making	NSS WRES WDES NHS EDI Improvement Plan progress report	All
	7.2 Increase completion of NSS from marginalised groups	Oct 23	Dec-23	EDI Lead	· Increased number of responses from staff within a marginalised group	NSS WRES WDES NHS EDI Improvement Plan progress report	All

8. **To create and utilise a cultural dashboard for TSD to understand areas requiring cultural development to improve workforce lived experience and patient safety**	**8.1** To integrate the data that WIT produce for fragile services, with selenity, F2SU, patient safety, Junior Dr exception report, People Survey to identify hotspots across TSD. Data to be integrated by Care Group, employee type, and protected characteristic to identify appropriate cultural, leadership or management (CLM) development intervention.	Jul-23		Hd of Inclusion and Culture Development	Reduced hotspots as a result of targetted development for CLM - reduced sickness absence, reduced grievances, increased us of mediation, reduced demand on F2SUG,	NSS WRES WDES F2SUG report	All

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Medical Appraisal and Revalidation Board Report			Meeting date: 26 July 2023
Report appendix	Nil		
Report sponsor	Chief Medical Officer		
Report author	Appraisal Lead		
Report provenance	Discussion with Responsible Officer and Appraisal Lead but no other formal presentation prior to this meeting.		
Purpose of the report and key issues for consideration/decision	This is the annual report relating to medical appraisal and revalidation presented by the Chief Medical Officer. The report addresses key issues as follows: • Recruitment and retention of enough appraisers to provide timely appraisals for all licensed medical practitioners • Challenge of encouraging doctors to have a regular, supportive, appraisal due to ongoing high clinical workload. • Ongoing deferrals due to lack of supporting information, particularly Colleague and Patient 360 feedback.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Foundation Trust Board is asked to approve the contents of the Annual Report of the Responsible Officer relating to Medical appraisal and Revalidation. The monitoring of appraisal and revalidation continues as described and reporting will be undertaken on an annual basis.		
Summary of key elements			
Strategic 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**		

Public

External standards affected by this report and associated risks	

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

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

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

Contents

Introduction:

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

- **Board Report template:**

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

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

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

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

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

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

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

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

Designated Body Annual Board Report

Section 1 – General:

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

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

Date of AOA submission: Not applicable

Action from last year: Continue to re-engage medical staff with the appraisal process.

Context:- We have approximately 60 Locally Employed Doctors (LED) and contracted locums at T&SDFT. They have only recently been added to PReP so appraisal figures for these doctors are not included in this year's report.

We have approximately 290 Consultant and SAS doctors- this figure changes all the time as staff leave, join and retire. Because of this the figures below do not relate to percentages, but actual numbers of appraisals undertaken.

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

Appraisal data from 1/10/20 to 12/7/23

Since appraisal restarted in October 2020 after the pandemic, all but 4 doctors have had at least one appraisal compared to 29 (10%) at this time last year. 1 doctor is on long term sick leave and another has retired and returned as a locum Consultant. Two doctors are being actively supported to help them to achieve an appraisal in the near future.

Numbers of completed appraisals:-

1/4/2020-31/03/2021 97 appraisals

1/4/2021 – 31/03/2022 213 appraisals

1/4/2022 – 31/03/2023 250 appraisals

1/4/2023 – 13/07/2023 68 appraisals (part year)

2 doctors have been discussed for non-engagement with the GMC. Both of these doctors have now left the Trust

1 doctor had their licence to practice removed by the GMC for a non-engagement recommendation in the previous year. This doctor was supported to regain their licence to practice to allow a return to work.

Revalidation recommendations to the GMC:

01 April 2022 – 31 March 2023

Recommendations for revalidation: 42

Recommendations for deferral: 17

Recommendations for non-engagement in the appraisal process: 2

Action for next year: Continue to encourage doctors to have a yearly appraisal and where possible to stick to their allocated appraisal month.

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

Action from last year: Mr Ian Currie continued in post as Responsible Officer (RO) for Torbay and South Devon NHS Foundation Trust.

Comments: Dr Catherine Lissett took over as Responsible Officer for Torbay and South Devon NHS Foundation Trust on 01/07/2023

Action for next year: Dr Lissett to continue as RO

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

Action from last year: Due to increasing workload, the requirement for quality assurance and to provide robust support to the Responsible Officer together with succession planning for the Appraisal Lead, a 1 PA Deputy Appraisal Lead appointment would be advisable.

Comments: Funding identified and Dr Rebecca Green appointed as Deputy Appraisal Lead, 1 PA per week, from 01/04/2023.

Action for next year: Dr Green to develop in role in support of RO and Appraisal Lead.

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

Action from last year: Continue to maintain list as accurately as possible

Comments: Whilst we endeavour to be as accurate and up-to-date as possible, there is margin for doctors to connect themselves inappropriately or fail to connect to the list.

Action for next year: Continue to maintain list as accurately as possible

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

Action from last year: Review the Appraisal and Revalidation policy in 2023. Comments: Appraisal and Revalidation Policy reviewed but ratified by the Joint Local Negotiating Committee (JLNC) delayed due to industrial action. Action for next year: Policy ratification at JLNC meeting

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

Action from last year: Await date of HLROP Quality Review visit. Comments: Higher-Level Responsible Officer Quality Review visits recommenced from 01 September 2022. The visits are not intended to be a formal inspection of Trust process but aim to provide support and education. Action for next year: Date of HLROP Quality Review visit still awaited.

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

Action from last year: Finalise a formal appraisal process for Locally Employed Doctors (LED) and locum doctors with Responsible Officer and Medical Workforce. Comments: Locally Employed Doctors (LED) Lead, Dr Simon Barnes, now in post and working closely with the Appraisal Lead and Medical HR. Agreement to prioritise locally employed doctors and locum doctors on a fixed-term contract when offering in-house appraisals. This is a pragmatic decision based on the shortage of available appraisers within the Trust. Doctors employed as bank locums to be supported to gather supporting information for appraisal and encouraged to seek a yearly appraisal from a commercial appraisal agency or through their locum agency as appropriate. Revalidation will be supported if connected to our organisation at the time. Action for next year: Communicate policy widely within the Trust.

Section 2 – Effective Appraisal

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

Action from last year: Introduce the Medical Appraisal 2022 format for appraisal. Comments: Medical Appraisal 2022 template now available on Premier IT revalidation system and being used for yearly appraisals. This continues to emphasise the importance of maintaining health and well-being alongside statutory requirements. Action for next year: Continue to encourage as many doctors as possible to have a yearly appraisal for personal and professional development.

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

Action from last year: Continue to monitor and provide support. Monitor timelines and encourage doctors to have a supportive appraisal meeting. Missed appraisals to be identified, reasons understood and appropriate action taken. Comments: Work pressures, episodes of sick leave and maternity leave continue to be the main reasons for missed appraisals. A more active approach to managing missed appraisals has been undertaken over the past year, with a doctor's Clinical Service Lead and Operational Manager being contacted if the doctor has not had a recent appraisal to encourage this to take place. Work has also taken place to improve the accuracy of information on the Electronic Staff Record (EPR) so that Operational Managers receive regular reports on appraisal compliance for the doctors in their department. Action for next year: Continue to develop process for actively managing situations where doctors are late with appraisals.

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

Action from last year: Policy to be reviewed and ratified in 2023. Comments: The Appraisal and Revalidation Policy has been reviewed and is awaiting approval by the Joint Local Negotiating Committee (JLNC) due to delay by industrial action. Action for next year: Await ratification at JLNC meeting

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

Action from last year: Ongoing active recruitment to the appraiser role and support for existing appraisers. Ongoing work to ensure Locally Employed Doctors receive appropriate support and access to appraisal. Explore retention of retired doctors as medical appraisers.

Comments: Retention and recruitment of appraisers remains one of the biggest challenges to appraisal currently. Over the past year, 7 appraisers have stepped down due to new roles, ill health, retirement or work pressures. We currently have 44 active appraisers for Consultant and SAS doctors. Not all of these appraisers will appraise a full complement of 7 doctors per year due to other commitments or working less than full time. 6 new Consultant and SAS appraisers were trained in 2023 with 5 agreeing to take on appraisees. 1 doctor has ongoing job planning issues which means they cannot start appraising at the current time. We have 1 retired doctor who is employed to provide appraisals at the present time (previously 2). The lack of a ring-fenced budget to pay appraisers is a barrier to more creative solutions to this problem.

Some directorates continue to have low numbers of appraisers compared to their workforce.

Action for next year: Continue to recruit and train new appraisers where possible. Continue to seek a way of funding appraisal that allows PA's to be recycled when an appraiser retires or gives up the role. Encourage Clinical Service Leads and Operational Mangers to use team job planning to work towards 1 appraiser for every 7 Consultant and SAS doctors in their team.

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

Action from last year: continue.

Comments: Appraiser Update session held on 22/03/2023 having been postponed due to industrial action. This was a one-day introduction to coaching skills for appraisers run by Amanda Brunt from the Organisational Development team. This session will be repeated in Autumn 2023 due to excellent feedback. MS Teams Appraiser update sessions are held monthly as a forum for problem solving and shared experience.

Action for next year: Appraiser update session in Diversity and Inclusivity planned for 08/11/2023.

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

Action from last year: Review of Quality Assurance processes in advance of the Higher-Level Responsible Officer Quality Review visit. Comments: New appraisers reviewed after two appraisals to provide support and guidance. Action for next year: Re-introduce Quality assurance tool review of post appraisal outputs

Section 3 – Recommendations to the GMC

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

Action from last year: Continue Comments: The Responsible Officer has regular meetings with the GMC Employment Liaison Officer to discuss any potential fitness to practice issues. Action for next year: Continue.

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

Action from last year: Continue Comments: All revalidation recommendations have been submitted to the GMC prior to the doctor's revalidation date. Revalidation recommendations are communicated to the doctor after submission via GMC Connect. Deferral and non-engagement recommendations are communicated to the doctor before submission to the GMC and an action plan is discussed with the doctor by the Appraisal Lead. Action for next year: Continue.

Section 4 – Medical governance

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

Action from last year: Continue Comments: Medical Examiner system now embedded in practice. Incidents, complaints and litigation cases recorded on the Datix system. Action for next year: Continue.

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

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

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

Action from last year: Continue Comments: Maintaining High Professional Standards and Remediation policies are in place. Close liaison continues between the Responsible Officer, Appraisal Lead, Deputy Appraisal Lead and Medical Workforce team. Action for next year: Continue.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: Continue Comments: Following a Maintaining Professional Standards Investigation the Case Manager will meet with the Case Investigator and Medical Workforce team to debrief and consider any lesson that can be learned. These are communicated to the Responsible Officer. The Trust is committed to

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

preventing discrimination, valuing diversity and achieving equality of opportunity. No individual will receive less favourable treatment on the grounds of the nine protected characteristics as governed by the Equality Act 2010.

Action for next year: Continue.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: Continue

Comments: Transfer of Information requested from previous organisation and provided, on request, to the doctor's next employer. Regular liaison meetings between the Responsible Officer and the GMC Employment Liaison Officer provide a forum to discuss any concerns about a doctor who may be relocating to another employing organisation.

Action for next year: Continue.

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

Action from last year: Continue

Comments: The Responsible Officer and Medical Workforce Service Managers meet on a regular basis with the GMC Employment Liaison Officer to discuss, in confidence, any concerns and agree the best way of handling these concerns balancing the safety of patients with supporting the clinician.

Action for next year: Continue.

Section 5 – Employment Checks

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

Action from last year: Continue

Comments: All medical staff, both substantive and locum, are subject to pre-employment checks as per the NHS Employers Employment Check Standards and NHS Employers Guidance on appointment of Locum Doctors.

Action for next year: Continue.

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

Section 6 – Summary of comments, and overall conclusion

General review of last year's actions:

- Appointment of Deputy Appraisal Lead, Dr Rebecca Green
- Dr Catherine Lissett to take over as Responsible Officer from 1/7/2023
- Contract for use of Appraisal and Revalidation system, PReP, renegotiated with the supplier, Premier IT
- New Appraiser training held on 7 June 2022 and 19 March 2023 with 5 consultant/SAS doctors joining the Trust Appraiser group. The training is facilitated by MIAD Healthcare.
- Monthly Appraiser Group updates held via MS Teams
- Annual Organisational Audit currently stood down since the COVID 19 pandemic and recovery planning.
- National guidance received with revised medical appraisal template for Appraisal 2022 now in place. Support and information provided to doctors on this format. This template has been incorporated within the electronic toolkit and is designed to be similar to the light touch 2020 template however with more pre-appraisal input required from the individual doctor.
- The Medical Appraisal Guide (MAG) Model Appraisal Form is no longer fit for purpose and will no longer be used for appraisal.
- Locally employed doctors to use PReP system for appraisal as MAG form not fit for purpose and being phased out.

Actions Still Outstanding:

Date for Higher-Level Responsible Officer Quality Review visit still awaited

Current Issues:

- Recruitment and retention of enough appraisers to provide timely appraisals for all licensed medical practitioners is of concern.

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

Actions:

- Recruitment and retention of enough appraisers to provide timely appraisals for all licensed medical practitioners.
- Encourage proportionate contribution to appraiser pool by all departments and specialties
- Explore possible solutions to identified funding for appraisal PA's
- Encourage doctors to have yearly appraisal and continue to develop active identification of those that fall behind, with provision of appropriate support to facilitate compliance.

- Continue to work with the LED Lead to develop a clear process for support and appraisal for this group of doctors.
- Monitor number of deferrals and understand the underlying reasons.

Overall conclusion:

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

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body:

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

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

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

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

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:** 26 July 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 July 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. 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. No new risks have been added to the CRR. Since the last meeting amendment have been made to Objectives 2, 3 and 6.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendations	The Board is asked to: (i) Review the BAF, and note the updates as described and (ii) Receive and note the Corporate Risk Register.		

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**		

NHS
Torbay and South Devon
NHS Foundation Trust

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	Risk rational wording amended and minor updates to aggravating factors and action log.
3	Financial Sustainability	CFO	25	16	Risk rationale wording amended.
4	Estates	CFO	25	10	
5	Operations and Performance Standards	COO	16	12	
6	Digital and Cyber Resilience	DTP	25	25	Risk scoring analysis updated to include reference to reprocurement of PARIS system and impact of paper record-keeping on quality of service provided.
7	Building Brighter Future (BBF)	DTP	15	15	
8	Transformation and Partnerships	DTP	16	9	
9	Integrated Care System	DTP	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	10 12	8 9 16 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**
	Nov 22	**Jan 23**	**Mar 23**	**Jul 23**	**April 24**	**Jul 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	4	4	4	4	4	5	
Consequence	4	4	4	4	*3*	4	
Risk Score	16	16	16	16	12	20	

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 at work where our people feel safe, healthy and supported.				
Internally Driven: ✓ Externally Driven:						
Responsible Executive:		Chief People Officer	**Committee:**	People Committee	**Last Updated:**	July 2023

BAF Risk Scoring

Current Position						**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Nov 22	**Jan 23**	**Mar 23**	**Apr 23**	**Jul 23**		**Jul 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. Our cultural dashboard data (sickness, rolling sickness, long term sickness, age profile, holiday taken, overtime hours, bank and agency spend, and turnover) highlights areas that 6 out of 9 are in red RAG 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 CQC letter following Well-led inspection highlighted the level of work to do regarding EDI. 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	5	5	4	4	
Consequence	4	4	4	4	4	4	4	
Risk Score	16	16	16	20	20	16	16	

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. Now approved at Board , the roll out plan to commence Q2 23. Leadership framework will used to identify leadership	2.4C	Continued poor leadership and management behaviours will exasperate an already fragile workforce and reinforce that their concerns are not

			expectations, standards & behaviours. Evaluate (through a 360 approach), recruit and develop leaders to improve effectiveness and consistency in leadership.		listened to, further compounding fragility challenges.
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. This was highlighted in the recent CQC letter following the Well -ed inspection.	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	CPO	Mar 24	Agency use monitored through Nursing & Midwifery Workforce Transformation Council from June 2023 and reported into Recovery group.
2.2A & 2.10	To improve the organisational culture, and therefore the well-being of the workforce, a plan is required to create and embed and Inclusive Culture in TSD	CPO	Sep 23	Cultural improvement plan was presented at People Committee 26.06.23. To be presented at Trust Board 26.07.23.
2.10A	1&2 New TSD Leadership and Management framework and resources will be launched from September 2023 that focus on a leadership responsibility of all to include. Will involve refreshed EDI training,	CPO	Sep 23	Leadership framework approved by Trust Board. All products – based on the framework- including a 360 and leadership & management induction programme under development.
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	**Dec 23**	Interim People Hub manager in post until Dec 23 and uplift to resources now in place June 23.

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:**	July 2023

BAF Risk Scoring						
Current Position				**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Nov 22	**Mar 23**	**Jul 23**	**April 24**	**Jul 22**	There is a risk that the Trust fails to deliver sufficient improvement to achieve the three-year system recovery plan (including productivity). 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	5	
Consequence	5	5	5	4	5	
Risk Score	25	25	25	16	25	

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**
	Nov 22	**Jan 23**	**May 23**	**Jul 23**	**2030**	**Jul 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	5	
Consequence	5	5	5	5	5	5	
Risk Score	25	25	25	25	10	25	

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
	Nov 22	**Jan 23**	**Mar 23**	**Jul 23**	**April 24**	**Jul 22**	
Likelihood	5	5	4	4	3	4	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.
Consequence	4	4	4	4	4	5	
Risk Score	20	20	16	16	12	20	

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 .	5.4.C	Failure to deliver on SOF4 exit criteria resulting in reduced organisational control

			Regional Mutual Aid including access to Nightingale Hospital Exeter.		
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**
	Nov 22	**Jan 23**	**May 23**	**Jul 23**	**April 24**	**Jul 22**	Current IT systems and supporting infrastructure will not meet the current of future business need.
Likelihood	5	5	5	5	5	5	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.
Consequence	5	5	5	5	5	5	
Risk Score	25	25	25	25	25	25	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)

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
6.8A	Torbay Council procurement of replacement to PARIS (Internal Audit review has identified shortcomings in terms of reporting functionality of adult social care data and system is at its end of life)	6.8C	The procurement of a new system and the Trust's awareness of the fragility of the system, as well as oversight by internal audit ensure performance is monitored.	6.8C	The PARIS replacement system will provide a new platform to record adult social care data, however the Trust also uses PARIS for other community functions and it is not clear if the new system will include those functions. In addition, it is not known if Torbay Council will purchase the same system that is used by neighbouring Councils to enable a streamlined approach.
6.9.A	Efficacy of clinical record keeping and undertaking risk assessments at appropriate time frames relies on human based triggers and memory, rather than automated prompts to undertake processes.	6.9B	The procurement of the EPR and the Trust's awareness of the fragility of the system, as well as oversight by internal audit ensure performance is monitored.	6.9C	At times record keeping may not be as efficient and is not automated in line with process.

Gaps in control/assurance

Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
6.3A, 6.8A, 6.9A	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, 6.5A, 6.6A, 6.7A	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.
6.4A	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:**	June 2023

BAF Risk Scoring

Current Position					Target Position	Year on Year	Rationale for Risk Level
	Nov 22	**Jan 23**	**March 23**	**Jul 23**	**May 23**	**Jul 22**	
Likelihood	3	3	3	3	3	3	The availability of a national funding for cohort 4
Consequence	5	5	5	5	5	5	
Risk Score	15	15	15	15	15	15	

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	Site Enabling Fees – Programme Office will seek approval for the additional 'seed' funding required to complete the Site Enabling Full Business Case and the funding required for the subsequent works.	Director of Transformation & Partnerships	Submission – June 23 Approval - Sept 2023	
7.1B	Action to address lack of assurance in relation to capital funding and national timetable delay	Director of Transformation & Partnership	Ongoing	Bandwidth of capital allocation has now been confirmed . Interim NHP project director has now been appointed and the BBF programme office have commenced discussions with the postholder to agree next steps in relation to progress of the programme

7.2A	Site Enabling Business Case(s) – the Outline and Full Business Case(s) will be approved by the Trust Board and presented to the NHP National team	Director of Transformation & Partnerships	OBC – October 2023	
7.3A	Drumbeat 2.0 – the desk top research to evaluate best practice across our clinical specialities will be completed and reported to the BBF Committee	Health and Care Strategy Director	September 2023	
7.4A	Planning scenarios – the respective planning scenarios associated with the funding allocation will be shared with the BBF Committee	Director of Transformation & Partnerships	September 2023	
7.5A	Masterplanning – the outcome of the peer review master planning exercise will be presented to the BBF committee	Director of Transformation & Partnerships	September 2023	
7.6A	Digital Outline Business Case – Ensure that the EpR Outline Business Case secures national approval	Director of Transformation & Partnerships	July 2023	
7.7A	Digital procurement – ensure that procurement process associated with the EpR is completed in accordance with agreed project timetable	Director of Transformation & Partnerships	October – 2023	
7.8A	Digital Full Business Case – ensure that the EpR Full Business Case is completed in accordance with the agreed project timetable	Director of Transformation & Partnerships	December – 2023	
7.9A	EpR Readiness / Delivery -ensure that the Trust is in a position to manage the implementation process of the new EpR system	Director of Transformation & Partnerships	Readiness - July 2024 Delivery from August 2024	
7.10A	EpR go live – the go live for the new EpR will take place in accordance with agreed project timetable	Director of Transformation & Partnerships	August 2025	

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**
	Nov 22	**Jan 23**	**Mar 23**	**Jul 23**	**March 24**	**Jul 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	4	4	4	4	3	5	
Consequence	4	4	4	4	3	4	
Risk Score	16	16	16	16	9	20	

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**
	Jan 23	**May 23**	**Jul 23**	**April 24**	**Jul 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**
	Nov 22	**Jan 23**	**Mar 23**	**Jul 23**	**Sept 23**	**Jul 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	4	4	3	n/a	
Consequence	n/a	n/a	3	3	2	n/a	
Risk Score	n/a	n/a	12	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

CRR July 23.xlsx

Torbay and South Devon NHS
NHS Foundation Trust

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: 1168 - National Programme for IT HSCIC. 1174 - Increasingly Software Companies Are Changing Their Licensing.	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, national	Ctrl's 5.6.7.13, 14 & 15 total investment requirements outstrip the Trust's capital funding capacity to be allocated to reduce risks (2022 example - inability to fund the £1.4m EUD scheme).	01/10/2023	Catastrophic	Almost Certain	25	[14/06/2023 09:05:21 Gary Hotine] Updated Actions [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.	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)
											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				approval expected July 2023. FBC approval expected 2023/24.								
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 2023/24 deficit financial plan 2. Failure to address underlying financial performance of the Trust over £50m recurrent deficit, and failure to deliver the agreed financial plan for 2023/24 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 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 3. In-depth discussion on Financial Performance reports at operational governance meetings such as IGG, Executive meetings, Recovery Group (DCEO-chaired), System Financial Recovery Board, Finance, Performance and Digital Committee (FPDC) and Board. 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 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 now 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. 3. Governance and delegation compliance rate following spending protocols requires monitoring and addressing	31/07/2023	Catastrophic	Almost Certain	25	[26/05/2023 09:29:27 Dave Stacey] Updated DS May 2023 [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.	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 Risk	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

CRR July 23.xlsx

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)
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 deliver the financial plan 2023/24 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)Recovery Group 2)Restructured Integrated Governance Group for care pathways 3)Finance, Performance & Digital Committee 4)System Transformation and Efficiency Committee / System Recovery Board 5)PMO team in place with Delivery Director leading 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) Recovery Groupmeeting 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. 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 2023/24 2)Inadequate progress on embedding the requirements of GIRFT 3)Slow progress on significant system wide savings solutions	31/07/2023	Catastrophic	Almost Certain	25	[26/05/2023 09:33:22 Dave Stacey] Updated DS May 2023 [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	Catastrophic	Possible	15
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

CRR July 23.xlsx

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)
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
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 colonoscopy. 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. Dedicated outpatient space to deliver TP biopsies at Paignton Hospital in outpatient setting (Prostate pathway) building work completion awaited. Significant delays to TP biopsies. c. Consultant vacancies in Dermatology and Urology. Reliant on Locum cover. D. Insufficient capacity in diagnostics - CT, CTC, MRI and colonoscopy to achieve the timed pathways for Lung, Urology, LGI and Gynae. 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. D. Failing to achieve 62 day referral to treatment target across 8 cancer sites E. Failing to achieve 28 day referral to diagnosis standard across many specialities F. Additional work ongoing 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 7. Weekly PTL meetings set up with at risk cancer sites to escalate potential breaches and discuss concerns 8. Cancer Alliance fixed term A&C roles recruited to in order to try and recover PTL performance and data	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 increase in demand and unable to track PTLs daily and escalation where appropriate 6. 1 WTE fixed term band 3 data clerk post currently funded by the Cancer Alliance due to end October 2023 with no onward funding identified. This post is essential in order to maintain national standards and clinical audit compliance. Business case to be submitted	30/06/2023	Major	Almost Certain	20	[12/07/2023 11:58:37 Jacqui Robinson] Torbay have now moved out of Tier 1 for cancer performance however this needs to be sustained. Whilst the over 62-day backlog has reduced the Trust are still failing the 14d, 31d and 62 day standards and remains a significant organisational risk. To be reviewed in 3 months. [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.	Major	Possible	12

CRR July 23.xlsx

Torbay and South Devon 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)
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)	07/08/2023	Major	Almost Certain	20	[25/05/2023 14:32:32 Derren Westacott] Achieved reduction in waiting time. No 104 week waits target to reduce waits to under 65 weeks by 31 March 2024 [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	Moderate	Likely	12
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, performance, quality 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. 10. System Recovery Board. 11. Trust internal governance.	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	11/09/2023	Catastrophic	Likely	20	[22/05/2023 10:04:29 Sophie Byrne] The following controls were added to the risk: - System Recovery Board. - Trust internal governance. [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
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	[27/06/2023 15:44:13 Sarah Blacoe] [18/06/2021 14:41:56 Sally Simpson] In progress Resources just come back from comms for review [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	Major	Possible	12

CRR July 23.xlsx

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)
1603	08/07/2016	Corporate Level Risk	Breast Care	Sandie Heyworth	Derren Westacott	Chief Operating Officer	Performance Risk	Breast Care	Site Non-Specific	Delayed diagnosis for Breast Cancer - Capacity Constraints	Cause: 1. Insufficient Radiology capacity to meet demand of service 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 now completed training 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. 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. 4. Locum sessions are ad hoc	31/07/2023	Major	Likely	16	[05/06/2023 09:16:38 Sandie Heyworth] Cons Radiographer has been off sick for 2 weeks with a back problem - lost imaging capacity and locums cannot support any more than already [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.	Major	Unlikely	8
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

CRR July 23.xlsx

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)
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
3484	14/11/2022	Corporate Level Risk	All Departments	Adel Jones	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. All Boards signed up to Acute Provider Collaborative 2. Acute Sustainability programme in place with engagement from CEO, CMO, DTP and clinical teams 3. Workshops underway with outcomes reported to TMG 4. Fragile Services workstream in place led by DTP for the system 5. System Recovery Board for ICS with Execs reporting on key system workstreams	Internal 1.ICS governance frameworks are maturing and aligned with Trust Improvement Plan 2. TSD proposal to improve board oversight to BBF committee 3. SOF4 plan in place providing additional resource to deliver the strategic acute provider collaborative objectives	07/08/2023	Major	Likely	16	[30/05/2023 10:55:15 Amanda Anders (Risk Officer)] Reviewed by Adel Jones 26/05/23- Controls and gaps in control updated [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	Adel Jones	Liz Davenport	CEO (Liz Davenport)	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	07/08/2023	Major	Likely	16	[30/05/2023 10:49:58 Amanda Anders (Risk Officer)] Reviewed by Adel Jones on 26/05/23 [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

CRR July 23.xlsx

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)
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 (Workforce Risk)	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	31/07/2023	Major	Likely	16	[24/05/2023 11:26:44 Anthony Lowe] Head BMS of Histo has currently left. Job matching of JD completed, awaiting vacancy approval. Uncertainty around Histo build may impact on Consultant Microbiologist will be retiring end of August 2023. will return as retire and return in short term but reduced hours. Locums etc being investigated. Network has been approached with a mutual aid request for Microbiology clinical support. Other sites(e.g. RCHT) under pressure. Both Histo and Micro to be reviewed as fragile services. Not sure yet of remedial actions. Biochemistry under sever operation pressure du to band 5/6 maternity leave/sickness impacting on 24/7 rota. Under review with ADO [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.	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	31/07/2023	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

CRR July 23.xlsx

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)
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
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.	29/12/2023	Catastrophic	Possible	15	[12/07/2023 10:56:06 Neil David Elliott] The Data Engineering team have now taken over the submission of this data set from the agency resource. It is still a partial submission as the PARIS system does not comply with the requirements and that system needs to be updated in order that to get sufficient data to make a submission. John Broom is leading that project. [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.	Catastrophic	Rare	5
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.	26/07/2023	Catastrophic	Possible	15	[26/05/2023 11:21:14 Claire Jones] Progress delayed due to difficulties in recruiting ODP's both locally and nationally. Awaiting update from theatres regarding workforce planning. [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.	Catastrophic	Rare	5
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	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

CRR July 23.xlsx

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)
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. The directors of ITH Pharma do not envisage any impact on day-to-day trading of the company, despite the admissions of guilt in relation to the Crown Court case. (1 x Insufficient risk assessment in place and 2 x supplying medicinal products not of nature or quality specified in the prescription). They have had almost 8 years of continued trade with the NHS since 2014 with no repeat issues and their business has continued to grow. The directors are also advised that, should any civil claims arise in the future (and they are expecting them), their insurers will continue to defend their position and, if these cases are found against them,	Catastrophic	Possible	15
3372	26/04/2022	Corporate Level Risk	Head and Neck (Including Dentistry)	Heather Barlow	Derren Westacott	Chief Operating Officer	Clinical Safety Risk	ENT and Plastic Surgery	HOS, Torbay Hospital Outpatients Department	Potential Harm to Patients Due to Long Waits (Workforce Risk)	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 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	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	03/07/2023	Major	Possible	12	[24/05/2023 14:04:30 Derren Westacott] Amended risk description to describe the risk rather than the issue. Mitigation is lowering the risk however more needs to be done to build a resilient team and recruit to vacancies. [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	Major	Rare	4

CRR July 23.xlsx

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)
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	07/08/2023	Moderate	Likely	12	[28/06/2023 20:23:54 April Hopkins] We would like to close this risk. A new one has been opened (linked) that describes the risk as an increase in complex acute admissions and pervasive presentation resulting in long or repeated admissions due to significant increase in referrals to CAMHS for Eating Disorders compared to pre-Covid numbers. We have scored this as a 12 (clinical risk with increased hospital stay. The actions are: 1) There may be a possibility of a CAMHS dietetic support funded through CAMHs. Ongoing exploration needed to ascertain how to secure this. 2) Exeter have a Job plan for dietetic support. AC to enquire further. 3) Discussions ongoing regarding in- house ACP support. Therefore we would like to remove it from the corporate risk register [12/05/2023 08:22:58 Natalie Tidball] This risk is currently under review. It does not reflect the current situation and therefore it is being re-written to fully depict current pressures. Scoring has been reduced in the meantime. [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	Moderate	Unlikely	6