Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors

Date: Wednesday 27th September 2023

Time: 11.30 am – 2.30 pm

The Boardroom
Hengrave House
Lowes Bridge
TQ2 7AA

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TSDFT Public Board of Directors

27/09/2023 11:30

Torbay and South Devon NHS Foundation Trust

	6.2	Chief Executive's Report Receive and Note	CEO	12:10-12:25	45
7.	Safe Quality Care and Best Experience				61
	7.1	Integrated Performance Report (IPR): Month 5 2023/24 (August 2023 data) Receive and Note	ICFO	12:25-12:40	61
	7.2	September 2023 Mortality Score Card Receive and Note	MD	12:40-12:55	119
	7.3	Maternity Workforce Oversight Report Receive and Note	CNO	12:55-13:05	144
	7.4	Report on Safeguarding Adults, Mental Capacity and Deprivation of Liberty Safeguards Receive and Note	CN	13:05-13:15	157
	7.5	Safeguarding Children - Annual Board Report - April 2022 - March 2023 Receive and Note	CNO	13:15-13:25	183
	7.6	BREAK		13:25-13:35	
	7.7	Infection Prevention Control Annual Report Approve	HCSD/DIPC	13:35-13:45	223
8.	Well Led				256
	8.1	Annual Strategic Agreement Summary Receive and Note	COO	13:45-13:55	256
	8.2	Trust Strategy Update Approve	DTP/DCEO	13:55-14:05	284
	8.3	Board Assurance Framework and Corporate Risk Register Receive and Note	DCG	14:05-14:15	306
	8.4	Fit and Proper Persons Test for Board Members Receive and Note	DCG	14:15-14:20	345
9.	Compliance Issues				
10.	Any other business notified in Advance				
11.	Date and time of Next Meeting - 11.30am, Wednesday 25 October 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

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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 26 JULY 2023

Present:	Sir Richard Ibbotson	Chairman
	Mrs Liz Davenport	Chief Executive Officer
	Professor C Balch	Non-Executive Director
	Mr M Brice	Interim Chief Finance Officer
	Mr R Crompton	Non-Executive Director/Vice Chairman
	Mr I Currie	Chief Medical Officer
	Ms A Jones	Director of Transformation and Partnerships
	Ms D Kelly	Chief Nurse
	Mrs E Long	Director of Corporate Governance and Trust Company Secretary
	Mrs J Lyttle	Non Executive Director (left for item 141/07/23)
	Mr P Richards	Non-Executive Director
	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
In attendance:	Mrs J Bassett	Director of Midwifery and Gynaecology
	Mrs V Browning	Governor
	Mrs S Byrne	Board Secretary
	Mr J Cutting	Associate Director of Nursing, Devon Partnership Trust
	Mr R Fisher	Podiatrist
	Mrs A Hall	Governor
	Mr D Hazel	Patient
	Mr P Milford	Governor
	Mrs H Milner	Governor
	Mr A Postlethwaite	Governor
	Mrs A Ramon	Governor
	Mrs J Thomas	Governor

130/07/23 **Welcome and Introductions**

The Chairman welcomed all those in attendance to the meeting.

Preliminary Matters

131/07/23 **Apologies for Absence and Quoracy**

The Board noted apologies of absence from Dr K Lissett, Mrs V Matthews and Dr J Watson.

132/07/23 **Declarations of Interest**

No declarations of interest were received.

133/07/23 **Patient Story**

Ms Kelly introduced Mr Hazel, a regular patient of the Podiatry Team and Mr Rob Fisher, Podiatrist, to the Board. Mr Hazel spoke to the Board about the excellent management of care he received from a mutli-disciplinary team to bring him back to mobility and good health.

He explained that initially he contacted the GP Surgery and a GP called him out of hours, prescribed him antibiotics and referred him to the Podiatry team at Castle Circus. After two more infections, it had become apparent to his Podiatrist, Ruth Gornall that further investigations were required; he was referred for an x-ray which did not reveal anything. Therefore, casts were prescribed initially, a slipper cast and secondly, a pressure cast. Upon removal of the latter cast, the wound had healed.

He continued to receive treatment for his varicose veins, which were well managed. He informed the Board his feet do swell and he found it difficult to get appropriate footwear and therefore, he was incredibly grateful when Mr Ian Parks, the Trust's Orthotist, kindly agreed to measure him for a hand made pair of shoes to his specification. The personalised and continued care from a range of professionals was commended.

The Chairman thanked Mr Hazel for describing his care and asked if there was any disconnect in the pathways he had utilised noting the multiple teams involved. Mr Hazel said there was no disconnect and that he was grateful that he only had to tell his story once. He believed the service he received was brilliant and commended Ruth Gornall's calm, easy, professional approach.

Mrs Davenport commended the acknowledged importance of timely decision making and intervention coupled with the willingness of staff to go above and beyond; enabling Mr Hazel to return to the quality of life he expected and in particular, be able to go walking.

Mr Scott explained the Diabetic Foot Team had received awards for their work and their approach to MDT's which was considered exceptional as they ask patient's to be in attendance, which was learning that should be shared.

The Board received and noted the patient story.

134/07/23 **Board Corporate Objectives**

The Board received and noted the Board Corporate Objectives.

For Approval

135/07/23 **Unconfirmed Minutes of the Meeting held on the 28 June 2023 and Outstanding Actions**

The Board approved the minutes of the meeting held on 28 June 2023 pending the following amendments:

From:
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.*
To:
Mrs Lyttle asked for the Board to note: The Nursery monies would *be re-alligned*; and, the League of Friends monies would *come outside of the charitable funds budget.*

The Board approved the minutes of the meeting held on

Consent Agenda (Pre-notified questions)

136/07/23 **Committee Reports**

The Board received and noted the Committee Reports.

Reports from the Executive Directors (for noting)

137/07/23 **Chief Operating Officer's Report - July 2023**

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

138/07/23 **Workplace Team Strategic Performance Update**

The Board received and noted the Workplace Team Strategic Performance Update.

Reports of the Chairman and Chief Executive

139/07/23 **Report of the Chairman**

The Chairman verbally briefed the Board on the following:

- Mr Mark Brice, newly appointed Interim Chief Finance Officer, was welcomed to his inaugural board meeting.
- Following a vigorous interview process Mr Arun Chandran had fomally accepted the post of substantive Chief Operating Officer.
- He had the pleasure of visiting and presenting Torquay District Nursing Team with the Chairman's Our People Award award, at Union House.
- The NHS was 75 years old on 5 July 2023 and the BBC had selected to broadcast from the Trust, it was well received and there had been positive feedback.
- CQC conducted a well led inspection of the Trust on 12 - 13 July 2023. The report was expected in draft during September 2023.
- The Non-Executive Director recruitment process was underway and being led by Odgers Berndtson as part of a two stage NED recruitment process, with the previous recruitment taking place in 2022.
- The Trust had received it's Veteran's Covenant Health Care Alliance accreditation to improve care for the armed forces community.

The Board received and noted the report of the Chairman.

140/07/23 **Chief Executive's Report**

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

Interim Chief Finance Officer: As noted by the Chairman, Mr Mark Brice was welcomed to his inaugural Board meeting.

CQC Well Led Inspection: The inspection took place during 12-13 July 2023 and verbal feedback was received in the afternoon of 13 July 2023 which enabled the Trust, based on high level messages to enact an improvement plan together with stakeholders and staff.

Ms Kelly made the Board aware of the following verbal feedback:

- The unity of the Board and strength of leadership and calibre of the current people and new appointments within team was recognised as the right set of skills and experience to undertake the transformation programme.
- The embedding of the clinical governance arrangements and care group structure was seen as positive.
- There was a need to ensure the Strategies of the Trust and Devon ICS aligned but, the Trust were recognised as strong system leaders.
- The staff experienced challenges with IT, infrastructure and the Equality, Diversity and Inclusion agenda.
- Staff had described how they felt heard but a response or reassurance was not always communicated. Significant pieces of work were being undertaken in respect of the challenges staff identified.
- A draft CQC Report was expected at the end of August, beginning of September 2023 once the data had been triangulate, with publication likely to happen in October 2023.

Theatre expansion and Radiology CT Scanner: Work had begun on the two new modular theatres as well as the preoperative assessment and recovery rooms on the Torbay Hospital site; and the new extension for the replacement of the Radiothepray CT scanner had been completed, this work was aligned to the Building a Brighter Future Programme and would support the transformation of services and the Trust's strategy.

Electronic Patient Record (EPR): Following Board approval, on the 19 July 2023 the National Team recommended the approval of the Trust's Digital Outline Business Case. The Trust would now be moving at pace to tender. With recruitment to EPR team having commenced. The Council of Governors would be briefed on 2 August 2023.

NHS New Homes Alliance: Mrs Caroline Cozens was commended for her work to support access to affordable housing in the area, it was recognised as an important initiative to enable recruitment and retention.

Industrial Action: The action had, had an impact on flow throughout the hospital and the Operating Plan was under review.
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The Board received and noted the report of the Chief Executive.

Safe Quality Care and Best Experience

141/07/23 **Integrated Performance Report (IPR): Month 3 2022/23 (June 2023 data)**

Dr Westwood presented the Integrated Performance Report for Month 3 2022/23, as circulated, and asked the Board to note:

The System Oversight Framework (SOF) had been renamed to the National Operating Framework (NOF) and the Trust remained in level 4 scrutiny and oversight.

Quality

- One incident severe harm; and one death were reported due to falls. Evidence was currently being gathered.
- The Stroke pathway had reported an improved performance against the Sentinel trajectory despite significant challenges.
- The Maternity Department had retained it's 10/10 score in respect of Clinical Negligence Scheme for Trusts.

Workforce

- Increased rigour over decision making was being implemented to reduce the level of bank and agency staff; and all interim, bank and agency spend was being reviewed.
- Triangulation of waiting list times and key recruitment was being undertaken.

- The ESR system had been commissioned to be re-built in August therefore it was likely there would be less staffing data from September 2023 but, it would place reporting in a stronger position going forward.

Prof. Balch noted half of the yearly Bank and Agency budget had been spent in the first three months of the year and asked for understanding where the costs were being incurred. Mr Brice confirmed that £600k of bank and agency spend had been linked to Industrial Action in the current year. Dr Westwood informed the Board there were plans in place for Procurement to support the Temporary Staffing Team to ensure value for money. She confirmed all non-clinical bank, agency or interim posts had been reviewed and managers had been asked for end dates. Mr Brice acknowledged the importance of strong grip and control around the Vacancy Panel but explained risk appetite needed to be established. This was acknowledged, noting the need to improve the workforce spend position whilst concurrently improving operational performance in line with NOF4 targets.

Mr Richards asked what work was being undertaken to make it attractive for Nurses to join the Trust on substantive contracts. Mrs Kelly explained last year, with the support of the workforce, the Trust ceased reliance on Thornberry and Tier 3 Agency Workers and controls were put in place to support budget holders to understand their budget and the recruitment process. This provided the Trust with a £1.6m recurrent saving. A workforce summit was to take place between the Senior Nursing Team and People Team with the aim of triangulating data and delivering further savings for 2023/24.

Performance

- The Trust's Urgent and Emergency Care (UEC) performance was 64.6% against a trajectory of 65%, with work on going to improve the position.
- Ambulance handover had improved in June, however, the percentage of patients waiting over 15 minutes remained unchanged at 72%.
- The Trust remained focus on early in the day discharges and 19.9% were achieved against a target of 33%.
- The 104 week wait target of zero was achieved at the end of June 2023.
- The 78 week wait list was 123 against a plan of 130.
- For cancer wait times the Trust was no longer in any tier and was now at position 90 of 122.

Mr Crompton noted that the Trust were at 40% of fracture neck and femur theatre access against a bar of 90% and challenged whether there was the opportunity for system collaboration to ensure better utilisation. Mr Currie confirmed that the Trust, along with others in the system, were optimising the use of The Nightingale and seeking opportunities to ensure there wasn't inequity to patient care.

Mr Currie explained the emergency neck and femur work placed pressure on the elective waiting list and mitigations had been put in place to split between emergency and elective work. At present The Nightingale was undertaking elective work, therefore protecting the acute theatres for emergency work, which was a more efficient model of care.

Mrs Davenport explained this was a strong example of a workforce issue having a material impact on capacity and the drivers were being triangulated. She said the

workforce issues needed to be considered by the Trust and system and addressed accordingly.

Mrs Jones informed the Board commitment had been received from the Local Care Partnerships to develop winter plans that supported the Trust and a report would come to the Board for assurance and oversight.

Mr Scott reminded the Board in the last 14 days the Trust had been on Opel 3, twice; Opel 2 once; and Opel 1 eleven times therefore the Trust was making improvements to ensure delivery of safe and calm care safe and this had been inpart due to the learning sought through Industrial Action performance.

Finance

- The financial position for month three was favourable to plan.
- There were continued cost pressures due to Industrial Action.
- Pay had been identified as the Trust's and the System's biggest expenditure and work was underway to reduce interim, bank and agency spend.
- 166 Cost Improvement Plans had been identified and 88 schemes had been assessed as achievable, the generated savings were circa £25m and were being scrutinised by Devon ICS.

As Chair of Finance Performance and Digital Committee Mr Crompton wished to draw the Boards attention to the risk that £10m of CIP savings for the Trust's share of system wide schemes with a route to cash was yet to be identified. Mr Brice confirmed this had been escalated to the Devon ICS Financial Planning Board and himself and Mary Ridout were meeting with Deloitte to identify routes to cash.

Mrs Davenport said the conversation reflected the complexity of delivering an operating plan with key requirements for the Trust and as part of the System. She confirmed she would be meeting together with the System CEO's on Wednesday 2 August 2023 where she was aware these questions would be raised.

The Board received and noted the Integrated Performance Report (IPR): Month 3 2022/23 (June 2023 data)

142/07/23 **July 2023 Mortality Safety Scorecard**

Mr Currie presented the July 2023 Mortality Safety Scorecard, as circulated. He confirmed:

- The Hospital Standardised Mortality Rate (HSMR) had come down, with the support of the coding team, in March 2023 and this brought the Trust in line with similar sized Trusts.
- Improvements had been made to the Policy from learning from deaths of patients with Learning Disabilities or Autism.

The Board received and noted the July 2023 Mortality Safety Scorecard.

143/07/23 **Report of the Guardian of Safe Working Hours - Doctors and Dentists in Training**

Mr Currie presented the Report of the Guardian of Safe Working Hours - Doctors and Dentists in Training, produced by Dr Claire Blandford, as circulated.

He highlighted to the Board that due to this being the year end report for the Junior Doctor cycle it would be realistic to see less exception reports and this was likely to change in the next quarter when the new Junior Doctor's would have commenced in post.

The Board received and note the Report of the Guardian of Safe Working Hours - Doctors and Dentists in Training

144/07/23 **Maternity Governance Safety Report**

Mrs Bassett presented the Maternity Governance Safety Report, as circulated, to the Board. She asked the Board to note:

- The Devon system had come together to develop a Devon provider Neonatal Strategy based on a single delivery plan.
- The verbal feedback received from the Ockenden Insights visit had been positive with guidance offered on strengthening the system approach.
- The department was participating in a national programme of quadrompherate learning and a score culture survey in November 2023.
- A full service consultation had been undertaken and models of care and shift patterns had been reviewed which would come into effect by January 2024.
- The department had received a successful Clinical Negligence Scheme for Trusts (CNST)score of 10/10 but, there was greater risk in year 5 due to the need to invest in the Obstetric Consultant workforce.
- The Saving Babies Lives care bundle required a 52 point data submission, which added pressure to an already pressurised service, which would require investment from the CNST Incentive Scheme rebate.

As Chair of the Quality Assurance Committee Mrs Lyttle would support the recommendation for additional investment into the Maternity Department. Mrs Davenport confirmed the Executive team were aware of the Gynaecologist and Obstetric Consultant risk and were developing a plan with support of the clinical team.

The Board received and noted the Maternity Governance Safety Report

145/07/23 **Complaints, Feedback and Engagement Service Annual Report 2022/23**

Mrs Kelly presented the Complaints, Feedback and Engagement Service Annual Report 2022/23, as circulated. She informed the Board:

- A significant amount of informal concerns had been received but formal complaints remained static.
- 95% of complaints were responded to in three working days; 74% responded to in six weeks; with some referred to the Ombudsman.
- A new compact with patients was being created through the formal complaints process part of which would ensure the Feedback and Engagement Team were more visable to patients with a Patient Contact Centre being on site. Visability should reduce the stress and anxiety for patients.

Mrs Walker McAllister asked for a breakdown of the complaint cases that went to the Health Ombudsman and the Health and Social Care Ombudsmian to consider inequity. **ACTION: Ms Kelly**

Mrs Lyttle noted the Friends and Family Test feedback had increased and said this was likely to correlate to more informal complaints.

Mrs Davenport supported the need for consideration to be given to how the Trust engaged with service users. Ms Kelly explained the QR code feedback system had been successful but, counselled feedback need to be given at the appropriate point of care for it to be captured accurately and effectively.

The Board received and noted the Complaints, Feedback and Engagement Service Annual Report 2022/23.

Valuing our Workforce

146/07/23 **Creating and Embedding a Culture of Inclusion**

Dr Westwood presented the inaugural Creating and Embedding a Culture of Inclusion Report as circulated. She explained this had been brought together using evidence from the WRES Report, DES Report, Staff Survey and CQC findings. With the aim of creating a culture where people feel safe, supported and healthy. She said learning had been sought from the Mersey Trust and aligned to the verbal feedback from the CQC in respect of the Trust's Equality, Diversity and Inclusion position.

She confirmed a mandatory EDI training package would be put in place for all staff as part of the their induction and mandatory training.

To measure the EDI objective the Board agreed it would be placed on the Board Assurance Framework. **ACTION: Dr Westwood**

She confirmed the EDI Board Charter would be placed on the Board Development Agenda. **ACTION: Dr Westwood**

However, there were risks to delivery due to limited resource within her Senior Leadership Team but, she assured the Board she was not looking to grow the team but reshape.

Mr Crompton asked how the Trust were preparing people to have difficult conversations skilfully, Dr Westwood explained the EDI work dove tailed with the Leadership and Management Framework, which would support conversation.

Prof. Balch counselled that one simple message, would be more likely to resonate with people.

Mr Sutton said the culture of Inclusion needed to also be embedded within community settings and those who work remotely.

Mrs Davenport said this needed to be a living document to be engaged with as the Trust's cultural approach evolves and stories of change begin to be heard.

The Chariman was in support of the agenda and agreed for the Creating and Embedding a Culture of Inclusion report to be quarterly.

The Board approved the creating and embedding a culture of inclusion agenda.

Well Led

147/07/23 **Medical Appraisal and Revalidation Board Report**

Mr Currie presented the annual Medical Appraisal and Revalidation Board Report, as circulated. He highlighted:

- All doctors were required to revalidate with the GMC every five years.
- Due to a pause to the process during the pandemic 250 of 290 doctors had their first post pandemic annual appraisal in the last year.
- Dr Sykes had strengthened the revalidation team; and had appointed Dr Green to support.
- The Responsible Officer for Medical Appraisal and Revalidation was now Dr Kate Lissett, Interim CMO.
- There was a need to train appraisers to ensure they were evenly distributed across the Trust. He confirmed some retired medics had agreed to come back as appraisers through the bank.

The Board approved the Medical Appraisal and Revalidation Board Report

148/07/23 **Board Assurance Framework and Corporate Risk Register**

Mrs Long presented the Board Assurance Framework and Corporate Risk Register, as circulated to the Board. She noted the following:

- With regard to digital and quality risks noted that the EPR would allow the Trust to mitigate and manage risks as it would create prompts for specific tasks.
- The overdue risks on the Corporate Risk Register would be reviewed at Risk Group on 8 August 2023.
- Ms Kelly had agreed to update the Quality BAF objective.
- Ms Jones would update the digital risk as the EPR OBC had now been approved.

The Board received and noted the Board Assurance Framework and Corporate Risk Register.

149/07/23 **Compliance Issues**

150/07/23 **Any other business notified in advance**

151/07/23 **Date and Time of Next Meeting:**

11.30 am, Wednesday 27 September 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. 26.07.23 Lottie raised a significant amount and LoF. Sociallising the design and in the current climate confident we have the right design to build up the funding pot. Thank Nikki, Consultant Intesivist, advocated and leading this. Nikki Freeman	
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. 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. 26.07.23	26.04.23

			Mrs Davenport confirmed the Board to Board would take place in Autumn 2023.	
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. 26.07.23 Dr Lissett confirmed the action had been completed. 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 26.07.23 Naomi Chapman had acknowledged the request and there was commitment to follow up with a formal plan.	31.05.23
145/07/23	Ms Kelly to provide Ms Walker-McAllister a breakdown of the complaint cases that went to the Health Ombudsman and the Health and Social Care Ombudsman to consider inequity.	Ms Kelly		26.07.23
146/07/23	EDI objective to be placed on the BAF	Dr Westwood		26.07.23
147/07/23	EDI Charter to be placed on the Board Development Agenda	Dr Westwood	Mrs Byrne placed the item on the Board Development workplan	26.07.23

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Report to the Trust Board of Directors			
Report title: Committee Chair Reports			Meeting date: 27 September 2023
Report appendix	Committee Chairs' Report		
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 attached report provides the Board with a summary of the discussions held at Board sub-committees in the reporting period. To enable any issues to be easily highlighted, the report is divided into the following categories: • Alert • Advise • Assure • Risk • Celebrating Outstanding 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 Center>TSDFT Board and Sub-Committee Minutes		
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**		

Chairs' Report
Board Sub-Committees
27 September 2023

Torbay and South Devon NHS Foundation Trust

	Charitable Funds Committee 13th September 2023	BBF Committee 20th September	TP Management Committee 21st September
ALERT: Alert to matters that need the Board's attention or action, eg an area of non-compliance, safety or a threat to the Trust's Strategy	No alerts need to be brought to the board's attention	• Recommend Board approval of OBC for NHP Site Enabling • Note progress with Trust Strategy and need to tweak and refresh.	• The Sale of TP is progressing the timetable is tight, but everyone remains focussed • Operationally TP has missed earned revenue targets for passed 2 months
ADVISE: Advise the Board of areas subject to ongoing monitoring or development or where there is negative assurance	The Committee: • approved the 2022/23 annual report and accounts • agreed that the nursery should be accounted for within trust operational budgets rather than within charitable funds following approval by the Trust Governance Group • agreed to adjustments to the Charitable Funds Investment Policy, including changes to benchmark • agreed a 3 quotation process be started to appoint a new Investment Manager	• Ongoing work on NHP National Team data gathering exercise • Timetable for submission, review/approval of Site Enabling OBC • Manpower and physical resources to ensure successful implementation of EPR.	The Committee • Agreed the revised ToR of the re-formed Committee • Did a deep dive into the reasons for the missed targets and explored plans to hit year end targets/forecast with misses in Aug/Sept and October (prediction) • TP Management have a plan that they talked the committee through
ASSURE: Inform the Board where positive assurance has been received	The committee received full assurance that internal controls are in place to	• EPR procurement process underway and revised national funding profile agreed • Confirmation of additional seed funding for work on Site Enabling FBC	• Positive assurance given in terms of quality controls • Mgmt forecast Y/E EBITDA to be slightly above budget
RISK: Advise the Board which risks were discussed and any new risks identified	No new risks were identified	• Timetable for necessary approvals and procurement of site enabling works and subsequent main build • Funding allocation to enable delivery of Trust's preferred way forward/clinical model • Clinical engagement in transformation programmes given pressures on workforce	• • Any delays in change parts, PCIP or associated validation will push all USA activity on lines into 2024. Current timelines must be maintained. • Availability of line time for HSVL between Nov – end Q1/Q2 –incentive program needed to deliver extra slots required.
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding	The committee celebrated the success of the new fundraising strategy and the positive progress being made by the newly appointed fundraising manager	• Delivery of Site Enabling OBC demonstrating strong team working and individual commitment	The committee celebrated the success of some significant new business wins and a number of bids reaching final stages of acceptance It was noted that delivery is contingent on FDA compliance
To note: Both FPDC and QAC met on Monday 25th September, however due to the timing of the Committees it was too late to include feedback in this paper. Committees which have not met in the reporting period: Audit and Risk Committee, People Committee, Ethics Committee			

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report			Meeting date: 27 September 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			

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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. However, there has been deterioration in some key metrics in August which have been impacted by continuation of industrial action and outbreaks of infections resulting in reduced bed capacity.

3.0 Urgent & Emergency Care (UEC) update

August saw 10,245 attendances for the integrated care organization (ICO). This was an average of 330 patients per day. This was the second consecutive month of 10,000 plus attendances and the second busiest month in the past three years. Compared to August 2022 the attendance across the ICO has increased by 6.1% and emergency admissions by 26.5%.

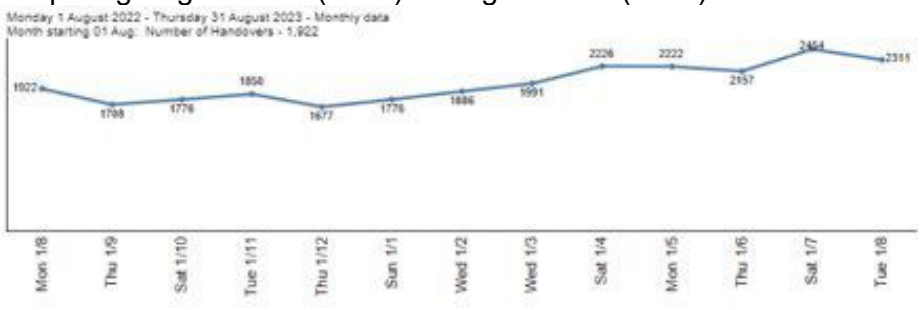
Performance was on trajectory for the National Oversight Framework 4 (NOF4) recovery target of 68% at 67.90%. The increase in performance has been achieved prior to the planned reconfiguration of the emergency department designed to create additional non-admitted capacity. That change was implemented on 20th September and supports the step up in the NOF4 recovery trajectory to 72%.

Comparison to August 2022 remains favourable with an increase in all types 4 hour performance of 14% and of Type 1 (ED) attendance of 37%. Moreover, our performance against 12 hour delays has improved by 10.7% and the number of patients seen within 60 minutes of arrival by over 89%.

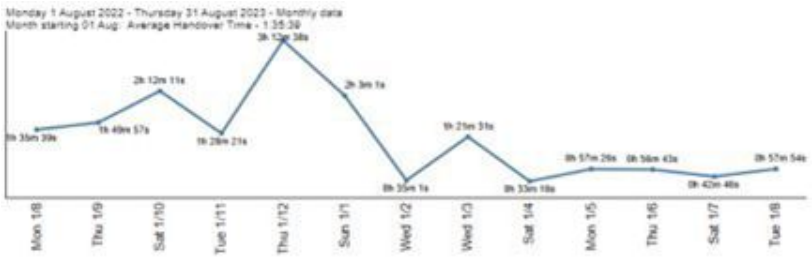
3.1 Ambulance Handovers

Ambulance handover delays increased in August compared to the previous month with 1707 arrivals over 15 minutes.

Despite the increase the overall direction of travel for the Trust is one of improvement against a backdrop of increased demand. Ambulance handovers have risen 20% comparing August 2022 (1922) to August 2023 (2311).



Despite this increase in activity, the average time lost per ambulance to handover has decreased from 1hr 35min (including the 15 mins) in August 2022 to 57min in August 2023.



3.2 Inpatient Flow

Infection outbreak issues contributed to flow performance with ward closures in August. A total of 532 bed days were lost due to closed beds as a result of Covid and Norovirus infections; an average of over 25 beds closed each day.

The impact of a higher number of closed beds can be seen in the August discharge date where we had 1,680 acute adult ward discharges compared to 1,755 in July. However, thanks to the Ready to Go unit we saw an improvement in the time of discharges; 362 patients pre-noon (21.6%) and 1,186 pre-5pm (70.6%).

We launched our 'ready to go' unit on 24 July. The ward has been working very hard on transforming into a 'ready to go' unit, and we are already seeing great results and positive change. In August McCallum ward discharged 106 patients. 65.1% of the patients were discharged by noon and 91.5% by 5pm.

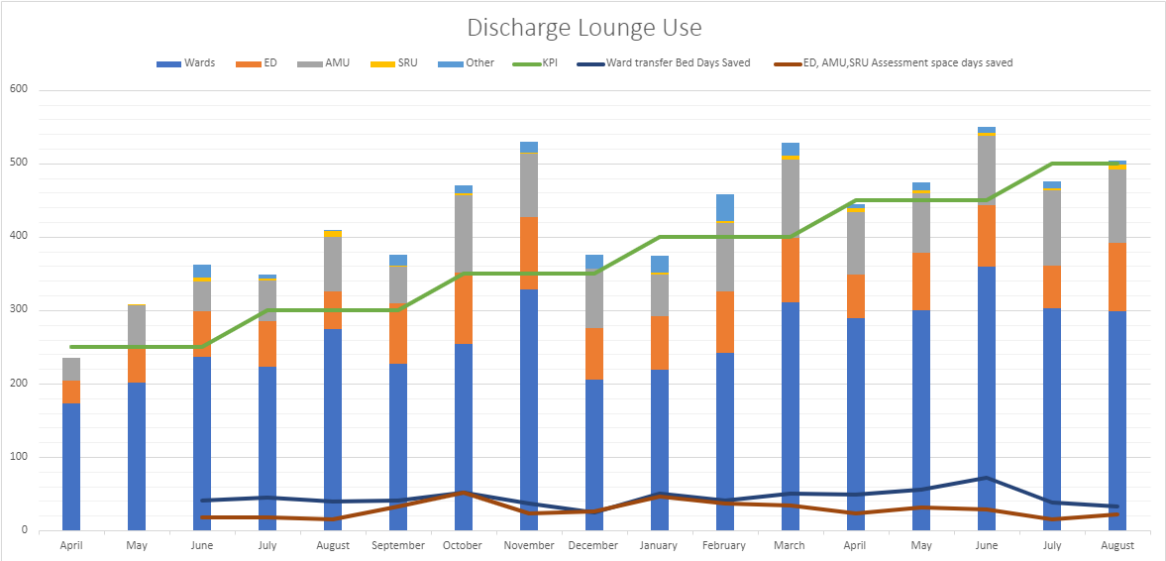
Tuesday 1 August 2023 - Thursday 31 August 2023

The number of discharges in this period is above or below the baseline.
Weekday target is 71%; Weekend target is 28%.
Pre-Noon target is 33%; Pre-5pm target is 75%.

(Baseline: Saturday 1 July 2023 - Monday 31 July 2023)

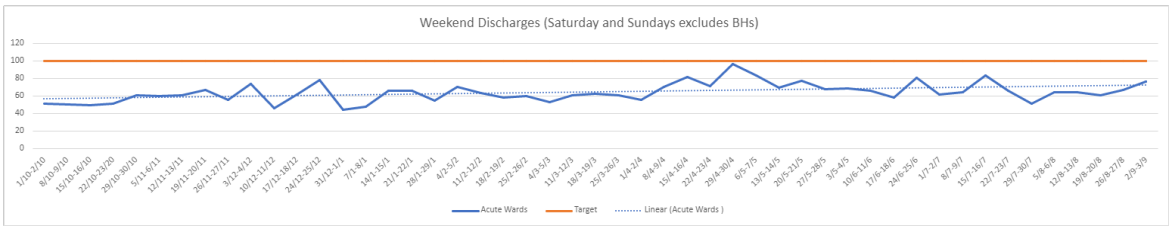
Ward Name	Total	Discharges	Transfers to a Community Hospital	Transfers to the Discharge Lounge	Deaths	Pathway 0	Pathway 1	Pathway 2	Pathway 3	Average LoS (Days)	# Pre Noon	% Pre Noon	# Pre 5pm	% Pre 5pm	# Weekday	% Weekday	# Weekend	% Weekend
AINSLIE	106	81	6	19	0	84	6	15	1	5.04	18	17.0%	70	66.0%	91	85.8%	15	14.2%
ALLERTON	138	116	7	9	6	125	5	7	1	6.59	17	12.3%	92	66.7%	112	81.2%	26	18.8%
CHEETHAM HILL	81	50	9	17	5	40	28	10	3	7.93	19	23.5%	62	76.5%	71	87.7%	10	12.3%
CHEST PAIN UNIT	42	41	1	0	0	41	0	1	0		0	0.0%	24	57.1%	35	83.3%	7	16.7%
CORONARY CARE	39	36	0	0	3	39	0	0	0		6	15.4%	34	87.2%	27	69.2%	12	30.8%
CROMIE	149	131	3	12	3	141	2	4	2	5.01	21	14.1%	103	69.1%	123	82.6%	26	17.4%
DUNLOP	83	64	3	12	4	71	6	5	1	10.1	19	22.9%	63	75.9%	74	89.2%	9	10.8%
EAU4	236	153	11	68	4	209	9	16	2	2.7	54	22.9%	182	77.1%	194	82.2%	42	17.8%
ELLA ROWCROFT	71	59	3	7	2	54	5	10	2	6.06	20	28.2%	48	67.6%	65	91.5%	6	8.5%
FORREST	85	51	8	19	7	60	8	11	6	9.05	22	25.9%	52	61.2%	73	85.9%	12	14.1%
GEORGE EARLE	131	83	29	11	8	60	29	41	1	6.11	17	13.0%	72	55.0%	118	90.1%	13	9.9%
MCCALLUM	106	42	9	53	2	25	33	41	7	11.7	69	65.1%	97	91.5%	93	87.7%	13	12.3%
MIDGLEY	118	70	7	29	12	83	10	22	3	7.56	31	26.3%	90	76.3%	105	89.0%	13	11.0%
SIMPSON	71	34	0	28	9	52	4	14	1	8.92	20	28.2%	49	69.0%	61	85.9%	10	14.1%
TURNER	50	41	5	0	4	33	8	7	2		6	12.0%	26	52.0%	47	94.0%	3	6.0%
WARRINGTON	173	158	0	14	1	171	2	0	0	3.19	23	13.3%	122	70.5%	134	77.5%	39	22.5%
Grand Total	1,679	1,210	101	298	70	1,288	155	204	32	6.29	362	21.6%	1,186	70.6%	1,423	84.8%	256	15.2%

Beyond metrics, we have also been requesting feedback from all patients who have been on the unit. From the patient experience surveys provided, 70% of respondents have stated that they strongly agree/agree that have had more opportunities for the care they would like to receive on discharge, with several commenting on how "nice the ward" has been or how "lovely" staff are.



The discharge lounge (DCL) supports both our wards, ED, and assessment areas to generate capacity earlier. Total number of patients transferred to the discharge lounge for discharge/transfer last month has increased compared to the previous month. (504 patients) The lounge meeting the key performance indicator (KPI) of 500 patients. Of the 298 patients from our adult base wards, this generated 784 bed hours/32 bed days.

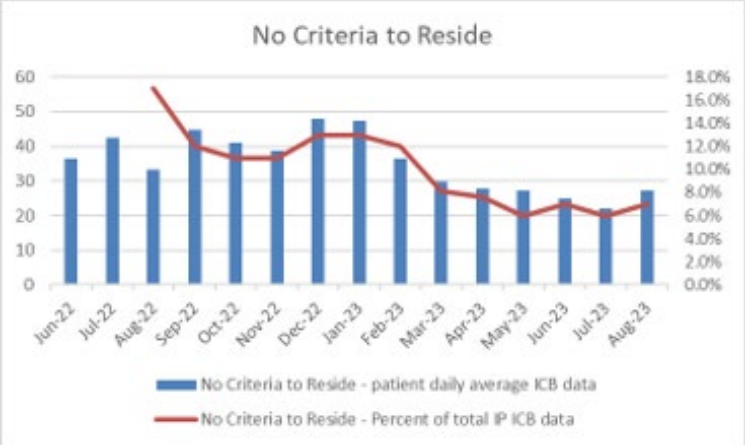
We know to support us to achieve 33% of discharges by noon, additional effort is needed to ensure that patients who could use the discharge lounge do so.



Weekend discharges continue to be below expectation. In August, on average we discharge 65 patients across the weekend which is 35 patients below the target. The flow and improvement group are working with teams to improve this. Part of this work includes changing the system we use to generate a working list of patients for our multidisciplinary team (MDT).

3.3 No Criteria to Reside

The average number of patients with No Criteria To Reside (NCTR) was 7.5% for August achieving the NOF4 trajectory of 7.5% in month however up from a position of 6% in July.



In addition to delays caused by infection outbreaks external processing changes have resulted in prolonged sourcing and approval of post-acute placements beyond Torbay.

As the "Ready to Go ward" continues to grow this is expected to impact on reducing NCTR further and reduce delays in Sept.

4.0 Cancer Demand

In August, Torbay and South Devon received 2,024 two-week wait referrals (2WW). This brings the year-to-date total to 9,199 which represents a 5.3% average growth across the Trust.

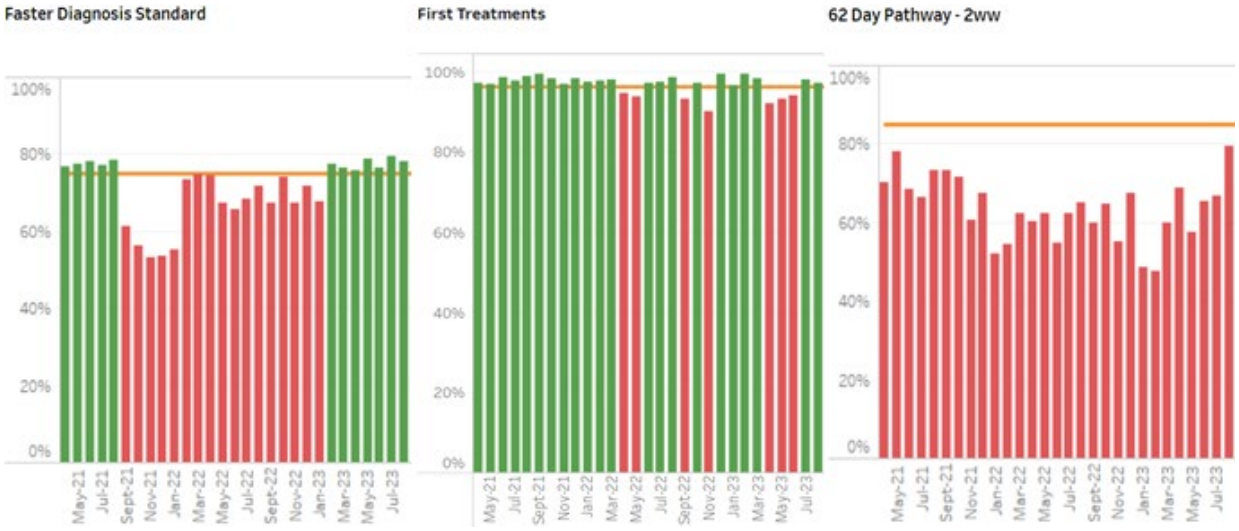
This sustained referral growth remains a challenge for a few of the high-volume tumour sites which have received above average growth.

Specialty	2022/23	2023/24	% change
Breast	1013	1211	19.5%
Gynae	708	800	13.0%
Urol	700	789	12.7%
Skin	3321	3638	9.5%
H&N	897	980	9.3%

April-August 2WW referrals received.

4.1 Cancer Performance

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



The Trust has achieved the 28-day Faster Diagnosis Standard since February, with August's preliminary position of 77.3%. Improvements across Colorectal and Urology have supported this change with reductions in endoscopy and biopsy times.

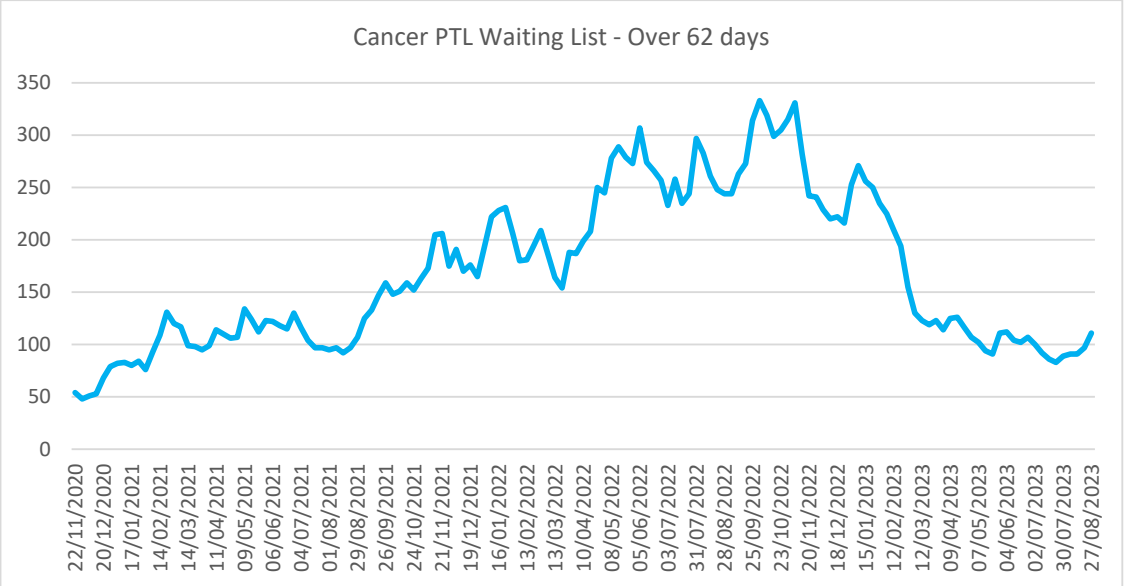
31-day performance is currently at 96.4% for August. There were seven breaches during the months, all attributable to Skin pathways. The capacity issues in Plastic Surgery remain, which accounted for four breaches; the other three breaches were due to additional medical tests needed pre-treatment.

August was the highest performance against the 62-day standard since September 2020, with 78.7% of patients being treated within two months of referral. This reflects continued improvements in diagnosis times and the sustained position of the 62-day backlog.

Over 62-day Backlog (Open Pathways)

As of 27 August 2023, the number of open pathways over 62-days was 111 and represents 6.5% of the total patient tracking list (PTL). There are only ten patients over 104 days.

This position places Torbay in the top 40 performing Trusts nationally and 2nd in the South West Region.



Outlook

A positive cancer performance position has been achieved in August with the achievement of the 28-day, 31-day and the improved 62-day metric. This progress stands as a testament to the unwavering commitment and tireless efforts of our dedicated teams, including clinical staff, nurses, allied health professionals (AHPs), and administrative personnel. Their resilience and dedication have been instrumental in delivering outstanding care to our patients.

The continued industrial action during July and August coupled with increased annual leave and patient availability over the summer presents a risk to performance in September. Early indications in September suggest we are maintaining performance at the current time.

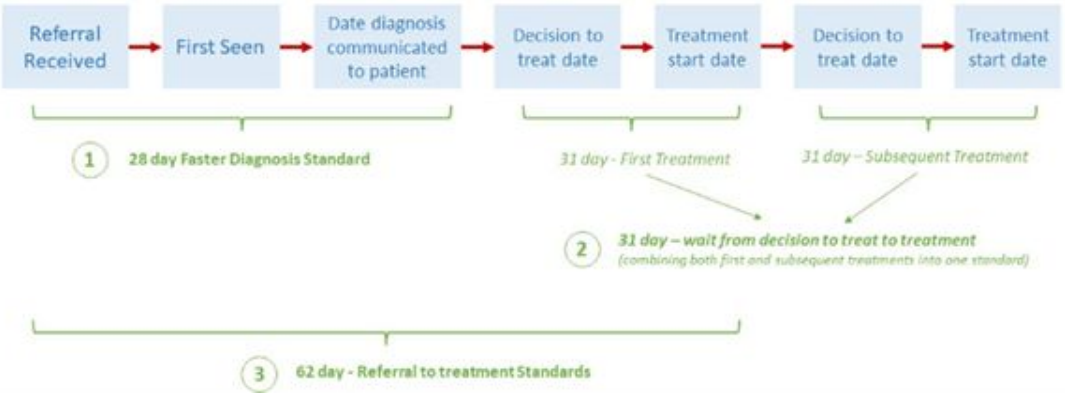
The coordinated strikes by both Junior Doctors and Consultants scheduled for September and October will undoubtedly create significant disruptions to elective care. Whilst we continue to prioritise cancer care a reduction in our clinical capacity is inevitable.

New Cancer Waiting Time standards – October 2023

In August, NHS England announced a change the national Cancer Waiting Time standards. This follows on from the 'clinically-led review of cancer standards', proposals from this review were published in spring 2022, these proposals are designed to simplify and modernise the existing nine cancer standards.

New cancer standards have been consolidated from 9 constitutional measures into 3.

- the 28 Day Faster Diagnosis Standard (75% target) and removal of the 14-day, two-week wait standard.
- one headline 62-day referral to treatment standard, combing previously suberate Consultant Upgrade and Screening standards (85%)
- one headline 31-day decision to treat to treatment standard (96%), combing the current First and Subsequent treatment standards.



These standards will be applicable from October 2023.

Performance expectations

Alongside the adjusted metrics, there are new performance expectations and 'Tier' criteria:

- The Faster Diagnosis Standard, 75%, is expected to be met by March 2023.
- 62-day backlog will continue to be monitored, and Trusts will be held to previously agreed March 2024 trajectories.
- On the new combined 62 days standard, there will be a target of reaching 70% by March 2024, with incremental improvement up to this point expected.

Torbay performance

Torbay and South Devon NHS Foundation Trust has completed initial analysis to review local data and produce an indication of how Torbay would be performing against the new adjusted standards.

- The Trust is currently on target to achieve the 62-day backlog target and is forecast to be meeting the 28-day Faster Diagnosis standard.
- The Trust has seen incremental improvement against the 62-day referral to treatment standard and is currently reporting 78.7% for August (subject to validation) against the March 24 target of 70%.

5.0 Referral to Treatment (RTT)

5.1 Long waits (August 2023)

- 104 weeks – The Trust has reported no 104 week waits since March 23.
- 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 31st March 2024.

		June Q1	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
78 week	Forecact Plan	130	130	130	111	92	73	65	35	19	0
	Actual	123	129	156							
	Total	-7	-1	26	0	0	0	0	0	0	0

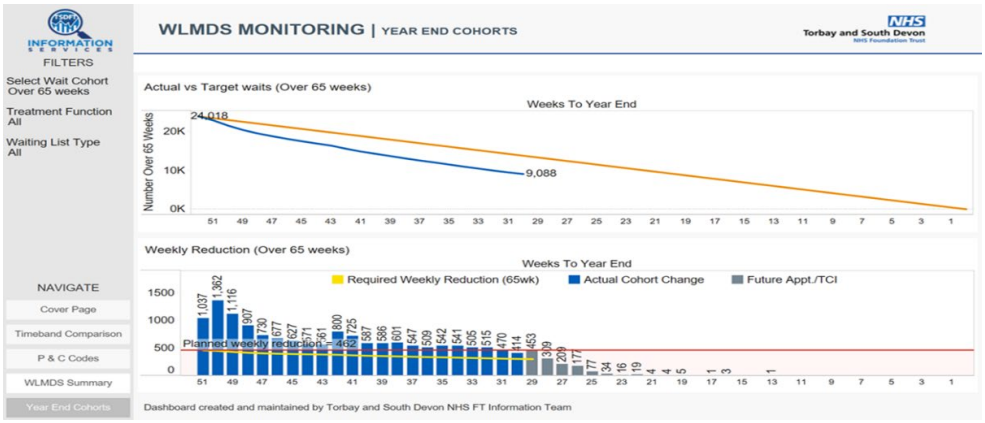
		June Q1	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
65 week	Forecast Plan	1312	1307	1387	1189	991	793	650	397	199	0
	Actual	1196	1169	1296							
	Variance	-116	-138	-91	0	0	0	0	0	0	0

Progress against these plans has been positive throughout Q1 and July but has now come under pressure from the impact of Industrial Action (IA).

August is the first month that our control totals have not been met for 78 weeks, missing the target by 26. The teams have co-ordinated their responses to industrial action very effectively given more than 700 patient episodes were lost in August as a result of the strikes. Our progress against our 65-week plans have remained positive.

Whilst our "in month" performance against actual breaches has been maintained, the loss of critical capacity in the first 6 months of the year due to industrial action has had a negative impact on our planned clearance of future long waiters; to date approximately 800 clock stops have been lost due to industrial action. If the same pattern of strikes are maintained to March 31 2024 we anticipate an impact of approximately 2,000 RTT clock stops to be lost in 2023/24.

Plans to mitigate this position are under review, this work will include the Devon ICB to ensure Devon-wide solutions can be explored for our most "at risk" services.



Our clearance of the 65-week cohort remains ahead of plan, this position will come under pressure if the current pattern of strike actions continues.

5.2 Protecting and Expanding Elective Services

- **First outpatient appointments**
  Booking rates for all but seven services are ahead of the rates required to achieve a first outpatient appointment for all 65-week cohort patients by 31 October.

Specialty & current risk	Mitigations	Remaining risk
ENT - 751 undated	Medinet Super Clinics	150
Gynae 527 undated	Medefer & Medac IS	Fully mitigated
Ophthalmology 613 undated	18 weeks. Extra inhouse. Glaucoma Locum	Fully mitigated
Oral Surgery 634 undated	Weekend clinics , convert Operating to OPA	200
T&O 648 undated (248 Hand & Wrist)	Glanso, extra inhouse. Mutual aid request	200 Hand & Wrist if Mutual aid not agreed

- Endocrinology and paediatrics are out of scope because of the high level of clock stops at first outpatient appointment. The focus for these two specialties will be full clearance of the cohort by 31st March 2024

Other measures to further mitigate this position including clinical and technical validation which will continue to be explored alongside leveraging the Medefer care model to other at-risk specialties.

- **Outpatient Follow-ups**

The Board receives an Integrated Performance Report (IPR) outlining performance against RTT measures. In July the measure of follow ups against 19/20 activities was minus 1.4% against a March 2024 target of minus 25%. Performance against this metric is reported to the Trust Management Group and escalated through the executive to the Finance, Performance and Digital Committee.

The key enabler to achieving 25% is using Model Hospital and GIRFT guidance alongside Royal College guidance for supporting pathway specific recommendations to reduce Consultant : Consultant variation. This will focus on 2 key things –

- Earlier appropriate discharge to GP and
- early appropriate discharge to PIFU

The Executive Team have agreed to focus Transformation activities to engage and implement the actions within the GIRFT Handbooks.

- **Monthly Validation:**

Our Data Quality index has improved by 34% between Feb-23 and Jul-23 and is based on LUNA reports.

All the LUNA query lines are reviewed monthly and reported to the Planned Care System Director and included in the weekly Tier 1 review meetings.
We have engaged with an external validation partner 'Xylem' who have delivered the following technical validation program:

- All Follow-up Patients who have had at least one attendance in the potential 52-week cohort (9,097 pathways) - process repeated 10 weeks later to include patients who had subsequently attended (8,582 pathways);
- Potential duplicates from LUNA (1,310 pathways);
- DQ stage from the Patient Target List (PTL) 'Patients with no future events' (724 pathways);
- The top longest waiters without a review status (1,000 pathways).

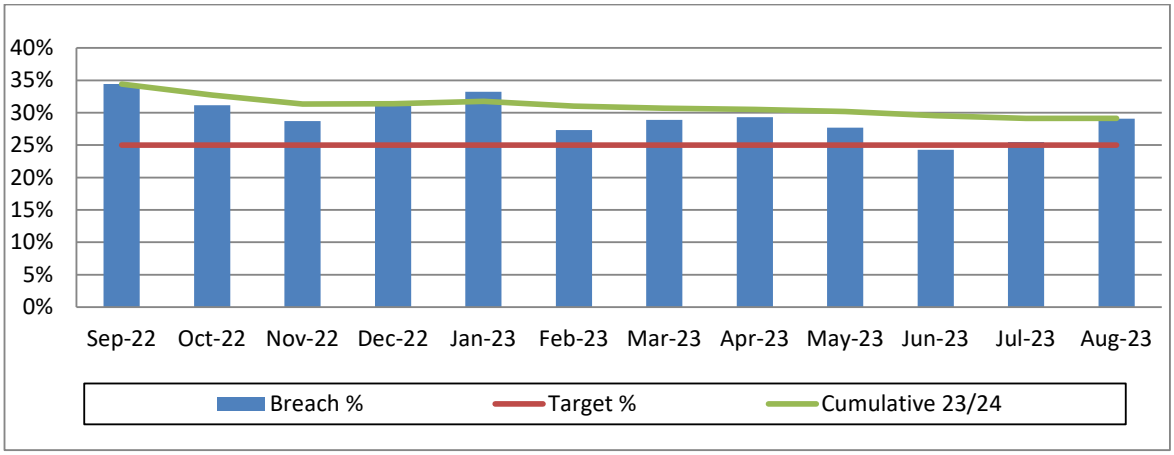
The current position is that 44% of current incomplete pathways have been validated.

We are required to validate a minimum of 90% of patients waiting longer than 12 weeks in a 12-week cycle. A combination of patient contact, technical and clinical validation is currently delivering 57% against the target of 90%. This is the highest level currently within the South West Region. In conjunction with NHS England, we are exploring the use of digital validation platforms to improve our position to the required 90% target.

NHS England Support:
We continue to work closely with Michael Wilson and the NHS England support team and have recently successfully bid for funding (£80K) from the 'Further : Faster' program. This funding will be used to create more program management and operational capacity.

6.0 Diagnostics Performance

Our diagnostic performance has worsened in August. The Trust reported 29.10% of patients waiting longer than six weeks against the end of August target of 25%.



The drivers for our August position are the reduction in capacity due to industrial action.

- MRI remains a challenge with a worsening position of 35% in August against a performance of 30% in July.
- CT performance has deteriorated from 7% in July to 11% in August but remains in target. Non-obstetric ultrasound has worsened from 17% in July to 20% in August but also remains in target.

Echocardiology (July 18%) is breaching target in August at 27% and colonoscopy (69%), flexi sig (63%), cystoscopy (31%) and gastroscopy (52%) remain in a breached position in August.

DM01 Forecast – March 2024, target 15%
The overall trust DM01 prediction is 14% by end of March-24 against a 15% target. However, this does not currently factor in capacity lost owing to industrial action – work will continue to include this into the future forecasting.

	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-2
Total waiting list	7052	7009	6978	6971	6931	6896	6870	6850
>6weeks	1852	1829	1813	1830	1657	1456	1226	969
	26%	26%	26%	26%	24%	21%	18%	14%

7. Children and Family Health Devon (CFHD)

7.1 Performance

As CFHD services are not consultant-led the waiting times for the Care Group are 'non-reportable' RTT. However, monitoring of these waits and achievement of waiting time reduction remains a priority.

7.2 CAMHS services

Children and Adult Mental Health Services are delivered by our partners in Devon Partnership Trust as part of the Alliance model.

Services are currently working to improve data capture and quality to ensure we are recording all clinical contacts effectively.

Considerable work has been undertaken to improve data capture and the 2023/24 trajectory shows that the service will exceed the national target.

8.0 Families and Communities Care Group Update

8.1 Child Health / Paediatrics

There have been a number of projects underway over recent months with the aim of improving quality and safety, making services more sustainable and meeting our financial envelope. These include:

- Blue star babies – process confirmed for the preschool pathway and information for parents/carers updated to reflect the pathway and support options.
- Kidzmed – Kidzmed boxes and communications materials (internal and external) developed to begin delivering Kidzmed training sessions to children and young people to teach them in how to swallow pills.
- Eating disorders – in hours and out of hours pathways confirmed.
- Discharge – CPS (Care Plan Summary) pathways developed, and recent CPS completion has improved significantly.
- Paediatric admin improvement project initiated, focusing on CPS completion and ward clerk processes initially.
- Rheumatology – Patient booklet reviewed and updated.
- Comms – good news stories shared with Trust Comms team and child health improvement work is likely to feature in September's Trust Talk.
- Endocrinology – pathway for growth hormones drafted and currently being reviewed by colleagues.
- Short stay paediatric assessment unit (SSPAU) – exploratory meetings underway with stakeholders and extraordinary meeting planned for 13 September with the acute pathway group about SSPAU's function.
- Child health culture survey carried out and analysis of findings underway.
- The consultant rota has been re-worked to eliminate gaps and the need for a locum while we continue to try and recruit to a vacant post.
- Tier 1 & 2 rotas have been re-designed and implemented with the aim of reducing gaps and increasing training opportunities for doctors.

Child health has supported international medical graduates over the last year. One medical support worker has completed her licensing exam and secured a fixed term post with us. Another international medical graduate who was in a Trust post has now gone into paediatric training and we are hoping to appoint a third doctor on a permanent basis into a specialty role.

The continued industrial action has had the following impact since April:

2 x cardiac clinics
1 x community registrar clinic
1 x Epilepsy clinic
6 x General clinic
6 x Allergy clinic.

The community clinic would have seen patients over 65 weeks. The allergy clinic is seeing people over a 52 week wait. Cardiac wait is being maintained, but this is causing delays in patients being followed up at a scheduled time. However, the number of clinics lost has been fairly minimal for paediatrics and we have continued to run many of our clinics during strike periods.

8.2 Children's Torbay 0-19 Service

A recent joint Ofsted/CQC thematic review to Torbay family hubs was well received. The inspectors commented on how impressed they were by the dedication and commitment of everyone they spoke to. During the visit they spoke with parents and our 0-19 team and maternity staff delivering a variety of programmes within the hubs.
Our aim with family hubs is to provide seamless support for families with voluntary, community, health and council working together to complement services so that families have access to the right service, from the right organisation, at the right time.
The range of help and information on offer through the hubs include community activities, help with baby feeding, emotional wellbeing, physical and mental health, early years and education, parenting support, housing and debt advice, youth activities and domestic abuse support, as well as services run by charities.

We know that the families who may need our help the most, will not find it easy to explain what they need or ask for help. That's why feedback on the new hubs will be vital so we know what is and what isn't working well for families.

As with all our work around children and families, we have formed the family hub and Start for Life parent carer panel (PCP) to ensure that parents and carers voices can influence how support and services are delivered in Torbay via the new hubs.

8.3 Community Dental Service

There is a continued demand for urgent dental care. This is because of a reduction in dental provision due to capacity in the team, and long waiting lists for accessing dentistry on the high street, as well as seasonal increase in population due to the holiday season. Recent recruitment will provide some additional capacity to alleviate some of these pressures in the longer term.

8.4 Torbay Recovery Initiatives (TRI) (Drug & Alcohol Service)

The first report as a Multi Complex Needs Alliance (MCNA) has been submitted to Torbay Council Oversight Board, this report includes governance and performance metrics for the newly formed Alliance.

TRI Numbers in treatment: Latest total number in treatment is 1,361 as of June 2023, with increases across all substance groups. This exceeds our annual Office for Health Improvement and Disparities (OHID) target.

Continuity of care: Continued improvements being made on this metric.
Latest rolling annual figure is 54% (Mar 22-Feb 23 exit, May 23 community pick up).
Rolling three months figure is 77% (Feb-Apr 23 exit, May 23 community pick up).

Successful completions: successful completions have remained low over several quarters. This has been discussed in depth with staff and closely monitored with new approaches implemented to improve this.

8.5 Maternity

Achievements

The follow up Ockenden Insights visit was conducted on 7 July by the ICS and regional team. The final report is due imminently but informal feedback on the day was positive with areas of good practice highlighted.

Risks & Challenges

Early pregnancy pathway:
Meetings have been held with the Chief Nurse and senior nursing/midwifery staff to discuss feedback received from women experiencing early pregnancy loss, being nursed in surgical receiving unit (SRU). An improvement working group has been convened, comprising nursing, medical and operational representatives to agree how enhanced pathways/SOPs can be developed to support women experiencing early fetal loss. Additional relevant stakeholders will now be invited to join the group, including representatives from ED and SRU. The work undertaken will utilise the recently published Independent Pregnancy Loss Review document.

Theatre Pathway for 2nd theatre out of hours:
Recruitment of ODPs is still difficult. Alternative solutions are being sought.

Service review – obstetrics and gynaecology establishment:
An in-depth service review of the obstetrics and gynaecology pathways and establishment is in progress being supported by the quality and improvement / transformation team. This is to address a shortfall in the consultant workforce thus impacting on the ability to fulfil all service requirements.

8.6 Gynaecology

Significant Improvement in our colposcopy backlog. Quarter 1 Cervical Screening Programme showed a significant improvement also, though we still failed the standards of the programme.

Post-Menopausal Bleeding (PMB) nurse training is complete though one of the two nurses has resigned.

Women waiting for a first OPA:

Routine	14 Months
Uro-gynae	12 Months
MIT	14 Months
Colposcopy	6 Months

Cancer Targets

14-day figures (93%)

	Gynae	Cervical	Ovarian	Uterine	Vaginal	Vulvar
July	34	37	80	24	25	75
August	37	71	76	12	100	67
Sept	2	0	0	2	NA	0
28-day figures (75%)						
July	68	94	75	60	67	100
August	55	76	67	42	80	100

Risks and Challenges

We are engaging with outsourcing companies:

- Medefer to support our new general gynaecological outpatient appointments.
- Medac to support our new minimally invasive treatment (MIT) outpatient appointments.
- 18 weeks to support the backlog of our elective patients and exploring their support with uro-gynae outpatients.

We have engaged with these companies to work towards having no women waiting longer that 65 weeks by the 31 March 2024.

8.7 Community Sexual Health Service

Torbay as part of the Devon Sexual Health Service has received formal notification for the contract entering the plus two years from 1 July 2023.

The Commissioners (Devon and Torbay Councils) of the sexual health contract have issued a Prior Information Notice on the tender portal. Sub-contract arrangement currently held with Royal Devon University Hospital (RDUH) will remain until 30 June 2025.

8.8 Healthy Lifestyles and Personalised Care

TSDFT is the first Trust in Devon to reach 'fully implemented' on the treating tobacco dependency pathways. We have a fully in-house pathway in maternity which is proving successful, with smoking at the time of delivery in July at 4.8%. We also now have a fully implemented acute pathway in the Acute Medical Unit and on Midgley ward. The Treating Tobacco Dependency (TTD) work will become business as usual from April 2024 and we need to ensure that momentum is not lost at this point.

8.9 Social Care

Innovation in adult social care (ASC) waiting list risk management has resulted in a tool for triaging which is undertaken by skilled and experienced Registered Social Workers. Waiting list client risk is identified using clinical judgement, which considers a range of issues, including (but not excluded to): risk of care breakdown, risk of client to self or others, concerns related to abuse or neglect, environmental concerns, concerns around mental capacity, contact with other agencies including police and ambulance service, as examples. The ASC waiting list risk matrix has been developed to support the triaging of front end and complex care team waiting lists and is currently in a trial stage. The tool allows ASC to evidence their decision making by practitioners when allocating cases in order or prioritisation according to risk and ensures that we can assess people on the waiting more effectively and efficiently and supporting evidential processes whilst supplementing professional judgement analysis.

From a projects and improvements perspective, overall financial contribution to cost improvement plans continue to progress well and critical to the financial risk associated with adult social care is at the entry into commissioned services confirmed through the diagnostic exercise completed by Newton Europe, from which the implementation plan is to be developed. Work has begun to reduce the number of contracts and total 12-week variance across consecutive provider invoices, reported across the monthly domiciliary care framework costs which will involve identifying reason for variance, re-assessment of client needs where required, and resolving discrepancy between contracts and invoicing. Our Hospital In-Reach Project performance sees a third

decrease (48% in June '23) to 46% reduction in discharge pathway; 200 patients have been reduced from P2 to P1 since inception.

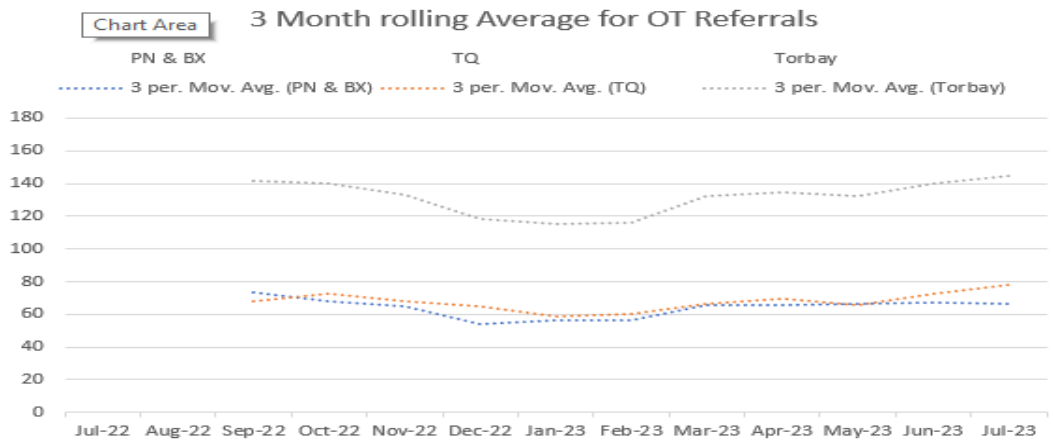
TSDFT Adult social care contract management procedure received overall positive feedback from Torbay Council procurement team, as part of the collaborative approach to improving procurement and contract management functions. Subsequently, TSDFT reported to Torbay Council Health and Social Care Scrutiny Committee on progress of the contract management policy, procedures and plans in all market segments. The Scrutiny Committee were satisfied with the progress against the requirements of the local government association (LGA) contract management review. Torbay Council will be auditing the use of the policy and procedures in Q3 2023/24.

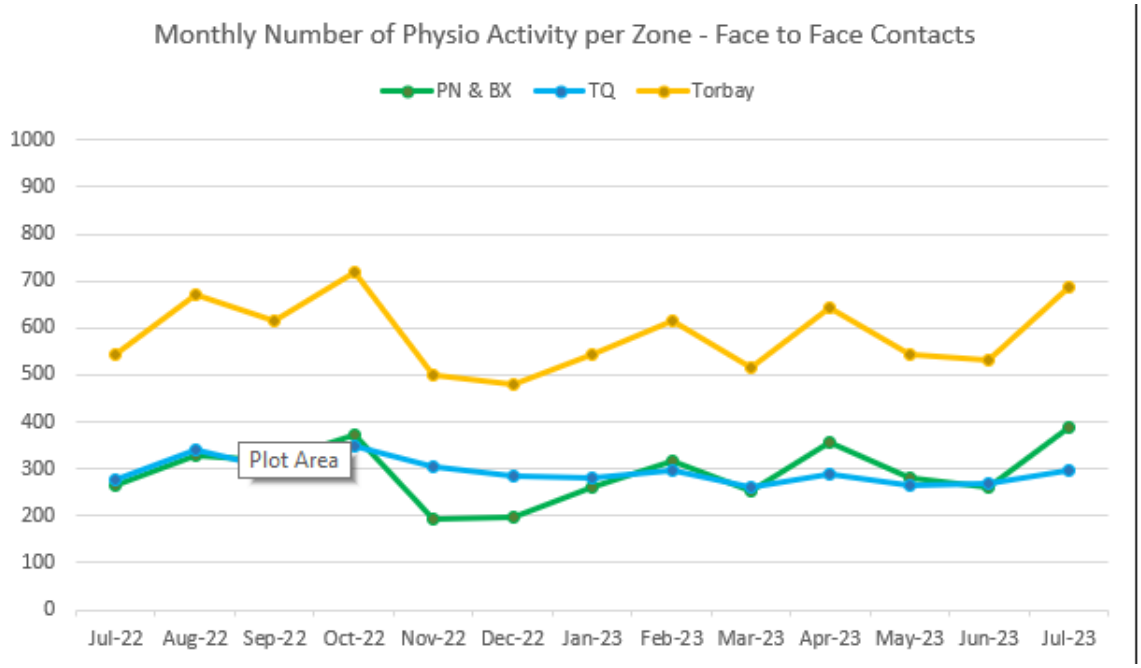
Two care homes in Torbay move from CQC 'Requires Improvement' to 'Good' and one moves from CQC 'Inadequate' to 'Requires Improvement'. Over a three-and-a-half-year period, which includes COVID, Torbay has seen a positive trend with the proportion of care homes rated as 'Outstanding' or 'Good' increasing by +7% and the proportion rated as 'Requires improvement' or 'Inadequate' decreasing by -6%. In terms of care provision requiring improvement, Torbay has a higher proportion than Devon County Council and the South West average, but a lower proportion than Plymouth County Council and the Chartered Institute of Public Finance and Accountancy (CIPFA) and England average and the 'Requires Improvement' project continues with all providers undertaking actions plans to improve the overall position to 'Good' in Torbay.

8.10 Bay Wide Community Health Services

8.10.1 Therapy

The occupational therapy (OT) waiting list is 99 in both areas with the longest wait from June for a referral. Physiotherapy (PT) team in Torquay is 37 with a wait of three weeks and Paignton and Brixham is 65 with a 4.5 week wait. These services have all reduced their waiting list.





8.10.2 Community Nursing (CN)
Paignton and Brixham (P&B) continue to support their new starters with training to develop community-facing skills and competencies.

The Torquay CN team completed more CN visits in the last month than the whole of the South Devon CN teams collectively.

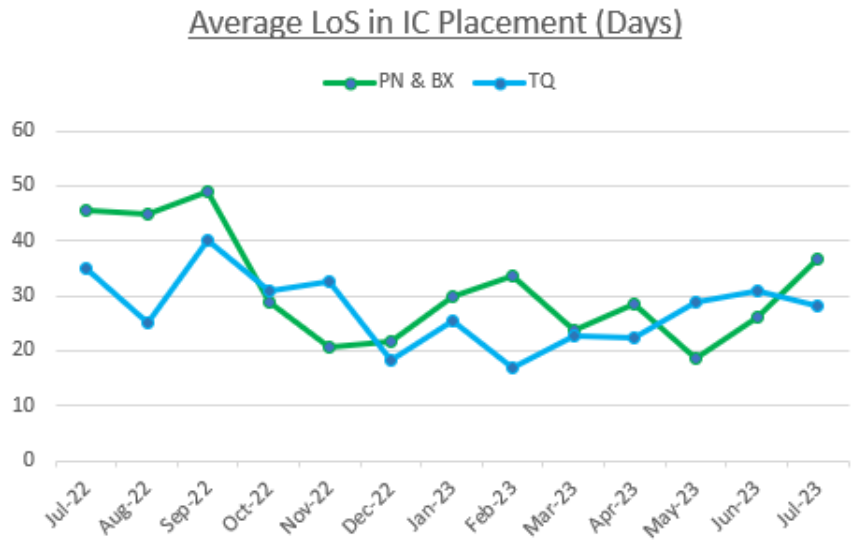
The number of insulin-dependent diabetic patients that are being managed by the CN teams are continuing to increase. This continues to be a concern that is actively monitored and managed. We are interviewing this week for a band 6 community nurse with a specialist interest in diabetes to help manage this ongoing situation.

Paignton and Brixham CN team have recruited to a band 6 community nurse who has a special interest in tissue viability. Both these band 6 posts in each area are to assist with recruitment and retention in the CN teams.

The out of hours (OOH) service CN lead has returned to work following long-term sickness. Meeting weekly with Baywide community service manager (CSM) for health once a week for support. The consultation process has been completed and the team is now based at one central office.

Herts Urgent Care (HUC) have given notice on the management of the OOH CN call handler, which is being managed by the care group director.

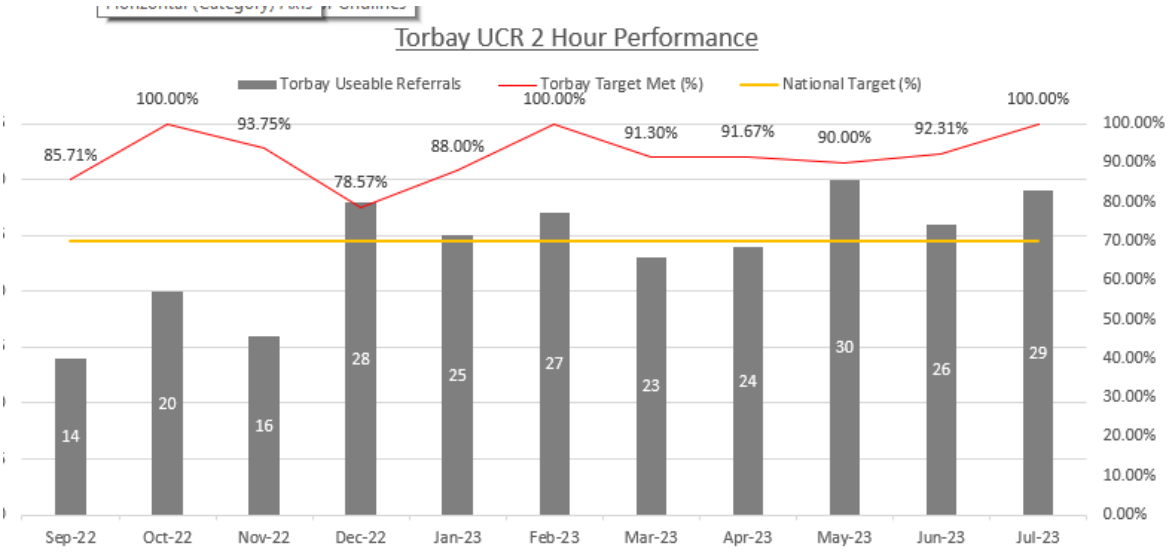
8.10.3 Intermediate Care (IC)
The IC teams are managing their home-based workloads well and are seeing a reduction in length of stay (LOS). In bedded placements, work is underway to monitor and reduce the length of stay. The teams are managing the 17 extra block pathway 2 rehab beds in care homes to assist with hospital flow. The career promotion of the 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 33 days.



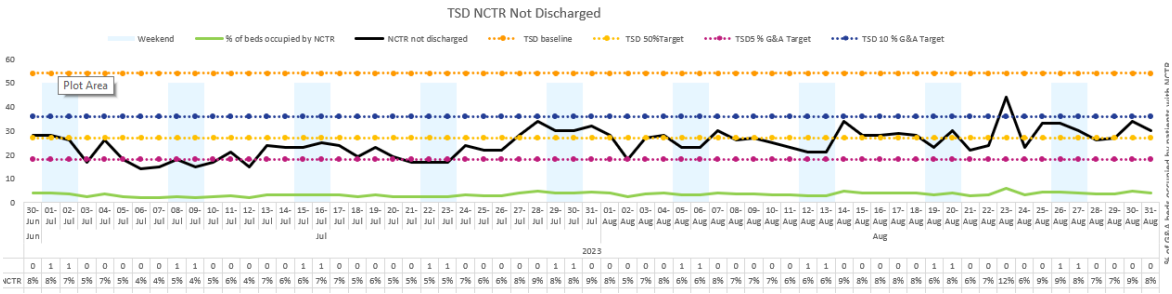
Intermediate care referrals.

8.11 Urgent Care Response (UCR)

The teams are achieving the national target in their response times, meeting the two-hour response target, and exceeding the target for two to 48-hour response.



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



Pathway 1 (P1) - we have movement and good flow. Time to transfer reduced to on average at two days.

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

Torbay residents will be in receipt of 4-week interim health funding (IHF).

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

Pathway 2 (P2) - The 17 block purchased 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 seven days to five.

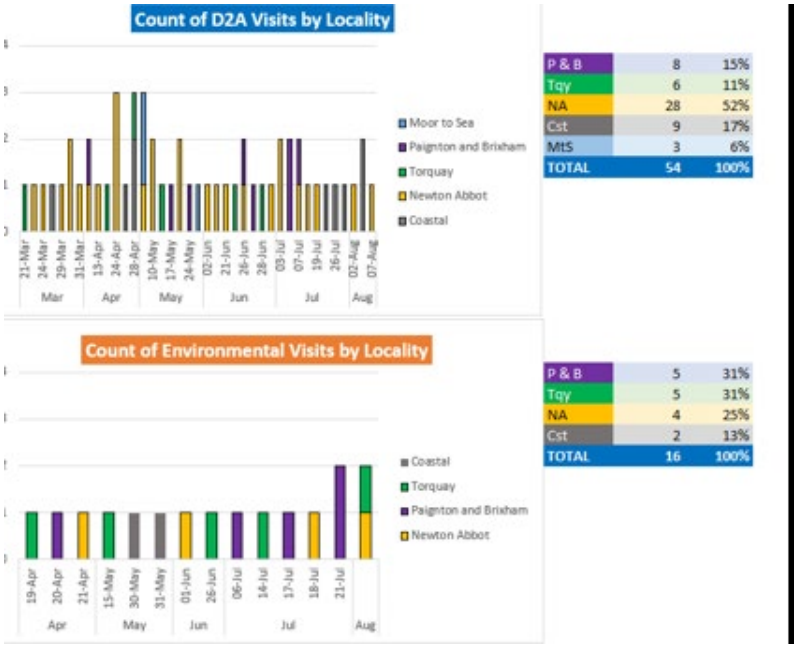
Mapleton in South Devon continues to provide 10 block purchased IC beds. The LOS and onward support is being monitored and reviewed. This is being fed back through the DCC governance structures.

The Integrated Care Board (ICB) and DCC are completing a workstream to look at P2 provision across the DCC footprint and looking to introduce a new model of working by September 2023.

Pathway 3 (P3) - 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.

DCC have introduced greater due diligence on patients requiring funding for P2 and 3. The Bed Bureau is having to contact 15 homes for each referral before requesting authorisation for funding. This has contributed to reduction in daily complex discharges.

The clinicians in the discharge hub continue to complete D2A visits to support the community teams when they do not have capacity. We have commenced capturing the data and the number of bed days saved by the discharge hub. Many of these visits being completed in the Newton Abbot locality.



8.13 Continuing Healthcare (CHC)
Torbay and South Devon CHC team are currently achieving 78% against a national target (80%) for CHC decisions made within 28 days.

The external CHC review provider contract has now been ended, as the provider was unable to undertake face to face reviews. The Trust CHC team have been managing to undertake CHC reviews and have achieved significant progress in covering the CIP target. The team are currently managing CIP alongside the current case management and new assessment work. The clinical team are working hard to triage workloads so that resource is focused in the right areas.

We have successfully recruited into two vacancies but have yet to recruit a mental health nurse. We are working to try and find alternative solutions to this issue with some external providers.

The CHC IT system requires detailed work to bring in line with Department of Health (DoH) performance requirements. There is lack of capacity to manage as system updates are required via Torbay Council staff. There is an alternative system available offering an end-to-end solution which is used by most ICBs to record CHC performance and activity but would create possible costs involved along with information governance (IG) issues around data housing.

Personal Health Budgets – there is a lack of infrastructure to deliver a default offer. Risks in relation to correct employment rules, calculation of budgets, insurances, and legal challenges around redundancy etc.

9.0 Healthcare of Older People (HOP) and Frailty
The review of the work of the Frailty Intervention Team (FIT) continues. The team have proposed a new dual model of delivery encompassing same day emergency care (SDEC) and ward in-reach. Dr Andrew Williams from the Emergency Care Intensive Support Team (ECIST) has been asked to support FIT in developing their new model of care and agrees that there is an SDEC opportunity for delivering improved care to older people with frailty who use our urgent and emergency care pathways. There are several

dependencies before an SDEC model can be trialled; the two primary challenges being releasing the FIT team from managing 12 beds on EAU 4 and finding a space that is fit for purpose and appropriately staffed.

Barton and Compass House Surgeries, which deliver the medical cover for Dawlish and Brixham Community Hospitals, respectively gave notice at the end of last year that an uplift in the contractual value would be required if they were to continue providing services from October this year, when the current contract expires. A final draft of a paper developed over several months was discussed at Trust Management Group (TMG) on Tuesday 1 August 2023. The paper sought approval for the new medical model at Totnes Hospital and made recommendations for the contract negotiations for Brixham, Dawlish and Newton Abbot Hospitals, and outlines the financial implications and requirements for the new contract. Further discussion is required before the recommendations can be accepted.

Two new locally employed doctors (LEDs) started at the end of July in Totnes Hospital. This is a new model of care providing resilient junior doctor cover with senior support from HOP registrars or consultants. Early indications are that the model is working well and has even provided the opportunity for one of our registrars to link with the 'Moor to Sea' community team.

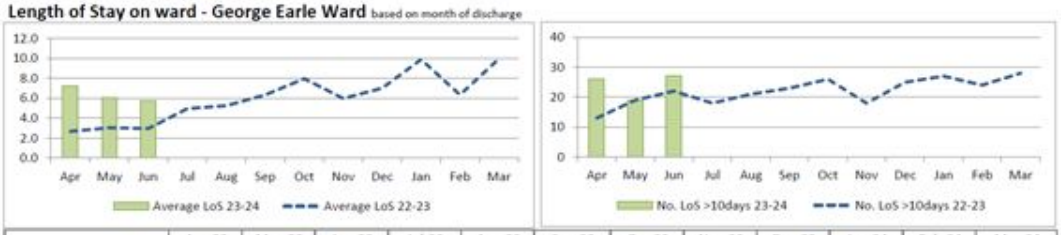
On 10 August, Dr Kath Bhatt, a GP with a specialist interest in older people's care and frailty, was appointed as GP and clinical lead for the frailty virtual ward. Kath has lots of experience in community-based care of older people with frailty and lots of ideas. The HOP team feel fortunate to have her join them, and work is now continuing at pace to get the frailty virtual ward operating by winter. Further recruitment is underway to appoint two trainee advanced clinical practitioners (ACP) (interviews 7 September) and additional healthcare support workers for our community teams.

SDEC and frailty virtual ward are just two components of a single pathway of care for older people with frailty and complex co-morbidities who need specialist input to support them remaining as close to home as possible and represents a long-held ambition for the team to be more community focussed.

9.1 Stroke and Neuro Rehab

Both June and July saw the number of patients admitted to George Earl ward with a stroke continue to rise. The numbers seen for the four consecutive months since April 2023 are the highest since June 2021 when we had 61 admissions. A review of the mean number of beds occupied by stroke patients on George Earl ward between 1 April and 12 July on two consecutive years shows an increase in the number of stroke patients of approximately 64%. Length of stay data for the ward (*not specific to stroke patients*) also shows an increase in mean length of stay of approximately two days.

Number of patients	**1st April – 12th July 2022**	**1st April – 12th July 2023**
Stroke	18	11
Neurology	4	6
Medical	5	10



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Average days on ward	7.2	6.1	5.8									
No. stays >10 days	26	19	27									

nb. These figures relate to the total days spent on George Earle during the whole hospital stay. If the patient had multiple spells on George Earle during a single hospital stay then the days from each spell have been added together.

This increased demand on hyper-acute and acute stroke beds combined with ongoing challenges with flow continues to be reflected in our time critical standards, as demonstrated in the Sentinel Stroke National Audit Programme (SSNAP) DIY tool results for June and July (last reported results in the COO report were from May). There was a reduction in performance for scanning within one hour and a further reduction in the number of patients getting to the stroke unit within four hours; 47 patients did not reach the stroke unit in four hours. This was despite an improvement in the availability of the stroke pathway. In July the pathway was available 58% of the time and 61% of the time at 08:00 however, the pathway turns over multiple times a day and a different strategy is required to get the improvement our stroke patients deserve. Discussions with the care group leadership team are ongoing to identify who best to support further sustained improvement.

Time critical Stroke Standards	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Number of patients (N)	42	33	46	32	39	34	41	42	56	56	59	60
% Scanned within 1 hour	40.5	45.5	45.7	57.8	48.7	61.8	41.5	57.1	50.9	65.5	59.3	53.3
% Scanned within 12 hours	88.1	93.9	93.5	93.3	92.3	94.1	95.1	100	92.7	98.2	91.5	96.7
% 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	26.3	21.1
% 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	61.4	69.5
% (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)	11.9 (7)	6.9 (4)
% Received Thrombolysis within 1 hr	25	20	50	100	0	50	0	50	50	0	42.9	75
SSNAP		A	B	C	D	E						

There has been successful recruitment to the 0.64 whole time equivalent (WTE) specialist stroke nurse vacancy and the successful candidate who is an existing member of the stroke team should be in post in the next six weeks. Recruitment to the SSNAP administrator post is still awaiting agenda for change job matching.

The stroke report is discussed at Quality Assurance Committee and September will see a deep dive into stroke performance and quality and safety. A national collaborative is being set up to support improvement in thrombolysis rates. Nominations need to be by Integrated Stroke Delivery Networks (ISDNs). The chair of the Peninsula ISDN has indicated that they would wish to nominate Torbay; this would need approval of the ISDN overview group.

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: Chief Executive's report			Meeting date: 27 September 2023
Report appendix			
Report sponsor	Chief Executive		
Report author	Associate Director of Communications and Partnerships		
Report provenance	Reviewed by Executive Team 19 September 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: 27 September 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 culture at work where everyone feels safe, healthy and supported
- improve access to specialist services through partnerships across Devon
- improve financial value and environmental sustainability.

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

3 Our key issues and developments

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

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

Preparing for winter – flu and COVID-19 vaccination programme for our people

We have begun our annual flu and COVID-19 vaccination programme for our staff, volunteers and most vulnerable patients. In the first week just under 400 people received their flu jab and almost 250 received their COVID-19 vaccination (COVID-19 vaccines were received slightly later than flu vaccines).

Preparing for winter – new OPEL framework

We welcome the publication of the new Operational Pressures Escalation Levels (OPEL) framework for 2023/24 and we are working with our operational teams and system colleagues to ensure robust implementation. The new frameworks aims to:

- Provide a unified, systematic and structured approach to detection and assessment of acute hospital Urgent and Emergency care (UEC) operating pressures – achieved through standardisation of parameters and assessment within acute NHS trusts. These parameters have been identified through consultation and collaboration with operational and clinical leaders from across the country. The parameters are designed to reflect the key drivers of operational pressures
- Provide a consistent framework for the proportional representation of each acute trust hospital's OPEL score toward the corresponding Integrated Care System (ICS), NHSE regions, and NHSE nationally
- provide guidance to acute hospital trusts, ICS and NHSE regions that that supports an effective, integrated and coordinated response to acute trust operational pressures
- provide guidance on the alignment of, and interaction between, the OPEL Framework 2023/24 and the national Emergency Preparedness, Resilience and Response (EPRR) framework.

Preparing for winter – our winter plan
Work is well underway locally and at a system level to ensure our winter plan is as robust and resilient as possible. Our focus is on providing more care at home where we can safely do so, improving flow through our hospitals, supporting our people and continuing to reduce our waiting lists.

Our Board of Directors is fully engaged in the process of reviewing and signing off the plan and the detailed plan will be presented at a future Board meeting.

Improving access to scans and investigations locally
People in Torbay and South Devon will be able to access more scans and investigations following the government's announcement that to open five community diagnostic centres (CDCs) in the South West. This is a partnership model for delivery of diagnostic services. InHealth has been appointed as the provider for the centre, following a competitive procurement led by NHS England, and the centre will open in Market Street, Torquay next spring.

The centre will provide x-ray, MRI, CT and ultrasound scans, endoscopy, blood-tests, and other tests to assess heart and lung problems. The range of scans and tests the CDC can offer will help with the diagnosis and treatment of people with a range of conditions, from cancer to joint problems, and will complement the work that is underway at Torbay Hospital to expand our endoscopy and day theatres capacity.

We are working closely with InHealth to ensure that we can provider a seamless service to people and that we have a complementary approach to recruitment of key staff.

Local research contributes to national multi-cancer blood test findings
A number of our teams have contributed to a study which found that a blood test that detects more than 50 types of cancer has real promise.

In 2021, we were selected to take part in the SYMPLIFY trial, led by the University of Oxford Clinical Trials Unit (OCTO). This trial used GRAIL's new

Galleri blood test to detect tumour DNA in patients with symptoms of possible cancer.

Cancer researchers have long sought to develop an easy to use, minimally invasive test to detect cancer at an earlier and potentially more curable stage. Delivering this trial required significant collaboration and enthusiasm from a wide range of teams including collaboration between teams approaching patients for the trial and the oncology clinical trial staff and 386 of our patients were successfully recruited.

The results of the SYMPLIFY trial have now been published which showed the blood test demonstrated the ability to detect a cancer diagnosis in 75% of cases, while also correctly identifying in 85% of cases where the cancer had originated from.

This trial demonstrated the dedication of our teams who are involved in the diagnosis of cancer, and the enthusiasm of everyone in offering this cutting-edge technology to patients was heart-warming. We are deeply appreciative of the work and commitment of everyone involved in this important research (patients, colleagues and researchers).

Annual members meeting 2023
Our annual members meeting took place on Thursday 21 September in TREC at Torbay Hospital and was live-streamed for those who could not join us in person. A recording of the event will shortly be available on our website.

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 August and September.

For the fifth 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 August our performance was 67.90% which is on trajectory.

We have achieved the Faster Diagnosis Standard consistently since February 2023. 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 work to reduce the number of people waiting for cancer treatment over 62 days continues and accordingly to the latest figures we are in the top 40 high performing trusts nationally in this area and second in the south west region.

Our performance in planned care services has remained strong. We have robust plans in place to have no one waiting more than 65-weeks by 31 March 2024 but these are coming under increasing pressure from continued industrial action. Plans to mitigate this position are under review and this work will take place with the involvement of our partners to ensure Devon wide solutions can be explored for our most ‘at risk’ services.

Our community urgent care response teams are achieving the national target in their response times, meeting the two-hour response target, and exceeding the target for two to 48-hour response.

Care Quality Commission visit
Our two day well-led inspection visit took place on 12-13 July 2023. We are currently awaiting the draft inspection report which we hope to receive shortly. Following receipt of the draft report we will undertake a factual accuracy check in line with established processes and the full report will be published once this process is concluded. We will confirm dates as soon as we are in a position to do so.

Industrial action
We continue to proactively manage the impact of continuing industrial action involving a number of trade unions as part of their ongoing dispute with the government over pay and conditions. These are a matter between government and trade unions and we hope that an agreement will be reached as soon as possible.

During the summer we have managed action involving some of our junior doctors and consultants and radiographers. Junior doctors took five days of action from 11 to 15 August; consultants took part in action from 24 and 25 August (and further action is scheduled from 19 to 22 September, and 02 to 04 October).

We have well-rehearsed plans in place to mitigate the impact of industrial action as much as possible. We fully support everyone’s right to make an individual decision on what action to take and we continue to ask our people to share their plans with us so we can maintain patient safety. We would also like to thank the public for their support and understanding.

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.

Ensuring the safety of people in our care
Like the rest of the country, we were shocked and distressed by the findings of the Lucy Letby case. Our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

As an NHS trust, our immediate response was to ensure we are supporting and listening to the fears of parents and staff. We took a number of steps in the days following Letby’s conviction and continue to work with the South West Neonatal Network and NHS England to implement measures that are aimed at supporting families and our workforce, and strengthening systems and processes for listening and responding to issues of patient safety and risk. These include:

- reviewing and triangulating all patient complaints and adverse incidents reported through our incident reporting system
- undertaking a thorough review of our perinatal and neonatal mortality data - there are no indications of an adverse position comparatively to our peers regionally and nationally
- reviewing all aspects of our Learning from Deaths process to further assure ourselves that we have no outlying mortality issues

- instructing our internal auditors to provide external assurance of our policies and procedures – we are scoping the terms of this audit which will take place in early autumn
- establishing a weekly safety huddle between the executive and the service to maintain an ongoing dialogue and space for concerns to be escalated and addressed.

We have a robust child death overview process and medical examiner process where all deaths are reviewed and we have no current concerns relating to practice and care outcomes for our babies.

The new patient safety incident response framework will be implemented across the NHS later this year. It represents a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

Sexual misconduct
The findings contained in the Working Party on Sexual Misconduct in Surgery report which outlined the extent of sexual misconduct within the UK surgical workforce was truly shocking.

While the focus of the research is on the experiences of people working in surgery, we recognise that people working in other services or specialities may have experienced in the past, or may be experiencing now, sexual misconduct from colleagues too.

There is absolutely no place in our operating theatres, on our wards, clinics or any of our services for sexual misconduct as described in this study. We have encouraged our people – both clinical and non-clinical - to raise concerns about sexual misconduct with our Freedom to Speak Up guardian or through our online anonymous platform WorkInConfidence so we can take action, and investigate any concerns they have. We have also provided information on a range of support available including independent support.

Our people priority is to build a healthy culture at work where everyone feels safe, healthy and supported. Our digital futures programme team have been working on this important issue for several months already and are developing a sexual harassment virtual reality facilitated workshop which is based on real experiences of trainee doctors in the south west. Dr Bijal O'Gara has led the scripting and filming with Jacqui Rees-Lee's support and guidance. While we need to trial the training with full facilitation and it will be some months before we are able to launch it, at our September all staff briefing (Trust Talk) we will be sharing a short but powerful video clip and we hope Jacqui will be able to join us to talk through what the training aims to achieve.

CQC adult inpatient survey 2022 results published
We have received the results of the annual NHS patient survey programme's (NPSP) adult inpatient survey: Torbay and South Devon NHS Foundation Trust - Care Quality Commission (cqc.org.uk)

The NPSP is commissioned by the Care Quality Commission (CQC) and looks at the experiences of adults who stayed at least one night in our hospitals as an inpatient during November 2022. They are asked to comment on a number of areas about their care from admission to hospital, their treatment and discharge to help us to understand the risk and quality of our services.

From January to April 2023, 1,250 people at NHS trusts across the country were invited to take part in the survey. In Torbay and South Devon, 551 people took part – 76% of respondents had received urgent and emergency care as an inpatient, and 24% had received planned care.

The response rate this year was 45%, which was greater than the national average of 40%, but slightly lower than our response rate of 48% last year.

Overall, we have seen improvements in the areas we focused on following the publication of last year's survey results; people were positive about the level of care they received, felt listened to and had important information about their care explained to them in a way they understood, and were supported to get home from hospital.

There are a number of areas that we need to focus on to improve, including reducing noise on wards which prevent people from sleeping at night, and doing more to increase patient feedback about the quality of care they have received.

Areas where we were better than expected:

- staff explaining the reason for needing to change wards at night
- being able to take their own medication when needed
- having enough to drink while in hospital
- doctors answering their questions in a way people understand
- having confidence and trust in the nurses treating them
- staff did all they could to help control people's pain.

Areas where we were worse than expected:

- waiting to be admitted
- noise from other patients who prevented them from sleeping at night
- being asked to give their views on the quality of their care.

We are analysing the feedback and will create an action plan, which will be shared with the Quality Assurance Committee and then brought to our November meeting of our Board of Directors.

Launching our compassionate leadership approach
Later this month we will launch our compassionate leadership approach with a dedicated education, learning and development programme. Our compassionate leadership approach is: we include with care, we listen with genuine curiosity, we act with courage.

Two test of change workshops have taken place during August including corporate, clinical and operational managers and leaders. The feedback and

insights from both tests of change are directly informing programme as well as informing the Board development agenda.

Welcoming our new junior doctors
Last month we welcomed our new postgraduate doctors in training who are joining us as part of their rotation. We hope they enjoy the next stage of their training with us and we extended our warmest thanks to those junior doctors who rotation ended in July 2023 for their much-valued contributions.

Dementia conference
More than 11,000 people in Devon have dementia. It can affect anyone, and we want to improve care for people with the condition.

On 06 September, 51 people attended our living well with dementia conference at Torbay Hospital, which aimed to support people living with or caring for someone with dementia, including our staff.

The conference was hosted by Rhoda Allison, Deputy Chief Allied Health Professional and Mike Vango, carer representative of our dementia steering group. The speakers were Dr Claire Pentecost, programme manager of Exeter University's IDEAL project who spoke about the Living Well with Dementia toolkit; and Dr Jo Sykes, consultant in palliative medicine who spoke about the importance of advance care planning.

We will now consider what people told us and what was important to them to help us design and improve dementia services in Torbay and South Devon. Thank you to everyone involved, particularly Rhoda Allison and her personal assistant Maria Luzzardi for organising such an important event.

Innovation by care team shortlisted for national award
The Post Anaesthetic Care Unit (PACU) at Torbay Hospital has been shortlisted for acuity-based patient allocation in the Theatre and Surgical Nursing category of the Nursing Times Awards 2023.

PACU is a 14-bed unit that cares for everyone that goes through the inpatient theatre suite at Torbay Hospital. The unit frequently cares for more than 50 people a day, with the team made up of nursing staff and operating department practitioners.

Every member of the team is a highly skilled, competent practitioner who provides exemplary care to people as they emerge from anaesthesia, which can often be a very vulnerable time.

The team has been nominated for the new ways of working they have developed following the pandemic. 85% of cases are now day surgeries, which means that the flow of people through the unit has increased exponentially. They have had to adapt to new ways of working without additional capacity or resource, which has seen the team take on a more flexible, considered approach.

Practitioners have had to adapt while prioritising and maintaining high standards of care and safety. They are competent and accountable, making important care

decisions in a practitioner-led environment.

People also stay in the unit overnight in a range of cases, including day cases who are too poorly to go home yet, those needing high levels of care but not suitable for intensive care treatment and those awaiting a ward space.

Changes to ways of working has fostered a strong sense of team in the unit, with everyone pulling together to provide the best care possible. Anaesthesia colleagues have praised the team for the reduction of handover time, which makes more efficient use of theatre space.

The team presented to the judging panel in September ahead of the awards ceremony in London on 25 October 2023.

Healthcare assistant shortlisted for national nursing award
Tara Johnson, a healthcare assistant who works at our emergency department, has been shortlisted for a prestigious Royal College of Nursing award.

Tara was nominated for a nursing support worker award by a colleague in recognition of her efforts to improve services for children and young people being cared for by the department, and the high level of support she provides.
Last year Tara won healthcare assistant of the year at the PAFTAs (Paediatric Awards for Training Achievements), which recognise the hard work and commitment of the people working to support children and young people across Devon and Cornwall.

The winner from the category's shortlist of five will be revealed on Friday 10 November 2023 in a ceremony at Liverpool Cathedral.

Congratulations to our latest PRIMROSE and DAISY award winners
Our latest PRIMROSE award winner is Jack Doxey, health care support worker at Dawlish Community Hospital. Jack was nominated by his ward who praised Jack's empathy and understanding for patients. Jack joined the team at Dawlish Hospital as his first role within the NHS. As of this month, Jack is now training to be a physiotherapist.

Our latest DAISY award winner is Ellie Banning, a registered nurse working in our Emergency Department. Ellie was nominated by a colleague for her commitment to supporting children and young people with their mental health and wellbeing and her work in improving the pathway for supporting children and young people's mental health in the department.

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
Six of our wards underwent accreditation in the last month. New Forrest ward achieved white while our special care baby unit achieved bronze. Ainslie ward maintained their silver accreditation and Brixham, McCullum, and Warrington wards also received silver.

3.3 Excellent value and sustainability

Delivering best value for people in Devon

We are working in very challenging times, and Devon's entire health and care system was placed in segment 4 of the NHS operating framework (NOF4) due to its performance and financial challenges.

Our performance has improved significantly and this is due to the tremendous work taking place across clinical, operational and corporate services, working with our improvement and innovation team to make sustainable improvements.

Earlier this year we were in tier one monitoring for cancer performance, but we have now improved services and have exited tier monitoring.

We are maintaining our improvement trajectory for both cancer and planned care despite the challenges we face. We now have no one waiting more than 104 weeks for planned care, which is fantastic news and reflects the tremendous amount of work taking place in our planned care services to reduce the time people are waiting to be seen.

Our people, along with colleagues and partners across Devon, recently received a personal message from Professor Tim Briggs, NHS England's national director for clinical improvement and elective recovery and chair of the national Getting it right first time (GIRFT) programme praising their work to reduce waiting times for people who need our care as outstanding.

We have recently successfully bid for additional money to alter our emergency department (ED) processes to improve waiting times for people with minor injury and illnesses, and to allow us to set up our new ready to go unit on McCullum which is helping to support more people to get home quickly and safely.

McCullum ward has significantly improved the numbers of patients who are discharged before midday. They are achieving 65% which is well above our target of 33%. Getting patients home for lunch is something we need to work on for all our wards so that we can move patients from our ED and free ambulances for people waiting for them. It also allows wards to better manage patients when staffing is at its best rather than leaving this to the evenings where there are fewer people on shift.

For the fifth consecutive month our urgent and emergency care performance was more than 60% and in August we reached 67.90% which keeps us on track for our improvement trajectory.

The Devon system continues to be in Tier 1 monitoring for urgent and emergency care performance and we have weekly meetings with regional senior staff to discuss our progress and provide assurance that we are continuing with our plans and actions to exit Tier 1 as soon as we can. All the plans for exiting Tier 1 are focussed on creating safe and calm hospitals.

Financial performance continues to be a challenge. Our forecast for the financial year shows we are at risk of not meeting our planned deficit. We continue to develop our plans with our people, and as a system to work together to reduce cost pressures and overspend to deliver savings before the end of the financial

year which have minimal impact on the safe delivery of patient care or negatively affect our ability to reduce waiting times.

We are asking our people to challenge and question what we spend to help us develop our detailed financial recovery plans and have put a number of processes in place to ensure that we are delivering best value for our people and our communities.

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 NOF4.

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 130 conversations have taken place with our teams. Initial feedback has been very positive and we are now looking at how we take this forward in phase two of our engagement plan.

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.

Recruitment to our executive leadership team
We are currently recruiting to recruit for our Chief Finance Officer and Chief Medical Officer roles with interviews scheduled to take place next month.

As reported to July's meeting, Mark Brice has joined us as interim Chief Finance Officer until we recruit a substantive appointment. Ian Currie, our Chief Medical Officer, is retiring at the end of this year and we hope to be able to have his successor in post before he leaves us.

Following a robust interview process we have appointed Adel Jones, Director of Transformation and Partnerships, to be our new Deputy Chief Executive. Adel will retain her current role and responsibilities and become Director of Transformation and Partnerships/Deputy Chief Executive as of 01 September 2023. The appointment is for an initial six months at request of our nominations and remuneration committee while we do a more detailed review of what we need in the longer term.

Launching our long service awards
Last month we launched our long service awards which celebrate colleagues who have been with the NHS for more than 25 years. Launched to coincide with the NHS 75 celebrations, we have been holding cream tea events to celebrate our long service award winners dedication and commitment to delivering care. We have more than 800 people working for us who are set to receive their award this year.

Our electronic patient record
The Tender for our electronic patient record is now with suppliers. The deadline for responses is the end of September. Our evaluation of responses will be complete by the end of November and we hope to be in a position to announce our preferred supplier in early December. In line with NHS procurement rules we are not permitted to share anything else at present.

Holly's extraordinary portrait
We were delighted to watch one of our hospital porters, Holly Crawshaw, feature on BBC One's Extraordinary Portraits. Holly joined us during the COVID-19 pandemic as she wanted to give back to a service that saved her young daughter's life when she was diagnosed with a brain tumour.

Holly is an incredibly warm and strong person and plays a vital role in helping us deliver the best care we can to our patients. We are very proud of her and delighted with the portrait that Mark Draisey produced: BBC iPlayer - Extraordinary Portraits - Series 3: 6. Holly and Mark

Local people benefit from generous donation from Lord and Lady Darling
During July our endoscopy unit was able to carry out an additional 60 tests thanks to a generous donation from Lord and Lady Darling.

For these 60 local people waiting for diagnostic tests, which may potentially indicate gastro-intestinal cancer, the donation meant a reduced waiting time and faster diagnosis. For people undergoing medical investigations such as diagnostic endoscopy, a faster diagnosis leads to quicker treatment. This makes a significant difference to outcomes.

Lord and Lady Darling were inspired to give after seeing singer Rod Stewart generously fund MRI scans in an effort to reduce down waiting times. Their donation was enough to fund two full days of running the endoscopy unit.

The rapid diagnosis of gastro-intestinal cancers are vital for improved outcomes. Lord Darling's support will ensure the people who are classed as most urgently requiring investigation will be seen earlier. This will help to also bring down the wait time for those classed as less urgent cases.

Work is progressing on the expansion to our endoscopy service at Torbay Hospital and we hope that this will be open by late November, helping achieve faster diagnosis for lower and upper gastro-intestinal cancers. On behalf of the Board I would like to record our formal thanks for the Darlings' generous donation.

Thank you to our fundraisers for supporting people undergoing chemotherapy

We held a thank you cream team on our Ricky Grant Day Unit at Torbay Hospital to recognise some of our dedicated fundraisers who raised the funds needed to purchase two new scalp cooling machines.

The funds were raised for the Torbay and South Devon NHS Charity during 2022 and will support patients undergoing chemotherapy at Torbay Hospital. Each machine costs £10,000, with further costs for maintenance and training; all of which has been raised by fundraisers.

The Paxman scalp cooling units work by reducing the temperature of the scalp by a few degrees immediately before, during and after the administration of chemotherapy. This in turn reduces blood flow to hair follicles, which can prevent or minimise hair loss.

Losing hair can be distressing for people who are already under strain from dealing with a cancer diagnosis and treatment, and being able to offer these new Paxman scalp cooling units will make a significant positive difference to their mental wellbeing.

The new scalp coolers replace the unit's current scalp cooling machine which is over ten years old, and offers significantly improved technology. Thank you again to everyone involved, including Dartmouth Rotary and Pat and Zoe's fundraising events.

Charity seafront bed push raises more than £1,000

Thank you to our Torbay Hospital League of Friends which raised more than £1,000 during its annual bed push in Torquay in August.

It was the first time the bed push had taken place since the COVID-19 pandemic, which sees league members and supporters push a hospital bed, complete with a teddy patient, along Torquay seafront while collecting donations.

Members of Torbay Hospital League of Friends were joined by councillor Mark Spacagna, The Worshipful the Mayor of Torbay, who has chosen the League as one of the charities he will be raising funds for during his year-long Mayoral term. Thank you to everyone for supporting, including the Offshore Bar and Restaurant and Harbour Gifts and Antiques.

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 • BAME representative • Dawlish Community Hospital • Lead head and neck / thyroid cancer clinical nurse specialist • Long service awards • Library photography presentation	• Chief Executive Officer, NHS England SW • Chief Executive Officer, Integrated Care System Devon (ICSD) • Chief Finance Officer, ICSD • Medical Director, ICSD • Chief Executive, University Hospital Plymouth NHS Trust • Deputy Chief Executive Officer, Royal Devon University Healthcare NHS Foundation Trust • Chief Executive Officer, Devon Partnership Trust (DPT) • Chief Finance Officer and Deputy Chief Executive Officer, DPT • Chief Executive Officer, Torbay Council • Director of Children's Services, Torbay Council • Director of Adult Social Services, Torbay Council • Director of Integrated Adult Social Care, Devon County Council • Chief Executive Officer, Healthwatch • Chief Superintendent for South West Police

5. Local health and care economy developments

5.1 Partner and partnership updates

5.1.1 Integrated Care System for Devon (ICSD)

Leadership changes
We welcome Paul Roberts who joins ICSD as interim Chief Executive at Royal Devon University Healthcare NHS Foundation Trust.

Jane Milligan, Chief Executive, ICSD, retires at the end of October 2023.

Substantive recruitment is underway for the Chief Executive at Royal Devon University Healthcare NHS Foundation Trust and for Chief Executive of ICSD itself.

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:

- NHS Devon consultant and bank holiday release – promoting the Devon-wide release signposting people to help and support available during industrial action and bank holidays
- Extraordinary portraits featuring Holly – one of our porters who featured on the BBC programme
- Local research contributions to national cancer blood test findings – celebrating the contributions of our teams to the SYMPLIFY trial – the trial found a blood test that can detect more than 50 types of cancer has real promise
- Fundraising pharmacists take on cycling mission – JJ and Jamie at Compass House Medical Centre in Brixham are taking on a cycling challenge to raise money for our breast care unit

Recent engagement on our social media channels includes:

- bank holiday prescriptions – reminding people to be prepared and reorder regular medication – our urgent and emergency care services often see people who have run out of medication over bank holiday weekends
- norovirus – following rising cases of norovirus in our hospitals we shared information on the importance of handwashing and infection prevention
- executive vacancies – promoting our vacancies for Chief Medical Officer and Chief Finance Officer
- dementia conference – promoting our dementia conference at Torbay Hospital
- charity support – celebrating our new wellbeing area in our special care baby unit which was made possible thanks to the support of our Torbay and South Devon NHS Charity
- results day 2023 – congratulating those who received their A-level or equivalent results, signposting NHS career path university courses as well as university alternatives such as apprenticeships and employment opportunities
- new junior doctors – welcoming our new postgraduate doctors in training who joined us in August
- Primrose Award winner – congratulating Jack, our most recent award winner, a healthcare support worker at Dawlish community hospital

Development of our social media channels:

Channel	End of year target	As of 31 March 2021	As of 31 August 2023
LinkedIn	8,000 followers	2,878	6,600 followers ↑ 3,722 followers
Facebook	15,000 likes	12,141	14,056 ↑ 1,915 followers
X (formerly Twitter)	8,000 followers	6,801	7,962 followers ↑ 1,161 followers

7 Recommendation

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to Trust Board of Directors			
Report title: Integrated Performance Report (IPR): Month 5 2023/24 (August 2023 data)			Meeting date: 27 September 2023
Report appendix	M5 2023/24 IPR Dashboard of key metrics M5 2023/24 IPR Focus Report		
Report sponsor	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: 5 September 2023 Executive Director sign off: 21 September 2023 Finance, Performance, and Digital Committee: 25 September 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.

Introduction

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

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.

The report highlights areas of risk that have been escalated through governance meetings and System Care Group Directors against National Oversight Framework (NOF) and general performance metrics agreed with executive leads.

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

The Trust remains in NOF 4 being the highest level of national performance oversight. The Focus Report gives greater detail against the agreed NOF 4 exit criteria where these are not being met.

The People Committee provides governance and oversight for workforce and the Quality Assurance Committee for quality and safety metrics.

Quality Headlines

Incidents
In August 2023, 1 incident of severe harm were reported onto the national StEIS (Strategic Executive Information system) and 2 deaths. The incident was a patient falls resulting in fractured of the hip. The incidents of death were related to a fall with a neck fracture at C1 and an unexpected death following delay to treatment. All incidents are being investigated as per the national reporting framework.

Infection, Prevention, and Control
There has been an increase in the number of Norovirus cases reported across some of our wards in the month of August and this has resulted in a significant increase of bed closures. An action plan has been completed with the Infection, Prevention, and Control team which includes a focus on cleaning measures, patient flow, and use of gloves and Personal Protective Equipment in these specific areas as a priority.

Maternity
There was one late fetal loss in August 2023, this case has been reported to MBRACE (Mothers and Babies: Reducing Risk though Audits and Confidential Enquiries across the UK) and a perinatal mortality review (PMRT) is in progress.
The new implementation tool to enable providers to assess compliance against Saving Babies Lives v3 has been published. This will form part of the assurance mechanism for Clinical Negligence Scheme for Trusts compliance for this safety action and will need to be signed off through LMNS/ICS.

Safer Staffing
The Registered Nurse fill rate for days during August 23 was 97.9% which is a slight increase on July fill rate of 96.3% and for night duty reported as 88.7% which is a decrease on the July fill rate of 90.2%.

The fill rate for health care support workers for days is 101.5% which is a decrease on July figures of 106.9% and 119.9% for night duty which is a slight increase on July figures of 118.4%.

Workforce Headlines

Progress in delivering the workforce implications of the 2023/24 Operational Plan
The Trusts substantive workforce is 29 Whole Time Equivalent (WTE) over plan in August 2023, improving from the previously reported 86 WTE above plan in July. This improvement was anticipated as a result of 2022/23 Junior doctor cohort starting to leave the Trust as they continue their rotation.

Local workforce factors affecting NOF4 exit criteria and mitigating actions
Workforce is one of the key factors affecting specialties that are challenged in delivering Referral to Treatment (RTT) performance targets. Substantive clinical and consultant vacancies are seen across several of the most challenged areas of ENT, Urology, Gynaecology, 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 August are lower than those forecasted in the operational plan.

Mandatory training compliance continues to perform well overall at 91.97%. 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 79% 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 provides oversight against key Care Group performance. Performance exceptions are included against areas not meeting the National Oversight Framework (NOF) exit criteria indicators.

As a Trust we remain in Tier 1 (highest level of performance oversight) for Planned Care and Urgent and Emergency Care. The Chief Operating Officer meets weekly to review recovery action plans and performance against trajectories with NHS England.

National Oversight Framework level 4 exit criteria

Urgent and Emergency Care NOF 4 headlines
The Trust is meeting one of the NOF 4 exit criteria, being performance trajectory for the percentage of inpatients with No Criteria to Reside (NCTR).

- Ambulance handover time lost increased in August reporting 1707 hours lost waiting over 15 minutes (from 1223 hours lost in July); this does not meet the

trajectory of 1111 hours. The Trust, however, is achieving the ICB expectation of average handover time of 56 minutes.
- The percentage of patients waiting over 3 hours for an ambulance handover is maintained at 3.7% in August.
- The Trust's Urgent and Emergency Care (UEC) 4-hour performance improved in August achieving 67.9% against the trajectory of 68.0%. The trajectory of improvement agreed in the operating plan for September is 72%.
- Operational focus remains on improving the discharges earlier in the day. 21.6% of discharges were achieved before noon against the 33% target this being the highest monthly performance since November 2022.
- The Trust has continued to meet the trajectory for the percentage of beds occupied with No Criteria To Reside with 7.5% of occupied beds in August against the trajectory of 7.5%.

Elective Recovery NOF 4 headlines

Elective Referral to Treatment (RTT)
Elective recovery against the NOF 4 exit criteria is ahead of trajectories for 6 of the 7 exit indicators. The trajectory to reduce the number of patients waiting over 78 weeks for treatment was not met with 156 reported against the trajectory of 130. The cumulative impact of industrial action is the main factor impacting this performance. The Trust continue to engage with the 'Further Faster' GIRFT work programme to enhance the Trust's recovery programme and reduce the number of people waiting for treatment. The impact of further industrial action is a future risk being accessed with an expected impact on long-wait trajectories. The Trust continues to provide oversight and mitigations of industrial action through the Industrial Action Patient Safety Committee.

Cancer standards
The Trust is meeting the Faster Diagnosis Performance and 62-day backlog position against the exit criteria target. Torbay is no longer included in Tier 1 performance oversight for cancer standards.

Finance headlines

As at Month 5, the Trust reported an adverse financial variance to plan of **£1.29m.** This is primarily driven by the net impact of the ongoing Industrial Actions.
At this stage of the year, we are still formally reporting a no variance to plan in the forecast position, however the overall risk to forecast at M5 is £32.3m (please see details on slide 17 of the 'Monthly Performance Report') this is reduced comparing to M4 which was £38.5m, we will continue to explore mitigations to reduce the risk further. Month 5, the Trust has fully worked up schemes to the value of **£33.12m,** additional schemes being worked up and being validated by the PMO to the value o**f £5.15m** and red schemes (high risk) to the value of **£16.56m total £54.83m** of the full year required value of **£46.58m** CIP target. The PMO will continue to grow the pipeline for 23/24 allowing for slippage against the required value of £46.58m. YTD delivery remains in a positive position of **£10.57m** vs plan **of £8.04m**. We continue to confidently report a fully year delivery of **£46.58m** to our regulators.

Please also note that the YTD operating expenditure includes an unplanned net cost pressure of £1.293m arising from Industrial Actions, anticipating that this cost will escalate further with industrial actions planed in the coming months. This potential risk has been duly incorporated into the risk and mitigation schedule which has been

reported to the Integrated Care Board (ICB) and NHS England and Improvement (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 **£9.1m** adverse, largely due to pay down of the capital creditor **£9.2m**. The plan assumed that this would have happened at the end of the prior year. PDC capital drawn down **£1.6m** adverse and in year capital expenditure **£2.1m** adverse, due to delays in capital expenditure requirement.

Debtor movement is **£10.2m** favourable, which is principally due to the 22/23 pay award **£12.1m**, partly offset with an increase in ASC debtors.

Integrated Performance Focus Report (IPR)

Torbay and South Devon NHS Foundation Trust

September 2023: reporting period August 2023 (Month 5)

Working with you, for you

National Oversight Framework - Introduction

NHS Torbay and South Devon NHS Foundation Trust

NHS National Oversight Framework

In December 2022 NHS England rated the Trust at SOF level 4 for financial and operational performance along with the wider Devon System. The levels are rated as levels 1 to 4 with NOF 4 being the highest level of oversight. This decision was reached due to our financial performance and delivery against planned care and urgent care performance targets.

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.

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.

Operational performance updates for each of the Care Groups and any associated risk and escalation is described in the Chief Operating Officer's report. Commencing in September the new Care Groups Performance and Accountability meetings will commence.

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 Integrated Care System leads.

Tier 1 performance oversight:

The Trust remains in the Tier 1 (the highest level of oversight) performance regime from NHS England against Referral to Treatment (RTT) long waits and against Urgent and Emergency Care performance.

The Trust attends weekly executive meetings with the Southwest region performance leads to review progress and gain assurance on agreed action plans to exit Tier 1.

National Oversight Framework 4 Exit Criteria – Indicative Measures

Torbay and South Devon NHS Foundation Trust

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)	Improving	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	Improving	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	No	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

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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. • ED demand rises	• Ongoing transition 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. • Continuation of McCullum Ready to go NCTR unit 30-day trail. • Operational 'drum-beat' bed meetings process changing to streamline Directorate information gathering. • GIRFT review of UEC agreed for October. • Winter Plan in development • Winter plan and Elective recovery review by Michael Wilson underway in September
Positive assurances	**Decisions made**
• Planned care performance achievement is above trajectory. • UEC 4hr performance above 60% for fifth month in a row and hit trajectory for NOF4. Performance improvement of 14% compared to Aug 22 • Ambulance average handover delay trajectory of 56min to support the Devon System either achieved or within 2 minutes for the past 5 months. • NCTR performance is best in Southwest • Management of Industrial Action and Bank Holidays resulting in lower numbers of cancellations and improved flow. • PTL meeting governance and performance management assurance complete by Michael Wilson's team	• Weekend plans to focus on Friday handover medical and nursing meeting information. • GP identified for UTC and recruitment process complete. • GP appointed to support Frailty Virtual Ward. • UEC funding agreed with ICB for ED re-configuration, McCallum Ready to Go ward, and UTC/MIU upgrade.

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

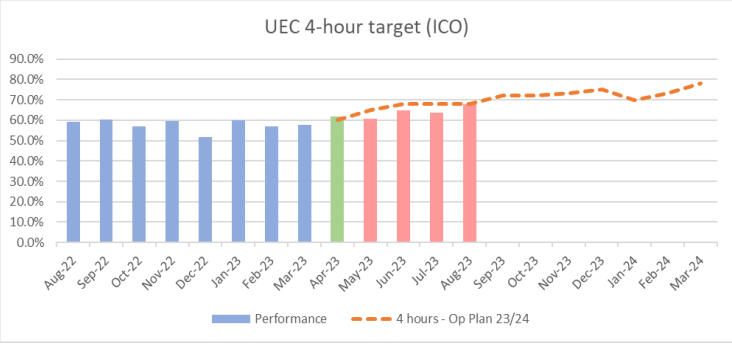
Torbay and South Devon NHS Foundation Trust

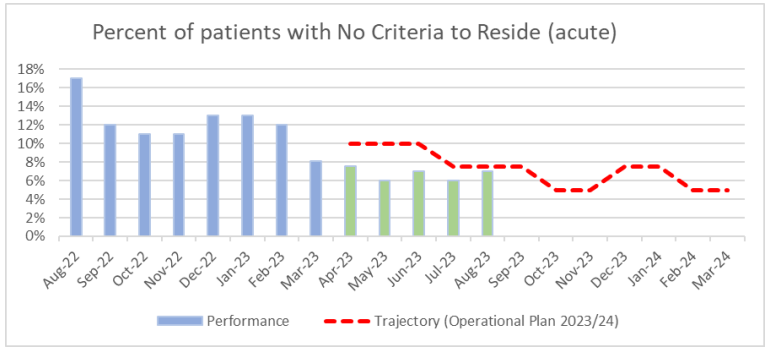
	Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Operational Plan trajectory August 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual				2844	3512	2448	5017	3280	740	2260	796	1630	1569	1223	1707	1111
Percentage of Ambulance handovers greater than 3 hours		16.7%	19.5%	23.8%	27.0%	18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	3.7%	3.7%	No trajectory
Total average time in ED (hours/minutes)		07:02	07:06	07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	05:41	06:05	No trajectory
ED attendances where visit time over 12 hours	0	827	920	906	988	939	1207	823	599	977	568	893	797	637	794	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68%
% patient discharges pre-noon	33%				18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	20.5%	21.6%	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%	6.0%	7.5%	7.5%

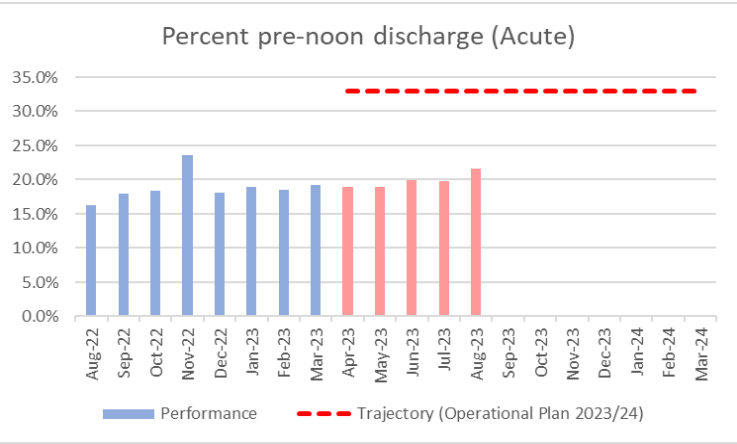
Trajectories have been agreed as part of the 2023/24 Operational Plan submission. The latest month trajectory, where applicable, is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories.

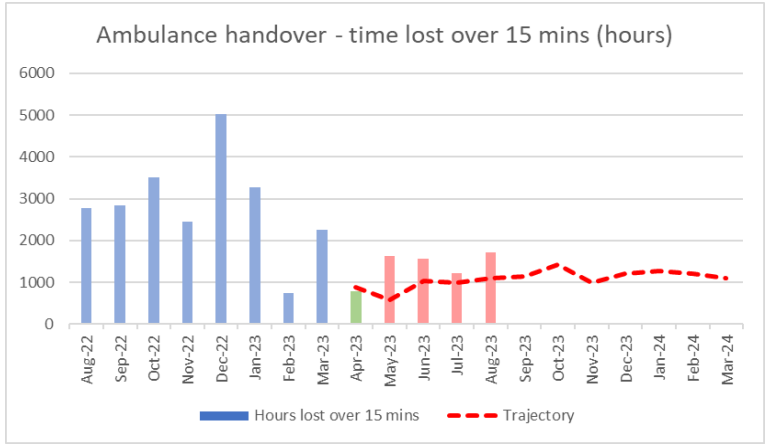
2023/24 RAG indicator

- Meeting monthly trajectory
- Not meeting monthly trajectory









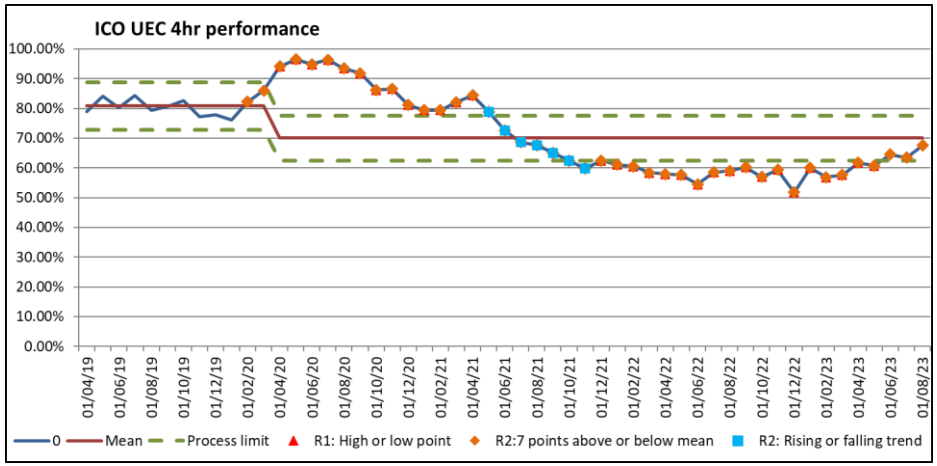
Exception report: 4-hour ED target: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

ED Type 1 performance 52.45%
ICO Performance 67.9%

This is a 37% improvement compared to Aug 2022 for type 1 and 14% improvement for the ICO.



Operational update

- August recorded a second consecutive month of 10000 plus attendances to the ICO and the second busiest month in the past three years.
- Type 1 performance - Overall attendances decreased from 6953 in July 2022 to 6748 in Aug 2023. We achieved 52.45% against our ED 4-hour target, the first time the Trust has been over 50% since July 2021.
- Type 3 demand (UTC and MIU) increased from 3440 in July 2023 to 3497 in August. We achieved 97.1% against our Type 3 4-hour target.
- Overall, our UEC performance was 67.90%, the fifth month in succession above 60% and the first time above of 67% since August 2021. September already looks positive in terms of further performance gains.

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 Same Day Emergency Care (SDEC), JETS, Frailty and Acute Medical Unit Level 2 configuration to support Emergency Department escalation bed reconfiguration to support the non-admitted pathway.
- Virtual Ward – rapid expansion of pathways and volume.
- Urgent Treatment Centre (UTC) / Minor Injury Unit (MIU) stability and plans to open Dawlish.

Risks/issues

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

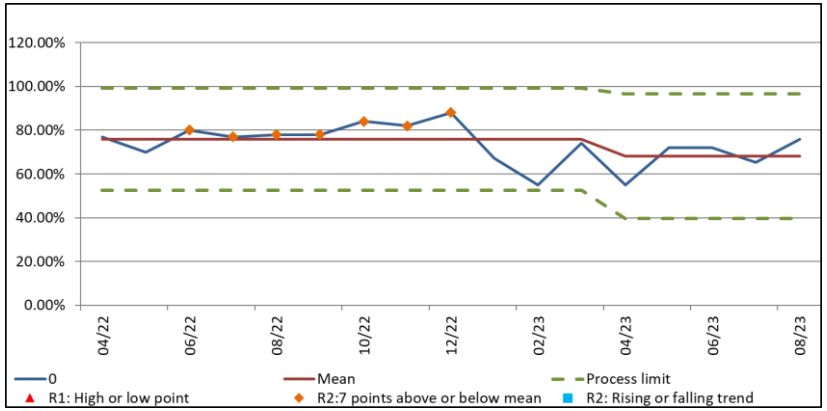
Exception report: Ambulance Handovers over 15 minutes: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

Ambulance handover delays increased in August compared to the previous month with 1707 arrivals over 15mins. The 30-day rolling average has improved for time lost to ambulance delays from 40hrs per day mid August to 38:40 as of the 6th September.

TSD NHS FT - % of Ambulance Handovers >15mins



Average time lost to ambulance handover delays (hours)

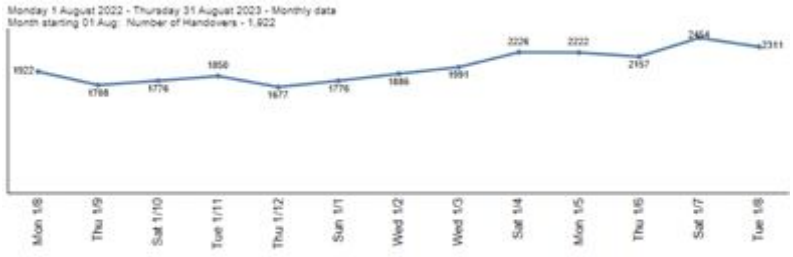
Rolling 30-day position as at **06 September 2023**

Ambulance Trust	Site	
South Western	Derriford Hospital	147:50:23
South Western	Gloucestershire Royal Hospital	70:40:28
South Western	Royal Cornwall Hospital (treliske)	60:23:33
South Western	Royal Devon & Exeter Hospital (w	50:27:36
South Western	The Great Western Hospital	44:23:00
South Western	Torbay Hospital	38:40:14
South Central	Queen Alexandra Hospital	36:01:01
South Western	Bristol Royal Infirmary	24:36:44
South Western	Royal Bournemouth Hospital	19:09:05
South Western	Musgrove Park Hospital	17:18:52
South Western	Royal United Hospital	15:16:24
South Western	Poole Hospital	15:12:17
South Western	Southmead Hospital	11:29:47
South Western	Salisbury Health Care NHS Trust	9:40:43
South East Coast	Royal Sussex County Hospital	7:41:41

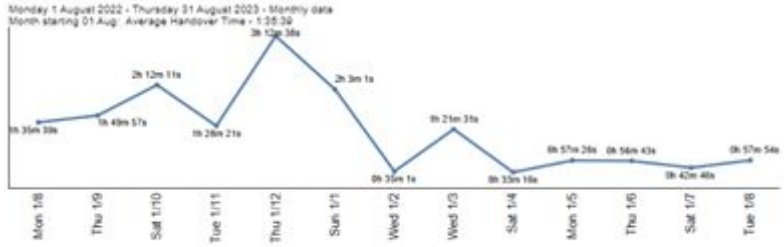
Operational update

In August, the Trust continued to make progress on ambulance handover delays.

Ambulance Handover demand has risen 20% comparing August 2022 (1922) to August 2023 (2311) handovers.



Despite the increase in activity the average time lost per ambulance to handover has decreased from 1hr 35min (incl the 15 mins) in August 2022 to 57min in August 2023.



Actions to complete next month

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

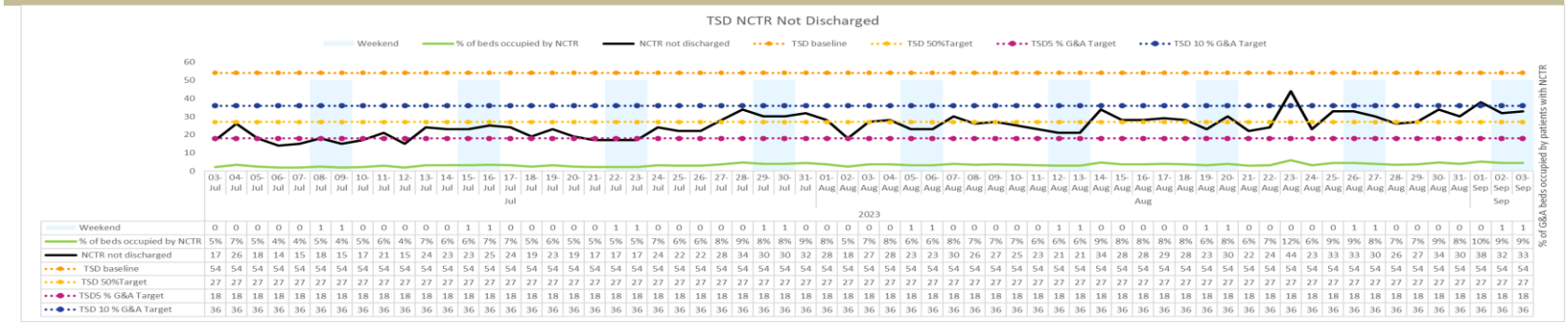
1. Increasing the number of patient discharges before noon and;
2. Increasing the number of patient weekend discharges.

Risks/issues

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

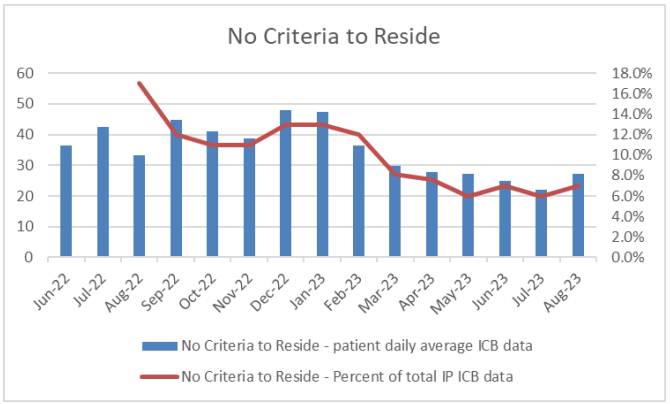
Exception report: No criteria to reside: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust



Performance - July

The average number of patients with No Criteria To Reside (NCTR) was 7.5% for August; **achieving 5% for one day in the month.** We continue to have the lowest NCTR across the ICB.



Operational update

Key actions that have supported the improvement in NCTR

- Trusted placement assessor.
- McCallum UEC funding agreed - pilot ready to go ward model implemented.
- 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 Discharge Co-ordinator now attending NCTR meeting and taking actions to improve flow and validate patients converted to CTR on day of discharge.
- Discharge Hub is competing D2A visits to support discharge when locality lack capacity to meet demand.

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.
- Ongoing PDSA cycles for McCallum Ready to Go Ward.

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
- Devon County Council prolonged sourcing and approval of placements due to financial constraints.

Exception report: Percent of pre-noon discharges: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance - July

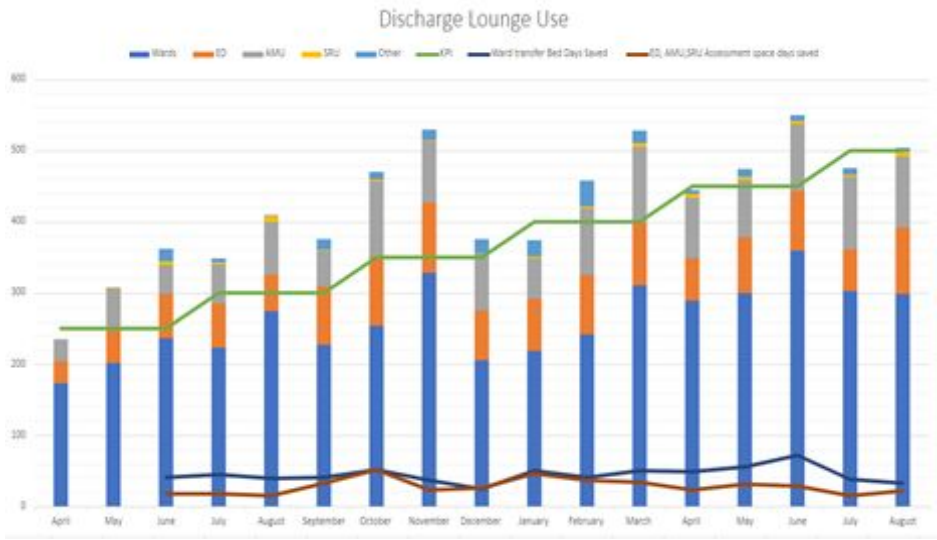
We saw a decrease in our overall general and acute discharges in August totalling 1679 compared with 1755 in July. Infection issues in month on wards will have contributed to this reduction. The percentage discharges pre 5pm improved. Pre –noon discharges increased in month supporting flow and performance; 21.6% being the best performance month in year.

The Flow and Ward Improvement Group (Subgroup to UEC Board) seek to continue to drive this improvement, with a focus on pre-noon, with workstreams to maintain and improve this position and our patient experience.

	Pre-noon	Pre 5PM
July	20.5%	69.8%
August	21.6%	70.6%

Operational update

The Discharge Lounge (DCL) remains a key part of the strategy for generating timely ward capacity. August saw 504 patients attend the discharge lounge.



Actions to complete next month

- 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 implementation of best practice.
- Formal weekend discharge meeting with clinical engagement every Friday; a new process to support Industrial action in August.
- 'Home for lunch'.
- Patient transport and Medication To-Take-Away 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.

National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

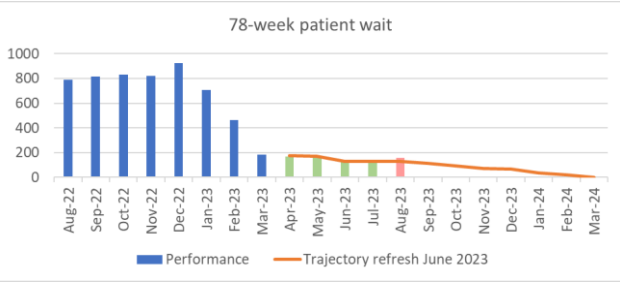
Torbay and South Devon NHS Foundation Trust

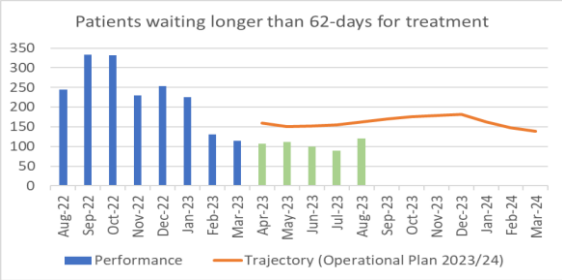
	Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Operational Plan trajectory August 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																
Elective recovery																
RTT 104 week wait incomplete pathway	0	70	51	50	47	34	29	22	14	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	686	787	813	829	822	923	708	462	183	166	167	123	129	156	130
RTT 65 week wait incomplete pathway	0		2093	2252	2485	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1387
RTT 52 week wait incomplete pathway	Reduction	4578	5083	5060	5412	5585	6027	5554	5116	4427	4024	3926	3938	3879	0	Not set
Patient waits over 2.5 years	0	54	47	24	24	17	12	9	6	0	0	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	67.7%	72.1%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	75.5%	78.0%	77.7%	79.5%	77.6%	75%
Number of patients waiting longer than 62 days for treatment	138	283	244	333	331	229	253	225	130	114	107	111	100	89	120	162

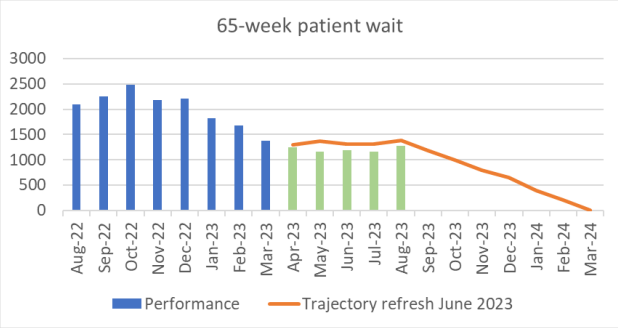
Trajectories have been agreed across NOF exit indicators as part of the 2023/24 Operational Plan submission. The latest month trajectory, where applicable, is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories. The Trajectory for reduction in patients over 78-week RTT has not been met in August. The impact of industrial action being a significant factor, the exception report (next page) describes in more detail the position and actions being taken.

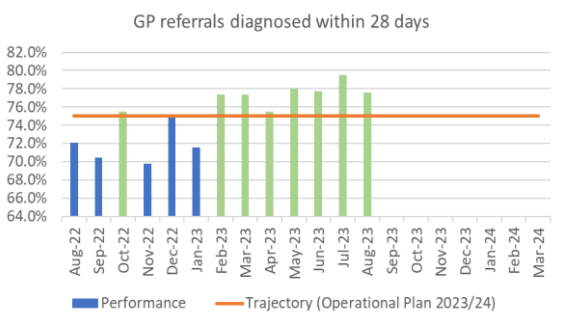
2023/24 RAG indicator

- 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;
- Medefer virtual outpatient appointments - contract in place and now commenced in gynaecology;
- Continued utilisation of the Nightingale elective centre for orthopaedics, cataract surgery, and diagnostics.

Risks and Barriers

- Industrial action – impact of August strike actions more pronounced than previous actions. Greater impact on long-wait trajectories is expected;
- Workforce – clinical, nursing, admin insourcing supporting gaps in clinical workforce capacity. HR programme to support recruitment and retention with ICS system support.

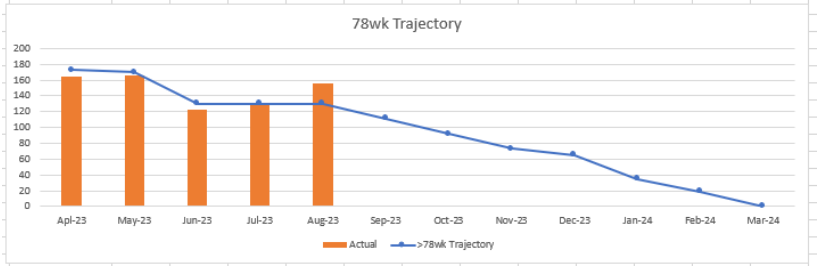
Exception report: 78 Week Clearance: NOF 4 Exit Criteria – Elective Recovery

Torbay and South Devon NHS Foundation Trust

Performance

The trajectory for reduction in patients over 78-week RTT has not been met in August.
In August, 156 patient remain waiting over 78-weeks against the target of 130.

	Apl-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
>78wk Trajectory	173	170	130	130	130	111	92	73	65	35	19	0
Actual	165	166	123	129	156							
Revised FoT due to Indutrial Action - via Tier1					160	141						



Operational update

Failure to deliver the 130 target is due to the impact of Industrial Action in August.

698 cancellations across both Junior Doctor and Consultant strikes impacting on capacity to deliver the necessary number of treatment and clinics to achieve the 78-week trajectory.

Good work from the teams minimised the overall impact on the longest waits with the target missed by 26 patients.

Actions to complete next month

- Complete a specialty assessment of likely strike impact to March 2024 to measure the potential shortfalls against operating plans.
- Assessment of insourcing and outsourcing plans to identify opportunities to compensate for lost capacity from Industrial Action in Q1 and Q2.
- Reassessment of ESRF plans may be required to address any likely shortfall in capacity.
- Work will continue to support the delivery of productivity across non- admitted and admitted pathways that are already built into original plans for delivery.
- Engage with Devon ICB to further explore Devon-wide solutions for capacity gaps arising from Industrial Action.

Risks/issues

- Continued Industrial Actions becoming more co-ordinated across staff groups and professions further limiting ability to provide any cross cover for routine delivery.
- Recruitment of critical posts in theatres clinical and support staff.
- Estate issues continue to cause downtime as a result of humidity and temperature.

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 August 2023, 1 incident of severe harm were reported onto the national StEIS (Strategic Executive Information system) and 2 deaths. The incident was a patient fall resulting in a fracture of the hip. The incidents of death were related to a fall with a fracture C1 and an unexpected death following delay to treatment. All incidents are being investigated as per the national reporting framework.

VTE (Venous Thromboembolism) Assessment

The overall VTE assessment conformity for all relevant in patients in August 2023 was 98.5%, which is a slight decrease from the previous 2 months but has maintained 95% national target. The number of VTE assessments completed within 24 hours of admission was reported as 95.1% which is a slight improvement on previous months. 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.

Infection, Prevention, and Control

There has been an increase in the number of patients admitted with Covid-19 during the month of August and increased outbreaks of Norovirus. This has resulted in an increased number of bed closures. The bed closures were mainly across 2 wards with one ward caring for 12 symptomatic patients. Focused work is being undertaken to ensure Infection, prevention, and control standards continued to be maintained.

Maternity

There was one late fetal loss in August 2023, this case has been reported to MBRACE and a PMRT is in progress.
The new implementation tool to enable providers to assess compliance against Saving Babies Lives V3 has been published. This will form part of the assurance mechanism for CNST compliance for this safety action and will need to be signed off through LMNS/ICS.

Fractured neck of femur

58.3% of patients had access to theatre within the recommended time frame in August 2023 against a target of 90%. This is a slight improvement, but more work needs to be undertaken. The Care Group are working through an improvement plan to ensure that beds can be ringfenced to ensure easier access to theatre.

Safer Staffing

The Registered Nurse fill rate for days during August 2023 was 97.9% which is a slight increase on July fill rate of 96.3% and for night duty reported as 88.7% which is a decrease on the July fill rate of 90.2%,
The fill rate for Health care support workers for days is 101.5% which is a decrease on July figures of 106.9% and 119.9% for night duty which is a slight increase on July figures of 118.4%.

CQC update 2021 and 2020 Action plans

2020 CQC inspection

The Quality Improvement action plan arising from the 2020 CQC inspection is nearing completion, and all closed actions continue to have oversight through the Care Groups. The Trust has one remaining Must Do action regarding staff appraisal achievement rate. The Trust position in August 2023 remains at 79.%. The People Directorate have created a two-phase recovery plan with improvement trajectories to ensure the 85% target is achieved and sustained. This includes clear expectations as set out in Peoples Promise, effective rollout of appraisal training, and a transition to electronic records.

2021 CQC Focused Inspection – Quality Improvements

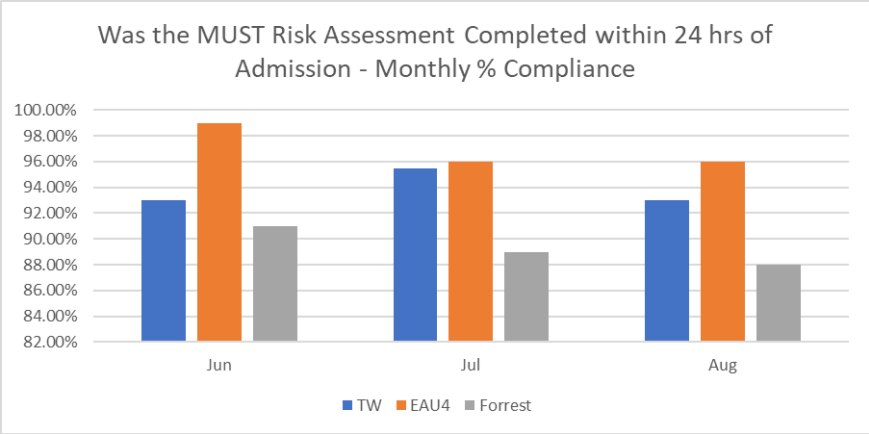
The daily 5 patient Risk Assessment audits continue to be being recorded electronically and the results viewed in real time. The audit covers 43 questions across several assessments and daily, weekly, and monthly compliance reports are generated. MUST risk assessment completion within the 24-hour time standard, has a TW compliance rate of 93%.

August 2023 Data

✓ Audit results report Trust wide nutritional risk assessments completed within 24 hours remains at 93%

✓ Forrest Ward has reduced to 89% with the ADNPP working with the ward to rectify and increase compliance

✓ EAU4 compliance remains high at 96%



CQC Well Led Inspection

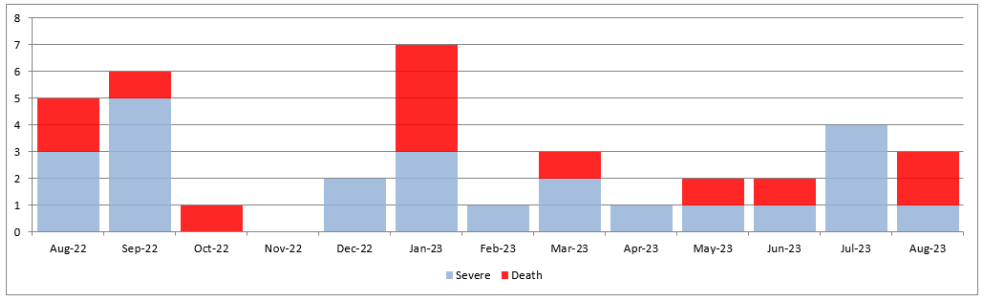
Following the inspections of Medical Care, Urgent & Emergency Care, Outpatients Department, Radiology & Imaging and Trust wide Well Led, the CQC have sent the draft report to their sign off committee. Unfortunately, this has been delayed and therefore we are waiting confirmation on when the report will be received. Once the Trust have received the draft report, a two-week period of factual accuracy checks will then be undertaken by the Trust, with the final report expected to be released mid-October. Once released, any Must Do actions will be included on this report page and monitored through the well-established CQC Assurance Group chaired by the Chief Nurse.

Quality and Safety exception reports – reported incidents / HSMR

Torbay and South Devon NHS Foundation Trust

Reported Incidents - Severe and Death

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

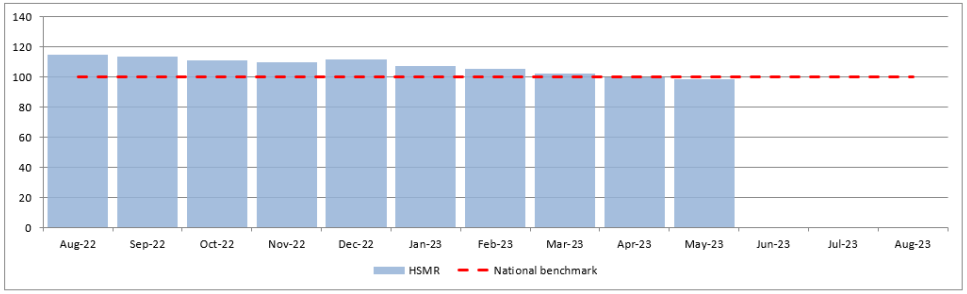


In August 2023, 1 severe incident and 2 deaths incident was reported.
One patient death was following a fall and fracture of anterior arch of C1, the other death was reported as an unexpected death following possible treatment delay; both incidents are being fully investigated as per the national policy.

The severe incident is a fall with a reported fracture of the hip – again this incident is being investigated as per national guidance.

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
HSMR	114.7	113.4	111	109.9	111.5	107.1	105.5	102.4	99.9	98.5	0	0	0
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



The latest HMSR for April 22 - March 23 is **101.7** (↓) (97.8 – 107.9), this is within the expected range compared to hospital trusts nationally. There has been a steady decline and the HSMR has been within the expected range for the last three data periods.

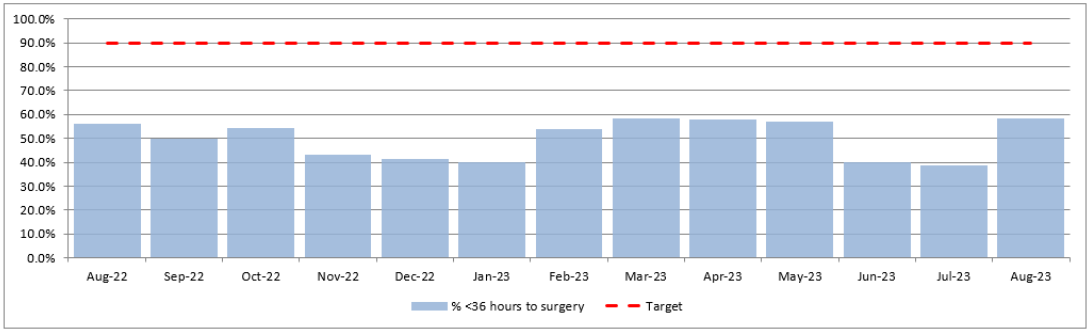
The emergency weekday HSMR remains statistically within the expected range. The emergency weekend HSMR remains statistically higher than expected, however, a more stable trend can be seen in latter periods. Previous work has demonstrated that at the weekend there were more individuals in the 75 and older 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

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
% <36 hours to surgery	56.0%	50.0%	54.3%	43.3%	41.5%	40.0%	53.8%	58.3%	58.0%	57.1%	40.0%	38.7%	58.3%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



58.3 % of patients had access to theatre within the recommended time frame in August 2023 against a target of 90%. This is a slight improvement, but more work needs to be undertaken.

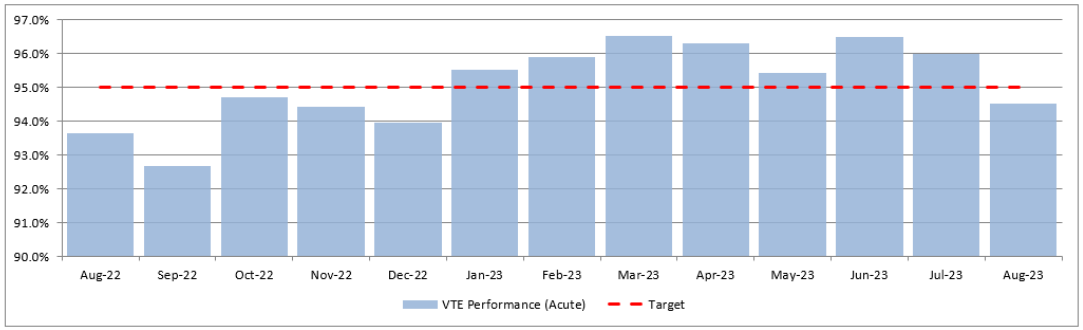
Reasons for failing to achieve the required standard includes;

- More patients requiring a total hip replacement which require an arthroplasty surgeon which can cause delays;
- Non ring-fencing of trauma beds;
- Assessment times and transfer times increasing resulting in fewer cases per list.

There has been a commitment from the Winter Planning Board to ring fence beds on Ainslie to support this vulnerable group of patients.

Acute VTE risk assessment on admission

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
VTE Numerator	5255	5102	5433	5521	4896	5631	5437	6050	5152	5104	2563	5911	5717
VTE Denominator	5612	5505	5737	5847	5210	5894	5669	6267	5349	5349	2656	6157	6048
VTE Performance (Acute)	93.6%	92.7%	94.7%	94.4%	94.0%	95.5%	95.9%	96.5%	96.3%	95.4%	96.5%	96.0%	94.5%
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%



VTE assessment

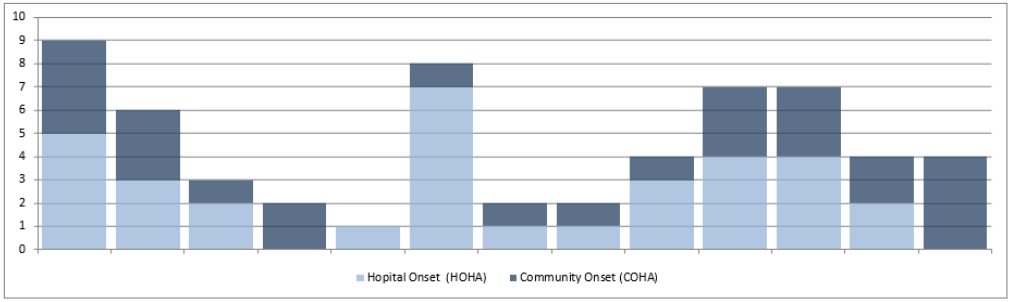
- VTE assessment audit achieved 94.5% in August, this is a slight deterioration on July's position and does not meet the 95% target.
- It is possible that this decrease in compliance is due to junior doctor industrial action;
- The VTE Steering Group are reviewing all ward areas and levels of compliance.

Quality and Safety exception report - Infection control

Torbay and South Devon NHS Foundation Trust

Number of Clostridium Difficile cases

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

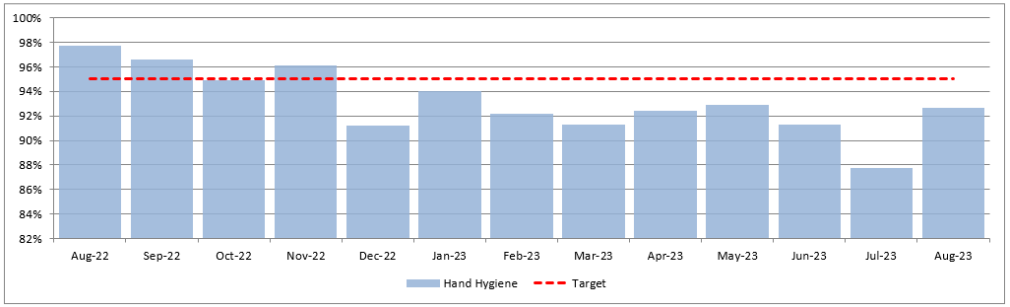


In August, 4 cases of Clostridium Difficile were reported.

Quarter 1 saw an increase in the number of cases of C Diff reported and an action plan is being developed to understand this increase.

Hand Hygiene

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Hand Hygiene	98%	97%	95%	96%	91%	94%	92%	91%	92%	93%	91%	88%	93%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

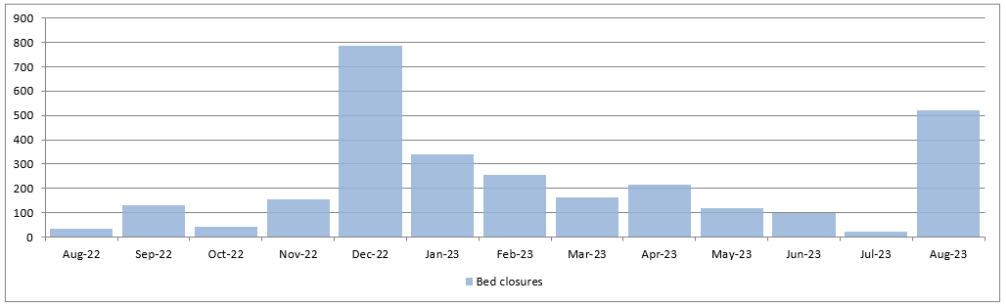


There has been an improvement in compliance in the Trust wide hand hygiene audits for August 2023. The Infection, Prevention, and Control team continue to provide targeted training on hand hygiene and have been using methods such as the 'glowbox' to ensure compliance.

The main issues were previously identified as inappropriate glove usage and therefore a Gloves Off campaign has been delivered Trust wide during the month of August 2023.

Infection control - Bed days lost (Acute)

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Bed closures	36	132	42	156	786	339	254	164	217	120	99	24	522



Bed closures increased from 24 in July to 522 in August. There was a significant increase in the number of patients being admitted with Covid-19 as well as outbreaks of Norovirus.

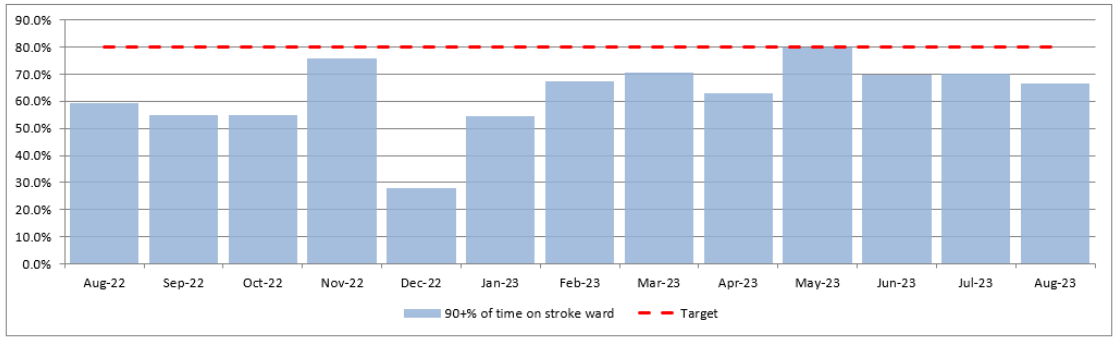
The bed closures were mainly across 2 wards with one ward caring for 12 symptomatic patients.

Quality and Safety exception report – stroke care

Torbay and South Devon NHS Foundation Trust

Stroke

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
90+% of time on stroke ward	59.3%	54.8%	55.0%	75.9%	28.0%	54.5%	67.4%	70.7%	63.0%	80.0%	70.0%	70.2%	66.7%
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

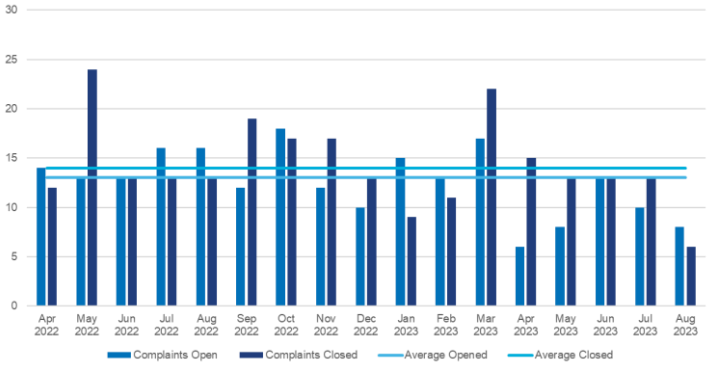
- 66.7% of patients spent more than 90% of their stay on the stroke unit which is a slightly worsening position from July 2023;
- 20.8 % of patients were admitted to the Stroke Unit with 4 hours of admission; this metric is a further deterioration on last month;
- 100% of patients received a nutrition screen and a continence plan within 12 hours;
- 53.3% of patients received a scan within one hour;
- 96.7% of patients received a scan within 12 hours which is an improved position on last month
- 81.6 % of patients saw a stroke nurse within 24 hours which is a slightly worsening position from July 2023.

Stroke performance governance and oversight

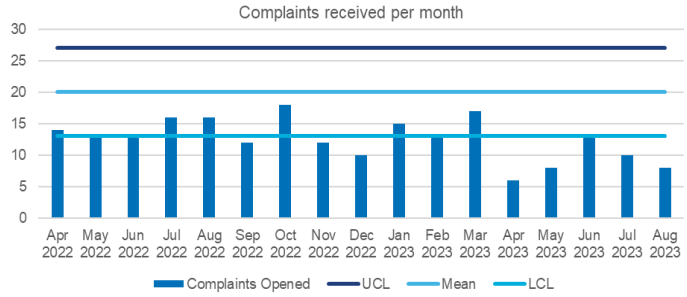
Actions identified from a review of the latest SSNAP data will be added to the Stroke Improvement Plan and managed via the Stroke Governance and SSNAP meetings.

A detailed report on stroke performance was presented at the Quality Assurance Committee earlier this month.

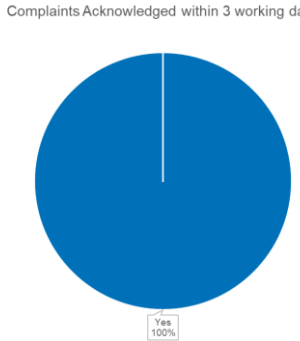
Total Number of Complaints and PAL's contacts during May 2023



On a month-by-month basis, an average of 13 complaints was received per month, and 14 complaints were on average closed per month.
August 23 saw a reduction in complaints closed this is a result of summer holiday leave across services elongating the investigation stage.



The number of complaints received in the financial year to date stands at 45; this is lower than the same period last year by 27 complaints which equates a 46% decrease.
The Trust received 8 new complaints during August 2023

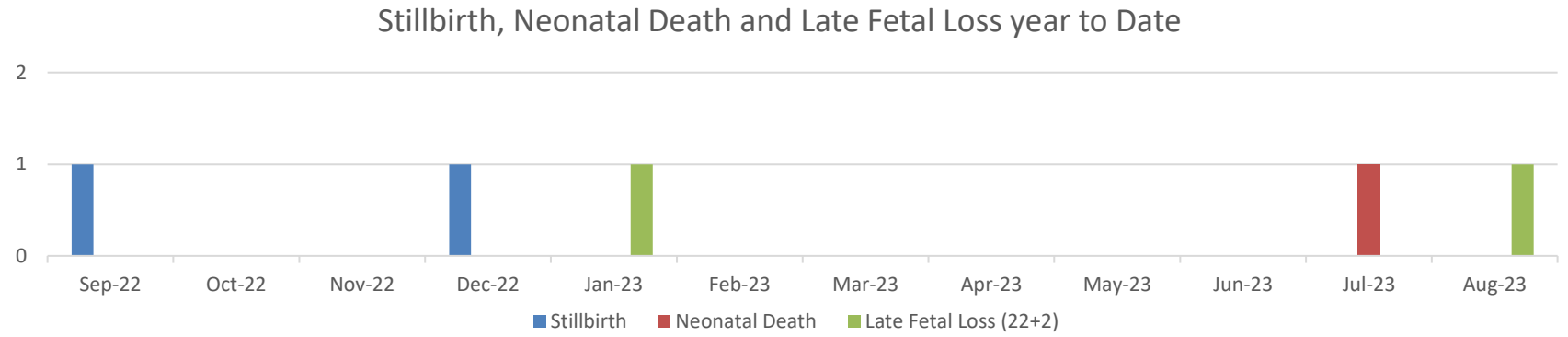


Within the 45 complaints received in the 2023/24 financial year, all are reported as being acknowledged within 3 working days.

20

Quality and Safety- Perinatal Clinical Quality Surveillance August 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



- August - Late fetal loss at 22+2, reported to MBRACE requiring a PMRT.
- 1 referral to HSIB for a second twin that went to Derriford for therapeutic cooling, this baby has now been repatriated to Torbay.

	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Running Total
% of women booked for continuity of carer	50.9%	54.9%	52.2%	49.7%	61.0%	62.1%	64.8%	74.4%	75.7%	94.0%	96.2%	75.7%	67.6%
Number of Stillbirths	1	0	0	1	0	0	0	0	0	0	0	0	2
% Robson Group 1	37.5%	12.0%	22.9%	12.0%	19.4%	0.0%	26.9%	5.6%	17.6%	22.7%	6.7%	26.7%	17.5%
% Robson Group 2	48.3%	38.2%	36.4%	36.4%	42.9%	42.9%	18.5%	37.0%	22.2%	28.0%	23.1%	19.0%	32.7%
% Robson Group 5	90.9%	57.1%	90.5%	90.9%	88.9%	88.9%	87.5%	75.0%	76.5%	81.3%	88.9%	92.3%	84.1%
% Breastfeeding at Delivery	70.8%	63.9%	64.7%	63.0%	63.1%	71.8%	71.0%	67.1%	71.7%	69.9%	78.4%	67.6%	68.6%

- The new implementation tool to enable providers to assess compliance against Saving Babies Lives V3 has been circulated. This will form part of the assurance mechanism for Clinical Negligence Scheme for Trusts compliance for this safety action and will need to be signed off through LMNS/ICS.
- The Perinatal quadrumvirate have the next round of culture and leadership training in early September. The SCORE survey will be sent out in mid-October and the dissemination and debriefing of results will be supported by an external organisation commissioned by NHS England.

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	Aug 2023 **29** WTE over plan	• enhanced vacancy and scrutiny measures have been established
Bank WTE	Aug 2023 **86** WTE over plan	
Agency WTE	Aug 2023 **80** 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%)	Aug 2023 **4.96%**	• 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 • Management induction and development to include training in sickness absence management
Sickness, 12m rolling % (target 4%)	Aug 2023 **5.19%**	
Achievement review rate (target 90%)	Aug 2023 **79.92%**	

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 **29 WTE** over plan in August 2023, improving from the previously reported 86 WTE above plan in July. As anticipated this improvement has largely been as a result of 2022/23 junior doctor cohort starting to leave the Trust as they continue their rotation.
- Use of our temporary workforce has increased between July and August and remains above plan. This is largely as a result of Industrial Action (Junior Doctors 11-15th August and Consultant 24-26th August) and some increase in sickness absence. The industrial action was not factored into any of the operational plans.

- **Bank usage** has increased by 23% since July, equating to 64.03 WTE and is **86 WTE** above plan.
- **Agency usage** has increased by 5%, since July equating to 8 WTE and is **80 WTE** over plan in August.

To mitigate these increases, and to support the Trust to achieve its substantive, bank and agency plans, we continue to operate enhanced 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

		Plan - As at the end of																
	Baseline: Staff in post	Plan Apr 23	Apr 23 Actual	Plan May 23	May 23 Actual	Plan Jun 23	Jun 23 Actual	Plan Jul 23	Jul 23 Actual	Plan Aug 23	Aug 23 Actual	Plan Sep 23	Plan Oct 23	Plan Nov 23	Plan Dec 23	Plan Jan 24	Plan Feb 24	Plan Mar 24
	31-Mar-23	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 WTE*
Total Workforce	6710.23	6,498	6636.15	6,508	6662.09	6,520	6788.34	6,522	6707.55	6,531	6727.04	6530	6,552	6,579	6,609	6,619	6,622	6,644
Total Substantive	6189.91	6,170	6188.1	6,170	6168.33	6,178	6196.22	6,180	6266.13	6,184	6213.48	6,190	6,197	6,199	6,212	6,222	6,225	6,241
Total Bank	319.4	237	282.02	243	289.44	247	362.58	246	273.16	251	337.19	249	251	270	281	280	282	281
Total Agency	200.92	91	166.03	95	204.32	95	229.54	96	168.26	96	176.37	91	104	110	116	117	115	122

Service Level – Workforce Implications affecting NOF4 exit

Torbay and South Devon NHS Foundation Trust

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. However, 1 post has now been filled. Mitigating action: A bespoke recruitment video has been developed to enhance marketing and attraction. Current advert has one potential applicant with interviews booked for September.
Urology	Issue: Continue to have 2 consultant vacancies being filled by locums. Mitigating actions: Developing a clinical model with Royal Devon for out-of-hours (OOH) cover and a long-term plan with hot and cold sites.
Gynae	Issue: Gynae clinic demand profiles and Okenden requirements require additional clinical capacity. Mitigating actions: Undertaking a full-service review to ensure that there is a single plan that encapsulates all of the actions and interventions that are needed to reduce the risk.
Colorectal / Upper GI	Issues: Consultants moved to a second on-call rota during COVID which has impacted job plans and the delivery of elective capacity. There have been 3 Specialist Registrar(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 September 2023. A Senior House Officer has been appointed for the next 8-12 months and will also support ST3 on-call (to make the on-call rota compliant). August 2023 is first time we have had a full quota of Junior Doctors starting for 18 months.
Interventional Radiology	Issue: Since April 2023, the 24/7 Interventional Radiology (IR) service has not been able to provide 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, 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 programme of international recruitment is being piloted, with interviews being held in October 2023. 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	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Performance
Month Sickness %	<4%	4.90%	5.86%	5.39%	6.54%	5.26%	4.59%	4.63%	5.07%	4.46%	4.88%	4.98%	4.96%	
12 Mth Rolling Sickness %	<4%	5.74%	5.71%	5.69%	5.76%	5.69%	5.58%	5.62%	4.96%	5.29%	5.32%	5.18%	5.19%	
Achievement Rate %	>90%	75.77%	76.61%	77.96%	76.70%	77.68%	76.71%	76.87%	77.87%	78.12%	78.08%	78.08%	79.92%	
Labour Turnover Rate	10-14%	13.88%	13.66%	13.74%	13.48%	13.33%	13.09%	12.85%	12.92%	12.74%	12.46%	12.71%	12.46%	
Overall Training %	>85%	88.70%	88.65%	89.10%	89.70%	89.94%	90.09%	90.45%	90.72%	91.24%	91.74%	91.49%	91.97%	
Nuring Staff Average % Day Fill Rate- Nurses		96%	99%	99%	92%	92%	91%	93%	92%	96%	100%	96%	98%	
Nuring Staff Average % Night Fill Rate- Nurses		86%	89%	86%	87%	88%	87%	88%	91%	90%	89%	90%	89%	
Safer Staffing- Overall CHPPD		7.53	7.72	7.75	7.54	7.72	7.83	7.75	7.9	8.05	7.99	8.4	8.17	

Sickness

The operational plan trajectories reflects revised key performance indictors for sickness absence based upon the previous 5 years trend data. We have seen an improvement in the 12 months ending August to **5.19%**, which is below our plan of 5.58% and lower than the same time last year (5.72%). Rolling sickness cost at the end of August was £11.6m which whilst lower that the £12m in August 2022, represents a significant opportunity for improvement.

Turnover

Following marginal increases in April and July, there has been a general downward trend in turnover since the start of the calendar year. This remains the case in August with an actual turnover of **12.46%**, against a plan of 13.09% and representing an improvement from the previous month. Turnover is significantly lower that the same time last year (13.82%). Actions as part of the Integrated Care System Retention project are showing a positive impact e.g. stay interviews, legacy mentors, 5 high impact measures.

Mandatory Training

There has been a steady upward trend in overall compliance over the last 12 months. Compliance continues to improve by 0.5% in August to **91.97%** against a target of 85%. However, at a topic level we remain challenged in Manual Handling at **78%** and Information Governance at **87%.**

Achievement Review

Compliance has improved by just under 0.9 % in August to **79.92%** but remains below the target of 90%. To aid improvement the data is made available to cost centre managers and will continue to be part of the revised Care Group dashboard.

Safer Staffing – planned versus actual

Torbay and South Devon NHS Foundation Trust

Aug-23

Ward	Day						Night						Total Patients	Day			Night		
	RN / RM		Nursing Associates		Care Staff		RN / RM		Nursing Associates		Care Staff			Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)
	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours							
Ainslie	1783	1685	0	0	1783	2098	1426	1323	0	0	1070	1376	700	94.5%	0.0%	117.7%	92.7%	0.0%	128.7%
Allerton	2933	2796	0	0	1070	1124	1426	1332	0	0	1070	1227	885	95.3%	0.0%	105.1%	93.4%	0.0%	114.7%
Cheetham Hill	1783	1782	0	0	2139	2492	1070	1058	0	0	1426	2207	820	100.0%	0.0%	116.5%	98.9%	0.0%	154.8%
Coronary Care	1426	1504	0	0	0	0	1070	1058	0	0	0	0	381	105.5%	0.0%	0.0%	98.9%	0.0%	0.0%
Cromie	1691	1932	0	0	891	1741	1070	1070	0	0	713	1501	757	114.3%	0.0%	195.4%	100.0%	0.0%	210.5%
Dunlop	1426	1400	0	0	1248	1121	1070	1081	0	0	1070	983	739	98.2%	0.0%	89.8%	101.1%	0.0%	91.9%
EAU4	1783	1809	0	0	1426	1403	1783	1415	0	0	1426	1468	742	101.5%	0.0%	98.4%	79.4%	0.0%	102.9%
Ella Rowcroft	1070	1004	0	0	1426	1400	1024	736	0	0	713	730	360	93.9%	0.0%	98.2%	71.9%	0.0%	102.4%
Warrington	1070	1141	0	0	713	759	713	713	0	0	713	724	492	106.7%	0.0%	106.5%	100.0%	0.0%	101.5%
George Earle	1783	1673	0	0	2139	2057	1070	1024	0	0	1426	1679	829	93.9%	0.0%	96.1%	95.7%	0.0%	117.7%
ICU	3209	2371	0	0	357	58	3209	2231	0	0	0	0	141	73.9%	0.0%	16.1%	69.5%	0.0%	0.0%
McCullum (Escalation)	713	937	0	0	1070	1047	713	713	0	0	1070	1036	513	131.3%	0.0%	97.9%	100.0%	0.0%	96.8%
Louisa Cary	2496	1773	0	0	713	819	2496	1578	0	0	713	832	418	71.1%	0.0%	114.8%	63.2%	0.0%	116.6%
John Macpherson	1070	977	0	0	713	588	713	644	0	0	357	356	391	91.3%	0.0%	82.4%	90.3%	0.0%	99.7%
Midgley	1783	2285	0	0	1783	1299	1426	1541	0	0	1426	1538	796	128.2%	0.0%	72.9%	108.1%	0.0%	107.8%
SCBU	1070	918	0	0	357	305	1070	827	0	0	357	323	219	85.8%	0.0%	85.4%	77.3%	0.0%	90.6%
Simpson	1783	2086	0	0	2139	2456	1070	1126	0	0	1426	2145	844	117.0%	0.0%	114.8%	105.3%	0.0%	150.4%
Turner	1426	1596	0	0	1783	1642	713	713	0	0	1426	1413	546	111.9%	0.0%	92.1%	100.0%	0.0%	99.1%
New Forrest Ward	1783	1874	0	0	1426	1816	1426	1437	0	0	1426	1876	889	105.1%	0.0%	127.3%	100.8%	0.0%	131.5%
Total (Acute)	*32074*	*31539.55*	*0*	*0*	*23172.5*	*24222.75*	*24552.5*	*21617.25*	*0*	*0*	*17825*	*21410.5*	*11462*	98.3%	0.0%	104.5%	88.0%	0.0%	120.1%
Brixham	868	852.5	434	0	1302	1326	1023	759	0	0	682	918	531	98.2%	0.0%	101.8%	74.2%	0.0%	134.6%
Dawlish	868	846.75	0	0	1085	1125	744	682	0	0	682	1035	488	97.6%	0.0%	103.7%	91.7%	0.0%	151.8%
Newton Abbot - Teign Ward	1953	1789	0	0	1953	1705	1023	1047.5	0	0	1023	1308	911	91.6%	0.0%	87.3%	102.4%	0.0%	127.9%
Newton Abbot - Templar Ward	1736	1678.5	0	0	2170	1844.5	1023	1036.5	0	0	1116	1034.5	912	96.7%	0.0%	85.0%	101.3%	0.0%	92.7%
Totnes	868	857.5	0	0	1302	1226.5	744	671	0	0	682	688.5	530	98.8%	0.0%	94.2%	90.2%	0.0%	101.0%
Organisational Summary	38367	37564	434	0	30985	31450	29110	25813	0	0	22010	26395	14834	97.9%	0.0%	101.5%	88.7%	0.0%	119.9%

- The Registered Nurse fill rate for days during August was 97.9% which is a slight increase in July fil rate of 96.3 % and for night duty reported as 88.7% which is a decrease on the previous months fill rate of 90.2%.
- The fill rate for Health care support workers for days is 101.5% which is a decrease on July figures of 106.9% and 119.9% for night duty which is a slight increase on July figures of 118.4%.
- 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

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	9.30	4.30	0.00	5.00	1	7	0	0	3.2%	22.6%	0.0%	0.0%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	7.30	4.70	0.00	2.70	14	22	0	7	45.2%	71.0%	0.0%	22.6%	7.74	4.74	0	2.91
Cheetham Hill	7.39	3.29	0.00	4.11	9.20	3.50	0.00	5.70	0	9	0	0	0.0%	6.5%	0.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.70	6.70	0.00	0.00	4	4	0	0	12.9%	12.9%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.75	3.68	0.00	2.07	8.20	4.00	0.00	4.30	0	5	0	0	0.0%	16.1%	0.0%	0.0%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.20	3.40	0.00	2.80	19	15	0	19	61.3%	48.4%	0.0%	61.3%	7.74	4.74	0	2.91
EAU4	8.63	4.79	0.00	3.83	8.20	4.30	0.00	3.90	24	28	0	9	77.4%	90.3%	0.0%	29.0%	7.74	4.74	0	2.91
Ella Rowcroft	8.63	4.31	0.00	4.31	10.80	4.80	0.00	5.90	3	10	0	1	9.7%	32.3%	0.0%	3.2%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	6.80	3.80	0.00	3.00	3	3	0	5	9.7%	9.7%	0.0%	16.1%	7.74	4.74	0	2.91
George Earle	7.39	3.29	0.00	4.11	7.80	3.30	0.00	4.50	6	13	0	6	19.4%	41.9%	0.0%	19.4%	7.74	4.74	0	2.91
ICU	21.85	20.70	0.00	1.15	33.00	32.60	0.00	0.40	1	1	0	26	3.3%	3.3%	0.0%	86.7%	7.74	4.74	0	2.91
McCullum (Escalation)	6.76	2.71	0.00	4.06	7.30	3.20	0.00	4.10	6	1	0	13	19.4%	3.2%	0.0%	41.9%	7.74	4.74	0	2.91
Louisa Cary	10.89	8.47	0.00	2.42	12.00	8.00	0.00	3.90	9	18	0	1	0.0%	58.1%	0.0%	3.2%	7.74	4.74	0	2.91
John Macpherson	5.11	3.19	0.00	1.92	6.60	4.10	0.00	2.40	6	5	0	5	20.0%	16.7%	0.0%	16.7%	7.74	4.74	0	2.91
Midgley	7.96	3.98	0.00	3.98	8.40	4.80	0.00	3.60	3	0	0	25	9.7%	0.0%	0.0%	80.6%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	10.80	8.00	0.00	2.90	5	7	0	8	16.1%	22.6%	0.0%	25.8%	7.74	4.74	0	2.91
Simpson	7.39	3.29	0.00	4.11	9.30	3.80	0.00	5.50	0	2	0	0	0.0%	6.5%	0.0%	0.0%	7.74	4.74	0	2.91
Turner	9.58	3.83	0.00	5.75	9.80	4.20	0.00	5.60	10	0	0	16	32.3%	0.0%	0.0%	51.6%	7.74	4.74	0	2.91
New Forrest Ward	6.74	3.57	0.00	3.17	7.90	3.70	0.00	4.20	1	3	0	1	3.2%	9.7%	0.0%	3.2%	7.74	4.74	0	2.91
Brixham	7.72	3.39	0.78	3.56	7.30	3.00	0.00	4.20	20	27	31	4	64.5%	87.1%	100.0%	12.9%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	7.60	3.10	0.00	4.40	1	19	0	1	3.2%	61.3%	0.0%	3.2%	7.74	4.74	0	2.91
NA - Teign Ward	6.40	3.20	0.00	3.20	6.40	3.10	0.00	3.30	10	16	0	7	32.3%	51.6%	0.0%	22.6%	7.74	4.74	0	2.91
NA - Templar Ward	6.50	2.97	0.00	3.53	6.10	3.00	0.00	3.20	25	11	0	28	80.6%	35.5%	0.0%	90.3%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	6.50	2.90	0.00	3.60	12	13	0	17	38.7%	41.9%	0.0%	54.8%	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
	7.53	4.20	0.03	3.30	8.17	4.27	0.00	3.90
Total Planned Beds / Day	518							
Days in month	31							

- The Registered Nurse actual CHPPD has been reported as 4.27 in August but still remains below the carter recommendation of 4.7.
- The actual Health Care Assistant CHPPD was 3.90 in August 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 August the Trust was operationally challenged with 5 days in OPEL 4 and 16 days at OPEL 3
- The planned CHPPD total was reported as 7.53 with an actual of 8.17 which reflects an increase in escalation areas due to operational challenges.

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%)		⬆

Operational Performance 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		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		↑

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Monthly Financial Performance Report

M05 (Period Ended August 2023)

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Torbay and South Devon NHS Foundation Trust

Executive Summary

Description	YTD Bud £000	YTD Act £000	Var £000	Var %	YTD R.A.G	F'cast Bud £000	F'cast Exp £000	Var £000	Var %	F'cast R.A.G
Operating Income	266,159	267,934	1,775	0.7%		635,632	635,632	0	0.0%	
Operating Expenditure and Financing Cost	(286,157)	(289,605)	(3,448)	(1.2%)		(668,205)	(668,205)	0	0.0%	
Surplus / (Deficit)	**(19,998)**	**(21,671)**	**(1,673)**	**8.4%**		**(32,573)**	**(32,573)**	**0**	**0.0%**	
Add back: Donated Assets	(148)	232	380	(256.6%)		2	2	0	0.0%	
Adjusted Surplus / (Deficit)	**(20,146)**	**(21,439)**	**(1,293)**	**6.4%**		**(32,571)**	**(32,571)**	**0**	**0.0%**	
Capital (CDEL)	15,635	14,118	(1,517)	(9.7%)		56,755	47,851	(8,904)	(15.7%)	
Cash & Cash Equivalents	19,055	12,184	(6,871)	(36.1%)		14,975	14,975	0	0.0%	

As at Month 5, the Trust reported an adverse financial variance to plan of **£1.293m** . This is primarily driven by the net impact of the ongoing Industrial Actions. At this stage of the year, we are still formally reporting a no variance to plan in the forecast position, however the overall risk to forecast is £32.3m (please see details on slide 17). We have started a conversation within the Integrated Care System (ICS) regarding the timing and appropriate governance routes to follow before jointly reporting a likely in-year forecast variance to plan around M9 (December).

Up to this point the Trust is forecast to achieve **£21.52m** of the full year **£46.58m** CIP target, of which **£18.56m** (86%) being Recurrent schemes. Furthermore, **£11.58m** of CIP schemes have been identified as achievable in future months, leaving a remaining **£13.47m** still to be identified and delivered.

Please also note that the YTD operating expenditure includes an unplanned net cost pressure of **£1.293m** arising from Industrial Actions, anticipating that this cost will escalate further with industrial actions planed in the coming months. This potential risk has been duly incorporated into the risk and mitigation schedule which has been reported to the Integrated Care Board (ICB) and NHS England and Improvement (NHSE/I).

Torbay and South Devon NHS Foundation Trust

In Month (Aug-23) Position by Category

	M05 Bud £000	M05 Act £000	Var £000
Patient Income – Block incl. Torbay Council	43,350	42,639	(711)
Patient Income – Variable	3,876	4,147	271
ASC Client Contribution	1,258	1,882	624
Other Patient Income incl. Private Patient	482	321	(160)
Torbay Pharmaceutical Sales	1,710	2,355	645
Other Income	2,602	3,044	441
Total Income (A)	**53,278**	**54,388**	**1,110**
Pay – Substantive	(25,176)	(26,489)	(1,313)
Pay – Bank & Agency	(1,933)	(1,890)	44
Non-Pay – Other	(14,155)	(14,881)	(726)
Non- Pay – ASC / CHC	(11,725)	(12,775)	(1,050)
Financing & Other Costs	(2,889)	(2,613)	277
Total Expenses (B)	**(55,879)**	**(58,648)**	**(2,769)**
Sub-Total Surplus / (Deficit) (A+B)	**(2,601)**	**(4,260)**	**(1,659)**
Adjustments - Donated Items / Impairment / Gain on Asset disposal	(79)	(12)	66
Adjusted Surplus / (Deficit)	**(2,680)**	**(4,273)**	**(1,593)**

In Month Variance Overview

In month planned financial deficit for Aug-23 was **(£2.68m)**. The actual net expenditure reported was **(£4.27m)**, showing an adverse variance to the plan of **(£1.59m)** in month.

Income Variance

In M05, the total Patient and Other Income shows a favourable variance of **£1.11m** compared to the plan. Torbay Pharmaceutical Sales saw favourable variance of **£0.65m** which higher than expected activity levels for the month. ASC Client Contribution was higher this month by **£0.62m** partially offset by increased expenditure for the period.

Patient block income is **(£0.71m)** lower than anticipated in month and for the year due to the treatment of non-recurrent Integrated Care Board (ICB) income received at year-end 22/23, this is released via the balance sheet which is slightly behind the phasing initially anticipated. The **(£0.16m)** adverse variance in Other Patient Income mainly relates to provider-to-provider income and Private patient income.

Pay Variance

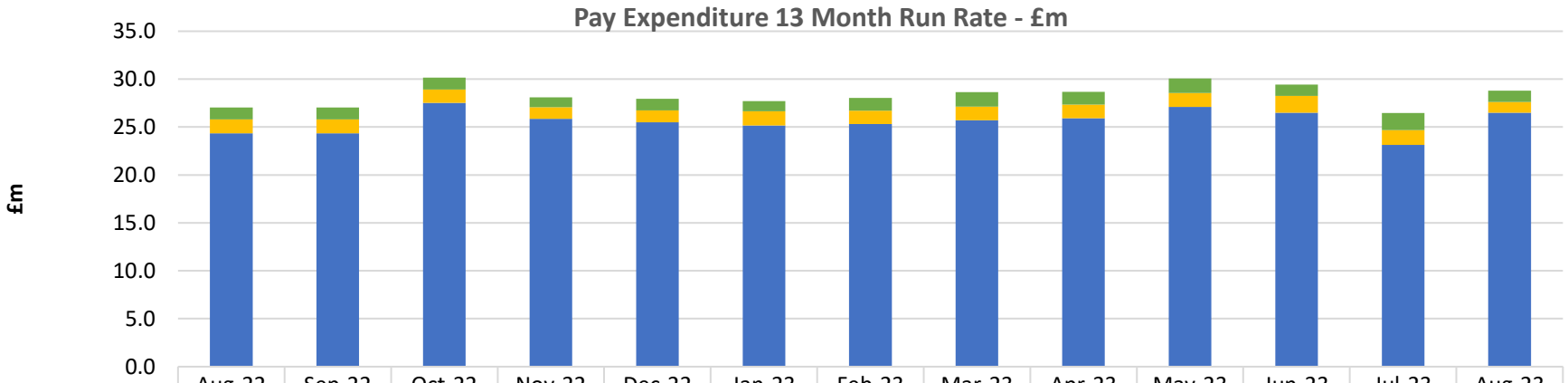
In M05, the cost of pay for substantive staff indicated an in month adverse variance to plan of **(£1.31m)**, this includes the medical workforce inflationary backpay in August. The other reason is linked to the CIP target being phased more heavily from M5 onwards. This phasing is aligned with the workforce plan and supports the objective of maintaining a no workforce growth position from 31st March 2023.

Non-pay Variance

Total Non-Pay expenditure position was **(£1.50m)** adverse to plan. This is partial due to under-achievement of CIP and higher than plan costs in Adult Social Care (ASC) and Continuing Health Care (CHC) due to client complexity and increase in volume.

Torbay and South Devon NHS Foundation Trust

Pay Expenditure – Run Rate



	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Agency	1.2	1.2	1.2	1.0	1.2	1.1	1.3	1.5	1.3	1.5	1.2	1.8	1.2
Bank	1.4	1.4	1.4	1.2	1.2	1.5	1.4	1.4	1.4	1.5	1.8	1.6	1.1
Substantive	24.3	24.3	27.5	25.9	25.5	25.2	25.3	25.7	25.9	27.1	26.5	23.1	26.5
Total	27.0	27.0	30.1	28.1	28.0	27.7	28.0	28.7	28.7	30.1	29.4	26.5	28.8

The graph above displays the run rate for overall pay expenditure over the previous 13 months* excluding technical adjustments, covering data that includes bank, agency, and substantive pay, along with any overtime hours worked. As at M05, there had been a slight reduction in bank and agency usage despite ongoing industrial actions. The increase in substantive pay includes medical staff inflationary back-pay, partially attributed to the impact of industrial action. Further industrial actions in M06 and M07 could result in additional cost escalations.

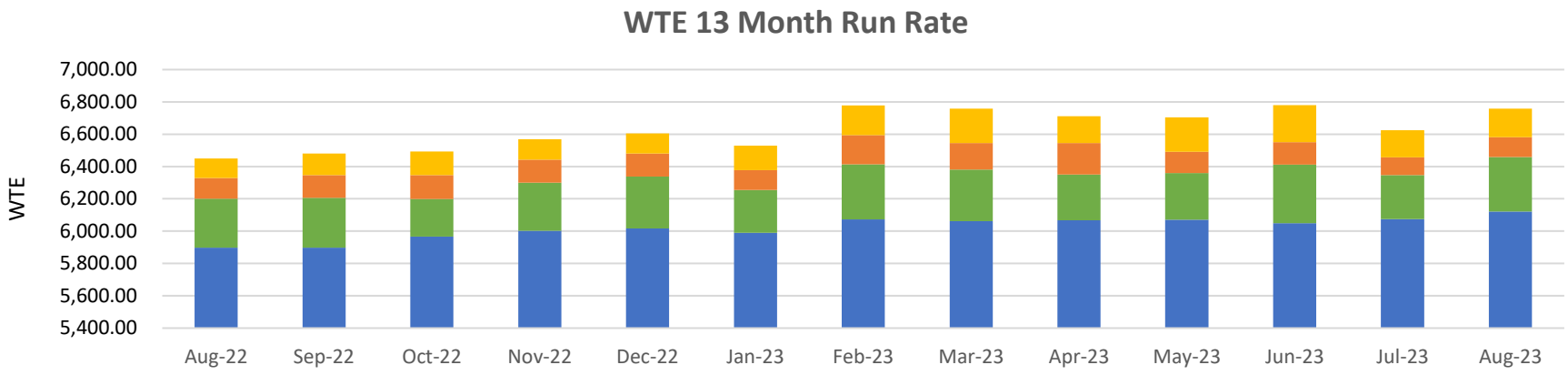
At present, the ongoing run rate for bank and agency spending consistently exceeds **£1.0m**. This heightened level of expenditure is a direct response to the necessity of addressing staffing vacancies across the Trust and providing coverage for sickness leave. Moreover, this situation is exacerbated by the continued Industrial Actions.

It is imperative to emphasise that within the first five months of this fiscal year, almost 65.4% of the agency spending limit for the year, as stipulated by NHSE/I, has already been expended. Therefore, it becomes an urgent requirement to implement corrective measures aimed at controlling agency expenditure

* Periods prior to Mar-23 have been inflated to 23/24 uplift to aid comparison in spend

Torbay and South Devon NHS Foundation Trust

WTE Worked – Run Rate



	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Agency	119.40	134.13	145.46	126.06	125.82	151.95	185.33	213.26	166.03	212.49	229.54	168.27	176.40
Overtime	128.70	140.23	148.18	143.08	142.42	121.88	179.81	163.13	195.29	131.83	139.46	110.35	122.50
Bank	303.50	309.42	233.21	298.67	320.89	265.84	340.81	320.19	282.01	289.41	362.58	273.16	337.20
Contracted	5,897.70	5,896.85	5,966.01	6,001.71	6,016.66	5,989.61	6,072.92	6,061.50	6,067.76	6,071.08	6,049.39	6,073.81	6,121.90
Total	6,449.00	6,449.00	6,480.64	6,492.87	6,569.52	6,605.79	6,529.28	6,778.86	6,758.08	6,711.08	6,704.81	6,780.97	6,758.00

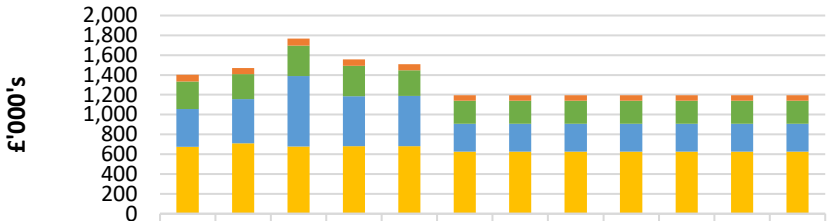
The table provided a summary of the Whole-Time Equivalent (WTE) run rates observed over the course of the last 13 months. This summary includes data on bank, agency, and substantive WTE, and overtime. *It's important to note that the figures presented in this table may exhibit slight differences when compared to the information available in the workforce pack. These variations arise due to the inclusion of overtime data within this table.*

During this period, there were notable increases in contracted WTE. These increases can largely be attributed the new cohort of rotational Medical and Dental staff as they join us in August whilst the other cohort left in June. In addition, there were some increases in overtime, agency and bank WTE. These increases were primarily driven by the need to provide coverage for vacancies across the Trust and during Industrial Actions.

Torbay and South Devon NHS Foundation Trust

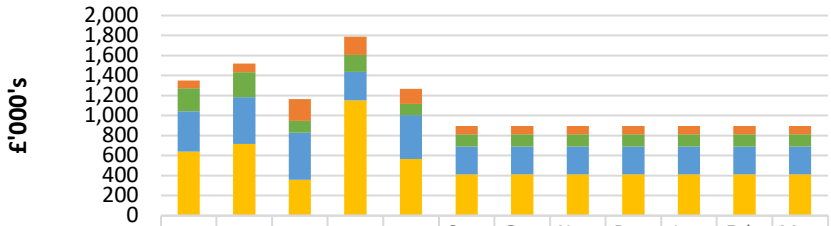
Temporary Staffing

Bank Spend by Type



	Apr-23 Act	May-23 Act	Jun-23 Act	Jul-23 Act	Aug-23 Act	Sep-23 F'cast	Oct-23 F'cast	Nov-23 F'cast	Dec-23 F'cast	Jan-24 F'cast	Feb-24 F'cast	Mar-24 F'cast
Other Clinical	66	61	69	65	62	55	55	55	55	55	55	55
Non Clinical	279	250	309	307	257	232	232	232	232	232	232	232
Medical	380	447	709	501	509	281	281	281	281	281	281	281
Nursing	676	710	679	683	680	626	626	626	626	626	626	626

Agency Spend by Type



	Apr-23 Act	May-23 Act	Jun-23 Act	Jul-23 Act	Aug-23 Act	Sep-23 F'cast	Oct-23 F'cast	Nov-23 F'cast	Dec-23 F'cast	Jan-24 F'cast	Feb-24 F'cast	Mar-24 F'cast
Other Clinical	77	87	217	185	151	81	81	81	81	81	81	81
Non Clinical	230	249	121	167	112	121	121	121	121	121	121	121
Medical	405	467	471	287	438	279	279	279	279	279	279	279
Nursing	638	716	357	1,150	565	412	412	412	412	412	412	412

The chart presented above is based on the source data from allocate system. As of the current reporting period, the Trust has incurred Bank expenditure amounting to **£7.70m**, which constitutes 54.1% of the total expenditure, and Agency expenditure of **£7.09m**, accounting for 45.9% of the total.

The cumulative expenditure for Nursing (mainly agency) and Medical (mainly bank) services to date stands at **£11.47m**, representing 77.6% of the total expenditure. This expenditure is primarily allocated towards addressing staffing vacancies in both workforce categories, meeting increased clinical demand to achieve performance targets, and responding to Industrial Action requirements.

This data also suggests that Medical and Nursing bank and agency spend is not aligned to actual vacancies, and the booking of shifts is above and beyond the establishment and vacancy level.

In contrast, the cumulative expenditure for Other and Non-Clinical services to date amounts to **£3.32m**, making up 22.4% of the total expenditure. This spending is predominantly directed towards addressing vacancies within both workforce categories.

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Non-Pay Expenditure – Spend Category

Non-Pay Category	In Mth			YTD			F'cast			R.A.G
	Bud £'000	Act £'000	Var £'000	Bud £'000	Act £'000	Var £'000	Bud £'000	Act £'000	Var £'000	
CNST	783	758	25	3,916	3,792	125	9,399	9,399	(0)	
Drugs costs	3,709	3,566	143	19,197	18,610	588	44,087	44,087	(0)	
Excluded - Donated depreciation	96	89	7	457	429	29	1,115	1,115	(0)	
Other operating costs	5,516	5,421	95	27,931	28,328	(397)	67,438	67,438	(0)	
Other Non-pay contracts (Inc Purchase of Social Care)	17,763	19,605	(1,842)	89,529	91,596	(2,066)	207,876	207,876	(0)	
Total Non-Pay	**27,868**	**29,439**	**(1,571)**	**141,032**	**142,754**	**(1,722)**	**329,915**	**329,915**	**(0)**	

In M05, the Non-Pay expenditure deviated from the plan, resulting in an adverse variance of **(£1.57m)**. This movement was primarily attributable to increased expenses associated with the Purchase of Social Care and CHC.

The year-to-date figures shows, the Non-Pay expenditure remained adverse to the plan, amounting to **(£1.72m)**. The adverse variance was driven by the continued escalation of costs related to the Purchase of Social Care and Other non-pay operating expenses.

Torbay and South Devon NHS Foundation Trust

YTD Position By Care Group

The table below provides a snapshot of our YTD financial position at the end of M05 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
Children and Family Health Devon	0.24	0.82	0.57		- Pay reported a favourable variance of **£28k** for vacancy slippage offsetting externally funded posts. - Non pay reported an adverse variance of **£1.88m** for recharge of expenditure (funded via external income), un-planned risk share, offset by an underspend on core CAMHS services recharged from external organisations. - Income is reported as a **£2.43m** favourable variance for funding via external organisations.
Families & Communities	(86.70)	(88.08)	(1.38)		- The adverse variance is driven by Adult Social Care (increase in client volume and increase in complexity) and Placed People (Torbay CHC - Dom Care and Nursing activity) packages of care. - In addition, there are pressures in Child Health (unachieved CIP & medical costs - junior doctor strikes) and Community Hospitals.
Medicine and Urgent Care	(31.46)	(38.06)	(6.59)		Adverse variance is due to number of factors including: - Unachieved CIP across all divisions in the Care Group, - Ward pressures within the Older Peoples Care directorate, - Recovery / Escalation wards that are fully operational from prior year winter pressures, - Medical Cost Pressures inclusive of Industrial Action and locum pressures.
Pharmacy Manufacturing Unit	0.03	(0.21)	(0.24)		- Reported separately to this report
Planned Care and Surgery	(59.24)	(58.34)	0.91		- Favourable variance **£0.97m**, reflected in pay (excluding CIP) locum, agency costs, industrial actions costs, offset with vacancies **£0.6m**. Non pay under spends of **£1.5m** – is due to ESRF activity earlier in the year, theatres consumables, offset with overspends in Radiology outsourcing. - Other income **£0.3m** favourable for external funding received, CIP **£0.1m** adverse against plan.
Shared Corporate Services incl. Reserves & Other Income	156.98	162.42	5.44		- Primarily due to achievement of ESRF Productivity Growth CIP
Total	**(20.15)**	**(21.44)**	**(1.29)**		

Torbay and South Devon NHS Foundation Trust

ESRF Income Position

Setting	YTD 19/20 Activity	YTD 23/24 Activity	YTD Var	YTD Var %	YTD 101% of 19/20 Income £'000	YTD 23/24 Income £'000	YTD Income Var £'000	YTD Income Var %
Day Cases	12,530	11,287	(1,243)	90%	10,366	10,496	131	101%
Electives	1,487	1,234	(253)	83%	5,941	4,731	(1,210)	80%
APC TOTAL	**14,017**	**12,521**	**(1,496)**	**89%**	**16,307**	**15,227**	**(1,080)**	**93%**
Firsts	36,754	35,821	(933)	97%	7,199	7,491	292	104%
First Procedures	7,758	8,948	1,190	115%	1,349	1,578	229	117%
Follow-up Procedures	21,758	22,389	631	103%	3,088	3,399	311	110%
OPA TOTAL	**66,270**	**67,158**	**888**	**101%**	**11,636**	**12,468**	**832**	**107%**
Total ESRF Performance	**80,287**	**79,679**	**(608)**	**99%**	**27,943**	**27,694**	**(248)**	**99%**

The above shows the System income target of 101% of 19/20 baseline. 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% considering its impact. The 19/20 baseline has been adjusted by 2.3% to reflect the increase to the tariff for the pay award and we have increased our actuals by the same % to match that as this has still not been reflected in SUS.

The bottom-line position of 99% has increased by 2% compared to last month, this present an improved position given that there has been a further increase in cancelled appointments due to Industrial Action.

Please note months 01 to 03 are based on 'Secondary Uses Services (SUS) freeze submission' and months 04 to 05 are based on 'Flex submission'. It is also worth noting that NHSE's data shows a better performance for providers due to unpunished phasing used, further work is required on finalising the baseline data with NHSE/I and ICB so the system can report an overall agreed position in the coming months based collective performance.

Torbay and South Devon NHS Foundation Trust

Bed Utilisation

Point of Delivery	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	Jul 23 Act	Aug 23 Act
Occupied Beds DGH	10,756	10,578	10,810	10,590	10,939	11,221	9,992	11,195	10,576	11,044	10,625	10,600	10,715
Available Beds DGH	11,652	11,109	11,388	10,994	11,375	11,598	10,376	11,559	11,092	11,460	11,125	11,385	11,342
Occupancy	92%	95%	95%	96%	96%	97%	96%	97%	95%	96%	96%	93%	94%

In Aug-23, the overall bed occupancy for Acute beds is **94%**. Occupancy below **95%** is considered a minimum to support timely patient flow.

The reduced overall bed occupancy over the last two months has coincided with improved ED waiting times performance and reduced handover delays.

Improvement initiatives are being supported by the Transformation and Improvement team reporting through the Unscheduled Care Board meeting every 2 weeks. Further improvements are needed as we prepare for winter and the expected increase in demand for admission to a hospital bed. In August, a “Discharge Ready” ward has been designated to focus on patient having No Criteria to reside, this is proving to be successful and reducing the length of stay for these patient and freeing up acute ward capacity earlier in the day.

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.
- Discharge Ready ward to support the focus on the number of patients identified as medically fit and having “No Criteria to Reside” in an acute hospital bed. In Aug-23 the Trust reported 7.5**%** of occupied as "No Criteria to Reside". This is against the plan to deliver **5%** by Mar-24.

Torbay and South Devon NHS Foundation Trust

CIP Programme Delivery

For the financial year 2023/24, the total CIP delivery requirement is **£46.6m**. As of Aug-23, the 23/24 CIP programme includes 134 schemes, of which 91 schemes (68%) totalling **£33.1m** are assessed as Green and have been confirmed in the Plan.

Divisions and workstreams are working through 43 new ideas, of which 23 schemes have a high-level value of **£5.2m**.

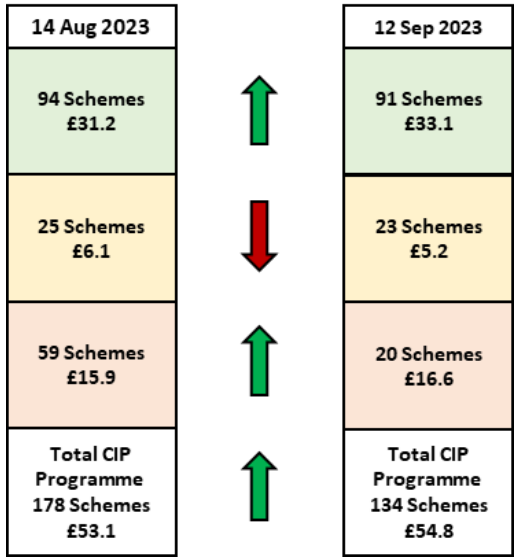
The Strategic ICB Collaborative schemes totalling **£10.4m** have been assessed as **£9.9m** Red and **£0.4m** Amber by the PMO on the basis that although there are signed off PIDs in place, there is not a clear delivery plan for these schemes available and there has been little progress, and therefore 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 **£54.8m** (non-risk-adjusted value).

2023/24 Scheme Development (£m)



Torbay and South Devon NHS Foundation Trust

Cash Position

Description	YTD Bud £000	YTD Act £000	YTD Var £000
Opening Cash Balance	**14,961**	**34,734**	**19,773**
Capital Expenditure (Accruals Basis)	(16,345)	(14,268)	2,077
Capital Loan/PDC Drawn Down	10,660	9,108	(1,552)
Capital Loan Repayment Principal	(989)	(990)	(1)
Proceeds on Disposal of Assets	0	1	1
Movement in Capital Creditor	0	(9,237)	(9,237)
Other Capital-related Elements	(469)	(824)	(355)
Subtotal - Capital-Related Elements	**(7,143)**	**(16,209)**	**(9,066)**
Cash Generated From Operations	(6,339)	(9,448)	(3,109)
Revenue PDC Drawn Down	20,146	4,768	(15,378)
Working Capital Movements – Debtors	(955)	9,219	10,174
Working Capital movements – Creditors	(28)	(10,035)	(10,007)
Net Interest	(1,049)	(317)	732
PDC Dividend Paid	0	0	0
Other Movements	(538)	(527)	11
Sub Total - Other Elements	**11,237**	**(6,341)**	**(17,578)**
Closing Cash Balance	**19,055**	**12,184**	**(6,871)**

- 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.
- 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**). Please refer to the supplementary Capital and Cash paper for further details.
- Capital-related cashflow is **£9.1m** adverse, largely due to pay down of the capital creditor **£9.2m**. The plan assumed that this would have happened at the end of the prior year. PDC capital drawn down **£1.6m** adverse and in year capital expenditure **£2.1m** adverse, due to delays in capital expenditure requirement.
- Cash generated from operations is **£3.1m** adverse due to the adverse operational elements within in the I&E position. Revenue PDC drawdown **£15.4m** behind planned value, however, **£12.2m** support has been received on the 18th September 23.
- Debtor movement is **£10.2m** favourable, which is principally due to the 22/23 pay award **£12.1m,** partly offset with an increase in ASC debtors.
- Creditor movement is **£10.0m** adverse. This principally due to the favourable debtor movement for the 22/23 pay award **£12.1m**, partly offset with an increase to HEE deferred income.

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Capital Position

	FY23/24 £m	FY24/25 £m	FY25/26 £m	FY26/27 £m	FY27/28 £m	Total £m
Net Applications of Funds						
IM&T Investment - exclude EPR	4.8	4.0	4.0	4.0	4.0	20.8
Digital EPR - Trust Funded Element - (i)	0.0	12.8	2.0	0.3	0.3	15.4
Estates Backlog Maintenance	4.6	4.0	4.0	4.0	4.0	20.6
Approved Estates Development Schemes	3.3	0.0	0.0	0.0	0.0	3.3
Medical Equipment	3.0	3.0	3.0	3.0	3.0	15.0
Torbay Pharmaceuticals - (ii)	2.0	0.0	0.0	0.0	0.0	2.0
Purchase of Dawlish Hospital	0.0	2.0	0.0	0.0	0.0	2.0
Other - Services Developments - TBC - (iii)	5.8	(5.8)	7.0	8.7	8.7	24.4
Prior Year Schemes	(0.1)	0.0	0.0	0.0	0.0	(0.1)
Sale of Assets - (iv)	(1.4)	0.0	0.0	0.0	0.0	(1.4)
Net ICB CDEL Total (v)	**22.0**	**20.0**	**20.0**	**20.0**	**20.0**	**102.0**
Source of Funds						
Revenue Surplus	0.0	0.0	0.0	0.0	0.0	0.0
Depreciation / Amortisation	23.6	25.9	26.9	28.9	30.9	136.2
Repayment of ITFF Loan Funding	(2.9)	(2.9)	(2.4)	(2.4)	(2.4)	(13.0)
Repayment of Finance Leases	(3.4)	(3.4)	(3.4)	(3.4)	(3.4)	(17.0)
Repayment of PFI Debt	(1.6)	(1.4)	(1.1)	(1.2)	(1.3)	(6.6)
Sub-Total	**15.7**	**18.2**	**20.0**	**21.9**	**23.8**	**99.6**
PDC Support Required (vii)	6.3	1.8	0.0	(1.9)	(3.8)	2.4
Total	**22.0**	**20.0**	**20.0**	**20.0**	**20.0**	**102.0**

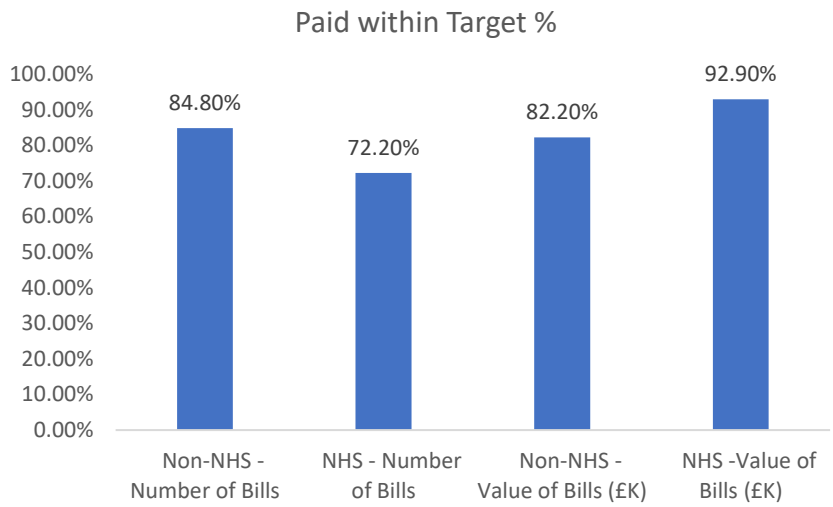
- M05 YTD expenditure is **£14.1m**
- Fall year forecast **£48.3m** with no variance reported under national and System CDEL. However,
- Local position indicates an overspend on national CDEL with is mitigated by system CDEL budget mainly relates to Endoscopy Expansion project

	Capital Exp Programme M04 £'000	Capital Exp F'cast M05 £'000	Mov £'000	Capital Exp YTD M05 £'000
ICB CDEL	21,409	21,409	0	5,939
National CDEL	23,571	23,642	71	8,180
IFRS 16 CDEL	2,800	2,800	0	0
Other - Charitable Funds and PFI	282	479	197	197
Total	**48,062**	**48,330**	**268**	**14,136**

Torbay and South Devon NHS Foundation Trust

Better Payment Practice

Better Payment Practice Code	Paid	Paid within Target	Paid within Target %
Non-NHS - Number of Bills	56,124	47,586	84.8%
Non-NHS - Value of Bills (£K)	138,696	114,045	82.2%
NHS - Number of Bills	576	416	72.2%
NHS -Value of Bills (£K)	9,712	9,024	92.9%
Total - Number of Bills	**56,700**	**48,002**	**84.7%**
Total - Value of Bills (£K)	**148,408**	**123,069**	**82.9%**



The Department of Health and Social Care has established the Better Payment Practice Code (BPPC) to ensure prompt payment of invoices within the Trust. The code sets a target of 95% for invoices to be settled within the stipulated payment term, unless there is a dispute in progress.

Currently, the Trust has achieved an 82.9% compliance rate in terms of paying invoices within the specified payment periods.

Efforts are underway to enhance the punctuality of invoice payments, encompassing various stages of the process, and prioritizing the prompt resolution of any ongoing disputes

Torbay and South Devon NHS Foundation Trust

Balance Sheet

	YTD Bud £000	YTD Act £000	YTD Var £000
Intangible Assets	11,763	12,711	948
Property, Plant & Equipment	255,919	209,130	(46,789)
On-Balance Sheet PFI	17,167	20,087	2,920
Right of Use assets	19,037	20,191	1,154
Other	1,843	1,606	(237)
Non-Current Assets Total	**305,729**	**263,725**	**(42,004)**
Cash & Cash Equivalents	19,054	12,183	(6,871)
Other Current Assets	41,616	60,895	19,279
Current Assets Total	**60,670**	**73,078**	**12,408**
Total Assets	**366,399**	**336,803**	**(29,596)**
Loan - DHSC ITFF	(2,917)	(2,918)	(1)
PFI and Leases	(4,238)	(4,399)	(161)
Trade and Other Payables	(56,240)	(63,513)	(7,273)
Other Current Liabilities	(5,267)	(11,219)	(5,952)
Current Liabilities Total	**(68,662)**	**(82,049)**	**(13,387)**
Net Current Assets/(liabilities)	**(7,992)**	**(8,971)**	**(979)**
Loan - DHSC ITFF	(21,303)	(21,301)	2
PFI and Leases	(30,074)	(31,248)	(1,174)
Other Non-Current Liabilities	(4,615)	(4,644)	(29)
Non-Current Liabilities Total	**(55,992)**	**(57,193)**	**(1,201)**
Total Assets Employed (Assets + Liabilities)	**241,745**	**197,562**	**(44,183)**
Reserves			
Public Dividend Capital	225,500	209,491	(16,009)
Revaluation	61,351	62,093	742
Income and Expenditure	(45,106)	(74,022)	(28,916)
Total	**241,745**	**197,562**	**(44,183)**

- Non-Current Assets are **£42.0m** lower than plan. This is largely due to a revenue impairment **£20.5m** and reclassification of an asset held for sale **£15.6m** to current assets. In addition, a FY22/23 property revaluation was lower than planned **£4.7m**. This is partly offset by reduced depreciation **£1.0m** due to delays in bringing assets into service.

- Cash & Cash Equivalents is **£6.9m lower** than plan, as explained in the commentary to the Cash Flow Statement.

- Other Current Assets are **£19.3m** higher than planned. This is mainly due to the assets held for sale **£16.7m,** ASC debtors **£1.8m** and other deferred expenditure **£0.8m** higher than planned

- Trade and Other Payables are **£7.3m** higher than plan. Principally this value is due to increased **£1.3m** capital creditors, **£3.2m** provider to provider recharges, **£1.6m** general provisions and **£1.2m** payroll creditors.

- Other Current Liabilities are **£6.0m** higher than planned, mainly due to additional HEE deferred income **£2.0m** and other deferred income not reducing as quickly as anticipated.

- PDC reserves are **£16.0m** lower than planned, due to mostly Revenue PDC support being drawn down later than planned.

- The Income and Expenditure reserve is **£28.9m** lower than plan, principally due to below-the-line asset impairment in 23/24 **£20.5m** and an impairment processed late in FY22/23.

Torbay and South Devon NHS Foundation Trust

Risks & Mitigations

Ref	Risk Description	Most Likely £'000	Best Case £'000	Worst Case £'000
R01	High-Cost Drugs Growth	(1,000)	(500)	(2,500)
R02	Income Risk Income Risk (Incl. ICB ASC funding Shortfall & ESRF)	(3,100)	(3,100)	(6,500)
R03	ASC and CHC Volume	(5,800)	(5,800)	(6,600)
R04	Additional Cost (Capacity/ Winter Pressure)	(3,000)	(3,000)	(3,000)
R05	Medicine Speciality (Medical Agency / Locum)	(3,000)	(3,000)	(3,000)
R06	Industrial Strike Action	(1,810)	(1,552)	(2,069)
R07	Efficiency - System Strategic Schemes	(6,984)	(4,848)	(9,108)
R08	Efficiency Schemes (Local Schemes)	(7,204)	(3,881)	(10,700)
R09	Inflationary Pressures – Utilities	(2,400)	(2,400)	(3,600)
R10	Pay Award Pressure	(500)	(500)	(500)
R11	Band 2 to Band 3 Uplift (HCA)	(2,060)	0	(2,060)
R12	Diagnostic Cost Pressure (Outsourcing)	(1,200)	(1,000)	(1,500)
Sub Total		**(38,058)**	**(26,481)**	**(51,137)**
A01	ICB Flexibilities	5,808	5,808	5,006
Total		**(32,250)**	**(20,673)**	**(46,131)**

The table on the left highlights the significant risks and corresponding measures to attain the financial stability of the Trust split by best, most likely and worst-case scenario.

The efficiency risk of **£14.9m** shown in the most likely has been pinpointed, primarily associated with the anticipated shortfall in achieving Cost Improvement Program (CIP) targets. Within this risk, **£6.9m** is attributed to strategic initiatives spanning Integrated Care Systems (ICS).

To address this challenge and ensure the successful attainment of the overarching goal of **£46.6m**, efforts are underway to identify potential local schemes that can help mitigate these risks.

Furthermore, an Income Risk of **£3.1m** is primarily linked to the potential deficit in funding for Adult Social Care (ASC) from the Integrated Care Board (ICB)

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QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		3	5	0	0	2	3	1	2	1	1	1	4	1	8
Reported Incidents - Death	Trustwide	<1		2	1	1	0	0	4	0	1	0	1	1	0	2	4
Medication errors resulting in moderate harm	Trustwide	<1		0	0	0	1	0	0	0	0	1	2	3	0	0	6
Medication errors - Total reported incidents	Trustwide	N/A		59	64	36	44	48	47	44	62	68	72	76	70	74	360
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		0	1	3	1	1	0	3	1	0	0	1	0		1
Never Events	Trustwide	<1		0	0	1	0	0	0	2	0	0	0	0	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		3	2	3	0	6	13	3	13	5	7	8	11	7	38
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	0	0	1	0	0	2	1	2	1	0	6
Formal complaints - Number received	Trustwide	20		16	10	16	11	10	14	12	12	5	7	6	8	8	34
VTE - Risk Assessment on Admission (acute)	Trustwide	>95%		93.6%	92.7%	94.7%	94.4%	94.0%	95.5%	95.9%	96.5%	96.3%	95.4%	96.5%	96.0%	94.5%	95.6%
Hospital standardised mortality rate (HSMR) (3 months in arrears)	Trustwide	<100		114.7	113.4	111	109.9	111.5	107.1	105.5	102.4	99.9	98.5				98.5
Safer staffing - ICO - Day time	Trustwide	90% - 110%		94.4%	96.4%	99.1%	99.4%	91.6%	92.1%	91.3%	93.1%	92.4%	96.0%	100.1%	96.0%	97.6%	97.6%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		86.2%	85.6%	88.8%	86.4%	87.4%	87.9%	87.0%	88.4%	91.3%	90.0%	89.0%	90.0%	88.7%	88.7%
Infection Control - Bed Closures - (Acute bed days in month)	Trustwide	<100		36	132	42	156	786	339	254	164	217	120	99	24	522	982
Hand Hygiene	Trustwide	>95%		97.7%	96.6%	94.9%	96.2%	91.2%	94.0%	92.1%	91.3%	92.5%	92.9%	91.3%	87.7%	92.6%	91.5%
Number of Clostridium Difficile cases (COHA+HOHA)	Trustwide	<3		9	6	3	2	1	8	2	2	4	7	7	4	4	15
CDiff - Hospital Onset Healthcare Associated (HOHA)	Trustwide			5	3	2	0	1	7	1	1	3	4	4	2	0	13
CDiff - Community Onset Healthcare Associated (COHA)	Trustwide			4	3	1	2	0	1	1	1	1	3	3	2	4	13
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		56.0%	50.0%	54.3%	43.3%	41.5%	40.0%	53.8%	58.3%	58.0%	57.1%	40.0%	38.7%	58.3%	58.3%
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		59.3%	54.8%	55.0%	75.9%	28.0%	54.5%	67.4%	70.7%	63.0%	80.0%	70.0%	70.2%	66.7%	56.0%
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		21797	21821	20806	20257	21452	20030	20048	19979	19618	19609	18738	18842	19582	19582
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.7%	5.7%	5.7%	5.6%	5.6%	4.7%	5.7%	5.6%	5.0%	5.3%	5.3%	5.2%	0.0%	5.2%
Appraisal Completeness	Trustwide	>90%		78.0%	75.8%	76.6%	77.6%	76.7%	77.7%	76.7%	76.9%	77.9%	78.1%	78.1%	78.1%	0.0%	0.0%
Mandatory Training Compliance	Trustwide	>85%		89.2%	88.7%	88.6%	89.1%	89.7%	89.9%	90.1%	90.4%	90.7%	91.2%	91.7%	91.5%	0.0%	0.0%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		13.8%	13.9%	13.7%	13.7%	13.5%	13.3%	13.1%	12.8%	12.9%	12.7%	12.5%	0.0%		0.0%

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COMMUNITY & SOCIAL CARE FRAMEWORK																	
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%						6.5%			6.5%			5.5%			
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		714	737	751	735	756	755	781	814	784	804	817	823	852	
Intermediate Care - No. urgent referrals	Trustwide	113		223	205	277	297	299	318	307	298	287	321	371	308	312	214
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		222	197	193	203	208	198	200	251	224	218	224	275	226	265
Urgent Community Reponse (2-hour) - Referrals	Trustwide	NONE SET		15	20	26	27	40	34	34	30	26	34	36	37	45	349
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	70%		80.0%	85.0%	100.0%	74.1%	77.5%	79.4%	94.1%	90.0%	92.3%	88.2%	88.9%	97.3%	95.6%	81.7%
Urgent Community Reponse (2-48 hour)- Referrals	Trustwide	NONE SET				195	196	182	177	171	160	138	162	151	124	126	1064
Urgent Community Reponse (2-48 hour) - Target achievement	Trustwide	NONE SET				85.6%	86.2%	84.6%	92.7%	83.3%	86.3%	86.2%	85.8%	85.4%	85.5%	88.1%	83.1%
ADULT SOCIAL CARE TORBAY KPIs																	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		40.8	32.6	27.2	29.9	32.6	32.6	28.5	29.9	32.6	27.2	24.5	27.2	16.3	24.5
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		939.6	931.5	861.5	901.9	915.4	840	802.3	826.5	805	748.5	729.6	729.6	735	576.2
Proportion of clients receiving direct payments	Trustwide	25%		20.0%	20.4%	20.3%	20.2%	20.3%	20.0%	20.2%	19.5%	20.1%	20.1%	20.0%	20.6%	21.1%	19.5%
% reablement episodes not followed by long term SC support	Trustwide	83%		85.4%	85.2%	86.0%	85.5%	85.4%	86.6%	86.4%	86.4%	85.3%	88.3%	88.9%	87.7%	87.9%	84.5%

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LOCAL PERFORMANCE FRAMEWORK 1																	
Cancer - Two week wait from referral to date 1st seen	Trustwide	>93%		38.4%	45.3%	63.8%	58.4%	67.4%	76.3%	82.6%	76.0%	55.9%	74.1%	76.3%	68.6%	69.5%	69.5%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		58.5%	79.1%	87.7%	82.8%	100.0%	93.5%	97.6%	88.9%	87.9%	76.7%	69.6%	61.5%	83.6%	83.6%
Cancer - 28 day faster diagnosis standard	Trustwide	75%		72.1%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	75.5%	78.0%	77.7%	79.5%	77.6%	77.6%
Cancer - 31-day wait from decision to treat to first treatment	Trustwide	>96%		98.0%	92.8%	96.4%	89.0%	98.3%	95.5%	98.3%	95.9%	89.7%	92.3%	93.3%	95.6%	97.9%	97.9%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		100.0%	98.7%	100.0%	90.4%	98.6%	100.0%	100.0%	100.0%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		98.4%	92.2%	94.4%	98.0%	100.0%	85.7%	100.0%	86.9%	100.0%	96.9%	80.8%	85.5%	93.3%	93.3%
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		95.5%	96.8%	89.7%	86.8%	89.7%	80.0%	96.2%	83.3%	88.5%	87.5%	89.7%	88.9%	92.3%	92.3%
Cancer - 62-day wait for first treatment - 2ww referral	Trustwide	>85%		57.0%	60.8%	64.2%	54.5%	63.1%	47.2%	47.1%	63.2%	66.8%	54.7%	65.6%	67.4%	78.6%	78.6%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		70.0%	90.9%	100.0%	81.0%	76.9%	100.0%	100.0%	72.7%	100.0%	100.0%	77.4%	80.0%	57.1%	57.1%
Cancer - Patient waiting longer than 104 days from 2ww	Trustwide	20		37	43	71	62	69	68	53	24	20	11	7	10	11	11
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		48.5%	42.5%	45.5%	45.5%	43.3%	43.9%	44.3%	48.1%	49.7%	49.8%	51.2%	53.1%	52.0%	52.0%
RTT 65 week wait incomplete pathway	Trustwide	1091		2093	2252	2485	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1274
RTT 78 week wait incomplete pathway	Trustwide	178		787	813	829	822	923	708	462	183	166	167	123	129	156	156
RTT 104 week wait incomplete pathway	Trustwide	0		51	50	47	34	29	22	14	0	0	0	0	0	0	0
On the day cancellations for elective operations	Trustwide	<0.8%		3.1%	1.4%	1.7%	1.5%	2.1%	1.4%	1.5%	1.5%	0.8%	1.4%	1.8%	1.4%	1.6%	1.4%
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		13	8	7	15	6	11	10	7	7	10	14	13	23	67
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		16.9%	16.8%	n/a	16.6%	16.1%	16.5%	15.3%	14.6%	15.8%	15.2%	15.0%	15.3%	n/a	
Bed Occupancy	Acute	90.0%		94.3%	92.3%	92.3%	95.2%	94.9%	96.3%	96.2%	96.3%	95.3%	96.4%	95.5%	93.1%	94.0%	95.5%
Percentage of inpatients with No Criteria to Reside (acute)	Trustwide	<5%						13.0%	13.0%	12.0%	8.1%	7.6%	6.0%	7.0%	6.0%	7.5%	
% patient discharges pre-noon	Acute	33%								18.5%	19.2%	18.9%	18.9%	19.9%	20.5%	21.6%	
% patient discharges pre-5pm	Acute	75%								67.9%	67.3%	69.8%	66.7%	67.7%	67.9%	70.6%	
Number of patients >7 days LoS (daily average)	Trustwide			167.0	184.9	177.0	162.0	172.6	183.5	166.1	167.0	154.2	159.8	156.2	129.9	156.0	151.2
Number of extended stay patients >21 days (daily average)	Trustwide			48.0	49.2	49.8	32.0	42.3	57.1	40.7	38.6	39.3	33.2	35.2	30.6	35.9	34.8

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LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide	Trajectory		1156	1012	1208	1112	1232	865	534	1043	598	1025	1002	936	1098	4659
Ambulance handover delays > 60 minutes	Trustwide	0		871	764	933	787	983	623	263	687	277	595	615	490	629	2606
UEC - patients seen within 4 hours (23/24 plan target 76%)	Trustwide	76%		59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	67.9%
ED - patients with >12 hour visit time pathway	Trustwide			920	906	988	939	1207	823	599	977	568	893	797	637	794	3689
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute				39%	37%	39%	31%	46%	44%	41%	52%	53%	55%	59%	61%	61%
Clinically Ready to Proceed delay over 1 hour - Emergency Department	Acute								42%	40%	44%	41%	40%	29%	26%	28%	28%
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute				04:51	05:21	05:14	06:05	05:02	04:53	05:08	04:24	04:42	04:22	04:17	04:03	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute				14:22	14:06	13:14	16:05	13:42	10:06	12:47	09:10	11:15	10:55	08:47	11:19	
Diagnostic tests longer than the 6 week standard	Trustwide	15%		33.9%	34.9%	32.4%	30.1%	29.0%	34.0%	26.1%	29.7%	29.8%	27.7%	24.3%	25.5%	29.1%	29.1%
Dementia - Find - monthly report	Trustwide	>90%		90.6%	94.1%	87.2%	93.0%	91.6%	87.9%	84.5%	87.1%	83.6%	90.7%	85.2%	86.1%	n/a	n/a
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		70.7%					72.3%	65.7%	58.1%	65.0%	61.5%	71.7%	70.3%	73.0%	68.4%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		48.3%					48.1%	45.1%	39.4%	49.1%	55.5%	52.7%	58.5%	46.2%	52.5%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		80.2%	59.0%	60.0%	62.0%	68.0%	73.9%	69.2%	62.8%	67.7%	64.4%	63.7%	61.9%	71.6%	

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NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-4412	-5783	-7140	-10433	-13434	-16118	-19884	-21358	-394	-342	-761	-1254	-3116	
Agency - Variance to NHSI cap	Trustwide			-2.10%	-2.00%	-1.90%	1.90%	-1.80%	-1.80%	-1.90%	-1.90%	0.00%					
Agency - Spend in month against budget value	Trustwide												55.00%	-22.78%	141.06%	155.12%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide			-3858	-4403	-4872	-5005	-5874	-5328	-5512	-3390	-449	17	2478	2486	2529	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			1065	975	1988	2787	3280	4076	944	-18162	-993	3619	1616	-515	1517	
Distance from NHSI Control total (£'000's)	Trustwide			-2978	-4014	-5022	-7421	-9995	-12182	-15796	-17186	22	307	300	300	-1293	
ACTIVITY VARIANCE vs 2019/20 BASELINE* (* March 2023 compared to March 2022)																	
Outpatients - New	Trustwide			2.4%	0.2%	-11.7%	3.6%	-2.0%	-5.2%	-0.6%	16.1%	-10.0%	7.7%	11.2%	-5.6%	7.0%	1.8%
Outpatients - Follow ups	Trustwide			4.0%	-0.8%	-10.1%	4.4%	-4.1%	-6.9%	-2.4%	9.0%	-8.0%	5.7%	9.0%	-3.0%	7.2%	2.9%
Daycase	Trustwide			-3.5%	3.2%	-4.6%	-3.0%	-5.5%	-1.7%	5.1%	21.7%	-12.8%	-5.5%	8.4%	-4.0%	-2.0%	-3.0%
Inpatients	Trustwide			-15.5%	9.6%	-16.3%	-19.5%	-21.4%	-18.1%	-16.4%	42.0%	-16.2%	-1.3%	-1.4%	-20.8%	0.7%	-9.3%
Non elective	Trustwide			-2.9%	-7.1%	-7.0%	-12.7%	-18.1%	-5.7%	-11.2%	-0.2%	-7.1%	-8.9%	0.4%	0.4%	12.3%	-1.0%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			0	0	0	0	0	0	0	0	#N/A	#N/A	#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			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	#N/A	#N/A	#N/A	#N/A	#N/A	

	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	Jul-23	Aug-23	Operational Plan trajectory August 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual				2844	3512	2448	5017	3280	740	2260	796	1630	1569	1223	1707	1111
Percentage of Ambulance handovers greater than 3 hours		16.7%	19.5%	23.8%	27.0%	18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	3.7%	3.7%	No trajectory
Total average time in ED (hours/minutes)		07:02	07:06	07:33	07:58	07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	05:41	06:05	No trajectory
ED attendances where visit time over 12 hours	0	827	920	906	988	939	1207	823	599	977	568	893	797	637	794	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	58.5%	59.1%	60.2%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68%
% patient discharges pre-noon	33%				18.4%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	20.5%	21.6%	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%	6.0%	7.5%	7.5%
Elective recovery																
RTT 104 week wait incomplete pathway	0	70	51	50	47	34	29	22	14	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	686	787	813	829	822	923	708	462	183	166	167	123	129	156	130
RTT 65 week wait incomplete pathway	0		2093	2252	2485	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1387
RTT 52 week wait incomplete pathway	Reduction	4578	5083	5060	5412	5585	6027	5554	5116	4427	4024	3926	3938	3879	0	Not set
Patient waits over 2.5 years	0	54	47	24	24	17	12	9	6	0	0	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	67.7%	72.1%	70.4%	75.5%	69.8%	74.8%	71.6%	77.4%	77.4%	75.5%	78.0%	77.7%	79.5%	77.6%	75%
Number of patients waiting longer than 62 days for treatment	138	283	244	333	331	229	253	225	130	114	107	111	100	89	120	162

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: September 2023 Mortality Score Card			Meeting date: 27th September 2023
Report appendix	Appendix 1 – Hospital Mortality Appendix 2 – Unadjusted Mortality Rate Appendix 3 – Mortality Analysis Appendix 4 – Focused Mortality Reviews Appendix 5 – Glossary of Terms		
Report sponsor	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	To receive and note this report		

Summary of key elements

Strategic goals supported by this report

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

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

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

BAF Ref. 1 – Quality and Patient Experience

External standards affected by this report and associated risks

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

Report title: September 2023 Mortality Score Card		**Meeting date:** 27th September 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 death's 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 101.7 ↓
• B. Summary Hospital Mortality Index (SHMI)	Mortality	DH SHMI data		1.0299↓ (Mar 22 – Feb 23)
Appendix 2 • Unadjusted Mortality Rate • By number • By location		Trust Data	Yearly Average ≤3%	3.59%
Appendix 3 • Mortality Analysis		Trust Data Dr Foster DH HSMR data	New CUSUM alerts ***	1
Appendix 4 • Mortality Reviews and Learning		Trust Data		

*** Cumulative sum alert: designed to signal that a pattern of activity has gone beyond a defined threshold.

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 March 2023 with a relative risk of 101.7 against a 100 benchmark. The rolling 12-month trend shows that the HSMR became statistically higher than expected in the

August 2020 to July 2021 period and remained so until the January to December 2022 data point. There has been a steady decline and the HSMR has been within the expected range for the last three data periods. 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 (6.9% v 6.0% national). However a rising trend is indicated and, in conjunction with a higher specialist palliative care rate, is reflected in the rising expected rates. This more accurately reflects that 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.

Quite appropriately, the appalling crimes of Lucy Letby and the fact that they were not identified in a timely manner means that our organisation and the NHS will place more scrutiny on mortality rates and unexpected deaths. Importantly, we cannot and should not say "It won't happen here" as to do so would potentially stifle the intellectual curiosity required to pick up such trends and situations. However, some things are significantly different now in comparison to the time when these crimes occurred. Specifically, the role of the medical examiners (Appendix 4). All inpatient deaths are now reviewed by the medical examiners, this system that started in 2019 is designed to provide greater safeguards by ensuring independent scrutiny of deaths and giving bereaved people a voice. By April 2024 the process will become statutory and will include all community deaths.

In Appendix 4 you will also find details of any Neonatal, Perinatal, and Maternal Deaths. These data do not provide any cause for concern.

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 s based on the *Diagnosis all* Groups using the December 2020 monthly benchmark and analysed by Relative Risk - Trend / Month

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

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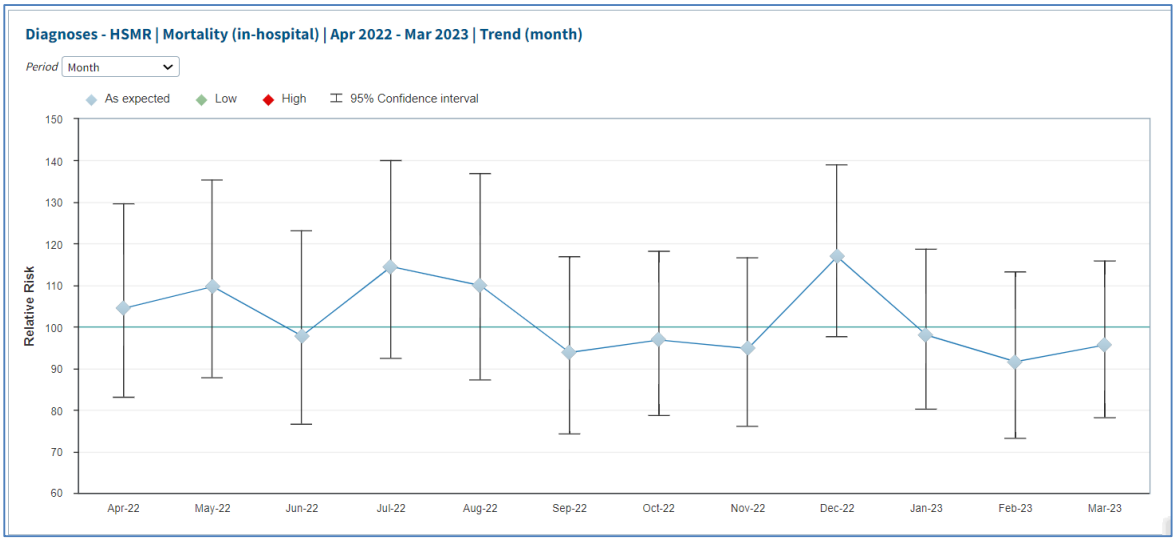
Chart 1 - HSMR by Month April 2022 to March 2023

Chart one (as below) shows a longitudinal monthly view of HSMR.



The usual one-month lag has not been applied to this data due to this being the second iteration of the 2022/23 data submitted as month 13.

The latest HMSR for April 22 - March 23 is **101.7** (97.8 – 107.9), this is within the expected range compared to hospital trusts nationally. (↓). There were 32,044 superspells recorded in the time period and 1102 deaths versus an expected 1083.1. 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 three data periods.

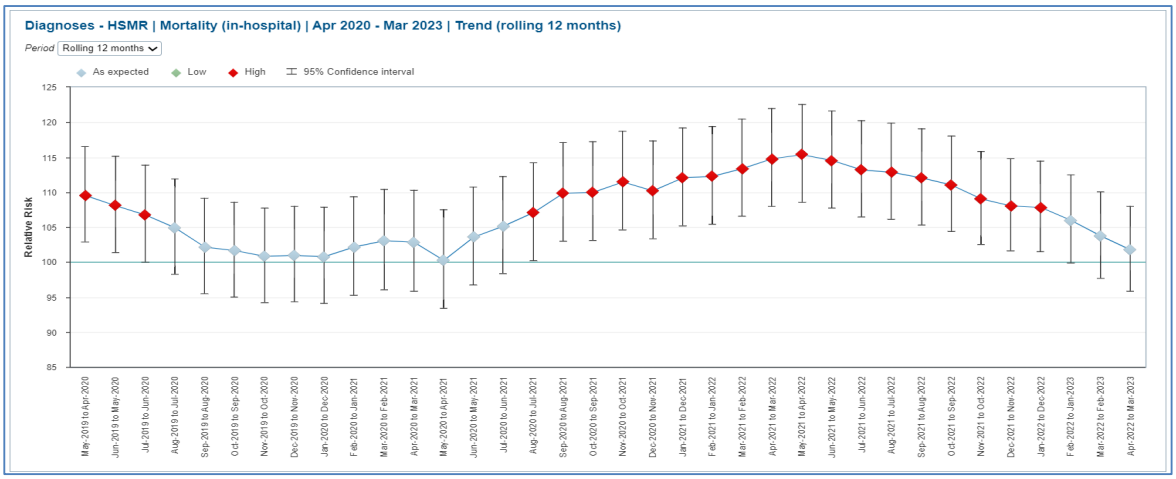


Chart 3 -HSMR Crude versus expected

The gap between the crude and expected rates continues to narrow, predominantly due to the increase in the expected rate. The crude rate has remained relatively stable from the July 21 to June 22 period and has seen a downward trend over the last two periods. The narrowing gap between the crude and expected rates has subsequently caused the Relative Risk to decline.

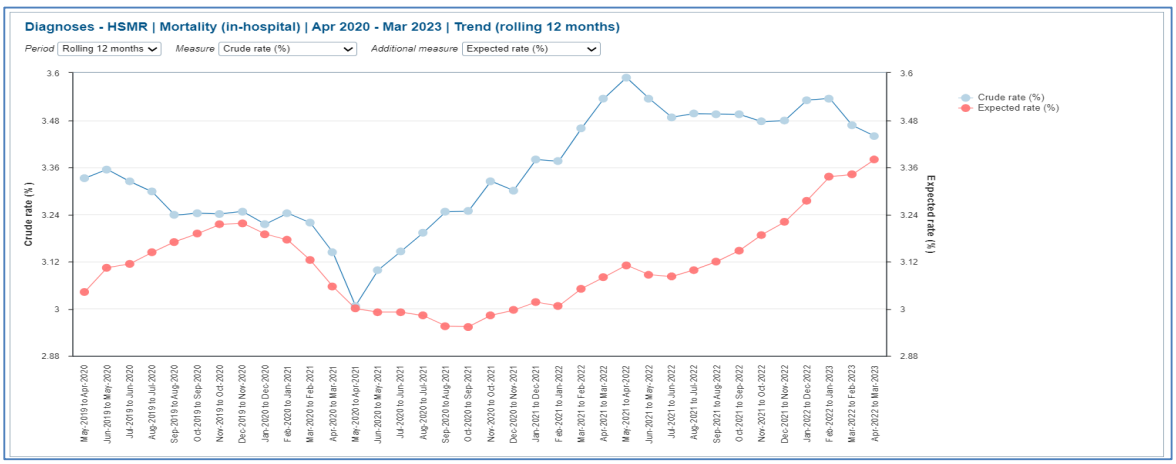


Chart 4 -HSMR Peer Comparison – Similar Peers

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.

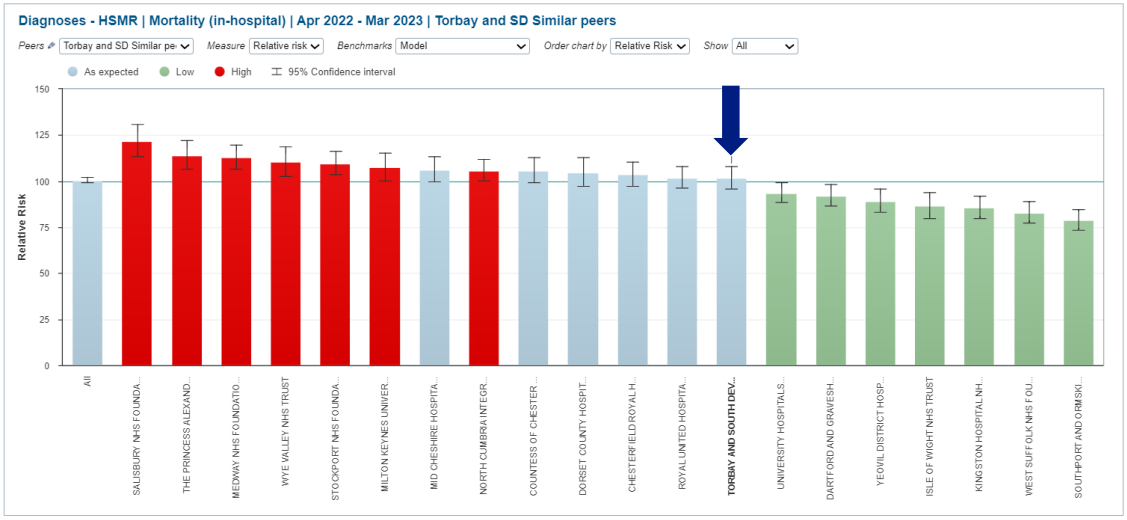


Chart 5- HSMR Peer comparison – Regional Peers

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 of 14).

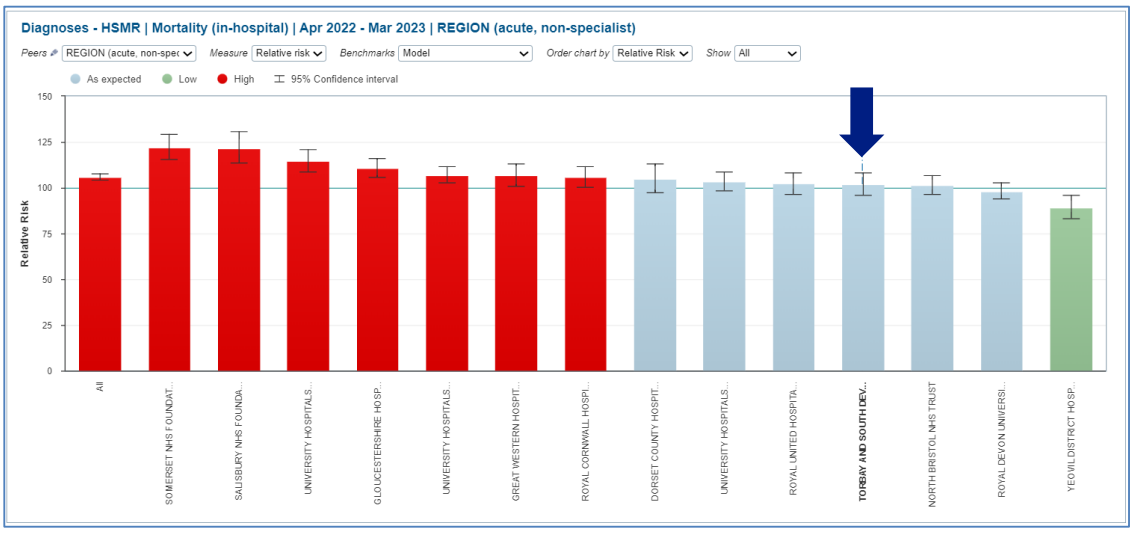


Chart 6- HSMR Expected Rate (%) vs National

The expected rates have 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 the national in the last 3 data periods.

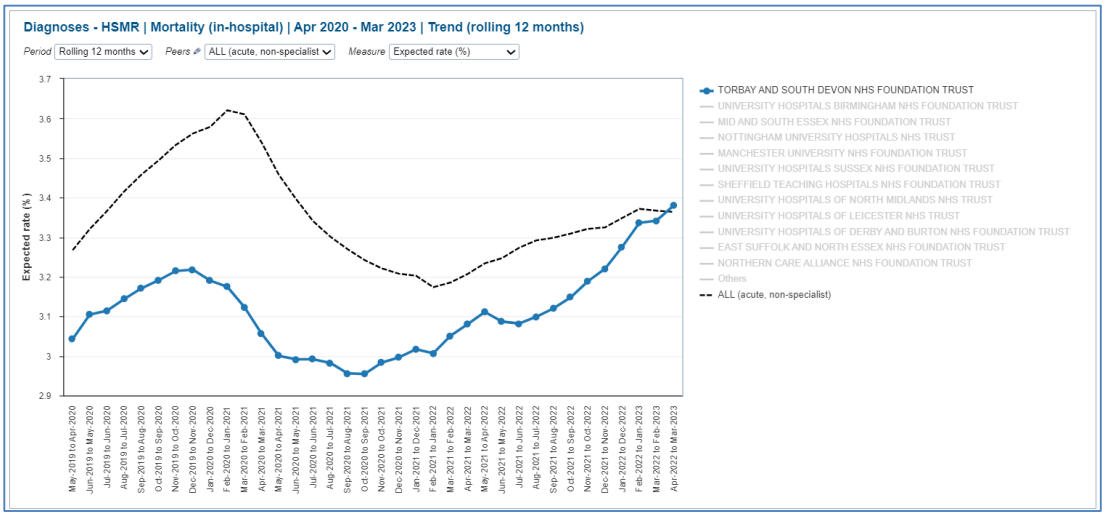


Table 2 – Coding Case Mix Summary

The following table reports a higher percentage of spells in the Symptoms & Signs chapter (6.9%). This continues to demonstrate improvement (reported 7.9% in the last report) 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 (14.7%). This is slightly higher than in the previous report (14.6%).

Mortality Influencers				
Performance	Site	Trust	Peer	National
HSMR		101.7	105.9	99.9
SMR		97.8	104.7	99.6
Non-elective (HSMR)		101.1	105.8	99.6
Weekday, emergency (HSMR)		97.2	103.8	98.2
Weekend, emergency (HSMR)		114.6	112.7	103.9
Saturday, emergency (HSMR)		118.8	112.4	103.4
Sunday, emergency (HSMR)		110.0	112.9	104.1
Coding/Casemix	Site	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)		50.6%	41.5%	41.4%
% Non-elective spells with palliative care (HSMR)		5.8%	4.8%	5.1%
% Spells in Symptoms & Signs chapter		6.9%	6.4%	6.0%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		40.4%	43.0%	41.5%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		14.7%	15.1%	16.0%
% Non-elective spells in Risk Band (0-10%) (HSMR)		83.1%	84.2%	83.6%

Chart 7- Financial Year Co-morbidity coding

The following chart indicates an increase in the proportion of super spells with a co-morbidity score of 20 – 49 compared to previous financial years.

This, in conjunction with the higher specialist palliative care rate detailed in Table 2, is reflected in the rising expected rates.

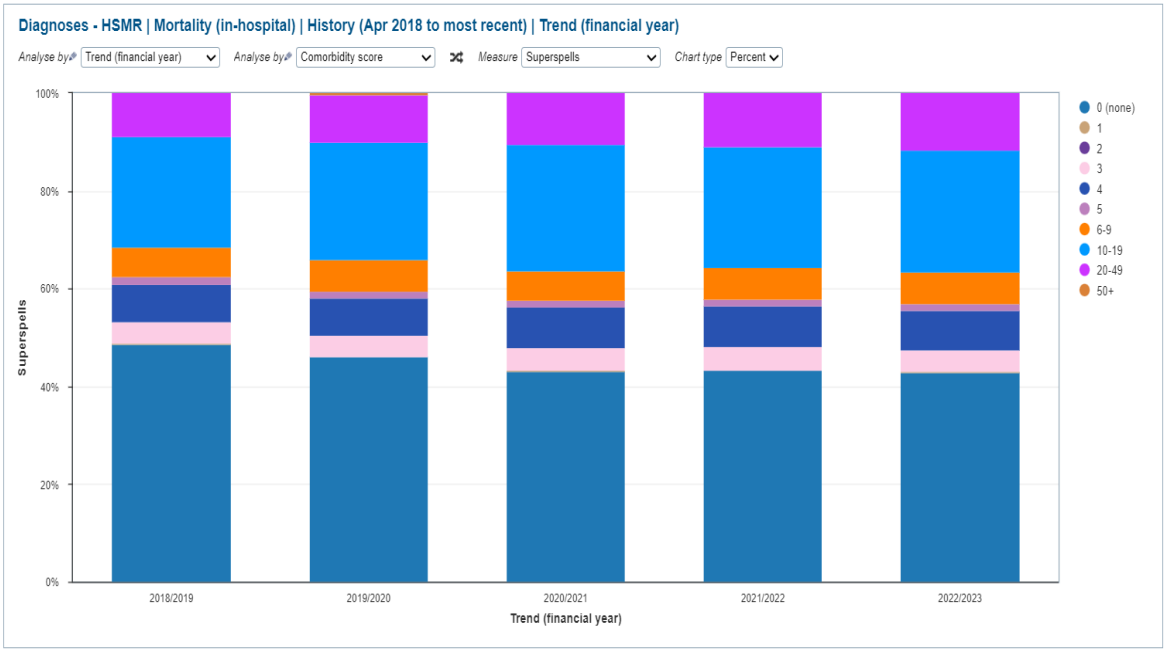


Chart 8- Emergency Weekday / Weekend HSMR

The emergency weekday HSMR remains statistically within the expected range. The emergency weekend HSMR remains statistically higher than expected.

Chart 9- Emergency Weekday HSMR

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

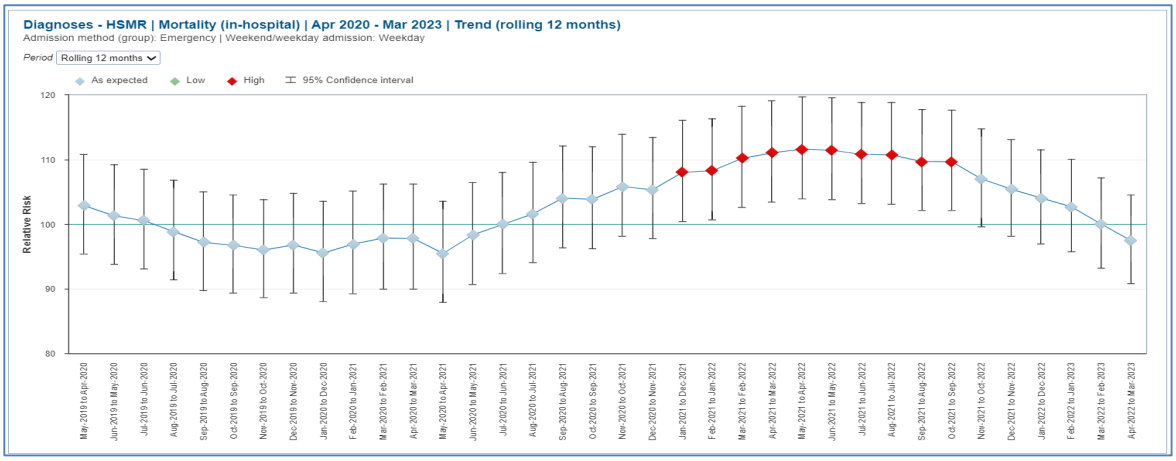
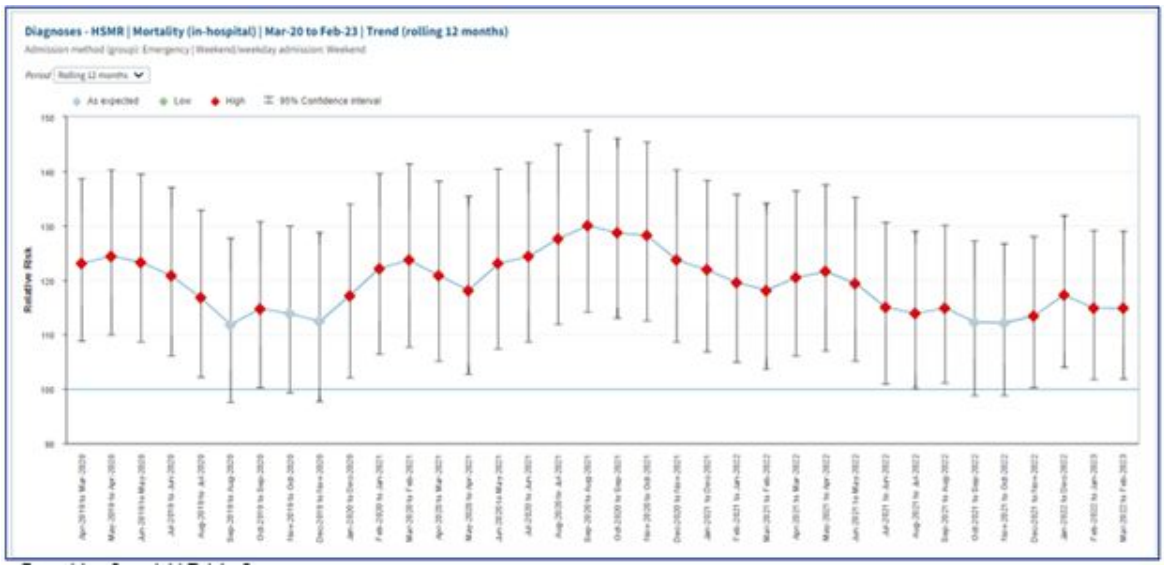


Chart 10- Emergency Weekend HSMR

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 March 2022 – February 2023

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 **March 2022 – February 2023** data period and is different to HSMR.

Chart 11- Trust SHMI compared to National Baseline

The Trust is rated 'as expected' compared to trusts nationally with a SHMI value of 1.0299

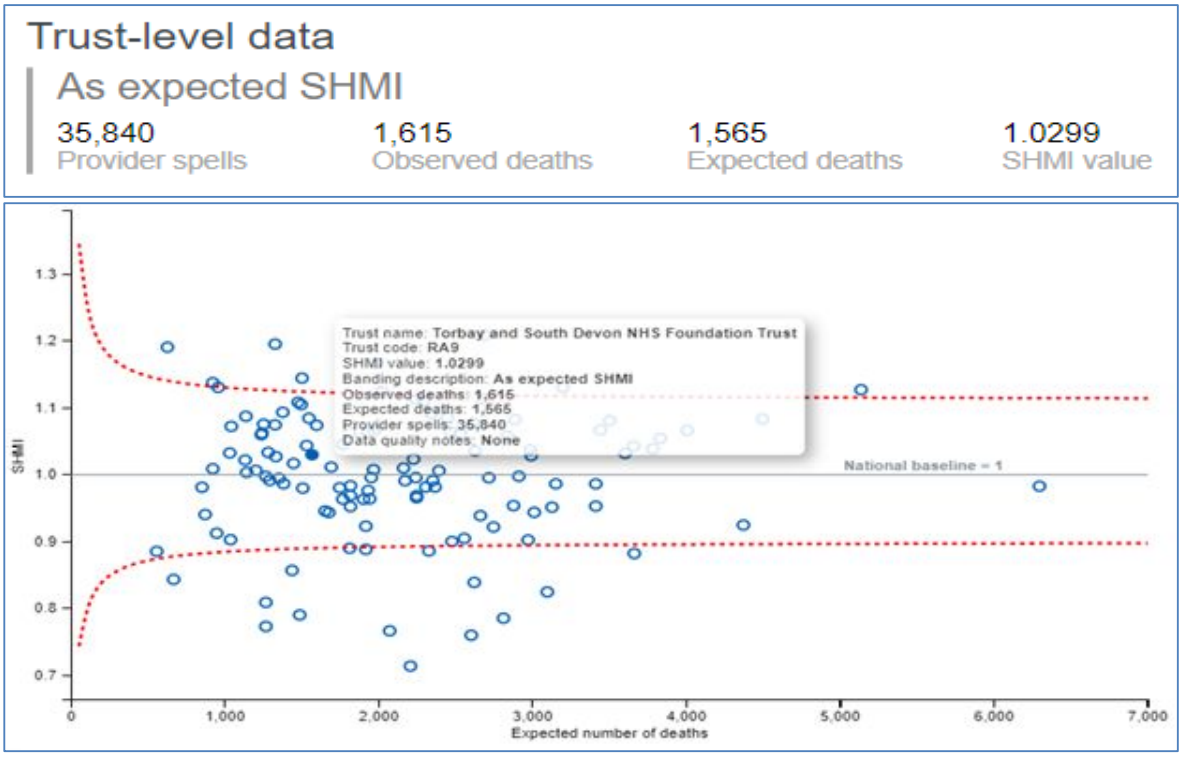


Table 3 – SHMI diagnostic groups

Secondary malignancies has moved banding and is now within the expected range (previously 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 12, below, highlights the Trust's in-hospital unadjusted mortality. The rolling 12-month average is 3.59%. 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-19, Flu and RSV infections.

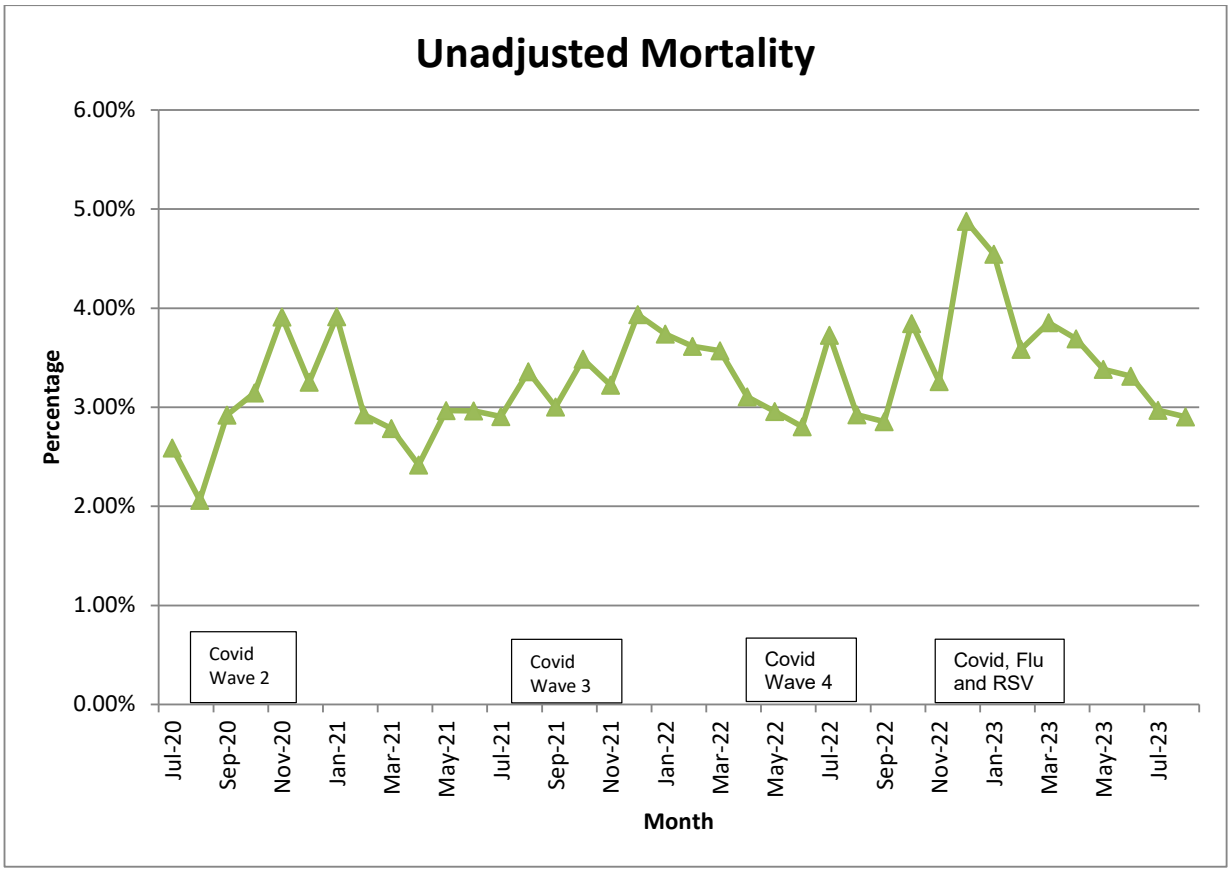
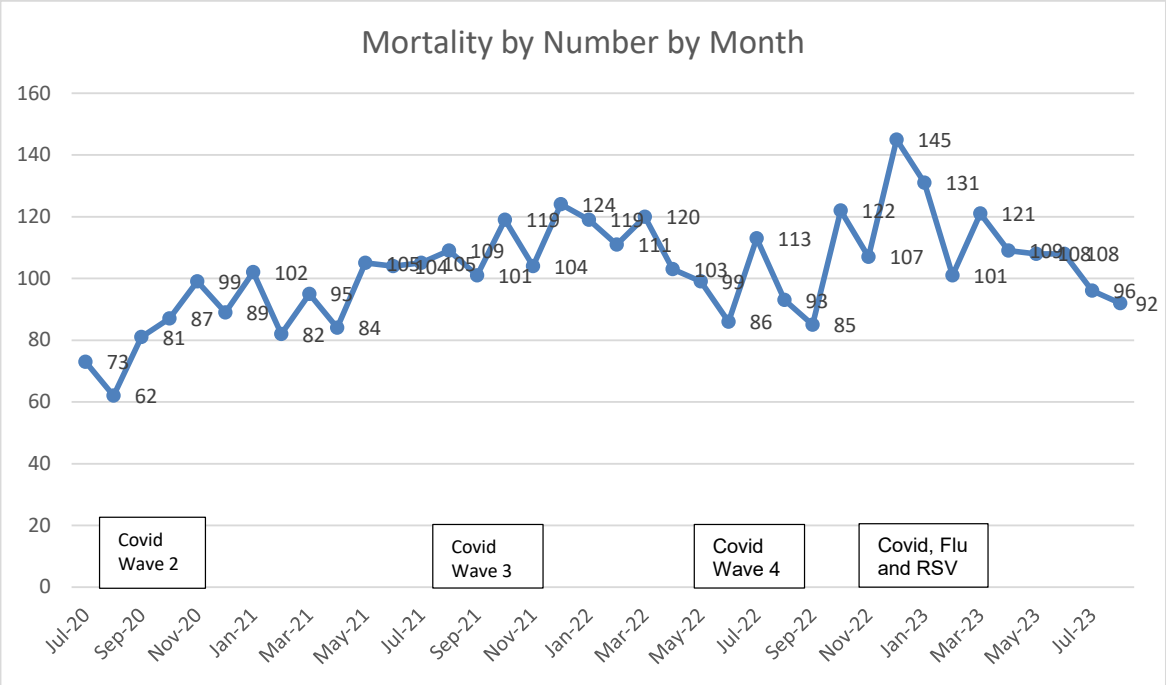


Chart 13 indicates the monthly number of hospital deaths excluding (excluding stillbirths and deaths in A & E).

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.



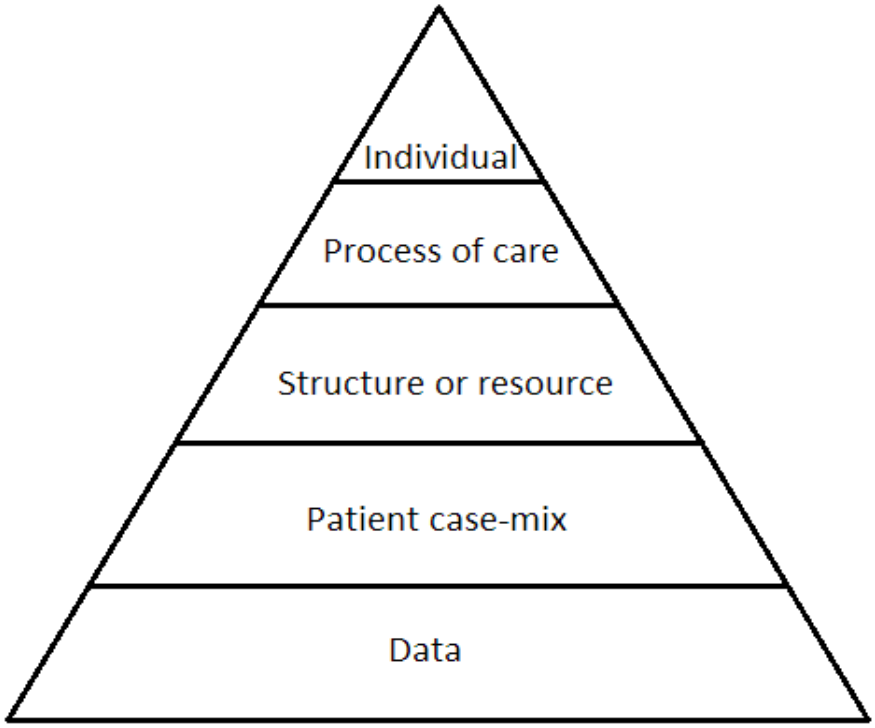
Appendix 3 – Mortality Analysis

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.

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Care Group - Families and Communities													
BRIXHAM			2			1		2	2			1	
DART	1				2		1		1		1	3	4
DAWLISH	1		2		3	1	2	1	1	2	1	1	2
DELIVERY SUITE												1	
LCHDU													
LOUISA CARY													
MOTHER AND BABY													
TEIGN WARD	2	3	3	1	4	3	2	5	2		1		2
TEMPLAR WARD			3	2	3				2			1	1
Care Group - Planned care													
AINSLIE	3	3	3	5	2	1		7	3	5		1	
ALLERTON	5	6	9	8	14	7	4	6	6	7	4	5	6
CROMIE	5	2	4	6	4	3	7	5	2	4	6	7	3
ELLA ROWCROFT	1	1		1	1		1			1	1	1	2
INTENSIVE CARE UNIT	6	1	6	9	10	13	11	6	6	8	7	9	9
THEATRES					2			1		1			
WARRINGTON	3	3	4	2	2	5	4	1	5	1		2	1
Care Group - Medicine and Urgent Care													
ACUTE MEDICAL UNIT					5	4	10	6	3	5	2	5	4
CARDIAC CATHETER SUITE								1			1		
CHEETHAM HILL	11	7	11	10	9	5	8	9	8	8	12	8	5
DUNLOP	7	4	6	1	14	13	6	2	8	1	3	4	4
EAU4	6	6	7	9	9	13	3	4	7	12	7	4	4
FORREST	6	6	11	11	10	12	7	8	8	10	4	5	7
GEORGE EARLE	7	11	14	10	6	9	7	12	11	12	14	9	8
MCCALLUM	4	2	2	2	5	9	3	4	3	1	3	3	2
MIDGLEY	11	17	18	12	17	16	13	17	16	13	18	12	12
NEW MEDICAL RECEIVING UNIT	1	3	1	2	4								
SIMPSON	8	3	10	11	6	8	4	15	8	8	11	8	9
TORBAY CHEST PAIN UNIT					1			1					
TORBAY CORONARY CARE BEDS		1	2	1	5	3	2	2	3		2	1	3
TURNER	5	6	4	4	7	5	6	6	4	9	10	5	4
Grand Total	**93**	**85**	**122**	**107**	**145**	**131**	**101**	**121**	**109**	**108**	**108**	**96**	**92**

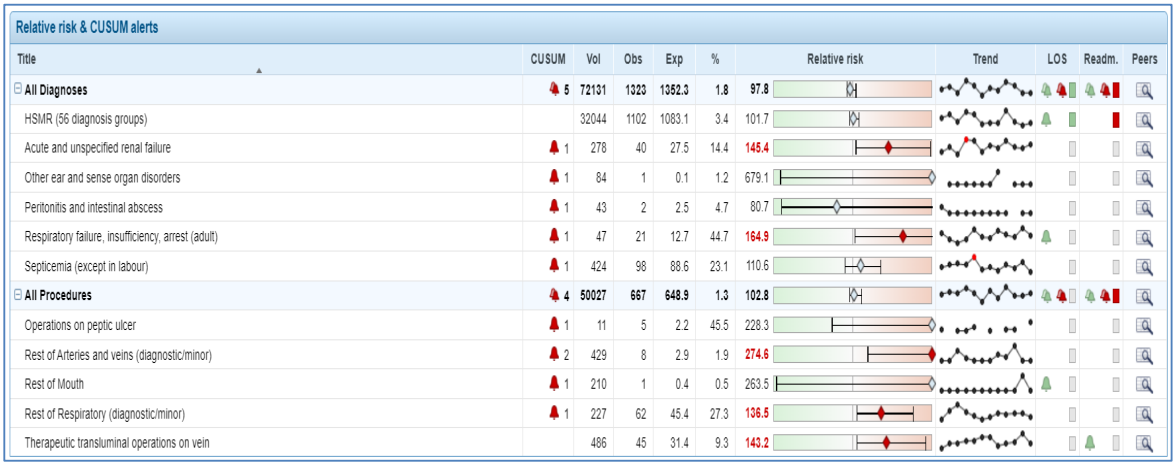
Alerts by Clinical classification

An ‘alert’ is raised when the expected number of deaths is significantly exceeded by the actual number of deaths. The Trust adopts the ‘pyramid of investigation for special cause variation’ shown below to further investigate alerts.



1) 1st Step **Data**: has the data been coded accurately, have all the comorbidities been recorded and coded, does the coding reflect what actually happened to the patient?
2) 2nd Step **Patient case-mix**: Has something happened locally to affect the case mix? For example, patients admitted for end-of-life care and, if so, has a palliative care coding been recorded?
3) 3rd Step **Structure or Resource**: were there any changes to the structure and availability of resources e.g. availability of beds, equipment and staff
4) 4th Step **Process of car**e: have new treatment guidelines been introduced, have appropriate care pathways been consistently followed, have there been changes to admission or discharge practices?
5) 5th Step: **Individual:** An individual is rarely the cause of an alert. A consultant name may be recorded against the primary diagnosis, but many individuals and teams are involved in providing care. Have there been any changes to staff or teams during the investigation

Table 5 – Dr Foster Alerts by clinical classification



Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	5	72131	1323	1352.3	1.8	97.8				
HSMR (56 diagnosis groups)		32044	1102	1083.1	3.4	101.7				
Acute and unspecified renal failure	1	278	40	27.5	14.4	145.4				
Other ear and sense organ disorders	1	84	1	0.1	1.2	679.1				
Peritonitis and intestinal abscess	1	43	2	2.5	4.7	80.7				
Respiratory failure, insufficiency, arrest (adult)	1	47	21	12.7	44.7	164.9				
Septicemia (except in labour)	1	424	98	88.6	23.1	110.6				
All Procedures	4	50027	667	648.9	1.3	102.8				
Operations on peptic ulcer	1	11	5	2.2	45.5	228.3				
Rest of Arteries and veins (diagnostic/minor)	2	429	8	2.9	1.9	274.6				
Rest of Mouth	1	210	1	0.4	0.5	263.5				
Rest of Respiratory (diagnostic/minor)	1	227	62	45.4	27.3	136.5				
Therapeutic transluminal operations on vein		486	45	31.4	9.3	143.2				

Compared to the dashboard previous dashboard there is one new CUSUM alert and two new diagnosis groups with a relative risk statistically higher than expected.

CUSUM and relative risk - Acute and unspecified renal failure (Alert in February 23)

- Previous deep dive end undertaken regarding this cohort of patients. This indicated patients at end stage of complex illness. In addition there is some selection bias as treatable renal failure patients are transferred for treatment whereas end stage patients are cared for within the Trust.
- Medical Examiners will be asked to monitor this cohort of patients over next 2 months.

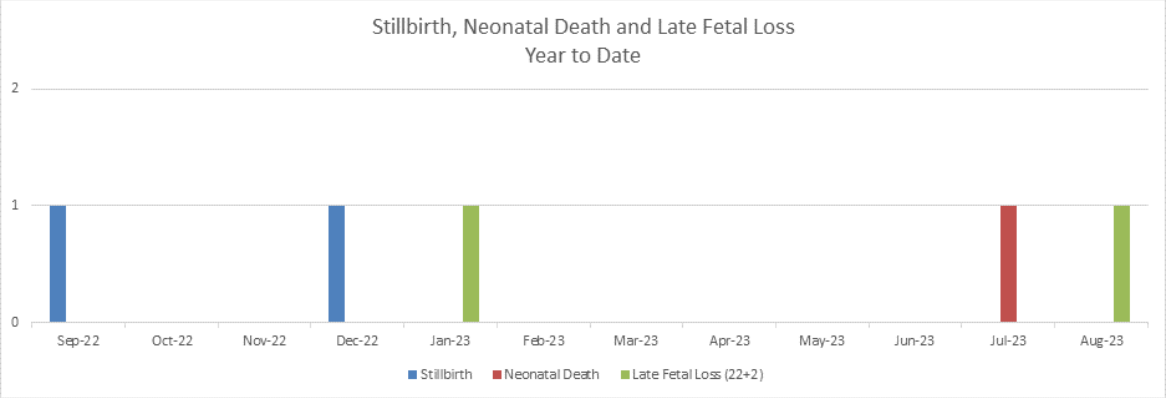
Relative Risk - Respiratory failure, insufficiency, arrest (adult)

- No one month is statistically higher
- No age group statistically higher
- Analysis of co-morbidity score indicates lower numbers within the 20 – 49 cohort which may suggest the acuity is not accurately represented which negatively impacts on the expected rates.

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 July and August 2023 we had one late fetal loss and one neonatal loss.

Chart 14 – Stillbirth, Neonatal Deaths and Late Fetal Losses



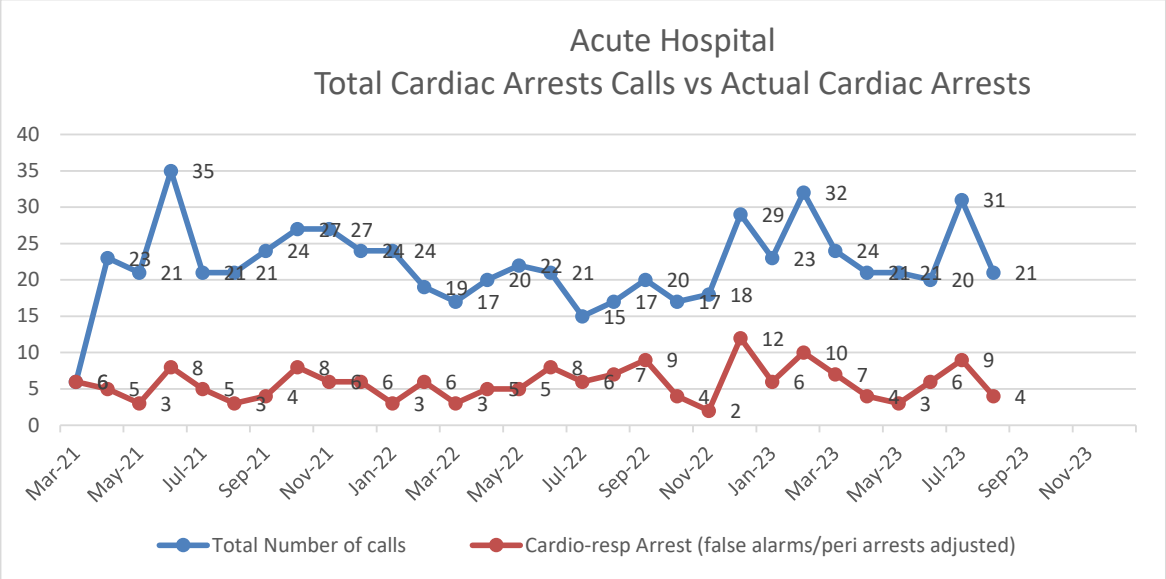
The neonatal loss in July was the result of a termination of pregnancy for Down syndrome and complex cardiac anomalies. The baby was born showing signs of life and lived for 13 minutes. Due to new guidance this case has been referred to the coroner.

During August there was a late fetal loss at 22+2. A Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRACE) Perinatal Mortality Review (PMRT) has been requested.

Cardiac Arrest

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

Chart 15– Acute Hospital – Cardiac Arrests



Medical Examiners

The Medical Examiners service was due to become statutory in April 2023 however the government have now revised this date to April 2024. The service hosted at TSDFT will continue to encourage local GP practices to engage on a voluntary basis.

100% of the deaths in the acute and community hospital settings, which are not directly referred to the coroner have had Medical Examiner scrutiny.

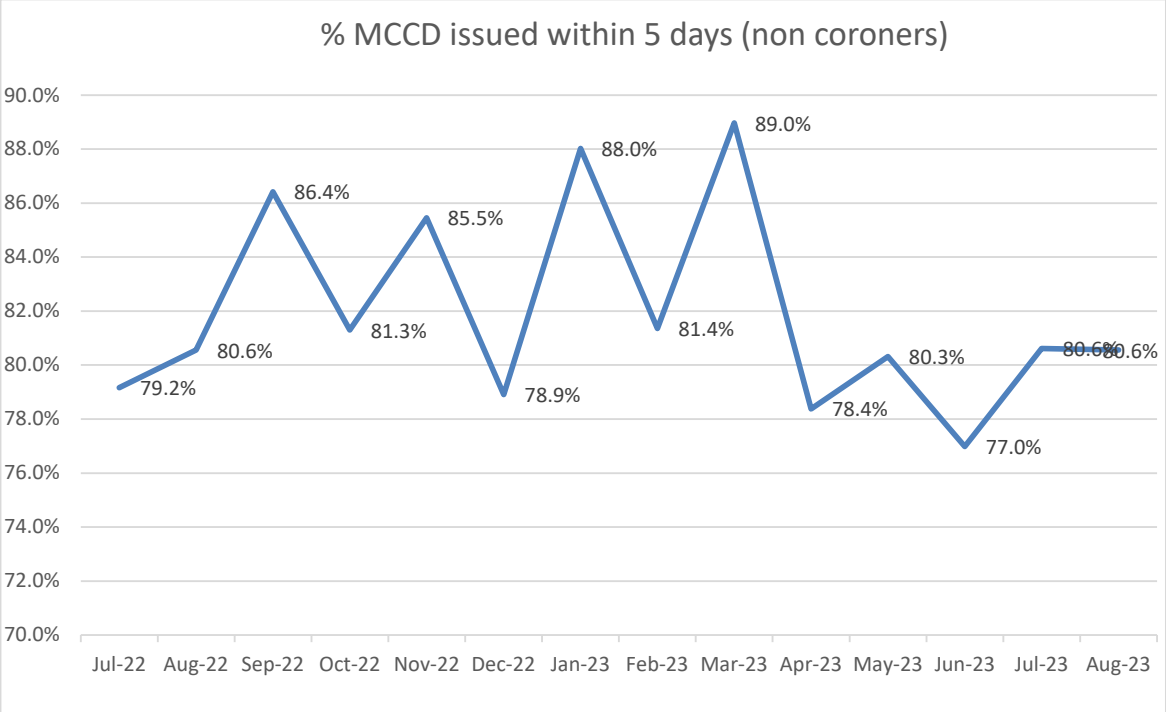
Table 6 – Medical Examiners - Community vs Acute Activity

Month	Number scrutinised by ME	Acute	Community	Number subsequently referred to the 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
Jul-23	117	103	14	19
Aug-23	123	97	26	15

Chart 16 – MCCD completion within 5 days

The ongoing episodes of industrial action and the Bank Holiday during July and August 2023 continues to negatively impact on the timescales for completion of MCCD's.



A total of 20 incidents have been raised to the Trust for review due to concerns raised by the next of kin or the Medical Examiners. In addition a total of 12 bereaved families were signposted to PALS.

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.

During July and August 2023 the Trust received no LeDeR reviews outcomes.

During these months a total of one (1) LeDeR referral has been made from the acute hospital. A Structured Judgement Review was undertaken which indicated no evidence the death could have been avoided and identified no issues in care provision.

Learning from Inquests

In July 2023 the Trust was due to attend 2 inquests but both were opened and adjourned.

In August 2023 1 of the adjourned inquest was held and is summarised in the table below. There were no other inquests held.

Table 7 – Summary of Inquests attended.

Month of Inquest	**Month of Death**	**Case Outline**	**Verdict**	Learning / actions/ feedback
July and August 2023	March 2022	Fall at home	Natural Causes	The Coroner had considered if this matter required a Regulation 28 Prevention of Future Deaths Report however she suggested that, because of the thorough RCA Investigation along with the evidence that the recommendations highlighted in the RCA being implemented, she was satisfied that significant learning had been taken. The Coroner highlighted that, in her opinion, there was no causal link between the lapses in care and the passing of the deceased.

Number of deaths in which concerns and complaints were raised by the family

During July and August 2023 there have been no formal complaints however there have been 23 concerns raised.

- 5 related to care
- 3 related to communication
- 2 related to post-discharge
- 2 related to discharge planning
- 1 related to delay in MCCD
- 1 relating to parking
- 3 related to property
- 1 related to social care
- 5 related to treatment

There have been 2 compliments received regarding treatment and care.

Trust learning: Serious Adverse Event Group

1. **INC-100984**

A patient attended a community hospital for a chest x-ray and fell whilst leaving resulting in a #NOF. The patient then received timely imaging and escalation to orthopaedics and was swiftly transferred to Torbay Hospital for treatment. The patient was operated on within 36 hours; however, the patient subsequently died. The patient's primary cause of death (1a) is recorded as Sepsis. This report was prepared for sharing and comment from HM Coroner. Issues discussed related to TEP form, contact with the out of hours medical cover at community hospital and contact with next of kin.

2. **INC-84263**

The report relates to a child who died at home following 2 attendances in ED in the week prior to their death. The mother of the deceased child had various noted co-morbidities during pregnancy, and that was placed on the Teenage Pregnancy Care Pathway. The baby was induced at 39+ weeks and was born by normal delivery with good Apgar scores. There were no risks identified and mother was discharged with routine post-natal care. The Health Visitors Team saw the family regularly as part of the Universal Plus Service. At 7 weeks the child was taken into ED via ambulance, a diagnosis was made of suspected early bronchiolitis and a decision made to discharge home with safety-netting provided to the mother. Three days later the child was reattended ED via ambulance, upon attendance observations were taken whilst the child slept and were recorded as within normal parameters. Routine safeguarding enquiries were made again, with no concerns highlighted. An inpatient stay was offered to the parents who declined and therefore the patient was discharged home.
Two days after this second discharge the patient died at home. The maternity services were found to deliver good care throughout the pregnancy and that no safeguarding concerns were raised. All management was within Trust policies and NICE guidelines. The cause of death was noted as Sudden Infant Death Syndrome. Although the case notes had been reviewed by two independent paediatricians, the SAE group requested the opportunity to discuss the case further with the paediatric team.

3. **INC-91521**

A urology patient was due to undergo a regular annual flexible cystoscopy on the 20/02/2020 for squamous metaplasia of the bladder, however, they did not attend this appointment or a number of others. NICE guidelines indicate these patients should have a biopsy initially every six months and then, after a couple of years, annually because squamous metaplasia has the potential for malignant change.
The investigation found that the importance of attending for review and biopsy was not explained fully to the patient initially, and therefore they may not have recognised the

significance of this. Further, investigation found the template letters used within the Trust did not appropriately emphasise the importance of these appointments.
The investigation findings have resulted in a number of actions including Clinical Nurse Specialists requesting Consultant reviews of cystoscopies undertaken for any patients with a poor view, or needing clarification of diagnosis and pathway. The template letters have been amended to reflect the clinical impact of potential non-attendance. Issues discussed included the need for a tracker system for bladder cancer similar to that used for prostate cancer and the confidence in the actions taken to prevent this occurring in the future.

4. **INC-89227**

A patient from the neighbouring mental health unit attended ED for self-harm and then reattended following an unknown mixed medication overdose. The medical plan recommended that if the patient remained in hospital they would require a further medical review, Venous Thromboembolism (VTE) risk assessment and VTE prophylaxis. The patient remained in ED for approximately 32 hours awaiting transfer to a ward, during this period became acutely unwell and diagnosed with a saddle embolism.
The investigation found that despite the long stay, ED is not intended to deliver ward level care the note for VTE prophylaxsis was recorded on the Medical O Drive for the ongoing medical team to deliver and not recorded on Symphony. The primary cause of the event related to capacity and onward flow from ED into medical areas. Discussion on harm occurring to patients as a result of prolonged waits in ED.

5. **INC - 93192**

89 year-old man looked after by intermediate care team in his own home after a number of inpatient episodes, recently widowed. Sadly, took an overdose which despite urgent transfer to ED resulted in his death. Issues of response to remarks wishing to end his life and communication issues within community team and concern around potential silo working. Delays in ambulance attendance investigated by SWAST.

6. A number of falls cases and pressure ulcer cases were presented. The learning from these cases will be collated into thematic reviews of falls and pressure ulcers.

Key Issues and Risks

Pressures in emergency care with prolonged waits for definitive in-patient ward treatment and delayed and impaired transfer of care. The impact of prolonged waits in ED has previously been presented to QAC.

The importance of clinical attendance at QAC to present clinical cases is invaluable to enable share learning from incidents.

A number of patients suffered harm after admission to acute inpatient beds for non-clinical reasons, often due to unavailability of suitable family or community support services in patients with deteriorating cognitive function.

Appendix 5 - Glossary of Terms

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

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

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

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

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

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Maternity Workforce Oversight Report			Meeting date: 27 September 2023
Report appendix			
Report sponsor	Chief Nurse		
Report author	Deputy Director of Midwifery and Gynaecology/Director of Midwifery		
Report provenance	This report is a summary of Midwifery and Obstetric Workforce within the maternity service. This reflects NICE guidance around safe staffing levels as well as recent Ockenden recommendations. This is monitored by the Maternity Clinical Governance Group.		
Purpose of the report and key issues for consideration/decision	The purpose of the report is to provide an update to the TSDFT Board members and provide assurance around systems and processes to ensure continuous monitoring and oversight around safer staffing levels as per NICE guidance, NG4 (2015). The guidance recommends that the maternity establishment is reviewed at Board level at least every 6 months. The TSDFT Board should note that following key issues: • Overall improvement in the sickness absence rate • The birth to midwife ratio falls well within the national recommendation of 1:28 • Excellent position in relation to % of women receiving one-to-one care in labour • Good compliance with staffing levels meeting acuity levels (>90% of the time) • Positive/innovative approach to midwifery retention being led by senior midwives within the service. Torbay maternity service has been highlighted as having very positive results from the retention work within midwifery, as a result of this, the retention midwives are now working with Kings College, London.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to: • Note the ongoing improvements in midwifery workforce metrics and the influence of the retention midwifery role. • Note the mitigations to ensure safety and quality. • Note the ongoing service review of the Obstetrics and Gynaecology team. • Note the conclusion of the midwifery organisational change staff consultation regarding shift pattern alignment.		

<table>
<tr><td></td><td>

- Consider the support for a further maternity workforce assessment later in 23/24

</td></tr>
<tr><td colspan="2">Summary of key elements</td></tr>
<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>x</td><td colspan="2"></td></tr>
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<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>

<table>
<tr><td>Board Assurance Framework</td><td>N/A</td><td>Risk score</td><td></td></tr>
<tr><td>Risk Register</td><td>N/A</td><td>Risk score</td><td></td></tr>
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<tr><td>External standards affected by this report and associated risks</td><td>

<table>
<tr><td>Care Quality Commission</td><td>x</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS England</td><td>x</td><td>Legislation</td><td></td></tr>
<tr><td>National policy/guidance</td><td>x</td><td colspan="2"></td></tr>
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CNST set clear safety standards for Trusts in relation to maternity services. Demonstration that these standards have been met, result in the Trust being eligible for a rebate on their maternity CNST contribution and a share of any unallocated funds.

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1.0 Introduction

This report covers the period from 1 January 2023 to 30 June 2023 and details compliance with the standards set out in national and regulatory frameworks (as set out below).

2.0 Context and Standards

There are clear standards for effective midwifery workforce planning. NICE guidance, NG4 (2015) recommends that the midwifery establishment is reviewed at Board level at least every 6 months. This has been achieved through inclusion in the Chief Nurse's 6 monthly Midwifery staffing report that is taken to the Board.

The three-year delivery plan for maternity and neonatal services also includes workforce as one of its 4 key pillars (2023)
'Growing, retaining and supporting our workforce.'
The Clinical Negligence Scheme for Trusts (CNST) maternity incentive, Year 5, set out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows:

1. A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
2. Trust Board to evidence midwifery staffing budget reflects establishment as calculated in establishment report (Birthrate Plus)
3. The midwifery coordinator in charge of labour ward must have supernumerary status (defined as having no caseload of their own during a shift) to ensure there is an oversight of all birth activity within the service
4. All women in active labour receive one-to-one care
5. Submit a bi-annual midwifery staffing oversight report that covers staffing / safety issues to the Board.

3.0 Midwifery Staffing Establishment

3.1 Birthrate Plus®

In light of the Ockenden Review (Dec 2020), Trusts have been required to set out they are meeting the minimum maternity staffing requirements as set out by the most recent Birthrate Plus ® report. Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

A BR+ establishment review was undertaken at TSDFT in November 2020 and the final report received April 2021. A variance of **-13.27wte** within the midwifery workforce was identified. National funding was received following the Ockenden Report (2020) and an uplift approved by the Trust board has addressed this gap.

3.2 Monthly Establishment Review.

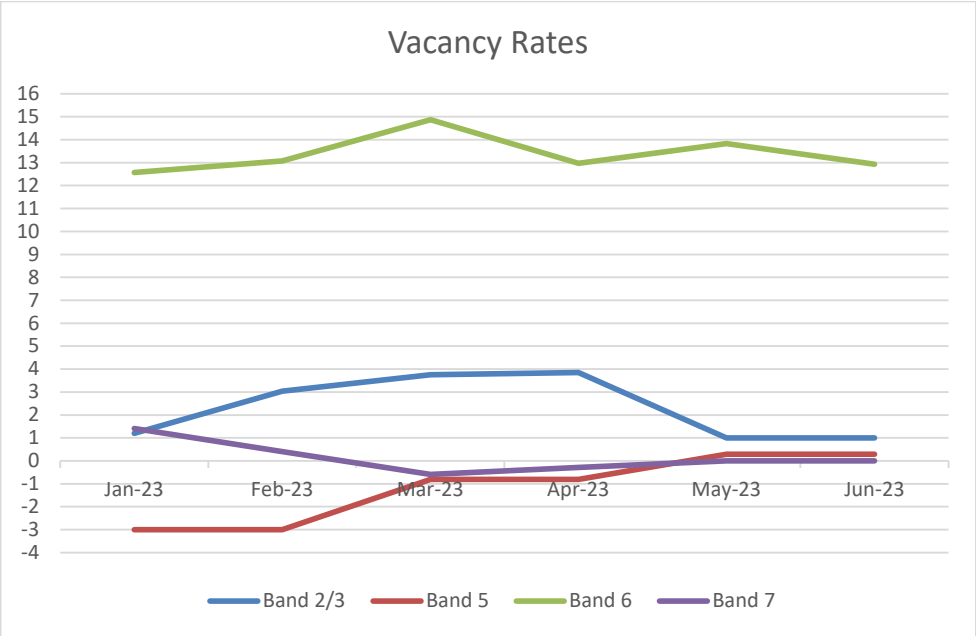
The midwifery establishment is reviewed on a monthly basis by the senior midwifery leadership team. Reviews are undertaken with the relevant team leaders within the maternity service to ensure that appropriate plans are made to recruit to vacant posts and identify teams with staffing issues, so that support can be provided where it is

needed. Levels of long-term sickness and staff working non-clinical duties are also monitored to ensure efficient staffing cover in all areas of the service.

3.3 Recruitment

During the 6-month period covered within this report, we have seen little change in the monthly vacancy range. The table below shows the rate across different bands of staff. (WTE vacancy rate is on left axis)

Chart 1



At the end of this reporting period, in June 2023 the percentage vacancy rate across all levels of maternity staff was 10.91%, this compares to the Trust percentage vacancy rate of 12.94%. Of the 10.91% vacancy rate in maternity services, Band 6 vacancies account for 9.89% of this total.

The vacancy rate reflects the national picture of midwifery establishment and difficulties recruiting into midwifery posts, in particular band 6 midwifery posts. In Torbay and South Devon NHS Foundation Trust, this has been compounded by several staff reducing their hours to support work life balance as well as some staff retiring, offsetting any external recruitment that has been undertaken.

Maternity services nationally have also received additional funding streams for specialist posts. This has created further temporary vacancies locally, by the provision of fixed term specialist midwifery posts that have been filled by internal staff. In addition, we have faced challenges in backfilling these roles, due to their temporary nature. For this reason, temporary vacancies resulting from these fixed term posts have had to be covered using bank staff and staff working additional hours.

The retention midwives have played a fundamental role in our plans to retain current midwifery staff. They have undertaken specific work on reducing attrition rates and supporting staff in post. A particular focus has been early career midwives (those within

the first 3 years of qualifying), who, research has shown, have a higher rate of leaving the profession. Chart 1 demonstrates stability in the band 5 workforce and may be representative of the additional support that has been put in place to retain this cohort.

We have also been working with our Business Partner to formulate a robust action plan for recruitment and retention, particularly of band 6 midwives. We have undertaken forward projections and anticipate that, at the end of Quarter 2, our midwifery vacancy factor will be 8.64wte (compared to 13.23wte in June 2023).

3.4 Retention

The valuable work of the retention lead midwife posts (1.0wte) has been funded by NHSE until March 2024. Their work within TSDFT maternity services has been the subject of a report, which is being compiled following a service review by Kings College London. The report is due to be published in October 2023. Relevant stakeholders have been invited to the feedback meeting on 4 October 2023, including the senior leadership team in maternity, the LMNS and Trust executives.

A case study of good practice focussing on the work of the retention midwives has been included in the new national maternity transformation single delivery plan, which was published in quarter 1 of 23/24.

The retention midwives were presented with an innovation award at the regional perinatal conference in May 2023. This was in recognition of their work to support all levels of maternity staff, through the provision of wellbeing resources for staff including psychological and physical resources, service development and support for women following a traumatic delivery.

A national PMA (Professional Midwifery Advocates) conference was hosted by the retention midwives at TSDFT in May 2023, this was attended by delegates from across the UK and online from Ireland & Kenya. This explored the role that PMAs can play in the retention of maternity staff (including medical staff), the conference was very well reviewed by attendees on the day.

The retention midwives are currently in the process of writing a 3-year retention strategy, in collaboration with our People Business Partner. This will consolidate the work they have already undertaken and give direction for the future of this vital aspect of the service.

The Score culture survey is now due to be repeated within maternity and neonatal services and the retention midwives will help to facilitate this project. This will be targeted at all maternity and neonatal staff, including medical, midwifery, nursing and admin teams. The results will be used to inform service development and improvement, as will the report from Kings College. The retention team are also focussing on induction of labour pathways and the delivery of a supportive homebirth service, building skills and confidence in the provision of homebirth.

The retention midwives are also planned to teach on the maternity mandatory training, providing a session on trauma-informed care and they are working with UHP to provide a module for student midwives on working in a fear-based culture.

3.4.1 Birth to Midwife Ratio

The midwife to birth ratio data provides further insight into maternity workforce models and staffing levels. The ratio is calculated by dividing the total number of births by the whole-time equivalent number of midwives. The calculation is crude, as it only considers births and not the impact of all of the other activity/acuity. It also does not include gaps in establishment caused by sickness, maternity leave and staff working amended duties.

The current national recommendation is a ratio of 1:28 midwives.
Between January 2023 – June 2023 there was an average birth rate per month of 142 births. This is a slight reduction from the previous reporting period.
This has resulted in a Midwife to Birth ratio as displayed in Table 2. The birth to midwife ratio falls within the national recommendation.

There is a continuing increase in the complexity and acuity of women, both medically and socially, evidenced by the increased rates of medical interventions, such as induction of labour and caesarean section, and a subsequent rise in the length of stay for women.

Table 1: Midwife to Birth ratio (exc. HOM, matrons and specialist roles)

Time period	Midwife: Birth Ratio
Jan 23	1:19
Feb 23	1:14
March 23	1:19
April 23	1:17
May 23	1:18
June 23	1:18

3.4.2 Nationally Mandated Workforce Models across Maternity Pathway

In addition to the above, there have been a number of national trajectories that have been set by NHSE in relation to the provision of maternity care. This has resulted in the need to redesign our midwifery service, to meet the requirement that the majority of women receive continuity of carer (MCoC) from a small team of midwives. The recommended ratio for community midwifery care is 1:36, however our teams are currently configured for 1:45-50.

The Birthrate Plus® review undertaken in November 2020 took this into account and, therefore, identified the increase in midwifery establishment to meet this need. However, it is still difficult to encourage some staff to work within these teams due to the discord amongst the midwifery workforce around the shift/ on call patterns. associated with this model.

The Director of Midwifery has been working with the RCM and other stakeholders to review and resolve this and an organisational change staff consultation was undertaken. This three-month formal consultation commenced in April 2023 and has recently concluded. The process of the consultation was applauded by the SW regional RCM officer in view of the staff engagement and collaboration demonstrated. The

consultation has resulted in shift alignment and a termination of the on-call model of care. It will align the hospital and community shift patterns and will address much of the staff feedback that has been collated over the last 2 years.

The three-year delivery plan specifies the need for a maternity specific workforce strategy to be in place. This will be progressed in the coming months.

4.0 Women receiving one-to-one care in labour.

The maternity service records the number of women receiving one-to-one care in labour. The aim is to achieve 100%. This data is captured on the maternity dashboard.

Table 2: Percentage of women receiving one-to-one care in labour

Time period	%
Jan 23	100%
Feb 23	100%
March 23	100%
April 23	100%
May 23	100%
June 23	100%

The maternity service works extremely hard to ensure this standard is met and in the six-month reporting period this was 100%

5.0 Obstetric Workforce

Obstetric workforce levels have seen an improvement in the latter part of this 6-month reporting period, as all consultants returned from long term sickness absence. Since mid-January we have not required the use of any locum cover.

There continues to be some challenge in providing all aspects of clinical and leadership activity. A gap analysis demonstrated a shortfall of approximately 4 WTE consultants. This was escalated to the executive team and a full-service review is in progress, supported by the Trust's transformation team. This is expected to conclude by the end of September 2023.

Another factor contributing to the service review, is the requirement to ensure a standard operating procedure (SOP) for the implementation of compensatory rest by consultants after an on-call period. For the purpose of self-certification for the Maternity Incentive Scheme (CNST), this SOP is required to be in place by October 2023, with an action plan to address non-compliance provided to the Trust Board.

The gaps identified have delayed the work to initiate the protected time that is required to undertake several obstetric leadership roles within the service. This was identified as part of the Ockenden insights visit, as well as following completion of the maternity self-assessment tool (NHSE).

As part of the workforce strategy it is anticipated that we will start to explore the role of the Advanced Care Practitioner in Midwifery. This has been recently commissioned as part of the Health Education England programme and would address some of the wider challenges in obstetric recruitment.

6.0 Red flags

NICE guidance identifies a number of events that can be viewed as red flags. These indicate that there may not be enough midwives available to meet the acuity demand. 9 red flag events were identified by NICE, whilst locally we have added a further flag (denoted with an *):

Red flag events and actions taken in response to these are captured using the Birthrate Plus ® Acuity Tool. Refresher Training in the use of the Birthrate Plus acuity tool took place for the Delivery Suite Coordinators in early 2023, to ensure accuracy, consistency and confidence in the acuity data that is being collected. The midwifery red flags for the reporting period are detailed in Table 3 below.

Table 3

Red flag	**Descript**	**Incidence**						
		Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**Tot**
RF1	Delayed or cancelled time critical activity	0	1	0	0	0	0	**1**
RF2	Missed or delayed care	3	1	0	0	1	0	**5**
RF3	Missed medication	0	0	0	0	0	0	0
RF4	Delay in providing pain relief	0	0	0	0	0	0	0
RF5	Delay between presentation and assessment	0	0	0	0	0	0	0
RF6	Full clinical examination not carried out when presentation in labour	0	0	0	0	0	0	0
RF7	Delay of ≥2 hours between admission for induction of labour and beginning of process	1	1	1	0	1	0	**4**
RF8	Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	0
RF9	121 care in labour	0	0	0	0	0	0	0
RF10 *	Unable to facilitate out of hospital birth	1	0	3	0	0	2	**6**
RF11	Coordinator unable to maintain supernumerary status- providing 1:1 care in Labour	**-**	**-**	0	0	0	0	0
RF12	Coordinator unable to maintain supernumerary status - Not providing 1:1 care	**-**	**-**	3	0	0	7	**10**
	Totals	**5**	**3**	**7**	**0**	**2**	**9**	**26**

From our analysis of the system, red flags generally occur at times of high acuity. The Maternity Matron reviews any red flag events and discusses these with the Delivery Suite Co-ordinator, where relevant, using the same process as the supernumerary status. The red flags are also discussed at the daily safety huddle and mitigations to address them are enacted. There has been a reduction in the number of red flags reported in this period from **29** to **26** in the last bi- annual report.

All red flag instances were due to a conscious decision to trigger the red flag, to ensure safety across the whole service was maintained. The most common reason for a red flag within this reporting period, has been the inability for the coordinator to maintain supernumerary status but whilst not providing 1:1 care to women in labour. This is an additional red flag that was added to the acuity app in March 2023. (Please see section 6.1 for a further details).

The second most common reason relates to our inability to provide an out-of-hospital birth. This is often due to the requirement to have two staff members attend a home birth/out of hospital birth experience. However, there has been a reduction in the frequency that this is reported in this period from 21 occasions previously, to 6 in this period. We had taken steps to address some of the reticence from more junior midwives, who have less exposure to births outside of the hospital setting, to attend. Additional mentoring support had been provided to increase confidence and exposure. This, combined with improved staffing levels, is likely to have contributed to this improvement.

6.1 Labour Ward (Delivery Suite) Co-ordinator Supernumerary Status

There is a national recommendation that all Delivery Suites have a supernumerary Midwifery Co-ordinator on duty 24 hrs/day. This specialist role ensures that a clinical specialist is available to oversee safety within the department, provide support, advice and clinical interventions as needed.

Our maternity staffing/escalation document sets out that the Delivery Suite Co-ordinator must be a supernumerary role. All instances where the coordinator has not been working in a supernumerary status are recorded on the Birthrate Plus® acuity tool.

The ongoing ambition is to achieve 100% supernumerary status for the Delivery Suite Coordinators. Table 4 (above) demonstrates our compliance with this ambition for the period January to June 2023.

Guidance received from NHS Resolution for the Maternity Incentive Scheme criteria, states that this supernumerary status will be maintained if the coordinator is not providing 1.1 for women in labour. This has been achieved 100% of the time.

From March 2023 there was an additional red flag added (as displayed in table 4) to report the compliance with supernumerary status if caring for women who do not require constant observation (e.g., when relieving for breaks etc) This must not be on a regular or recurrent basis.

During the six-month period there were 10 instances out of 901 recording points; this equates to 1.1%, indicating that this is not a regular event. For all instances where the co-ordinator was not in a supernumerary capacity, this was not the intention for the shift and is generally a result of sickness or a sudden rise in acuity.

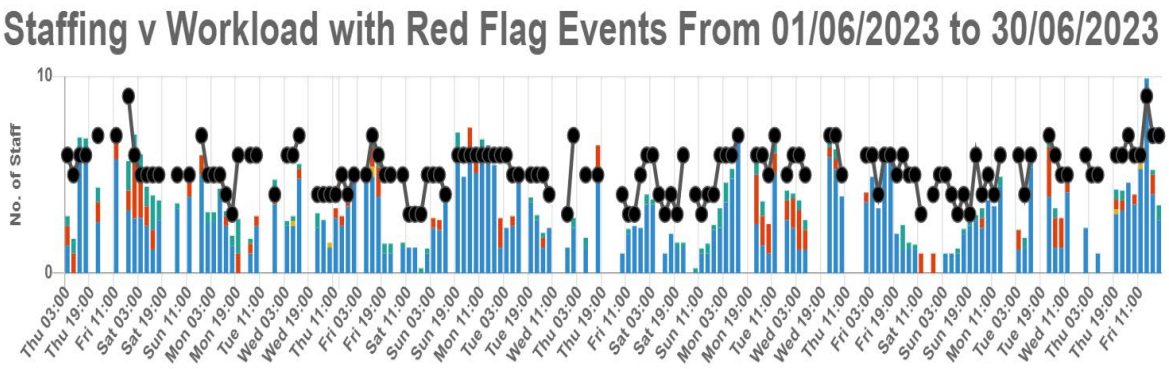
The service has a clear escalation plan with clear actions for the co-ordinator to take at times of high acuity or if there is unexpected staff absence. The co-ordinator caring for a woman on Delivery Suite is one of the last actions that will be considered. This is due to the importance of the co-ordinator maintaining a helicopter view of the maternity service. The co-ordinator will return to supernumerary status at her earliest opportunity.

This escalation process has recently been updated by the Director of Midwifery to align with LMNS and regional guidance. This escalation policy was aligned to the maternity OPEL framework. At times of high acuity, the specialist midwives and midwifery managers will work clinically to support the service.

7.0 Acuity Data

Acuity of the patients on Delivery Suite is captured via acuity monitoring, available from the Birthrate Plus ® Acuity Tool. Charts 1 and 2 provide examples of this data

Chart 1: Staffing v Workload Example



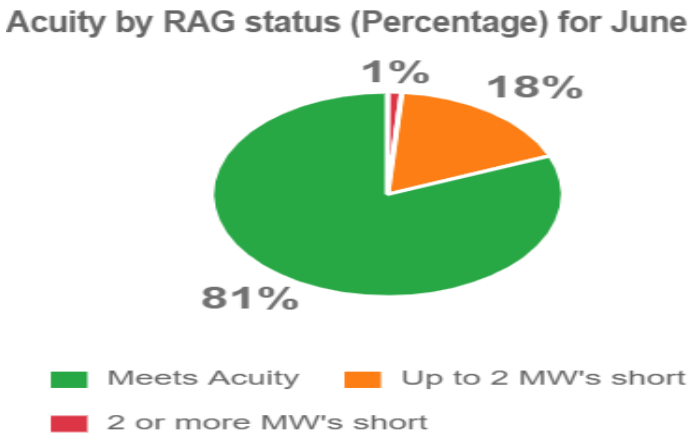
On the above bar chart, the individual bars represent the total number of women on the Delivery Suite. Each woman is categorised into a colour, blue in labour and requiring 1 to 1 care in labour or antenatal high risk, yellow relates to low risk postnatal women, red to high risk postnatal women, green to women requiring assessment or induction of labour. The data provided in the above table is from **June 2023.** This month was chosen as it was the month with the greatest number of red flags. This tool provides assurance that the appropriate number of midwives, indicated by black dots, are available to provide care for women within Delivery Suite.

As demonstrated, on most occasions there are sufficient midwives to manage the acuity of the women on the Delivery Suite.

The chart below (chart 2) indicates the number of occasions per week where staffing met the acuity level and is indicated in green. Red and amber indicate that staffing levels were not met. The period demonstrated here is **June 2023** to triangulate with the data captured in chart 1.

The data for this period indicates that staffing levels were more than 2 midwives short (Red) 1% of the time during the month and that 18% of the time staffing levels were up to 2 midwives short. (Amber) Therefore staffing levels met the acuity levels 81% of the time.

Charts 2: Staffing levels met acuity



In summary, acuity was met for > 90% of the time, with June 2023 being the exception. A review of the dashboard data for June does not highlight any deviations in birth rate or activity. As described below (chart 3), we have not had sight of sickness data for June so are unable to triangulate this as a reason for the reduction in being able to meet the acuity this month. In spite of ongoing vacancies, we have managed to maintain this metric by use of bank staff and staff working additional hours.

Table 4: Acuity percentages

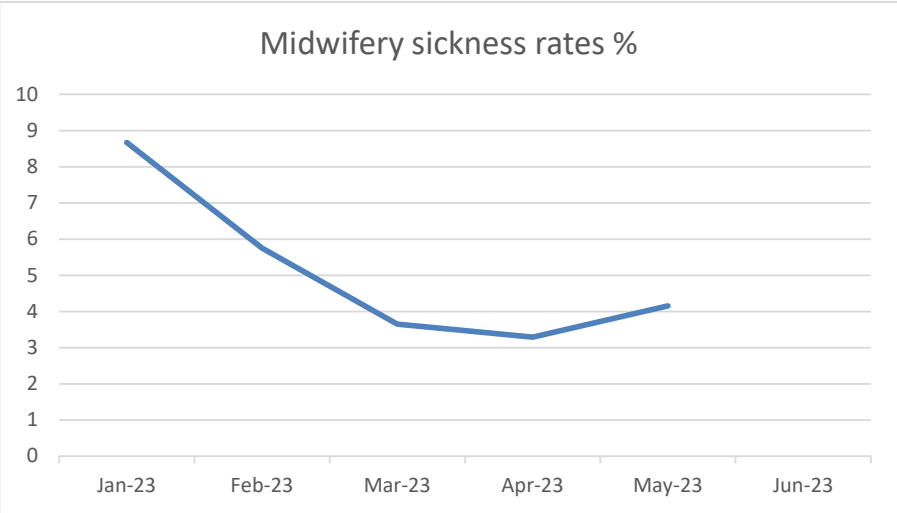
Time period	%
Jan 23	91%
Feb 23	95%
March 23	90%
April 23	90%
May 23	94 %
June 23	81%

8.0 Sickness

The first 4 months of this reporting period showed a marked decrease in sickness levels within the maternity service, with March and April showing a significant reduction. Of note, 3 community midwifery teams out of 6 had 0% sickness in April and one had only 0.31% sickness. A fall in rates was also noted in Meridian (core hospital-based team). Targeted support had previously been provided to staff following long term absence, including flexibility and adaptations to working patterns to support staff with ongoing health needs and there has been a continued decline in Covid related absence. Further support has also been provided to staff by the Retention Midwives and Professional Midwifery Advocates (PMAs).

We are awaiting data for June 2023. The delay is believed to be due to the change in the Care Group structure and the ability to pull the data.

Chart 4: Midwifery Sickness Percentage



9.0 Escalation and Interventions to Assure Safety

The maternity service continues to utilise its documented escalation process for when demand exceeds capacity. Support is provided by the senior leadership team out of hours and, when available, the use of a nominated escalation midwife. This is monitored through the Birthrate Plus ® Acuity Tool.

Table 5: Summary of escalation midwife usage

Time period	No. of Times Escalation Midwife Used
Jan 23	0
Feb 23	0
Mar 23	1
Apr 23	0
May 23	0
Jun 23	0

There have been ongoing conversations with staff side and senior colleagues within the service to determine an appropriate model for midwifery escalation. The escalation out of hours service has been used intermittently, as detailed above, and the number of staff volunteering to support this service is declining. This is a common issue in maternity services across the country and, at the present time, there is no clear resolution that can be found for this issue. There are plans to review the escalation rota after consultation with the other maternity services within the ICS and region. In the meantime, the senior leadership team provide mitigation and support in times of high acuity to ensure there remains safe cover and proportionate work life balance for our teams.

10.0 Conclusion

Over this period there has been a continued improvement in a number of metrics pertinent to being able to provide optimum staffing levels within maternity. This includes the staffing levels meeting acuity needs, as well as supernumerary status of the delivery

suite coordinator. There has also been a reduction in the number of red flag events reported.

A service-wide consultation has been completed to address the challenges with providing an on-call model of care and this has been in response to staff feedback around the shift patterns.

An Obstetric and Gynaecology service review is in progress, to address a gap in service provision. This may result in a requirement to consider additional consultant workforce to address the gaps.

The senior professional leadership team will continue to work with workforce and the finance team to ensure we strengthen, and triangulate service-held maternity establishment data to ensure accuracy of funded establishment. The staffing against acuity data has shown a marked improvement in being able to meet acuity, even with continued vacancies. It would be worth considering a deeper analysis of the reasons behind this after the consultation on shift alignment has been completed. This may mean the consideration of a further workplace establishment review to ensure accuracy of updated requirements for the service.

All levels of maternity staff continue to make every effort to ensure that we provide a safe and quality service for the women and families that we care for.

11.0 Recommendations

The Board is asked to:

- Note the ongoing improvements in midwifery workforce metrics and the influence of the retention midwifery role.
- Note the mitigations to ensure safety and quality.
- Note the ongoing service review of the Obstetrics and Gynaecology team.
- Note the conclusion of the midwifery organisational change staff consultation regarding shift pattern alignment.
- Consider support for a further maternity workforce assessment later in 23/24.

NHS
Torbay and South Devon
NHS Foundation Trust

<table>
<tr><td colspan="4">Report to the Trust Board of Directors</td></tr>
<tr><td colspan="3">Report title: Report on Safeguarding Adults, Mental Capacity and Deprivation of Liberty Safeguards</td><td>Meeting date: 27 September 2023</td></tr>
<tr><td>Report appendix</td><td colspan="3">None</td></tr>
<tr><td>Report sponsor</td><td colspan="3">Chief Nurse</td></tr>
<tr><td>Report author</td><td colspan="3">Head of Safeguarding Adults MCA DOLS</td></tr>
<tr><td>Report provenance</td><td colspan="3">The report has been informed by data collated by TSDFT performance management team for Torbay and Devon Safeguarding Adults Partnership (TDSAP), activity within the TDSAP arrangements, Adult Social Care Outcomes Framework (ASCOF) data, Torbay Council KPI’s, Care Quality Commission (CQC) regulated activity Safeguarding Adult and Mental Capacity Operational Group and TSDFT Integrated Safeguarding and Inclusion Group. The report is also informed by regional and national guidance and legislative frameworks.</td></tr>
<tr><td>Purpose of the report and key issues for consideration/decision</td><td colspan="3">This annual report will inform TSDFT Board members on issues relating to safeguarding vulnerable adults in Torbay and South Devon. The Trust has delegated responsibility for Local Authority statutory safeguarding duties for adults on behalf of Torbay Council. This is governed by The Care Act 2014.

Priority considerations within this report are as follows

1. To note the operational challenges to meet the strategic priorities.
2. The current strategic priorities and activity to meet priorities.
3. Safeguarding Adult performance data for the period 2022-2023.
4. Mental Capacity Act and Deprivation of Liberty Safeguards performance data.</td></tr>
<tr><td>Action required (choose 1 only)</td><td>For information
☐</td><td>To receive and note
☒</td><td>To approve
☐</td></tr>
<tr><td>Recommendation</td><td colspan="3">The Board is asked to note the contents of the report for assurance.</td></tr>
<tr><td colspan="4">Summary of key elements</td></tr>
<tr><td>Strategic objectives supported by this report</td><td colspan="3"><table>
<tr><td>Safe, quality care and best experience</td><td>x</td><td>Valuing our workforce</td><td></td></tr>
<tr><td>Improved wellbeing through partnership</td><td>x</td><td>Well-led</td><td>x</td></tr>
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<tr><td>Is this on the Trust's Board Assurance Framework and/or Risk Register</td><td>
<table>
<tr><td>Board Assurance Framework</td><td></td><td>Risk score</td><td></td></tr>
<tr><td>Risk Register Deprivation of Liberty Safeguards Delegated ASC duties. Risk 3570</td><td>x</td><td>Risk score</td><td>12</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>x</td><td>Terms of Authorisation</td><td></td></tr>
<tr><td>NHS Improvement</td><td></td><td>Legislation</td><td>x</td></tr>
<tr><td>NHS England</td><td>x</td><td>National policy/guidance</td><td>x</td></tr>
</table>

The standards and legal frameworks that drive the Safeguarding Adult and Mental Capacity Act agenda are referenced at Para. 5 of this report. These inform our local policies and practice guidance, many of which are co-produced by the Torbay and Devon Safeguarding Adult Partnership.
</td></tr>
</table>

Report title: Report on Safeguarding Adults and Mental Capacity Act and Deprivation of Liberty Safeguards	**Meeting date: 27 September 2023**
Report sponsor	Chief Nurse
Report author	Head of Safeguarding Adults, Mental Capacity Act and Deprivation of Liberty Safeguards.

Introduction

The Safeguarding Adult Annual Report for 2022/2023 provides key information in relation to core messages, performance, legal frameworks, governance and safeguarding activity during this period.

Discussion

1. National and Local Context

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

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

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

2. COVID-19

The Local Government Association published its 3rd Report titled COVID-19 Adult Safeguarding Insight Project Third Report in December 2021. The report provided an updated national picture relating to safeguarding adult's activity during the COVID-19 pandemic up to June 2021. The report provided a national picture for strategic reflection and offer a framework for analysis of the local experience in comparison to the national trends. Themes included –

- Reduction of preventive work during the pandemic
- Increased layers of complexity in safeguarding situations
- Increased vulnerabilities relating to domestic abuse, self-neglect, financial abuse, exploitation.
- Impact on younger people, declining mental health, older people, people with learning disabilities.

- Impact on the provider market (e.g. staffing shortages)
- SEND Becoming and Adult and Learning Disability agendas

The reporting period has provided the opportunity to locally reflect and respond both internally and through local partnership arrangements such as –

- Torbay and Devon Safeguarding Adult Partnership (TDSAP) Strategic Priorities
- Development of local provider market management and quality provision
- Domestic abuse Initiatives
- SEND Becoming and Adult and Learning Disability agendas

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

There continues to be strong partnership arrangements across geographical boundaries such as Torbay and Devon Safeguarding Adult Partnership (TDSAP) and the Torbay and Devon Anti-Slavery and Prevent Partnership Boards. Lead professionals continue to attend and contribute to safeguarding and mental capacity networks at a county and regional level including those led by NHS England SW and Regional Association of Director of Adult Social Services (ADASS). The close partnership arrangements ensure TSDFT systems and processes are informed by local, regional and national drivers.

4. Culture and Leadership

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

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

Three examples of how we are putting this into practice include

- Mandatory Mental Capacity Act training for all staff
- Mental Capacity ‘How to’ weekly seminars
- Qualitative feedback from those experiencing local safeguarding responses.

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

5. Quality Assurance and Governance

5.1 **Torbay and Devon Safeguarding Adult Partnership**

The Devon and Torbay Safeguarding Adults Board (TDSAP) merged in December 2020 to form the Torbay and Devon Safeguarding Adult Partnership. The Partnership oversees and leads adult safeguarding across Torbay and Devon and are interested in a range of matters that contribute to the prevention of abuse and neglect. Safeguarding Adult Boards have three statutory duties -

- It must publish a strategic plan

- it must publish an annual report
- it must conduct any safeguarding adults review in accordance with Section 44 of the Act.

The Trust has been at the centre of creating the new partnership arrangement and has a key role in the business activity and function of the Board in response to Torbay delegated safeguarding duties. The governance structure is described below. The TSDFT has membership at all levels of governance, provides data and contributes to local policy and practice development.

TDSAP Organisational Structure

5.2 **Trust Integrated Safeguarding and Inclusion Group (ISIG)**:

This is an Executive led group with a mandate to deliver safeguarding and children statutory functions as a provider of health and social care and priorities of local safeguarding adult boards. The group also maintains oversight of other partnership arrangements linked to themes such as exploitation, domestic abuse and sexual violence. Delivery of priorities are largely connected with the strategic priorities and activities referenced in para 6.

5.3 **Safeguarding Adults and Mental Capacity Operational Group.**

The purpose of the group is to ensure that clinical teams are leading the delivery of the safeguarding adult's and mental capacity agenda.

The monitoring and quality assurance of Trust wide safeguarding adults processes are reported to this group. This group reports to the Integrated Safeguarding and Inclusion Group, chaired by the Chief Nurse and will now report into the newly established Executive Quality Group.and the Torbay and Devon Safeguarding Adults Board externally. The Trust's Integrated Safeguarding and Inclusion Group have overseen the

operational work plan and directly links with the outputs in para 6. During 21/22 a review of membership and restructure occurred and the new arrangement means the group has separated its adult social care and health oversight with a minimum of 2 joint meetings per year.

5.4 Dementia Steering Group.

The Dementia Steering Group is tasked with embedding national dementia strategy into local systems. This includes having a clear overview and understanding of how staff in TSDFT can support people with dementia within our services.

A member of the safeguarding team is committed to supporting the work of the steering group but our current capacity issues means that this is unlikely to be until November 2023. We will continue to support the groups agenda in the interim in an advisory capacity as and when needed.

5.5 Adult Social Care Governance reporting to Adult Social Care Improvement Board

Monthly reports are submitted to the adult social care governance structure relating to Safeguarding and MCA DOLS activity and risk. The Operational Oversight Committee reports direct to the ASC Performance and Transformation Committee which feeds reports by exception to the Adult Social Care Improvement Board.

5.6 Families and Communities Care Group Governance

The same report also feeds into this group within the Adult Social Care report

5.7 Torbay and Devon Prevent Partnership Board

Prevent Duty Guidance 2021 is one part of the UK Counter terrorism strategy CONTEST.

The Trust is a key partner within the Torbay and Devon Prevent Partnership Board. The Board leads on the delivery of the Torbay and Devon Prevent agenda and creation of the Counter Terrorism Local Profile. The Trust is a standing member of the Torbay Channel Panel and attends Devon Channel Panel as required.

5.8 Torbay and Devon Anti-Slavery Partnership

The Trust is a member of the Torbay and Devon Anti-Slavery Partnership Board. The Partnership has a key role in coordinating local arrangements in the prevention and responses to modern slavery concerns. A recent review of Partnership arrangements is likely to lead to a wider Devon and Cornwall arrangement within the next 6 months.

5.9 Domestic Abuse and Sexual Violence

The Trust continues to attend local domestic abuse and sexual violence partnership arrangements at a strategic and operational level.

5.10 **Regional Health and Social Care Networks**

There are a number of regional safeguarding adult and health networks that are attended by the Trust. All of these networks have a key role in ensuring the Trust safeguarding MCA agendas remain contemporary and are informed by local, regional and national drivers. These include –

- ✓ South West Association of Directors of Adult Social Services (ADASS) Safeguarding Adult Leads and Mental Capacity Act networks.
- ✓ Regional ICB led Safeguarding adult and Mental Capacity Act networks.
- ✓ NHS South West Prevent Network.
- ✓ NHS Safeguarding Adult National Network.

6 Legislation and Guidance

6.1 **Care Act 2014**

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

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

6.2 **The Mental Capacity Act 2005 (MCA 2005)**

This Act provides a statutory framework for

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

The Act is underlined by 5 key principles –

Principle 1 – A presumption of capacity unless proved otherwise.
Principle 2 – Individual's must be supported to make their own decisions.
Principle 3 – People have the right to make unwise decisions.
Principle 4 – Anything done on behalf of a person who lacks capacity bust be undertaken in their best interests.
Principle 5 – Someone deciding or acting on behalf of a person who lacks capacity must do so in a way that is least restrictive.

The Mental Capacity Act is an essential piece of legislation.

During 22/23 audits continued to be undertaken within clinical and adult social care teams. Overall application of MCA is improving but ongoing monitoring and development activity is necessary to meet MCA statutory duties particularly in regulated health services. The quality of recording and completion of MCA assessments was often cited. During this period, there was good evidence of improved recognition of Deprivation of Liberty Applications (DOLS) applications to Supervisory bodies from our regulated services.

6.3 **Deprivation of Liberty Safeguards (Dols)**

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

The TSDFT continues to hold a backlog of Deprivation of Liberty Safeguards applications in its delegated Supervisory Body role. This reflects a national picture although during 22/23 our ability to manage backlog was compromised by a long-term vacancy and long-term team sickness (see 6.1). Whilst agency Best Interest Assessors were utilised, the Adult Social Care Outcomes data does benchmark Torbay at a lower than average level of performance than the national average and in previous years. We have also seen an increase in the number of applications from our hospital services (which is a positive), which has added to this pressure from a supervisory body stance. Risk is managed on an ongoing basis through weekly triage of applications against national ADASS guidance. The DOLs position is on the risk register and monthly updates are provided through adult social care a core group governance.

6.4 **The Mental Capacity (Amendment) Act 2019 (Liberty Protection Safeguards)**

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

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

In April 2023, the government announced that implementation of Liberty Protection Safeguards was being stood down 'beyond the life of this parliament'. The current Deprivation Liberty Safeguards system will therefore remain for the foreseeable future.

6.5 **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13**

The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005. The regulation states -

- Service users must be protected from abuse and improper treatment in accordance with this regulation.
- Systems and processes must be established and operated effectively to prevent abuse of service users.
- Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.
- Care or treatment for service users must not be provided in a way that
- includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,
- includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,
- is degrading for the service user, or
- significantly disregards the needs of the service user for care or treatment.
- A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority

With effect from April 2023 the CQC regulated activity extended to include local authority adult social care services. The Trust is working in partnership with Torbay Council in safeguarding MCA self-assessment to plan and prepare for inspection.

6.6 **Other Key Statutory Frameworks**

- Human Rights Act 1998
- Equality Act 2010
- Modern Slavery Act 2015
- Counter Terrorism and Security Act 2015
- Safeguarding Vulnerable Groups Act 2006
- Domestic Abuse Act 2021

7. Torbay and Devon Safeguarding Adult Partnership (TDSAP). Strategic Priorities and Driving Improvement.

TSDFT is a key partner in the Business arrangements and activities of the TDSAP. The core objective of the Partnership, set out in section 43(2) of the Care Act 2014, is to help and protect adults in its area in cases where the adult has care and support needs:

- they are experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs they are unable to protect themselves from either the risk of or the experience of abuse or neglect.

7.1 **The Partnership has 4 Strategic Plan Priorities for 2021-2024**

- ✓ **Priority 1** – To embed the learning from Safeguarding Adult Reviews into organisational practice.
- ✓ **Priority 2** – To improve outcomes for people with needs for care and support by finding the right solution at the right time.
- ✓ **Priority 3** – To work with partners to better understand the risk of hidden harm.
- ✓ **Priority 4** – Improving and involvement and engagement with people in receipt of safeguarding services.

Our workplan objectives include these 4 priorities and we continue to support Partnership activity to achieve the objectives. The TDSAP Sub Groups are assigned responsibility for completion of specific activities that support the 4 Strategic Priorities. The following is a summary of –

- What the Partnership says it will do to meet each priority
- How TSDFT is supporting the Partnership to meet the priority
- What Impact this is having or will have on our local population

Priority 1 To embed the learning from Safeguarding Adult Reviews into organisational practice	
What the Partnership says it will do to meet this priority	• Partners will contribute to the SAR process and play a key role to identify the relevant learning • We will embed a process to identify immediate learning and implement this swiftly • We will ensure the learning is SMART with key success criteria in place • Partners will provide strong evidence to assure the TDSAP that sustained improvements have been embedded • Promote multi-organisational communication, ensuring cooperation as an underlying key principle • Develop swift and dynamic processes for delivery of Safeguarding Adult Reviews • Each Safeguarding Adult Review will have an underlying principle to 'Focus on the learning' for each organisation • We will regularly monitor, identify and resolve reoccurring SAR themes to prevent reoccurrence.
How TSDFT is supporting the Partnership to meet this priority	➢ Chairing and membership of Safeguarding Adult Review (SAR) panels. ➢ Attendance at SAR Group meetings. ➢ Contribute to the creation of SAR practice briefings. ➢ Dissemination of learning from SAR's. ➢ We will provide evidence through audits and other processes that learning is embedded into front-line practice.
What Impact will this have on our local population	➢ Our workforce learns from experience to inform their own practice. ➢ Local systems and processes are reviewed and improved to safeguard people from abuse or neglect. ➢ Outcomes for people we support are improved as a direct consequence of learning review recommendations.

Priority 2 To improve outcomes for people with needs for care and support by finding the right solution at the right time	
What the Partnership says it will do to meet this priority.	• Seek assurance that partners and service representatives work together to establish more effective coordination to achieve person centred solutions • Work with partners and service representatives to better understand and embed a creative approach to finding effective solutions for people with complex lives • Develop and share key data and information to help develop effective communications and co-ordination between partner organisations, including strengthening links with the districts and community safety partners • Focus on preventative strategies to better understand how we can avoid the need for safeguarding intervention • Work with service representatives and commissioning partners to better understand people's needs and support them to achieve their desired outcomes • Have regular assurance from partners that people are safeguarded during and after the COVID-19 pandemic and that attention to safeguarding continues in accordance with statutory responsibilities, recognising that some people will be put at greater risk as a consequence of the pandemic.
How TSDFT is supporting the Partnership to meet this priority	➢ Contribute to the creation and sign up to new Multi-Agency Risk Management Meeting Principles guidance that covers Torbay and Devon. (this has been the primary focus for the partnership).
What Impact will this have on our local population	➢ Our workforce has a consistent set up principles to work to that all partners have agreed to follow to improve outcomes for people with multiple / complex needs. ➢ People with multiple complex needs receive improved outcomes in response to their circumstances. ➢ Outcomes are supported through more effective partnership support responses.

Priority 3 To work with partners to better understand and reduce the risk of 'Hidden Harm'	
What the Partnership says it will do to meet this priority.	• Support and encourage all safeguarding partners to focus on the 'Hidden Harm' that is usually out of sight from public view and often not recognised or reported • Ensure that the emphasis is on having a culture of 'spotting early signs' and helping to prevent the risks escalating • Use COVID 19 quantitative and qualitive data and information to seek assurance that partners are all uncovering and responding to hidden harm • Ensure that all safeguarding partners who work with people who have needs for care and support, exercise professional curiosity and take appropriate action • Embed the theme of 'professional curiosity' within multi agency case audits (MACA) • Develop and deliver a multi-organisational workshop and awareness campaign for partners and service representatives to better understand, encourage and support professional curiosity and escalation within their organisations
How TSDFT is supporting the Partnership to meet this priority	➢ Contribute to the planning of Safeguarding Adult Awareness Week w/b 20th November 2023. Led by the Community Reference Sub Group. ➢ Chair and support task and finish activity relating to priority 3.
What Impact will this have on our local population	➢ Our local population will better understand safeguarding in the context of hidden harm and greater empowered to raise concerns through a sustainable safeguarding adult awareness campaign created by the partnerships Community Reference Group. A focus will be on the themes of - • Making Safeguarding Personal • Hidden Harm / Curiosity • Financial abuse • Exploitation • Healthy relationships ➢ Our workforce will have increased resources at their disposal to inform their own practice and support service users in raising safeguarding adult concerns in confidence.

Priority 4 Improving Involvement and Engagement with people in receipt of safeguarding services	
What the Partnership says it will do to meet this priority.	• We will build on past Safeguarding Awareness Campaigns by targeting communications within our communities to raise further awareness of safeguarding • We will learn from COVID 19 experiences and use this feedback to shape future engagement • We will work with key partners to improve the interface with children's services especially for those who transition to adult services • To seek assurance that all partners are involving and listening to people about their experience of safeguarding • Ensuring that all people are listening to, valuing and responding to relatives, friends and people in communities • The partnership will have a focus on 'Making Safeguarding Personal' to ensure that safeguarding is person-led and outcome-focussed • We will continue to invest and engage with community groups to ensure the 'voice of the person' is central to partnership working
How TSDFT is supporting the Partnership to meet this priority	➢ Attend the Community Reference sub group and signpost voluntary organisations to represent Torbay communities. ➢ Implement revised quality checker feedback system supported by Living Options Devon. ➢ Receive and disseminate quality checker feedback to front line teams to help inform their practice in safeguarding responses. ➢ Provide quality checker feedback to the Partnerships Performance and Quality Assurance sub group to support qualitative and improvement activity across the partnership
What Impact will this have on our local population	➢ All people who experience a safeguarding response are offered the opportunity to provide feedback on the quality of their safeguarding response. ➢ Qualitative feedback is used to inform local safeguarding systems and response and achieve better outcomes for people in receipt of a safeguarding adult response.

8. TSDFT Strategic Objectives and How These Connect With TDSAP.

Our priorities and activities are described in the SA/MCA Operational Group Workplan. They are informed by Safeguarding Partnership arrangements, internal and external regulatory and adult health and social care agendas.

The priorities and examples of how we have progressed these are set out below. The narrative also describes how these connect to TDSAP priorities and their impact on our local community.

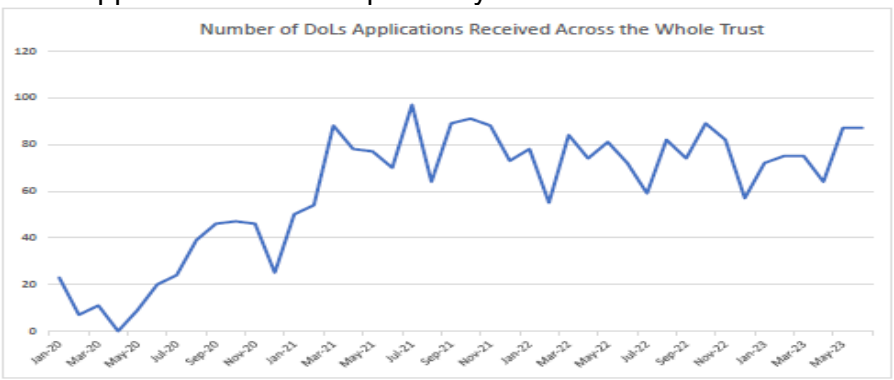
It should be noted In February 2023 we increased our capacity to support the safeguarding MCA agenda with the appointment of an Operational Manager. In the latter part of 2022 one lead was on long term leave for several months and since April 2023 our two lead postholders in health have been on long term leave. Within the same period, we have had additional shortages relating to administrative functions due to maternity and unexpected long-term leave and absence through recruitment processes. Core safeguarding MCA operational priorities have been maintained in health and social care but the team had to implement business continuity planning in response.

The core areas of business maintained during this period have been identified as –

- Training delivery and compliance
- Care Act s.42 safeguarding activity and safety planning
- Hospital email monitoring and phone duty system
- Safeguarding and core meeting attendance
- Legislation compliance

Our capacity to drive forward service development and audit activity but despite this, there have been a number of key achievements which are included within the following narrative.

Objective 1 To have a Mental Capacity Act legally literate workforce	
What the Trust is doing to meet this objective	✓ Training compliance trajectories monitored via Mandatory Training Group ✓ New refresher training framework for Level 3 MCA ✓ 'How to' weekly drop in sessions set up for clinical staff for MCA DOLS ✓ Weekly advice surgeries for specific case discussions ✓ MCA DOLS resource packs maintained within clinical areas – inclusive of 7-minute briefings, exemplar templates for MCA assessments, Best Interest Decision checklist, DOLS process map. ✓ Additional Best Interest Assessor financial resource received from Torbay Council in response to Risk 3570. ✓ MCA Walkaround (Torbay Hospital) MCA Audit completed. ✓ Support Adult Social Care practice week for Torbay Councillors (MCA DOLS awareness)

	✓ Good engagement with local and regional health and social care networks ✓ Early review of MCA DOLS documentation to streamline processes in response to LPS delay and Risk 3570 ✓ All Substantive vacancy posts filled with effect from September 2023. ✓ Improved monthly reporting to each in patient ward relating to DOLS activity including themes and trends. ✓ Adult Social Care MCA Audit. ✓ MCA / restraint hospital walkaround. ✓ Overall sustained increase in number of in patient DOLS applications to the Supervisory Bodies. 
How does this link to TDSAP Strategic Priorities?	Priority 1. MCA is a key learning outcome from safeguarding adult reviews. Our activity includes evidencing how we are embedding learning relating to the application of MCA in practice. Priority 2. The consideration of mental capacity and executive capacity is informed and considered within the principles in a multi-agency context. Priority 3. Representatives of those that lack mental capacity or have concerns relating to mental capacity are greater empowered to raise safeguarding concerns. Priority 4. Valid consent in regard to specific decisions relating to health and care.
What Impact is this having on our local population	➢ We have a legally literate workforce who apply the principles and protection of article 5 and 8 of the Human Rights Act. ➢ Decisions relating to care and support arrangements are lawful and taken in the persons best interests

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Objective 2 Local safeguarding priorities work to prevent abuse or neglect. When adult abuse concerns are raised, these are responded to in a timely and consistently, using making safeguarding personal principles.	
What the Trust is doing to meet this objective	✓ Compliance trajectories agreed for all levels of safeguarding adult training. ✓ Compliance targets achieved for level 1 and level 2 training (i.e. if you see something say something). ✓ Revised mandatory training framework for level 3 to realistically achieve trajectory targets.

	✓ Refresher module at level 3 implemented. ✓ Revised TSDFT Managing Allegations Against People in Position of Trust Policy. ✓ Revised Prevent Policy (awaiting CCP approval) ✓ Independent review into large scale enquiry completed ✓ ADASS Partners in Health and Care Programme review of local adult safeguarding. ✓ Strengthened data reporting relating to safeguarding adult single point of contact care provider intelligence. ✓ Strengthened adult social care quantitative data relating to open s.42 enquiries. ✓ New monthly data reports relating to caused out enquiries related to TSDFT health regulated services. ✓ New quality assurance checker (service user feedback scheme) implemented with quality checker reports being received and disseminated. ✓ Contribute to all TDSAP partnership sub groups and workplan activity, including the chairing role for the Operational Delivery Group. ✓ Joint leads in TDSAP Business support arrangements. ✓ Support adult social care practice week for Torbay Councillors (safeguarding adult sessions) ✓ Co-Lead in the creation of a Predatory Marriage podcast and information resource. ✓ Contribute to ICB and ADASS safeguarding workstreams – policy / workforce development programmes – consistency across ICB / Regional ADASS arrangements. ✓ Clinical safeguarding supervision introduced upon request with a number of sessions undertaken. ✓ Ongoing Safeguarding Adult enquiry closure panels. ✓ ASC review of live s.42 enquiries open more than 90days. ✓ Increased oversight of live safeguarding adult enquiries within operational teams. ✓ Qualitative feedback (lived experience) of safeguarding enquiry responses. ✓ Contribute to the health partnership response to the counter terrorism local profile. ✓ Attendance at local Torbay and Devon Prevent Partnership Board to inform organisational priorities. ✓ Attendance at South West Regional Health Prevent Partnership including NHS SW Prevent conference 2023. ✓ Monthly attendance at Torbay Channel Panel – standing member. ✓ In progress planning of Prevent safeguarding adult's forum – early 2024. ✓ Completion of annual Prevent self-assessment tool. ✓ Contributed to the development of the Torbay and Devon Anti-Slavery Partnership Modern Slavery Protocol. ✓ Corporate sign up to the Protocol. ✓ Attendance at Torbay and Devon Anti-Slavery Partnership Board.

	✓ NHS Modern slavery short film included in induction training for all staff.
How does this link to TDSAP Strategic Priorities?	Priority 1. Local responses are informed by local safeguarding adult reviews and the dissemination of practice briefings and partnership policy and practice guidance. Our responses are better informed by quantitative and qualitative data to prevent abuse or neglect. Our staff understand their safeguarding adult roles and responsibilities to safeguarding people from abuse or neglect. Our audit processes evidence how we are embedding learning relating to safeguarding practice and what if any action is required, Priority 2. New local Multi-Agency Risk Management Partnership Principles will provide our staff with a consistent partnership approach to improve outcomes for people with multiple complex needs. Priority 3. Our local systems, processes policies and practice guidance are well informed through partnership initiatives and support the hidden harm agenda. E.g. production of Predatory Marriage podcast, use of intelligence led data. Priority 4. We receive lived experience feedback on the quality of local safeguarding adult responses and learn from feedback.
What Impact is this having on our local population	➢ The way we work to prevent and respond to abuse or neglect is informed by multi-agency policies, practice guidance and dissemination of practice briefings to improve outcomes for our local community. ➢ People with lived experience of safeguarding responses have a voice in improving our local systems and processes. ➢ Making safeguarding personal and working to achieve the preferred outcomes of those experiencing safeguarding response is fully embedded within local systems and processes.

Objective 3. Domestic Abuse and Sexual Violence People who use our services and staff have prompt access to the right support at the right time.	
What the Trust is doing to meet this objective	✓ Adult Social Care representation at local Multi-Agency Risk Assessment Conferences (MARAC). ✓ Domestic Abuse Specialist Practitioner (1WTE) to provide on-site specialist advice and support to patients and staff (funding until October 2024 only). ✓ Domestic Abuse Training Framework available to all staff via the HIVE. ✓ Screensavers and bulletins relating to domestic abuse. ✓ Bespoke DA awareness sessions delivered to 10 different teams including F1 doctors, wards and therapists. ✓ Domestic abuse and sexual violence leadership – launch of sexual safety charter.

How does this link to TDSAP Strategic Priorities?	Priority 3. Domestic Abuse is seen in the context of hidden harm Priority 4. Responses to incidents of domestic abuse and sexual violence are person centred.
What Impact is this having on our local population	➢ In 2023, in excess of 70 patients have received direct specialist advice and support whilst in hospital. ➢ Staff have access to confidential specialist advice and support. ➢ Increased domestic abuse awareness sessions within our health services improves the opportunity for increased vigilance, routine enquiry discussion and signposting to timely specialist advice and support.

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9. Criminal Exploitation

County Lines remains an ongoing problem in Devon which is directly linked to criminal exploitation. County lines, is when gangs and organised crime networks exploit vulnerable adults and children to sell drugs, which originate in major cities. Often these people are made to travel across counties, and they use dedicated mobile phone 'lines' to supply drugs.

It can also involve ‘cuckooing’ which when those gangs take over the home of a vulnerable adult and use it to sell drugs from. We retain close links with our local safer community partnerships and Devon and Cornwall Police in response to County Lines Concerns.

The Safeguarding Adult Partnership recently published SAR Erik which includes recommendations to partners. The Trust is supporting the learning response action plan and has already considered within its adult social care leadership how we can develop local guidance for working with adults at risk of exploitation in the context of Cuckooing. Our recommendations are being taken forward by the TDSAP to localise existing best practice guidance referenced in SAR Erik.

10. Statement from NHS Devon Integrated Care Board (ICB)

NHS Devon CCG became an Integrated Care Board (ICB) in July 2022. NHS Devon ICB has continued to support TSDFT in fulfilling their statutory duties under the Care Act. The relationship between NHS Devon safeguarding team and TSDFT adult social care and health care teams is well established. NHS Devon is a member of the Torbay Integrated Safeguarding and Inclusion Committee which supports both TSDFT and NHS Devon to gain assurance of safeguarding adult processes and activity. NHS Devon provides an independent health perspective to whole service safeguarding processes as well as individual enquiries. The NHS Devon safeguarding team provides supervision to the nurses within the TSDFT Safeguarding Adult team, and although this year the team has experienced staffing issues, they have continued to engage well.

11. Our Role in Ensuring Quality of Care in Care Homes

The Trust has developed a Contracts Management Policy & Procedure which includes proportionate contract monitoring processes which can be used by everyone involved in

the contract management, contract monitoring and quality assurance process and dovetails with joint safeguarding processes.

The 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 scope of the policy applies to all contracts entered into by the Trust for the provision of Adult Social Care services and Community Health services provided by Independent Sector and Community and Voluntary Sector organisations, including contracts with external providers, partnerships, collaborations, charities and community interest companies. The policy covers the entire contract lifecycle from pre-contracting, contracting, implementation, monitoring, evaluation, and closure as well as variations, novation and extensions.

The Trust is committed to delivering high-quality services to meet the needs of service users. Contract management plays a crucial role in ensuring the delivery of quality services, maintaining productive relationships with providers, and mitigating legal and financial risks. The intelligence from our monitoring supports our safeguarding work and dovetails with the Provider Quality Support Policy (PQSP), which is currently in final draft. The PQSP has been developed to establish a formal and coordinated response to concerns about standards of care within regulated and unregulated care provider services in Torbay and establishes a formal means of responding to concerns about care provider services where there is reason to believe that there are a number of people whose well-being needs, as defined within Chapter 1 of Care Act 2014 Statutory Guidance, are not being met. This applies to all persons living within a care provider service regardless of whether the host authority or other placing authorities are carrying out a care and support function. In terms of Quality Support Thresholds this is represented by Business as Usual and Low Risk Tier 1, and should make up the bulk of the work done to support providers.

The guiding principles for monitoring the quality of care in the local provider market are:

- The gathering of real-time provider information such as Incidents, complaints, Care Quality Commission Reports and KPI data in order to create a picture of quality.
- This information is analysed to aid the understanding of the performance of care providers and assist in the determination of the care provider Quality Threshold/Tier.
- Effective interventions to ensure that standards of care meet regulatory, statutory and contractual requirements.

Business as Usual and Tier 1 work is mainly preventative, aimed at avoiding concerns from escalating further with constructive advice and support offered. This will include regular reviews between the Provider and QAIT and including any proactive work undertaken such as a Service Improvement Plan (SIP), clinical and practical support, sign posting and /or quality audit, in addition to the support of contract management.

If concerns should escalate to the extent as indicated by Tier 2 a PQSP Planning Meeting should be considered. Any care quality concerns that meet the Tier 3 description must be considered by QAIT Lead professionals with Community Service Management and the Safeguarding Adults Team. The purpose of this will be to review

all relevant information and agree if a large-scale safeguarding initial enquiry meeting is required or otherwise.

The PQSP does not replace responses to individual safeguarding adult's s.42 Care Act safeguarding enquiries. Any concern where there is reason to believe an adult with care and support needs is at risk or experiencing abuse or neglect should be reported to the Torbay Safeguarding Adult Single Point of Contact. The Torbay Safeguarding Single Point of Contact will as a matter of normal business liaise with the QAIT team to support Care Act s.42 decision making.

12. Performance

12.1 Concerns and Section 42 Care Act 2014 Enquiries (Adult Social Care duties)

Table 1 sets out concerns raised between April 2022 and March 2023, 1159 safeguarding adult concerns were received
which is a 16.1% increase on the previous year. The number of concerns which proceeded to Care Act s.42 enquiry increased by 8.8% to 299.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend	Total
CONCERNS:														
Raised	81	98	106	87	105	109	92	104	77	94	102	104		1159
Closed	67	116	65	76	114	73	75	81	83	100	150	117		1117
Open at month end	214	196	237	248	239	275	292	315	309	303	255	242		
ENQUIRIES:														
Raised	22	22	34	25	22	37	22	22	20	26	27	20		299
Closed	19	36	6	21	27	19	20	29	36	73	41	37		364
Open at month end	181	167	195	199	194	212	214	207	191	144	130	113		
% Concerns raised that become enquiries	27.2%	22.4%	32.1%	28.7%	21.0%	33.9%	23.9%	21.2%	26.0%	27.7%	26.5%	19.2%		25.8%

Table 1: Concerns raised

The table below provides a comparator over the past 3 years.

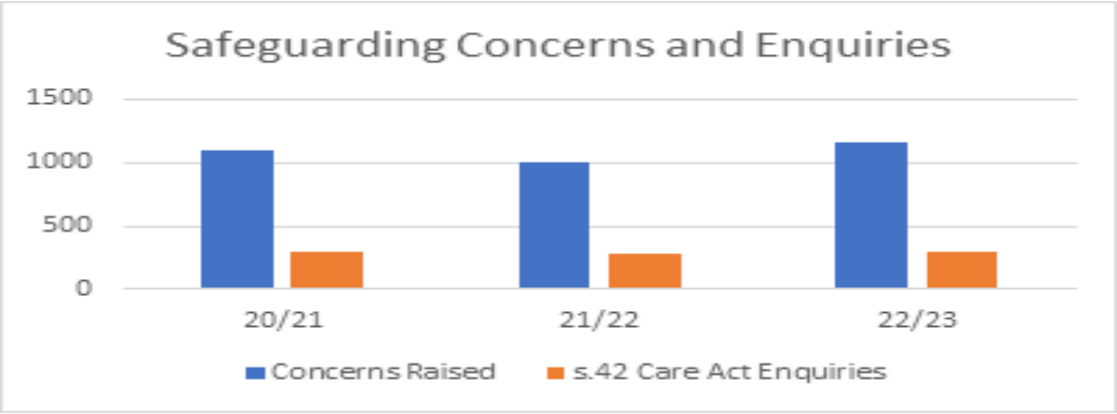


Table 2: Comparable Trends

Analysis

We also work closely with Devon and Cornwall Police, Devon Partnership NHS Trust, NHS Devon and the Care Quality Commission, providers and others both in causing enquiries to be made and maintaining strong local partnership arrangements.

The most common reported types of abuse are neglect, physical, emotional and psychological and financial.

The National Adult Social Care Benchmarking data for 22/23 has not been published at the time of writing this report. In 21/22 Torbay Safeguarding was not an outlier in the number of concerns received per 100k of the population against comparators – for example Torbay is 901 per 100k compared to 866 in Blackpool. Our number of safeguarding statutory safeguarding enquiries per 100k was also average against other comparators.

12.2 **Repeat Referrals**

Between April 2022 and March 2023 our safeguarding adult repeat referral rate increased slightly from to 8% to 10.2%. The increase will continue to be monitored but is within the agreed key performance Indicator (KPI) agreed with Torbay Council of 15% or lower. The table below provides an overall comparator between 2020-2023.(Table 3)

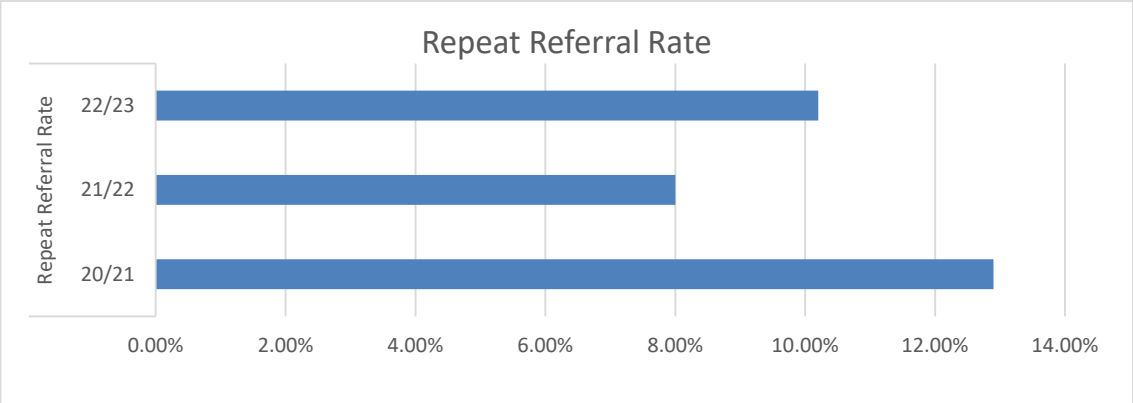


Table 3: Repeat Referrals

12.3 **Asking people their preferred outcomes**

In April 2022 we set a target of asking 90% of people experiencing a safeguarding response what their preferred outcomes where. During 2022-2023 we did not meet this target, recording that 67.9% of people where asked their preferred outcomes. This is a reduction of 14.1% compared to the previous year. 20.1% of our records did not capture this data and this is therefore a key improvement requirement for 2023-2024. (Table 4)

Analysis

Monthly panels are now focusing on non-recording with a key target to increase the number of people asked to at least 90% by the end of the 22/23 period. There is also regular reporting to operational teams with an advisory to be more vigilant to this issue.

Preferred outcomes asked:	18-64	65-74	75-84	85-94	95+	Not Recorded	Total	%Total	
Asked & expressed	88	30	48	35	4	0	**205**	**56.3%**	**67.9%**
Asked & not expressed	15	4	14	8	1	0	**42**	**11.5%**	
Not asked	11	6	7	10	4	0	**38**	**10.4%**	
Don't know	1	1	3	0	1	0	**6**	**1.6%**	
Not Recorded	30	11	17	14	1	0	**73**	**20.1%**	
Total	**145**	**52**	**89**	**67**	**11**	**0**	**364**	**100.0%**	
% Total	**39.8%**	**14.3%**	**24.5%**	**18.4%**	**3.0%**	**0.0%**	**100.0%**		

Table 4: Enquiries closed

12.4 **Qualitative feedback**

Qualitative feedback is important in understanding people's experiences of safeguarding responses. In Torbay, we commission an independent advocacy group to undertake discovery interviews with people or appropriate representatives who consent to giving qualitative feedback. We developed this process during 2022 and received our first feedback report in May 2023. To date, two feedback reports have been received with each summary narrative below.

May 2023 Cohort Feedback

'*All…felt included, they felt that the process was fully explained and that they had input whilst being heard. The benefits of the safeguarding process were appreciated with more needs identified and acted upon. This led to a very positive response on the outcomes.'*

July 2023 Cohort Feedback

'Similar to the previous cohort all of those who were contacted felt included, that the process was fully explained and that they had input whilst being heard. The safeguarding referral process was appreciated as it often led to further needs identified and then effectively actioned'.

Moving forward, we will receive frequent reports to help us understand people's experiences of our safeguarding responses and learn from these.

12.5 **Outcomes**

Preferred outcomes achieved:	18-64	65-74	75-84	85-94	95+	Not Recorded	Total	%Total
Fully Achieved	45	19	30	25	2	0	**121**	**59.0%**
Partially Achieved	38	8	15	8	2	0	**71**	**34.6%**
Not Achieved	5	3	3	2	0	0	**13**	**6.3%**
Not Recorded	0	0	0	0	0	0	**0**	**0.0%**
Total	**88**	**30**	**48**	**35**	**4**	**0**	**205**	**100.0%**
% Total	**42.9%**	**14.6%**	**23.4%**	**17.1%**	**2.0%**	**0.0%**	**100.0%**	

Table 5: Enquiries where outcomes achieved

Analysis

Of those asked their preferred outcomes, over 93% of preferred outcomes were either fully or partially achieved. 6.3% were not achieved but our analysis is that this is likely to be due to external factors.(Table 5)

12.6 **Risk**

94% of individuals reported risk had either been reduced or removed as a consequence of a s.42 enquiry response

	Source of risk:					
Risk outcome:	SC Support	Other Known	Other Unknown	Not Recorded	Total	% Total
Risk Remained	0	7	1	1	9	5.6%
Risk Reduced	34	56	2	6	98	60.5%
Risk Removed	33	16	0	6	55	34.0%
Not Recorded	0	0	0	0	0	0.0%
Total	67	79	3	13	162	100.0%
% Total	41.4%	48.8%	1.9%	8.0%	100.0%	

Table 6: Source of Risk

12.7 **Deprivation of Liberty Safeguards (DOLS). Risk 3570**

The Trust continues to hold a backlog of Deprivation of Safeguard referrals to the Supervisory Body. The 22/23 DOLS statutory return has not been published yet but the 09/22 return identified the following.

- TSDFT has the lowest proportion of granted applications in our comparator group, however we are in line with the South West region.
- We have the fourth highest number of incomplete applications at 31/3/22 in our comparator group, however this is not a rate per population.
- Our estimated time to complete outstanding applications is one of the highest in SW and comparator group.

We have a number of risk management plans in response to the backlog including -

- 1 x per week applications are triaged against National ADASS guidance.
- This identifies high, medium and low priority referrals.
- The high priority referrals are prioritised and allocated to BIA's against their availability.
- A standard letter is returned to the managing authority, which acknowledges receipt and process of triage. The letter advises the managing authority.
- (e.g. residential home, hospital etc.) to contact the supervisory body (delegated LA function) should these be any change in presentation.
- We conduct an annual contact review for all outstanding applications to check on the circumstances of the individual.

- Where available community BIA's based within ASC teams are asked to undertake BIA's. Compliance with this request is subject to team capacity pressures which is challenging at the moment.
- Agency being used to backfill vacant BIA posts within established budget.
- HSCC now in recruitment process having gone through AfC process. Focus on triage and provider engagement. Interviews 10th July '22.
- 2xBIA's appointed (from 9/23) BUT as development posts as not able to recruit BIA qualified staff (qualification anticipated January 2024).
- DOLS reintroduced to risk register.
- Review of risk with senior management to ensure that all options are explored and risk reviewed against other operational priorities.
- Additional funding allocated by Torbay Council for agency support. Mobilisation to utilise funds on schedule beginning October 2023.
- We are contributing to regional review to ensure that the DOLS system is as streamlined as far as possible whilst remaining lawful.
- Revised form 3 (assessment) forms to reduce the volume of written information required by Best Interest Assessors.

12.8 **Large Scale Safeguarding Enquiries**

Between June '22 – October '22 the Trust led a multi-agency large scale enquiry in response to safeguarding concerns within a local care home. The home ceased trading in October 2022.

The large-scale enquiry concluded that people may have been placed at risk of abuse or neglect. This was primarily in the form of neglect or acts of omission. It is likely that there was not an open culture where staff felt able to express concerns and have full confidence that these would be acted on appropriately by management.

Large scale safeguarding responses are time consuming and complex and as such learning is always identified from such responses. Following contact from CQC a decision was taken to commission an independent review to identify what if any learning could be taken from the Trust response.

The review was very positive about the way the Trust was able to mobilise, assess and manage risk in a multiple disciplinary health and social care context and sighted a total of 18 learning recommendations in response. An action plan is held by the safeguarding adult team with most actions on track or having been completed at the time of writing. The Trust greatly values the approach in response to such incidents and it has been of particular value in undertaking a partnership away day with CQC in response, to further reflect and strengthen this particularly important relationship.

13 Performance Quality Assurance

13.1 **Case Closure Panel Meetings.** All safeguarding enquiries are reviewed within panel meetings prior to closure. This involves a lead safeguarding professional and social work supervisor reviewing safeguarding records to confirm that the local authority has satisfied itself that it has met its statutory safeguarding duties. Any further activity needed is directly fedback to practitioners by supervisors which also provides opportunity for reflective practice.

13.2 **Multi-agency case file audits** are included within the TDSAP Performance and Quality Assurance Sub Group. This increases our opportunities to review safeguarding performance within a multi-agency context with assurance provided direct to the safeguarding adult partnership.

13.3 **Provider Quality Assurance Huddles** occur weekly and allow the opportunity to review and escalate emerging intelligence relating to care provider settings.

13.4 **Internal Audit**. Monthly Adult Social Care Audits include safeguarding adult enquiry case file audits. However, to provide a deeper analysis these often expand to more targeted audits such as MCA or safeguarding related audits. Safeguarding MCA hospital walkarounds provides a targeted review.

13.5 **Peer Audit**. The Trust is always keen to seek opportunities to engage in peer audit programmes such as the Health and Care Insights Project earlier this year (see 6.4).

13.6 **Learning Reviews** – Incidents and Safeguarding Adult Reviews. The Safeguarding Adults MCA DOLS team have close working links with the incident reporting team and strong representation at the TDSAP Safeguarding Adult Core Group. This allows for good oversight of safeguarding related incidents and learning and review activity undertaken by the TDSAP.

13.7 **Clinical Safeguarding Adult Supervision**

The impact of a safeguarding incidents within clinical teams cannot be underestimated and it is important that we continue to prioritise offering clinical supervision to individuals or teams if requested. This not only enables teams to discuss the impact of a safeguarding incident, put reflect on what learning can be taken from such incidents.

14 Conclusion

14.1 Our Hospital safeguarding services have had a diminished team resource for an extended period of time and this has resulted in business continuity planning to retain priority activity. Despite this, a number of developments have been achieved such as the good progress with MCA mandatory training compliance, review of level 3 safeguarding training, introduction of Safeguarding MCA refresher training, introduction of ‘how to MCA sessions’, increased engagement at a partnership level and improved DOLS data for clinical teams. The challenges have also enabled our core safeguarding adult team to identify new ways of working within an integrated health and social care organisation.

14.2 Safeguarding activity remained high during 22/23 with slightly higher reporting than in 21/22. Other quantitative data was broadly the same as in previous reporting years although there has been a steady rise in the number of enquiries linked to alleged domestic abuse, sexual abuse and self-neglect. Data was comparative within national benchmarking.

14.3 The quality checker feedback is very positive; however, we need to be better at evidence in our recording that we are asking everyone their preferred outcomes and if they consent to giving feedback.

14.4 We continue to support the Torbay and Devon Safeguarding Adult Partnership agreed 4 strategic priorities for 2021-2024. TSDFT has membership at all levels of the partnership structure and has actively contributed to the development of important new frameworks such as the Multi-Agency Risk Management Meeting Principle Guidance.

14.5 The Trust has a strong commitment to other local and regional partnership arrangements to ensure our services are informed and we contribute fully to the safeguarding and mental capacity act agendas.

14.6 Other TSDFT priorities are embedded in the Safeguarding / MCA workplan and captures key areas of safeguarding including Mental Capacity Act.

14.7 Liberty Protection Safeguards has been stood down beyond the life of this parliament within no further indication of when this will be implemented. The current DOLs system remains for the foreseeable future. DOLs is on the corporate risk register due to the high backlog of applications but there is risk management, increasing staffing resilience and regional activity in response.

15. Recommendations

The Board is asked to note the contents of the report for assurance.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Safeguarding Children – Annual Board Report – April 2022 – March 2023			Meeting date: 27 September 2023
Report appendix			
Report sponsor	Chief Nurse Deputy Chief Nurse Care Group Director - CFHD		
Report author	Named Nurse for Safeguarding Children (TSD) Named Nurse (CFHD) with contributions from: Named Midwife Safeguarding Midwife Child Death Coordinator Named Doctor for Child Death Named Doctor for Child Protection Named Doctor for Child Protection Service Lead 0 to 19 Torbay service Named Doctor for Looked After Children Practice Lead Torbay Sexual Medicine service Paediatric Matron		
Report provenance			
Purpose of the report and key issues for consideration/decision	This annual report will inform Torbay and South Devon NHS Foundation Trust Board members on issues relating to the safeguarding of children in Torbay and South Devon. The Trust is a partner agency and has statutory duties outlined in the Children's Act and supported by "Working together to Safeguarding Children" 2019 guidance. The report will inform members of the activities of the Safeguarding Children Team and the activities of the wider safeguarding duties and activities completed by Trust staff, both directly and indirectly to safeguard children. The Chief Nurse is the Executive Lead for Safeguarding and is supported by the Families and Communities Care Group Director, Children and Family Health Devon Care Group Director and the Named Professionals in this role.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To approve recommendations set out in report.		

Torbay and South Devon NHS Foundation Trust

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

Torbay and South Devon NHS Foundation Trust

Report title: Safeguarding Children – Annual Board Report April 2022 – March 2023		Meeting date: 27th September 2023
Report sponsor	Chief Nurse	
Report author	Named Nurse for Safeguarding Children (TSD) Named Nurse (CFHD) with contributions from: Named Midwife Safeguarding Midwife Child Death Coordinator Named Doctor for Child Death Named Doctor for Child Protection Named Doctor for Child Protection Service Lead 0 to 19 Torbay service Named Doctor for Looked After Children Practice Lead Torbay Sexual Medicine service Paediatric Matron	

1.0 Introduction

This Annual Report for Safeguarding Children outlines progress and delivery against the overarching strategic priorities for the period April 2022/March 2023. In addition, the report will set out the Trust's safeguarding children's assurance framework, including performance and quality improvements against the statutory requirements set out in in the HM Government (2018) 'Working Together to Safeguard Children' document and under Section 11 of the Children Act 2004. The information included in the report will provide evidence and assurance that the Trust is discharging its duties for observing both the safety and wellbeing of children and young people using services provided by Torbay South Devon NHS Foundation Trust (TSDFT), including Child and Family Health Devon (CFHD) services.

1.1 Vision

The Torbay and South Devon Foundation Trust mission statement for safeguarding children services is:

Torbay and South Devon NHS Foundation Trust work with a mixture of partner agencies, parents and carers; to support children in having safe, healthy and happy childhoods that help to prepare them for adult life. All staff working within the Trust, including those services we contract to other organisations, are aware of the need to safeguard and promote the welfare of children.

We all have a responsibility to recognise children who may be at risk of suffering harm and those in need of protection and how to respond to those concerns in a timely fashion. This includes services that predominately care for adults, which need also to always consider the safety and wellbeing of children associated with the adults receiving their care. By safeguarding children, we act to:

- *Promote their welfare and protect them from harm.*
- *Protect them from abuse and maltreatment*

- *Prevent harm to their health and development*
- *Ensure they grow up with the provision of safe effective care*

The mission statement directly aligns to the Trust values. These values foster a culture of safeguarding practice such that all staff employed by Torbay and South Devon NHS Foundation Trust will seek to keep children and young people safe by:

- Valuing them and listening to and respecting them
- Adopting child protection practices through procedures and code of conduct for staff and volunteers
- Providing effective management for staff and volunteers through supervision, support and training.
- Recruiting staff and volunteers safely all employees who come into contact with children and young people are subject to a formal Disclosure and Barring Service check.
- Sharing concerns with agencies who need to know and involving parents and children appropriately

2.0 Context for Safeguarding Children and Young People

2.1 National

2.1.1 National legislation updates.

- Child Protection in England – National Review (May 2022)
  The Child Safeguarding Practice Review Panel undertook a review following the murders of Arthur Labinjo-Hughes and Star Hobson. It examined the circumstances leading up to the deaths of the children and considered whether their murders reflected wider national issues in child protection.
  The report identified a set of issues which hindered professionals understanding of what was happening to Arthur and Star, within the context of the restrictions to working practices due to the COVID pandemic. The issues identified were:
  Weaknesses in information sharing and seeking within and between agencies.

  A lack of robust critical thinking and challenge within and between agencies, compounded by a failure to trigger statutory multi-agency child protection processes at a number of key moments.

  A need for sharper specialist child protection skills and expertise, especially in relation to complex risk assessment and decision making; engaging reluctant parents; understanding the daily life of children; and domestic abuse.

  Underpinning these issues, is the need for leaders to have a powerful enabling impact on child protection practice, creating and protecting the optimum organisational conditions for undertaking this complex work.

  The issues have been incorporated into a revision of the Working Together to Safeguard Children guidance which is out for consultation June-Sept 2023.

- Stable Homes, Built on Love (Feb 2023)

Following findings from recent national independent reviews, this strategy, open for consultation until May 2023, aims to provide a framework of reform for Children's services based on the premise that the best way of promoting children's welfare is very often by supporting children's families and the loving relationships around them. To achieve this vision, there is a need to rebalance children's social care away from costly crisis intervention to more meaningful and effective help for families, so that it achieves the outcomes children deserve. Achieving this will require a major reset that puts love and stable relationships at the heart of what children's social care does.

The strategy is based on six pillars to support the change to transform children's social care, in a phased system of reform.

Pillar one: Family Help provides the right support at the right time so that children can thrive with their families
Pillar two: A decisive multi-agency child protection system
Pillar three: Unlocking the potential of family networks
Pillar four: Putting love, relationships and a stable home at the heart of being a child in care
Pillar five: A valued, supported and highly skilled social worker for every child who needs one
Pillar six: A system that continuously learns and improves, and makes better use of evidence and data.

The strategy has influenced the practice changes that are included in the revision of the Working Together to Safeguard Children guidance which is out for consultation June-Sept 2023.

- RCPCH - Safeguarding guidance for Children and Young People under 18yrs accessing early medical abortion (EMA) services (Feb 2023)

  Parliament made the decision to legislate to make permanent provision for the remote delivery of early medical abortion services in England and Wales, in line with the temporary arrangements introduced at the start of the COVID-19 pandemic.

  The Department of Health and Social Care (DHSC) commissioned the Royal College of Paediatrics and Child Health (RCPCH) to lead on the development of guidance to strengthen safeguarding for children and young people (CYP) under 18 years old accessing EMA services. This is to ensure that under 18s are appropriately safeguarded when accessing EMA services, and to ensure there is consistency across the system in the implementation of robust safeguarding processes and procedures.

  This legislation has been considered and embedded into Trust practice and policy.

- Mandatory reporting of child sexual abuse: call for evidence

  This consultation will be progressed in May 2023, following the investigations undertaken by the Independent Inquiry into Child Sexual Abuse, which documented unacceptable cases of organisations and institutions failing to

protect those in their care from child sexual abuse. In its final report, the inquiry recommended that Government introduce a mandatory reporting duty for cases of child sexual abuse.
The outcomes and impact of the consultation on Trust process and policy will be discussed in the Trust Board report for 2023/24.

- Working Together to Safeguard Children 2023

  The learning from national practice reviews and the children's social care reform consultation "Stable Homes, Built on Love" have significantly influenced the proposed updates to the multiagency practice guidance. The updated guidance has potential to significantly impact partner agency roles and responsibilities within the safeguarding process, potentially increasing pressure on services already challenged with capacity issues and waiting lists.

  The consultation for the document guidance is happening for June – Sept 2023. The outcomes will be discussed in detail in the Trust Board report for 2023/24.

2.1.2 Integrated Care System (ICS) development

As described by the Kings Fund audit group, Integrated care systems (ICSs) are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population. The central aim of ICSs is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and health and social care.

As an established Integrated Care Organisation, Torbay and South Devon NHS Foundation Trust is an integral partner in the development of the required systems to support local health and social care provision and is therefore supporting the Devon ICS, known as One Devon. One Devon's vision is: equal chances for everyone in Devon to lead long, happy and healthy lives.

One Devon has embedded the ICS model, but will be entering into a consultation period throughout 2023, to consider efficiencies and ICS roles within the adult and children safeguarding local partnerships. There is a clearly defined and embedded relationship between Torbay and South Devon Trust, as a partner agency, and the Designated Safeguarding professionals within the ICS. This is framed by the Named Professionals meetings and shared representation at both the Adult Safeguarding Board and the Safeguarding Children Partnerships in Devon and Torbay.

2.2. Local

2.2.1 Local Safeguarding Children Partnerships

Torbay and South Devon Foundation Trust, including Child and Family Health Devon services, are aligned to two safeguarding children partnerships; Devon Children and Families Partnership (DCFP) and Torbay Safeguarding Children Partnership (TSCP).

Torbay Safeguarding Children's Partnership – Business Plan 2021-2024

The Torbay Safeguarding Children Partnership business plan maps the vision of 'One Devon' in their ambition; to ensure that Torbay is an area in which children feel safe, listened to, are able to freely access the best possible learning opportunities and feel enabled to actively contribute to their society.

The partnership will focus on four specific safeguarding priority areas for the period 2021-2024, in addition to ensuring that all other functions regarding the safeguarding and welfare of children in Torbay are undertaken effectively.

The four key priority areas for the TSCP in the period 2021-2024 are:

- Priority 1: Reduce the level of child neglect in the Torbay area and challenge the causes of local neglect to prevent re-occurrences.
- Priority 2: Prevent child exploitation and sexual harm within the Torbay area and ensure the safety of all children, resident or visiting Torbay, from these forms of abuse.
- Priority 3: Prevent children in Torbay from being harmed by the effects of domestic abuse.
- Priority 4: Ensure that children in Torbay receive appropriate mental health support at their time of need and that this support dovetails with any other care planning needs of the child.

Devon Children and Families Partnership – Children and Young Peoples plan 2019-2023

Devon Children and Families Partnership have in place their Children's and Young Peoples plan 2019-2023 with the vision: We believe that every child in Devon should have the best possible start in life and the opportunity to thrive. We want to ensure children and families receive the right support, at the right time and in the right place.

They have identified 4 principles, which are:

- Children are best brought up in families
- We will support families to find their own solutions
- We will listen to each other and work together with services shaped by all
- Children and families will always know where they stand with us

They have also identified clear priorities for action, including:

- Life Chances – achieve their potential with the opportunities to thrive
- Be Healthy and well – have the best start in life, stay well and thrive. With good information and specialist help when they need it
- Feel safe – be protected from neglect and supported when vulnerable
- Be Protected from Harm – swift action to protect them from harm, abuse and exploitation.

Section 11 self-assessment audit

Section 11 of the Children's Act (1989) places a statutory duty on a range of organisations, agencies and individuals to make arrangements to ensure that in

discharging their functions and any services that they contract out to others, they have the regard to the need to safeguard and promote the welfare of children.

The Section 11 audit is designed to allow the multiagency Safeguarding Partnerships to gain assurance that agencies placed under these duties are cooperating with the legislation and are fulfilling their responsibilities to safeguard children and promote their welfare.

Torbay Safeguarding Children Partnership and Devon Children's and Families Partnership (DCFP) requested their audits in June and September 2022 respectively. The audit returns were completed for TSDFT, including CFHD.

The self-identified action plans arising from these audits were incorporated into the workplan of the Safeguarding Children Operational Group (SCOG) for oversight of the Trust governance structure, including the Trust Board.
The actions identified were:

- Clarification of roles, responsibilities and positions for the Organisational structure of the Trust.
- Improved evidence of inclusion of children and family's views on service provision and planning.
- Robust system in place to allow for monitoring and governance of all safeguarding children referrals completed by Trust staff.

No further actions were identified by the local partnerships and no challenges to the audits were made.

Trust representation at Safeguarding Partnership meetings

Following the Woods Review, Safeguarding Children Partnerships are represented by 3 key agencies; Health, Local Authority and Police. Health representation is provided by NHS Devon ICB from the Designated professionals and Executive Leads for Safeguarding. Both of the Safeguarding partnerships have a number of groups which require Health representation – this is provided by the Named Doctors, Named Nurses for TSDFT and CFHD and deputised by the Safeguarding Children Nurses from both of the Children's Safeguarding Teams.

Meetings include:

- Quality Assurance delivery group (DCFP / TSCP)
- Children and Young peoples' exploitation prevention (DCFP / TSCP)
- Learning and Development group (TSCP)
- Neglect group (TCSP)
- Sexual abuse group (DCFP)
- Child Safeguarding Practice Review Group (DCFP/TSCP)

The Safeguarding Children's Team also support, alongside Service Leads / Team Leads from relevant services, when there are task and finish groups formed to complete workstreams resulting from Child Safeguarding Practice Review (CSPR) recommendations and action plans.

The information and actions resulting from the groups and meetings is shared via newsletters, Best Practice forums, briefings and the Safeguarding supervisors network meetings, to be disseminated to all staff via team meetings. CFHD also disseminate the learning through the champions meetings and managers supervision sessions.

2.2.2 Director of Public Health Annual Report (Torbay)

The Public Health report was published in November 2022 and focused this year on the impact of alcohol use on the local community.

For full report details: Director of Public Health Annual Report 2022 - Torbay Council

The report found:

• there are approximately 1,500 adults with an alcohol dependency in Torbay.
• the rate per 100,000 young people being admitted to hospital due to alcohol consumption locally is 72, compared to the national average rate of 31.
• Torbay has a higher rate of Child in Need assessments where alcohol is a factor than the rest of England, the South West and other coastal areas. This is an assessment carried out by a social worker to see whether a child needs extra help.

Torbay's rates of alcohol-specific hospital admissions and mortality are significantly above the national and regional average. We have made progress in understanding the impacts of alcohol consumption and attitudes are changing but there is more to be done to make responsible drinking the norm in Torbay and to reduce the harms that affect individuals, families, and the wider community.

The report identified that young adults aged 16-24 are less likely to drink that any other age group, however alcohol consumption on their heaviest day of drinking has been found to be higher than all other age groups. Youth drinking may cause the young person to have trouble at school or even with the law and Children who begin to drink before the age of 14 are at increased health risks including alcohol related injuries and alcohol dependency in adulthood.

In Torbay, while the proportion of school suspensions related to drug and/or alcohol use is similar to the national picture (4% in Torbay), the proportion of school children permanently excluded due to drug and/or alcohol use in Torbay is much higher than the national average, with 18% of permanent exclusions being a result of drug and/ or alcohol use.

The data captured for young people (those aged under 18) within Torbay admitted to hospital due to alcohol suggests Torbay's young people are experiencing greater levels of alcohol related harm compared to the national average. Latest data shows that for Torbay the rate per 100,000 young people being admitted is 72, compared to the national average rate of 31. On a more positive note, however, the general trend for Torbay (as well as nationally) has been a downward one in number of young people being admitted to hospital for alcohol specific conditions.

While there is often an assumption that young people and alcohol dependency have the greatest impact in Torbay, the reality is more nuanced. For young people the overall general trend is away from drinking alcohol when compared with previous

generations, but problems with alcohol for this smaller number of young people who do drink is often more complex and impactful.

Alcohol consumption within the family for a small but distinct number is adversely affecting the development and safety of children. The relationship between consequences of alcohol use and parenting is more marked in Torbay than elsewhere.

Children and adults accessing support for alcohol use, have a variety of services which are accessible and data shared by the services suggests that the Torbay treatment provision is high performing with key metrics being higher than the national average.

2.2.3 Ofsted inspections for Local Authorities – Devon and Torbay

Devon

Devon Children's services received a monitoring visit on 6th / 7th December 2022. This was the fourth monitoring visit since the local authority was judged inadequate in January 2020. The report was published on 30/01/2023.

The focus of the inspection was for areas of specific concern identified at previous inspections:

- Permanence planning for children.
- The experiences and progress of children living in unregulated and/or unregistered provision.
- The experiences and progress of disabled children in care.
- Strategic oversight and grip on areas for improvement and oversight by senior leaders, including of case audits and supervision.

There was concern that Devon County Councils leaders had not ensured enough progress for care experienced children since the full inspection 3 years previously. Quality assurance through the auditing of social work practice was found to be weak and lacking in the quality and clarity required to drive the significant changes required in Devon, although examples of stronger, child focused practice are outnumbered by those where children experience changes of social worker and delay.

The reliance on temporary and agency staff is decreasing, but many children still experience too many changes of social worker and newly allocated workers do not have good quality oversight of issues for the family's due to poor handover processes.

There have been some improvements for children that have taken tenacity to secure, such as an increase in the number of children receiving timely health reviews and a positive offer of private dental care. The report noted that Children were seen to be actively involved in shaping the service and holding corporate parents to account. A complete change of the senior leadership team is too recent to be able to identify any direct impact on the quality of practice with children, but it is certainly unsettling for staff.

Torbay

A full inspection visit took place from 21/03/2022 until 01/04/2022. Services were considered to have improved significantly by Inspectors with strategic partnerships considered to be strong with good communication across both corporate and operational management, resulting in a tangible difference for Torbay's children. This improvement will require continued commitment from all partner agencies to ensure that this level of care is maintained. In particular, Ofsted identified the need for partner agencies within the TSCP to assume individual responsibility for the provision of data for monitoring and quality assurance purposes, as opposed to reliance of data gathered by the Local Authority.

Areas of focus for improvement identified were:

- The oversight of arrangements when care leavers move in and out of temporary accommodation.
- The focus on reading in personal education plans.
- The quality of planning for some children in need.
- The frequency and quality of management oversight.

3.0 Torbay and South Devon NHS Foundation Trust Statutory Framework responsibilities

3.1 Children Act 1989

The overarching principle of the Children Act 1989 states that "The welfare of the child is paramount". Section 27 of the Children Act 1989 places a specific duty on health bodies to cooperate in the interests of children in need ("need" is defined under Section 17 of the Children Act 1989). Section 47 of the Children Act 1989 places a specific duty on health bodies to assist Local Authorities (Social Care) in carrying out enquiries into whether a child is at risk of significant harm.

3.2 Children Act 2004

Section 11 of the Children Act 2004 places a legal duty on all health organisations to ensure that in discharging their functions they have regard to the needs to safeguard and promote the welfare of children. To be effective it requires staff members to acknowledge their individual responsibility for safeguarding and promoting the welfare of children. It also requires Torbay and South Devon NHS Foundation Trust to support them in this role. This includes ensuring that all staff have access to appropriate training advice, support and supervision in relation to this responsibility. In order to fulfil this responsibility, the Trust will ensure that all staff have access to expert advice, support and training in relation to child protection.

Self-assessment audits have been completed for both Devon and Torbay Safeguarding Children Partnerships this year. Identified actions have been completed, except for a system to support oversight and quality assurance monitoring of all safeguarding children referrals made by the Trust, which is influenced by external change factors by Devon County Council in response to their

Ofsted recommendations. This issue is highlighted on the Trust risk register and progress is monitored via internal governance pathways.

3.3 Torbay and South Devon NHS Foundation Trust accountabilities

Torbay and South Devon NHS Foundation Trust accepts that:

- The welfare of the child is paramount as enshrined in the Children Act 1989
- All children regardless of age, disability, gender, racial heritage, religious belief, sexual orientation or identity, have a right to equal protection from all types of harm or abuse.
- Some children are additionally vulnerable because of the impact of previous experiences, their level of dependency, communication needs or other issues.
- Working in partnership with children, young people, parents, carers and other agencies is essential in promoting young people's welfare.

4.0 Governance and Assurance Framework

4.1 Safeguarding Standards with Partner agencies

The Trusts commitment to the legislative responsibility provides the foundation to the agreed standards between TSDFT and NHS Devon Integrated Care System for the provision of safeguarding/child protection services

The standards are aligned to the key legislative guidance supported by Working together to Safeguard children (2018), the Intercollegiate Document (Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019) and reinforced by the quality assurance requirements set out by Section 11 of the Children's' Act 2004.

As the standards are aligned to the legislation, this enables the governance process to link to the multiagency practice of the local safeguarding partnerships.

The TSDFT Safeguarding Children service is commissioned on a block contract basis and, as such, does not have key performance indictors to monitor effectiveness of service provision. For the CFHD Team, the service level agreement with Devon County Council for the Public Health Nursing Service ceased in April 2023 and so there are no longer any separate performance indictors required by that service.

The Trust operates under a set of standards which were last agreed with Devon Clinical commissioning group (CCG) in 2017/18, and which remain in place, continuing to underpin the Trust requirements for 2021/22. The standards have remained under scrutiny and discussion in the Trust Governance meetings (for TSDFT and CFHD), supported by Designated Professional representation from the Devon ICS (One Devon), with a consideration to refresh and update the standards in line with strategic ICS plans.

4.2 Internal Trust Governance

4.2.1 TSDFT Safeguarding Governance

For TSDFT, the Safeguarding Children Operational Group (SCOG) meets on a monthly basis. It is chaired by the Families and Communities Care Group Associate Director of Nursing and Professional Practice and is well attended by Paediatric service Leads and Named Professionals. There are terms of reference for the group, which have been updated during 2022. The dashboard and reporting arrangements have also been updated to reflect the increasing safeguarding responsibilities and activities delivered across the Trust.

SCOG monitors the progress of Trust compliance against the ICS standards via the dashboard and the workplan for the group. The audit and policy ratification process are also held within this group. All Trust Paediatric services are represented in the membership of the SCOG and the agenda ensures that all incidents, the risk register, complaints, policy updates, audits, mandatory safeguarding training and safeguarding supervision compliance, and internal managements reviews are considered and monitored on a monthly basis. The minutes from the SCOG meeting are then reported into the Trusts Integrated Safeguarding and Inclusion Group to ensure appropriate oversight of all safeguarding children issues.

SCOG also holds monitoring responsibilities towards external factors, such as child safeguarding practice reviews. Any action plans arising from multiagency reviews are monitored via the SCOG workplan and trust briefing reports are submitted by the Named Nurse for review by the attendees and Trust Executive Board accordingly.

4.2.2 CFHD Safeguarding Governance

Further to the establishment of Child and Family Health Devon (CFHD) in April 2019 the governance process has been incorporated into the CFHD Care Group for Torbay and South Devon Foundation Trust responsibilities.

CFHD have established a Safeguarding Governance Group with representation from each of the clinical pathways. The Safeguarding workplan, compliance data and action plan are monitored by the group and highlight information is reported into the TSDFT Integrated Safeguarding Group for Trust Board oversight and to the Integrated Safeguarding Committee for DPT for their assurance.

The memorandum of understanding between the alliance partners is in the final draft awaiting sign off by the Chief Nurse for Torbay and South Devon (TSDFT) and Safeguarding Executive Lead for Devon Partnership Trust (DPT). Review and monitoring of the agreement will be within the CFHD Safeguarding group and will report any safeguarding concerns to the respective partners.

4.3 Child Safeguarding Practice Reviews (formally Serious Case Reviews)

Child Safeguarding Practice reviews (CSPR) were established under the Children Act (2004) to review cases where a child has died and abuse or neglect is known or suspected. CSPRs could additionally be carried out where a child has not died, but has come to serious harm as a result of abuse or neglect.

Initial consideration for a Child Safeguarding Practice review (CSPR) is undertaken under the 'rapid review' process. This is an information gathering process where all partner agencies who have been involved with the child/family complete a chronology of key events and an analysis of their interventions. This information is then submitted to the CSPR review panel, within 15 working days, for the Local Children's Safeguarding Partnership (Devon or Torbay) for consideration. The outcome is determined by the CSPR group and then submitted to the National panel for agreement.

Rapid reviews undertaken in 2022/2023:
Torbay: 2
Devon: 4
CSPR identified in 2022/2023:
Torbay: 2 (1 carried over from 2021/2022)
Devon: 1

Actions plans and progress are monitored via the Trust governance structure, initially considered at SCOG and the CFHD Safeguarding Governance Group.

When the CSPR reports have been completed, they require sign off by the Partnership, in accordance with recognised National process. Even though the reports may not have been released, the actions that were identified for the Trust as part of the reviewing process are able to be completed and monitored within the internal governance system.

For 2022/23, learning themes included improvements required to professional curiosity when expectant parents report that they have other children; including the extent of their contact and relationship with them, information sharing between professionals and bruising and injuries to non-mobile children.
There is one report that is currently in progress in Torbay, identified as C101. There are no current outstanding actions for TSDFT from CSPR – all required actions have been completed.

4.4 Allegations against staff

Allegations against staff in relation to safeguarding children are heard by the Local Authority Designated Officer (LADO). Any allegation or concern that an employee or volunteer has behaved in a way that has harmed, or may have harmed, a child must be taken seriously and dealt with sensitively and promptly, regardless of where the alleged incident took place. Any allegation in relation to Trust staff must be referred to the LADO, in accordance with Trust policy.

For TSDFT, there have been 5 LADO contacts from April 2022 – March 2023 in response to allegations against staff. The outcomes of the contacts were 4 contacts did not meet threshold, 1 in progress due to police investigation. Professional bodies were contacted in accordance with multiagency safeguarding processes. 1 contact resulted in allegations management meetings. Where allegations were linked to stresses due to impact of covid on their personal circumstances; additional employee support plans were provided for members of staff where appropriate.

For CFHD Integrated Therapies and Nursing (TSDFT Employed staff) there have been no LADO referrals within the duration of this report.

4.5 Safeguarding Children Audit 2022/2023

Safeguarding audits are planned and presented at SCOG. Any identified actions are added to the SCOG meeting workplan and monitored by the group, reporting the progress to Board via the internal governance structure. Internal audit and associated learning is also shared with Torbay Safeguarding Children Partnership via the Quality and Assurance Group, which is attended by the Named Nurse for Safeguarding Children.

CFHD have actively participated in the Devon Children and Families Partnership multiagency audit programme, leading the thematic review of disordered eating and childhood obesity, in November 2022. Within this review period, CFHD have contributed to learning through table top audits for children experiencing domestic abuse and challenge sessions to ensure learning had been embedded into practice from the previous thematic review of children returning to education (post pandemic) and electively home educated children.

Safeguarding Children Audits completed by TSDFT include:

- Special Case Flagging audit (May 2022)
- Medical report writing for Child Case conferences review (June 2022)
- Safeguarding Children Court report process review (June 2022)
- 0 to19 Torbay service Record keeping audit (Oct 2022)
- Injuries to non-mobile baby's review (Nov 2022)
- Multiagency Torbay MASH quality assurance dip sample audits of all enquiries submitted by Health partners – continues monthly

5. Performance of Safeguarding Children Services

5.1 Maternity Safeguarding Children Activities (completed by Named Midwife / Safeguarding Midwife)

During 2022, midwives completed 287 interagency communication forms (ICF), identifying pregnant women who have safeguarding and vulnerability factors. This includes substance misuse, domestic abuse, mental health, teenager etc. This equates to approximately 12% of women using the maternity services within Torbay and South Devon and requires a significant amount of resource to ensure that needs are assessed and appropriate plans are put in place to safeguard the baby and family.

In May 2022, the new electronic patient record 'SystemOne' went live. The Safeguarding Midwife worked closely with the IT Midwife and the IT Team to respond to any issues that arose and continues to develop the system to best safeguard families.

Relevant multiagency meetings have been held as planned, mainly via MS Teams. The Safeguarding Midwife continues to be a member of both Torbay and Devon Rural Multi Agency Risk Assessment Conference (MARAC), contributing to meetings and appropriate safety plans when pregnant women are being discussed.

The Safeguarding Midwife is also a member of Torbay's Unborn Baby Tracker Panel. This is a multiagency panel of professionals, which meets fortnightly. The unborn baby panel is an early opportunity to track and monitor the wellbeing and safety of vulnerable children at the pre-birth stage.

During 2022, the Vulnerable Pregnancy meeting continued for pregnant women within Devon. This is attended by either the Safeguarding Midwife or Public Health Midwife. The meeting occurs monthly, and offers holistic support for families who are identified as having social complexities – this provides a safety net for families who do not meet the threshold for statutory intervention, but who maternity staff feel do need a robust plan of support for the family to thrive. The panel is attended by maternity staff, Action for Children, Devon Partnership Trust, Health Visiting and other local agencies who can offer support.

The Public Health Midwife continues to chair the monthly Public Health Liaison meeting. This is a multi-disciplinary meeting involving Midwifery, Consultant Paediatrician, Perinatal Mental Health Team and Paediatric Pharmacist. The aim of the meeting is to develop a care plan for babies who have additional care needs due to maternal substance use or other prescribed medication which may have an impact on the baby. This enables a clear plan to be put into place regarding the observations the baby will require. The Public Health Midwife is collaborating with the Local Maternity & Neonatal System (LMNS) to align this process Devon-wide.

Our High-Risk Consultant Clinic is run weekly, and attended by the Specialist Public Health Midwife. Women with significant mental health disorders, substance and alcohol misuse, teenagers and women with complex social support needs are referred to this clinic by their midwife at booking. Multi-disciplinary care is offered, and safeguarding concerns are frequently identified due to the nature of the referrals. The Public Health Midwife and Safeguarding Midwife liaise closely to support staff and the women themselves.

The Safeguarding Midwife attends the Safety Briefing twice daily on Delivery Suite, where capacity allows, to offer supervision and support for the staff managing families with safeguarding support requirements currently in the Maternity Unit or expected for that week. She also meets with all new staff, including the junior doctors, as part of their induction. She participates in presentations at the monthly Perinatal Meeting where the women being discussed require safeguarding support considerations. The Named Midwife and the Safeguarding Midwife continue developing networks both in the South West and Nationally. In 2022, they attended regular SW Safeguarding Midwives forums, Named Professional events and national events albeit virtually.

TSDFT has been chosen as a pilot site for the HOPE Box trial. The HOPE Boxes are an intervention to help support women who are separated from their baby close to birth due to safeguarding concerns. The HOPE Boxes intervention has been co-produced with a group of women with lived experience and builds on research findings from the *Born into Care: Developing new national guidelines when the state intervenes at birth* project. The HOPE Box was launched here in December 2022.

Due to continued service capacity issues, the Safeguarding Midwife provides operational support to the Midwifery Teams by attending Child Protection Conferences, Strategy Meetings, Core Groups and Child in Need Meetings and

Discharge Planning Meetings where required. This can be either due to capacity issues or to support with complex cases. She additionally supports Health in MASH, for both Devon and Torbay, with requests for maternity health information, in response to MASH enquiries.
There continues to be an increase year on year of court directed report requests for Family Court, to be completed by maternity staff. This has a significant impact on the service both for the midwife completing the report and on the senior staff supporting them.
Maternity staff continued to provide support for Multi-Disciplinary Team Local Child Death Review Meetings and Child Safeguarding Practice Reviews, providing detailed chronologies and attending relevant meetings.
The impact of increasing safeguarding children considerations and support for statutory duties continues to provide challenge for the maternity service.

5.1.2 Safeguarding Supervision in Maternity Services

Safeguarding supervision continues to be embedded within maternity. There were 10 Safeguarding Supervisors trained additional to their clinical role to support the delivery of safeguarding supervision within Maternity in 2022.

The Trust Safeguarding supervision policy is followed, with a clear and embedded structure across Maternity services. This is led by the Named Midwife and Safeguarding Midwife and supported by the Community Team Leaders and Maternity Services Safeguarding Supervisors to ensure that safeguarding supervision is accessed and accessible by all staff, both community and hospital based. In addition, the Named Nurse provides quarterly updates for the Community Team Leaders and Maternity Services supervisors, which are well attended. The Named Midwife and Safeguarding Midwife access additional support from the Designated Nurse.

The standard of 100% for safeguarding supervision for community midwives with a case load is three monthly and all other maternity staff six monthly. Internal reporting systems of supervision both ad-hoc and planned, were enhanced utilising admin support, to provide accurate centrally recorded data and monthly reporting. Compliance has been variable due to capacity across the clinical services but will be monitored and reported via the Safeguarding Children's Operational Group in accordance with the updated dashboard.

In addition, there has been collaborative work with the wider Trust Safeguarding Teams to support learning and action plans in response to Child Safeguarding Practice reviews.

5.2 Paediatric Liaison service activities

The Paediatric Liaison Service believes that by effectively and safely communicating with health partners/other agencies, we can help to ensure that children and young people have their health and wellbeing needs appropriately supported.
The service has continued to achieve this through four main overarching themes; information sharing, special case flagging, staff advice/supervision and staff training.

5.2.1 Information sharing

Within this time frame, the service has had oversight of **3,666** safeguarding referrals. They include; Paediatric Liaison Referrals, Multiagency Safeguarding Hub (MASH) referrals and Multiagency Risk Assessment Conference (MARAC) referrals. The service received **3,232** Paediatric Liaison Referrals from across the trust.

The service had oversight of **367** Emergency Department (ED)/Minor Injury Unit (MIU) Multi Agency Safeguarding Hub (MASH) referrals, providing additional information forms as appropriate to ensure effective sharing of information to relevant safeguarding hubs and health partners.

The service has also continued to support the ED/MIU by providing an overview of all Multi Agency Referral Assessment Conference (MARAC) referrals completed by the Emergency Department and Minor Injury Units. The service has processed **67** MARAC referrals, once more providing additional information as appropriate.

These figures showed a **35% decrease** on the previous year. This is due to improved quality of referrals and improved staff awareness of threshold discussions. There has been additional support with collaborative working between the Paediatric Liaison Team and the Domestic Abuse support worker. Referrals made that do not meet the threshold for referral to MARAC are shared to the Domestic abuse support worker who establishes contact with the patient and considers support from local domestic abuse support services

5.2.2 Special Case Flagging

The service has continued to develop the special case flagging to ensure relevant and accurate information is readily accessible to frontline practitioners. The service can receive flag requests from different service providers and from this the service currently manages **354** active special case flags. This is a **decrease of 3%** from last year. The current special case flags include; medical flags (**93**), safeguarding flags (**25**), high risk missing person flags (**5)**, drug box flags (**66**), and SARC (**165**). In recognition of the services expansion these flags are reviewed annually, and the process regularly audited with the support of the TSDFT Clinical Auditing Team to ensure they are relevant and up to date.

5.2.3 Supervision and staff training

The Paediatric Liaison Service has continued to be a point of contact to all agencies as well as providing ad hoc supervision to trust staff, mainly focussed on the Emergency Department / Urgent Treatment staff. The service is also supported by the Safeguarding Nurse Practitioners, who are providing regular contact direct to the staff in paediatric clinical areas; Special Care Baby Unit, Louisa Cary Ward, Short Stay Paediatric Assessment Unit, and Paediatric Outpatients. The Paediatric Liaison Nurse works collaboratively with the Safeguarding Children Team to ensure that the children / young people / parents who are presenting to the Trust services are supported with timely and accurate information sharing to ensure that they receive support or intervention that is required for their family.

Safeguarding Supervision practice is recognised by the Trust staff and is embedded in their clinical practice. Regular contacts from clinical staff are made to the service

and recorded within clinical records/staff records as appropriate and in accordance with Trust policy. Safeguarding supervision continues to be highly regarded by staff, as evidenced in formal feedback, and forms an essential part of the safety and wellbeing of staff who are required to engage in the challenge and complexities of safeguarding children practice. Compliance in safeguarding supervision will be monitored on the updated dashboard for the Safeguarding Children Operation Group for the clinical teams who are working with children and young people on a regular / routine basis. This will be in effect by Quarter 2 of 2023.

5.2.4 Staff training

The Paediatric Liaison Service recognises that for children and young people to have their health and wellbeing needs appropriately supported, frontline practitioners need awareness of local contextual safeguarding issues. With support from the Safeguarding Nurse Practitioners, the Paediatric Liaison Service provides advice, guidance and supervision to staff in their consideration and contacts with children and young people who are accessing Trust services. The Paediatric Liaison Service recognises that at the heart of improving the quality of safeguarding referrals is through improved staff awareness and understanding.

The Paediatric Liaison Nurses have increased their capacity by 0.2wte to enable support for additional teaching sessions for the Emergency Department staff cohort, in collaboration with the Practice Educators. Training sessions are completed in response to staff queries, incident reporting, national legislation changes and Child Safeguarding Practice reviews and can range from informal 1 to 1 session’s to group “turbo teaching” sessions delivered to all staff who are on duty at the time. The Paediatric Liaison Nurses also support the training of staff through shadowing opportunities for Medical / Nursing / Public Health Nursing staff.

The service continues to audit and record training feedback to ensure the provision can continue to develop and evolve to best support frontline practitioners and promote Safeguarding Children within Adult and Paediatric Services.

5.3 Children in Care 5.3.1 CIC & Safeguarding (Report by Named Doctor for Children in Care)

We continue to strive to produce high quality health assessments for children and young people in the local area, supporting their health needs and ensuring where at all possible that their health needs are met and not disrupted by their vulnerable child in care status. We continuously adapt our practice to meet their needs.

There have been a number of challenges in the past 12 months but there are also strengths that can be identified.

As a result of long-term administrative staffing absence at the start of the year (which did have a significant impact on our capacity to return reports in a timely manner), our vulnerability with a small admin team has been recognised and the wider team are being trained and have been able to support the Children in Care administrative work. There will be less gaps moving forward and improved cover during periods of annual leave and absence, I would like to acknowledge the support we have received from the wider safeguarding team and child health admin staff during this really challenging period.

Additional temporary funding from the ICO was allocated to Royal Devon University Hospital Trust to support the Children in Care work across the whole of the ICO which we have drawn on in particular to support the increased number of unaccompanied asylum-seeking young people in the area.

Education session for GP's was provided to improve wider networks and understanding of the health needs of vulnerable, unaccompanied asylum-seeking children.

Recent meetings with Torbay Children's Services, led by Corinne Foy, Associate Director of Nursing and Professional Practice around how to improve timing of provision of consent for health assessments by the local authority have been positive and it is hoped this will result in improved completion of health assessments within statutory timescales.

However, there remain challenges within the whole system for cared for children who have increasingly complex health needs with our capacity remaining the same.

Initial Health Assessments

Total numbers of request's have remained consistent over the last 12 months until April 2023 (approximately 140 per year) and we have completed and returned the reports to children's services on time in 44% of cases for those living in our area (a reduction of 6% from the previous 2 years).

As previously the majority of these delays are due to delay in receiving paperwork from the Local Authority which remains static at 38% of the time (statutory timescales mean they should be received within 5 working days of a child becoming cared for). We were able to offer a first appointment within 15 working days for 72% despite the delays but these are not always taken up which is why our figures of 44% are disappointing. This has been similar over the last 2-3 years.

As highlighted in previous reports, these are statutory timescales and there are multiple reasons for the first appointment not to be accepted including multiple placement moves for a child, foster carer's availability, trying to accommodate siblings in one assessment and clashes with family time for the child and their birth parents. We continue to provide exception reports for this to SCOG and the ICO.

On a positive note, when a child or young person is cared for under an interim care order in Torbay in particular, the business support team are very quick to provide consent from the social worker and there are fewer delays for those children. Our admin team and the business support team do work closely together.

It is more complex when children are placed with a family member and under a Section 20 voluntary agreement which means parents have to provide consent. We are working with the local authority to try and improve this.

There are fluctuations in the monthly numbers which means as a health team we can struggle to meet demand at times.

It is also important to recognise that we also provide many other medical services including adult health reports and permanence medical reports as well as meetings

with prospective adopters so IHA's are not the only important pieces of work as we often have tight timescales for Court in relation to this work. These numbers have been fairly static over the past 12 months with 92 permanence (adoption) medical reports completed and 294 adult medical reports completed.

Unaccompanied Asylum-Seeking Children (UASC)

The number of young people living in our local area have increased significantly over the past few years and with the National Transfer Scheme allocation, these will continue to rise. We have completed 9 heath assessments for Unaccompanied asylum-seeking children (until April 2023) which are complex appointments requiring interpreters and often result in requirement for follow up of health issues.

Not fully included in these figures are the large cohort of young people (21) who arrived in Torbay whom we were made aware of in October 2022 having been assessed as adults by the home office but subsequently disclosed that they are children which has had a huge impact on Children's services and safeguarding issues arising for these young people who had to be accommodated in alternative provision.

Many of these young people are still awaiting completion of their age assessments by Children's services and therefore have not had their health assessments. At the present time, I estimate we may still have 8-10 that are outstanding. I have been working with the local authority and public health team to offer support to try and ensure their basic health needs are met before the health assessments are completed. However there have been health issues particularly a case of active TB which may have been identified earlier if these assessments had been able to be offered in a timely manner. This increased activity has had an impact on our overall capacity over the past 12 months.

In summary, it has been a challenging year with regard to staffing issues and increasing numbers of unaccompanied young people but this work is vital and important to reduce potential health inequalities and ensure these most vulnerable children have their health needs assessed. Over the next 12 months the focus will be an audit of the quality of our assessments, seeking feedback from our young people and ongoing work alongside the local authority to try and improve the timeliness of the health assessments to meet statutory timescales.

5.3.2 Children and Young People in Care Nurse Team (report by the Named Nurse for CYPIC & Care Leavers)

Our team offers a service to all 'Children in Care' (CiC) and 'Care Leavers' that incorporates a resilience-based and trauma-aware approach. This approach aims to identify and build upon children's strengths with the aim of improving their health, well-being, safety and to improve their life chances. This is achieved by offering comprehensive statutory health reviews, support, guidance and sign-posting as well as multi-agency working and listening to young people and acting as their advocate.

The team work alongside safeguarding colleagues, contributing to strategy and secure criteria meetings and rapid review reports etc. The complexity and frequency of safeguarding incidents is increasing as children and young people are coming into care later and therefore have a more complex history. The named nurse and children

in care team work in partnership with agencies such as education, social care (including fostering) and NHS Devon to ensure that a high standard of care and safety frameworks are continually developed at an individual and strategic level. These children and young people must be seen as a priority in health services to ensure a preventative approach and to promote their current and long-term health outcomes.

5.3.3 Significant safeguarding issues for Children and Young People in Care and Care Leavers 2022-23

The impact of pressures from previous financial years carried on into 2022-2023, these included long term sickness and vacancies within the team as well as an increase in children coming into care. This pressure resulted in a backlog of health assessments, at a high of 112 in August 2022, with only 24% of assessment completed within time for this month.

To address this the team completed a job planning, productivity and utilisation review and action plan in November 2022 to identify efficiencies and increase the number of assessments completed. One change implemented is that every CiC is triaged for suitability for a virtual assessment and CIC can choose format for review – face to face or virtual assessment (once risk assessed). Virtual reviews have reduced travel time and increased capacity / assessment activity.

The team are investing in training of carers, social workers and personal assistances to raise the profile and importance of health assessments, aiming to improve effective partnership working and increased capacity with the CIC nursing team and outcomes for CIC.

These actions resulted in a backlog of health assessments, at a high of 112 in August 2022 being reduced to 31 at the end of the financial year, along with the percentage of review health assessments being completed on time increasing to 76%.

A review into the delays for CiC receiving review health assessments in 2022/2023 found that the most common reason (60% of delays) was from incorrect notifications, incorrect documentation and late requests from the local authority. Pressures in the child in care nursing team accounted for 25% of the delays, with the remaining delays a result of varied reasons including CiC declining appointments.

The child in care nursing team is now approaching a full complement of staffing, and the use of trained bank staff is being utilised to address the backlog and aim to increase the number of children and young people seen within statutory timescales while we wait for the onboarding of new staff.

5.4 Public Health Nurses – 0 to 19 Torbay service

0 to 19 Torbay continue to work in collaboration with Action for Children and The Children’s Society and are now in year 5 of their contract.

This report will focus on the public health nursing (PHN) element of the service for which the TSDFT safeguarding children Team provide safeguarding support and supervision to staff.

The service continues to provide support for families across two teams; the Universal, providing the Healthy Child Programme https://www.gov.uk/government/collections/healthy-child-programme and Plus teams. The Plus team provide enhanced intervention to all families with children with child protection plans and Children in Need. They also support any children cared for by the local authority.

Torbay council were awarded Family Hub and Trailblazer status in September 2022. https://www.gov.uk/government/publications/family-hubs-and-start-for-life-programme-local-authority-guide

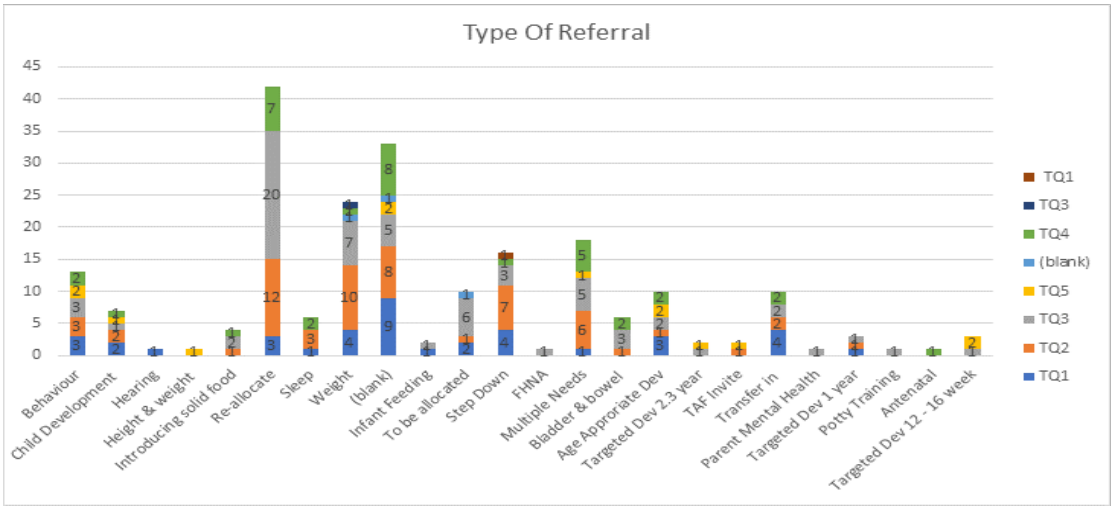
We are one of 75 local authority areas that are eligible to receive a share of £301.75 million. The funding package extends from September 2022 to March 2025. The programme builds on the government's commitments to champion family hubs and support babies, children, and families to get the best start in life.

There are three Family Hubs in Torbay; The Barn in Brixham, The Beehive in Paignton and Zig Zags in Torquay. The Torquay venue is not ideal, and St Edmunds Health Centre has been identified as an alternative venue. Work will commence shortly to facilitate some internal changes to enable delivery of services from the ground floor of the building. Both the PHN Plus team and one Universal pod are based within the Hub, enabling easy access for families to practitioner support.
All of our clinic and group work is held in the Family Hubs (formerly known as Children's Centres) and our collaboration with partner agencies has increased with co-facilitated training, training opportunities (such as Trauma Informed), co-working complex families and shared access to our electronic record keeping system for our Partners. This supports a safe approach and sharing information enables families to only tell their stories once.

Requests for support for universal work has continued to increase. This pressure on the service has been complicated by internal reorganisation of staff and some staff leaving the service. There are plans in place for Quarter 1 in 2023 for reallocation management which should result in increased capacity and a subsequent decrease in waiting times. Sleep clinics and bladder and bowel clinics remain popular, and plans are being formalised to introduce antenatal group contacts through Family Hubs in the autumn of 2023.

The Plus team pressures are directly related to the impact of increasing legal action through Family Court for families in Torbay. Requests for strategy meetings and court reports have seen an increase and this pressure is continuing into quarter one of 2023. This situation has oversight of the Named Nurse and Service Lead / Plus Team Lead for 0 to 19 Torbay and is monitored via SCOG to ensure Trust awareness and support.

Demand overall for the service has been increasing and the decision not to close services during Covid has helped to ensure we have not had a backlog or waiting lists to manage.



An element of the Family Hub work focuses on perinatal infant mental health (PNIMH) and, to support this, we have developed a team who are developing a local offer to support parents based on the Institute of Health Visiting's Well Being Visit model. This identifies women at risk of post-natal depression or those who have struggled to bond with their babies and offers an enhanced programme of support over 8 weeks.

As part of the Family Hub agenda, we have invested in 'DadsPad' which is both a physical and virtual offer for Dads. This has been developed in collaboration with the NHS. Additional training has been offered to the workforce around infant mental health with a particular slant on supporting dads, which has been hugely beneficial when working with families who are experiencing poor mental health, which was developed in consideration of the recommendation from the 'Myth of the Invisible Man' report based on child safeguarding practice reviews that was published in 2021.

Infant feeding is also a Family Hub area and we have recruited an infant feeding lead health visitor who is leading a team of staff across health and voluntary sector to increase breast feeding rates locally and to ensure healthy eating is a priority. We have ensured that all staff have received adequate training around this subject, and for the first time this year we have included our School Nursing and Administrative staff so the workforce are informed and feel able to offer support or recognise when parents may need additional help.

We have developed our preceptorship offer to our newly qualified SCPHN staff. This has involved utilising our qualified Professional Nurse Advocates (PNA). By utilising the Advocating for Education and Quality improvement (A-EQUIP) model there have been supportive discussions around areas of practice and an opportunity for self-development. Themes from this work have included Early Help referrals, safeguarding supervision, record keeping, moral injury and resilience.

To support positive outcomes for children, young people and families an opportunity for greater understanding of roles, responsibilities and service provision was identified between the 0to19 team and the Safeguarding Children Team. In response, the Team Leaders from the 0 to 19 Torbay service have shadowed the Safeguarding Nurse Practitioners in their roles and the Safeguarding Nurse Practitioners have reciprocated and attended the 0 to 19 Torbay operational service. The Safeguarding

Nurse Practitioners have also been invited to and attended the 0 to 19 service public health nursing forum, allowing for networking to all practitioners. This has had a positive impact on appropriate considerations of outcomes of safeguarding meetings, improved quality of information sharing and increased value in relationships.

5.5 Torbay Sexual Medicine Service (TSMS) – under 18's

The service has been working in close collaboration with TSDFT Safeguarding Children Team to support robust safeguarding processes and practice. There is an ethos across the service of high-level professional curiosity. There has been positive feedback for the referrals completed by TSMS staff to Torbay MASH via the Named Nurse at the monthly MASH dip sampling audits.

High levels of staff engagement at Level 3 mandatory safeguarding children training and Safeguarding supervision compliance at both group sessions, led by the Named Nurse for Safeguarding Children, and individual 'ad-hoc' sessions. Additional multiagency training provided by Torbay Safeguarding Partnership attended by practitioners includes Child Exploitation, Prevent, Modern Slavery, Trafficking, Neglect and Restorative Practice. Themes discussed at group supervision sessions include information sharing, learning from Child Safeguarding Practice reviews, National media reported events and criminal proceedings and new legislation that are applicable to the service; such as the RCPCH Safeguarding guidance for children and young people under 18yrs accessing early medical abortion services, published in February 2023.

Identified staff with a special interest in safeguarding children practice have taken the lead on service improvements. The staff who have been trained as Safeguarding Supervisors additional to their clinical role have been actively supporting the staff across the service and there has been active engagement by practitioners at TSCP escalation meetings, Professionals meetings and strategy meetings where there are concerns of significant harm for young people, and safety planning for vulnerable adults / young people. This has resulted in a service that has good relationships with commissioners and multiagency partners, that continues to consider the service framework that best meets the needs of the young people of Torbay, with staff who are well informed on local safeguarding risks and appropriate support networks.

Attendances to Young Peoples Walk in clinics, which are held weekly are continuing to gain good attendance levels, averaging at 50 attendances per session. They are mainly attended by female patients, requesting contraceptive advice and treatments. Telephone appointments are also offered alongside the face to face provision. The covid pandemic has had a lasting impact on young men accessing the service and this has been further influenced by the funding cuts impacting on the ceasing of the Outreach service and Boys and Young men's worker specialist post. This is a concern in light of the significant impact of exploitation on young people in Torbay and South Devon and this can impact on the risk of sexual exploitation for both young men and women.

TSMS staff continue to work closely in sharing and corroborating information shared with the service by Torbay's young people to support safeguarding duty of care, supporting Torbay MASH enquiries, and multiagency risk assessment meetings such as MACE (Missing and Child Exploitation meeting) and CEMOG (Child Exploitation and Missing Operational Group).

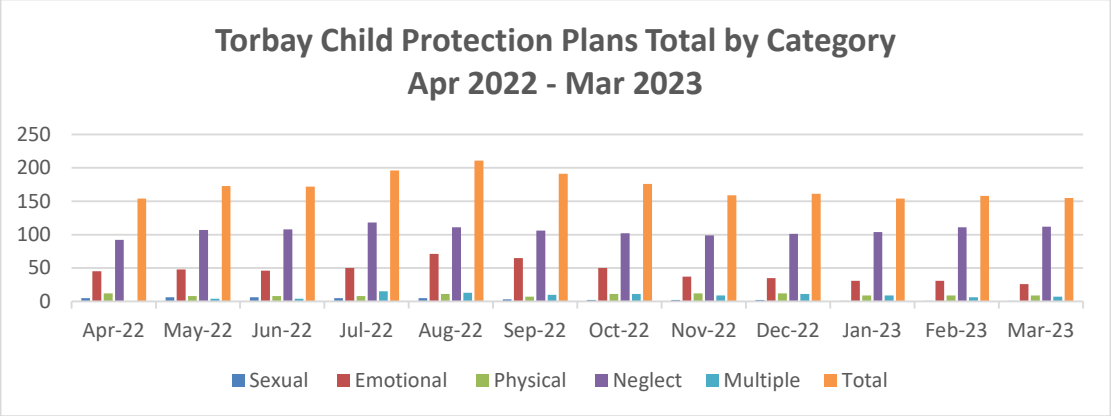
Torbay and South Devon NHS Foundation Trust

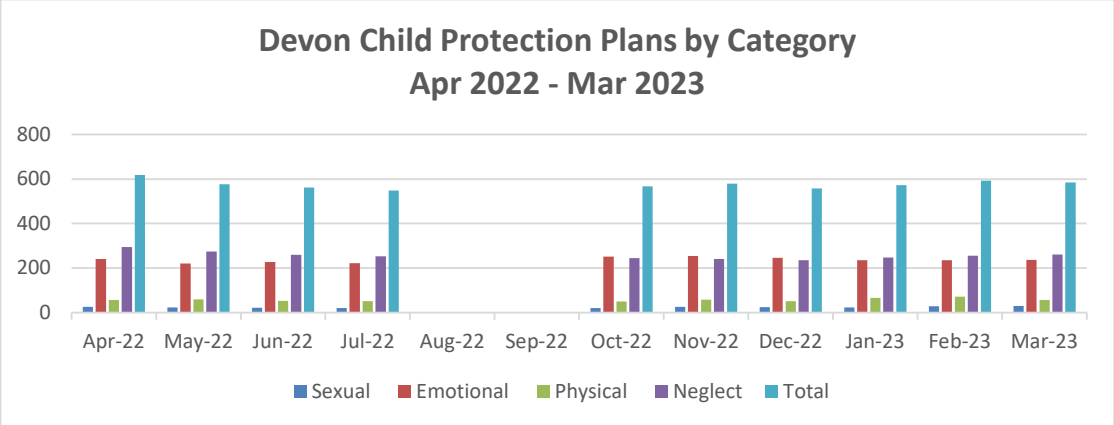
5.6 Safeguarding Children Team performance activities

The Safeguarding Team performance report information will be based on the agreed Devon ICS standards. In order to understand the context of the needs of the local population the figure below shows the data for the children subject to child protection plans in Devon and Torbay; split by category.

For Torbay and Devon, the highest categories are consistently neglect and emotional abuse, which continues to be in direct correlation with the local figures for deprivation, poverty and domestic abuse. Torbay, especially, has experienced a significant increase in children requiring support in relation to neglect during 2022/23.

In response, the dynamics of the collaborative working practice of the Torbay and South Devon (TSDFT) and Child and Family Health Devon (CFHD) Safeguarding Children's Teams ensure that all Trust staff have awareness of both Devon and Torbay Local Authority working practice and Safeguarding Children Partnership strategies.





5.6.1 Health in MASH

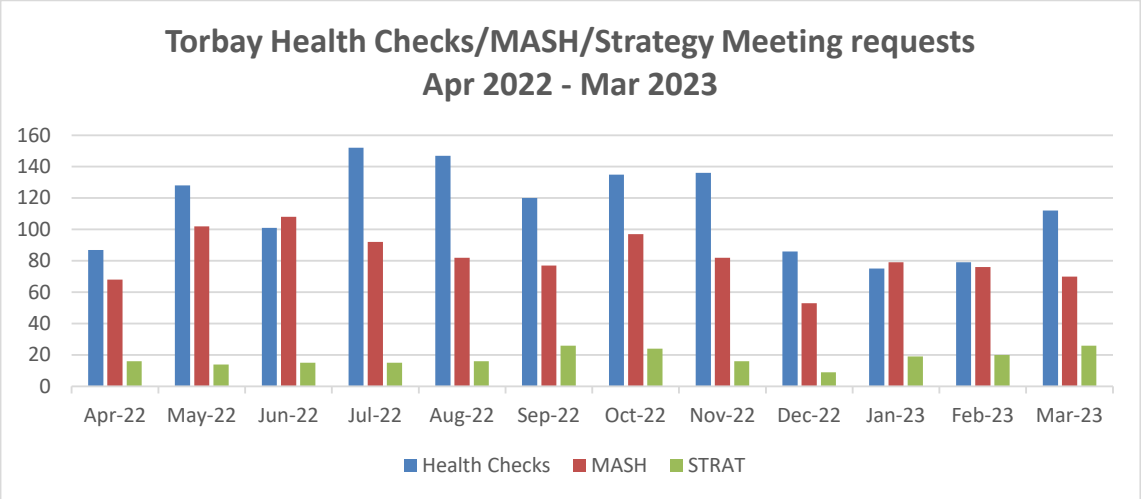
TSDFT Safeguarding Children Team provide the health support to the Torbay Multiagency Safeguarding Hub (MASH). The support for Devon MASH is provided by the CFHD Safeguarding Children team.

The MASH receives all of the child protection contacts for local authority Children's services. The health team support the investigations for each contact by completing health enquiries for all parties related to the referrals. This may then lead to contributing to virtual MASH enquiries and face-to-face strategy meetings by information gathering from all available health sources; including TSDFT Health services, adult support services, GP's and CAMHS, and then providing analysis and recommendations for threshold decisions.

The numbers of Mash enquiries continue to increase (see figures in 5.6.1.1 and 5.6.1.2 below) and, in spite of service redevelopment and additional recruitment, the MASH responsibilities have an increasing impact on the capacity of the both the CFHD and TSDFT safeguarding children teams. This is compounded in Devon by the many changes of management and continued drive to support improvements as outlined by Ofsted. The Named Nurse for CFHD and Service Manager for CFHD are supporting operational and strategic MASH meetings to manage the impact of a lack of consistent operational practice for partner agencies.

The complexities of family situations and impact on the children and young people have increased significantly; influenced by the decreased support and surveillance of professionals due to covid working guidance restrictions and the support offers remain challenged due to long waiting lists for decreased service availability. The Safeguarding Children Partnerships are bringing together multiagency partners to work collaboratively to identify shared solutions, support staff in their practice and to share learning and embed recommendations from local and national Child Safeguarding Practice reviews.

5.6.1.1 Torbay – Health in MASH



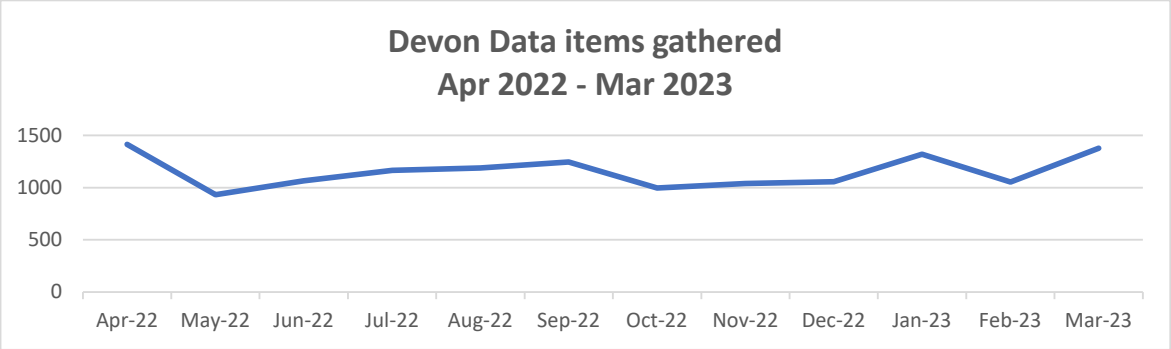
TSDFT Safeguarding Children Team provide health information to support consideration of children / young person's safeguarding needs following MASH enquiries / contacts. The Safeguarding Nurse Practitioners gather data, supported by the Admin staff, from a variety of sources, including acute, public health, sexual medicine service, CAMHS, GP and adult support services. They then provide an analysis of the information to support a multiagency consideration and outcome.

This process has been either in a virtual mash response, facilitated via secure emails or by strategy meetings, completed using Microsoft Teams technology. Networking and liaison with the other partner agencies have remained in place during 2022/2023, facilitated by access to Microsoft Teams technology. The practice of using Microsoft Teams has continued to support efficiencies in prompt safeguarding planning, as families have a telephone consultation with the MASH social worker prior to the meeting, allowing for information gathering and for family members views to be shared within the assessment process.

Return of staff to the shared multiagency office hub has evidenced the importance of face to face contact and the positive impact of the ability of contemporaneous discussion and professional rigor to the decision making. Attendance by the Health Team to the MASH operational and strategic meetings also ensures multiagency consideration of quality process and change management.

The TSDFT team have also continued to work from a base at Torbay Hospital, developing a mix of office based and home working, subject to risk assessment, to support a robust and sustainable approach for clinical staff from across the Trust. It has enabled the team to adopt a flexible approach and for staff wellbeing, supervision and mutual support to be sustained throughout the year.

5.6.1.2 Devon - Health in MASH



CFHD Safeguarding Children Team provide health information to support consideration of children / young person's safeguarding needs following MASH enquiries / referrals. The Safeguarding Nurse Practitioners gather data, supported by the Researcher, from a variety of sources, including public health nursing, CAMHS, GP's, acute and adult support services. They then provide an analysis of the information to support a multiagency consideration and outcome.

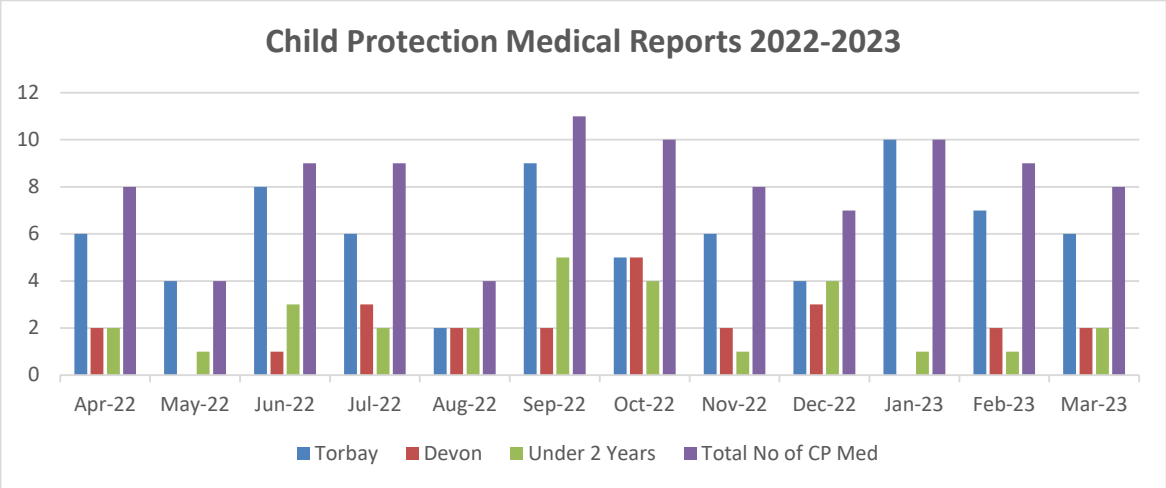
During lockdown, the Devon MASH team established multiagency communication process to replace the office systems of communication i.e. remote notice board for prompt notification of strategy meetings, office remote huddles (clinical and restorative function). The Devon MASH partner agencies remain predominantly working from home or remote locations, maintaining contact with the MASH multiagency team via Microsoft Teams.

The CFHD Safeguarding team participate in the improvement plans and service review, via attendance at weekly MASH partnership meetings and monthly attendance by the Named Nurse to the MASH operations group. In order to support staff wellbeing, the team are supported twice weekly team meetings to monitor, train and support team members.

5.6.2 Child Protection Medicals

Child protection medical examinations form part of the statutory response to child protection referrals from the health perspective. Child protection medical examinations are completed by Consultant Paediatricians / Middle grades and are completed in accordance with Royal College of Paediatrics guidance which is incorporated into Trust process.

Referrals for Child protection medicals are made following strategy meetings held in either Devon or Torbay MASH's, or from strategy meetings held in regulated service where children are currently supported by local authority children's social workers. (see figure below). The current performance around timeliness of the medical is in line with the 10-day target. There are no outstanding medicals and we achieve the timeframe set.



To improve outcomes for children and young people, TSDFT Named Professionals have supported multiagency improvements to develop a shared protocol for the procedure of the medical examinations, liaising with both Devon and Torbay children's services. This is well embedded in Torbay and is improving in Devon. As a result of the new processes, Trust Consultant Paediatricians are regularly supporting decision making at strategy meetings for children who have experienced physical harm. This practice has been shared at online National Named Professionals meeting, as it is not common practice nationally, and is considered as best practice.

The Trust has adapted the multiagency protocol to ensure alignment to RCPCH standards for Child Protection medicals which supports improved quality outcomes for children / young people who require child protection medical examinations. The protocol has been embedded but there is a continued training need, which is being supported by the Named Doctors, due to high turnover of social care child protection staff. The Named Doctors chair a group in Torbay, attended by all Team Leads and Service Managers in Torbay Children's services to consider shared safeguarding processes and support shared process and practice improvements. This is an established monthly meeting in Torbay and is currently being established in Devon.

Medical examinations in relation to sexual abuse / assault are completed by the Sexual Assault Referral Centre (SARC). The Trust has developed an information sharing protocol to ensure that professionals are in a position to ensure continuing appropriate support is provide to children / young people. There has been a significant increase in requirement for and completion of SARC medicals for young people during 2022/23, due to sexual assaults in relation to child exploitation and familial sexual abuse, complicated by the covid lockdown restrictions.

5.6.3 Safeguarding Supervision Compliance

In addition to safeguarding supervision, staff require advice and guidance to support their safeguarding children practice. As the dynamics of family situations have become more complex, particularly as a result of the covid lockdown periods, staff are making increased contacts for this support.

Safeguarding supervision is provided by the Safeguarding Childrens Teams; in accordance with the recently reviewed Safeguarding Supervision policy, it is provided as a blend of ad-hoc or duty contacts, formal group sessions or one-to-one sessions. All of the sessions allow for group case discussions and updates on current practice or areas of learning highlighted by Child Safeguarding Practice reviews. It is essential that staff are supported in their safeguarding duties and the TSDFT and CFHD Named Nurses have worked closely together to ensure / support appropriate provision for all staff in their responsibilities.

For TSDFT, many contacts are initially directed through the Paediatric Liaison service which is well established and embedded into clinical practice across all Trust teams; particularly unscheduled care and Adult inpatient wards. The Safeguarding Nurse Practitioners are responsible for safeguarding supervision provision to the Public Health Nursing, Children's Community Nurses, Torbay Sexual Medicine Service, Torbay Adult Young Carers, Louisa Cary Ward, Short stay Paediatric Assessment Unit and Special Care Baby Unit. This is delivered in face to face contact, facilitated by regular contact visits to clinical areas for ward rounds / team meetings and scheduled group supervision sessions. Any Trust staff can access ad-hoc safeguarding supervision / advice / guidance by contacting the Safeguarding Children Team.

CFHD Safeguarding team offer a duty system for ad hoc advice and guidance to all staff. The number and complexities of these contacts escalated during the pandemic and remain high. Initial safeguarding supervision for staff is carried out as part of the clinical supervision delivered regularly, in situations where children's experiences are more complex clinicians attend the remote access supervision and share learning

with other CFHD staff. Safeguarding supervision and support is offered to clinical managers to enhance their knowledge and confidence, and update of local and national information is shared to the safeguarding champions.

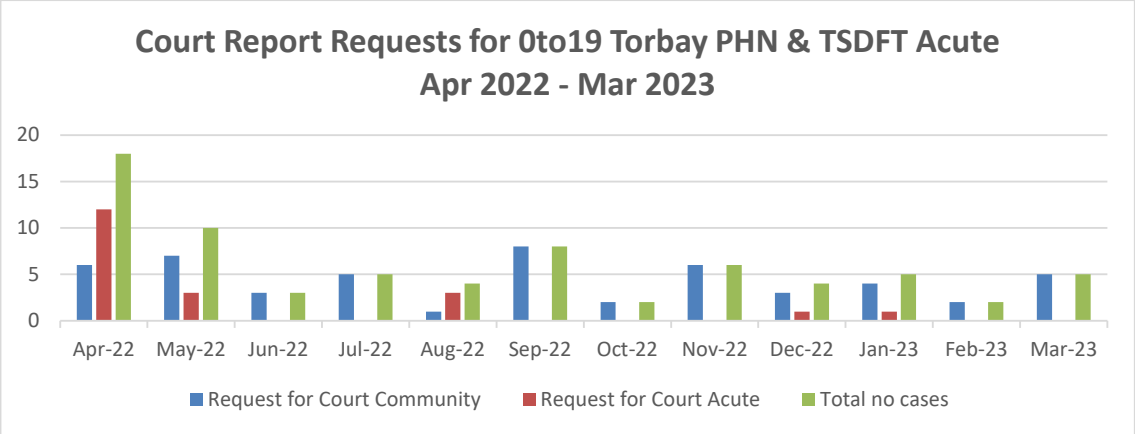
The data for the Safeguarding Children activities is reported and monitored via the governance meetings. Improvements to the data reporting for safeguarding supervision compliance have been made and the dashboard for SCOG has been updated accordingly. The report for 2023/2024 will have improved data to evidence Trust staff compliance for those Teams who have regular contacts with children and young people. Both teams have continued to identify themes of impact on capacity due to the high levels of children and families requiring support, increasing complexities of family's needs due to impact of lockdown, and fatigue of healthcare professionals undergoing work related and personal challenges of their own.

Additional Safeguarding supervisors have been trained from both TSDFT and CFHD by the TSDFT Named Nurse, who delivers a 2-day training programme followed by quarterly updates. Staff from a range of teams such as midwifery, speech and language therapists, paediatric diabetes nurses, sexual medicine nurses, emergency department staff, paediatric consultants and adult drug and alcohol service; in order to support the supervision provision in specialist paediatric services, particularly for ad-hoc supervision discussions. These sessions will only be delivered bi-annually, instead of bi-monthly due to the withdrawal of training support from the Organisational development team who are impacted by capacity issues.

5.6.4 Court duties

Court duties in relation to Family court form an important part of the safeguarding duties for TSDFT/CFHD staff. For staff who have been directly involved in the care of a child, there may be a requirement for them to participate in legal proceedings if the child becomes a child in care. Both TSDFT and CFHD have experienced increasing demand on staff to complete court reports and attend court as witnesses. It is a regular request for Health Visitors, School Nurses and Consultant Paediatricians, but increasingly requests are being made from Emergency Department Clinicians, Paediatric Nurses, CAMHS staff and Midwives.
For CFHD this service provision has altered significantly since the ending of the service level agreement for Devon Public Health Nursing service. The CFHD team continue to support integrated nursing and therapies staff but also CAMHS service practitioners, who are seeing increasing legal requests for their service.

The Trust are receiving increasing numbers of court requests for reports and release of health records, which are in direct correlation to the increasing numbers of children and young people who are subject to child protection or who have become children in care. This is especially pertinent for the 0to19 Torbay Public Health Nursing service who receive the majority of court reports. This is a factor regularly reported to SCOG by the Service Lead and remains under scrutiny as a significant challenge to TSDFT services. The data is not reported for CFHD for 2022/23 as the majority of the information pertains to Devon County Council PHN service. (See figure below)



Both the TSDFT and CFHD Safeguarding Children Teams offer support to all staff who are required to complete a court report, in accordance with Trust policy. Staff are also offered safeguarding supervision and support for court attendance. The increasing numbers of requests for reports has implications on capacity for all staff groups, including the Safeguarding Children Teams. The recent audit of Trust Court report process evidenced the significant impact on resources of the court duties but also showed that the reports completed are robust and provide a high quality of professional analysis which supports a low-level requirement for Trust staff to attend Family Court proceedings.

For TSDFT, all court requests and release of health records are managed with the support of the Data Access Team to ensure oversight of all information sharing and medical record release for court purposes. This ensures monitoring of a high standard and consistent process for all children and families.
CFHD Safeguarding Team continue to support all staff, both DPT and TSDFT, to complete information sharing into court, and court attendances, with oversight by DPT legal team for CAMHS requests. The process and oversight are due to be formalised within the pending Memorandum of understanding.

5.6.5 Child Death Statutory Duties

Under statutory guidelines, issued October 2018, all child deaths, both expected and unexpected, are reviewed in the location/hospital of death, if out of area (OOA) reports would be shared with the Child Death Overview Panel (CDOP) of child's home address.

These reviews are currently supported by two staff within the Trust; the Named Doctor for Child Death review and the Child Death Review Coordinator. The Named Doctor role is provided by a Paediatric Consultant with dedicated time to the role. The Child Death Review Coordinator admin role has been reviewed in service restructure in 2021 and is now provided as a stand-alone role over 18.5hrs per week, with flexible working. This enables review meetings and training to be managed and adapted to service demand.

Reviews can be in the form of an Early Response meeting (ERM), Child Death Review Meeting (CDRM) chaired by the Named Doctor for Child Death, hospital-based mortality meeting (one meeting held at this time, due to covid), perinatal mortality review (held last Thursday in month), serious adverse event (SAE) or other

investigatory bodies including Healthcare Safety Investigations Branch (HSIB). Depending on the nature of treatment interventions that are in place prior to the death of a child, they may be transferred for specialist care to tertiary centres, such as Bristol Children's Hospital or Derriford Hospital in Plymouth or to a local Children's Hospice. This would result in the review meetings taking place in the location / hospital where the death occurs. The local practitioners and Child Death review practitioners would still be involved but the information would be shared to CDOP via the other location / hospital.

Figures for child death review process managed by Child Death Review Coordinator / Named Doctor for Child Death for TSDFT for 2022-2023 are as below:

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	2 x c/o from 2021 1 x held OOA c/o from 2021
Expected	3	4	3	2	2	3 x held 00A 1

Torbay figures are below National average for 2022/23.

5.6.5.1 National Child Mortality Database

The National Child Mortality Database (NCMD) was launched 1 April 2019. The purpose of collating information nationally is to ensure that deaths are learned from, learning is shared and actions are taken, locally and nationally, to reduce number of children who die. In May 2021, holding two years of data for child deaths, NCMD were able to begin reporting on key issues and trends in child mortality through thematic reports and webinars; generating significant national interest from clinicians, professionals and the public.

"Suicide in Children and Young People" report published October 2021 drew on data to identify characteristics of children and young people who died by suicide,

investigate factors associated with these deaths and identify common themes. Key findings included that services should be aware that child suicide is not limited to certain groups, that 62% of deaths reviewed the young person had suffered significant personal loss in their life, both bereavement and "living losses", over one third had never been in contact with mental health services and also one quarter had experienced bullying, either face to face or online.

Recommendations from report relevant to TSDFT resulted in the provision of suicide awareness and prevention training which was provided by "Pete's Dragons" bereavement charity staff.
Audit return in regards to each NCMD report is shared to the Trust and identified service improvements for 2023 to the Child Death review process include reporting and monitoring of the audit and any actions or learning via Child Health governance (Child Health Senate), Safeguarding Children Operational Group and CFHD Safeguarding governance meetings accordingly.

5.6.5.2 Child Death training and Mortality/Morbidity meeting

Following the death of two young people in 2021, the Trust was provided 6-months free "5-steps to suicide awareness" training funded from the donation of a bereaved family. This training was provided by a local charity "Pete's Dragons". The one and half hour sessions, maximum 30 attendees, started May 2022 and unfortunately due to the ongoing COVID pandemic some sessions had to be rearranged, so the last session was held April 2023. The sessions were well attended by Trust staff from a variety of services, with positive feedback and resulted in increased staff accessing further mental health awareness training, including access to 'We can Talk' programme.

At the end of March 2022, Torbay & South Devon NHS Foundation Trust held their inaugural Child Health Mortality/Morbidity Meeting. Initially, there was a Child Death training session with multiagency representation from Police, Coroner's Officers, Mortuary, Consultant Paediatricians, Paediatric Registrars, nursing staff from children's ward and Emergency Department. The session facilitated a peer review presented by Police of challenging historic events, sharing the learning and enabling staff to be aware of some of the complexities faced, to increase staff knowledge should they be faced with similar issues in the future. This training was delivered both face to face and via Microsoft Teams.

The Child Death Review Coordinator attends bi annual meetings with other counterparts across the South West Peninsula to review processes and policies, share good practice and access learning via guest speakers, such as local Medical examiners and Coroners Officers. The Review Coordinator and Named Doctor also attend the National Conference of Child Death review professionals to share national networking information, knowledge, learning and skills.

5.6.5.3 Learning points for TSDFT identified at Early Response and Child Death Review meetings 2022/2023

- Safe sleep considerations to be considered by all professionals but especially in Emergency rehousing situations.
- Public Health Service to clarify parents understanding of safe sleeping practice and to make enquiries as to sleeping arrangements of infants at contacts.

- Improve communication – Paediatric Consultants to establish contact with Joint Agency Response Nurse prior to providing post mortem outcomes to family, to enable responsive support.
- Improve communication – ensure Primary Care professionals are updated during treatment of patient to support their key role in supporting wider family and local community.
- Establishing communication strategies when multiple teams involved in a child's care are important to ensure families support needs are met but they do not feel overwhelmed
- Improve communication – oversight of ERM / CDRM actions by SCOG / Child Health Senate governance meeting to prevent delays in actions or investigations and to create shared responsibilities in disseminating learning.

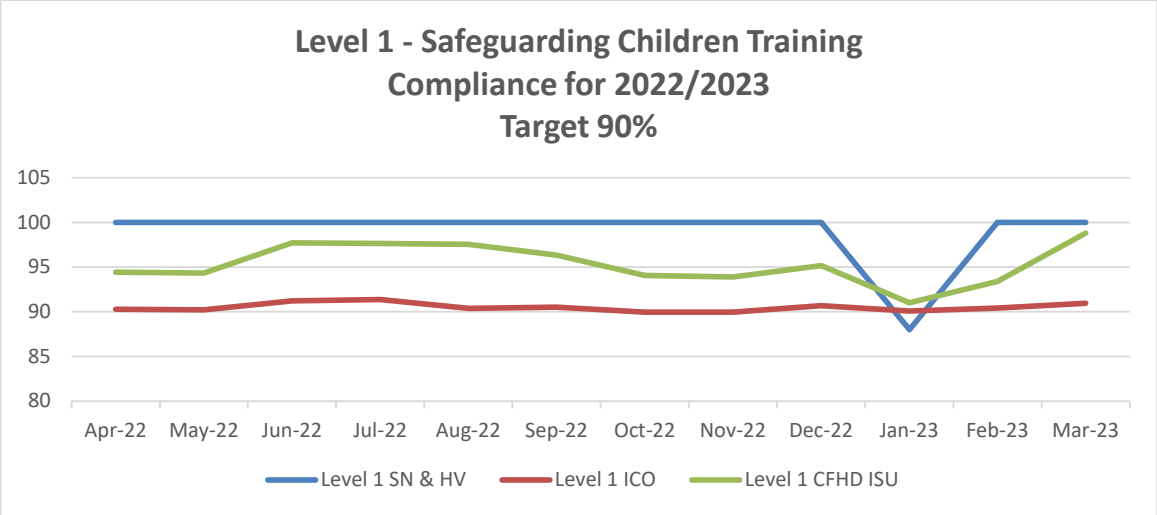
5.6.6 TSDFT Mandatory Safeguarding Children training

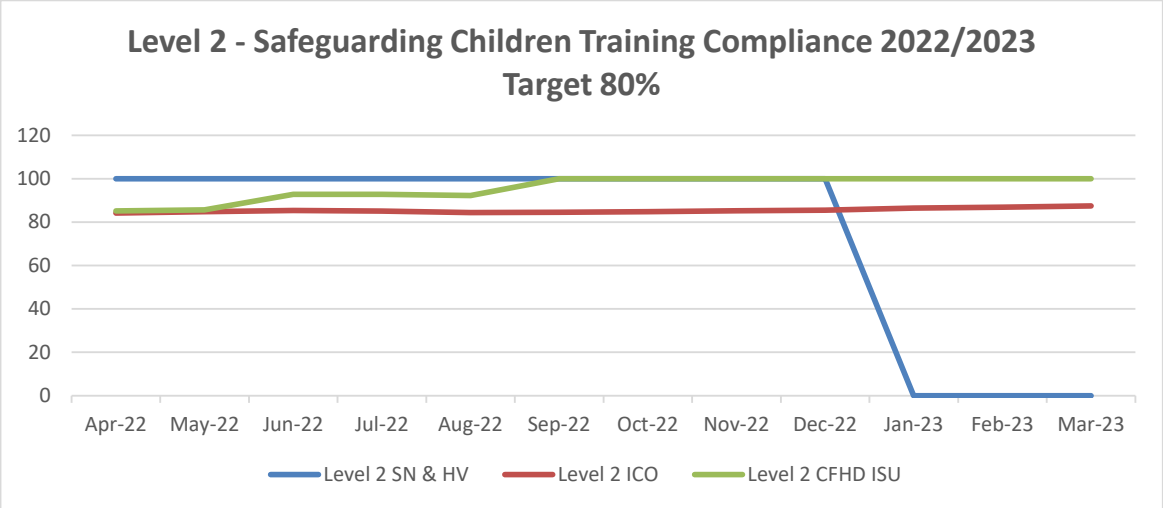
Safeguarding Children training compliance is measured and monitored on a monthly basis. The data is reported to the TSDFT Safeguarding Children Operational Group (SCOG) and CFHD Safeguarding Operational Board for oversight. For monitoring purposes, the responsibility is initially held by the individual staff member; highlighted by email and on their individual training record on HIVE. The compliance data is also emailed on a monthly basis to the Line Managers / Service Lead. Trust Training compliance is monitored via the Trust mandatory training group, which is attended by the Named Nurse.

The training levels are set by the Named Nurses for Safeguarding Children in direct consultation and reference to the Intercollegiate document guidance (updated 2019) and is agreed by the Trust training lead and the Chief Nurse on an annual basis on submission of the training needs analysis.

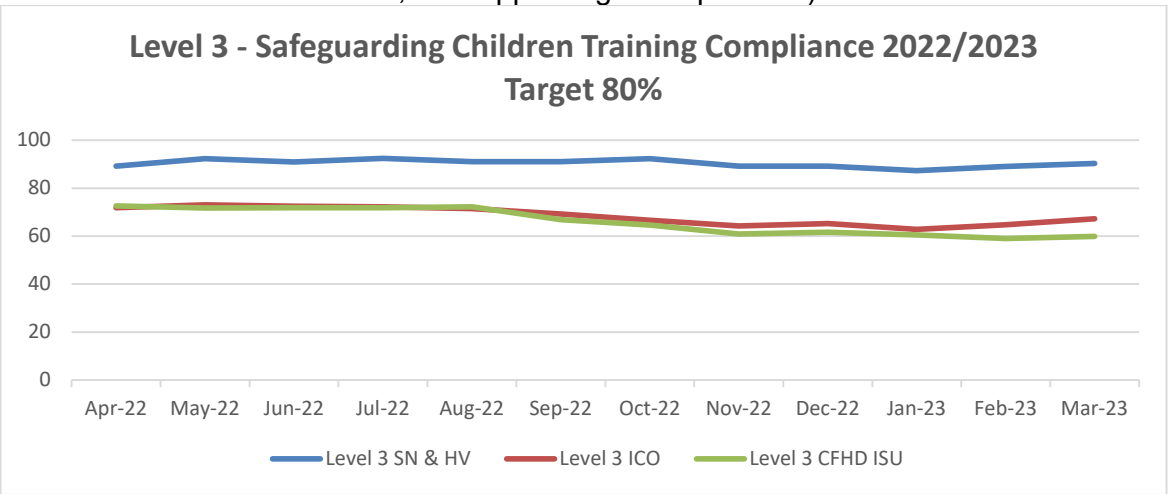
To support key performance indicator monitoring for all aspects of TSDFT service provision, the compliance data has been reported for the Integrated Care Organisation (ICO) compliance, the 0-19 Torbay service (Torbay Public Health Nurses – Health Visitors / School Nurses) and Child and Family Health Devon is also split for reporting to the alliance governance and performance purposes. This has been recently been updated following clarification of the CFHD structure and agreement of the memorandum of understanding between DPT and TSDFT.

Compliance levels are aligned to the current ICS standards of:
Level 1 - 90%
Level 2 - 80%
Level 3 - 80%





(Due to review of training levels in Dec 2022, all staff in 0to19 Torbay service are allocated to Level 1 or Level 3, thus appearing to drop to 0%.)



Compliance for Mandatory training has been significantly impacted due to the pandemic working arrangements and continuing demands on service capacity. This has led to extreme pressure of staff to prioritise the support of clinical patient care. The staff availability for completing Level 1 and 2 was challenged by the

redeployment, altered working practices and Trust acute escalation status levels. The Trust Mandatory training group has identified training strategies for each subject matter and continues to support considerations for compliance improvement opportunities. For both CFHD and TSDFT there was a plan to complete a deep dive into the falling compliance and to understand the barriers faced by practitioners. We have seen gradual improvements as we move through the year and continue to improve along proposed trajectories.

For staff working with children who live within Torbay local authority service arrangements, the Level 3 course is commissioned via the Torbay Safeguarding Children Partnership (TSCP). The course has been delivered face to face with multiagency attendance.

For staff working with children who live within Devon local authority arrangements, the Level 3 course is commissioned via the Devon Children and Families Partnership (DCFP). The course is currently delivered online and is a combination of face to face and online modules.

The DCFP and TSCP have launched additional supporting training provision, following recommendations from local CSPR's, and these are accessed by a hybrid model of online modules, webinars and face to face sessions. Additional training arrangements are highlighted to staff via ICON staff newsletters, Team Leads and by utilising the Safeguarding supervisor networks at update meetings, Champions meetings and Group supervision sessions.

Achievements for 2022-2023

- Leading in the DCFP thematic review programme, dissemination of learning through the champions system and incorporating into advice and supervision.
- Safe transfer of Devon County Council Public Health Nursing services to their in-house safeguarding team.
- Active participation in the Ofsted Devon MASH improvement plan
- Support joint review of working practice within Devon MASH to implement change in line with new management strategies.
- Appointment of CFHD Deputy Director for Nursing with a safeguarding portfolio.
- Improvements in recording Safeguarding supervision to staff by the Safeguarding Children's Teams – both in ad-hoc/duty calls and formal one to one or group sessions.
- Revision of TSDFT safeguarding supervision offer and improvements in face-to-face support to operational staff, resulting in positive feedback from staff and positive outcomes for families.
- Completion of local CSPR action / recommendations resulting in no current actions for TSDFT / CFHD.
- Named Doctor initiated multiagency group working with Local Authority Service Leads to improve shared operational processes, resulting in more efficient processes and clarification of process and expected timescales for parents and families.
- TSDFT and CFHD Safeguarding Children's Teams support to improved practice standards in Torbay and Devon MASH respectively; through attendance to Operational and Strategic meetings.

- Trust staff understanding of importance of safeguarding supervision and compliance in accordance with policy has improved and will be reported via SCOG dashboard for Trust oversight.
- Torbay 0 to 19 Public Health Nursing service arrangements flexibility in delivery of care to children / young people and families – evidenced by positive feedback from families and achieving positive outcomes evidenced in safeguarding audit.
- Participation of TSDFT / CFHD Safeguarding Children Team members at TSCP / DCFP group meetings to ensure health partner considerations are made in multiagency strategic planning.
- Joint working between Paediatric Team and CAMHS service in supporting young people exhibiting challenging behaviour on Louisa Cary Ward – presentation to Executive Complex Case panel to support evidencing the child's experiences.
- All policies updated and reviewed to current legislation and to include consideration of staff cohort processes for TSDFT and CFHD.
- Highlight on young people's mental health with Paediatric Consultant identified as Mental Health Lead and staff engagement in accessing "We can Talk" mental health online resources – positive impact on practice changes and young people's outcomes when accessing Paediatric care on Louisa Cary Ward.
- Discharge planning meeting process embedded following action resulting from previous CSPR – resulting in support to safeguarding referrals via Early Help and MASH, active support for parents undergoing financial hardship with food parcels and positive outcomes for safe care for children and families.
- Support from Paediatric Matron and staff on Special Care Baby Unit to achieve improvements in staff compliance with mandatory training; now 100% and embedding safeguarding supervision into routine practice.

Challenges for 2022-2023

- Mandatory Safeguarding Children Training compliance – in particular Level 3 due to accessibility and provision restrictions, significantly impacted by continuing Opel 4 service pressures.
- Arrangements to support CFHD Safeguarding Team with requests for court reports, witness statements, legal contacts require further clarity in TSD / DPT organisational structure.
- Staff capacity for both CFHD and TSDFT Safeguarding Children's Teams to provide support to MASH services which are subject to increasing operational pressures as a result of changing legislation and Ofsted recommendations may require further consideration from Devon ICS.
- Proposed changes to processes within Devon MASH requiring training and support for all health staff.
- Impact of consultation processes across CFHD and wider Devon ICB on stability of services and staff recruitment and retention.
- Gaps in wider partnership service provision causing impact on children / young people's health and wellbeing support, placing additional pressures on TSDFT services / waiting lists.
- Torbay 0to19 service capacity to provide mandated contacts – work in progress with commissioners to consider revision to service planning.

- Torbay 0to19 service capacity to sustain support for significant rise in safeguarding activity and resulting legal action in Family Court requiring court report and record provision by TSDFT staff.
- Covid pandemic life experiences continue to impact on young people's anxiety and mental health challenges causing significant impact on CAMHS service and Trust acute services (e.g. Paediatric Emergency Department / Louisa Cary Ward)
- Challenges to completing statutory health reviews for Children in Care – both initial and review health assessments – multiagency work being undertaken to resolve service challenges and barriers.
- Trust IT support in Trust processes to enable internal monitoring and quality assurance of Safeguarding Children data.
- Embedding of practice in accordance with Bruising and Injuries in non-mobile children policy and process has not been consistent and this has resulted in complexities arising for patient care – managed via incident reporting ad additional supervision and training for relevant teams.
- Impact of additional pressures on CIC service due to statutory health assessments and support for Unaccompanied Asylum-Seeking Children.
- Incident report highlighting safeguarding practice issues and poor compliance for mandatory training and supervision for staff on Special Care Baby Unit – action plan supported by Safeguarding Team and Paediatric Matron achieved 100% compliance with staff Level 3 training and safeguarding supervision within 3-month period.

6. Conclusion

Learning from Child Safeguarding Practice reviews and the recommendations from the national review of Child protection in England in response to the murders of Arthur Labinjo-Hughes and Star Hobson is of importance for all partner agencies involved in the care and protection of children and young people. TSDFT have ensured that the continued prioritisation of safeguarding children has supported staff to continue to provide timely, appropriate and proportionate interventions and support for children, young people and families throughout the last year. This has been evidenced in the sustained levels of activity supported by the Safeguarding Children Teams. As a result, across the Trust, in all areas of child facing care, the Safeguarding Children Teams have supported and advised teams having to adapt services and find ways to support children's safety in the altered service provision post COVID. The impact of this has been felt most strongly in maternity, child health, Torbay 0 to 19 service, the Emergency Department and Child and Family Health Devon services.

Research and monitoring of local data have shown continued and sustained significant increases in domestic abuse reports, increasing presentations of parents and young people in mental health crisis or exhibiting emotional dysregulation, families suffering financial crisis contributing to neglect of children's basic needs and multiagency challenges in ability to engage in meaningful, consistent direct contact with children, young people and their families. Support and safety planning for children and young people has been managed in the context of service redevelopment where identified and required and as service provision alters there has been important liaison nationally between Named Professionals to ensure safe practice and that organisational statutory responsibilities are met.

The challenge to support capacity requirements towards the Trust safeguarding children practice has continued to increase during 2021/2022. The services changes and subsequent IT system challenges to TSDFT ability to monitor and quality assure completed safeguarding activities have been highlighted by local Safeguarding Partnership review. There is work in progress across the services to consider this issue and the need for service redevelopment and future planning.

7. Recommendations

The Board to receive the annual report and recognise the scope of work undertaken across the organisation that aligns to our statutory responsibilities and accountabilities to safeguard children and young people which is achieved through robust system, processes and partnership working.

Board to recognise the achievements and support the increasing operational service provision of the TSDFT and CFHD Safeguarding Children Teams, with consideration of future planning, to support the team in provision of the statutory requirements for Torbay and South Devon Foundation Trust.

Board to recognise the challenges of the current Trust IT systems in supporting the management of safeguarding information by the Safeguarding team, including monitoring/quality assurance for submission of safeguarding children referrals and other data, across the wider Trust.

Board to recognise the emerging complexities of the support needs for our children, young people and their families and the impact of service capacity issues / operational demand on the safety planning and safeguarding considerations for our patients.

Board to recognise and support Trust activity, to improve staff compliance mandatory multiagency safeguarding children training, in accordance with Intercollegiate document guidance.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Infection Prevention and Control Annual Report 2022-23			Meeting date: 27 September 2023
Report appendix	No Appendices		
Report sponsor	Director of Infection Prevention and Control		
Report author	Director of Infection Prevention and Control		
Report provenance	Report approved through Infection Prevention and Control Group on 29 6 2023 Presenting at Quality Assurance Committee prior to Board		
Purpose of the report and key issues for consideration/decision	This Infection Prevention and Control (IPC) Annual Report seeks: • To inform the Board and Quality Assurance Committee of the achievements in 2022-23 and identify the forthcoming challenges in this area for 2023-24 • To demonstrate compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board is asked to approve the Annual Infection Prevention Control 2022/23.		
Summary of key elements			
Strategic goals supported by this report	**Excellent population health and wellbeing**		**Excellent experience receiving and providing care** x **Excellent value and sustainability**
Is this on the Trust's Board Assurance Framework and/or Risk Register	**Board Assurance Framework** x **Risk score** 16 **Risk Register** **Risk score** BAF Ref No. 1 – Quality and Patient Experience		

External standards affected by this report and associated risks	

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

Report title: Infection Prevention and Control Annual Report 2022-23		**Meeting date:** 27 September 2023
Report sponsor	Director of Infection Prevention and Control	
Report author	Director of Infection Prevention and Control	

Introduction and Background

This Infection Prevention and Control (IPC) Annual Report seeks:

- To inform the Board and Quality Assurance Committee of the achievements in 2022-23 and identify the forthcoming challenges in this area for 2023-24
- To demonstrate compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance

The purpose of this paper is to inform the Board of how the Trust's infection prevention and control team (IPCT) has engaged in the prevention and control of health care associated infections (HCAI) during the period of April 2022 to March 2023. The 2022-23 IPC Annual Report seeks to provide assurance to the Board on our progress against the ten criteria of the Health and Social Care Act 2008: code of practice on the prevention and control of infections This code of practice document (also referred to as the Hygiene Code) has been updated (December 2022) to take account of changes to the IPC landscape and nomenclature that have occurred since the COVID-19 pandemic.

During 2022-23 the IPC Board Assurance Framework (BAF) was updated by NHS England in September and again November (version 1.8). The BAF further supports health care providers to include learning from the pandemic in effective IPC measures and effectively self-assess compliance against national standards. It was set out using the code of practice framework referenced above and therefore this annual report also provides assurance of compliance with this framework.

Conclusion

The report also sets out our priorities and plans to achieve further improvement and reductions in infection during 2023-24 as we continue to manage and move beyond the challenges of the COVID-19 pandemic.

Recommendations

The Board is asked to approve the Annual Infection Prevention Control 2022/23 Annual Report.

Annual Report 2022-23

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

Torbay and South Devon NHS Foundation Trust Board
Ratified through the Infection Prevention and Control Group 29 06 2023 and Quality Assurance Committee 24 06 2023

		Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	24
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Executive summary:

Criterion 1: Systems to manage and monitor the prevention and control of infection.

• Leadership and governance arrangements are in place in line with the Hygiene Code
• A multi-disciplinary Infection Prevention and Control Team is in place to provide the services required for IPC measures to be in place
• We met our annual infection reduction target for Gram negative bacteraemia. However, we had a never event with an MRSA bacteraemia (hospital acquired) and were over trajectory for *Clostridioides difficile* by four cases (50 cases with trajectory of 46).
• A range of actions were taken during the year to identify and implement key improvements needed so that we can achieve the infection reductions needed.

Criterion 2: Provide and maintain a clean and appropriate environment in managed
premises that facilitates the prevention and control of infections.

• Our cleaning standards are well maintained with national recognition in the PLACE audits for being in the top five NHS England trusts for cleanliness.
• New cleaning standards introduced in 2021 are embedded in practice
• Ventilation monitoring is carried out according to industry standards with ventilation group meeting quarterly
• Water monitoring is carried out with on going maintenance as required.
• Decontamination equipment risks are understood with replacement plan for equipment to be actioned in 2023.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and
to reduce the risk of adverse events and antimicrobial resistance.

• The work of the Antimicrobial Stewardship Group (ASG) has resulted in a greater understanding of the issues and actions needed to improve antimicrobial stewardship.
• We are improving prescribing of antimicrobial agents with further work to do in order to decrease frequency of alert organism infections and antimicrobial resistance. TSD remains with low though increased antimicrobial resistant organisms in 2022-23
• There are 2 WTE vacancies in the consultant microbiology workforce; this is recognised as a fragile service within work underway to find pan Devon/ Peninsula solutions

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and person concerned with providing further support or nursing/medical care in a timely fashion.

• Our internet contains key information for our patients and visitors, and we have used social media to share key messages to the public, especially during the pandemic and times of other outbreaks e.g. Norovirus.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

• Assessment tools for infection risks are in use for patients on admission and throughout the in-patient stay. This includes diarrhoea and vomiting as well as COVID-19 infection.

• Our Infection Prevention and Control Team provide a service to advise and support clinical staff on all infection-related queries. During the year the service has provided a full weekday service (Mon-Friday 08.30- 17.00) with consultant microbiologist on-call for out of hours support service out-of-hours. This has been an essential part of our response to the pandemic.
• Point of care testing for COVID 19 has been introduced as the new standard for COVID-19 testing with PCR testing stood down by NHSE (available through specific request only now).
• A range of non-COVID-19 outbreaks and infection-related incidents have been effectively dealt with in 2022-23.

Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infections.
• Statutory and mandatory training and Trust induction continue to include infection prevention and control as core requirements. This rose in clinical areas from 83% in 2021-22 to 89% in 2022-23 (standard is 90% or above)
• At the end of 2021-22 mandatory level 1 training (non-clinical staff) achieved 91.34% compliance meeting the Trust requirement. Level 2 training (clinical staff) was just below the 97.87% standard.
• A very significant amount of ward-based training, electronic resources and posters have been put into place to support staff knowledge and awareness of IPC measures particularly during the pandemic.
• Staff continued to wear masks during work and on site for much of 2022-23. This has been stood down since Spring 2023 along with other pandemic requirements such as social distancing.

Criterion 7: Provide or secure adequate isolation facilities.
• The Trust has 67 single rooms available to support isolation requirements. This is a risk for the organisation and we have to have a robust risk approach to the management of patients with infections that require isolation.
• Trust policy includes use of cohort facilities to nurse patients with the same infections when numbers exceed the number of single rooms.
• This cohort model has been used extensively during the pandemic, with wards progressively being turned into COVID-19 wards as the third wave built up and patient numbers increased. We put into place a robust cleaning process to ensure that all wards were deep-cleaned once they were no longer needed for the care of COVID-19 patients.
• Throughout the year we have amended our processes in response to the changing national guidance for the management of COVID-19 infection.
• We reviewed the distance between beds in our wards to ensure they were supporting 2 metres social distancing. As an additional measure we have installed some fixed partitions between beds in some areas, and use of clear plastic curtains in all other bays, however these caused additional risk and were removed.

Criterion 8: Secure adequate access to laboratory support.
• We had an onsite microbiology laboratory which is accredited by UKAS,
This service is UKAS accredited confirming it operates an effective
and quality controlled service.
• The laboratory links with regional and national laboratory networks as required to provide a full range of microbiology testing.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

• We have continued to progress the review of our non-COVID-19 polices in 2021-22, though the pandemic has resulted in the review programme being slowed due to the need to focus on COVID-19 policies and procedures.
• Throughout the year we have implemented a wide range of policies and procedures to manage COVID-19, in line with national guidance.
• Participation in hand hygiene audit has been affected the pandemic, however hand hygiene practice compliance has remained high and has met our target of 98%.

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

• Our Occupational Health Service along with Human Resources Team (supports the health and wellbeing of our staff
• A health monitoring and vaccination programme is in place, including COVID-19 vaccination programme
• In 2022-22 we nearly met our staff influenza vaccination target, achieving 67% (70% target)
• During the pandemic the Occupational Health Service and our Human Resources Team
have provided a significant amount of support to staff, including counselling and psychological support. There continues to be a focus on staff health and wellbeing.

Statement of Compliance

Following self-assessment against the criteria in Health and Social Care Act (2008): code of practice on the prevention and control of infections and related guidance (2015), the Trust is able to declare near full compliance for the year 2022-23. The Trust reported an MRSA bacteraemia in the reporting year and Clostridioides difficile hospital-associated cases were 50 against a nationally set trajectory of 46 cases. Continuous improvements for infection prevention and control are set out in the plan for 2023-24.

Criterion 1: Systems to manage and monitor the prevention and control of infection

Leadership Arrangements for IPC

The Trust Board remains committed to the prevention of infection as a priority ensuring detailed scrutiny by the Quality Assurance Committee on behalf of the Board. The Director of Infection Prevention and Control (Dr Joanne Watson) is the Board Member with IPC responsibility to meet the requirements of the Hygiene Code. Torbay and South Devon has a multi-disciplinary IPC team led by the DIPC with a dedicated lead nurse in the IPCT. The team has allocated resources available to support their work with an internal schedule of meetings (daily/ weekly/ monthly) to respond agilely. The ongoing dedication of the team to support the organisational response to COVID-19 and other infections is recognised as the challenges have been significant throughout the pandemic which the team have responded to effectively as demonstrated by results and outcomes.

The Trust's clinical microbiologists support the team in all aspects of IPC including outbreak management, surveillance for and management of HCAIs and policy development. In the report period the Deputy DIPC role has been with Dr Selina Hoque who has diligently applied her expertise to skilfully manage risk around HCAIs. Dr Hoque is also the lead infection control doctor. It is to be noted that the Trust continues to run with vacancies for consultant microbiologists; two WTE posts are vacant in the face of national consultant microbiologist shortages. The fragility this results in for the service is recognised with support being sort through collaborative work across Devon, led by the Trust's Chief Medical Officer. The Trust has an antimicrobial pharmacist who works alongside the consultant microbiologists and clinical teams to support improved use of antibiotics as a key part of antimicrobial stewardship. The Trust's clinical microbiology laboratories offer high quality services and are run as part of the Trust's core services serving primary and secondary health care.

The responsibility of all staff to ensure they adhere to expected standards of IPC practice is set out in Trust job descriptions and is reinforced on a weekly basis via a range of communications.

IPC Structure Governance and Assurance

The DIPC reports to the Chief Executive and to the Board on all matters relating to infection prevention and control against HCAIs.

Infection Prevention and Control Group

The Trust's IPC Group is chaired by the DIPC and meets quarterly. It has established terms of reference and cycle of business as per the statutory code of practice. The Group members are from across the Trust with community and hospital teams represented. Senior Nurses and AHPs attend with representatives from Estates,

Facilities, Pharmacy and Decontamination Services. Relevant reports are received from the Trust's Integrated Service Units on compliance with key-performance indicators and learning from post infection reviews, outbreaks and audit results. The IPC team provide a report on the current Trust performance against national targets and on appropriate action plans.

The minutes of the meeting are submitted to the Quality Assurance Committee.

IPC Team meetings

The Trust has a dedicated IPC team which works across the Torbay and South Devon footprint working in the community, including care homes and primary care and the hospital sites. There are Memoranda of Understanding to provide IPC services with Rowcroft Hospice and Children and Family Health Devon. The IPC team meet with the Lead Nurse daily for the discussion of new clinical cases / situations and meet formally once a week at the IPC Issues meeting to review current work and situations. This is an open meeting for colleagues across the Trust to attend with their IPC 'issues'. Key services such as Estates and Facilities report to IPC weekly / monthly as well as to the IPC Group. Through this governance framework, issues are identified and worked upon both proactively and reactively, coordinating actions between multiple parties to reduce infections and improve standard. The reporting framework ensures oversight and insights into variations in practice, with a focus on hotspots requiring targeted action.

Infection Performance against standard reporting of HCAIs

In order to demonstrate continuous improvement with HCAIs, national targets, also called trajectories are set annually for the major HCAIs which are:

- MRSA (MSSA not reportable but good practice to record these, thus data given here)
- C difficile
- Gram negative bacteraemia

The Trust HCAI objective for MRSA, Clostridioides difficile infection (CDI) and Gram-negative bloodstream infections (GNBSI) are determined nationally and usually received from NHSE at the start of the reporting year.

Meticillin- Resistant Staphylococcus aureus (MRSA) bacteraemia – target = 0
We had 1 Trust attributable MRSA bacteraemia in 2022-23.

MRSA bacteraemia surveillance has been undertaken since 2001 by all NHSE Trusts. Nationally and as a Trust there is a zero-tolerance approach to avoidable MRSA bacteraemias.

The one MRSA bacteraemia case was in a person who had been in hospital with chronic respiratory illness and known MRSA colonisation. The person was discharged but quickly readmitted. At this point the MRSA bacteraemia was diagnosed. Learning from this event is that decolonisation needs to be followed up closely. Less MRSA screening is performed now as per national guidance but important to monitor known cases which is the IPCT's standard practice.

To update on an issue identified in 2020-21 with respect to MRSA bacteraemia, the vascular access team have had dedicated space for the insertion of cannulae since 2021 and a permanent place had been identified on level 2 in the MRU (West) space this year. It was recognised that appropriate space is required for these procedures to support IPC measures.

Methicillin- Sensitive Staphylococcus aureus (MSSA) bacteraemia
We had 13 cases of MSSA bacteraemia in 2023 which developed after 48 hours of admission.
Whilst reported there is not national target in MSSA bacteraemia.

This is a steady-state result for TSD. We have looked to improve the incidence through changing the devices for introduction of cannula. Results of this change will be monitored in the year 2023-24. Ongoing care of line management is important and this is addressed through monthly audits on compliance against use of peripheral cannulae with feedback given on performance for improvement. It is an area highlighted in the IPC plan 2023-24 as continuous improvement on performance is a key quality target in the Trust Strategy.

Clostridioides difficile Infection (CDI)
National target was not to exceed 46 cases in 2022-23
TOTAL CDI in Trust 2022-23 = 50

Hospital onset healthcare associated (HOHA): cases that are detected in the hospital > 48 hours after admission = 33 cases
After Action Reviews (AARs) are carried out on all *C. difficile* HOHA.

Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks = 17 cases
N.B. Cases reported to Devon ICS are those which have demonstrated a positive PCR test for a toxigenic strain of *C. difficile* and the toxin is also identified.

We exceeded our trajectory by 4 cases for the year, as aiming to have 46 or less cases to improve on the previous year's performance. This is a similar picture to all acute providers in the SW. Although the reasons for this have been considered at a regional level it has not been identified that there are specific, additional precautions to take around IPC save for immediate isolation of persons with diarrhoea to reduce risk of spread. High levels of escalation in OPEL status throughout much of 2022-23 have repeatedly made isolation more difficult such that the hierarchy of controls around IPC and general patient care are considered routinely.

There has been evidence of transmission within the hospital setting as an outbreak on McCullum ward (two patients) showed the same strain of *C. difficile*; these two cases were identified within 2 days of each other. McCullum ward has been opened as part of the escalation plan). This clinical area is used as a lower risk medical ward where the emphasis is on rehabilitation or waiting for a care-package at home. Nursing staff were drawn together from a pool of nurses and allied health care professionals across the Trust. Medical input is with locum post holders as the medical work force has significant gaps. It has been established through specific case reviews that delays in isolation of patients with diarrhoea and obtaining samples are common themes in learning from post infection reviews. It is also recognised that had specimens been collected earlier, when the first loose stool was noted, then assignment as a community case may have been correctly made.

Pressure on side room availability is the principle reason for delay in isolation. Decisions about priority of side room use must be made in liaison with ward staff and the bed

management team. When planning new buildings and refurbishment, IPC factors are considered with single facilities being the new norm. This is seen within the new acute medicine unit which opened in December 2022; all single cubicles / rooms.

Our results for CDI are in line with other acute providers of care in the SW. TSD has a higher percentage of community hospital beds with an elderly population which leads to a relatively higher rate of *C. difficile* infection rates than other local providers. This is well established in the data. The focus is on decreasing this infection and preventing internal transmission. Low numbers of side- rooms is a contributory factor, particularly for outbreaks. Better care is supported with assurance around stool culture being sent off and early start of treatment. These points are contained within the guidance for managing a patient with diarrhoea.

Furthermore in 2022-23 we reported that a person had died from *C. difficile* infection. This person was in McCullum ward and part of the outbreak referenced above. This demonstrates the importance of IPC for HCAIs and the consequences for vulnerable people in hospital. Death is an uncommon occurrence and reviews are important to identify whether more treatment may have delivered a better outcome. It has been agreed that the underlying frailty of the person was a major contributory factor in this death.

Given the prolonged and intense periods of bed escalation from demand and increased length of stay, CDI is more likely especially in outbreak form. This is the first time an outbreak for CDI has been recorded since at least 2019-20.

Gram Negative Bacteraemia (GNB)

Escherichia coli (*E. Coli*) **total target to be at or beneath= 62**
HOHA infections 29
COHA infections 27 total for Trust 2022-23= 56,
Klebsiella (all species) **total target to be at or beneath = 16**
HOHA infections 8
COHA infections 2 total for Trust 2022-23= 10
Pseudomonas aeroginosa **total target to be at or beneath = 3**
HOHA infections 1
COHA infections 6 total for Trust 2022-23= 7

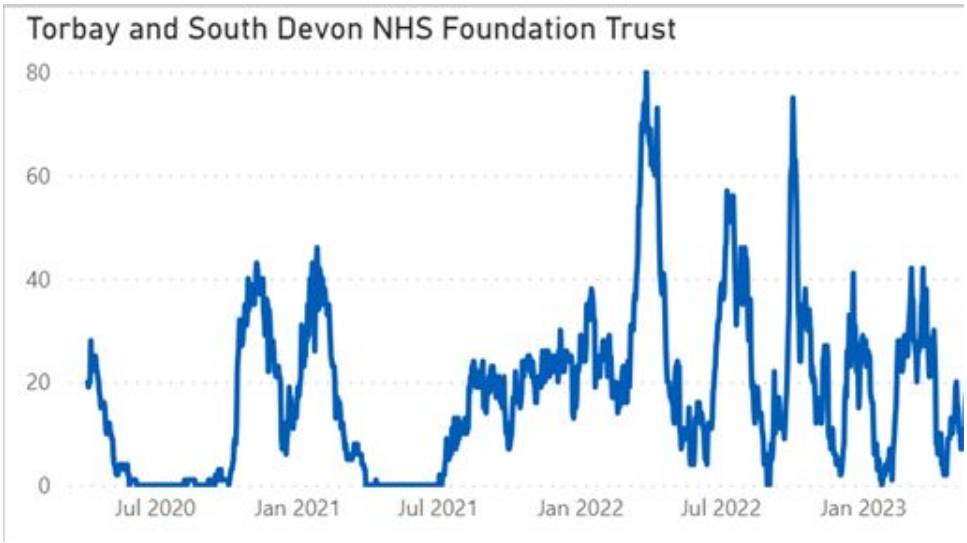
There is a national ambition for NHSE acute service providers to reduce the healthcare - attributable GNB by 50% by 2023/24: this remains in place. For the purpose of this ambitious goal GNB are defined as three organisms: *Escherichia coli* (*E. Coli*), *Klebsiella* (all species) and *Pseudomonas aeroginosa* as these constitute a majority of reported GNB. Of these three, *E.coli* are by far the most numerous.

Since 2018, PHE, and now UKHSA, assigned these infections to community or to a provider organisation based on whether the positive culture was indentifed within 48 hours of admission. Overall there have been fewer reportable GNB infections in 2022-23 after a large increase last year compared to 2020-21. For the second year running the Trust performance was within national target setting overall (total) and for two out of three bacteria of interest. Hydration in hospital settings is important as there is a

correlation with incidence of GNB in hospital in Q2, the summer months when wards can get hot due to no mechanical ventilation and old estate.

COVID-19 in 2022-23

The pandemic continued throughout the reporting year 2022-23. The growing focus was from response to recovery as the pandemic progressed. In the current reporting year (2022-23), the WHO stood down COVID-19 as a *public health emergency of international concern*, on 5 May 2023. The graph below shows the number of beds occupied with COVID-19 during the three years of the pandemic. Omicron has been the dominant variant since first emerging in November 2021. It is more infectious but less virulent than previous dominant variants. Vaccination remains highly effective.



NHSE guidance in March and April 2022 changed screening for COVID-19 on admission to hospital to LFD testing with step down on a number of other COVID-19 precautions such as spacing. TSD followed the national guidance except for two areas which were the continued use of PCR testing on admission and isolation of contacts for five days due to high infectivity of the COVID-19 variant in circulation (Omicron). These decisions were made through the Clinical Management Group and supported by the Board. They were in response to this being new territory for the management of COVID and a more conservative approach advocated from TSD microbiologists.

These decisions led to a higher detection of COVID-19 in TSD with impacts on patient flow becoming more evident over winter. Whilst impact of COVID-19 in terms of severity of outcomes (for example respiratory support, death, long COVID) declined significantly, potential for harm remains including death for the vulenerable including non-vaccinated/ non-immune. Thus tactics for IPC processes balanced with hospital flow management need continual monitoring and adjustments.

HCAI from COVID-19 were unavoidable even with the multiple and continued IPC measures in place. This fact has been experienced nationally and internationally. In terms of HCAI, 73 outbreaks were recorded in 2022-23; an outbreak is 2 or more cases of COVID-19 (infection) in the same time frame with no alternative explanation as to acquiring the disease. These were reportable to NHSE. In the reporting year there were a total of 96 deaths with COVID-19 on the death certificate. Of these 7.3% (7 deaths) were from COVID-19 as an HCAI; below national average which is reported at ~10%.

The total of 24 deaths from COVID-19 HCAIs are to be included as part a report in progress to understand the impact of COVID-19 HCAIs.

In February 2023, TSD aligned COVID-19 inpatient outbreak measures with the national guidance from March 2022, these were less stringent than TSD has been practising to decrease the spread of COVID-19. This was in response to the extreme pressures from patient flow as exemplifed by ambulance waits with evidence of increased harm. TSD will continue to develop IPC responses to COVID-19. Subsequent to the reporting period, the WHO stepped down COVID-19 as an infeciton of international concern, identifying it as an established and on-going health issue now.

IPCT working with care homes and primary care

The IPCT work across our hospitals and out of hospital sites. Since April 2020 our IPC team has been contracted through Devon CCG (now ICS) to provide IPC advice to our local care homes, domiciliary care, supported living and GP surgeries. Work with the community in 2022-23 has focused on UTI and prevention work e.g. with supporting hydration. Support around COVID-19 and how this is managed in care homes has been ongoing in response to Government guidance. In order to reduce CDI, work had started to improve antibiotic prescribing and the early diagnosis and treatment of *C. diff* in people with diarrhoea.

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises to facilitate IPC

Cleanliness.
The Trust's facilities team have continued with high levels of cleanliness in 2022-2023. There is a programme of weekly cleans on floors, walls and beds in all areas and response to requests as needed for further cleans. Any areas that have not met the expected standards through auditing or visual inspection, have been reviewed and re-audited so as to meet standards expected.

It has also been the first full year with the new cleaning standards, going from a percentage score to a score rating from 1 – 5 with 5 being very good. The average annual cleaning scores for each frequency risk for April 2022 - March 2023 were as overleaf:

	Monthly Average
FR1 - Weekly	4.98

FR2 - Monthly -	4.97
FR3 - Bi-Monthly	4.95
FR4 - 4-Monthly	4.99
FR5 - 6-Monthly	5.00
FR6 - Annual	5.00

A monthly breakdown for each area with average scores is available through the Head of Facilities.

Hydrogen Peroxide Vapour (HPV) cleans

The table below shows the number of deeper cleans per month in 2022-23. Whilst the number of HPV fell between spring to summer, this did not rise again in winter due to severe bed pressures; HPV cleaning takes 4 hours minimum per room done. In times of OPEL escalation, deep cleans are done as a shorter time duration required for them, rather than an HPV. The average HPV's was 28.5 per month in 2022 – 2023. Monthly numbers for 2022 – 2023 are below.

Deep Cleans.

Deep cleans have seen numbers per month from a low of 712 rising to 1146 with an average of 925.67 per month for 2022 - 2023. The highest consistent numbers happened over the winter period. The extra time required for HPV compared to a deep clean means that in escalation, the decision to deep clean is made.

(By way of explanation here, a deep clean is done using Actichlor at 5:1 litre of water. An HPV is a deep clean with the additional HPV treatment being used in the room. A deep clean will take an hour whereas a HPV will take 4 hours. Monthly numbers for 2022-2023 are below.)

Standard operating procedures are followed in terms of when deep cleans are done and are a key part of IPC tools. This is a corner stone of infection control. Cleans are planned with IPC team and site management.

HPV and Deep Clean numbers

2022-23 Quarter One			2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four		
Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Average
HPV /m	86	49	45	23	25	32	31	14	8	6	6	17	28.50
Deep /m	981	834	1009	973	724	740	873	712	1086	1036	1146	994	925.7

Cleaning Audits

Auditing has continued to take place in line with the National Standards of Healthcare Cleanliness 2021, with consistency being maintained in all areas. PLACE inspections happened on October 2022 with excellent and consistent results coming out from the visits to all in-patient sites. Torbay and South Devon NHS Foundation Trust were 5th in the national standings for the best PLACE results. PLACE Inspection results below. This was also highlighted in the HSJ report about national NHS PLACE results for 2022.

Organisation Name	Commissioning Region	efm Organisation Type	Company	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance	Dementia	Disability
TSD	SOUTH WEST COMMISSIONING REGION	ACUTE - MULTI-SERVICE	NHS	100%	98.%	96.6%	98.9%	94.7%	99.8%	97.2%	97.86%

We have continued to meet demand whilst maintaining and adhering to the National Standards of Healthcare Cleaning 2021 across the organisation.

Ventilation

In line with national guidance, an external Authorising Engineer (AE) on ventilation is in place to audit the management of the Trust's ventilation systems and appoint authorised persons to manage the ventilation systems. All critical ventilation systems are verified in accordance with HTM03-01 and systems are broadly compliant. Where there is a lack of compliance there are additional controls required to be in place which would be actively reviewed and managed via the Estates Team or PFI partners in the cases of Dawlish and Newton Abbot Hospitals.

Our specialist units such as theatres, endoscopy, ICU and mortuary have additional ventilation in line with guidance. A continuing challenge during the pandemic and in summer is that much of our hospital estate was built to have natural ventilation only.

Carbon dioxide monitoring (a marker of air changes) has been done in Torbay Hospital wards (Tower and Hetherington wards) and Brixham hospital. Air quality was satisfactory in the main, even when the measurements were taken in winter when windows were more likely to be shut. When managing respiratory viral infections (includes COVID-19) in outbreak, ventilation is addressed in the outbreak policy using window opening as this is what is available in our wards in the main.

Water Safety

Our Water Safety Group meets quarterly, providing assurance on water quality and compliance with HBN 01-04. Positive results for Legionella species or *Pseudomonas aeruginosa* are subject to remedial actions, re-tested until clear and reported to the group and Capital Infrastructure and Environment Group (CIEG). Non-pathological Legionella species have been isolated in Paignton Hospital and separately in the Tower Block at Torbay Hospital (several sites) and other wards. Actions are given to eradicate these isolates with ongoing surveillance after containment. In summer 2022, pathological Legionella was identified in outpatient areas of Paignton Hospital (patient facing areas). This required more intense monitoring and more containment interventions to protect the service users which included pregnant women. Follow-up measurements showed clearance of the Legionella infection. There were no cases of Legionella pneumonia recorded from this source. Our older estate, particularly with changed use and altered plumbing means that water safety is particularly relevant to the Trust as more likely to have these infections being identified.

Sewage leaks on level 2 in the Tower have happened recurrently in two different sewage lines in 2022-23. The increased clinical use in the areas of the Medical Receiving Units (East in particular) were responsible for one of these blockages. It is unacceptable for staff to have recurrent sewage leaks in their work areas and there is increased clinical issues as specific areas such as orthodontics and maxillary facial surgery has been repeatedly affected (the other sewage line).

Estates have responded by putting in place specific containment interventions which have worked for these two sewage lines; i.e. no blockages since in place for these ones. A mapping exercise of the pipe lines has been requisitioned which will further support keeping these open. The pipe work is over 50 years old.

Decontamination

The Decontamination Lead provides assurance on compliance with the Trust's decontamination policies and National policies from Medicines and Healthcare products Regulatory Agency (MHRA) April 2015 and best practice guidance. The Decontamination Lead role has been reviewed and the committee are seeking to appoint a new Decontamination lead from within sterile services with technical skills and competencies aligned with decontamination risks and strategy.

The Decontamination Group Terms of Reference were reviewed in June 2022 and agreed on 11 July 2022. This extended membership to the increased satellite areas requiring sterile services. Exception reporting and the risk register have been maintained during 2022/23. The Decontamination Policy has been updated to include the latest cleaning guidelines and is currently with clinical effectiveness for inclusion on iCON.

There are risks within the Hospital Sterilisation and Decontamination Unit (HSDU) and a high level of the equipment is on the risk register. Whilst these risks are mitigated (through testing and local servicing and the experience of our HSDU lead) should the washers fail there would be limited contingency support available from Devon organisations and this would have an impact on our ability to maintain a 7-day elective and emergency service. The highest rated risk is the Unclean Washer Disinfectors (6) and associated Water Treatment Plant (RO Plant). This had a 10-year life span after which it should all be considered for replacement; the supplier is only required to maintain and supply spare parts for 10 years. The current washer disinfectors and associated Water Treatment Plant are due for replacement in August 2023.

The HSDU Washer Disinfectors and Sterilisers for surgical instruments have all servicing and testing up to date. The Reverse Osmosis Water Systems that supply the Washer Disinfectors and Sterilisers are also serviced and satisfactory. The air handling unit servicing is up to date to maintain a class 8 clean room; gas plasma sterilizer, BHT Automated Endoscope Re-processor and Niagara washer disinfector.

The HSDU have an annual compliance audit carried out by a Notified Body (Société Générale de Surveillance), appointed on behalf of the MHRA. The successful 2022/23 audit shows that the HSDU continues to be accredited to the UKCA Medical Devices Directive and allows the department to continue to supply sterile medical devices outside of the Trust.

The Tristel representative has completed audits across the Trust which run to a summer annual completion plan. He is scheduled to carry out Trio training on the McGrath video laryngoscopes with the Theatre team. The representative is arranging an audit for the Day Surgery Unit on the next anaesthetic audit day. He is reviewing the remaining satellite areas that use high level disinfection with Tristel (chlorine dioxide), Tri-wipe and Tristel Duo Systems. The audit annual completion is expected August 2023; due to organisation issues not completed Q1 2023-24; mitigations in place.

The Automated Endoscope Reprocessors are due to be commissioned in Endoscopy Unit in July 2023. These washers are designed to kill microorganisms in or on reusable flexible endoscopes by exposing their outside surfaces and interior channels to high level disinfectant or liquid chemical sterilant solutions. Once installed this will mean that flexible endoscope sterilisation will transfer from HSDU. Within Endoscopy all staff are fully trained around the decontamination process.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial stewardship is ‘an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness’ (NICE NG15). Slowing the development of antimicrobial resistance is essential as this is one of the leading risks to human health. Without effective antimicrobials many routine practices (chemotherapy, immunosuppression, surgery) could become too dangerous to perform.

Report on antimicrobial use and monitoring at TSD

The Antimicrobial Team (AMT) consists of the antimicrobial pharmacist and consultant microbiologist. They provide antimicrobial stewardship throughout the Trust. The Antimicrobial Prescribing Policy is documented in CG1098. Within this policy are the

Antimicrobial Prescribing Standards such as 'Start Smart then Focus', Restricted Antimicrobials, Adult IV to Oral Switch Guidelines, the AMT's Terms or Reference and the 3 year Antimicrobial Strategy from 2022 to 2025. In line with good practice and governance there is an antimicrobial steering group chaired by the Deputy DIPC with attendance across specialities to share knowledge on effectiveness of antibiotics and prevention of HCAI is covered and disseminated via this group to medical staff.

Detailed Antimicrobial Prescribing Guidelines are available for Adults (CG0040), Paediatrics (CG1118) and Neonates (CG1670) on the Trust intranet site and previously on an app called BugBuster3000. In 2022-23 work has been in progress to transfer to the TSD supported MicroGuide app, onto which all TSD's Guidelines will be transferred. To this end the AMT has updated all the Antimicrobial Guidelines listed above and liaised with all relevant Clinical Service Leads for approval.

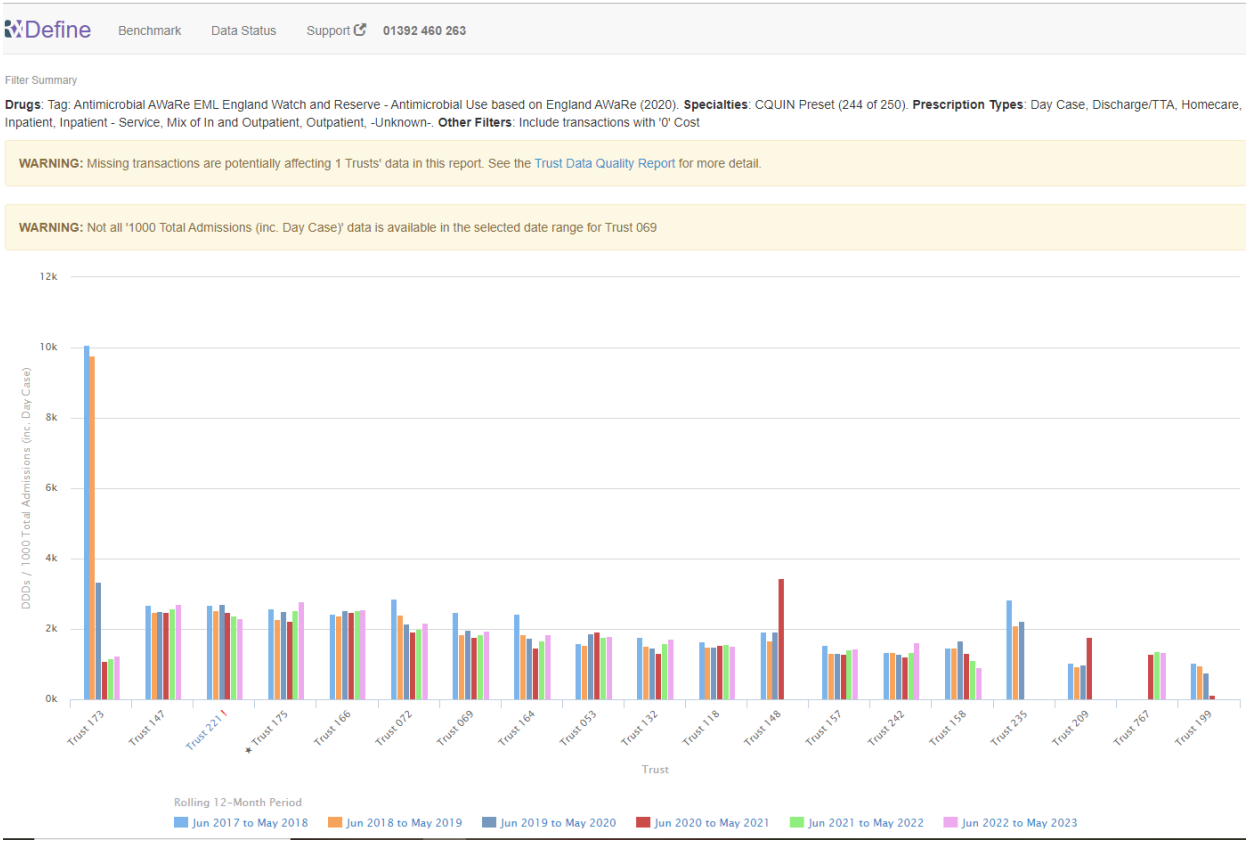
The importance of antibiotic stewardship in tackling antimicrobial resistance (AMR) was published in the 'HM Government Tackling Antimicrobial Resistance 2019-2024'. The UK's five-year national active plan, January 2019.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784894/UK_AMR_5_year_national_action_plan.pdf

The fundamentals of Antimicrobial Stewardship are set out below:
Also see Doron S, Davidson LE. Antimicrobial stewardship. Mayo Clin Proc. 2011 Nov;86(11):1113-23. [PMC free article]

1. To work with healthcare practitioners to prescribe **5"D"s** of antimicrobial therapy, which is the right **D**rug, correct **D**ose, right **D**rug-route, suitable **D**uration, timely **D**e-escalation to pathogen-directed therapy.
2. To prevent antimicrobial overuse, misuse and abuse in inpatient, outpatient and community settings, including the agriculture industry.
3. To reduce antibiotic-related adverse effects, for example CDI
4. To minimise resistance.

TSD benchmarks its antimicrobial prescribing against other Trusts in South1. TSD is Trust 175 and it can be seen that we have high prescribing of the WHO's 'Watch and Reserve', antibiotics. These antibiotics include the second and third-line antimicrobials such as Tazocin, Meropenem, Ciprofloxacin, Clarithromycin and Clindamycin. However, the Define data will use FCE's as denominator data and our Community hospital patients do not have FCEs, nor do the OPHAT (Out-Patient-Hospital Antimicrobial Therapy) so the Define's denominator data, for TSDFT, will be too small to be accurate. Much of the prescribing of Tazocin and Meropenem is driven by concern for presentation with sepsis and the need to maintain a low threshold for administering broad-spectrum antibiotics. Our existing use of Tazocin and Meropenem does not seem to have been associated with any major clinical issues, but TSDFT's Clinicians can reduce their use by practising good Antimicrobial Stewardship.

Diagram: Define Antimicrobial Database for South1, prescribing rates of the WHO's 'Watch and Reserve', Antimicrobials 2017 to May2023.



Saving Lives Antimicrobial Prescribing Results January 2021 to March 2022

The antimicrobial pharmacist performs monthly, Antimicrobial Saving Lives audits on: allergy status recorded, appropriate cultures taken before antibiotics, indication given, duration specified and evidence of review, on all in-patient wards every month. These results are fed-back to teams each month with an action plan and reported to the IPandCG Meeting as part of the Saving Lives reports.

It can be seen that overall results are satisfactory with 91% compliance in 2022.

Ward	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Year Totals
Ainslie	60%	60%	60%	60%	80%	100%	80%	80%	100%	80%	100%	100%	80%
Allerton	60%	60%	60%	80%	80%	100%	100%	100%	100%	100%	100%	100%	87%
Cheetham Hill	60%	60%	80%	80%	80%	80%	80%	80%	100%	80%	100%	100%	82%
Cromie (level 5)	60%	60%	60%	60%	80%	80%	80%	80%	80%	80%	80%	100%	75%
Dunlop	100%	80%	80%	80%	60%	80%	80%	100%	100%	100%	100%	100%	88%
EAU3 (Closed)													0%
EAU4 (level 6)	80%	80%	80%	80%	80%	80%	100%	100%	100%	80%	100%	80%	87%
Ella Rowcroft	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%
Forrest	100%	80%	80%	80%	80%	80%	80%	80%	100%	100%	80%	80%	85%
George Earle	80%	80%	80%	100%	80%	80%	80%	80%	80%	60%	80%	80%	80%
ICU	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Louisa Carey	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
McCallum	100%	100%	100%	100%	100%	100%	80%	80%	80%	80%	100%	100%	93%
Midgley	60%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%
Simpson	60%	60%	80%	60%	80%	80%	80%	80%	80%	100%	100%	100%	80%
Turner	80%	80%	80%	80%	100%	100%	80%	100%	100%	100%	100%	100%	92%
Warrington	60%	60%	80%	80%	60%	80%	80%	80%	80%	100%	80%	80%	77%
Torbay Hospital Overall Score	74%	75%	78%	79%	81%	85%	83%	85%	89%	85%	90%	95%	88%
Brixham Hosp	100%	100%	100%	80%	80%	100%	100%	80%	100%	80%	100%	100%	93%
Dawlish Hosp		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	92%
Teign wd (NA)	100%	100%	100%	100%	100%	100%	100%	100%	100%	80%	80%	60%	93%
Templar wd (NA)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Totnes Hosp		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	92%
Comm Hospitals Overall Score	92%	100%	100%	96%	96%	100%	100%	96%	100%	92%	96%	92%	94%
TRUSTWIDE SCORE	74%	88%	89%	87%	89%	93%	91%	91%	94%	89%	93%	94%	91%

Ward	Jan-23	Feb-23	Mar-23
Ainslie	100%	60%	100%
Allerton	100%	100%	100%
Cheetham Hill	80%	100%	80%
Cromie (level 5)	80%	100%	100%
Dunlop	100%	80%	100%
AMU	100%	100%	80%
EAU4	80%	80%	80%
Ella Rowcroft	100%	100%	100%
New Forrest	100%	80%	60%
George Earle	80%	100%	80%
ICU	100%	100%	100%
Louisa Carey	100%	100%	100%
McCallum	60%	60%	80%
Midgley	100%	100%	100%
Simpson	100%	100%	100%
Turner	100%	100%	100%
Warrington	80%	80%	80%
Torbay Hospital Overall Score	93%	91%	91%
Brixham Hosp	100%	60%	100%
Dawlish Hosp	100%	100%	100%
Teign wd (NA)	100%	100%	80%
Templar wd (NA)	80%	60%	60%
Totnes Hosp	100%	100%	100%
Comm Hospitals Overall Score	96%	84%	88%
TRUSTWIDE SCORE	93%	88%	90%

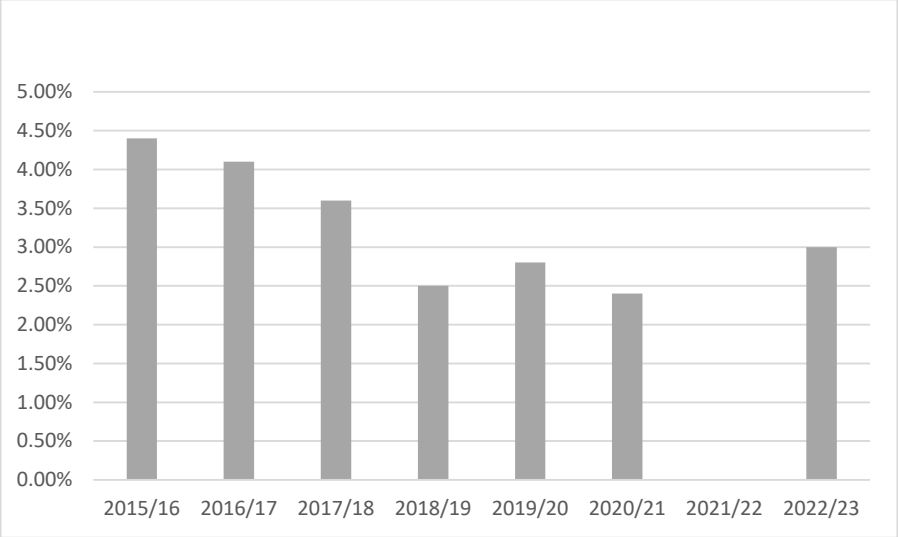
<u>Antibiotic Resistance as recorded at TSD</u>

Extended Spectrum Beta-Lactamase (ESBL) producing *Escherichia coli* (E. coli) bacteria in blood cultures are one of the markers of antibiotic resistance in bacteria and by definition are resistant to 3rd generation cephalosporins.

Below, the graph shows the total rate of ESBLs in blood cultures most of the E. coli BSI are from admissions from the community. The rates of ESBL in E coli blood cultures for 2022/23 were 3%.

In the UK, the ESPAUR Report 2021/22 report the South of England to have a resistance rate, to 3rd generation cephalosporins (ESBLs), in blood stream infections (BSI) of around 14% in E. coli. TSD has antibiotic resistance rates well below the national average.

ESBL producing E. coli blood stream infections. April 2015 March 2023



Antibiotic Resistance to First line Sepsis treatment

TSDFT's recommendations for first-line sepsis treatment is Tazocin and Gentamicin and the rate of E. coli resistance to this combination is 2% (in 2020/21= 0.8%). Even though the rate of resistance has risen, combination treatment with Tazocin and Gentamicin, remains an effective treatment combination for sepsis. Consultant microbiologists observe these data and make choices around antibiotic use in response to changes seen. Guidelines are currently up to date taking account of current patterns of resistance.

Carbapenemase Producing Enterobacteriaciae (CPE)

These are bacteria that have resistance mechanisms against the third-line antibiotics. This means that if a patient develops a serious infection with a CPE then treatment is likely to be sub-optimal. In 2022/23 there was zero CPE TSD.

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and person concerned with providing further support or nursing / medical care in a timely fashion.

Our approach throughout the pandemic has been to ensure open and clear communication with our patients, their carers, family and the wider public. We have used a mixed mode approach for this, all of which has been discussed and documented in the IPC Issues meetings.

We have continued to communicate and display information about Infection Control Standards, with vlogs, weekly updates in standard meetings, posters, screen savers etc as well as website information and the use of social media via our communication team.

Information on COVID-19 continues to available on our iCON site for staff and public facing TSD website. IPC is referenced in the managers' weekly briefing.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection are identified promptly and receive appropriate treatment and care to reduce the risk of transmission of infection to other people.

The routine screening for infection through our urgent and emergency pathways is well established with the use of assessment tools commonplace to reduce the risk of transmitting Infection. Other admission pathways for planned care have a similar focus to assess patients for signs of infection.

The IPCT works closely on a daily basis with wards, site management teams, and cleaning teams, to ensure patients with infection are rapidly identified and isolated correctly with additional cleaning in place as required. This close working enables efficient responses to outbreaks in order to limit spread through standard work and precaution usage.

Responses were effective in managing outbreaks. These were most often outbreaks from COVID-19 though includes IPC work against norovirus, flu and RSV. Policies are regularly updated on iCON for management of outbreaks.

Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infections.

Strong and visible leadership by all senior clinical leaders on IPC was evident throughout the pandemic continuing in the third year of this as well, 2022-23. The Trust requires all staff to complete the electronic mandatory training rather than face-to face sessions. Our compliance target in 2022-23 was 90%, of our 29 clinical areas, the median compliance was 89.4% range (80-97.7%); an improvement on 2021-22 which achieved 83%. Mandatory training is on-line via the Hive, so is available if staff have access to IT. The training videos have been updated this year in line with all national guidance.

In addition a growing amount of ward- based training was put in place supporting standard practice in the pandemic (PPE particularly level 2) as well all round IPC principles. Increasingly during 2022-23, IPCT members were visiting wards to educate and support staff. The newly established network of IPC champions will support this work further and will include more use of teaching techniques such as the glow box to pick up hand hygiene practice.

Support for COVID-1919 IPC issues continued throughout 2022-23 responding to local prevalence and national guidance. These were regularly communicated across the Trust and to the local community via continued good working relationships with Torbay Council and public health.

Criterion 7: Provide or secure adequate isolation facilities. (N.B. this section includes TSD's response to pressures from COVID-19 infection as related to 2022-23 priorities)

In general, isolation for infection prevention reasons means caring for someone in a single room, preferably with ensuite toilet and washing facilities. ~30% of our inpatient beds on the Torbay Hospital site are single rooms. The majority of beds are in bays for 4-6 people. The side room capacity is higher in our more modern community hospitals (Newton Abbot, Dawlish, and Totnes) with larger footprints in the bays there as well (includes Brixham Hospital). Side rooms and side rooms with ensuite facilities are at a premium across the Trust. Therefore, we have an established risk-based approach to allocation of side rooms.

Cohort isolation was used extensively throughout the pandemic in 2020-23. As the number of positive patients escalated through each wave of the pandemic, we increased the number of wards designated as COVID-19 wards, where patients were cared for in a cohort. We responded to the changes in COVID-19 presentations and management in 2022-23 as our bed-stock enabled us to. These changes centred around the decrease in respiratory support required with the Omicron variant of the COVID-19 virus established as the dominant type and immunity against COVID-19 increasingly present through an ongoing, successful vaccination programme and acquired, natural immunity.

In late summer (Q2) 2022-23, it was no longer necessary to have a dedicated COVID-19 ward as patients could be managed in side-rooms or within the eight bedded isolation unit within the ward on level 6. This was created within this 29 bedded ward. Patients without respiratory COVID-19 could be managed with appropriate isolation in general medical wards.

In 2022-23 the increased infectiousness of the subvariants of Omicron COVID-19 was evident in that we saw repeated outbreaks of COVID-19 across the organisation with less serious pathology and consequence than with previous variants during the pandemic. This led to a high number of patients with COVID-19 in our hospital beds through July 2022 but without the need to support respiratory function including using ICU facilities. Previous extreme pressures were not generated in terms of illness severity. This demonstrated that for TSD a designated COVID-19 ward was no longer required. National guidance stepped down isolation requirements in April and August 2022. COVID-19 was becoming an infection which we could accommodate in standard ways. The number of cases caused pressure on being able to isolate to a single room though as this is a new and frequently encountered reason for a side-room alongside other reasons such as behavioural needs and end of life care.

In Autumn 2022, to accommodate improved respiratory care and support for those people with respiratory infections (includes COVID-19), the respiratory ward moved from the Hetherington Building to level 6 in the Tower. The Oxygen supply and sub-unit for infection management within this ward gave improved facilities for managing respiratory conditions as well as being closer to ICU.

Thus, during the year 2022-23 standard patient pathways for people admitted with COVID-19 and those who developed COVID-19 during admission were updated repeatedly in line with national policy and local developments. This has led to the establishment of COVID-19 positive patients being cared for in places best suited to

their needs as opposed to cohorting due to COVID-19 status. The availability of side-rooms in the best ward is frequent limitation which is constantly mitigated and managed. In addition, isolation of COVID-19 patients diagnosed after admission (HCAI or late presentation) is frequently an issue when the organisation is in escalation due to bed pressures (OPEL 4 and critical incident). The need for isolation including bed closures are constant dual tensions. Close working relationships between IPCT and operational colleagues are required and are supported at every level within the organisation.

Criterion 8: Secure adequate access to laboratory support as appropriate
The Microbiology laboratory at TSD works to supports IPC management within both acute and community settings. The Microbiology department is accredited to ISO 15189 (2012) quality standards in the following IPC relevant testing repertoire:

Respiratory Viruses
High-through-put (up to 1000 tests a day)
SARs CoV 2 RT- PCR: Viasure
Flu A B and RSV RT-PCR: Viasure
Rapid (up to 40 tests a day)
SARs CoV 2 RT- PCR: Cepheid GenXpert
Flu A B and RSV RT-PCR: Cepheid GenXpert
Enteric Pathogens
High-through-put (up to 100 tests a day)
C. diff PCR: Serocep EntericBio
Rapid (up to 40 tests a day)
Noro PCR: Cepheid GenXpert
C. diff Antigen test for Toxin: Quikcheck
Multi-resistant organisms
MRSA culture: Chromogenic Culture media
Rapid (up to 10 tests a day)
MRSA PCR: Cepheid GenXpert
VRE Vancomycin resistance testing: Cepheid GenXpert
CPE Carbapenem resistance testing: Cepheid GenXpert

The IPC testing repertoire includes both routine screening and rapid testing. There is a flexible approach to testing which enables urgent samples to be fast tracked All positive results will be reported to IPC team in real-time via email alerts. Workload for 2022/23 in relation to 2021/22 and Pre-Pandemic is shown below:

	2022-23	2021-22	2019-20	Change workload since 21-22	Change since pre-pandemic
C diff	6531	5872	5500	659	1031
C diff Toxin	308	324	296	-16	12
Noro **MRSA**	369 6789	273 6558	240 25214	96 231	129 -18425
Biofire Flu	390	381	86	9	304
COVID-19 PCR	65520	178561	83	-113041	65437
FluA/B/RSV **CPE**	7942 112	7347 69	2767 86	595 43	5175 26
VRE	58	28	34	30	24

Increases in testing can be seen across the repertoire (excluding MRSA screening), this is a result of the laboratory's response to the IPC team's need for increased rapid diagnostics in order to responded affectively to the COVID-19 pandemic and other outbreak situations. MRSA screening has dropped due to revision of the pre-op IPC guidance.

The flow of rapid good quality results through to IPC team is essential and as such is monitored to ensure compliance by way of turn-around time (TAT) in the laboratory, the TAT performance and compliance for 2022-23 is shown below:

Target test	Target TAT	Month	TAT 1	TAT 2	Comment
Rapid Influenza A/B/RSV	<24 hrs	January and July	1.8 hrs	1.2 hrs	Compliant
MRSA culture	24hrs/2days	February and August	22.3h/ 2.2d	22.7/2.3 d	Compliant
C diff PCR	18 hrs	April and October	14.9 hrs	10.2 hrs	Compliant
Rapid COVID-19 only	<3 hrs	May and November	1.7hrs	2.1 hrs	Compliant
Rapid Influenza A/B/RSV	<24 hrs		1.3hrs	7.4 hrs	Compliant

There have been a small number of incidents/ Datix raised relating to IPC testing repertoire 2022/23. Six Datix relating to COVID-19 testing were raised; however, root cause analysis (RCA) for all was delay in the sample reaching the lab. One Datix raised regarding a delay in MRSA PCR admission screening RCA revealed the sample had been sent to incorrect laboratory and one Datix relating to pre-op screening, swabs for MRSA and MSSA only processed for MRSA, RCA indicated laboratory error and actions have been put in place to prevent reoccurrence.

Criterion 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

A comprehensive set of over 30 detailed infection control policies are available to all staff on the hospital intranet. Policies requiring updates during the year are included in the work plan which then go through a process of ratification. There has been some slippage during the year and updates need addressing for many of the policies. There is a plan in place to address this situation and ensure that no major changes within the policy are able to create a clinical risk.

Audit Programme

Completion of the audit programme was less consistent during the pandemic. In 2022-23 this situation was re-focused on as able to do so with less (and changing) COVID-19 activity.

The IPC Team perform these audits for:

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

Results are emailed to the Ward Managers, Matrons, ADN/PPs and Consultants. The pass score is 95% and the results should be displayed on the ward dashboards. When a pass is not achieved the standard is for the Ward Manager to repeat the audit within 15 days; focus is required to ensure this part of the audit cycle is followed up on (see plan for 2023-24 when our ward champion network will be working on quality improvement to support better health and care for all.

Mandatory Training
The IPC Team work with the Education and Training Team in the important area of mandatory training for IPC. IPC team is focused on improving the percentage of staff members who are up to date with respect to mandatory (IPC) training. Level 2 requires further focus to reach the standard of 90% of staff being in date. Currently the range of clinical teams in date is between 80-97.7%, average 90.6%. This is an improvement on 2022-23 when Level 2 compliance was at 83%.

The IPC team is working with mandatory training to improve further on compliance with this.

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
Our Occupational Health Service is contracted to Optima. There has been support for those who have had COVID-19 and those with Long COVID-19 as well as other infections. The service has a programme of staff health assessment to ensure staff are both protected from infectious disease by vaccination and are screened, as required, on employment to ensure they do not pose an infection risk to patients.

Our staff vaccination programme 2022-23:
Flu vaccine 67%
COVID-19 vaccination 54.5%
Both flu and COVID-19 48.4%
These figures are in line with the national picture.

Safer Sharps Group

Incidents with sharps, such as a needlestick injury has potential for the spread of infection and an occupational health hazard. November saw the Trust in receipt of a visit from the Health and Safety Executive (HSE) as part of an investigation into a Reportable Injuries, Diseases and Dangerous Occurrence (RIDDOR) incident that occurred on Midgley Ward at the acute site on 13th September 2022.

The purpose of the HSE's investigation was to find out what happened in the incident, why, and to take enforcement action where appropriate. During their visit, the HSE identified contravention of Health and Safety law and have issued the Trust with two improvement notices. The improvement notices issued relate to staff training and the management of risks in relation to exposure to blood borne viruses as a result of injury from a sharp object.

In response to these:

- Revised annual, online mandatory training for needlestick and contamination injuries in health care workers. This update addresses the identified gaps from

the HSE inspection and is available on the Hive with roll out started already, being Trust wide by 30 November 2023.

- The Trust's Safer Sharps Group (SSG) has been re-launched and consists of suitable representatives from various staff groups. The SSG, accountable to the Trust's Health and Safety Committee owned the response plan to the improvement notices to ensure compliance.

The HSE's re-inspection in May 2023 confirmed to the Workplace Director that the two notices had been addressed sufficiently.

TSD Infection Prevention and Control Improvement Plan 2023-24

In support of better health and care for all in Torbay and South Devon, TSD's IPC Team Mission Statement is:

In our Organisation the responsibility of infection prevention and control is everyone's business. Our work as the IPC team is to continuously build the skills and knowledge that keep all of us (staff, patients, carers and visitors) safe from infections in all locations, in the Torbay and South Devon footprint.

The prevention of infection is a tactical imperative for TSD given the low bed base and growing demand for services; it is evident that beds shut as a result of infection on the ward increase stress on bed-occupancy. Good IPC practice in all areas supports the patient journey and the Trust's quality of care agenda. Excellence in IPC standards will be achieved through a continuing and determined focus on improving clinical practices, antimicrobial prescribing and the environment of care and by continually improving the knowledge of our staff.

The plan below sets out the objectives and actions that will be taken across TSD by IPC team to improve on performance to reduce HCAIs. The IPC team is determined to demonstrate compliance with Care Quality Commission Standards and COVID-19 Living with COVID-19-, 'the Hygiene Code' (2015 and updated).

TSD Infection Prevention Priority Aims 2023-24:

1. Continue to strengthen governance and assurance in relation to infection prevention across the Trust, to demonstrate compliance with regulatory standards.
2. Focus on the prevention and management of COVID-19 and delivery of the infection prevention principles set out in national guidance.
2. Achieve national improvement targets for healthcare-associated infections with the ambition to improve beyond these targets.
3. Building a Brighter Future – IPC involvement in the development and ensuring infection control is embedded in the built environment.
4. Appoint new team members to vacancies so that the service is at full strength and best able to develop new ways of working.
5. Improve the Trust's sustainability performance in terms of reducing glove use by December 2023.

Focus: Infections	**Priority elements of TSD Trust Strategy**	**Drivers: Guidance, Standards, Reports**
• COVID-19 • Clostridioides difficile infection • MRSA bacteraemia • E. Coli and other GNB • UTI, including those related to urinary catheters • Preparedness for Ebola, MERS, Plague and other novel or emerging infections • Norovirus **Alert organism national trajectories 2023-24:** • C. diff- 47 • E. coli- 58 • P. aeruginosa- 3 • Klebsiella - 9	• Building a Brighter Future • Hand hygiene and bare below the elbows • Environmental cleanliness • Management of the environment to minimise transmission, inc improvements in ventilation • Stewardship of prescribing antimicrobial agents • Decontamination of medical devices • Audit of monitoring policies and practices • Sharps safety and waste management • Screening for MRSA and CPE etc • Refurbishment of facilities • Emergency preparedness for annual threats and novel/ emerging infections • Public involvement and information provision • Collaborative working across the ICO and Devon ICS • Research and development opportunities	• Update to Health and Social Care Act 2008 • COVID-19 BAF (2022) • Patient Feedback • Learning for incidents, complaints and outbreaks • CQC standards • National guidance on infections e.g. MRSA, TB, CPE, NG 15 • NICE Quality Standard 113 (2016), 49 (2013) and 61 (2014) • UK five- year antimicrobial resistance action plan (2019-24) • National Standards of Healthcare Cleanliness (2022)

Key Objectives to report on:

	Objective	Reporting
1.	**COVID-19 Pandemic** Patients, staff and visitors will be protected as much as possible from nosocomial COVID-19 infection • The number of HCAI COVID-19 infections will be minimised; aiming to benchmark at or better than the SW rate :2022 we had low rates of infection	Weekly meetings at the IPC Issues Monthly IPC Ops meeting as part of Issues
2.	**Building a Brighter Future** • Building on site is progressing and there needs to be IPC involvement and decision making from the outset; in place and needs to be there for future builds • Site visits to be conducted to ensure HTM/HBNs are compliant, and IPC is embedded in construction	Bimonthly meeting with capital planning/ BBF
3.	***Clostridioides difficile* infection (C. diff)** • The number of new cases of Trust-attributable *Clostridioides difficile* infection will meet the national target of no more than 47 (national target)	Audit review of IPC standards. Use of IPC champion network set up from May 2023 for audit cycle completion/ QI process Monthly IPC meeting with microbiologist and follow up from AARs on C. diff. Also follow up with matron and ADNPP Quarterly IPC Group meeting
4.	***Staphylococcus aureus* bacteraemia** • There will be zero tolerance of Trust-attributable cases of MRSA bacteraemia.	See above point 3 as relevant for MRSA bacteraemia
5.	**Gram negative Infections** • The number of *E. coli* bacteraemia will reduce to no more than 58 cases • The number of *P. aeruginosa* will be no more than 3 cases • The number of *Klebsiella* cases will be no more than 9 cases	See above point 3 as relevant for GNB
6.	**Carbapenemase-Producing Enterobacteriaceae (CPE) and other multi-drug resistant organisms** • Any identified CPE case will be managed in accordance with national guidance • CPE screening programmes will be in place in key departments	See above point 3 as relevant for GNB

7.	**Norovirus and Influenza Preparedness** • The Trust will be appropriately prepared for infection emergencies, including large outbreaks in hospitals, and new or emerging infections with significant health risks	Monthly Ops meeting in IPC Issues meeting with EPPR
8.	**Key Standards to Prevent Infection** Hand hygiene performed consistently by staff in accordance with the World Health Organisation '5 moments for hand hygiene' at least 98% of the time	See above point 3 as relevant Hand Hygiene
9.	**Cleanliness and Care Environments** • All areas across TSD will consistently meet or be above the national minimum standards for cleanliness • Environments will support effective infection prevention, by complying and being maintained in compliance with relevant Health Building Notes, and Health Technical Memoranda • Water safety and the safety of critical ventilation systems will be maintained • Improvements will be made in ventilation in clinical areas to reduce risk of spread of airborne infections	See above point 3 as relevant for cleanliness
10.	**Decontamination of Medical Devices** • Medical devices will not pose a risk of infection to patients; they will be single-use or decontaminated effectively in compliance with HTM 01-01 and 01-06 • Mitigation of risk with replacement programme • New Decontamination Lead in place	Decontamination meeting chaired by lead and reporting to Director of Estates
11.	**Staff Training and Competence** Staff will possess the knowledge, skills and competence needed to practice safely and minimise risk of infection, mandatory training: 90% minimum. • All staff will complete donning/doffing training, and relevant staff will be FFP3 mask fit-tested	ESR reporting Care Group Governance meetings
12.	**Patient and Public Involvement** • Patients, visitors and the public will be informed about and involved in infection prevention. • Information on the internet will be developed and improved	IPC Group meeting quarterly

Governance and Management

This plan underpins, integrates and influences improvement plans in the Trust and IPC team. Responsibility and accountability for local plans to prevent and control infections rests within the ISU structure (replaced July 2023 with Care- Groups).

Progress with this programme will be monitored via the IPC Group, chaired by the DIPC.

Updates will be provided in line with the governance structure to be introduced 2023-24. Progress with local plans and escalated issues will be monitored and managed via Care Group Governance Meetings, and updates will also be provided to the Infection Control Group.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Annual Strategic Agreement Summary			Meeting date: 27 September 2023
Report appendix	N/a		
Report sponsor	Care Group Director, Families and Communities		
Report author	Associate Director of Operations for Integrated Service Unit		
Report provenance	Published as Local Account Summary for Adult Social Care, Torbay Council		
Purpose of the report and key issues for consideration/decision	Annual strategic agreement summary		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	To note contents of the Annual Strategic Agreement Summary which is provided for information.		
Summary of key elements			

Strategic goals supported by this report

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

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

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

External standards affected by this report and associated risks

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

Report title: Annual Strategic Agreement Summary		Meeting date: 27 September 2023
Report sponsor	Care Group Director, Families and Communities	
Report author	Associate Director of Operations for Independent Service Unit	

Introduction

There is an annual strategic agreement between Torbay Council and Torbay and South Devon NHS Foundation Trust (TSDFT) in respect of adult social care. Adult social care is a delegated function, the following report is for information.

Discussion

Torbay has a long and strong history of integrating health and care services within the Bay and has delegated the responsibility for delivery of Adult Social Care to Torbay and South Devon NHS Foundation Trust. Torbay Council remains accountable for Adult Social Care, retaining the lead for Strategic Commissioning.

Torbay Council leads the delivery and oversight of our Adult Social Care strategy but in close collaboration with TSDFT. Both organisations retain leadership and oversight of the implementation and delivery. Torbay Council's Cabinet, Overview and Scrutiny Committee, and TSDFT Board are supported by the Adult Social Care Continuous Improvement Board (ASCCIB), which provides an independently-chaired forum for partners to oversee their joint and integrated work on Adult Social Care, providing support and challenge and escalating any risks and concerns through each organisations' governance arrangements, and will provide key oversight of the strategy going forward.

Conclusion

Torbay Adult Social Care will continue to transform and improve services as well as strive to deliver value for money through Cost Improvement Plans. Adult Social Care will continue to meet Care Act (2014) responsibilities in the delivery of services within Torbay and all other associated legislation.

There will be a continued focus on safeguarding adults, autism, learning disabilities, mental health and the transition team as noted in further detail in this report.

Recommendations

No recommendations, for information only.

The following is extracted from the Local Account Summary which can be found on Torbay Council's website here

Forewords

Councillor Hayley Tranter
Cabinet Member for Adult and Community Services, Public Health and Inequalities

Welcome and thank you for reading our Local Account Summary. But what is this summary and why do we produce it?

This summary is an annual report which sets out how our Adult Social Care Service has been performing in Torbay over the past 12 months.

It includes contributions from our people working at the forefront of social care but just as importantly, we have included submissions from the people who use these services.

We believe very strongly in working collaboratively with residents and partner organisations so that we can constantly improve on our efforts.

Partnership working has certainly been at the forefront of our minds as we deal with the twin impacts of the COVID-19 pandemic and the rising cost of living – our voluntary sector organisations work closely with some of our most vulnerable residents.

I would like to express my gratitude to those working in the Adult Social Care System, and our partners across Torbay, for their continued efforts to meet whatever challenges are thrown at them.

We could not deliver our services without the hard work and dedication of our workforce and that's why we are continuing to invest in training and development to enable our teams to reach their potential for you.

Sir Richard Ibbotson
Chair of Torbay and South Devon NHS Foundation Trust

Liz Davenport
Chief Executive of Torbay and South Devon NHS Foundation Trust

Our Adult Social Care Annual Local Account gives us the opportunity to reflect on the successes and challenges of the past year care while recognising the progress we have made and identifying areas for further development. It is now more than eight years since we became an Integrated Care Organisation which enabled us to join Up Adult Social Care in Torbay with hospital and community care, delivering integrated health and social care.

Three years of the pandemic has only increased the pressure across all aspects of health and social care and those who live in our most deprived coastal communities have seen an increasing gap in health inequalities. The health and care challenges communities like ours face in terms of both physical and mental health was the focus of Professor Chris Whitty's (England's Chief Medical Officer) 2021 annual report.

Our established partnership between health and social care services has provided a solid and enduring foundation on which to build and develop further as we strive for better health and care for all. While the attention (and media) often focuses on blue light and hospital services, the work our teams do together is central to our belief that care as close to home as possible benefits everyone.

We passionately believe that the best way to care for people is by focusing on what matters to them, putting them at the centre of everything we do and integrating services around them. The stories shared in this document reinforce the importance of home and community and of listening to what matters to the people we support. We all need

somewhere where we can feel safe, where we feel connected to others and where we feel valued. Helping people find a home or assisting them to stay in their home, supporting people with their choices about how they live, empowering people to achieve what matters most to them – this is what our Adult Social Care teams are doing each and every day and it is changing people's lives for the better.

But our Adult Social Care teams do not work alone. They not only work with each other and in partnership with our hospital and community services but, importantly, with people who use their services, their carers and loved ones and our fantastic local voluntary and community partners such as Torbay Community Development Trust, Healthwatch and many others too numerous to mention (but each uniquely valued). Together they are creating sustainable networks of care and support for people.

During the past year, we have further strengthened our local relationships. The launch of the Devon Integrated Care System and the development of the South Local Care Partnership has offered and will continue to offer new opportunities to work closer together on the wider complex web of issues which affect people's health and wellbeing – housing, education, environment and employment. Together through the South LCP we are putting an increased focus on suicide prevention, self-harm and the experience of children in care. We are working together with statutory bodies, the voluntary sector, communities and local people on a plan to address each priority.

As we look to the future, we plan to continue the positive progress made this year across many of our services. For example, teams working on discharge to assess are delivering better outcomes for people living in the community who need support or care, including reducing the risk of people being permanently admitted to residential care and supporting people to get home from hospital quickly as soon as they are well enough to leave. We know the care home market and domiciliary care markets are fragile, we know attracting and retaining the right people to join us is difficult and we know that the cost of living crisis is affecting everyone – not only individuals but organisations (both statutory and in the voluntary sector).

Despite the challenges we all face, we have confidence that by working together through our established partnerships and by focusing on the work we are doing together to reduce the health inequalities experienced by local people, we can continue to improve health and wellbeing while also supporting the regeneration of the bay area.

Together we will build on the strengths we have so that we can co-create a brighter future for everyone in Torbay.

Jo Williams
Director of Adult and Community Services

Our health and care system continue to face challenges, but we believe we are resilient enough together, to continue to rise to meet these head-on.

Demand on our services is high and is expected to rise in the coming years due to our ageing population. Like many other parts of the country, we continue to face difficulties with recruitment and the cost of living crisis. We do well in Torbay with hospital discharge, and people do not wait a long time for care to go home. We have our provider partners to thank for that.

All of us working in Adult Social Care are constantly looking for new ways to innovate, improve and overcome barriers. For example, in this year's report, you will read about how we are using the Adult Social Care precept from your Council Tax to fund several local projects alongside our community partners.

You will also learn how our joined-up approach with the NHS and other partners is helping us to look at new digital tools to help people maintain their independence and remain in their homes for longer.

You will be able to read how engagement and co-design have played a big part in our work this year, but don't take my word for it – people who have benefited from these projects share their experiences in this report. I do hope you enjoy reading it.

How Adult Social Care works in Torbay

We want people in Torbay to live happy, healthy, independent lives, with care provided closer to their home. We want to support people to manage any health conditions they may have, wrapping health and care services around them to help them stay in their homes, surrounded by their family, friends and loved ones.

Our ambitious Adult Social Care Strategy will be delivered through a number of plans, including the Adult Social Care Transformation and Sustainability Plan, Safeguarding Adult strategic business plan our joint carers strategy.

We will achieve our goals by working together with our partners, including people who use our services and their carers, Healthwatch Torbay, partnership forums, care and support providers, the voluntary sector network, and Devon Partnership NHS Trust. Partners routinely measure the impact of their work to tackle risk and drive improvements in Adult Social Care.

We can only deliver our vision by working with people with experiences of our services, and the public. They are equal partners both in the planning and delivery of services and we will learn from them to build a more accessible, responsive, resilient and personalised system.

Torbay has a long and strong history of integrating health and care services within the Bay and has delegated much of the responsibility for delivery of Adult Social Care to Torbay and South Devon NHS Foundation Trust. Torbay Council remains accountable for adult social care, retaining the lead for strategic commissioning and employing the Director of Adult Social Services.

Torbay Council leads the delivery and oversight of our Adult Social Care Strategy but in close collaboration with our NHS trust. Both organisations retain leadership and oversight of the implementation and delivery. Torbay Council's Cabinet and Overview and Scrutiny Committee, and the Trust's Board are supported by the Adult Social Care Continuous Improvement Board (ASCCIB), which provides an independently-chaired forum for partners to oversee their joint work on Adult Social Care, providing support and challenge and escalating any risks and concerns through each organisations' governance arrangements, and will provide key oversight of the strategy going forward.

Most providers are on the Torbay supported living framework, which facilitates referrals from practitioners through a vacancy register, and provides a focus on promoting people's independence, quality of life, health, and wellbeing. Only one provider is not on our framework but working towards the same quality measures.

Torbay Voluntary Sector

During 2022/23 the partnership work between the statutory sector and voluntary and community organisations in Torbay matured further. Together we have built upon close working and trust that accelerated in response to the pandemic with the creation in 2020 of our Community Helpline.

Torbay Council has promoted a community-led approach in Torbay to promote people's opportunities to build local contacts and improve their access to community assets,

through investment in the voluntary sector. It is in everyone's best interests to provide community-based support to address loneliness and isolation leading to better outcomes for people. We work in partnership with the Community Development Trust and the voluntary sector to help people to get home from hospital when they no longer need clinical care and wrap services and support around them to help combat loneliness and isolation and avoid being readmitted to hospital unnecessarily. We are committed to continuing to support this type of help and will commission a longer-term contract for this type of care and support.

The cost of living crisis has created distress for people, with the rising costs of food, gas and electricity adding strain to household budgets.

We have worked with the voluntary sector to create a Voluntary Sector Procurement Alliance to agree how we can use allocated money including the Adult Social Care Precept to help it reach the people who need it the most.

The Voluntary Sector Procurement Alliance completed a procurement process to address the impacts of the cost-of-living crisis and awarded £500,000 across eight local voluntary sector organisations.

This money has been used to:

- support people to manage debt and income
- access energy advice
- discover employment opportunities
- develop community-based support projects.

These schemes will run from 2023 to 2025 and will enhance the voluntary sector offer.

Community centres in Torbay have been repaired and improved thanks to extra investment and we are talking to people who live and work in Torbay to co-design a more impactful use of these valuable resources at the heart of the community.

National State of Social Care

The CQC's State of Care Report in 2022 highlighted that the health and social care system is gridlocked and unable to operate effectively:

Most people are still receiving good care when they can access it, although this is less likely to be the case for people living in deprived areas, disabled people and people from ethnic minority groups. Too often, however, people just can't access the care they need. Capacity in Adult Social Care has reduced and unmet need has increased. During 2021/22 only two in five people were able to leave hospital when they no longer had a clinical reason to be there and these delayed transfers of care contributed to long ambulance handover delays, and people waiting longer than we would have liked in our emergency department for assessment and treatment.

Like other parts of the country, we have high numbers of vacancies in our health and care system as people leave to take up jobs in other sectors. This is creating challenges to recruit, and our high vacancy rates are having a direct impact on our ability to provide the safe consistent care we want to.

Recognising the challenges facing our health and care system, the government has embarked on a programme of reform. Its white paper, People at the heart of care, sets out the government's ambitious 10-year vision to transform care and support in England based around three objectives:

1. People have choice, control, and support to live independent lives.
2. People can access outstanding quality and tailored care and support.
3. People find Adult Social Care fair and accessible.

Context and overview of Torbay

Torbay offers a great quality of life for people and families, with a great natural environment on the English Riviera, a wide range of outdoor activities, excellent schools and a growing arts and cultural sector. Like other coastal communities, Torbay faces major challenges. Our Joint Strategic Needs Assessment (JSNA) shows us where our major challenges lie: there is a six-year gap in life expectancy between different areas of the Bay. Torbay has the highest levels of deprivation in the South West. We have an ageing population which faces the challenges of ill-health, loneliness and frailty. The number of people older than 85 is expected to increase by more than 50% within the next decade or so. As our population ages, so too will the demand on our health and care system.

We also have high levels of children living in poverty, child and adult obesity, and suicide. Demands on limited housing options locally reflect National shortages leading to poorer living conditions for some which inevitably associated with poorer physical and mental wellbeing.

The level of need and inequality within the Bay has widened during the past 10 years and younger people and adults have higher levels of poor mental health and higher levels of drug and alcohol problems. There are higher incidences of younger people (under 18) with mental health problems and self-harm.

Joint Strategic Needs Assessment

Joint Strategic Needs Assessments (JSNA) help work together to understand and agree the needs of all local people, with the joint Health and Wellbeing Strategy setting the priorities for collective action.

Read the Torbay JSNA

Our People in Numbers

Our teams	195 team members across 12 teams
Ethnicity	96.4% White, 2.6% BAME and 1% not shared
Gender	84.5% Female and 18.5% Male
Age	30.8% over 55 years old with an average age of 47
Retention	Turnover rate of 14%

Adult Social Care Strategy

Our strategy outlines how we want to work with people in Torbay who may need our care and support, and those who care for them. We want to work together to make sure people have the best start in life and are supported to live happy, healthy lives, in their community.

A vital part of what we do is providing care and support, which covers a range of activities to promote people's wellbeing and support them to live independently, staying well and safe. It can include helping people to get washed, dressed and get out of bed in the morning. It also includes wider personalised support to help people stay connected with their community and live their life how they want to. It supports adults of all ages and covers a diverse range of needs, including autistic people, people with a learning disability or physical disability, people with mental health conditions, people with sensory impairments, people who experience substance misuse, people with dementia, and other people with long-term conditions.

Since July 2022 we have worked as one health and care system – called One Devon – which brings together our NHS, Torbay Council, and our voluntary and community sector partners to share our valuable resources and knowledge to provide joined-up care for the people who need us. Our joint Health and Wellbeing Strategy is our four-year plan to address our challenges and how we will work as one health and care system to improve people's health and wellbeing until 2026. We have identified five areas to focus on during the next four years:

- mental health
- healthy ageing
- good start to life
- complex needs
- digital inclusion

We will use these themes as our chapters in this summary.

Engagement and co-design

Torbay Council, and Torbay and South Devon NHS Foundation Trust are committed to developing health and care services together, and with the people who use them. The people who use our services, and their carers, are best placed to tell us what works well, what doesn't, and what we need to make better. Providing opportunities to listen, talk and involve them in our work to co-design services remains a priority. We intend to build on the firm foundations created through the pandemic and create meaningful opportunities to involve people with experience whenever possible. It is equally important to consider and address areas where identified improvements should be made and we are engaged with a developing programme which will ensure learning is put into practice. Throughout all areas where improvement and innovation are being considered, we are committed to working with people with experience to co-design our future with us.

During 2021/22, our communities benefitted from the partnership working that has emerged from the joint work arrangements we have made with the Learning Disability Partnership Board (LDPB) and the Autism Partnership Board (APB). Working relationships have developed so well that our Treat Me Well Group is now closely entwined with the LDPB and our learning disability ambassadors are helping to drive the agendas and work plans.

During 2022, Torbay Council developed its relationships with the voluntary sector, partner organisations and people with experience to create services to meet the needs of people with mental health issues. We are working together to decide how best to invest £400,000 to support people and prevent further decline in their mental health and wellbeing. We hope to report more on this in next year's Local Account Summary but

this is a really exciting time and progress continues to be made in this area with partnership working and co-production at its heart.

Adult Social Care Improvement Plan

The Adult Social Care Improvement Plan (ASCIP) in 2022/23 supported our vision of developing thriving communities in Torbay by delivering the strategic priorities, deepening integration with partners and promoting a strength-based approach throughout all conversations. Whilst the pandemic necessitated us redirecting our resources in 2021/22, we built on collaborative relationships, the valuable skills of our partner agencies and their knowledge. As a result, ASCIP enabled many successes and in 2022/23 built the foundation on which we set our Transformation & Sustainability Plans from 2023/24.

Progress updates

Essential in 2021/22 was the continual development of value for money in our services and working within the assigned budget of Adult Social Care in Torbay, whilst recognising the well-publicised increasing growth in need across England, and equally so in Torbay. ASCIP continued to develop and deliver a transformational approach to improving value for money. The approach to reviewing our support packages adopted by Torbay was a critical tool and approach to focus client support package reviews using a strength-based, asset focused and community-led approach as its primary foundation.

Our Review and Insights Programme focused on the Care Act 2014 principles of promoting wellbeing through engaging the person in genuine conversations about “what is important to them”. These conversations are supported by a commitment to personalisation and co-production of support plans and an assurance of how we spend public funds. The effectiveness of our programme presented an opportunity to identify insights relating to commissioning, market management and social work best practice.

Through 2021/22 ASCIP delivered the following successes:

- Developed our social care professional workforce structure and improved our Bay-wide approach to service delivery, deepening integration by understanding the integral parts of social care and health joint working.
- Created a Delivery, Markets, Contracts and Quality Team (DMCQ), bringing key business functions together within an accountable structure to complement social care professional services.
- Developed the brokerage function developing standard operating procedures, best practice guidelines when working to arrange support for our clients and supporting the quality monitoring function.
- Focused on our need for data and insight to develop evidence-based decision making, the outcome of which has supported ASC oversight of operational activity and continuous improvement activities.
- Allocation of the Market Sustainability and Fair Cost of Care Fund for 2023/24
- Developed financial oversight and governance controls, recognising it is doing so in a national environment of social care underfunding, inflationary pressures and rising cost of living.
- Standardised the approach with a clear mechanism for Providers for financial contract variations (financial uplifts requests) providing a transparent approach to Provider fee requests.

- Between hospital discharge and social care assessment, we reduced delays in clients receiving appropriate reviews of care to meet their developing needs and eased financial pressure on the Adult Social Care budget, resulting in an improved outcome for the patient. The work was greatly assisted by the lack of barriers in Torbay as an integrated care organisation.
- Torbay's In-reach Project, with a community-based Occupational Therapist Lead working alongside our acute hospital wards, successfully ensured that patients were on the right discharge pathway. In practical and cultural terms, within our system the Integrated Care Organisation makes the most of the expertise of acute and community health and social care to have informed conversations ensuring people in Torbay live independently for longer.
- Quality Assurance huddles were formed to share relevant information pertaining to quality about commissioned providers, concentrating on new and emerging risks and responding proactively and supportively with our providers. Torbay is continuously developing the continuum from proactive support and commissioning-led assistance, through to active and dynamic safeguarding intervention, which is supported by our integrated services and multi-disciplinary approach.
- Developed best practise within our strength-based Review & Insights activity.

We recognised in 2021/22, that our systems and processes must be reviewed to ensure a consistent and equitable approach across ASC in Torbay which we have brought forward as learning to the Transformation and Sustainability (T&S) plans in 2022/23, for which the Adult Social Care Improvement Plan (ASCiP) laid the foundations. The scope of the plan is divided into seven areas of ambition and they are interrelated demonstrating the complexity of developing and improving adult social care. The seven ambitions are:

- Value for money and financial improvement, ensuring we are utilising technology enabled care and review our support packages using a strength-based, asset focused and community-led approach as a primary foundation.
- Support for Living which will focus on delivering Care Act (2014) duties to facilitate a diverse, sustainable, high-quality market for the local population as outlined in Torbay's Market Position statement 2021-2024. T&S will support delivery of A Blueprint for market transformation in Torbay related to transforming care for people with enduring mental illness, autistic people and people with a learning disability.
- Pathways through adult social care building on the success and insight of the Front Door work with the voluntary sector and our external Delivery Partner, Newton Ltd. We will work together to support activities, including insight from data and staff engagement to understand the existing pathways to Adult Social Care and provide a detailed diagnostic and change plan to support future improvement.
- Improvement market management, oversight and business continuity planning including development of a contract management function as recommended by our Local Government Association, improved commissioning function and develop the relationship with our market, development of fee matrices and banded rates, and delivery of critical projects such as Torbay's Reablement facilities.

- We intend to increase our capabilities by developing digital and technology solutions that meet the needs of social care operations, enable flow management and provide access to good quality data.
- Develop our assurance capabilities through the CQC assessment framework themes to enable us to test and challenge our performance and develop continuous improvement projects.
- Torbay Care Home 'Future Capability' Review, which is strategic commissioning-led workstream that will support delivery of the local authority's Care Act (2014) section 5 duties to facilitate a diverse, sustainable, high-quality market, now and in the future, for the local population as outlined in Torbay's Market Position statement 2021-2024.

Each T&S ambition has impacts and benefits that are aligned with social policy, regulation, and our vision for Adult Social Care. Our alignment of benefits must also demonstrate links to Quality Assurance Framework for Torbay, ADASS social policy drivers, CQC Frameworks and NICE Quality Standards, which cover the experience of adults using social care services. Torbay works along the principle of continuous improvement and the outcomes of ASCiP are embedded in the T&S Plan as a continuation of the work started.

Performance in 2022/23

The quality of Adult Social Care Performance reporting has been further developed through 2022/23. A monthly performance report, comprising data and commentary on areas such as service waiting lists, overdue reviews, safeguarding adults, active contract finances, Adult Social Care Outcomes Framework (ASCOF) and Care Home quality has been implemented and is reported on and scrutinised through appropriate governance routes.

Further development of performance reporting will be undertaken in the months ahead, broadening its scope to encompass all the key areas of Adult Social Care.

Additionally, the use of data visualisation business intelligence platforms like Tableau is becoming more widely used to assist teams working in Adult Social Care to better understand their data and their services.

Performance at a glance

3,287 adults received long term support services, compared to 3,152 in 2021-22 (+4.3%). 37% are aged between 18-64 and 63% are aged 65+, the same proportions as in 2021-22.

2,463 clients were accessing long term support services at the end of 2022/23, compared to 2,292 at the end of 2021/22 (+7.4%)

8,571 requests for support were received, compared to 8,420 in 2021-22 (+1.8%)

717 people received one-off support, compared to 771 in 2021-22 (-7.0%)

2,339 people received Short Term Reablement services to help them gain independence, compared to 2,226 in 2021-22 (+5.1%)

1,068 people started to receive an ongoing support service, including community activities, compared to 1,092 in 2021-22 (-2.2%)

1,915 people did not go on to receive a service (e.g. self-funder / not eligible, etc) compared to 2,128 in 2021-22 (-10.0%)

5,206 carers are on Torbay's carers register, compared to 4,747 in 2021-22 (+9.7%)

1,226 carers were assessed and reviewed, compared to 1,355 in 2021-22 (-9.5%)

585 carers accessed Direct Payments, compared to 678 in 2021-22 (-13.7%)

394 people with mental health issues were supported by services, compared to 386 in 2021-22 (+2.1%)

85 people with learning difficulties are living in residential or nursing accommodation, compared to 92 in 2021-22 (-7.6%)

1,862 people received home care support to enable them to stay in their own home, compared to 1,775 in 2021-22 (+4.9%)

968 people were in permanent residential placements, compared to 949 in 2021-22 (+2.0%)

1,694 people were directed to other types of help and support, including community activities, compared to 1,871 in 2021-22 (-9.5%)

392 service users received direct payments, compared to 423 in 2021-22 (-7.3%)

1,161 safeguarding concerns were raised. This compares to 998 in 2021-22 (+16.3%)

In 2021/22, changes were made to the way requests for support were recorded, resulting in a sharp increase in recorded volume on the previous year (+10%). With this new recording system operational for a second year, 2022/23 has seen a further increase in the number of requests for support, but marginal compared to the increase seen a year ago, (+1.8%).

The number of people who did not go on to receive a service reduced by 10% on the previous year, from 2,128 in 2021-22 to 1,915. When looked at as a proportion of the total requests for support, 22% did not go on to receive a service in 2022-23, compared to 25% the previous year.

Proportionally there has been a slightly higher use of Short Term reablement services to help people gain independence in 2022-23 than the previous year and a slightly lower use of one off and ongoing support.

An area where Torbay has over several years performed poorly compared to national and regional data is in permanent admissions to residential and nursing care homes. As reported in the 2021-22 Local Account Summary, a large increase in this KPI on the previous year was predominantly due to system and reporting changes. Over 2022-23, the rate of admissions for both 18-64 and 65+ has remained high compared to the national and regional data, but is trending down. In the case of 65+ admissions, the annual data in ASC 2A does show a slight increase, but the rate has been trending down month on month since Q3 of 2022-23. Given work being undertaken to redesign other areas of adult social care at the front end, it is expected the rate will continue to decrease through 2023-24.

Data from the Carers Service shows the number of carers on the Carers Register increasing by 9.7% on the previous year. This follows a 7.7% increase the previous year. Increases in the Carers Register is aided by all major health and care organisations in Torbay having signed a Commitment to Carers, supporting the identification of carers and signposting to services.

The number of carers with direct payments reduced by 13.7% compared to 2021-22. This may be a result of an increase in the use of the Carers Emotional Support scheme.

The number of safeguarding concerns raised was 16.3% higher in 2022-23 compared with the previous year. This increase is partly attributable to a large-scale safeguarding enquiry undertaken in response to safeguarding adult concerns within a care home which received an inadequate CQC rating. Another care home had also seen a larger

than normal level of concerns raised. This has been closely monitored by Quality Assurance and Safeguarding Adults teams through a Provider of Concern process, contract monitoring and a Supporting Action Plan including ongoing monthly meetings.

Annual survey

Every year adult social care services across the country carry out an annual user satisfaction survey. The questions are set by central government and help us ascertain the experience of adults in receipt of support. The results of the survey help us inform our future priorities and identify any areas for needed improvement.

National benchmarking data is published in the autumn each year.

In total 363 completed surveys were returned in 2022/23, down from 402 the previous year. There have been positive moves in the direction of scores in the ASCOF Domains 3 and 4, which are sourced from the Adult Social Care Annual Survey and concern satisfaction levels and feeling safe.

68.6% of service users said they were overall satisfied with the care and support services they receive, slightly up from 67%. Historically, we have reported similar figures which indicates the service is likely to remain in the top quartile for England.

84% of those who completed the standard survey rated their quality of life as alright or better, which is no significant change from 2022 (85%).

The proportion of people who say they find it easy to find information about services increased marginally from 72.1% in 2021-22 to 73.4% in 2022-23. Front End services continue to refer into Torbay Community Development Trust (TCDT) as part of the ongoing ASC Front Door pilot initiated in 2021. This pilot supports the transfer of queries to the TCDT Helpline for support and signposting to the Voluntary, Community and Social Enterprise (VCSE) sector. Options for further improvements will be explored following the release of the diagnostic work undertaken by Newton Europe.

The proportion of people who use services who say they feel safe increased from 64.8% in 2021-22 to 68.5% in 2022-23, and the proportion who say that those services have made them feel safe and secure increased from 85.2% to 89.0%.

The increases in performance relating to these survey questions is a reversal of what was reported a year ago, which saw a drop in performance across many of these questions. However, it should be noted that differences in survey KPIs are not always statistically significant due to survey margin of error and response rates. A general upward trend in these questions may also be a consequence of moving out of Covid, with the pandemic likely to have had a negative effect on responses to these questions in the previous years.

Principal Social Workers Annual Review

Audit

We are committed to learning and developing to help us improve the care we provide, and during the past year we have embedded a clear and robust audit structure in our work. Each month a group of our senior social workers (half of which is fixed for consistency, the other half rotates) meet to audit several cases. The fixed group includes an operational service lead, a carer's lead, and the Principal Social Worker (PSW). The rotating group comprises social work leaders in frontline operational practice. The group audits two cases before the meeting, and then analyse to develop a greater awareness of what constitutes good recording.

Issues that might be discussed include:

- consent
- Carer input
- risk
- how we record information

By discussing these issues in detail with a group of senior social workers, we get a real opportunity to question our own practice, look at how we interpret the use of legislation and policy and learn from each other.

The importance of being a practice educator and developing our workforce
During the past year, three experienced social workers undertook specialist post - qualifying training called the Practice Educator (PE) award. This role works with social worker students on their work placements, and as Social Work England states a PE is someone:

who supports, teaches and assesses a student whilst on placement. They are a mentor, teacher, assessor and supervisor and a consistent presence to ensure the student feels safe and secure whilst on their placement.

This is an important role, and people who undertake this award provide a lot of support to students, whilst working full time and completing the academic requirements of the programme.

Naomi, a Practice Educator, said:
I joined Torbay and South Devon NHS Foundation Trust in 2008 as a health and social care coordinator. In 2012 I was thrilled to be given the opportunity to study for my social work degree and I haven't looked back since. My journey has been nurturing, supportive and an enriching learning experience, and I'm now sharing my skills and knowledge with our future social work students. I completed my Practice Educators' Award in 2022 and it instilled in a sea change within me, both professionally and on a personal level. It has also helped enhance my critical reflection skills and my professional development. I feel very proud and privileged to be supporting our students and shaping our future social workers to ensure the highest standards of practice. The skills for this role do not just start and finish with students but my peers as well, supporting others to learn new theory and expand their knowledge, whilst creating a culture of a shared learning environment.
I genuinely feel that without the support of the Trust I would not have achieved my social work degree and practice educators' award. I am now looking forward to the next stage of my career and helping others to achieve their learning outcomes.

The journey to being a qualified social worker
John, a recently qualified in-house trainee social worker, said:
I have worked in the broad field of health and social care since I was 18, having tried several different roles and taken something from all of them. I always said that I wouldn't want to be a social worker because I had an impression of what they do; I did not think I would be able to do it but moving from the charitable sector to Torbay and South Devon NHS Foundation Trust six years ago as a community care worker (a social care role within the Trust) changed how I saw social workers. I was immersed in the complex and fascinating world of ethics, values and morals and found that all the social

workers I worked with had one thing in common: the desire to support people in the most empathetic and non-discriminatory way possible.

My perception of the world of social work quickly changed and when I was informed of the Trust's programme to become a social worker, I jumped at the opportunity to start my degree and with the support of my manager and team I was able to work full-time and study full-time; something which I did not think would be possible. I started when I was 31 and like most people, could not have afforded to completely stop work to study full-time; the fact I could continue working (and being paid) made this possible.

It was not easy, but the infrastructure and support was so good and I was always given the time I needed to study and focus on my degree. The placements are within the Trust's own teams and everyone I met was so invested in training new social workers that I found I never struggled and never felt unsupported.

I am now a qualified social worker and I often reflect on the statement, I wouldn't want to be a social worker and believe that I would still be saying this, if it weren't for joining the Trust and seeing the excellent social workers this programme has created. I am now looking forward to a career in social work where many opportunities are open to me.

Focus on Safeguarding Adults

Our aim in the broadest sense is for the public, volunteers, and professionals to work together to uphold human rights and ensure everyone is treated with dignity and respect, and that people have choice, control, and compassionate care in their lives. Everyone has the right to live their lives free from violence, fear and abuse and all adults have the right to be protected from harm or exploitation. But not everyone can protect themselves.

'Safeguarding' is a term used to mean both specialist services and other activity designed to promote the wellbeing and safeguard the rights of adults with care and support needs where neglect or abuse has or is suspected to have occurred. Our responses to concerns are driven by Care Act 2014 statutory guidance and the national Making Safeguarding Personal (MSP) agenda. This includes working with individuals or their representatives to establish their preferred outcomes to concerns and work with individuals to meet those outcomes. Where adults with care and support needs do not have the mental capacity to make specific decisions, we will ensure there is an appropriate legal advocate to act on the individual's behalf.

Repeat referrals

From April to March 2022, our safeguarding adult repeat referral rate increased slightly from to 8% to 10.2%. The increase will continue to be monitored but is within the agreed key performance Indicator (KPI) agreed with Torbay Council of 15% or lower. The table below provides an overall comparator between 2020-2023.

Asking people their preferred outcomes

In April 2022 we set a target of asking 90% of people experiencing a safeguarding response what their preferred outcomes where. During 2022 to 2023 we did not meet this target, recording that 67.9% of people where asked their preferred outcomes. This is a reduction of 14.1% compared to the previous year. 20.1% of our records did not capture this data and this is therefore a key improvement requirement for 2023-2024.

Where outcomes were expressed 93.6% of people said their outcomes where fully or partially achieved.

Qualitative feedback

Qualitative feedback is important in understanding people's experiences of safeguarding responses. In Torbay, we commission an independent advocacy group to undertake discovery interviews with people or appropriate representatives who consent to giving qualitative feedback. We developed this process during 2022 and received our first feedback report at the beginning of 2023. The report concluded:

All felt included, they felt that the process was fully explained and that they had input whilst being heard. The benefits of the safeguarding process were appreciated with more needs identified and acted upon. This led to a very positive response on the outcomes.

Moving forward, we will receive quarterly reports to help us understand people's experiences to help us further develop our operational responses to safeguarding concerns.

Safeguarding adult enquiries summary

From April 2022 to March 2023, 1159 safeguarding adult concerns were received which is a 16.1% increase on the previous year. The number of concerns which proceeded to Care Act s.42 enquiry increased by 8.8% to 299. The table below provides a comparator during the past three years.

Torbay and South Devon NHS Foundation Trust's work in this area primarily divides between the adult social care community operational teams who respond to safeguarding concerns and our Quality, Assurance, and Improvement Team (QAIT) which works with care homes and domiciliary care providers to promote high quality care and proactively monitor quality standards.

We also work closely with Devon and Cornwall Police, Devon Partnership NHS Trust, NHS Devon, and the Care Quality Commission both in causing enquiries to be made and maintaining strong local partnership arrangements.

The most common reported types of abuse are neglect, physical, emotional, and psychological and financial. In 2022 we also undertook a large-scale safeguarding enquiry in response to safeguarding adult concerns within a care home which received an inadequate Care Quality Commission rating. The value of an integrated health and social care system was particularly evident in the response to the concerns.

Torbay and Devon Safeguarding Adult Partnership (TDSAP)

TDSAP oversees local safeguarding arrangements and has a structure to support its objective to help and protect adults in its area where there is reasonable cause to believe the adult has needs for care and support, is experiencing or at risk of abuse or neglect and as a result of those needs is unable to protect themselves against abuse or the risk of it.

The structure includes community reference, learning and improvement and performance and quality assurance subgroups. The partnership also has a specific Safeguarding Adult Core Group responsible for commissioning and overseeing safeguarding adult learning reviews. The partnership has an independent chair who oversees local arrangements.

Structure

View the TDSAP organisational structure in an accessible format

Business plan

The TDSAP strategic business plan for 2021-2024 sets four priorities overseen by the board.

- To embed learning from Safeguarding Adult Reviews (SARs) into organisational practice.
- To improve outcomes for people with needs for care and support by finding the right solution for them.
- To work with partners to better understand the risk of hidden harm, especially in the context of COVID.
- To improve involvement and engagement with people in receipt of safeguarding services.

More information on the partnership can be found on the Torbay and Devon Safeguarding Adult Partnership website.

Learning from Safeguarding Adult Reviews

The TDSAP must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult. Boards must also arrange a SAR if an adult in its area has not died, but the Safeguarding Adult Board (SAB) knows or suspects that the adult has experienced serious abuse or neglect. Boards may also arrange for a SAR in any other situations involving an adult in its area with needs for care and support if it deems it appropriate. The focus of SARs is to identify learning, not to apportion blame.

The partnership commissioned one new safeguarding adult review and published two reviews in 2022-2023. The partnership arrangements support greater collective learning outcomes across the Torbay and Devon footprint.

Advocacy for people unable to make decisions for themselves

We continue to use advocacy services across the three legal frameworks: Independent Mental Health Advocacy, Independent Mental Capacity Advocacy and Care Act Advocacy. This is via a contract with Devon Advocacy consortium. We regularly refer people and have contract monitoring systems in place to monitor uptake of services.

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) procedure is designed to protect your rights if the care or treatment you receive in a hospital or care home means you are, or may become, deprived of your liberty, and you lack mental capacity to consent to those arrangements. For example, where due to the serious onset of dementia an individual's capacity to act safely is significantly affected. Throughout the past year we planned and prepared for the national implementation of the replacement system Liberty Protection Safeguards (LPS) in response to the Mental Capacity (Amendment) Act 2019. In April 2023 the government announced LPS would be further delayed 'beyond the life of this parliament' meaning the existing DoLS system will remain for the foreseeable future.

Safeguarding adults summary

While our performance is good, we must constantly strive to understand emerging issues for safeguarding adults in Torbay and act proactively to maintain our performance. Our board arrangement has assisted in driving a consistent approach in these agendas across our local safeguarding adult partnership. A key message is to promote a zero tolerance of adult abuse and that safeguarding adults is everyone's business. When adult abuse concerns are raised, we work in a multi-disciplinary and multi-agency context to understand risk and ensure responses are person centred, include the right people, and include the right partner agencies. Our main focuses in the forthcoming year are to continue to embed learning from safeguarding adult reviews and support delivering the strategic priorities of the TDSAP. We must also ensure we are recording if we are asking people their preferred outcomes and extend our use of data to understand other trends and areas for development.

Focus on Autism

Torbay Advice Network (TAN) is commissioned to support people with adult social care need and carers to have increased knowledge of entitlements to benefits and improved access to support with appeals via their supported pathway service. This service also includes:

- Advice
- Support
- Help with housing-related benefits and discretionary payments
- Signposting for additional support needs such as housing rights and legal support

TAN supported pathway also help people with adult social care receive more support to obtain and maintain employment through advice and guidance with reasonable adjustments and the access to work scheme. This covers:

- letter templates and help writing them
- guidance on the Equality Act 2010

- support to help people find and stay in work.

Examples of TAN support

Here are two examples of how TAN has supported people this year.

Shaun

Shaun is a 31-year-old man with autism who was referred to our service by an autism specialist social worker. We had previously helped him to receive benefits, including visiting Brixham Job Centre, and working with him out of hours. We helped Shaun to manage the complexities of the benefit system and helped reduce his anxiety and sensory overload during this time of great change in his life. Without our support he would not be in the settled position he is now in his own home.

Shirley

Shirley is a 19-year-old woman with autism, who was living in temporary accommodation in a hotel in Torbay after relationships with her family broke down. We supported her when she moved back to her family home, and helped her to complete a PIP application. We helped by providing medical evidence to support her claim and attending calls with the DWP.

Dimensions for Autism (DFA)

DFA facilitate support groups for autistic people. The group usually meet on the last Monday afternoon of each month at Jasmyn House, Midvale Road, Paignton, TQ4 5BD. DFA also has online support groups that meet at least twice a month to support people who do not feel able to attend real-life events. DFA Torbay members can attend any online group, regardless of where they live in Devon. These groups provide a vital platform for people to share interests and hobbies and speak about day-to-day matters that may be affecting them.

Here are some of the things people have said about the help they've received from the DFA.

DFA user

I am immensely grateful to have found the DFA support group, a community that has played a crucial role in my personal journey with autism. This support group has consistently been a source of solace and an invaluable resource in my life.

From the very beginning, the autism support group welcomed me with open arms and provides a safe and nurturing environment where I can freely share my experiences, challenges, and successes. We're a close-knit community that thrives on empathy, understanding, and encouragement.

Trish and the experienced facilitators, who are well-versed in autism-related issues, have fostered constructive conversations and shared invaluable advice. They have not only addressed my concerns with sensitivity but also provided me with practical tools and strategies to better support me.

The friendships forged in the group have provided us with a strong network of support, and we know we can always count on each other in times of need. Being around other people similar to myself has helped my confidence in myself grow in general; I am more confident in work and have even joined another social group that is not associated with autism. This is something I would never have dreamed I could do a couple of years ago. Without DFA my life would have taken a completely different trajectory and I would not be where I am today. I now am proud to be an ambassador for people with autism in Torbay and have gone from needing help to being able to help others. I cannot even explain the difference this group is making to the lives of people like me.

Tom's story

Tom, an autistic man in his thirties, always wanted his own home, but he was living with his mother with no social care support. He was unable to meet his own care needs without support. Tom and his mother were being supported by the mental health team and benefiting from family and music therapy.

Society has not yet fully understood the challenges I face as an autistic adult, but the task of rising to that challenge is similar to those that we all have experienced at one point; like a loss of controls that happens during a transition from childhood to adult. We will be facing dangers and vulnerabilities for the first time and we need a family and support system to help us. We need advocates, and my social worker has taken up this role for me and been radically accepting of the challenges and viewpoints of autistic persons.

The specialist social worker spent time building relationships with Tom and his mother, and they took time to listen and learn about his needs and life experiences. Tom was supported and his strengths were highlighted and promoted in a step-by-step approach to change. Eventually a not for profit housing association that supports people with disabilities was identified and Tom finally achieved his goal and bought his own home. Tom now has a personalised package of care to support him to build and maintain his independence in his own home.

Autism Partnership Board

The Autism Partnership Board launched in November 2022 and members meet four times a year. The board is driven by the voices of autistic people, their carers and professionals who will work together to improve outcomes for Torbay's autistic community. The board is supported by six ambassadors and two carers' representatives who raise issues important to the autistic community.

The ambassadors planned an event in June 2023 in Torbay to raise awareness of adult autism, promote good practice for our community to health and social care professionals and the wider community, and take part in the Torbay Autism Partnership Board. The local account summary 2022/23 will report on the group's progress and achievements.

Focus on Learning Disabilities

During 2022/23, our adult social care strategic commissioning team has continued to work towards the outcomes set out within the 10-year market transformation blueprint for our learning disability and neuro diverse community.

We want to support people to live happy, independent lives, knowing we're there to support them when they need us. This includes helping people to live in their own home. We have undertaken a significant amount to create the development of new housing specifically for people with health and social care needs and develop the related market for supported living services.

The learning disability partnership board has continued to develop and its learning disability ambassadors have become adept at targeting issues of particular concern to the learning disability community; they've successfully used their specially-commissioned advocacy support to achieve change where they feel statutory services have not recognised or adjusted to meet their needs. The availability of housing is a particular concern, and the ambassadors organised an extremely well-attended housing event at the Riviera Centre in October 2022 to raise awareness of the shortage of suitable housing to providers, developers, commissioners, and councillors.

Our strategic commissioning team has continued to develop the social care market, particularly around supported housing and the associated care and support services. The new Torbay housing strategy contains key information about housing needs for social excluded and Care Act-eligible people to support the ongoing development of new, much needed supported living schemes across the bay. Despite significant inflation pressures within the construction industry and increases in interest rates, various partners have acquired sites and are progressing schemes. Our Homes England-regulated housing company, TorVista Homes, is now in place and actively buying and developing housing on council-owned sites to support the work of our integrated adult social care system.

Focus on Mental Health

Our adult social care strategic commissioning team has worked intensively with TorVista to develop a new extra care housing scheme at Torquay's Torre Marine. The design of the whole scheme, comprising of 72 one--bed and two bed social rent apartments which offer a multi-generational supported living service, has used best practice for a dementia-friendly environment and has been audited by the Dementia Design Development Centre at the University of Stirling. We commissioned a new support provider, Agincare, in 2022/23 to deliver care and support in both the existing and planned extra care schemes.

The second iteration of the Torbay support for living framework was procured during 2022/23. The new specification for supported living sets out our vision and underlines our commitment requiring providers to demonstrate how they promote independence and gradually reduce the need for formal care where possible, where families and communities are helped and given the support they need to help care for people in their home.

Focus on the Transitions Team

Moving from children to adults' services is a big step in someone's life and we are committed to making this as seamless as possible for people. We have already made significant progress to improve the way people move from services and our new transitions panel, which was created in September 2021, is helping us to deliver this change. Our weekly multi-agency panel includes key representatives from children's services, the adult transitions team, health and education.

The panel considers referrals for children aged 14 to 17 who are:

- cared experienced
- children with disabilities
- subject to child protection planning
- subject to the national referral mechanism (the national framework for identifying and referring victims of modern slavery)
- subject to a red (highest risk) on the exploitation toolkit assessment (toolkit to assess risk and safeguard children and young people under 18 from sexual and criminal exploitation).
- who are at risk of youth homelessness.

Young people who are supported by the children with disabilities team are automatically considered by the panel.

The panel oversees transition planning in the following areas:

- current placements and support packages
- transition planning and joint work with adult services
- issues in relation to DOLS and restrictive measures if identified
- joint work between the allocated social worker and personal advisor, where appropriate
- preparation for independence

The panel also provides consistent managerial oversight of the allocation of personal advisors when children are 15 years and 9 months. This is to allow for a personal advisor to be co-allocated, and for relationship-building and information gathering to take place at a much earlier point than it has historically, to help young people transition from cared for to care experienced.

The panel also provides a way to identify and track parent and carers who may need extra support while the child moves services. This is shared with the adult transitions team to ensure the parent or carer receives appropriate support when the child becomes an adult. A parent/carer consent form has been created for a transition pack and resource guide. Easy-read sheets outlining the key factors in relation to transition are also sent to parents and carers when the child turns 16 and this is co-ordinated through the panel.

Feedback about the panel from adult social care is positive, with one colleague saying it has had a very positive impact on communication between services, focussing on preparing people for adulthood. Carers are identified much earlier, ensuring more timely referrals.

The joint transitions protocol has been designed with partners and children and young people to ensure children's and adult social care are joined up and there is a continuity of care.

A young person's guide to transition has also been created, alongside a transitions guide and resource pack for the teams that support children.

A preparation for independence strategy is in place which focuses on the importance of transition, preparing for adulthood outcomes and how social workers can reflect this in assessment and planning through a child's life, regardless of their legal status.

The care planning pathway procedure has been updated to ensure that Special Educational Needs and Disabilities are included in the transition process.

During the next 12 months we are aiming to continue improving our support by:

- jointly agreeing a set of key performance indicators (KPIs) in respect of transition performance
- ongoing engagement in the becoming an adult steering group being led by adult services as part of the written statement of action response
- renewed focus on mental capacity and best interests training for the children's workforce
- finalise our children's DOLS workforce development plan
- revision of the preparation for independence strategy in line with the work aligned to the written statement of action response
- create a transitions guide for parents and carers

Young people on transition

- Talk to us about transition, and not when it's too late!
- What would make the experience better is that we are informed fully and clearly about what we should aim to do, what opportunities are there for people in our position and how we can achieve this.
- A better planned transition between being a child and becoming an adult is important. [It is good] to have things planned in advance rather than be rushed.

Developing opportunities for our young people

Improving the range of opportunities and choice for children and young people with special educational needs and disabilities (SEND) when they reach 16 or transition to adulthood is a key area of our improvement journey.

An Internships Work project is funded by the Department for Education and will double the current supported internship provision in England. It is designed to support more young people with additional needs to have greater choice and control over their future, opening up opportunities that prepare them for adult life and independent living.

Supported internships

Supported interns are enrolled and supported by their school or college, but spend most of their learning time in a workplace as part of their course. Every young person is supported in the work placement by a trained job coach, put in place by their education provider, who provides in-work support that tapers off, if appropriate, as the supported intern becomes familiar with their role. Job coaches also work with employers, increasing their confidence in employing individuals with additional needs and helping them to create and support a diverse workforce. Internships are a great way to support people to learn a job and gain hands-on experience, while supported in their studies.

Internships work is a collaboration between the National Development Team for Inclusion (NDTi), DFN Project SEARCH and BASE.

- The National Development Team for Inclusion (NDTi) is supporting local authorities to establish and develop SEND employment forums as well as administrating and monitoring section 14 grants to support them with this programme.
- DFN Project SEARCH is leading on engaging employers and support them to offer high- quality work placements by providing information, advice and training that enable growth in internships and job opportunities.
- BASE will also lead on delivering job coach and systematic instruction training to more than 700 job coaches. The bespoke training has been developed in line with the Supported Employment National Occupational Standards (NOS) and reflect the key principle to training job coaches in the Supported Internships Guidance .

Torbay Council has been awarded a grant to support the development of a SEND employment forum and will work with local employers to increase the number of Supported Internship opportunities in Torbay. Using our baseline survey, we now have a Torbay local area action plan in place to deliver on the requirement of the grant and are working closely with our regional neighbouring local authorities in Devon, Plymouth and Cornwall on joint initiatives and good practice. We will be able to report on progress in the local account summary 2022/23.

Helping to get People Home from Hospital

We are committed to helping people to live independently, and to receive any care and support in their home whenever possible. We believe your own bed is the best bed and when people are ready to leave hospital, we will ensure they have access to the health and care support they need to be cared for and recover at home. We'll start planning to get them home from hospital as soon as they're admitted and get them home when they have no clinical reason to be there, and support them to ensure they avoid being readmitted to hospital or a care home unless it's absolutely necessary.

We work as one joined-up health and care system, and work in partnership with GPs, pharmacists, community nurses, physiotherapists and other people involved in arranging and providing care to ensure everyone knows who is involved with the person's care.

The average age of people using this service is 83. The deeper integration of these services has helped reduce the length of time people stay in hospital, and the roll out of our discharge to assess at home pathway has helped us to care for people at home.

How Digital Tools Can Help Patients

The Technology Enabled Care Service (TECS) has been available across Torbay since 2018. The service is provided by NRS Healthcare in Paignton and provides solutions to keep people safe and independent in their own homes for longer, potentially delaying any need for formal service interventions (See below for examples)

NRS Healthcare offers a private purchase option to allow people to choose different ways to support how they access the community and live independently or care for loved ones. It's available to anyone, not just people who live in Torbay. For those who are eligible following a Care Act Assessment, TECS will be considered before other packages of care are put in place.

During 2022/23, the supported service grew by 38% up to 833 at the end of February 2023, (compared to 603 at the end of March 2022) - a marked increase of the 2021/22 financial year that saw an 18% increase in people using the service.

As of the end of February, the 12-month rolling average of NHS' referrals broke the 30 mark (32.58) for the first time since the service began. The increase in both referrals and people using the service is largely down to the work the TECS team has concentrated on engagement and training with people who are either conducting Care Act assessments or are involved with the care cycle. Training is also offered to people working in care agencies, voluntary sector organisations, and health staff involved in the hospital discharge process.

It's estimated that during 2022/23 the TEC service has saved more than £7 million in preventative savings, of which about £2.7 million are new this year.

We're working hard to develop the skills of our people who work in care, and more than 20 teams have received equipment training and many more receiving help and advice from the NHS and our partners NRS.

In January, the service launched a new initiative to help with flow through the hospital. Staff working at the discharge hub and two wards at Torbay Hospital were shown how to use the technology to help get people who are well enough to go home but are awaiting a care package to try the equipment for six weeks. In its first month, this trial saw 19 hospital bed days saved, a reduction in discharge pathway, and all but one patient with a likelihood of a reduction of calls to primary or emergency services. This is

free to the client and is not dependent on meeting eligibility criteria, only that the referrer at the point of discharge decides that equipment can reduce the discharge pathway, reduce the number of days spent in hospital, or reduce the number of calls to the patient's GP, 111, or 999. The trial run for six months until the end of July and will be widened to include the short-term services such as rapid response and reablement teams.

Ms T's story

Ms T is a 52-year-old with learning difficulties. She is an independent and active member of her community, attending craft sessions every Tuesday and other support groups. Ms T suffers from anxiety, especially in the evening, as she lives alone, and she is a frequent visitor to Torbay Hospital's emergency department. When her anxiety increases in the evening she calls 999. She was worried about having a fall at home and being left alone and wanted someone to talk to for reassurance.

The team met Ms T and suggested installing a Footprint GPS device at her home, and she now says she feels less anxious as she knows that if she has a fall or her anxiety level increases, she can press the SOS button and talk to an operator for reassurance.

Mrs G's story

Mrs G has poor mobility and had a few falls when trying to get out of bed. She lives with her daughter. Mrs G had an assessment and a bed sensor with a Care Assist Pager has been installed to decrease the likelihood of falls. The bed sensor did not work as Mrs G slept sitting up, which triggered the alarm while she was asleep. A staff member contacted the TEC team for advice, and they suggested trying a long-range beam kit with an infrared light beam that triggers a local alarm within the property when broken.

A kit was installed and Mrs G's daughter said she's sleeping better now and knows she will be alerted if her mum tries to get out of bed. Mrs G has not had a fall since the beam was installed.

Mr R's story

Mr R, 60, has mental health issues and often forgets to take his medication, shower and wash his clothes. He said he felt unsafe in the community.

The TECS team met with Mr R and arranged an automatic pill dispenser to help him manage his medicine; an electronic device which reminds him to carry out his personal care, and a home security system which helps him feel safe and call for help when he needs it.

Health Connect Coaching was designed by patients and staff from Torbay and South Devon NHS Foundation Trust and matches people who may be struggling to manage their health and wellbeing with a trained peer coach who has experience of the same condition or challenges they face.

People with a long-term condition such as diabetes, rheumatology, and chronic pain can refer themselves to receive tailored one-to-one support during the six-month programme. With the help of a coach they are encouraged to make simple but long-lasting changes to their life such as taking gentle exercise or changes to their diet, and signposted to services and support. It's designed to encourage, support and empower people to build their knowledge, skills and confidence in a way that matters most to them, reduce their dependency on medical interventions and live well to manage their condition.

We know that encouraging people to make simple changes to their lifestyle can help them to take control of their condition and reduce their dependency on NHS services. It's about matching them with someone who has walked in their shoes and just gets it.

Financial Position

Our aim with this section of the review is to describe the financial resources available and how they have been used in the care sector. On 01 October 2015 our Integrated Care Organisation (ICO) was formed to provide adult social care for people in Torbay. From a financial perspective, the council's role as a commissioning body is to provide a funding contribution to the overall running costs of the ICO.

In 2022/23 the core contract value was £50.6 million plus £2.5 million held as a specific contract contingency with an additional £0.5m grant funding for adult social care market sustainability and improvement. In 2022/23 this contingency was fully used meaning a total contribution of £53.6 million was made to cover cost of client care and operational costs.

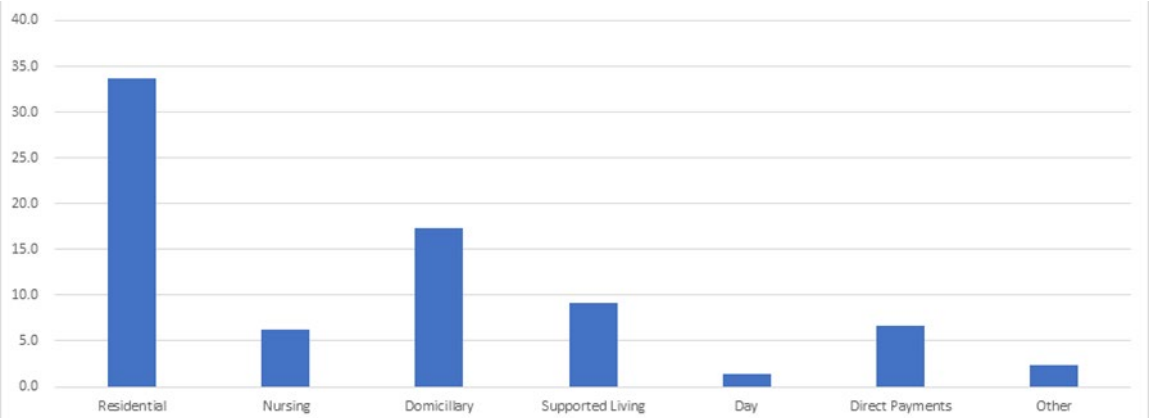
The ICO provides a diverse range of services, of which adult social care is a part. This aspect specifically comprises of care management and social care support across Torbay as well as the cost of social workers, community care workers, occupational therapists, physiotherapists, finance and benefit assessors and support service staff. Therefore, the council's contribution towards ICO running costs aims to cover the cost of these staff, in addition to the actual cost of client care (outlined in more detail below).

The vast majority of adult social care is spent is on the purchase of client care (including residential, nursing, supported living and domiciliary care) from independent providers. The majority of these providers are based within Torbay; however, the ICO also funds some specialist residential care provided out of area. At any point in time there is on average 2,400 people receiving a service of some type.

Net expenditure on the cost of care totalled £61.8million in 2022/23. This is the net figure after taking in to account all client contributions towards the cost of care.

Under national legislation people assessed as having a social care need are also given an individual financial assessment. This assessment can result in a client being asked to contribute towards the cost of any care that the council then puts in place. The income collected from these client contributions in 2022/23 amounted to £14.8million. The total (gross) expenditure on services was therefore £76.6million and the allocation of this gross expenditure across different types of services is illustrated in the following chart.

Gross expenditure breakdown 2022/23 (£ms)



View the Gross expenditure Breakdown in an accessible format

These services are provided to clients aged 18 and older, with a range of needs such as learning disabilities, mental health issues, dementia, as well as those with sensory or physical disabilities, vulnerable people, and the frail and elderly.

Throughout 2022/23 the trust has faced a number of challenges, driven by sustained pressure from the acute system and commercial market volatility.

There has been an increase in complexity and market fragility which has seen the average cost of packages of care rising throughout the year (over and above any inflationary uplift). Underpinning this is the dynamic between care work and hospitality work and the latter have increased renumeration to attract workers into their sector. To acknowledge this, the council, through national funding – adult social care market sustainability and improvement grant - has been able to increase some rates to residential / nursing providers for people older than 65.

Financial outlook for 2023/24 and beyond

The 2023/24 fee setting process (which incorporated additional increases linked to ASC Market Sustainability and Improvement grant) is now complete and a new structure communicated to providers. The fee uplift is on average 8.4% and takes into account employee cost increases through the National Living Wage and general inflationary uplifts. It is hoped this level of uplift will help stabilise the rates which are broadly in line with the rest of Devon.

The ICO and its partners are committed to ensuring resources are managed so that the ICO can provide the best level of care, for the highest number of clients. Both the council and NHS Devon acknowledge the pressures facing social care and continue to believe that the ICO is still best placed to manage these services (current agreement runs until 31 March 2025).

The ICO will aim to achieve this through the managing of resources across health and social care to deliver a more efficient and effective profile of expenditure. This is needed not only to maintain a financially stable and sustainable model of care, but one that can improve people's experiences of the service. Such development will be done in consultation with the council and, where it is necessary to make changes to the way services are delivered. Consultation will take place with the people and carers who use those services.

Healthwatch Response

Pat Harris, Chief Executive Officer
Healthwatch Torbay
June 2023

Healthwatch in Devon, Plymouth and Torbay (HWDPT) are the independent consumer champion for people using local health and social care services. Healthwatch listens to what people like about services and what could be improved and shares those views and experiences with those who have the power to make change happen.

We welcome the opportunity to respond to this year's local account summary for Torbay and we are encouraged to see how the collaborative approach between the NHS, the local authority and the voluntary and community sector continues to strengthen and grow. This approach builds upon the joint response to meeting the needs of the most

vulnerable within the local community through the pandemic, with the creation of the Community Helpline, which has gone on to become the heart of the new Community Hub for Torbay in Paignton Library, which is a fantastic example of partnership working and empowering communities to work together to support those in need within Torbay.

We commend the approach taken by Torbay Council and the Trust to work collaboratively with patients, carers and families, with support from Healthwatch Torbay, to develop the new adult social care strategy. The engagement process has provided considerable insight into what matters to people in terms of how they want to be supported. We are pleased to be working with Torbay Council and the Trust to ensure people's voices are heard and that their experiences and ideas will be used to shape how services are planned and delivered going forward.

We look forward in the next year to working in partnership to gain more from feedback and engagement, providing evidence to further support the culture of learning from people's experiences. We have developed effective channels for providing feedback to The Trust and the local authority and working together with stakeholders on the Adult Social Care Improvement Board, we will work closely with them in working towards the CQC assurance capabilities through CQC's assessment framework for quality assurance. We will also continue to strengthen our relationship with the Quality, Assurance and Improvement Team (QAIT) to ensure people's experiences of care are heard and where concerns are raised, these are acted on.

During this year we have heard from thousands of people who have shared their experiences in relation to health and social care. More specifically we have produced reports based on the experiences of unpaid carers and people's experiences in relation to the cost of living and the impact it has had on people's health and wellbeing. Our reports and evidence have been well received by the Trust and local authority and have provided key insights into how people are coping with and responding to the demands and pressures of everyday life, particularly when it has an impact on their health and wellbeing. Our evidence highlights the barriers that people face when they are seeking help or need support and together, we can help to identify and address these issues before people reach crisis.

Throughout this last year, the public has continued to appreciate the quality and commitment of our local NHS and social care workforce and has recognised the pressure that they all work under. Healthwatch Torbay continues to have a positive relationship with the Trust, where our role as critical friend remains strong and the Voice of local people is valued and acted on.

This Account clearly demonstrates the strength of integration across health and social care and the voluntary sector, with a primary intent to build resilience in populations and individuals and we are proud to be continue supporting this approach to ensure the public Voice is at the heart of service design, delivery and improvement throughout the coming year and beyond.

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Trust Strategy update (September 2023)			Meeting date: 27 September 2023
Report appendix	N/A		
Report sponsor	Director of Transformation and Partnerships		
Report author	Associate Director of Strategy and Provider Partnerships		
Report provenance	This report has been approved by the BBF Committee		
Purpose of the report and key issues for consideration/decision	This document and associated appendices bring together learning from approximately 18 months of active engagement alongside delivery of the strategy that the board approved in January 2022. It is the first in what is expected to be regular briefings that summarise progress delivering the agreed strategic objectives and also reflects on other developments and learning that will inform future strategic developments.		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation	The Board are asked to: • Approve continuation of the existing strategic direction - incorporating our vision, purpose and strategic priorities. • Note the amendment to the wording within the People Promise • Note the alignment of our strategy with the “One Devon” system’s Joint Forward Plan, feedback from our own organisation and the wider environment within which we operate. • Note progress being made against our strategic priorities and delivery of our supporting strategies. • Note the intention to further develop the Board Assurance Framework (BAF) to provide ongoing assurance for delivery of our strategic priorities. • Approve the supporting strategy review document		

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<tr><td>Excellent value and sustainability</td><td>X</td><td colspan="2"></td></tr>
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BAF Ref. 8 – Transformation and Partnerships
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<tr><td>NHS England</td><td></td><td>Legislation</td><td></td></tr>
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Torbay and South Devon
NHS Foundation Trust

Report title: Strategy Update (Sep 2023)		**Meeting date:** 27/09/2023
Report sponsor	Director of Transformation and Partnerships	
Report author	Associate Director of Strategy and Provider Partnerships	

Our strategy: Delivery update

Briefing paper for Board of Directors

Date: 21 September 2023

Contents

1 FOREWORD

This document and associated appendices bring together learning from approximately 18 months of active engagement alongside delivery of the strategy that the Board approved in January 2022. It is the first in what is expected to be regular briefings that summarise progress delivering the agreed strategic objectives and also reflects on other developments and learning that will inform future strategic developments.

This briefing is not a comprehensive and detailed evaluation of the strategy and all its component parts – rather a stock-take of key achievements to date and critical reflection on the most important elements for consideration by the Board. It will contribute to an on-going conversation between stakeholders so that our strategy continues to respond to internal and external developments and evolves over time.

For context: A note on our role as an "anchor organisation"

Every NHS organisation across the country forms a critical part of its local community. There is increasing evidence that NHS organisations, as anchor institutions, can make a meaningful impact on the long-term health of their communities. The evolving role of ICSs and establishment of ICBs provides a further opportunity for local health and care systems to make the most of the NHS's role as an anchor institution.

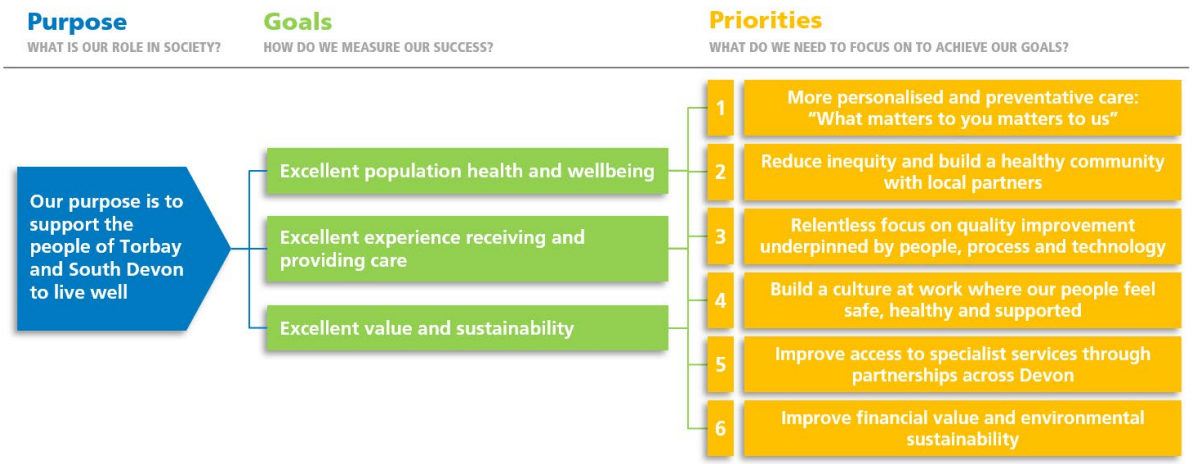
NHS Long Term Workforce Plan (June 2023)

2 Executive Summary – Purpose, goals and priorities

In January 2022 we published our first formal strategy refresh since we became an integrated care organisation in 2015. This was a positive process that re-affirmed that our ambition and direction of travel towards greater integration and moving services closer to people's homes remained true.

At the same time, it provided opportunity to articulate our goals more clearly and highlight new priorities to reflect the changing world around us, what matters to our people and our communities and how we can best support them to improve their health and wellbeing.

At the core of our strategy is our purpose, goals and priorities:



Our purpose, goals and priorities draw heavily on our understanding of our local communities' wants and needs, and we engaged staff and partner organisations in their development. We felt it was important to be flexible and responsive to feedback, and we have engaged many more people since publishing, seeking views about what the strategy means for people when it is applied to their day-to-day roles and interactions with our organisation. We have learned much in this process, and feedback has been broadly positive.

The main challenge that people have raised relates to the high-level nature of our strategy, and the difficulty some people have had stepping back to consider strategic factors in context of operational crises they deal with day-to-day. This is something that we continue to support people with to ensure there is a golden thread based on our strategic goals that runs from our high-level strategic planning, through regular operational planning processes, to team discussions and interactions with people who use our services every day.

Another point of learning we have taken following feedback from staff is that our strategic priorities lose some of their essence and meaning when they have been simplified for more visual communication styles and this will be addressed in the next set of communication assets.

Overall, following 18 months of the strategy being in place, and having undertaken wide staff and partner engagement, our reflection is that this strategy is a good fit for our organisation's current circumstances and will serve us well for the foreseeable future.

The strategy remains responsive to the needs of our communities, staff and partners and will reflect the transformation ambitions of the Peninsula Acute Provider Collaborative and our Local Care Partnership.

3 WHAT OUR STRATEGY MEANS TO PEOPLE

In the course of sharing our strategy with people over the last year and listening to what they have to say, we have reflected on what it means to people and how to best communicate it. Key messages learned include:

- for **all of our people**, our vision matters, and it is important to know how their roles contribute to it.
- for **leaders and managers**, it is especially important to see where their services and plans fit into the bigger picture, and to have confidence that supporting services and activities are coherent.
- **not everybody** wants to think strategically or spend time understanding long-term plans – many are comfortable with a good knowledge of their closer and more immediate context.
- In relation to this, we recognise the extraordinary short-term pressures that our people have faced through COVID-19 pandemic and subsequent operational pressures.

We have undertaken many activities to share our vision, goals and priorities through a variety of channels, including:

- all-staff briefings and executive vlogs
- staff cascades – encouraging discussion, debate and feedback among teams
- one-page documents at key locations, alongside posters and graphics on walls
- public facing strategy document on our website and printed copies available across our sites
- information on our intranet (ICON) and public website
- creation of an online strategy hub for our staff, with resources, newsfeed, documents, etc.
- Ongoing strategy development group, involving broad representation

We recognise that for a number of our people, it can be difficult to find time and headspace to think about our long term strategy, particularly when they are managing operational pressures and current challenges. However, we recognise that the value of strategic thinking and empowering and enabling our people to engage with this is essential to ensuring that our services meet the needs of our communities now and in the future. Therefore, we will continue to pursue a nuanced, reflective and sustained approach to engagement that is sensitive to competing demands which face our teams.

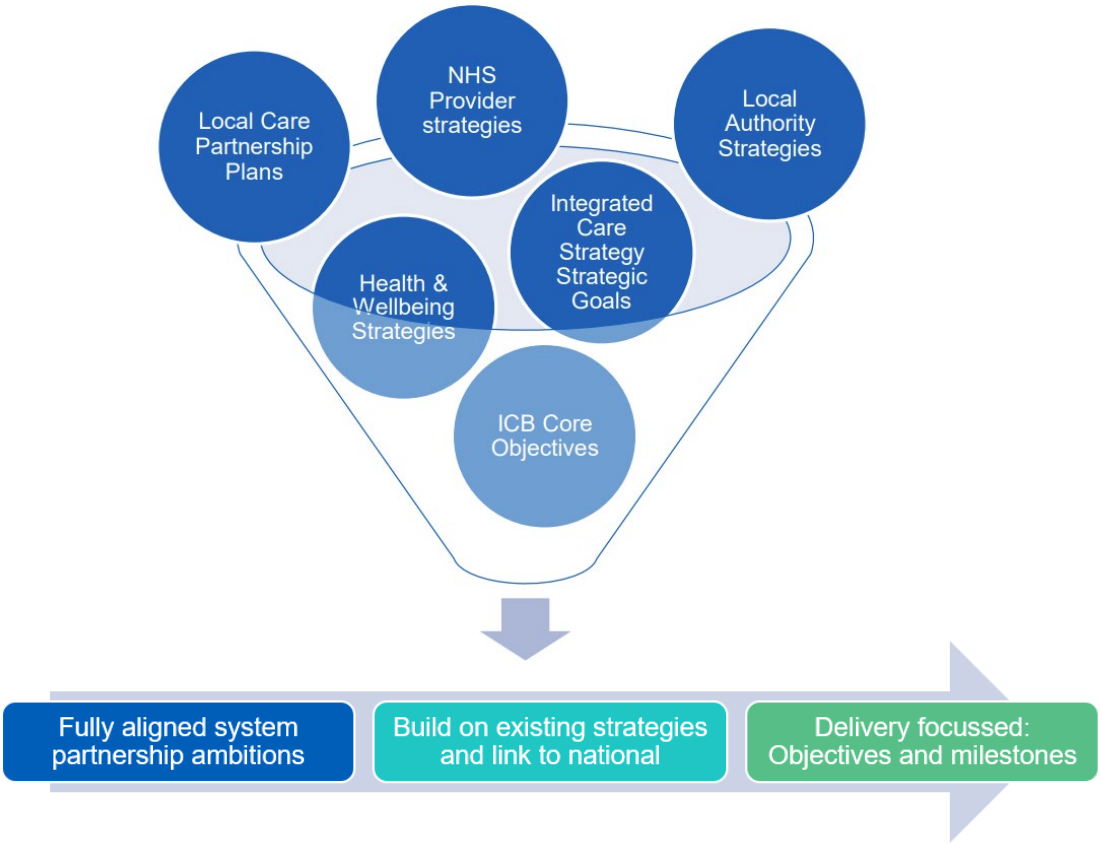
4 THE WIDER HEALTH AND CARE SYSTEM

The One Devon Integrated Care System (ICS)

For over twenty-five years ourselves and our predecessor organisations have recognised and championed the importance of partnership working and integration of services as a key enabler to:

- delivering better outcomes and experiences for patients, with minimal disruption as they transition between different organisations and services.
- providing more effective and efficient services, delivering better value and reducing bureaucracy and duplication at the interface between services and organisations.
- It is heartening to see our long-held beliefs now reflected across the wider NHS supported by the recent reconfiguration of statutory NHS bodies and delivery frameworks to deliver more partnership working and closer integration as a key solution to improving performance in Devon. The One Devon Integrated Care System (ICS) has set out a strategy and draft Joint Forward Plan (JFP) that seeks to align NHS, Local Authority and Third Sector providers in Devon with the following core aims:
- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- supporting broader social and economic development.

We are working closely with colleagues in our Local Care Partnership (the South LCP) to agree what the One Devon strategy means for our people and communities and aligning our plans and activities accordingly. We will also be working together to feed into future iterations of the plan with a coherent voice on behalf of the communities we serve.



Alignment of our strategy with the Joint Forward Plan

Devon's Joint Forward Plan (JFP) is made up from nine key delivery programmes and ten "enabling programmes", which between them, aim to deliver the One Devon strategy. It is important that all local health and care providers align their strategies with the JFP, and also that they have an opportunity to feed into and refine the JFP. This will be a key focus for members of our South LCP in the coming months.

In addition to our engagement through the South LCP, we will regularly sense-check our own strategy and plans with the JFP to ensure we are aligned and to highlight any potential omissions, dependencies or planning conflicts that might arise.

The following table summarises our position with respect to each of the JFP programmes:

Element		Relationship with our core services	Early commentary in advance of detailed reconciliation and alignment through 2023/24
Key delivery programmes	Primary and community care	Close	Strong alignment with our strategic priorities and well-established principles relating to an integrated care model, with a focus on collaborative prevention and implementation of best practice through Local Care Partnerships (LCPs). We will continue to refine our approach with local partners and to develop our care model, informed by the "BBF Drum Beat" sessions, ongoing improvement work and other engagement activities.
	Mental health, learning disability and neurodiversity	Moderate	While mental health services do not form a large part of our service offering, we are the lead partner for community children's services (Children and Family Health Devon) and work closely with colleagues in DPT to support CYP and adult mental health across acute and community services (and adult social care). This will continue to be an important plan for us to monitor and support in close collaboration with partners and service teams.
	Women and children	Close	The Devon ambition to create an integrated system and care model for children and young people (CYP) is closely aligned with our current care model delivered through Children and Family Health Devon (CFHD). We will continue to work with system partners to develop our offer for CYP as well as our acute and community services for women throughout 2023/24.
	Acute services	Close	Strong focus on recovery of planned/unplanned care and addressing health inequalities – close alignment with our existing focus. Our internal activities are informed and complemented by partnership work with the Peninsula Acute Sustainability Programme, and we will be working closely with Devon partners to meet system-level targets in 2023/24.

	Housing	Indirect	We do not have a role commissioning or providing housing, but as a founder member of the NHS Homes Alliance, we recognise the well-evidence links between the quality of living environments and related factors on people's health and wellbeing. We will engage with this work through our role as a local anchor organisation and commitment to shared community agendas such as Turning the tide on poverty, Community Wealth Building and Local Motion.
	Community development	Indirect	This element of the JFP focuses on the role of Local Care Partnerships (LCPs) in supporting local communities to be more resilient. As a key member of the LCP and an anchor organisation we will be actively involved in this work with local communities and community groups in their area, co-producing a plan to empower and support local people to live well.
	Employment	Indirect	We recognise the well-evidenced links between employment and wellbeing, health and social mobility, alongside its role supporting individuals to thrive, young people to advance, support services to better manage demand. Employment alongside appropriate training and development is also critical to providing the health and social care system with the future workforce it needs. As a large local employer we provide work experience and volunteering opportunities for local people. We engage with this work through our people function(s) as well as through our role as a local anchor organisation and commitment to shared community agendas such as Turning the tide on poverty, Community Wealth Building and Local Motion.
	Health protection	Indirect	This part of the JFP focuses on protecting the population from preventable diseases, hazards and infections. There may be some cross-over with our services or we may be commissioned to provide screening or infection controls services. While not a major part of a core service, we will monitor these plans closely and work with partners to help design and deliver plans as required.
	Suicide prevention	Indirect	The JFP refers to the national suicide and self-harm prevention strategy and the NHS Long Term Plan to transform mental health and care services to enable better access to care for people having a mental health crisis. While this does not form a major part of our core services we will work closely with key system partners to improve in our role where we are close to patients and to support mental health services where appropriate.

Enabling programmes	System development	Some of these enabling programmes will be primarily driven from within the Integrated Care Board itself, while others will be (to some degree) delegated to other parts of the One Devon system framework. For instance, our South LCP has established a population health management group, that will help local partners to understand available health data and make better collaborative decisions on behalf of our population as a whole. It is early days for planning in most of these enabling programmes as the operational governance infrastructure for One Devon and LCPs is still established. We will continue to work collaboratively through our roles at all levels within the emerging structure to both support delivery of the system-wide plans, and to influence their development to speak on behalf of the Torbay and South Devon community.
	Workforce	
	Digital and data	
	Estates and infrastructure	
	Finance	
	Communications and involvement	
	Research, innovation and improvement	
	Equality, diversity and inclusion	
	Climate change	
	Population health	

While the Joint Forward Plan is still new, our response to it is relatively brief and high-level. There will be an active focus throughout 2023/24 on working with partners in the South LCP to collaboratively develop detailed plans and feedback relating to our communities to explore with the wider system.

Acute provider collaborative: Our role in system developments

Together with partners in Devon and Cornwall we have established the Peninsula Acute Provider Collaborative (PAPC). Provider collaboratives are partnerships involving at least two NHS trusts with a shared purpose and effective decision-making arrangements. All trusts providing acute health services are required to be part of one or more provider collaboratives as part of new ways of working across health and care in England.

The role of the PAPC is to work on behalf of individual trust Boards to set the direction and provide the strategic leadership across organisational boundaries to stabilise, sustain and transform acute care for the population of Devon and Cornwall.

5 CURRENT STRATEGIC CONTEXT

The external context within which we work is continually developing, and the following table highlights how we are responding to some of the most significant external developments:

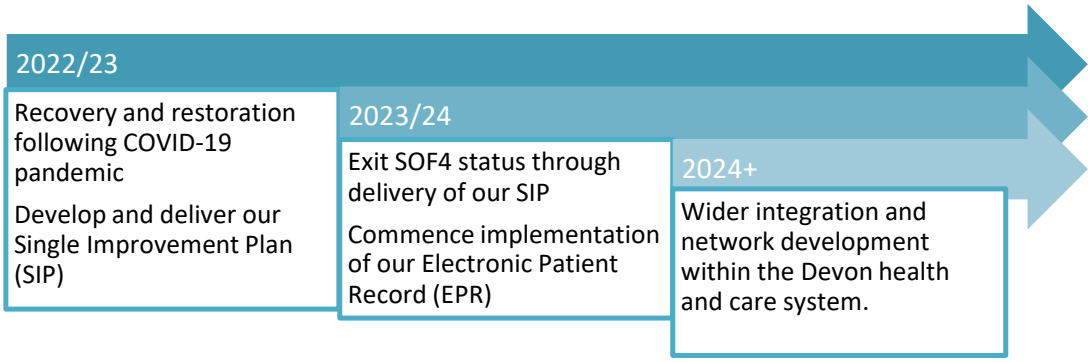
Factor	Impact	Our response
Our community's developing needs - as described in the Joint Strategic Needs Assessment (JSNA) now updated to June 2023	Health, wellbeing and economic inequalities have widened as a consequence of pandemic and cost-of-living challenges, with growing demand for social care, physical and mental health services. This has had a particularly significant impact on deprived coastal towns where Torbay (among others) has seen the impact of widening health and wellbeing inequalities alongside economic challenges. Further, the historic tendency for the South Devon population to be older than national average is increasing, with the number of people aged over 85 expected to increase by 50% over 10 years.	Increasing focus on wellbeing and prevention alongside major work programmes to reduce waits for care. Active engagement with local partners in turning the tide on poverty, community resilience and other initiatives.
One Devon Joint Forward Plan (JFP) and strategic priorities: 1) population health 2) inequalities 3) productivity and value for money 4) social/economic development	Provides direction for the "One Devon" system to improve services for people across the County with a framework for local care partnerships to align their priorities and delivery plans with the wider Devon system.	Working with system partners in the Local Care Partnership (LCP) and the acute provider collaborative (PAPC) to align priorities, deliver improvements and shape local services to meet local people's needs in a sustainable manner. LCP members will be actively mapping their plans against the JFP priorities, looking for opportunities to work together and address gaps in the course of 2023/24.
Continuing impact from COVID-19 disruption	Waiting lists, staff fragility, public/patient behaviours, clinical vulnerability, "saved-up problems" that weren't presented earlier, etc.	Engagement with national/regional programmes for elective and urgent care in the course of delivering local improvement programmes aligned with Devon partners. Delivery of our People promise and embedding our Compassionate Leadership Framework is critical to creating a culture at work where our people feel safe, healthy and supported, in order to provide the best services to local people while protecting each other's wellbeing and helping individuals to thrive.

6 PROGRESS DELIVERING OUR STRATEGY

Strategic objectives

In the course of 2022/23 our Board agreed a small number of broad strategic objectives for our organisation as a whole. These reflect the most significant achievements that have an major impact for our organisation, and will unlock future strategic developments to ensure our long-term relevance to our community and wider partners across Devon for the long-term.

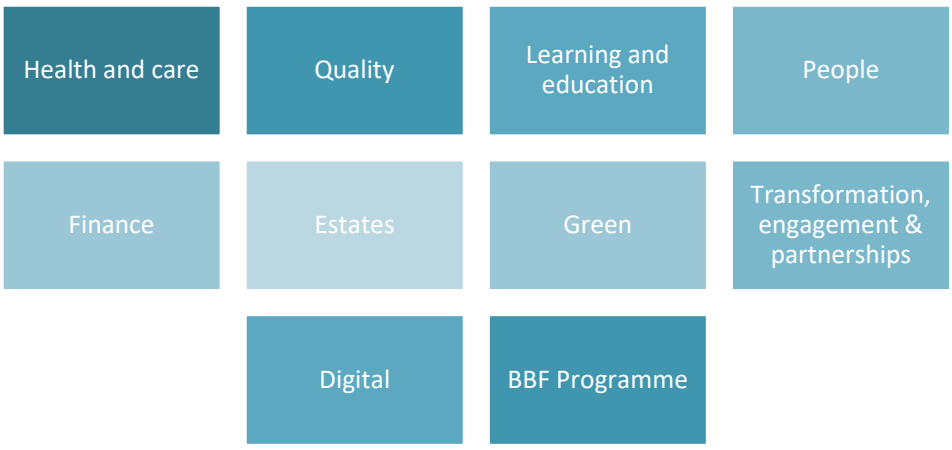
These objectives are as follows:



These remain the “must-do” aims for the current year, while also recognising that they may be affected or impacted by transformation and change within the Devon health and care system.

Supporting strategies

Core to delivery of these strategic objectives is our executive-director-owned supporting strategies, as follows:



A new supporting strategy, learning and education, was added to the list following executive director discussions in the course of 2022/23.

Each supporting strategy has clear actions and objectives aligned with them, for which we have undertaken a review for this briefing. This assessment has demonstrated that we are largely on-track to deliver the objectives set out by our supporting strategies, although there are a number of areas where further attention is warranted.

Strategic priorities

The Board agreed a set of strategic priorities in January 2022 to focus our organisational energies on a small number of the most critical areas for long-term development. These have been widely shared over the last year, and have provided a helpful framework to focus development of supporting strategies and plans.

The following table summarises key achievements to date and next steps against each of these priorities. In reviewing progress against our priorities, the Board may like to sense-check that they are still right for our current ambitions, reflecting changes to our external environment since they were first agreed.

Strategic priority	Highlight achievements in 2022/23	2023/24 and beyond
1. More personalised and preventative care: "What matters to you matters to us"	• Development of community engagement forums aligned with our "place based" services • Paediatric mental health network launched by Torbay hospital staff • We launched our "drumbeat" programme with 14 clinical specialities to help us design our care model for our brighter future • We secured funding (£400K) to co-develop a software application for augmented reality (AR) glasses to improve motor function assessments of people with MS. The grant will help us to set up the new PARAMS research study and develop our AR MS clinics as part of the drive to use technology to provide care closer to people's homes	• Coordination of cross-organisation engagement activities with local partners through the Local Care Partnership (LCP) to involve more local people in better targeted ways • Drumbeats 2.0: Building on our learning from drumbeats 1.0 and developing our planned care and prevention of ill-health work alongside developing new ways of working including virtual wards and hospital at home • Evolving our model of outpatient care to see more people and adapting how we do this (virtual appointments, making best use of technologies such as Hololens, introducing patient led follow up)

2. Reduce inequity and build a healthy community with local partners	• The South West Ambulatory Orthopaedic Centre began to offer surgery to Torbay and South Devon patients – drawing on the expertise of our nationally recognised day surgery unit at Torbay Hospital, and from leading orthopaedic units across the country, SWAOC offers people in Devon an exemplary pathway of care • New treating tobacco dependency service launched for pregnant women and birthing people • MS Brain Health Team Award won by our MS service in recognition of their unique healthy lifestyle clinic and service • Our alcohol care team launched at Torbay Hospital to provide support and advice to people in hospital with alcohol use disorders • Children and young people in our hospitals received new equipment and aids to support emotional wellbeing	• Opening of Dartmouth Health and Wellbeing Centre • Establishment of a Population Health Management sub-group within the South LCP to develop and share our knowledge base, improve decision-making and build a whole population culture • Greater focus on prevention and wellbeing in operational planning • Continued engagement with Community Wealth Board, working with local partners to turn the tide on poverty and support the local economy • Expansion of Health Connect Coaching (HCC) pilot (now winners of a regional NHS Parliamentary award) to bring peer coaching and support to more of our community. • Continued engagement with Local Motion, working with partners to understand local strengths in the places where we live and work. • A confirmed pathway for paediatric specialist clinical nurses has led to the development of improved standard-operating-procedures for the epilepsy service ensuring children, young people and their families/carers receive a consistent pathway of care and support.

3. Relentless focus on quality improvement underpinned by people, process and technology	• Funding secured to expand our endoscopy service (creating a fourth room and a training room) – due to be completed November 2023 • Funding secured for day theatres and ophthalmology expansion (including new entrance for heart and lung, eye clinic and theatres) – due to be completed early next year – supporting us to care for 4,500 more people a year • TORPEdO clinical research trial opened at Torbay Hospital enabling local people with throat cancer can benefit from proton beam therapy • We submitted our Electronic Patient Record Outline Business Case for regional/national approval. It is a fundamental part of our digital strategy and a significant achievement • We launched our Emergency Department patient journey map, part of a range of quality improvement work led by our people • Acute Medical Unit welcomed its first patients • Our COVID Medicines Delivery Unit (CMDU) finished 2022 as the busiest CMDU in Devon with the fastest response time – supporting our most vulnerable people to access effective treatment in a timely manner	• Building work completed on expansion of endoscopy and day theatres • Commence implementation and wider engagement with supporting activities related to our new Electronic Patient Record (EPR) • The rollout of eRostering across the trust will contribute towards significantly improved efficiencies of staff rostering across departments and reduced dependency on temporary staffing. • Respiratory and Cardiology Virtual Wards supported 29 patients between 11-15th September 2023. Operationalisation of the Frailty Virtual Ward model us underway, with a go live date of October 2023. Discussions are underway to explore other speciality Virtual Ward opportunities for Torbay's community There has been an uptake in Respiratory and Cardiology Virtual Wards supporting 24 patents and exceeding our virtual ward occupancy target for the period of 9-15th June. Operationalisation of the Frailty VW model is currently underway, with a go live date of September 2023. Refresh please • Four-day Improvement and Innovation practitioner programme commences on the 27th June with over 30 staff, all bringing a range of projects to develop during their work • The Introduction to Improvement and Innovation interactive workshop was launched with a number of dates scheduled across the summer and autumn. This short course introduces staff to how to do improvement and in particular supports the successful use of our Quality Boards

4. To build a culture at work where our people feel safe, healthy and supported	• Launch of “Our people” awards to help our people thrive. • We launched our first multi-channel recruitment campaign including television advertising • The number of people trained as wellbeing buddies in our teams reached over 200 • Pastoral Care Quality Award recognises pastoral support provided to international nurses • We launched stay conversations and career coaching pilots set up as part of the Devon retention project • Our education and research facility reopened after an extensive redevelopment project that will support the training of medical students, multi-professional learners and staff from across the organisation • Launch of our BME Leadership programme	• Launching our welcome events for new starters • Introducing our compassionate leadership framework (co-designed with our people) to support leadership development and recruitment and create a culture of impactful learning and improvement

5. Improve access to specialist services through partnerships across Devon	• Patient-led support group launched for people living with head and neck cancer – the first in the South West. • Start of the Peninsula Acute Sustainability Programme (PASP) developing collaborative working across Peninsula acute providers • Launch of TRI – Torbay Recovery Initiatives – an innovative partnership between the NHS and voluntary sector to support people with their recovery from substance abuse	• Continued close engagement with our South LCP to establish the framework for overseeing and delivering local improvements more collaboratively. • Enhanced Health in Care Homes Delivery Group are collaborating on the creation of a set of webpages that will act as a single point of information so that care homes can access everything they need from one main space rather than having to make multiple calls or emails to find out about the services they need. • The delivery of RESTORE 2 is being enhanced by the introduction of a digital application, designed by the education team and piloted with 10 Care Homes. It will provide a consistent approach to assessing the deteriorating patient and provides a comprehensive falls prevention assessment tool, with a commissioner dashboard which will provide population-level data on the incidence and prevalence of falls.
6. Improve financial value and environmental sustainability	• Desflurane completely removed from Torbay Hospital and good progress being made to reduce the use of nitrous oxide • Strategic outline business case for New Hospital Programme resubmitted • We welcomed 18 Medical Support Workers from Myanmar and India, supporting them to rebuild their lives in this country and enabling our people to benefit from their skills while they progress their medical careers • We launched our green plant project (funded by NHS Charities Together) and delivered over 1,300 plants to offices and non-clinical areas	• Site clearance at Torbay Hospital begins for our “Building a brighter future” programme. • Theatre productivity and utilisation is a key national priority. Focusing on delivery of the national standard to achieve 85% touch-time utilisation, the improvement team have supported main theatres through the provision of an in-depth data analysis, literature review and observations to understand identify and deliver the greatest opportunities for improvement. • Following successful delivery of the Smart Tech project where 25% of care homes in Torbay and South Devon are supported to upskill staff to become digitally competent to support residents in using smart technology, Healthwatch has been awarded funding to implement Phase 2.

Supporting strategy delivery update

The following table summarises the position of our supporting strategies at August 2023:

Supporting strategy	Purpose	Key Risks
Health and care Health and Care Strategy Director	Design, implement and continuously improve a model of care that best meets the needs of local people for the foreseeable future.	• N/A
Quality Chief Nurse	Maintain standards and continuously improve the quality of the services we provide. Our services will be even more safe and clinically effective, with the best possible experience and outcomes.	• Further work to provide assurance around 100% compliance with admission risk assessments.
Learning and education Chief Nurse	To create an integrated and multi professional learning and education platform that is inclusive, collaborative and participative, for effective and high performing teams, where everyone can flourish.	• N/A
People Chief People Officer	Our people will have the skills and capacity to deliver quality services, delivered in conditions that support ongoing improvement. To build a culture at work where our people feel safe, healthy and supported, embodied within our “People Promise”, where our people thrive.	• N/A
Finance Chief Financial Officer	Improve value for money of our services, support judicious investment of capital funds and ensure effective financial governance.	• Nation-wide operational demands limit ability to shift resources towards ill-health prevention and wellbeing in the short-term • Risk to delivery of efficiency targets
Workplace Director of Workplace	Provide, maintain and improve facilities and environments to support care delivery and relevant support services.	• Community health and wellbeing centre implementation is part-delivered, but strategy and timeline need refreshing
Sustainability and decarbonisation Workplace Director	Improve the sustainability of care and supporting services, reduce waste and move towards net-zero carbon emissions.	• Risk to full delivery of our “Green plan” and rapid replacement of broken plant/equipment in the most sustainable manner due to more urgent priorities within our capital plan
Transformation, engagement & partnerships Director	Work with our community, staff and partners to transform our organisation and the local health and care system to shape services fit for the future.	• N/A

Digital SDHIS Director	Design, implement and improve our underlying digital infrastructure, alongside development of new digital clinical and communication services aligned to our goals.	• N/A
BBF Programme BBF Programme Director	Cutting across all supporting strategies, the BBF programme will design, secure funding for and deliver a modern hospital infrastructure to support a sustainable future model of care.	• Uncertain timing of funding allocation (determined by national programme) may lead to delayed implementation of enabling works

7 SUMMARY OF RECOMMENDATIONS

The Board are asked to:

- Approve continuation of the existing strategic direction - incorporating our vision, purpose and strategic priorities.

- Make a minor amendment to the wording of the “People” priority to align with the aim of the People Promise, changing from:
  - “Build a healthy organisational culture where our workforce thrives”; to
  - “To build a culture at work where our people feel safe, healthy and supported”

- Note the alignment of our strategy with the “One Devon” system’s Joint Forward Plan, feedback from our own organisation and the wider environment within which we operate.

- Note progress being made against our strategic priorities and delivery of our supporting strategies.

- Provide feedback throughout 2023/24 on development of the Board Assurance Framework (BAF) to provide ongoing assurance for delivery of our strategic priorities.

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Report to the Trust Board of Directors			
Report title: Board Assurance Framework and Corporate Risk Register			**Meeting date:** 27 September 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 September 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. Since the last meeting amendments have been made to Objectives 1, 2, 3, 5, 6, 7 and 8.		
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**		

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BOARD ASSURANCE FRAMEWORK 2023/24

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	General updates
2.	People	CPO	20	16	Minor updates, proposal to remove 3.3A under internal gaps in control.
3	Financial Sustainability	CFO	25	16	Minor updates
4	Estates	CFO	25	10	
5	Operations and Performance Standards	COO	16	12	General updates and risk score amended to 15
6	Digital and Cyber Resilience	DTP	25	25	General updates
7	Building Brighter Future (BBF)	DTP	15	15	General updates, in particular to progress reports on the action log
8	Transformation and Partnerships	DTP	16	9	General updates
9	Integrated Care System	DTP	16	8	
10	Green Plan/Environmental, Social and Governance	CFO	12	6	

Strategic context:

The Board Assurance Framework ("BAF") is the key source of evidence that links the delivery of the Trust's strategic objectives to risk, control and assurance; and is the primary internal control that the Board uses for strategic oversight and assurance.

The current Trust Strategy was approved in February 2022 and can be found on our website here: https://www.torbayandsouthdevon.nhs.uk/about-us/our-vision-and-strategy/

An Executive Lead is nominated for each BAF Objective, to maintain, review and manage the narrative around each Objective, as well as overseeing the associated risk and controls impacting on delivery. Each Objective is then delegated to a Board Sub-Committee who scrutinise their individual BAF Objectives and undertake a detailed review at each meeting.

The Risk Group also review the BAF and Corporate Risk Register ('CRR').

The Board then undertake a review of the whole BAF, assuring themselves that the narrative and controls contained therein provide sufficient oversight and mitigation of risk as well as noting progress against the Trust strategy; noting the risk position and any exception reporting at their meetings.

Methodology:

In reviewing this document Executives will have regard to the Trust's risk management policies, procedures and methodology, as amended from time to time. Noting the importance of tiered mitigation for controls through the "3 lines of defence" as a matter of good governance:

- First Line Assurance - (assessments undertaken and owned by functions that own and manage the risk) – An example of this could be a local monthly compliance check that is undertaken within a specific function.
- Second Line Assurance - (oversight of functions that oversee or who specialise in compliance or the management of risk) – An example of this could be a system, process or piece of assurance that has been reviewed and assessed by the Risk or Governance Team, independently from the first line. Produced distinct from those who are responsible for delivery
- Third Line Assurance - (objective and independent assurance) An example of this could be an assessment of a system and processes by the Trust's Internal Auditors, External Auditors, or regulatory bodies.

The current policies in place are: Risk Management Policy, approved September 2022 & Risk Management Strategy, approved September 2022. It should be noted that these are to be merged during 2023 ensuring consistency of methodology.

When reviewing the BAF objective risk analysis section it should be noted that a risk analysis reference number will be utilised to read across each identified aggravating, mitigation and impact area; linking to gaps in assurance to specific actions. Creating a "golden thread", which is essential for analysis, audit and mapping of risk management.

BAF Current Risk Score Heatmap

Consequence (Impact) / Likelihood	1 Minimal	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 - Almost Certain	5	10	15	20	25 (6, 4, 3)
4 - Likely	4	8	12 (10)	16 (8, 9, 1)	20 (2)
3 - Possible	3	6	9	12	15 (5, 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:**	September 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**April 24**	**Aug 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: • Awaiting outcome of CQC Inspection in June/July 2023 which will determine scope of internal QOI program • Demand and Capacity modelling presents a significant gap in terms of TSDFT meeting levels of activity at pace and scale • New operational structure • Capacity challenges in operational and medical leadership • Continued Pressure on the emergency pathway • Clinical Governance Framework new and not mature • Informatics / Quality metric a significant challenge • NoF 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	4	
Consequence	4	4	4	4	*3*	5	
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 NOF 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 Regular review Mortality and Morbidity through to Board incorporated into overall Harm review framework and through QA Governance framework	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 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 Maturing	1.1C	System /ICS around plans to address inequalities in access and treatment
1.3A	Strengthen accountability and improvement through new Care Group Structure	1.1C	Central government control restricting ability to prioritise local needs
1.3A	Need to strengthen and Mature Governance and oversight through new divisional structure 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 NOF 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 following the June/July 2023 Inspection	CNO	October 2023	• Quality Metrics being reviewed to ensure focus on appropriate quality and patient safety issues and ensure alignment with risks and NOF 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 • 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	CNO	April 2023	• Revised Structure in place but inconsistent • Development Program to be designed and implemented • AWS to deliver development program
1.3A	Strengthening of quality oversight and assurance at service at Care group level through new operating model	CNO	July 2023	• 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.	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:**	August 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**Aug 24**	**Aug 22**	
Likelihood	4	4	5	5	4	4	NOF4 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.
Consequence	4	4	4	4	4	4	
Risk Score	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 September 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 24	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 NOF4 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.	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 excerbate 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 Complete~~	~~Cultural improvement plan was presented at People Committee 26.06.23 and approved at Trust Board on 26.07.23. Now in the delivery phase.~~
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 listen and act. Will involve inclusion enhancement training to complement EDI mandatory 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. To be launched end of September 2023.
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:**	Aug 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**April 24**	**Aug 22**	
Likelihood	5	5	5	5	4	4	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.
Consequence	5	5	5	5	4	4	
Risk Score	25	25	25	25	16	16	

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 NOF 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 NOF 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 NOF 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 NOF 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 NOF 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 NOF 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 NOF 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 NOF 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	Dec 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**
	Jan 23	**Mar 23**	**Jul 23**	**Sep 23**	**2030**	**Aug 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 NOF4 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 NOF4 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 NOF4 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 NOF4 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:**	August 2023

BAF Risk Scoring

Current Position	Jan 23	Mar 23	Jul 23	Sept 23	Target Position April 24	Year on Year Aug 22	Rationale for Risk Level
Likelihood	5	4	4	5	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	3	4	4	
Risk Score	20	16	16	15	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 Group improvement programmes overseen by Trust Recovery Board UEC funding agreed with ICS. Weekly Tier 1 meetings with ICS and NHSE	5.1.C	Delays in progressing patient decisions resulting in delays in treating patients both internally and externally
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. Community Transformation Group being established overseen by Trust Recovery Board Agreement on funding arrangement to incentivise market development. Newton Europe Report concluded, and actions being implemented	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 Group improvement programmes overseen by Trust Recovery Board.	5.4.C	Failure to deliver on NOF4 exit criteria resulting in reduced organisational control

			Weekly PLT review meetings to progress patient pathway for Cancers and Electives. Tier 1 Regional Support . Regional Mutual Aid including access to Nightingale Hospital Exeter. TIF funding for additional capacity agreed.		
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.
5.7A	Industrial action continues to impact elective and non-elective recovery programmes.	5.7 B	Trust Industrial Action and Patient Safety Committee in place, chaired by COO. Strike specific 'playbook; developed to ensure information and coordination of mitigating actions is developed and managed. Engagement with clinical teams increased to assess and clarify IA impact and resolution to identified areas of concern.	5.7 C	Failure to deliver on NOF4 exit criteria resulting in reduced organisational control. Patients' appointments delayed resulting in poor patient experience and harm.

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.	5.7 A	Externally driven engagement between concerned parties resulting in settlement and end of IA

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	Continued application of improvement methodologies to ensure appropriate decision making and engagement
5.1 A	Job planning analysis agreed using external consultancy Kendell Bluck	COO	Nov 23	
~~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 Group and Planned Care Group to focus actions on delivery~~	~~COO~~	~~May 23~~	~~Complete~~

~~5.4.A~~	~~Establishment of outsourcing and Insourcing capacity to manage demand~~	~~COO~~	~~Apr 23~~	~~Complete~~
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~~	~~Complete~~
5.7 A	Development of IA specific Trust 'playbook' for management of different IAs	COO	Sept 23	

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:**	August 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**April 24**	**Aug 22**	Current IT systems and supporting infrastructure will not meet the current of future business need. The current likelihood has increased for two reasons, firstly the level of known vulnerability of the PAS / LIMS systems which will cease to be supported from 2024. National security vulnerabilities (such as Log4shell) are significant concerns to IT systems globally, additionally the cyber-attack against the Ortivis provider used by SWAST is the second within a calendar year (the other being against Advanced). The current consequence is scored at 5 as the reliance on digital systems in the delivery of business processes and clinical services is high and the impact of a cyber-attack could be catastrophic (for example, extended loss of essential service in more than one critical area)
Likelihood	5	5	5	5	5	5	
Consequence	5	5	5	5	5	5	
Risk Score	25	25	25	25	25	25	

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 OBC approved, 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/NOF4 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	2023/24 capital plan, including external network 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	2023/24 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	2023/24 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	2023/24 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 dependent on FBC approval 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:**	August 2023

BAF Risk Scoring

Current Position					Target Position	Year on Year	Rationale for Risk Level
	Jan 23	**March 23**	**Jul 23**	**Sept 23**	**May 23**	**Aug 22**	
Likelihood	3	3	3	3	3	3	The availability of a national funding for cohort 4
Consequence	5	5	5	5	5	4	
Risk Score	15	15	15	15	15	16	

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	The 'seed' funding for 2023/24 has now been confirmed at a further £1.06m, which is in line with the funding provided for the last 2 years. In addition, the Trust has been able to secure a further £422,000 which will be required to complete the Site Enabling FBC.	7.4.C	The Trust now has the required funding to complete the site enabling FBC, which will enable the business case to be presented to the Trust Board in either April or May 2024.
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~~	~~**Action complete** – This additional funding (£422,000) to secure the completion of the Site Enabling FBC has now been received, and the programme office are now progressing with the detailed planning required for a April / May 2024 presentation to Trust Board~~
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	The OBC for the site enabling measures will be presented to Trust Board in September 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~~	~~**Action complete** - The work has been completed and shared with the BBF committee.~~
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	The planning scenarios required by NHP have been shared with the BBF committee.
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	

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:**	August 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Jan 23	**Mar 23**	**Jul 23**	**Sept 23**	**March 24**	**Aug 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 NOF4 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 Executive		

			Quality Group) oversight of overall programme of change proposed will sit with new BBF Committee TOR – implementation in July 2023.		
1.8A	Culture of Continuous Improvement not embedded into organisation to enable improvement capability across workforce.	1.8B	Oversight of programme to embed continuous improvement methodology, including self-assessment against national NHS Impact standards delivered through Transformation Group and reported to BBF Committee. (October 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. Turnover within team (maternity, retirement and internal promotion) leading to additional recruitment drive October 2023.
1.7A, 1.7B	All transformation portfolios led by Executive leads and delivering against agreed milestone actions with robust monitoring	DTP	Sept 2023	Improvement portfolios with milestones aligned to NOF 4 exit criteria commissioned by Executive Directors and regular monitoring in place via monthly reports to recovery board. Detailed oversight of delivery via UEC Group, Planned Care Group and Community Group all chaired by COO.
1.3A	Capability programme delivery for 23/24	DTP	Mar 2024	Curriculum in place to deliver improvement training at Foundation & Practitioner levels. Induction training now in place for all new staff. Training for clinical cohorts established. Organisational baseline assessment due October 2023 for NHS IMAPCT (national Improvement Board newly established).
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	Business case presented – PAPC required further review, next case to be presented at end of August 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	**Mar 23**	**Jul 23**	**Sept 23**	**April 24**	**Aug 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	4	2	n/a	
Consequence	4	4	4	4	4	n/a	
Risk Score	16	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:	Chief Finance Officer supported by Workplace Director	**Committee:**	Board	**Last Updated:**	May 2023

BAF Risk Scoring

Current Position					Target Position	Year on Year	Rationale for Risk Level
	Jan 23	Mar 23	Jul 23	Sept 23	Sept 23	Aug 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	4	4	4	3	n/a	
Consequence	n/a	3	3	3	2	n/a	
Risk Score	n/a	12	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.~~
10.4A	Attain Biodiversity Benchmark from The Wildlife Trust in recognition of habitat preservation on site	CFO	01/04/2025	Work to enhance habitat preservation methods has begun (bug hotels, wildseed meadows etc), biodiversity policy under construction and benchmark framework provided

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DATIX RISK MODULE REPORT

(Exceptions highlighted in Yellow.)

ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	Specialty	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)	Action Point/Plans relating to Risk Synopsis of Open Action Point/Plan	Action Point Owner	Review due date (Action Plan)	Completed by	Completed on	Action Plan Progress Notes Last 3 entries minimum.
1083	01/01/2016	Corporate Level Risk	Estates	Karen Robertson	Jake O'Donovan	Chief Finance Officer (Mark Bivol)	Financial Risk		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) DRM ID 3621 External Wall Tiles on Tower Block becoming loose with potential to detach from their fixings and fall from height (20) DRM ID 2718 Inability to expand clinical services due to lack of space (15) DRM ID 2878 Increased fire risk in the Torbay Hospital tower block due to sustained failure to meet statutory standards (15)	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.	31/10/2023	Catastrophic	Almost Certain	25	[31/07/2023 12:09:44 Paul Hayman] No change - review in October 2023. [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.	Catastrophic	Possible	15						
1159	19/09/2012	Corporate Level Risk	All Departments (Risk Only)	Gary Hotine	Adél Jones	Director of Transformation and Partnership (Adél Jones)	Information and Communications Technology Risk		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 (2023) of 100% having or implementing EPRs by 2026. 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. 2019 - Symphony IT System for Emergency Dept not Reliably Sending Safeguarding Referrals to Allocated Drive. 2698 - 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	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 approval expected July 2023. FBC approval expected 2023/24.	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	Support the activities described in the Trust's Digital Strategy regarding the priority action to procure an EPR	Gary Hotine	21/02/2024			[14/06/2023 09:04:44 Gary Hotine] OBC with national team for approval
3309	03/11/2021	Corporate Level Risk	IT Operations	Gary Hotine	Adél Jones	Director of Transformation and Partnership (Adél Jones)	Information and Communications Technology Risk		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.	17/01/2024	Catastrophic	Almost Certain	25	[14/07/2023 10:48:39 Gary Hotine] No Change - EPR Procurement starting in July 23 and Preferred Bidder expected in November 24. This will enable the score to be reassesed [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.	Catastrophic	Rare	5	The business case for additional HIS resources provides the minimum resources to enable the HIS to maintain BAU services, and increase the project capacity required to implement a PAS which is a major undertaking.	Adél Jones	01/03/2024			[26/09/2022 18:31:33 Gary Hotine] Taken to Execs and FPDC twice but no funding solution available
																									Obtain formal extension for support from supplier, including for the Microsoft and Intersystems components upon which the PAS is built.	Gary Hotine	01/01/2025			[02/05/2023 13:15:48 Gary Hotine] Supplier has agreed that at least 2 years notice will be provided [08/03/2023 10:48:17 Gary Hotine] Supplier maintains the agreed position. [07/03/2023 08:22:45 Gary Hotine] Daedalus have confirmed that 2 years' notice will be provided when the platforms from ISS are to become unsupported, but cannot put in writing.

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NHS Foundation Trust

ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	Specialty	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)	Synopsis of Open Action Point/Plan	Action Point Owner	Review due date (Action Plan)	Completed by	Completed on	Action Plan Progress Notes Last 3 entries minimum.
2996	01/02/2021	Corporate Level Risk	Finance	Tian Ze Hao	Tian Ze Hao	Chief Finance Officer (Mark Bloor)	Financial Risk		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 3274 Failure to Identify and Deliver CIP	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	30/11/2023	Catastrophic	Almost Certain	25	[23/08/2023 14:08:07 Tian Ze Hao] Risk still remain the same driven by unidentified / under-delivery of CIP schemes and the increasing cost pressure in Adult Social Care. This is not just for 23/24, for the medium term we are developing a joint understanding with ICB on interventions required. [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.	Catastrophic	Likely	20							
2416	23/04/2019	Corporate Level Risk	PMU Finance	Emma Routh	Emma Routh	Deputy Chief Executive Officer	Financial Risk		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	Full implementation TP 5 year plan and ability of TP to make one-off investment.	Emma Routh	31/10/2023			[05/09/2022 14:02:08 Kim Hodder] Unable to close gaps due to pause due to NHSE Review [06/03/2020 12:03:39 Kim Hodder] TP Strategy Plan refreshed. Ongoing discussions with Trust.
																									Gain clarity on strategic direction of TP	Emma Routh	31/10/2023			
1070	29/05/2014	Corporate Level Risk	Emergency Department (ED)	Joann Hall	Lisa Houlihan	Chief Operating Officer	Performance Risk		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)	30/10/2023	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	To support improvements an urgent care board has been established to monitor the workstreams affecting flow and process issues across ED, medicine , frailty , bed management and discharge processes. Each workstream holds a specific action plan for improvement measures which is monitored weekly with oversight weekly at the urgent care board .	Joann Hall	29/03/2024			[16/07/2023 13:37:34 Joann Hall] Minutes and action log available in shared teams drive
3547	05/04/2023	Corporate Level Risk	Human Resources	Sarah Lehmann	Michelle Westwood	Chief Operating Officer	Reputational Risk		Site Non-Specific	Upwards Trend in Equality, Diversity and Inclusion (EDI) Related Investigations (Workforce Risk)	Cause: 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. Effect: This may lead to an increasing level of staff dissatisfaction, impacting on retention, absence and sickness, as well as a growing trend in reason for Employment Tribunal that will pose financial and reputational issues for TSD.	Major	Almost Certain	20	1. EDI training is mandatory for all 2. People Policy clear that bullying and harassment will not be tolerated and will be investigated fully	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	25/10/2023	Major	Almost Certain	20	[08/08/2023 13:49:37 Amanda Anders (Risk Officer)] Agreed at risk group to add to the CRR [27/06/2023 15:41:05 Sarah Blacoe] The overarching delivery plan is part of our People promise programme plans- and the detail is being developed, by a series of task and finish groups, with the aim of having sufficient products and development opportunities ready by the launch date. [23/06/2023 14:15:47 Sarah Blacoe] Just culture survey ended 9 June. Data being analysed to identify themes, trends, hotspot areas and action plans to be put in place and will form part of wider culture development plan. Findings and plans to be presented at July PSIRF expert advisory group meeting.	Major	Possible	12	New TSD Leadership and Management framework and resources will be launched from Summer 2023 that focus on a leadership responsibility of all to include.	Sarah Lehmann	30/09/2023			[26/06/2023 12:17:42 Sarah Lehmann] The overarching delivery plan is part of our People promise programme plans- and the detail is being developed, by a series of task and finish groups, with the aim of having sufficient products and development opportunities ready by the launch date.
																									A Just and Learning Culture staff survey will be launched in Apr 23 that will enable an understanding of whether there is a holistic issue in the Trust or whether there are teams that can receive focused EDI and cultural development. Data from the survey will be triangulated with data from People Survey, and People MI relating to grievances, absence and turnover, and patient safety, to ensure that targeted interventions tackle the wellbeing and culture of staff.	Christina Edworthy	25/09/2023			[23/06/2023 14:15:28 Sarah Blacoe] Just culture survey ended 9 June. Data being analysed to identify themes, trends, hotspot areas and action plans to be put in place and will form part of wider culture development plan. Findings and plans to be presented at July PSIRF expert advisory group meeting.
1266	01/02/2015	Corporate Level Risk	All Departments (Risk Only)	Sandie Heyworth	Darren Westacott	Chief Operating Officer	Performance Risk		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 specialities 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)	31/08/2023	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							

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Torbay and South Devon NHS
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3486	14/11/2022	Corporate Level Risk	All Departments (Risk Only)	Liz Davenport	Liz Davenport	CEO (Liz Davenport)	Financial Risk		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 Linked risks: 3484: Failure of acute provider collaborative to deliver on acute sustainability plan programme 3485: Failure of ICS operating framework to support collaboration in line with health and social care policy requirements	Catastrophic	Likely	20	1. Chair,CEO and Executive engagement with ICS Committees and decision 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	31/05/2023	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	Single Improvement Plan	Liz Davenport	31/05/2023			
																									System Operating Plan	Liz Davenport	31/05/2023			
																									Trust Governance Process - Recovery Board	Liz Davenport	31/08/2023			
																									Leadership Capacity and Capability	Liz Davenport	31/05/2023			
																									Regain and Renew (SOF4 Exit plan)	Liz Davenport	31/08/2023			
1815	05/09/2014	Corporate Level Risk	Cancer Wait Team	Alex Atkins	Ria McCoy	Chief Operating Officer	Performance Risk		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	2. Fortnightly 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 Planned Care Board 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	27/10/2023	Major	Almost Certain	20	[06/09/2023 16:18:27 Jacqui Robinson] Review with AAJ/R - current performance for August positive passing 28 and 31 day standards. 62 day best performance since September 2020. However, 62 backlog starting to rise, main impact in Gynaecology due to staffing absences (secretaries, consultants and nurses). New CWT v12 released from 1st October 2023 - performance impact expected to be minimal. Joint consultant and junior doctors strikes in September and October expected to impact on cancer performance. [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.	Major	Possible	12	review of new processes in multiple pathways to support the 28 day faster diagnosis standard. Update pathway and processes to ensure delays are reduced where clinically appropriate.	Jacqui Robinson	21/09/2023			[24/07/2023 11:18:07 Jacqui Robinson] Trust is currently 25th highest performing trust across the country, maintaining position at present and achieved 28 day standard for the past 5 months. Work ongoing to improve performance within Gynae, Colorectal and Urology who are our main areas of concern and all failing 28 day target. Improvements still to be made in order to improve 2ww, 31d and 62d targets across numerous sites. Diagnostic delays, in particular radiology, having the biggest impact. [21/06/2023 08:38:41 Jacqui Robinson] Trust no longer in Tier 1 as great improvements made in 62 day performance and PTL. 28 day national target has been achieved each month from February. Improvements still to be made in 2ww and 31 day performance in order to achieve national targets. Best Practice Timed Pathways work ongoing across various sites. Diagnostic delays continue to be our main challenges along with staff vacancies across the service. [04/05/2023 09:07:56 Jacqui Robinson] The Trust
																									The Urology service are an outlier across the Peninsula for template prostate biopsy service. Should be delivering as an outpatient procedure under LA, which will reduce delay to diagnosis and increase DSU capacity. An appropriate outpatient suite required to deliver a safe service at Torbay Hospital	Kevin Pile	08/07/2023			[24/07/2023 08:02:23 Emma Brooks] 24/7/23 - TP biopsy waiting times now within target and works currently underway at Paignton Hospital to create a procedure room, due for completion August 23 [09/05/2022 12:23:38 Ali El-Eleimi] No change in status following the relocation of urology services to Paignton, still waiting an EXE decision on suitable space within OPD at the main site. [05/05/2022 09:43:09 Jake Gibbons] Reassigned to Ali El-Eleimi from Neal Foster
																									There a 10s of actions related to the achievement of this risk, these are need to be recorded in a central Trust's Cancer Action Plan and overseen through the Cancer Cabinet structure.	Alex Atkins	31/03/2024			[02/08/2022 08:20:39 Alex Atkins] Action plans in place for key sites - ongoing monitoring needed [10/03/2022 14:43:51 Alex Atkins] Completed for Breast, Derm, Urology and LGI. [25/02/2022 08:41:14 Alex Atkins] 25/02/2022 - Action plan template created and started to be populated [14/12/2021 11:00:18 Alex Atkins] 14/12/2021 - Draft action plan in place
1697	07/12/2016	Corporate Level Risk	Human Resources	Darran Armitage	Darran Armitage	Chief Peoples Officer	Financial Risk		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	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						
2412	23/04/2019	Corporate Level Risk	PMU Finance	Emma Rodin	Emma Rodin	Chief Finance Officer (Mark Brist)	Financial Risk		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						

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3536	14/03/2023	Corporate Level Risk	Human Resources	Darran Armitage	Michelle Westwood	Chief Peoples Officer	Operational Risk		HOS, Torbay Hospital Regents House	Pressure in the People Hub due to a Combination of Increase in Demand on Services and Personnel Churn (Workforce Risk)	Cause: There is considerable pressure in the People Hub due to a combination of increase in demand on services and personnel churn (change of People Hub Manager and the long term sick of one full time member of People Hub and the Associate Dir of People Ops). Effect: There is a risk of reduced output and productivity from the People Hub, with the inability to deliver the Just Culture change in all People policies, to support the growing number of ETs and to support the Org Change throughout the Trust.	Major	Almost Certain	20	1.Appointment of an Interim People Hub Service Manager has been made (6month appointment). 2.Additional resourcing for the People Hub has been approved and recruitment activity is underway. 3.Ongoing sickness absence management reviews are taking place to address LTS of staff (Although there is an unlikelihood of immediate return to work - therefore additional resource demands need consideration throughout May-July) . 4.Temporary resource support is also in place to address some of the work demands but funding for this expires end of June. 5.Training for JLC commences in May to enable work to be undertaken on changes to people polices, and organisation change demands from June onwards. 6. To support Org Restructure, role/requirement of BP and People Hub to be reviewed so scope, number and capacity is set to best meet the organisation.	1.Lack of funding to increase WTE to alleviate pressure 2.Lack of system wide support available 3.Lack of triage and prioritisation of Trust wide projects that impact on People Hub	25/08/2023	Major	Almost Certain	20	[08/08/2023 13:54:19 Amanda Anders (Risk Officer)] Risk approved onto the CRR at risk group. [18/07/2023 08:52:02 Sarah Blacoe] Interim People Hub Service Manager continues to develop knowledge and understanding of working within the Trust/NHS and this is enhancing support to the team. Band 6 vacancy now filled and resulting band 5 vacancy out to advert, Associate Director of People (Ops) has returned to work on a phased basis and is providing support and guidance. [09/05/2023 11:24:29 Amanda Anders (Risk Officer)] Discussed at risk group- members couldn't agree the score and want the scoring matrix to be reviewed. Additional meetings will be set to re-score against new matrix	Major	Possible	12						
1603	09/07/2018	Corporate Level Risk	Breast Care	Saruki Heyworth	Darren Westacott	Chief Operating Officer	Performance Risk		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	31/10/2023	Major	Likely	16	[04/08/2023 20:14:30 Sandie Heyworth] Cons Radiographer back at work. Strikes causing issues with capacity, but continue to micromanage the radiology slots [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.	Major	Unlikely	8						
3030	12/09/2021	Corporate Level Risk	Human Resources	Darran Armitage	Darran Armitage	Chief Peoples Officer	Operational Risk		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						
3195	19/09/2021	Corporate Level Risk	PMU Finance	Leon Rudd	Emma Routh	Managing Director Torbay Pharmaceuticals (Emma Routh)	Financial Risk		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 Medicine	James Hobbs	Tracey McKenzie	Chief Operating Officer	Clinical Safety Risk		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. Linked risks: 1069 Stroke Service Performance Measured in SSNAP - Bed Occupancy and Direct Admission.	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	30/09/2023	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	1) Stroke improvement plan in place to monitor actions/improvements particularly in respect of staff training/compelencies across all professions. Improvement plan monitored via Management meetings or when these are cancelled due to operational pressures via direct links to action holders	James Hobbs	31/05/2023			[06/03/2023 16:23:14 Lesley Wade] Plan has been refreshed & key actions clinical owned. Detail now being built into plan which is being monitored by Clinical Lead & Operational Manager [11/01/2023 08:51:18 Lesley Wade] Ongoing. James Hobbs is refreshing the plan [12/10/2022 13:48:58 Lesley Wade] Ongoing. Actions from Peer review being added to plan

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											3150 Stroke Nursing: Skills & Capabilities (Workforce Risk)																			
2966	30/11/2020	Corporate Level Risk	Pathology and Laboratories	Anthony Lowe	Ria McCoy	Chief Peoples Officer	Operational Risk		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	30/09/2023	Major	Likely	16	[24/08/2023 17:01:44 Anthony Lowe] Currently recruiting to replace two 8b Lab managers Fragile services review for Histology and Microbiology ongoing in network. Locums etc will be used to maintain out of hours coverage until March 2024 [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	Major	Unlikely	8						
2948	13/11/2020	Corporate Level Risk	Emergency Department (ED)	Lisa Houlihan	Nicola McMinn	Chief Operating Officer	Clinical Safety Risk		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	All Departments (Risk Only)	Kate de Burgh	Ria McCoy	Chief Nurse (Deborah Kelly)	Health and Safety Risk		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	04/08/2023	Major	Likely	16	[24/07/2023 16:42:20 Tim Simpson] arranging meeting with RPA asap [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 laboratories 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	Major	Rare	4	To formally review this risk following the Radiation Safety Committee Meeting on 10/2/22.	Tim Simpson	04/08/2023			[24/07/2023 16:28:28 Tim Simpson] arranging meeting with RPA asap [21/06/2023 07:44:22 Tim Simpson] RPA has started but no availability to discuss before w/c 10/7, will arrange a meeting [17/05/2023 16:03:05 Tim Simpson] Have been unable to review with RPA who has no retired. New starter in June 2023, will review radiology aspects with her at that time
3316	12/11/2021	Corporate Level Risk	Building a Brighter Future / New Hospitals Programme	Christopher Knights	Christopher Knights	Director of Transformation and Partnership (Adel Jones)	Financial Risk		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.	01/11/2023	Major	Likely	16	[01/08/2023 10:37:38 Emily Widdicombe] Risk reviewed by CK, no updates required - rescheduled review date for 01/11/23. [27/03/2023 14:07:20 Sandi Clemo] Risk reviewed, no updates required - rescheduled review date for 01/06/2023 07/12/2021 10:52:13 Amanda Anders (Risk Officer)] Agreed to add to CRR	Major	Likely	16						

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3437	09/08/2022	Corporate Level Risk	PMU Operations	AR3	Emma Routh	Deputy Chief Executive Officer	Operational Risk		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	Evaluate and investigate the upgrade to existing chiller system for HVAC in GMP manufacturing and prep rooms	Alun Rees (Inactive User)	31/10/2023			
2920	12/10/2020	Corporate Level Risk	Finance	Neil David Elliott	Ariel Jones	Director of Transformation and Partnership (Ariel Jones)	Performance Risk	Business Intelligence 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	The issue has been raised in reports sent to FDG and Board over many years, and raised again in the NCC report submission in October 2020	Neil David Elliott	29/12/2023			[07/07/2023 11:41:44 Neil David Elliott] The partial submission of this dataset has now been taken on by the Data Engineering team. The work to make the data collection with the PARIS system compatible with the return requirements is still ongoing. [04/04/2023 07:52:07 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. [18/08/2022 15:22:49 Neil David Elliott] This situation has not changed since the last updated in February. An external agency resource is still employed to submit CSDS data from the systems that are able to comply. The PARIS system is still not able to meet the requirements and will not be for some years to come.
2965	30/11/2020	Corporate Level Risk	Maternity Services	Jonathan Hindley	Joanna Bassett	Chief Operating Officer	Clinical Safety Risk		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 4) SOPS in place to support staff in and use of the emergency theatre team and enabling access to theatre out of hours.	1) Still potential that we are unable to go straight to theatre if clinically indicated.	27/11/2023	Catastrophic	Possible	15	[31/08/2023 16:01:07 Claire Jones] Update email received from Dave Brown, Matron for Theatres We presented the costs for 12 months of required agency usage, which was essentially refused. Unfortunately we therefore have no quick fix. We are now engaging with other Trusts looking at potentially recruiting anaesthetic technicians from overseas who may be able to register as ODPs in this country. This will take months if it turns out to be fruitful, but is reflective of the national situation. We are doing all we can to recruit. [31/08/2023 15:50:25 Claire Jones] Request sent to Dave Brown and Sharon Boyne requesting a Guideline around obstetric access to emergency theatres [26/07/2023 10:27:36 Claire Jones] Meeting held with Ian currie and agreement for ODP's to be sourced on the bank pending board agreement. Awaiting update on progress with Dave Brown and Sharon Boyne.	Catastrophic	Rare	5						
3293	14/10/2021	Corporate Level Risk	PMU Finance	David Houghton	Emma Routh	Deputy Chief Executive Officer	Financial Risk		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						

Torbay and South Devon NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Fit and Proper Persons Test for Board Members			Meeting date: 27 September 2023
Report appendix			
Report sponsor	Director of Corporate Governance and Trust Secretary		
Report author	Corporate Governance Manager		
Report provenance			
Purpose of the report and key issues for consideration/decision	The NHS Fit and Proper Persons Test (FPPT) framework, seeks to test a person's suitability to hold office within the NHS, noting the requirement to discharge responsibilities with care and skill, in accordance with the Nolan Principles. On 2 August 2023, NHS England reissued the Fit and Proper Persons Test (FPPT) framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT. The revised framework is effective from 30th September 2023 for all new board appointments and is therefore duly presented to the Board for their information, noting the Chairman and SID's roles to lead this work for the Board. The changes are predominantly procedural, however, further analysis of the practicalities of adopting these is required. A more detailed report will therefore be presented in October with a view to ensuring proper oversight and compliance. A link to the Framework is available here: NHS England » NHS England Fit and Proper Person Test Framework for board members		
Action required (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Board is asked to receive and note the report.		

Summary of key elements

Strategic goals supported by this report

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

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

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

External standards affected by this report and associated risks	

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