NHS
Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors

Date: Wednesday 29th November 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

29/11/2023 11:30

Torbay and South Devon NHS Foundation Trust

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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, HENGRAVE HOUSE
AT 11:30AM ON 25 OCTOBER 2023

Present:	Sir Richard Ibbotson	Chairman
	Mrs Liz Davenport	Chief Executive Officer
	Prof. C Balch	Non-Executive Director
	Mr R Crompton	Non-Executive Director/Vice Chairman
	Mr I Currie	Chief Medical Officer
	Ms A Jones	Deputy Chief Executive and Director of Transformation and Partnerships
	Ms D Kelly	Chief Nurse Officer
	Dr C Lissett	Interim Medical Director
	Mrs E Long	Director of Corporate Governance and Trust Company Secretary
	Mrs V Matthews	Non-Executive Director
	Mr P Richards	Non-Executive Director
	Mr J Scott	Chief Operating Officer
	Mr R Sutton	Non-Executive Director
	Ms S Walker-McAllister	Non-Executive Director
	Dr J Watson	Health and Care Strategy Director
	Dr M Westwood	Chief People Officer
In attendance:	Mrs S Byrne	Board Secretary
	Mrs C Foy	Associate Director of Nursing
	Ms T Ze Hao	Director of Operational Finance
	Mrs M Ridout	Delivery Director
	Ms T Buckley	Hydration Champion, Briarcroft Care Home
	Ms M Hedesiu	Deputy Manager, Briarcroft Care Home

175/10/23 **Welcome and Introductions**

The Chairman welcomed all those in attendance to the meeting.

Preliminary Matters

176/10/23 **Apologies for Absence and Quoracy**

The Board noted apologies of absence from Mr Mark Brice with Ms Tian-Ze Hao and Mary Ridout deputising.

177/10/23 **Declarations of Interest**

The Board did not receive any declarations of interest.

178/10/23 **Patient Story**

Ms Kelly introduced Mrs Corinne Foy, Mrs Vicky Wicks, Specialist Community Dietitian and Mrs Mihela Headsiu and Mrs Tammy Buckley from Briarcroft Care Home. They showcased to the Board the preventative work that had been undertaken through the Hydration Project, which had led to a successful reduction in admissions; Urinary Tract Infections; falls and overall a noticeable improvement in the quality of life of care home residents. Mrs Wicks informed the Board through short term funding schemes fifty homes and 1500 residents throughout Torbay had benefited from the project but, all funding streams would cease in December 2023.

The support took the form of Hydration Champions per home who undertook the training and fed it back and implemented it in their homes; together with the development of Hive E-learning.

Tammy and Mihala explained Briarcroft had been part of the Hydration Project since 2020 when they were approached by Mrs Wicks. They explained that had taken the learning and implemented it within the care home setting making modifications to suit the needs of the residents. This had led to a decrease in Unrinary Tract Infections, falls and hospital admissions.

They spoke about two of their residents. Muriel, whose quality of life had improved due to this project had not had a Urinary Tract Infection or moisture lesion recently and her family had noticed she was far more aware of her surroundings; and Ruth who no longer required cystitis relief and has gained weight due to drinking fortified milk.

Mr Sutton noted fifty care homes were part of the Hydration Project but, noted there were a further hundred homes in Torbay and South Devon and asked whether they would be interested in the Hydration Project. Mrs Wicks confirmed all homes were willing to be part of the Hydration Project but, funding was limited.

Prof. Balch asked where were the benefits of the community projects captured. Ms Kelly explained community projects complied with the Integrated Care Organisation Strategy and met the Trust's Out Of Hospital strategic objectives.

Mrs Davenport said Muriel's and Ruth's stories showed the importance of working in partnership to reduce Urgent and Emergency Care admissions and there quantifiable was a quantifiable benefit to these projects.

The Chairman thanked the team for raising the profile of the Hydration Project which materially improved the quality of life of the people in the Trust's care.

The Board received and noted the patient story.

179/10/23 **Board Corporate Objectives**

The Board received and noted the Board Corporate Objectives.

For Approval

180/10/23 **Unconfirmed Minutes of the Meeting held on the 25 September 2023 and Outstanding Actions**

The Board approved the minutes of the meeting held on 25 September 2023.

The Board approved the minutes of the meeting held on

Consent Agenda (Pre-notified questions)

181/10/23 **Committee Reports**

The Board received and noted the Committee Reports.

Reports from the Executive Directors (for noting)

182/10/23 **Chief Operating Officer's Report - October 2023**

Mrs Matthews asked within the Winter Plan how the bed gap would be closed.

Mr Scott explained the largest bed gap was 76 beds but he assured the Board up until January the bed gap was closed and in January 30 more beds would be required but the position was rag rated and a series of actions were in place to support an increase in bed base.

He asked the Board to note the Virtual Ward RAG rated position had moved from yellow to green, with a current fill rate of 86%.

Mrs Davenport explained in respect of the delay to the Jack Sears project Mrs Machin had put actions in place to mitigate the impact on capacity. He confirmed the delay had been escalated to Torbay Council this project was outside of the Trusts control.

To support the bed position heading into winter there was to be a renewed focus on Ward Rounds and Weekend Discharges and enabling clinicians to discharge patients. As the data had identified an increased length in stay.

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

183/10/23 **Report of the Director of Transformation and Partnerships**

Mr Crompton asked for the Board Sub Committees to have sight of the achievement metrics of the Trust's position as an Anchor Institution as this initiative built upon the Trust's ICO strategy. Ms Jones said the Trust's position as an Anchor Institution derived process measures that would give the Board oversight of its beneficial impact on the local community and that this was reviewed through the Strategy Group.

Mrs Davenport informed the Board Torbay were to receive benefit from the Department of Levelling up, who she was meeting with on 3 November 2023.

Report of the Director of Transformation and Partnerships

Reports of the Chairman and Chief Executive

184/10/23 **Report of the Chairman**

The Chairman verbally briefed the Board on the following:

- The disposal of Torbay Pharmaceuticals was in progress.
- He attended the SAS Doctors Awards Event alongside Mrs Davenport, Mr Currie and Dr Lissett.
- SingHealth had visited the Trust over the course of October 2023 and some of their Doctors had been embedded into Teams to seek learning from the Trust as an Integrated Care Organisation. He thanked Dr Liz Thomas and her team for organising an extensive programme for the SingHealth Team.
- He attended the opening of the Radiotherapy CT Scanner and recognised and thanked the League of Friends for their contribution of £590k for the Radiotherapy CT scanner.
- Dr Kate Lissett had been successfully appointed to the post of Chief Medical Officer and would undertake the role from December 2023.
- After a 9 year tenure Mrs Jacqui Lyttle had taken leave from her post as Non-Executive Director and he wished her well in her new role as Non-Executive Director, LiveWell CIC.
- Mr Scott was formally thanked by the Chairman for his role as COO over the last twelve months.

The Board received and noted the report of the Chairman.

185/10/23 **Chief Executive's Report**

Mrs Davenport formally thanked Mr Scott for his time as the Trusts Chief Operating Officer and his support with the NOF4 Exit Criteria, Urgent and Emergency Care and Planned Care. He had identified best practice and supported teams to meet their improvement trajectories whilst implementing the Organisational Restructure; and had challenged the Boards thinking around culture. Mr Scott thanked the Board for their support.

The Board received the report of the Chief Executive, as circulated. Mrs Davenport informed the Board of the following:

- Ms Kelly had successfully secured a Chief Nurse post in London and would be leaving the Trust at the end of 2023. There were succession plans in place which would allow for a smooth transition upon the departure of Ms Kelly.
- Following the recruitment process, Dr Kate Lissett had been appointed to the post of Chief Medical Officer and would commence in December 2023 upon the retirement of Mr Currie.

Amanda Pritchard: At Amanda Pritchard's request she met with her on 20th October 2023 as part of one to one's with all Chief Executives. Mrs Pritchard was particularly interested in the Trust's ICO status and proposed the Trust looked to form an ICO Network Board with other similar providers, with the support of NHSE.

Young People's Mental Health: With the support of Child Family Health Devon and Dr James Derden, Mrs Davenport had been invited to speak to their ground breaking Mental Health work with young people on 8 November 2023.

Black History Month: There were various events taking place across the Trust to celebrate Black History Month and Mrs Davenport was honoured to attend the Saluting all our Ethnic Minority (BME) Sisters and brothers in conjunction with Unison event on 24th October 2023.

NHS Schools Prize presentation: She was invited to Ivybridge Community College to present the NHS Schools prize and speak to a group of young people about NHS Careers and alternative pathways into health and social care careers. She said this was important engagement work to be undertaken as current modelling suggested going forward one in six people would need a career in Health and Social Care to meet the demand.

Peninsula Acute Provider Collaborative: The collaborative was engaged with clinicians and focused on sustainable services for now and in the future acknowledging the change in demand. Engaging with our clinicians and experience of services. Context of increasing demand workforce challenges and a finite resource.

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

Safe Quality Care and Best Experience

186/10/23 **Integrated Performance Report (IPR): Month 6 2022/23 (August 2023 data)**

Dr Watson presented the Integrated Performance Report for Month 6 2023/24, as circulated, and asked the Board to note:

Quality

- One Strategic Executive Information System (STEIS) had been reported due to a fall which resulted in a broken hip.
- Nutrition assessments continued to be upheld.

- Ensuring stroke patients received 90% of their care on a Stroke Ward remained a challenge. However, several domains within the metrics were meeting the targets.
- The fracture neck and femur surgery trajectory remained challenged.
- Norovirus continued to be a national problem.
- Covid waves and CDIF outbreaks had led to a high number of beds being shut; and with the support of the Infection Prevention and Control Team hand hygiene refresher courses were being disseminated.

Workforce

- Vacancies within key areas across organisation were clearly impacting the Trusts performance.

Mrs Matthews asked the Board to note the Retention and Sickness metrics had been falling for the last three months.

Performance

- The Emergency Department performance had improved for the sixth month in a row with 60% of patients being seen within the four hour target. Despite Type 1 attendance having increased by 18%.
- Regionally the Trust was fifth in respect of ambulance waiting times.
- The Trust had ensured 20% of patients were home by midday for the third month in a row.
- The 78 week wait position was not currently meeting the trajectory due to Industrial Action.

Finance

- An adverse financial variance to plan of £2.398m driven by the net impact of Industrial Action was reported.
- £32.3m risk to forecast outturn had been identified and mitigating actions are currently being worked up to minimise the forecast risks.
- Cost Improvement Plan schemes with plans in place for delivery total £36.6m.

Mr Crompton noted that in respect of the NOF4 Exit Criteria at present the Trust were only hitting four of the thirteen objectives and asked what mitigations were in place to improve operational and financial performance and meet the objectives. He challenged whether the current governance structure was providing the appropriate level of grip and control.

Mrs Davenport explained the Trust were aware a timely exit out of NOF4 was best for the public and staff; and through the Recovery Group and supporting working groups helpful strides had been undertaken to exit NOF4 and the correct governance structure was in place but, decisions needed to be enacted. She confirmed there CIP plans were plans in place that had been verified. However, in order to minimise the variance to plan difficult decisions would need to be made to deliver the right care within the financial envelope going forward.

Ms Kelly explained in respect of nursing budgets her teams had been meeting with finance and workforce to ensure there was a triangulated approach to safer staffing. However, she explained bank staff requests needed to be reconciled against

vacancies and articulated; as some teams were requesting bank staff within the allocated budget.

The Board received and noted the Integrated Performance Report (IPR): Month 6 2022/23 (September 2023 data).

187/10/23 **Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training**

Dr Lissett presented the Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training, as circulated. She informed the Board:

- F1 Doctors were those who tended to raise reports
- The Guardian of Safe Working Hours worked closely with the education department to identify any training needs or support required.
- Based on the reports coming in the Guardian of Safe Working Hours had contacted the medical and operational leaders for the relevant wards to allow review of staffing levels on particular wards.

The Board received and noted the Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training

188/10/23 **Maternity Governance & Safety Report 1July 2023 – 30 September 2023**

Mrs Bassett presented the Maternity Governance & Safety Report 1July 2023 – 30 September 2023, as circulated. She explained:

- The department were working towards compliance of the National Maternity Assurance Position – The Single Delivery Plan.
- The follow up Insights visit post the Ockenden Insights visit had taken place and the feedback was positive.
- Version 3 of the Saving Babies Lives Care Bundle would be fully implemented by March 2024. The Trust's Midwifery Smoking Cessation Service had been commended.
- Maintaining a safe Obstetrics and Gynaecology Consultant rota remained a challenge as the unit was small but, the department were working with the Quality Improvement Team to implement change. This presented a risk to the Clinical Negligence Scheme Trusts (CNST).
- Sadly, two mid-trimester losses had been reported and were currently being reviewed through the Perinatal Mortality Review Tool (PMRT).
- A review had been undertaken of the neonatal unit post the Lucy Letby case and she informed the Board there were no themes of concern.
- The Kings College Study commissioned by Devon ICB regarding the attrition and retention rates had been released and the key findings were perceived changes to the role of the midwife; an erosion of professional autonomy; and workplace culture and relationships.

Ms Jones asked what learning could be sought to reduce turnover rates. Mrs Bassett explained the Trust were fortunate to have been allocated funding for a Band 7 Retention Midwife and this was why retention had improved.

Mrs Matthews asked whether since the Lucy Letby case whether families had become more anxious, Mrs Bassett confirmed an increased level of anxiety from families had not been seen.

Mrs Long asked if there was anything further the Board could do to support the Maternity Service. Mrs Bassett informed the Board the floor to Board visibility for the service was strong.

In respect of Obstetric Consultant capacity, as a smaller organisation it was difficult to meet the ask of the Ockenden recommendations and consideration was being given to how this could be addressed. Mr Currie explained there were financial implications to the recommendations and consideration needed to be given to how the Trust's prioritises in the short term and the structure in the longer term, especially in light of workforce retention issues. However, the Executive Team were fully sighted on this matter and were awaiting recommendations.

The Board received and noted the Maternity Governance & Safety Report 1July 2023 – 30 September 2023.

Valuing our Workforce

189/10/23 **Culture Update**

Dr Westwood presented the Culture Update, as circulated. She highlighted to the Board:

- The Embedding and Inclusive Culture plan had been incorporated into the People Promise Programme of work;
- Further to the culture development day on the 18 September 2023 a draft Board Commitment to Create an Inclusive Culture was shared and the Board were asked to commit to the same.
- Additional capacity for the Equality, Diversity and Inclusion Team, Employee Relations Team and Freedom to Speak Up Guardian were currently a corporate risk and the plan was waiting to be signed off.
- The Scaling HR Services/People Digital ICS vanguard work was being explored.

Mrs Matthews said there was a noticeable, coherent step change with this programme of work that was supported by data.

The Board received and noted the Culture update; and approved commitment to Create an Inclusive Culture.

Well Led

190/10/23 **Updated Trust Constitution**

Mrs Long presented the Updated Trust Constitution, as circulated. She confirmed the Governor working group had, had an active role in the drafting of the Trust Constitution and external legal advice had been received. She confirmed:

- PL postcodes would come under the South West Peninsula;
- The Constitution linked into the new Care Group Structure;
- One more Governor would be recruited; and
- Best practice was going to be adopted in respect of the Fit and Proper Persons Test.

The Board approved the Updated Trust Constitution

191/10/23 **Board Assurance Framework and Corporate Risk Register**

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

- A new BAF objective in respect of Equality, Diversity and Inclusion had been developed.

The Board agreed a Board Development session be scheduled to review the BAF profile. **ACTION: Mrs Long**

Prof. Balch asked if the community would form part of the Peninsula Acute Provider Collaborative. Mrs Davenport explained when forming the Acute Provider Collaborative the decision was made to remain focused on the Acute Providers but, through the clinical workshops it was noted the community settings impact the performance of the acute settings. However, it had been agreed Devon Integrated Care System would drive this agenda through the Local Care Partnerships.

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

192/10/23 **Compliance Issues**

193/10/23 **Any other business notified in advance**

Letter from the Secretary of State
Mrs Matthews informed the Board the Secretary of State wrote to Devon ICS on 18th October 2023 in respect of back office functions and requested funding for Equality, Diversity and Inclusion posts cease and the money be used to support the front line. Richard Meddings, Chair, NHSE responded on behalf of all providers and the matter has now been addressed.

The Board received and noted the letter from the Secretary of State.

194/10/23 **Date and Time of Next Meeting:**

11.30 am, Wednesday 29 November 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. Socialising the design and in the current climate confident we have the right design to build up the funding pot. Thank Nikki, Consultant Intensivist, advocated and leading this. Nikki Freeman	
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 Mrs Davenport confirmed the Board to Board would take place in Autumn 2023. 25.10.23 MW away defer	26.04.23
146/07/23	EDI objective to be placed on the BAF	Dr Westwood	27.09.23 Mrs Long confirmed she was to place the EDI Objective on the BAF. 25.10.23 Closed	26.07.23

168/09/23	Ms Jones agreed for the Strategy Group to undertake an assessment of the impact the ICO has had on the population it served.	Ms Jones	25.10.23 Will be part of the Health and Care Strategy which JW is leading and on Strategy Agenda for Friday.	27.09.23
170/09/23	The Industrial Action impact and mitigations to be reviewed across all sections of the BAF.	Mrs Davenport	25.10.23 Work in progress.	27.09.23
191/10/23	Board Development session to be scheduled to review BAF profile.	Mrs Long		25.10.23

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Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report			Meeting date 29th November 2023
Report appendix:			
Report sponsor:	Chief Operating Officer		
Report author:	Care Group Directors		
Report provenance:	The report reflects updates from theTrust's Care Groups.		
Description/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.		
Action required:	**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			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	This report provides the Trust Board with narrative information to support the Integrated Performance Report and allows for greater understanding of the issues and greater opportunity for assurance to be gained.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources Operational performance supports all three aims.		
Relevant BAF Objective(s):	Objective 5 - Operations and Performance Standards		
Risk: Risk ID: *As appropriate*			
External standards affected by this report and associated risks	Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance		

Report title: Chief Operating Officer's Report		Meeting date: 29th November 2023
Report sponsor	Chief Operating Officer	
Report author	Care Group Directors	

1.0 Purpose

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

2.0 Introduction

The operational position for October 2023 was challenging, with high numbers of unscheduled patients coupled with infection issues that have impacted on bed capacity, thereby placing greater pressure on urgent and emergency care performance (UEC).

The trust is preparing to move to the new national Operational Pressures Escalation Level (OPEL) framework, due to launch on the 4th of December. This national framework focuses on operational pressures within the acute hospital as this is the area of system health provision that often carries the highest risk from operational pressure. As the Trust is an integrated care organisation (ICO) we are ensuring that our local plan expands beyond the acute trust. We will do this by introducing safety barometers across the care group divisions.

We are anticipating this will mean the Trust remains in heightened escalation due to our continued pressures across urgent and emergency care.

Month	OPEL 1	OPEL 2	OPEL 3	OPEL 4	OPEL 4 + Critical incident
Dec-22	0	1	3	22	5
Jan-23	0	7	6	18	0
Feb-23	0	6	15	7	0
Mar-23	0	0	20	11	0
Apr-23	0	8	17	5	0
May-23	0	7	10	12	2
Jun-23	0	7	17	6	0
Jul-23	12	7	12	0	0
Aug-23	0	10	16	5	0
Sep-23	0	1	19	10	0
Oct-23	0	3	15	11	2

3.0 Winter Plan

The key actions to progress the Winter Plan are highlighted below. At present there still remains a gap in capacity in relation to peak winter demand. Further mitigation is being considered in conjunction with ICB schemes to reduce demand to the Acute Trust.

Winter Plan Actions	Bed Impact	Comment	RAG	Current Bed Impact Estimate
Initial Bed Impact	-76			-76
Elimination of patients waiting for beds	-13			-13
Implementation of SHOP Ward Rounds		ECIST to support with improvement work		
Implementation of Weekend Discharges		Key short term focus - Portal Implementation to support		
Infection Control Buffer	-5	Potential for wider gap given last x2 month experience		-10
Removal of 11 beds in ED	-11	Implemented		-11
Expansion of virtual ward capacity	21.45	Agreed in month numbers are growing		16.67
Opening of Jack Sears Unit	5.5	Delayed		0
Expansion of SDEC	12	Works when level 2 is not bedded		5
Reduction in Community LoS	5.8	Delivering		5.8
Intermediate bed gap	60			83
Acute bed occupancy increase to 97%	26	Implemented		26
Development of the Emergency Village	6	Cover for EAU4 now in place to support Front Door Frailty		6
Implementation of Surge Protocol	6	Implemented		6
Virtual Ward Occupancy increasing to 95%	3.5	Virtual Ward Occupancy is currently 80-90% of 55 available		2.3
Reduction in Acute LoS	8	NCTR tickin up along with LoS - target wards to be identified		0
Reinstatement of patients waiting for beds	13	Agreed		-13
Final Bed Gap	2.5			30

The Winter Plan is monitored through the Winter Plan Group, which meets fortnightly, and through the Urgent and Emergency Care Improvement Group. Further scrutiny will now be provided through the Trust Recovery Group. Where actions are not yet fully delivered, these groups will help expedite actions and provide focus and support to delivery. The new COO is reviewing the plan with the up-to-date data and revising the bed deficit forecast as required.

4.0 Urgent & Emergency Care (UEC) update

October saw 9,550 attendances for the integrated care organization (ICO). This was an average of 308 patients per day. Whilst lower than the last three months, it is 697 patients higher than October 2022, with the increase being in attendance to Torbay Emergency Department (ED).

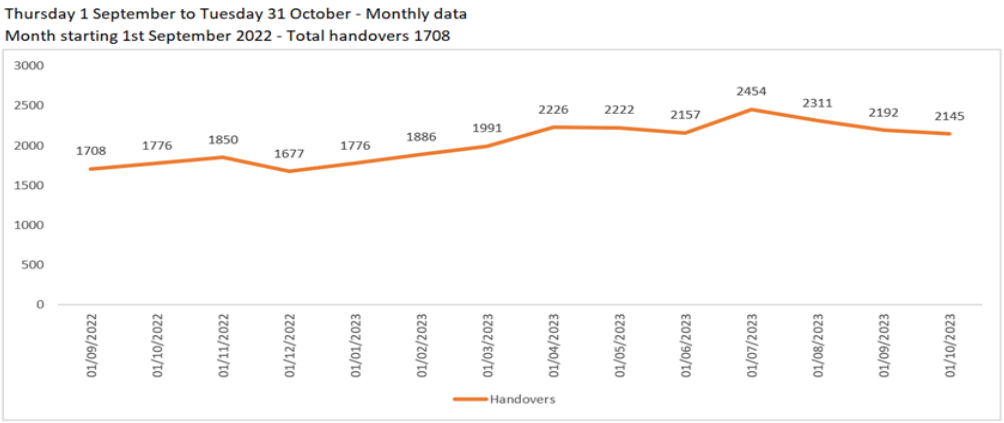
Performance was behind the trajectory for the National Operating Framework (NOF4) recovery target of 72% at 66.62%, representing a 2% drop from September. The additional space created for non-admitted capacity is regularly being utilised to support capacity challenges for all Emergency Department patients.

Consequently, non-admitted performance has decreased from 67.88% in September to 63% in October.

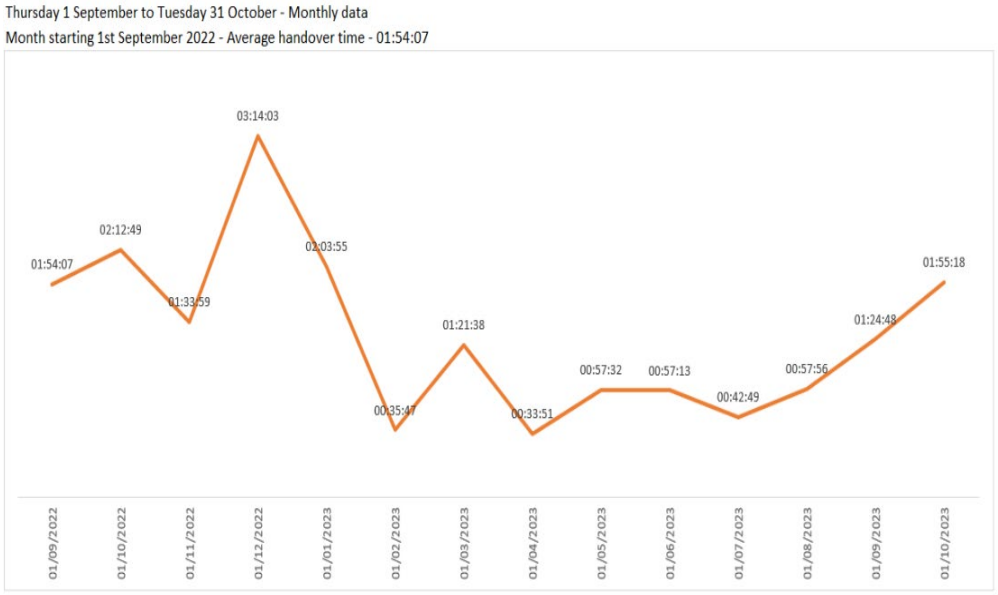
The Urgent Treatment Centre (UTC) and Minor Injuries Unit (MIU) performance remains consistent at 99.12%.

4.1 Ambulance Handovers

Ambulance handover delays were reduced by 47 in October compared to the previous month, with 2,145 arrivals over 15mins.



The trend of increased demand continues with Ambulance Handovers increasing by 311 handovers (+17.5%) from October 2022 (1,776) to October 2023 (2,087).



The average time lost per ambulance to handover, at 1hr 55min (incl. the 15 mins) in October 2023. The performance challenge in this area is due to the fact the acuity of patients remains high in addition to the changes made in ED to accommodate the Paediatric pathway.

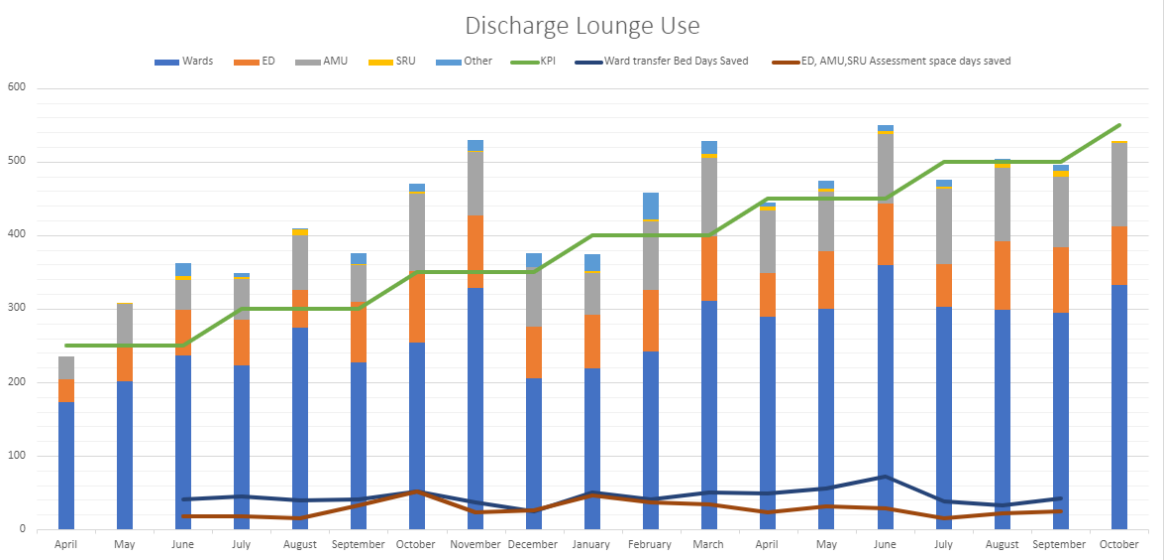
Continuous improvement underway on various elements of the UEC pathway to improve handover times.

4.2 Inpatient Flow

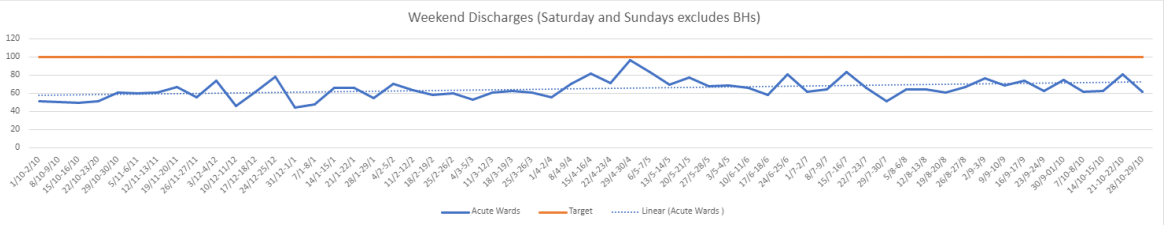
Across the ICO (including our community hospitals), we had 1,881 discharges from our adult inpatient areas. Of which 24.8% (467) of patients were discharged by noon and 72.0% (1,355) pre-5 PM. We saw an increase in weekday discharges but a reduction in weekends.

The discharge lounge supported 528 patients in October. We continue to manage our adult inpatient wards at maximum capacity and, therefore, are focused on opportunities to improve our patient flow. We know to support us in achieving 33% of discharges by

noon; additional effort is needed to ensure that patients who could use the discharge lounge do so. These include planning to open our discharge lounge at weekends.



Weekend discharges continue to be below expectation. In October, on average we discharge 62 patients across the weekend. A review is being undertaken with support from the Emergency Care Improvement Support Team (ECIST) on improving the number of discharges at weekends. Part of this work includes changing the system we use to generate a working list of patients for our multidisciplinary team (MDT), which will go live in November. Additional continuous improvement work has been commenced in November by the COO to increase the weekend discharges.



5.0 Cancer Demand

Torbay and South Devon received 2,035 urgent suspected cancer referrals in October. So far for 2023/24, the Trust has received 13,697 referrals, 6.0% greater than last year.

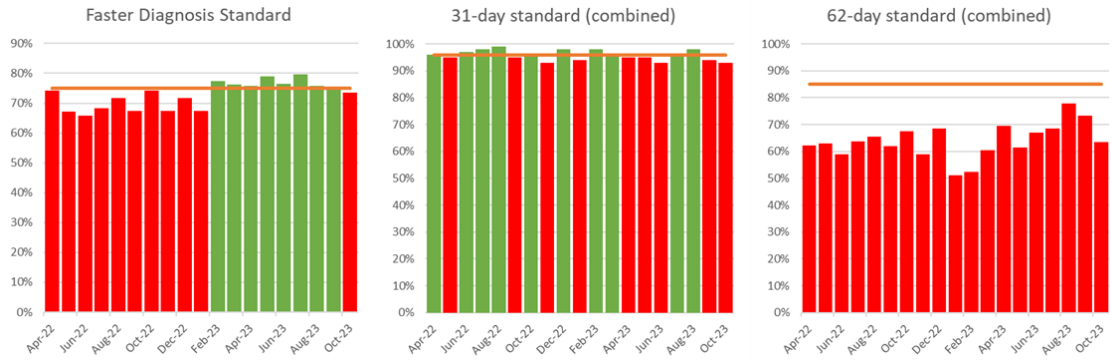
Skin, Breast, Gynaecology and Urology continue to receive above average referral growth, with these sites accounting for two thirds of the overall referrals.

Site	Gh	Number of referrals Apr-Oct 23
Skin	15.3%	5,208
Breast	13.5%	1,652
Gynaecology	10.5%	1,103
Urology	8.3%	1,123
Grand Total	**6.0%**	**13,697**

5.1 Cancer Performance

From the 1st of October, the methodology for calculating has been updated, in line with the publication of the refreshed Cancer Waiting Time standards. These three measures are the headline targets monitored by NHS England:

- the 28-Day Faster Diagnosis Standard (75% target).
- one 31-day decision to treat to treatment standard (96%), combining the previously separate First and Subsequent treatment standards.
- one 62-day referral to treatment standard, combining previously separate Consultant Upgrade and Screening standards (85%).



October's performance remains subject to validation. The 28-day Faster Diagnosis Standard (FDS) is currently at 73.4%. Performance across Urology and Colorectal has remained relatively static, however a decrease in performance is apparent in Gynaecology and Dermatology. Later in this report, there is a short brief on the changing performance in Gynaecology and the outlook for cancer performance.

The combined 31-day performance standard is at 92.4% (96% target). Of the 26 breaches, 17 were for patients awaiting first treatment and 9 were for subsequent treatments. The strike activity in September and October had an impact on this month's 31-day performance, with theatre sessions in colorectal and gynaecology postponed, this equated to 5 breaches directly and indirectly also caused delays to future booked patients.

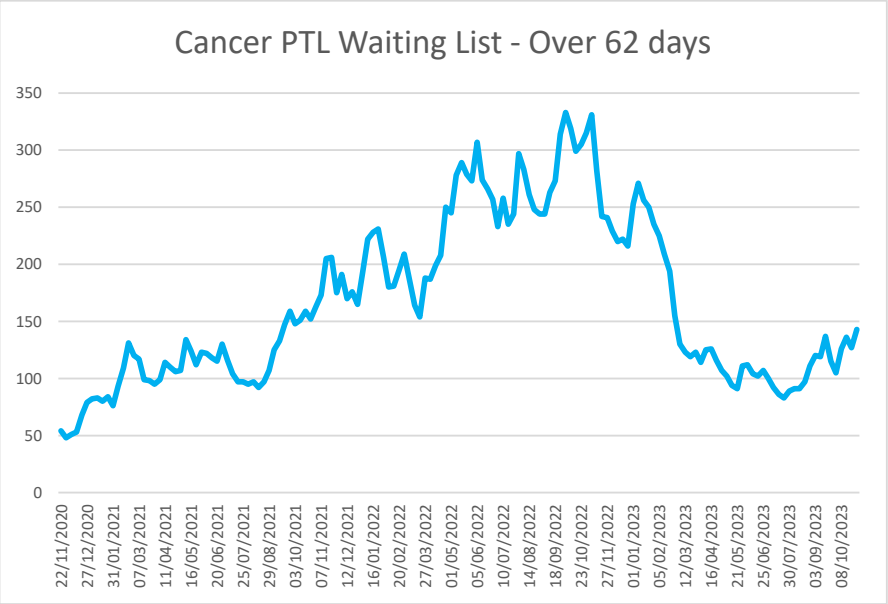
Please note, the above is being validated and we expect post validation we will meet the 28-day FDS. Currently, as an organisation, we are above plan for our cancer performance.

Performance for the combined 62-day standard is 63.6%, against the 85% target. Urology, Gynaecology and Colorectal account for the majority of the breaches. The culmination of diagnostic delays and increases in treatment time has compounded delays, particularly in these three specialities.

Over 62-day Backlog (Open Pathways)

As of 29 October 2023, the number of open pathways over 62-days was 143 and represents 7.2% of the total patient tracking list (PTL). There were 21 patients over 104 days and these patients are reviewed by the consultant managing the patient. Any harm observed is reported to the Clinical harm Review Panel, chaired by the Medical Director.

Although this latest position takes the Trust over our 138 patient target, we remain below our forecast for this point in the year and Torbay remains in the top half of all Trusts nationally, with regard to the over 62-day backlog.



Outlook

Performance in October reflects the anticipated challenges of co-ordinated strike action over the summer. Many of our services have fragile medical workforces, which had to prioritise safe levels of on-call provision and unfortunately had to postpone clinics and theatre lists.

For November so far, we continue to see an increase in the waiting times for first appointments. However, teams are responding well to these challenges with additional activity being conducted over the coming weeks. Colorectal, Urology and Gynaecology have all contracted insourcing support, to supplement the sessions our internal staff are providing. This will allow more robust recovery and maintain the wellbeing and resilience of our staff.

Gynaecology Overview

Last month's report highlighted the challenges in gynaecology, and these are anticipated to remain in the coming months. The culmination of demand increases, competing obstetric pressures, staff absence and strike activity has led to a rise in waiting times. Suspected cancer referrals into gynaecology have been increasing annually, with 45 additional referrals being received each month, compared to 2021/22. The majority, 70%, of these referrals are for suspected uterine cancers, this pathway relies on two key diagnostic stages - Post-Menopausal Bleeding (PMB) ultrasound clinics and hysteroscopies.

These diagnostic delays in the PMB pathway have had a cumulative impact in the overall gynaecology Cancer Waiting Times performance. The specialty has been unable to meet the 28-day Faster Diagnosis Standard, with performance below 40% in October 2023. The 62-day cancer Referral To Treatment standard is also not being achieved, with diagnostic delays being the primary cause.

For immediate recovery, additional sessions for both PMB ultrasounds and hysteroscopies have been arranged throughout the next two months. To sustain waiting times, additional workforce is required. Alongside the service leads, the Improvement & Innovation Team and Deputy Medical Director are aiding in the development of a formal service review with a workforce strategy and a corresponding business case due to be presented to the Trust Executives in December.

6.0 Referral to Treatment (RTT)

6.1 Long waits (August 2023)

- **104 weeks –** The Trust has reported no 104 week waits since March 23.

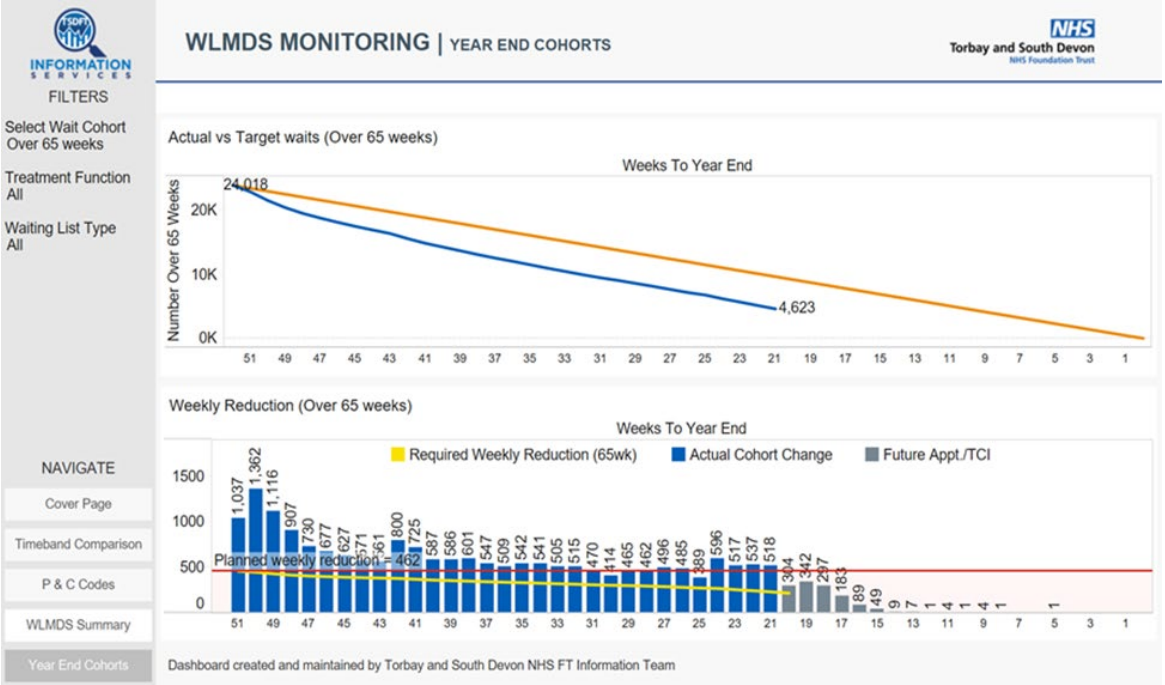
- **78 and 65 weeks –** Progress against our 78- and 65-week clearance plans has been impacted by Industrial Action.

		June Q1	July	August	Sept	Oct
78 week	Forecact Plan	130	130	130	111	92
	Actual	123	129	156	187	155
	Total	-7	-1	26	76	63
		June Q1	July	August	Sept	Oct
65 week	Forecast Plan	1312	1307	1387	1189	991
	Actual	1196	1,169	1296	1180	1018
	Variance	-116	-138	-91	-9	27

August was the first month that our control totals were not met for 78 weeks, missing the target by 26. Our performance against our 78-week plan deteriorated further in September, the position has now improved in October but remains behind our control total of 92. 65-week clearance has also improved in October but is also behind our control total.

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 (Apr – Oct) 4,500 clinical events have been lost to Industrial Action, of these lost events it is estimated that 1,500 would have been clock stop events for patients in our long wait cohorts. T

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.



It is encouraging to see that despite the impact of strike actions the Trust has maintained clearance rates of the overall 65 week cohort that are well ahead of our weekly requirement. This is particularly evident in the past 4 weeks since the latest strike actions.

6.2 Protecting and Expanding Elective Services

65-week cohort - 1st Outpatient by 31st October

The Trust cleared the 65 week 1st Outpatient cohort from 6K in August to 1.3K at the end of October. Work continues with our surgical specialties to ensure all patients in the 65-week cohort are seen before the end of Quarter 3.

Endocrinology and Paediatrics are out of scope because of the high level of clock stops at 1st outpatient appointment. The focus for these 2 specialties will be full clearance of the cohort by 31st March 2024.

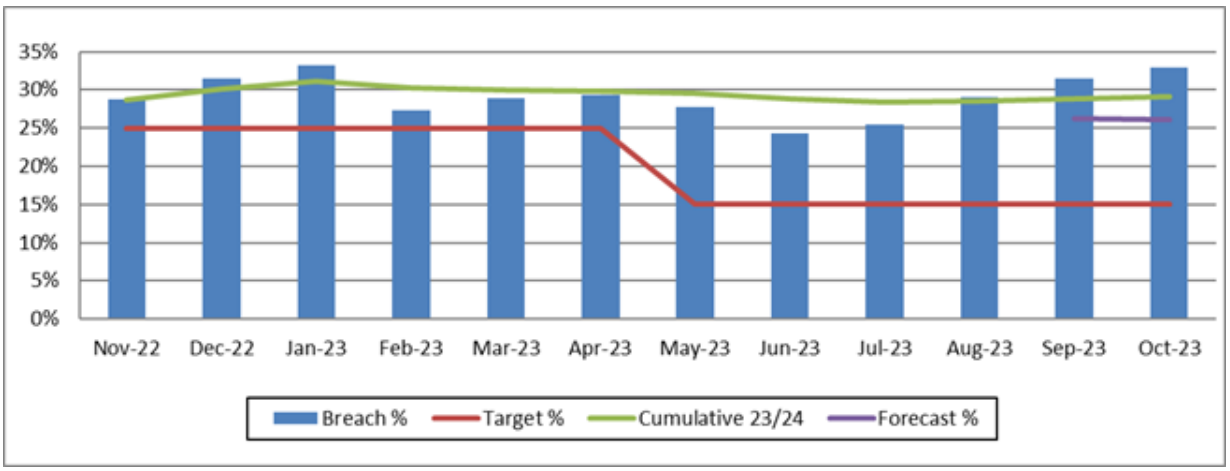
Validation activities

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%. Further support has been agreed with the Devon ICB which will increase patient contacts from 500 per week to 1,000. This is expected to improve our position to c80% by the end of November and deliver 90% by the end of Q3.

7.0 Diagnostics Performance

Our diagnostic performance has worsened in October 2023. The Trust reported 32.86% of patients waiting longer than six weeks against the end of October target of

25%. Plans to meet the amended target of 15% by the end of March 2024 are in the process of being signed off.



Diagnostic services remain in recovery from industrial action and work continues to target the main areas of concern.

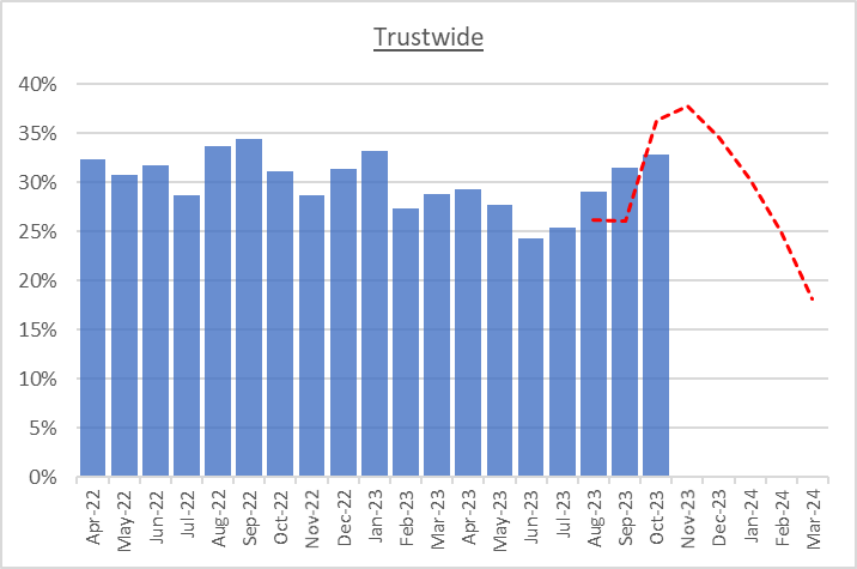
- MRI remains a challenge with a worsening position of 44% in October against a performance of 35% in September. The main driver being lack of elective capacity during October strikes and changing pathways in stroke, meaning a significantly higher proportion of inpatient requests to be accommodated. Work continues to mitigate this, including clinical review of acuity of OP referrals which could be provided at alternate locations (Nightingale/Mount Stuart/Newton Abbot Hospital mobile).
- CT performance has deteriorated to 26% in October – this is due to lost capacity from industrial action in October but there are plans to open an additional CT mobile unit at NAH on 1 December 2023 which will deliver further capacity to recover from strike actions.

Areas of Improvement

- Echocardiology has significantly increased in performance, achieving target at 13% in October 2023 (Sept: 31%)
- Colonoscopy has slightly improved to 63% in October 2023 (Sept: 71%)
- Gastroscopy has improved to 50% in October 2023 (Sept: 64%)

DM01 Forecast – March 2024, target 15%

The overall trust DM01 prediction is 18% by end of March-24 against a 15% target. However, this will be impacted by further industrial action so will be closely monitored (dotted red line = forecast)



CT is the main driver for the forecast peak – this will be mitigated by the additional CT capacity at NAH in December 2023.

Additional capacity plan to meet 15% March 2024 (not yet in place)

- Additional MRI to go to Nightingale and business case for more locum support to support increasing referrals from stroke service. Mitigation in place to ensure only consultants sign off on MRI requests where patient has already had CT diagnostics.
- Additional CT mobile van at Newton Abbot from December 2023
- 2 x additional endoscopy rooms to open end Nov-23

8 Children and Family Health Devon (CFHD)

8.1 Performance

Performance continues to receive on-going focus with some targeted work underway within Child and Adolescent Mental Health Services (CAMHS). This month's waits data shows the following in relation to the previous month:

Mean waiting times:

- Reduced mean waits in five service areas – Children's Community Nursing Occupational Therapy, Autism Assessment Service, Specialist Children's Assessment Service (under 5s), and Speech and Language Therapy
- Stable mean waits for CAMHS
- Small increases in the mean wait for Learning Disability and Physiotherapy

Referral to Treatment (RTT) (non-consultant led)

- Improved RTT in five service areas, Children's Community Nursing, Learning Disability, Occupational Therapy, Autism Assessment Service and Speech and Language Therapy
- Stable RTT in CAMHS

- Reduced RTT in one service area – Specialist Children's Assessment Centre (under 5s)

RTT, Mean waits by clinical pathway

Clinical pathway	**Mean Wait**	**% waiting < 18 weeks**
Community Children's Nursing	3	100%
Palliative Care	Null	Null
Specialist School Nursing	3.7	100%
Occupational Therapy	23.9	40.3%
Physiotherapy	10.7	81.8%
Speech & Language Therapy	36.7	29.2%
Autism Assessment Service	47.3	23%
Specialist Children's Assessment Centre	51.1	21.5%
CAMHS	17.3	56.1%
Children in Care Nursing	Assessment within 28 days -70%	
Children in Care mental health	24.1	52.1%

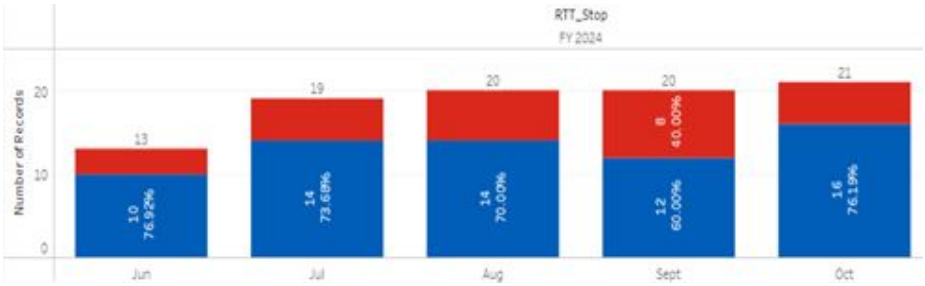
Long Term Plan Deliverables: Children / young people's mental health

Among the LTP deliverables for mental health, children and young people's waiting times for eating disorder services and overall access is measured against national targets.

Eating disorders

Routine referral: RTT Completed pathway

The graph below shows that 76% (16/21) of young people who had their first treatment appointment within October were seen within the 4-week target.



Urgent Referrals

There were no urgent referrals during October.

CAMHS Access performance

The national access target measures the number of children within the year who have attended one appointment within an NHS funded service to address their mental health condition. The data is gathered from a number of sources including specialist community CAMHS, Kooth and Young Devon. The target for this year is 11,801 by year end. Including CAMHS, Kooth and Young Devon this month, our current access data stands at 10,069 which is ahead of our Q3 target. We should see increases over the next 6 months as we are working on improving data capture and have not accounted for the Care Notes outage which will only be fully realised at the end of March. The graphs below show the CAMHS only data.

8.2 Transformation

As previously reported, work continues to prepare to mobilise the new service model. Notable developments in the month include the following:

- Development of develop detailed internal specifications for clinical pathways (in light of specification review work with the ICB). These outline the evidence informed interventions, their duration and intensity for all conditions treated in each clinical pathway, follow-up and PIFU timescales, clinical outcome measures to be used and timescales for review of baseline measures.

  Once complete, these will form the basis for standardising the clinical interventions delivered across the county according to best practice and we anticipate this will improve quality overall.

- Continued development of standard documentation such as the new Clinical Assessment, and Clinical Screening templates.
- Development of tools to aid clinical decision making during clinical triage regarding response times.
- SystemOne implementation delayed until
- Continued waiting list and caseload cleansing.
- Continued staff engagement and co-design regarding the change process through whole service meetings and face to face workshops.
- Website development – plan for the new website to go live in March 2024.

8.3 Joint Targeted Area Inspection (JTAI) Torbay

A Joint Targeted Area Inspection (JTAI), undertaken by Ofsted, Care Quality Commission (CQC) and Health Management Information Consortium (HMIC) is underway between 13th and 17th November within Torbay. The inspection is focussed on' the multi-agency response to identification of initial need and risk'. The agencies within the scope of the investigation are the police, children's social care, education, and relevant health services. The inspection framework evaluates both strategic and operational responses to the needs of children and families. The inspection will evaluate the efficacy of the following:

- How the 'front doors' of individual agencies identify and respond to initial need and risk.
- The multi-agency safeguarding hub (MASH).
- The contribution of individual agencies to decision making across early help, children in need and child protection.
- How the local partnership, through its multi-agency safeguarding arrangements (MASA), monitors, promotes, coordinates and evaluates the work of the statutory partners.
- The impact of leaders and managers on practice with children and families in relation to the front door
- The timeliness of this work and the impact of the local area's actions to improve the multi-agency response to children in need of help and protection

CFHD has been fully involved in the inspection preparation and engagement including undertaking detailed case audits as required.

9.0 Families Community and Home Care Group Update

9.1 Child Health / Paediatrics

The primary focus in this area is to deliver safe care, maintain 65 week waits from referral to treatment and financial recovery. All 65-week waits are on track to be cleared by February 2024 and the focus is shifting to plans to reduce this to 52 weeks in 24/25. The team are undertaking some transformation work and the section below highlights some of the highlights from the improvement work.

- **Patient panels:** The procurement processes have started, and expressions of interest released for two panels, one for young people and one for parents.
- **Diabetes:** Signposting/information leaflet has been developed for teens, children and parents.
- **Kidzmed**: Children and Young People are being supported to move from liquid medicine to tablets.
- **Was not Brought**: A review and analysis of data has been undertaken and agreement reached to survey parents to understand reasons behind non-attendance to reduce unattended appointments.
- **Referral Pathway**: key stakeholders met and agreed the following actions (i) Move to an "Advice & Guidance first" model (ii) update guidelines/criteria for referral for specialities to ensure high quality referrals come through (iii) Enhanced training on the e-referral system.

9.2 Children's Torbay 0-19 Service

The team have recently been invited to take part in a Start for Life National Evaluation case study. The purpose of the case study research is to gain a better understanding of the Start for Life local delivery models, and to understand key issues and lessons learned from set-up and early implementation. The case studies will take place in eight (8) Local Authorities (LAs), offering a mix of local programmes, levels of service maturity and socio-demographic characteristics. Torbay has been chosen as one of these 8 LAs. For each participating Local Authority & partners the case study research will involve a set of interviews, focus groups, and a short online survey of key strategic and operational staff involved in the local Start for Life programme. The survey will explore awareness and satisfaction with the programme, and key aspects such as partnership working, training and service delivery. This work will take place during November 2023, to allow enough time for the National Evaluation team to complete the data collection and analyse the evidence to include in a report to the Department of Health and Social Care (DHSC) in March 2024. As such the first step is for the National Evaluation team to visit us on the 2nd of November where a number of face-to-face meetings will be held with the National Evaluation team.

9.3 Torbay Recovery Initiatives (Drug & Alcohol Service)

The service is increasing numbers in treatment as required to be eligible for future Supplemental Substance Misuse Treatment and Recovery (SSMTR) grant funding for next year. Opiates needs to increase by 12 over the next 2 quarters.

Numbers in treatment	Q2 2022-23	Q3 2022-23	Q4 2022-23	Q1 2023-24	Success criteria
Opiates	569	565	559	576	588
Non-opiate only	121	136	141	156	331
Non-opiate and Alcohol	177	190	182	188	
Alcohol	387	408	407	441	388
Total	1254	1299	1289	1361	1307

9.4 Maternity & Gynaecology

An Emergency Department early pregnancy pathway has been launched to streamline care and onward referral pathways.

A case study in maternity at Torbay and South Devon NHS Foundation Trust (TSDFT) into why midwives leave the profession has been published. The report was commissioned by Devon ICB, the team are working in collaboration around next steps to pick up on culture issues noted in the report.

9.5 Community Sexual Health Service

One of the service Doctors Jane Simpson was nominated for the Innovation & Service Improvement SAS Doctor award recently for her work in implementing the telemedicine

service for Torbay Pregnancy Advisory Service (ToPAS) making early medical abortion more accessible for women.

9.6 Healthy Lifestyles & Personalised Care

The service is working on a wating list equity project, using population health management data to drive improvements in elective pathways. The project aims to reduce inequality within elective waiting lists by flagging those most in need, without increasing waiting times for those not flagged. This has the potential to significantly reduce waiting times for those most in need.

"The COVID-19 pandemic has impacted on urgent and elective services across the UK and here in Devon waiting times for patients needing urgent care, planned appointments and procedures have increased significantly, impacting on our ability to deliver timely hospital services to the people of Torbay and South Devon." (NHS Devon)

There is good evidence to support an equitable approach to elective backlog reduction. This includes consideration of unmet need, influenced by Indices of Multiple Deprivation (IMD) and other patient attributes (e.g., learning disability, mental health needs, caring responsibilities).

Overall, this project will improve outcomes for those on the waiting list identified as vulnerable by providing added support, thereby reducing 'Did Not Attends' (DNA) and supporting the waiting well initiative.

9.7 Social Care

Cost Improvement Plans progressing well, and verification complete with a £2.6M contributed in 2023/24 to Cost Improvement Plans for Adult Social Care (ASC). Hospital In-Reach Project performance sees an increase to 48% reduction in discharge pathway; In-reach reviews have expedited discharge for 452 patients since inception, 241 patients have been reduced from P2 to P1, meaning that they are able to return to their usual place of residence and Length of Stay reduced for 425 patients, reducing the risk of patient deconditioning. The majority (61%) of reviews in October completed in McCallum Ready-to-go wards, 20 McCallum reviews - 16 reductions (80% reduction rate). Winter Plans submitted alongside Demand & Capacity Modelling. Winter layering completed further layering into the model begins to support ASC budget setting and financial impact of transformation plans.

Since November 2022, there has been a consistent decline in the number of clients awaiting allocation, particularly due to the Interim Health Funding (IHF) project initiated in mid-February 2023. This project, aimed at allocating and assessing IHF cases within a four-week funding period, has significantly reduced the backlog of IHF clients, although it has led to increases in other categories, primarily those awaiting review.

In M05 and through to M06, the number of clients waiting for allocation had dropped substantially, far below the average for the period. The data also shows a decrease in clients waiting for longer durations, with the majority now in the 0-14 day waiting category.

Simultaneously, the Complex Care Team experienced an increase in their waiting list, especially in initial assessments and reviews, largely due to the focused efforts of the IHF project. However, there has been a notable reduction in cases awaiting allocation in the 'S9 Review' category.

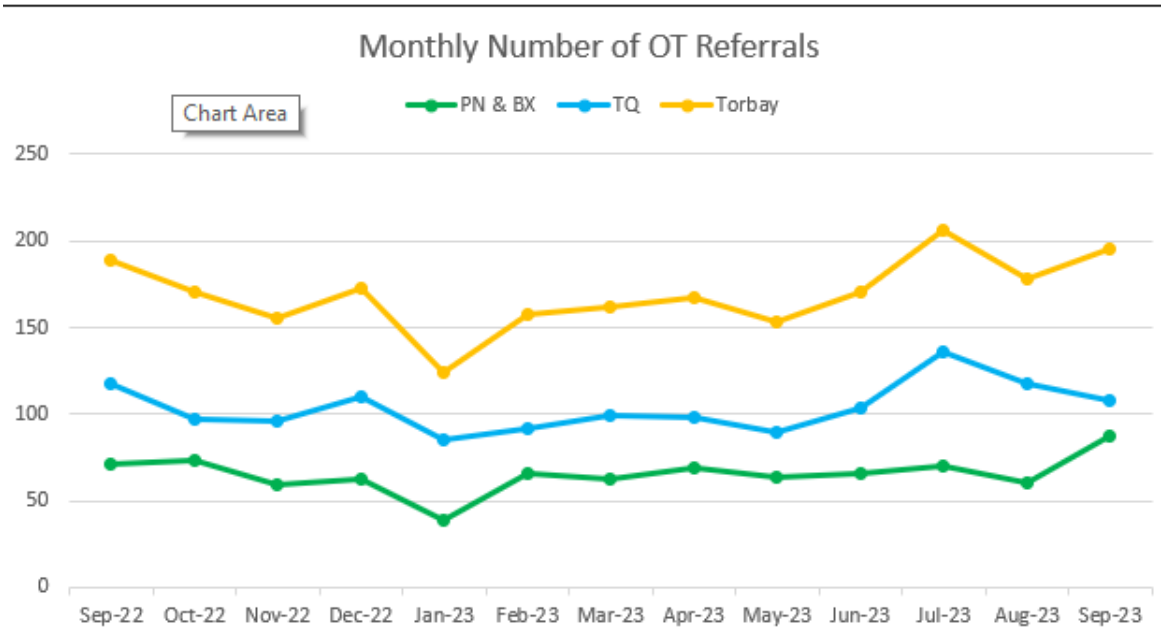
Furthermore, Adult Social Care (ASC) has been involved in a pilot improvement project with a primary provider of complex dementia nursing in Torbay. This project introduced a new level of care, the High Enhanced Bed, between the existing Standard Bed + 1:1 and Enhanced Bed (1:3 staffing ratio) categories. The goal was to end 1:1 support sooner, improving patient outcomes and reducing costs. This initiative has successfully decreased the need for 1:1 support and is set for further expansion following the pilot's evaluation.

Overall, these developments represent significant progress in managing and improving Adult Social Care services, demonstrating effective strategies in reducing waiting times and enhancing care delivery.

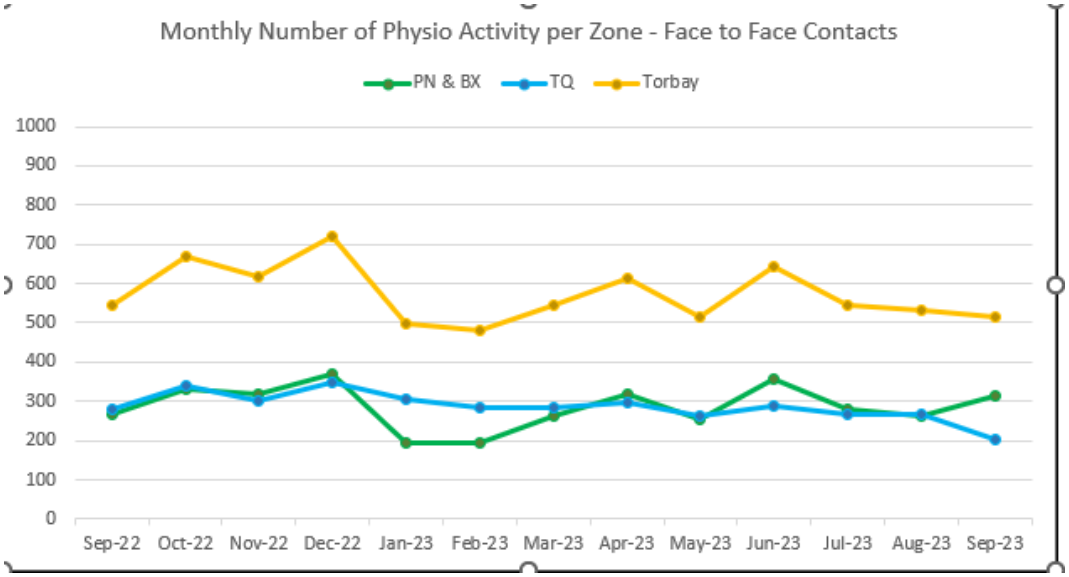
9.8 Bay Wide Community Health Services

9.8.1 Therapy

The occupational therapy (OT) waiting list is on average 100 in both areas with the oldest wait from June for a referral.



Physiotherapy (PT) team in Torquay is 45 with a wait of three weeks and Paignton and Brixham is 60 with a 4.5 week wait. An Assistant Practitioner 0.5 WTE due to return from her placement which will assist in reducing the waiting lists. The waiting list have reduced in this month.



9.8.2 Community Nursing

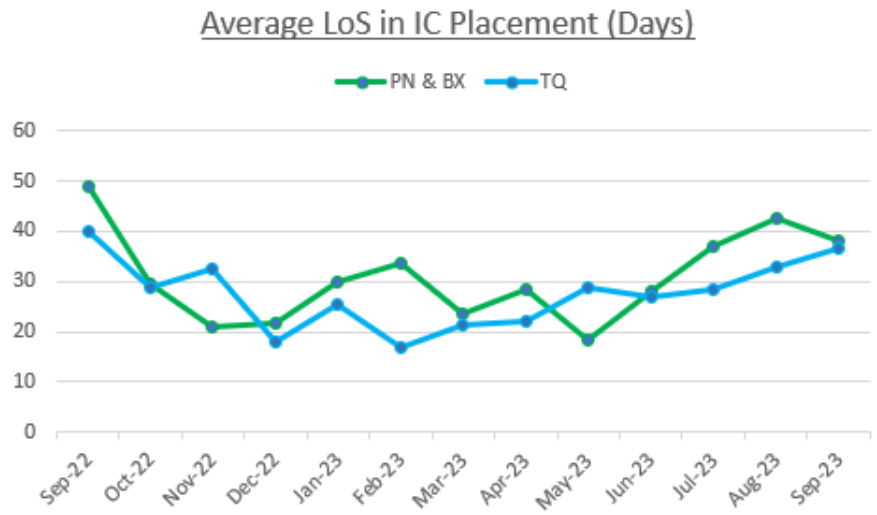
The community nursing team are continuing to recruit into their vacancies. We have currently recruited a Band 6 community Nurse with a special interest in Diabetes. The aim is to support the 50 insulin dependent diabetics patients that cannot be delegated due to their unstable presentation.

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

The OOH CN team are recording the number of visits and mileage travelled so that we can reskill mix the service in line with productivity. We have moved some budget to support recruitment in busier CN teams.

9.8.3 Intermediate Care

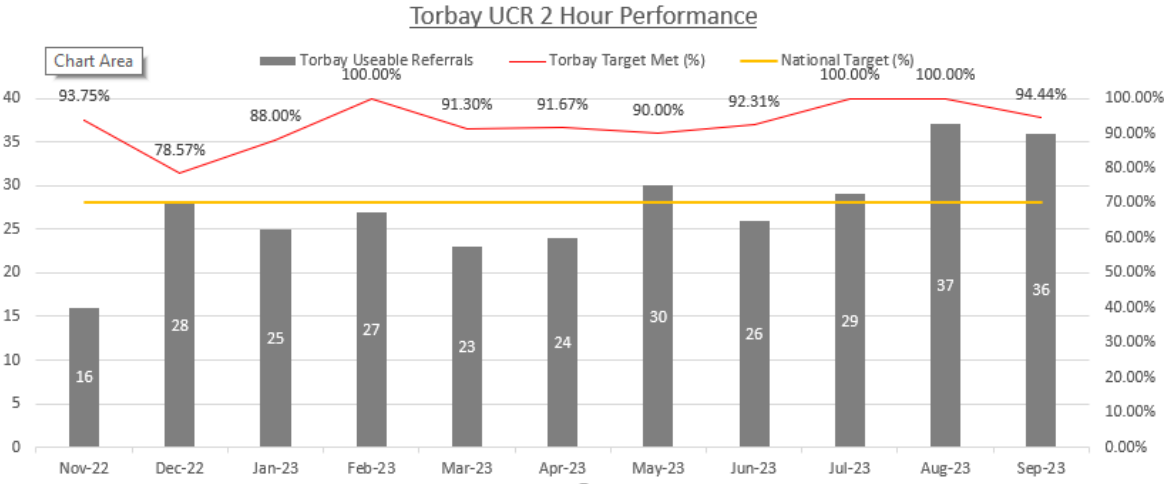
The IC teams are managing their home-based workloads well and are seeing a reduction in length of stay (LOS). In bedded placements, work is underway to monitor and reduce the length of stay. The teams are managing the 17 extra block pathway 2 rehab beds in care homes to assist with hospital flow. The career promotion of the IC lead in Torquay has created the opportunity to redesign and develop a Bay wide response. Currently we have 40 patients across the Bay in placement, with an average LOS of 39 days impacted by several very complex patients. This spiked last month as we had a number of long LOS who were waiting for diagnoses.



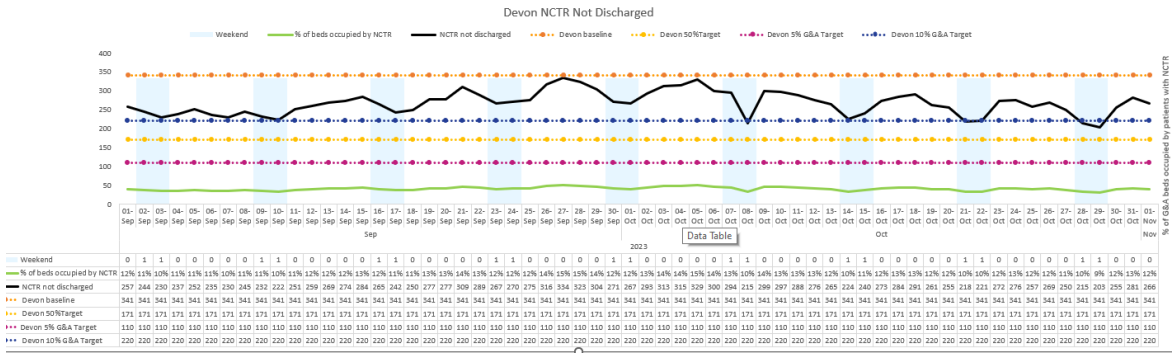
Intermediate care referrals.

9.9 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. We have achieved 100% 2hour response and increased the volume by 27% in the last month. UCR 2-48hour response is 96%. The ICB is looking for the Organisation to report weekly on top of the monthly Community Data set.



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



	01-Sep	02-Sep	03-Sep	04-Sep	05-Sep	06-Sep	07-Sep	08-Sep	09-Sep	10-Sep	11-Sep	12-Sep	13-Sep	14-Sep	15-Sep	16-Sep	17-Sep	18-Sep	19-Sep	20-Sep	21-Sep	22-Sep	23-Sep	24-Sep	25-Sep	26-Sep	27-Sep	28-Sep	29-Sep	30-Sep	01-Oct	02-Oct	03-Oct	04-Oct	05-Oct	06-Oct	07-Oct	08-Oct	09-Oct	10-Oct	11-Oct	12-Oct	13-Oct	14-Oct	15-Oct	16-Oct	17-Oct	18-Oct	19-Oct	20-Oct	21-Oct	22-Oct	23-Oct	24-Oct	25-Oct	26-Oct	27-Oct	28-Oct	29-Oct	30-Oct	31-Oct	01-Nov
Weekend	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0
% of beds occupied by NCTR	12%	11%	10%	11%	11%	11%	10%	11%	11%	10%	11%	12%	12%	12%	13%	12%	11%	11%	13%	13%	14%	13%	12%	12%	12%	14%	15%	15%	14%	12%	12%	13%	13%	14%	14%	15%	14%	13%	10%	14%	13%	13%	13%	12%	10%	11%	12%	13%	13%	12%	12%	10%	10%	12%	13%	12%	12%	11%	10%	9%	12%	13%	12%
NCTR not discharged	257	244	230	237	252	235	230	245	232	222	251	259	269	274	284	265	242	250	277	277	309	289	267	270	275	316	334	325	304	271	267	293	313	315	329	300	294	215	299	297	288	276	265	224	240	273	284	291	261	255	218	221	272	276	257	269	250	215	203	255	281	266
Devon baseline	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341	341
Devon 50%Target	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171	171
Devon 5% G&A Target	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110
Devon 10% G&A Target	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220	220

NCTR- has fluctuated between 5% and 10% throughout October. Plans in place to reduce to 5% or less.

- Daily review of NCTR and validate recording.
- Twice weekly meeting established this week to review the patients that have been referred for assessment by Complex Discharge Team to reduce time from referral to the team to the assessment documentation (referral form) being sent to the Discharge Hub. This will reduce the potential of deconditioning by reducing loss of bed days.
- Continue with clinicians in Discharge Hub to complete functional D2A assessments.
- Need to commence a Long le

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.Monitoring utilisation of these block hours and scheduling of workload to maximise efficiency.

Pathway 2 (P2) - The 17 block beds in Torbay provided by the demand and capacity monies are being utilised. Senior review multidisciplinary team (MDT) review of all P2 referrals to the discharge hub is influencing positively however further improvement of the triage is required to reduce the time to transfer from seven days to five.
Mapleton in South Devon continues to provide 10 block IC beds. The LOS and onward support are being monitored and reviewed. This is being fed back through the DCC governance structures.

Pathway 3 (P3) – Time to transfer is reduced.

DCC continue to exert 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.

Time to transfer has increased for South Devon in September

Number of patients per pathway, split by locality:

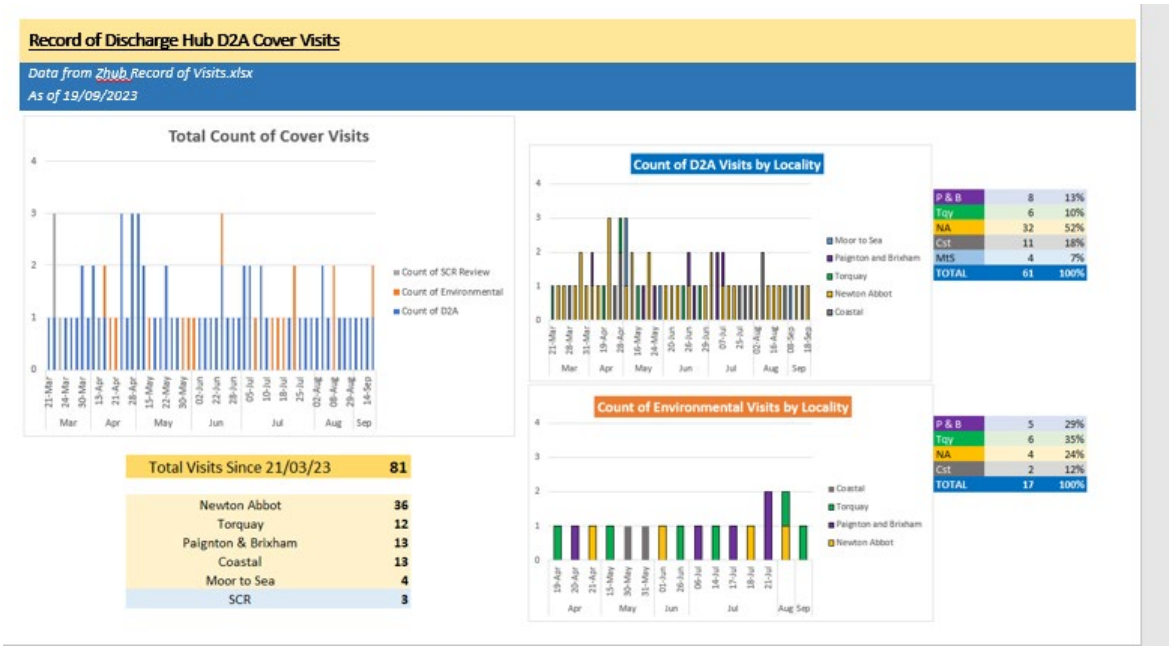
	South Devon	Torbay
P1	2	6
P2	5	5
P3	5	1

Time to transfer (in days) per pathway, split by locality:

	South Devon	Torbay
P1	4	1
P2	7	4
P3	13	3

**Outliers in Devon P3*

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 this is due to capacity in the locality. Discussed with the CSM.



9.11 Continuing Healthcare (CHC)

Torbay and South Devon CHC team are currently achieving 60% against a national target for CHC decisions made within 28 days. The target is 80%. This is a significant drop in performance from 80% last month. There have been several contributing factors

to this drop in performance. We have had several staff off sick with COVID, there has been a significant shortage of social care staff in the DCC area to support with assessments and decisions causing a significant delay to a number of cases.

Whilst the above things have had a significant impact last month prior to that the CHC team have made good progress on reviews and new assessments. The Laison outsourcing contract has ended having delivered very little against a target set for them of £1.2m The Trust CHC team have been managing to undertake CHC reviews and have achieved covered the CIP target. There haven't been any transactions this month but there are several contract changes that will be reflected in next month's position.

CHC IT system requires detailed work to bring in line with DOH performance requirements. Lack of capacity to manage as system updates required via Torbay Council Staff. Alternative system available offering an end-to-end solution. Used by most ICB's to record CHC performance and activity. Possible costs involved along with IG issues around data housing.

10.0 Healthcare of Older People (HOP) and Frailty

Frailty virtual ward admitted its first patients during October. Due to only having our Specialty GP in post the first pathways being supported were for those patients in existing places of safety such as residential or nursing homes and being supported by Intermediate Care services.
Locality teams have been supportive and very positive about the service. Most of the first patients were patients requiring advanced care planning discussions and palliative care pathways. Step-down pathways have also been supported from HOP wards.

Planning for a Frailty Same Day Emergency Care (SDEC) is progressing. This model of delivery supports the Integrated Care Board (ICB) ambitions for Urgent and Emergency Care but is also fully in line with the recommendations of the recent Getting it Right First Time (GIRFT) visit. We have been supported in its design by ECIST. There are several significant challenges with implementing this model not least releasing the Frailty Intervention Team (FIT) from managing beds on EAU 4 but also identifying a suitable environment. Discussions are progressing and we are optimistic that we will be able to implement ambulatory pathways for our patients towards the middle of December.

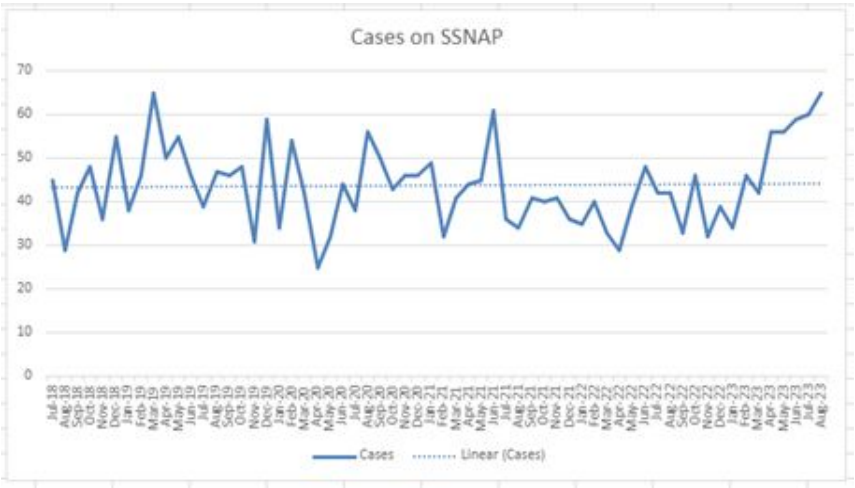
10.1Stroke and Neuro Rehab

During September we continued to be challenged in achieving our time critical standards for stroke. Only 18.5% of patients reached the stroke unit within 4 hours; this means that 45 patients did not reach the stroke unit within 4 hours. The October Sentinel Stroke National Audit Programme (SSNAP) meeting included colleagues from the Emergency Department (ED) and the site team, and this produced a very helpful discussion with actions to clarify and hopefully improve the clerking process in ED which in turn means that when a bed is available on George Earl that there are fewer

impediments to them getting there.

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	Aug-23	Sep-23
Number of patients (N)	42	46	60	47	59	49	54	69	66	72	62	62	65	55
% Scanned within 1 hour	40.5	39.1	46.7	57.4	44.1	57.1	44.4	53.6	50	59.7	58.1	51.6	55.4	52.7
% Scanned within 12 hours	88.1	93.5	88.3	93.6	91.5	89.8	92.6	95.7	90.9	97.2	90.3	95.2	92.3	85.5
% Admitted to Stroke Unit within 4 hours	25	17.4	8.8	27.3	0	14.9	15.1	29.9	23.1	28.2	25	20.3	27	18.9
% of patients spending 90% of their time on the Stroke Unit	65	53.3	59.3	76.1	41.1	61.7	68.5	71	61.5	77.8	59.7	70.5	69.8	69.1
% (No.) Patients that received Thrombolysis	9.5 (4)	10.9 (5)	10.2 (6)	11.1 (5)	6.9 (4)	10.4 (5)	7.7 (4)	10.4 (7)	9.4 (6)	8.3 (6)	11.5 (7)	6.7 (4)	3.1 (2)	5.6 (3)
% Received Thrombolysis within 1 hr	25	20	50	100	25	60	0	57.1	50	16.7	42.9	75	0	0
SSNAP		A	B	C	D	E								

A delay to inputting SSNAP forms into the national data base has meant that there has been an under-reporting of the numbers of stroke patients.



Recent interrogation of the national data demonstrates that there has been a consistent rise in the last 12 months (as reported last month) however it also shows that numbers are back to pre-covid levels, but that if the numbers we are seeing currently sustain it will be higher than before the pandemic.

By the end of November, we would hope to have recruited a SSNAP Co-ordinator post which will support the accurate and timely inputting of data across the whole pathway.

A bid was submitted on the 3rd November to be part of the national Thrombolysis in Acute Stroke Collaborative (TASC). This collaborative has been set up with support from NHS Elect with the primary aim to increase thrombolysis rates in participating sites. The NHS Plan set out the national ambition that 20% of stroke patients should receive thrombolysis. Currently national rates are around 11.5% and locally we are just over 9%. This bid is supported by our local Integrated Stroke Delivery Network (ISDN), the ICB and our Executive. We should know during December whether we are one of the 6 sites nationally to be selected.

11.0 Recommendation

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Workplace Team Strategic Performance Update			Meeting date: 29th November 2023
Report appendix:	Appendix 1: Trust Health & Safety Report Appendix 2: Workplace Compliance Dashboard		
Report sponsor:	Interim Chief Finance Officer		
Report author:	Workplace Director		
Report provenance:	Workplace Performance and Compliance Group		
Description/Purpose of the report and key issues for consideration/decision:	The purpose of this report is to brief the Trust Board on strategic Workplace Team performance and compliance exceptions for September and October 2023.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	To note the current performance and compliance of Workplace Team and headline summary of key exceptions and activities		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	This report outlines the work being undertaken by the Trust to enable the delivery of patient care through the provision of compliant and safe environments, services and people. This report also covers the work being undertaken to reduce the Trust's carbon footprint to the benefit of the local environment.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources		
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 4 - Estates Objective 5 - Operations and Performance Standards Objective 10- Green Plan/Environmental, Social and Governance Objective 11 – Equality, Diversity and Inclusion		
Risk: Fit for Purpose Estate Risk ID: 2179	Risk is already included in DATIX and outlined on the corporate risk register		
External standards affected by this report and associated risks	Laws or regulations Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance		

Report title: Workplace Team Strategic Performance Update		**Meeting date:** 29th November 2023
Report sponsor	Interim Chief Finance Officer	
Report author	Workplace Director	

1.0 Introduction

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

2.0 Discussion

2.1 Corporate Health & Safety

October saw the local fire brigade undertake unannounced audits at: Paignton Health & Wellbeing Centre; Totnes Hospital; Dawlish Hospital; Newton Abbot Hospital; Brixham Hospital; and Ashburton Health and Wellbeing Centre. Whilst concerns around the storage of clinical engineering equipment and lithium batteries were identified at Paignton Health and Wellbeing Centre, these were quickly addressed and no enforcement action was received. No significant concerns were identified at any of the other aforementioned sites and the exercise was a positive one.

In order to improve its compliance with fire safety legislation and to improve the overall safety of the Trust for colleagues, patients, visitors and third-parties and following advice from the Trust's Authorising Engineer for fire safety, work has commenced on removing kitchen appliances from non-compliant spaces. An amnesty for the removal of these is currently in place across the Trust with advice and guidance provided on suitable alternative locations.

As at September 62 Health and Safety open risks were currently on the Trust wide risk register of which 28 were scoring 12 and above. September had the highest number of low harm incidents reported over the last twelve-month period. Slips, trips, and falls remain the highest category reported. A slight increase in non-patient handling events and in Sharps incidents was seen in September but no trends identified.

2.2 Compliance and Performance

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

August and September continued to be strong for the Estates Delivery team within Workplace, with notable month on month improvements in relation to: routine planned-preventative maintenance; reactive task performance; fire door compliance; lightning protection compliance; and LOLER lifting equipment compliance.

A small number of areas of concern have been identified within the Workplace Team's performance and compliance in the reporting period, primarily as a result of resource challenges, and these are outlined in detail below:

Area of concern	Performance Overview	Summary	Risk RAG
Emergency lighting compliance	Decline of 10% compliance from 100% - 90% in September when compared to August	Due to electrical resource shortages (two vacancies, combined with annual leave and long-term sickness), 12 maintenance routines were cancelled. Plan in place to deliver this routine activity via third party suppliers. This will result in demonstrable improvements in this space for by December 2023.	Short term issue – high risk issues and areas prioritised, no significant concerns
Generator service & load bank test	Significant decline of 88% in August and September when compared to July	Same issue and solution as per above. To be back on track by December 2023.	Short term issue – high risk issues and areas prioritised, no significant concerns
Generator monthly load test	Significant decline of 60% in August and September when compared to July	Same issue and solution as per above. To be back on track by December 2023.	Short term issue – high risk issues and areas prioritised, no significant concerns
Water Safety checks	Decline of 5% compliance from 100% - 95% in September when compared to August	Same issue (albeit resource shortages in this case relate to the water management team opposed to electrical) and solution as per above. To be back on track by December 2023.	Short term issue – high risk issues and areas prioritised, no significant concerns

Whilst the above does represent a decline in a small number of areas, the management and maintenance in respect of these activities has up until recently been very strong and as a result of this, there are no significant concerns expressed by internal subject matter experts or the Trust's Authorising Engineers about the impact of these very short-term issues, the recovery plan for which is already in place and progressing as planned.

All other areas, including catering, cleaning, and waste management services as well as estates delivery and cleaning services contractors in the Trust's community estate remains strong. This is also the case for the respective Private Finance Initiative (PFI) service providers at Newton Abbot and Dawlish Hospitals.

There are no overarching concerns relating to broader Workplace compliance and performance, which is consistently strong in the overwhelming majority of areas.

2.3 Car Parking and Traffic Management

August saw the commencement of the Trust's new commercial relationship with SABA who have replaced MBSS as the organisation's car parking and traffic management provider at the Acute site.

All staff have been asked to re-apply for a parking permit as a new permitting system has been implemented as part of the arrangement with SABA. This will allow the Trust to ensure permits are only provided to those who qualify which will contribute, albeit it subtly, to easing pressure on the limited number of spaces available. Going forward, 'permit runs' which require staff to update their details and reapply for permits, will be undertaken on an annual basis in accordance with the Trust's car-parking policy. It is worth noting that the Trust's car parking policy has not been changed as a result of these operational changes, nor has the criteria for permit qualification.

SABA will be focussing on the installation of new ANPR cameras, payment meters and barriers across November and December, with the new technology going live in January, by which time, all colleagues who have applied for a parking permit have had the outcome of this confirmed.

Communication regarding these essential but emotive operational changes has not been optimum and a 'lessons learned' exercise is currently taking place to establish what should be done better in this respect for the future. In addition to this, a series of routine updates are being shared with all staff which have been tailored to the trends in feedback received from them regarding this change. This will be ongoing until the new approach to car parking management has been fully embedded.

Car parking on the acute site remains significantly challenged with a regular flow of highly emotive complaints from staff and patients regarding the inability to park, particularly Tuesday to Thursday during core working hours. This is resulting in staff being late for shifts and patients missing appointments.

Calculations show that in recent years, 191 parking spaces on site have been lost due to the development of the building footprint site. The Workplace Team are working closely with colleagues at Torbay District Council and SABA to identify further solutions to address this significant issue. In reality, all solutions which result in a material improvement to the situation will require a moderate to significant investment from the Trust.

2.5 Environment and Sustainability

October saw the launch of the Trust's new 'Keep Cup' (figure one) initiative which will take effect in November. This means that all Trust staff will be issued with a free reusable travel mug to take to use at all various catering outlets and will receive a monetary discount on any hot beverage when they use this. This will also reduce a significant proportion of the 35,000 cardboard coffee cups the Trust disposes of each year and the associated financial implications.

Figure One: Trust 'Keep Cups'

Work to achieve a Power Purchase Agreement (PPA) for the provision of solar-generated energy through a private wire to the Trust's acute site continues via the appropriate procurement process. This is taking slightly longer than anticipated due to some challenges with the preferred bidder, it is anticipated that these issues will be ironed out by in December and formal award will take place in January 2024, subject to Finance, Performance and Digital Committee (FPDC) approval.

2.5 Excellent Customer Experience

In September, the team completed the Trust's new vaccination hub (figure two) on the acute site. This multi-purpose space will act as the 'home' of the vaccination programme for the foreseeable future, following longstanding year on year challenge of identifying fit for purpose, permanent space for this crucial activity. This was a complex piece of work with an exceptionally short turnaround.

Figure Two: Acute site vaccination hub

The Workplace Team were pleased to support the sourcing and installation of the Trust's new modular Radiopharmacy Unit (figure three), following compliance issues which were identified with the former location. This was a significant effort from the team with a short turnaround which will support the delivery of safe care to patients.

Figure Three: Modular Radiopharmacy Unit

Patient Led Assessment of the Care Environment (PLACE) visits commenced in October 2023. PLACE assessments involve assessors (including governors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing things such as: cleanliness; condition; appearance and maintenance; privacy, dignity and wellbeing; and food.

2022's PLACE results put the Trust in the top five acute Trusts in England for cleanliness and food quality, a position that there is a strong belief can be maintained into 2023. Visits undertaken thus far indicate that in the majority of areas, this strong performance has been sustained. Upon the conclusion of the PLACE assessments in November, a report will be compiled for submission to the national team, which will be shared with FPDC in December. The national results will be published in the fourth quarter of the 2023-2024 financial year.

2.5 CIP Delivery and Financial Performance

As at month seven, the Workplace Team reported adverse variance of £2.4m including undelivered CIP target of £1.3m (significant CIP value to be transacted from month eight onwards), the remaining balance of £1.1m

is mainly caused by further utility and business rate increases which were higher than predicted along with repairs and maintenance and food costs. It is noteworthy that the Workplace Team's run rate improved by 264k in month seven.

The total forecast position compared to budget is an overspend of £4.2m including undelivered CIP target of £2.5m

- Pay (£112k) (favourable)
- Non-Pay £2.2m (adverse)
- Income (£342k) (favourable)

The total year to date position compared to budget is an overspend of £2.4m (including £1.3m unachieved CIP target):

- Pay (£35k) (favourable)
- Non-Pay £1.3m (adverse)
- Income (£196k) (favourable)

The Workplace Team will continue to focus on all elements of spend within its control to identify sustainable financial efficiencies and recover the current forecast position.

2.5 Acquisitions and Disposals

Following FPDC's approval to dispose of the former Bovey Tracey Hospital site, an offer of £422k, which is £72k above the book value and £172k above the reserve price has been received an accepted. Work to complete the transaction has commenced and completion is anticipated in November 2023.

Both the former Dartmouth Clinic and former Dartmouth and Kingswear Hospital have been placed on the electronic Property Information Management System (e-PIMS) for in excess of 40 working days. The marketing packages for both sites have been finalised by the Trust's appointed property agent Montagu Evans and are awaiting sign off from the Trust communications team. Once this has been received, the sites will be advertised on the open-market, it is anticipated that this will take place in November. Several parties have already expressed an interest in the properties to Montagu Evans and dialogue with these is being maintained. Further updates to FPDC will be provided as appropriate.

3.0 Conclusion

August and September have seen strong and consistent levels of compliance and performance across all operational areas of the Workplace Team and, where issues have been identified, a plan is in place for remedy.

There continues to be significant focus on delivering excellent customer experience in line with the Workplace strategy and driving the green agenda. Car parking capacity remains a significant challenge for the Workplace Team and the Trust more broadly, work continues to identify suitable solutions.

The scale of the financial challenge remains significant largely due to factors beyond the direct control of the Trust. The anticipated disposal of the former Bovey Tracey Hospital site and the progress in to getting the former Dartmouth Clinic and Former Dartmouth and Kingswear Hospital sites to open market is positive.

4.0 Recommendations

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

Report Date	Octobers Committee meeting (reporting period up to 30th September 2023)		
Report Title	Corporate Health & Safety and Fire Monthly Report (TLB)		
Report Authors	Kevin Wood - Head Safety Health, Environmental & Quality (SHEQ) Suzanne Ellis - Senior Corporate Health and Safety Advisor Neil Faulkner - Corporate Fire Safety Advisor Jake O'Donovan – Workplace Director		
Lead Director	Jon Scott – Chief Operating Officer		
Corporate Objective	Safe, quality care and best experience / Well led		
Corporate Risk/ Theme	Statutory Safety		
Purpose	**Information**	**Assurance**	**Decision**
	✓.	✓.	✓.

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

- **Risk register**

  There are a total of 62 Health and Safety open risks on the Trust wide Risk Register of which 28 are currently scoring 12 and above.

1. **Analysis of Performance**

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

Table 1

	Death	Severe	Moderate	Low harm	No harm	Near miss	Totals
Oct 2022	0	3	2	30	65	17	117
Nov 2022	0	6	4	57	126	20	213
Dec 2022	1	1	7	59	133	29	230
Jan 2023	0	3	5	64	133	21	226
Feb 2023	0	5	4	66	87	10	172
Mar 2023	0	4	6	71	114	22	217
Apr 2023	0	3	2	65	115	18	203
May 2023	1	2	4	75	105	24	211
Jun 2023	1	2	3	72	142	35	255
Jul 2023	0	6	7	68	142	24	246
Aug 2023	1	3	4	56	118	21	203
Sept 2023	0	1	4	76	99	26	206
YTD Totals	4	39	52	759	1378	267	2249
Average	0.333	3.25	4.33	63.25	114.83	22.25	208.25
Averages Last August report	1	4	5	65	117	23	214

September saw a slight increase in recorded events up by 3. Incidents overall were below the monthly average of 208.25 recording a total of 206.

Across the board we have seen the monthly figures reduce in each section when we look at the average calculations.

Chart 1

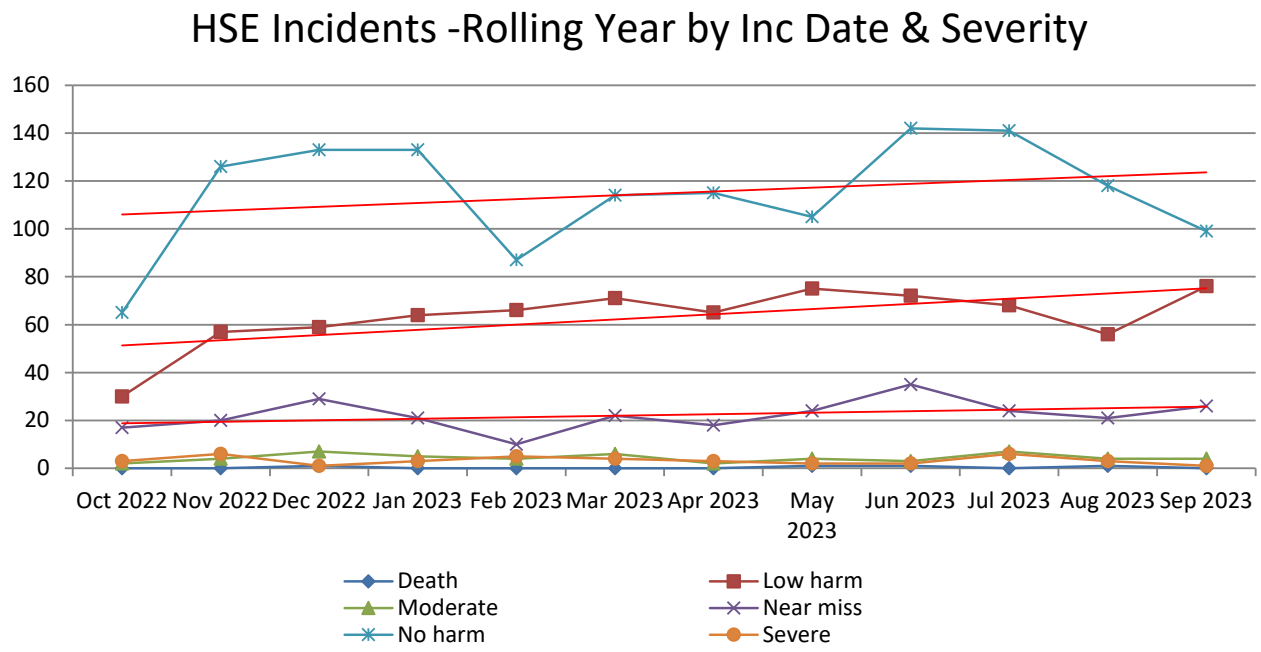


Chart 2

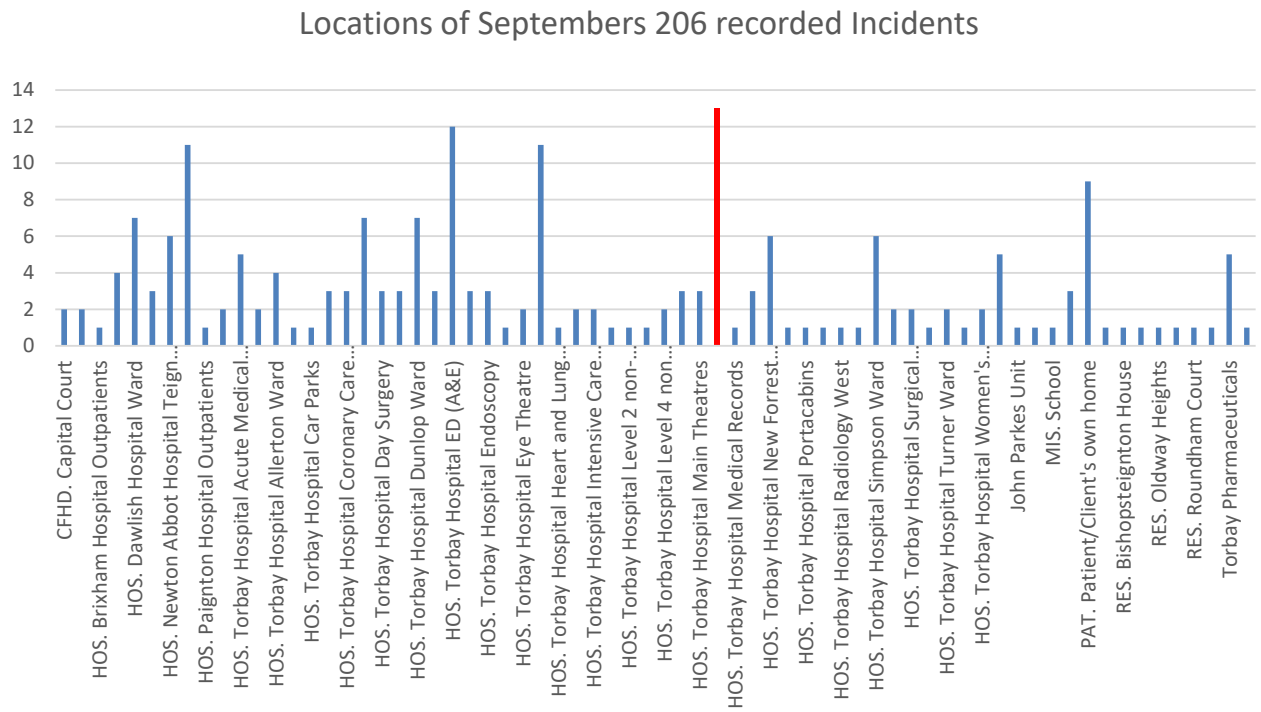


Chart 3

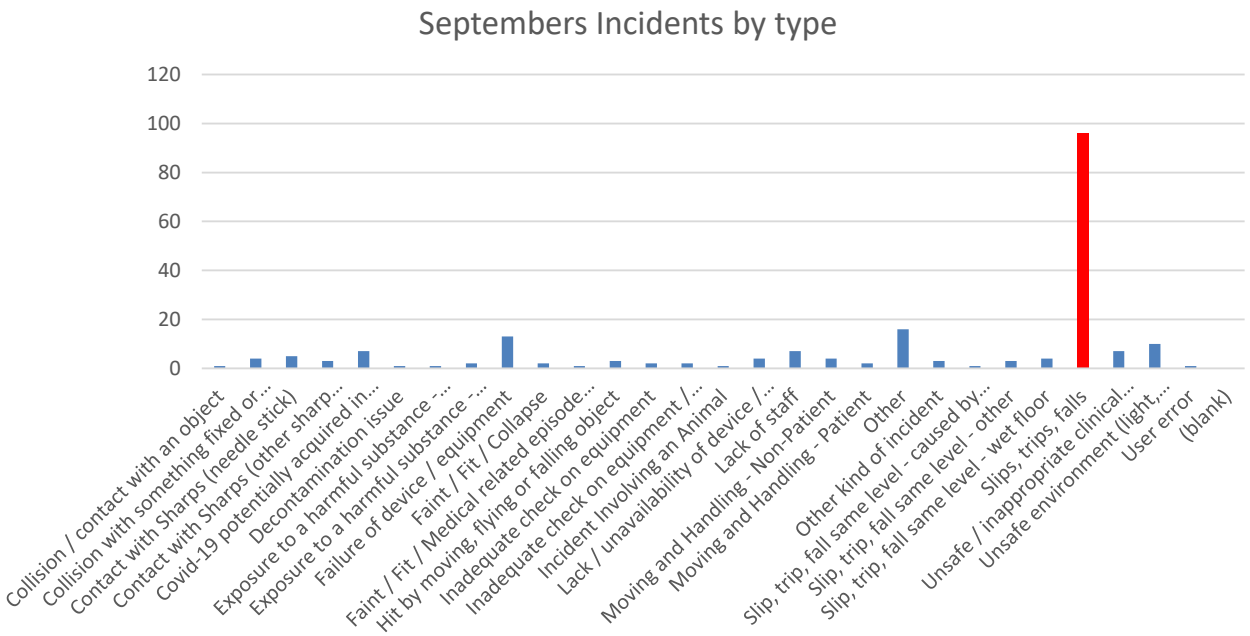
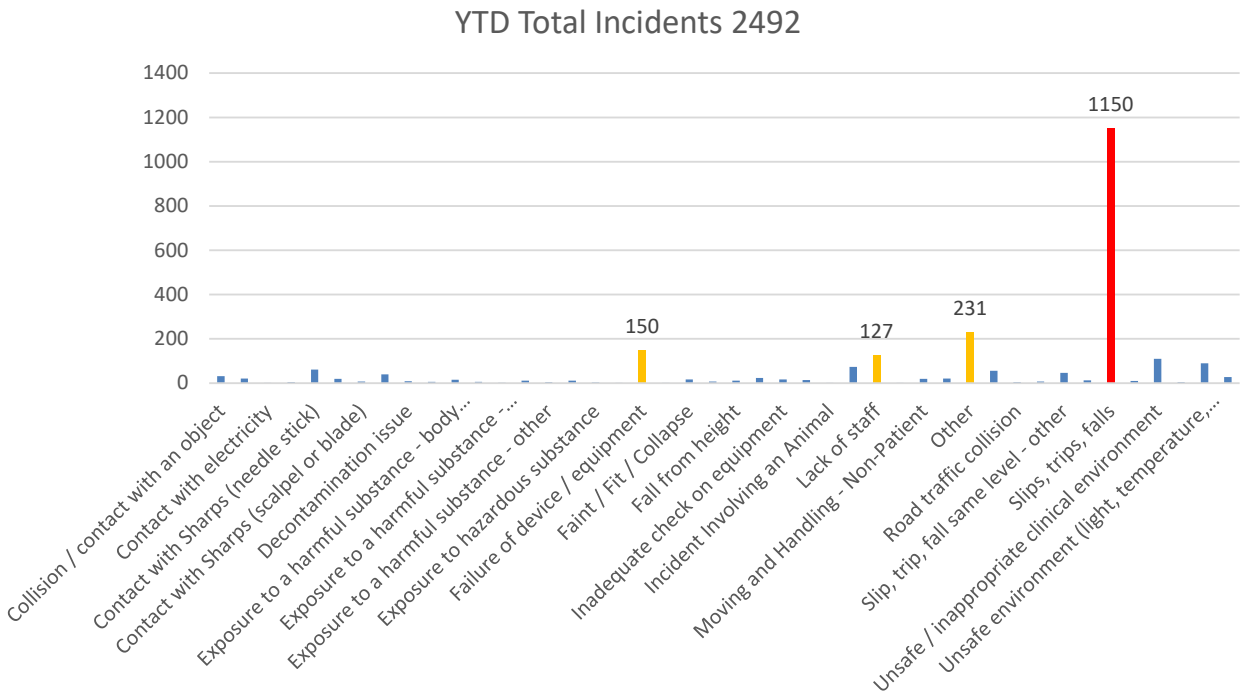
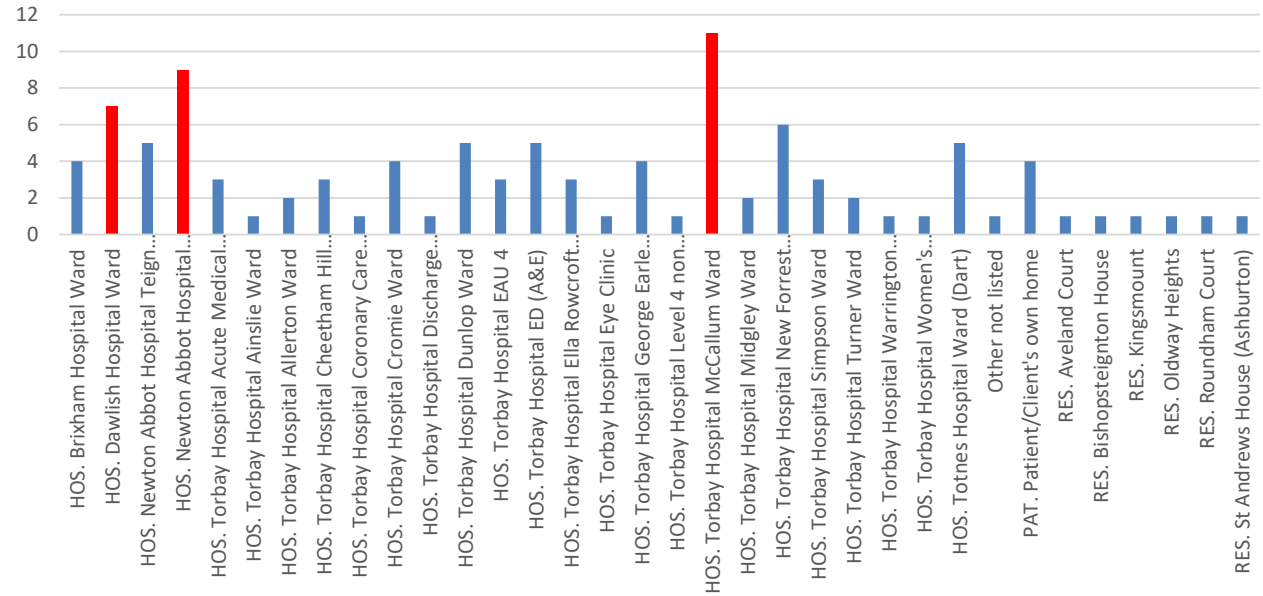


Chart 4



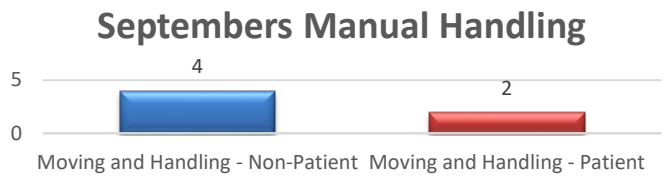
Slips Trips and Falls is our biggest issue equating to 46% of all recorded incidents
Other 9.2 %
Failure of device 6%
Lack of staff 5%

Chart 5
Breakdown of locations for Slips Trips and Falls



3.0 Manual Handling

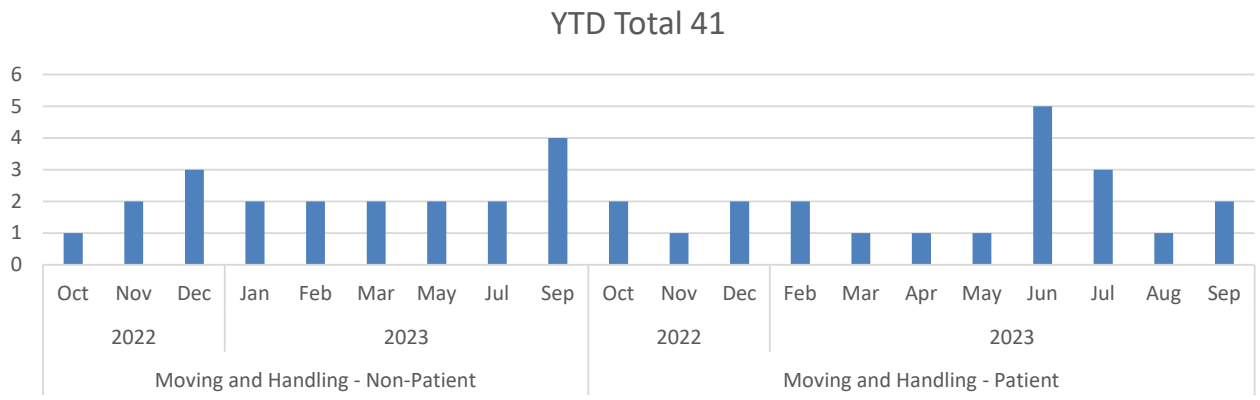
Charts 6 & 7



Recorded averages for YDT monthly totals

Non-Patient 2

Patient 2

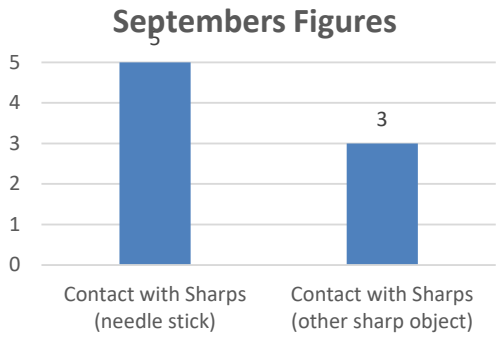


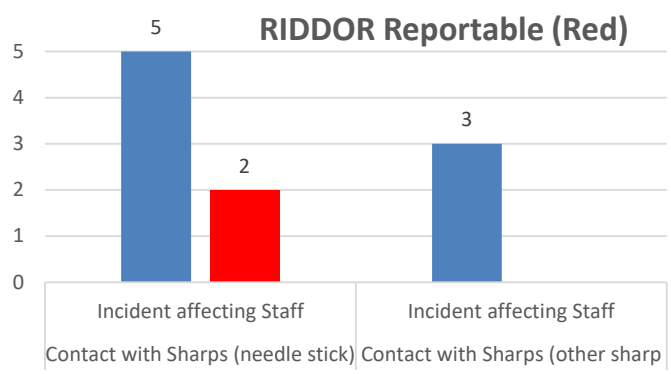
Non-Patient and Patient handling issues saw a slight increase over August.

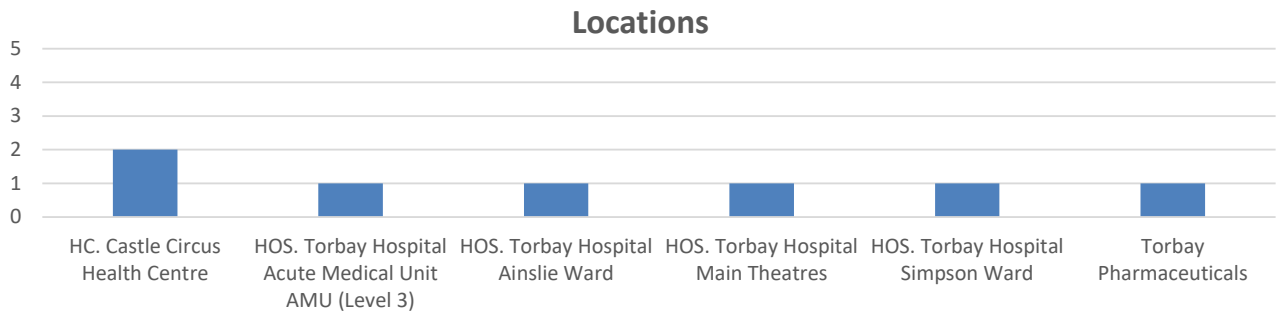
4.0 Sharps

There were no trends identified during September. RIDDORs relate to over 7 days absence

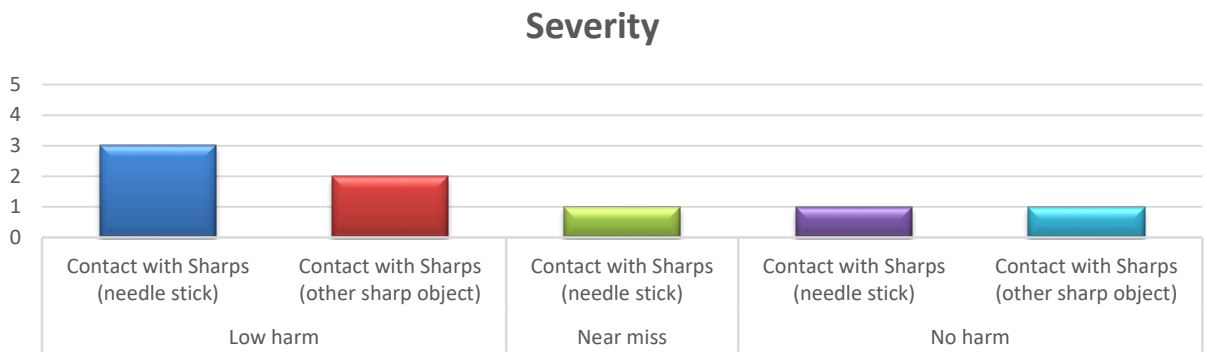
Chart 8,9,10







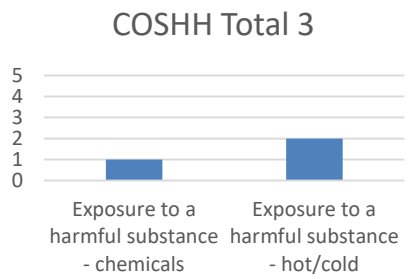
No trends identified



5.0 COSHH

Chart 11

September's incidents



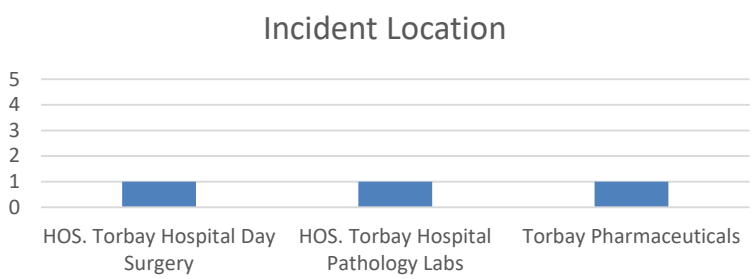


Chart 12

Breakdown YTD incidents – Exposure to a harmful substance

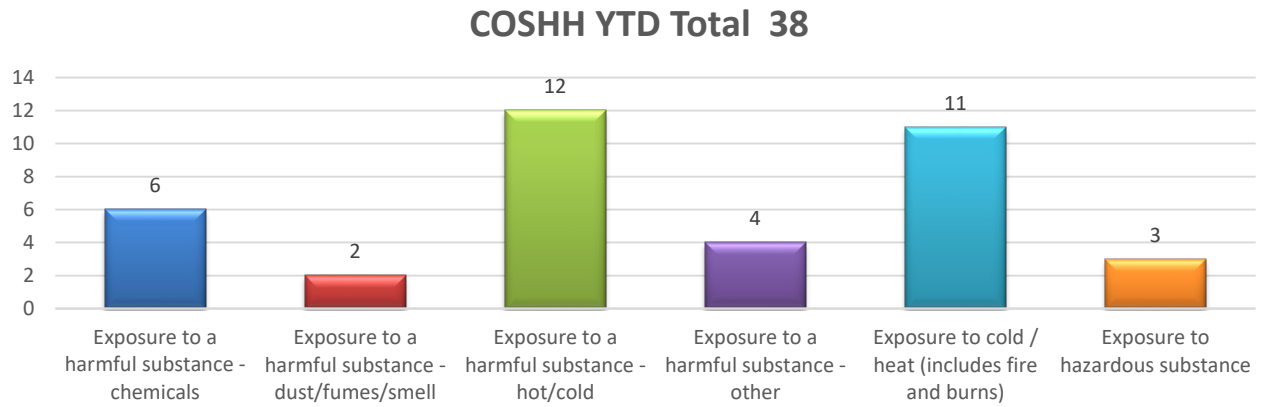


Chart 13

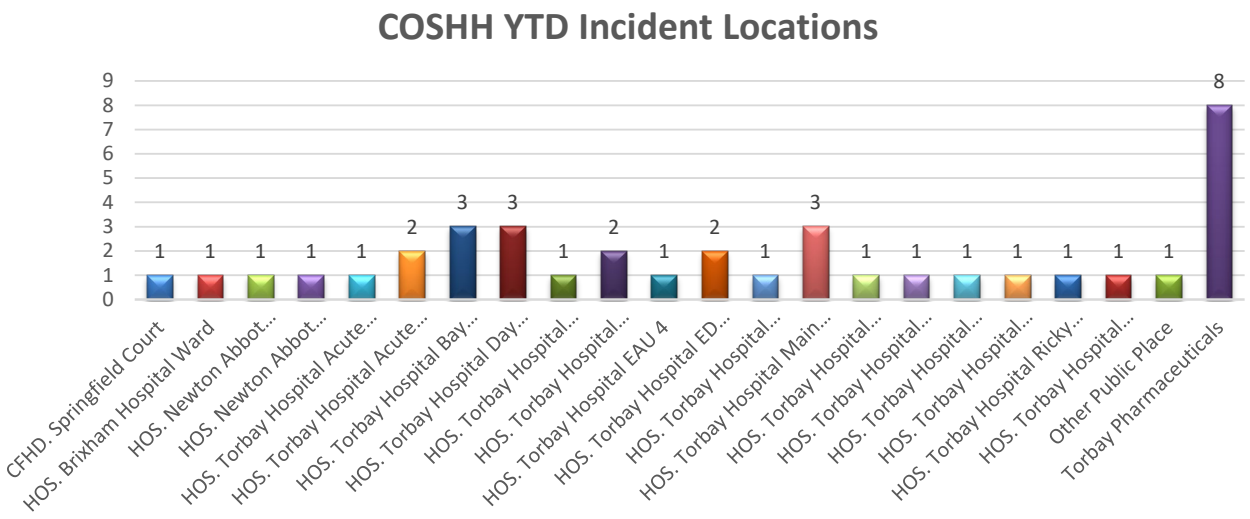


Table 2 - Copy of Datix entries for September 2023:

Unlabelled auto titrator beakers left soaking in the wash up area filled with an unknown liquid. No note or any communication with the wider team of who they belong to or what they are filled with.
MH made a coffee and then spilt it down arm
The consultant urologist was lasering and the laser fibre snapped as he fired it and it burnt his finger. All safety procedures were followed. Warmed saline was being used as irrigation.

6.0 Stress and working environment YTD

September – No recorded Incidents for Stress

7.0 RIDDOR Reports

No new covid RIDDORS reported in September.

Two identified following sharp injuries (ref Section 4 Chart 8)

8.0 Training September

IOSH – Managing Safely

1 course completed during September, undertaken on the acute site

Induction Training for Managers

Fire Training

- Evacuation leads – 12
- Fire wardens – 20

Trust wide – current status on bespoke training:

- 99 evacuation chair operatives
- 59 Albac Mat trained operatives
- 49 evacuation lift operators
- 12 staff evacuation trained in new SALUS building

9.0 Lost Working Time.

Four events recoded as lost time in September: two have no details on return date – Datix entries

Description	From	To	Total days Lost
Other kind of incident (Staff seizure)	27.09.2023	28.09.2023	1
Slip, trip, fall same level – (fall from café location)	20.09.2023	NK	
Faint / Fit / Medical related episode (staff) TP	20.09.2023	NK	
Unsafe environment (light, temperature, noise, air quality) - personal safety (fumes from Contractors machinery)	13.09.2023	14.09.2023	1

10.00 Key areas of concern - Top 5

Table 4

	Location	Concerns	Assistance Required from Committee	Update
1	Histopathology	Building condition / extraction	Capital funding identified as part of the BBF project for new build and volumetric control of chemicals internally remains an issue and needs to be addressed prior to relocation or ensure adequate storage transferred	
2	Paignton Hospital incorporating Fairweather Green	Building condition / fire stopping / use of rooms	Identification of appropriate relocation for Clinical Engineering to complete maintenance and repairs to equipment (workshop)	Looking at potential areas with DW
3	Acute site – wards and corridors breaching fire regulations	Escape routes / use of rooms	Senior management to ensure room changes/refurbishment etc follow correct Trust processes as outlined in Trust Fire Policy Accountability for persistent offenders and enforcement criteria when breaches are identified	Fire AE conducted annual audit – findings to be published. Improvement noted with regard to oxygen on trollies in corridors but still struggling overall with clutter in wards and corridors, and room appropriation / change of use without following Trust process (as per Trust Fire Policy)
4	Hengrave Basement – storage breaching regulations	Building condition unsuitable for use as storage area	Resources allocated to assess records for ownership and relocation/disposal	No Progress
5	Level 1 Basement office	Unsuitable for current use	Support to SUG for identification and prioritisation of relocation for teams based in this area	No progress

11.0 Policies and Procedures

Table 5

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

12.0 Fire

12.01 Audits / Fire Risk Assessments @ 82%, reduction due to reviews coming out of date, staff sickness and A/L.

September - W.I.P Oncology, Dental – Max Facial, Residencies and Newton Abbot Hospital

Paignton Hospital & FWG inspection carried out by Devon and Somerset Fire Brigade, resulting in actions and possible Enforcement Notices.

12.02 Fire strategies

Received Endoscopy Fire strategy; Project Safety response being compiled

CT, and New Theatres projects, to be reviewed when received from AE / Capital projects. To confirm fire compartmentation, evacuation routes, occupancy factors and proximity of build

Chart 14

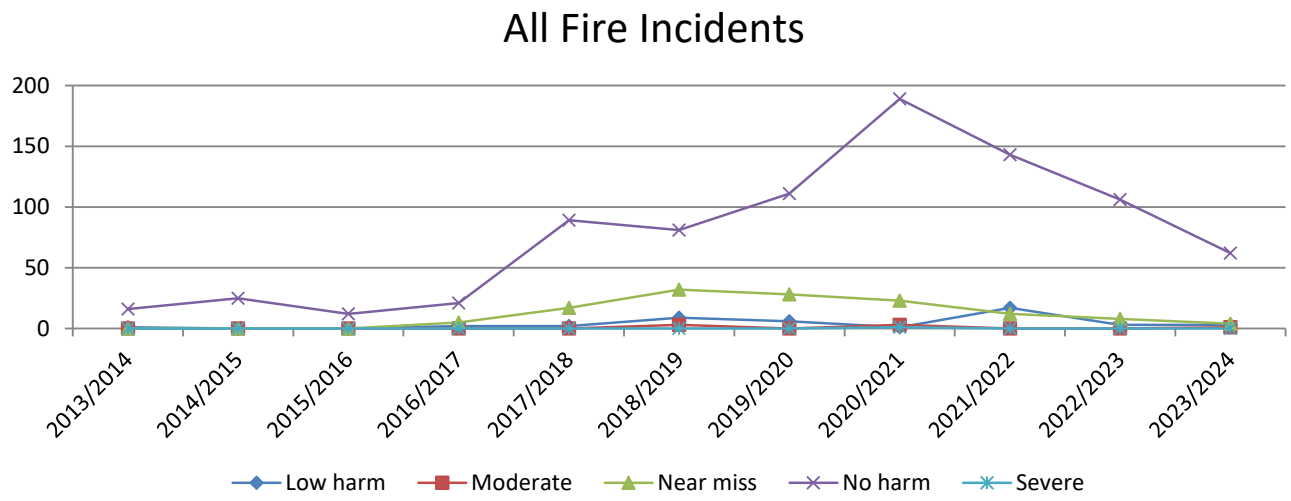
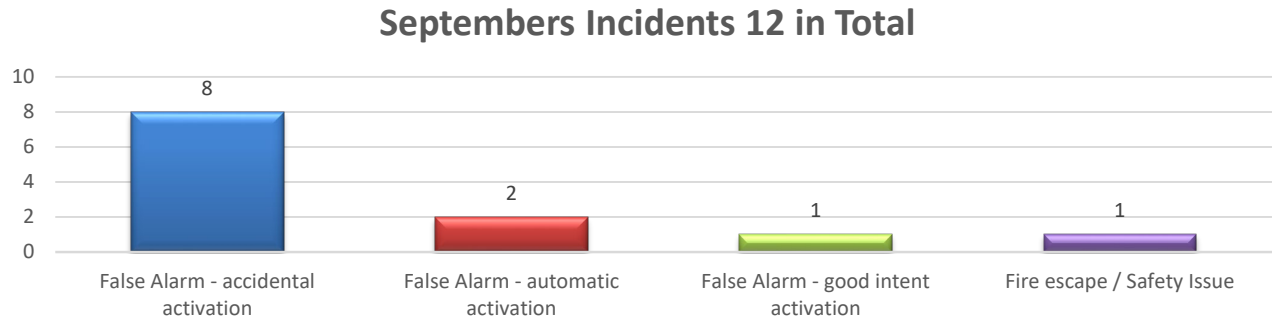


Chart 15 & 16



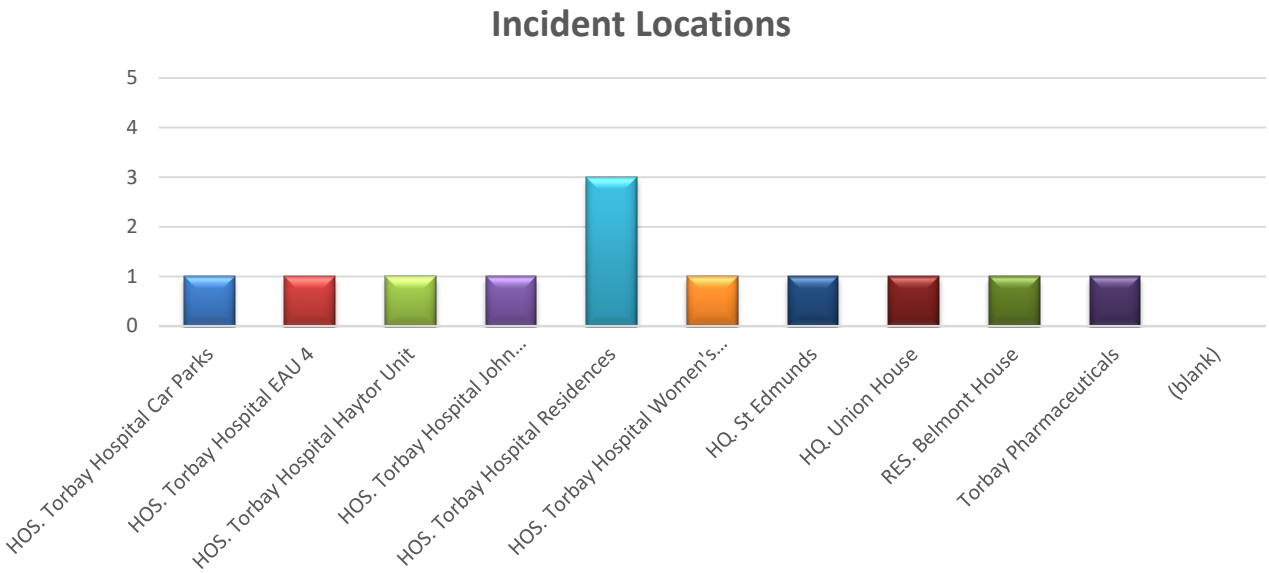

Incident Locations
5
4
3
2
1
0
HOS. Torbay Hospital Car Parks
HOS. Torbay Hospital EAU 4
HOS. Torbay Hospital Haytor Unit
HOS. Torbay Hospital John...
HOS. Torbay Hospital Residences
HOS. Torbay Hospital Women's...
HQ. St Edmunds
HQ. Union House
RES. Belmont House
Torbay Pharmaceuticals
(blank)

Chart 17

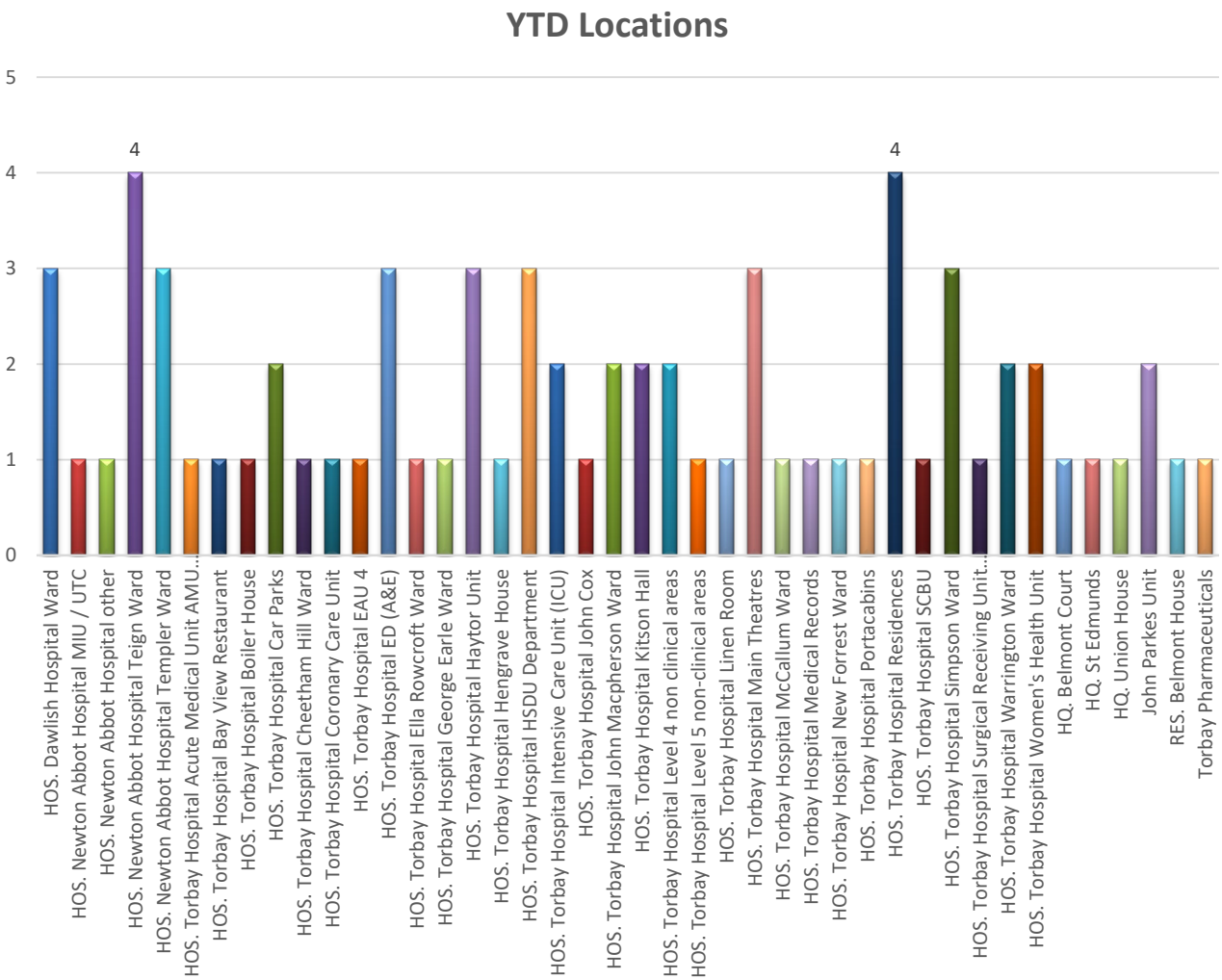
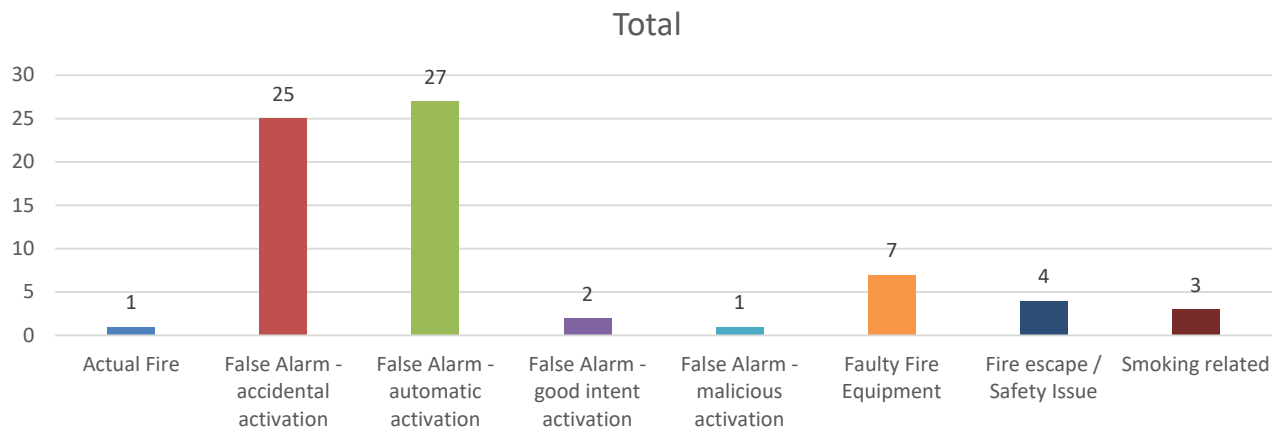

YTD Locations
5
4
3
2
1
0
4
4
HOS. Dawlish Hospital Ward
HOS. Newton Abbot Hospital MIU / UTC
HOS. Newton Abbot Hospital other
HOS. Newton Abbot Hospital Teign Ward
HOS. Newton Abbot Hospital Templer Ward
HOS. Torbay Hospital Acute Medical Unit AMU...
HOS. Torbay Hospital Bay View Restaurant
HOS. Torbay Hospital Boiler House
HOS. Torbay Hospital Car Parks
HOS. Torbay Hospital Cheetham Hill Ward
HOS. Torbay Hospital Coronary Care Unit
HOS. Torbay Hospital EAU 4
HOS. Torbay Hospital ED (A&E)
HOS. Torbay Hospital Ella Rowcroft Ward
HOS. Torbay Hospital George Earle Ward
HOS. Torbay Hospital Haytor Unit
HOS. Torbay Hospital Hengrave House
HOS. Torbay Hospital HSDU Department
HOS. Torbay Hospital Intensive Care Unit (ICU)
HOS. Torbay Hospital John Cox
HOS. Torbay Hospital John Macpherson Ward
HOS. Torbay Hospital Kitson Hall
HOS. Torbay Hospital Level 4 non clinical areas
HOS. Torbay Hospital Level 5 non-clinical areas
HOS. Torbay Hospital Linen Room
HOS. Torbay Hospital Main Theatres
HOS. Torbay Hospital McCallum Ward
HOS. Torbay Hospital Medical Records
HOS. Torbay Hospital New Forrest Ward
HOS. Torbay Hospital Portacabins
HOS. Torbay Hospital Residences
HOS. Torbay Hospital SCBU
HOS. Torbay Hospital Simpson Ward
HOS. Torbay Hospital Surgical Receiving Unit...
HOS. Torbay Hospital Warrington Ward
HOS. Torbay Hospital Women's Health Unit
HQ. Belmont Court
HQ. St Edmunds
HQ. Union House
John Parkes Unit
RES. Belmont House
Torbay Pharmaceuticals

Chart 18 Type of incidents YTD activations



To help reduce false activations we are implementing an amnesty for domestic appliances (kettles, Toasters and Microwave Ovens) currently located in non-hazard rooms to be removed or re located. This will run for October and November; December items will be removed.

Full fire report to be delivered at the Fire Safety Group Committee meeting on the 18.09.2023

EFM Performance Report

Domain	Workplace Services Performance Data September 2023 for October 2023 Report	2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			2023-23 Quarter Two			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		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	Sep-23					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6								
Estates - Planned work Performance	Total PPMs planned per month (not KPI)	898	937	832	961	832	855	887	694	747	619	643	913	1006	895	870		12589	839	Variable				Not a KPI - an indicator of planned work volumes
	Statutory PPMs planned per month	456	380	338	415	350	397	415	280	307	263	229	372	428	371	359		5360	357	Variable				
	Statutory PPM % success against plan	99%	91%	96%	98%	99%	98%	100%	99%	100%	100%	100%	100%	97%	99%	96%			98%	97%	85%	85%	97%	12 cancelled emergency lighting PPM, due to staff shortages. A plan now in place for emergency lighting to be carried out by an external supplier whilst resource
	Mandatory PPMs planned per month	258	342	270	322	258	249	217	163	154	171	214	259	317	261	235		3690	246	Variable				
	Mandatory PPM % success against plan	94%	87%	83%	85%	99%	99%	100%	100%	100%	100%	100%	100%	100%	94%	94%			96%	97%	85%	85%	95%	Includes 8 cancelled generator tests and 7 AHU not completed within month
	Routine PPMs planned per month	184	215	224	224	224	209	255	251	286	185	200	282	261	263	276		3539	236	Variable				
	Routine PPM % success against plan	79%	82%	80%	98%	100%	99%	100%	100%	100%	100%	100%	96%	94%	85%	97%			94%	90%	70%	70%	80%	
Estates - Reactive work Performance	Total Reactive Requests per month (not KPI)	797	873	801	841	981	921	1074	837	832	748	693	1013	1005	928	792		13136	876	Variable				Not a KPI - an indicator of reactive work volumes
	Emergency - P1 - requests per month	131	137	125	148	139	170	143	108	83	111	107	143	143	140	141		1969	131	Variable				
	Emergency - % P1 completed in < 2hours	98%	96%	98%	99%	96%	99%	99%	93%	98%	96%	97%	85%	97%	100%	99%			97%	97%	90%	90%	95%	Still some work with team to do to ensure correct feedback times are entered correctly
	Urgent - P2 - requests per month	198	170	179	181	205	213	217	163	175	164	166	219	210	238	242		2940	196	Variable				
	Urgent – % P2 completed in < 1 - 4 Days	87%	79%	81%	90%	88%	82%	90%	86%	88%	88%	88%	84%	86%	82%	88%			86%	97%	85%	85%	90%	
	Routine - P3 - requests per month	352	426	377	399	495	436	525	428	431	357	317	539	482	420	409		6393	426	Variable				
	Routine - % P3 completed in < 7 Days	82%	75%	81%	78%	86%	80%	85%	84%	80%	79%	77%	73%	72%	80%	82%			80%	97%	75%	75%	85%	
	Routine - P4 - requests per month	116	140	120	113	142	102	189	138	143	116	103	112	170	130			1834	131	Variable				
	Routine - % P4 completed in < 30 Days	79%	74%	74%	72%	73%	74%	72%	75%	71%	75%	88%	93%	62%	78%				76%	97%	65%	65%	75%	P4 Routine will always be a month in arrears.
	Estates Internal Critical Failures per month	0	1	0	1	1	1	0	1	0	1	0	1	1	2	0		10	0.7	0	2	1	0	
Progress Desk Requests	Total Requests open at end of reporting month	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	1095			#N/A	Variable				Added September 2023
	Workplace Delivery Work Requests over 120 days old															354			354	Variable				Added September 2023
	Workplace Delivery Work Requests over 60 days old															176			176	Variable				Added September 2023
	Workplace Delivery Work Requests less than 60 days old															565			565	Variable				Added September 2023
Estates - Fire Engineering Compliance	Fire Alarm Testing - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	126 Fire Alarm systems
	Fire Alarm Remedials Outstanding	267	267	269	269	269	269	263	263	263	263	263	263	263	263	263		3977	265	Variable				Annual inspections completed, defects report to follow RCO is reviewing. Room ID works are in progress
	Emergency Lighting - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%		Stat	99%	97%	85%	85%	97%	139 Locations - 25 Locations require a test facility (key switch)
	Emergency Lighting Remedials Outstanding	0	0	30	30	TBC	59	6	9	0	0	6	0	19		51		210	16	Variable				12 cancelled emergency lighting PPM, due to staff shortages. A plan now in place for emergency lighting to be carried out by an external supplier whilst resource
	Fire Extinguisher - % In date	99%	99%	99%	98%	99%	98%	99%	99%	99%	99%	99%	99%	99%	99%	99%		Stat	99%	97%	85%	85%	97%	
	Fire Extinguisher Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				Rolling programme. No outstanding items
	Fire Dry Risers - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	
	Fire Dry Risers Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				Confirmation from Fire Safety Team on requirements with DFRS
	Fire Hydrants - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	12 Hydrants
	Fire Hydrants Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				
	Fire Dampers - % In date	85%	85%	85%	85%	85%	85%	85%	86%	86%	86%	86%	86%	87%	87%	87%		Stat	86%	97%	85%	85%	97%	1177 dampers inspected, 1025 passed
	Fire Dampers Remedials Outstanding	186	186	175	175	175	167	167	156	156	156	156	156	152	152	152		2467	164	Variable				Report has been received, seems to have generated similar finding to previous year
	Fire Risk Assessments - % plan to date														80%	82%		Stat	81%	97%	85%	85%	97%	New Metric from September 2023
	Fire Risk Assessments - Remedials Outstanding														22	22		44	22	Variable				Further details to be obtained from Current programme in October 2023.
	Fire Supression - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	3 Systems
	Fire Supression Remedials Outstanding	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0		2	0	Variable				
	Fire Doors Inspections - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	127 Locations (989 Fire Doors) - Inspections only from Existing Records and plan
	Fire Doors Compliance - % In date	10%	10%	10%	10%	10%	11%	11%	19%	29%	29%	29%	29%	29%	29%	29%			20%	97%	85%	85%	97%	% of doors with Remedials compared to known asset base -(ongoing PRIME inspection programme will provide updated asset base by June 2024.
	Fire Doors Inspections - % In date - from PRIME												100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	% of Fire Doors Inspected to PRIME plan
	Fire Doors Compliance - % In date - From PRIME												56%	43%	36%	44%			45%	97%	85%	85%	97%	% of Fire Doors with remedials compared to PRIME asset base, expected to be fully populated by June 2024) (959 as at month 4 of 12 in the plan)
	Fire Doors with Remedials Outstanding	950	950	950	950	950	940	940	853	746	0	8	142	362	451	536		9728	649	Variable				No of doors requiring works. - reported in month from Existing Information
Mand Compliance	Fixed Wire Testing - % In date	88%	88%	89%	89%	90%	90%	90%	90%	91%	92%	93%	93%	93%	93%	94%		Stat	91%	97%	85%	85%	97%	Good progress made within Substation's 2 & 5
	Fixed Wire Remedials Outstanding	272	272	895	895	895	895	895	895	895	895	895	895	895	895	895		12179	812	Variable				All C1 remedials have been addressed. C2 391 & FI's 504 [213 completed]
	Portable Appliance Testing - % in date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Mand	100%	97%	85%	85%	95%	Year 3 PAT Inspection areas in progress.
	Portable Appliance Testing Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				Contract on programme schedule. Items not found, or not presented, during visit should be reported via the Helodesk
	HV Equipment Testing - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	HV Substation rolling programme, coinciding with Gen Testing
	HV Equipment Remedials Outstanding	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1		15	1	Variable				Sub 3: Tx fins, LV ACB require replacement, programme to be arranged. Parts delivered, works will be arranged through Capital Programme.

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Appendix Two - Workplace Performance and Compliance Dashboard 1.xlsx

EFM Performance Report

Domain	Workplace Services Performance Data September 2023 for October 2023 Report	2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			2023-23 Quarter Two			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		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	Sep-23					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6								
Estates - Electrical - Stat /	Generator Service & Load Bank Test - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	12%	12%		Mand	88%	97%	85%	85%	95%	Annual Load Bank & Service. 16 Generators (Gen Set 2 & Salus in Date) Ashburton to be decommissioned (Reducing Gen Sets to 15) - Contract awarded. programme Gen 7 exhaust stack split - Remedial to be covered under warranty Contractor will address under maintenance visit.
	Generator Service & Load Bank Remedials O/S	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1		15	1	Variable				
	Generator Monthly Load Test - % In date	87%	87%	87%	87%	100%	100%	77%	100%	100%	100%	100%	100%	100%	38%	42%		Mand	87%	97%	85%	85%	95%	Monthly Testing - 12 Generator's (Plus 2 PFI & 1 DPT) Ashburton to be decommissioned Gen Set 3 Off Line for LV Works (2 x Temo Gen Set in place). 7 Auto transfer units for Sub 3 (Haytor); Replacement designed and agreed, working with Capital Programme. Works in Progress.
	Generator Monthly Load Test Remedials O/S	0	0	0	1	0	0	0	0	2	2	2	2	1	1	1		12	1	Variable				
	Lightning Protection - % In date	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	97%	97%		Stat	95%	97%	85%	85%	97%	2 Systems to be tested after new building have been completed.
	Lightning Protection Remedials Outstanding	0	0	3	3	3	3	3	3	3	3	3	3	3	2	3		38	3	Variable				AMU assessed awaiting report. Fault found with Main Enterance System remedial action instructed.
	Auto Door Inspection - % In date	99%	99%	99%	98%	94%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Mand	99%	97%	85%	85%	95%	[Last 6 months] 27 maintenance visits, 11 repairs, 14 call-outs.
	Auto Door Remedials Outstanding	0	0	1	0	0	0	1	1	1	1	0	0	1	0	1		7	0	Variable				1 repair in progess - Main Enterance Inner Door
Estates - Mechanical - Stat / Mand Compliance	LEVs Testing - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	All current identified LEV's have been inspected. 2023 LEV report now received
	LEVs Testing Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				
	Critical Vent Verification - % In date	91%	94%	92%	90%	96%	95%	96%	98%	98%	100%	100%	100%	100%	100%	98%		Stat	97%	97%	85%	85%	97%	General Recovery Due October 2023.
	Critical Vent Remedials Outstanding	96	96	90	90	87	58	74	55	52	50	48	46	53	47	24		966	64	Variable				38 remedials completed - 15 remedials added from recent verification reports.
	Kitchen + Extract Duct Cleaning - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	
	Kitchen + Extract Duct Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				
	Gas Protection systems - % In date	88%	95%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	99%	97%	85%	85%	97%	
	Gas Protection Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				
	Gas Appliance - % In date	97%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	
	Gas Appliance Remedials Outstanding	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		1	0	Variable				
	Landlord Gas Appliances - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	
	Landlord Gas Appliance Remedials Outstanding	0	0	0	3	0	18	18	18	18	18	11	0	0	0	0		104	7	Variable				
	Pressure Systems inspection - % In date	93%	93%	93%	94%	100%	100%	100%	100%	98%	98%	98%	98%	98%	98%	99%		Stat	97%	97%	85%	85%	97%	Next PSSR Inspection due on 7th November 2023
	Pressure Systems Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	1	1	1	2	2		7	0	Variable				DSU heating calorifier tube nest failure - replacement on order Hetherington G tube bundle on order. delivery due in November
	LOLER Lifts Safety Checks - works % in date	100%	100%	97%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	
	LOLER Lifts Safety Remedials Outstanding	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1		3	0	Variable				Hethrington G lift remedial works required with lift shaft (Mottram Aware)
	LOLER Lifting Appliances - works % in date	91%	91%	91%	90%	91%	91%	94%	94%	95%	95%	95%	96%	96%	98%	100%		Stat	94%	97%	85%	85%	97%	Manual Checks/records reflect 98 % compliance - Prime Portal indicticating 58% this is due to inspection records not being processed in a timely manner by LMP.. Process for identifying and actioning remedial works to be created. Inspector have been reporting in an inconsistant manor and some actions have been missed.
	LOLER Lifting Appliances Remedials Outstanding	0	0	0	5	0	0	0	0	1	1	1	0	0	1	47		56	4	Variable				
	Water Safety Risk Assessments - % plan to date														100%	99%		Stat	99%	97%	85%	85%	97%	New Metric from September 2023 - 74 WRAs one out of date across Acute and Community. Awaitine new Buildine details (Endoscoov. CT-RT Scanner etc) from
	Water Safety Risk Assessments - Remedials Outstanding														0			0	0	Variable				Nil reported, expect more details for Water management Software system for October 2023.
	Water Safety Checks - works % in date	99%	100%	100%	99%	100%	97%	99%	97%	97%	100%	100%	100%	100%	100%	95%		Stat	99%	97%	85%	85%	97%	87 PPMs not carried out in acute due to resource issue. (vacancy and leave) to be completed during Oct.
	Water Safety Remedials Outstanding	642	777	578	312	288	296	268	238	317	284	136	158	245	227	248		5014	334	Variable				
Estates - Buildings - Stat / Mand Compliance	Window & Restrictor Insp - % In date	95%	96%	96%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Mand	97%	97%	85%	85%	95%	Inspections only, window condition survey is independent to this functional test
	Window & Restrictor Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				
	Asbestos Inspections - % in date	98%	95%	95%	98%	100%	100%	100%	93%	88%	98%	98%	98%	95%	94%	94%		Stat	96%	97%	85%	85%	97%	1020 separate areas programmed for reinspections in RfB.
	Asbestos Inspection Remedials Outstanding	0	0	0	0	0	0	0	6	5	5	2	2	4	1	0		25	2	Variable				Re-inspections outstanding for elements of both Kitson Hall & Podium Block, as a result of access issues. Teignmouth & parts of Castle Circus.
	Edge Protection inspection - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	Edge Protection condition and requirements
	Edge Protection Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	10	10	10	10	10		50	3	Variable				Asset survey incl. Community sites for first time, by Access Testing highlighted £66k+ of remedial works.
	Fixed Ladder Inspection - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Stat	100%	97%	85%	85%	97%	Fixed ladder Inspections
	Fixed Ladder Inspection Remedials Outstanding	0	0	0	0	0	0	0	3	3	2	2	2	2	2	2		18	1	Variable				Carried out by external contractor
	Site Safety Audits - % in date								68%	76%	82%	92%	76%	88%	80%	87%		Stat	81%	97%	85%	85%	95%	Outstanding Community sites being completed 29/9/23 (6) Rest during Oct.
	Current Red Status Safety Reports Outstanding								3	1	0	0	6	4	1	1		16	2	Variable				New residences.
	Site Safety Audits Remedials Outstanding								118	119	113	113	89	89	86	84		811	101	Variable				20 for the Grounds & Gardens Team as winter works and the remaining 64 will be sent to a contractor for completion.

EFM Performance Report

Domain	Workplace Services Performance Data September 2023 for October 2023 Report	2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			2023-23 Quarter Two			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		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	Sep-23					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6								
Facilities - National Cleaning Standards (from April 2022)	FR1 - Weekly - Torbay Hosp ICU, ED, Oncol, Thtrs	5.00	5.00	4.93	4.97	5.00	5.00	4.90	5.00	5.00	4.90	5.00	5.00	5.00	5.00	5.00			4.98	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR1 - Weekly - Torbay Hosp OPD	5.00	5.00	4.57	5.00	4.98	4.90	4.80	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			4.95	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR1 - Weekly - Newton Abbot Oncology, UTC	5.00	5.00	5.00	5.00	5.00	5.00	4.70	5.00	5.00	4.80	5.00	5.00	5.00	5.00	5.00			4.97	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR1 - Weekly - Totnes Hosp MIU	5.00	5.00	5.00	5.00	5.00	5.00	4.70	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			4.98	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR1 - Weekly - Teignmouth Hosp Theatre	5.00	5.00	5.00	4.99	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			5.00	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR2 - Monthly - Torbay Hosp Wards, CCU, Xray	5.00	5.00	4.69	4.88	5.00	5.00	4.90	5.00	5.00	5.00	5.00	5.00	5.00	4.90	5.00			4.96	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Torbay Hosp OPD Phrmcy, Eye Cl	5.00	5.00	5.00	4.93	5.00	5.00	4.80	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			4.98	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Newton Abbot Wards, Maternity	5.00	5.00	5.00	5.00	5.00	5.00	4.30	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			4.95	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Brixham Hosp Ward	5.00	5.00	4.89	5.00	5.00	5.00	4.10	5.00	5.00	4.50	5.00	5.00	5.00	5.00	5.00			4.90	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Totnes Hosp Ward	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			5.00	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Paignton H+WBC Oncology	5.00	5.00	5.00	5.00	5.00	5.00	4.70	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			4.98	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Ashburton Hosp Treatment Room	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			5.00	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR3 - Bi-Monthly - Torbay Hosp Dental, Day Units		5.00		4.88		4.92		5.00		5.00	4.00		5.00		5.00			4.85	5	3	3	4	Bi-Monthly Audits - Target - 90% completed each 2 Month period
	FR3 - Bi-Monthly - Torbay Hosp, OPD Pharm,		5.00		4.73		4.91		5.00		5.00		5.00		5.00				4.95	5	3	3	4	Bi-Monthly Audits - Target - 90% completed each 2 Month period
	FR4 - 4-Monthly - Torbay Hosp - Rms, Audiology		5.00				4.85		5.00		5.00	5.00				5.00			4.98	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Torbay Hosp access wait areas		5.00				4.95	5.00	5.00		5.00	5.00			5.00				4.99	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Newton Abbt access wait areas		5.00				5.00				5.00		5.00			5.00			5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Brixham Hosp access wait areas		5.00				5.00				5.00				5.00				5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Totnes Hosp access wait areas		5.00				5.00				5.00				5.00				5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Teignmth Hosp access wait areas		5.00				4.95				5.00				5.00				4.99	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Paigntn H+WBC access wait areas		5.00				5.00				5.00				5.00				5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Ashburton Access Waiting Areas		5.00				5.00				5.00				5.00				5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR5 - 6-Monthly - Torbay, MDSS, Chapel, PTS Vehs				5.00						5.00	5.00				5.00			5.00	5	3	3	4	6 Monthly Audits - Target 80% completed each 6 months
	FR5 - 6-Monthly - Torbay, OPD				5.00			5.00						5.00	5.00				5.00	5	3	3	4	6 Monthly Audits - Target 80% completed each 6 months
	FR6 - Annual - Torbay Admin, Training, Stores										5.00								5.00	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Torbay OPD Admin Offices, Stores							5.00			5.00					5.00			5.00	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Newton Abbot, Admin Offices, Stores															5.00			5.00	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Brixham, Admin Offices, Stores																		#DIV/0!	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Totnes, Admin Offices, Stores																		#DIV/0!	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Paignton, Admin Offices, Stores																		#DIV/0!	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Ashburton, Admin Offices, Stores																		#DIV/0!	5	3	3	4	Annual Audits - Target 75% completed each year
	HPV Cleans per month	23	25	32	31	14	8	6	6	17	31	12	13	58	31	22		329	22	Variable				From Porter HPV data to 21st Nov 22 then Navenio, back to Backtraq 17th March 23
	Deep Cleans per month	973	724	740	873	712	1086	1036	1146	994	852	938	778	782	899	861		13394	893	Variable				From Porter Deep Clean data to 21st Nov 22 then Navenio, back to Backtraq 17th March 23
Facilities - Catering	EHO Audit Scores - Acute	5	5	5	5	5	5	5	5	5	4	4	4	4	4	4			4.6	5	2	2	4	EHO Audit score back to 5 following audit in January 2022. Routine EHO Audit could be at any time
	EHO Audit Scores - Brixham Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5			5.0	5	2	2	4	
	EHO Audit Scores - Dawlish Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5			5.0	5	2	2	4	
	EHO Audit Scores - Newton Abbot Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5			5.0	5	2	2	4	EHO Visit in November - no change
	EHO Audit Scores - Totnes Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5			5.0	5	2	2	4	
	Catering Audits	22	22	22	22	22	22	22	22	22	22	22	22	22	22	21			21.9	5	19	19	19	
	Catering Audit Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	Variable				
ities - Waste	Total Tonnage all waste streams per month	136.3	162.0	151.8	170.1	158.7	155.4	144.6	140.5	172.1	128.2	146.5	132.5	133.4	132.3	126.9		2191.3	146.1	Trend				
	% of Total tonnage Recycled Waste per month	29.2%	31.1%	33.6%	43.1%	34.9%	31.7%	35.7%	35.3%	36.1%	34.5%	42.8%	30.1%	31.8%	34.3%	44.1%			35%	Aim is ↑	25.0%	25.0%	30.0%	
	Tonnage Recycled Waste per month	39.8	46.1	52.6	73.3	55.4	47.1	51.6	49.6	62.1	44.2	62.7	42.9	43.3	45.3	56.0		772	51.5	Trend				13 tonnes of cardboard disposed of in September
	% of Total tonnage Landfill Waste per month	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			0%	Aim is Zero	5.0%	5.0%	2.0%	
	Tonnage Landfill Waste per month	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0	0.0	Trend				
	% of Total tonnage of Clinical Non-Burn waste per month	18.9%	16.7%	14.6%	14.5%	14.0%	18.2%	18.6%	14.1%	15.6%	17.0%	11.6%	15.4%	13.7%	13.6%	9.9%			15%	Aim is ↓	22.0%	22.0%	18.0%	
	Tonnage of Clinical Non-Burn waste per month	25.7	24.7	22.9	24.6	22.1	27.1	26.8	19.5	26.8	21.8	17.0	20.4	18.7	18.0	12.6		329	21.9	Trend				
	% of Total tonnage of Clinical Burn waste per month	15.9%	13.5%	17.1%	10.8%	11.5%	11.8%	14.0%	11.4%	12.7%	12.3%	6.2%	6.7%	7.9%	9.5%	6.8%			11%	Aim is ↓	18.0%	18.0%	14.0%	

EFM Performance Report

Domain	Workplace Services Performance Data September 2023 for October 2023 Report	2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			2023-23 Quarter Two			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		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	Sep-23					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6								
Facil	Tonnage of Clinical Burn waste per month	21.6	19.9	26.9	18.3	18.3	17.5	20.2	15.7	21.9	15.8	9.1	8.9	10.8	12.5	8.6		246	16.4	Trend				
	% of Total tonnage of Clinical Offensive waste per month	16.0%	20.0%	15.0%	16.4%	14.1%	16.8%	14.9%	17.0%	15.6%	16.0%	19.9%	17.0%	15.2%	16.2%	16.6%			16%	Aim is ↑	12.0%	12.0%	15.0%	
	Tonnage of Clinical Offensive waste per month	21.8	29.6	23.5	27.8	22.4	24.9	21.6	23.4	26.8	20.5	29.2	22.5	20.8	21.5	21.0		357	23.8	Trend				
	% of Total Tonnage Waste to Energy (General Waste)	20.1%	18.7%	16.6%	15.4%	25.5%	19.8%	16.9%	23.3%	20.1%	20.3%	19.5%	28.5%	29.2%	27.0%	22.7%			22%	Aim is ↑	15.0%	15.0%	18.0%	
	Tonnage Waste to Energy (General Waste)	27.4	41.7	25.9	26.1	40.5	38.8	24.5	32.2	34.5	26.0	28.6	37.7	39.9	35.0	28.8		487	32.5	Trend				
	Statutory Waste Audits - % completed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%	Trend	90%	90%	95%	
Workplace Incidents and Safety	Workplace Serious/RIDDOR incidents	0	0	0	0	0	0	0	0	1	0	1	2	1	1	0		6	0.4	0	2	1	0	
	Workplace incidents resulting in moderate harm	0	2	0	0	1	0	2	0	0	0	0	1	1	1	0		8	0.5	0	3	3	1	
	Workplace incidents resulting in minor harm	2	6	1	2	2	3	3	0	0	2	4	5	1	3	5		39	2.6	0	10	10	5	2x Collision with Door, 2 x tripped over Bin, 1 Bin closed on Finger.
	Workplace incidents resulting in no harm	7	32	7	15	10	7	19	5	6	4	13	54	12	44	79		314	20.9	0	50	50	15	71 security Incidents inc 31 Aggressive Pts, 33 Section 2 Pts, 1 burglay (Shop) 1 insecure premises and a Dog in a parked car.
	Workplace Incidents resulting in Near Miss	3	0	3	4	3	1	2	1	2	0	5	6	2	7	4		43	2.9	0	20	20	5	4 x Aggressive Patients
	Workplace Datix incidents open for > 8 weeks	63	63	66	86	68	71	77	53	46	42	38	36	35	38	50		832	55.5	0	50	50	15	
	Workplace Teams Safety Walks - % Completed		90%	90%	90%	70%	50%	40%	78%	80%	80%	90%	60%	67%	63%	75%			73%	Trend	75%	75%	90%	8 Meetings per month.
	Workplace Safety Action Group Mtgs - % Completed		90%	80%	80%	60%	50%	30%	78%	70%	70%	90%	60%	67%	63%	75%			69%	Trend	75%	75%	90%	8 Meetings per month.

EFM Performance Report

Domain	Workplace Services Performance Data September 2023 for October 2023 Report	2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			2023-23 Quarter Two			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		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	Sep-23								
	Metrics	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6					Constant Review	Cause for Concern	No Concerns	
Lorne Stewart Planned Work	Total PPMs planned per month (not KPI)				#N/A	98	82	94	109	73	156	131	89	45	83	86		1046	95	Variable				Not a KPI - an indicator of planned work volumes
	Statutory PPMs planned per month					27	21	67	27	19	38	45	29	29	21	21		344	31	Variable				
	Statutory PPM % success against plan					96%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%			99%	97%	85%	85%	97%	
	Routine PPMs planned per month					71	61	27	82	54	118	86	60	16	62	65		702	64	Variable				
	Routine PPM % success against plan					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%			100%	90%	60%	60%	70%	
	Grand Total Reactive Work (not KPI)				#N/A	199	127	107	108	154	113	120	130	129	128	120		1435	130	Variable				
Lorne Stewart Class A - Reactive	Total Class A Reactive Requests per month (not KPI)				#N/A	62	55	38	40	69	47	63	62	87	62	41		626	57	Variable				Not a KPI - an indicator of reactive work volumes
	Class A - Emergency - LD1A - requests per month					6	9	3	1	5	4	2	8	10	6	2		56	5	Variable				Note LD1A is 1hr response, LD1B is 2hr Response
	Class A - Urgent - LD2 - requests per month					21	25	17	14	32	22	15	19	25	23	17		230	21	Variable				
	Class A - Routine - LD3 - requests per month					28	18	8	22	30	21	37	31	30	28	20		273	25	Variable				
	Class A - Routine - P4 - requests per month					7	3	10	3	2	0	9	4	22	5	2		67	6	Variable				
Lorne Stewart Class B - Reactive	Total Class B Reactive Requests per month (not KPI)				#N/A	137	72	69	68	85	66	57	68	42	66	79		809	74	Variable				Not a KPI - an indicator of reactive work volumes
	Class B - Emergency - LD1B - requests per month					4	3	3	6	6	4	2	6	4	1	0		39	4	Variable				Note LD1A is 1hr response, LD1B is 2hr Response
	Class B - Urgent - LD2 - requests per month					30	27	24	32	25	22	24	24	11	25	37		281	26	Variable				
	Class B - Routine - LD3 - requests per month					88	37	32	28	46	30	26	32	21	28	38		406	37	Variable				
	Class B - Routine - P4 - requests per month					15	5	10	2	8	10	5	6	6	12	4		83	8	Variable				
KPIs	Attendance KPI - % Completed on Time					97%	98%	100%	98%	98%	99%	100%	100%	98%	98%	99%			99%	97%	65%	65%	75%	Reactive
	Completion KPI - % Completed on Time					97%	93%	95%	97%	98%	96%	91%	90%	90%	87%	91%			93%	97%	65%	65%	75%	Completion due - 9% (12 jobs within KPI target, 30 day jobs)
Other Contract KPIs	Health and Safety Incidents per month					0	0	0	0	0	0	0	0	0	0	0		0	0.0	0	2	2	0	
	Service Level - provide Financial Report within 10wkg days of month end					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		95%	95%	100%	
	Service Level - Provide Contract Report within 10wkg days of month end					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		95%	95%	100%	
	Building Maintenance Statutory Compliance					99%	99%	100%	100%	99%	100%	99%	100%	100%	100%	100%			100%	Trend	95%	95%	100%	
	Building Maintenance Routine Priority					100%	100%	100%	100%	98%	99%	99%	100%	100%	100%	99%			100%	Trend	95%	95%	100%	
	Community Sites Critical Defects					0	0	0	2	0	0	0	0	0	0	0		2	0.2	0	2	2	1	

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Domain	Workplace Services Performance Data September 2023 for October 2023 Report	2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			2023-23 Quarter Two			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		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	Sep-23					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6								
Community Cleaning Contract - Quality Control	Number of Cleaning Audit Scores									10	11	11	11	11	11	11		76	11	Variable				
	Average % of Cleaning Audit Scores									97%	95%	97%	97%	96%	96%	95%			96%	97%	85%	85%	95%	
	Belmont Court									97%	80%	98%	97%	97%	96%	96%			94%	97%	85%	85%	95%	
	Castle Circus Health Centre									95%	88%	92%	95%	95%	95%	93%			93%	97%	85%	85%	95%	
	Dartmouth Clinic									98%	98%	98%							98%	97%	85%	85%	95%	Removed from June 2023
	Dartmouth H+WBC											98%	95%	97%	96%	97%			97%	97%	85%	85%	95%	Added from May 2023
	Hollacombe CRC									97%	98%	97%	98%	95%	97%	97%			97%	97%	85%	85%	95%	
	Kings Ash House									97%	96%	97%	96%	97%	96%	96%			96%	97%	85%	85%	95%	
	Sherbourne House									98%	98%	97%	97%	98%	98%	97%			98%	97%	85%	85%	95%	
	Shrublands									96%	97%	97%	97%	96%	94%	89%			95%	97%	85%	85%	95%	
	Teignmouth Clinic									97%	97%	95%	95%	95%	93%	95%			95%	97%	85%	85%	95%	
	Union House									98%	98%	96%	97%	95%	98%	98%			97%	97%	85%	85%	95%	
	Unit 7									96%	96%	98%	97%	97%	94%	96%			96%	97%	85%	85%	95%	
	Walnut Lodge									96%	98%	98%	99%	97%	97%	96%			97%	97%	85%	85%	95%	
Community Cleaning Contract - Re-Audit Scores (as required)	Number of Re-audits required									0	2	0	0	0	0	1		3	0.4	0	3	3	0	Under 90% for re-audit
	Belmont Court										97%								97%	97%	85%	85%	95%	
	Castle Circus Health Centre										91%								91%	97%	85%	85%	95%	
	Dartmouth Clinic																		#DIV/0!	97%	85%	85%	95%	
	Dartmouth H+WBC																		#DIV/0!	97%	85%	85%	95%	
	Hollacombe CRC																		#DIV/0!	97%	85%	85%	95%	
	Kings Ash House																		#DIV/0!	97%	85%	85%	95%	
	Sherbourne House																		#DIV/0!	97%	85%	85%	95%	
	Shrublands															97%			97%	97%	85%	85%	95%	
	Teignmouth Clinic																		#DIV/0!	97%	85%	85%	95%	
	Union House																		#DIV/0!	97%	85%	85%	95%	
	Unit 7																		#DIV/0!	97%	85%	85%	95%	
	Walnut Lodge																		#DIV/0!	97%	85%	85%	95%	
Community Cleaning - Health & Safety	Accidents									0	0	0	0	0	0	0		0	0.0	0	3	3	1	
	Near misses									0	0	0	0	0	0	0		0	0.0	0	8	8	5	
	RIDDORs									0	0	0	0	0	0	0		0	0.0	0	3	3	1	
	Health & Safety breaches									0	0	0	0	0	0	0		0	0.0	0	30	30	15	
	New starters									0	0	2	0	4	1	0		7	1	Variable				Not a KPI - for info only.
	New starter inductions within 7 days of start date									0	0	2	0	4	1	0		7	1	Variable				
Feedback	% Feedback from completed Satisfaction Certificate																	0	#DIV/0!	Trend	75%	75%	90%	
	Client Compliments									1	0	0	1	0	0	0		2	0.3	0	0	0	1	Not a KPI - for info only.
	Client Complaints									1	1	2	2	1	0	1		8	1.1	0	2	2	0	Castle Circus - performance plan in place for two members of staff
	Complaints resolved within 5 days									1	1	1	2	1	0	1		7	1.0	0	10	10	0	

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Domain	Workplace Services Performance Data September 2023 for October 2023 Report	2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			2023-23 Quarter Two			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		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	Sep-23					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6								
PFI Dawlish	PPMs planned per month					50	50	66	43	38	44	44	37	51	65	35		523	48	Variable				
	PPM % success against plan					100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%			100%	97%	85%	85%	97%	
PFI Dawlish - Reactive work Performance	Total Reactive Requests per month (not KPI)	#N/A	#N/A	#N/A	#N/A	35	43	29	20	37	22	21	38	19	21	21		306	28	Variable				Not a KPI - an indicator of reactive work volumes
	Emergency - P1 - requests per month					2	3	2	0	3	5	3	5	4	1	1		29	3	Variable				
	Emergency - % P1 completed in < 3hours					50%	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%			94%	97%	90%	90%	95%	
	Primary Important - P2 - requests per month					3	8	3	4	3	5	1	5	7	2	4		45	4	Variable				
	Primary Important - % P2 completed in < 24 Hours					100%	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%			98%	97%	75%	75%	85%	
	Very Important - P3 - requests per month					5	3	3	2	2	1	5	8	2	4	2		37	3	Variable				
	Very Important – % P3 completed in <48 hours					100%	100%	100%	100%	100%	100%	80%	88%	100%	100%	100%			97%	97%	85%	85%	90%	
	Important - P4 - requests per month					25	28	21	14	29	11	12	20	6	14	14		194	18	Variable				
	Important - % P4 completed in < 60 hours					100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	93%			99%	97%	65%	65%	75%	One failure - broken skylight
	Routine - P5 - requests per month					0	1	0	0	0	0	0	0	0	0	0		1	0	Variable				
	Routine - % P5 completed in < 6 Business Days					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%	97%	65%	65%	75%	
PFI Dawlish - Cleaning	FR1 - Weekly - Dawlish Hosp MIU	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			5.00	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR2 - Monthly - Dawlish Hosp Ward	5.00	5.00	4.78	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00			4.99	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR4 - 4-Monthly - Dawlish Hosp access wait areas		5.00				5.00				5.00				5.00				5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR6 - Annual - Dawlish, Admin Offices, Stores										5.00								5.00	5	3	3	4	Annual Audits - Target 75% completed each year
PFI Dawlish	PFI Paymech Report					3	0	0	1	2	4	1	1	0	0	1		13	1.2	0	5	5	2	One Failure Deduction - £50 - 3 default points for emergency jobs, 1 for routine
	Energy Performance (GJ / 100m3)	1.75	1.63	1.91	2.11	3.39	4.49	4.62	3.95	4.14	3.04	2.35	1.64	1.28	1.47	1.46		39	2.62	0	5	5	3	

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Domain	Workplace Services Performance Data September 2023 for October 2023 Report	2022-23 Quarter Two			2022-23 Quarter Three			2022-23 Quarter Four			2023-23 Quarter One			2023-23 Quarter Two			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		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	Sep-23					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6								
PFI Newton Abbot - Planned work	Total PPMs planned per month (not KPI)	#N/A	#N/A	#N/A	#N/A	81	81	69	74	59	79	91	72	94	78	92		870	79	Variable				Not a KPI - an indicator of planned work volumes
	Statutory PPMs planned per month					25	13	16	21	20	18	21	20	19	24	25		222	20	Variable				
	Statutory PPM % success against plan					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%	97%	85%	85%	97%	
	Routine PPMs planned per month					56	68	53	53	39	61	70	52	75	54	67		648	59	Variable				
	Routine PPM % success against plan					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%	90%	60%	60%	70%	
PFI Newton Abbot - Reactive work	Total Reactive Requests per month (not KPI)	138	108	178	134	167	155	166	121	181	167	116	94	105	111	104		2045	136	Variable				Not a KPI - an indicator of reactive work volumes
	Emergency - requests per month	2	8	4	2	9	5	4	9	9	3	8	9	6	21	21		120	8	Variable				Increased emergencies - majority are nurse call (13)
	Emergency - % completed in < 24hours											100%	100%	100%	100%	100%			100%	97%	90%	90%	95%	
	Non- Emergency - requests per month	68	50	87	66	79	75	81	56	86	82	108	85	99	90	83		1195	80	Variable				
	Non-Emergency – % completed in < 1 - 5 Days											100%	99%	100%	100%	99%			100%	97%	85%	85%	90%	One failure - door issue. Denied access by nursing staff
PFI Newton Abbot - KPIs	PFI Contract 1 - User Satisfaction	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%	Trend	84%	84%	95%	
	PFI Contract 2 - Absenteeism & Sickness	0%	0%	0%	0%	0%	0%	0%	0%	6%	0%	0%	0%	0%	0%	0%			0%	Trend	16%	16%	10%	
	PFI Contract 3 - Complaints per month	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0.0	0	3	3	1	
	PFI Contract 4 - % downtime of assets affecting operations	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			0%	Trend	6%	6%	1%	
	PFI Contract 5 - Meeting Annual Energy Targets	100%	100%	100%	100%	103%	90%	100%	110%	90%	100%	100%	100%	100%	100%	100%			100%	Trend	113%	113%	103%	
	PFI Contract 6 - Energy Performance (GJ / 100m3)	2.52	2.26	3.02	3.04	3.82	5.10	4.55	4.18	4.57	3.64	3.00	2.47	2.22	2.47	1.15		48	3.20	0	5	5	3	

Workplace Services Performance Data September 2023 for October 2023 Report

23-Nov-23

Workplace Policies and Procedures

TITLE	Procedure	Lead	Group Developing Doc	Pre-ratification Route	Ratification Group / Committee	Policy / Procedure review cycle	Date to begin next review	Next Review date	Notes & Target Date for completion
Water Safety Policy	Policy	Head of Estates Delivery	Water Safety Group	DIPC	Infection Control Committee	3 Yearly	Mar-24	May-24	
Water Safety Plan	Procedure	Head of Estates Delivery	Workplace Senior Leadership Team	Workplace Director	WPCG	Annual	Oct-22	Jan-23	To be reviewed by RCa and AE for Oct 23 Commttee. CC to SM
Management of Fire Safety and Evacuation Including Trust Fire Safety Policy Evacuation Including Trust Fire Safety Policy	Policy	Workplace Director / Corporate H&S Mgr	Fire Safety Group	WPCG	Health and Safety Committee	2 Yearly	Jul-24	Oct-24	
Control and Management of Contractors, Professional Consultants and Third Parties Policy	Policy	Head of Estates Delivery	Workplace Senior Leadership Team	Workplace Director	H&S Committee	2 Yearly	Sep-24	Dec-24	
Medical Gases	Policy	Head of Technical Services	Workplace Senior Leadership Team - Medical Gas Committee	Head Pharmacy . Workplace Director	H&S Committee	1 Yearly	Jul-24	Oct-24	Ratified
Electrical Safety	Policy	Paul Morgan	Workplace SMT	AE	H&S Committee	3 yearly	Apr-23	Jul-23	A Corporate Policy. With AE and will presented at November 2023 H+S Committee. Reviewed, amendments to be agreed in Electrical Safety Group prior to H&S Meeting.
Electrical Safety	Procedures	Richard Coombes	Electrical Safety Group	AE	WPCG	3 yearly	Apr-23	Jul-23	A Corporate Procedure. With AE and will presented at November 2023 H+S Committee. Reviewed, amendments to be agreed in Electrical Safety Group prior to H&S Meeting.
Ventilation Systems Policy	Policy	Head of Technical Services	Workplace Senior Leadership Team	AE	H&S Committee	2 Yearly	Jan-24	Apr-24	No Copy on ICON yet!
Lifting Operations & Lifting Equipment Management	Policy	Head of Technical Services	Workplace Senior Leadership Team	Manual Handling Group	H&S Committee	2 Yearly	Aug-24	Nov-24	
Lift Management Plan	Procedure	Head of Estates Delivery	Workplace Senior Leadership Team	Workplace Director	WPCG	2 Yearly	Sep-19	Dec-19	Out for review by SLT as of October 2023.
Pressure Systems Policy	Policy	Head of Technical Services	Workplace Senior Leadership Team	AE	H&S Committee	2 Yearly	Jan-24	Apr-24	Current Copy of PSSR Policy? ICON Version is not ratified.
Asbestos Policy	Policy	Head of Technical Services	Workplace Senior Leadership Team	Workplace Director	H&S Committee	3 Yearly	Jun-24	Sep-24	
Asbestos Management Plan	Procedure	Asbestos Coordinator	Workplace Senior Leadership Team	Workplace Director	Asbestos Safety Group. WPCG	6 Monthly	Nov-23	Dec-23	6-monthly review.
Cleaning Policy	Policy	Head of Facilities Operations	Environment Gp	DIPC	Infection Prevention Control Gp	3 Yearly	Jan-24	Apr-24	.
Linen & Laundry Policy	Policy	Head of Facilities Operations	Workplace Senior Leadership Team	DIPC	Infection Prevention Control Gp	3 Yearly	Jul-23	Oct-23	Under review by SLT as of 30th Oct 2023
Waste Management Policy	Policy	Head of Facilities Operations	Environment Gp	DIPC	H&S Committee	3 Yearly	Apr-25	Jul-25	
Food Hygiene Policy	Policy	Head of Facilities Operations	Workplace Senior Leadership Team	Nutritional Steering Gp	Infection Prevention Control Gp	3 Yearly	Jan-24	Apr-24	
Pest Control Policy	Policy	Head of Facilities Operations	Workplace Senior Leadership Team	Environment Group	Infection Prevention Control Gp	3 Yearly	Dec-23	Mar-24	
Transport of Dangerous Goods and the Accompanying Procedures for the Transport of Various Items classified under ADR 2019	Policy	Head of Facilities Operations	Workplace Senior Leadership Team	Workplace Director	H&S Committee	3 Yearly	May-26	Aug-26	
Confined Space Management	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Sep-24	Dec-24	
Control of Substances Hazardous to Health (COSHH), The	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Jan-24	Apr-24	
Display Screen Equipment (DSE) Eyesight Reimbursement	Procedure	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	May-24	Aug-24	
Display Screen Equipment (DSE) Procedure	Procedure	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	May-24	Aug-24	
Display Screen Equipment User Self Assessment Form	Form	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	May-24	Aug-24	
Electronic Cigarette Management Policy	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	3 yearly	Jul-24	Oct-24	
First Aid Management	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	3 yearly	Sep-25	Dec-25	
Health and Safety Action Plan Template	Form	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Oct-24	Jan-25	
Health and Safety Policy	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Feb-24	May-24	
Health and Safety Representatives	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Jan-24	Apr-24	
Health and Safety Risk Assessment Form- excel	Form	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	3 Yearly	Dec-23	Mar-24	
Health and Safety Risk Assessments	Form	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	3 Yearly	Dec-23	Mar-24	
Hot Desking SOP	Procedure	Health and Safety Committee		Corporate H&S Manager	H&S Committee	Annual	Aug-23	Nov-23	
Ladders Checklist- EFM-SO18	Form	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	3 yearly	Jul-25	Oct-25	
Latex Management	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Oct-24	Jan-25	
Latex Product Use Authorisation Form	Form	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Oct-24	Jan-25	
Ligature Points, Assessing and Managing	Procedure	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Aug-20	Nov-20	To H+S Cmmttee for ratification in November 2023.
Ligature Risk Assessment, Environmental Blank Form - Excel	Form	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Jan-25	May-25	Ratified by H&S Group.
Management of Confidential Waste	Policy	Environment and site Services Manager		Corporate H&S Manager	H&S Committee		Jun-21	Sep-21	Was under Data Protection on the system now moved to Workplace. To Emma Davies for IGSG for ratification in May 23. Chased Emma Davies, Data Protection Team and Jo Oakden for update.
Management of Liquid Nitrogen Procedure	Procedure	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Mar-24	Jun-24	
New and Expectant Mothers Risk Assessment Form'	Form	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	3 yearly	Jan-25	Apr-25	
New and Expectant Mothers Risk Assessment Procedure	Procedure	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	3 yearly	Jan-25	Apr-25	
Noise at Work, Management of	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Mar-24	Jun-24	

Personal Protective Equipment Management	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Mar-24	Jun-24	
Preliminary Noise Assessment Form	Form	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Mar-24	Jun-24	
Sharps Management Procedure	Policy	Corporate H&S Manager	Sharps Committee	Corporate H&S Manager	H&S Committee	2 Yearly	Mar-25	Jun-25	
Sharps, Authorisation form for the use of non-safer sharps	Form	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Mar-25	Jun-25	
Sharps/Contamination Incident Investigation	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Mar-25	Jun-25	
Smoke free Environment Policy	Policy	Medical Director		Medical Director	H&S Committee	2 Yearly	Nov-23	Feb-24	SE
Working at Height Procedure	Procedure	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	3 Yearly	Jul-25	Oct-25	
Workplace Health and Safety Audit Procedure	Procedure	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Jan-24	Apr-24	
Workplace Management	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	3 Yearly	Jan-24	Apr-24	
Workplace Slips Trips and Falls Management Procedure	Procedure	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	2 Yearly	Jun-25	Sep-25	
Young Persons and Work Experience, Management of Health and Safety	Policy	Corporate H&S Manager		Corporate H&S Manager	H&S Committee	3 Yearly	Jan-21	May-21	To H+S Cmmttee for ratification in November 2023.
CCTV & Body Worn Video Policy	Policy	Trust LSMS		Workplace Director	H&S Committee	2 Yearly	May-24	Aug-24	
Management of Lone Working Policy	Policy	Trust LSMS		Workplace Director	H&S Committee	2 Yearly	Oct-23	Jan-24	
Violence Prevention and Reduction Policy	Policy	Trust LSMS		Workplace Director	H&S Committee	2 Yearly	Jan-25	May-25	
Security Procedures Policy	Policy	Trust LSMS		Workplace Director	H&S Committee	2 Yearly	Aug-24	Nov-24	
Zero Tolerance to Harrassment	Policy	Trust LSMS		Workplace Director	H&S Committee	2 Yearly	Oct-24	Jan-25	

Workplace Services Performance Data September 2023 for October 2023 Report

Workplace Roles and Responsibilities

Compliance area	Authorising Engineer	Responsible Persons	Authorised Persons	Competent Persons / Other Competent Persons	Other Key Personnel	Notes
Water	Neil Edmonds	Rae Callcut	John Armstrong Emma Hughes	Churchill Services, PFI Contractors	Trust DIPC – Dr Joanne Watson	
Fire	Darren Kirk	Fire Safety Manager – Jake O'Donovan.	Fire Safety Advisor - Kevin Wood/ Neil Faulkner	Suzanne Ellis, Keith Pascoe Neil Faulkner	Estates Team - Weekly Testing AlarmTec - Periodic Maintenance Chubb - Periodic Maintenance, Hydrant & Dry Riser Inspections Westcountry Fire Alarms - Fire Extinguisher Maintenance	
Medical Gases	Malcolm Thompson		Paul Morgan Tim Coysh Vacant	Gary Jones Mark Fahy Medical Gas Pipelines Ltd M&M Medical – Newton Abbot PFI. Quality Controller (MGPS) Accredited External Contractor as required. Porters - Cylinder Handling Mechanical Team - First Response and Cylinder Handling	Designated Medical Officer (MGPS) and Designated Nursing Officer (MGPS) to be appointed.	
Electrical Systems	Alex Bray (HV/ LV)		Paul Morgan (HV/ LV) Richard Coombes (HV/ LV) Mark Wykes (HV/ LV)	Steve Thompson (HV Res/ LV), Richard O'Reilly (HV Res/ LV), Andy Maddock (HV Res/ LV), Mark Hodges (HV Res/ LV), Declan Pearson (HV Res/ LV), Richard Hicks (LV - Gas safe) Contractors: Enerveo, HV Power Services (HV/ LV), Addicott Electrics, Bender, Starkstrom.	External Specialist Consultants (ETA Projects Ltd)	
Ventilation Compliance	Graham Powell		Vacant Tim Coysh	Mechanical Team trained in November 2021. D&S - Steve Wallis, Howorth Air Technology Ltd Camfil ltd Medical Air Technologies	Trust DIPC – Dr Joanne Watson	
Lifts / LOLER	Mottram Associates (Competence for Lift systems but not AE)		Mottram Associates Ltd	Lift Release DEL Staff (Lifts) Specialist contractor - Kone Lifts	LmP (examination systems), Allianz Insurance Inspectors for Lift and Fixed / Portable hoist and Lifting beams LOLER. Declan Pearson, Emma Hughes to Lift AP level for day to day management Paul Morgan, Richard Coombes (Electrical)	
Pressure Systems	LmP - Corporate AE		Tim Coysh - (AE has assessed) Paul Morgan - (AE has assessed)	CP Examination is Allianz CP Written Schemes prepared by LmP Technical Services Mechanical Team	Mark Wykes - Operational Support	
Decontamination Engineering Systems	Jim Tinsdale		Richard Coombes Paul Morgan	Ben Armstrong (Weekly Testing) Serve Medical MMM Limited Lancer		
Asbestos	N/A	Asbestos Coordinator – Ian Hackney		All EFM Staff trained in Asbestos Awareness Contractors as appointed, (Tony Mayne for Environmental Services)	Asbestos Removal Projects - Controlled by Capital projects	
Cleaning	N/A	Infection Control – Tony Hopkins, Cleaning in IPC – Rachel Russell		Alan Stephens, Lynn Northcott, Matt Acton Lucy Woodward – Community Inpatient Norse Cleaning - Community Non-Inpatient	Norse Cleaning – Non-Inpatient Areas, managed by Emma Hughes	
Waste Management	N/A	IPC - Rachel Russell		Tony Hopkins, Matt Acton, Ryan Evans	Catalyst	
Catering	N/A	Tony Hopkins	Nathan Simms Kathryn Sherlock			
Security	N/A	LSMS - Andrew Chorlton		Chris Sparks Tom Holland		

Workplace Services Performance Data
September 2023 for October 2023 Report

Workplace Business Continuity Plans

TITLE	Lead	Group Developing Doc	Pre-ratification Route	Ratification Group / Committee	Date to begin next review	Next Review date	Notes & Target Date for completion
#064A Estates Operations BC Implementation Plan	Rae Callcut / Karen Robertson	Estates Delivery, Tech Services Teams	SLT Review	WPCG	Jan-24	Apr-24	Copy in EFM Management Drive
#066A Facilities Helpdesk BC Implementation Plan	Susan Morgan / Tony Hopkins	Facilities Operations Team	SLT Review	WPCG	Jan-24	Apr-24	Copy in EFM Management Drive
#067A Hotel Services BC Implementation Plan	Susan Morgan / Tony Hopkins	Facilities Operations Team	SLT Review	WPCG	Jan-24	Apr-24	Copy in EFM Management Drive
#069A Catering BC Implementation Plan	Ian Armstrong / Tony Hopkins	Facilities Operations Team	SLT Review	WPCG	Jan-24	Apr-24	Copy in EFM Management Drive
#072A Linen BC Implementation Plan	Susan Morgan / Tony Hopkins	Facilities Operations Team	SLT Review	WPCG	Jan-24	Apr-24	Copy in EFM Management Drive
#074A Portering BC Implementation Plan	Susan Morgan / Tony Hopkins	Facilities Operations Team	SLT Review	WPCG	Jan-24	Apr-24	Copy in EFM Management Drive

Workplace Services Performance Data
September 2023 for October 2023 Report

Notes

Ref	Comments	Date
1	Staff numbers are FTE	30-Apr-19
2	For Workforce stats - use average of the 5 Pink rows - Estates, Facilities Management, and the three Hotel Services groups.	22-May-19
3	Porter data from 'Porter Requests' and 'Request Analysis' for the completed requests for the month being reported. Extract the data and pivot by urgent routine and planned and for top three categories	11-Jun-19
4	Cleaning data added for community sites	11-Jun-19
5	Added SSEP Trust wide metrics - not required for the CIEG Report	12-Jul-19
6	Incidents table added as a tab monthly, Annual Deep Cleans + Incidents added.	13-Sep-19
7	Facilities Essential Training and Catering Cleaning Audits added	18-Oct-19
8	Catering costs and community cleaning scores added.	15-Nov-19
9	To preserve Conditional Formatting when adding the next quarter: **Ensure the new quarter column is inserted to the left** of columns O, P & Q, then delete the three left-most columns. Clear contents of Columns O, P & Q ready for the new months, taking care not to erase the average figures. Update the Quarter and Month names at the top of the new columns, and the Dashboard month info in Cell B1. Check the Sparklines updated too. Save!	22-Apr-20
10	Used Bold borders to denote Reactive and Planned PPM data incomplete - used for Board Reports on odd-numbered Months	21-Sep-20
11	Added Fire Doors and Fire Safety Engineering to Estates	01-Feb-21
12	Draft version for Apr 21 - added remedial count tallys with trends. First version to capture the Compliance area remedials. Really needs a comprehensive set of subgroups, with the time ringfenced to agree planning for all remedials.	25-Feb-21
13	Added If(reactive number cells)=0, N/A)(reactive number cells) to show N/A if no value, so the Sparklines don't show zero for a null. Also removed Porters info - never used.	31-May-22
14	Added EFM Incidents > 8wks old	28-Sep-22
15	Total revision of Waste KPI thresholds following review of invoice tonnages.	03-Oct-22
16	Changed cleaning KPIs to National Cleaning Standards	06-Oct-22
17	Split Estates and Facilities Ops Dashboards into two tabs	27-Oct-22
18	Added All Risks from CRR and added MDSS KPIs	14-Nov-22
19	Added Estates and Cleaning Contracts tabs, plus DAW and NAb PFI Tabs. Note that 'normal' estates and facilities Dashboards are for the whole Trust performance and compliance (where possible), whereas tabs with the two contracts and PFIs are intended to be for reporting the performance of the Contracts and any KPIs set in the Contract documents.	10-Jan-23
20	Removed CES (was MDSS) as they have transferred to the Planned Care Group.	01-Aug-23
21		
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NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Chief executive's report			Meeting date: 29th November 2023
Report appendix:			
Report sponsor:	Chief executive		
Report author:	Associate director of communications and partnerships; head of communications and engagement		
Report provenance:	Reviewed by the executive team		
Description/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:	**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			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	This report provides the board of directors' board with narrative information on key corporate matters as well as local, system and national initiatives and developments that contribute to our vision and purpose.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources.		
Relevant BAF Objective(s):	Objective 1 - Quality and patient experience Objective 2 - People Objective 4 - Estates Objective 5 - Operations and performance standards Objective 8 - Transformation and partnerships Objective 9 - Integrated Care System.		
Risk: Risk ID: *As appropriate*			
External standards affected by this report and associated risks	Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance		

Report title: Chief Executive's report		**Meeting date:** 29th November 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 25 October 2023 are as follows:

3.1 Excellent population health and wellbeing

Proud to support our armed forces' community

Our commitment to supporting the health and wellbeing of our community's armed forces has been recognised, with the presentation of the Armed Forces' Covenant Healthcare Alliance Accreditation Award.

There are 84,000 people living in Devon who have served our country. They often have different health and care needs once they have left the armed forces and may need tailored help to access the support they may need. The Armed Forces' Covenant recognises our commitment to ensuring veterans in Torbay and South Devon receive the health care and support they need.

Our Chairman Sir Richard Ibbotson, a retired vice admiral who served for 38 years in the Royal Navy, and Captain Sarah Oakley Royal Navy, Captain of Britannia Royal Naval College, unveiled the award at Torbay Hospital on 13 November.

We have also employed our first defence welfare medical service officer who provides invaluable support to people who are likely to have moved around the country during deployments.

South west paediatric mental health network leads the way
I was very proud to present the work of the south west paediatric mental health network, which has been established over the last 20 months by Dr James Dearden, consultant paediatrician to a national meeting of chief executives earlier this month.

The shared purpose and vision of the network is to bring parity of esteem between physical and mental health conditions through collaboration, support and leadership across traditional silos and normal geographical and organisation boundaries, while advocating and amplifying at local, system, regional and national level for children and young people's mental health agenda. The network links together professionals in statutory and voluntary sector services involved in children and young people’s mental health across seven south west ICBs.

The network has already allowed departments to capitalise on available funding for children and young people through sharing of business plans and funding bids across trusts. In practice this has resulted in successful bids for equipment to improve ward environments for children and young people with mental health difficulties, recruitment of mental health support workers, engagement of in-reach youth workers on the paediatric wards across Devon and rapid dissemination of recent NHS England mental health champion funds.

Drawing on the expertise across the network the provider collaborative has established a regional expert advisory panel to support clinicians caring for children and young people with complex eating disorders.

Families who have lost little ones invited to annual remembrance service
Families who have experienced the heart-breaking loss of a child or a baby in pregnancy are being invited to our annual remembrance service and crafting session next month. The events are organised by our maternity unit, chaplaincy services and children’s community nursing team, alongside local parents.

A craft morning takes place in Torbay Hospital’s Bayview restaurant on Saturday 02 December, from 10am – noon. The Little One’s remembrance service is on Sunday 03 December at 3pm at All Saints Church in Babbacombe and provides an opportunity for families to remember their little one. Families can ask for their child’s name to be read out as part of the service and then hang a star on our tree. After the service, the tree is moved to Torbay Hospital chapel, where it stays throughout December.

We know that Christmas is always a poignant time for people who have lost someone, and that supporting each other is so important. We are grateful to All Saints Church for hosting the service again and for our teams and chaplain for their support.

Teignmouth care home reaches diamond standard for hydration support
Briarcroft Care Home has gained a diamond award for embracing a project to reduce hospital admissions through good hydration.

Many older people don't feel thirsty and need extra support to stay hydrated, and people in residential or nursing homes can be more likely to experience falls or illnesses such as urinary tract infections as a direct result of dehydration. Staff at the care home in Teignmouth worked with our community dietitians to support their residents to stay hydrated.

Our community dieticians are supporting nursing and residential homes across Torbay and South Devon, providing training, supporting the homes to appoint hydration champions, and implementing ideas including themed and seasonal drinks rounds, a greater variety of fluids and detailed documentation and fluid intake monitoring. As a result, the homes involved with the project saw a dramatic decrease of dehydration-related hospital admissions (63%) and incidences of urinary tract infections requiring antibiotics fall by 18.5% during an 18-month period.

Supporting people with malnutrition
Malnutrition affects millions of people across the UK, and it is more common in people who are older than 65, have a long-term condition that affects appetite, weight and digestion, have problems swallowing or are socially isolated.

We celebrated the work of our Macmillan oncology dietitian team during November's malnutrition week to shine a light on the support they provide people who are receive their care through a nasogastric feeding tube. The team develops tailored plans for patients who are unable to swallow while receiving chemotherapy and radiotherapy treatments.

International cancer conference hosted in Torquay
Our head and neck cancer team along with our ENT colleagues hosted The Swallows Charity annual conference in Torquay earlier this month. Our teams presented and showcased the work of our acupuncture clinic and our 14-day cancer treatment pathway.

Michelin Star chef Michael Caines MBE presented at the event, alongside TV personality Tommy Walsh, who was diagnosed with cancer last year.

The event was a huge success, with more than 200 people attending – some of whom travelled from Ireland and the United States to attend. On behalf of the Board I would like to formally thank all those involved.

3.2 Excellent experience receiving and providing care

Current pressures
Infection prevention and control continues to affect patient flow through our acute and community hospitals. Working with our system colleagues we are strongly encouraging people to take up the offers of flu and COVID-19 vaccinations where these are offered. We actively discourage people from visiting our sites if they have any signs or symptoms of diarrhoea and vomiting or other infectious illnesses that could negatively affect our patients or staff.

For the seventh consecutive month our urgent and emergency care performance was above 60%. We saw 697 more people in October 2023 than we saw in October 2022. Our performance remains behind our trajectory for the national oversight framework (NOF) 4 recovery target of 72% and dropped by 2% from September to 66.62%.

Our performance in planned care services has remained strong and we are meeting our targets for 104 week waits and cancer care. We are seeing the impact of the industrial action from earlier this year on progress towards our targets of having no one waiting more than 65 or 78 weeks by the end of March 2024 and we are behind our improvement trajectory. Our teams are working hard to bring us back on track so that we can meet this target and reduce the length of time people are waiting across all our planned care 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. We have achieved 100% on the two-hour response target and saw 27% more people in the last month. Our two to 48-hour response rate is at 96%

Care Quality Commission inspection report welcomed
In July the Care Quality Commission (CQC) conducted a well-led inspection following a short notice announced focused inspection of medical care, outpatients and the emergency department in May 2023. Inspectors also undertook a short notice announced comprehensive inspection of our diagnostic and imaging service in June 2023.

On 03 November 2023 our inspection report was published which rated us as requires improvement while retaining outstanding for caring. Medical care, outpatients, the diagnostic and imaging service and the emergency department are all rated as requires improvement.

We welcome the CQC’s report which reflects our challenges and our strengths. We feel it is a fair reflection of the issues our teams and our organisation face. The majority of the areas for improvement were already known to us and work is well underway to address these.

We are proud that our people’s commitment to compassionate care is recognised and we retained our outstanding for care rating. Our people work tirelessly to provide the best possible care across our hospital, community and adult social care services and on behalf of the Board I thank them for their support, kindness and dedication.

We are pleased the inspection recognised our focus on continuous learning and improvement and we will use the findings to help us make things better for our people and our communities. The report recognises that safety remains a priority for us.

We recognise we have more work to do to show our people how we are responding to concerns they share with us.

We know we have more to do to tackle inequalities for our people and our communities and our inclusion plan, which was approved by our board in July, is shaping and directing our work to create a culture where our people are safe and healthy. We have launched our compassionate leadership programme which complements our approach

to create a inclusive, fair and welcoming environment for everyone.

We have some of the oldest NHS estate in the country which poses particular challenges. This has been recognised nationally and we are included in the new hospital programme which will deliver modern, fit for purpose environments to deliver high quality, safe healthcare from. Since the inspection we have relocated our children's emergency department and this now has a separate waiting area for children which is compliant with CQC standards, as well as a triage space and treatment area for children with minor injuries.

Devon's healthcare system is working as one to address our financial and operational performance challenges. The report recognises our commitment to working in partnership to improve services, and we are seeing improvements. Our waiting times are reducing and our performing is improving across planned care and cancer services but have more to do to make things better for everyone in Torbay and South Devon.

Booked appointments now available at Totnes minor injuries unit
Our minor injuries unit at Totnes community hospital has moved to an appointment-priority service to provide greater consistency and maintaining the operating hours. Bookings will only be taken for the same day, and people should call 01803 862622 and select option 1.

People can still walk in, but appointments will be prioritised. If the service is at capacity, people may be redirected or called back at an alternative time. It will continue to be a nurse / paramedic-led unit, open from 8am to 5pm, seven days a week.

DAISY award winner went above and beyond to support family
Phil Barker, registered nurse on our cardiac care unit, is our latest DAISY award winner.

Phil was nominated by a patient's family after caring for their dad. They said: "Phil is an incredible professional, caring, and supportive member of staff. He explained what was happening, and what treatment they were giving dad. He went above and beyond to ensure dad was not in any pain, and always checked on our mum. He even called the ward on his day off to see how dad was doing, and if we were okay.

"Phil was a role model and having him around made our experience a more comforted and cared-for one in what were terrible circumstances."

His Majesty celebrates our nurses and midwives at royal event
Our practice educator, Hervika Whitley was invited to attend a reception at Buckingham Palace with His Majesty, King Charles this month to celebrate the contribution of internationally educated nurses and midwives to the united kingdom.

Hervika joined around 450 international nurses and midwives at the event, which also coincided with the King's birthday. She spoke with the Duchess of Gloucester about her work and our achievement of becoming the first trust in Devon to receive the pastoral care quality award for international nurses, midwives and allied health professionals.

National award nomination for our theatre and surgical nursing team
Our theatre and surgical nursing team were shortlisted for a Nursing Times award for their acuity-based patient allocation work.

The team was up against some very tough competition and while they did not win the top prize we are very proud of their achievements.

New exhibition in the HeArts gallery at Torbay Hospital
A new exhibition at the HeArts gallery in Torbay Hospital focuses on reflections from conversations about the challenges and rewards of working in the NHS, as well as questioning the meaning of clinical objects.

'Once.. the.. applause.. faded..' is a joint exhibition with Helen Snell, our artist in residence, and Dr Paul Clark. It will be on display until Monday 15 January 2024.

3.3 Excellent value and sustainability

Delivering best value to our people and communities
Our financial performance continues to be a challenge. In line with the national letter published earlier this month we have recast and resubmitted our operating and financial plan.

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 continue to ask 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.

We will need to make difficult decisions and prioritise key areas in order to support our delivery against national and local targets.

Phase two of 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).

More than 130 conversations have taken place with our teams and following a review of phase one, we are now moving forward with phase two of our engagement plan in which we will be adopting the relationship model which has been piloted in our planned care services. In this model, each executive is paired with a senior leadership buddy and have a number of services/teams allocated to them. The intent is that this will give consistency of approach and allow trusted relationships to form, creating executive and

senior leadership advocates for dedicated areas, enabling and fostering rich conversations and supporting actions.

The programme is closely aligned to and congruent with our compassionate leadership framework through which we are supporting 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.

More people will receive a quicker diagnosis at our new £4.99 million endoscopy training centre

We are pleased to have welcomed our first patients into our new multi-million-pound Torbay endoscopy training centre, which opened on 14 November.

The centre was opened by our chairman Sir Richard Ibbotson and Lord Julian Darling, whose generous donation during the summer enabled the endoscopy team to run a weekend of extra diagnostic tests for 60 local people in July. On behalf of the Board I would like to formally thank Lord and Lady Darling for their generosity which has made a significant difference to people who were waiting for a potential diagnosis of cancer or bowel disease.

The increased space in the new centre will allow our endoscopy service – which conducts around 200 procedures a week – to see and treat more people who are awaiting diagnosis and treatment for a range of conditions, including cancer and inflammatory bowel disease; reduce waiting times, and improve people's experiences and outcomes.

The unit was funded by NHS England to address diagnostic delays and improve cancer outcomes, and the extra funding from the South West Endoscopy Training Academy to create a state-of-the-art training centre will help train the region's future endoscopists and nurses in modern buildings that are fit for the 21st century.

The opening marks another significant milestone in our Building a Brighter Future programme to improve people's experiences and outcomes of care, following the opening of our £2.8 million radiotherapy planning CT suite in October and a £15 million acute medical unit last December. A new £15million investment in two new theatres will open in January which will significantly increase capacity, with an extra 4,500 people treated each year needing hip, knee and eye operations.

Leadership team changes

This month we welcomed Arun Chandran, our new chief operating officer. Arun began his NHS career as a nurse and has held a variety of leadership roles in London and the South West. He is passionate about addressing health inequalities and is focused on high-quality patient care and supporting and developing colleagues and teams. He brings a passion for equality and inclusion which aligns with our work and vision to deliver better health and care for all. Arun's input will help us to develop our care model and transforming our clinical services so that they meet the needs of our communities now and in the future.

Following a robust and competitive recruitment process, we have appointed Dr Kate Lissett, our interim medical director, as our new chief medical officer. Kate will take up

her new role following the retirement of Ian Currie, our current chief medical officer, at the end of this calendar year (December 2023). Kate joined us as a consultant in 2006 and is currently working clinically as an acute physician.

I want to take this opportunity, on behalf of the Board, to formally thank our interim chief operating officer, Jon Scott, who left us in October for his leadership and to thank Ian for his many years of dedicated NHS service and wish him a happy and healthy retirement.

Welcoming our new non-executive directors
We are delighted to welcome the appointment of our three new non-executive directors: Barbara Gregory, Martin Beaman and Robert Williams.

Barbara trained as a chartered accountant, auditor and business consultant and has worked in the NHS in senior finance roles for 24 years before retiring in 2017. She has been a non-executive director with Somerset NHS Foundation Trust and chair of the Health Service Managers' Association CNL Faculty.

Martin is a consultant physician and nephrologist and has held a number of Postgraduate Dean roles across the South West. After retiring in 2019 he was appointed as a non-executive director to Devon Partnership NHS Trust (DPT). He chaired the Quality Assurance Committee at DPT for four years.

Robert, who joins us as an associate non-executive director, provides management consulting and advisory services to private and public sector organisations across the globe, specialising in business transformation and organisation change. He is a trustee for Step One, a South West charity supporting people with mental health and other challenges; he provides mentoring and coaching to developing executives; and was a former chair of governors at a large school, where he led the funding, development and opening of a new, state-of-the-art school complex.

Securing the future of Torbay Pharmaceuticals
Earlier this year we took the significant decision to sell Torbay Pharmaceuticals to ensure growth and job security. On Friday 17 November 2023 we announced the sale of Torbay Pharmaceuticals (TP) to leading regional private equity firm, NorthEdge.

Over the last six years Torbay Pharmaceuticals has grown to become a contract manufacturer and licence holder serving global markets.

TP colleagues have been transferred to their new employer, Torbay Pharmaceuticals Ltd. The business is looking forward to expanding its global reach and increasing the number of people employed at its head office in Paignton.

NorthEdge is a regional private equity firm, owned and built by its senior team. The firm backs entrepreneurial and ambitious management teams in the technology, healthcare, business services and specialised industrials sectors and has a strong track record of supporting regional businesses reach to their potential, while placing an emphasis on responsible investing.

We are justly proud of how TP has grown from a backroom in Torbay Hospital in the 1970s to a sizable manufacturer. Over the years, TP has constantly grown and innovated to deliver an increasing volume and range of medicines, while supporting local jobs and the NHS.

Two firms generously sponsor our 2024 Our People Awards
Kier Construction Western and Wales and Nevada Construction have been announced as the first sponsors for our 2024 Our People Awards. Our annual awards event celebrates the achievements of our people who have gone above and beyond to provide compassionate care, supported their colleagues, or improved services.

4 Chief executive engagement November

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
• Staffside • Freedom to Speak Up Guardian • BAME representative • Veteran plaque unveiling • Endoscopy opening event • Trust Talk	• Chief executive, University Hospital Plymouth NHS Trust • Interim chief executive officer, Royal Devon University Healthcare NHS Foundation Trust • Chief finance officer/interim chief executive officer, Devon Partnership NHS Trust • Director of integrated adult social care, Devon County Council • NHS leadership event.

5 Local media update

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

Key media releases and responses

Care home reaches diamond standard for hydration support
Celebrating the work of our dieticians who are supporting care homes to reduce hospital admissions by highlighting the importance of good hydration.

Families who have lost little ones invited to remembrance service
Families who have experienced the loss of a child or a baby in pregnancy or the early months of life are invited to a remembrance service and crafting session.

Torbay and South Devon NHS Foundation Trust welcome Care Quality Commission report

The Care Quality Commission publishes its report following its well-led inspection in July this year.

Coverage

Thank you, BBC Spotlight, ITV West Country, BBC Radio Devon, Greatest Hits Radio and Riviera FM for covering our work during November. We are grateful for your support.

ITV West Country attends the opening of the Torbay endoscopy training centre

BBC Radio Devon interviews chief people officer about the Armed Forces' healthcare covenant award

BBC Spotlight attends the unveiling of the Armed Forces' healthcare covenant award

Engagement

We had meaningful conversations with a range of people and groups during November to listen to their experiences and ideas about how we can improve our services, including:

Membership committee attended by 10 people and we agreed to run a telethon to members to increase the number of email addresses held on our database. This will allow us to issue more regular, digital communications to build connections with members. A membership stall was also run at the volunteering event on 23 October to encourage new members' sign-up.

We have started a project to interview families to understand reasons why child health appointments were missed and what changes we can make to reduce non-attendances.

User survey has now closed for the Torbay adult social care webpages redesign. We received 31 completed surveys and held two follow-on group discussions, with five survey participants to gain more in depth insights.

Released child health engagement forum brief to VCSEs and other interested stakeholders – good level of interest and the deadline for formal expressions of interest is 24 November.

Progressing the set-up of a new special care baby unit discharge survey with the South West Neo Natal Network.

Recruitment

We have managed the marketing for a range of specific roles including registered nurses on Midgley ward; clinical physiologists (respiratory); physiotherapists; and an employee relations manager.

We are also planning to launch a marketing campaign during the next four weeks to recruit healthcare support workers to join us.

6 Recommendation

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

NHS
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Report to the Board of Directors			
Report title: Committee Chairs' Report			Meeting date: 29 November 2023
Report appendix:	Nil		
Report sponsor:	Director of Corporate Governance and Trust Secretary		
Report author:	Corporate Governance Manager		
Report provenance:	n/a		
Description/Purpose of the report and key issues for consideration/decision:	Verbal feedback will be provided to the Board on the key issues discussed at Board Sub-Committees since the last meeting, or where written feedback has not yet been provided. Those meetings are detailed below: • Finance and Performance Committee – 23 October and 27 November 2023 • Building a Brighter Future Committee – 15 November 2023 • Quality Assurance Committee – 27 November 2023		
Action required:	**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			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	In providing the Board with a high-level report of the activities of the Committees that have met in the reporting period, it gives the Board with opportunity to consider if any action needs to be taken to support any areas of concern that might impact on its population.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources The report provides information that will enable the Board of Directors to support the Triple Aim.		
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 4 - Estates Objective 5 - Operations and Performance Standards Objective 6 - Digital and Cyber Resilience Objective 7 - Building a Brighter Future Objective 8 - Transformation and Partnerships Objective 9 - Integrated Care System Objective 10- Green Plan/Environmental, Social and Governance Objective 11 – Equality, Diversity and Inclusion		

Risk: Risk ID: *As appropriate*	N/a
External standards affected by this report and associated risks	Terms of authorisation, NHS England licence and regulations National policy, guidance

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Report to the Trust Board			
Report title: Integrated Performance Report (IPR) M7 2023/24 (October 2023 data)			Meeting date: 29 November 2023
Report appendix:	Appendix 1: IPR Month 7 2023/24 Focus Report Appendix 2: IPR Month 7 2023/24 Dashboard of Key Metrics		
Report sponsor:	Chief Finance Officer		
Report author:	Executive Directors		
Report provenance:	Finance, Performance, and Digital Committee Executive Directors		
Description/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:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Board is asked to receive and note the documents and evidence presented.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	The report highlights performance against the delivery of care for the people of Torbay and South Devon.		
How does the report support the Triple Aim:	*1*) population health and wellbeing *2)* quality of services provided *3)* sustainable and efficient use of resources		
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 5 - Operations and Performance Standards		
Risk: Risk ID: *As appropriate*	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.		

External standards affected by this report and associated risks	Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance

Report title: Integrated Performance Report (IPR) M7 2023/24 (October 2023 data)		**Meeting date:** 29 November 2023
Report sponsor	Chief Finance Officer	
Report author	Executive Directors	

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 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 October 2023, 3 incidents were reported as severe harm. The incidents related to two patient falls resulting in fractures and the care of a young patient during a cardiac/respiratory arrest.

VTE (Venous Thromboembolism) Assessment

The overall VTE conformity for all relevant in-patients in October 2023 is 97.7% which continues to be above the national target. However, the percentage of patients who have their assessments completed within 24 hours has improved to 95.8% this month. The Haematology Nurses continue to coordinate the positive VTE results and facilitate weekly reports to identify those patients who were treated, on an in-patient basis, within the previous 90 days of the result.

Infection, Prevention, and Control

The number of closed bed days due to infection has reduced and compliance with hand hygiene audits has improved.

There has been an increase in the number of patients acquiring C- Diff and targeted work is taking place to review every patient with the MDT and IPC team. This is being supported by the Lead Nurse for Infection, Prevention, and Control and Associate Directors of Nursing for Professional Practice.

Maternity

One neonatal death was reporting in October. This was a baby born with a known life limiting condition who died at 13 hours of age.
Mock CQC held September 2022, Maternity Service have developed a local action plan having reviewed other CQC reports from neighbouring trusts. A full unannounced CQC inspection is anticipated in the next few weeks.

Fractured neck of femur

55.5% of patients had access to theatre within the recommended time frame in October 2023 against a target of 90%. The Care Group are working through an improvement plan to ensure that beds can be ringfenced to ensure easier access to theatre. Torbay is maintaining an average or above average performance in all the KPIs except on KPI 0 which reflects the timeliness of admissions to a specialist ward

Workforce Headlines

Progress in delivering the workforce implications of the 2023/24 Operational Plan

The Trusts substantive workforce is 92 Whole Time Equivalent (WTE) over plan in October 2023, worsening from the previously reported 63 WTE above plan in September. Areas of growth since September have been seen in the Nursing and Midwifery staff group showing an increase of 5 WTE, Medical and Dental 9 WTE and Infrastructure is 64 WTE above plan.

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 held across several of the most challenged areas.

Overview of workforce metrics

The turnover and sickness rates for October are lower than those forecasted in the operational plan.

There has been a steady upward trend in overall compliance over the last 12 months. Compliance has decreased slightly by 0.52% in October to 91.07% against a target of 85%. However, at a topic level we remain challenged in Manual Handling at 77.31% and Information Governance at 86.74%.

Achievement Review compliance has dropped by just under 0.53 % in October to 78.40% 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.

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 with NHS England to review recovery action plans and performance against trajectories.

National Oversight Framework 4 exit criteria

Urgent and Emergency Care (UEC) NOF 4 headlines

The Trust is not meeting the UEC NOF 4 exit criteria.

- Ambulance handover time lost increased in October reporting 3591 hours lost waiting over 15 minutes (from 2579 hours lost in September); this does not meet the trajectory of 1416 hours.
- The percentage of patients waiting over 3 hours for an ambulance handover remained at 14.7% in October.
- The Trust's Urgent and Emergency Care (UEC) 4-hour performance decreased to 66.6% and did not meet the October trajectory of 72%.
- 20.3% of discharges were achieved before noon against a target of 33%.
- For the first time in 7 months, the Trust has not met the trajectory for the percentage of beds occupied with No Criteria To Reside with 8.3% of occupied beds against the October trajectory of 5.0%.

Elective Recovery NOF 4 headlines

Elective Referral to Treatment (RTT)

Elective recovery against the NOF 4 exit criteria is meeting the planned trajectory for 4 of the 7 exit indicators. The trajectories to reduce the number of patients waiting over 78 and 65-weeks for treatment were not met. The cumulative impact of industrial action has been a main factor impacting this performance. The impact of further industrial action is a future risk being assessed with an expected impact on long-wait trajectories.

Cancer standards

From 1st October 2023, the methodology for calculating the cancer metrics below has been updated inline with the publication of the refreshed Cancer Waiting Time standards. These three measures are now the headline targets monitored by NHS England:

- the 28 Day Faster Diagnosis Standard (75% target).
- one 31-day decision to treat to treatment standard (96%), combining the previously separate First and Subsequent treatment standards.
- one 62-day referral to treatment standard, combining previously separate Consultant Upgrade and Screening standards (85%)

The Trust is not meeting the Faster Diagnosis performance with 73.4% achieved against a target of 75% in October; this is due to the impact of industrial action. The Trust is ahead of the October trajectory for the number of patients waiting longer than

62 days for treatment. Torbay is no longer included in Tier 1 performance oversight for cancer standards.

Finance headlines

As at M07, the Trust reported an adverse variance to plan of £4.587m. This is primarily driven by the net impact of the ongoing Industrial Actions. £1.975m relates to the net cost implication and £0.866m for potential Elective Recovery Fund (ERF) clawback due to activity delivery being lower than planned. The remaining £1.7m YTD overspend mainly relates to pay and non-pay overspend partially offset by other income.

The original ERF target for 23/24 was to meet 103% of the 19/20 tariffed baseline, however due to the Industrial Action, NHSE/I has revised the target to 100% taking into account its impact. Our current financial performance up to M7 is reported at 99%.

Our current 23/24 CIP programme includes 172 schemes, of which 134 schemes (78%) totalling £34.7m are assessed as Green and have been confirmed in the Plan. Against the Strategic ICB Collaborative target totalling £10.4m we have £0.2m assessed as Green and £5.7m assessed as Red.

The Trust's net (CDEL) annual capital expenditure forecast incorporated into the 2023/24 Operational Plan was an expenditure sum of £56.8m. To align with more recent planning assumptions this sum had in recent month reduced to £47.8m, predominantly associated with reduction in planned expenditure across National PDC funded schemes. The planned net expense has now reduced further to £30.8m due to a recent asset sale. Our overall cash position at M7 is £1.79m ahead of plan with £4.4m headroom within our YTD deficit PDC support drawdown allowance. Please note TP sales transaction had been completed in November, further cash receipts will be reported in M8.

Integrated Performance Focus Report (IPR)

Torbay and South Devon NHS Foundation Trust

November 2023: reporting period October 2023 (Month 7)

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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 the 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 are described in the Chief Operating Officer's report.

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 Chief Executive Officers 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

NHS 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

Torbay and South Devon NHS Foundation Trust

	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)		
Ambulance handovers greater than 15 minutes	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	No trajectory	
Over 12-hour visit time; and ED (type 1) 4-hour target	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	No trajectory	
Increase in pre-noon patient discharges	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG		
Reduction in 'No criteria to reside'	SCGD – Families community and place based	Deputy Medical Director	Chief Operating Officer	ORG TMG	No	
Patient wait over 104 weeks	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	Yes	Yes
Patient wait over 78 and 65 weeks	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	No	No
75% of GP referred patients diagnosed within 28 days	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	No	No
Cancer longer than 62-day wait	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	Yes	Yes

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

Torbay and South Devon NHS Foundation Trust

Matters of concern/key risks to escalate	Major actions commissioned/work underway
• Future Industrial Action. • TIFF Theatre recruitment of workforce and delivery of activity, • Infection outbreaks impacting on staff and bed availability. • Medical workforce gaps and the availability of locums to support. • ED demand rises. • Medical engagement in adoption of changes to ward rounding to improve the timeliness of discharges. • Speed of delivery for changes to Portal to allow common view of potential discharges over the weekend. • Capacity of transformation team support to improvement plans.	• ECIST support to Frailty pathway / SHOP on wards • ECIST review of the bed management process and Ambulance Handover Delays. • Establishing a further x4 cubicles in ED to support Ambulance Offloads. • Operational 'drum-beat' bed meetings process changing to streamline Directorate information gathering. • Review of Transformation support for improvement plans and review of audit of wards to increase medical engagement. • Implementation of the 'Emergency Village'.
Positive assurances	**Decisions made**
• Whilst RTT control totals have not been met performance against 78 and 65 weeks improved in October. • 62-day cancer backlog is 28th best in England. • UEC 4hr performance above 60% for sixth month in a row and continuing to rise month on month. Performance ranked nationally at 60th out of 119 (104th in October 2022) • NCTR performance is best in Southwest. • Management of Industrial Action becoming business as usual with established playbooks. • Winter Plan reviewed by Michael Wilson's team. • GIRFT review of UEC processes complete. • Virtual ward occupancy has consistently improved	• Ongoing transition of space and process changes within ED for non-admitted patient performance improvement. • Weekend plans to focus on Friday handover medical and nursing meeting information. • IT prioritisation of Portal. • Winter Plan agreed. • Review of Pathway 1-3 processes report completed and under review. • Locum employed to support Front door frailty • Level 2 decant to support Frailty Team

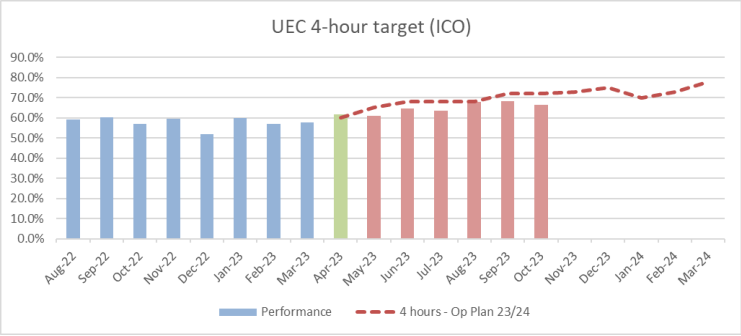
National Oversight Framework (NOF) 4 Exit Criteria – Urgent and Emergency Care Performance Summary

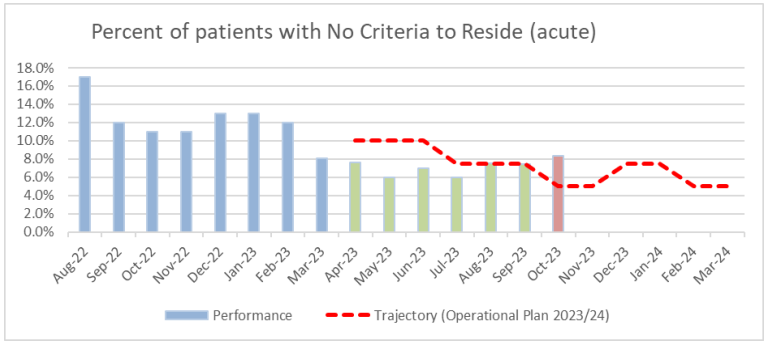
Torbay and South Devon NHS Foundation Trust

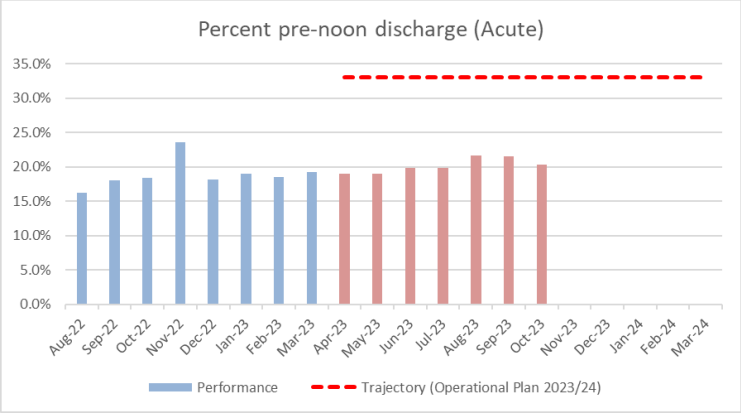
	Target March 2024	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Operational Plan trajectory Oct 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA															
Urgenct and Emergency Care															
Ambulance handovers - time lost over 15 mins - Actual (hours)	1110	3512	2448	5017	3280	740	2260	796	1630	1569	1223	1707	2579	3591	1416
Percentage of Ambulance handovers greater than 3 hours		27.0%	18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	3.7%	6.5%	14.7%	14.7%	No trajectory
Total average time in ED (hours/minutes)		07:58	07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	05:41	06:05	05:46	06:15	No trajectory
ED attendances where visit time over 12 hours	0	988	939	1207	823	599	977	568	893	797	637	794	686	822	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68.4%	66.6%	72%
% 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%	21.5%	20.3%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%	11.0%	11.0%	13.0%	13.0%	12.0%	8.1%	7.6%	6.0%	7.0%	6.0%	7.5%	7.4%	8.3%	5.0%

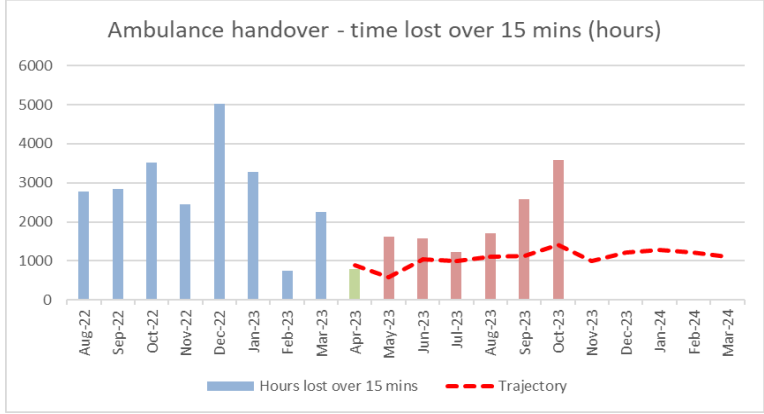
Trajectories have been agreed as part of the 2023/24 Operational Plan submission. The latest month trajectory, where applicable, is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories.

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







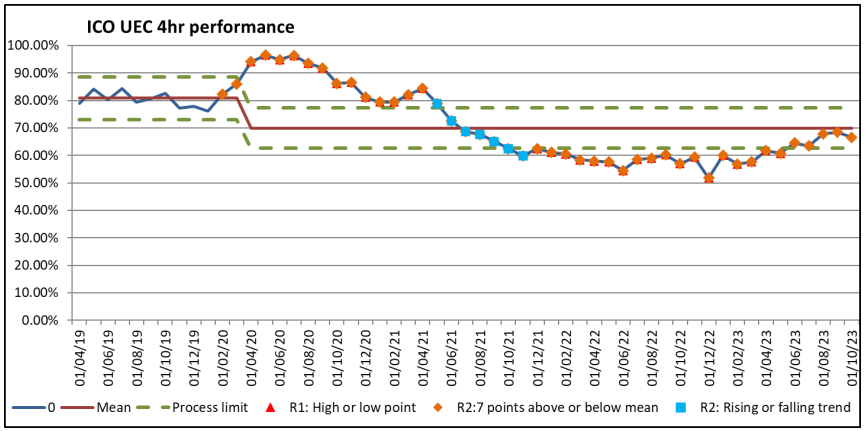


Exception report: 4-hour ED target: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

	October 2022	October 2023	Improvement in performance
ED Type 1 performance	35.7%	51.4%	44%
ICO Performance	57%	66.6%	17%



Operational update

- October recorded an increase in the average time in ED with 6h 15 m compared to 5h 46m for September.
- Type 1 performance - overall attendances increased from 5721 in October 2022 to 6499 in October 2023; a 12% increase in attendance. We achieved 51.4% against our ED 4-hour target, the third consecutive month the Trust has been over 50% since July 2021.
- Type 3 demand (UTC and MIU) had minimal change from 3132 attendances in October 2022 to 3051 in October 2023. We achieved 99% against our Type 3 4-hour target.
- Overall, our UEC performance across the ICO was 66.6%, the seventh month in succession above 60%.

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:

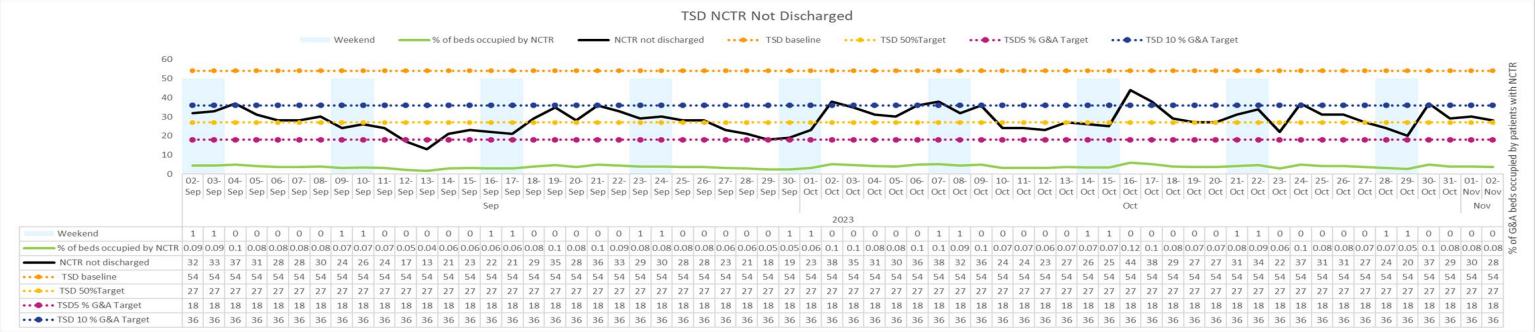
- Implementation of the Emergency Village - Same Day Emergency Care (SDEC), JETS, Frailty, Acute Medical and discharge lounge co-located on within the Level 2 footprint
- Virtual Ward – rapid expansion of pathways and volume.
- Urgent Treatment Centre (UTC) / Minor Injury Unit (MIU) stability and plans to open Dawlish.

Risks/issues

- Further infection issues
- Further Consultant industrial action
- Combination of the above

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

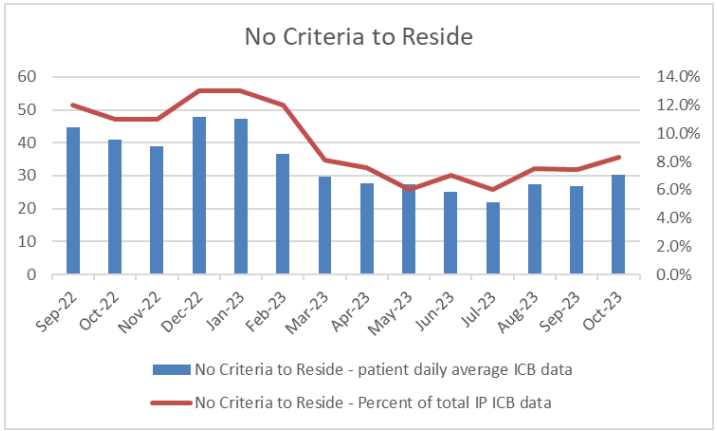
Torbay and South Devon NHS Foundation Trust



	02-Sep	03-Sep	04-Sep	05-Sep	06-Sep	07-Sep	08-Sep	09-Sep	10-Sep	11-Sep	12-Sep	13-Sep	14-Sep	15-Sep	16-Sep	17-Sep	18-Sep	19-Sep	20-Sep	21-Sep	22-Sep	23-Sep	24-Sep	25-Sep	26-Sep	27-Sep	28-Sep	29-Sep	30-Sep	01-Oct	02-Oct	03-Oct	04-Oct	05-Oct	06-Oct	07-Oct	08-Oct	09-Oct	10-Oct	11-Oct	12-Oct	13-Oct	14-Oct	15-Oct	16-Oct	17-Oct	18-Oct	19-Oct	20-Oct	21-Oct	22-Oct	23-Oct	24-Oct	25-Oct	26-Oct	27-Oct	28-Oct	29-Oct	30-Oct	31-Oct	01-Nov	02-Nov
	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Nov	Nov
															Sep																2023															Oct																																Nov	
Weekend	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0
% of beds occupied by NCTR	0.09	0.09	0.1	0.08	0.08	0.08	0.08	0.07	0.07	0.07	0.05	0.04	0.06	0.06	0.06	0.06	0.08	0.1	0.08	0.1	0.09	0.08	0.08	0.08	0.08	0.06	0.06	0.05	0.05	0.06	0.1	0.1	0.08	0.08	0.1	0.1	0.09	0.1	0.07	0.07	0.06	0.07	0.07	0.07	0.12	0.1	0.08	0.07	0.07	0.08	0.09	0.06	0.1	0.08	0.08	0.07	0.07	0.05	0.1	0.08	0.08	0.08
NCTR not discharged	32	33	37	31	28	28	30	24	26	24	17	13	21	23	22	21	29	35	28	36	33	29	30	28	28	23	21	18	19	23	38	35	31	30	36	38	32	36	24	24	23	27	26	25	44	38	29	27	27	31	34	22	37	31	31	27	24	20	37	29	30	28	
TSD baseline	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	54	
TSD 50%Target	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	27	
TSD5 % G&A Target	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	18	
TSD 10 % G&A Target	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	36	

Performance

The average number of patients with No Criteria To Reside (NCTR) was 8.3% for October; **achieving 5% for five days in the month.** We continue to have the lowest NCTR across the ICB.



Operational update

The increase in NCTR in month can be directly attributed to infection issues experienced throughout October with a ward and numerous bays closed.

Key actions that have supported the improvement in NCTR

- Trusted placement assessor.
- McCallum UEC - pilot ready to go ward model implemented.
- 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.
- Infection control action plan management of key risk wards

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.

Risks/issues

- Further infection control issues
- Further industrial action
- Local Care Market to support patient discharges
- Devon County Council prolonged sourcing and approval of placements due to financial constraints

8

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

Torbay and South Devon NHS Foundation Trust

Performance

The number of ambulance handover delays over 15 minutes increased in October with 1951 over 15 minutes (1828 in September).

The hours lost due to ambulance delays over 15 minutes increased in October to 3591 hours compared to 2579 in September.

Average time lost to ambulance handover delays (hours per day)

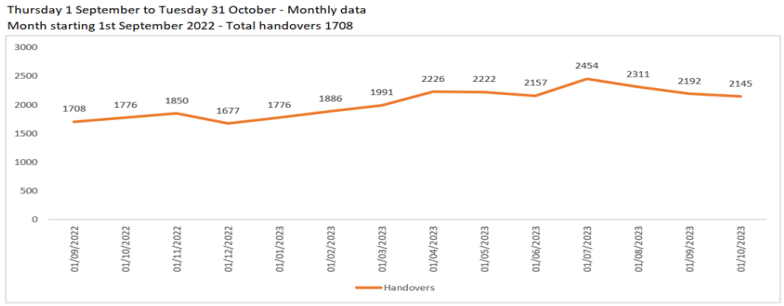
Rolling 30-day position as at **07 November 2023**

click on a bar to highlight site on the trend chart

Ambulance Trust	Site	
South Western	Derriford Hospital	296:22:50
South Western	Royal Cornwall Hospital (treliske)	204:00:15
South Western	Gloucestershire Royal Hospital	140:09:10
South Western	Torbay Hospital	98:00:30
South Western	The Great Western Hospital	89:39:24
South Central	Queen Alexandra Hospital	77:24:11
South Western	Royal Devon & Exeter Hospital (w..	66:45:19
South Western	Royal United Hospital	52:11:25
South Western	Southmead Hospital	45:53:17
South Western	Bristol Royal Infirmary	33:26:06
South Western	Royal Bournemouth Hospital	27:09:37
South Western	Poole Hospital	21:54:05
South East Coast	Royal Sussex County Hospital	16:31:22
South Western	Musgrove Park Hospital	10:39:53
South Central	Stoke Mandeville Hospital	10:32:29

Operational update

In September, the Trust saw an increase in handover delays. Ambulance handover demand has risen 21% comparing October 2023 (1776) to October 2023 (2145) handovers.



The average time lost per ambulance to handover has increased from 1hr 23min in September 2023 (including the 15 mins) to 1h 53m in October 2023. This remains an improvement from average time lost in October 2022 of 2h 12m.

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
- Further Consultant industrial action
- Combination of the above

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

Torbay and South Devon NHS Foundation Trust

Performance

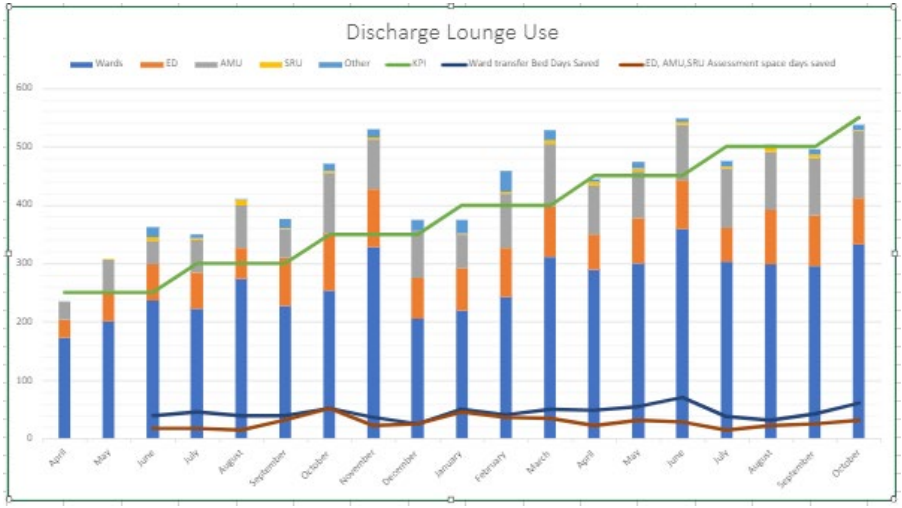
We saw a decrease in our overall general and acute discharges in October totalling 1476 compared with 1533 in September. Infection issues in month on wards contributed to this reduction. The percentage discharges pre-5pm and pre–noon dropped slightly compared with September.

The Flow and Ward Improvement Group 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
August	21.6%	70.6%
September	21.5%	70.9%
October	20.3%	69.4%

Operational update

The Discharge Lounge (DCL) remains a key part of the strategy for generating timely ward capacity. October saw 537 patients attend the discharge lounge up from 495 in September



Actions to complete next month

- ECIST to support SHOP process
- Exec focus on Plus 1 protocol
- Refresh of weekend discharge process – to include Friday discharge sheets and development of the Portal system
- Patient transport and medication To-Take-Away monitoring via the Control Room.
- 10 day Formal Length of Stay reviews

Risks/issues

- Further infection issues.
- Further Industrial Action
- Consistent additional staffing support to the discharge team at weekends and senior cover.

National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

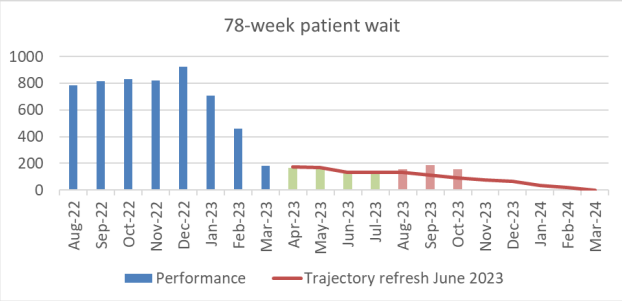
Torbay and South Devon NHS Foundation Trust

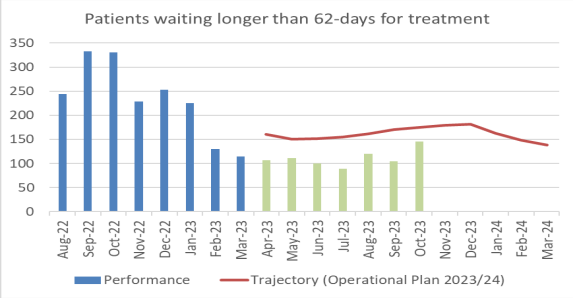
	Target March 2024	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Operational Plan trajectory Oct 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA															
Elective recovery															
RTT 104 week wait incomplete pathway	0	47	34	29	22	14	0	0	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	829	822	923	708	462	183	166	167	123	129	156	187	155	92
RTT 65 week wait incomplete pathway	0	2485	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1161	1018	991
RTT 52 week wait incomplete pathway	Reduction	5412	5585	6027	5554	5116	4427	4024	3926	3938	3879	3977	3471	2961	Not set
Patient waits over 2.5 years	0	24	17	12	9	6	0	0	0	0	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	74.2%	67.3%	71.7%	67.5%	77.3%	76.3%	75.5%	78.0%	77.7%	79.6%	75.6%	75.1%	73.4%	75%
Number of patients waiting longer than 62 days for treatment	138	331	229	253	225	130	114	107	111	100	89	120	105	143	175

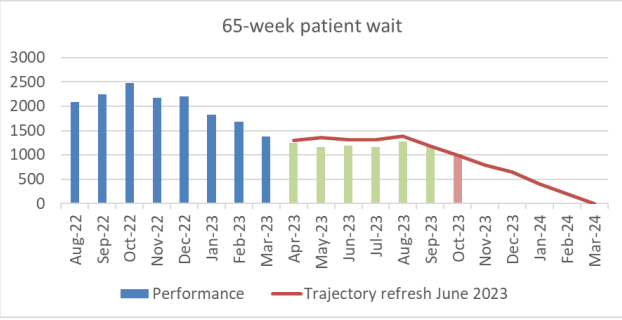
Trajectories have been agreed across NOF exit indicators as part of the 2023/24 Operational Plan submission. The latest month trajectory, where applicable, is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories. The Trajectories for reduction in patients over 78-week and 65-week RTT has not been met in October. The impact of industrial action being the driving factor, the exception reports describes in more detail the position and actions being taken.

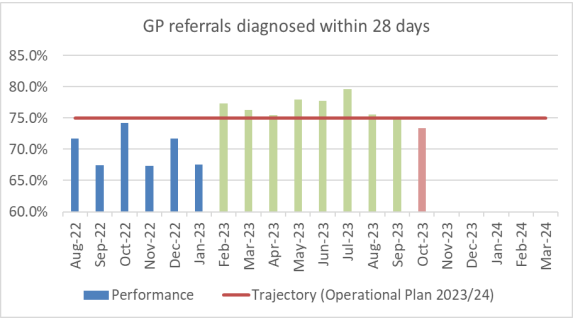
2023/24 RAG indicator

- 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 strike actions more pronounced than in previous months. Greater impact on long-wait trajectories is observed in our 78-week position.
- Workforce – clinical, nursing, admin insourcing supporting gaps in clinical workforce capacity. HR programme to support recruitment and retention with ICS system support.

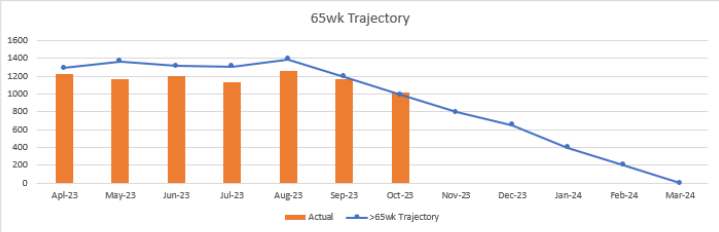
Exception report: 78-Week and 65-Week Clearance: NOF 4 Exit Criteria – Elective Recovery

Torbay and South Devon NHS Foundation Trust

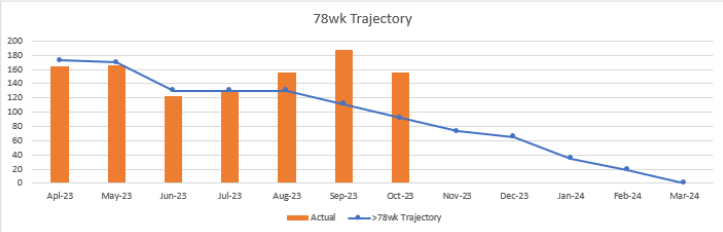
Performance

The trajectory for reduction in patients over 78-week and 65-week RTT has not been met in October.

	Apl-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
>65wk Trajectory	1292	1362	1312	1307	1387	1189	991	793	650	397	199	0
Actual	1220	1163	1196	1136	1260	1161	1018					
Revised FoT due to Indutrial Action - via Tier1						1287						



	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	187	155					
Revised FoT due to Indutrial Action - via Tier1					160	200	181	195	196			



Operational update

Failure to deliver the October 92 trajectory target is due to the impact of Industrial Action in August, September, and October. This has directly impacted on the numbers of treatments required to maintain the 78- and 65-week trajectory. Industrial action in October was more co-ordinated and lost capacity increased by 50% compared to August. This will have a direct impact on our November forecasts.

Good work from the teams minimised the overall impact on the longest waits with the target for 78-week breaches only missed by 63 patients in October.

Based on clock stop rates during strike and non-strike days it is estimated that >1,500 clock stops were lost between and April and October 23.

Actions to complete next month

- 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 will be required to address any growing shortfall in capacity.
- Engage with Devon ICB to further explore Devon-wide solutions for capacity gaps arising from Industrial Action.
- Increase in technical validation and direct patient contact to deliver the 12-week cycle of validation and potentially reduce waiting list pressures.

Risks/issues

- Continued Industrial Actions becoming more co-ordinated across staff groups and professions further limiting our ability to maintain clearance rates in our longest waiting groups.
- Recruitment of critical posts in theatres, clinical and support staff groups.

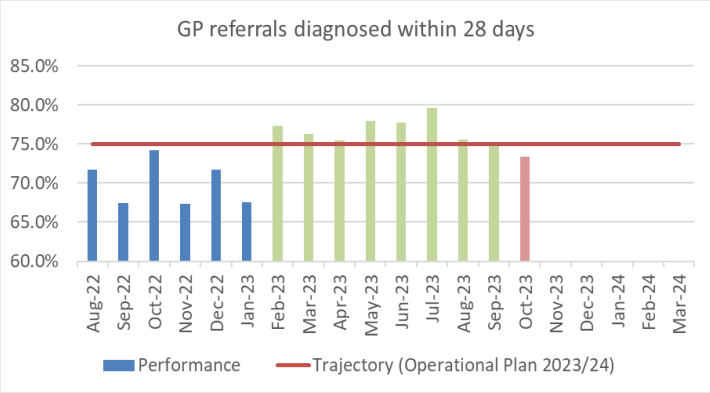
Exception report: 75% of GP referred patients diagnosed within 28-days: NOF 4 Exit Criteria – Elective Recovery

Torbay and South Devon NHS Foundation Trust

Performance

The target for 75% of GP referred patients diagnosed within 28-days (Faster Diagnosis) has not been met in October at 73.4%.

Torbay and South Devon received 2,035 urgent suspected cancer referrals in October. So far for 2023/24, the Trust has received 13,697 referrals, 6.0% greater than last year.



Operational update

Performance across Urology and Colorectal has remained relatively static, however a decrease in performance is apparent in Gynaecology and Dermatology.

Performance in October reflects the anticipated challenges of co-ordinated strike action over the summer. Many of our services have fragile medical workforces, which had to prioritise safe levels of on-call provision and unfortunately had to postpone clinics and theatre lists.

Actions to complete next month

For November so far, we continue to see an increase in the waiting times for first appointments. However, teams are responding well to these challenges with additional activity planned over the coming weeks. Colorectal, Urology and Gynaecology have all contracted insourcing support to supplement the sessions our internal staff are providing. This will allow more robust recovery and maintain the wellbeing and resilience of our staff.

Risks/issues

- Further industrial action
- Increased demand

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 October 2023, 3 incidents were reported as severe harm. The incidents related to two patient falls resulting in fractures and the care of a young patient during a cardiac/respiratory arrest.

VTE (Venous Thromboembolism) Assessment
The overall VTE conformity for all relevant in-patients in October 2023 is 97.7% which continues to be above the national target. The percentage of patients who have their assessments completed within 24 hours has improved to 95.8% this month.
The Haematology nurses continue to coordinate the positive VTE results and facilitate weekly reports to identify those patients who were treated, on an in-patient basis, within the previous 90 days of the result.

Infection, Prevention, and Control
The number of closed bed days due to infection has reduced and compliance with hand hygiene audits has improved.
There has been an increase in the number of patients acquiring C- Diff and targeted work is taking place to review every patient with the Multi-Disciplinary Team and Infection, Prevention, and Control (IPC) team; this is being supported by the Lead Nurse for IPC and ADNPP's.

Maternity
One neonatal death was reporting in October. This was a baby born with a known life limiting condition who died at 13 hours of age.
Mock CQC held September 2022, Maternity Service have developed a local action plan having reviewed other CQC reports from neighbouring trusts. A full unannounced CQC inspection is anticipated in the next few weeks.

Fractured neck of femur
55.5% of patients had access to theatre within the recommended time frame in October 2023 against a target of 90%. The Care Group are working through an improvement plan to ensure that beds can be ringfenced to ensure easier access to theatre. Torbay is maintaining an average or above average performance in all the KPIs except on KPI 0 which reflects the timeliness of admissions to a specialist ward

Safer Staffing
The RN actual CHPPD has been reported as **4.22** in October but still remains below the carter recommendation of **4.7.**
The actual HCA CHPPD was **3.79** in October 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.

CQC update 2021 and 2020 Action plans

CQC 2023 Well Led Inspection

Following the final factual accuracy checks TSDFT CQC report was officially released 3rd Nov 2023. The overall organisation rating has moved from Good to Requires Improvement. The Trust are rated as Requires Improvement in four of the five domains (safe, effective, responsive and well-led). TSDFT retained the rating of Outstanding for Caring. Given the system's challenged position in respect of both financial and operational it was not anticipated that a Good rating would be maintained. The report is a fair and honest reflection of the organisation and accurately reflects the challenges. There were a number of areas in the report where the organisation excelled and these were noted by the CCQ. Reassuringly the majority of the areas for improvement were already known to the Trust and work is well underway to address these.

Ratings for the service inspections are:

- Medical care – rated as Requires Improvement. Safe and Effective remained as Requires Improvement. Responsive and Well-Led were inspected not rated. Caring was not inspected.
- Emergency Department – rated as Requires Improvement. Safe improved from Inadequate (when inspected in July 2020) to Requires Improvement. Well-led improved from Requires Improvement to Good. Effective, Caring and Responsive were inspected but not rated.
- Diagnostics and imaging – rated overall as Requires Improvement. Safe and Well-Led were rated as Requires Improvement, Caring and Responsive were rated as Good. Effective was inspected but not rated.
- Outpatients – rated as Requires Improvement (previous rated as Good in May 2018). Safe was rated as Inadequate and Responsive was rated as Requires Improvement. Caring and Well-Led were inspected not rated. Effective was not inspected.

The Trust has 15 Must Do actions and 36 Should Do actions, as recorded below:

CQC Core Service	No. of Actions	
	Must Do	Should Do
Trustwide	2	7
Urgent and Emergency	2	6
Medical Care	3	6
OPD	1	10
Diagnostics Imaging	7	7
TOTAL	**15**	**36**

The action plan that accompanies the Must Do and Should Do requirements was approved at the November Quality Assurance Committee and will be shared with the CQC. This action plan replaces the previous work on the 2020 and 2021 inspections. For the 2021 inspection the actions are complete and will be monitored for assurance at the Nutritional and Hydration Steering Group and through the relevant Care Groups.

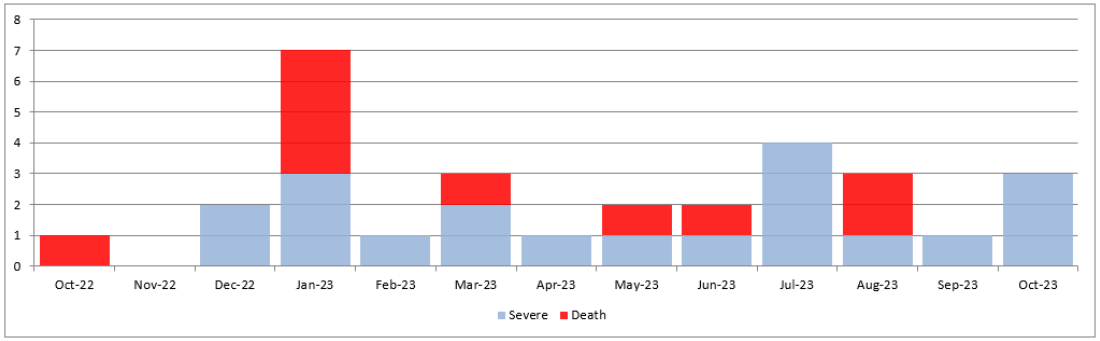
The CQC Quality Assurance Group will remain as the oversight group for the new action plan and report to the Board any exception on progress on a monthly basis.

Quality and Safety exception reports – reported incidents / HSMR

Torbay and South Devon NHS Foundation Trust

Reported Incidents - Severe and Death

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

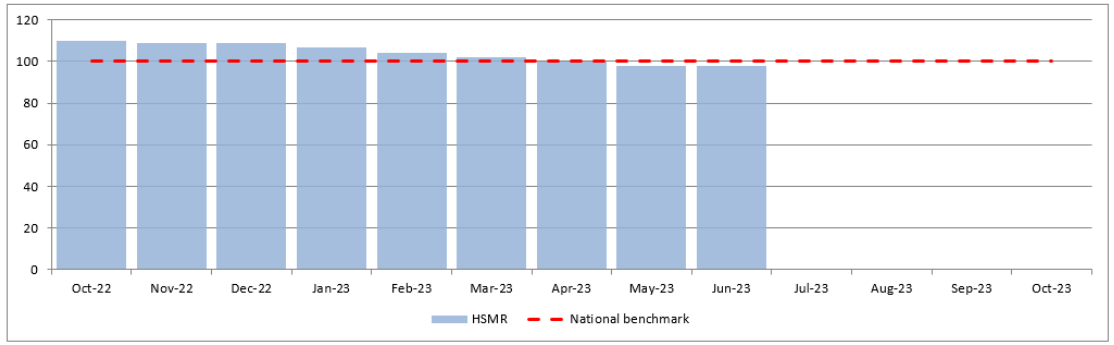


In October 3 incidents were reported as severe.

- Investigation into the care for a young patient during / following cardiac arrest.
- Patient fall with fracture neck of femur.
- Patient fall with displaced transverse supracondylar fracture of distal humerus.

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
HSMR	110	108.9	108.7	106.8	104.2	101.9	99.9	98.1	98.1	0	0	0	0
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



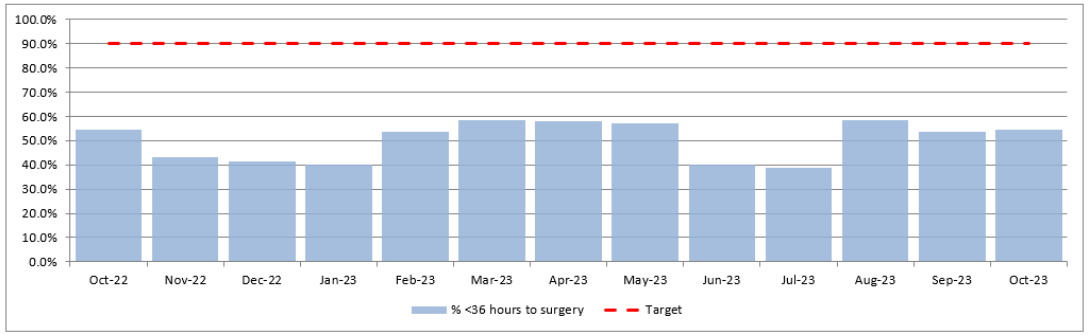
From October 2023 a one-month lag has been applied to the HSMR data to exclude the high numbers of null diagnosis codes experienced while coding processes occur. These null diagnosis effect the relative risk and the HSMR assessment resulting in an adversely inaccurate picture.
The latest HMSR for June 22 - May 23 is 98.1 (92.4 – 104.0), this is within the expected range compared to hospital trusts nationally. (↓). The Trust is one of five trusts in the region that is within the expected range with the second lowest HSMR.
The rolling twelve-month picture for weekday emergency HSMR continues to show a downward trend and has been within the expected range for eight data periods. The weekend emergency HSMR is now also within the expected range and demonstrates a downwards trend in the last two data periods.

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

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
% <36 hours to surgery	54.3%	43.3%	41.5%	40.0%	53.8%	58.3%	58.0%	57.1%	40.0%	38.7%	58.3%	53.8%	54.5%
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%

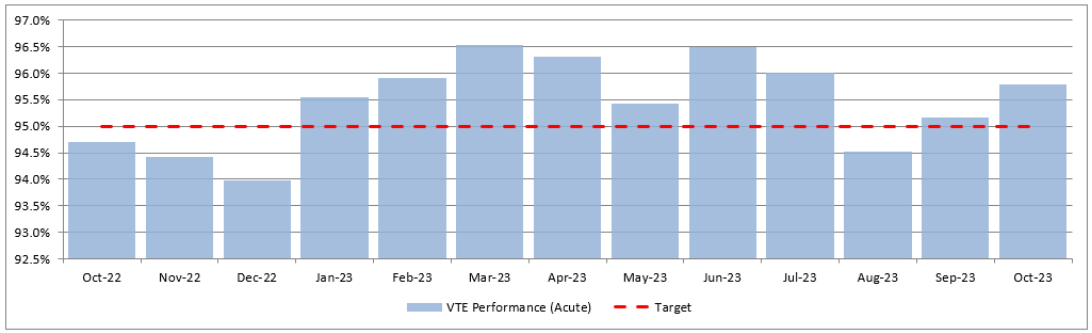


Fractured Neck of Femur

- 54.5 % of patients had access to theatre within the recommended time frame in October 2023 against a target of 90%.
- Torbay is maintaining an average or above average performance in all the KPIs except on KPI 0 which reflects the timeliness of admissions to a specialist ward
- To improve the performance in admissions we require
  - a refresh of our fast-track policy;
  - no trauma beds to be allocated to medicine;
  - Ring-fenced hip fracture beds

Acute VTE risk assessment on admission

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
VTE Numerator	5433	5521	4896	5631	5437	6050	5152	5104	2563	5911	5717	5624	5643
VTE Denominator	5737	5847	5210	5894	5669	6267	5349	5349	2656	6157	6048	5910	5891
VTE Performance (Acute)	94.7%	94.4%	94.0%	95.5%	95.9%	96.5%	96.3%	95.4%	96.5%	96.0%	94.5%	95.2%	95.8%
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

The overall VTE assessment conformity for all relevant in-patients in October 2023 is 97.7%, which continues to be above the 95% national target.

There has been much improvement across the acute site with only 2 area failing to undertake risk assessment in 24 hours;

- Louisa Cary 75%
- Ella 91.7%

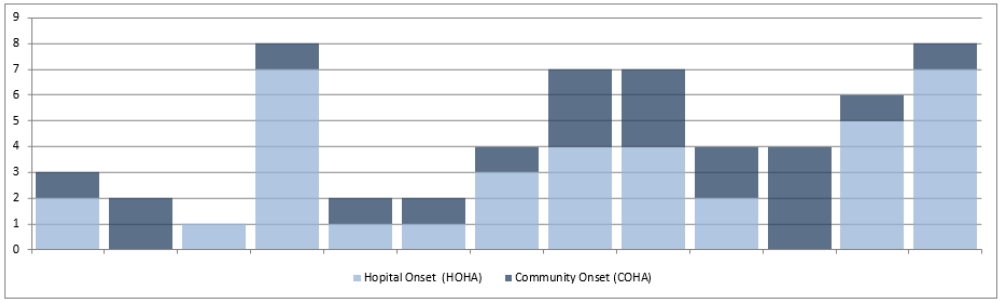
The team continue to review how the number of VTE cases can be benchmarked against other organisations as there is currently no standardised tool.

Quality and Safety exception report - Infection control

Torbay and South Devon NHS Foundation Trust

Number of Clostridium Difficile cases

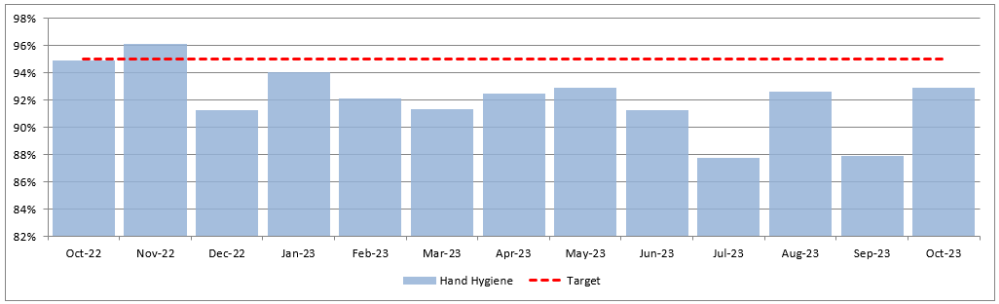
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Hopital Onset (HOHA)	2	0	1	7	1	1	3	4	4	2	0	5	7
Community Onset (COHA)	1	2	0	1	1	1	1	3	3	2	4	1	1



During October 8 cases of Clostridium Difficile were reported which is the highest this year.
A plan is in place to ensure an MDT After Action Review is undertaken for all cases and that there is a medical representatives at these meetings.
Anti-microbial prescribing has been identified as an issue and this is being monitored and advice given by the consultant microbiologist.

Hand Hygiene

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

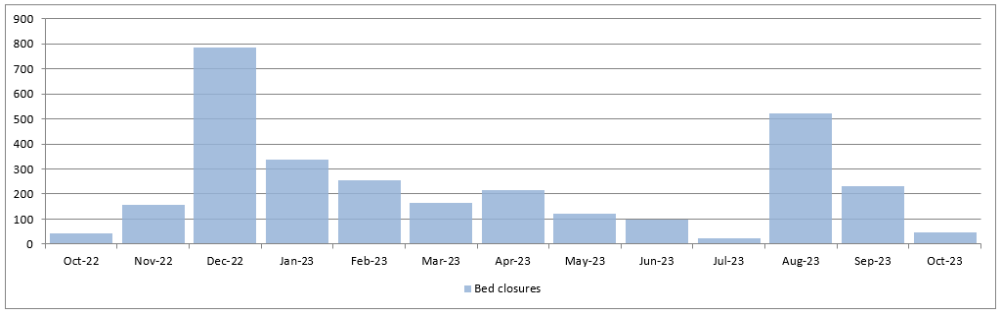


There has been an increase in compliance in the Trust wide hand hygiene audits.

The Infection, Prevention, and Control team continue to provide targeted training on hand hygiene and have been monitoring compliance using the IPC Quality Boards.
The "Gloves Off" campaign has worked well and that work continues.

Infection control - Bed days lost (Acute)

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Bed closures	42	156	786	339	254	164	217	120	99	24	522	231	46



Bed closures decreased significantly from 231 in September to 46 in October.

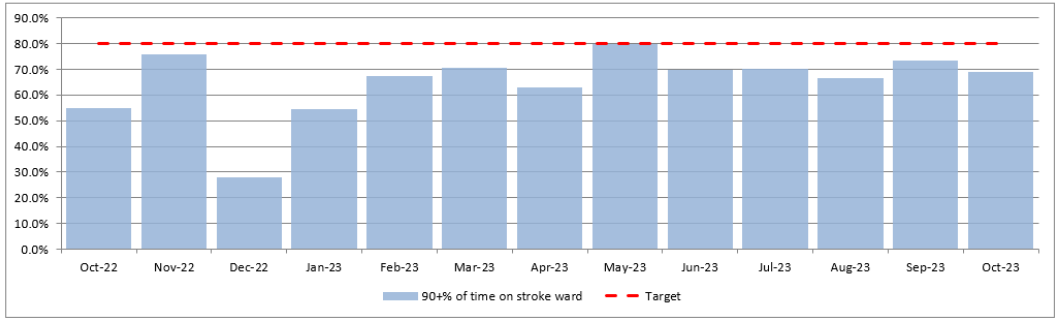
Bed closures have been due to a Vancomycin Resistant Enterococci (VRE) outbreak on one wards.
Further advice and guidance has been sent to all staff with regards COVID-19 advice retesting and precautions.

Quality and Safety exception report – stroke care

Torbay and South Devon NHS Foundation Trust

Stroke

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
90+% of time on stroke ward	55.0%	75.9%	28.0%	54.5%	67.4%	70.7%	63.0%	80.0%	70.0%	70.2%	66.7%	73.3%	68.8%
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%



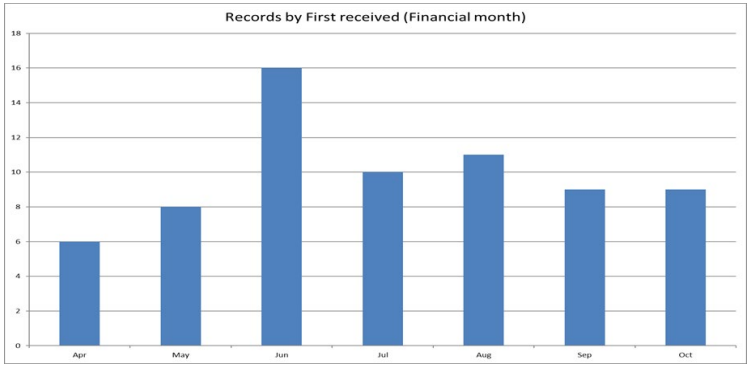
Time critical stroke standards

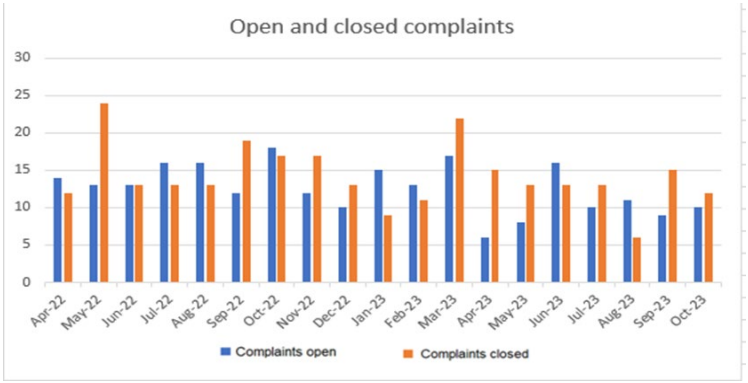
- 68.8% of patients spent more than 90% of their stay on the stroke unit which is a deteriorating position from Sept 2023;
- 31.7 % of patients were admitted to the Stroke Unit with 4 hours of admission; this metric is a comparable with last month;
- 45.2 of patients received a scan within one hour;
- 90.5% of patients received a scan within 12 hours which is a comparable position on last month
- 100% of patients received Lysis within one hour of admission which is a significant improvement on previous months.

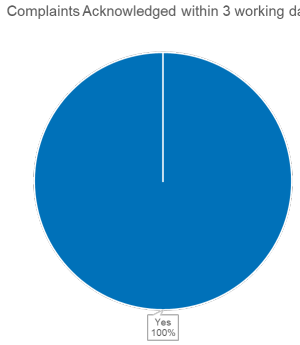
Stroke performance governance and oversight

SSNAP meetings are held at least monthly (operational pressures have impacted on ability to have bi-monthly). The most recent meeting in October led to very helpful discussions with ED and site team operational input. Clerking processes in ED are being reviewed. Recruitment is underway for an SSNAP Co-ordinator to support timely inputting of data. A daily focus on the 4-hour target to GE is being maintained with operational oversight.

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







The number of complaints received since 1st April 2023 to date stands at 69; this is lower than the same period last year by 32 complaints which equates a 31% decrease. The numbers received are consistently below the lower control limit (13) with an average of 11 a month, this has remained so since the beginning of 2023/24 financial year.

Concerns received in October decreased by 20% compared to September, from 147 in September to 118 in October.

The largest number of reported complaints and concerns within Q1 and Q2 of 23/24 relate to the surgical division. The top three themes are:

- Wait times
- Access to pathways
- Poor communication

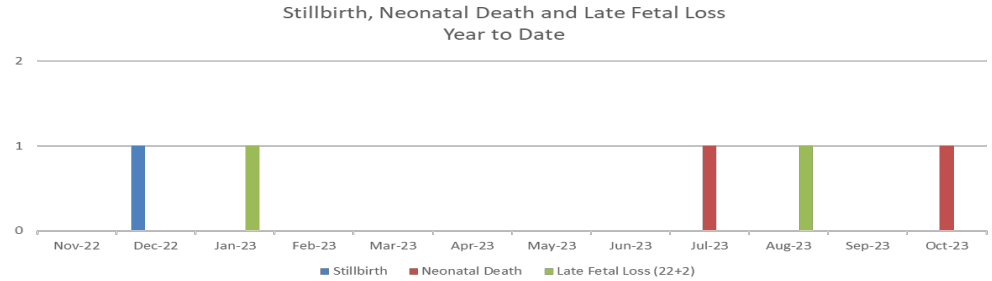
On a month-by-month basis, an average of 11 complaints received per month, and 14 complaints on average closed per month. Associate Director of Nursing Professional Practice colleagues have been working hard with their teams regarding closing of complaints and this is reflected in the last 8 months where 6 where there has been a greater number closed than received.

Within the 69 complaints received in the 2023/24 financial year, all are reported as being acknowledged within 3 working days.

Quality and Safety- Perinatal Clinical Quality Surveillance September 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

One neonatal death reported in October 23 – baby born with a known life limiting condition died at 13 hours of age.



	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Running Total
Number of new pregnancies (All CCG's)	208	170	177	177	213	180	169	202	210	183	176	215	**2280**
% of women booked for continuity of carer	52.2%	49.7%	61.0%	62.1%	64.8%	74.4%	75.7%	94.0%	96.2%	90.4%	76.9%	63.8%	71.8%
% of women booked from ethnic minorities groups & COC	90.0%	84.6%	83.3%	88.9%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.2%
% of women booked from low deprivation postcodes & COC	100.0%	94.7%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%
Number of Births (TOTAL)	163	137	156	115	155	138	144	144	146	136	141	164	1739
Number of Stillbirths	0	1	0	0	0	0	0	0	0	0	0	0	1
% Robson Group 1	22.9%	12.0%	19.4%	0.0%	26.9%	5.6%	17.6%	22.7%	6.7%	26.7%	11.5%	14.3%	15.5%
% Robson Group 2	36.4%	36.4%	42.9%	42.9%	18.5%	37.0%	22.2%	28.0%	23.1%	19.0%	40.9%	30.4%	31.5%
% Robson Group 5	90.5%	90.9%	88.9%	88.9%	87.5%	75.0%	76.5%	81.3%	88.9%	92.3%	94.4%	82.4%	86.5%
Total Inductions %	33.7%	34.3%	32.7%	29.6%	34.2%	35.5%	29.2%	25.0%	37.7%	38.2%	31.2%	32.3%	32.8%
% PPH >1500	2.5%	0.7%	3.8%	0.0%	1.9%	2.9%	2.1%	2.8%	4.1%	2.9%	5.0%	3.7%	2.7%
% 3rd and 4th degree tears (total)	6.6%	3.4%	3.1%	6.5%	9.1%	6.0%	6.2%	3.4%	3.0%	2.6%	2.5%	2.1%	4.5%
% 1-1 care in labour	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%
% Smoking at Delivery	6.1%	6.6%	7.1%	11.3%	7.1%	5.8%	6.3%	7.7%	4.8%	8.8%	6.4%	7.3%	7.1%
% Breastfeeding at Delivery	64.7%	63.0%	63.1%	71.8%	71.0%	67.1%	71.7%	69.9%	78.4%	67.6%	75.5%	74.9%	69.9%

Reporting from our new IT system reporting is slowly improving. Work is continuing to improve data quality but is very time intensive with the impact felt by the digital midwife who is restricted in her ability to perform other elements of her role. An area that needs a further quality review is the breastfeeding at delivery data as it is felt that there is missing data which is affecting the overall rate and stated rates must be taken with this caveat.

Workforce Status

The report provides an update on progress in delivering the Trust-wide workforce implications of the:
- operational plan
- local workforce factors impacting NOF4 exit criteria and mitigating actions and;
- an overview of Trustwide workforce KPI's

As part of the iterative process of on-going improvement subsequent reports will see a revised format for the overview of workforce metrics, which has been endorsed by the People Committee and 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	Oct 2023 **92** WTE over plan	• enhanced vacancy and scrutiny measures have been established
Bank WTE	Oct 2023 **3** WTE over plan	
Agency WTE	Oct 2023 **104** 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%)	Oct 2023 **5.24%**	• 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%)	Oct 2023 **5.13%**	
Achievement review rate (target 90%)	Oct 2023 **78.40%**	

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 **92 WTE** over plan in Oct 2023, worsening from the previously reported 63 WTE above plan in Sep.

- Areas 'Above plan' since Sep have been seen in Nursing and Midwifery staff group showing an increase of **5 WTE**, Medical and Dental staff group have increased by **9 WTE** with the greatest growth in Infrastructure by **64 WTE** (20 WTE increase from September), Management staff grew by 5.92 WTE (3.4%), Clerical workers grew by 11.88 WTE (2.64%) and Advisers grew by 6.41 WTE (2.09%)

- **Bank usage** has decreased by 20% since Sep, equating to 63.81 WTE and is **3 WTE** above plan.
- **Agency usage** has increased by 1.5%, since Sep equating to 3 WTE and is **104 WTE** over plan in October.

To mitigate these increases, and 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 and all requests received in recruitment are thoroughly checked ahead of this meeting. Decisions to support or decline requests are made in line with the latest guidance from ICB.

	Plan - As at the end of																	
	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	Sep 23 Actual	Plan Oct 23	Oct 23 Actual	Plan Nov 23	Plan Dec 23	Plan Jan 24	Plan Feb 24	Plan Mar 24
	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 WTE*	*Total WTE*
Total Workforce	6,498	6636.15	6,508	6662.09	6,520	6788.34	6,522	6707.55	6,531	6727.04	6530	6776.66	6,552	6752.49	6,579	6,609	6,619	6,622	6,644
Total Substantive	6,170	6188.10	6,170	6168.33	6,178	6196.22	6,180	6266.13	6,184	6213.48	6,190	6252.81	6,197	6289.51	6,199	6,212	6,222	6,225	6,241
Registered Nursing, Midwifery and Health Visiting Staff	1387.8	1382.73	1387.78	1381.35	1387.78	1384.89	1387.78	1379.20	1389.03	1390.10	1395.03	1409.20	1399.03	1414.47	1401.03	1411.74	1414.74	1417.62	1417.67
Registered/ Qualified Scientific, Therapeutic and Technical staff	962.48	966.84	962.48	964.18	962.48	967.02	962.48	974.39	962.48	975.10	962.48	984.47	962.48	987.58	962.48	962.48	962.48	962.48	972.87
Support to Clinical Staff	1443.3	1440.32	1443.25	1426.86	1443.25	1425.82	1443.25	1435.83	1443.25	1411.46	1443.25	1423.57	1443.25	1422.49	1443.25	1443.25	1443.25	1443.25	1440.05
NHS Infrastructure support	1789.3	1817.12	1789.33	1817.42	1789.33	1829.83	1789.33	1836.24	1789.33	1835.37	1789.33	1833.32	1789.33	1853.94	1789.33	1789.33	1793.18	1793.18	1801.95
Medical and Dental	579.7	573.68	579.70	571.10	587.60	574.65	589.60	633.05	592.60	594.17	592.60	594.97	595.60	604.75	595.60	597.60	600.60	600.76	600.76
Total Bank	237	282.02	243	289.44	247	362.58	246	273.16	251	337.19	249	318.07	251	254.26	270	281	280	282	281
Total Agency	91	166.03	95	204.32	95	229.54	96	168.26	96	176.37	91	205.78	104	208.73	110	116	117	115	122

Service Level – Workforce Implications affecting NOF4 exit

Torbay and South Devon NHS Foundation Trust

Referral to Treatment Time (RTT)

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 continue to be 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 filled. **Mitigating action:** A bespoke recruitment video has been developed to enhance marketing and attraction.
Urology	**Issue:** Continue to have 2 consultant vacancies being filled by locums. **Mitigating actions:** Developing a clinical model with Royal Devon for out of hours 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 team job planning and 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 2nd on-call rota during COVID which has impacted job plans and the delivery of elective capacity. There have been 3 SpR gaps on the general surgery rota over the last 2 years. **Mitigating actions:** Job plans are currently being signed off to increase elective activity. Locally Employed Doctors have been recruited to fill the SpR gaps and start in December. From December General Surgery will have zero agency usage for their Junior Doctor rotas.
Interventional Radiology	**Issue**: Since April 23, the 24/7 Interventional Radiology (IR) service has not been able to provide out of hours (OOH) cover due for Exeter and Torbay as there has been insufficient substantive IR Consultants in post. **Mitigation**: In July 2023 a 10-week trial, established by the Peninsular Acute Sustainability Programme, for a 24/7 IR on call service covering North Devon, Taunton, Yeovil, Torbay and Exeter. During the trial, the on-call service will be provided at a single centre, with patients transferred to Musgrove Park Hospital (MPH), Taunton for emergency IR treatment.
Operating Department Practitioners	**Issue:** Local and national shortage of Operating Department Practitioners (OPD), which is impacting on elective recovery and coverage of emergency obstetric theatre service out of hours. **Mitigation:** Active and on-going recruitment campaigns to support the filling of ODP vacancies, and the use of ODP agency has been approved on a temporary basis. A programme of international recruitment is 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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Performance
Month Sickness %	<4%	5.39%	6.54%	5.26%	4.59%	4.63%	5.07%	4.46%	4.88%	4.98%	4.96%	4.97%	5.24%	
12 Mth Rolling Sickness %	<4%	5.69%	5.76%	5.69%	5.58%	5.62%	4.96%	5.29%	5.32%	5.18%	5.19%	5.20%	5.13%	
Achievement Rate %	>90%	77.96%	76.70%	77.68%	76.71%	76.87%	77.87%	78.12%	78.08%	78.08%	79.92%	78.93%	78.40%	
Labour Turnover Rate	10-14%	13.74%	13.48%	13.33%	13.09%	12.85%	12.92%	12.74%	12.46%	12.71%	12.46%	12.16%	12.19%	
Overall Training %	>85%	89.10%	89.70%	89.94%	90.09%	90.45%	90.72%	91.24%	91.74%	91.49%	91.97%	91.59%	91.07%	
Nuring Staff Average % Day Fill Rate- Nurses		99%	92%	92%	91%	93%	92%	96%	100%	96%	98%	98%	101%	
Nuring Staff Average % Night Fill Rate- Nurses		86%	87%	88%	87%	88%	91%	90%	89%	90%	89%	90%	92%	
Safer Staffing- Overall CHPPD		7.75	7.54	7.72	7.83	7.75	7.9	8.05	7.99	8.4	8.17	8.08	8.02	

Sickness – The operational plan trajectories reflects revised KPI's for sickness absence based upon the previous 5 years trend data. We have seen an improvement in the 12 months ending Oct to **5.13%**, which is below our plan of 5.43% and lower than the same time last year (5.71%). Rolling sickness cost at the end of October was £11.6m which whilst lower than £12.2m in October 2022, represents a significant opportunity for improvement.

Turnover – October turnover is **12.19%**, against a plan of 12.99% and representing a slight increase from the previous month. Turnover is significantly lower that the same time last year (13.66%). Actions as part of the ICS Retention project are showing a positive impact e.g. stay interviews, legacy mentors, 5 high impact measures

Mandatory Training –There has been a steady upward trend in overall compliance over the last 12 months. Compliance has decreased slightly by 0.52% in October to **91.07%** against a target of 85%. However at a topic level we remain challenged in Manual Handling at **77.31%** and Information Governance at **86.74%**.

Achievement Review – Compliance has dropped by just under 0.53 % in October to **78.40%** 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 – Care hours per patient day (CHPPD) and planned versus actual

NHS Torbay and South Devon NHS Foundation Trust

CHPPD Monthly Summary

Ward	Planned Total CHPPD	Planned RN / RM CHPPD	Planned NA CHPPD	Planned HCA / MCA CHPPD	Actual Mean Monthly Total CHPPD	Actual Mean Monthly RN / RM CHPPD	Actual Mean Monthly NA CHPPD	Actual Mean Monthly HCA / MCA CHPPD	Total CHPPD days not met in month	RN / RM CHPPD days not met in month	NA CHPPD days not met in month	HCA/MCA CHPPD days not met in month	Total CHPPD % days not met in month	RN / RM CHPPD % days not met in month	NA CHPPD % days not met in month	HCA/MCA CHPPD % days not met in month	Carter Median CHPPD All (September 2016)	Carter Median CHPPD RN (September 2016)	Carter Median CHPPD NA (September 2016)	Carter Median CHPPD HCA (September 2016)
Ainslie	7.52	3.98	0.00	3.54	8.30	4.30	0.00	4.00	3	10	0	2	9.7%	32.3%	0.0%	6.5%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	7.60	4.10	0.00	3.50	12	31	0	0	38.7%	100.0%	0.0%	0.0%	7.74	4.74	0	2.91
Cheetham Hill	7.39	3.29	0.00	4.11	8.40	3.20	0.00	5.20	1	16	0	1	0.0%	9.7%	0.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.90	6.70	0.00	0.30	3	5	0	0	9.7%	16.1%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.75	3.68	0.00	2.07	7.80	4.10	0.00	3.70	0	1	0	0	0.0%	3.2%	0.0%	0.0%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.60	3.40	0.00	3.20	10	10	0	9	32.3%	32.3%	0.0%	29.0%	7.74	4.74	0	2.91
EAU4	8.63	4.79	0.00	3.83	8.60	4.40	0.00	4.30	18	23	0	3	58.1%	74.2%	0.0%	9.7%	7.74	4.74	0	2.91
Ella Rowcroft	8.63	4.31	0.00	4.31	9.90	4.50	0.00	5.40	2	11	0	1	6.5%	35.5%	0.0%	3.2%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	8.50	4.30	0.00	4.20	0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
George Earle	7.39	3.29	0.00	4.11	8.00	3.50	0.00	4.50	3	10	0	4	9.7%	32.3%	0.0%	12.9%	7.74	4.74	0	2.91
ICU	21.85	20.70	0.00	1.15	29.10	28.30	0.00	0.70	0	0	0	19	0.0%	0.0%	0.0%	61.3%	7.74	4.74	0	2.91
McCullum (Escalation)	6.76	2.71	0.00	4.06	7.00	3.10	0.00	3.90	9	0	0	14	29.0%	0.0%	0.0%	45.2%	7.74	4.74	0	2.91
Louisa Cary	8.63	6.71	0.00	1.92	10.30	7.10	0.00	3.20	3	10	0	0	0.0%	32.3%	0.0%	0.0%	7.74	4.74	0	2.91
John Macpherson	5.11	3.19	0.00	1.92	6.20	3.80	0.00	2.40	7	7	0	4	22.6%	22.6%	0.0%	12.9%	7.74	4.74	0	2.91
Midgley	7.96	3.98	0.00	3.98	8.60	4.80	0.00	3.80	4	0	0	17	12.9%	0.0%	0.0%	54.8%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	9.40	7.00	0.00	2.40	13	16	0	11	41.9%	51.6%	0.0%	35.5%	7.74	4.74	0	2.91
Simpson	7.39	3.29	0.00	4.11	8.80	3.70	0.00	5.10	0	3	0	0	0.0%	9.7%	0.0%	0.0%	7.74	4.74	0	2.91
Turner	9.58	3.83	0.00	5.75	9.90	4.30	0.00	5.60	10	2	0	14	32.3%	6.5%	0.0%	45.2%	7.74	4.74	0	2.91
New Forrest Ward	6.74	3.57	0.00	3.17	7.40	3.80	0.00	3.70	2	3	0	3	6.5%	9.7%	0.0%	9.7%	7.74	4.74	0	2.91
Brixham	6.95	2.50	0.70	3.75	6.40	2.70	0.00	3.70	25	9	31	13	80.6%	29.0%	100.0%	41.9%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	7.60	3.50	0.00	4.10	3	8	0	4	9.7%	25.8%	0.0%	12.9%	7.74	4.74	0	2.91
NA - Teign Ward	6.40	3.20	0.00	3.20	6.10	3.10	0.00	3.00	20	18	0	17	64.5%	58.1%	0.0%	54.8%	7.74	4.74	0	2.91
NA - Templar Ward	6.50	2.97	0.00	3.53	6.00	2.90	0.00	3.20	23	17	0	23	74.2%	54.8%	0.0%	74.2%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	6.30	2.80	0.00	3.50	18	22	0	17	58.1%	71.0%	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
	7.63	4.24	0.03	3.37	8.02	4.22	0.00	3.79
Total Planned Beds / Day	525							
Days in month	30							

The RN actual CHPPD has been reported as **4.22** in October but still remains below the carter recommendation of **4.7.**
The actual HCA CHPPD was **3.79** in October 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 October the Trust was operationally challenged with 13 days in OPEL 4 and 15 days at OPEL 3
The planned CHPPD total was reported as 7.63 with an actual of 8.02 which reflects an increase in escalation areas due to operational challenges.

Safer Staffing – planned versus actual

Torbay and South Devon NHS Foundation Trust

Oct-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	1725	1812	0	0	1725	1738	1380	1357	0	0	1035	1254	745	105.1%	0.0%	100.8%	98.3%	0.0%	121.1%
Allerton	2814	2502	0	0	1035	1665	1380	1162	0	0	1035	1422	892	88.9%	0.0%	160.8%	84.2%	0.0%	137.4%
Cheetham Hill	1725	1683	0	0	2070	2294	1035	1038	0	0	1380	2167	856	97.5%	0.0%	110.8%	100.3%	0.0%	157.0%
Coronary Care	1426	1365	0	0	0	104	1070	1074	0	0	0	0	366	95.7%	0.0%	0.0%	100.4%	0.0%	0.0%
Cromie	1679	2025	0	0	891	1486	1070	1067	0	0	713	1292	751	120.6%	0.0%	166.7%	99.7%	0.0%	181.2%
Dunlop	1426	1384	0	0	1248	1302	1070	1104	0	0	1070	1034	736	97.1%	0.0%	104.3%	103.2%	0.0%	96.7%
EAU4	1783	1774	0	0	1426	1660	1783	1484	0	0	1426	1501	743	99.5%	0.0%	116.4%	83.2%	0.0%	105.2%
Ella Rowcroft	1070	1118	0	0	1426	1452	1012	909	0	0	713	965	449	104.5%	0.0%	101.8%	89.8%	0.0%	135.3%
Warrington	1070	1350	0	0	713	1123	713	828	0	0	713	1020	506	126.2%	0.0%	157.5%	116.1%	0.0%	143.1%
George Earle	1783	1899	0	0	2139	2179	1070	1084	0	0	1426	1633	850	106.5%	0.0%	101.9%	101.4%	0.0%	114.5%
ICU	3209	2626	0	0	357	120	3209	2385	0	0	0	12	177	81.8%	0.0%	33.7%	74.3%	0.0%	0.0%
McCullum (Escalation)	713	904	0	0	1070	1003	713	726	0	0	1070	1008	519	126.8%	0.0%	93.8%	101.8%	0.0%	94.2%
Louisa Cary	2496	2402	0	0	713	852	2496	1770	0	0	713	1020	585	96.2%	0.0%	119.5%	70.9%	0.0%	143.0%
John Macpherson	1070	1018	0	0	713	696	713	652	0	0	357	359	442	95.2%	0.0%	97.7%	91.4%	0.0%	100.6%
Midgley	1783	2262	0	0	1783	1329	1426	1518	0	0	1426	1713	794	126.9%	0.0%	74.6%	106.4%	0.0%	120.1%
SCBU	1070	823	0	0	357	264	1070	756	0	0	357	276	226	76.9%	0.0%	74.1%	70.7%	0.0%	77.4%
Simpson	1783	2015	0	0	2139	2390	1070	1186	0	0	1426	1999	859	113.1%	0.0%	111.7%	110.8%	0.0%	140.2%
Turner	1426	1582	0	0	1783	1515	713	713	0	0	1426	1495	538	111.0%	0.0%	85.0%	100.0%	0.0%	104.8%
New Forrest Ward	1783	1928	0	0	1426	1644	1426	1446	0	0	1426	1640	897	108.2%	0.0%	115.3%	101.4%	0.0%	115.0%
Total (Acute)	*31829*	*32470.95*	*0*	*0*	*23011.5*	*24813.75*	*24414.5*	*22256.25*	*0*	*0*	*17710*	*21805.5*	*11931*	102.0%	0.0%	107.8%	91.2%	0.0%	123.1%
Brixham	868	944.75	434	0	1302	1286	682	695	0	0	1023	938.5	602	108.8%	0.0%	98.8%	101.9%	0.0%	91.7%
Dawlish	868	1027.25	0	0	1085	1084.25	744	748	0	0	682	957.5	502	118.3%	0.0%	99.9%	100.5%	0.0%	140.4%
NA - Teign Ward	1953	1825.75	0	0	1953	1654.5	1023	1009	0	0	1023	1110	915	93.5%	0.0%	84.7%	98.6%	0.0%	108.5%
NA - Templar Ward	1736	1584.5	0	0	2170	1901.5	1023	1023	0	0	1116	1000.25	911	91.3%	0.0%	87.6%	100.0%	0.0%	89.6%
Totnes	868	813.5	0	0	1302	1243.5	744	704.75	0	0	682	682.5	551	93.7%	0.0%	95.5%	94.7%	0.0%	100.1%
Organisational Summary	38122	38667	434	0	30824	31984	28631	26436	0	0	22236	26494	15412	101.4%	0.0%	103.8%	92.3%	0.0%	119.2%

The Registered Nurse fill rate for days during October was **101.4%** which is an increase in the September fill rate of **98.1%** and for night duty reported as **92.3%** which is an increase on the previous months fill rate of **90.1%**.

The fill rate for Health care support workers for days during October was **103.8%** which is consistent on September fill rate of 103.8%. For night duty reported as **119.2%** which is a slight increase on the previous months fill rate of **117.3%**
The increase in fill rate for Health Care support workers at night is to mitigate any risks associated with the registered nurse fill rate.

Community and Social Care Indicators - dashboard of key metrics

NHS Torbay and South Devon NHS Foundation Trust

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

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

NHS Torbay and South Devon NHS Foundation Trust

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

Cancer – 2 week wait from referral to date first seen – regional reporting		↓
Cancer – 28-day faster diagnosis standard		↓
Cancer - 31-day wait from decision to treat to treatment - national reporting		↓
Cancer - 62-day wait for treatment - national reporting		↓
Cancer - Patient waiting longer than 104 days from 2 week wait		↓
Referral to treatment - % Incomplete pathways less than 18 weeks		↑
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		↓
UEC - patients seen within 4 hours		↓
ED 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		↓
Diagnostic tests longer than the 6-week standard		↓
Dementia Find		↑
Care Planning Summaries % completed within 24 hours of discharge – Weekend		↓
Care Planning Summaries % completed within 24 hours of discharge – Weekday		↓
Clinic letters timeliness - % specialties within 4 working days		↓

NHS
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Monthly Financial Performance Report

M07 (Period Ended Oct-23)

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Torbay and South Devon NHS Foundation Trust


Executive Summary


Non-Pay Spend Category


YTD Expenditure by Care Group


ESRF Income Analysis


Bed Utilisation


CIP / Efficiencies


Cash Position


Capital Position


Balance Sheet

Executive Summary

Torbay and South Devon NHS Foundation Trust

Description	YTD Bud £000	YTD Act £000	Var £000	YTD R.A.G	F'cast Bud £000	F'cast Exp £000	Var £000	F'cast R.A.G
Operating Income	377,615	381,639	4,024		637,940	633,660	(4,280)	
Operating Expenditure and Financing Cost	(398,875)	(427,234)	(28,359)		(670,513)	(686,254)	(15,741)	
Surplus / (Deficit)	**(21,260)**	**(45,595)**	**(24,334)**		**(32,573)**	**(52,594)**	**20,021**	
Remove Donated Assets, Cost on Impairment	43	19,520	19,477		2	20,023	20,021	
Adjusted Surplus / (Deficit)	**(21,217)**	**(26,075)**	**(4,857)**		**(32,571)**	**(32,571)**	**0**	
Capital (CDEL)	28,060	21,820	(6,240)		56,754	30,836	25,918	
Cash & Cash Equivalents	15,365	17,146	1,790		14,975	21,075	6,100	

As at M07, the Trust reported an adverse variance to plan of **£4.587m**. This is primarily driven by the net impact of the ongoing Industrial Actions. **£1.975m** relates to the net cost implication and **£0.866m** for potential Elective Recovery Fund (ERF) clawback due to activity delivery being lower than planned. The remaining £1.7m YTD overspend mainly relates to pay and non-pay overspend partially offset by other income.

At M07, we are formally reporting a no variance to plan, however significant risk to this position had been reported previously with work currently underway to mitigate these risks.

YTD Position By Care Group

NHS Torbay and South Devon NHS Foundation Trust

The table below provides a snapshot of our YTD financial position at the end of M07 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	0.34	1.32	0.97		Pay Expenditure reflects a **£0.4m** adverse variance to plan, this primarily due to agency costs supporting waiting list work Non-Pay Expenditure reflects a **£2.6m** adverse variance to plan due to recharges of expenditure incurred and un-planned risk share. Income is reported as a **£3.5m** favourable variance to plan offsetting non pay and pay expenditure. CIP delivery of **£0.5m** has been processed relating to net surplus position reported in-year.
Families & Communities	(121.17)	(123.41)	(2.24)		The adverse variance to plan is driven by Non-Pay expenditure on ASC (volume and complexity) and Placed People (Torbay CHC - Dom Care and Nursing activity) packages of care of **£2.4m**. In addition, continued pressure on Child Health Pay Expenditure relating to Unachieved CIP & Medical costs - junior doctor strikes) and Community Hospitals (Unachieved CIP) of **£1.1m**. Other Divisions across the Care Group are reporting a favourable variance of **£1.3m** for additional achievement of CIP and vacancy slippages.
Medicine and Urgent Care	(43.56)	(50.44)	(6.87)		The adverse variance is due to the following: - - Unachieved CIP across all divisions in the Care Group **£2.3m**, - Ward pay pressures within the Care Group **£0.9m**, - Recovery areas that are still fully operational **£1.0m**, and - Medical cost pressures (includes Junior strikes and Locum spend) **£2.6m**.
Planned Care and Surgery	(83.65)	(82.55)	1.10		Favourable variance of **£1.1m**, includes Pay Expenditure (excluding CIP) eg Locum, Agency usage, this is offset with vacancies of **£0.7m**. Non-Pay favourable variance of **£0.5m** – is due to ESRF **£1.0m** less than planned activity earlier in the year, Theatres consumables, Clinical Engineering, Labs, offset with overspends in Radiology outsourcing of **£0.5m**. Drugs overspend **£0.2m**. Other income **£1.0m** surplus is for external funding received (offset mainly pay costs), CIP **£0.5m** additional delivery against plan.
Shared Corporate Services incl. Reserves & Other Income	226.82	229.00	2.17		Adverse variance includes **£0.8m** undelivered CIP, **£1.1m** Energy and other Estate related cost pressures, offset by **£3.1m** underspends against depreciation and interest income received, **£1.0m** net Reserves & Other Income
Total	**(21.22)**	**(26.07)**	**(4.86)**		

ERF Income and Activity Position

Torbay and South Devon NHS Foundation Trust

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	16,534	15,904	(630)	96%	14,183	14,634	450	103%
Electives	2,054	1,710	(344)	83%	8,676	6,471	(2,206)	75%
APC TOTAL	**18,588**	**17,614**	**(974)**	**95%**	**22,859**	**21,104**	**(1,755)**	**92%**
Firsts	50,138	51,851	1,713	103%	10,204	10,759	555	105%
First Procedures	10,910	12,820	1,910	118%	1,966	2,258	291	115%
Follow-Up Procedures	31,359	31,249	(110)	100%	4,602	4,714	112	102%
OPA TOTAL	**92,407**	**95,920**	**3,513**	**104%**	**16,772**	**17,730**	**958**	**106%**
Total ESRF Performance	**110,995**	**113,534**	**2,539**	**102%**	**39,222**	**38,726**	**(496)**	**99%**

The above shows the System target of 100% 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 100% taking into account its impact. The 19/20 baseline has been adjusted by 2.3% to reflect the increase to the tariff for the pay award, actuals have also been increased by 2.3% as this has now also been reflected in SUS.

Our YTD financial performance is reported at 99%.The reason for activity being at 102% and finance at 99% is due case mix.

Please note M1 to 5 are based on SUS freeze submission and M6 & M7 are at Flex Submission.

Bed Utilisation

Torbay and South Devon NHS Foundation Trust

Point of Delivery	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	Sep 23 Act	Oct23 Act
Occupied Beds DGH	10,810	10,590	10,939	11,221	9,992	11,195	10,576	11,044	10,625	10,600	10,715	10,542	11,126
Available Beds DGH	11,388	10,994	11,375	11,598	10,376	11,559	11,092	11,460	11,125	11,385	11,342	10,999	11,534
Occupancy	95%	96%	96%	97%	96%	97%	95%	96%	96%	93%	94%	96%	96%

In M07, the overall bed occupancy for Acute beds is **96%**. Occupancy below **95%** is considered a minimum to support timely patient flow.

The increase in overall bed occupancy over the last two months has coincided with challenges in patient flow impacting an increase in Handover delays in the Emergency Department and levels of escalation. The impact of managing infection control across wards has also contributed to the operational challenges of maintaining patient flow.

Improvement initiatives are being supported by the Transformation and Improvement team reporting through the Unscheduled Care Board meeting every 2 weeks. The winter plan describes actions to increase capacity for winter to meet the expected increase in demand for admission to a hospital bed.

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 September the Trust reported 7.4**%** of occupied beds as "No Criteria to Reside". This is against the plan to deliver 5% by March 2024.

CIP Programme 23/24 Pipeline

NHS
Torbay and South Devon
NHS Foundation Trust

The current 23/24 CIP programme includes 172 schemes, of which 134 schemes (78%) totalling **£34.7m** are assessed as Green and have been confirmed in the Plan.

Divisions and workstreams are working through 38 new ideas, of which 27 schemes have a high-level value of **£1.7m**.

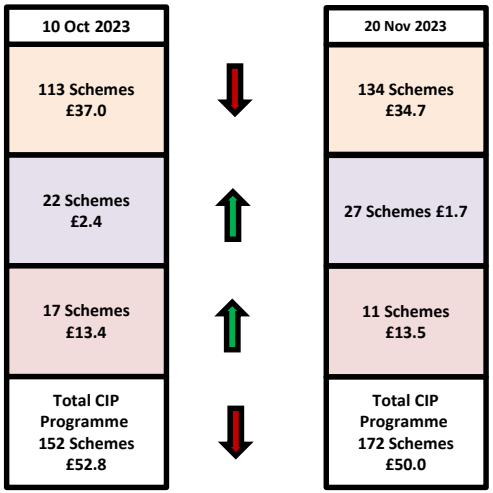
Scoping work continues to be developed whilst maintaining a balance with ensuring the delivery of existing schemes. Considerable focus must be placed on Amber and Red schemes to reach the in-year target.

Against the Strategic ICB Collaborative target totalling **£10.4m** we have **£0.2m** assessed as Green and **£5.7m** assessed as Red.

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 23/24 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 **£50m** (non-risk-adjusted value).

2023/24 Scheme Development (£m)



Cash Position

Torbay and South Devon NHS Foundation Trust

Description	Bud £000	Act £000	Var £000
Opening Cash Balance	**14,961**	**34,734**	**19,773**
Capital Expenditure (Accruals Basis)	(28,825)	(21,682)	7,143
Capital Loan/PDC Drawn Down	17,651	12,669	(4,982)
Capital Loan Repayment Principal	(1,459)	(1,459)	0
Proceeds on Disposal of Assets	0	1	1
Movement in Capital Creditor	0	(11,016)	(11,016)
Other Capital-related Elements	1,103	(965)	(2,068)
Sub Total – Capital Related Elements	**(11,530)**	**(22,451)**	**(10,921)**
Cash Generated From Operations	(1,588)	(9,871)	(8,282)
Revenue PDC Drawn Down	22,587	18,152	(4,435)
Working Capital Movements – Debtors	(1,337)	2,864	4,201
Working Capital movements – Creditors	(40)	(1,316)	(1,276)
Net Interest	(1,469)	(431)	1,037
PDC Dividend Paid	(4,106)	(3,839)	267
Other Movements	(2,122)	(697)	1,425
Sub Total - Other Elements	**11,925**	**4,863**	**(7,063)**
Closing Cash Balance	**15,356**	**17,146**	**1,790**

- 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.
- Our overall cash position at M7 is £1.79m ahead of plan.
- Access to capital and revenue PDC support remains absolutely critical to the Trust's cashflow. FY23/24 planned total capital and revenue PDC funding is originally £70.8m, however this have now been revised to £54.4m, this reflects the delaying in completing of the national funded programme e.g. EPR and NHP and sale of TP. TP sale concluded on the 16th November 2023, We will continue to revise this figure once confirmation has been received for the associated use of CDEL in year. Please refer to the supplementary Capital and Cash paper for further details.
- Capital-related cashflow is £10.9m adverse, largely due to pay down of the capital creditor £11.0m. The plan assumed that this would have happened at the end of the prior year. PDC capital drawdown £5.0m adverse and in year capital expenditure £7.1m fava rouble, due to delays in capital expenditure requirement.
- Cash generated from operations is £7.1m adverse due to the adverse operational elements within in the I&E position. Revenue PDC drawdown £4.4m behind planned value, with £1.2m has been received in October 23.
- Debtor is £4.4m favourable, which is principally due to the 22/23 pay award £12.1m, partly offset with an increase in ASC debtors £3.1m, Local authority £3.9m and other centrally funded items.
- Creditor is £1.3m adverse. This principally due to the favourable debtor movement for the 22/23 pay award £12.1m, partly offset with payroll creditors and provider to provider recharges as highlighted on the balance sheet.

Balance Sheet

	YTD Bud £000	YTD Act £000	YTD Var £000
Intangible Assets	12,847	13,630	783
Property, Plant & Equipment	261,615	213,248	(48,367)
On-Balance Sheet PFI	17,125	19,997	2,872
Right of Use assets	20,568	19,466	(1,102)
Other	1,843	1,623	(220)
Non-Current Assets Total	**313,998**	**267,964**	**(46,034)**
Cash & Cash Equivalents	15,356	17,147	1,791
Other Current Assets	41,998	68,678	26,680
Current Assets Total	**57,354**	**85,824**	**28,470**
Total Assets	**371,352**	**353,788**	**(17,564)**
Loan - DHSC ITFF	(2,917)	(2,918)	(1)
PFI and Leases	(4,076)	(4,536)	(460)
Trade and Other Payables	(53,503)	(64,063)	(10,560)
Other Current Liabilities	(5,267)	(14,840)	(9,573)
Current Liabilities Total	**(65,763)**	**(86,356)**	**(20,593)**
Net Current Assets/(liabilities)	**(8,409)**	**(532)**	**7,877**
Loan - DHSC ITFF	(20,833)	(20,832)	1
PFI and Leases	(31,596)	(30,824)	772
Other Non-Current Liabilities	(4,615)	(4,656)	(41)
Non-Current Liabilities Total	**(57,044)**	**(56,311)**	**733**
Total Assets Employed (Assets + Liabilities)	**248,545**	**211,121**	**(37,424)**
Reserves			
Public Dividend Capital	233,562	226,436	(7,126)
Revaluation	61,351	60,112	(1,239)
Income and Expenditure	(46,368)	(75,427)	(29,059)
Total	**248,545**	**211,121**	**(37,424)**

- Non-Current Assets are **£46.0m** lower than plan. This is largely due to a revenue impairment **£19.1m** and reclassification of an asset held for sale **£17.0m** to current assets. In addition a FY22/23 property revaluation was lower than planned **£4.7m** and year to date capital expenditure **£6.2m** behind plan. This is partly offset by reduced depreciation **£2.1m** due to delays in bringing assets into service.
- Cash & Cash Equivalents is **£1.8m higher** than plan, as explained in the commentary to the Cash Flow Statement.
- Other Current Assets are **£26.7m** higher than planned. This is mainly due to the assets held for sale **£18.1m,** ASC debtors **£3.1m** and accrued income **£3.6m** higher than planned
- Trade and Other Payables are **£10.6m** higher than plan. Principally this value is due to **£5.6m** provider to provider recharges such as CFHD, **£4.0m** general provisions including placed people and **£1.2m** payroll creditors. There has been a reduction in capital creditor of **£0.6m,** which is consistent with the year to date capital expenditure.
- Other Current Liabilities are **£9.6m** higher than planned, mainly due to income received ahead of time and being deferred to match expenditure.
- PDC reserves are **£7.1m** lower than planned, due to Revenue PDC and Capital PDC support being drawn down later than planned.
- The Income and Expenditure reserve is **£29.1m** lower than plan principally due to below-the-line asset impairment in 23/24 **£19.1m** and an impairment processed late in FY22/23, in addition to the below the line revenue deficit to plan position at **£4.9m**

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	4.7	4.0	4.0	4.0	4.0	21.1
Digital EPR - Trust Funded Element	0.0	6.0	2.0	0.3	0.3	15.4
Estates Backlog Maintenance	6.2	4.0	4.0	4.0	4.0	21.1
Approved Estates Development Schemes	5.9	0.0	0.0	0.0	0.0	2.6
Medical Equipment	3.0	3.0	3.0	3.0	3.0	15.0
Torbay Pharmaceuticals	2.0	0.0	0.0	0.0	0.0	2.3
Purchase of Dawlish Hospital	0.0	2.0	0.0	0.0	0.0	2.0
Other - Services Developments - TBC	1.8	1.0	7.0	8.7	8.7	24.1
Prior Year Schemes	0.0	0.0	0.0	0.0	0.0	(0.1)
Sale of Assets	(19.2)	0.0	0.0	0.0	0.0	(1.4)
Net ICB CDEL Total (v)	**4.4**	**20.0**	**20.0**	**20.0**	**20.0**	**102.1**
Source of Funds						
Revenue Surplus	0.0	0.0	0.0	0.0	0.0	0.0
Depreciation / Amortisation	19.3	25.9	26.9	28.9	30.9	136.2
Repayment of ITFF Loan Funding	(6.7)	(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	**11.7**	**18.2**	**20.0**	**21.9**	**23.8**	**99.6**
PDC Support Required	(7.3)	1.8	0.0	(1.9)	(3.8)	2.5
Grand Total	**4.4**	**20.0**	**20.0**	**20.0**	**20.0**	**102.1**

Torbay and South Devon NHS Foundation Trust

- M07 YTD expenditure is £21.8m against a Planned value of £28.0m
- We formally reported a full year forecast of £48.3m to NHSE, however this was prior to the disposal of TP CDEL assets totalling £17.0m. The below numbers have been adjusted to reflect this CDEL credit.

	Captial Exp M06 F'cast £'000	F'cast M07 £'000	Movement M07 £'000	YTD M07 £'000
ICB CDEL	21,409	21,409	0	8,813
ICB CDEL Asset Disposal	0	-17,021	-17,021	0
National CDEL	23,648	23,648	0	13,008
IFRS 16 CDEL	2,800	2,800	0	0
Total	**47,857**	**30,836**	**-17,021**	**21,821**
Other - Charitable Funds and PFI	479	489	10	230
Grand Total	**48,336**	**31,325**	**-17,011**	**22,051**

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - October 2023

	ISU	Target	13 month trend	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		0	0	2	3	1	2	1	1	1	4	1	1	3	12
Reported Incidents - Death	Trustwide	<1		1	0	0	4	0	1	0	1	1	0	2	0	0	4
Medication errors resulting in moderate harm	Trustwide	<1		0	1	0	0	0	0	0	1	2	2	2	0	0	7
Medication errors - Total reported incidents	Trustwide	N/A		36	44	48	47	44	62	68	72	76	70	74	58	53	471
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		3	1	2	0	3	1	0	0	1	0	0	0		1
Never Events	Trustwide	<1		1	0	0	0	2	0	0	0	0	0	0	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		3	0	6	13	3	13	5	7	8	11	7	7	5	50
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	1	0	0	2	1	2	1	0	0	1	7
Formal complaints - Number received	Trustwide	20		16	11	10	14	12	12	5	7	6	8	8	7	9	50
VTE - Risk Assessment on Admission (acute)	Trustwide	>95%		94.7%	94.4%	94.0%	95.5%	95.9%	96.5%	96.3%	95.4%	96.5%	96.0%	94.5%	95.2%	95.8%	95.6%
Hospital standardised mortality rate (HSMR) (4 months in arrears)	Trustwide	<100		110	108.9	108.7	106.8	104.2	101.9	99.9	98.1	98.1					98.1
Safer staffing - ICO - Day time	Trustwide	90% - 110%		99.1%	99.4%	91.6%	92.1%	91.3%	93.1%	92.4%	96.0%	100.1%	96.0%	97.6%	98.1%	101.4%	101.4%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		88.8%	86.4%	87.4%	87.9%	87.0%	88.4%	91.3%	90.0%	89.0%	90.0%	88.7%	90.1%	92.3%	92.3%
Infection Control - Bed Closures - (Acute bed days in month)	Trustwide	<100		42	156	786	339	254	164	217	120	99	24	522	231	46	1259
Hand Hygiene	Trustwide	>95%		94.9%	96.2%	91.2%	94.0%	92.1%	91.3%	92.5%	92.9%	91.3%	87.7%	92.6%	87.9%	92.9%	91.3%
Number of Clostridium Difficile cases (COHA+HOHA)	Trustwide	<3		3	2	1	8	2	2	4	7	7	4	4	6	8	18
CDiff - Hospital Onset Healthcare Associated (HOHA)	Trustwide			2	0	1	7	1	1	3	4	4	2	0	5	7	25
CDiff - Community Onset Healthcare Associated (COHA)	Trustwide			1	2	0	1	1	1	1	3	3	2	4	1	1	15
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		54.3%	43.3%	41.5%	40.0%	53.8%	58.3%	58.0%	57.1%	40.0%	38.7%	58.3%	53.8%	54.5%	54.5%
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		55.0%	75.9%	28.0%	54.5%	67.4%	70.7%	63.0%	80.0%	70.0%	70.2%	66.7%	73.3%	68.8%	
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		20806	20257	21452	20030	20048	19979	19618	19609	18738	18842	19582	20140	19265	19265
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.7%	5.6%	5.6%	4.7%	5.7%	5.6%	5.0%	5.3%	5.3%	5.2%	5.2%	5.2%	5.1%	5.2%
Appraisal Completeness	Trustwide	>90%		76.6%	77.6%	76.7%	77.7%	76.7%	76.9%	77.9%	78.1%	78.1%	78.1%	79.9%	78.9%	78.4%	78.4%
Mandatory Training Compliance	Trustwide	>85%		88.6%	89.1%	89.7%	89.9%	90.1%	90.4%	90.7%	91.2%	91.7%	91.5%	91.8%	91.6%	91.0%	91.0%
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		13.7%	13.7%	13.5%	13.3%	13.1%	12.8%	12.9%	12.7%	12.5%	12.7%	12.5%	12.2%	12.2%	12.2%

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - October 2023

	ISU	Target	13 month trend	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Year to date
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%				6.5%			6.5%			5.5%					
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		751	735	756	755	781	814	784	804	817	823	852		834	
Intermediate Care - No. urgent referrals	Trustwide	NONE SET		277	297	299	318	307	298	288	322	325	308	312	335	327	1555
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		193	203	208	198	200	251	224	218	225	278	226	199	239	1609
Urgent Community Reponse (2-hour) - Referrals	Trustwide	NONE SET		26	27	40	34	34	30	26	34	36	37	45	45	30	349
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	70%		100.0%	74.1%	77.5%	79.4%	94.1%	90.0%	92.3%	88.2%	88.9%	97.3%	95.6%	88.9%	90.0%	81.7%
Urgent Community Reponse (2-48 hour)- Referrals	Trustwide	NONE SET				182	177	171	160	138	162	151	124	126	127	129	1064
Urgent Community Reponse (2-48 hour) - Target achievement	Trustwide	NONE SET				84.6%	92.7%	83.3%	86.3%	86.2%	85.8%	85.4%	85.5%	88.1%	85.8%	87.6%	83.1%
ADULT SOCIAL CARE TORBAY KPIs																	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		27.2	29.9	32.6	32.6	28.5	29.9	32.6	27.2	24.5	27.2	16.3	24.5	32.6	16.3
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		861.5	901.9	915.4	840	802.3	826.5	805	748.5	729.6	729.6	735	740.4	775.4	735.0
Proportion of clients receiving direct payments	Trustwide	25%		20.3%	20.2%	20.3%	20.0%	20.2%	19.5%	20.1%	20.1%	20.0%	20.6%	21.1%	20.7%	20.7%	21.1%
% reablement episodes not followed by long term SC support	Trustwide	83%		86.0%	85.5%	85.4%	86.6%	86.4%	86.4%	85.3%	88.3%	88.9%	87.7%	87.9%	88.3%	88.6%	87.9%

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	ISU	Target	13 month trend	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Cancer - Two week wait from referral to date 1st seen - regional reporting	Trustwide	>93%		63.8%	58.4%	67.4%	76.3%	82.6%	76.0%	55.9%	74.1%	76.3%	68.6%	69.5%	70.7%	67.3%	67.3%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	Trustwide	>93%		87.7%	82.8%	100.0%	93.5%	97.6%	88.9%	87.9%	76.7%	69.6%	61.5%	83.6%	100.0%	n/a	
Cancer - 28 day faster diagnosis standard - national reporting	Trustwide	75%		74.2%	67.3%	71.7%	67.5%	77.3%	76.3%	75.5%	78.0%	77.7%	79.6%	75.6%	75.1%	73.4%	73.4%
Cancer - 31-day wait from decision to treat to treatment - national reporting	Trustwide	>96%		96.5%	93.0%	98.1%	93.9%	98.4%	95.7%	94.8%	95.1%	93.2%	95.3%	97.5%	94.4%	92.5%	92.5%
Cancer - 31-day wait for second or subsequent treatment - Drug	Trustwide	>98%		100.0%	90.4%	98.6%	100.0%	100.0%	100.0%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	Trustwide	>94%		94.4%	98.0%	100.0%	85.7%	100.0%	86.9%	100.0%	96.9%	80.8%	85.5%	93.3%	91.1%	n/a	
Cancer - 31-day wait for second or subsequent treatment - Surgery	Trustwide	>94%		89.7%	86.8%	89.7%	80.0%	96.2%	83.3%	88.5%	87.5%	89.7%	88.9%	92.3%	100.0%	n/a	
Cancer - 62-day wait for treatment - national reporting	Trustwide	>85%		67.5%	58.9%	68.5%	51.1%	52.5%	60.8%	69.5%	61.5%	67.0%	68.4%	77.9%	73.3%	64.6%	64.6%
Cancer - 62-day wait for first treatment - screening	Trustwide	>90%		100.0%	81.0%	76.9%	100.0%	100.0%	72.7%	100.0%	100.0%	77.4%	80.0%	57.1%	33.3%	n/a	
Cancer - Patient waiting longer than 104 days from 2ww - regional reporting	Trustwide	20		71	62	69	68	53	24	20	11	7	10	11	14	21	21
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		45.5%	45.5%	43.3%	43.9%	44.3%	48.1%	49.7%	49.8%	51.2%	53.1%	52.0%	54.1%	54.8%	54.8%
RTT 65 week wait incomplete pathway	Trustwide	1091		2485	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1161	1018	1018
RTT 78 week wait incomplete pathway	Trustwide	178		829	822	923	708	462	183	166	167	123	129	156	187	155	155
RTT 104 week wait incomplete pathway	Trustwide	0		47	34	29	22	14	0	0	0	0	0	0	0	0	0
On the day cancellations for elective operations	Trustwide	<0.8%		1.7%	1.5%	2.1%	1.4%	1.5%	1.5%	0.8%	1.4%	1.8%	1.4%	1.6%	1.7%	2.1%	1.6%
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		7	15	6	11	10	7	7	10	14	13	23	37	13	117
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		n/a	16.6%	16.1%	16.5%	15.3%	14.6%	15.8%	15.2%	15.0%	15.3%	15.9%	15.4%	15.3%	
Bed Occupancy	Acute	90.0%		92.3%	95.2%	94.9%	96.3%	96.2%	96.3%	95.3%	96.4%	95.5%	93.1%	94.0%	96.0%	96.5%	95.1%
Percentage of inpatients with No Criteria to Reside (acute)	Trustwide	<5%						12.0%	8.1%	7.6%	6.0%	7.0%	6.0%	7.5%	7.4%	8.3%	
% patient discharges pre-noon	Acute	33%								18.9%	18.9%	19.9%	20.5%	21.6%	21.5%	20.3%	
% patient discharges pre-5pm	Acute	75%								69.8%	66.7%	67.7%	67.9%	70.6%	70.9%	69.4%	
Number of patients >7 days LoS (daily average)	Trustwide			177.0	162.0	172.6	183.5	166.1	167.0	154.2	159.8	156.2	129.9	156.0	159.8	169.4	155.0
Number of extended stay patients >21 days (daily average)	Trustwide			49.8	32.0	42.3	57.1	40.7	38.6	39.3	33.2	35.2	30.6	35.9	38.3	49.6	37.4

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	ISU	Target	13 month trend	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Year to date
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide			1208	1112	1232	865	534	1043	598	1025	1002	936	1098	1346	1508	7513
Ambulance handover delays > 60 minutes	Trustwide	0		933	787	983	623	263	687	277	595	615	490	629	907	1070	4583
UEC - patients seen within 4 hours (23/24 plan target 76%)	Trustwide	76%		57.0%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68.4%	66.6%	66.6%
ED - patients with >12 hour visit time pathway	Trustwide			988	939	1207	823	599	977	568	893	797	637	794	686	822	5197
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute				39%	31%	46%	44%	41%	52%	53%	55%	59%	61%	71%	68%	68%
Clinically Ready to Proceed delay over 1 hour - Emergency Department	Acute								44%	41%	40%	29%	26%	28%	29%	29%	29%
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute				05:14	06:05	05:02	04:53	05:08	04:24	04:42	04:22	04:17	04:03	03:59	04:15	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute				13:14	16:05	13:42	10:06	12:47	09:10	11:15	10:55	08:47	11:19	09:53	10:58	
Diagnostic tests longer than the 6 week standard	Trustwide	15%		32.4%	30.1%	29.0%	34.0%	26.1%	29.7%	29.8%	27.7%	24.3%	25.5%	29.1%	31.5%	32.9%	32.9%
Dementia - Find - monthly report	Trustwide	>90%		87.2%	93.0%	91.6%	87.9%	84.5%	87.1%	83.6%	90.7%	85.2%	86.1%	87.8%	81.7%	94.2%	94.2%
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%			n/a		72.3%		58.1%	65.0%	61.5%	71.7%	70.3%	73.0%	78.3%	72.6%	70.4%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%			n/a		48.1%		39.4%	49.1%	55.5%	52.7%	58.5%	46.2%	62.4%	59.0%	54.9%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		60.0%	62.0%	68.0%	73.9%	69.2%	62.8%	67.7%	64.4%	63.7%	61.9%	71.6%	73.9%	73.1%	

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	ISU	Target	13 month trend	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-7140	-10433	-13434	-16118	-19884	-21358	-394	-342	-761	-1254	-3116	-5341	-8279	
Agency - Variance to NHSI cap	Trustwide			-1.90%	1.90%	-1.80%	-1.80%	-1.90%	-1.90%								
Agency - Spend in month against budget value	Trustwide										55.00%	-22.78%	141.06%	155.12%	159.29%	162.70%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide			-4872	-5005	-5874	-5328	-5512	-3390	-449	17	2478	2486	2529	2529	464	
Capital spend - Variance from PBR Plan - cumulative (£'000's)	Trustwide			1988	2787	3280	4076	944	-18162	-993	3619	1616	-515	1517	3267	6240	
Distance from NHSI Control total (£'000's)	Trustwide			-5022	-7421	-9995	-12182	-15796	-17186	22	307	300	300	-1293	2389	-4861	
ACTIVITY VARIANCE vs 2019/20 BASELINE* (* March 2023 compared to March 2022)																	
Outpatients - New	Trustwide			-11.7%	3.6%	-2.0%	-5.2%	-0.6%	16.1%	-10.0%	7.7%	11.2%	-5.6%	7.0%	14.8%	11.1%	5.0%
Outpatients - Follow ups	Trustwide			-10.1%	4.4%	-4.1%	-6.9%	-2.4%	9.0%	-8.0%	5.7%	9.0%	-3.0%	7.2%	-1.2%	-5.8%	1.0%
Daycase	Trustwide			-4.6%	-3.0%	-5.5%	-1.7%	5.1%	21.7%	-12.8%	-5.5%	8.4%	-4.0%	-2.0%	3.1%	-7.2%	-2.8%
Inpatients	Trustwide			-16.3%	-19.5%	-21.4%	-18.1%	-16.4%	42.0%	-16.2%	-1.3%	-1.4%	-20.8%	0.7%	-0.4%	-23.7%	-10.5%
Non elective	Trustwide			-7.0%	-12.7%	-18.1%	-5.7%	-11.2%	-0.2%	-7.1%	-8.9%	0.4%	0.4%	12.3%	9.1%	2.1%	0.7%
INTEGRATED CARE MODEL																	
Intermediate Care Referrals (All)	Trustwide			0	0	0	0	0	0	#N/A	#N/A	#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	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	

Report to the Trust Board of Directors			
Report title: Care Quality Commission Well Led Inspection Action Plan Report			Meeting date: 29th November 2023
Report appendix:	Appendix 1: Must Do and Should Do Actions		
Report sponsor:	Chief Nurse		
Report author:	Deputy Chief Nurse Care Quality Commission Quality & Compliance Manager		
Report provenance:	Care Quality Commission Assurance Group		
Description/Purpose of the report and key issues for consideration/decision:	The aim of the report is to update the Board on the CQC action plan for the Must Do and Should Do requirements within the CQC report following the Well Led Inspection The actions once approved will be shared with the CQC at our Quarterly Engagement meetings.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	1. Receive and note the report including the Must Dos and Should Do actions. 2. Acknowledge the approach to oversight and governance of the action plan including timely review of evidence and achievement of actions.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	The CQC is the independent regulator of health and social care in England. It ensures health and social care services are safe, of a high-quality, effective, compassionate, and meet legal standards. The action plan, through its delivery, will enhance the safety & quality of the individual services we provide.		
How does the report support the Triple Aim:	The Well-led assessment reviewed the organisational culture, strategy, values, and governance of the Trust, and the action plan report supports all elements of the Triple aim, through the enhancement and assurance of providing services that are safe and of high quality, that are engaging with others to deliver the best care possible. 1) Population health and wellbeing 2) Quality of services provided 3) Sustainable and efficient use of resources		
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 4 - Estates Objective 5 - Operations and Performance Standards Objective 6 - Digital and Cyber Resilience Objective 7 - Building a Brighter Future Objective 8 - Transformation and Partnerships Objective 9 - Integrated Care System Objective 11 – Equality, Diversity and Inclusion		

Risk: Risk ID:	ID 3567 Failure to Comply with Regulation 12: Safe Care and Treatment under the Health and Social Care Act.
External standards affected by this report and associated risks	Care Quality Commission National Oversight Framework NHS People Promise and Plan

Report title: Care Quality Commission Well Led Draft Inspection Report		**Meeting date: 27th November 2023**
Report sponsor	Chief Nurse	
Report author	Deputy Chief Nurse CQC Quality & Compliance Manager	

1 Introduction

CQC 2023 Well Led Inspection

Following final factual accuracy checks, the CQC report was released on the 3rd November 2023.

The overall organisation rating has moved from Good to Requires Improvement. The organisation was rated as Requires Improvement in four of the five domains (Safe, Effective, Responsive and Well-Led). The rating of Outstanding for Caring was maintained.

Given the current system financial and operational performance challenges the overall assessment of the organisation is one that is recognised by the Board as a fair and honest reflection of the organisation and reflects the known challenges and strengths.

Many areas identified for development in the report were part of the current improvement programme already underway.

Ratings

Subsequent ratings for the individual service inspections were as follows:

- Medical care – rated as Requires Improvement. Safe and Effective remained as Requires Improvement. Responsive and Well-Led were inspected but not rated. Caring was not inspected.
- Emergency Department – rated as Requires Improvement. Safe improved from Inadequate (when inspected in July 2020) to Requires Improvement. Well-led improved from Requires Improvement to Good. Effective, Caring and Responsive were inspected but not rated.
- Diagnostics and imaging – rated overall as Requires Improvement. Safe and Well-Led were rated as Requires Improvement, Caring and Responsive were rated as Good. Effective was inspected but not rated.
- Outpatients – rated as Requires Improvement (previous rated as good in May 2018). Safe was rated as Inadequate and Responsive was rated as Requires Improvement. Caring and Well-Led were inspected not rated. Effective was not inspected.

2 Actions Required and Themes

Following the inspection, the Trust received 15 Must Do enforcement actions and 36 Should Do actions across the 5 areas inspected. For comparison, in 2020, the Trust received 28 Must Do and 43 Should Do notices. For a full list of the 2023 Must Do and Should Do actions please see **Appendix 1**

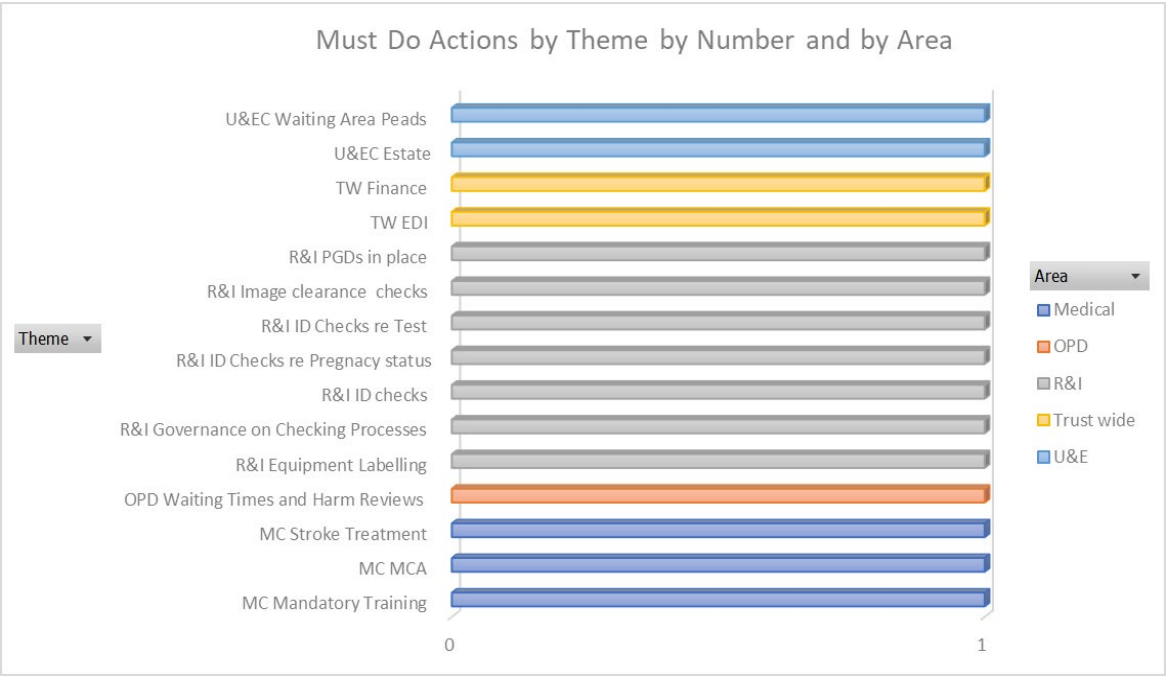
These actions are recorded below in their respective core service area and by number of actions.

CQC Core Service	No. of Actions	
	Must Do	Should Do
Trustwide	2	7
Urgent and Emergency	2	6
Medical Care	3	6
OPD	1	10
Diagnostics Imaging	7	7
TOTAL	**15**	**36**

The CQC have used 4 key regulations to frame their 15 enforcement notices and the below table highlights this, as well as by the Core Service.

Regulations Breached	No	Trustwide	Radiology	U&EC	Medical	OPD
Reg 17 Good Governance	3	2	1			
Reg 15 Premises & Equipment	2			2		
Reg 13 Safeguarding	1				1	
Reg 12 Safe Care & Treatment	9		6		2	1

The themes from the notices are outlined as below by core service.



Thematic analysis highlights several singular issues across the core services inspected. The Trust wide requirements concerning Finance and the Equality Diversity and Inclusion (EDI) agenda may appear as singular actions but are complex, multifaceted, and affect every aspect of the organisation. Therefore, the oversight and governance of these action plans will be monitored through the People Committee and the Finance and Performance Committee, but provide evidence and actions into CQCCAG.

The Chief Finance Officer and Chief People Officer are the lead Executives on these actions.

Urgent and Emergency Care (U&EC) have a departmental wide Estates action to review cross infection and general repair and to decrease overcrowding all of which are in the Building a Brighter Future project.

The second U&EC action has been completed. This was to create a separate waiting and treatment area for paediatrics which is now in place.

In Radiology and Imaging (R&I), of the 7 Must do actions, 5 are related to checks for;

- pregnancy status,
- patients ID,
- correct investigation,
- pervious images are viewed,
- governance oversight on room checks IPC checks etc.

The remaining two actions are:

- correct labelling of MRI equipment
- having PDGs in place

Medical Care have actions to

- Ensure all mandatory training is at the required completion rate,
- Mental Capacity Assessments are fully completed.
- Stroke treatment meets the national standards and guidelines.

Outpatients Department have 1 action, which is:

- to continue to reduce waiting times to treatment and ensure those waiting are continually risk assessed so they don't come to harm

The CQC Quality Assurance Group will maintain the monthly oversight and check and challenge to the action owners, as well as reporting by exception to the Quality Assurance Committee and Board of Directors.

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3. Action Plan Oversight and Assurance

An action plan will be completed by each area and Care Group to deliver the Must and Should Do requirements. The plan has named leads and executive leads and clear governance routes for review and escalation.

The Action Plan will be updated to the Quality Assurance Committee on a Quarterly basis or via exception and will be reviewed monthly with the key Leads at the monthly CQC Quality Assurance Committee

Where actions are Trust wide e.g., Finance and EDI these will be presented to the Finance and Performance Committee and People Committee and presented to the CQCCAG for assurance.

A monthly update will also be given via the Integrated Performance Report to the Board.

Once the Action Plan is nearing completion, a formal process of review on the closure evidence will be formulated with Internal Audit, Executive and Action Leads. This independent review will officially close the actions or prescribe further interventions that are needed to close the action.

4 Conclusion

This report has provided an update to the Board on TSDFT's recent CQC Well - Led inspection and resultant actions and action plan.

5 Recommendations

The Committee is asked to:

1. Receive and note the report including the Must Dos and Should Do actions.
2. Acknowledge the approach to oversight and governance of the action plan including timely review of evidence and achievement of actions.

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Must Do Enforcement Actions			Regulation Breached		Brief Description
Trust wide (2)	1	The organisation to have a stable financial position and systems and processes continue to ensure financial pressures are managed so they do not compromise the quality of care.	**Regulation 17(1)(2)(a)**	Good Governance	1 - Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part 2a assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);
	2	There must be an increased focus on equality, diversity, and inclusion to address the increase in bullying and harassment across the organisation. The trust must set a clear strategy, improve the effectiveness of the equality business forum and staff networks, ensure clear policies and procedures, support reasonable adjustments, and consider the resources to support this work.	**Regulation 17(2)(b)**	Good Governance	Assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;
Diagnostic Imaging (7)	3	Make sure all existing and new specialist equipment for use in MRI is clearly labelled as safe to enter the scan room.	**Regulation 12(2)(e)**	Safe Care & Treatment	ensuring that the equipment used by the service · Providers must ensure the safety of their premises and the equipment within it. They should have systems and processes that assure compliance with statutory requirements, national guidance, and safety alerts. · Providers retain legal responsibility under these regulations when they delegate responsibility through contracts or legal agreements to a third party, independent suppliers, professionals, supply chains or contractors. They must therefore make sure that these regulations are adhered to as responsibility for any shortfall rests with the provider.
	4	Make sure patient identity checks consistently take place.	**Regulation 12(2)(a)(b)**	Safe Care & Treatment	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
	5	Make sure all eligible patients have their pregnancy status determined in line with legal requirements.	**Regulation 12(2)(a)(b)**	Safe Care & Treatment	Guidance for providers on meeting the regulations 44
	6	Ensure previous images and information are reviewed when vetting imaging are requested, to ensure scans are carried out on the intended patients and at the intended time	**Regulation 12(2)(a)(b)**	Safe Care & Treatment	provider for providing care or treatment to a service user is safe for such use and used in a safe way;
	7	Make sure checks to ensure the correct patient receives the correct scan are effective.	**Regulation 12(2)(a)(b)**	Safe Care & Treatment	a- assessing the risks to the health and safety of service users of receiving the care or treatment; b -doing all that is reasonably practicable to mitigate any such risks;
	8	Have PGDs or a scheme of delegation in place for all medicine administered by radiographers in the department and that these are up to date and regularly reviewed	**Regulation 12(2)(g)**	Safe Care & Treatment	the proper and safe management of medicines;

	9	Make sure processes to monitor and evaluate risk and information are effective and take account of all available information	**Regulation 17(2)(f)**	Good Governance	evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).
Urgent & Emergency Care (2)	10	Review all areas of the emergency department to maintain them in a good state and minimise the risk of cross infection. Some areas of the emergency department needed repair. The department was too small for its growing needs, and some areas were cramped, crowded with equipment, paperwork, and patients were sometimes too close together	**Regulation 15(1)(e)**	Premises & Equipment	properly maintained. Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained.
	11	Review paediatric waiting and treatment areas for children. The department does not meet The Royal College of Paediatric and Child Health Standards for Children in Emergency Care Settings recommendations for emergency departments, including waiting and treatment areas and those for families in a crisis	**Regulation 15(1)(e)**	Premises & Equipment	
Medical Care (3)	12	Ensure Mental Capacity assessments are completed fully and contain relevant detail.	**Regulation 13(2)(5)**	Safeguarding service users	Systems and processes must be established and operated effectively to prevent abuse of service users.
	13	Ensure care and treatment provided to stroke patients meets national standards and guidelines.	**Regulation 12(1)**	Safe Care & Treatment	Care and treatment must be provided in a safe way for service users. Providers should consult nationally recognised guidance about delivering safe care and treatment and implement this as appropriate.
	14	Ensure that all mandatory training is completed	**Regulation 12(2)(c)**	Safe Care & Treatment	ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;
Outpatients (1)	15	Continue to reduce patient waiting times to treatment and ensure people are continually risk assessed so they do not come to harm while waiting to be seen.	**Regulation 12(2)(a)(b**	Safe Care & Treatment	Assessing the risks to the health and safety of service users of receiving the care or treatment; b -doing all that is reasonably practicable to mitigate any such risks;
Should Do Actions			**Regulation Breached – as listed (not all Should Do actions are based on a breach)**		**Brief Description**
Trust wide (7)	1	Continue to pursue and invest in improvements to IT systems to reduce the risks associated with the current IT infrastructure and support delivery of integrated care.			To ensure systems and processes meet the demands of modern and evolving NHS
	2	Ensure personnel files include all evidence of recruitment in line with trust policy, to include interview and assessment documentation and 2 references.			To follow best practice HR policy
	3	Ensure the board are sufficiently aware of the key safety issues for clinical services at risk and understand and can articulate the impact.			Effective communication across the entire Board on all key issues and risks
	4	Consider how to ensure the visibility and understanding of community, adult social care and mental health services at board.			To ensure total trust wide coverage of the Trusts key sectors, issues demands and progress
	5	Consider how to ensure staff feel listened to and their ideas and solutions are well considered, and			Ensure the Trusts forums not only capture and listen to issues but feedback on actions or decisions taken, so the staff feel included and up to date on progress

		appropriate actions taken and monitored, or feedback shared with staff.			
	6	Consider the current resource for freedom to speak up. Consider implementing a long-term workforce plan across all roles in the organisation to address vacancies and succession planning.			Review and plan need vs demand
	7	Continue to embed, prioritise and focus quality improvement across the organisation and support staff to be involved in this work, and to have clear processes and policies and hold a repository of quality improvement work.			Test and feedback on the embedding of QI across the Trust in terms driving and improving patient safety and quality within the Trust
Diagnostic Imaging (8)	8	Ensure staff undertake all relevant mandatory training for their role.	Regulation 12(2)(c)	Safe care and treatment	ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;
	9	Ensure all radiation risk assessments are reviewed and updated as highlighted by the previous radiation protection advisor.	Regulation 12(2)(a)(b)	Safe care and treatment	Risk assessments relating to the health, safety and welfare of people using services must be completed and reviewed regularly by people with the qualifications, skills, competence and experience to do so. Risk assessments should include plans for managing risks. Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control measures to make sure the risk is as low as is reasonably possible. They should review methods and measures and amended them to address changing practice.
	10	Ensure temperatures for the storage of iodine-based contrast agents are carried out.	Regulation 12(2)(g)	Safe care and treatment	Staff responsible for the management and administration of medication must be suitably trained and competent and this should be kept under review. Staff must follow policies and procedures about managing medicines. These policies and procedures should be in line with current legislation and guidance and address: • supply and ordering • storage, dispensing and preparation • administration • disposal • recording.
	11	Ensure all staff receive annual appraisals.	Regulation 18(2)(a)	Staffing	Providers must ensure that they have an induction programme that prepares staff for their role. It is expected that providers that employ healthcare assistants and social care support workers should follow the Care Certificate standards to make sure new staff are supported, skilled and assessed as competent to carry out their roles.
	12	Display safeguarding from abuse information where most patients can see it and chaperone information for all modalities.			Effective communication and signposting
	13	Provide adequate changing facilities for patients attending for CT scans.			Privacy and dignity is assured in suitable and sufficient facilities
	14	Consider dedicated waiting areas for children.			Age related privacy and dignity, suitable and sufficient facilities
	15	Continue to work towards meeting the week the 6-week diagnostic imaging standard.			Meeting patients' needs within the required timeframes
Urgent & Emergency Care (6)	16	Ensure staff undertake all relevant mandatory training for their role.	Regulation 12(2)(c)	Safe care and treatment	Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;
	17	Continue to focus on improving patient flow through the emergency department.			Minimising waits and delays to place

	18	Consider the privacy of computer screens in the department. Some of the computer screens were left open and unsupervised with patient records visible. The names and summary of a patient were shown, and we were able to enter and access the detailed records.			Information governance compliance – ensuring patients data is protected
	19	Review all patient group directions which have passed review date and ensure they are current and up to date.			Systems and process are up to date and reviewed as necessary
	20	Review storage of oxygen cylinders and ensure they are consistently stored securely and safely.			Health and safety requirements for the safe storage of equipment
	21	Rotate sterile fluids and ensure no products are held which are out of date.			Health and safety requirement
Medical Care (6)	22	Keep under review the actions from the speech and language audit for patients with dysphagia. Confirming fluid thickener is stored correctly and safely, ensuring staff are adequately trained and have the right equipment to care for patients with specific nutritional and hydration needs, and care plans are followed by staff. Continue to ensure there are suitable staffing numbers and vacancies are recruited to.	Regulation 18 (1)	Staffing	Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards).
	23	Continue to audit hand hygiene compliance and improve compliance where wards are underperforming.			Providing care or treatment that is safe and to the required infection control standards
	24	Review agency staff induction and ensure they receive appropriate induction in all areas.			Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;
	25	Review the processes and action taken when temperatures for medicines storage are identified to be outside of the indicated range and confirm action is taken in accordance with policy.			Staff responsible for the management and administration of medication must be suitably trained and competent and this should be kept under review. Staff must follow policies and procedures about managing medicines. These policies and procedures should be in line with current legislation and guidance and address: • supply and ordering • storage, dispensing and preparation • administration • disposal • recording.
	26	Continue to store hypoboxes contents consistently across the trust and in accordance with trust policy.			Safe, standardised, and consistent access to emergency treatments
	27	Review the trust's locked door policy and relevant risk assessments and ensure patients are aware of how they can exit and enter ward areas.			Safe systems for access and egress
Outpatient Care (10)	28	Ensure ophthalmology equipment is kept visibly clean.	Regulation 12(2)(h)	Safe care and treatment	The Department of Health has issued a Code of Practice about the prevention and control of healthcare associated infections Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
	29	Ensure staff receive training in how to interact appropriately with autistic people and people who have a learning disability. This should be at a level appropriate to their			Attend the Oliver McGowan training
	30	Confirm staff are clear in how to access crisis management teams and have appropriate training in how to support patients with mental health needs.			Systems in place that are understood and accessible for staff for patients who require mental health support

	31	Continue to explore how it organises outpatient services to meet the needs of patients.			Review the structure and flow of the OPD department to maximise ease of use by the patients
	32	Ensure the privacy and dignity of patients is respected at all times.	Regulation 10(1)(2)(a)	Dignity & respect	When people receive care and treatment, all staff must treat them with dignity and respect at all times. This includes staff treating them in a caring and compassionate way
	33	Ensure prescription pads are stored securely in line with guidance.	Regulation 12(2)(g)	Safe care and treatment	Staff responsible for the management and administration of medication must be suitably trained and competent and this should be kept under review. Staff must follow policies and procedures about managing medicines. These policies and procedures should be in line with current legislation and guidance and address: • supply and ordering • storage, dispensing and preparation. • administration • disposal • recording.
	34	Consider how it ensures training in manual handling is delivered to staff.			Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;
	35	Consider introducing separate or segregated waiting areas for children being seen in the department.			Age related privacy and dignity, suitable and sufficient facilities
	36	Consider introducing a policy to guide staff on safe procedures for children visiting the outpatient department.			Guidance document for staff to follow
	37	Mitigate risks and the likelihood of error in the outpatient appointment booking process while awaiting the implementation of the electronic patient record system.			Creating safe systems of work that maintain patient safety

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Care Quality Commission (CQC) NHS Inpatient Experience Surveys 2022 Report (received September 2023)			**Meeting date:** 29 November 2023
Report appendix:	Care Quality Commission (CQC) NHS Inpatient Experience Surveys 2022 Report (received September 2023) - https://www.cqc.org.uk/provider/RA9/surveys/34 Appendix A – Full Adult Inpatient CQC published report September 2023 Appendix B – Feedback and Engagement Action Plan		
Report sponsor:	Chief Nurse		
Report author:	Interim Deputy Chief Nurse		
Report provenance:	Feedback and Engagement Group 14 November 2023		
Description/Purpose of the report and key issues for consideration/decision:	The purpose of the report is to briefly highlight the current CQC patient experience survey schedule, with a view to providing a detailed analysis of the results of the NHS Adult Inpatient Survey. The paper will describe and outline the improvement plan for the NHS Adult Inpatient Survey. The Board should note the trust is not an outlier compared to the results of other trusts, areas of good practice highlighted in the report are in the following areas: • Patients being given enough support from health and social care services to help them recover or manage their condition on leaving hospital • Access to food outside meal times • Patients being able to access medications they had brought into hospital • Patients felt they had been given enough information regarding who to contact about their condition or treatment after leaving hospital • Patients felt staff explained the reason for needing to move wards during the night if required However, we recognise there are improvements to be made, specifically in the following areas: • Length of time on the waiting list before your admission to hospital • Prevented from sleeping at night by noise from other patients • Prevented from sleeping at night by noise from staff • Prevented from sleeping at night by ward lighting • Where you ever asked to give your views on the quality of your care		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐

Recommendation:	The Board is asked to support the following recommendations: • Note the schedule of CQC Patient Surveys • Note the findings from the Adult Inpatient Survey 2023, and the five areas for improvement with the outline plan described in the report. • Note the proposed communication plan.
Summary of key elements	
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	The report provides the trust a summary of the experience of adult inpatients. It will allow focused work to provide a better experience of care to those who are admitted to our inpatient wards.
How does the report support the Triple Aim:	*1) population health and wellbeing: The experience of our service user/patient is a strong indicator of their overall wellbeing.* *2) quality of services provided: The experience of our service user/patient is a strong indicator of their overall wellbeing.* *3) sustainable and efficient use of resources: Not applicable*
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience
Risk: Risk ID: *As appropriate*	*ID 3649 Harm to Trauma Patients and Risk of Poor Patient Outcomes* *ID 3495 Risk of cancelled activity, resulting in delays in patient pathway and treatment.*
External standards affected by this report and associated risks	*Care Quality Commission*

Report title: Care Quality Commission (CQC) NHS Inpatient Experience Surveys 2022 Report (received September 2023)		**Meeting date:** 27 November 2023
Report sponsor	Chief Nurse	
Report author	Interim Deputy Chief Nurse	

1. Introduction

A programme of Patient Experience Surveys is commissioned by the Care Quality Commission (CQC) to support their programme of regulation, monitoring and inspection of NHS acute trusts in England through a programme called NHS Patient Survey Programme (NPSP). The survey field works for a number of surveys (see below) which will be completed in 2022/23 with a publication schedule for these surveys in late 2023 and early 2024. These include:

The Adult Inpatient Survey
The Urgent and Emergency Care Survey
The Children and Young Peoples Inpatient Survey
The Maternity Survey.

The aim of the report is to provide detailed analysis and insight into the Adult Inpatient Survey results.

The programme of the 2023 CQC surveys as provided below:

2023	Sample month(s)	Trust Submit sample to PP	Fieldwork	CQC Benchmark reports
Adult Inpatient 2022	Nov-22		closed	12-Sep-23
Maternity 2023	Feb-23		closed	Nov-23 tbc
Adult Inpatient 2023	Nov-23	Dec-23	Jan-Apr24	Aug/Sep-24 tbc
2024				
Urgent & Emergency Care 2024	Feb-24	Mar-24	Apr - Jul24	Oct-24 tbc
Maternity 2024 (TBC)	Feb-24	Mar-24	Apr - Jul24	Oct-24 tbc
Children/Young Peoples IP/DC 2024	Apr&May24	Jun-24	Jul-Oct24	Mar-25 tbc

2. Background and Context

2.1 Adult Inpatient Survey

2.1.1 The trust level benchmarking report which sets out the results of the Adult Inpatient Survey for 2022 was published on the 12 September 2023. This is commissioned by CQC, the independent regulator of health and adult social care in England. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS acute trusts in England.

2.1.2 The trust survey results provide an opportunity to gain greater insight and understanding of the experiences of people who use our adult inpatient services and utilises this valuable feedback to reflect on what we have been told. This allows us to focus on what matters to the people we care for, and work to improve experience by taking positive action and embedding change.

2.1.3 It is essential that the survey results are shared and understood widely by staff working across the organisation, as the experience of those people who are inpatients will interface with a broad range of services, teams, wards and individuals. To a greater or lesser extent everyone has a role to play in our improvement journey. The communication plan developed by the communication team is comprehensive and inclusive to meet this requirement.

2.1.4 The Feedback and Engagement Group for the trust includes a wide membership both internally and with our local system partners. Members of this group will hold accountability for overseeing the delivery of the improvement plan developed in response to the survey results. This will be regularly reported to monitor key milestones within the plan.

2.1.5 The 2022 Adult Inpatient Survey involved 133 NHS trusts in England with a total of 165,181 invited to participate with a response rate of 40.2%. Patients were eligible for the survey if they were aged 16 or older, had spent at least one night in hospital and were not admitted to a maternity or psychiatric unit. The inpatients included in the sample included those discharged during November 2022. The field work for the survey, which is the time where questionnaires are sent out and returned took place between January and April 2023. Local response was received from 551 patients, a response rate of 45%. A reduction in 3% from 2021.

2.1.6 The survey results provide comparison against all trusts who have a response rate of greater than 30, all NHS trusts average, all NHS trusts lowest score and all NHS trusts highest Score. The results also provide the trust with its five best and worst questions performance relative to other NHS trust national averages. The questions are scored through a numbering system 0-10. 10 being the trust fully meets the question and 0 being the trust doesn’t meet the question.

2.2 Trend data

2.2.1 The Adult Inpatient 2022 survey was conducted using a push-to-web methodology (offering both online and paper completion). There were minor questionnaire changes, including three new questions and changes to question wording. The 2022 results are comparable with data from the Adult Inpatient 2021 survey, unless a question has changed or there are other reasons for lack of comparability such as changes in organisation structure of a trust. Where results are comparable, a section on historical trends has been included.

2.2.2 To provide a comprehensive picture of inpatient experience within each NHS trust, CQC calculated the overall proportion of responses each trust received for the ‘most negative’, ‘middle’ and ‘most positive’ answer option(s) across the scored questions in the survey. Where people’s experiences of a trust’s inpatient care are better or worse than elsewhere, there will be a significant difference between the trust’s result and the average result across all trusts. Each trust is then assigned a banding of

either ‘much worse than expected’, ‘worse than expected’, ‘about the same’, ‘better than expected’ or ‘much better than expected’ depending on how significant that variation is.

2.2.3 To complement the trust benchmarking survey there is also an outlier report this report allows analyse of trust variation, CQC focus on identifying significantly higher levels of better or worse patient experience across the entire survey.

3. Discussion- Analysis of Benchmarking report

3.1 The full benchmarking report for the Adult Inpatient Survey 2022 results are set out in Appendix A and provided for completeness. Within the main body of the report salient facts will be highlighted, focused upon and responded to.

3.2 1,250 patients who had experienced adult inpatient services provided by Torbay and South Devon NHS Foundation Trust (the trust) in November 2022 were invited to take part. 551 responses were completed and submitted to CQC. The response rate was 45% compared to 2021 of 48%. The trusts response rate was better than that of the national response rate by 5% for this year’s survey results.

An excellent response rate according to SmartSurvey (2023) is 50% or higher, they go further to suggest results at the higher end of the scale is likely to be as a result of a strong personal relationship between the business and the customer which would be suggestive that as a trust our relationship with our patients is one that empowers them to feel safe to talk of their experiences.

The demographic of those taking part is included in table 1 below:

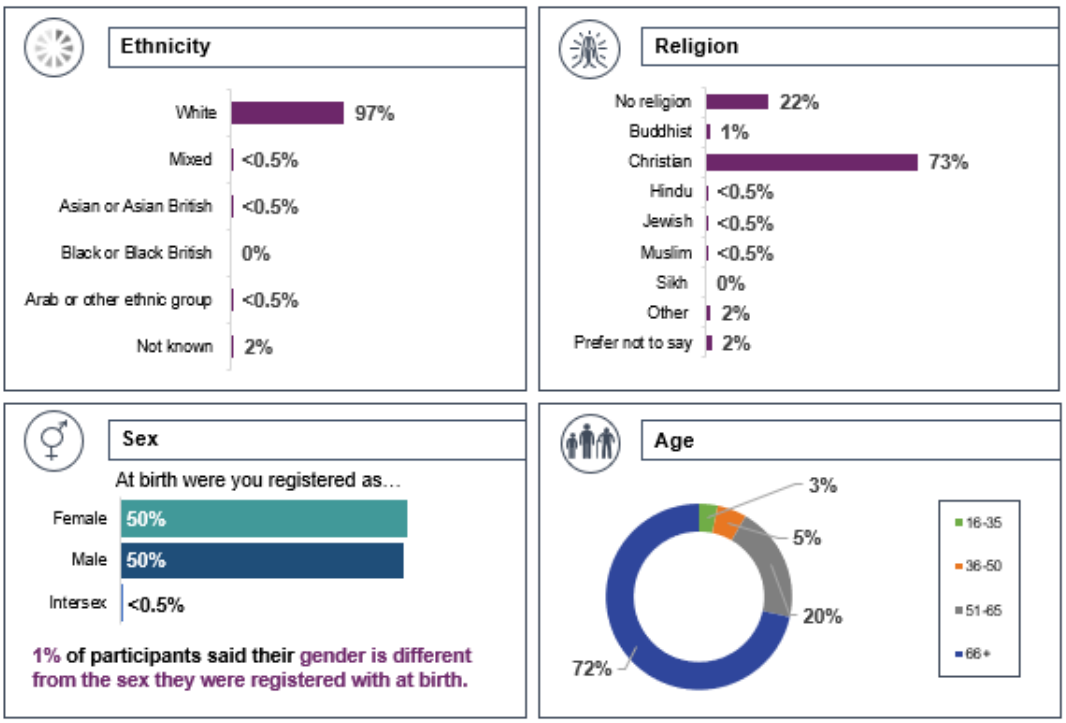


Table 1: Demographics of patients who took part in TSDFT survey

82% of participants said they have a physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last 12 months or more (excluding those

who selected “I would prefer not to say”). This is a 2% decrease on 2021 survey capture.

3.3 Table 2 demonstrates a summary of the trust compared to other trusts regarding performance. For 35 of the 46 questions the trust scored “About the same” an increase in 2 from last year. For 2 questions the trust performed “Worse than expected” this had not changed from last year. For 6 questions we performed “Somewhat better than expected”, this remained static. 1 question we performed “Better than expected” a reduction of 3 compared to last year. However, for 3 questions the trust had statistically significantly decreased compared to 2021.

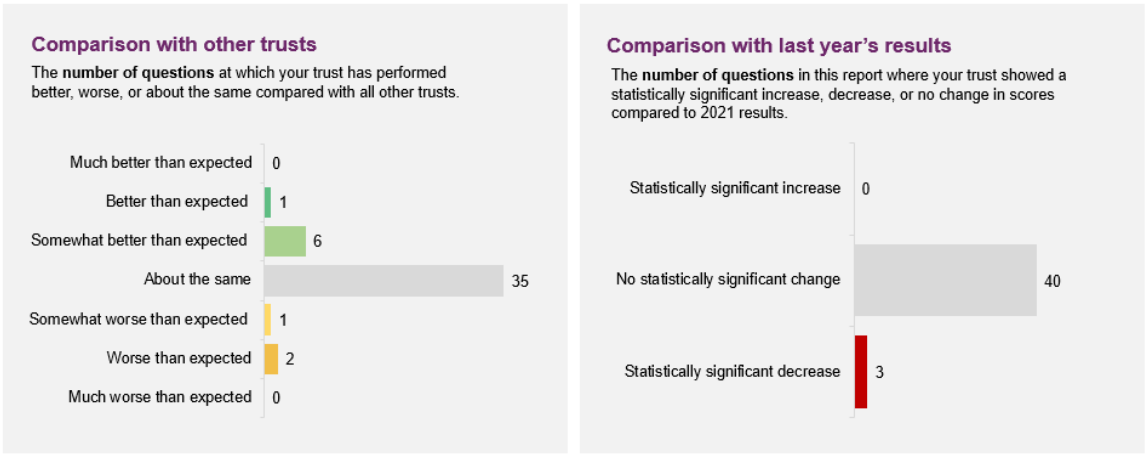


Table 2: Comparison of local results against other trusts, and previous year’s results

3.4 Table 3.1 and 3.2 below set out the best and worst performance relative to the trust average. These five questions are calculated by comparing the trust’s results to the national trust average (the average trust score across England).

- **Top five scores**: These are the five results for the trust that are highest compared with the national trust average.

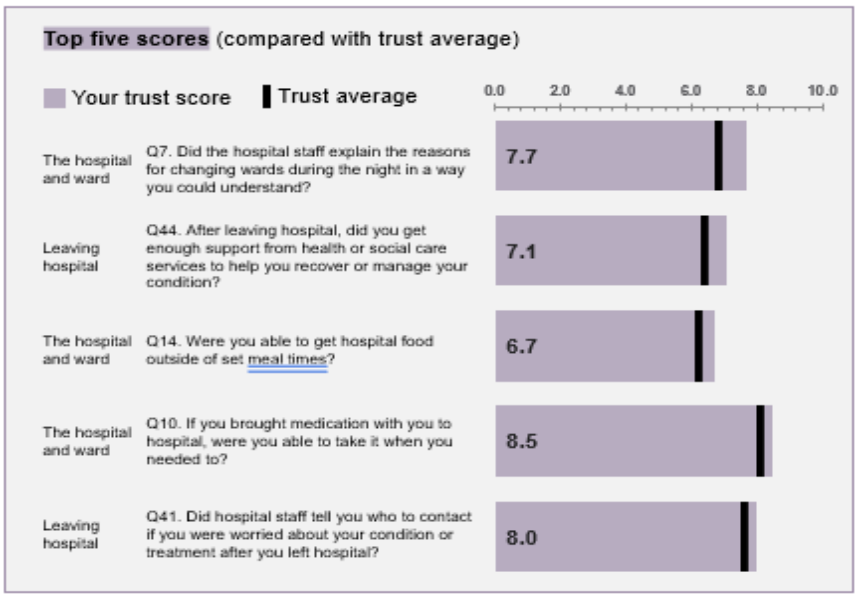


Table 3.1: Best performance relative to the trust average

Bottom five scores: These are the five results for the trust that are lowest compared with the national trust average.

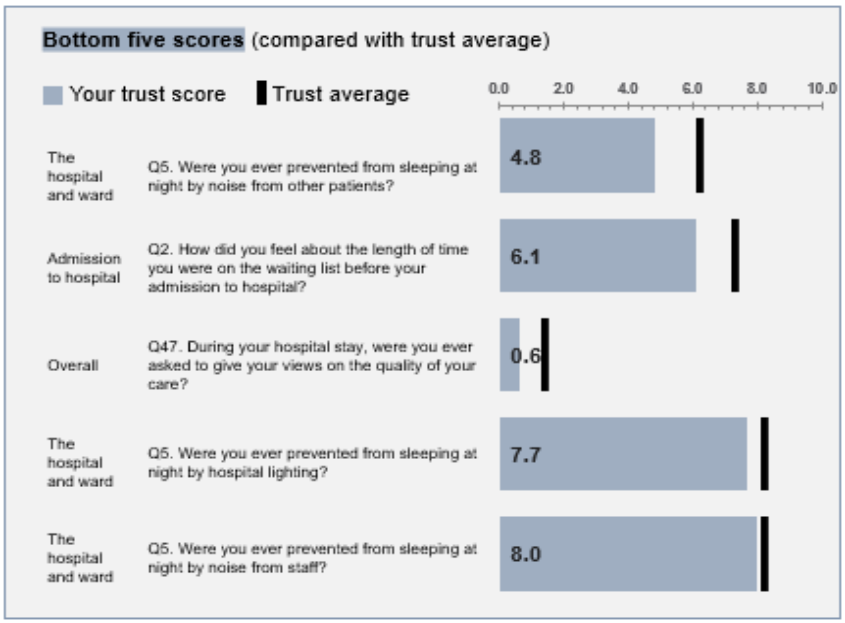


Table 3.2: Worst performance relative to the trust average

3.5 Top 5 scores

The top 5 areas for the trust fell into two domains ‘The hospital and ward’ (3 questions) and ‘Leaving hospital’ (2 questions), which is the same as 2021 survey outcomes. Three of these 5 where reported within the top 5 within 2022 survey which demonstrates that processes and pathways in place are embedded and supporting the patients who are admitted to bed-based care.

‘The hospital and ward’

Within ‘The hospital and ward’ domain three questions scored within the trust top areas of success. These included:

Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand? This is an area where the trust works hard not to move patients at night and the result reflects the fact that staff are only transferring patients when there is a clinical need, supported with clear communication to the patients. Q7 was within the top 5 last year that provides reassurance that the process in place regarding moving of patients overnight is clear and adhered to.

Q10. If you brought medication with you to hospital, were you able to take it when you needed to?
The trust introduced an education programme looking at professional standards regarding fundamentals of care early Autum 2022. This included a rolling programme of daily seminars for Ward Managers, Matrons and clinical staff with regular sessions focusing on medicines management. This was further supported with Associate Director of Nursing and Professional Practice, Matrons and Deputy Chief Nurses doing peer reviews on a twice monthly basis with a focus on professional standards, patient safety and experience.

Q14. Were you able to get hospital food outside of set meal times?

There has been a significant focus on the delivery and support for all patients to ensure they have their nutritional and hydration needs met. These improvements include red trays being used to identified patients who need nutritional support, protected mealtimes, volunteers, safety huddles and daily audits are only a few to ensure all patients are receiving the care they require. The trust also has a Nutritional and Hydration Steering Group whose focus is to ensure all patients receive the relevant nutritional and hydration support whilst an inpatient.

A 5-a-day audit has been designed and in place across all inpatient areas which reviews 5 sets of notes daily for each ward area to ensure individuals nutritional and hydration risk assessments are being completed with 24hrs of admission to the first ward. The audit also assesses to ensure relevant care plans are created with the patient and/or family to meet an individual patient need. Compliance is currently measured and reported into the Care Groups where escalation is required through the Care Group Governance structure along with Feedback and Engagement Group.

This audit commenced in December 2021 after a CQC review and compliance was measured as an average of 86% for completing within the timeframes set. Work continues regarding improving the compliance through the Nutrition and Hydration Steering Group data collected for the month of October 2023 shows an improvement with the average compliance now at 94% an increase from last year November 2022 which was 91.8%. This is also reflective within the Safety Thermometer (Table 4) which is completed for all inpatients on a specified day each month with the current compliance at 96.8%, with 89% completed within the desired 24hr timeframe.

Nutritional Risk Assessments (Acute and Community)

Source: Safety Assessment Audit (formerly Safety Thermometer audit) (spot-audit)

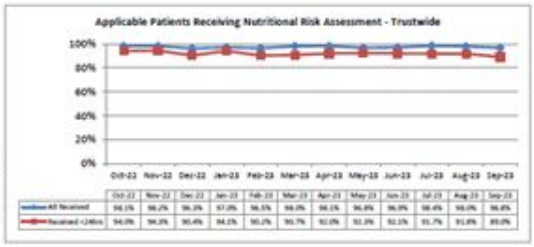
Torbay and South Devon NHS

Trustwide (Acute and Community Combined)

	Sep-23	YTD
Patients in Audit:	411	2403
Patients for whom RA is NOT applicable: [1]	32	207
Patients for whom RA IS applicable:	379	2196

[1] Includes Patients who were admitted within 24 hours prior to the audit and have not yet been assessed.

	Sep-23	YTD
Patients for whom Risk Assessment IS applicable ...	379	2196
... and who DID receive the assessment	366	2138
... and who did NOT receive the assessment	13	58



... of those Patients who DID receive a Nutritional Risk Assessment:

Sep-23	OUTCOME		
	Not at Risk	At Risk (100)	
		With Care Plan	Without Care Plan
Completed within 24 hrs	241	89	5
NOT Completed within 24 hrs	25	5	1
TOTAL	266	94	6

YTD	OUTCOME		
	Not at Risk	At Risk (681)	
		With Care Plan	Without Care Plan
Completed within 24 hrs	1351	638	10
NOT Completed within 24 hrs	106	31	2
TOTAL	1457	669	12

Table 4: Safety Thermometer Nutritional Risk Assessment (Acute and Community)

The trust energised the importance of Nutrition and Hydration by celebrating its importance week 13 March 2023, where staff were actively involved in activities to enhance the nutritional and hydration agenda.

Q14 was within the top 5 last year this provides reassurance that the process in place regarding assessing patient's nutritional needs and providing patients food outside of mealtimes is an embedded practice across the trust.

‘Leaving hospital’

The remaining two questions in the top 5 sits within the domain ‘Leaving hospital’ these also compared favourably against the national trust average, both questions are new to the top 5:

Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
Work has been undertaken in the last year to review the experience of patient discharge. The information provided to patients on discharge has also undergone a review both verbally and in written format and new processes have been introduced to provide patients with information and to prompt staff to ensure details have been provided and understood. The work around patients experience of discharge continues.

The final question with regards to ‘Leaving hospital’ is as follows:

Q44. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition? As an integrated care organisation this result indicates the combined health and social care strategy that the trust aims to deliver for all patients. It demonstrates the joined up and partnership working in place across the trust to ensure the transition from hospital to home is safe and reflecting the care required.

Q44 was within the top 5 results last year, this provides reassurance that the process in place regarding care after discharge through integration across health and social care can provide those being discharged with the appropriate support as required.

3.6 Bottom 5 scores

The bottom five scores have a variety of themes, ‘Admission to Hospital’, ‘The Hospital and Ward’ and ‘Overall’. For a second year we have two of the same questions remaining within the bottom five for the trust in the CQC Adult Inpatient survey 2022 compared to 2021 results.

‘Admission to hospital’

Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital? For a second year we see this question within the bottom five. The impact of the COVID-19 pandemic has far reaching consequences and this is being reflected in the significant wait’s patients are enduring prior to admission to hospital. The trust is prioritising the admission pathway across all services and where activity was previously paused in the height of the pandemic current work is underway to resume and enhance service availability. This is evident in the Chief Operating Officers Report, November 2023, where the trust has reported no 104 week waits since March 23, and control totals being met for 78 week waits and 65 week waits although recent months have been impacted by Industrial Action.

‘The hospital and ward’

Three questions relating to the ‘The hospital and ward’ fell within the bottom five scores for the trust all relating to sleep at night.

Q5. Were you ever prevented from sleeping at night by noise from other patients?
Q5. Were you ever prevented from sleeping at night by hospital lighting?
Q5. Were you ever prevented from sleeping at night by noise from staff?

Significant work was undertaken in 2022 as the three questions above all fell within the bottom five questions for 2021 Adult Inpatient Survey. The 2022 survey reflected the significant work undertaken i.e., the use of sleep packs, dimmer lights and soft door closures etc. with two of the three questions no longer falling within the bottom five in the 2022 Adult Inpatient Survey. The remaining question related to sleep regarding noise in relation to other patients which is much harder to manage depending on individuals' diagnosis and the clinical condition of patients.

The results demonstrate is a focus on sleep for patients on the wards. Associate Directors of Nursing and Professional Practice continue work with their Matrons and Ward Managers to focus on next steps regarding improvements.

'Overall

Another question in the bottom 5 related to the domain 'Overall':

Q47. During your hospital stay, were you ever asked to give your views on the quality of your care? The Patient and Service User Experience of Health and Care Strategy has recognised the need for investment in the Feedback and Engagement Team to ensure all patients have the ability to compliment or raise complaints and concerns with regards to the care they have received within a timely manner. Ongoing work continues to embed the "Friends and Family Test" (FFT) across all inpatient areas utilising a variety of mediums to support data capture in order for areas to understand how they are performing and respond accordingly.

To support the FFT agenda the Real Time Patient Experience survey has been reinstated across inpatient areas. This questionnaire has been redesigned to reflect the CQC Inpatient Survey which is being undertaken and supported by trust volunteers. The survey allows results to be given to the ward manager in real time for any concerns to be addressed promptly. This work will be overseen by the Real Time Patient Experience Group which has been reinstated. An audit has been introduced in May 2023 as part of the experience of discharge workstream to capture real time data to help understand the experience of the people who have been a patient within the trust.

3.7 Respect and Dignity

A programme of work has taken place throughout 2022/23 with a focused monthly programme in relation to respect and dignity across the trust which has included wards auditing practice through the eyes of the patient. This work is reflective in the trust coming second within the region for a second year regarding respect and dignity from the view of the patient, as shown in table 5. Work continues as part of pathways to excellence programme to maintain a focus on respect and dignity for the people who are admitted to hospital and wider.

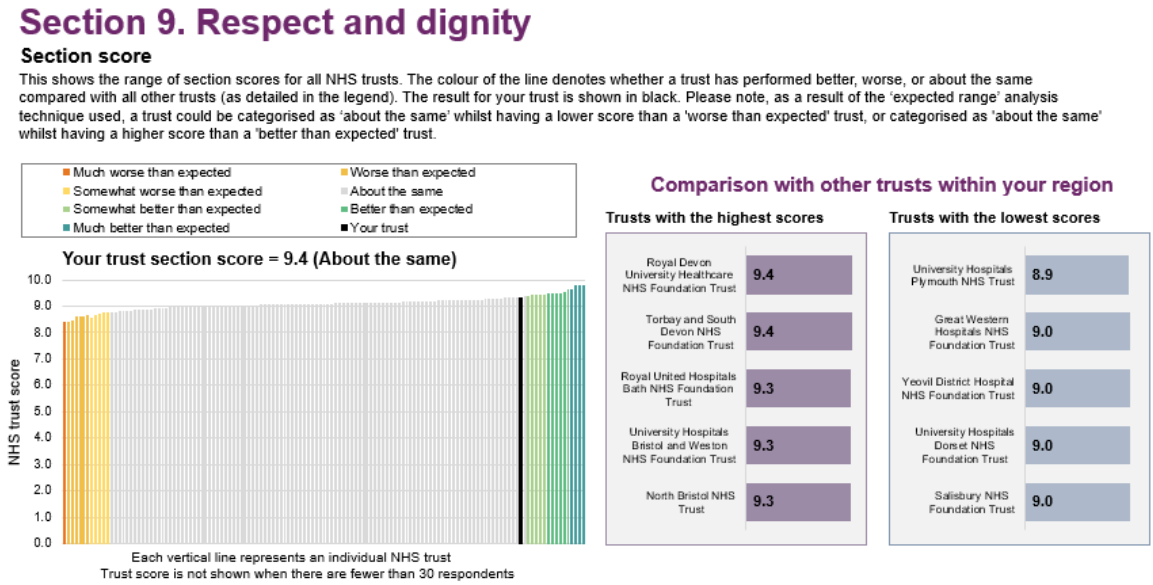


Table 5: Comparison of trusts regarding Section 9: Respect and Dignity

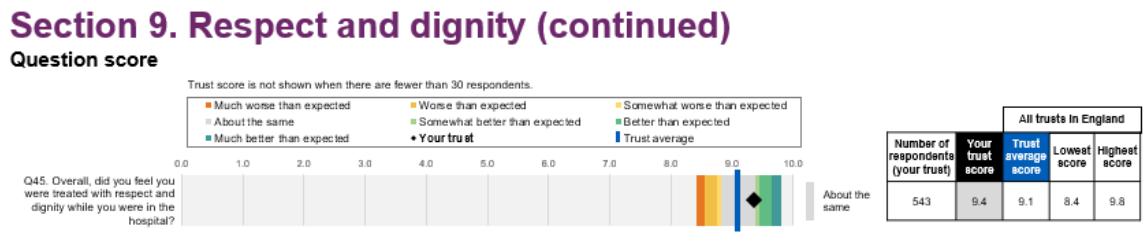


Table 6: The trusts score for Section 9: Respect and Dignity against national trust average score

Table 6 illistrates how as a trust we are preforming against the national trust average which is testiment to the staff caring for our inpatients. There is an action plan in place to support this work further through 23/24. Some exapmles of work undertaken to improve patients experinces is as follows:

- Review of work regarding how we address patients e.g., preferred name and how we communicate this through areas. Along with individualising above boards to reflect patient's needs
- Review of information governance processes to ensure computer screens are locked when not in use
- Review of hospital gowns to ensure all sizes are available to patients who receive care
- Introduction of signs for curtains to remind staff to knock and wait before entering, and a review of which length of curtains are used within all areas of the trust
- There is also a programme of work to look at staff taking part in immersive exercises to gain insight into the patient journey

3.8 Overall Experience

Section 10 questions relate to overall experience. This is an area of focus for the trust during 2023/24, where we will continue to develop and nurture new relationships with our local community to understand what matters to them. As a trust we are cognisant that to develop and enhance our health and care services the voice of our community is

central. The people who access, interface and use our health and care services are pivotal and have been instrumental in developing a co-designed Patient and Service User Experience of Health and Care Strategy 3-5-year plan.

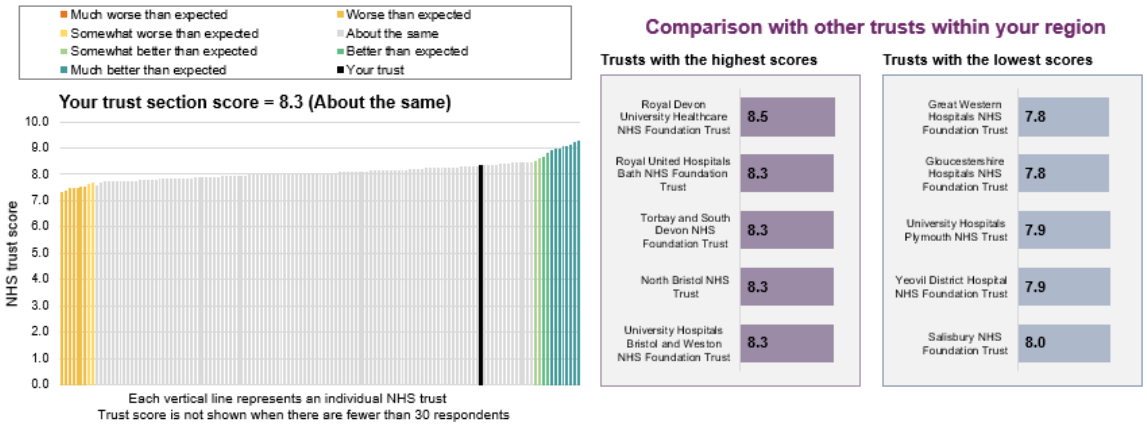


Table 7: Overall experience comparison

Table 7 evidences the work the trust is undertaking to ensure inpatients experiences are of the expected standard. It illustrates whilst there is still some work required to move into the national trusts 'better than expected' we compare favourably with our regional trusts falling third within the top 5 highest scores regionally. An improvement from forth in the published report 2022 survey results. The launch of the Patient and Service User Experience of Health and Care Strategy work continues and will further enhance this moving forward.

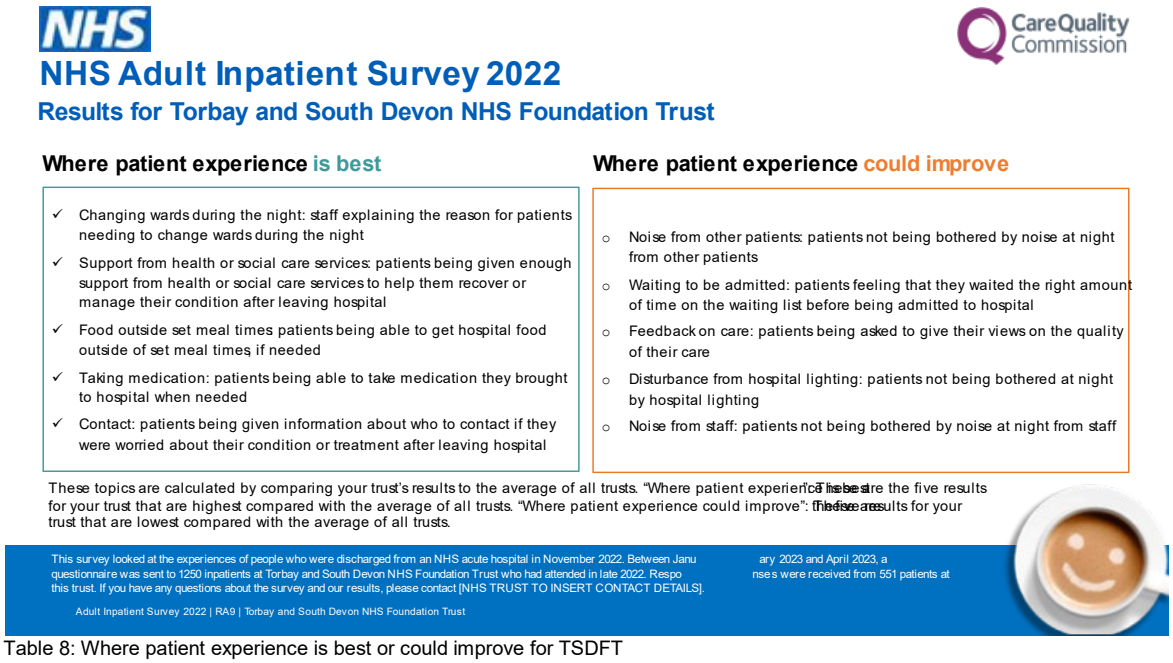
4. Communication Plan

The communication team will lead on the communication plan to disseminate the results across the organisation. This includes:

- Chief Executive Officer Liz Davenport and Chief Nurse Deborah Kelly to include the outcome of the Adult Inpatient Survey results within Vlogs.
- Article in ICO News sharing top lines and action we are taking, links to published reports to be included.
- Highlight top lines in Healthy Futures newsletter (issued monthly to stakeholders)
- Feedback and Engagement Group to monitor Care Groups Action Plans.

5. Conclusion

The CQC Adult Inpatient Survey for 2023 provides clarity on areas where experience is best and areas where patient experience can be improved as shown in table 8 below:



NHS

NHS Adult Inpatient Survey 2022

Results for Torbay and South Devon NHS Foundation Trust

Care Quality Commission

Where patient experience is best

- ✓ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night
- ✓ Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital
- ✓ Food outside set meal times: patients being able to get hospital food outside of set meal times, if needed
- ✓ Taking medication: patients being able to take medication they brought to hospital when needed
- ✓ Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital

Where patient experience could improve

- ○ Noise from other patients: patients not being bothered by noise at night from other patients
- ○ Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- ○ Feedback on care: patients being asked to give their views on the quality of their care
- ○ Disturbance from hospital lighting: patients not being bothered at night by hospital lighting
- ○ Noise from staff: patients not being bothered by noise at night from staff

These topics are calculated by comparing your trust's results to the average of all trusts. "Where patient experien" These are the five results for your trust that are highest compared with the average of all trusts. "Where patient experience could improve": these are the five results for your trust that are lowest compared with the average of all trusts.

This survey looked at the experiences of people who were discharged from an NHS acute hospital in November 2022. Between Janu ary 2023 and April 2023, a questionnaire was sent to 1250 inpatients at Torbay and South Devon NHS Foundation Trust who had attended in late 2022. Respo nses were received from 551 patients at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

Adult Inpatient Survey 2022 | RA9 | Torbay and South Devon NHS Foundation Trust

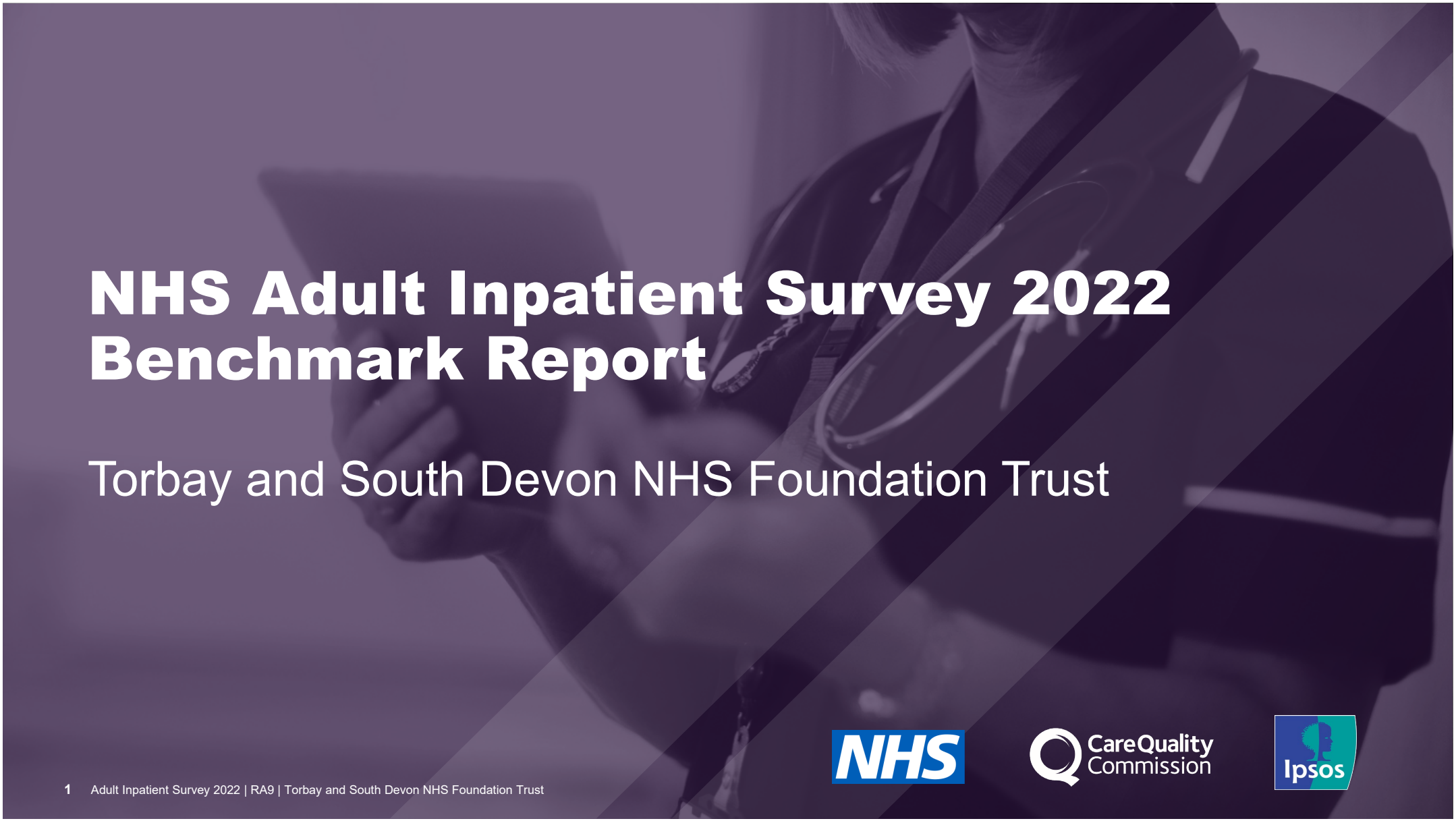
Table 8: Where patient experience is best or could improve for TSDFT

The results provide the trust with an anchor to celebrate what we are doing well, understand areas where we are preforming similar to other trusts and through focused effort and improvement work to address deficits. However, our primary focus initially is to address the challenges that adult inpatients contributing to this survey have very clearly identified above in the areas we can improve upon. These five areas will form part of the Care Group meetings which will feed into the monthly Feedback and Engagement Group for oversight of their improvement plans.

6. Recommendations

The QAC is asked to support the following recommendations:

- Note the schedule of CQC Patient Surveys and the proposed reporting to the Board.
- Note the findings from the CQC Adult Inpatient Survey 2022 and the five areas for improvement with the outline plan described in the report which are supported and agreed.
- Note the proposed communication plan.



NHS Adult Inpatient Survey 2022 Benchmark Report

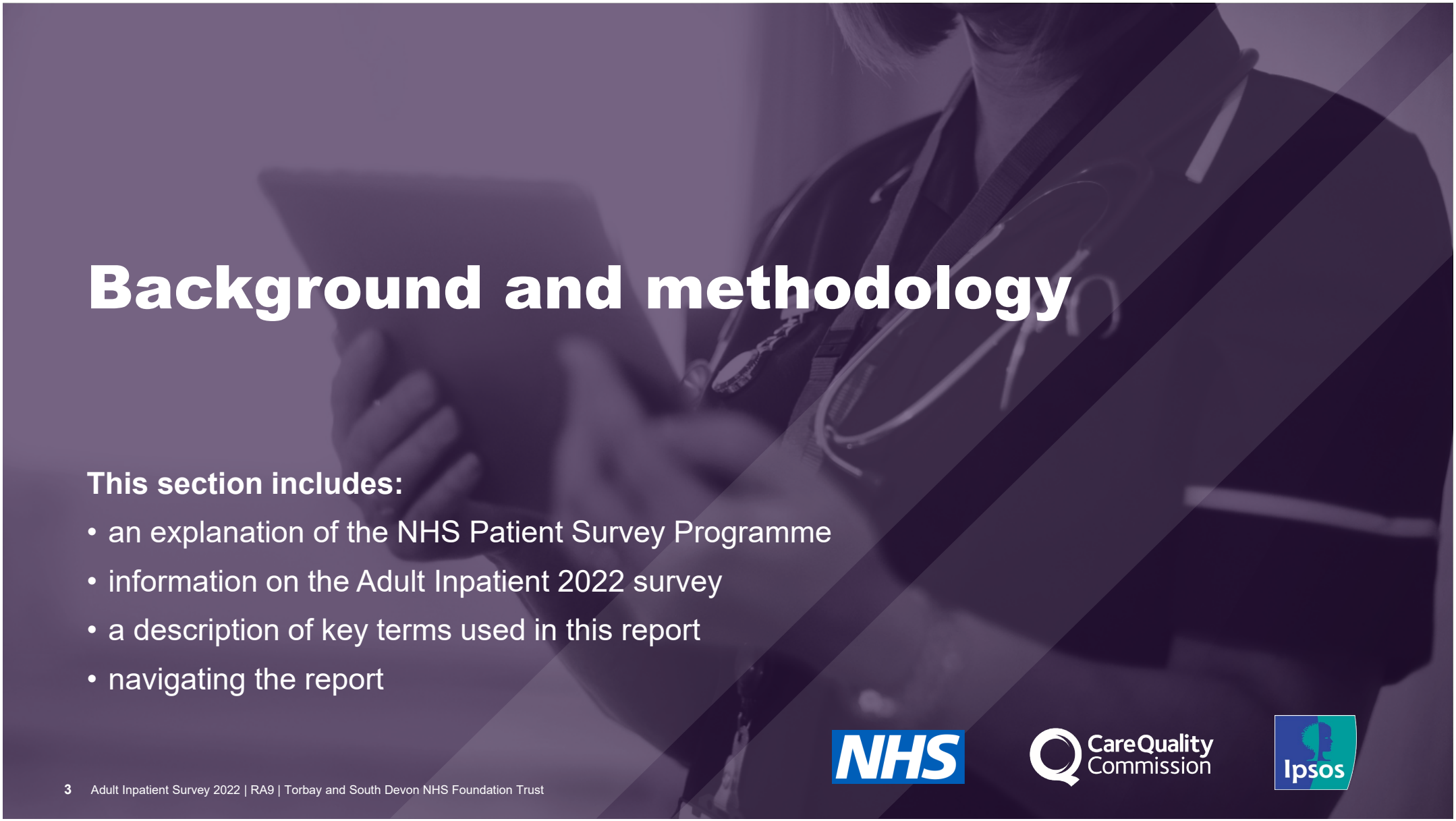
Torbay and South Devon NHS Foundation Trust

Contents

1. Background & methodology
2. Headline results
3. Benchmarking
4. Trust results
5. Trends over time
6. Appendix

3. Benchmarking	4. Trust results	5. Trends over time
Section 1. Admission to hospital	Section 1. Admission to hospital	Section 1. Admission to hospital
Section 2. The hospital and ward	Section 2. The hospital and ward	Section 2. The hospital and ward
Section 3. Doctors	Section 3. Doctors	Section 3. Doctors
Section 4. Nurses	Section 4. Nurses	Section 4. Nurses
Section 5. Your care and treatment	Section 5. Your care and treatment	Section 5. Your care and treatment
Section 6. Operations and procedures	Section 6. Operations and procedures	Section 6. Operations and procedures
Section 7. Leaving hospital	Section 7. Leaving hospital	Section 7. Leaving hospital
Section 8. Feedback on care	Section 8. Feedback on care	Section 8. Feedback on care
Section 9. Respect and dignity	Section 9. Respect and dignity	Section 9. Respect and dignity
Section 10. Overall experience	Section 10. Overall experience	Section 10. Overall experience
Section 11. Long-term condition	Section 11. Long-term condition	

This work was carried out in accordance with the requirements of the international quality standard for Market Research, ISO 20252, and with the Ipsos Terms and Conditions which can be found at http://www.ipsos.uk/terms.



Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the Adult Inpatient 2022 survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Adult Inpatient Survey has been conducted annually since 2002. CQC will use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The Adult Inpatient Survey 2022

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos. A total of 165,181 patients were invited to participate in the survey across 133 acute and specialist NHS trusts. Completed responses were received from 63,224 patients, an adjusted response rate of 40.2%.

Patients were eligible to participate in the survey if they were aged 16 years or over, had spent at least one night in hospital, and were not admitted to maternity or psychiatric units. A full list of eligibility criteria can be found in the survey sampling instructions.

Trusts sampled patients who met the eligibility criteria and were discharged from hospital during November 2022. Trusts counted back from the last day of November 2022, sampling every consecutively discharged patient until they had selected 1,250 patients. Some smaller trusts, which treat fewer patients, included patients who were treated in hospital earlier than November 2022 (as far back as April 2022), to achieve a large enough sample.

Fieldwork took place between January and April 2023.

Trend data

The Adult Inpatient 2022 survey was conducted using a push-to-web methodology (offering both online and paper completion). There were minor questionnaire changes, including three new questions and changes to question wording. The 2022 results are comparable with data from the Adult Inpatient 2020 and 2021 surveys, unless a question has changed or there are other reasons for lack of comparability such as changes in organisation structure of a trust. Where results are comparable, a section on historical trends has been included.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about CQC's survey programme, please visit the CQC website.

Key terms used in this report

The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement.

This report also includes site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that the performance ratings presented here may differ from that presented in the trust level benchmarking.

More information can be found in the Appendix.

Standardisation

Demographic characteristics, such as age and gender, can influence patients’ experience of care and the way they report it. For example, research shows that men tend to report more positive experiences than women, and older people more so than younger people.

Since trusts have differing profiles of patients, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual patient responses to account for differences in demographic profile between trusts.

For each trust, results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to reflect the ‘national’ age, sex, and method of admission distribution (based on all respondents to the survey).This helps ensure that no trust will appear better or worse than another because of its profile of service users, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results. Site level results are standardised in the same way.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example Q1) and others are ‘routing questions’, which are designed to filter out respondents to whom the following questions do not apply (for example Q6). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

Trust average

The ‘trust average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting or standardisation is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document.

Using the survey results

Navigating this report

This report is split into six sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the patients who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Section score slides also include a comparison with other trusts in your region. It may be helpful to compare yourself with regional trusts, so you can learn from and share learnings with trusts in your area who care for similar populations.
- **Trust results** – includes the score for your trust and breakdown of scores across sites within your trust. Internal benchmarking may be helpful so you can compare sites within your organisation, sharing best practice within the trust and identifying any sites that may need attention.
- **Trends over time** – includes your trust's mean score for each evaluative question in the survey shown in a significance test table, comparing it to your 2020 and 2021 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.
- **Appendix** – includes additional data for your trust; further information on the survey methodology; interpretation of graphs in this report.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; link to view the results for each trust; technical document: www.cqc.org.uk/inpatientsurvey
- National and trust-level data for all trusts who took part in the Adult Inpatient 2022 survey: https://nhssurveys.org/surveys/survey/02-adults-inpatients/year/2022/. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors hospitals: www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-nhs-acute-hospitals

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the top and bottom scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.

1,250 invited to take part

551 completed

76% urgent/emergency admission

24% planned admission

45% response rate

40% average response rate for all trusts

48% response rate for your trust last year

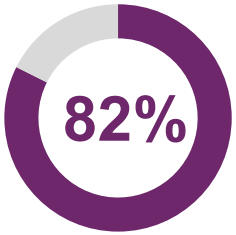
Ethnicity

White	97%
Mixed	<0.5%
Asian or Asian British	<0.5%
Black or Black British	0%
Arab or other ethnic group	<0.5%
Not known	2%

Religion

No religion	22%
Buddhist	1%
Christian	73%
Hindu	<0.5%
Jewish	<0.5%
Muslim	<0.5%
Sikh	0%
Other	2%
Prefer not to say	2%

Long-term conditions



of participants said they have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").

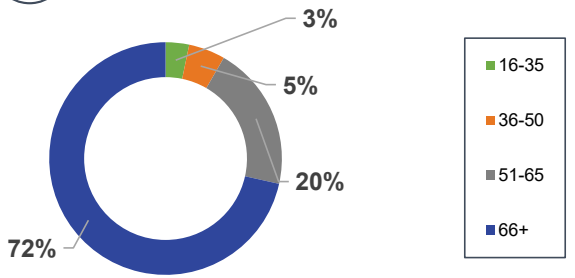
Sex

At birth were you registered as…

Female	50%
Male	50%
Intersex	<0.5%

1% of participants said their gender is different from the sex they were registered with at birth.

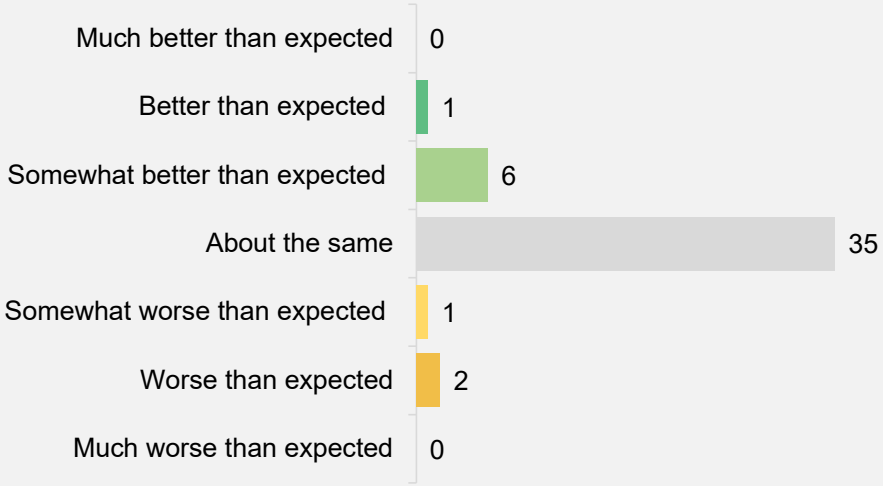
Age



Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

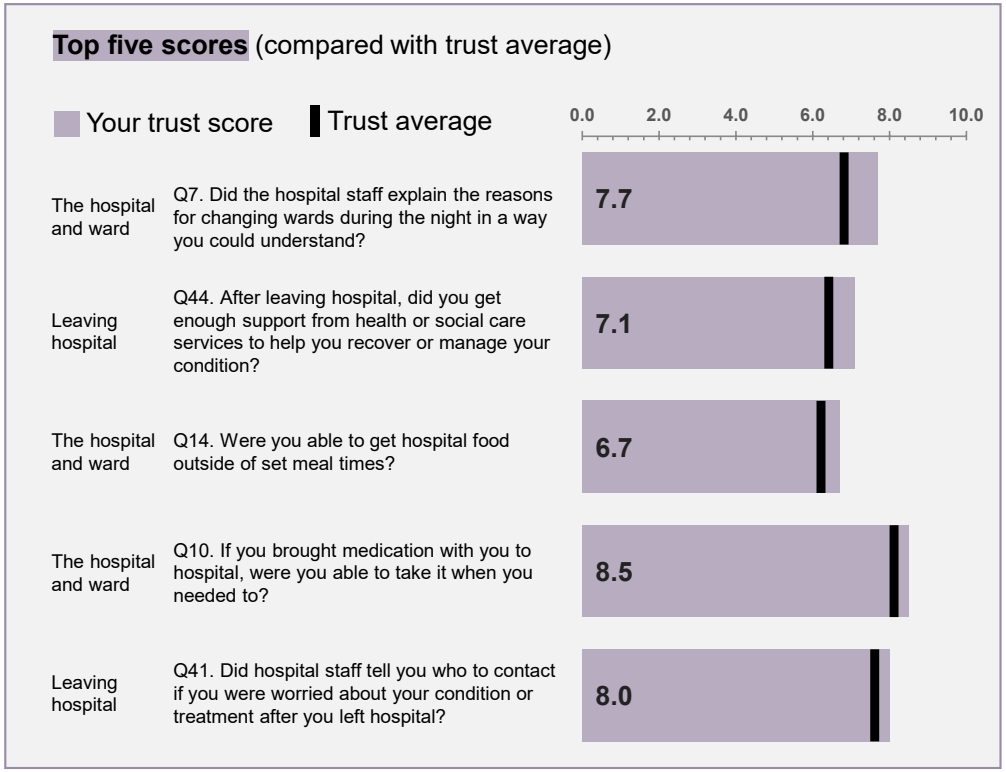
The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2021 results.

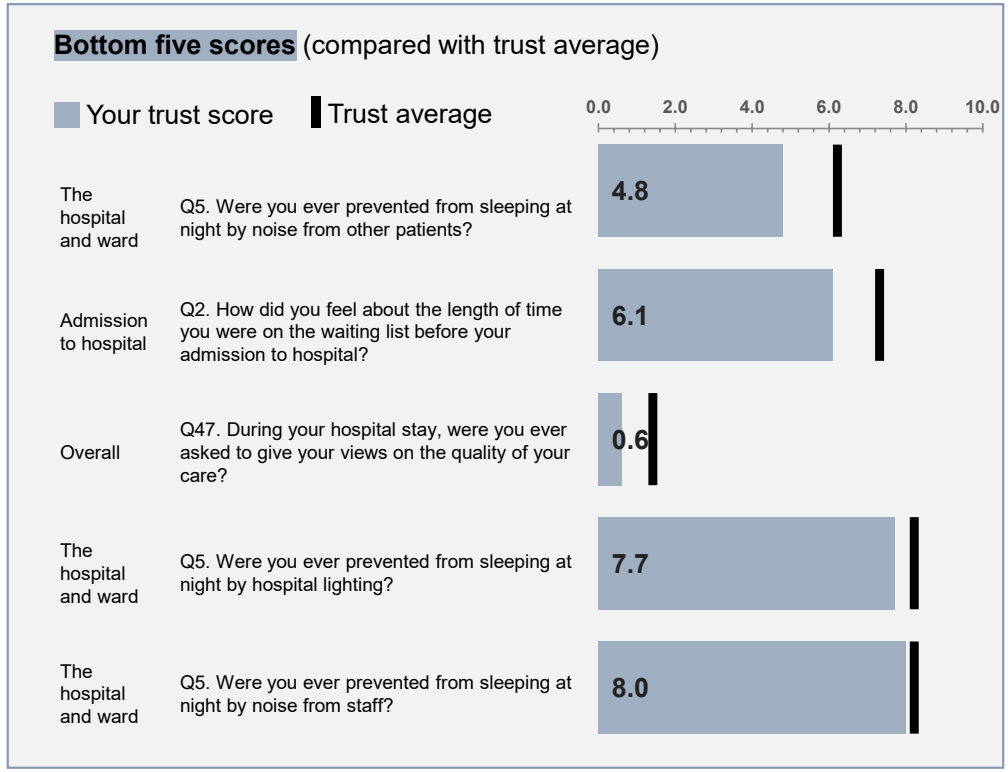
For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "comparison to other trusts". For a breakdown of the questions where your trust showed a statistically significant increase or decrease in scores compared to 2021 and 2020 results, please refer to the appendix section "comparison to 2021 results" and "comparisons to 2020 results".

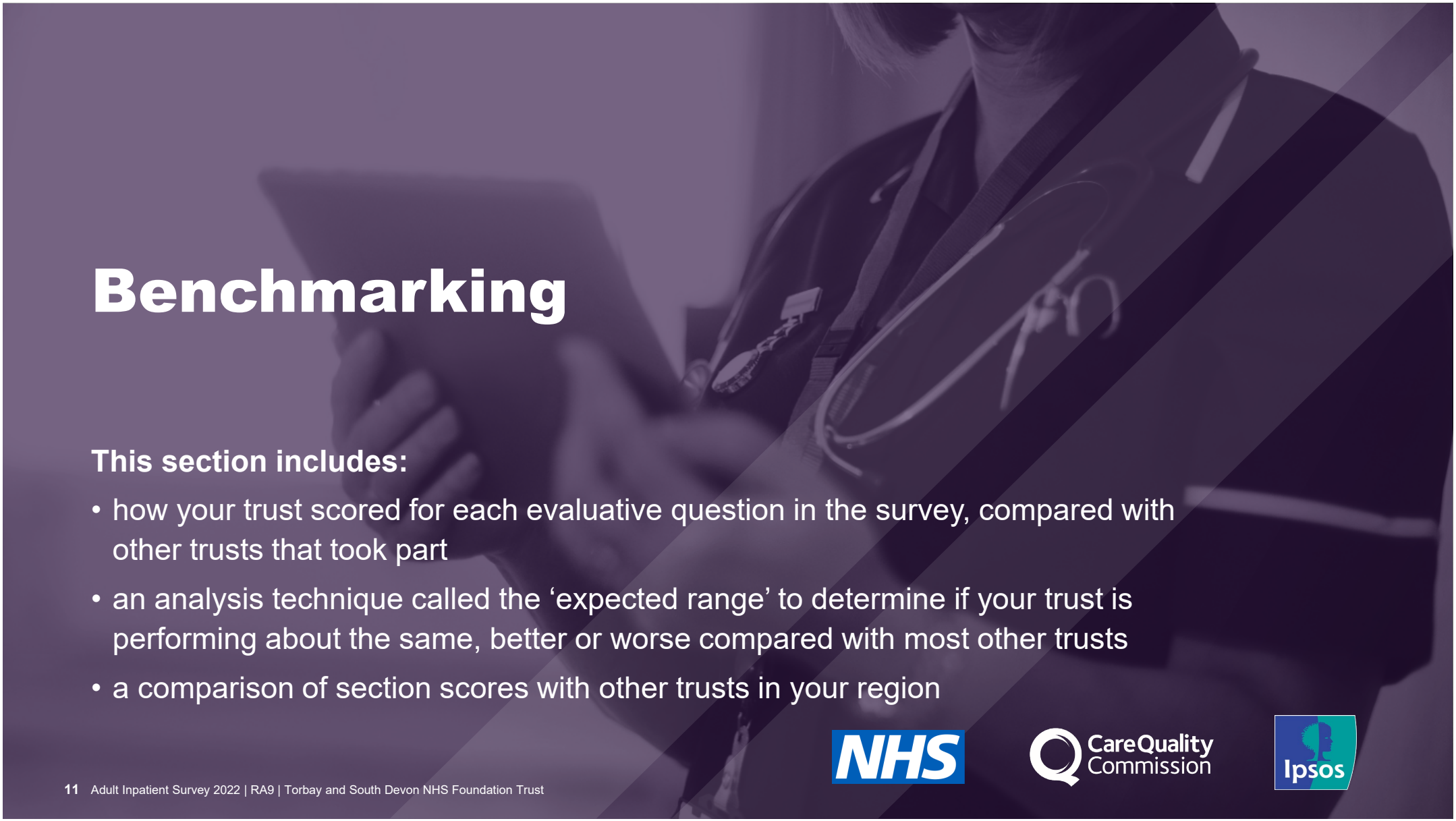
Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average (the average trust score across England).

- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.







Benchmarking

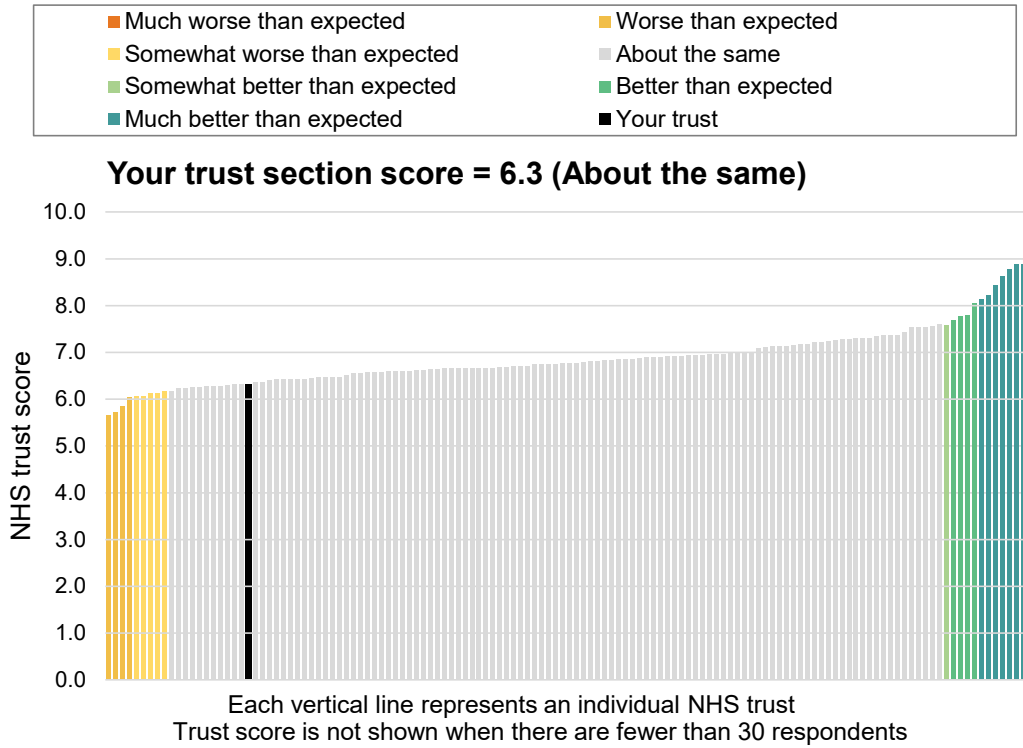
This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts
- a comparison of section scores with other trusts in your region

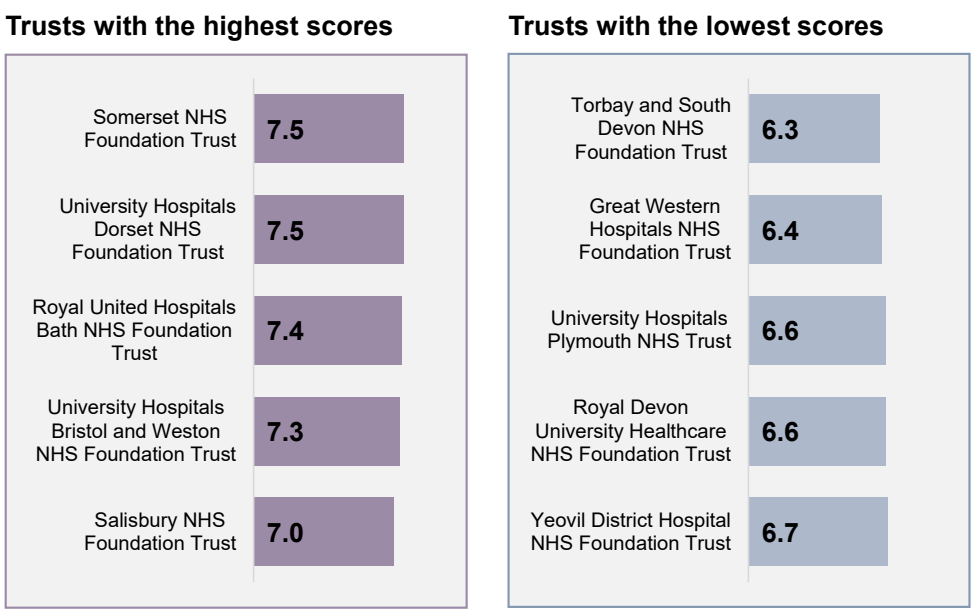
Section 1. Admission to hospital

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



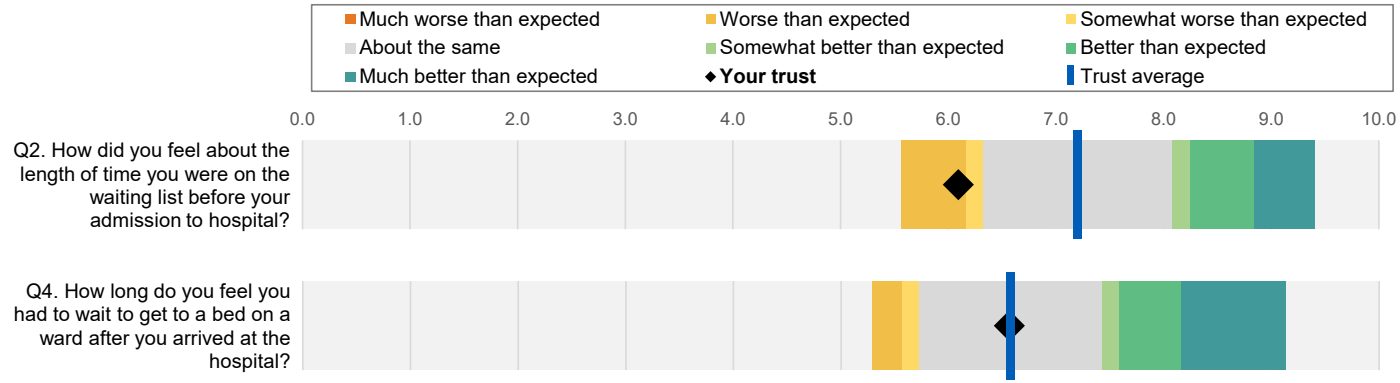
Comparison with other trusts within your region



Section 1. Admission to hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



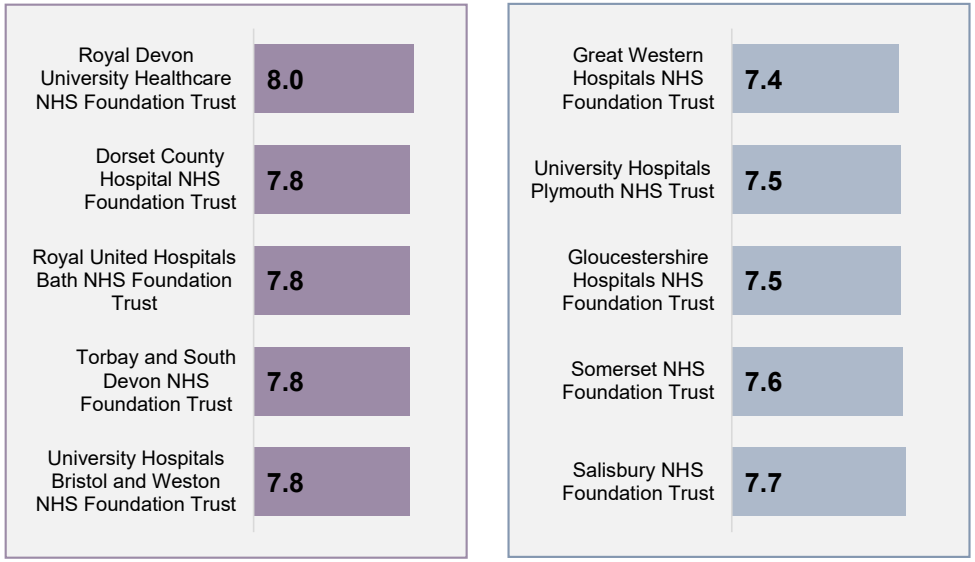
	Number of respondents (your trust)		All trusts in England	Lowest score	Highest score
Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?	134	Worse	7.2	5.6	9.4
Q4. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	524	About the same	6.6	5.3	9.1

Section 2. The hospital and ward

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

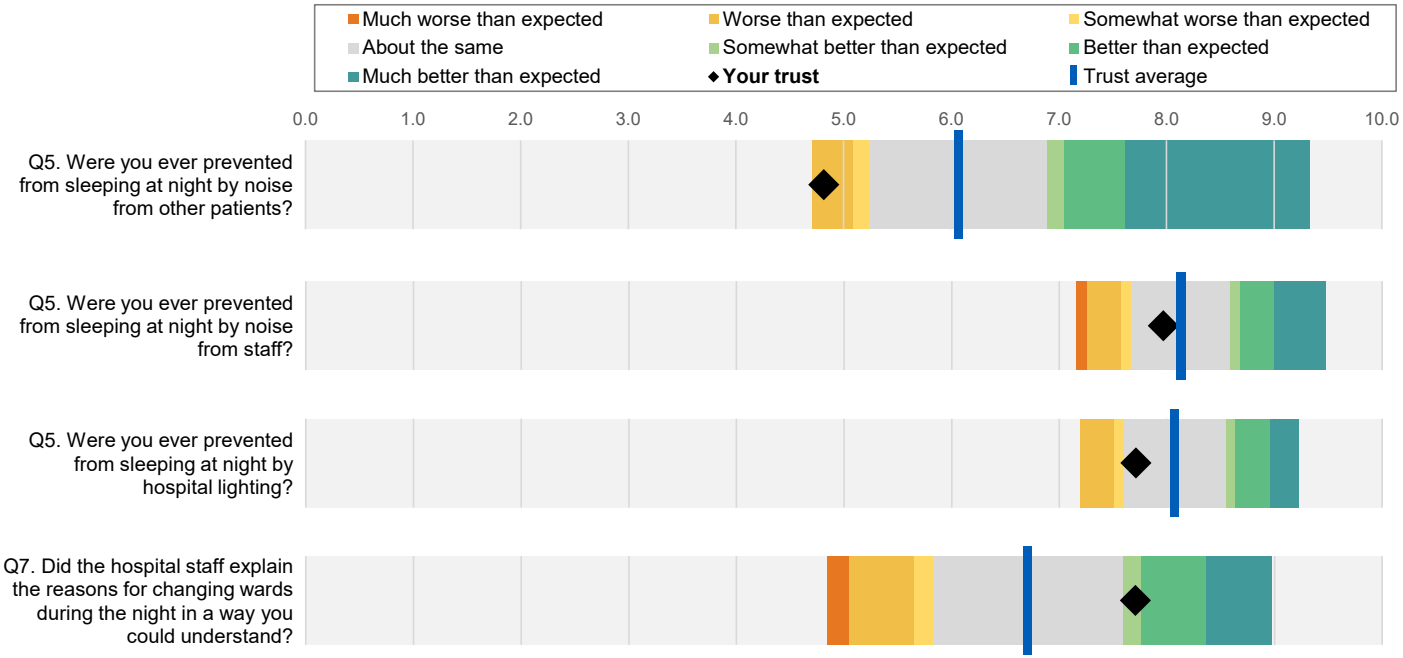
Comparison with other trusts within your region



Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

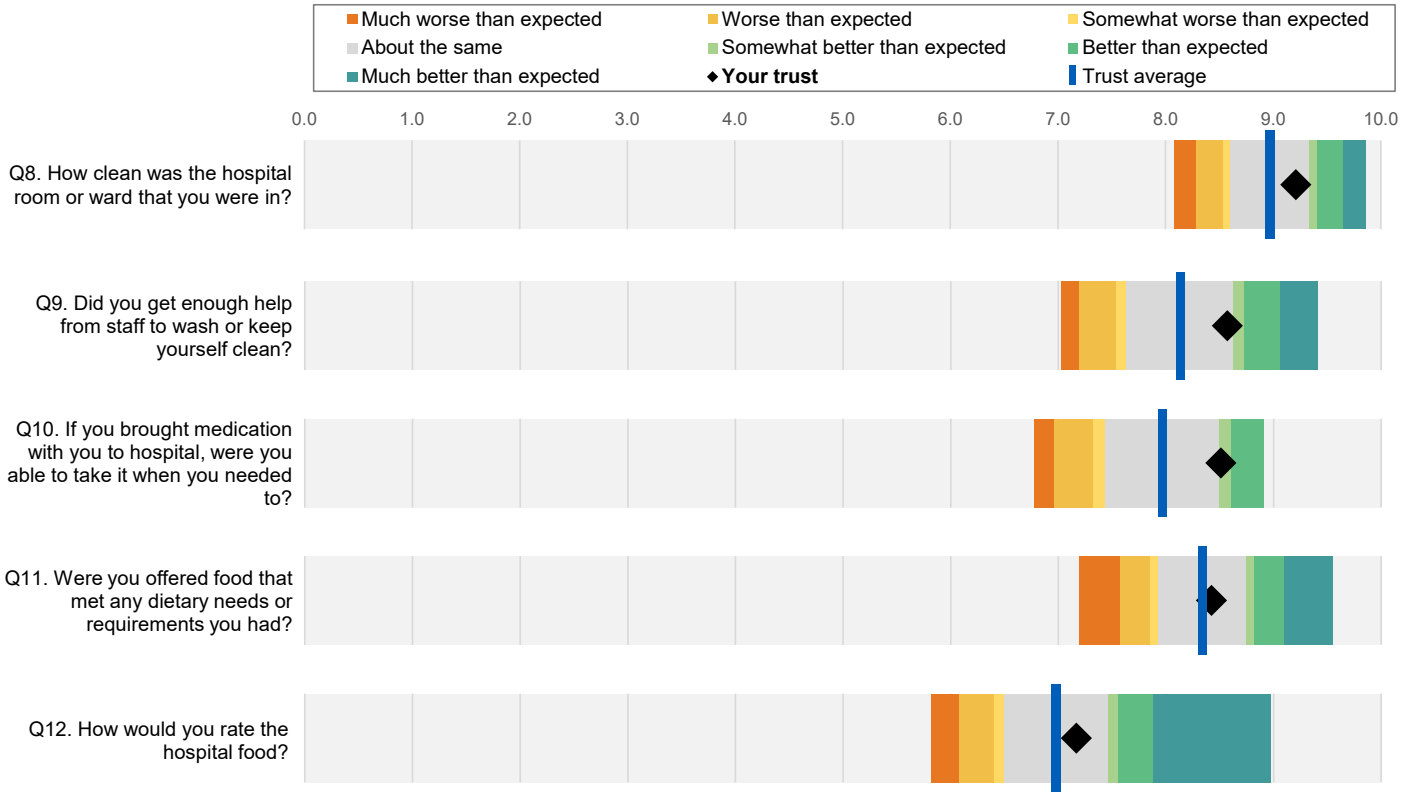


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Worse	491	4.8	6.1	4.7	9.3
About the same	491	8.0	8.1	7.2	9.5
About the same	491	7.7	8.1	7.2	9.2
Somewhat better	95	7.7	6.7	4.8	9.0

Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



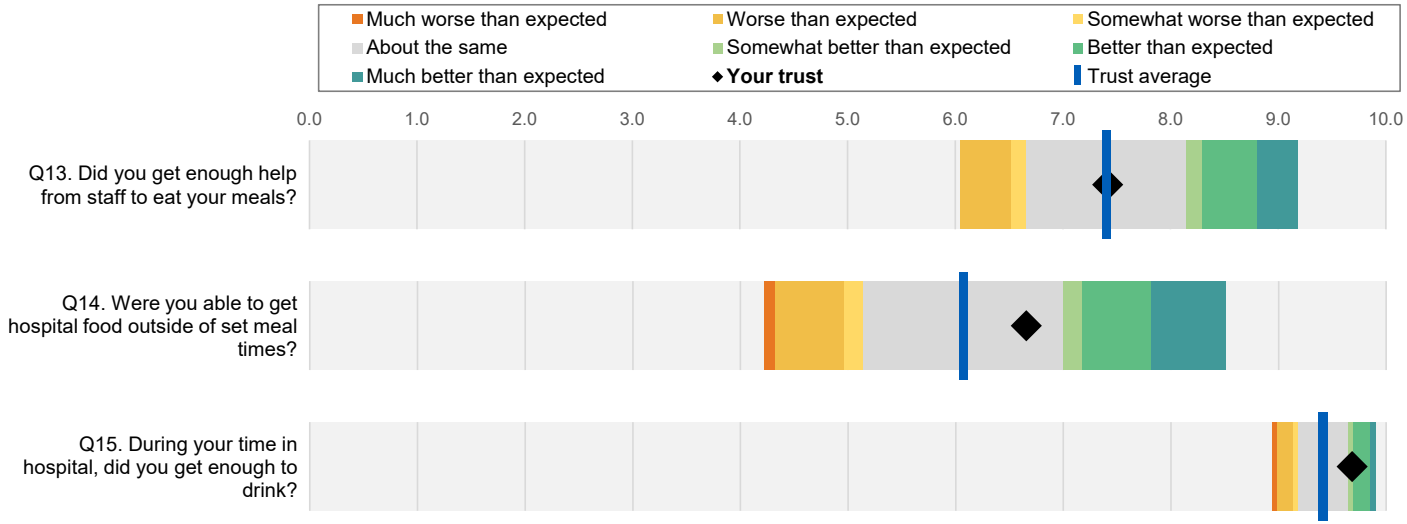
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Q8. How clean was the hospital room or ward that you were in?	532	9.2	9.0	8.1	9.9
Q9. Did you get enough help from staff to wash or keep yourself clean?	381	8.6	8.1	7.0	9.4
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?	275	8.5	8.0	6.8	8.9
Q11. Were you offered food that met any dietary needs or requirements you had?	272	8.4	8.3	7.2	9.5
Q12. How would you rate the hospital food?	523	7.2	7.0	5.8	9.0

Q8. How clean was the hospital room or ward that you were in?	About the same
Q9. Did you get enough help from staff to wash or keep yourself clean?	About the same
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?	Somewhat better
Q11. Were you offered food that met any dietary needs or requirements you had?	About the same
Q12. How would you rate the hospital food?	About the same

Section 2. The hospital and ward (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

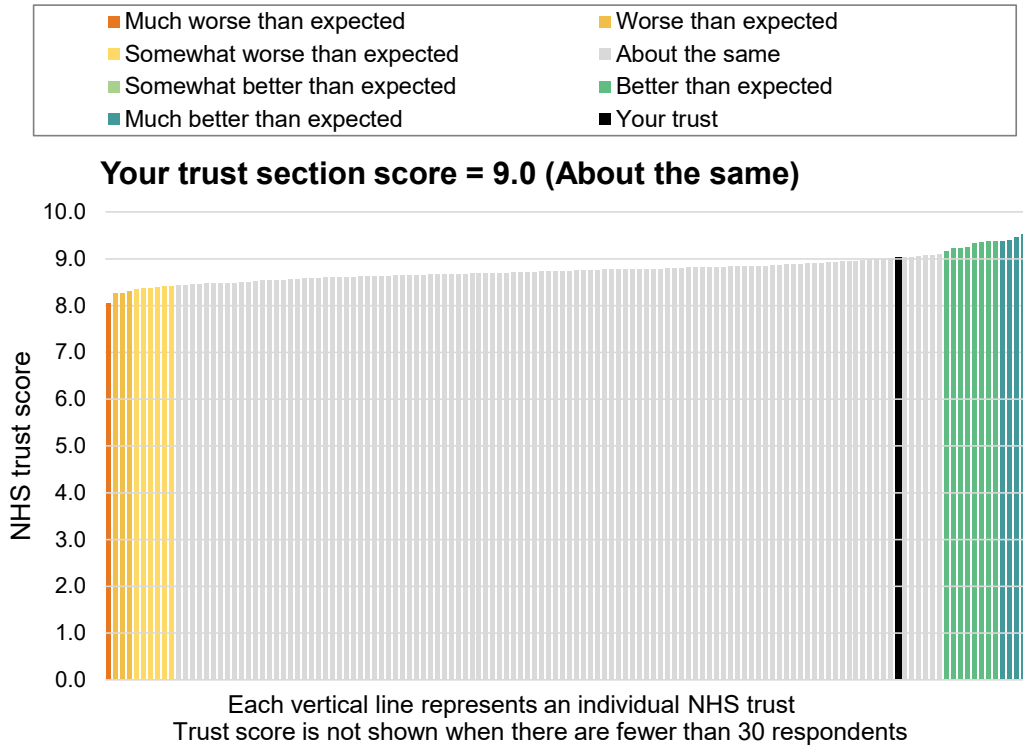


			All trusts in England	
Number of respondents (your trust)			Lowest score	Highest score
126	About the same	7.4	6.0	9.2
203	About the same	6.7	6.1	4.2	8.5
514	Somewhat better	9.7	9.4	8.9	9.9

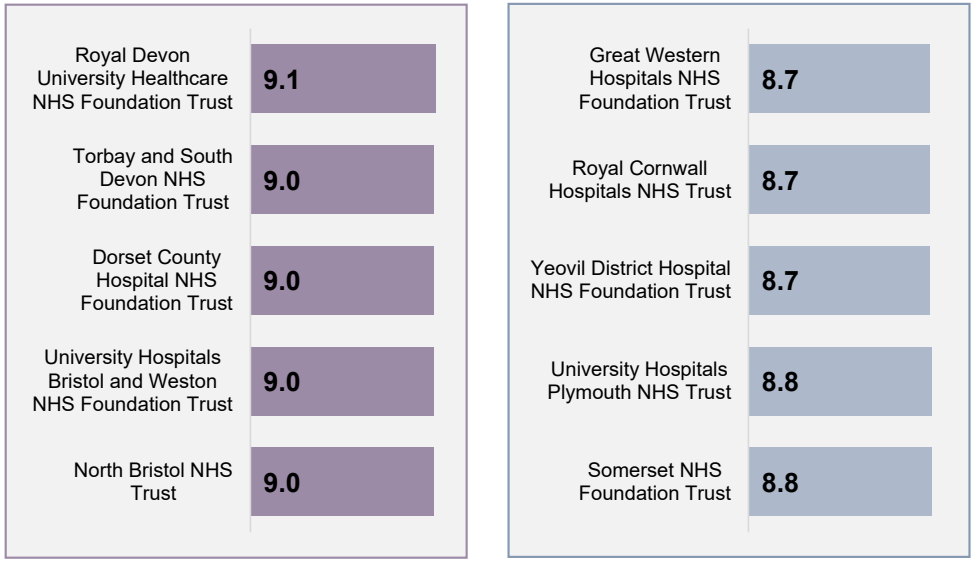
Section 3. Doctors

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region



Section 3. Doctors (continued)

Question scores

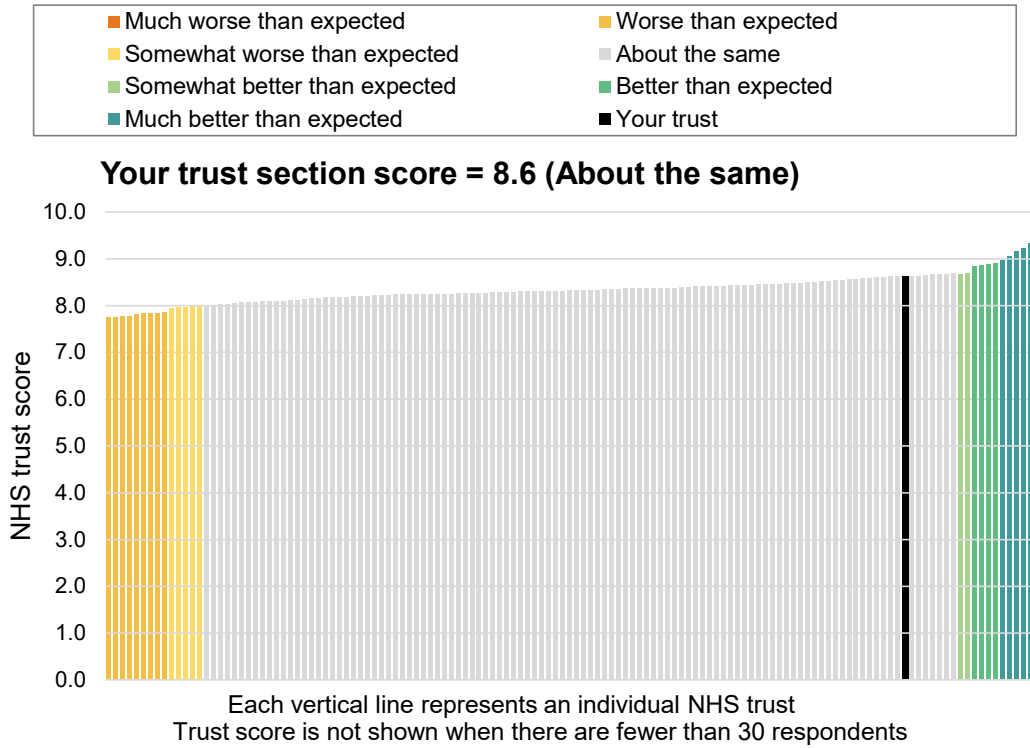
Trust score is not shown when there are fewer than 30 respondents.

			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Q16. When you asked doctors questions, did you get answers you could understand?	501	9.0	8.6	7.9	9.5
Q17. Did you have confidence and trust in the doctors treating you?	543	9.3	9.1	8.4	9.8
Q18. When doctors spoke about your care in front of you, were you included in the conversation?	538	8.8	8.6	7.9	9.7

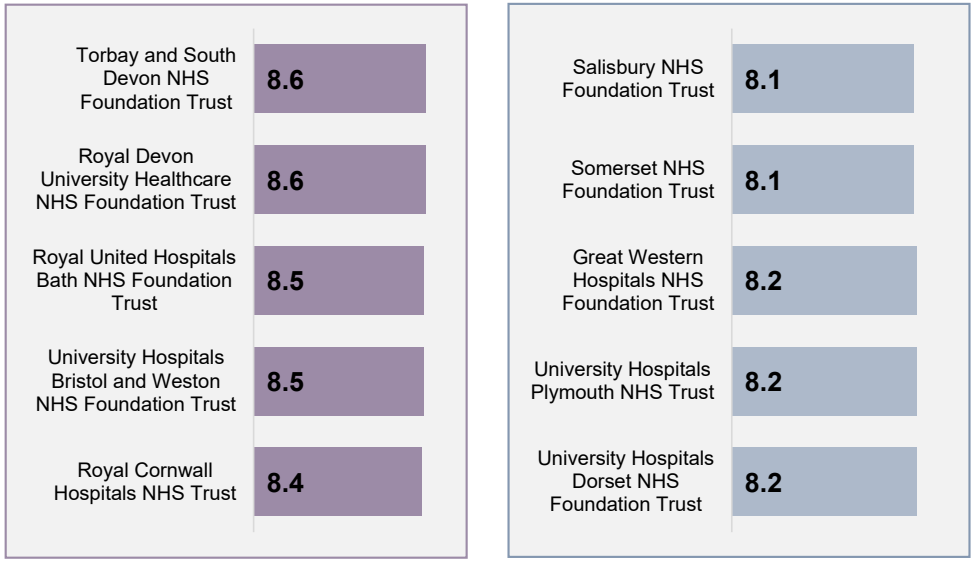
Section 4. Nurses

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



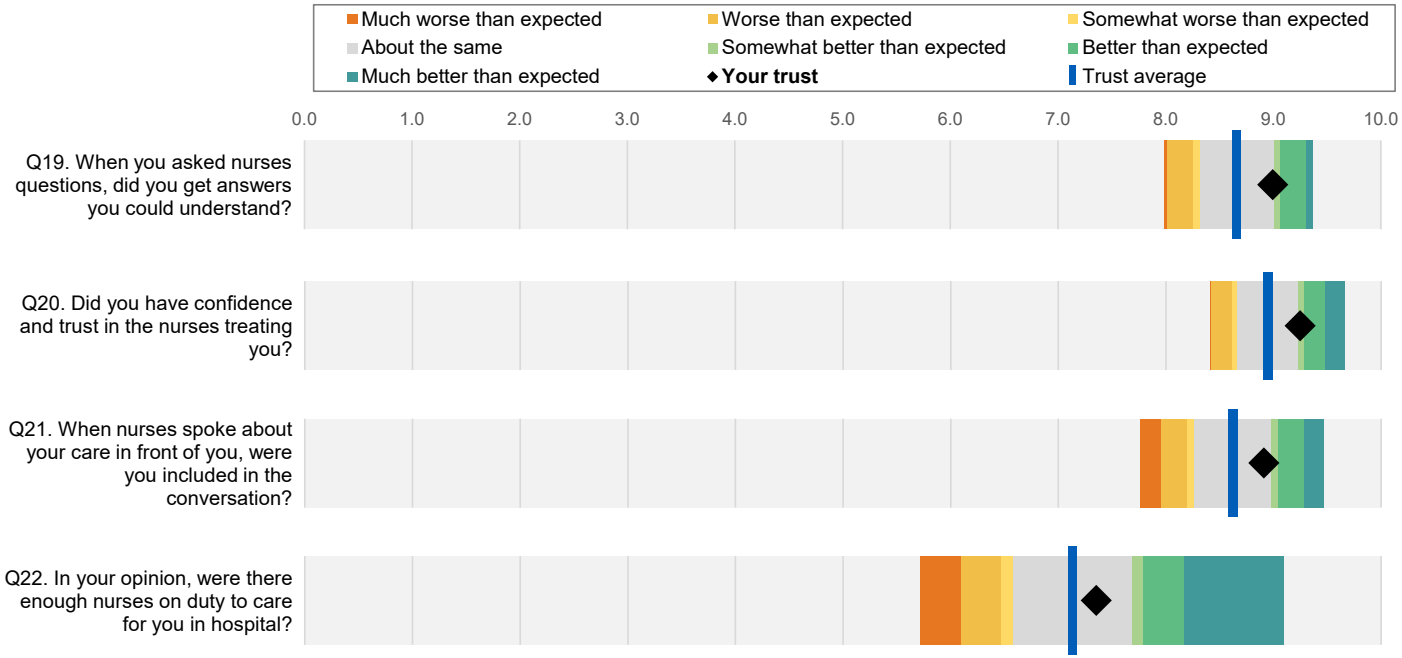
Comparison with other trusts within your region



Section 4. Nurses (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



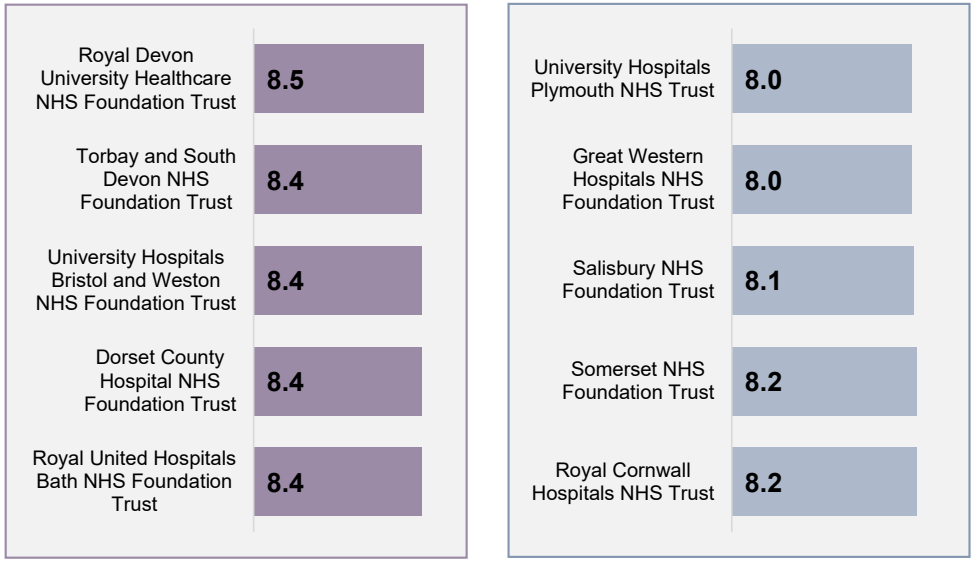
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	512	9.0	8.7	8.0	9.4
Somewhat better	542	9.2	8.9	8.4	9.7
About the same	537	8.9	8.6	7.8	9.5
About the same	540	7.4	7.1	5.7	9.1

Section 5. Your care and treatment

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

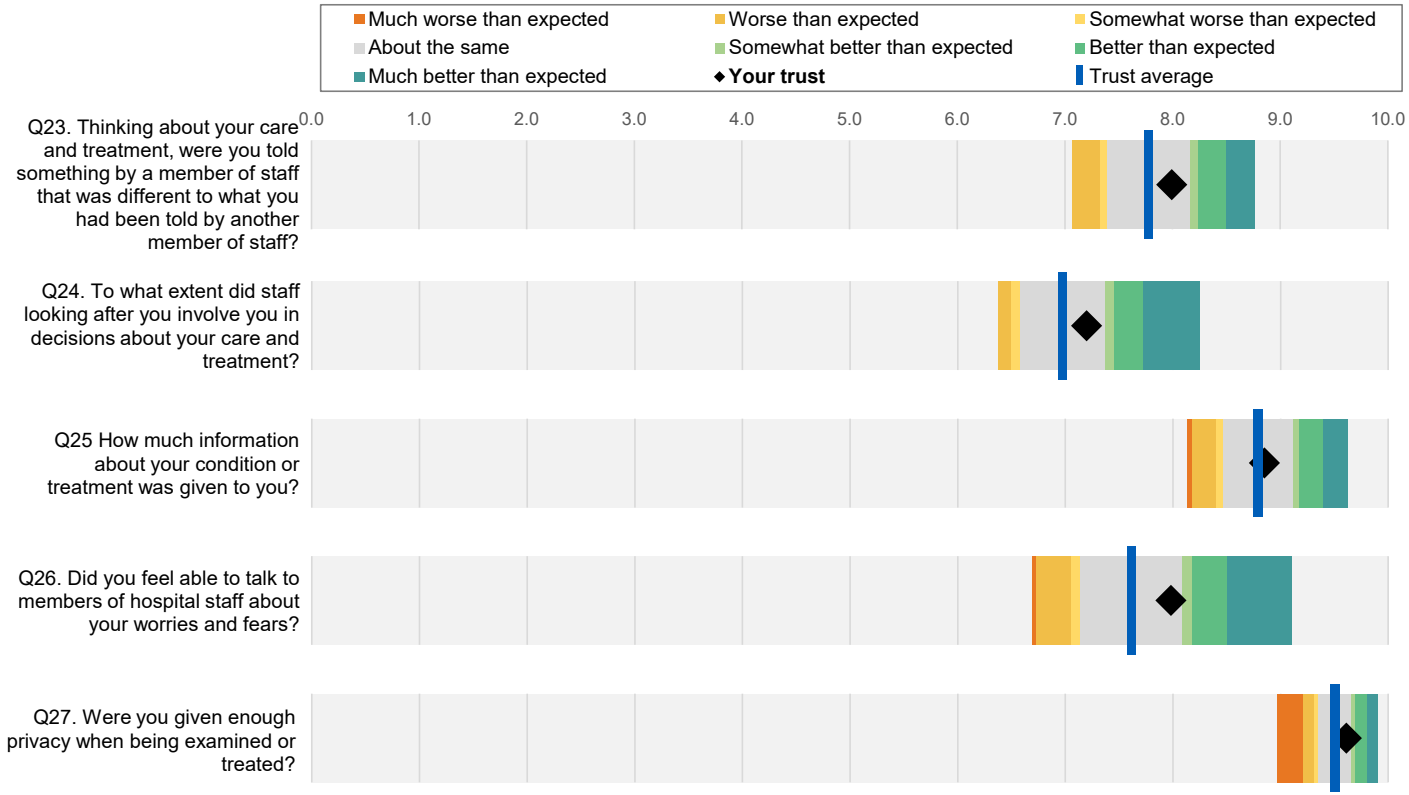
Comparison with other trusts within your region



Section 5. Your care and treatment (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.



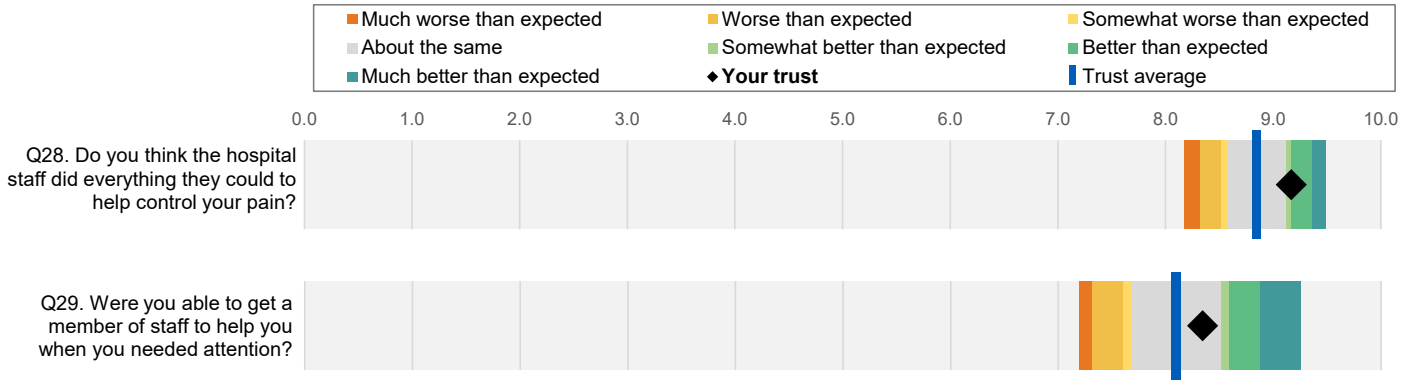
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Q23. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	490	8.0	7.8	7.1	8.8
Q24. To what extent did staff looking after you involve you in decisions about your care and treatment?	517	7.2	7.0	6.4	8.2
Q25 How much information about your condition or treatment was given to you?	530	8.8	8.8	8.1	9.6
Q26. Did you feel able to talk to members of hospital staff about your worries and fears?	458	8.0	7.6	6.7	9.1
Q27. Were you given enough privacy when being examined or treated?	536	9.6	9.5	9.0	9.9

About the same

Section 5. Your care and treatment (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

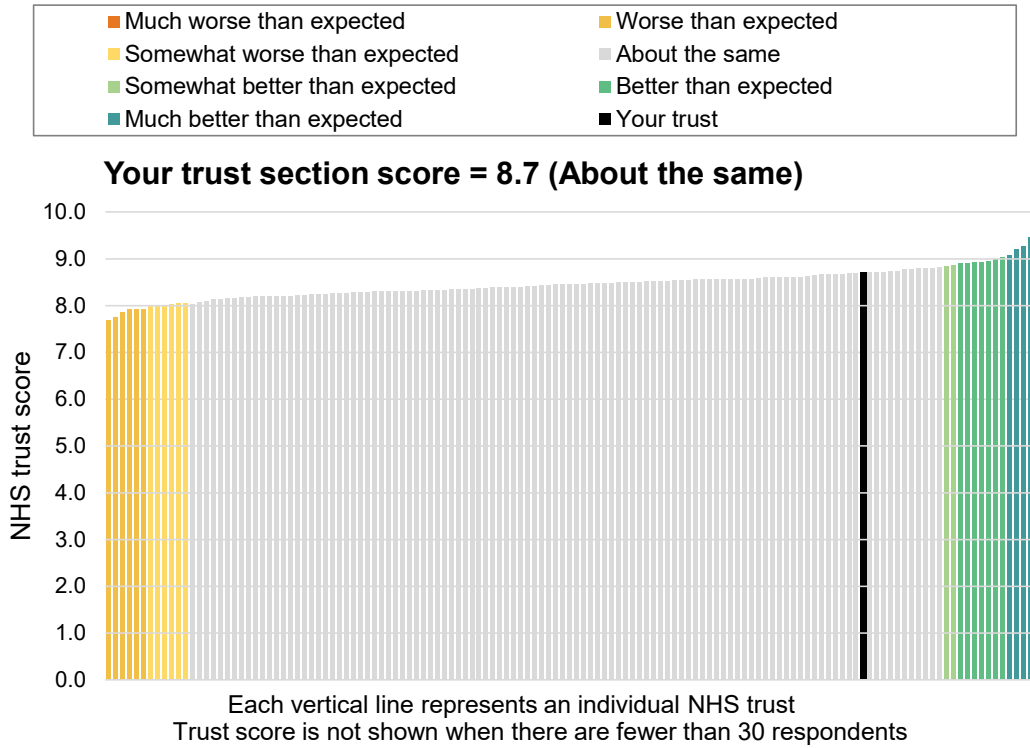


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
454	9.2	8.8	8.2	9.5
495	8.3	8.1	7.2	9.3

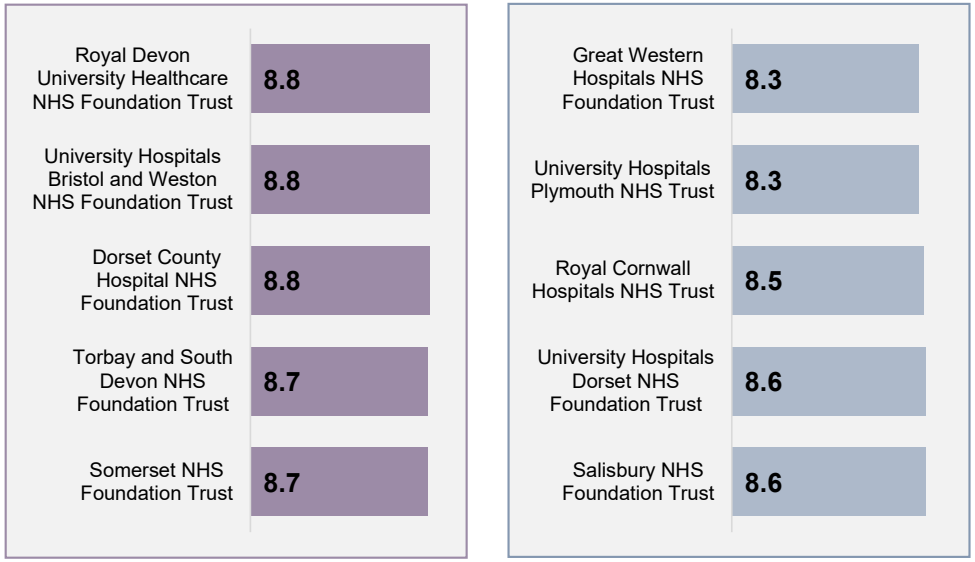
Section 6. Operations and procedures

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



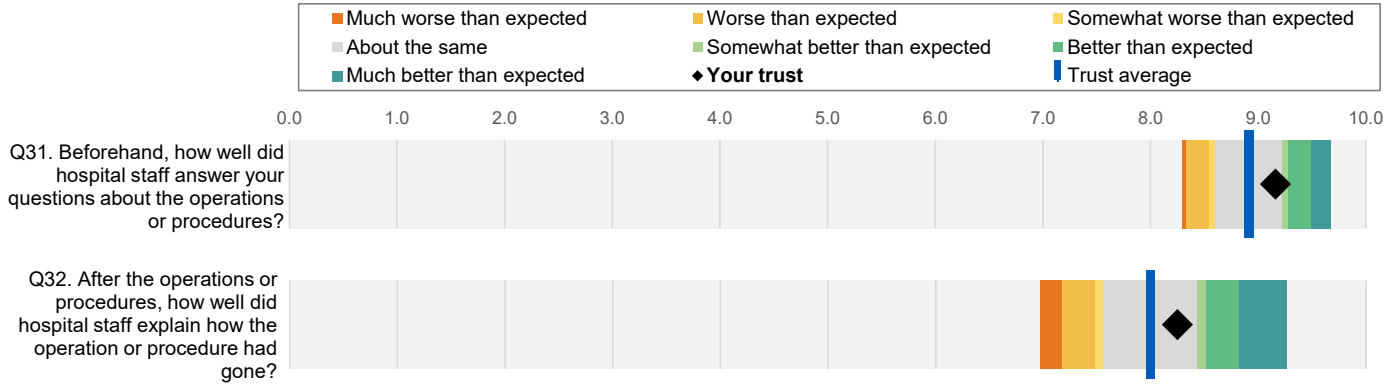
Comparison with other trusts within your region



Section 6. Operations and procedures (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

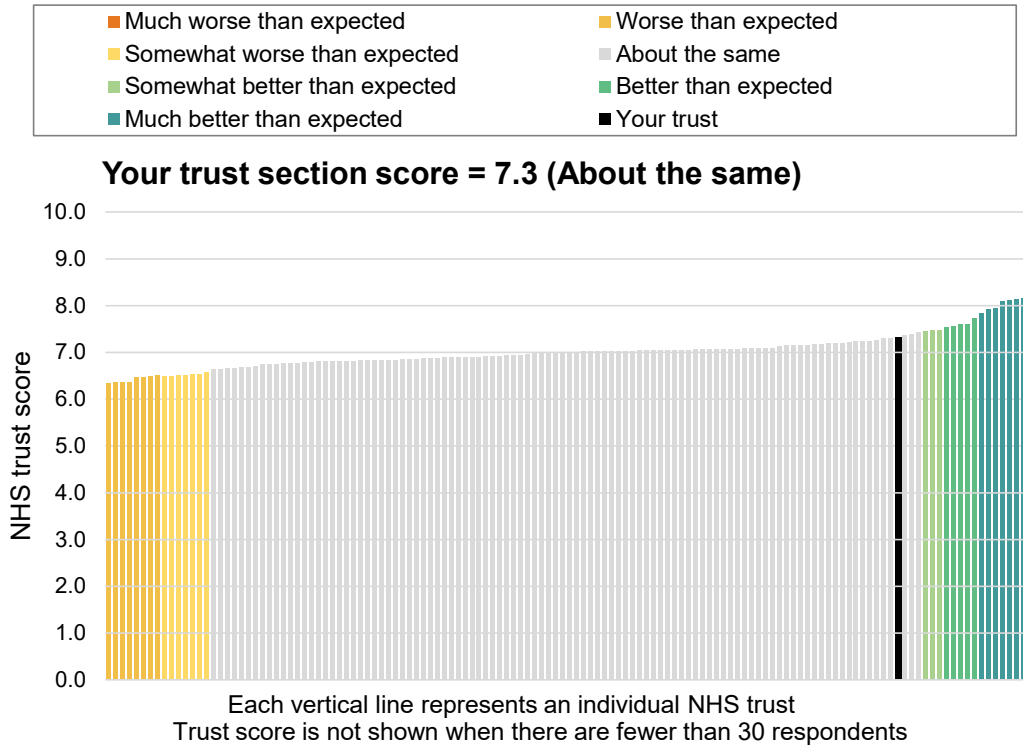


			All trusts in England	
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
275	9.2	8.9	8.3	9.7
298	8.2	8.0	7.0	9.3

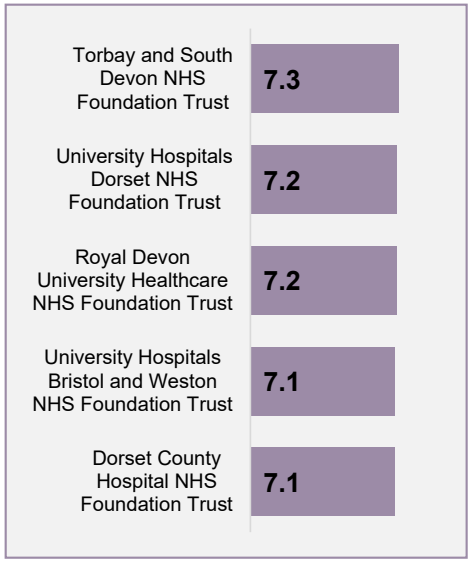
Section 7. Leaving hospital

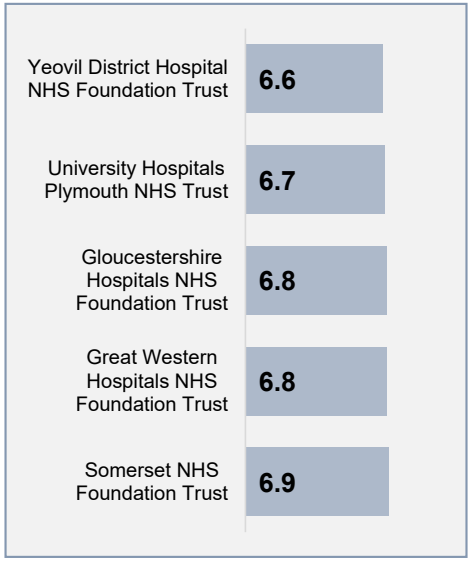
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region

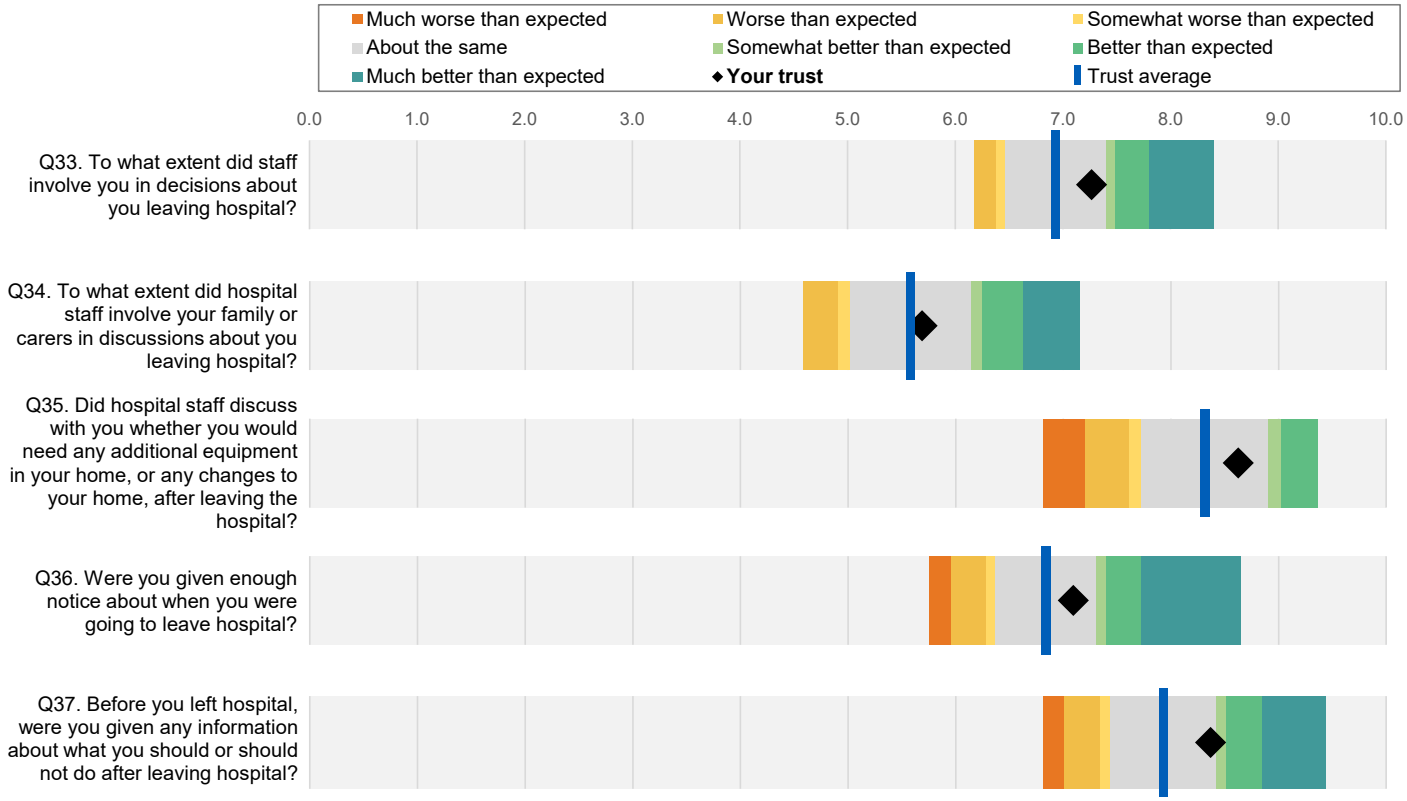




Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

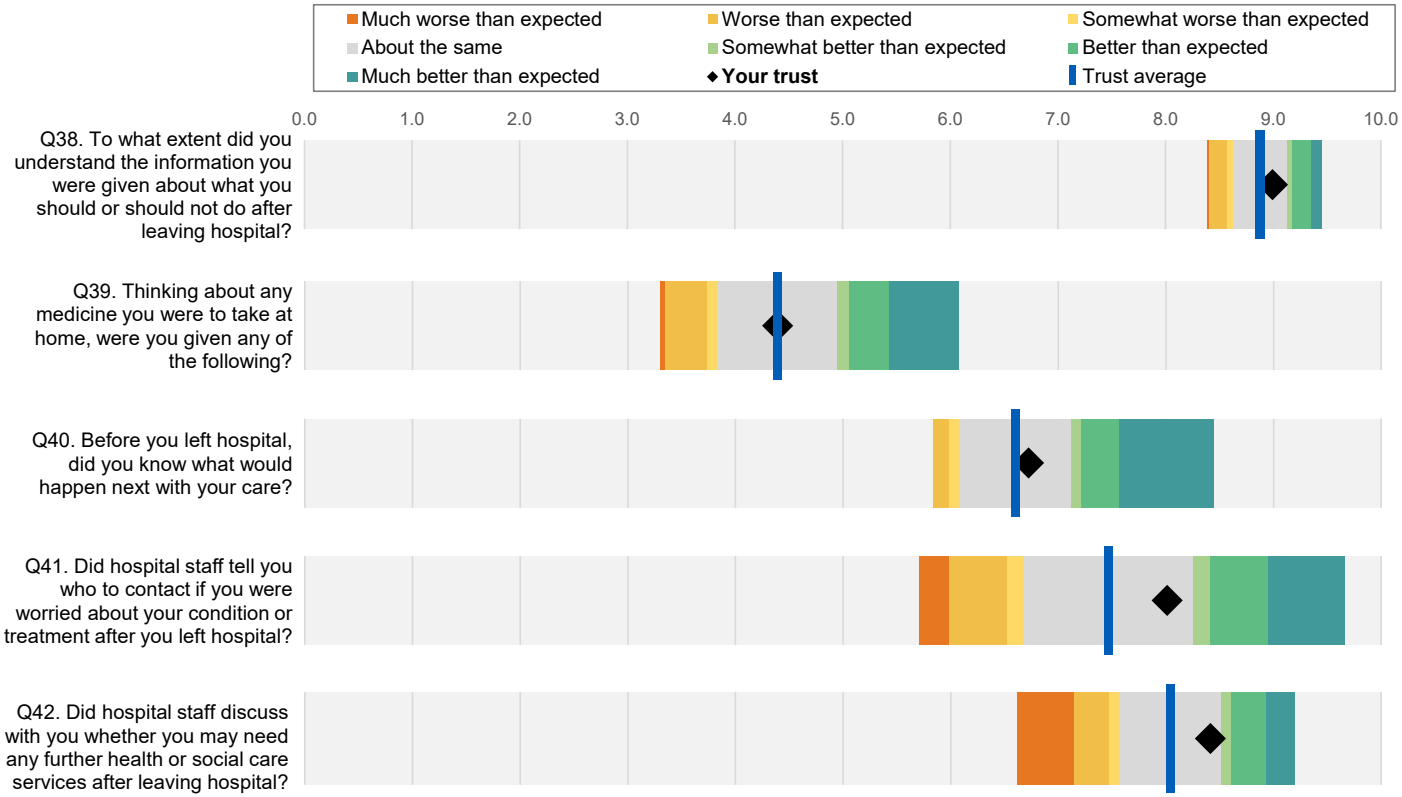


	Number of respondents (your trust)	Your trust score	All trusts in England: Trust average score	All trusts in England: Lowest score	All trusts in England: Highest score
Q33. To what extent did staff involve you in decisions about you leaving hospital?	537	7.3	6.9	6.2	8.4
Q34. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	367	5.7	5.6	4.6	7.2
Q35. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	225	8.6	8.3	6.8	9.4
Q36. Were you given enough notice about when you were going to leave hospital?	543	7.1	6.8	5.8	8.7
Q37. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	512	8.4	7.9	6.8	9.4

Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

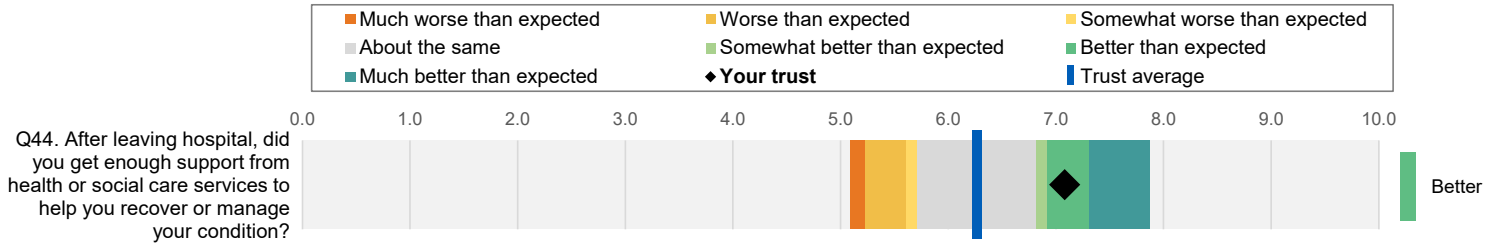


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
404	9.0	8.9	8.4	9.4
402	4.4	4.4	3.3	6.1
494	6.7	6.6	5.8	8.4
496	8.0	7.5	5.7	9.7
316	8.4	8.0	6.6	9.2

Section 7. Leaving hospital (continued)

Question scores

Trust score is not shown when there are fewer than 30 respondents.

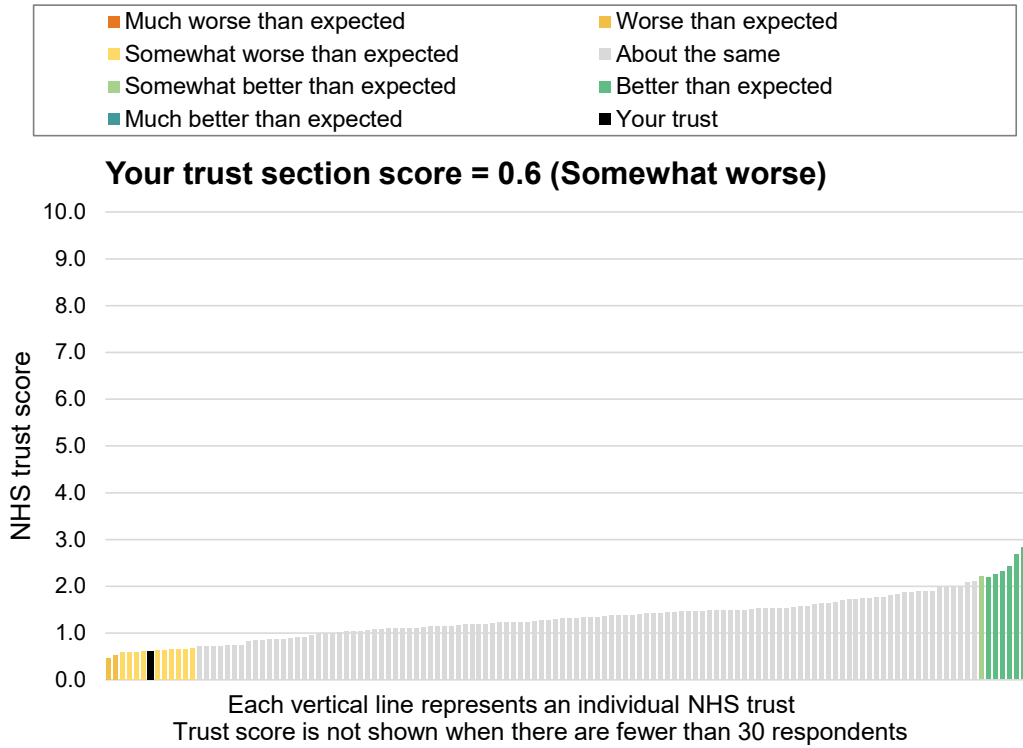


		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
313	7.1	6.3	5.1	7.9

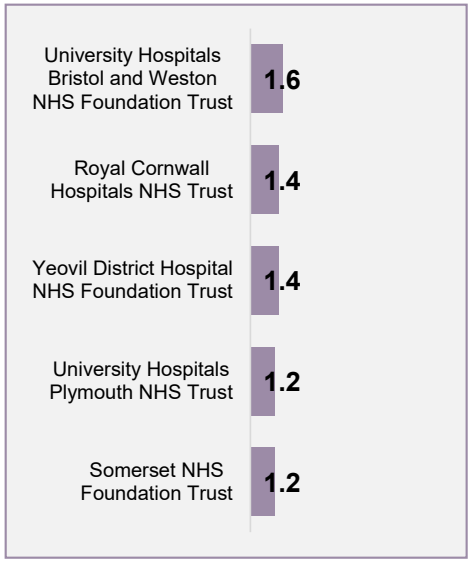
Section 8. Feedback on the quality of your care

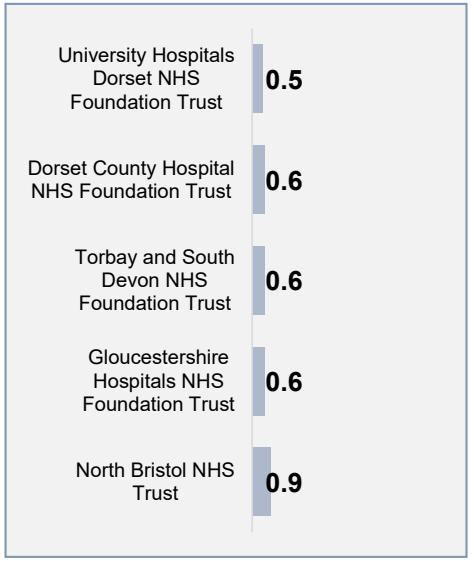
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region

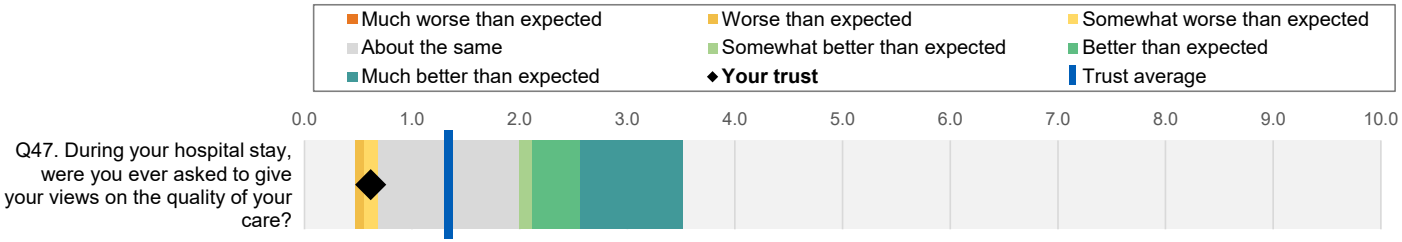




Section 8. Feedback on the quality of your care (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.

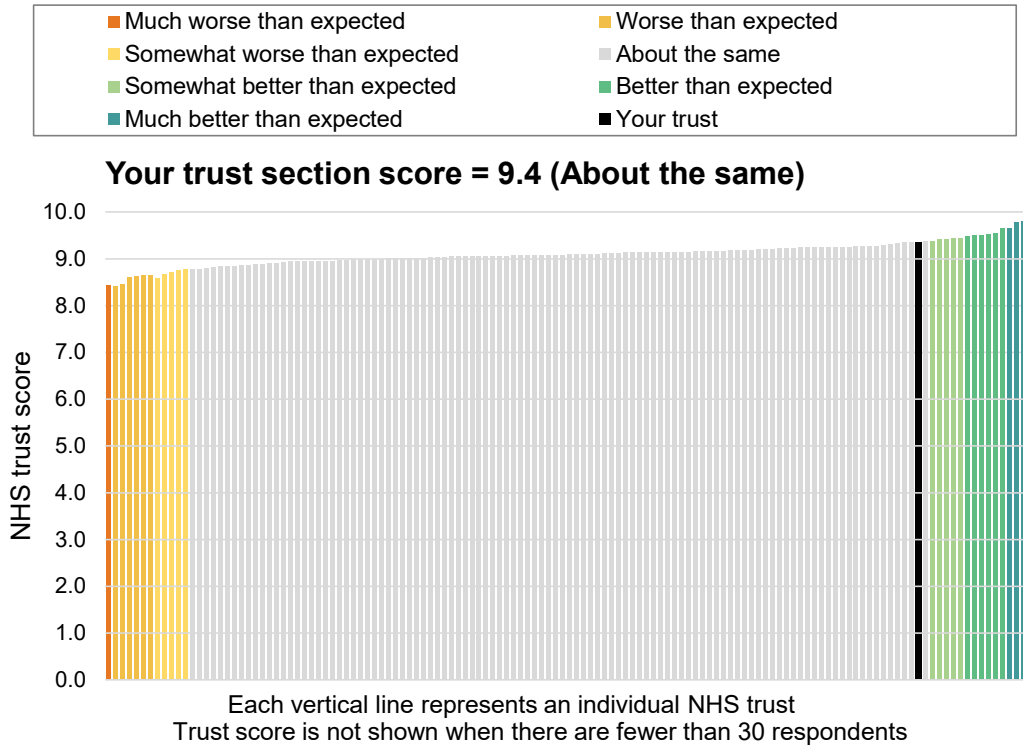


		All trusts in England		
Number of respondents (your trust)			Lowest score	Highest score
468		1.3	0.5	3.5

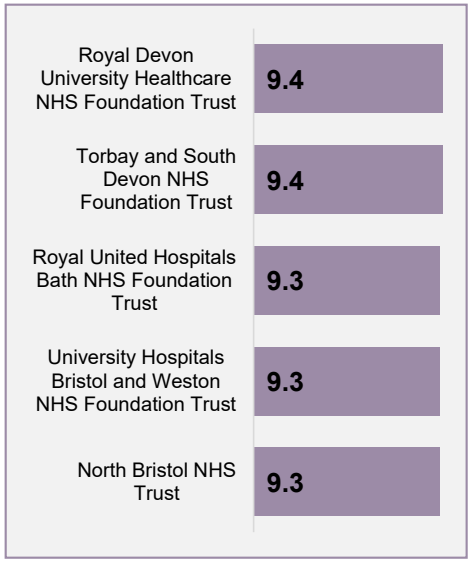
Section 9. Respect and dignity

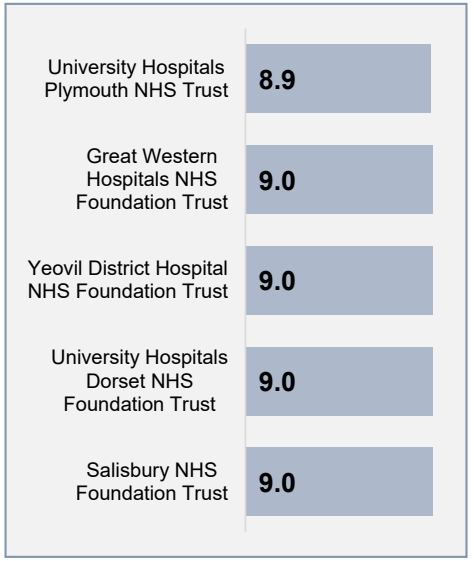
Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region

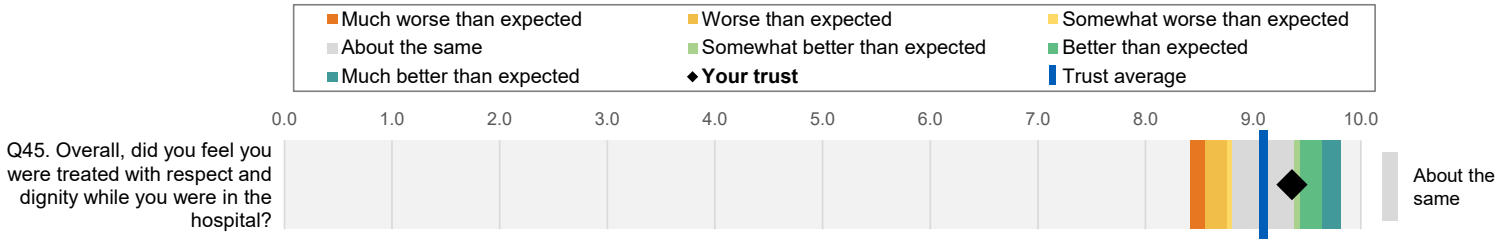




Section 9. Respect and dignity (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.



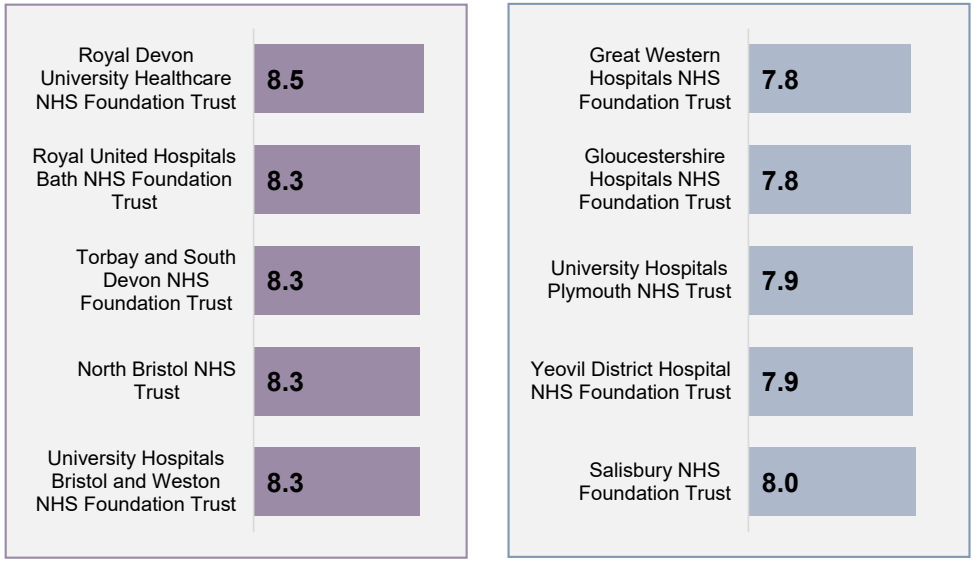
		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
543	9.4	9.1	8.4	9.8

Section 10. Overall experience

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

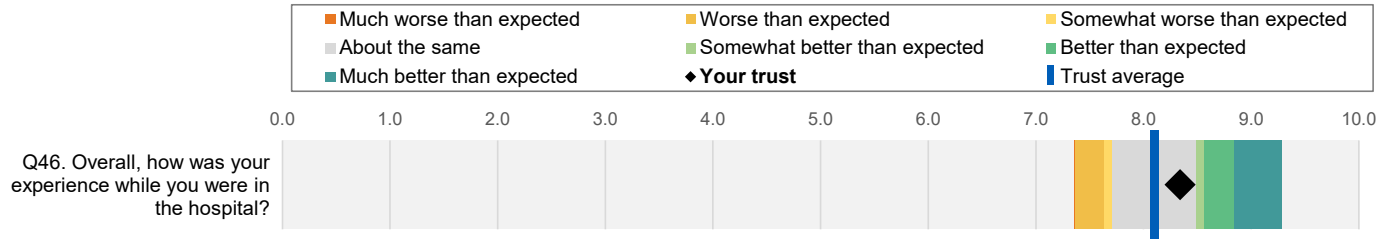
Comparison with other trusts within your region



Section 10. Overall experience (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.

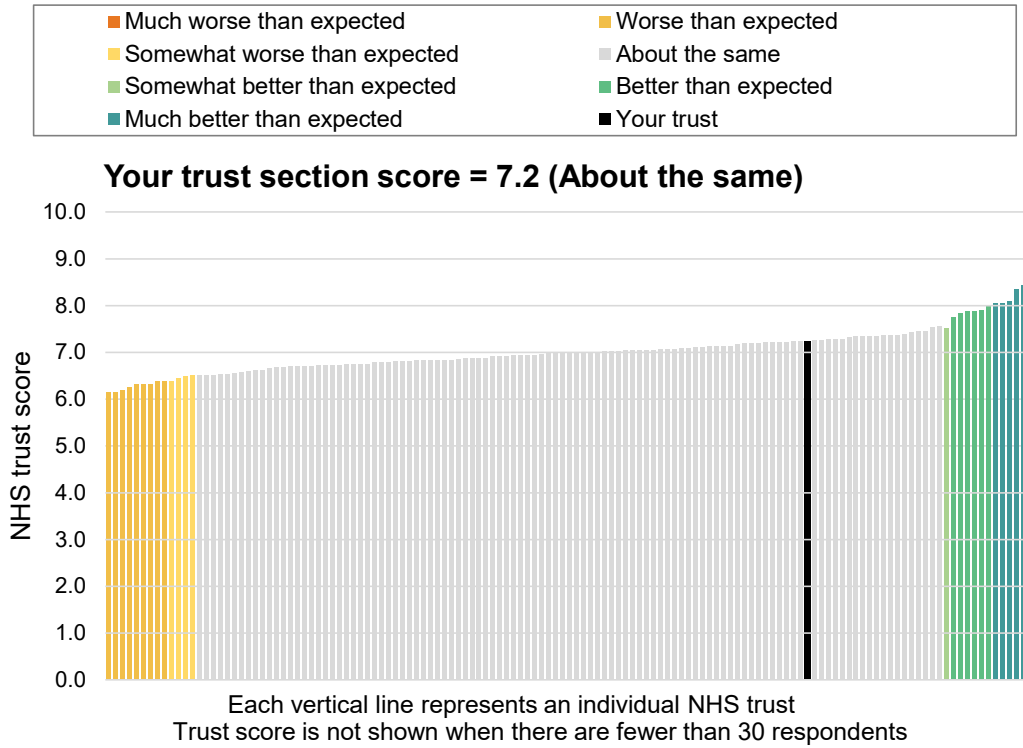


		All trusts in England		
Number of respondents (your trust)			Lowest score	Highest score
543		8.1	7.4	9.3

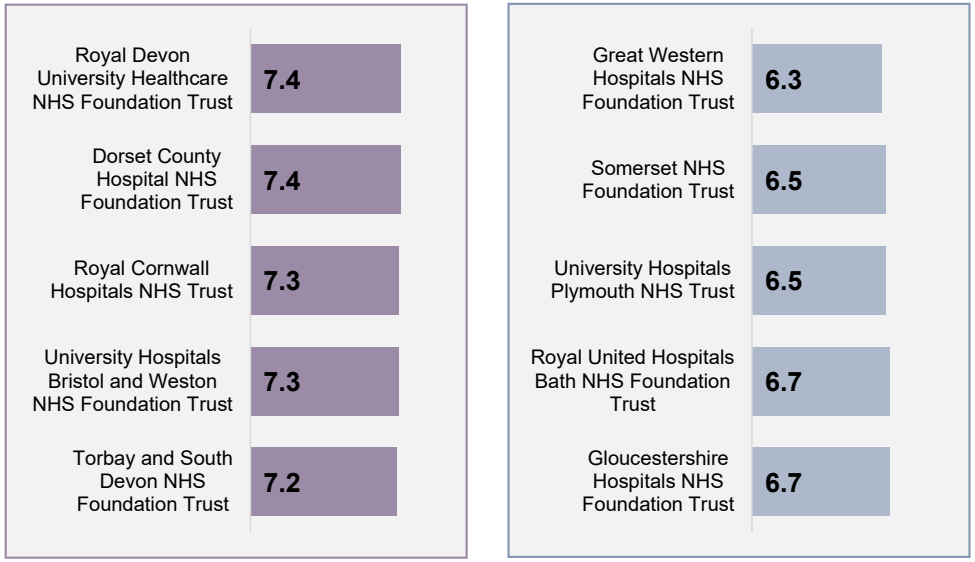
Section 11. Long-term condition

Section score

This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



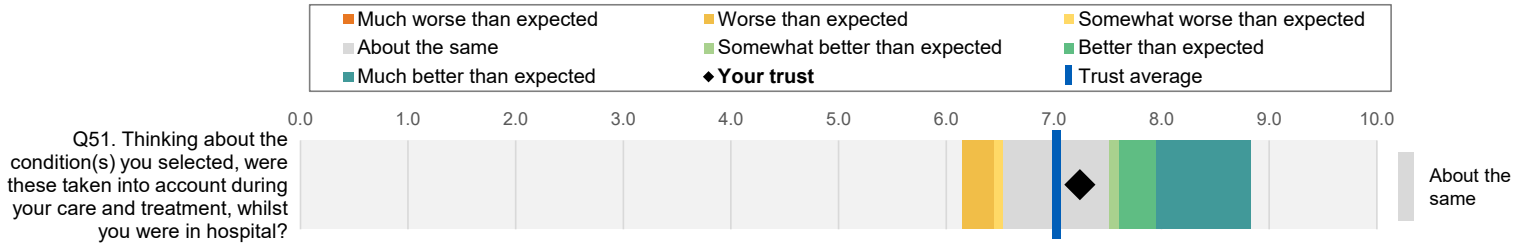
Comparison with other trusts within your region



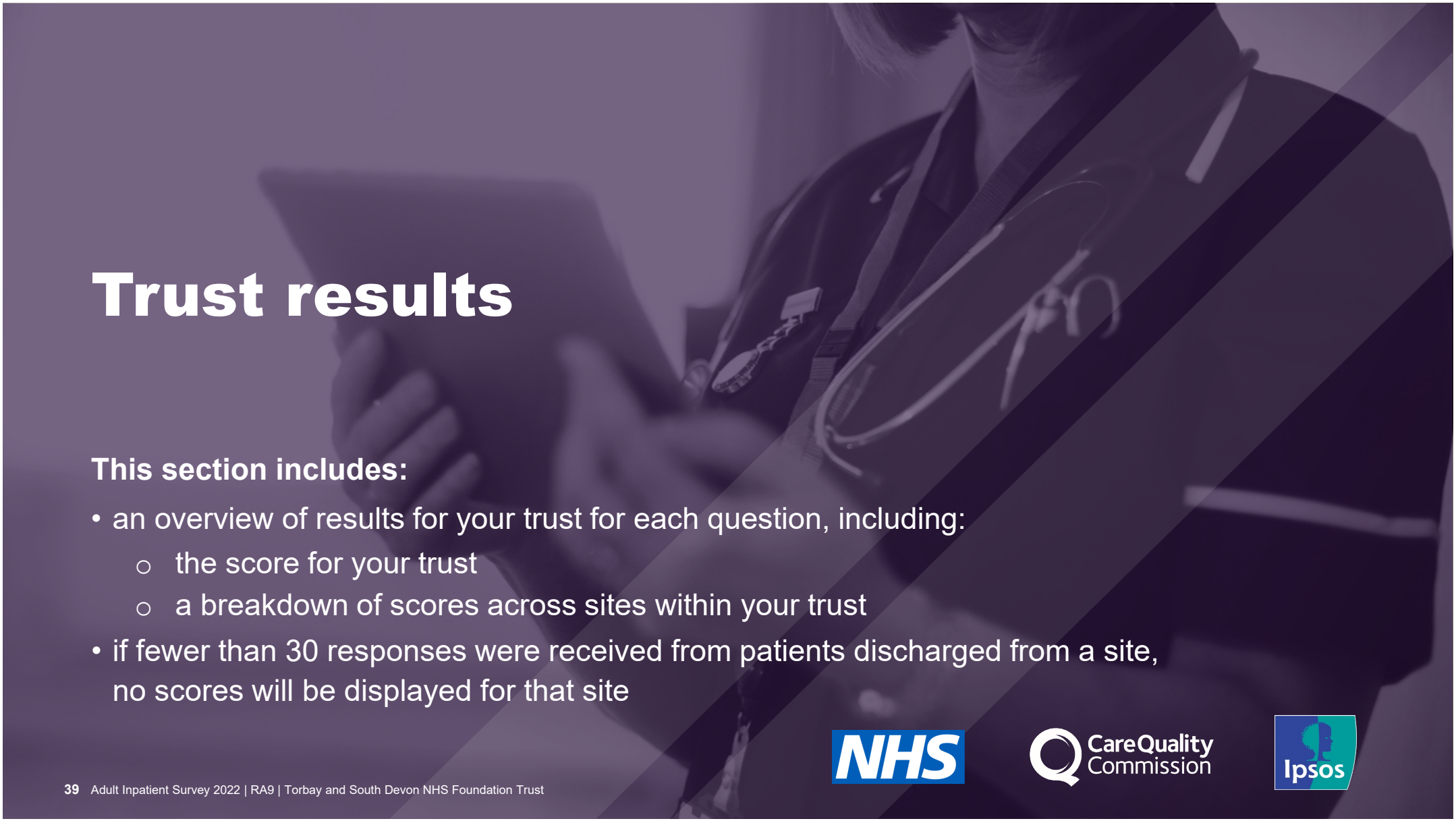
Section 11. Long term condition (continued)

Question score

Trust score is not shown when there are fewer than 30 respondents.



		All trusts in England		
Number of respondents (your trust)			Lowest score	Highest score
407		7.0	6.2	8.8



Trust results

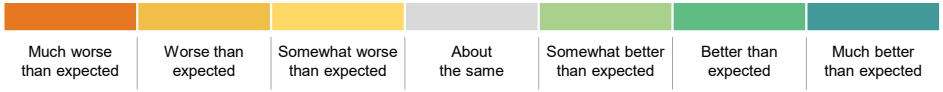
This section includes:

- an overview of results for your trust for each question, including:
  - the score for your trust
  - a breakdown of scores across sites within your trust
- if fewer than 30 responses were received from patients discharged from a site, no scores will be displayed for that site

Admission to hospital

Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?

Results for your trust

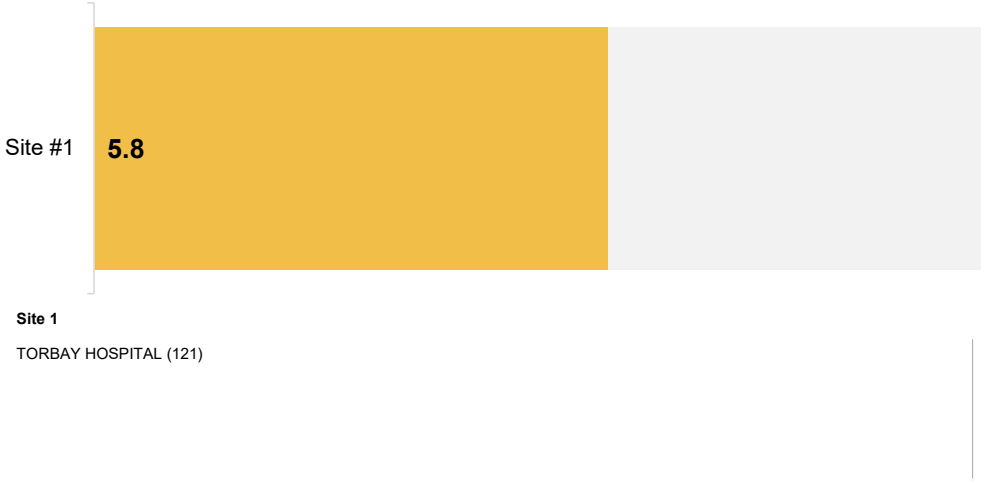


Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

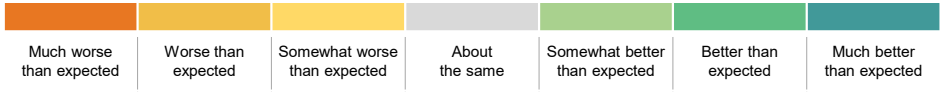
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Admission to hospital

Q4. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?

Results for your trust



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Breakdown of scores for sites within your trust:

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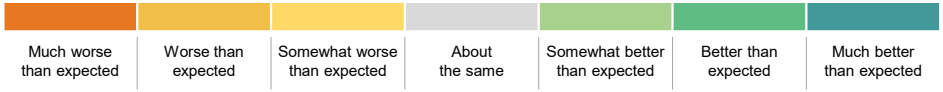
The hospital and ward

Q5. Were you ever prevented from sleeping at night by noise from other patients?

Results for your trust



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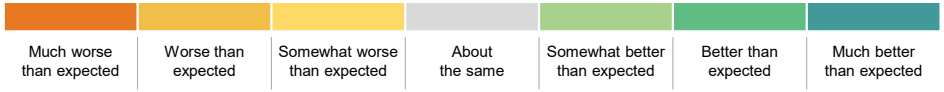
The hospital and ward

Q5. Were you ever prevented from sleeping at night by noise from staff?

Results for your trust



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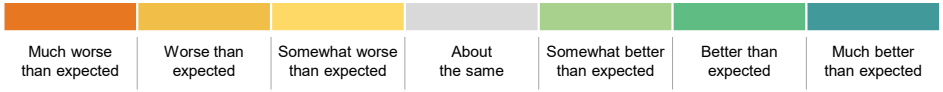
The hospital and ward

Q5. Were you ever prevented from sleeping at night by hospital lighting?

Results for your trust



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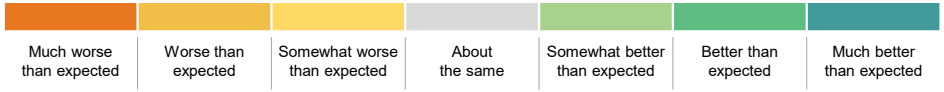
The hospital and ward

Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?

Results for your trust



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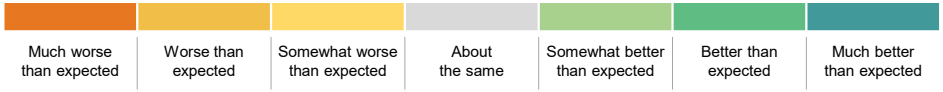
The hospital and ward

Q8. How clean was the hospital room or ward that you were in?

Results for your trust



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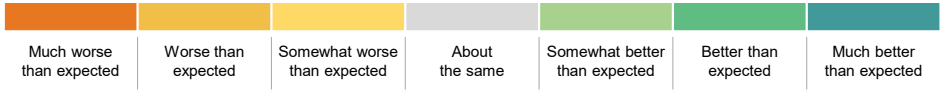
The hospital and ward

Q9. Did you get enough help from staff to wash or keep yourself clean?

Results for your trust



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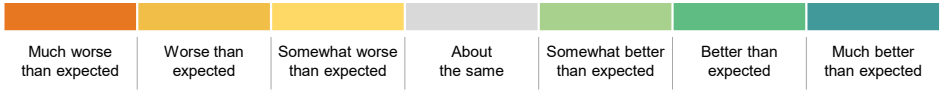
The hospital and ward

Q10. If you brought medication with you to hospital, were you able to take it when you needed to?

Results for your trust



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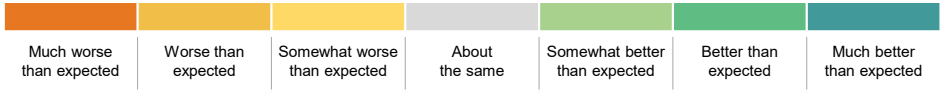
Site 1

TORBAY HOSPITAL (258)

The hospital and ward

Q11. Were you offered food that met any dietary needs or requirements you had?

Results for your trust



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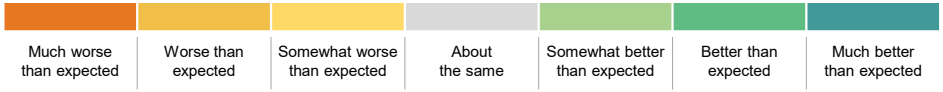
Site 1

TORBAY HOSPITAL (255)

The hospital and ward

Q12. How would you rate the hospital food?

Results for your trust



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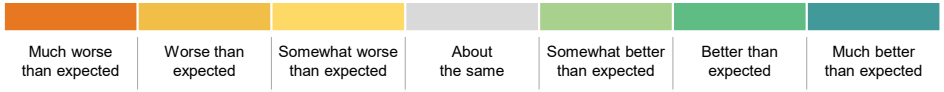
The hospital and ward

Q13. Did you get enough help from staff to eat your meals?

Results for your trust



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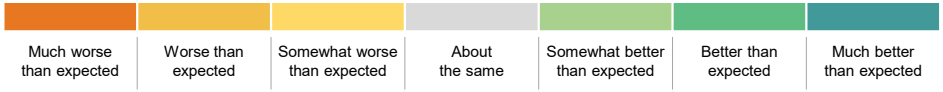
The hospital and ward

Q14. Were you able to get hospital food outside of set meal times?

Results for your trust



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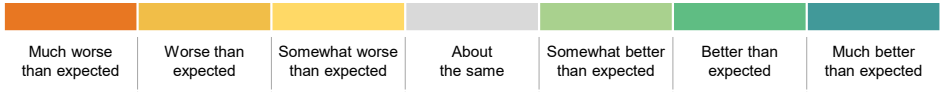
The hospital and ward

Q15. During your time in hospital, did you get enough to drink?

Results for your trust



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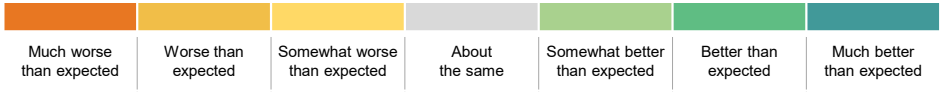
Doctors

Q16. When you asked doctors questions, did you get answers you could understand?

Results for your trust



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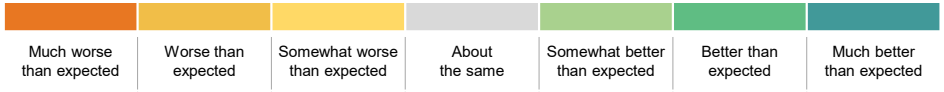
Doctors

Q17. Did you have confidence and trust in the doctors treating you?

Results for your trust



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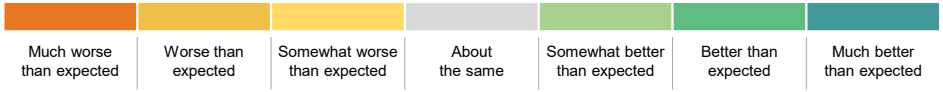
Doctors

Q18. When doctors spoke about your care in front of you, were you included in the conversation?

Results for your trust



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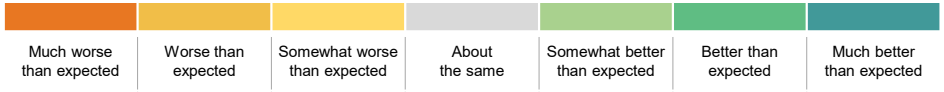
Nurses

Q19. When you asked nurses questions, did you get answers you could understand?

Results for your trust



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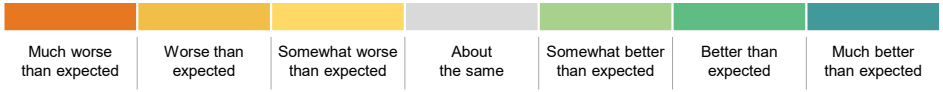
Nurses

Q20. Did you have confidence and trust in the nurses treating you?

Results for your trust



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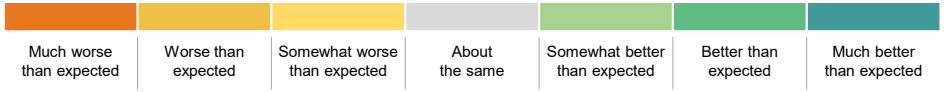
Nurses

Q21. When nurses spoke about your care in front of you, were you included in the conversation?

Results for your trust



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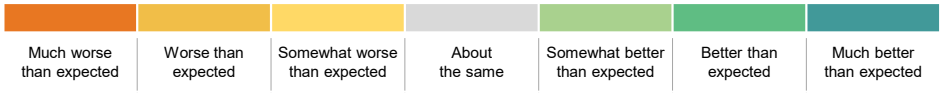
Nurses

Q22. In your opinion, were there enough nurses on duty to care for you in hospital?

Results for your trust



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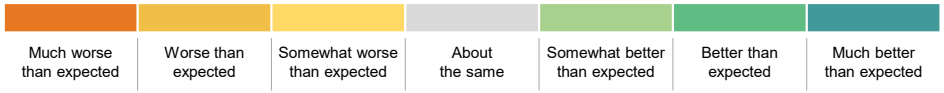
Your care and treatment

Q23. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?

Results for your trust



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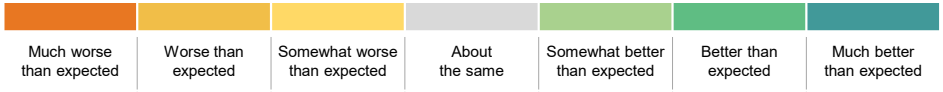
Your care and treatment

Q24. To what extent did staff looking after you involve you in decisions about your care and treatment?

Results for your trust



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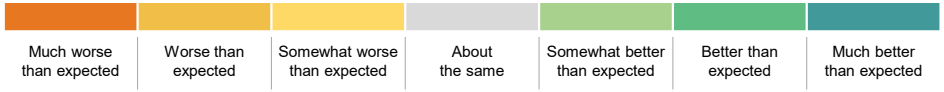
Your care and treatment

Q25. How much information about your condition or treatment was given to you?

Results for your trust



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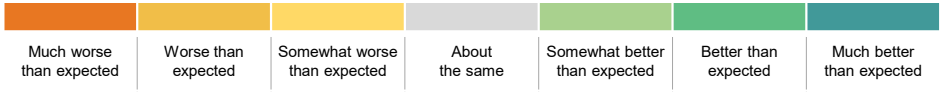
Your care and treatment

Q26. Did you feel able to talk to members of hospital staff about your worries and fears?

Results for your trust



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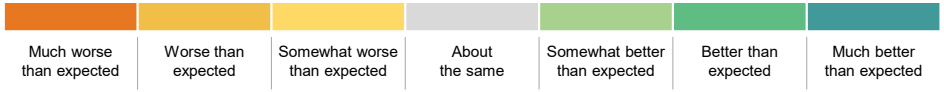
Your care and treatment

Q27. Were you given enough privacy when being examined or treated?

Results for your trust



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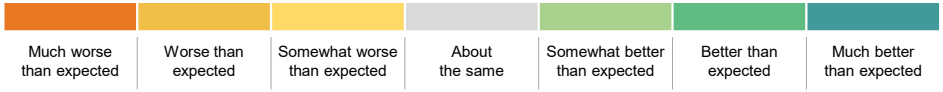
Your care and treatment

Q28. Do you think the hospital staff did everything they could to help control your pain?

Results for your trust



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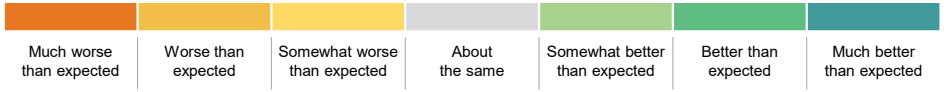
Your care and treatment

Q29. Were you able to get a member of staff to help you when you needed attention?

Results for your trust



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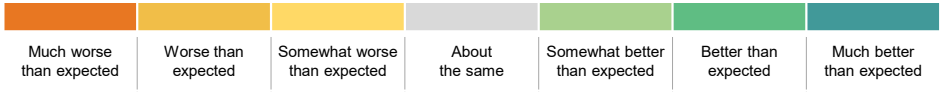
Operations and procedures

Q31. Beforehand, how well did hospital staff answer your questions about the operations or procedures?

Results for your trust



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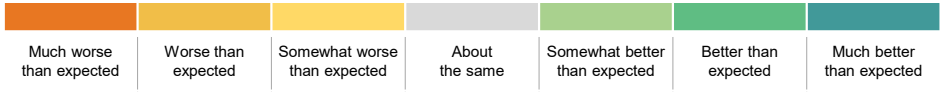
Operations and procedures

Q32. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?

Results for your trust



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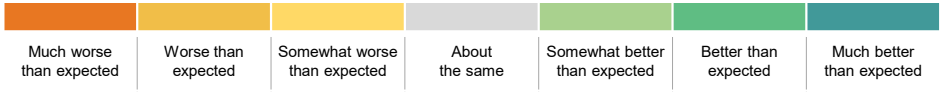
Leaving hospital

Q33. To what extent did staff involve you in decisions about you leaving hospital?

Results for your trust



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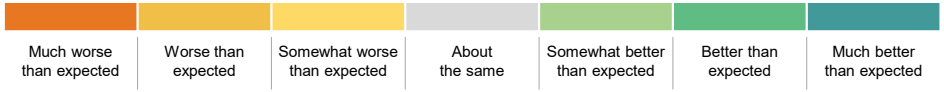
Leaving hospital

Q34. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?

Results for your trust



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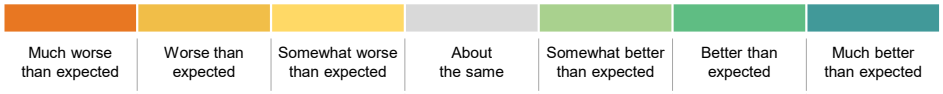
Leaving hospital

Q35. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?

Results for your trust



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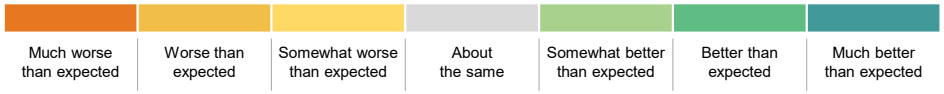
Leaving hospital

Q36. Were you given enough notice about when you were going to leave hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

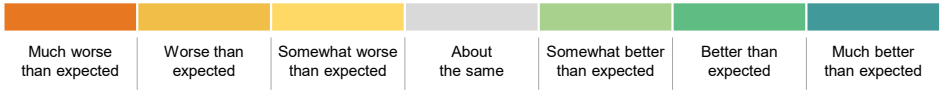
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Leaving hospital

Q37. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

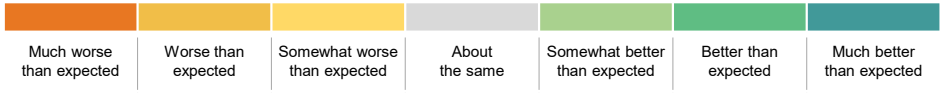
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Leaving hospital

Q38. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

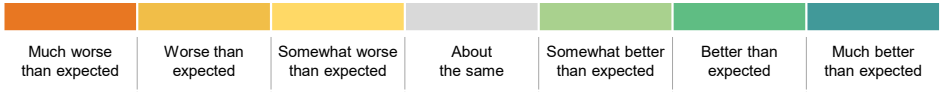
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Leaving hospital

Q39. Thinking about any medicine you were to take at home, were you given any of the following?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

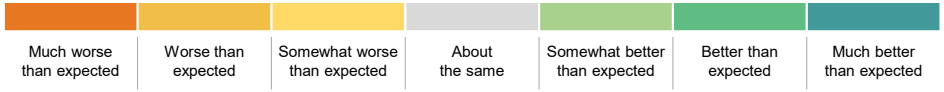
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Leaving hospital

Q40. Before you left hospital, did you know what would happen next with your care?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

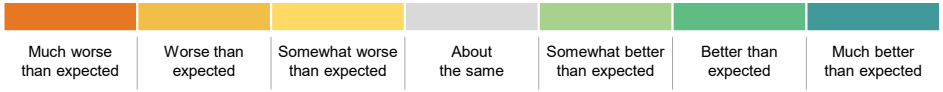
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Leaving hospital

Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

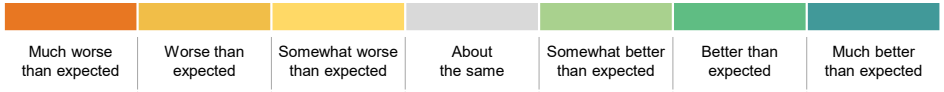
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Leaving hospital

Q42. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

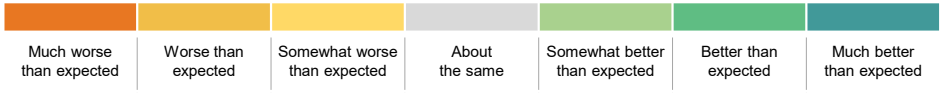
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Leaving hospital

Q44. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

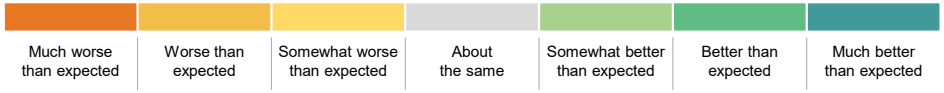
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Feedback on care

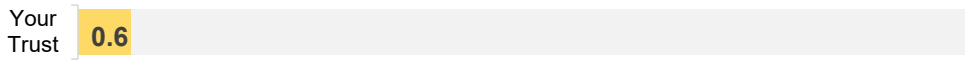
Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?

Results for your trust



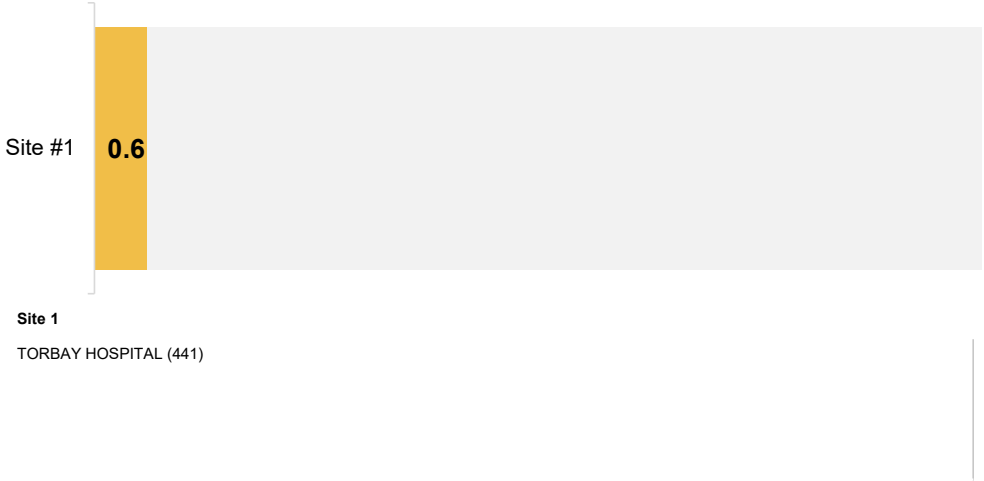
Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.



Breakdown of scores for sites within your trust:

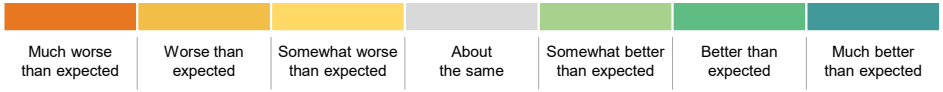
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.



Respect and dignity

Q45. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

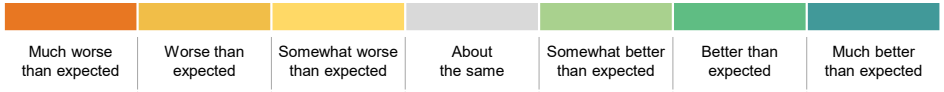
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Overall experience

Q46. Overall, how was your experience while you were in the hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

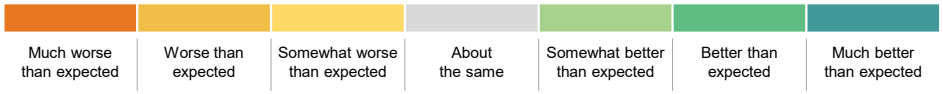
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Long term condition

Q51. Thinking about the condition(s) you selected, were these taken into account during your care and treatment, whilst you were in hospital?

Results for your trust



Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Trends over time

This section includes:

- your mean trust score for each evaluative question in the survey
- where comparable data is available, statistical significance testing using a two sample t-test has been carried out against the 2020 and 2021 survey results for each relevant question. Where a change in results is shown as ‘significant’, this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust. Significant increases are indicated with a up arrow and significant decreases are indicated with a down arrow.
- the following questions were new or changed for 2022 and therefore are not included in this section: Q34, Q51
- the following questions were new or changed for 2021 and therefore no comparable data will be available for 2022 compared to 2020: Q11, Q12, Q14, Q38

Trends over time – Admission to hospital

The following table displays changes since 2020 and 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		Number of respondents	2022 Trust Score		2021 Trust Score	2020 Trust Score
Admission to hospital						
Q2.	How did you feel about the length of time you were on the waiting list before your admission to hospital?	134	6.1	▽	6.3	8.0
Q4.	How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	524	6.6	▽	6.5	7.4

▼▲	Significant difference between 2022 and 2021
▽△	Significant difference between 2022 and 2020
-	No comparable data available
Blank	No significant difference between 2022 and 2021 or 2022 and 2020

Trends over time – The hospital and ward

The following table displays changes since 2020 and 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		Number of respondents	2022 Trust Score	2021 Trust Score	2020 Trust Score
The hospital and ward					
Q5.	Were you ever prevented from sleeping at night by noise from other patients?	491	4.8	4.8	5.3
Q5.	Were you ever prevented from sleeping at night by noise from staff?	491	8.0	8.1	7.6
Q5.	Were you ever prevented from sleeping at night by hospital lighting?	491	7.7	8.2	7.8
Q7.	Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	95	7.7	8.0	7.7
Q8.	How clean was the hospital room or ward that you were in?	532	9.2	9.2	9.3
Q9.	Did you get enough help from staff to wash or keep yourself clean?	381	8.6	8.6	8.6
Q10.	If you brought medication with you to hospital, were you able to take it when you needed to?	275	8.5	8.3	8.2
Q11.	Were you offered any food that met any dietary needs or requirements you had?	272	8.4 -	8.7	-
Q12.	How would you rate the hospital food?	523	7.2 -	7.2	-
Q13.	Did you get enough help from staff to eat your meals?	126	7.4▼	8.6	7.4

▼▲	Significant difference between 2022 and 2021
▽△	Significant difference between 2022 and 2020
-	No comparable data available
Blank	No significant difference between 2022 and 2021 or 2022 and 2020

Trends over time – The hospital and ward

The following table displays changes since 2020 and 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

					2021 Trust Score	2020 Trust Score
The hospital and ward						
Q14.	Were you able to get hospital food outside of set meal times?	203	6.7	-	6.8	-
Q15.				△		9.4

▼▲	Significant difference between 2022 and 2021
▽△	Significant difference between 2022 and 2020
-	No comparable data available
Blank	No significant difference between 2022 and 2021 or 2022 and 2020

Trends over time – Doctors / Nurses

The following table displays changes since 2020 and 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		Number of respondents	2022 Trust Score	2021 Trust Score	2020 Trust Score
Doctors					
Q16.	When you asked doctors questions, did you get answers you could understand?	501	9.0	9.0	8.8
Q17.	Did you have confidence and trust in the doctors treating you?	543	9.3	9.3	9.2
Q18.	When doctors spoke about your care in front of you, were you included in the conversation?	538	8.8	8.9	8.8
Nurses					
Q19.	When you asked nurses questions, did you get answers you could understand?	512	9.0	9.1	8.9
Q20.	Did you have confidence and trust in the nurses treating you?	542	9.2	9.3	9.1
Q21.	When nurses spoke about your care in front of you, were you included in the conversation?	537	8.9	9.1	8.8
Q22.	In your opinion, were there enough nurses on duty to care for you in hospital?	540	7.4 ▽	7.3	7.9

▼▲	Significant difference between 2022 and 2021
▽△	Significant difference between 2022 and 2020
-	No comparable data available
Blank	No significant difference between 2022 and 2021 or 2022 and 2020

Trends over time – Your care and treatment

The following table displays changes since 2020 and 2021, and whether those changes are statistically significant..

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		Number of respondents	2022 Trust Score	2021 Trust Score	2020 Trust Score
Your care and treatment					
Q23.	Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	490	8.0	7.9	7.8
Q24.	To what extent did staff looking after you involve you in decisions about your care and treatment?	517	7.2	7.4	7.2
Q25.	How much information about your condition or treatment was given to you?	530	8.8▼	9.1	8.9
Q26.	Did you feel able to talk to members of hospital staff about your worries and fears?	458	8.0	8.2	7.8
Q27.	Were you given enough privacy when being examined or treated?	536	9.6	9.5	9.5
Q28.	Do you think the hospital staff did everything they could to help control your pain?	454	9.2	9.0	9.0
Q29.	Were you able to get a member of staff to help you when you needed attention?	495	8.3	8.3	8.3

▼▲	Significant difference between 2022 and 2021
▽△	Significant difference between 2022 and 2020
-	No comparable data available
Blank	No significant difference between 2022 and 2021 or 2022 and 2020

Trends over time – Operations and procedures

The following table displays changes since 2020 and 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		Number of respondents	2022 Trust Score	2021 Trust Score	2020 Trust Score
Operations and procedures					
Q31.	Beforehand, how well did hospital staff answer questions about the operations or procedures?	275	9.2	9.1	9.2
Q32.	After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?	298	8.2	8.2	8.1

▼▲	Significant difference between 2022 and 2021
▽△	Significant difference between 2022 and 2020
-	No comparable data available
Blank	No significant difference between 2022 and 2021 or 2022 and 2020

Trends over time – Leaving hospital

The following table displays changes since 2020 and 2021, and whether those changes are statistically significant. The following questions were new or changed for 2022 and therefore are not included in this section: Q34.

Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected

		Number of respondents	2022 Trust Score		2021 Trust Score	2020 Trust Score
Leaving hospital						
Q33.	To what extent did staff involve you in decisions about you leaving hospital?	537	7.3		7.4	7.1
Q35.	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	225	8.6		8.5	8.7
Q36.	Were you given enough notice about when you were going to leave hospital?	543	7.1		7.1	7.4
Q37.	Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	512	8.4	△	8.5	7.3
Q38.	To what extent did you understand the information you were given about what you should or should not do after leaving hospital?	404	9.0	-	9.2	-
Q39.	Thinking about any medicine you were to take at home, were you given any of the following?	402	4.4	▽	4.8	5.0
Q40.	Before you left hospital, did you know what would happen next with your care?	494	6.7		6.9	6.7
Q41.	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	496	8.0		8.5	8.2
Q42.	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	316	8.4		8.3	8.5
Q44.	After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?	313	7.1		7.1	6.9

▼▲ Significant difference between 2022 and 2021

▽△ Significant difference between 2022 and 2020

- No comparable data available

Blank No significant difference between 2022 and 2021 or 2022 and 2020

Trends over time – Feedback on care / Respect and dignity / Overall

The following table displays changes since 2020 and 2021, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		Number of respondents	2022 Trust Score	2021 Trust Score	2020 Trust Score
Feedback on care					
Q47.	During your hospital stay, were you ever asked to give your views on the quality of your care?	468	0.6▼ ▽	1.3	1.0
Overall experience					
Q46.		543			8.3

▼▲	Significant difference between 2022 and 2021
▽△	Significant difference between 2022 and 2020
-	No comparable data available
Blank	No significant difference between 2022 and 2021 or 2022 and 2020

For further information

Please contact the Coordination Centre for Mixed Methods:
InpatientCoordination@ipsos.com


Appendix
NHS
Care Quality Commission
Ipsos
73 Adult Inpatient Survey 2022 | RA9 | Torbay and South Devon NHS Foundation Trust

Comparison to other trusts

The questions at which your trust has performed much worse or worse compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected	Worse than expected
• Your trust has not performed “much worse than expected” for any questions.	• Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital? • Q5. Were you ever prevented from sleeping at night by noise from other patients?

Comparison to other trusts

The questions at which your trust has performed somewhat worse or somewhat better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected	Somewhat better than expected
• Q47. Overall, how was your experience while you were in the hospital?	• Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand? • Q10. If you brought medication with you to hospital, were you able to take it when you needed to? • Q15. During your time in hospital, did you get enough to drink? • Q16. When you asked doctors questions, did you get answers you could understand? • Q20. Did you have confidence and trust in the nurses treating you? • Q28. Do you think the hospital staff did everything they could to help control your pain?

Comparison to other trusts

The questions at which your trust has performed better or much better compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected	Much better than expected
• Q44. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?	• Your trust has not performed “much better than expected” for any questions.

Comparison to 2021 results

The questions in this report where your trust showed a statistically significant increase or decrease compared to 2021 results are listed below.

Significant Increase	Point change	Significant Decrease	Point change
Your trust has not shown a statistically significant increase for any questions		Q13. Did you get enough help from staff to eat your meals?	-1.1
		Q47. Overall, how was your experience while you were in the hospital?	-0.6
		Q25. How much information about your condition or treatment was given to you?	-0.3

Comparison to 2020 results

The questions in this report where your trust showed a statistically significant increase or decrease compared to 2020 results are listed below.

Significant Increase	Point change	Significant Decrease	Point change
Q37. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	+1.1	Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?	-1.9
Q15. During your time in hospital, did you get enough to drink?	+0.3	Q4. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	-0.8
		Q39. Thinking about any medicine you were to take at home, were you given any of the following?	-0.6
		Q22. In your opinion, were there enough nurses on duty to care for you in hospital?	-0.5
		Q47. Overall, how was your experience while you were in the hospital?	-0.4

NHS Adult Inpatient Survey 2022

Results for Torbay and South Devon NHS Foundation Trust

Where patient experience is best

- ✓ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night
- ✓ Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital
- ✓ Food outside set meal times: patients being able to get hospital food outside of set meal times, if needed
- ✓ Taking medication: patients being able to take medication they brought to hospital when needed
- ✓ Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital

Where patient experience could improve

- Noise from other patients: patients not being bothered by noise at night from other patients
- Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- Feedback on care: patients being asked to give their views on the quality of their care
- Disturbance from hospital lighting: patients not being bothered at night by hospital lighting
- Noise from staff: patients not being bothered by noise at night from staff

These topics are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the average of all trusts. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts.

This survey looked at the experiences of people who were discharged from an NHS acute hospital in November 2022. Between January 2023 and April 2023, a questionnaire was sent to 1250 inpatients at Torbay and South Devon NHS Foundation Trust who had attended in late 2022. Responses were received from 551 patients at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

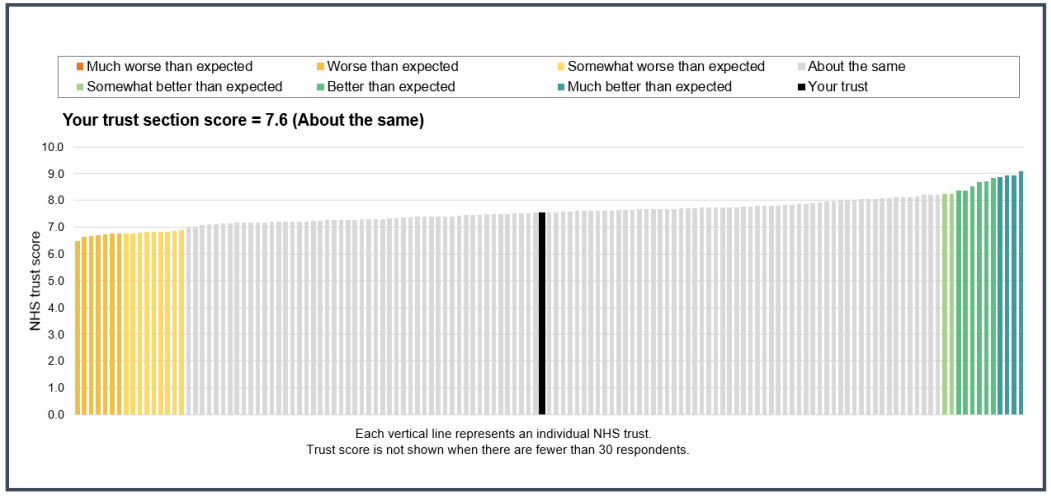
How to interpret benchmarking in this report

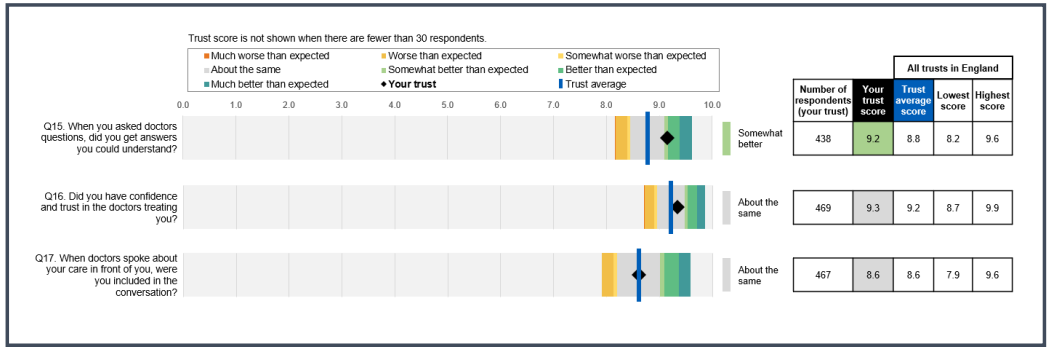
Trust level benchmarking

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

Trust level benchmarking

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Site level benchmarking

The charts in the ‘trust results’ section present site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that there may be differences between the average score of the sites provided and the overall score for the trust. This may be related to the size of the sites, results for suppressed sites or weighting, as sites and trusts are weighted separately. In addition, if a single site result is presented for a trust, the ‘expected range’ category may differ: although the score achieved will be the same for both the site and for the trust, the upper and lower boundary levels will differ between the two due to them being calculated differently in each case.

If fewer than 30 responses were received from patients discharged from a site, no scores will be displayed for that site.

Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the patient's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question 15 "When you asked doctors questions, did you get answers you could understand":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No, never" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer codes "I did not have any questions" and "I did not feel able to ask questions" would not be scored, as they do not have a clear bearing on the trust's performance in terms of patient experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the survey technical document.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

ıction Plan 23- 26

Action Number	Action	Action required; how will it be achieved and by whom?	Action completion	Accountable Action Lead(s)	Lead person	Completion Deadline Target	RAG Rating Actual
	Priority 1- To establish a collaborative model of Partnership with patients, service users, and partner organisations, to ensure we focus on what matters to individuals. Their families and loved ones						
1	To set up regular Health and Care Services Reference Group (HCSRG) to monitor and review Feedback and Engagement (F&E) priorities/actions	To identify relevant groups, individuals and stakeholders to attend quarterly meeetings to actvly involve our local community to develop robust, effective communcation underpinning the trust focus and values of what matters to people	Quarterly HCSRG meetings are undertaken on a regular basis with quaorate representation as idenfied in the Terms of Reference identified at first meeting	Deputy Chief Nurse		Nov-23	
	Patient panel being developed by the Communications and Partnerships team			Eli McCutchion and Jane Harris	Eli McCutchion		
2	To invite external partners to monthly F&E steering group meetings and ensure appropriate representation to ensure a transparent and open process of quality assurance. To invite feedback from external partners on a bi-montly basis	All relevant external partners invited to monthly F&E steering group meetings. To ensure all external partners have the opportunity to contribute to the agenda on a bi-monthly basis	External patrtners receive invitations to montly meetings with the opportunity to contribute to the agenda on a bi-monthly basis.	Deputy Chief Nurse		Feb-23	Closed
3	To work closely with Healthwatch as an independent Consumer champion for people using health and care services, and a critical friend, to enable us to hear the voice of our local community	Independent meetings with Healthwatch to ensure the trust is proactively seeking feedback and updates from the community and can devise relevant meeting agendas to reflect current issues	Independent meetings with Healthwatch sheduled on a regular basis	Deputy Chief Nurse	Natlie Herring, Eli McCutchion and Emily Taylor	Mar-23	
4	To work closely with carers to hear their views and share their experiences to improve the quality of care delivery.	To work with internal trust services and external partners to ensure representation of carers at all relevant meetings and specifically HCSRG	Ensure relevant carers groups receive invitations to relevant meetings with the opportunity to contribute to the agenda.	Deputy Chief Nurse	Katy Heard	Sep-23	
5	To celebrate success and address areas of concerns in the results of the four CQC National patient surveys including the Adult Inpatients Survey, Urgent and Emergency Care Survey, Children and Young People Survey and the Maternity Survey with robust actions plans to enhance positive experience	To effectively respond to the four CQC national patient surveys in accordance with the results received. To develop action plans as required based on the four patient surveys to reflect areas required for impovement and the actions needed.	Future CQC survey demonstrates improvement in areas identified. Reduction in complaints and concerns that align to specific areas in CQC surveys	Deputy Chief Nurse	Natalie Herring	Mar-26	
6	To share our learning from complaints and concerns with our local community through a suite of communication methods including our website, annual feedback and engagement board report, quality boards on inpatient wards and community services.	Complaints and concerns agend item to bi-montly F&E and HCSRG meetings giving all external stakeholders the opportunity to review and discuss. To ensure ward quality boards reflect local issues with required learning	All relevant stakeholders have the opportunity to review and discuss complaints and concerns in an appropriate forum. In-patient ward areas update quality boards to reflect any areas for improvement/learing form complaints and concers	Deputy Chief Nurse		Mar-26	
7	To proactively seek the views of local people in all re-design with regard to future care pathways and delivery models. This will be aligned to Building a Brighter Future.	To identify relevant groups, individuals and stakeholders to engage, actvly involving our local community to develop robust, effective communcation underpinning the trust focus and values of what matters to people. To work with the BBF team to ensure relevant up to date information is shared across all forums.	BBF added to relevant agendas to enaure co-design of healthcare servcies moving forward and giving all relevant stakeholders the opportunity to be part of the BBF vsison and strategy	Deputy Chief Nurse	Emily Taylor	Mar-26	
8	To Adopt The National Always Events ®Toolkit (Institute for Health care Improvement NHS England 2016).	To implement and embed the National Always Event toolkit into every day practice as an evidence- based tool that will improve patient experience and health and care pathways	To aligned to the outcomes of the National Always Events tool kit · To Form part of the F&E agenda reporting.	Deputy Chief Nurse		Mar-26	
9	To enhance our service user experience through improvement in our interpretation and translation services and emalgamation of two current guidlines in uses	To develop a robust policy adopted by the Trust for our translation and interpretation services which amalgamates the two policies currently in use	Development and socialisation of an Interpretation and Translation services policy that reflects trust service delivery. Positive feedback from patients and service users who have accessed the service	Natalie Herring	Chris Edworthy/ Sinnita	Nov-23	
10	To implement the Enhanced Health in Care Homes (EHCH) framework will enable the trust and wider system partners to improve our communication and partnership working with care homes as a key partner.	To fully implement The Enhanced Health in Care Homes (EHCH)Framework across Torbay and South Devon vis the EHCH strategy group.	Care home staff have received up to date training as required. Care home admssions via emergency department have reduced.	Natalie Herring	Toni Bora - project lead	Mar-26	
11	Enhance relationships and collaborative partnership working cross care providers including primary care, local authority, social care voluntary sector and mental health services.	To achieve collaborative working with all health and care partners across Devon as part of the Integrated Care System. To ensure this is reflected in the F&E steering group minutes	Improvement of patient and service users experience across care pathways	Deputy Chief Nurse	Chris Winfield/Eli McCutchion	Mar-26	
12	To focus on improving discharges from TSDFT inpatient services to onward care settings including the individuals own home.	To review and monitor complaints and concerns at F&E steering group meetings. To respond proactively to feedback from external partners. To feed into Discharge group as required	No complaints received with regrad to discharges across the TSDFT footprint. Positive feedback from external partners	Natalie Herring	Rachael Campbell	Mar-26	
	Priority 2 - To establish dynamic models of engagement and co-design, underpinned by digital opportunities to ensure we oprimise the scope and impact of the patient and service user voice						
13	To redesign and relaunch Trust F&E part of the website to reflect activity, learning and news from across the Integrated Care Organisation (ICO)	Implementation of a sub- group to develop and produce a Website to reflect current ICO services and news which is easy to access for all	Number of hits on TSDFT public website page for Patient Experience.Increase in contact made with the F&E team through the website page.	Deputy Chief Nurse	Eli McCutuchion	Sep-23	

14	To develop a local Newsletter to share developments and effectively communicate improvements with our local community based on feedback received together with the Building a Brighter Future team	To set up a sub-group via the F&E Steering group to develop a quarterly newsletter that is sent out to our local community and available in various formats	A quarterly Newsletter is produced and disseminated to the local community	Deputy Chief Nurse	Emily Taylor	Feb-24	
15	To develop a suite of digital solutions to support people to provide feedback including the use of QR code readers for the Friends and Family Test and wider surveys.	To support the Friends and Family Test (FFT) team member to develop and allocate aQR codes that allow people using the service to complete the FFT through this digital route. The number and range of people responding to FFT increases and is monitored through the F&E group	The number of services using a QR code reader increases each month and is monitored via F&E group	Deputy Chief Nurse	Tracey McKenzie/ Hayley Warrilow	Sep-23	
	Priority 3- The Volunteer role will be strengthened and transformed to ensure this workforce is central to facilitating unbiased opportunities to achieve a real-time feedback of our health anc care services. This will support responsive, timely changes, where achievable						
16	To support revitilise and support the developement of the Working with Us (WWU) Volunteers to underpin the commitment to independent service review	To work with the trust volunteer recruitment service to enhance the capacity of the WWU panel. To feedback at monthly F&E Steering group meetings re the capacity of the WWU volunteers	Increase in the number of active volunteers working across the trust being reflected in the questionairres being completed	Deputy Chief Nurse	Stephanie Robey	Jun-23	
17	To redesign the real time patient experience survey to reflect the in-patient survey results on a rolling programme	In-patient questionairres updated to reflect most up to date in-patient survey responses on a rolling programme	In-patient questionairre updated to reflect most recent inpatient surveys with feedback to the F&E Steering group.	Deputy Chief Nurse	Rachael Campbell	Mar-26	
18	Working with recruitment to actively secure volunteers to work across health and care pathways including inpatient and community services.	To increase the number of volunteers working across the trust by the WWU lead liaising with the the resource hub team. WWU lead identifying other actions to improve WWU volunteer levels	20 plus (pre COVID levels) WWU volunteers completing real-time in-patient surveys	WWU Lead	Stephanie Robey	Mar-26	
	Priority 4- To enhance capacity and capability of central Feedback and Engagement Team, and wider workforce, involved in patient and service user experience						
19	To progress the case for change increasing the dedicated resource into the Feedback and Engagement Team to effectively deliver on the Patient and Service user experience of Health and Care Strategy 2022-2025	Overarching F&E Service review to be undertaken with consideration given to working differently within current service. Business case developed to support increase in team as identified	The team is recruited in line with the case for change and can fully implement the strategy over 2022-2025	Deputy Chief Nurse	Matron for feedback for engagement services	Nov-23	
20	To achieve a visible forward- facing patient and real time service user offer that is easily accessible and responsive to our local community	To review current service to determine capacity required for team members to provide a front door facing service and to enable a real-time telephone answering service to deliver the F&E strategy. To work torwards a dedicated space in the main entrance for members of the team within core hours	Telephone calls to F&E team are answered on a real-time basis. The F&E team can provide front facing interface for all servcie users	Deputy Chief Nurse	Natalie Herring	Apr-25	
21	To develop a range of training for staff across the Trust to enhance their response to feedback including customer care training, complaint investigation and relationship management	To work with the Education team to identify appropriate training packcages to enable staff to access appropriate education.	To have trust staff that are highly skilled and competent to respond to feedback from patients, service users, their families and carers in a caring and compassionate way. A reduction in the number of concerns escalating to complaints. Fewer Ombudsman cases.	Deputy Chief Nurse	Education person	Apr-25	
	Priority 5 - To develop and implement a robust model that demonstrates continual learning and improvements in services, based on feedback from patients, service users, and other key stakeholders to ensure a continued drive for excellence in experience of services provided across the ICO						
22	Submission of a Feedback and Engagement Annual Report to the Trust Board to share themes of complaints, concerns and compliments and demonstrate the improvement plans that have been progressed to address deficits	Bespoke work to be aligned with issues raised to develop robust action plans within each area of practice. Identify improvement plans, with identified themes, as required and provide assurace via the annual report.	Yearly Trust Board submissons with relevant themes and trends identifed with action plans to address and mitigate risks	Deputy Chief Nurse	Natalie Herring	Mar-26	
23	Implement sub groups, feeding into the F&E Steering group, to address and resolve key themes with the application of Quality Improvement (QI)Methodology e.g. loss of patient's property, safe effective discharge etc. as they emerge via the F&E steering Group meetings.	To identify themes and trends with regard to service user involvement and identify QI improvement plans, via sub-groups, feeding back into the F&E steering group. To work with the QI team to drive the impovement agenda as required	Individual sub-groups are developed to address any QI issues identified via the F&E Steering groupand feed back into the F&E steering group identifying QI methodologies used enabling cross	Deputy Chief Nurse	San Boosey	Mar-26	
	Priority 6 - To establish a culture in our workforce which embraces, and values, feedback to ensure a consistent and continued drive towards positive service user experiences						
24	To undertake the NHSI Patient experience improvement framework benchmarking tool to establish current status with regard to patient experience identifying areas for improvement.	To establish a patient experience benchmark utilising the tool identified and develop improvement action plans dependant upon results. To revisit this on an annual basis	All improvement/action plans are developed and implemented with results shared across the ICO to ensure shared learning	Deputy Chief Nurse		Mar-26	
25	To develop a culture across our health and care services that welcomes and values all feedback and allows us to continually learn and improve our health and care services	To identify and participate in relevant staff and patient surveys to support cross boundary engagement and support shatred learning across the ICO	To be an exemplar trust in our approach to patient, staff and service users' feedback on our health and care services allowing continued servcie improvements.	Deputy Chief Nurse/ Associate Director of People	People Directorate/ Patient Safety	Mar-26	

26	REPEAT FROM 21 - Develop a range of training for staff across the Trust to enhance their response to feedback including customer care training, complaint investigation and relationship management	To work with the Education team to identify appropriate training packcages to enable staff to access appropriate education.	To have trust staff that are highly skilled and competent to respond to feedback from patients, service users, their families and carers in a caring and compassionate way. A reduction in the number of concerns escalating to complaints. Fewer Ombudsman cases.	Deputy Chief Nurse	Education person	Apr-25	

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Board of Directors			
Report title: Patient Safety Incidents Annual Report 2022/23			Meeting date: 29th November 2023
Report appendix:	None		
Report sponsor:	Chief Nurse		
Report author:	Patient safety Specialist Deputy Chief Nurse		
Report provenance:	Incidents discussed weekly at Executive review groups (ERG) and Incident review group (IRG). Monthly sign off of serious adverse events meeting (SEA)		
Description/Purpose of the report and key issues for consideration/decision:	The purpose of the report is to provide the Trust with an annual summary of principal activity and outcomes relating to the patient safety incidents that occurred in the Trust during the year 2022 to 2023. Key areas to note: • An increase of almost 5.5% in incident reporting activity across the Trust • A reduction in the number of serious incidents identified and reported to StEIS, compared with 2021-22 (but closer to the number reported in 2020-21) • 3 never events were reported in the period under review • Further development of robust review and assurance mechanisms, for example introduction of falls SI AARs and the introduction of the initial review process to the weekly Executive Incident Review Meeting		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Board is asked to receive the report and note the following: • An increase of almost 5.5% in incident reporting activity across the Trust • A reduction in the number of serious incidents identified and reported to StEIS, compared with 2021-22 (but closer to the number reported in 2020-21) • Three never events were reported in the period under review • Further development of robust review and assurance mechanisms, for example introduction of falls SI AARs and the introduction of the initial review process to the weekly Executive Incident Review Meeting		

Summary of key elements	
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	This report provides assurance that the Trust is responding and reviewing patient safety incidents to ensuring learning and quality improvement to improve the health and wellbeing and outcomes of our community.
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided This report provides evidence to support the Board on the Trust's patient safety and quality priorities
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience
Risk: Risk ID: *As appropriate*	
External standards affected by this report and associated risks	Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance

Report title: Patient Safety Incidents Annual Report 2022/23		**Meeting date:** 29th November 2023
Report sponsor	Chief Nurse	
Report author	Patient Safety Specialist Deputy Chief Nurse	

1.0 Introduction

The purpose of the report is to provide the Trust with an annual summary of principal activity and outcomes relating to patient safety incidents that occurred in the Trust during the financial year April 2022 to March 2023. This report provides evidence to support the Board with the Trust's patient safety and quality priorities. It is intended to provide information from which the Board can take assurance regarding compliance with external requirements for Serious Incident (SIs), Never Events and other patient safety incidents.

2.0 Context

The year 2022-2023 marks the final full year under which Trust patient safety practice followed NHS England's Serious Incident Framework (SIF). During the next financial year, 2023-24, the Trust will transition to the Patient Safety Incident Response Framework (PSIRF) which will provide the guiding principles for the ongoing approach and response to patient safety incidents and events.

The PSIRF fundamentally shifts how the Trust will respond to patient safety incidents, with a prime focus on learning and quality improvement. PSIRF advocates a co-ordinated and data-driven approach that prioritises compassionate engagement with those affected by patient safety incidents (patients, families and staff) and it embeds the patient safety incident response within a wider system of improvement, which prompts a significant cultural shift towards systematic patient safety management.

Led by the Chief Nurse, the Trust's PSIRF implementation project group is well established and work is currently underway to confirm the themes which will be selected for Patient Safety Incident Investigations (PSIIs). The Patient Safety Incident Response Plan is in draft form and the planned timeline for PSIRF implementation is February 2024.

Trustwide during 2022-23, staff continued to report patient safety incidents using the local risk management system, DatixWeb but this year also marked the last full year that this system was used for reporting patient safety incident activity. Throughout the year 2023-24 the new Datix system, Datix Cloud IQ (DCIQ) will be operationalised, initially for patient safety incident activity only, but then for the other safety and quality modules also currently hosted on DatixWeb, for example: feedback and engagement; mortality; and claims.

The previous Patient Safety Incidents Annual Report (2021-22) referred to the publication of the Ockenden review of maternity services in Shrewsbury and Telford, published in March 2022. This spotlight on maternity services has continued, with the CQC publishing 'Safety, equity and engagement in maternity services' in May 2022. This was followed in October 2022 by 'Reading the Signals', the report of the independent investigation into East Kent's maternity and neonatal services and the 'MBRRACE-UK Saving Lives, Improving Mothers' Care report for 2022', which was published in November. Influenced in part by the high-profile trial of a neonatal nurse, which lasted from October 2022 to August 2023, maternity and neonatal services have remained in the public eye, as Trusts across the country continue to be the focus of ongoing scrutiny. The Trust is fully committed to the safety of mothers and babies, and that of all patients using its services, and responds actively to the findings and recommendations of these national reports.

3.0 Analysis of Incident Data

From April 2022 to end of March 2023 a total of 13,099 patient safety incidents were reported onto the Trust's Local Risk Management System (DatixWeb). This was an increase of 680, or 5.47%, from the previous financial year (April 2021 to March 2022).

National Reporting and Learning System (NRLS) data has been included in previous reports, however in September 2023 NHSE posted on their webpages that publishing data workbooks on incidents reported to the NRLS has been paused while they consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service which will replace the NRLS. The Trust migrated to LFPSE in October 2023 and no longer submits incidents to NRLS.

Of the 13,099 patient safety incidents submitted during 2022-23, 71% (9,311) are reported to have had harm caused by the organisation, meaning that they directly impacted patient care and experience. Incidents may be considered not 'caused by us' when they have occurred outside of Trust-provided care, such as: pressure ulcers reported on admission where the patient is not in Trust funded social care or community nursing; incorrect advice by 111 Service – patient attending ED for non-emergency matters; incidents reported locally but relating to care from another NHS Provider.

3.1 Key Themes: All Patient Safety Incidents Reported

Initial analysis of the data for 2022-23 identifies that a theme which emerged in the previous report has continued, with 'access, admission, transfer and discharge' being the highest volume of patient safety incidents reported.

Top 10 categories of patient incidents (caused by us)	Count of Ref
Access, admission, transfer, discharge (including missing patient)	2208
Pressure ulcer	1457
Accident/Injury (including slips, trips and falls)	1135
Medication related issue	687
Blood Transfusion and Blood Sample incident	497
Implementation of care and ongoing monitoring / review	395
Documentation (including electronic & paper records, identification and charts)	316

Clinical assessment (including diagnosis, scans, tests, assessments)	281
Treatment, procedure	236
Infection Control Incident	225
Grand Total	**7437**

Table 1: Top 10 categories of patient safety incidents 'caused by us'

Prior to 2021-22, pressure ulcers were the highest reported category of incident reported. This change is most probably post-Covid and a recognition of continuing operational pressures with elective care pathways and patient flow.

Review of table 1 above shows a total of 7437 incidents recorded in the top 10 categories, where the incident appears to have been caused by the Trust. The remaining 1,874 patient safety incidents reported include categories with relatively low incident occurrence. Examples of these include: consent; and end of life related issues.

The majority of patient safety incidents reported were assessed as causing Low or No Harm to patients, as can be seen in figures 1 and 2 below.

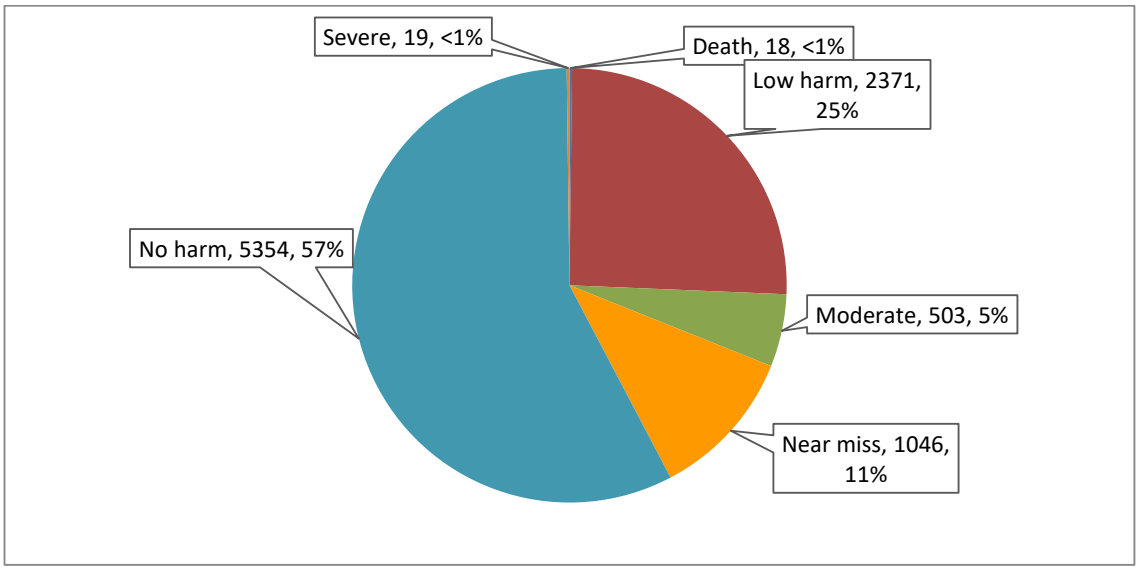


Figure 1: Incidents "caused by us" by severity (data source: DatixWeb)

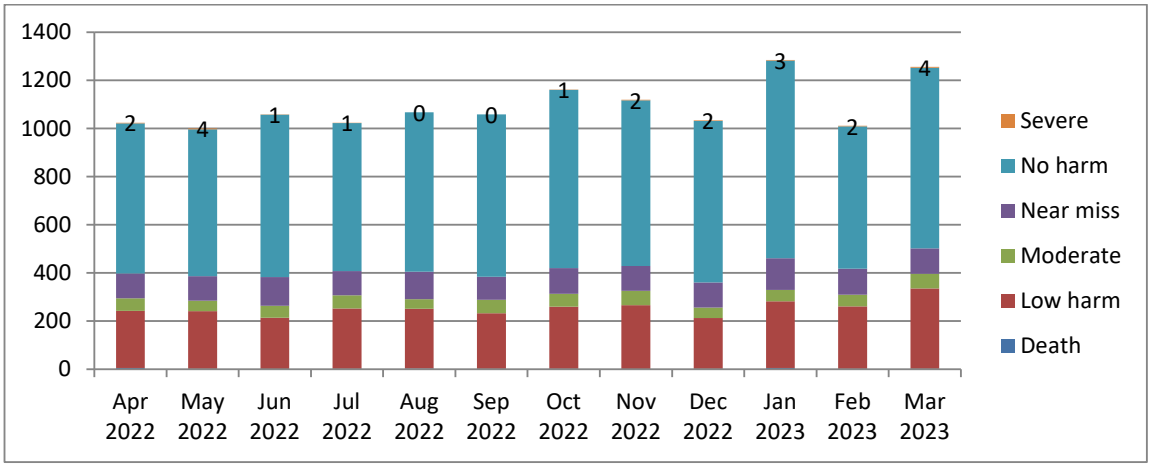


Figure 2: Total Patient Safety Incidents reported per month by severity (severe harm: numbers provided)

Incident reporting within the organisation appears to be relatively steady, and the spread of harm categorisation is also consistent, as seen in figure 3, below. The observable variation in numbers of incidents reported is broadly in line with the Trust's activity and escalation status.

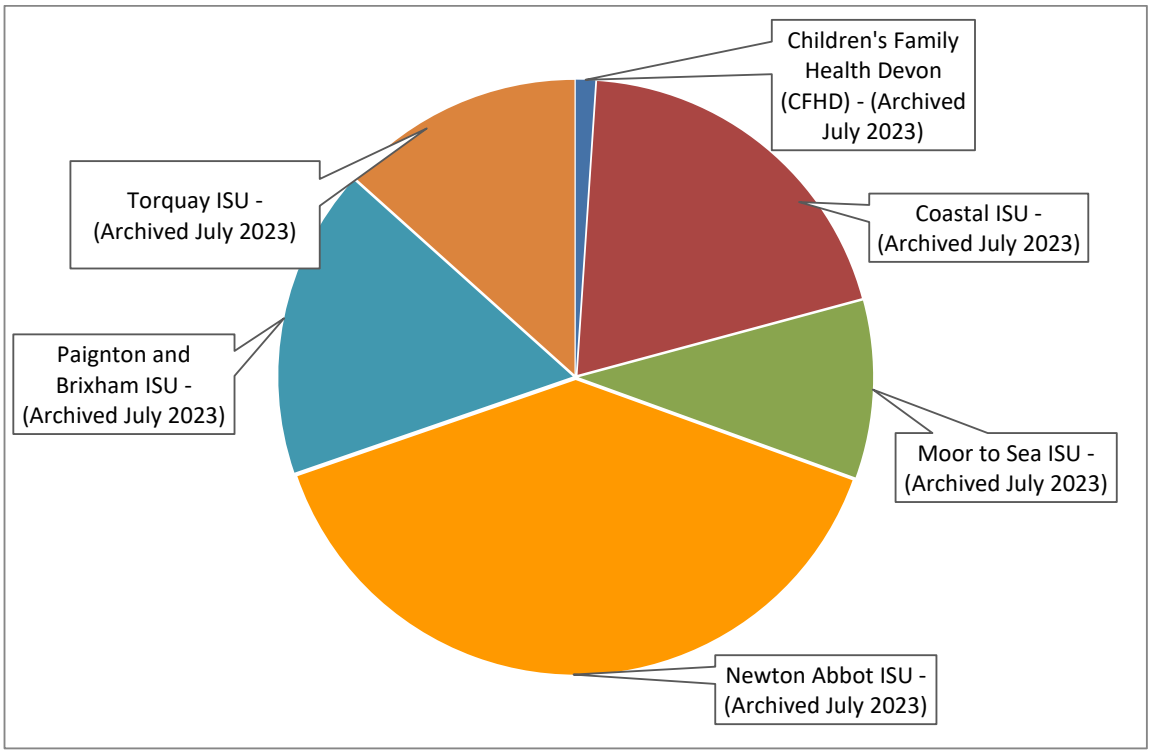


Figure 3: Total Patient Safety Incidents by Directorate (ISU)

The Trust has recently undergone internal restructuring, which resulted in Care Groups and Divisions, however this report references ISUs, as it relates to the period prior to the restructure. Analysis of where incident reporting activity is greatest fits with clinical service areas and is distributed as expected. The majority of reported patient safety incidents occurred within Newton Abbot ISU (39%), which is responsible for a high level

of urgent and emergency care provision, as well as the ED 12hr breach incidents. They are followed by Coastal ISU (20%), and Paignton and Brixham ISU (17%).

3.2 Near Miss Incidents

Of all patient safety incidents reported, 10% (1,294 of the 13,009), were categorised as 'near miss'. A near miss incident is one that could have harmed the patient but did not actually cause harm, as a result of chance, prevention, or mitigation.

Of the Trust's near miss incidents, the top four incident types are:

Near Miss Incidents (Top 4)	Corporate Response
Blood transfusion and blood sample incidents	Ongoing liaison, by Senior Specialist Practitioner of Transfusion, with clinical and operational teams to understand themes and engage with staff to develop support plans
Access, admission, transfer, discharge (including missing patient)	ADNPPs liaise with their clinical and operational leads to understand barriers to flow and identify improvement opportunities
Documentation (including electronic & paper records, identification and charts)	Progress with Trust plans towards commissioning a new Electronic Patient Record. IG team liaise with clinical teams to provide educational and improve awareness regarding data protection breaches
Medication related issue	Continued liaison and education by Pharmacy Governance Lead and Trust Medication Safety Officer to work with clinical teams to understand incident themes and develop strategies to support staff to identify and mitigate risk

3.3 Overview of Moderate and Above Incidents

Of the 9,311 patient safety incidents where harm was 'caused by us', a total of 540 (just under 6%) were reported to have harm caused that was graded as either Moderate, Severe or Death. There is a consistent average of around 135 patient safety incidents, with these gradings, reported in each quarter. The majority of the higher harm-level incidents are graded as moderate harm.

Analysis identifies the top 3 themes for moderate and above harm as:

1. Pressure Ulcers
2. Venous Thromboembolism Events (VTE)
3. Access, admission, transfer, discharge (including missing patient)

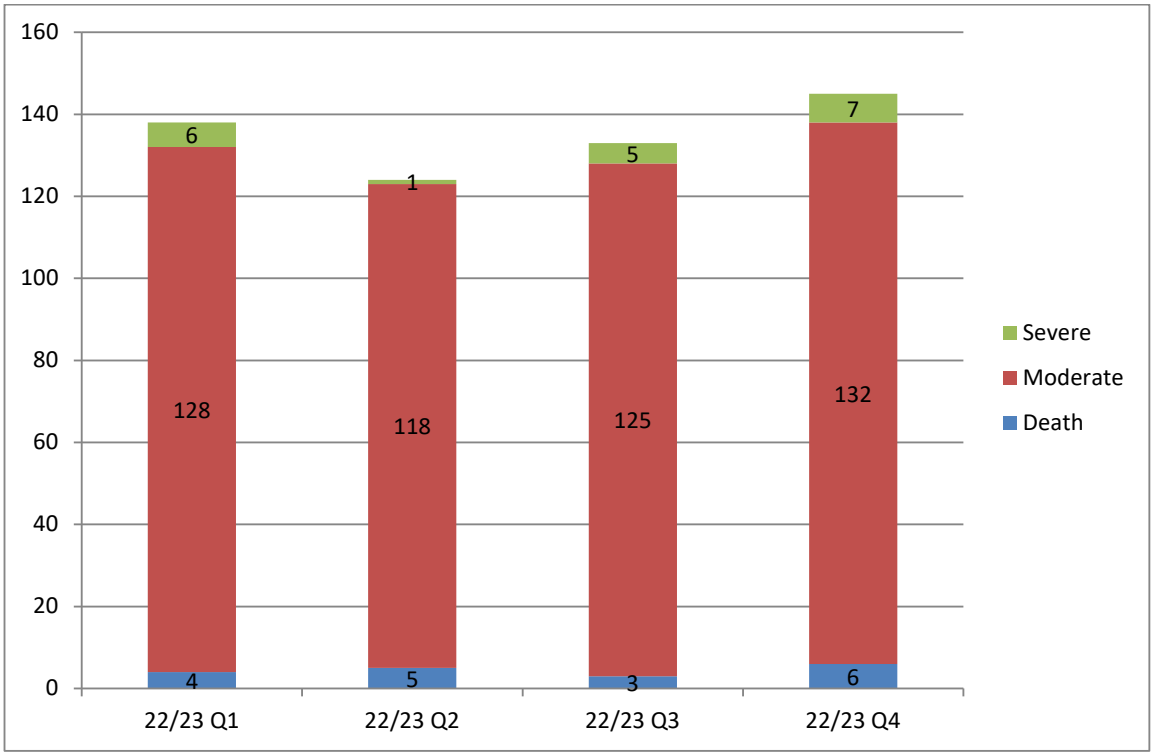


Figure 4: Moderate or above reported patient safety incidents "caused by us".

3.4 StEIS Reportable Serious Incidents

Serious incidents (SIs) are events in healthcare where there is substantial potential for learning, or where the consequences to patients, families/carers, staff, or the organisation, is so significant that they warrant a comprehensive response, generally in the form of a patient safety incident investigation. SIs, once identified, must be reported to NHSE using the Strategic Executive Information System (StEIS).

During the financial year 2022/23 there were 71 StEIS reported SIs; this is a decrease from the 97 reported in the previous financial year but is closer to the figure from 2020-21, which was 83. An average of 18 StEIS reportable patient safety incidents are reported each quarter. Figure 5 below, identifies the Trust's top 5 categories of SIs reported during 2022-23.

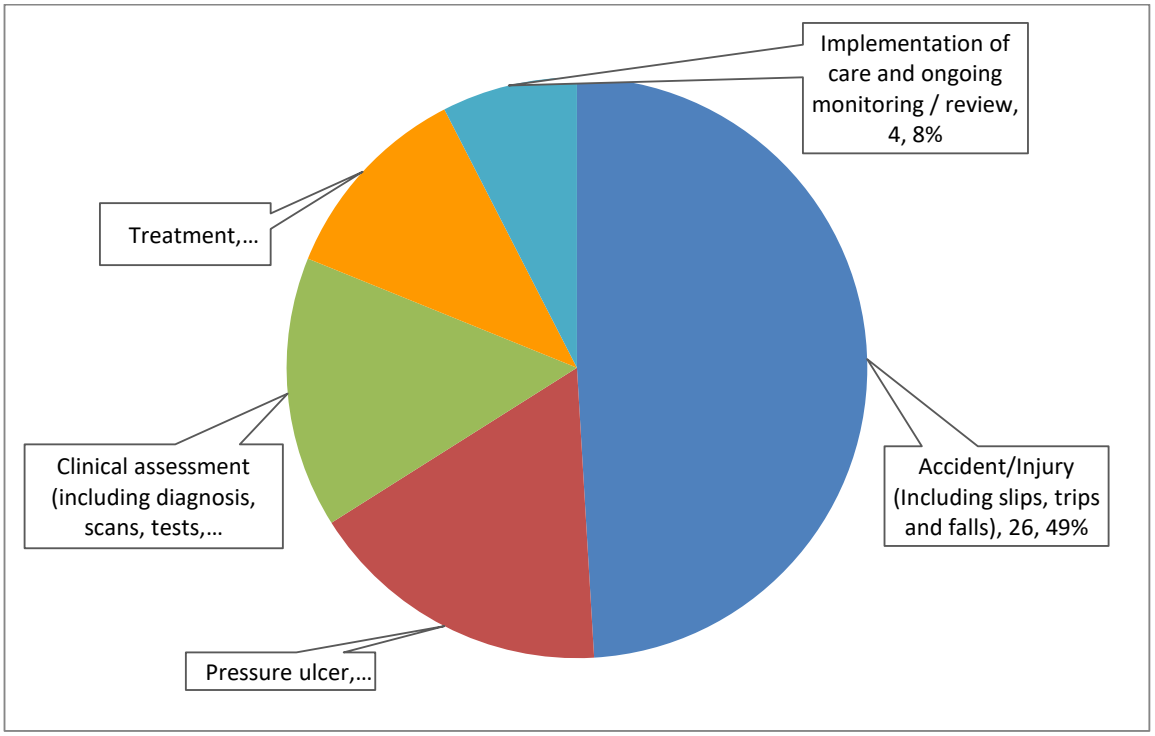


Figure 5: Top 5 category of StEIS reportable serious incidents

Falls, which are captured within the category of Accident/Injury, remain the highest category of StEIS reportable events (49%). As the Subject Matter Experts, the Trusts' Falls Prevention Leads have an overview of all falls related incident investigations where moderate harm or more, has been identified.

During 2022-23, the Falls Prevention Leads and Patient Safety Specialist agreed to trial a new approach to the review of falls SIs within the organisation. The new approach was to be more timely, dynamic, and involve ward staff more collaboratively in the review of the incident in order to quickly identify issues and learning. The approach selected was that of The Royal College of Physicians and National Audit of Inpatient Falls (NAIF) Hot Debrief and After Action Review (AAR) pilot scheme and documentation which promotes rapid reflection and learning. This change to the investigation approach for falls SIs was discussed with, and agreed by, the patient safety team for the Devon Integrated Care Board (ICB).

The Trust's falls Hot Debrief and AAR pilot was initially restricted to two acute hospital wards and two community hospital wards, with the process being supported by the Matrons, Ward Managers and Governance teams for those areas. The pilot was considered successful, with staff involved finding it far more dynamic, and much less onerous than the more traditional root cause analysis investigation approach. The Falls Prevention Leads have since extended this approach to the review of falls SIs to the whole Trust, and it is now the established process used to review falls SIs.

3.5 Never Events

Never events are serious incidents that are considered entirely preventable.

There is national guidance, or safety recommendations, providing strong systemic protective barriers that should have been adopted and which should stop never events from occurring. The Trust reported 3 never events in the financial year 2022/23.

The never event categories for these patient safety incidents were:

1. Retained foreign object post-procedure (2)
2. Chest or neck entrapment in bedrails (1)

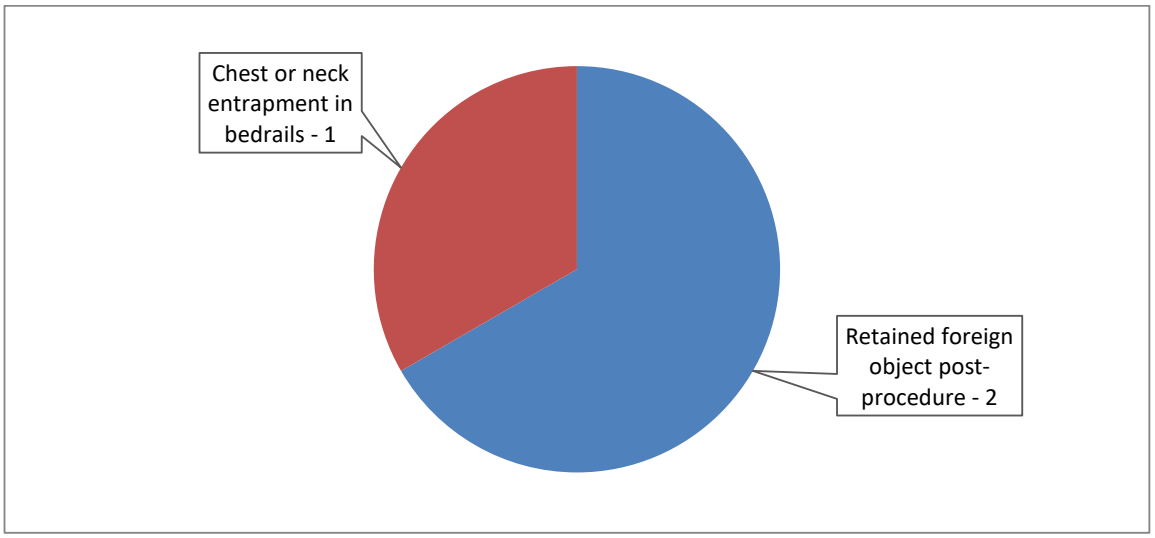


Figure 6: Never Events by Sub-category

There were no reported never events identified in 2021-22 but the Trust identified 5 during the year 2020-21.

The ICB has reported that the overall occurrence of never events within the Southwest Region (Bath, Wiltshire, West Bristol, Somerset, Gloucestershire, Cornwall and Isles of Scilly, Devon and Dorset) is high by comparison to other NHS regions. They have approached all Trusts within Devon to come together as a system and work collaboratively to address this issue. The Trust's Patient Safety Specialist, Director of Patient Safety and Clinical Governance Lead for Surgery are all working with ICB colleagues to support this system-wide approach.

4.0 External Assurance

Members of the ICB attend the Trust's incident review group meeting (IRG) which takes place weekly to quality review incident investigation reports before they progress to Executive-led final approval.

In addition to this, the ICB and central Patient Safety and Quality team meet regularly as part of their, and the Trust's, assurance processes:

- Every 2 weeks to review open actions from SIs
- Every 2 weeks for LFPSE drop-in session
- Monthly 1:1 between Patient Safety Specialist and ICB Head of Patient Safety

Regular contact is maintained between the Trust's CQC Compliance Manager and the CQC assigned inspector. These meetings address questions and queries relating to reported serious incidents and other incidents the CQC may be aware of, such as those reported to the Health and Safety Executive, or those reported under the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER).

No concerns have been expressed by the ICB or CQC regarding the Trust's handling of patient safety incident investigations during the year under review.

5.0 Internal Assurance

The Trust has a number of internal quality meetings through which the Board can take assurance regarding the management of patient safety incidents and investigations. Noting that the Trust has since devised a new governance structure, the meetings listed are those which were in effect during the year 2022-23, these are:

- Executive Incident Review Meeting – weekly
- Incident Review Group (IRG) – weekly
- SAE Group (Executive-led final approval for SIs) – monthly
- Quality Improvement Group (QIG) – monthly, with assurance bi-monthly
- Quality Assurance Committee (QAC) – bi-monthly

During 2022-23, the weekly Executive Incident Review Meeting was strengthened to include consideration of patient safety incident initial reviews (formerly termed 72hr reports) and to determine next steps which could be:

a) Report onto StEIS as an SI
b) Not an SI, but for further internal Trust investigation
c) No further action required

This additional scrutiny on the incident review process provides probity as well as a more robust and transparent structure to the overall decision made.

Reports submitted to the QAC provide information relating to SIs and other patient safety incident activity across the Trust. In addition to the regular meetings listed above, Internal Audit published their final report: Patient Safety – Management of Serious Incidents in April 2022. While some actions for improvement were noted, the overall conclusion was that the Trust has appropriate serious incident policies and procedures in place which are consistent with the NHS England Serious Incident Framework. Current arrangements for the practical investigation of serious incidents across the Trust, on the whole, meet the requirements of both this framework and the Trust.

6.0 Further Review and Analysis

This annual report provides an overview and analysis of patient safety incident activity from the year 2022-23. The Trust encourages and supports a reporting culture and, by establishing a culture where staff report safety indicators such as incidents and near misses, problems are acknowledged, assessed and acted upon. Although the Trust has experienced prolonged periods of operational pressure, reporting patient safety incidents has increased by almost 5.5%.

Patient safety incident activity is managed by the central Patient Safety and Quality team and the Governance Coordinators, and Governance Support Nurses and Radiographer, who support the various clinical areas, formerly ISUs, now Care Groups. Trust patient safety activity is overseen and supported by the Patient Safety Specialist.

The patient safety team are a recognised resource for clinical managers across the organisation and they have established a reputation for excellence both within and outside the Trust. This team of patient safety professionals continues to provide the strong foundation through which the national Patient Safety Strategy will be delivered.

As the Trust transitions further towards full implementation of the PSIRF, the Board can have confidence that patient safety remains a core priority and central focus for staff across the organisation.

7.0 Recommendations

The Board is asked to note the following:

- An increase of almost 5.5% in incident reporting activity across the Trust
- A reduction in the number of serious incidents identified and reported to StEIS, compared with 2021-22 (but closer to the number reported in 2020-21)
- 3 never events were reported in the period under review
- Further development of robust review and assurance mechanisms, for example introduction of falls SI AARs and the introduction of the initial review process to the weekly Executive Incident Review Meeting

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: November 2023 Mortality Score Card			Meeting date: 29th November 2023
Report Appendix:	Appendix 1 - Hospital Mortality Appendix 2 - Unadjusted Mortality Rate Appendix 3 - Mortality Analysis Appendix 4 - Focused Mortality Reviews Appendix 5 – Glossary of Terms		
Report sponsor:	Chief Medical Officer		
Report author:	Chief Medical Officer		
Report provenance:	Mortality Surveillance Group		
Description/Purpose of the report and key issues for consideration/decision:	The report is for bi-monthly assurance to ensure learning from deaths.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	To receive and note this report		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	Reviewing the care provided to people who have died, and gaining feedback from the bereaved, will help improve care for all service users by identifying problems associated with poor outcomes, and working to understand how and why these occur so that meaningful action can be taken. This supports the Board, providing visible and effective leadership to ensure the organisation addresses significant issues identified in reviews and investigations.		
How does the report support the Triple Aim:	2) quality of services provided – to provide learning to aid the improvement of service provision and indicate any issues with care		
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience		
Risk: Risk ID: *As appropriate*			
External standards affected by this report and associated risks	Care Quality Commission National guidance – Learning from deaths		

Report title: November 2023 Mortality Score Card		**Meeting date:** 29th November 2023
Report sponsor	Chief Medical Officer	
Report author	Chief Medical Officer	

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. Since April 2017, Trusts have been required to collect and publish, every quarter, 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 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 is to identify where problems in care may have contributed to death, and to learn, improve and prevent recurrence.

Since April 2020, it has been a requirement that all in-patient deaths be 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 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, the 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 five 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 a 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 98.1 ↓
• B. Summary Hospital Mortality Index (SHMI)	Mortality	DH SHMI data		1.0169↓ (May 22 – Apr 23)
Appendix 2 • Unadjusted Mortality Rate • By Number • By location		Trust Data	Yearly Average ≤3%	3.53% ↓
Appendix 3 • Mortality Analysis		Trust Data Dr Foster DH HSMR data	New CUSUM alerts	3
Appendix 4 • Mortality Reviews and Learning •		Trust Data		

2.0 Trust Wide Summary

The Hospital Standardised Mortality Rate (HSMR) is below the target level of 100 for our population and is within the expected range compared to hospital trusts nationally.

The rolling 12-month position was above the target range (<90) for the 12-months to May 2023 with a relative risk of 98.1 against a 100 benchmark. The rolling 12- month trend shows that the HSMR was 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 four 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 continue to be reviewed. The Trust has a lower number of patients who die with a recorded Charlson co-morbidity of 20+ and reports a higher percentage of spells in the 'Symptoms and Signs' chapter (6.5% v 6.2% national) than the national average. This is longstanding and impacts by reducing our expected mortality rate, potentially increasing the HSMR. However, as coding improves (capturing a greater number of comorbidities), in conjunction with a higher specialist palliative care rate, the expected mortality rate rises, and consequently the HSMR reduces. 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 in patient 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:

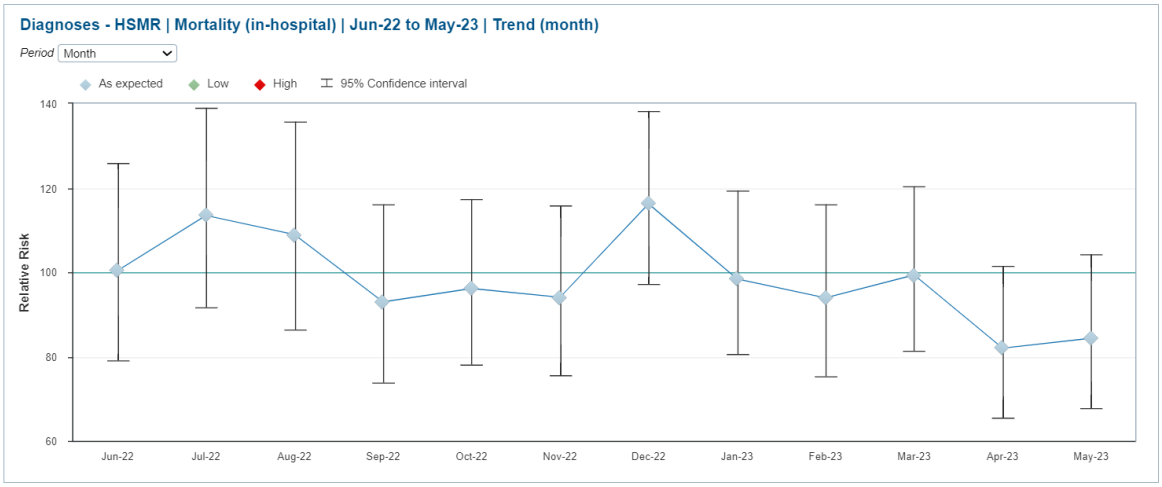
- 1A – Dr Foster's Hospital Standardised Mortality Rate (HSMR) and,
- 1B – Department of Health's Summary Hospital Mortality Index (SHMI)

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

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

Chart 1 - HSMR by Month June 2022 to May 2023

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



The usual one-month lag has been applied to the data to account for the potential data discrepancies due to the delays in coding which results in high volumes of super spells within the Residual codes, unclassified group in the last month of data in the extract (June 23).

The latest HMSR for June 22 - May 23 is **98.1** (92.4 – 104.0) and is within the expected range compared to hospital trusts nationally (↓). There were 32,434 super spells recorded in the period and 1110 deaths versus an expected 1132.1. 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 four data periods and now sits below the benchmark.

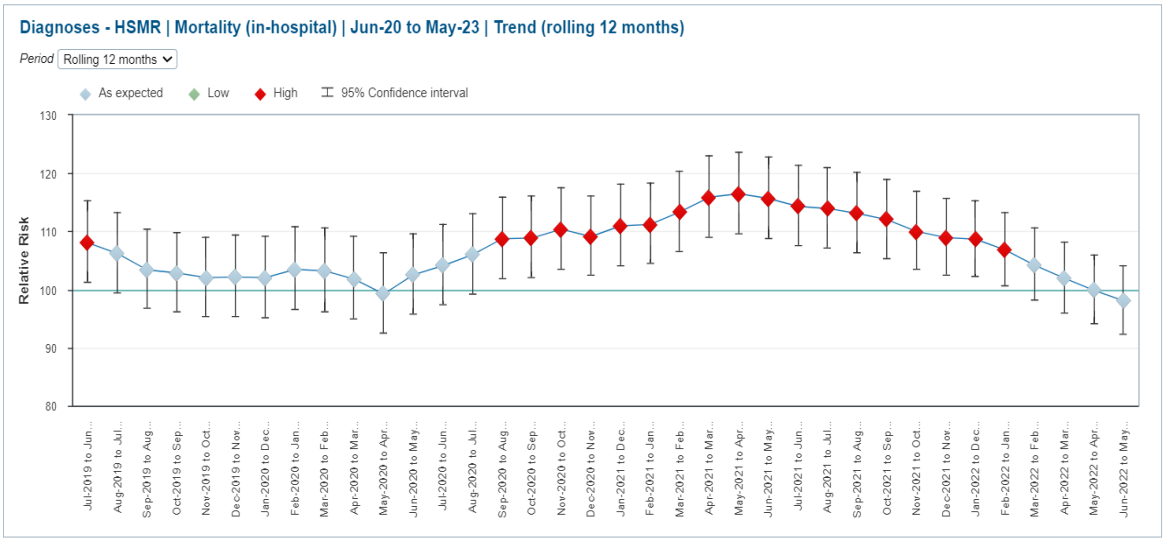


Chart 3 -HSMR Crude versus expected

The gap between the crude and expected rates has continued to narrow and the expected rate is now above that of the crude rate. The narrowing gap between the crude and expected rates has subsequently caused the Relative Risk to decline.

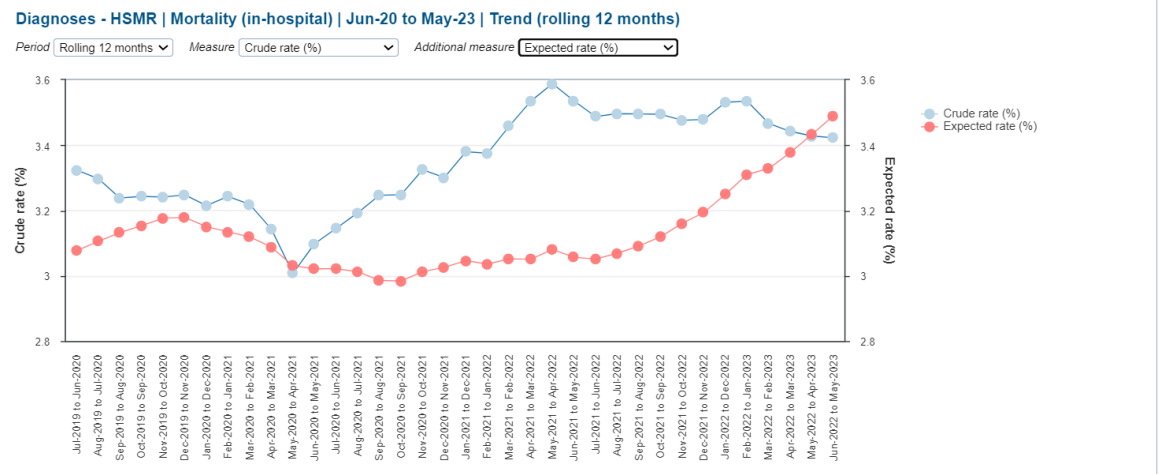


Chart 4 -HSMR Peer Comparison – Similar Peers

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.

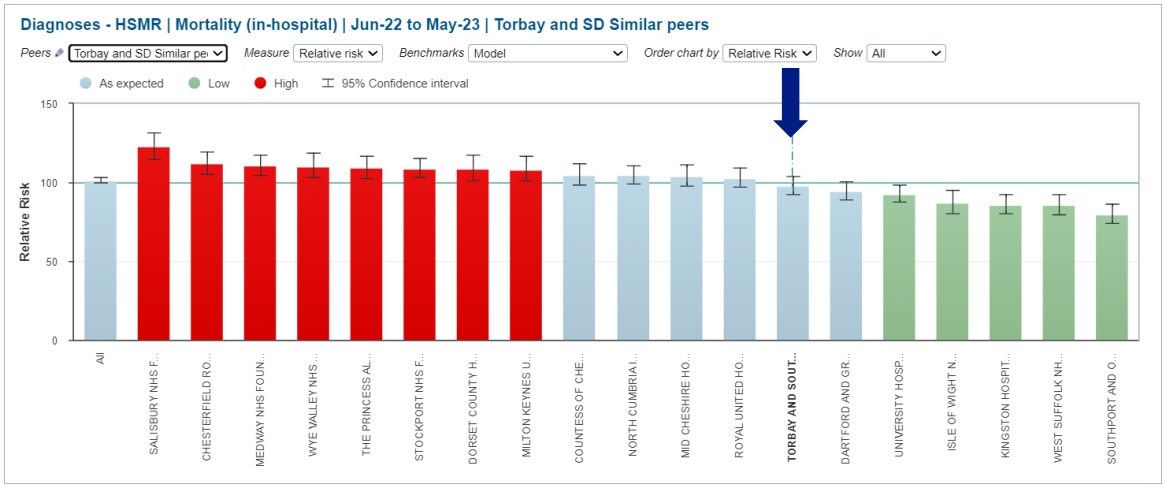


Chart 5- HSMR Peer comparison – Regional Peers

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 14) with the second lowest HSMR.

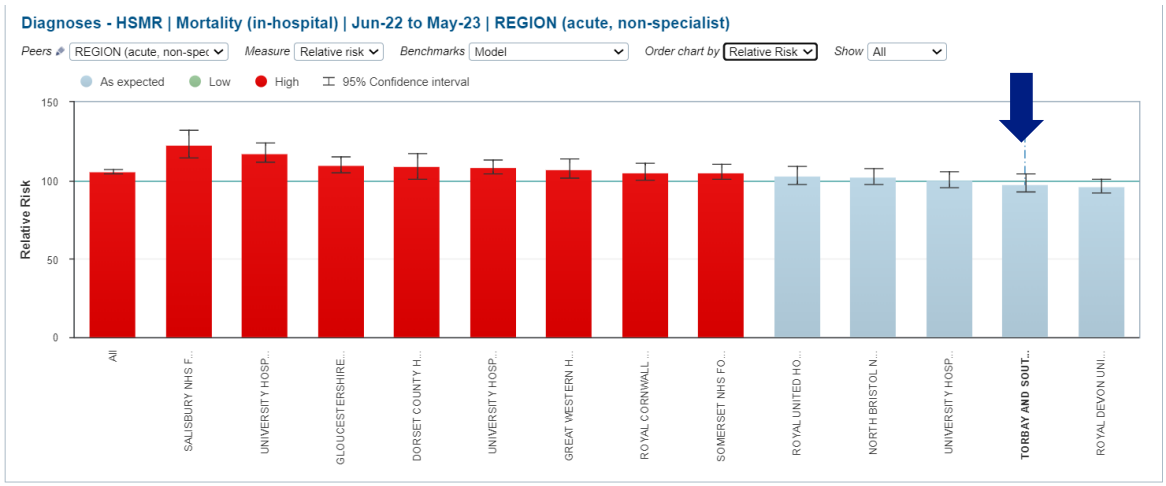


Chart 6- HSMR Expected rate (%) vs National.

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 four data periods.

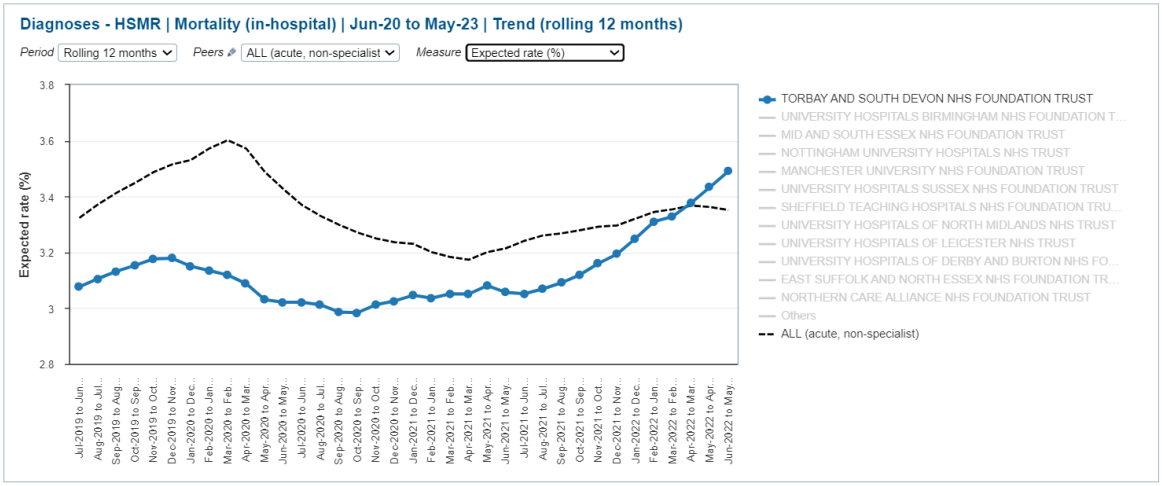


Table 2 below demonstrates the Trust's expected and crude rates against the National, Regional, and similar peer's benchmarks.

Table 2 – Crude and Expected rates.

Benchmark	Expected Rate	Crude Rate
Trust	3.5%	3.4%
National	3.4%	3.3%
Regional	3.1%	3.3%
Similar Peers	3.5%	3.9%

Table 3 – Coding Case Mix Summary

The following table reports a higher percentage of spells in the Symptoms & Signs chapter (6.5%). This continues to demonstrate improvement (reported 6.9% in the last report) but is still slightly above national rates. However, this is now lower than regional peers.

The percentage of spells with the Charlson comorbidity score of 20+ is 15.2% and is lower than the National (16%) but comparable with Peer averages (15.2%). This is slightly higher than in the previous report (14.7%).

Performance	Trust	Peer	National
HSMR	98.1	105.6	99.5
SMR	96.1	104.8	99.5
Non-elective (HSMR)	97.3	105.5	99.2
Weekday, emergency (HSMR)	94.1	103.3	97.8
Weekend, emergency (HSMR)	108.0	112.6	103.5
Saturday, emergency (HSMR)	111.7	113.5	102.8
Sunday, emergency (HSMR)	103.8	111.6	104.2
Coding / Casemix	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)	53.1%	41.3%	41.7%
% Non-elective spells with palliative care (HSMR)	6.0%	4.8%	5.0%
% Spells in Symptoms & Signs chapter	6.5%	6.8%	6.2%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	39.8%	42.9%	41.5%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	15.2%	15.2%	16.0%
% Non-elective spells in Risk Band (0-10%) (HSMR)	82.9%	84.3%	83.7%

Chart 7- Emergency Weekday / Weekend HSMR

The emergency weekday HSMR remains statistically within the expected range. The emergency weekend HSMR has now changed banding and is also within the expected range (previously statistically higher than expected)

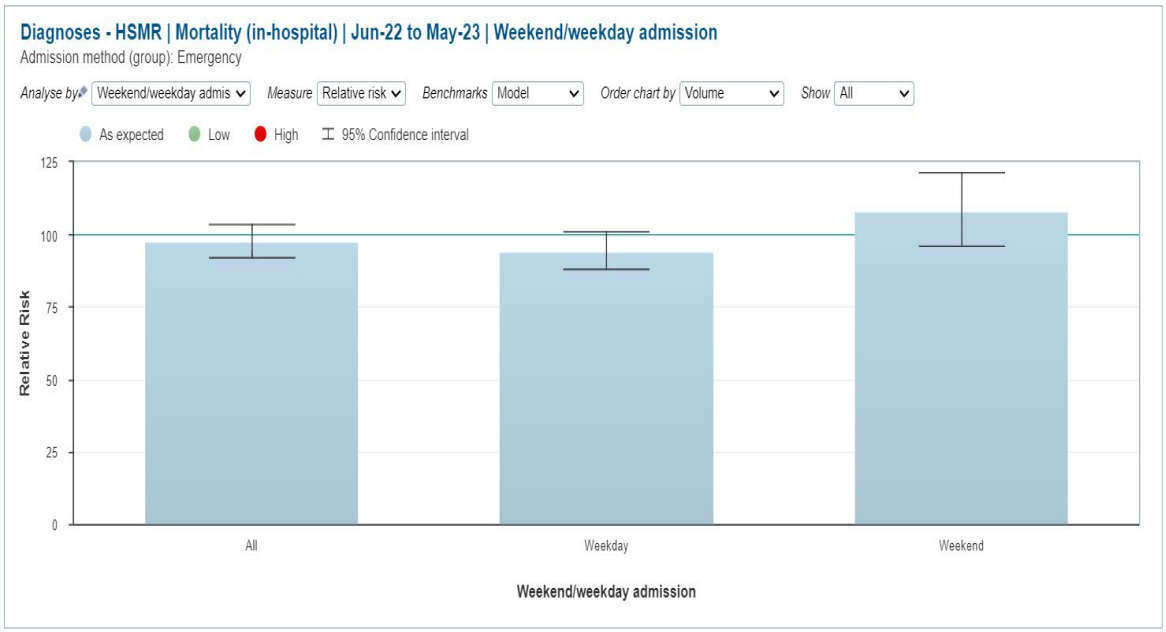


Chart 8- Emergency Weekday HSMR

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

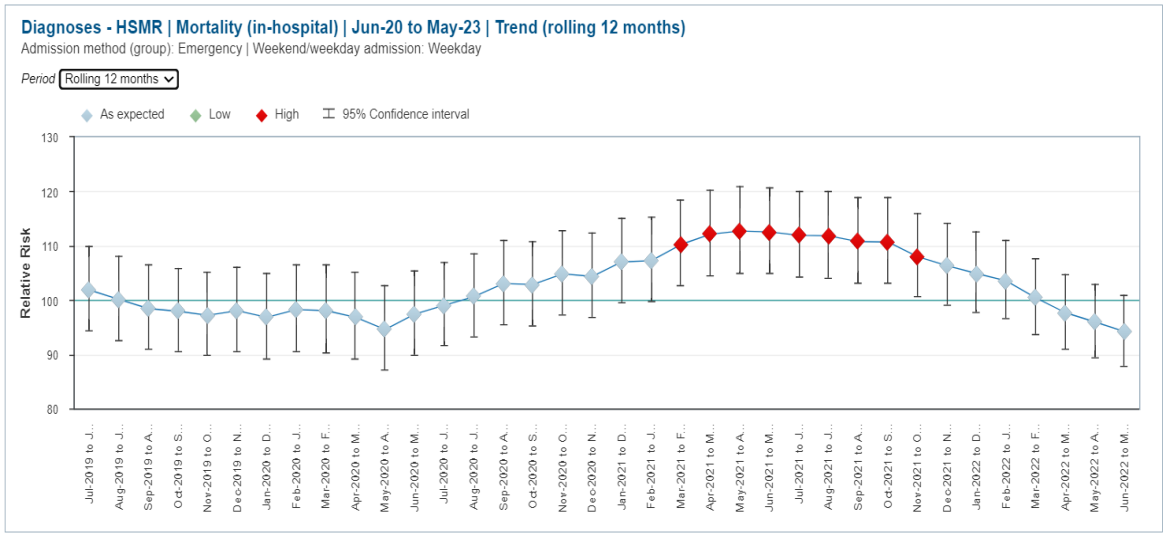
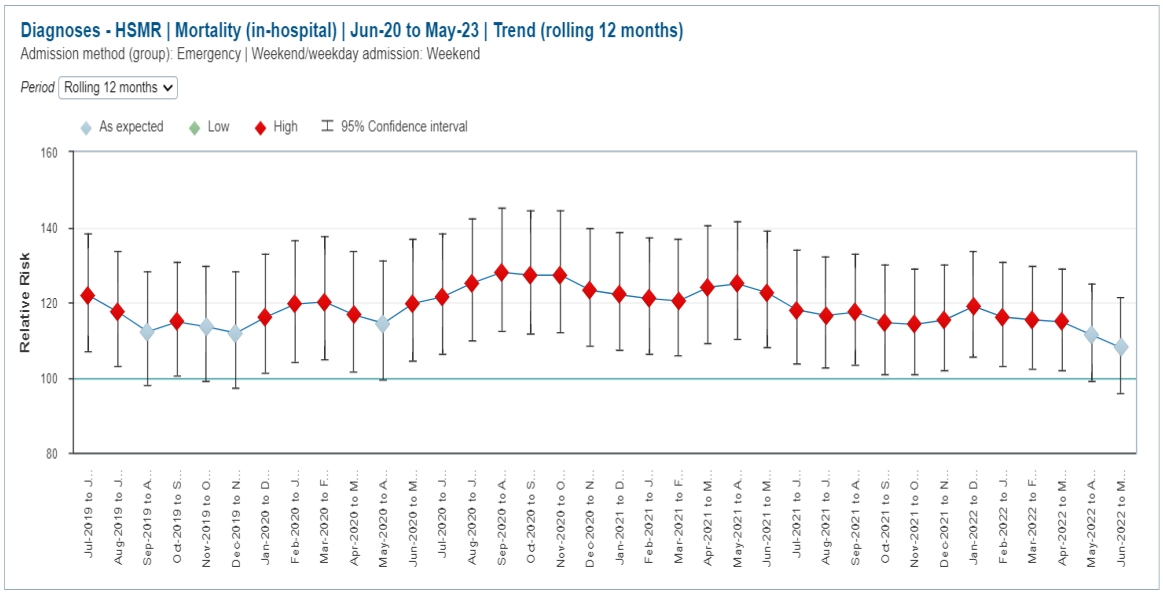


Chart 9- Emergency Weekend HSMR

The rolling twelve-month weekend emergency HSMR is within the expected range compared to trusts nationally. This constitutes a move in banding from statistically higher than expected in the previous report. The last two rolling 12-month periods are within the expected range.


Diagnoses - HSMR | Mortality (in-hospital) | Jun-20 to May-23 | Trend (rolling 12 months)
Admission method (group): Emergency | Weekend/weekday admission: Weekend
Period Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
160
140
120
100
80
Jul-2019 to J...
Aug-2019 to J...
Sep-2019 to A...
Oct-2019 to S...
Nov-2019 to O...
Dec-2019 to N...
Jan-2020 to D...
Feb-2020 to J...
Mar-2020 to F...
Apr-2020 to M...
May-2020 to A...
Jun-2020 to M...
Jul-2020 to J...
Aug-2020 to J...
Sep-2020 to A...
Oct-2020 to S...
Nov-2020 to O...
Dec-2020 to N...
Jan-2021 to D...
Feb-2021 to J...
Mar-2021 to F...
Apr-2021 to M...
May-2021 to A...
Jun-2021 to M...
Jul-2021 to J...
Aug-2021 to J...
Sep-2021 to A...
Oct-2021 to S...
Nov-2021 to O...
Dec-2021 to N...
Jan-2022 to D...
Feb-2022 to J...
Mar-2022 to F...
Apr-2022 to M...
May-2022 to A...
Jun-2022 to M...

1B Summary Hospital Mortality Index (SHMI) Reporting Period May 2022 – April 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 **May 2022 – April 2023** data period and is different to HSMR.

Chart 10- Trust SHMI compared to National Baseline

The Trust is rated 'as expected' compared to trusts nationally with a SHMI value of 1.0169 which is lower than in the previous report (1.0299). This is statistically as expected.

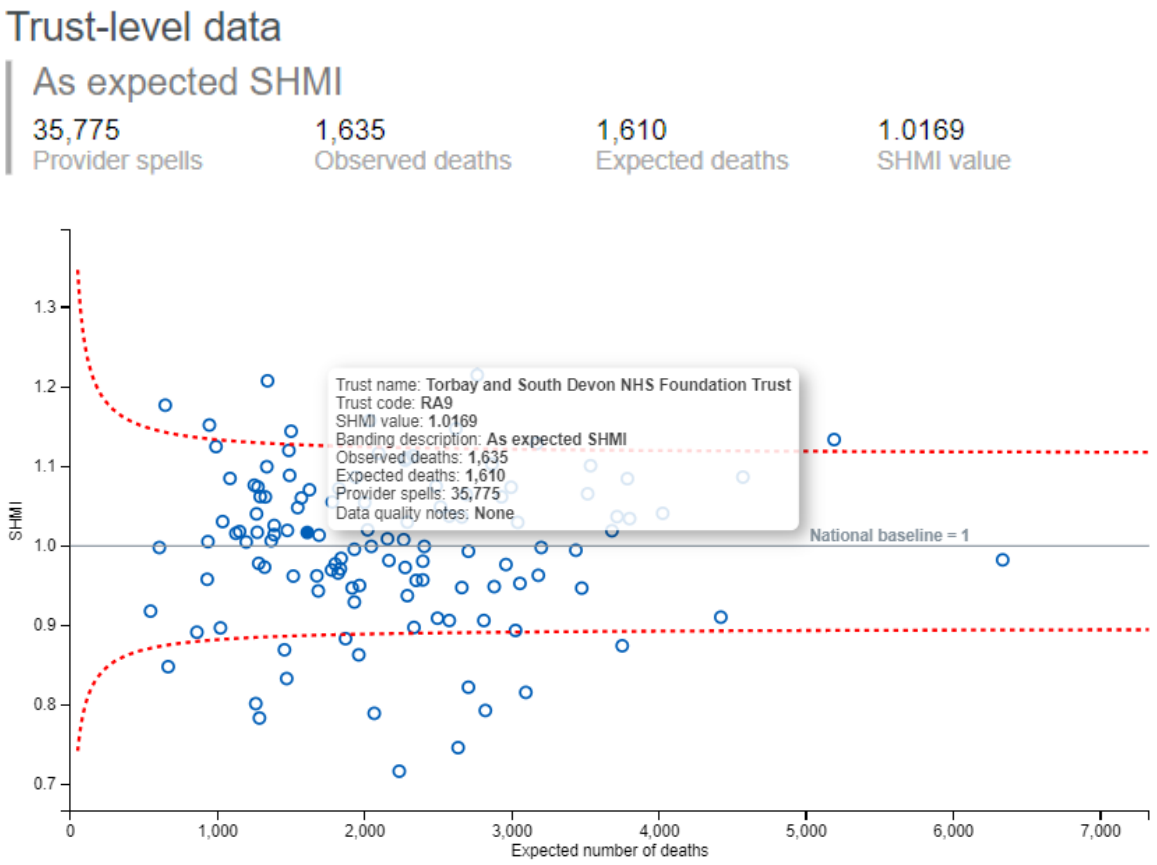


Table 4 – SHMI diagnostic groups

The diagnosis group of secondary malignancies has moved banding again and is now higher than expected once more (the previous data period was as expected). All other diagnosis groups are as 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 11, below, highlights the Trust's in hospital unadjusted mortality. The rolling 12-month average is 3.53%. This must be viewed along with the more in-depth analysis provided by HSMR and SHMI.

The chart below includes the COVID waves as annotated. December 2022 and January 2023 showed a rise in unadjusted mortality attributed to increased admissions with Covid, Flu and RSV infections.

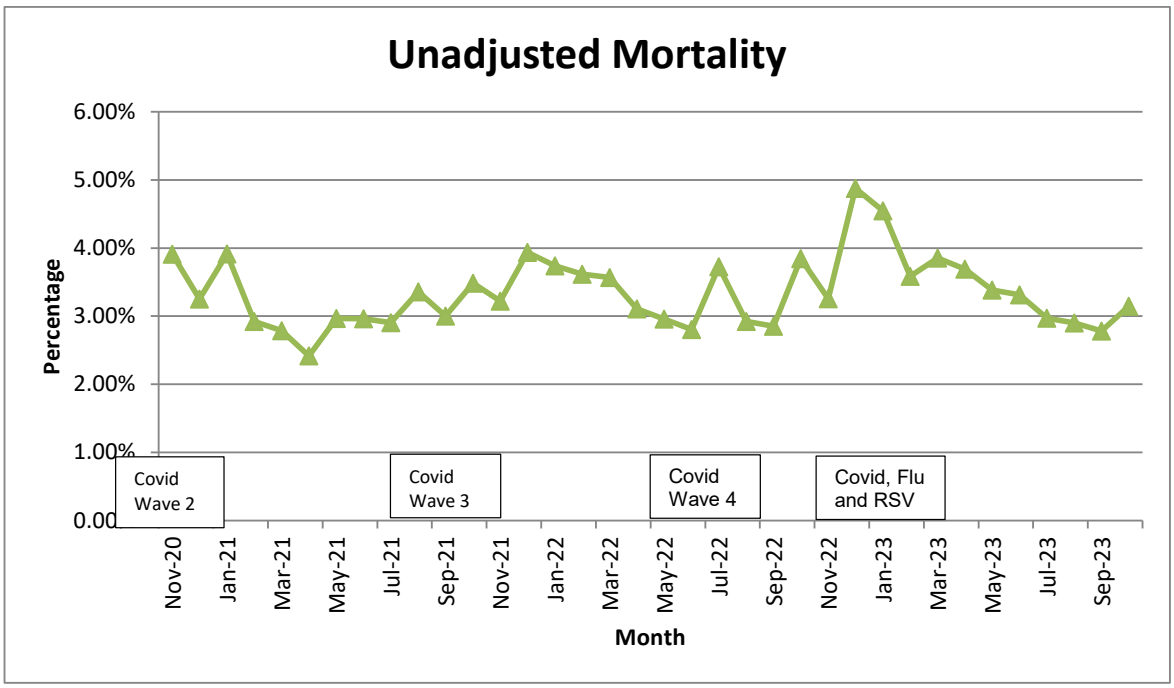
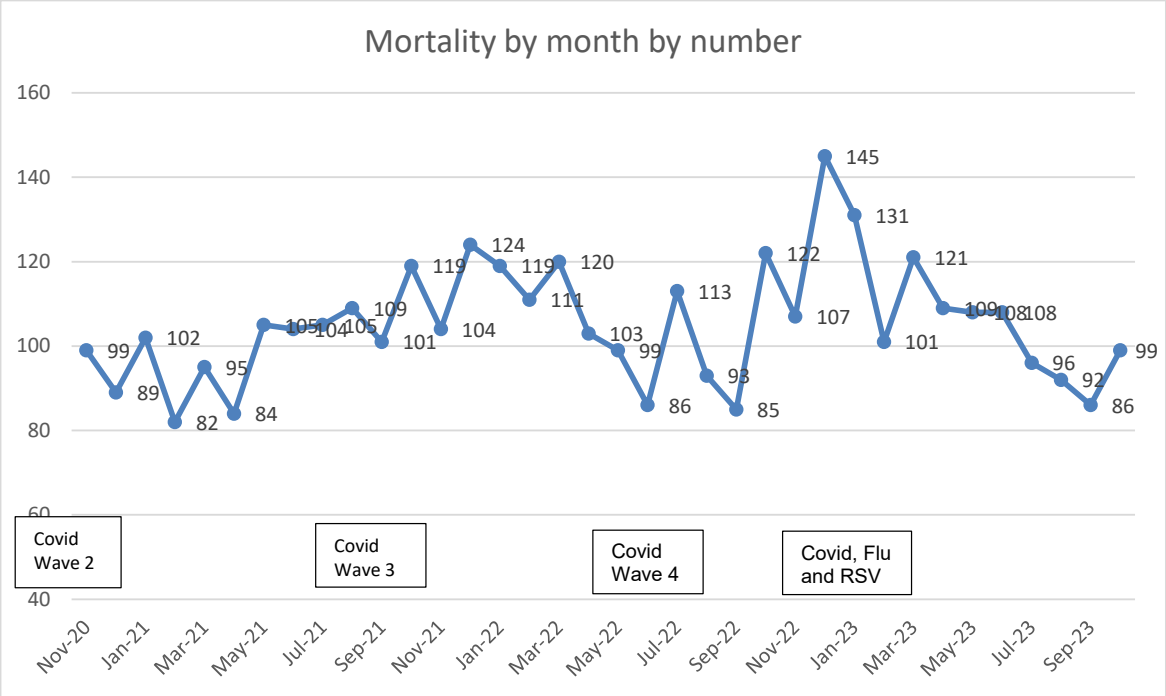


Chart 12 indicates the monthly number of hospital deaths excluding (excluding stillbirths and deaths in A & E).

Key points to note.

- The pattern of increased deaths related to winter pressures appears to re-emerge post-pandemic 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.



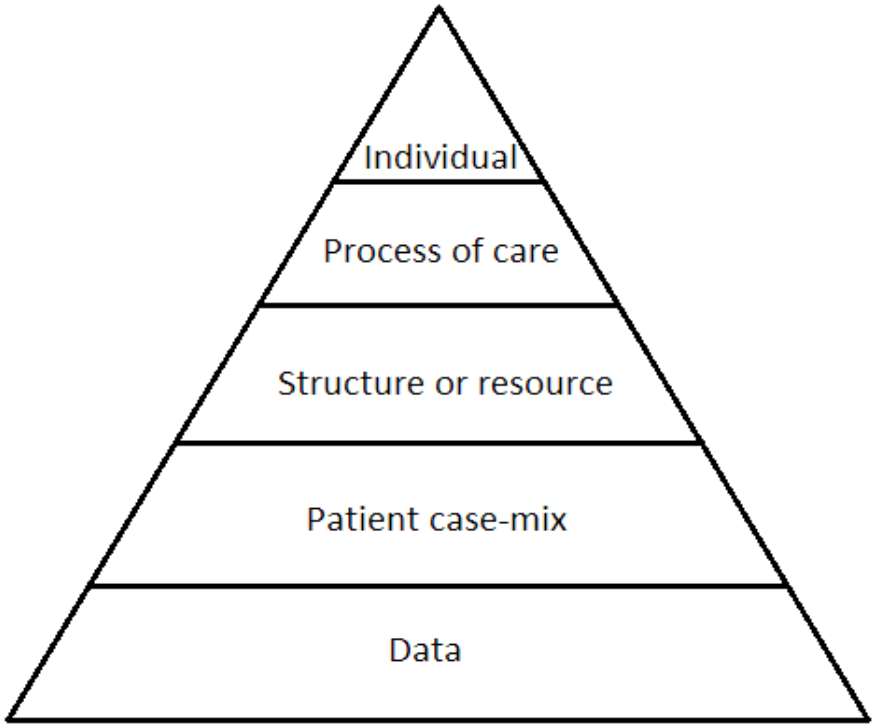
Appendix 3 – Mortality Analysis

Table 5–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 speciality.

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Care Group - Families and Communities													
BRIXHAM	2			1		2	2			1		2	
DART			2		1		1		1	3	4		2
DAWLISH	2		3	1	2	1	1	2	1	1	2	1	3
DELIVERY SUITE										1			1
LCHDU													
LOUISA CARY													
MOTHER AND BABY													
TEIGN WARD	3	1	4	3	2	5	2		1		2	3	
TEMPLAR WARD	3	2	3				2			1	1	1	
Care Group - Planned Care													
AINSLIE	3	5	2	1		7	3	5		1		5	
ALLERTON	9	8	14	7	4	6	6	7	4	5	6	9	2
CROMIE	4	6	4	3	7	5	2	4	6	7	3	2	3
ELLA ROWCROFT		1	1		1			1	1	1	2	1	
INTENSIVE CARE UNIT	6	9	10	13	11	6	6	8	7	9	9	2	10
THEATRES			2			1		1					
WARRINGTON	4	2	2	5	4	1	5	1		2	1	3	2
Care Group - Medicine and Urgent Care													
ACUTE MEDICAL UNIT			5	4	10	6	3	5	2	5	4	5	2
CARDIAC CATHETER SUITE						1			1				
CHEETHAM HILL	11	10	9	5	8	9	8	8	12	8	5	7	6
DUNLOP	6	1	14	13	6	2	8	1	3	4	4	4	7
EAU4	7	9	9	13	3	4	7	12	7	4	4	6	9
FORREST	11	11	10	12	7	8	8	10	4	5	7	10	6
GEORGE EARLE	14	10	6	9	7	12	11	12	14	9	8	9	8
MCCALLUM	2	2	5	9	3	4	3	1	3	3	2		
MIDGLEY	18	12	17	16	13	17	16	13	18	12	12	6	18
NEW MEDICAL RECEIVING UNIT	1	2	4										
SIMPSON	10	11	6	8	4	15	8	8	11	8	9	3	12
TORBAY CHEST PAIN UNIT			1			1							
TORBAY CORONARY CARE BEDS	2	1	5	3	2	2	3		2	1	3	2	1
TURNER	4	4	7	5	6	6	4	9	10	5	4	5	7
Grand Total	**122**	**107**	**145**	**131**	**101**	**121**	**109**	**108**	**108**	**96**	**92**	**86**	**99**

Alerts by Clinical classification

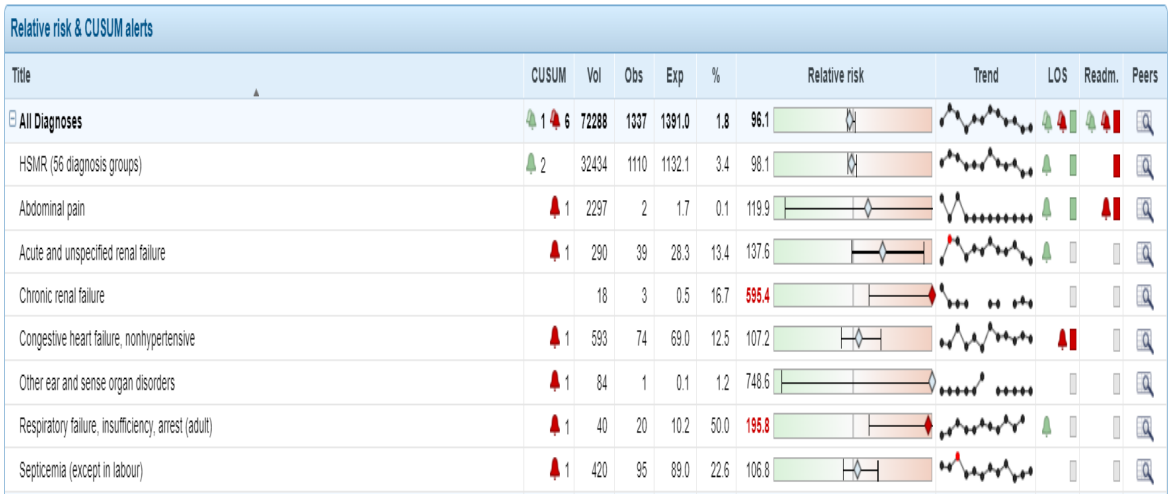
An ‘alert’ is raised when the expected number of deaths is significantly exceeded by the actual number of deaths. The Trust adopts the ‘pyramid of investigation for special cause variation’ shown below to further investigate alerts.



1) 1st Step **Data**: has the data been coded accurately, have all the comorbidities been recorded and coded, does the coding reflect what 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's 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?

Torbay and South Devon NHS Foundation Trust

Table 6 – Dr Foster Alerts by clinical classification



Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 6	72288	1337	1391.0	1.8	96.1				
HSMR (56 diagnosis groups)	2	32434	1110	1132.1	3.4	98.1				
Abdominal pain	1	2297	2	1.7	0.1	119.9				
Acute and unspecified renal failure	1	290	39	28.3	13.4	137.6				
Chronic renal failure		18	3	0.5	16.7	595.4				
Congestive heart failure, nonhypertensive	1	593	74	69.0	12.5	107.2				
Other ear and sense organ disorders	1	84	1	0.1	1.2	748.6				
Respiratory failure, insufficiency, arrest (adult)	1	40	20	10.2	50.0	195.8				
Septicemia (except in labour)	1	420	95	89.0	22.6	106.8				

Compared to the dashboard previous dashboard there are three new CUSUM alerts and one new diagnosis groups with a relative risk statistically higher than expected.

CUSUM Alerts

- Abdominal pain – This is a historic alert (June 2022) which is due to the change in the benchmark. No further analysis is required currently.
- Congestive Heart Failure, non-hypertensive - This a historic alert (June 2022) which is due to the change in the benchmark. No further analysis is required currently.
- Ear and sense organ disorders - This is a historic alert (November 2022) which is due to the change in benchmark. No further analysis is required currently.

Relative Risk – Chronic Renal Failure

- This alert involved three observed deaths and has not reached the indicated level (5 observed deaths) for further analysis at this time. The risk will be monitored by the Mortality Surveillance Group and case reviews requested if the risk continues to flag.

Previous CUSUM update – Acute and unspecified renal failure

- In the previous report a CUSUM and relative risk alert was noted for Acute and unspecified renal failure (Alert on February 23).
- A previous deep dive was undertaken regarding this cohort of patients which indicated patients at the end stage of complex illness. In addition, there is a tendency for selection bias as treatable renal failure patients are transferred for treatment whereas known end-stage patients are cared for within the Trust.
- The Medical Examiners service was asked to monitor this cohort of patients for two months.
- No issues or concerns were identified.

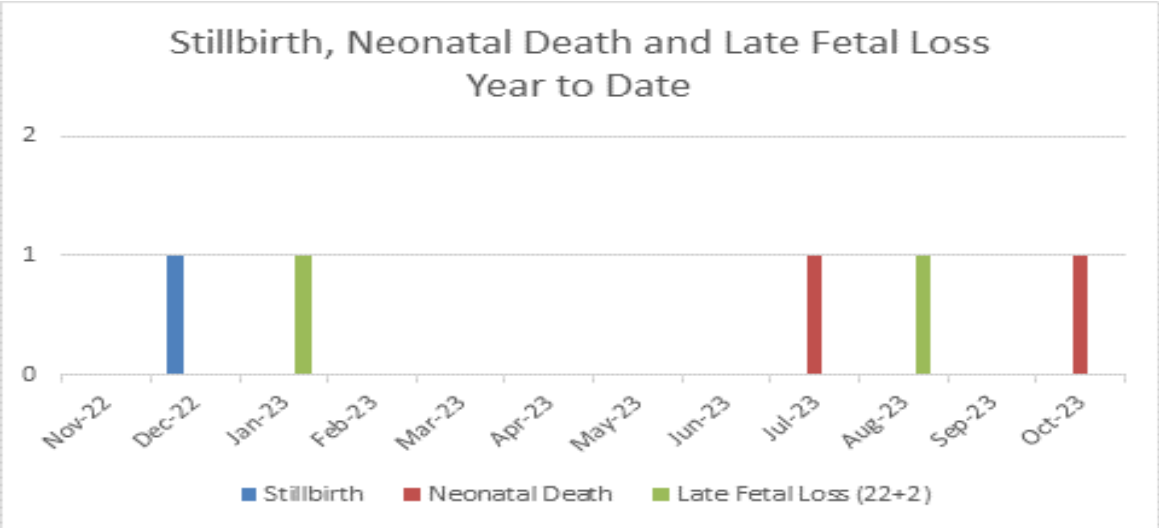
Appendix 4 – Focused Mortality Reviews

Number of Neonatal, Perinatal, and Maternal Deaths

A stillbirth is when a baby is born dead after 24 completed weeks of pregnancy. It occurs in around 1 in every 200 births in England.

We had no mortality in September 2023 but one neonatal death in October 2023

Chart 13 – Stillbirth, Neonatal Deaths, and Late Fetal Losses

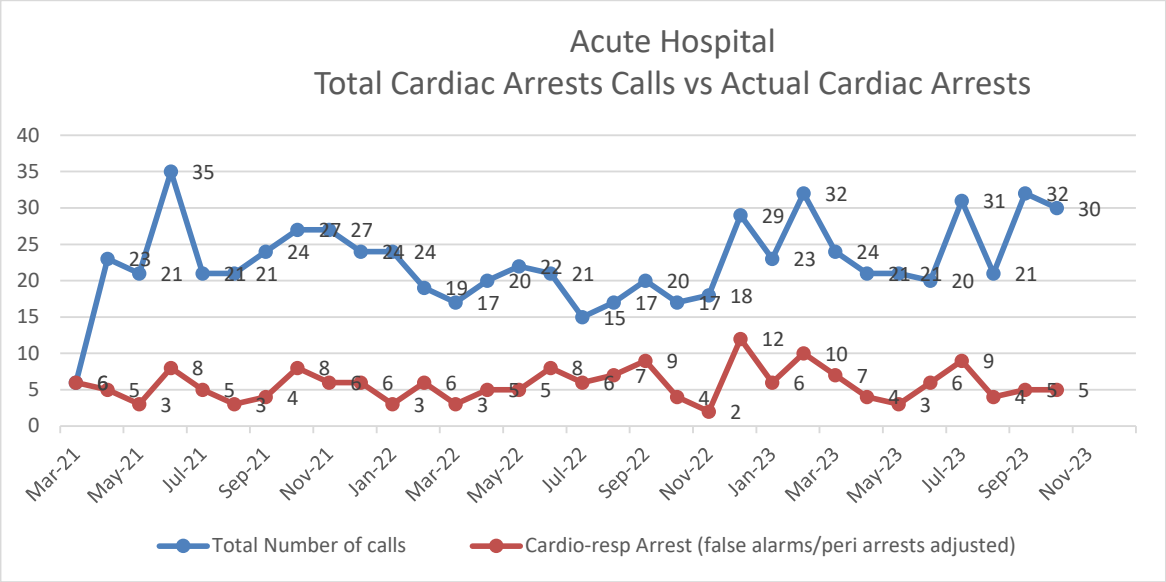


The neonatal death involved a Mother whose baby was sadly diagnosed in the early antenatal period with a genetic condition which was incompatible with life. The mother chose not to terminate the pregnancy and went into spontaneous labour at 37+ 4 weeks gestation. The baby was born alive and lived for 13 hours. Throughout this difficult time, the mother was supported by the multidisciplinary team in her choices and with the care of her baby following the birth.

Cardiac Arrest

The number of cardiac arrest calls and actual cardiac arrests continues to demonstrate a stable position since March 2021.

Chart 14– 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. Work with the Department of Health and Social Care (DHSC) is continuing towards commencing the statutory system and has already delivered the ministerial commitment to commence primary legislation in the autumn. Ministers have committed to publish the final draft regulations for medical examiners this autumn which is on course. The Medical Examiner's office expects to receive this information within the next month and will advise the Trust of any implications and expectations for which will need to be planned.

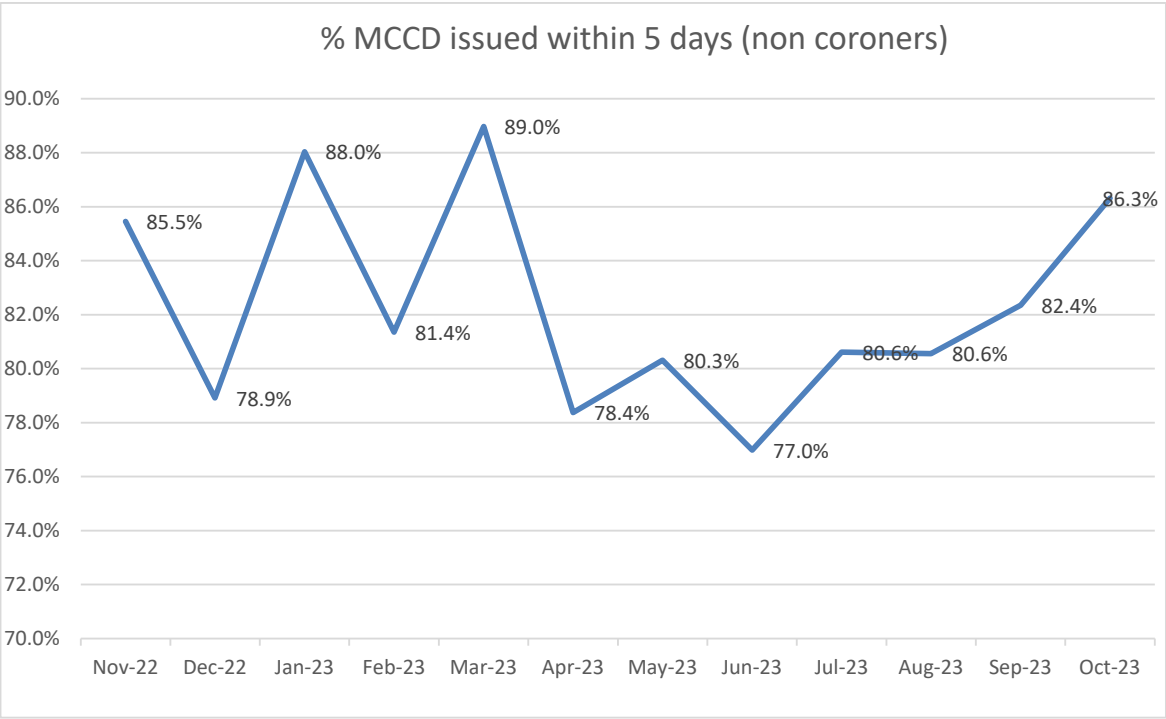
The Medical Examiner's Office continues to scrutinise 100% of the deaths in the acute and community hospital settings, which are not directly referred to the coroner.

Table 7 – Medical Examiners - Community vs Acute Activity

Month	Number scrutinised by ME	Acute	Community	The number scrutinised referred to the coroner
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
Sep-23	115	99	16	13
Oct-23	121	104	17	26

Chart 15 – MCCD completion within 5 days

The episodes of industrial action and the Bank Holidays between April and September 2023 can be seen to have negatively impacted on the timescales for the completion of MCCDs.



A total of eleven 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 eleven 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 of 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. In addition, any deaths occurring in the Acute or community Hospital settings undergo independent review by the Medical Examiners and a Structured Judgement Review by one of the Trusts GP advisers to identify any potential learning at the earliest opportunity.

During September and October 2023, the Trust received no LeDeR reviews outcomes.

During these months, a total of two (2) LeDeR referrals have been made from the acute hospital and one (1) from the community setting. A Structured Judgement Review has been completed on one of the cases which indicated no evidence the death could have been avoided and identified no issues in care provision.

The second case occurred in late October and is scheduled for review before the end of November.

Learning from Inquests

In September 2023 there were three (3) inquests which are detailed in Table 8.

In October 2023 one (1) inquest was held but the Trust was not called to attend. The record of this inquest is awaited.

Table 8 – Summary of Inquests attended.

Month of Inquest	Month of Death	Case Outline	Verdict	Learning/actions/ feedback
September 2023	February 2022	Family concerns that treatment should have been different	Natural Causes	The Coroner's view was that this was a naturally occurring disease process and this was an unexpected death. There was a delay in referral to a vascular consultant however the Coroner felt this delay was not causative
September 2023	November 2021	Sudden death of an infant	Sudden and unexpected death at 8 weeks of infancy	The Trust completed a Root Cause Analysis investigation into this matter as there had been two admissions to ED in the week before death. Child deaths lead had also produced a report for the coroner for the inquest.

				The Coroner was satisfied with the documentation provided by the Trust and death was confirmed as Sudden Unexpected Death in Infancy
September 2023	February 2021	Death occurred in another hospital had been discharged from our care one week earlier	Natural Causes	The coroner asked the Trust to provide reports as the patient had been in our care for 1 week before readmission into a neighbouring acute hospital. The Trust had already completed a 72-hour report from which the only action point made was about documentation.

Several deaths in which concerns and complaints were raised by the family.

During September and October 2023, there have been three (3) formal complaints. These are ongoing and relate to treatment and care.

In addition, there have been fifteen concerns raised.

- Six related to care
- One related to communication
- One requesting additional information.
- Two related to property.
- One related to safeguarding
- Four related to treatment

There have been four compliments received regarding treatment and care.

Trust learning: Serious Adverse Event Group

Key Issues	Learning and actions taken
A 60-year-old lady with multiple comorbidities died on the 17th of January 2023 of multi-organ failure relating to meningoencephalitis having initially presented to MIU on the 1st of January with a facial rash, tachycardia and a history of pyrexia. On 3rd January at about midday an ambulance was called and was assigned a category 2 call out (target 18 minutes) did not arrive until about 3.40. On arrival, there was a wait outside ED for an hour and was then transferred into resus at 5 pm as triage category 3. About 40 minutes later she was treated with antibiotics. At this point, she had an early warning score of 10 and was agitated	Understanding the impact of ambulance delays and possible impact on patient deaths, Risk ED delays Importance of rapid antibiotics in sepsis.

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 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 be alert.

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

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

and diagnosis grouping. The cumulative risk of dying within the spell for each patient within the selected group gives the number of expected deaths.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Research and Development Annual Report 2022/23			Meeting date: 29 November 2023
Report appendix:	n/a		
Report sponsor:	*Chief Medical Officer*		
Report author:	Director of Research and Development (R&D)		
Report provenance:	*QAC* *R&D Committee* *Dr Mark Gilchrist, Medical Research Lead* *Kathryn Bamforth Lead Research AHP.*		
Description/Purpose of the report and key issues for consideration/decision:	To provide the Board of Directors with an annual account of Trust Research and Development (R&D) activity and performance in 2022/23.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Trust Board is asked to consider the risks and assurance provided within this report and to agree any further action required.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	Being a research active trust gives opportunities and access to our local population and staff to novel and the latest treatments and technologies; providing high quality, safer care and practices. There is increasing evidence that research active trusts have improve outcomes whether a patient is in a trial or not.		
How does the report support the Triple Aim:	*1) population health and wellbeing – provides SoC at least. Access to new, novel and latest treatments and technologies. Early adopters of new treatments etc. Patient experience and choice* *2) quality of services provided: Protocol driven care and practice, staff kept up to date, external QA and monitoring. Improved standards, e.g. documentation.* *3) sustainable and efficient use of resources: e.g. improves outcomes, safer care (protocol driven), workforce (retention, recruitment, wellbeing job satisfaction), savings or cost avoidance (e.g. drugs radiotherapy fractions). Research provides value, health and wealth.*		
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 8 - Transformation and Partnerships Objective 9 - Integrated Care System Objective 11 – Equality, Diversity and Inclusion		

Risk: Risk ID: *As appropriate*	*Not currently on Datix*
External standards affected by this report and associated risks	*Care Quality Commission – well led domain* *UK Policy Framework for Health and Social Care Research* *UK Medicines for use in Clinical Trials regulations* *Health and Care Act 2022* *NHS Constitution* *NIHR Performance and Operating Framework* *NHS England and the NHS contract (commercial research)* *UK Clinical Research Strategy, Saving Lives*

Research and Development Annual Board Report 2022/23

Executive Summary:

1. This paper presents the Torbay and South Devon NHS Foundation Trusts (TSDFT) Research and Development Activity, Performance and Governance Report for 2022-23.
2. During 22/23, R&D supported a large portfolio of commercial and non-commercial clinical trials (around 270 studies), across many services and specialities to improve outcomes for our local population. This work is of crucial importance in providing our patients with new opportunities to benefit from research participation.
3. The Trust has a long successful history of hosting research studies especially the delivery of national and international clinical trials; with an increasingly excellent reputation in areas such as oncology, cardiology and anaesthetics.
4. Overall the Trust made good progress against our post pandemic recovery programme; despite staffing and other challenges facing the Trust and NHS.
5. TSDFT was one of the best performing Trusts for research activity compared to similar sized organisations across England; ranking 1st and best in class overall for recruitment and 2nd best for the number of studies recruited into during 22/23.
6. Torbay was the second highest recruiter to commercial cancer studies nationally in 22/23.
7. In common with other Trusts in England, the increased demand to set-up new studies as COVID-19-related restrictions have eased, and then to recruit to time and target, has been challenging with increased workforce, operational and financial pressures across the NHS.
8. Clinical research expands opportunities for the development of Trust staff, as well as empowering and engaging the patients we care for. There is clear evidence that more research active organisations have improved outcomes, even for those patients who do not participate directly in research.
9. When engaged clinicians have dedicated time to work with committed R&D staff, this has a life changing impact on patient care. We aspire to put research where it belongs: at the heart of the patient care we provide at TSDFT.
10. The findings and recommendations in the recent O'Shaughnessy review are welcomed as a national focus on how to improve performance for commercial trials.
11. Despite the lessons from Covid; research is still viewed by many as an added extra when time, interest, and capacity allows. More work is needed to get research seen as the norm and embedded into core everyday business and clinical practice.
12. Current workforce and funding models mean a lack of resilience; with reliance on too few people creating multiple 'single points of failure'. Consequently R&D is both a fragile and vulnerable service and this urgently needs to be addressed through new workforce plans and funding arrangements at national, regional and local levels.

Recommendation
The Trust Board is asked to receive this report and note the content.

1.0 Scope and Purpose

The purpose of this report is to provide the Board of Directors with an annual account of Trust Research and Development (R&D) activity, performance and governance, covering the period of April 2022 to March 2023.

2.0 Introduction and Background:

- The R&D Department is responsible for approving, supporting, facilitating and overseeing all research activity in the organisation in accordance with relevant regulations.

- The R&D Department is part of corporate services. Although a clinical service supporting all clinical specialities; it does not sit within any one of the clinical ISUs (now care groups).

- The main administrative base is in the Horizon Centre and R&D is also responsible for the Jubilee Research Unit (JRU) offering dedicated clinical outpatient research facilities located within Crowthorne on the main Torbay Hospital site.

- The R&D Department comprises circa 48 WTEs staff with specialist research training, skills, and knowledge to support, facilitate and deliver research studies; split into the following core teams:

    - NIHR Clinical trials Delivery teams: comprising speciality teams in cardiology, haematology, ophthalmology and oncology, with the Horizon team covering flexibly other specialties.
    - Research Management and Governance Team
    - Research Finance, information and contracting team
    - R&D A&C support team
    - Dedicated research staff within pharmacy, labs and radiology.

- The Trust is a partner in the National Institute for Health and Care Research (NIHR) South West Peninsula Clinical Research Network (SWP: CRN); which is one of 15 CRNs in England; commissioned and funded separately to patient care; to support NIHR clinical trials delivery in line with relevant national R&D strategies, policies, the NHS contract and the NIHR Performance and Operating Framework.

- The NIHR's commitment is to enhance the health and wealth of the nation through research, with the overall aim of embedding research in clinical practice. Working with health and care organisations and the NHS to improve the environment for health and care research in England.

- For several years, the Trust has been part of the IQVIA Peninsula Prime Site initiative. One of four UK Prime sites and over 40 globally. Through this initiative Trusts have preferred access and selection to IQVIA commercial trials and dedicated relationship managers.

- The Trust's primary research business centres around hosting (participating) in multicentre national and international commercial and non-commercial clinical trials

(>90% of our overall business), sponsored by other organisations; mostly adopted by and part of the NIHR CRN) portfolio. Staff work across all the clinical services supporting and facilitating clinicians to recruit to and conduct NIHR clinical trials and other research studies.

- In addition, R&D supports a small level of own account research activity, Trust led (sponsored) studies, mostly funded via the local charity: The Torbay Medical Research Fund (TMRF). R&D also support staff and external researchers involved with projects as part of educational studies (e.g. Masters and PhDs).

Value of being a research active origination;

- The NHS is committed to offering patients the opportunity to take part in research to ensure that current treatments and practices are the best they can be.
- Research and clinical trials are a key tool for advancing medical knowledge and patient care and can take many forms.
- Whatever we research, it is always about making a difference to the lives of real people.
- Research is integral to everything we do and provides us with the evidence to deliver the highest quality of care to our patients.

There is increasing evidence that being a research active organisation improves outcomes, even for those who do not participate directly in research. This is one of the foundation principles for the inclusion of research within the CQC Well -Led inspection framework.

Clinical research expands opportunities for the development of Trust staff, as well as empowering and engaging the patients we care for. Other benefits include contributing to workforce plans (wellbeing, job satisfaction, improved recruitment and retention), high quality care (practising and offering the latest treatments provided by knowledgeable and well-trained staff ;up to date with the latest treatments and technologies);safer care (through protocol driven practice); external accreditations, monitoring and audits, as well as financial benefits such as income generating, or cost savings / avoidance though drug savings, reduced radiotherapy fractions, outpatient appointment, admissions etc. Some examples showcasing some research outputs and outcomes can be found in Appendix 1.

Our research portfolio within the Trust has seen greater engagement and appreciation in the last couple of years; through our involvement with COVID-19 studies. The pandemic highlighted the importance and value clinical research played in responding to the crisis. Post pandemic; the role of research has never been more apparent than now. With the health service under severe strain and record numbers of patients on waiting lists, clinical research can again play a vital role in supporting the current and the future NHS challenges; by improving the effectiveness and efficiency of care; playing an essential role tackling backlogs and reducing pressures on the NHS.

With strengthened new duties as set out in the Health and Care Act 2022; NHSE has mandated ICB duties to facilitate and promote research and the use of the research evidence base; embedding research in the NHS to improve outcomes for patients on a statutory footing; expanding on the opportunity that research brings to improve patient outcomes and reduce inequalities.

The schematics below summarise the benefits around being a research active organisation.

The schematics below summarise the challenges to remaining a research active organisation.

Priorities in 22/23:

- The incidence of COVID-19 and the need for wide-ranging measures to reduce the risks of its spread in all settings, including hospitals, had reduced significantly by the start of 2022-23. At the same time the number of COVID-19 studies had also declined significantly and were no longer considered to be higher priority than other studies. The Urgent Punic Health (UPH) status assigned to Covid studies was discontinued at the end March 2022.

- In common with other Trusts in England, the focus and priority during 22/23, was to continue recovery to post Covid levels. During this '2nd recovery' year; we saw an increased demand to set-up new studies and increased focus on recruiting to time and target.

- During 22/23; the Trust was actively engaged in supporting all relevant aspects of the UK Clinical Research Recovery, Resilience and Growth (RRG) programme, led by DHSC and NHSE to ensure the restoration and delivery of a full portfolio of clinical research, maximise opportunities to build back better and deliver on the commitment to make the UK the leading global hub for life sciences.

- The main focus of RRG in 2022/23 has been 'Research Reset'; requiring the review of NIHR studies which are not progressing in the current context or climate, aiming to give as many studies as possible the chance of completing and yielding results, to generate new evidence needed to improve care and sustain our health and care system. Where studies had little chance of completing or being delivered in the challenged NHS environments, both sponsors and funders were strongly encouraged to close out studies, to release capacity and resource to enable new deliverable research to progress. Most of our paused hosted studies were re-opened with a few closed out as part of this national review process.

3.0: Clinical Research Activity and Performance:

Below provides a summary of the Trusts active hosted and sponsored research (i.e. open to recruitment, recruiting, in follow up or closed to follow up but not closed out) during 22/23.

Study type		Hosted	Sponsored	Total
Interventional	CTIMP	82	0	82
	Non CTIMP study	45	1	46
Non-interventional	Other study	130	9	139
Total		257	10	267

R&D currently do not sponsor any CTIMPs and are not in a position to be able to sponsor CTIMPs. This would require significant investment to ensure relevant capacity and expertise to support this activity and to comply with the UK legislation.

Although the number of Trust sponsored studies is small, compared to hosted studies; they each require considerably more resource from the R&D management and governance team to ensure the Trust's legal responsibilities as the research sponsor are met. However, this is an important part of the support provided by R&D especially for its staff, many of whom rely upon this level of expertise from the R&D Department as they take their first steps as Chief Investigators, leading their own studies.

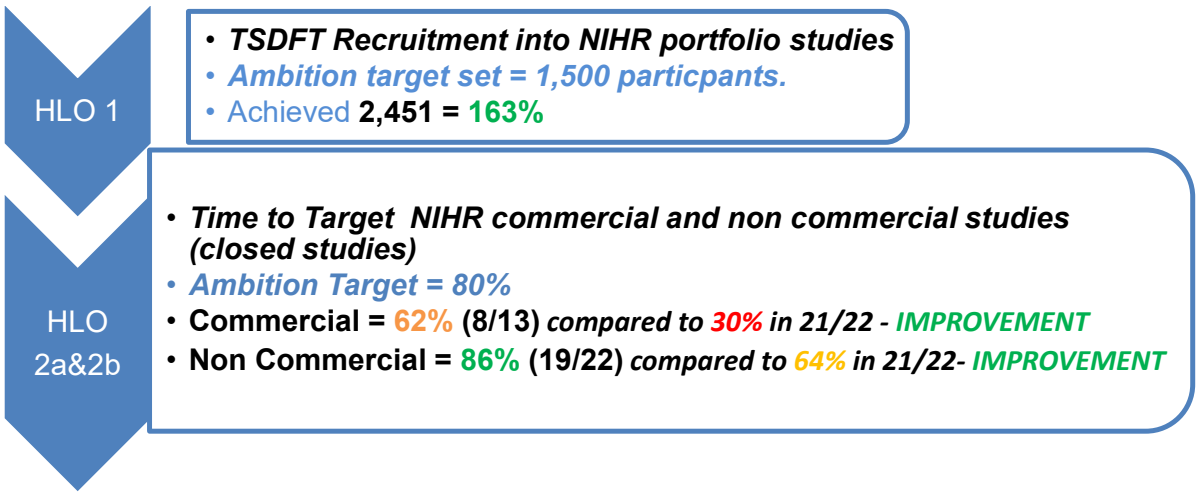
3.1: Research Performance: NIHR Clinical Research Network contract:

In 22/23 DHSC discontinued the need for Trusts to report on their Performance in Initiating and Delivering (PID) research metrics, thus it has not been necessary to report on the reasons why study set-up and first participant recruitment have been delayed (if applicable).

TSDFT is a member of the South West Peninsula Clinical Research Network (SWP: CRN) - the regional delivery arm of the National Institute for Health Research (NIHR). Our performance is monitored by the SWP: CRN against High Level Objectives (HLOs).

3.1.1: NIHR 22/23 Key Performance Indicators (KPIs) / High Level Objectives (HLOs)

- Similar to the previous year; due to the impact of Covid-19 still; but as part of the new RRG agenda; NIHR's HLOs were set as ambition targets as opposed to formal performance HLOs and introduced as part of a revised NIHR performance and operating framework: As a consequence, there was a shift in emphasis moving away from total recruitment; no longer an HLO; with priority focusing on research delivery performance and recruiting to time and to target (T2T).
- Following on from successes in 21/22, again as a Trust we surpassed our recruitment targets and signficantly imroved our Time to Target metric for both commercial and non commercial studies during 22/23. See below:



- The Equality, Diversity and Inclusion (EDI) agenda is also a key priority area; looking to diversify research; to broaden and expand access, opportunity and recruitment to studies across acute, community, mental health, public health, primary care and social care. Whilst total recruitment is no longer an HLO, the NIHR will look at organisation's recruitment profiles across the portfolio to assess the depth and breadth of activity across specialities and especially recruitment of hard to reach / underserved populations. The same principles are also applied to increasing access and opportunities to staff, especially under represented staffing groups.

- Life Sciences Research. (Commercial studies) –following the excellent work associated with our Covid research, was one of the Government's high priority areas for NHS Trusts; building on this reputation and to open up and increase overall commercial research activity. This remains a local priority too; as we need to generate more income to help cover R&D costs and subside a shortfall in NIHR CRN funding and the unfunded services such as research management and governance.

3.1.2: Summary statistics:
Overall the Trust made good progress against our recovery programme; despite staffing and other challenges facing the Trust / NHS. The table below highlights the key activity measures. During the covid year and 1st recovery year; activity related primarily to urgent public health studies as well as maintaining some activity in a few key priority areas such as cancer and cardiology where possible. Most other activity was paused. Our 22/23 activity reflects primariliy non covid research.

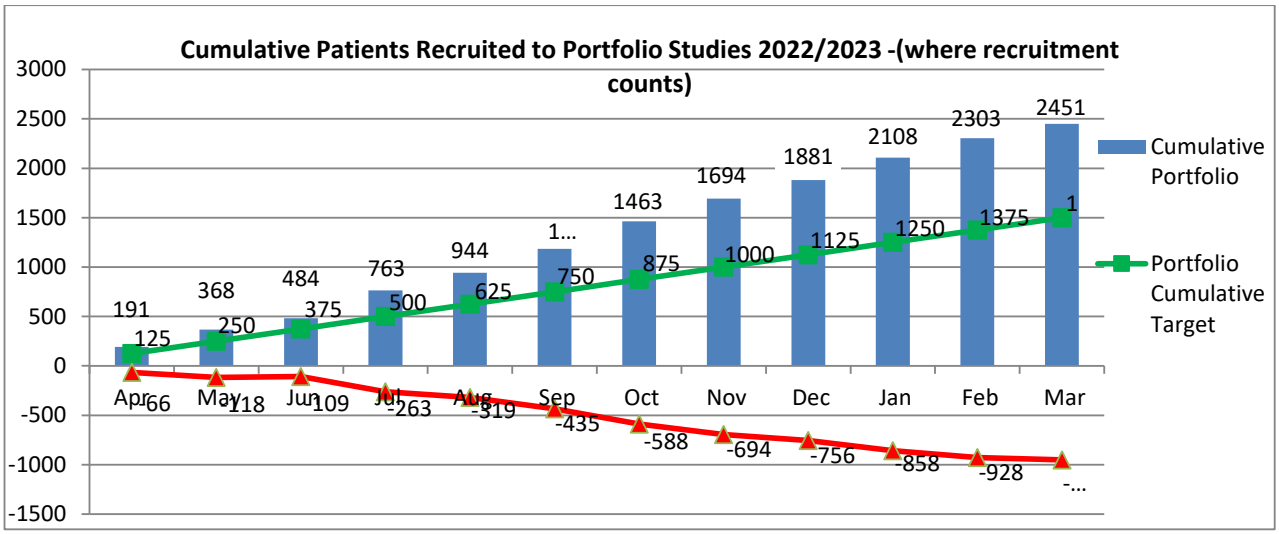
	19/20 (Pre Covid)	20/21 (Covid Year)	21/22 (Recovery Yr 1)	22/23 (Recovery year 2)
Total NIHR Recruitment	**1,525**	**2,240**	**2,570**	**2,451**
Commercial recruitment	**95 (6%)**	**37 (2%)**	**79 (3%)**	**301 (58 +248*) (12%)**

Total studies recruited into (no. of specialities)	**77 (n=21)**	**49 (n=18)**	**86 (n=20)**	**75 (n=20)**
ABF points (Complexity weighting NIHR non-commercial studies only)	**4,202**	**3,551**	**8,872**	**4,900**
New studies approved (no. of commercial)	**58 (n=13)**	**35 (n=8)**	**50 (n=9)**	**53 (n=7)**
Total EOIs rec'd	**349**	**321**	**441**	**433**
Total positive EOIs	**59 (17%)**	**53 (17%)**	**89 (20%)**	**96 (22%)**
Total Amendments Processed	**248**	**331**	**294**	**299**
Total Gross Trials income banked	**£551,196**	**£302,471**	**£716,447**	**£870,306**

**relates to one commercial onservational study bolstering numbers*

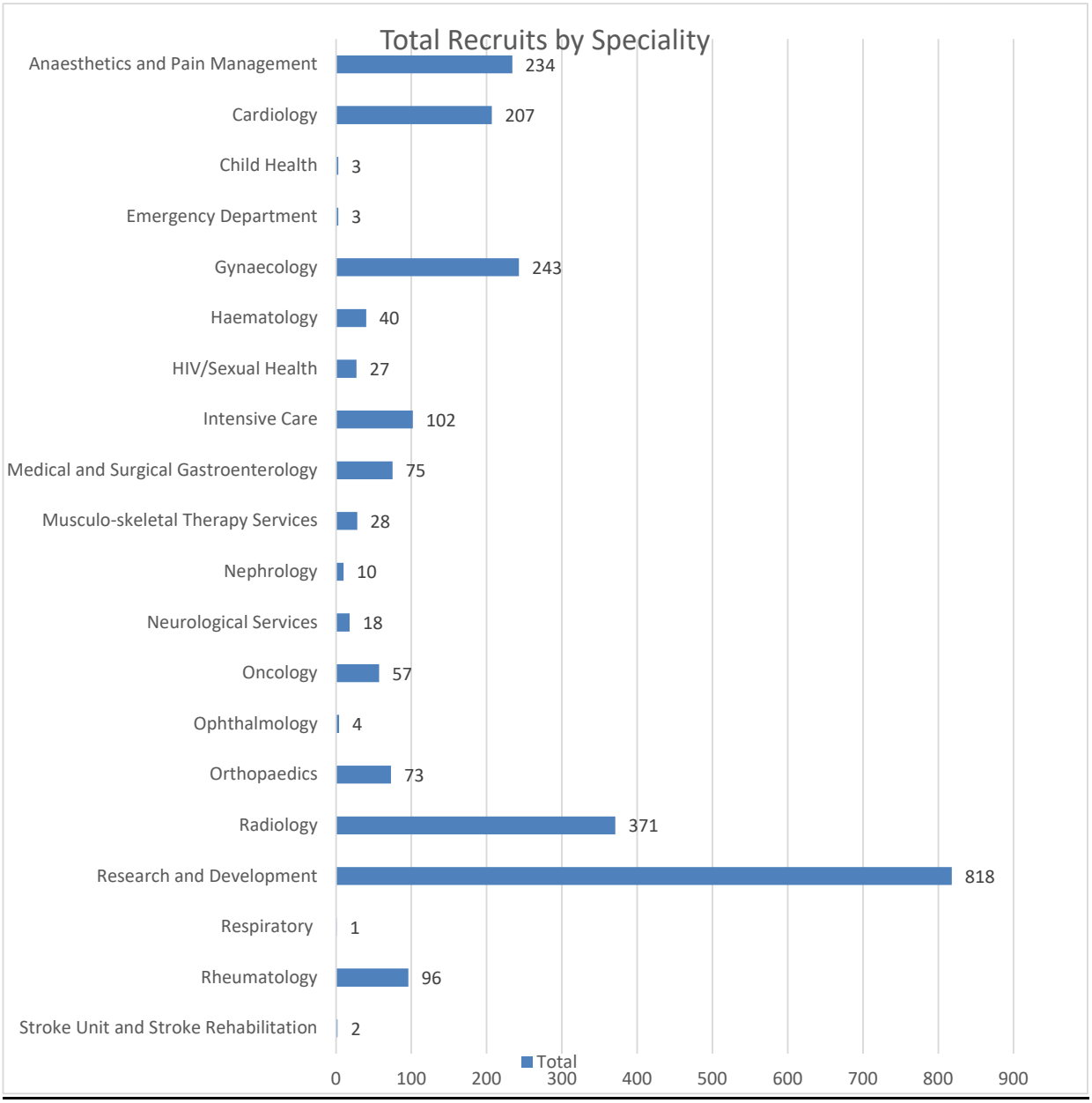
3.1.3: Recruitment

- Recruitment to NIHR studies was higher that pre covid levels and similar to the previous year. Below charts the cumulative totals across the year.



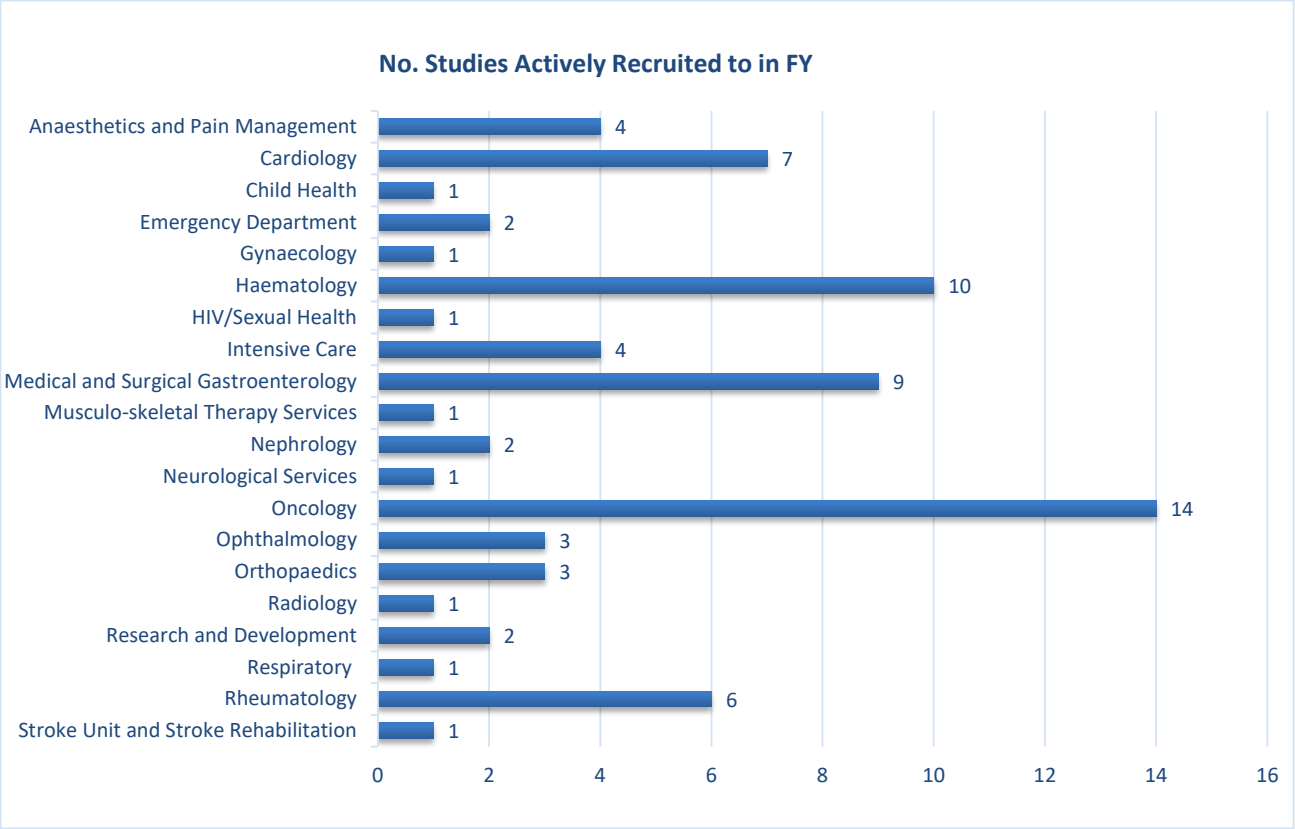
- Our commercial recruitment was signficantly inflated due to a single observational study; hence differentiating; as previous years only had interventional studies. With regards to interventional recruitment for 22/23 this was less than pre covid and the previous year.

Below summarises the recruitment per speclality:



3.1.4: Studies:

- The number of new studies approved and opened returned to similar levels.
- The % split of interventional: non-interventional active studies at TSDFT is 43:57.
- The number of studies recruited into has remained stable (n= 20 specialites). See schemetic below
- TSDFT like most NHS Trusts; has experienced significant issues and has struggled to recover the non-cancer commercial portfolios especially. A total of 7 new commercial studies were approved in 22/23; instead of 12-15 per annum pre-pandemic, of which 4/7 were cancer studies.
- All NHS environment are very pressurised making operational and logistical delivery of research more challenging (workforce pressures, backlogs, lack of investigators, staff, imaging, pharmacy, etc)
- This downturn has impacted on commercial trials activity and income generation (except for oncology and cardiology studies).



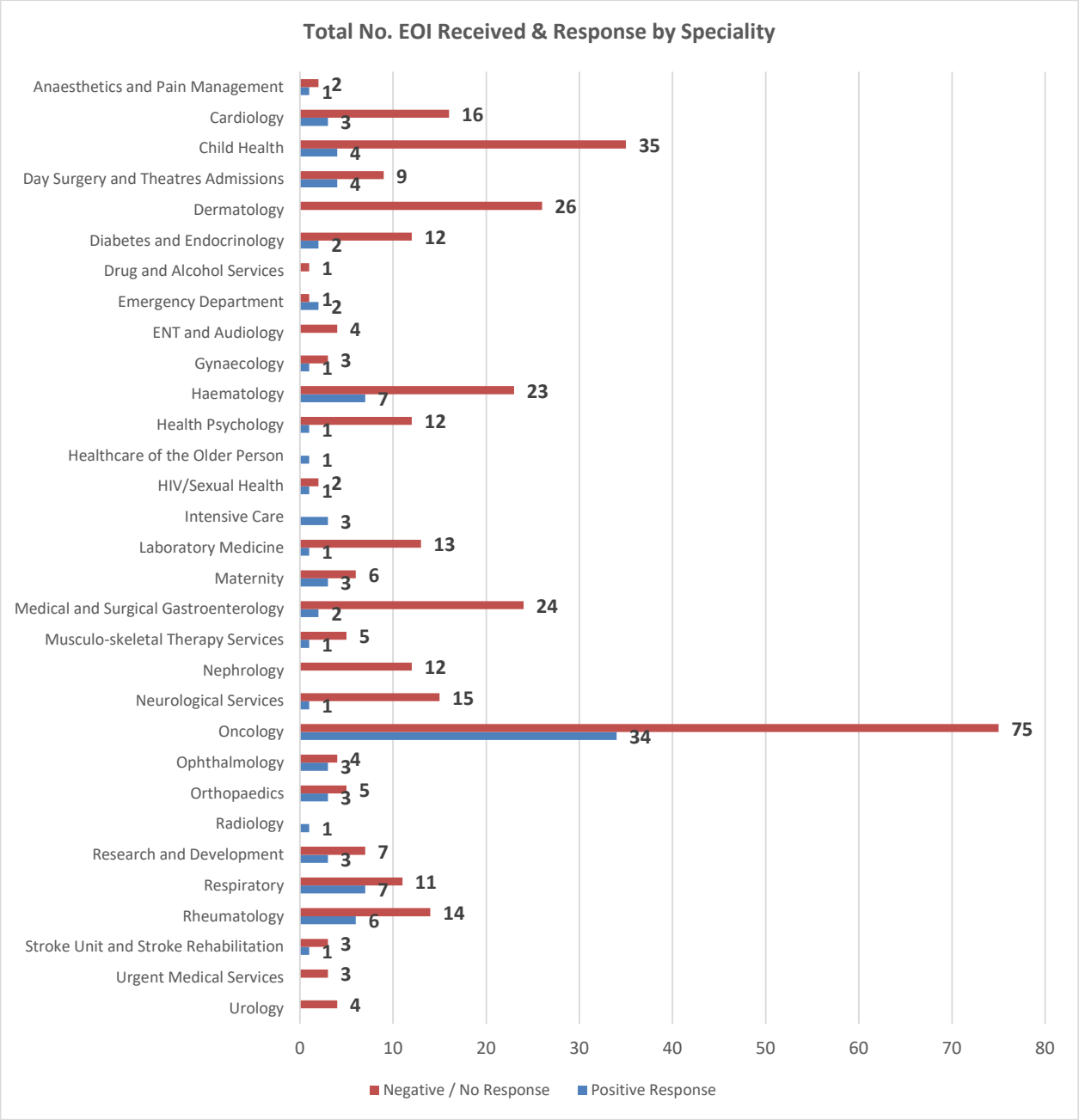
- Oncology has seen signficant successes; building on good performances and developing a strong organisational reputation. The oncology portfolio is very strong compared to other sectors, it is a national prority area and locally under the leadership of Drs Medley and Lydon they have seen their portfolio and team grow in size and success.

Torbay has been the second highest recruiter to commercial Cancer studies nationally in 22/23. This is in part due to the excellent recruitment for MCM5 study which has given the Trust great numbers as well as our Bladder, Prostate, Upper Gi and Lung commercial recruitment which has been consistently high.

- Several studies have had signficant impacts and examples can be found in Appendix 1.

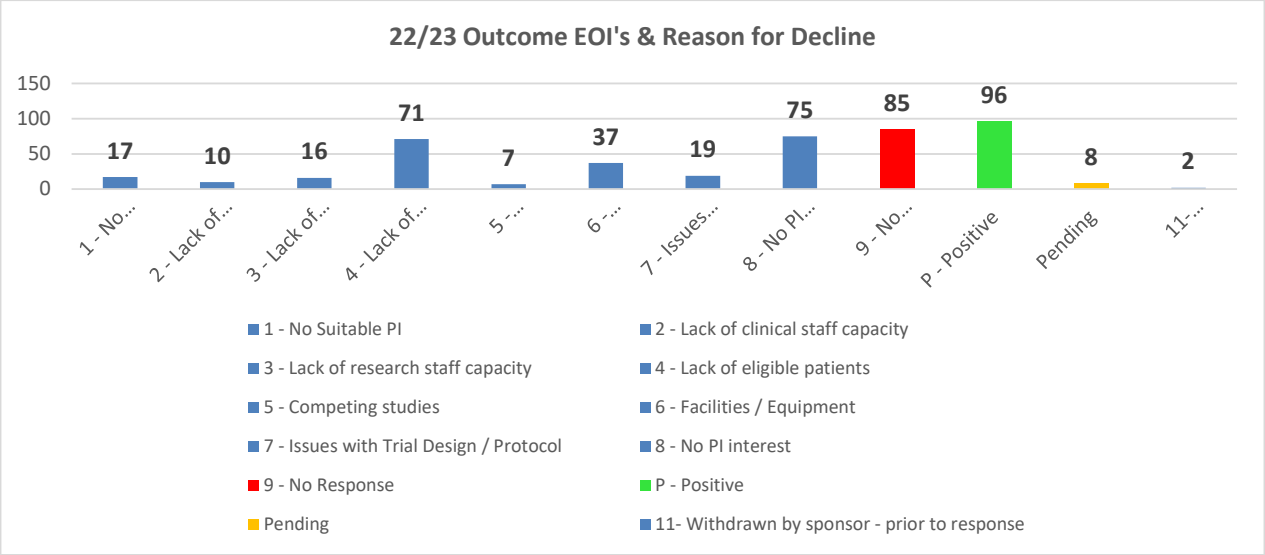
3.1.5: Expressions of Interest (EOIs)

- New potential business is measured through **Expressions of Interest (EOIs)** - our pipeline of potential future studies. Encouragingly we saw the total number received signficantly increased. The graph below shows the breakdown per speciality.



- Additionally the Trust's positive EOI rate increased too. There was a reduction of no response, but countered by an increase in negative responses. The graph below details a breakdwon of reasons for negative responses.

- As a result of positive EOIs, moving into 23/24 R&D had a total of 26 new studies (n=11 commercial studies) in set up.

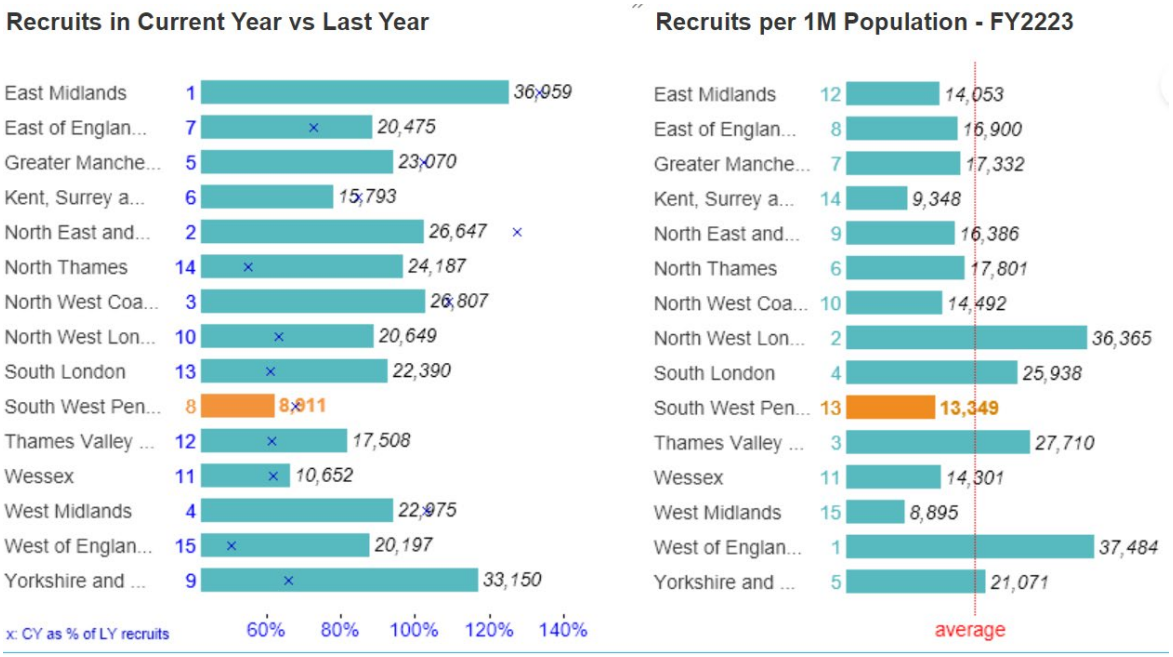


3.1.6: Amendments

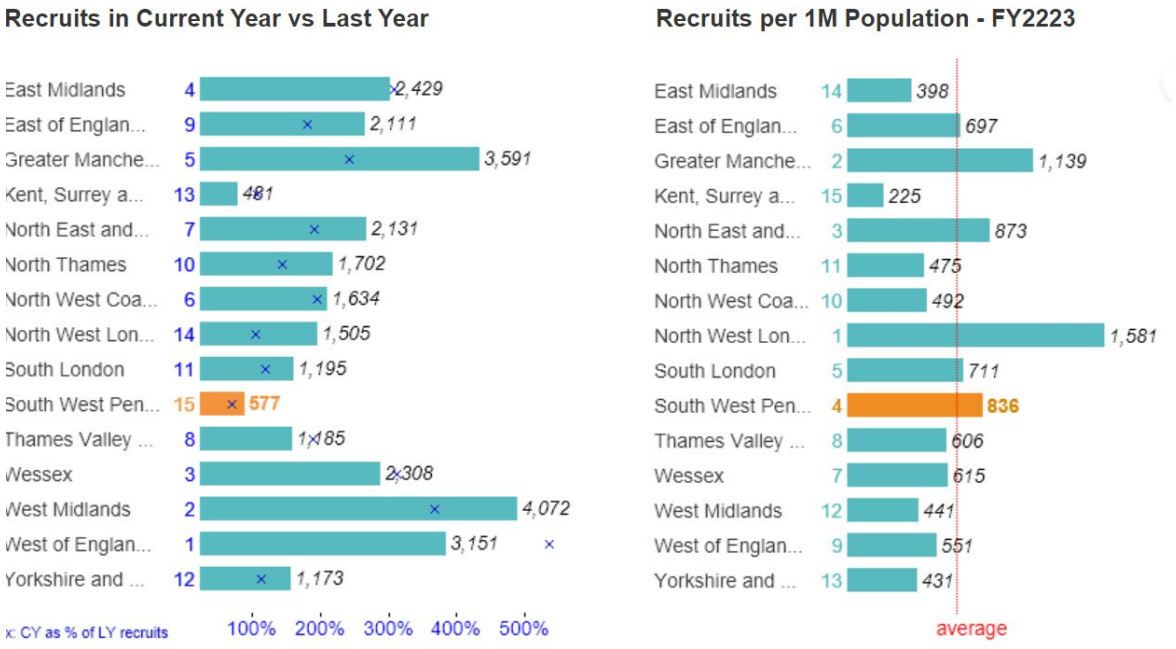
- In addition to setting-up new studies, processing amendments to active studies represent a significant amount of activity for the R&D teams with a total of 299 amendments processed during 22/23. All amendments are reviewed by R&D; to reassess capacity and capability; including revisions to contracts and finances.

3.2: Regional and National Benchmarking:

- The Trust is part of the SWP:CRN region and the regions performance is compared to that of others by DHSC and NIHR. Therefore it is important that all partner orgnsiations maximise their research activity and delivery as best as possible.
- The graphs below shows the SWP:CRN region improved on its overall rankings; 8th overall (population adjusted) compared to 10th in 21/22 and 4th overall for commercial recruitment compared to 5th in 2021/22.

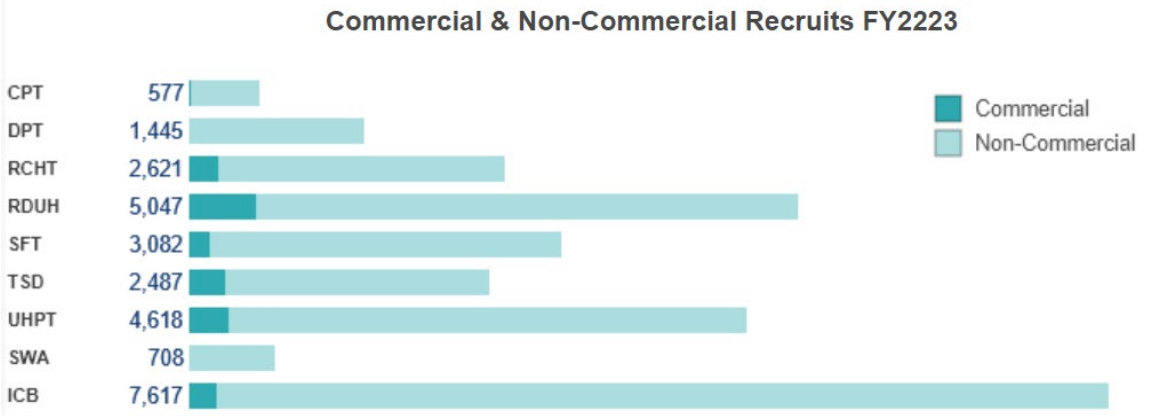


Commercial only – region was ranked 4th (population adjusted)



3.2.1 Trust performance compared to regional partners

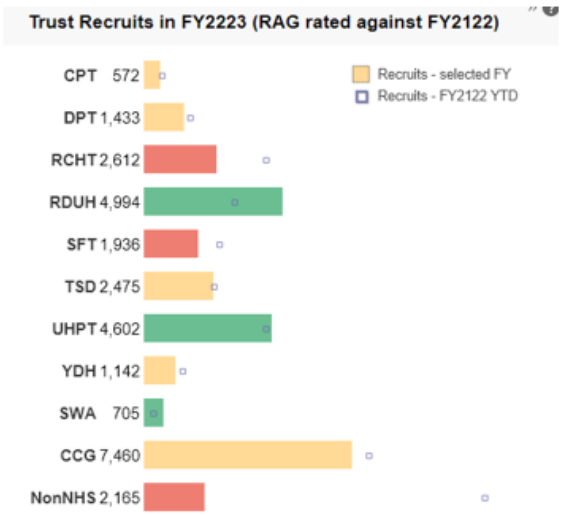
The series of graphs below show the Trusts performance compared to others within our regional Network. Please note that as each orgnsiation differs in size, services provded and levels of infratructure and resources, comparisions between individual organisations is difficuilt. However it does show TSDFTs relative contribution to the regional performance.

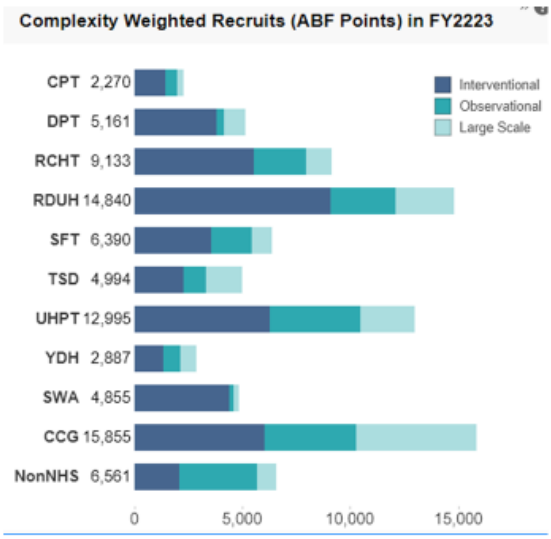


N.B: Commercial covid vaccine studies were undertaken at RDUH, UPHT and RCH, accounting for their higher recruitment figures

Below shows a RAG rated graph of performance compared to the previous year, with TSDFT amber – as vitually the same. Our ABF points (study complxity scores) dropped signficantly showing the complexity ratio of the portfolio had changed as the study portolio changed . Our relative performance is shown below.

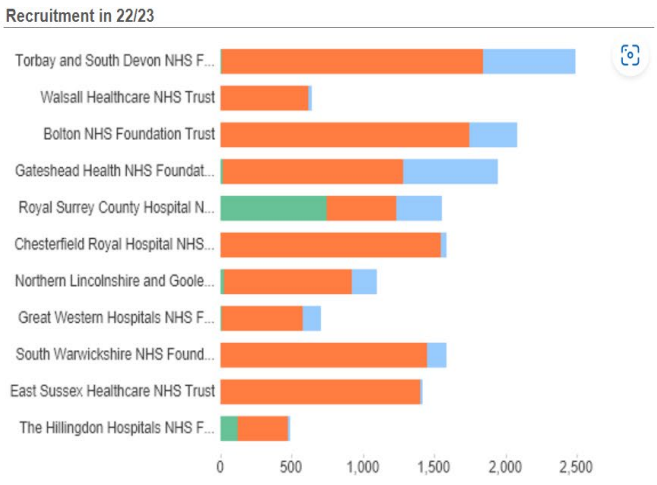
NIHR SWP:CRN report

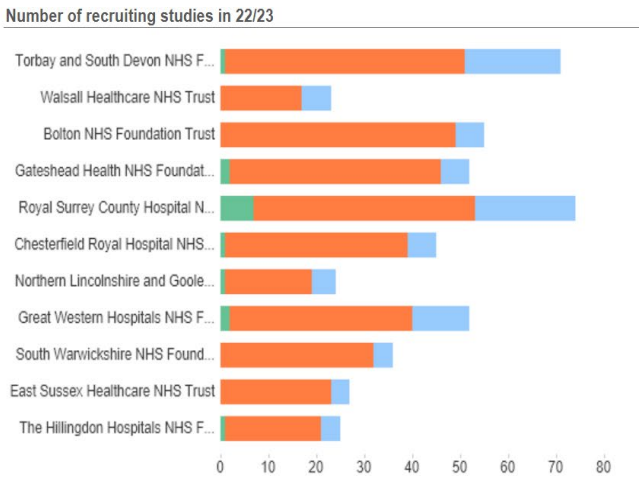




3.2.2: National benchmarking against other Trusts of a similar size

The Trust performed well when benchmarked against similar size organisations in England. An alternative benchmark is shown below where Torbay to benchmarked against the next nearest 10 similar sized organisations; based on population outpatient attendances. Torbay rank 1st and best in class overall for recruitment and 2nd best for the number of studies recruited into.





Research activity compared to 10 organisations in the same category (acute, care, CCG etc). Attendances (trusts) or population (CCGs) is used as a proxy for measuring similarity. The charts show the most similar organisation at the top with similarity decreasing down the chart

4.0: Sponsored (Trust led) studies, collaborative research & Research Grants

As well as increasing the opportunities for our patients and service users to take part in NIHR Portfolio research studies through our hosted clinical trials programme; R&D also supports Trust led /sponsored studies; often as part of collaborations and several staff undertaking research through educational studies at Universities (HEIs).

This work is aimed at developing our own researchers to become Chief Investigators, to lead research and to apply for grants. We continue to develop and grow with several successes; working closely with good opportunities and support especially through our local charity The Torbay Medical Research Fund (TMRF). We have also seen an increasing appetite and traction especially amongst our NMAHP community. This ambition is important for workforce development and career progression.

4.1: A summary of Trust sponsored studies: Active or in set up during 22/23:

Project Title	Chief Investigator	Funder (Grant award)	Current Status
PEER CONNECT: A feasibility randomised controlled trial of a targeted peer coaching service for outpatients with long-term conditions.	Dr Agne Straukeine and Helen Davies Cox	TMRF (£125,975)	Study completed July 2023. In process of data analysis and write up
Community Simulation	Liz Tooby Simulation team, Education	unfunded	Approved Suspended. Chief Investigator - on maternity leave and now left the Trust. New CI potentially identified to take project forward.
C-Peptide screening in a Secondary Care Type 1 Diabetes Clinic	Dr Chris Radford Consultant Endocrinologist	TMRF (£11,606)	Completed Summer 2023. Now in analysis and write up stage.
Exercise Programme in AAA surgery	Dr Mike Swart Consultant anaesthetist	TMRF (£16, 410.95)	Approved: Paused due to covid & operational and estates (space) challenges
Digital infra-red thermal imaging (DITI) to help manage foot health - a pilot study	Dr Rich Collings, Podiatrist	TMRF (£32,070)	In set up: Project delayed due to supply issues.

			Exploring a new partnership with UoE.
Patient activation and foot health in diabetes	Jen Williams, Podiatrist	unfunded	Approved: Open
Effects of neurological disease on effort as measured by The Word Memory Test.	Dr Isabel Ewart, Consultant Clinical Psychologist	Unfunded	Approved: Paused CI on prolonged leave
SENSE study Exploring the barriers to 'Clinical academic' career progression for Nurses, Midwives, Allied Health Professionals and non-medical staff in Torbay & South Devon.	Dr Rich Collings, Podiatrist	TMRF (£13,753)	Completed in Summer 2023
BioBeat Study: Bronchiectasis Exacerbation Assessment of Treatment	Dr Louise Anning, Consultant Respiratory Physician	TMRF (£58,299)	Approved and Open
Building a Brighter Future (BBF) bid 'An investigation of the role of the Torbay and South Devon NHS Foundation Trust New Hospital Programme in supporting the continued integration of person-centred care whilst not increasing the number of inpatient beds currently provided at Torbay Hospital'.	Dr Joanne Watson (In collaboration with UoP)	TMRF (£164,074)	In set up REC/HRA approvals – not in place yet
Evaluation of vascular immunohistochemistry markers (CD31, CD34, D2-40	Lloyd Quashie Laboratory BMS	Unfunded. MSc Project	Opened March 2023. Completed July 2023
Lipoprotein (a) as a cardiovascular risk factor in type 1 diabetes	Francesca Andrews Laboratory BMS	Unfunded. MSc Project	Opened February 2023, completed July 2023

4.2: Partnerships – grants awarded involving TSDFT (but sponsored / led from elsewhere)

Project Title	**Applicant**		**Amount Awarded**
Provision of a daily high protein and high energy meal: effects on the physical and psychological wellbeing of	Prof. Bowtell UoE Elizabeth Wardle, Irene McClelland	TMRF	£100,914 Project in analysis and write up stage

community-dwelling malnourished elderly adults	Dieticians (TSDFT)		
Understanding the high numbers of children in statutory care in Torbay: an engaged approach to supporting families and communities	Dr Thomas (University of Exeter) with Torbay Public Health team / Children's Services	TMRF	£208,619 Completed; awaiting final; report
A study to explore the implementation of the Enhanced Health in Care Homes framework in eight care homes in Torbay and South Devon	Dr Susie Peace (UoP) / Torbay Clinical School	TMRF	£71,797 Project in analysis and write up stage
Clinical effectiveness of a child-specific dynamic stretching exercise programme, compared to usual care, for ambulant children with spastic cerebral palsy - the SPELL trial",	Rachel Rapson Physiotherapist, Child Health	NIHR	Co collaborator on a multi-organisational grant awarded
"Clinical effectiveness of an adolescent-specific strengthening programme, compared to usual care, for ambulant adolescents with spastic cerebral palsy - the ROBUST trial",	Rachel Rapson Physiotherapist Child Health	NIHR	Co collaborator on a multi-organisational grant awarded
"Diabetic Foot Ulcer Research PlatFORM – DFU-REFORM",	Dr. Rich Collings Podiatrist	NIHR	Co collaborator on a multi-organisational grant awarded

5.0: R&D Workforce and Workforce Development:

Workforce challenges facing the NHS including TSDFT means the R&D service is both fragile and vulnerable. However, as the evidence shows, research and being a research active organisation can also serve as an incentive and an enabler to attract new staff and retain staff.

- **Resilience and depth** remain primary risks. Our minimal staffing levels are insufficient to meet the needs of the highly regulated environment and requirements for training and gaining of specialist experience. It is difficult to plan cover for absences, vacancies, shortages, let alone develop, grow and succession plan. The need for specialist knowledge makes it difficult to 'parachute' untrained staff into R&D. A couple of bank staff trained in research mitigate this risk in the clinical delivery team, however, reliance on a few key staff remain 'single points of failure' risks in vital areas e.g. governance, information, contracting, cost recovery and finance.

- **Investigators:** We are overly reliant on a few interested individuals trying to support research in their own time. This 'good will' is being tested and is waning. Without recognition of research in job plans investigators will not take on new studies.

- **Research PAs for PIs pilot:** A new initiative to try to help address the increasingly significant issue of the lack of dedicated time for research in job plans. R&D successfully submitted a business case to the Trust to support a pilot of up to £150K over 3 years in recognition of the work and responsibilities associated with being a Principal Investigator (PIs). The pilot also aims to evaluate better the benefits of research e.g. savings, impacts and outcomes to demonstrate the return on this investment. This scheme started in July 2022 and will run through to June 2025 with awards to oncology, haematology, anaesthetics, ICU and gastroenterology.

- **New Medical Research Lead:** The PAs for PIs funding has supports 1 PA for a medical research lead. It is hoped that this role will help strengthen and support the R&D leadership team, improve medical support, insight and representation as well as developing the medical research workforce. Dr Mark Gilchrist, Consultant Nephrologist and a Clinical Academic at the University of Exeter was successfully appointed and started his tenure from April 2023.

When engaged clinicians have dedicated time to work with our committed R&D staff, there is no doubt of the life changing impact this has on patient care. We aspire to put research where it belongs: at the heart of the patient care we provide at TSDFT. We would like to recognise the particular success of the oncology, cardiology and anaesthetic teams in demonstrating what we can achieve. The PAs for PIs pilot goes some way to helping us achieve this and with other specialties there are examples of specialty-funded research time e.g. in respiratory medicine. However, we need a more definite financial commitment to embedding research in our organisation by funding clinician time to realise this ambition fully across the organisation.

5.1: Developing the investigators and staff of the future:

A key priority nationally and locally is how to create more capacity and capability across our health and care professional workforce to meet the aims of the **UK Clinical Delivery Strategy: Saving Lives:** Saving and Improving Lives: The Future of UK Clinical Research Delivery (publishing.service.gov.uk)

- To create a sustainable and supported research workforce to ensure that healthcare staff of all backgrounds and roles are given the right support to deliver clinical research as an essential part of care.
- Support clinical research embedded in the NHS so that research is increasingly seen as an essential part of healthcare to generate evidence about effective diagnosis, treatment and prevention

Additionally, there is a need to have increased and greater focus looking how research is included within Trust and ICB workforce plans and to align to the new National Research strategies for Nursing and Midwifery and for AHPs.

R&D has various opportunities either through supporting individuals for example to apply for grants, awards, fellowships or associates to buy out their time and supporting Principal Investigators to lead clinical trials. Additionally, there has been a need to provide entry level opportunities for staff to grow their confidence and gain exposure and experience both in clinical academic study and in clinical research delivery.

The Trust also led on a research study:

The SENSE Study	The TMRF has funded local researchers to undertake the SENSE study: Exploring the barriers to 'Clinical academic' career progression for Nurses, Midwives, Allied Health Professionals and non-medical staff in Torbay & South Devon. Chief Investigator: Dr Rich Collings, Co investigators: Kathryn Bamforth, Jen Williams, Harriet Hughes and Chris Dixon This study was completed in the summer of 2023 and the report is anticipated by early 2024.

5.2 During 2022/23 - Several staff held regional / national research roles:

- Dr Kirsten Mackay: NIHR National Co-Clinical Speciality Lead and NIHR SWP:CRN Regional Clinical Speciality Lead for the Musculoskeletal portfolio
- Dr Agne Straukeine NIHR SWP: CRN Regional Clinical Sub Speciality Lead for the Multiple Sclerosis portfolio.
- Dr Louise Medley, NIHR SWP: CRN Regional Clinical Sub Speciality Lead for Lung Cancer
- Dr Richard Collings, Podiatrist: NIHR and Council for Allied Health, Professions Research (CAHPR) Champion:
- Dr Fiona Roberts, R&D Director: Regional HRA Champion and part of UKRD leadership group
- Kathryn Bamforth, Trust Lead Research AHP: Manager Representative on the UK Chartered Society of Physiotherapy Charitable Trust Scientific Panel

5.3: Research Fellowships / Associateships / Internships

The Trust has had significant success supporting several staff on various schemes in partnership with the HEIs, HEE and the NIHR – see details below.

These schemes provide excellent opportunities to develop a research ready, willing and able workforce; upskilling and enabling staff to get research experience and exposure; increase their confidence and ability to engage in and become more research active. They present opportunities to inspire others, champion embedding ‘research into practice’ as well as apply the academic training and rigour to improve services, practice, care and outcomes.

New careers for NHS staff once their academic training has completed remains an area of risk and needs more focused attention; Having made the time and investment in training and upskilling, we now need to address how to retain highly skilled and experienced staff in the NHS to remain research active. There is an urgent need to build research time into new job plans. R&D leads continue to work with the Trust, ICB and wider NHS in the development of their workforce plans.

5.3.1: National Schemes:

NIHR Associate PI (API) Scheme: - This is a six month in-work bespoke training package and opportunity to work alongside an experienced PI and learn the practical skills associated with clinical research delivery. Training includes Good Clinical Practice and Informed Consent as well as any other needs specifically identified. The API

scheme provides an opportunity for healthcare professionals (medics, NMAHPs) at the start of their career to gain practical experience in clinical research delivery. This programme continues to expand across more specialties and 11 members of staff, across a range of medical, nursing and allied health professions have completed the training in the last year. This not only proved to be a great support to the PI community, but is a way of increasing research activity within the Trust too.

Case study: More accurate information for patients thanks to physio spinal team research:

Our physiotherapy spinal team has contributed to the NIHR national multicentre **POiSE study** led by Keele University; which aims to look at predictors of outcome in patients with sciatica (nerve-related leg pain) following an epidural spinal injection.
This research will mean clinicians can offer better, more accurate information about treatment options and identify who is more likely to benefit from these injections.

The team has been celebrating after recently reaching their recruitment target. This was the first study undertaken by the physio spinal team, led by **Associate Principal Investigator (API), Martin Fancutt.** More information about Martin's experience with the API scheme can be found here: Torbay physiotherapist awarded place on national research leadership training scheme | NIHR

A fantastic example of how research has been embraced by the whole team and to celebrate the great work done by everyone to get the study open and so successful here at TSDFT.

NIHR / HEE Fellowships / Internships:

- Justine Tansley, Podiatrist, HEE/NIHR ICA PCAF: Pre-doctoral Clinical Academic Fellowship with the University of Plymouth; Oct 2021 - Sept 2023
- Rachel Rapson, Physiotherapist: NIHR DCAF Fellowship (part time PhD with the University of Plymouth looking at 'A novel interactive dynamic training device to improve walking ability and quality of life for children with cerebral palsy: A mixed methods study'. 2018 -2023

5.3.2: Regional Schemes:

NIHR Regional CRN Research Associates: Awards fund clinical staff to spend up to one day per week for 6 or 12 months in R&D to get some research training, exposure and experience in research delivery and / or undertake clinical academic training:

- Angela Foulds, Research Nurse, Sept 2020-August 2022.
- Rebecca Stride (CT Radiographer): October 2021- October 2022 – see below

- James Bruce (ICU Occupational Therapist): April 22-Oct 23
- Steph Baldock midwife sonographer, Oct 22-March 23. Her project explored the of women identified as being from deprived backgrounds at their antenatal appointments. Her service improvement project has just been published as an abstract in the first edition of the South West Clinical Schools journal: South West Clinical School Journal - Issue 3, Number 3, 2023 (plymouth.ac.uk).
- Katy Gass; Speech and Language therapist, April 23-March 24: Katy applied for PI funding to lead on the PhEAST study looking at the effect of transpharyngeal stimulation to improve the swallow ability of patients that have had a stroke.
- Dr Marie Jasim April 23-March 24: In addition to working on her own research, Marie is using her Research Associateship to support Katy Gass with the PhEAST study as an Associate PI and work with Dr Agne Straukiene on a neurology study (TALOS).

Case study: continuation of the Diagnostic research radiographer role (Becky Stride):
Following a successful pilot funded through the CRN research associate scheme in 21/22; we created a new role based in radiology working across Imaging and R&D, funded through trials income. This role has proved pivotal to improving communication between R&D and radiology and has impacted positively on our performance metrics (e.g. study set up times). Having expertise that can balance the patient's clinical need and the trial imaging protocols has improved both the experience of patients and use of resources by reducing the need for re-scanning. This, in tun has reduced the potential for protocol deviations which has subsequently released more radiology and research delivery staff time and capacity.
Case study: Your Path in Research - Rebecca Stride | NIHR

NEW - Chief Nurse Research Fellowships (CNRFs): This legacy was borne out of the successful National NIHR 70@70 programme. Chris Dixon, our former Lead Research Nurse, represented TSDFT in this programme. The NIHR LCRN has since established the new CNRF awards which support nurses, midwives, and Allied Health Professionals (AHPs) to get a taste of research. Each award is divided into three areas.

1. The fellows choose a service improvement project related to their clinical area and supported by their line manager.
2. They spend time with the research delivery team, getting experience in the practical day-to-day running of clinical trials.
3. They get academic mentorship from the University of Plymouth through the Torbay Clinical School and further support and mentorship from the Trust Chief Nurse Deborah Kelly.

The awards are coordinated by the Trust Lead Research AHP, Kathryn Bamforth. The Trust's first Chief Nurse Research Fellows in 2022/23 were:

- Rheanne Osben (CT Radiographer)
- Jess Mortimore (Physiotherapist)

We are pleased this programme continues into 23/24 recruiting 2 new CNRFs: an ultra-sonographer and a nurse from Dawlish Hospital, starting in November 2023.

5.3.3: Trust / UoP Clinical Schools / TMRF Fellowship programme:

This programme was ongoing through 22/23 and is a partnership between the Trust, UoP Clinical Schools and TMRF to support TSDFT staff: pre-doctoral studies (one-years funding – to prepare for a PhD application / fellowship) and doctoral fellowships

(up to 6 years funding to do a PhD part-time). Details of fellowship awarded under this scheme are summarised below:

TSDFT is the only trust and clinical school in the whole of the SW region with this programme which compliments regional and national fellowship awards from NIHR/HEE.

Year	Award	Awardee	Topic area
2019/20	Doctoral Fellowship 1	Kathryn Bamforth Physiotherapist and Trust Lead Research AHP	The WELLBEING Study: Exploring the psychological wellbeing of healthcare professionals: Status: ongoing
2020/21	Doctoral Fellowship 2	Corinne Lindsey Nurse	The importance of nursing culture for patient care. Status: ongoing
2021/22	Doctoral Fellowship 3	Harriet Hughes Physiotherapist	Improving mobility in children with cerebral palsy: ongoing: Status ongoing
	Pre-doctoral Fellowship 2	Stephanie Janka-Spurlock. Dementia Lead, Education Department	Improving dementia care in care settings: Status – completed. Proceeded to successful doctoral award
	Pre-doctoral Fellowship 3	Vanessa Kavanagh Podiatrist	Improving outcomes after bunion surgery. Status: Completed
2022/23	Doctoral Fellowship 3	Stephanie Janka-Spurlock Dementia Lead, Education Department	Exploring the social interactions between patients living with dementia (PLWD) and healthcare staff whilst in the acute hospital setting: An Experienced Based Co Design (EBCD) study Started 01.10.22
	Pre-doctoral Fellowship 3	Abi McWhinney, Midwife – Complete	Started 02.10.22. Status: Completed. Proceeded to successful to Doctoral award
23/24	Doctoral Fellowship 4	Abi McWhinney, Midwife	Started 01.10.23
	Pre-doctoral Fellowship 4	Claire Morgan, Occupational Therapist	Started 01.10.23

- An impressive alumnus has grown over the last three years, supported by a peer support network, the Clinical Academic Forum and Exchange (CAFÉ). In addition, to sharing and learning about research experiences, they have also undertaken several service improvement projects:
    - updated guidance for women in the latent phases of labour;
    - the use of bony markers to guide radiological scan length and reduce dose;
    - a discharge information pack for patients following intubation on the intensive care unit;
    - a research newsletter for the rheumatology department
    - a review of upper limb outcome measurement for patients following stroke;

- updated guidance on optimal positioning for patients undergoing a CT scan of their colon,
- a review of the reasons behind why some expectant mothers from deprived backgrounds do not attend antenatal growth scans.

More formal education has been completed by two fellows: a PGCert in CT scanning, an MSc in Advanced Practice and one fellow is now on a pre-doctoral programme. Two fellows have gone on to lead research studies as Principal Investigators (PIs) within the organisation. These are fantastic examples of how research can drive the Trust's Quality agenda.

5.4 CAFÉ research forum

The Clinical Academic Forum and Exchange (CAFÉ) was started in 2020 by 3 research-active clinicians: Chris Dixon, Rich Collings and Kathryn Bamforth. It aims to provide an informal peer support network for staff at any stage of their academic development from across the organisation. The membership now exceeds 20, ranging from entry-level Chief Nurse Research Fellows and those undertaking internships to post-doctoral staff. We have been proud to include Elizabeth Welch, Research Ambassador and former Non-Executive Director as our lay member.

This forum supports the exchange of knowledge and ideas and has led to various spin-off projects such as independent support with developing participant-facing information for research projects (the WELLBEING Study) and the CAFÉ-initiated SENSE study (see above). In addition, the CAFÉ provides a space for informal exchange of knowledge and experiences, for example, producing a poster and presenting at conferences.

The format of the CAFÉ continues to develop and its coordination and programme is now part of the Chief Nurse Research Fellowship. This is an ideal opportunity for staff to develop their skills in self-direction and identify their own needs in a supported environment. It is hoped that this forum will continue to grow and develop to support critical thinking and the value of evidence-based medicine across our organisation.

5.5: Research Council

The 'Magnet for Europe' research study underpinned the Pathway for Excellence initiative. TSDFT was one of the most engaged Trusts in this study and the 2nd highest recruiting site in the UK. Through this work the Trust introduced shared decision-making councils across the ISUs; including the first Trust Research Council; launched in August 2022. The Research Council has 3 themes

1. Foster a research culture for nurses, midwives and AHPs.
2. Identify how to improve research awareness across the trust and embedding it into everyone's roles.
3. Develop a research active workforce, especially for NMAHPs, by defining a clinical researcher pathway and improving the skills and capability of people to undertake research.

5.6: UoP Torbay Clinical School (Dr. Susie Pearce & Prof. Mary Hickson; Co Directors)

Torbay Clinical School has been running for 6 years and is part of a regional SW clinical school model where a UoP professor is linked to an NHS Trust in the South West

peninsula; working closely with Trust Chief Nurses to grow and develop NMAHP researchers. More recently it has linked into the ICBs.

Key aims – Provide mentoring and support to NMAHPs, as part building research capacity and capability. At TSDFT, they have set up a programme of locally funded doctoral and Pre-doctoral Fellowships (TMRF funded grant – see above). Keen to promote and build on staff doing part time PhDs, but remaining in practice as a way to retain staff in the NHS and develop their clinical academic / research career.

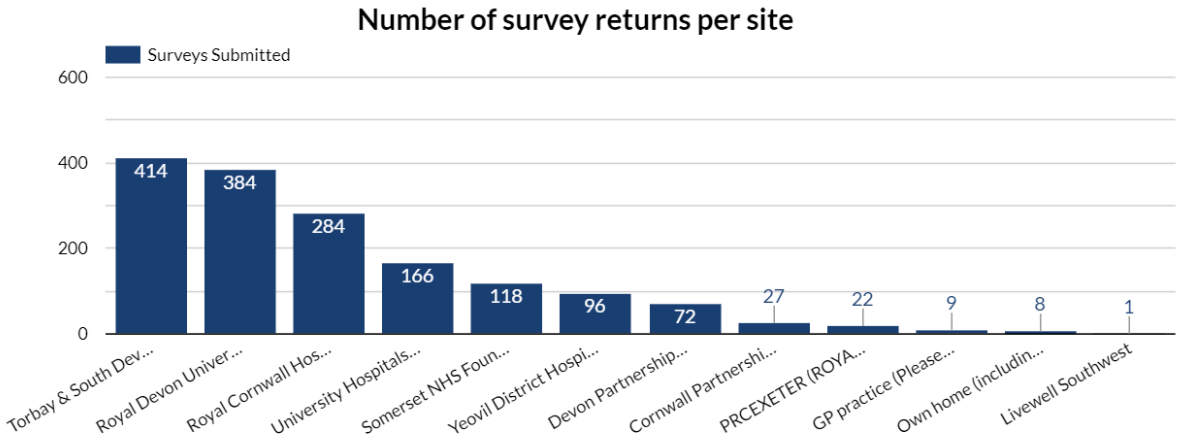
5.7: Research Strategy Day

Held at the Grand Hotel in March 2023, hosted and led by Deborah Kelly Trust CNO; supported by the Torbay Clinical Schools and Lead Research AHP Kathryn Bamforth with Professor Ruth Endacott, the NIHR Director of Nursing attending. This event brought together 60 NMAHP staff from across TSDFT to help inform a TSDFT NMAHP research strategy, incorporating and complementing the recently released national nursing, midwifery and AHP research strategies. The TSDFT NMAHP strategy is currently undergoing consultation and is due to be released by early 2024

6.0: Patient & Public Involvement (PPI)

6.1: NIHR CRN Patient Experience of Research Participation (PRES) 2022/23

For the 2nd year running, Torbay again topped the regional chart for PRES responses returned – see below summary graph. This was the result of a great collaborative effort across the department. Our R&D tablets were all set up with the link to the PRES and staff were encouraged to support participants to complete the survey as part of their clinic appointments.



The survey re affirmed previous results that patients and the public value the opportunity to be able to access and take part in research at their local Trust.

Results from all regions fed into the National 22/23 PRES report Participant in Research Experience Survey (PRES) | NIHR; recently release which showed:

More participants shared their experiences of taking part in research than ever before, and the results paint a picture of what is needed for a positive research experience.

Key results include:

- 95% of adults and 96% of young people felt that they were treated with courtesy and respect.
- 93% of adults and 97% of young people were positive about the information they received before taking part, which prepared them for their study experience.
- 91% of adults and 92% of young people said they would consider taking part in research again.

7.0: Equality, Diversity and Inclusion (EDI)

REND report: Inequalities in Research Participation in Devon

Torbay was part of the ICS Research Engagement Network Development (REND) programme, funded by NHS England and the NIHR. During 22/23:

- Devon ICS was one of 15 pilot programmes aiming to reduce inequalities in research participation in collaboration across ICS partner partners, VCSE organisations and local universities
- This phase of the work involved investigating inequalities in NIHR study participation relating to geography, personal characteristics and clinical factors (with a focus on mental health and learning disability)
- Activities to increase research participation through partners will be targeted using this intelligence
- A data pilot was undertaken as a proof of concept to establish inequalities in research participation This involved EDGE research data collected from Royal Devon University Healthcare NHS Foundation Trust, Torbay and South Devon NHS Foundation Trust, and Devon Partnership Trust between: 2018 to 2023, linked to the One Devon Dataset and the local linked population health care dataset, to investigate inequalities in relation to geographic, personal characteristics and clinical factors. A pseudonymisation process was used to convert NHS number in EDGE to a non-identifiable pseudonym to facilitate data linkage. The report concluded: As a proof of concept, it has shown that we can link data sets.

8.0: Information and Communications:

R&D is a complex ecosystem and more information, visibility and transparency is needed to help improve everyone's awareness and understanding. This will help to create the culture change needed to embed research into core everyday business. The R&D team has been working to make information more readily accessible and available as well as promoting research more widely. Unfortunately, several projects had to be paused due to other priorities e.g. re focusing on recovery plans and with staffing shortages. Our ambition to revisit and refresh these projects and improvements during 23/24 is reliant on more staff. We urgently need Trust investment to realise this aim.

QIG reports

R&D produced slides summarising research activity data for each ISU as part of the monthly ISU Governance reports to QIG. Whilst this concept initially showed some

success, it has become clear we need to re visit and re launch as the data and reports were not well understood and lacked meaning and therefore impact. Work to address this as part of improving R&Ds visibility and transparency will be a focus during 23/24. We are keen to understand how we can inform and be held to account in the Trusts new governance and care group structures.

Raising the profile of research

During 22/23 various events helped us to focus a spotlight on research to improve visibility, awareness and understanding: Some examples below:

- Following on from international clinical trials day, watch our research and development department's promotional video, showcasing the work we do to advance care through research.

- **#YourPathInResearch campaign**: Our staff have featured in this national campaign aimed to increase research awareness and carers in research

	Case study: Your Path In Research: Pauline Aspa, Research Nurse, Torbay and South Devon NHS Foundation Trust | NIHR
Case study: Your Path in Research - Rebecca Stride | NIHR	

9.0: Finance:

- R&D is commissioned and funded by the NIHR and receives an annual budget from the CRN, originally based on per capita and relative recruitment performance until more recently and now just a steady state basis. This is one of the primary funding streams.
- The SW Peninsula CRN is the least funded region out of the 15 CRNs; due to regional lower relative recruitment; primarily linked to the lower number of Chief Investigators and clinical academics leading research relative to other regions. This has resulted in a decrease in funding to the region and Trusts over the years.
- The other main source of funding is income generated and earned from clinical trials primarily commercial clinical trials; paid on a payment by results basis in arrears.
- The increasing complexity and personalised medicine developments associated with clinical trials; means more targeted trials and fewer patients per study; with greater associated per patient work up per study. As a consequence, in order to keep up funding flows there is a need to increase the number of studies, which also puts a strain on workforce capacity and capability.
- Over the years the commercial trials income has had to increasingly subside shortfalls; due to the declining CRN funding to support non-commercial activity; as well as subside the unfunded parts of the R&D service such as in research administration, management and governance (an organisation responsibility). With increasing costs, the need to subside more and more from commercial trials income has consequently placed more pressure on R&D's ability to break even each year.

Financial Position to 31 March 2023
For the 2022-23 financial year, the annual income and expenditure budget for R&D is summarised in the table below

High level breakdown of 2022-23 R&D budget	**Income (£)**
Research Funding by area	
NIHR CRN core	842,180
NIHR CRN contingency/other	101,754
NIHR Speciality leads funding (national / regional	26,234

NIHR CRN Fellowships	10,554
NIHR CRN Chief Nurse Fellowships	8.496
DHSC Research Capability Funding (RCF)	20,000
Trust PAs for PIs (did not pass through R&D budgets) *	0
Cancer Alliance Funding	18,800
RT funding (STP /NHSE)	51,646
Other grants / awards	7,000
Other income (commercial & non-commercial)	865,269
Income total	**1,943,445**
2022-23	**Expenditure (£)**
Staff	1,975,277
Non-staff	63,477
Expenditure total	**2,038,724**
Net Year End position	**-95,279**

N.B. TMRF grants do not pass through R&D accounts.

- R&D received less NIHR national and / or local contingency funding compared to previous years as part of Covid and Vaccine Task force arrangements which ended in March 22. Whilst the focus and ambition were to recover our business as well as possible especially commercial studies; this was still within a very challenged Trust / NHS operating and workforce environment. A picture reflected across the UK. Whilst some areas managed to recover more commercial business e.g. oncology and cardiology and made in year surpluses, others were not able to recover at the scale and pace needed and made in year losses.

- The national picture showed that the recovery of commercial trials, in the UK especially outside of oncology has been slow and overall the UK late phase commercial trials activity has dropped by 44% of pre covid levels. Work force, financial and operational pressures, backlogs etc are just some of the reasons. This has raised significant concerns by the Government and commissioned the 'O'Shaughnessy review' – please see section 11 for further details.

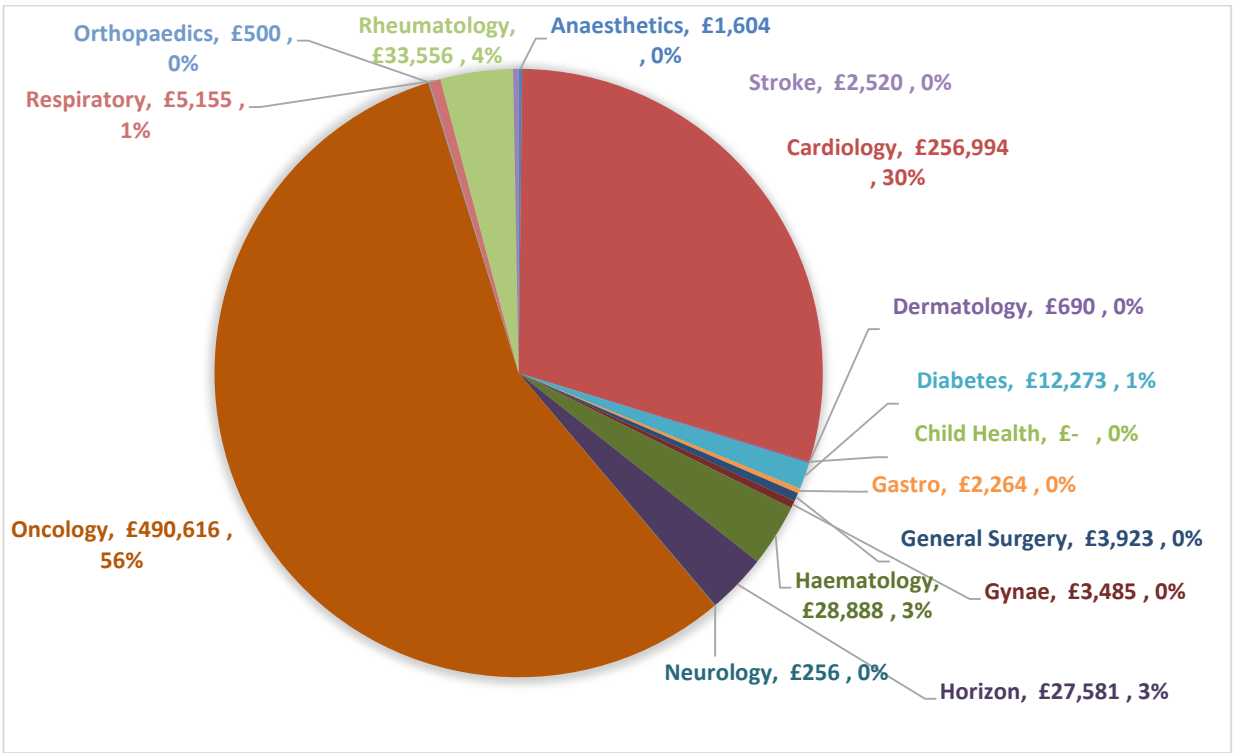
- Overall R&D made a net in year overall loss of circa £95; despite record-breaking trials income generated (see below),

- However, this does not consider the activity earned but payment not received at year end totalling £578K (see below). Equally it does not include any savings or other economic benefits that pass through other Trust budgets or the wider system e.g. drug savings, reduced RT fractions etc. The nearest proxy measure is the NIHR commissioned KPMG report from 2019 showing the estimated benefits to the NHS of contract (commercial) research as summarised in the graphic below:

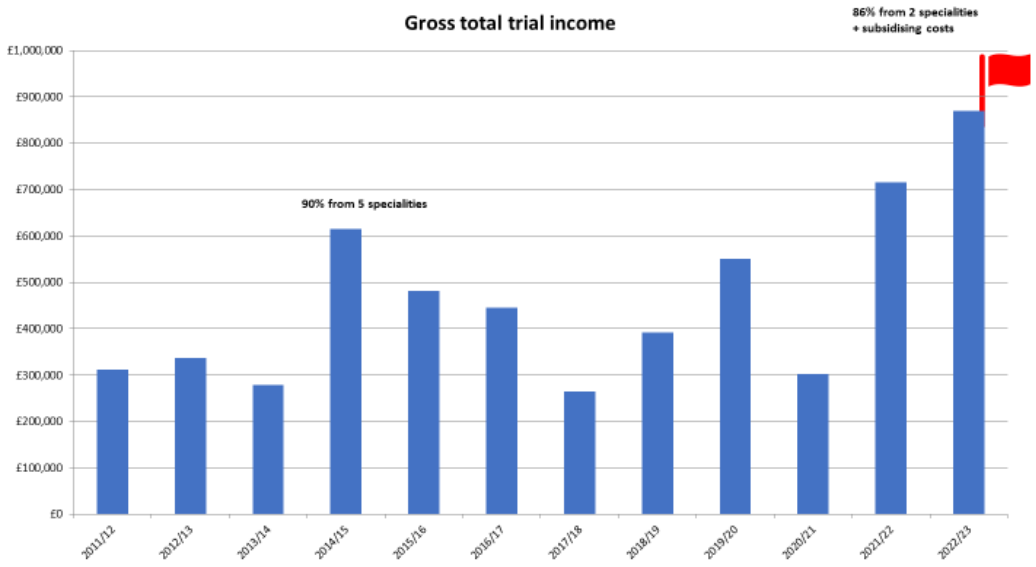
Ref: Impact and Value of the NIHR Clinical Research Network 2019 (infographic summarising key findings) | NIHR, KPMG report.

Trials Income

Commercial trials are the biggest income generators, but some specialties do not have a good pipeline or supply of commercial studies; so are limited. Whereas some specialties such as cardiology and oncology do have a good plentiful supply hence are the biggest earners. The graph below shows the 2022/23-year end position: Gross Trials income banked – specialties breakdown.



2022/23 saw the largest ever income generated from clinical trials. The graph below shows gross value banked over the years for activity undertaken.



- The fanatastic growth of the oncology commercial trials portfio has helped R&D exceed not only pre covid levels but also last years record income generated.

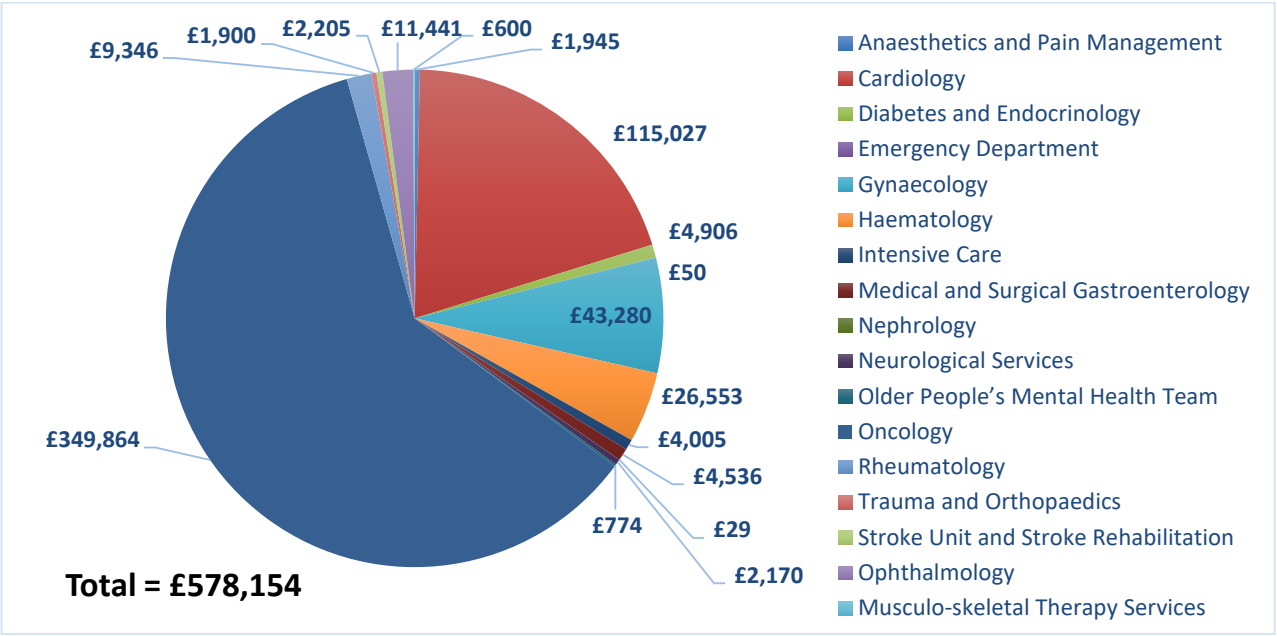
- Cardiology research has long been a good and consistent income generator with their strong commercial trial's portfolio. However, we saw income decrease; compared to previous years; attributed to the retirement of the primary researcher / Principal investigator and difficulties with succession planning.

- Whilst trial income increased; this was earned primarily by 2 specialties (oncology and cardiology). Whereas several years ago income was generated by several other specialties e.g. diabetes, rheumatology, ophthalmology, neurology, gastroenterology. This makes R&D funding variable and very fragile. The more specialities that do commercial research; the greater the 'smoothing effect' helping to mitigate the ups and downs of study availability, changes to staffing etc; which provides greater sustainability and reduces fragility

- The nuances of R&D finances are further complicated due to the payments per study contract; which vary and are dependent on the activity undertaken. Activity spans financial years and payments are made at least quarterly in arrears after source data verification from sponsors. This requires significant resource to ensure a robust cost recovery system and process. But despite this; it often means payments are made up to a year or more later from when the activity was actually undertaken. As a consequence, not all in year activity passes through the accounts in the same year.

- This activity needs to be recognised as part of the whole picture. At 22/23-year end there was an additional £578K of activity that was earned but had not yet been banked / passed through the Trust accounts (not ready to invoice); but will flow through the accounts during subsequent financial years. See below the breakdown:

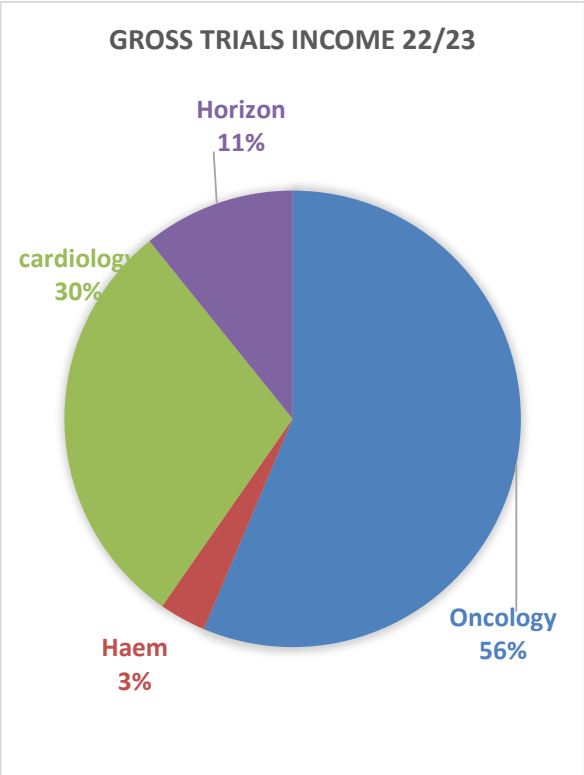
2022/23-year end position: Gross Trials income (for activity undertaken = earned, but not yet invoiced / banked) – speciality breakdown

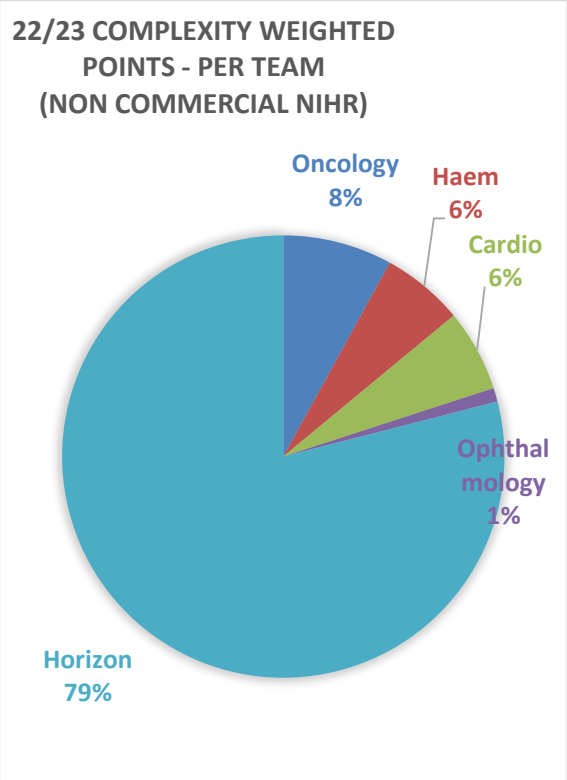


Whilst commercial research is important to support income generation as well as access to new novel therapies. In order to keep securing our CRN funding per annum, we still need a substantial level of non-commercial activity too. Therefore, it's important we have a balanced portfolio to best protect the 2 primary sources of funding into R&D.

The activity supported by the various clinical research delivery teams is variable regarding the split between commercial: non-commercial trials, dependant on study availability, interest, facilities etc.

The graph below shows that oncology was the biggest income generating power taking over from Cardiology; whereas the Horizon Team supports the largest non-commercial activity securing the CRN funding.





Cancer Alliance Funding

For the first time we received new funding from the Cancer Alliance; negotiated through the LCRN to support time in Consultant Job Plans. This was recognised as a leading barrier and limitation to staff engaging and undertaking research. Cancer is a key Government priority area and this funding (£18,800) was provided to help incentivise and recognise the value and contribution made and to support dedicated research PAs in oncology job plans

NIHR Capital Infrastructure call:

R&D submitted as part a regional bid back in January 2023 and recently received official confirmation TSDFT has been awarded £8i1K to cover the capital costs for new Radiotherapy (RT) equipment. Funding contracts have now been issued and funding will be available from 24/25.

This was a co-produced bid working with radiotherapy service and medical physics leads and the oncologists. An excellent example of how being research activity has given access to this funding stream that will benefit the Trust more widely. Our success as a radiotherapy trials centre; nationally one of the best recruiting sites was pivotal in gaining this award and will provide safer RT treatments to all our patients, as well as releasing time and resource to improve patient flow and throughput too (5-10% improvement). This will help the department meet increased demand alongside workforce challenges. This equipment will benefit all patients needing radiotherapy treatment not just trials patients. Additionally, this equipment will secure our future capabilities to support the increasing QA needed to take part in future RT trials and ensures the RT Quality Assurances remain up to date as a whole service. Through our RT trials we have changed practice; for example, enabling SABR RT to now be given to patients locally; significantly reducing radiotherapy fractions for example in breast cancer (25 fractions reduced to 5 fractions). A huge benefit to patients and the Trust.

Financial planning 23/24
The following budget has been set for 2023-24: -based on funds known to date

Research Funding by area	**Income (£)**
NIHR CRN core	864,970
NIHR CRN contingency/other	153,646
NIHR Speciality leads funding (national / regional	26,234
NIHR CRN Fellowships	29,974
NIHR CRN Chief Nurse Fellowships	10,000
Trust PAs for PIs	50,000
DHSC Research Capability Funding (RCF)	25,000
Cancer Alliance Funding	30,000
RT funding (STP /NHSE)	57,999
DHSC RCF- RESET Funding	35,000
Other income (commercial & non-commercial)	870,000
Income sun total	**2,152,825**

- The budget for income from commercial and other non-commercial studies and expenditure has been set in line with previous years. With regards to expenditure we are mindful of pay awards that will increase this. The aim is to reach an overall break-even position by the end of 23/24 providing the level of commercial trials continues to grow and the recovery of the non-cancer commercial portfolio starts to improve too nationally and locally. However, there is a risk this is not possible.
- The CRN funding remains static as the contract is up for renewal from October 1st 2024 and we are lobbying for a rebasing and improved funding models to increase allocations especially to this region and to local Trusts.
- The EOI data shows there is a plentiful pipeline of studies we are turning down due to pressures, workforce and capacity issues (e.g. imaging); and with only circa 16% of consultants research active; whilst we have scope to do more; we do need the organisation and its workforce to be in a better operational position to enable this. These factors all sit outside of R&Ds gift.
- The value and benefits through being a research active organisation are also important to consider; such as cost avoidance, drug savings, reduced attendances, safer practice and care, better outcomes, improved staff recruitment and retention, better patient experience etc. These all contribute to ‘softer’ financial benefit; that are hard to quantify and do not pass through the R&D budgets; but instead through other Trust or the wider system budgets. It is imperative these benefits are taken into consideration when reviewing the R&D economic position / financial risk.
- R&D is keen to pilot work to gather systemically more data demonstrating the benefits of research, but we need access and support from other parts of the system and manpower resource to undertake this work. Due to staffing shortages and other Trust pressures, this project is on hold.
- R&D needs a better long-term funding solution. With the real time reductions in Government (NIHR) funding, the over reliance on needing to subsidise through commercial trials is increasingly difficult and therefore increasingly at risk regarding our ability to continue to operate within diminishing financial envelops.

The National Contract Value Review (NCVR)
A new process for the costing of commercial studies was implemented during 2022-23, following a delay of more than two years due to the COVID-19 pandemic. The aim of this new process is to standardise and streamline the costing of commercial contract research, in particular to minimise duplication of effort at each site, so these trials can be set-up more quickly in the UK. The Trust's R&D contract and finance team has been actively involved in this process. This national single contract and cost will be mandated from October 2023 and no local negotiations will be allowed. At this moment we are unsure if this poses any financial risk and whether funding to Trusts will be similar, less or more than a locally negotiated contract.

10.0: Research Governance:

Research governance refers to the framework to manage the research process from end to end, to ensure that research is undertaken in a safe, appropriate and ethical manner, in accordance with national guidance and applicable laws to ensure that maximum benefit is derived from research for public and patients. It also provides assurances and responsible for quality management systems and processes. Compliance provides public assurance that the rights, safety and wellbeing of participants are respected and protected, and that the data generated are credible and accurate.

As part of governance, research should have policies, systems and SOPs forming part of the evidence base of an overarching Quality Management System. Additionally, it involves audits, monitoring and oversight of staff, studies, systems, practices and processes. Research Governance underpins the R&D office and service, research delivery and it is central to underpinning the Trusts ability to be MHRA inspection ready and compliant and remain a research active organisation. Research Management and Governance (RM&G) is a Trust responsibility but it is currently an unfunded service. This needs to change. We can no longer cover our costs through commercial trials income.

The departments Governance manager left the Trust in October 2022 and due to our financial pressures, we have not replaced this post. As a consequence, remaining staff members; primarily the R&D Director /Head of R&D and the Assistant Research Manager have tried to absorbed this workload. But with limited success and despite good intentions progress in renewing out of date policies and SOPs etc have been hampered. The workloads and other competing demands mean the attention and focus necessary has not been possible and this is an increasing area of risk.

Incident Data for 2022/23

Serious GCP Breaches	0
Incidents (research or otherwise)	11
Complaints	1
MHRA regulatory inspection (triggered or statutory)	0

All incidents (research and / or clinical) are recorded on the EDGE research management system and where applicable also on DATIX. Each incident is reviewed

and CAPA plans put in place. Incidents are reviewed by the senior team and discussed at the Department operational meetings.

Oversight of Compliance and Safety
GCP Monitoring – Many non-commercial sponsors and all commercial sponsors undertake regular monitoring of studies either remotely or on site. After each visit a monitoring report is issued to the investigator, delivery teams and to R&D. These reports are reviewed by the R&D management team to follow up actions and look for any trends or themes developing.

Compliance checks. R&D internally also aims to routinely undertake assessment of compliance with various aspects of clinical research; primarily focussing on informed consent, delegation logs and safety reporting. These checks were put on hold during the pandemic but restarted during 22/23.

Safety Reporting. The research protocols detail the process for safety reporting. Trial patients on interventional studies are flagged on the trust systems. Each morning a report is pulled to check any trial patent admissions and the team follow up and if applicable report as per protocol and GCP requirements to the study sponsors.

Changes planned for 23/24 – We aim to introduce monthly Governance Oversight (GO) Meetings to strengthen oversight and learning. This will enable a more focused review by the R&D team of all new and ongoing incidents, to improve the follow up of actions and CAPAs to completion in a timely manner. This will provide improved oversight and assurance, 'close the loop', and importantly to improve the learning and sharing of learning more formally and widely across the department and teams.

Monitoring reports will also be reviewed by this new group to see how further improvements in a more co-produced joined up manner can be taken forward. Safety (SAE) reports will also be reviewed which currently internally there is a lack of collective senior review. Although monitoring reports do highlight any issues in this area, a helicopter view of SAEs to see if any trends or training needs are necessary will strengthen this area; especially as the dedicated Governance Lead is no longer in post. This will help the Department and the Trust to improve its MHRA inspection readiness and compliance.

11.0: Research & Development: Next steps and looking forward into 23/24

Nationally the R&D agenda will be driven by several key polices and strategies summarised below. Locally we will need to align priorities and policy making to enable better delivery of research in the region.

Performance: Time to Target
DHSC and NIHR, have made it clear that delivery to time and target – especially for commercial studies – will be the main focus of attention for improvements at a national level. As part of the transition to the new national Research Delivery Network, which will replace the current Clinical Research Network from October 2024, it is expected that a new reporting process will be introduced to support this focus and there will be a greater emphasis on proactive engagement with sponsors to identify in a timely manner studies that are not progressing as planned, so that appropriate action can be taken.

Commercial trials and the O'Shaughnessy review'

- Following the ABPI report in Dec 2022 which showed the UK has been slow to recover compared to the global market; with a 44% decline in later phase studies compared to pre-pandemic levels. Additionally, industry is complaining the UK is too slow to set up and has inconsistent delivery to time and target.
- The Government is keen to prioritise commercial research and ensure 'UK PLC' can recover as it is important to both the UK and NHS economy. The Government commissioned the Lord 'O'Shaughnessy review' to offer recommendations on how commercial clinical trials can help the life sciences sector unlock UK health, growth and investment opportunities. The final report published in May 2023, includes eight 'problem statements' along with 27 recommendations to address these.
- In its response, the government has already accepted some of these recommendations and will be exploring the others over the coming months, ahead of a full implementation later in 23/24. R&D is already actively engaged with one of the key recommendations, the adoption of the National Contracts Value Review (NCVR) process. Other recommendations will be implemented, as appropriate, once the government's position has been confirmed, and R&D will take every opportunity to contribute to forthcoming discussions with relevant national bodies as part of this process.

Government Priority Research Programme - Vaccine Trials Regional Delivery

DHSC has signed new 10-year contracts with Moderna and BioNTecH SE; to undertake and deliver all their vaccine clinical trials programme in the UK (infection and cancer). There is an expectation that this will need significant support from all NHS Trusts to deliver these clinical trial programmes

National Strategy: UK Clinical Delivery Strategy: Saving Lives: 2nd phase implementation plan (2022-25). The Government published their three-year plan on 'transforming 'research from now until 2025. The plan focusses on research's 'recovery, resilience and growth' post- COVID-19 with five themes and a push for more pro-innovation, pro-patient and pro-digital approach:

1. a sustainable and supported research workforce to ensure that healthcare staff of all backgrounds and roles are given the right support to deliver clinical research as an essential part of care
2. clinical research embedded in the NHS so that research is increasingly seen as an essential part of healthcare to generate evidence about effective diagnosis, treatment and prevention
3. people-centred research to make it easier for patients, service users and members of the public across the UK to access research and be involved in the design of research, and to have the opportunity to participate
4. streamlined, efficient and innovative research so that the UK is seen as one of the best places in the world to conduct cutting-edge clinical research, driving innovation in healthcare
5. research enabled by data and digital tools to ensure the best use of resources, leveraging the strength of UK health data assets to allow for more high-quality research to be delivered

Patients across the UK will benefit from a supercharged clinical research system, which will save lives across the country. The UK-wide plan will enable innovative research to

be carried out more quickly, helping patients access cutting-edge treatments sooner, speeding up diagnosis and helping to bust the COVID-19 backlogs.

The plan is backed by £150 million of additional funding from the National Institute for Health and Care Research (NIHR) and £25 million additional funding from other delivery partners in the UK Clinical Research Recovery, Resilience and Growth Programme. It will:

- increase the amount of research and the size of the workforce putting the UK at the centre of cutting edge and global clinical studies
- improve the quality of research by broadening responsibility and accountability for studies across the NHS
- ensure studies address the needs and challenges facing the NHS, including improving inclusivity and accessibility
- take advantage of opportunities outside the EU to reduce regulations allowing for safe, speedy and flexible research
- improve participation in research across the UK by investment in digitally focused trials

This will further cement the UK's position as a world leader in life sciences and the delivery of clinical research, and follows the country's successful development and rollout out of COVID-19 vaccinations.

This aligns plans for clinical research with wider government strategies to ensure the UK is at the forefront of health innovation,

- Building upon existing commitments and priorities set out in the NHS Long Term Plan, the Life Science Sector Deals,
- Inclusion into CQC inspections
- Complement other initiatives to unlock the power of data to drive research. This includes those set out in the UK's National Data Strategy (NDS) published in September 2020 and includes the creation of Secure Data Environments (SDEs)
- ICS' roles and implementation of the Health and Care Act 2022.
    - A strengthened remit for research placed on the new ICBs.
    - Aimed at rebuilding the National Health Service (NHS) in the context of the continuing impacts of the COVID-19 pandemic, the Health and Care Act 2022 incorporates a valuable lesson learnt from the pandemic: the extraordinary value a research-active NHS can deliver. Embedding research in the NHS to improve outcomes for patients is now on a statutory footing expanding on the opportunity that research brings to improve patient outcomes and reduce inequalities.

NHSE/I published guidance for ICBs/ICSs: Maximising the Benefits of Research Document : This guidance sets out what good research practice looks like. It supports integrated care systems (ICSs) to maximise the value of their duties around research for the benefit of their population's health and care and, through coordination across ICSs, for national and international impact. It supports integrated care boards, integrated care partnerships and their partners to develop a research strategy that aligns to or can be incorporated into their integrated care strategy, and helps them and their workforce to build on existing research initiatives and activities across health and social care to improve sector-wide performance and best practice. Headline messages (section 3):

- this is all about embedding research & trials into everyday clinical practice
- Supporting delivery of research

- Understanding local needs
- Enabling cross-provider research
- acting at a joined up regional level for commercial trial opportunities
- public and patient involvement (PPI)
- Health data: implementation of secure data environments & population health management
- Knowledge dissemination for planning, commissioning and improving health and care
- Health and care workforce and research

Devon ICB – Regional Research and Innovation Strategy:

This is very much a work in progress. The SW Health Innovations Network (formerly the SW Academic Health Science Network (AHSN) is leading on the draft Regional Research and Innovation Strategy (RRIS) with the ICB. This remains very innovations and improvement centric. R&D leads from across Devon, Cornwall and Somerset alongside the LCRN are all working together as a collaboration to get the research agenda especially research delivery and clinical trials included and recognised. We will be part of the evolving ICB meetings to represent, inform and lobby for an improved position and role research can play in this strategy and subsequent work plans; as part of their new mandated remit, responsibilities and accountabilities.

NIHR New configuration

From October 1st 2024, a new contract will be awarded replacing the current NIHR CRNs. During 23/24 into 24/25 the NIHR CRN will be in transition mode as new contracts come into effect and will become NIHR Regional Research Delivery Networks (RRDNs). These new RRDNs will be realigned to the NHSE regional office boundaries and those of the ICSs. As a consequence, they will reduce from 15 to 12 networks. TSDFT will remain part of the SW Peninsula RRDN. Our geographical footprint remains unchanged in the new contract. We await further detail to confirm the scope and new funding models.

New Areas of Research Interest (ARIs): DHSC published 3 ARIs and several cross-cutting themes. For further details : DHSC's areas of research interest - GOV.UK (www.gov.uk)

- **ARI 1: early action to prevent poor health outcomes:**
  Prevention, early diagnosis and appropriate intervention for people at increased risk of poor health (in particular obesity, cardiovascular disease, type 2 diabetes, mental health and cancer) to prevent excess deaths, improve population health (including the health of the working age population), reduce disparities and decrease reliance on health and social care.
- **ARI 2: reduction of compound pressures on the NHS and social care**
  Improved patient outcomes and reduced pressure across the health and care system through preventing avoidable admissions, utilising innovations to make routine care more efficient and resilient, enabling smart discharge, and through effective pandemic preparedness and new treatments to tackle a range of infectious diseases.
- **ARI 3: shaping and supporting the health and social care workforce of the future**

A public health, NHS, social care and wider health workforce that is effectively structured, trained, deployed and supported to deliver future effective and efficient models of healthcare which meet the needs of the UK's changing population.

- **Cross-cutting themes**
  - Across all 3 ARIs we want to deliver research and innovation which:
  - reduces health disparities and improves health and economic outcomes for the most deprived 20% of the population so that we raise the floor and not just the ceiling for the whole population
  - promotes economic growth by delivering a healthier workforce, a more efficient NHS, a higher skilled health and social care workforce, and through investment in the life sciences sector
  - accelerates the adoption and scale of innovation in the health and care system

New MedTEch strategy published – to increased medical devices research and innovation: Medical technology strategy - GOV.UK (www.gov.uk)

Appendix 1: The value and benefits of research: Examples of research good news stories / commendations / impacts and outcomes:

Our staff and patients at TSDFT have helped to inform the emerging evidence base, make changes to practice etc through their participation in research. Below are examples giving a flavour of the work and various impacts and outcome from Torbay's involvement in research activity.

A&E / Emergency Medicine:

ACS:ED	**Acute Coronary Syndrome in the Emergency Department (ACS:ED)** TSDFT PI: Dr Liz Florey, ED Consultant

The Horizon team recruited over 60 patients for this one-week observational study looking at the different strategies for investigating suspected cardiac chest pain in ED.

Praise from the study sponsors as Torbay not only recruited 60 patients but completed all the data on time. A study led by Dr Liz Florey supported by the research team and colleagues in ED, further endorses R&D and TSDFT as a capable and reliable site for research activity.

'This is wonderful news and thank you so much to everyone who did all the leg work in data collection and entry. I now feel fully up to the task of being able to interrogate symphony for any future research projects and proud to be part of such a hard-working R&D team.' 'Dr Liz Florey, Consultant in Emergency Medicine, Torbay and South Devon NHS Foundation Trust

Anaesthetics / ICU

Little Journey	***A Multi-site randomised controlled trial assessing the effectiveness of the Little Journey app at reducing peri-operative anxiety compared to standard care.*** TSDFT PI: Dr Tom Nightingale, Consultant Anaesthetist

TSDFT is currently recruiting children aged 3-12 to the Little Journey study testing a virtual reality google cardboard headset that links to an app designed to reduce peri-operative anxiety. Children are given the opportunity to explore 360-degree virtual environments of the hospital areas and can interact with animated characters and equipment they will encounter on the day of their operation. There has been a surprising amount of interest in this study with parents contacting the research department and asking to enrol their children. So far, 36 participants have been enrolled into this study meeting target (n=36). The study is due to close in November 2023.

effort study	Results of the **EFFORT study** (ITU) revealed no benefit to high protein intake for critically ill patients (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)02469-2/fulltext)

UK-R90X	UK ROX (ITU) second highest recruiter nationally in March 2023 comparing low dose oxygen therapy with standard care for patients ventilated on Intensive Care.

Cardiology:

novo nordisk	**SELECT-LIFE** (cardiology): smashed the target of 44, recruiting 50 patients into this study, looking at the long-term effects of semaglutamide in people who took part in the SELECT Study where they were randomised to semaglutamide or placebo with the aim of preventing major cardiovascular events in patients with established cardiovascular disease and overweight but without diabetes.

Child Health

What constitutes 'usual Physiotherapy care' aimed at improving walking and balance for ambulant children aged 8-18 years who have cerebral palsy?- A consensus study.	**The novel Next Step test is a reliable measure of anticipatory postural adjustments made by children with cerebral palsy prior to taking a step** TSDFT CI and PI: Rachel Rapson, Physiotherapist and PhD student https://libkey.io/10.1016/j.gaitpost.2023.07.286

Covid-19:

valneva	**Valneva COVID vaccine** authorised in Europe and the UK for use in 18-50-year olds. Torbay and Plymouth as a collaborative recruited 286 participants - best in the UK. It is the sixth COVID-19 vaccine to be approved by the MHRA, but becomes the first, whole-virus inactivated COVID-19 to gain regulatory approval in the UK.

GenOMICC	**GenOMICC study** reported 49 genome-wide significant variants associated with severe Covid-19, together with extensive analyses to identify downstream drug targets and biological mechanisms. This paper is shows how genetics can point out the biological mechanisms of critical illness (https://www.nature.com/articles/s41586-023-06034-3) .

Haematology:

ARGO	ARGO study (haematology) stopped early as no significant benefit found when atezolizumab was added to standard chemotherapy

Hepatology

ASEPTIC Primary Antibiotic prophylaxis using co-trimoxazole to prevent SpontanEous bacterial PeritoniTis in Cirrhosis	ASEPTIC (hepatology) top national recruiter in November and December 2022 examining the effect of prophylaxis antibiotic co-trimazole in patients with cirrhosis

Oncology:

Torbay has been the second highest recruiter to commercial Cancer studies nationally in 22/23. This is in part due to the excellent recruitment for MCM5 which has given the Trust great numbers as well as our Bladder, Prostate, Upper Gi and Lung commercial recruitment which has been consistently high.

TORPEDO	**A phase III trial of intensity-modulated proton beam therapy versus intensity-modulated radiotherapy for multi-toxicity reduction in oropharyngeal cancer.** TSDFT PI: Dr Anna Lydon, Consultant Clinical Oncologist
TORPEdO trial (oncology) opened to determine whether the use of proton beam therapy reduces long-term side effects and improves quality	

of life for people treated with radiotherapy for throat cancer. TSDFT recruited its first participants randomised to standard care or proton beam therapy treatment at the Christie Hospital in Manchester

One of the first Devon cancer patients to be recruited onto a ground-breaking trial in the region has spoken of his relief at receiving cutting-edge treatment following his diagnosis. Gary Rowe, 53, from Paignton, was told he had cancer of the throat just before Christmas 2022 and was offered the chance to go on a clinical trial, giving him a new type of radiotherapy, and the prospect of a better long-term outcome. He has been receiving excellent care under Torbay Hospital land was told he was eligible for a trial called **TORPEdO** (Toxicity Reduction using Proton beam therapy for Oropharyngeal Cancer. The UK-wide study, funded by Cancer Research UK and run by the Institute of Cancer Research, is testing a brand new type of radiotherapy called proton beam therapy.

Story featured on Devon Daily Exeter Daily and featured on Cancer Research UK's webpage, providing a great spotlight on to the work at Torbay! Gary's story featured on their social pages during World Cancer Day, on Instagram and Facebook and all have done really well.

PIVOTALboost

A phase III randomised controlled trial of prostate and pelvis versus prostate alone radiotherapy with or without prostate boost
TSDFT PI: Dr Anna Lydon, Consultant Clinical Oncologist

Pivotal Boost study: Torbay was the joint 4th highest recruiter in the UK which is an amazing achievement for one of the smallest treatment centres in the UK

Top recruiting centres to end of June 2023

Centre	Recruitment	Centre	Recruitme
Clatterbridge Cancer Centre, Wirral	370	Freeman Hospital, Newcastle	66
Lincoln County Hospital & Pilgrim Hospital	107	Norfolk & Norwich University Hospital	60
Ipswich Hospital, Ipswich	100	Addenbrooke's Hospital, Cambridge	55
Mount Vernon hospital	72	Queen Elizabeth Hospital, King's Lynn	52
Torbay Hospital, Torbay	72	Cheltenham General hospital	53

As well as the good news above, additionally Torbay's endeavours to keep research as a priority have been nationally recognised:

The NIHR lead for cancer in Kent, Surrey and Sussex whilst at a national meeting discussing recruitment into NIHR portfolio studies. Torbay's success in terms of recruitment into radiotherapy trials was discussed. It was mentioned that cancer alliance funding helped pump prime workforce and equipment to increase recruitment to radiotherapy studies. Also demonstrating a cost saving in terms of hypofractionation helped and as a result Torbay is now the top recruiter to radiotherapy trials?

Asked to share the key elements of our success in terms of developing support for our radiotherapy trials portfolio; particularly interested in ways to improve radiographer/research radiographer retention, speed up IRMER, and which staff to focus pump priming

A Phase 1b/3 Study of Bemarituzumab Plus Chemotherapy and Nivolumab Versus Chemotherapy and Nivolumab Alone in Subjects With Previously Untreated Advanced Gastric and Gastroesophageal Junction Cancer With FGFR2b Overexpression (FORTITUDE-102)

TSDFT PI: Dr Louise Medley, Consultant Medical Oncologist

One of the oncology data managers, Dani Master – who redesigned the pre-screening form for a commercial study Torbay was working on (the Fortitude study). as the one the sponsor supplied was not great. This made such a huge difference to the smooth running of the trial; so much so the Sponsors have now adopted it worldwide. Another great bit of work from our data managers that is recognised on an international level and will have a big impact on everyone working on it all over the world!

Case Studies: Early action to prevent poor health outcomes at TSDFT

SYMPLIFY	Observational study to assess a multi-cancer early detection test in individuals referred with signs and symptoms of cancer **TSDFT PI: Dr Louise Medley, Consultant Medical Oncologist**

A large number of hospitals took part to recruit 5000 patients that were referred on to the 2 week wait cancer pathway. Torbay was the 4th highest UK recruiting site contributing 384 patients to the study which was a huge achievement! The blood test can detect more than 50 types of cancer. Results showed the test correctly identified cancer in two out of three cases and in 85% of these positive cases it also pinpointed the original site of the Cancer.

New cancer test could 'speed up diagnostic process' if approved – Channel 4 News Multi-cancer blood test shows real promise in NHS study - BBC News

This study required significant cross collaboration between several departments (gynae, Upper Gi, Lower Gi, Lung) at a time when many were already stretched with the pressures of covid. Another great example of the wonderful work that can be done

across departments and one which will hopefully help change the face of early diagnosis in Cancer.

"The test was 85% accurate in detecting the source of the cancer - and that can be really helpful because so many times it is not immediately obvious and will help doctors decide whether to order a scope or a scan and make sure we are giving the right test the first time. The test is particularly good at finding hard-to-spot cancers such as head and neck, bowel, lung, pancreatic, and throat cancers.

NHS national director for cancer Prof Peter Johnson said: *"This study is the first step in testing a new way to identify cancer as quickly as possible, being pioneered by the NHS - earlier detection of cancer is vital and this test could help us to catch more cancers at an earlier stage and help save thousands of lives."*

ARQUER DIAGNOSTICS	**EVALUATION OF MCM5 IN POSTMENOPAUSAL BLEEDING PATIENTS:** Utilising an innovative **MCM5 Urine TEst foR the dIagnosis of eNdometrial cancEr** (MCM5-UTERINE study). This study opened at Torbay Hospital who recruited **244 patients i**n 22/23.

Since January 2022, TSDFT has taken part in the MCM5 study which aims to use a urine test to detect endometrial cancer in patients with post-menopausal bleeding. The study is currently open and 299 participants have enrolled so far. Of the 15 sites that host this study across the UK and Europe, TSDFT is in the top three highest recruiting sites and was the national top recruiting site in May 2023.

MCM5 study preliminary results – look very exciting and promising, which will bring a field change in endometrial cancer diagnostics if successful. Well done to the research teams for all the hard work. will forward to the Gynae clinic nurses, sonographers and clerical staff who have all been very accommodating. Really pleased how this puts us on the map. Hopefully we will get more traction for projects like this and we can really establish ourselves as a serious research hub…. Exciting times!

Mr. Manpreet Singh, Study PI and Consultant Gynaecologist, TSDFT

MERCK	Keynote-859 trial (oncology) found that adding the Pembrolizumab to standard chemotherapy for patients with oesophageal cancer led to statistically significant increases in overall survival and progression free survival and overall response rates (https://pubmed.ncbi.nlm.nih.gov/33975465/)
STAMPEDE	**Stampede** (oncology) confirmed that adding abiraterone to standard hormone therapy improves the survival of patients with prostate cancer with no extra benefits of adding enzalutamide (https://www.thelancet.com/article/S0140-6736(21)02437-5/fulltext)

MAGNITUDE	**Magnitude** (oncology) found an improvement in progression-free survival for patients with prostate cancer harbouring a repair gene when treated with Niraparib (https://ascopubs.org/doi/abs/10.1200/JCO.2022.40.6_suppl.012)

Torbay and South Devon first for lung cancer research trial

We are delighted to have achieved both the coveted '*first site to open in the UK*' and '*first patient on trial in the UK*' spot for the KontRASt-06 trial.

This clinical trial will offer a new treatment for some of our patients with lung cancer. Over the last 30 years cancer research has made great progress in unearthing and understanding a large suite of genes that can drive tumour growth – these oncogenes are now the targets of exciting new and more personalised therapies for cancer.

The KontRASt-06 Clinical Trial is testing an oral medication that targets patients with a very specific KRAS G12C mutation. Patients participating in this study would have the new oral therapy first rather than standard chemotherapy or immunotherapy. The trial will also look for any features of a patient's cancer that may make them more likely to respond to this more personalized treatment approach.

Dr Medley, principal investigator for the study locally, commented: "I am delighted that at Torbay we can offer our patients the opportunity to access the latest clinical trials, and work together as a wider cancer community to drive forward more personalised care for the treatment of lung cancer".

Ophthalmology:

TIGER THE TIGER STUDY

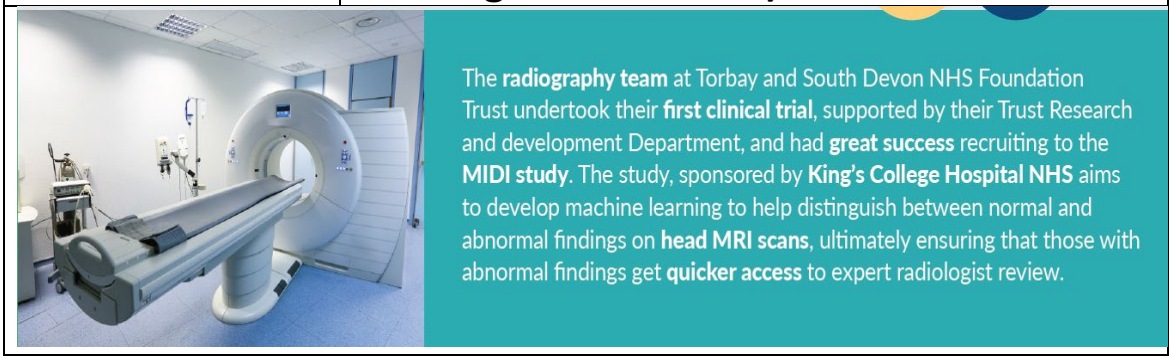
Congratulations to the Torbay Eye Unit - first in the Peninsula to recruit to the TIGER research study

Congratulations to Mr Eddie Doyle, Consultant Ophthalmologist and the ophthalmology clinical and research teams, as they became the first eye unit in the region to successfully recruit and randomise a patient to the TIGER study: A multicentre international clinical trial– comparing subretinal tPA injection to standard care for the devastating condition of submacular haemorrhage. Participation in this Europe-wide study means that Torbay patients now have access to high-quality, evidence-based ophthalmic care, on a par with what is available in units like Moorfields & Kings College Hospital, London. A fantastic achievement especially for an ophthalmic unit/ Trust of our size.

Ophthalmology Research Lead Mrs Yinka Osoba commented:
'More importantly, patients who may otherwise have been registered blind, now have the opportunity to preserve useful vision to help maintain independence, thereby becoming less of a social (and financial) burden on their relatives, CCG, NHS and the society at large, considering the current social and economic crisis in the UK'

Radiology

MIDI	**MIDI (MR Imaging abnormality Deep learning Identification)**



The MIDI study (aiming to develop a deep machine learning programme to distinguish between normal and abnormal MRI head scans) opened at TSDFT in November 2021. It is anticipated that this study will help triage the most appropriate scans for radiologist review and improve access for patients. Not only was this the first study that the Radiology and Imaging department had opened, but it was led by a non-medic Principal Investigator, CT Radiographer Becky Stride, who had previously been awarded NIHR Research Associate funding to develop expertise in research. The study successfully reached its target in November 2022 and recruited 432 participants in total, closing in January 2023

Rheumatology

SERENA study (Rheumatology)	**interim 2-year analysis: Real-world evidence for secukinumab in UK patients with psoriatic arthritis or radiographic axial spondyloarthritis:** This analysis demonstrates high retention rates for secukinumab over 2 years in patients with PsA or r-axSpA, with a favourable safety profile. https://libkey.io/10.1093/rap/rkad055

Surgery

PQIP Perioperative Quality Improvement Programme	620 participants recruited into the PQIP (surgery) study recording complications, mortality and patient-reported outcomes from major non-cardiac surgery – study has now surpassed its TSDFT target **TSDFT PI: Dr Mike Swart, Consultant Anaethetist**

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Report to the Trust Board of Directors			
Report title: Long Term Workforce Plan update			Meeting date: 29th November 2023
Report appendix:	**Appendix 1:** Long Term Workforce plan update presentation		
Report sponsor:	Chief People Officer		
Report author:	Associate Director of People; Strategic Workforce Planning Lead		
Report provenance:	People Committee October 2023		
Description/Purpose of the report and key issues for consideration/decision:	The presentation seeks to provide an update on; - a summary of the key messages within the national plan under the three themes: Recruit, Retain and Reform - a summary of the alignment with Devon Workforce Strategy - the identification of local workstreams and how these will be influenced by system and regional work		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Board are asked to note the update		

Summary of key elements	
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	The long term workforce plan is a key priority of our People Promise. Creating a robust and sustainable long term workforce plan for Torbay & South Devon, aligned to both the Devon Workforce Strategy and national long term workforce plan will support our people to have the right skills and working in the best way to deliver excellent care for our communities.
How does the report support the Triple Aim:	The long term workforce plan supports all of the Triple aim elements, mostly through promoting an appropriate workforce to deliver services in the most effective and sustainable way. 1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources
Relevant BAF Objective(s):	Objective 2 - People Objective 3 - Financial Sustainability Objective 7 - Building a Brighter Future Objective 9 - Integrated Care System Objective 11 – Equality, Diversity and Inclusion
Risk: Risk ID: *As appropriate*	*Risk 3536 (Risk on People Hub due to increased demand)* *Risk 1697 (Difficulty in recruiting service critical staff and scheduling of staff)* *Risk 3030 (Staff fatigue)*

External standards affected by this report and associated risks	Care Quality Commission NHS People Promise and Plan National Oversight Framework

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NHS Long Term Workforce Plan

Considering what it means for us?

Jenny Shepherd
Strategic Workforce Planner

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Summary

Torbay and South Devon NHS Foundation Trust

1. Initial event held in September with key stakeholder including Education, Medical HR, Digital, Community wealth building, Staff Group Workforce Leads, Transformation to;

   - review and reflect on the national context and the key messages within the three themes – Recruit, Retain and Reform
   - Discuss the context in Devon and the alignment with Devon workforce strategy

2. The output of this session was the identification of a number of workstreams (slide 3)

3. The draft workstreams have been shared with ICS to understand the opportunities to synergise, as many of the areas of work are not unique to TSDFT and are already being explored by staff group networks in the system e.g. PenRAD, AHP Faculty

4. South West LT WFP Regional events scheduled from December to March 24 to identify the three priorities for each system under each of the following themes to enable cross system/regional working with an identified programme of work;

   Supply and retention, Expansion, Clinical & Medial Reform, Infrastructure & productivity

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Potential Workstreams

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	Area of work
1	Understanding of what services will be delivered by the Trust in 10 years
2	Influence Education Model to genuinely co-design expansion in placement provision with HEI's, including simulation & digital, multi-professional and system based rotational clinical placements
3	Map profile and expected growth in educational supervisors/practice educators, setting out actions that will lead to sufficient capacity and quality of educators
4.	Work with HEI's to understand implications of shorter training programmes on preceptorship periods
5	Development of apprenticeship strategy to enable sufficient growth to reduce reliance on international recruitment and to widen access of opportunities to people from all backgrounds. To include funding and culture change.
6	To continue to develop and communicate career pathways both within and across professional groups. To include T-Levels, work experience
7	Development of digital technology strategy to include – how to genuinely co design digital solutions with patients and staff; scaling the implementation of digital skills into education, scaling adoption of AI/digital innovations
8	Create a widening participation strategy to provide local employment for local people supporting Torbay Councils strategic theme Torbay Council Community & Corporate Plan - draft for consultation
9	Continue to develop a clear Trust strategy for advanced, enhanced and non-medical consultant practice. To include the role of the Physicians Associate within the Trust
10	Continue to ensure a visible focus and drive on retention activities including but not limited to; internal progression, utilising transfer window, career conversations, development, flexible retirement and flexible working
11	Clear data set to understand current workforce profile to inform business planning
12	To have a clear and common understanding of fragile services and an underpinning data set to enable the prioritisation of interventions.

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National Long Term Workforce Plan Summary

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National context

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- **Healthcare need has been growing significantly** - driven by an ageing population and increasing morbidity, outstripping the growth in workforce.
- To fill service gaps and ensure safe staffing levels, the NHS is firmly **reliant on temporary staffing and international recruitment**. This leaves the NHS exposed to high marginal labour costs and risks the sustainability of services in the longer term given the growing global demand for skilled healthcare staff.
- In March across the NHS there were over **112,000** vacancies : **8.0% vacancy rate.** Levels of staffing in the NHS are proportionally lower than other comparable health systems internationally for the average numbers of nurses and medics per size of population
- Over the **next 15 years**, the **population of England is projected to increase by 4.2%,** but the number of people **aged over 85 will grow by 55%.**
- Without immediate action, we expect the **workforce shortfall will grow to between 260,000–360,000 FTEs by 2036/37**. The Long Term Workforce Plan therefore sets out a series of actions, reforms and proposals to demonstrate how the expected shortfall could be closed.
- The government is backing the plan with over £2.4 billion over the next five years to fund additional education and training places. This is on top of existing increases to education and training investment, reaching a record **£6.1 billion over the next two years**

Train: Growing the Workforce

Torbay and South Devon NHS Foundation Trust

- Compared to 2022, domestic education and training will need to **increase between 50% and 65% by 2030/31.**
- Over the next **five years**, we will train over 450,000 healthcare professionals (**27% expansion**). This means that by **2028:**
  - **Undergraduate Medical School training places** will grow by **33%** to 10k a year, with more medical school places in areas with the greatest shortages to level up training.
  - The number of **GP training places** will grow by **25%** to 5k a year
  - **Nurse training places** will grow by **34%** to 40k a year
  - **AHP training places** will grow by **13%** to 17k a year
  - **Healthcare scientists training places** will grow by **13%** to 850 places
  - **Pharmacy training places** will grow by **29%** to 4,300 a year
  - Training places for **new roles** such as nursing associates, advanced care practitioners, anaesthesia associates, peer support workers and others will grow by **more than 30%** to nearly 16k a year
  - Grown the number of **support to clinical workers** by more than **110,000**
- By 2028, the **number of apprentices will represent 16%** of all people in clinical training across the NHS, compared to 7% now. This will grow to 22% by 2031 and is vital to attracting more staff, including those from diverse backgrounds.

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Retain existing talent: Embed the right culture and improve retention

Torbay and South Devon NHS Foundation Trust

- Need to continue to take action to make the **NHS People Promise** a reality for everyone. This includes ensuring staff can work **flexibly**, have access to **health & wellbeing support** , and work in a **team** that is **well led**.
- Back plans to improve **flexible opportunities for prospective retirees** and work with government to deliver the actions needed to **modernise the NHS pension scheme**.
- From autumn, recently retired consultant doctors will have a new option to offer their availability to trusts across England, to support delivery of outpatient care, through the **NHS Emeritus Doctor Scheme**
- Commit to ongoing national funding for **continuing professional development** for nurses, midwives and allied health professionals, so NHS staff are supported to meet their full potential.
- Work to deliver the actions set out in the **NHS equality, diversity and inclusion plan**.
- The wider intention is to promote **greater flexibility of careers** (including across organisations), **improve recruitment processes**, and reduce reliance on agency staff through **better retention** and making bank a more attractive route to fill gaps
- If implemented, it would mean **leaver rates improve around 15%** over the course of the Plan and that the health service has an extra 60,000 doctors, 170,000 more nurses and 71,000 more allied health professionals in place by 2036/37.

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Reform: working and training differently

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- **Move care further upstream, delivering care closer to home and supporting people to keep well for longer**. This means growing the number and proportion of NHS staff working in primary, community and mental health services to deliver more preventative and pro-active care across he NHS.
- **Ambitious productivity target of 1.5%-2% per year**… compared to historic average of about 1% per year. Recovering productivity is categorically not about staff working harder. Productivity improvement needs to come from a combination of delivery of the same care in lower cost settings, capitalising on technological advancement, such as AI and robotic process automation, and delivering large-scale skills mix opportunities as well as upskilling and retaining our staff.
- **Focus on expanding enhanced, advanced and associate roles to offer modernised careers, with a stronger emphasis on the generalist skill**s needed to care for patients with multi-morbidities, frailty or mental health needs.
- Explore measures such as tie ins to encourage dentists to spend a proportion of their time delivering NHS care.
- Work with the NMC, GMC and others to reform education and training for doctors and nurses so that **learners have a good experience of training** that prepares them for work in the NHS.
- Work with medical schools and the GMC to **introduce four-year degree** programmes and pilot a medical internship programme which could shorten undergraduate training time.
- Take advantage of EU Exit freedoms to **explore reducing nurse clinical placement hours** and support education institutions to allow trainees to join the nursing register up to four months earlier

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Devon Context

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Devon context

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- Ambition to deliver a **sustainable financial balance** at the earliest opportunity, recognising that this will take a minimum of 2 years to achieve.
- **Vacancy rates** of c.10% in social care and c. 5% in health (March 2023)
- **Demand for health and care services** will continue to grow at an **expected 2.9% per annum** for the next decade.
- If workforce growth matched demand, over the next 5 years an **estimated 4290 WTE additional staff** would be required in Devon's health services alone. Not only can we not afford this, but it is unlikely we could recruit and retain the workforce to fill this expansion.
- Devon's **population is expected to grow 9.6% by 2037**. Currently 24% of Devon's population are over 65years, this increases to 35% by 2037
- Across Devon there are c14,000 people unemployed (Jan 2023), equating to an **unemployment rate of 1.8%** compared to the national unemployment level of 3.8%. The proportion of our population being of working age will reduce, making it harder to recruit.
- Currently we have workforce models that we can't resource properly and also can't afford. In short we must use our current and future workforce in different ways.

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Devon Workforce Strategy

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2035 Vision for Health and Social Care

- ***Prevention orientated*** - successful shift towards prevention in terms of the **resources allocated** across the system, **redoubled focus on promoting public health** - individual and collective wellbeing now forming an integral part of school curricula and helping create a greater sense of personal responsibility, **significant increase in social prescribing** as well as approaches such as **peer health coachi**ng intended to promote health education and awareness in the community
- ***Digitally sophisticated-*** successful transition to using one **fully integrated and interoperable IT system** helping increase the day-to-day usability and convenience of Devon's digital system for the workforce, and fostering stronger links between previously digitally-disparate organisations; **mandating of digital literacy training** for staff, **increased prevalence of digital tools** such as Hololens, virtual wards and the NHS app as ways of improving the patient experience
- ***Collaborative, system-orientated approach* to strategic decision making**, including workforce planning; **Wider system representation** at system level including universities; Move towards **longer term funding cycles** nationally enabling long term thinking, ICS uses **influence in relation to local priorities** such as housing, education & the economy, Sense of '**serving Devon, rather than an organisation**' – barriers between different providers gradually diminishing, **Genuine integration between Health and Social Care**.
- ***Reconsideration of roles and responsibilities*** – tasks allocated in a more **efficient** way, greater numbers of staff enjoying opportunities for **portfolio working**, **career pathways and progressions** encompassing the full breadth of the system, greater focus on the development of **generalist skills** across the workforce, **earlier engagement with educational institutions** to build key skills and competencies amongst the local population

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Devon Workforce Strategy

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Plans to deliver the strategy will include;

- **Increased opportunity to establish new and extended roles** e.g. learning and creating together advanced practitioner roles and physician associate roles to ensure that workforce skills are fully used as multi-disciplinary teams
- **Establishing our home-grown talent pipeline to reduce reliance on overseas resourcing** and development programs to enable our unregistered workforce have the right knowledge and skills to work at the top (and breadth) of their scope of practice
- **Development of our apprenticeship offer** both for undergraduate and post graduate optimising career development opportunities across our registered and unregistered workforce.
- **Improvement in the retention of our existing workforce** to retain expertise, knowledge and skills in Devon and reduce cost associated with attrition, by providing: Robust preceptorship offer, Clear career progression opportunities, Roll out of strategic job planning for all population facing roles
- **Transforming how we deploy our workforce within new sustainable models of care that:** Optimise the use of our support worker workforce, Builds community capacity – investing in rehabilitation, preventative interventions and strengths-based approaches, Enabling all of our workforce to work at the top of their scope of practice, Focus on skills over roles needed to meet people's needs
- **The voluntary sector playing an even bigger role**
- **A workforce supported by digital-** Digital technologies will transform the way our staff work and interact with patients.

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Report to the Trust Board of Directors			
Report title: Remodelling of Day Surgery Business Case			Meeting date: 29th November 2023
Report sponsor:	Chief Finance Officer		
Report author:	Director of Capital Developments		
Report provenance:	CIDG and FPC		
Description/Purpose of the report and key issues for consideration/decision:	The purpose of this business case is to formally finalise the financial allocation to progress with the delivery of the remodelling works for day surgery unit known as "Phase Two" works. This second phase is essential to deliver the full benefits committed to in securing the funding for Phase One known as TIF Theatres. Phase Two is the remodelling of the Day Surgery Unit to increase and improve recovery capacity to ensure we get maximum benefit and throughput of our two new TIF theatres. In the approval of Phase One it was acknowledged Phase Two investment will be required from Trust capital in 23/24, to realise the benefits as defined within (Phase One) the TIF Business Case.		
Action required:	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation:	To approve the business case as outlined for the Phase Two day surgery remodelling works with a provision of 23/24 Trust capital of £1.176M fully inclusive of fees and VAT.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	Delivering additional recovery capacity will ensure we get maximum benefit and throughput of our two new TIF theatres. This will help us address backlog waits for surgery and will support our communities to live well.		
How does the report support the Triple Aim:	1) Population health and wellbeing Our remodelled recovery spaces will deliver more capacity and better compliance to CQC and to modern standards including regarding privacy and dignity. The project also supports reduction of corporate risk we are holding. Environments will be improved for staff enabling them to provide better care alongside safe and compliant services including infection prevention and control. By having additional capacity, waiting times will continued to be reduced with more of our population living well. 2) Quality of services provided It is essential that we deliver care that is effective, safe and provides a positive experience to our patients. This project supports a series of targeted improvements, including directly addressing feedback from		

	CQC, NHSE/regional and GIRFT for example. We also understand that well cared for staff are better placed to deliver high quality care. The project also includes improvements to address wellbeing our staff. 3) Sustainable and efficient use of resources The project takes into account financial, environmental and social sustainability. Maximising the throughput of our theatres will maximise efficiency of staff, physical and financial resources.
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 4 - Estates Objective 5 - Operations and Performance Standards Objective 6 - Digital and Cyber Resilience Objective 7 - Building a Brighter Future Objective 8 - Transformation and Partnerships Objective 9 - Integrated Care System Objective 10- Green Plan/Environmental, Social and Governance Objective 11 – Equality, Diversity and Inclusion
Risk: Estates Risk ID: 1083	Failure To Provide A Fit-For-Purpose Estate That Supports The Delivery Of Safe/Quality Care.
External standards affected by this report and associated risks	*Relevant Health Technical Memoranda and Health Building Notes*

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Remodelling of Day Surgery Business Case

Organisation:	**Torbay and South Devon NHS Foundation Trust**
SRO/ Department Lead:	**Aran Chandran- Chief Operating Officer**
Project Manager:	**Steven Williscroft – Head of Capital Delivery**
Other Departments Consulted:	**Day Surgical Unit** **Ophthalmology** **Estates and Facilities** **Finance**
Business case register reference:	

	Name / Forum	Signature	Date
Prepared by:	Caroline Cozens		
Reviewed by:	Theresa Hinde		
Reviewed by:	Derren Westacott		
Approved by:	Kevin Pirie		

	Business Partner Name:	Signature	Date
Finance Implication Sign-off:	Nichola Rees		
Clinical Support Services Sign-off: e.g. diagnostic/ imaging	Derren Westacott		
Workplace Implication Sign-off:	Jake O'Donovan		
Procurement Implication Sign-off:	Mark Slaney		
IT Implication Sign-off:	Gary Hotine		
HR Implication Sign-off:			

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1. INTRODUCTION

The purpose of this business case is to formally finalise the financial allocation to progress with the delivery of the remodelling works for day surgery unit known as “Phase Two” works. This second phase is essential to deliver the full benefits committed to in securing the funding for Phase One known as TIF Theatres.

Phase Two is the remodelling of the Day Surgery Unit to increase and improve recovery capacity and ensures we drive maximum benefit and throughput of our two new TIF Theatres.

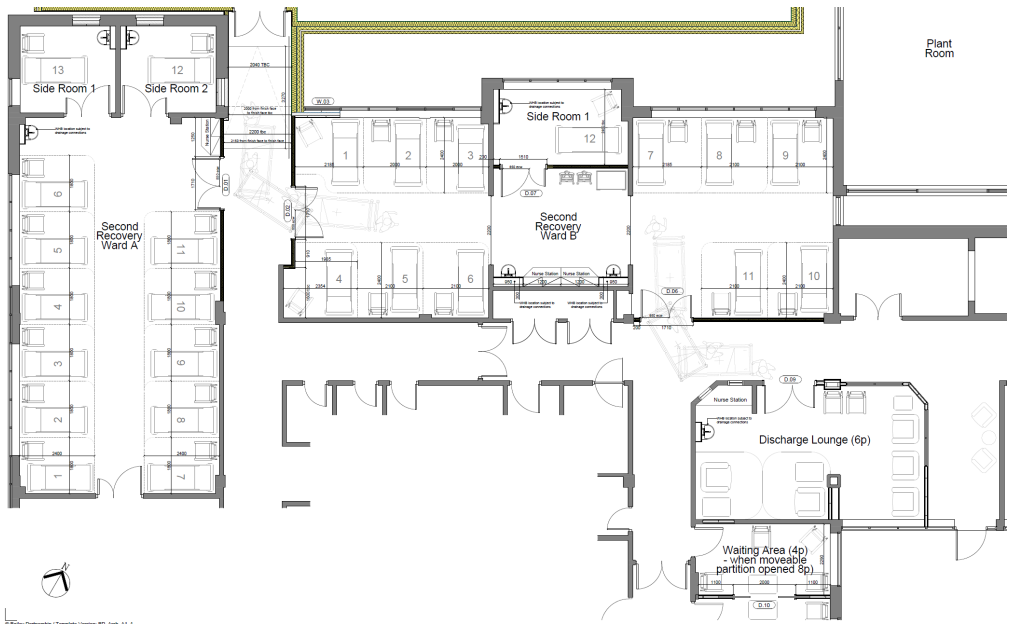
In the approval of Phase one it was acknowledged Phase two investment will be required from Trust capital in 23/24, to realise the benefits as defined within (Phase One) the TIF Business Case.

STRATEGIC FIT AND CASE FOR CHANGE

2.1 Describe the business needs to be addressed and the changes required?

The Trust is currently receiving support as it is facing some of the toughest challenges financially and in relation to patient waiting lists for planned surgery (Strategic Oversight Framework rating 4 or SOF4). It has significant waiting lists for surgery that are impacting on patients. The remodelling of the day surgery unit will recover and protect Elective Care capacity, to ensure the Phase one two new theatres with associated pre assessment and waiting spaces are maximised with the delivery of additional primary and secondary recovery. In doing so there will be significant improvements in productivity of the facility, across all specialties, enabling increased numbers of cases per list. The scheme provides a sustainable route to Torbay and South Devon rebuilding the national exemplar of our day surgical service with increased capacity.

Following the delivery of phase one, phase two will see the remodelling of the existing waiting area into additional secondary recovery spaces and the existing reception area developed into a dedicated discharge lounge.



2.2 Describe how does the measures proposed under the scheme specifically match the ICB's joint Strategic objectives and outcomes below:

The development will support the Devon system in being able to deliver the required reductions in waiting times for day case surgical activity, and in turn support our exit from SOF4.

Theatres – At the time of the capital bid submission the Trust has a total of 40K patients on its RTT PTL, this compares with the April 2020 position of 20K. Within this total our admitted waiting lists have grown from 5,094 to 6,388, an increase of 25%. The longest waiting for routine surgery being nearly 2 years. Conversions from our non-admitted position is expected to add significantly to the growth in our admitted long wait backlogs.

This proposal will clearly assist the Trust in being able to address its current waiting list through the provision of additional recovery capacity, which will enable the new theatres to be maximised.

With regard to long waits, these should be eradicated over the life cycle of the project. Essentially, the proposal would reduce longer waits to 0 when the new theatres are operating at full capacity (post the completion of phase two).

2.3 Describe how does the measures proposed under the scheme specifically match the Trust's Strategic Goals.

When considering phase one and phase two within the scope of this business case both will make a positive contribution to the strategic goals noted.

- **Excellent Population Health and Well Being –** following on from the pandemic waiting times across the NHS remain high, and from a Torbay perspective, the operational and clinical teams simply do not have the capacity within either service to deliver the rapid reduction in waiting times that are now required. The development will deliver new additional capacity (both spaces and staffing) to give the medium term capacity that is

required to ensure that the Trust is able to reduce its access times, and ensure that the local health and wellbeing of the local population is not compromised. In the longer term, the capacity required will be provided from the New Hospital Programme investment.

- **Excellent experience in giving and receiving care –**the new development will be delivered to HBN (Health Building Note) and HTM (Health Technical Memorandum) standards, thereby ensuring that the new facilities are delivered to the highest possible standard. In addition, the new development for Endoscopy will be delivered to JAG (Joint Advisory Group) standards . The accreditation promotes quality improvement through highlighting areas of best practice and areas for change, encouraging the continued development of the clinical service. Accreditation is a voluntary process for services to engage in.

2.4 Describe how the scheme will match NHSE/I and Commissioner's expectations, and whether there are any links to other programmes or projects?

Phase two remodelling will be funded from the trust 23/24 capital and will focus on the delivery of additional capacity and the reduction of waiting times. Therefore, in relation to the requirement to deliver the System Oversight Framework (SOF) 4 exit criteria, the development will ensure that the required capacity is in place to reduce waiting times and therefore assist with the Elective Recovery component of the SOF recovery plan.

Without the remodelling the benefits defined within the phase one TIF Theatres business case cannot be realised.

2.5 Describe advice and guidance from external bodies on the "best way" to deliver the service or statutory requirement for the service.

The remodelling of the additional capacity will be constrained by the existing footprint, therefore in the development of the remodelling the Capital Development team have worked closely with the clinical team and technical advisors to ensure the space can be used efficiently, however with a balance on delivery to minimise operational disruption throughout the execution.

3. OPTIONS APPRAISAL

3.1 MAIN OPTIONS SUMMARY

The following section illustrates the options that were considered in relation to the development of additional Theatre capacity:

Theatres

- Do nothing option. No increase in capacity, new additional theatre capacity not realised.
- Do minimum – Limited remodelling of day surgery to ensure benefits of the new theatres are realised.
- Do Maximum – complete refurbishment of day surgery with additional footprint.

Critical success factors – there were a range of critical success factors that were used in the assessment of the options noted above. These are noted below:

Strategic

- Continuity of Services – how would the option impact on existing clinical activity during the construction phase of the project.

- Improves Day Surgery capacity – the level of additional capacity that would be provided for the Day Surgery Unit.
- Improves Ophthalmology capacity - the level of additional capacity that would be provided for the Ophthalmology service
- Affordability – the overall affordability of the project from a capital and a revenue perspective.
- Programme – the length of time that it would take to deliver the project
- Consistency with the Building a Brighter Future vision for planned care – the extent to which the project would be consistent with the longer term vision of the BBF programme

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3.2 HOW EACH OPTION MEETS THE OBJECTIVES AND CRITICAL SUCCESS FACTORS

The new theatres will deliver against all the benefits criteria noted in the table below (see figure 1)

Figure 1 - benefits delivered from new theatres

Success factors	**Phase One-** Additional Theatres (TIF)	**Phase Two-** Reorganisation and remodelling of recovery capacity	**Phase Three** Refurbishment of 2 existing theatres with capacity mitigation
Affordability	Funded from Targeted Investment Fund	Funded from Trust Capital	Yes – from Trust Business as Usual Capital, with ICB Capital and Revenue
Delivery of additional capacity	Yes	Yes	No (but capacity mitigated)
Impact on clinical activity during project	Limited – 1/2 weeks Build delays require mitigation to meet bid commitment	Partial impact on capacity for eight weeks	Significant impact on capacity, mitigation for this supported by ICB and outlined later in the document.
See mitigation of capacity loss section 6 to deliver commitment in TIF bid			
Delivery of fully compliant facility (HBN/HTM standards)	Yes	Constraints of existing footprint	No (theatre size)
Delivery of improved clinical flow	Yes	Yes	No
Consistent with the BBF vision for planned care	Yes, as the new facility would be used for other clinical purposes within the BBF programme	Yes	Yes

3.3 BENEFIT, RISK AND MITIGATIONS COMPARISON AND CONCLUSION

The Trust is committed to realising significant benefit from the TIF new theatre capacity. The benefits anticipated from this remodelling are:

(i) Activity growth – the project would be able to deliver an additional 4,500 cases. This growth will be achieved when all the additional capacity has been delivered.

(ii) A significant reduction in waiting lists and the elimination of long waiters and the associated impact on patient well-being.

(iii) Better facilities for staff and patients.

(iv) Improved compliance to standards.

(v) Potential for ring-fenced elective and day case theatre capacity to ensure the delivery of uninterrupted elective activity throughout the year at a significantly improved rate.

3.4 DELIVERABILITY COMPARISON AND CONCLUSION

The tables below (see figures 2-3) highlights how each option was evaluated. It illustrates the options that were considered for this project. A fully costed option appraisal (see Appendix B) was undertaken in January 2022 and looked at all the options for the two projects.

- Do nothing option. No increase in capacity, new additional theatre capacity not realised.
- Do minimum – Limited remodelling of day surgery to ensure benefits of the new theatres are realised.
- Do Maximum – complete refurbishment of day surgery with additional footprint.

Figure 2 - Option appraisal of Theatre scheme

Options	Continuity of services	Improves Ophthalmology capacity	Affordability	Programme	Alignment to NHP strategy
Do nothing option. No increase in capacity, new additional theatre capacity not realised.	✗	✗	✗	✗	✗
Do minimum – Limited remodelling of day surgery to ensure benefits of the new theatres are realised.	✓	✓	✓	✓	✓
Do Maximum – complete refurbishment of day surgery with additional footprint	✗	✗	✗	✗	✗

Having assessed all of the options against the noted success criteria, the following options were chosen as the preferred option:

- New Build of two additional theatres (Phase One), supported by Phase Two- remodelling and reorganisation of recovery capacity and Phase Three – refurbishment of the two existing theatres and the mitigation of capacity.

3.5 COST AND BENEFIT ANALYSIS AND CONCLUSION

To complete the remodelling of the day surgery unit framework costs have be obtained from the preferred contractor currently implementing the grounds works remodelling for TIF Theatres. The Trust 23/24 capital requirement to implement the remodelling of Theatres is based on a cost plan of £1.176 M and is fully inclusive of fees and VAT.

The cost and benefits from phase one remain unchanged and are restated within this business case for completeness.

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3.6 EQUALITY AND ENVIRONMENTAL IMPACT

3.6.1 **Does it support the elimination of unlawful discrimination or other conduct prohibited by the Equality Act 2010?**

The development will ensure that Equality Act 2010 requirements are addressed. The theatre development will be compliant with all mixed sex legislative requirements.

3.6.2 **Does it address health inequalities?**

- Theatres – the Trust does have high waiting lists in a number of speciality areas which has been caused by the high level of emergency pressures both during and since the pandemic. The new theatre development will provide the additional capacity required to deliver significant reductions in surgical access times and, as such, reduce the health inequality that has been caused by these higher than average access times (when delivered alongside the phase two project).
- It also reduces harm to patients on waiting lists who are impacted physically and mentally by long waits for surgery.

3.6.3 **Does it encourage equality and create opportunities for people from different diverse groups and meeting their diverse needs?**

As mentioned in 3.6.1, the new facilities will be able to deliver improvements relative to the requirement of the Equality Act.

3.6.4 **Does it address an area with known inequalities (deprivation/unemployed/homeless/people with protected characteristics)?**

As mentioned in 3.6.1, the new facilities will be able to deliver improvements relative to the requirement of the Equality Act.

3.6.5 **Will it result in a positive environmental impact (reduce carbon emissions / reduce wastage /reduce harmful materials)?**

The remodelling of the day surgery unit will provide an increase to recovery capacity through the reuse of an existing facility minimising carbon emissions, wastage and harmful materials. Therefore, provides a carbon efficient solution until the new elective care facility is provided through the NHP.

3.7 PREFERRED OPTION

Based on all the options that have been assessed as part of this business case, the recommendation is that the “do minimum” is progressed alongside the phase one TIF business case in 2023/24.

From a capital perspective, funding for phase one has been secured from the Target Investment Fund and for the realisation of phase 2 the Trust will allocate capital funds in 2023/24.

This preferred option is aligned with the wider NHP programme and supports the building of a new elective care unit in the future.

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4 IMPLICATIONS OF PREFERRED OPTION

4.1 SERVICE IMPLICATIONS

4.1.1 **How does the preferred option specifically address our clinical and operational priorities?**

Phase two remodelling of day surgery ensures the benefits of phase one can be realised.

- ***Address long waiting list linked to high impact on and irreversible harm to patient*** – as highlighted *Figure 1 (Projected waiting times to 31st March 2025)* this development will assist in the reduction of the waiting times from c 29,300 patients in March 2023 to c.25,300 in March 2025. This 'stepped' change in waiting list improvement will be significantly impacted by the introduction of the remodelling of day surgery together with the new theatres which will primarily deliver low complexity / high volume activity.
- ***Address national pathway priorities*** – It is important to note that the requirement for improvement in elective recovery not only applies to routine activity (Referral to Treatment Time 18 weeks), but also the 62 day standard (GP Referral to first definitive treatment for suspected cancer) for access to cancer treatment. The overall improvement in elective waiting times is seen as a key national priority, and these new theatres will greatly assist the Trust in being able to firstly, reduce waiting time and secondly, maintain them in a compliant position when this is achieved.
- ***Support the Trust achieving elective recovery target or over and above*** - the Trust is currently in SOF4, and one of the key determinants of the being able to move away from this position will be the delivery of elective recovery. Whilst the plan will be to move away from SOF4 in advance of the new theatres being introduced, the Trust will be keen to ensure that the elective recovery continues and there is no doubt that the new additional capacity will assist in this regard.
- **Address the following leading cause of death in the SW region: Neoplasms; Dementia and Alzheimer, IHD or Cerebrovascular** – whilst remodelling of day surgery together with the new theatres are for the management of planned care, they will have a positive impact on the management of neoplasm cases. The day case surgical unit at Torbay is as an exemplar model of delivery as it is able to treat more complex patients on a day case basis when compared to other units across the UK. On that basis, the unit will be able to manage patients with suspected cancer on a day case basis. The new theatres will therefore have a positive impact in this regard.

  Another important issue to note is that the remodelling of day surgery together with the new theatres is this will also significantly increase the surgical capacity of the ophthalmology service. This will in turn reduce the risk associated with patients having to wait a long time for their elective ophthalmic surgery. This is particularly relevant to patients having to wait for cataract surgery whose condition will continue to deteriorate whilst they are waiting for surgical intervention.
- **Address any areas of health inequalities highlighted under Appendix 1 and related medical conditions –** the remodelling of day surgery will not be able to assist with the management of medical conditions.

4.1.2 **Productivity Implications –** as stated within the TIF Business case the operational teams have agreed that the additional capacity that can be delivered from the remodelling of day surgery together with the new theatres will be 4500 additional cases per annum. This will be achieved in the following manner:

Ophthalmology – 3000 additional cases per annum. The ophthalmology team have confirmed that they will be able to manage an additional 2 cases per list over and above they existing throughput in the adjacent eye theatre. In overall terms, this will equate to an average of 6.25 cases per list over a 48 week year operating 10 sessions per week. This average includes the slight reduction that will apply to teaching lists and is consistent with the guidance from the Royal College of Ophthalmologists in relation to the size of theatre lists.

Day Case Surgical – 1500 additional cases per annum. The draft theatre schedule below shows how the new day case surgical theatre will be managed in terms of new sessional capacity. Theatre 4 is the new theatre and will be used to accommodate the day case surgical requirements for Breast and Orthopaedics.

Figure 5 - new theatre session plan from December 2023

DSU 1	ENT	Urol	ENT	ENT	Urol	Urol	Urol	Urol	ENT	ENT
	ENT	Urol	ENT	ENT	Urol	Urol	Urol	Urol	Urol	Urol
	ENT	Urol	ENT	ENT	Urol	Urol	Urol	Urol	ENT	ENT
	ENT	Urol	ENT	ENT	Urol	Urol	Urol	Urol	Urol	Urol
DSU 2	Gynae	Gynae	Maxfax	Maxfax	Gynae	Gynae	Maxfax	Maxfax	Gynae	Gynae
	Gynae	Gynae	Maxfax	Maxfax	Gynae	Gynae	Maxfax	Maxfax	Gynae	Gynae
	Gynae	Gynae	Maxfax	Maxfax	Gynae	Gynae	Maxfax	Maxfax	Gynae	Gynae
	Gynae	Gynae	Maxfax	Maxfax	Gynae	Gynae	Maxfax	Maxfax	Gynae	Gynae
DSU 3	Colo/GI	Colo/GI	Colo/GI	Hotlist/2nd emerg	Colo/GI	Colo/GI	Colo/GI	Colo/GI	Colo/GI	Hotlist/2nd emerg
	Colo/GI	Colo/GI	Colo/GI	Hotlist/2nd emerg	Colo/GI	Colo/GI	Colo/GI	Colo/GI	Colo/GI	Hotlist/2nd emerg
	Colo/GI	Colo/GI	Colo/GI	Hotlist/2nd emerg	Colo/GI	Colo/GI	Colo/GI	Colo/GI	Colo/GI	Hotlist/2nd emerg
	Colo/GI	Colo/GI	Colo/GI	Hotlist/2nd emerg	Colo/GI	Colo/GI	Colo/GI	Colo/GI	Colo/GI	Hotlist/2nd emerg
DSU 4 54049	Breast	Breast	Ortho	Ortho	Ortho	Ortho	Ortho	Ortho	Ortho	Ortho
	Breast	Breast	Ortho	Ortho	Ortho	Ortho	Ortho	Ortho	Breast	Breast
	Breast	Breast	Ortho	Ortho	Ortho	Ortho	Ortho	Ortho	Ortho	Ortho
	Breast	Breast	Ortho	Ortho	Ortho	Ortho	Ortho	Ortho	Breast	Breast

4.1.3 Workforce implications of the preferred option

There are no additional workforce implications from the remodelling of day surgery works. The workforce impact was captured within the TIF Business Case (Phase One) and approved.

4.2 FINANCIAL IMPLICATIONS

4.2.1 Detailed life cycle Financial Implications and phasing of the preferred option

There is no change to the financial implications presented within the TIF Business Case (Phase One), which have been approved.

To implement phase two of the scheme there is a Trust 23/24 capital requirement of £1.176M fully inclusive of fees and VAT.

4.2.2 Describe and demonstrate affordability

Capital – to complete the remodelling of day surgery there is a Trust 23/24 capital requirement of £1.176 M fully inclusive of fees and VAT.

Revenue – There is no additional revenue implications from the remodelling of day surgery works. The workforce impact was captured within the TIF Business Case (Phase One) and approved.

4.2.3 Describe and justify the parameters used in the sensitivity analysis. Identify the impacts of realistic alternative assumptions, the probability of them occurring and mitigating actions to address.

The revenue models are captured within the TIF business case and were developed through robust discussions with the operational and clinical teams. Each area of cost has been examined by the speciality leads and alternative models of provision have been examined in all cases to ensure that the costs have been minimised.

4.2.4 Describe the sources and assumptions for the evidence supporting the recommended option, and why approvers should have confidence in the information provided.

This business case has been developed with the full involvement of the operational and clinical teams. From the perspective of the capital solutions for the two departments, the clinical teams have 'signed off' the designs for the new facilities, and the technical advisors have ensured the new department are fully compliant with all technical and health and safety requirements.

In terms of the revenue models, these again have been developed with the full engagement and support from the clinical and operational teams within Day Case Surgical Unit and Ophthalmology. In terms of the supporting services, the additional costs have been determined by all supporting services noted in the revenue models and approved via the TIF Business Case.

4.3 PROCUREMENT CONSIDERATIONS

To ensure value for money and to realise procurement savings the appointment of the preferred contractor will be a continuous appointment from the phase one works and will be procured via a framework agreement.

The services of the preferred contractor will be measured by independent experts.

5 MANAGEMENT AND DELIVERABILITY

5.1 Governance roles and responsibilities

The governance for the phase two works will be a continuation of the phase one works where the Senior Responsible Officer (SRO), Jon Scott, is the SRO for this project. The Executive Team of the Trust has significant experience across all portfolios in the leadership of services, nursing, clinical and operational teams and will be receiving regular progress reports.

The Trust's capital team will be managing the planning and implementation stages and are able to draw upon a deep level of experience from the Trust's complex New Hospitals Programme to ensure the project is delivered to schedule and budget.

It is important to note that the remodelling is technically a challenging project to deliver, given its proximity to existing theatre accommodation and also the amount of public access that will be necessary to maintain during the construction phase of the project. On that basis, it is important to note that the project will be subject to robust project governance arrangements with the following issues having already been agreed:

- Project Board – (as noted above) This project board will report into the Capital Investment Delivery Group, Co-Chaired by the Finance Director Tian-Ze- Hao and the Director of Capital Developments Caroline Cozens. This reports onto Finance, Performance and Digital Committee chaired by Richard Crompton a Non Executive Director. The Project Board will meet monthly.
- Project Group – this meeting will be managed by the Head of Capital Delivery, Steven Williscroft who will liaise with the contractor on a daily basis to ensure that the project is managed through to a successful conclusion. This group will meet regularly (weekly) and will report into the Project Board noted above.

5.2 Detailed feasibility study (where appropriate)

In advance of the capital bid submission, an internal feasibility study was undertaken with the support of Cliff Barnes, Peninsula Projects. It looked a range of options associated with the deliverability of the programme and guided the capital team in the development of the capital submission

5.3 Detailed resourcing and management requirement for delivery to planned budget and the delivery time scale

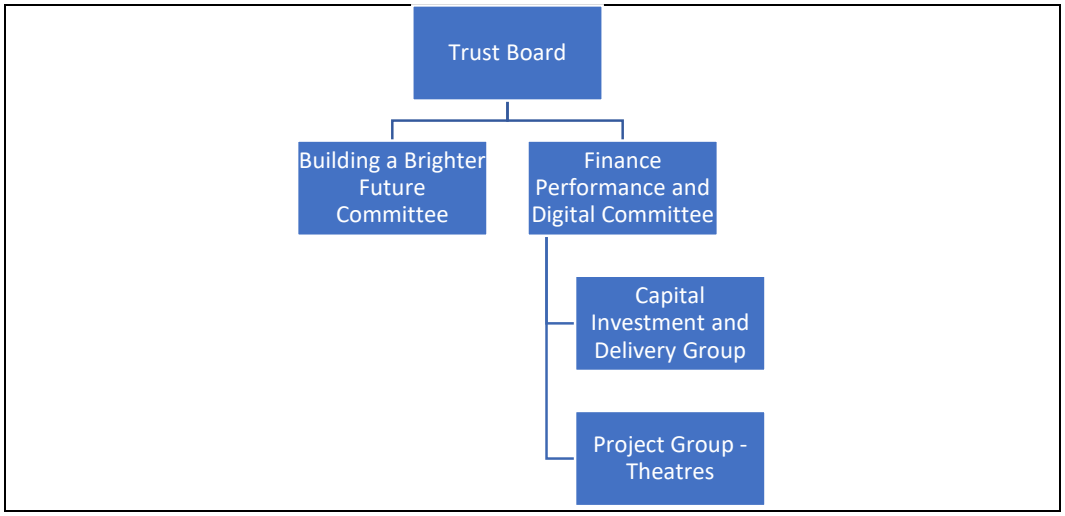
The project will be supported by the 'one capital team' under the supervision of the Director of Capital Development supported by the Head of Capital Delivery. Both of these individuals bring extensive experience to in the delivery of capital projects. In addition, to in-house Mechanical and Engineering support the Trust has the benefit of the following technical advice and support

- Architects - KTA –(Principal Architect- Ms Laura Freer)
- Principal designer – Alder King (Mr James Jacobs)
- Mechanical and Engineering support - Hulley and Kirkwood – (Mr Dean Marley)
- Planning advice – Lex Moran, Torbay Borough Council
- Cost advisor – Peninsula Projects (Mr Cliff Barnes)

5.4 Project plan, delivery timeline, project assurance and project dependencies.

- **Remodelling of day surgery -** this programme will commence in parallel to the delivery of theatres. However, will continue following the opening of the new theatres as vacant space becomes available following the completion of phase one.
- **Project Assurance –** as previously mentioned the project will be managed through the one capital team who will in turn report on progress to the Project Group and Capital Investment Delivery Group (CIDG). Any variance to the programme timetable and/or budget costs will be addressed through this governance model. Thereafter, the Finance Performance and Digital Committee and Building a Brighter Future (BBF) Committee and Trust Board will be kept informed of progress being made. The governance model noted is shown in Figure 3 below.

Figure 3 - Project Governance structure



- **Project dependency** - the main key dependency is the delivery programme for the phase one works and the transition to the new facility by Day Surgery and Ophthalmology. .

5.5 Any assistance required from other parts of government or the private sector

No additional support will be required from the government or private sector, with the exception of the technical advisory team and the main contractor for the development that will have been selected through a rigorous procurement process.

5.6 Main risks to delivery See section 3.3

6 SUMMARY RECOMMENDATIONS & CONCLUSIONS

This business case has been prepared to provide confirmation of capital associated with the remodelling of day surgery to ensure the capacity benefits of the new TIF theatres being delivered through phase 1 are realised. Therefore, FPDC and The Trust Board are asked to approve the following:

To approve the business case as outlined for the Phase Two day surgery remodelling works with a provision of 23/24 Trust capital of £1.176M fully inclusive of fees and VAT.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Board Assurance Framework and Corporate Risk Register			Meeting date: 29 November 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.		
Description/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 November 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 Objective 7.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Board is asked to: (i) Note the Board Assurance Framework; and (ii) Note the Corporate Risk Register.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	The report supports the Board in identifying those risks that could affect the Trust's aim of supporting the people of Torbay and South Devon to live well, and to take account to ensure those risks are mitigated against and managed.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources The report enables the Board to ensure any risks that affect delivery of the Triple Aim are identified and mitigated against.		

Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 4 - Estates Objective 5 - Operations and Performance Standards Objective 6 - Digital and Cyber Resilience Objective 7 - Building a Brighter Future Objective 8 - Transformation and Partnerships Objective 9 - Integrated Care System Objective 10- Green Plan/Environmental, Social and Governance Objective 11 – Equality, Diversity and Inclusion
Risk: Risk ID: *As appropriate*	N/A
External standards affected by this report and associated risks	Care Quality Commission NHS England licence and regulations National policy, guidance

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NHS Foundation Trust

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	
2.	People	CPO	20	16	
3	Financial Sustainability	CFO	25	15	
4	Estates	CFO	25	10	
5	Operations and Performance Standards	COO	16	12	
6	Digital and Cyber Resilience	DTP	25	25	
7	Building Brighter Future (BBF)	DTP	15	15	Changes made to action log section. Highlighting that the Site Enabling OBC has now been presented to the NHP national team.
8	Transformation and Partnerships	DTP	16	9	
9	Integrated Care System	DTP	16	8	
10	Green Plan/Environmental, Social and Governance	CFO	12	6	
11	Equality, Diversity and Inclusion	CPO	16	12	

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, 11)	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:**	October 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Mar 23	**Jul 23**	**Sept 23**	**Nov 23**	**April 24**	**Nov 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 morale – 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	4	
Risk Score	16	16	16	16	12	16	

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.	1.1 B	Setting out medium to long term plan for reconfiguration of services to meet risk/demand Recovery and Restoration plan with agreed targets as set out in Performance framework and operating plan for planned and emergency Care	1.1C	Inequities and inequalities in access resulting in increase in Mortality& Morbidity across Torbay and South Devon
					Performance and operational resilience remained constrained with ongoing impact of : a) Delays in diagnostics and access to treatment - analysis of harm in key high-risk service areas shows an increase in harm in Ophthalmology, Urology, Cancer Services

			Regular review Mortality and Morbidity through to Board incorporated into overall Harm review framework and through QA Governance framework		b) Failure to achieve recovery and restoration targets set out in the Recovery Plan c) Delayed ambulance handovers d) Adverse Mortality and Morbidity
1.2A	Clinical Leadership Capacity to lead change	1.2 B	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	1.3 B	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	1.4 B	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	1.5 B	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	1.6 B	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:**	October 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Mar 23	**Jul 23**	**Sept 23**	**Nov 23**	**Aug 24**	**Nov 22**	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, WDES, WRES, EDS, F2SU, and demands on the Employee Relations team, identifies that the Trust has room to build a culture where people feel safe, healthy and supported. The CQC letter following Well-led inspection highlighted the level of work to do regarding EDI. The link between this culture and patient safety is actively being investigated, with the full degree of risk to patient safety yet to be understood.
Likelihood	4	5	5	5	4	4	
Consequence	4	4	4	4	4	4	
Risk Score	16	20	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 including 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 started in post, working with BBF team and ICS to develop long-term workforce plan in line with the NHS long-term workforce plan.	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, impact on wellbeing and productivity 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 has commenced. 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

			expectations, standards & behaviours. Evaluate (through a 360 approach), recruit and develop leaders to improve effectiveness and consistency in leadership.		not 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 exacerbate workforce fatigue and wellbeing decline, and not aid recovery.
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, in addition to integrating CIP into budgets. 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	2. Skillset of managers to enforce policy or to investigate is in need of improvement		

	3. Capacity of Employee Relations 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.
2.10A	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	CPO	Sep 23 rollout	Leadership framework approved by Trust Board. All products – based on the framework- including a 360 and leadership & management induction programme under development. **Complete** - launched at the end of September 2023. A process of rolling out and embedding commences from now.
2.10A & 2.11 A&C	3. Key risk areas identified across the People Directorate including Employee Relations team capacity, EDI, Workforce analysis; 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 Directorate.	CPO	**Dec 23**	Interim Employee Relations Service manager in post until Jan 24 and uplift to resources now in place June 23. Additional resource uplift secured in key risk areas of ER Team, EDI. Medical Workforce and Workforce Data analysis.

Risk Summary					
BAF Reference:	**3. FINANCIAL SUSTAINABILITY**				
Objective:	To achieve financial sustainability and deliver the ICS five 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:**	October 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Mar 23	**Jul 23**	**Sept 23**	**Nov 23**	**April 24**	**Nov 22**	There is a risk that the Trust fails to deliver sufficient improvement to achieve the five-year system recovery plan (including productivity). This will result in regulatory intervention, further financial restriction, leading to issues with access to services, including waiting times, increased health inequalities, and an inability to improve and update equipment and infrastructure for the benefit of patients and staff. Some services may not be viable in the medium term.
Likelihood	5	5	5	5	4	5	
Consequence	5	5	5	5	4	5	
Risk Score	25	25	25	25	16	25	

Risk Scoring Analysis					
Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
3.1A	Inflation outstrips funding available resulting in a deterioration in financial performance	3.1B	Contract negotiation and non-pay controls	3.1C	Deterioration in financial performance and failure to deliver 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
3.8A	Financial impact of ongoing industrial action	3.8B	Robust operational planning to minimise financial impact where possible	3.8C	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.
3.5A	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:**
3.5A/3.7A	Efficiency plan for 2023/24	CFO	Ongoing	In delivery, significant gap with developing mitigations.
3.2A	Systems improvements (Prevero, Tableau, Genesis)	DOpFin	Oct 23	Underway with risk of slippage
3.2A	Ensure full reconciliation of workforce and financial data	DOpFin	Oct 23	Still work in progress – now depends on additional input within Workforce Information Team
3.2A/3.5A/3.7A	Develop MTFP model (5 year plan) in line with revised ICS principles and methodology (then informing BBF business cases)	DOpFin	Oct 23	First stage (baseline) model complete – Next steps to develop further the operational plan that supports the MTFP model – to include CIP identification workforce/activity/performance - and 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	Dec 23	Operational structure introduced and in the process of being 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:**	October 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Mar 23	**Jul 23**	**Sep 23**	**Nov 23**	**2030**	**Nov 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:**	October 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Mar 23	**Jul 23**	**Sept 23**	**Nov 23**	**April 24**	**Nov 22**	Consequence: Performance Risk - Failure to meet professional standards or statutory requirements. Likelihood: If the activity continues without controls in place, there is a strong possibility the event will occur as there is a history of frequent occurrences.
Likelihood	4	4	5	5	3	5	
Consequence	4	4	3	3	4	4	
Risk Score	16	16	15	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	
5.5.A	Development of new EPR and data system	DT&P	Jan 25	Funding streams in development
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:**	Building a Brighter Future Committee	**Last Updated:**	October 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Mar 23	**Jul 23**	**Sept 23**	**Nov 23**	**April 24**	**Nov 22**	Current IT systems and supporting infrastructure will not meet the current of future business need.
Likelihood	5	5	5	5	5	5	The current likelihood remains the same and is driven by two reasons; firstly the level of known vulnerability of the PAS / LIMS systems which will cease to be supported from 2024. Secondly, general cyber security vulnerabilities (such as Log4shell) are significant threats to IT systems globally. The recent cyber-attacks against the Ortivis provider used by SWAST has still not been fully resolved and restored and is the second within a calendar year (the other being against Advanced which affected CAHMS and CFHD).
Consequence	5	5	5	5	5	5	The current consequence is scored at 5 as the reliance on digital systems in the delivery of business processes and clinical services is high and the impact of a cyber-attack could be catastrophic (for example, extended loss of essential service in more than one critical area)
Risk 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. Exceptional ASW report relating to this 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) 2023/24 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, and being implemented through 2023 IM&T Prioritisation risk matrix in place to ensure that investment is made into the most critical infrastructure 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 and further enabled by a robust GIRFT process, facilitating standardisation in a shared EPR The Trust Board has undertaken the NHS Providers Digital Boards Programme and has a NED with a specialist expertise and experience 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 LIMS procurement underway with assurance regarding the required go-live timescales IM&T Prioritisation risk matrix in place to ensure that investment is made into the most critical 'end of life' IT system 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 underway 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 Learning from the Guys & St Thomas' critical IT failure and the 'Black Swan' element of risk they identified had been missing from their risk policy	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:**	November 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Mar 23	**Jul 23**	**Sept 23**	**Nov 23**	**May 23**	**Nov 22**	
Likelihood	3	3	3	3	3	3	The availability of a national funding for cohort 4
Consequence	5	5	5	5	5	5	
Risk Score	15	15	15	15	15	15	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
7.1A	Availability of central funding and political support to the original programme	7.1B	BBF programme office and capital development team are working through a range of different scenarios should capital funding not be made available at a national level.	7.1C	Should funding not be made available the Trust still requires significant capital investment on its estate infrastructure and as such, would then pursue one of the scenarios previously highlighted.
7.2A	Availability of the specialist support within the BBF programme team to deliver a project of this magnitude and complexity.	7.2B	The Programme office has a well-developed recruitment and retention strategy that highlights requirement for external specialist support in areas such as design, cost advise and legal services. The team will be able to draw on this expertise as required.	7.2C	The costs associated with the external support would be detailed in any 'seed' funding allocation and would be agreed with the national team in advance of the requirement for the specialist support
7.3A	Timeline for programme completion	7.3B	The programme office has developed a range of scenarios associated with the delivery of the programme and these have been shared with the BBF Committee	7.3.C	The inflationary pressures of the programme will continue to increase without the required clarity from the national team on timetable and funding allocation. These costs would be funded centrally.
7.4A	National team resourcing the 'seed' allocation not in line with our timetable	7.4B	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 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 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 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:**
7.1B	Action to address lack of assurance in relation to capital funding and national timetable delay	Director of Transformation & Partnership	Ongoing	Data gathering exercise with the NHP national team is now in its second stage and the latest return was provided to the national team on 5th October. This process will deliver a timetable and resource allocation for the Trust by 31st March 2024. It should also be noted that the next iteration of the national programme business case will be submitted to the Treasury in December.

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 has now been presented to Trust Board. This business case has now been presented to the NHP for their review. Approval scheduled for January 2024.
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	Master Planning – the outcome of the peer review master planning exercise will be presented to the BBF committee	Director of Transformation & Partnerships	October 2023	The initial drafts of the masterplanning work has now been presented to the BBF committee. A final report will be available in January which will set the direction for the future development of SOC and OBC

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:**	Building a Brighter Future Committee	**Last Updated:**	October 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Mar 23	**Jul 23**	**Sept 23**	**Nov 23**	**March 24**	**Nov 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	4	
Consequence	4	4	4	4	3	4	
Risk Score	16	16	16	16	9	16	

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:**	October 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Mar 23	**Jul 23**	**Sept 23**	**Nov 23**	**April 24**	**Nov 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	4	
Consequence	4	4	4	4	4	4	
Risk Score	16	16	16	16	8	16	

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:**	October 2023

BAF Risk Scoring							
Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Mar 23	**Jul 23**	**Sept 23**	**Nov 23**	**Sept 23**	**Nov 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	4	4	4	4	3	n/a	
Consequence	3	3	3	3	2	n/a	
Risk Score	12	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
10.4A	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

Risk Summary						
BAF Reference:	**11. EQUALITY, DIVERSITY AND INCLUSION**					
Objective:	To have an increased focus on equality, diversity and inclusion to address the increase in bullying and harassment across the organisation					
Internally Driven: ✓ Externally Driven:						
Responsible Executive:	Chief People Officer		**Committee:**	People Committee	**Last Updated:**	October 2023

BAF Risk Scoring

Current Position					**Target Position**	**Year on Year**	**Rationale for Risk Level**
	Mar 23	**Jul 23**	**Sept 23**	**Nov 23**	**Sept 25**	**Nov 22**	There is a risk we will not have fair and equitable behaviours, processes, policies and procedures. There will be a poor experience of staff with protected characteristics, which will lead to poor patient experience and outcomes. A failure to address inequalities across all protected characteristics- demonstrated by overrepresentation of minority ethnic groups and disabled groups in formal ER processes. We will not attract nor retain, nor develop a diverse leadership cadre.
Likelihood	n/a	n/a	4	4	3	n/a	
Consequence	n/a	n/a	4	4	4	n/a	
Risk Score	n/a	n/a	16	16	12	n/a	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
11.1A	Lack of inclusive leadership or management framework, development or key accountability expectations, results in direct and indirect discrimination.	11.1B	Our People Promise priorities and our Inclusion and culture plan are aligned with the High Impact areas of the NHS EDI improvement plan. A co-created leadership framework (Include, Listen, Act) and a management training programme have been designed. Now approved at Board , the roll out plan has commenced. Our compassionate leadership framework will be used to identify leadership expectations, standards & behaviours. Evaluate (through a 360 approach), recruit and develop leaders to improve effectiveness and consistency in inclusive leadership.	11.1C	We will experience high rates of ER cases and Employment Tribunals, high sickness levels and poor wellbeing, where a lack of psychological safety to raise concerns exists. The risk to the Trust reputation will be high, impacting on our ability to recruit and retain a diverse workforce.
11.2A	Unclear career pathways and talent management impacts on retention and wellbeing of workforce	11.2B	People Promise work will design clear career pathways and a trust wide talent management plan. Career conversations and career coaching are offered to everyone.	11.2C	Impact on recruitment and retention of a diverse workforce whereby managers' recruitment practices are not fair and equitable, nor are development and progression opportunities.
11.3A	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 long term conditions (Staff Survey Results 2022), suggests that the workplace culture in TSD is not	11.3B	Just and Learning Culture survey, aligned to Patient Safety, helped to identify where in the Trust there are particular issues in psychological safety. New Leadership framework, along with priority 3 (inclusive culture plan) has inclusivity at its heart. To	11.3C	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, wellbeing and patient care.

	inclusive. This was highlighted in the recent CQC letter following the Well led inspection.		focus on culture (including Just and Learning culture roll out- inc policies), inclusion, civility, safety to speak up and challenge inappropriate behaviour. A commitment to embedding and mainstreaming D&I through leadership, learning and development. Formal reports are completed, published with robust action plans, aligned to our inclusive culture plan/people promise priority including WRES, WDES, EDS-2, Gender pay gap review.		

Gaps in control/assurance

Internal		**External**	
Risk analysis reference:		**Risk analysis reference:**	
11.1A	EDI objectives and development is absent from Trust Board development	11.1A; 11.3A	No current system (ICS) EDI lead, so there is a lack of direction in terms of collaboration, and sharing of best practice across organisations.
11.3A	EDI element of induction for all staff is virtual, and is reported to have a less significant impact on behaviours and values.		
11.3A	The current mandatory training is not fit for purpose, nor aligned with our people promise and is not having the desired impact on some of the behaviours we are experiencing		
11.2A, 11.3A	Onboarding and induction for our internationally recruited staff		
11.3A	We have no identified, trusted individuals advocating for EDI across the organisation, within teams		
11.3A	Our networks are not complete- we have missing voices among marginalised groups, specifically our disabled colleagues and those with LTCs.		

Action Log: (actions identified to achieve target risk score)

No. Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
11.1A	EDI Trust Board development sessions to be identified.	CPO	March 24	EDI Trust Board development sessions have been identified and diarised aligned to the compassionate leadership framework development.
11.2A	The new induction that is in place to onboard our internationally recruited staff will include a more comprehensive EDI/cultural element – to create a more robust sense of belonging and empower them to speak up	CNO	Dec 23	EDI Lead now attends the induction to discuss culture/culture shock elements which is developing in line with feedback. EDI lead working with coordination of the induction to ensure a more robust follow up. Culture ambassador training has been offered to our nurse managers.
11.3A	To re-introduce face to face Trust induction, including a face to face EDI/Culture element.	CPO	Jan 24	
11.3A	To identify, train and roll out Inclusion Champions trust wide to advocates for EDI, Inclusion and belonging	CPO	March 24	

11.3A	Developing our staff networks and chairs to gain confidence in sharing their lived experience and inform decision making and improvements with a particular focus on our Disability network.	CPO	March 24	
11.3A	To create an enhanced mandatory EDI training module and a 12 month campaign to consolidate the training.	CPO	Jan 24	The inclusion module has been created. The creation of the enhanced module will begin in Nov 23.

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Torbay and South Devon NHS
NHS Foundation Trust

DATIX RISK MODULE REPORT

(Exceptions highlighted in Yellow.)

ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	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	Jake O'Donovan	Jake O'Donovan	Chief Finance Officer (Mark Brice)	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.	29/03/2024	Catastrophic	Almost Certain	25	[01/11/2023 11:35:35 Paul Hayman] No Change - review in March 2024 [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.	Catastrophic	Possible	15					
1159	18/09/2012	Corporate Level Risk	All Departments (Risk Only)	Gary Hotine	Adé Jones	Director of Transformation and Partnership (Adé 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. 2696 - WinPath V5 Incompatibility Risk. 2781 - Maternity Information System 2830 - Computer Hardware Risks (Replaces 1173 & 2280) 2831 - Computer Infrastructure Risks (Replaces 1164, 2275, 1166 & 1185) 2838 - Potential Failure to Meet Cyber Security and Information Governance Standards Set by NHS Digital. (Replaces 1158 & 1161) 2864 - Failure of the Trust Dell Storage Platform During Routine Patching Maintenance. 3309- Patient Admin System Becomes Unsupported 2161 - Viewpoint System End of Product Life 3460 - Compromise or Failure of Cloud Hosted IT Services or Systems	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).	01/03/2024	Catastrophic	Almost Certain	25	[05/10/2023 12:46:21 Joshua Langdon] Desktop, Server & Network environment all currently in warranty and support with no impending (12 month) risks of warranty. [14/06/2023 09:05:21 Gary Hotine] Updated Actions [09/05/2023 10:19:44 Gary Hotine] Risk scoring reviewed	Major	Possible	12	Support the activities described in the Trust's Digital Strategy regarding the priority action to procure an EPR	Gary Hotine 21/03/2024			[14/06/2023 09:04:44 Gary Hotine] OBC with national team for approval
2996	01/02/2021	Corporate Level Risk	Finance	Tian Ze Hao	Tian Ze Hao	Chief Finance Officer (Mark Brice)	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	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					

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Torbay and South Devon NHS
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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.
															12. the Delivery Director for improvement are now post (Jan 2023)														
3309	03/12/2021	Corporate Level Risk	IT Operations	Gary Hotine	Adel Jones	Director of Transformation and Partnership (Adel 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.	Adel Jones	01/02/2024			[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.
2416	23/04/2019	Corporate Level Risk	PMU Finance	Emma Rooth	Emma Rooth	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.	31/01/2024	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 Rooth	31/01/2024			[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 Rooth	31/01/2024			
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.	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 Emma Rooth	29/03/2024 31/01/2024			[16/07/2023 13:37:34 Joann Hall] Minutes and action log available in shared teams drive
1266	01/10/2015	Corporate Level Risk	All Departments (Risk Only)	Sandie Heyworth	Derren 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. DRM ID No 3574 - Waiting Times and Clinical Capacity in Speech and Language Therapy	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)	31/01/2024	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						
1697	07/11/2018	Corporate Level Risk	Human Resources	Daran Armitage	Daran 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 betweeen 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.	28/02/2024	Major	Almost Certain	20	[10/11/2023 10:17:00 Sarah Blacoe] Strategic Workforce Planner now in place and working collaboratively with Finance to purify the establishment, finance and ESR data so that there is one version of truth and a vacancy picture can be consistently produced and proactively utilised by resourcing. [09/11/2023 13:43:45 Sarah Blacoe] emailed manager for update [31/10/2023 14:14:07 Sarah Blacoe] emailed manager for an update.	Major	Possible	12						
2412	23/04/2019	Corporate Level Risk	PMU Finance	Emma Rooth	Emma Rooth	Chief Finance Officer (Mark Bliss)	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.	31/01/2024	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	19/01/2024	Major	Almost Certain	20	[10/11/2023 10:12:08 Sarah Blacoe] Funding approved to increase team by 2 x Band 7 and to recruit substantive 8a Lead of Employee Relations Team in reflection of a 55 week average turn around of cases (NHS average is 15 weeks) and an average of 38 cases per 1000 employees (NHS average 10.5). Interim 8a departs 12th January 2024 that will leave a temporary gap in team which maintains risk level. Recruit substantive 8A Employee Relations Lead and 2 x Band 7 to address triage, backlogs, processes, Just and Learning Culture roll out, management development and team development and leadership of team. [09/11/2023 13:37:26 Sarah Blacoe] emailed manager for an update [31/10/2023 14:14:47 Sarah Blacoe] emailed manager for an update	Major	Possible	12						
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	11/12/2023	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	04/12/2023			
																									System Operating Plan	Liz Davenport	04/12/2023			
																									Trust Governance Process - Recovery Board	Liz Davenport	04/12/2023			
																									Leadership Capacity and Capability	Michelle Westwood	04/12/2023			
																									Regain and Renew (SOF4 Exit plan)	Adel Jones	04/12/2023			
3547	09/04/2023	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	19/01/2024	Major	Almost Certain	20	[10/11/2023 09:50:40 Sarah Blacoe] EDI MUST DO from CQC received to focus on delivering EDI strategy and support to F2SU Guardian. Funding approved for 1 x 8a EDI Lead and a Band 7 in addition to Band 6. Recruitment in progress. New EDI training also in development, for release in January 2024 for all employees. Focused on walking in the shoes of employees with protected characteristics, it focuses on personal behaviours 'It Starts With Me'. [09/11/2023 13:36:48 Sarah Blacoe] emailed manager for update [31/10/2023 14:13:38 Sarah Blacoe] emailed manager for update	Major	Possible	12	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.	Sally Simpson	19/01/2024			[10/11/2023 09:55:37 Sarah Blacoe] Embedding an Inclusive Culture Plan was approved at Board in July 2023 and includes the creation of a Cultural Dashboard that will incorporate the results of the survey. [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.
																									Embedding an Inclusive Culture Plan was approved at Board in July 2023. Incorporates EDI, Just and Learning Culture and Health and Wellbeing, and marries with the Leadership Development (Include, Listen, Act) and Management training that commenced October 2023. Altogether the plans will lead to improving the inclusive nature of the organisational culture and contribute to building an environment at work where people feel safe, healthy and supported. Timelines and measures are being refined to enable communications plan. Recruitment in progress for the key leaders of the projects to fill gaps via long terms sickness at 8c and secondment at 8b.	Michelle Westwood	31/03/2024			
1815	05/09/2014	Corporate Level Risk	Cancer Wells 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	30/11/2023	Major	Almost Certain	20	[20/10/2023 15:00:26 Alex Atkins] Reviewed with NH and JR. New cancer waiting time standard applicable from 1st Oct 2023, however still non compliant with 31 and 62 day standards. [06/09/2023 16:18:27 Jacqui Robinson] Review with AAJR - 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.	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	22/12/2023			[26/10/2023 09:35:26 Jacqui Robinson] Trust continues to maintain their position outside of Tier 1 and have achieved 28 day standard for the past 9 months. Work ongoing to improve performance within Gynae, Colorectal and Urology who remain our 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 having the biggest impact. [24/07/2023 11:18:07 Jacqui Robinson] Trust is
																									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 Pirie	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

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Torbay and South Devon NHS
NHS Foundation Trust

ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	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.
3546	18/03/2013	Corporate Level Risk	CFHD Safeguarding	Val Watkins	Cheryl Vidall	Chief Nurse (Deborah Kelly)	Reputational Risk		CFHD, Capital Court	Insufficient Staffing Resources to Meet Increased Demand for Safeguarding Services and MASH Enquiries (Workforce Risk)	Cause: Increase in demand for specialist safeguarding nursing including MASH enquiries. Effect: There is potentially both a Patient Safety risk and Reputational risk from within the MASH service as CFHD safeguarding nurses are unable to manage daily workload, resulting in many cases each day timing out and staff then being unable to access. Potential damage to moral injury of staff who are not able to access each case.	Major	Almost Certain	20	1) Good communication with multiagency colleagues to inform them of cases not reviewed - managing expectations. 2) End-to-end mapping of MASH to identify bottle-necks, gaps and demand 3) Staff being rotated through MASH service to reduce risk of burn-out 4) Business case developed to evidence need for additional resource 5) Recent recruitment into B7 Safeguarding nurse role	1) Insufficient staffing levels to manage daily workload in MASH due to current high demand, staff are working long (unpaid) hours to cover / complete most urgent cases. 2) Many cases are becoming 'timed out' and not getting a health review 3) Risk of significant health needs not being included in MASH review if Safeguarding team are unable to get to review case within 24hr window. This 'missing information' could potentially influence decisions made for the child at risk 4) Long term sickness of WTE staff member further impacting on ability to deliver a safe and complete service 5) One member of staff due to reduce working hours	05/11/2023	Major	Almost Certain	20	[10/10/2023 11:38:22 Amanda Anders (Risk Officer)] This risk was discussed in Risk Group and added to the Corporate Risk Register. [04/10/2023 12:33:10 Cheryl Vidall] Risk score reviewed and remains at 20 as we currently continue to have daily amber MASH cases not getting a health review of risks. The initial risk rating is scored by a social worker, who then alerts Health in MASH that a health enquiry (searching all health record sources in Devon) relating to a child needs to be made. There has been a rapid turnover of Social Workers recently, resulting in someone quite inexperienced making the initial assessment and missing the nuanced risks presented on the MASH enquiry forms. Consequently, assurance cannot be offered that all ambers cases are correctly amber rated, as health in MASH has quite frequently increased the risk from amber to red once the health records have been reviewed. This presents a daily potential risk of inaccurate initial RAG rating and therefore the MASH could miss some children whose health information may increase their risk factors from amber to red. Most red cases trigger a strategy meeting where multiagency safeguarding needs are reviewed and action planned. This consequence is currently scored as a 4.	Major	Rare	4	Develop new team member to be able to work independently to address MASH staffing shortfall between service demands and service capacity. This will be a 6 month learning curve, with risk starting to reduce over coming months as more cases in MASH will be able to be researched and actioned.	Cheryl Vidall	03/04/2024			[04/10/2023 12:30:49 Cheryl Vidall] Induction underway with ongoing developmental needs being met in first 6 months in new role.
1603	08/07/2018	Corporate Level Risk	Breast Care	Sandie Heyworth	Derren 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	12/03/2021	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	31/03/2024	Major	Likely	16	[10/11/2023 10:21:45 Sarah Blacoe] Board have approved an Embedding and Inclusive Culture Plan that aligns one approach via EDI, Just and Learning Culture and Health and Wellbeing. Keeping Well for Winter Plan. [09/11/2023 13:40:18 Sarah Blacoe] emailed manager for an update [31/10/2023 14:14:28 Sarah Blacoe] Emailed manager for an update	Major	Possible	12						
3195	19/06/2021	Corporate Level Risk	PMU Finance	Leon Rudd	Emma Rodth	Managing Director Torbay Pharmaceuticals (Emma North)	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	31/01/2024	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						

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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. 3150 Stroke Nursing: Skills & Capabilities (Workforce Risk)	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	31/12/2023	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/competencies 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	30/06/2023			[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
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	30/11/2023	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 South 1 Network but any actions could be long	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.	31/01/2023	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)	Katy 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) 3637: Lack of Dosimetry Management Process	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	30/11/2023	Major	Likely	16	[24/07/2023 16:42:20 Tim Simpson] arranging meeting with RPA asap [06/06/2023 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 main 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 the 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 Executives to ensure that the matter is being escalated. 3) Data gathering work has commenced with the National team.	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.	24/01/2024	Major	Likely	16	[24/10/2023 09:57:14 Emily Widdicombe] Risk reviewed on 24/10/23 with CK. Title - added 'main' as risk relates to the main Programme OBC. Controls in place - added point 3. Risk Handler/Owner to be reviewed in 3 months (24/01/23) [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.	31/01/2024	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)	31/01/2024			
2920	12/10/2020	Corporate Level Risk	Finance	Neil David Elliott	Adé Jones	Director of Transformation and Partnership (Adé 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.	31/01/2024	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.	Catastrophic	Possible	15							

NHS
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Report to the Trust Board of Directors			
Report title: 2023 NHSE/ICB external assessment of the Trust against EPRR responsibilities and national standards			Meeting date: 29 November 2023
Report appendix:	Appendix 1: EPRR Core Standards 2023 Assurance Action Plan		
Report sponsor:	Chief Operating Officer		
Report author:	Emergency Preparedness, Resilience and Response Lead		
Report provenance:	EPRR Steering Group		
Description/Purpose of the report and key issues for consideration/decision:	To provide assurance to the Trust Board on compliance with legislation, standards and regulatory requirements relating to Emergency Preparedness Resilience and Response (EPRR).		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	• The Trust Board to note the EPRR assurance overall rating: Substantially Compliance. • The Trust Board to note the ongoing work to complete the actions listed in the EPRR Assurance Action Plan 2023.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	This report provides the output of the formal assessment by NHS England and the ICB of the Trust's Emergency Preparedness, Resilience and Response performance against the core national standards for the year ending 2023. The assurance process included an assessment of the organisation's state of emergency preparedness using the same compliance levels as utilised in the 2022 assurance process, namely: Fully, Substantially, Partially or Non-Compliant. The Trust Board is formally required to receive and sign off the outcome of the assessment and accompanying improvement plan in recognition of its responsibilities as a Category 1 responder under the Civil Contingencies Act (2004). The Board can take assurance that the Trust is Substantially Compliant in this year's assurance. Out of 62 standards, the Trust has scored: 60 fully compliant, 2 partially compliant and 1 non-compliant therefore making the Trust overall substantially compliant. The Trust are overall partial compliance in the following key areas: Duty to maintain plans: New and emerging pandemics Duty to maintain plans: Countermeasures The Trust are non-compliant in the following key areas: Hazmat/CBRN: Decontamination capability availability 24/7 Following the Trust's overall substantial compliance, the EPRR team are working on the action plan agreed with the ICB to improve the preparedness state of the Trust linked to Appendix 1.		

	• The Trust Board to approve the EPRR assurance rating overall Partial Compliance. • The Trust Board to note the ongoing work to improve on the actions listed in the EPRR Core Standards 2023 Assurance Action Plan.
How does the report support the Triple Aim:	1) population health and wellbeing This report details how TSDFT score against the core standards provided by NHS England which assess the preparedness of the organisation to respond effectively to support the population during incidents.
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 5 - Operations and Performance Standards Objective 9 - Integrated Care System
Risk: Risk ID: *As appropriate*	Risk ID 3659 documenting the CBRN Decontamination Capability Risk.
External standards affected by this report and associated risks	2023 NHS England EPRR Assurance Core Standards

EPRR Assurance 2023/24 Action Plan							
Standard Ref Number	Domain	Standard	Criteria	Scoring	Action Plan	Led by Whom	Due Date
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Partially Compliant	Infection, Prevention and Control maintain an Outbreak Control Plan, but the EPRR Team will work with IPC to create a new and emerging pandemics plan based on the "Operating Framework - Response to pandemic influenza" (December 2017)and will ensure it aligns with the current organisational structure and the Incident response plan.	Katie Manning	Mar-24
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Partially Compliant	The EPRR Team will review and update the existing Mass Prophylaxis Plan using the current "Guidance for the Requesting and recept of countermeasures" (April 2019) and will ensure it aligns with the current organisational structure and the Incident response plan.	Katie Manning	Mar-24
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Non Compliant	The TSDFT Decontamination Team has historically been made up of volunteers from around the organisation rather than clinical staff, and prior to 2022 volunteers were offered a financial incentive to maintain their participation. The financial incentive was removed and the number of volunteers reduced from 26 to 8, and the capabillity to respond to a CBRN incident 24/7 is significantly reduced. The EPRR Team are promoting volunteering to be a Decontamination volunteer and are delivering CBRN Decontamination Training (1x training in October, 2x training in November and 1x training in January 2024). TSDFT is an outlier in the Devon system as RDUH and UHP both regularly train ED and other clinicial staff to decontaminate casualties and it is in their job descripotion to carry out this role, which ensures 24/7 decontamination capability. Training ED and other clinical staff for decontamination will increase the Trust's capability and the EPRR team will work with clinicial teams to increase these decontamination volunteers among these categories of staff.	Katie Manning	May-24