Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors

Date: Wednesday 31st January 2024

Time: 11.30 am – 2.30 pm

The Boardroom,
Hengrave House,
Torbay Hospital

www.torbayandsouthdevon.nhs.uk

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TSDFT Public Board of Directors

31/01/2024 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

Torbay and South Devon NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARDROOM, HENGRAVE HOUSE
AT 11:30AM ON 29 NOVEMBER 2023

Present:	Sir Richard Ibbotson	Chairman
	Mrs Liz Davenport	Chief Executive Officer
	Prof. C Balch	Non-Executive Director
	Dr M Beaman	Non-Executive Director
	Mr A Chandran	Chief Operating Officer
	Mr R Crompton	Non-Executive Director/Vice Chairman
	Mr I Currie	Chief Medical Officer
	Mrs B Gregory*	Non-Executive Director
	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 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 Cozens	Director of Capital Estates
	Mrs A Hall	Governor
	Mr G Henderson	Press
	Mrs A Lowe	Director of Audit
	Mr P Milford Interim	Lead Governor
	Mrs H Milner	Governor
	Mr J Nutley	Governor
	Mr A Postlethwaite	Governor
	Mrs A Ramon	Governor

191/11/23 **Welcome and Introductions**

The Chairman welcomed all those in attendance to the meeting.

Preliminary Matters

192/11/23 **Apologies for Absence and Quoracy**

The Board did not receive any apologies of absence.

193/11/23 **Declarations of Interest**

The Board did not receive any declarations of interest.

194/11/23 **Patient Story**

The Chairman asked the Board to note on this occasion the Patient Story had been postponed to January 2024.

195/11/23 **Board Corporate Objectives**

The Board received and noted the Board Corporate Objectives.

For Approval

196/11/23 **Minutes for approval**

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

Consent Agenda (Pre-notified questions)
Reports from the Executive Directors (for noting)

197/11/23 **Chief Operating Officer's Report - November 2023**

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

198/11/23 **Report of the Director of Estates**

The Board received and noted the Director of Estates Report of November 2023.

Reports of the Chairman and Chief Executive

199/11/23 **Report of the Chairman**

The Board received and noted the report of the Chairman, with the following verbal updates given:

- Following the sale of Torbay Pharmaceuticals, Mr Clive Ronaldson, Torbay Pharmaceuticals, Independent Adviser to the Torbay Pharmaceuticals Management Committee, was thanked for the significant value he had added in his advisory role.
- Aduke Onafowokan, a national speaker on diversity and inclusivity was attending the Trust that afternoon to speak to Medical Education.
- The Public Governor Election process had commenced.
- On the 7 November 2023 the Governors toured Dartmouth Health and Well Being Centre led by Matron Tracey Cunningham.
- The Veteran's Plaque unveiling took place on 13 November 2023 by Captain Sarah Oakley, Commanding Officer of the Britannia Royal Naval College, Dartmouth.
- The opening of the Endoscopy Unit took place on 14 November 2023 the League of Friends were thanked for their contribution towards the required equipment, that would provide endoscopy services to the local population as well as training for the region.

- The recruitment of the Chair role had commenced and was likely to be completed by the end of January 2024.
  Mr Currie and Ms Kelly were thanked individually for the respective contributions as it was their last meeting.

200/11/23 **Chief Executive's Report**

The Board received and noted the report of the Chief Executive, with the following verbal updates given:

- Mr Arun Chandran, newly appointed Chief Operating Officer, was welcomed to the Trust.
- The exemplary clinical leadership and strong system working Mr Currie and Ms Kelly had brought during a very challenging time was acknowledged with thanks extended. She wished Mr Currie a happy retirement; and Ms Kelly the best for her role as Chief Nurse Officer in the South East.
- **South West Paediatric Mental Health Network:** The South West Paediatric network has been established by Dr James Deardon a Paediatrician in the Trust in response to concerns about how we work together to ensure that the needs of young people. It is hoped that the work of the network will continue to be developed and learning shared nationally.
- **International head and neck cancer conference:** The Swallows Charity Annual Conference was held in Torquay with over 200 people in attendance.
- **Updated Operating Plan:** The Trust had submitted its updated operating plan reflective of the Trusts current operational and financial performance. The plan had been scrutinised by the Board for assurance and was currently being reviewed by the Devon ICB. The Trust were in phase two of the Regain and Renew Plan engaging with teams across the organisation on the implementation of the plan.
- **Sale of Torbay Pharmaceuticals:** The sale of Torbay Pharmaceuticals had completed. It was noted that this sale would preserve jobs within the Paignton area, strengthen the supply chain and allow the Trust to solely focus on improving the health of a supporting the wider population.

201/11/23 **Committee Chair's Report**

The Board noted the following reports from Committee Chair's:

Finance Performance and Digital Committee

- There were significant system challenges in respect of the Operating and Mid-Term Financial Plan;
- The Mortuary Business case had been approved; and
- The remodelling of Day Case Surgery had been supported.

Quality Assurance Committee

- There had been focus on the CQC Maternity Inspection; the improvement plan would be taken to January 2024's Committee.
- The Adult Social Care CQC inspection had been discussed and the Deputy Director of Adult Social Care was progressing the legacy applications and backlogs in respect of the Deprivation of Liberty Safeguards.

BBF

- The Electronic Patient Record procurement process was on plan.

- An update report on the progress of the site enabling case had been received and assurance was provided as the bid was close to the level of cost requiring treasury approval.
- The Committee were seeking assurance in respect of the Health Informatic Service infrastructure programme recognising priorities were changing in order to make space for the Electronic Patient Record system whilst having to maintain legacy systems, he confirmed this had been placed on the Risk Register.

Safe Quality Care and Best Experience

202/11/23 **Integrated Performance Report (IPR): Month 7 2022/23 (October 2023 data)**

Dr Westwood presented the Integrated Performance Report for Month 7 2023/24, as circulated, and asked the Board to note the following:

Quality

- Further to the CQC Inspection the Trust remained Outstanding for care.
- Complaints through the Patient Advice and Liaison Service had decreased, and the Associate Director of Nurses and Professional Practice were reviewing this matter.
- There had been an increase in Clostridioides difficile cases. This was due to a rise in antibiotic use and a shortage of Microbiologists.

Workforce

- Currently, locums were required to deliver fundamental work.
- In response to NOF4 tighter controls on vacancies and temporary staffing were in place. This would be in preparation for zero based budgeting.

Performance

- Urgent and Emergency Care remained a NOF4 exit priority.
- The Trust had met it's NOF4 plan to reduce 104ww to zero; and the 62 day wait cancer targets.
- The Trust were in Tier 1 for Referral to Treatment Times.
- Currently, 55% of patients had access to theatre beds, going forward some beds would be ring fenced to make access to Theatre easier.
- The Trust would see the impact of Industrial Action in the Month 8 Integrated Performance Report.

Finance

- Financial Recovery remained a priority for the NOF4 exit criteria.

Following a detailed discussion focussing on productivity, risk to and likelihood of achieving NOF4 exit criteria given winter pressures and the Trust's financial deficit, the Board received and noted the Integrated Performance Report (IPR): Month 7 2022/23 (October 2023 data).

203/11/23 **Care Quality Commission Well Led Inspection Action Plan Report**

Ms Kelly presented the Care Quality Commission Well Led Inspection Action Plan Report, as circulated. She confirmed staff and external stakeholders had been engaged and for core areas of action, improvement ratings plans were being put in place.

She further explained the rating change from Good to Requires Improvement was reflective of the Trust's NOF4 status but, the CQC had seen genuine improvement and this was reflected in the core service inspection.

The CQC Assurance Group met monthly to receive updates against the action plan.

Mrs Davenport explained the issues the CQC had raised reflected many of the issues that we had received from staff.

Ms Kelly confirmed she would present the CQC findings and action plan to the Council of Governors. **ACTION: Ms Kelly**

The Board received and noted the Care Quality Commission Well Led Inspection Action Plan Report.

204/11/23 **Care Quality Commission (CQC) NHS Inpatient Experience Surveys 2022 Report (received September 2023)**

Ms Kelly presented the Care Quality Commission (CQC) NHS Inpatient Experience Surveys 2022 Report (received September 2023), as circulated. She informed the Board:

- The findings triangulated with the CQC Report.
- The Trust were in the top 10% for Nursing and Doctor's care.
- A Privacy and Dignity campaign had been enacted.
- Changes to the infrastructure, where appropriate, were being considered.
- Communication campaigns were taking place.
- The Friends and Family test was re-established in 2022 and was important in supporting the improvement plan.
- The detailed action plan and metrics were to be monitored through the Quality Assurance Group.

Prof. Balch counselled on the need to read the report in the context of the current environment and that despite the operational challenges of the Trust's estate that staff were able to provide outstanding care to their patients through their commitment to care.

Ms Kelly explained the survey results were testament to the Boards commitment to investing in safe, quality care. She said the Trust were offering the best service they could within the footprint based on the resource available.

The Board received and noted Care Quality Commission (CQC) NHS Inpatient Experience Surveys 2022 Report (received September 2023)

205/11/23 **Patient Safety Incidents Annual Report 2022/23**

Ms Kelly presented the Patient Safety Incidents Annual Report 2022/23, as circulated. The Patient Safety Incidents Reporting Framework (PSIRF) would be rolled out in the Trust in early Spring 2024 and this would provide a greater analysis of underlying themes. The Quality Assurance Committee would continue to oversee incidents and the implementation of PSIRF.

The Chairman counselled as a lay member of the Serious Adverse Events group a lot of time was spent reviewing safety incidents and highlighted the need to also seek learning from best practice. Ms Kelly confirmed that clinicians have the opportunity to present and learn from best practice from the Quality Improvement Hub.

Mrs Davenport said there was a need to ensure the learning was disseminated to front line staff. Ms Kelly explained this currently happened through the Quality Boards and the Quality Strategy. Dr Lissett said there was an opportunity for teams to undertake MDT huddles to share learning.

Dr Westwood informed the Board the People Culture Dashboard was in final stages of being rebuilt and the Care Group Directors would be able to access and use this information to establish if there were issues with particular teams and wards. However this data would also be accessed by the PSIRF Team and Practice Educators to support learning and cultural issues.

The Board received and noted the Patient Safety Incidents Annual Report 2022/23.

206/11/23 **November 2023 Mortality Score Card**

Dr Lissett presented the November 2023 Mortality Scorecard, as circulated, highlighting the following:

- An improvement in the data had been seen due to an improvement in Clinical Coding; which would further improve with the implementation of the EPR. In time it would therefore provide a truer picture of risk based on deprivation and the age of the population.
- The Hospital Level Mortality Indicator (SHMI) accounted for those patients who died in the community within 30 days of a hospital stay therefore contextualising data related to discharges;
- There had been one expected neo-natal death of a baby who had a genetic condition and who sadly would not have survived if they had been born full term;
- There was a delay to the care of one Category 2 Ambulance patient who was assessed and provided antibiotics whilst in the ambulance but was critically ill on admission to the hospital and passed away.

Mr Crompton asked if there was link with Learning Disability Regulatory Annual Health Checks and improved outcomes. Mrs Davenport said she would seek the data from the Mental Health and Learning Disability Network and disseminate.
ACTION: Mrs Davenport

The Board received and noted the November 2023 Mortality Score Card.

207/11/23 **Research and Development 2022-23**

Dr Fiona Roberts and Dr Mark Gilchrist presented the Research and Development 2022-23 paper, as circulated to the Board. They highlighted the benefits of the Trust offering Research and Development, these were:

- Staff retention;
- Clinical trials providing patients with opportunities to access new and broader care options, at their choice.
- Revenue generation;

- Supporting operational improvements;
- Drives positive culture change;

Dr Gilchirst, challenged the Board as to how research could be embedded into teams and staff enabled to access research opportunities as he believed there needed to be more time allocated to research within job plans. He commended the introduction an Electronic Patient Record that would provide the data required to support applications for clinical trials.

The Board discussed the report at length, in particular the following queries and actions were noted:

- Prof. Balch raised that the department had reported a £90k deficit for 2022-23. He proposed a three to five year business plan and strategy was prepared for research aligning to the medium term financial strategy work. He asked for clarification whether those working within clinical trials were paid by the Research and Development Department or whether time was being taken out of clinical activity. **ACTION: Dr Lissett**
- Dr Westwood said there would be value in the Research Team meeting with the Equality Diversity and Inclusion Team to undertake further work around supporting underserved populations into job opportunities. She also believed there would be value in the workforce planning tool incorporating education within operational plans to embed and integrate research into clinical care and practice. **ACTION: Dr Westwood**

The Board were in support of further embedding research into the culture of the Trust, noting the benefit to both the workforce and patients. It was agreed to receive these reports 6 monthly going forward. **ACTION: Dr Lissett**

The Board received and noted the Research and Development 2022-23 Report**.**

Valuing our Workforce

208/11/23 **Long Term Workforce Plan update**

Dr Westwood presented the Long Term Workforce Plan update, as circulated, to the Board; she explained that:

- There was currently an 8% vacancy rate nationally;
- Due to the growing ageing population there was likely to be a workforce shortage by 2036;
- The Government had committed £2.4bn towards additional education and training places for the Health and Social Care profession but the details of the plan had not been released;
- The reduction of nursing clinical placement hours was being reviewed at national level;
- Retention needed to be considered such as flexible working opportunities, care delivered in the community, associate roles and retire and return opportunities.

In respect of Devon, the system was mindful:

- Devon was a retirement destination of choice and therefore had an aged population;
- Demography impacted the Trusts workforce plans;
- There was a need to strategically transform the workforce; and
- For financial benefit to be derived.

Dr Beaman asked if there was plan in respect of training delivery to enable Devon to achieve the workforce plan. Dr Westwood explained the plans were in the very early stages and quality, capacity, capability and timelines were currently being scoped with Devon ICS but there was recognition there needed to be an increase in the training function. She confirmed consideration was being given to alternative pipeline options. Dr Watson highlighted the importance of forging strong relationships with South Devon College to support the pipeline.

The Board received and noted the Long Term Workforce Plan update

Well Led

209/11/23 **Remodelling of the Day Surgery Business Case**

Mrs Cozens presented the Remodelling of the Day Surgery Business Case, as circulated. She explained this was Phase 2, following Phase 1 of the Theatre Delivery project and would enable the Trust to maximise productivity and through puts. The Board noted that the revenue costs had been identified through the business case approved by them in April 2023, with phase 2 being a continuation of that work.

The Board approved the Remodelling of the Day Surgery Business Case.

210/11/23 **Board Assurance Framework and Corporate Risk Register**

Mrs Long presented the Board Assurance Framework and Corporate Risk Register, as circulated. It was proposed and agreed that given the CQC Assessment and Action Plan the Board Assurance Framework and Corporate Risk Register (alongside the revised Risk Policy and Strategy) be reviewed by the Board at the next Board Development Session. **ACTION: Mrs Long**

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

211/11/23 **2023 NHSE ICB external assessment of the Trust against EPRR responsibilities and national standards**

The Board received and noted the 2023 NHSE ICB external assessment of the Trust against EPRR responsibilities and national standards.

212/11/23 **Compliance Issues**
None reported.

213/11/23 **Any other business notified in advance**
No other business was escalated.

214/11/23 **Date and Time of Next Meeting:**
11.30 am, Wednesday 31 January 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	Ongoing since 26.10.22. An update would be provided when available.	28.09.22
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	The date for the Board to Board would be set in January 2024.	26.04.23
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. Update on BAF further work Execs are doing	27.09.23
191/10/23 203/11/23	Board Development session to be scheduled to review BAF profile.	Mrs Long	Scheduled for February 2023.	25.10.23
203/11/23	Mrs Davenport to seek data from the Mental Health and Learning Disability Network regarding annual reviews and improved outcomes and disseminate.	Mrs Davenport		29.11.23
207/11/23	Dr Lissett would seek clarification whether those working within clinical trials were paid by the Research and Development Department or whether time was being taken out of clinical activity.	Dr Lissett		29.11.23
207/11/23	There was value in establishing the benefit of the workforce planning tool being incorporated into education within operational plans to embed and integrate research into clinical care and practice.	Dr Westwood		29.11.23
207/11/23	The Research and Development Report would be received on a six monthly basis.	Dr Lissett		29.11.23

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Report to the Trust Board of Directors			
Report title: Chief Operating Officer's Report			Meeting date: 31st January 2024
Report appendix:	N/a		
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*	Multiple		
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:** 31st January 2024
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

We moved to the new national Operational Pressures Escalation Level Framework (OPEL) 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. With the national change, we updated our local plan and introduced safety barometers across the care groups.

Month	OPEL 1	OPEL 2	OPEL 3	OPEL 4	OPEL 4 + Critical incident
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
Nov-23	0	4	14	10	2
Dec-23	2	8	17	4	0

3.0 Winter Plan

Key actions taken in December to support the winter plan have been as follows:

- Recruitment and pathway development of the Frailty Unit to support an opening date w/c 8th January.
- Further expansion of the virtual ward with an expectation to take patient numbers above 50 and further towards the planned delivery of 77 patients when all pathways are open.
- Successfully running a proof-of-concept same-day emergency care (SDEC) trial in the Acute Medical Unit with positive results centred on admission avoidance. The plan is to consider a further extended trial in January.
- Development of a new initiative previously not in the Winter Plan called the Care Coordination Hub. This facilitates a Southwest regional approach to using services such as Urgent Community Response (UCR) to work with an external company called MedVivo around ambulance conveyance. Consequently, ambulances are either prevented from being dispatched, or through 'call before convey' paramedics are supported to utilise community pathways instead of attending the emergency department.

The care groups, are identifying the lessons learned from the winter schemes to explore new pathways and plan for the winter 2024/25.

4.0 Urgent & Emergency Care (UEC) update

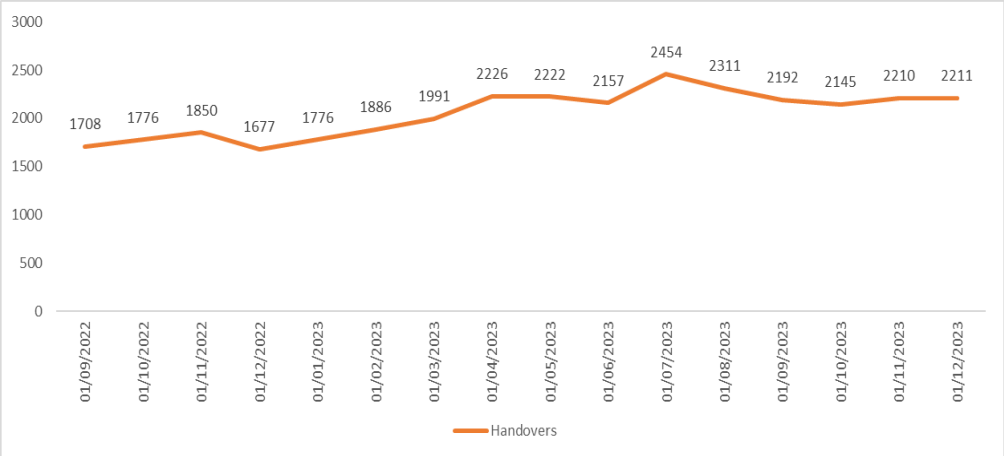
December saw 8,766 attendances for the integrated care organisation (ICO). This was an average of 282 patients per day. This is the first month of this year where the trend of increased attendances has been reversed in comparison to the same period in 2022. The reduction in activity has been in type 3 activity at the minor injuries unit (MIU) / urgent treatment centre (UTC) with a reduction of 490 patients in December 2023.

Performance was behind the trajectory for the National Operating Framework (NOF4) recovery target of 72% at 68.02%. However, this represents a 1.4% increase from November 2023. Non-admitted performance has improved to 68.10%

The Urgent Treatment Centre (UTC) and Minor Injuries Unit (MIU) performance remains consistent at 99.78%.

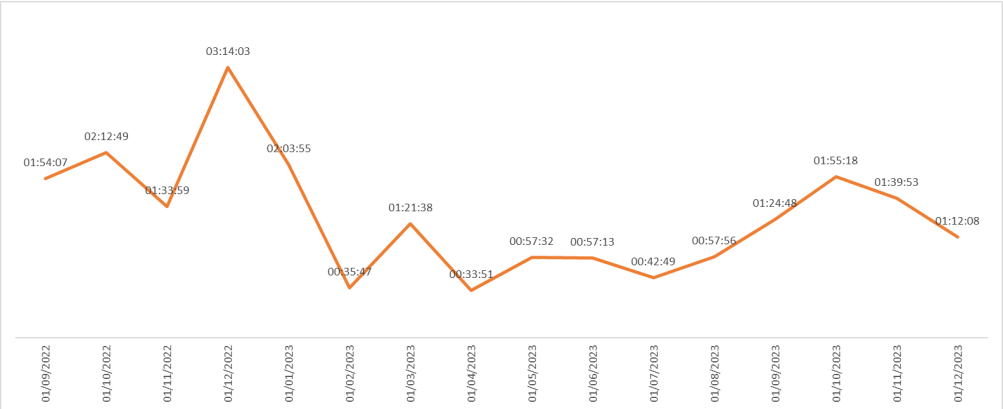
4.1 Ambulance Handovers

Ambulance handover delays were reduced by 275 fewer 15-minute breaches in December compared to the previous month, with 1,662 arrivals over 15mins.



The volume of ambulance handovers shows only a marginal increase (+1) from November 2023 at 2211. This continues the upward trend from December 2022 (1,677).

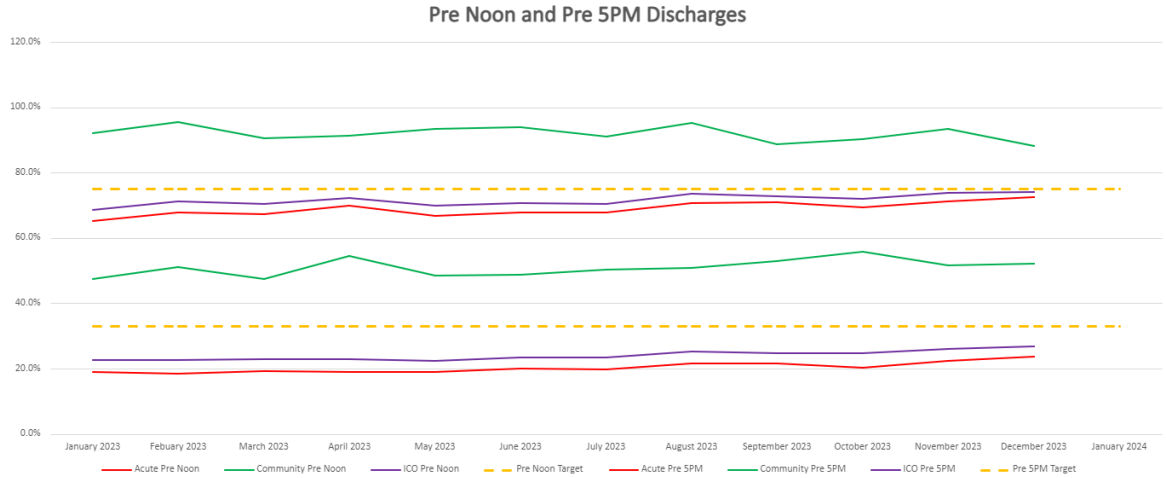
Thursday 1 September to Sunday 31 December - Monthly data
Month starting 1st September 2022 - Average handover time - 01:54:07



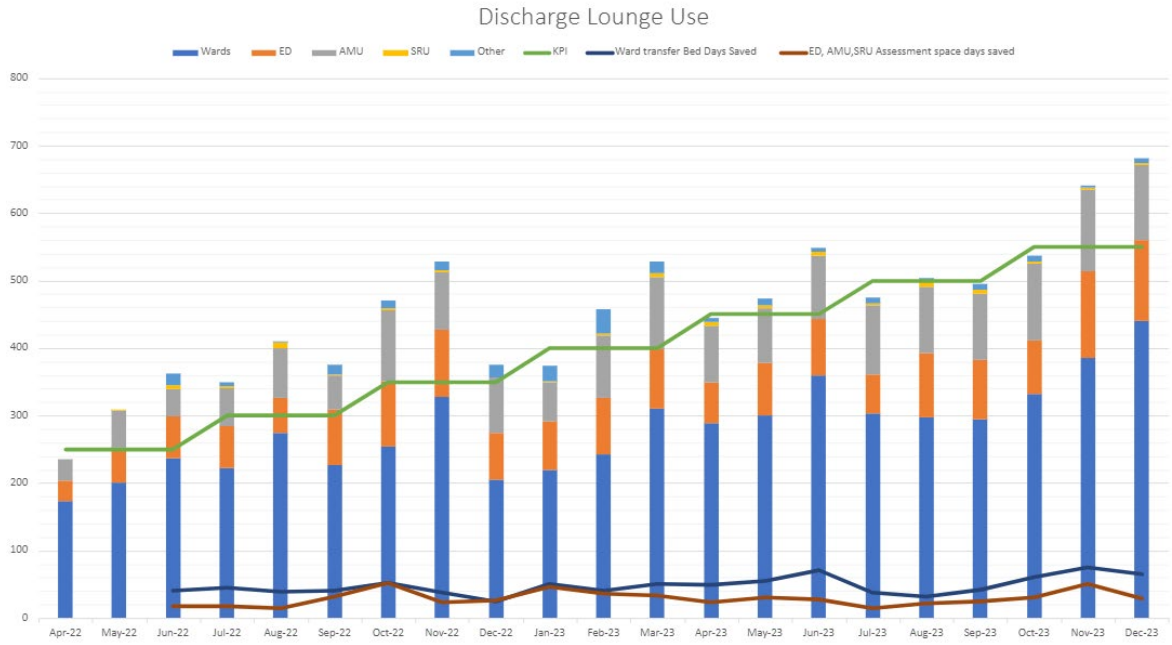
The average time lost per ambulance to handover, at 1hr 12min (incl. the 15 mins) in December 2023, remains an improvement in December 2022 where the average handover time was 3hrs 24 minutes.

4.2 Inpatient Flow

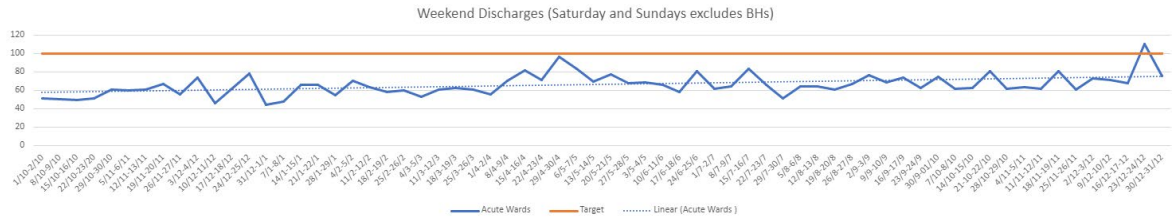
Across the Integrated Care Organisation (ICO) (including our community hospitals), there were 2,021 discharges from our adult inpatient areas. Of which 26.6% (538) of patients were discharged by noon and 74.2% (1,500) pre-5 PM



The discharge lounge supported 681 patients in December. 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. The discharge lounge is now open at weekends, and we remain so until April 2024 as part of our winter plan.



Weekend discharges continue to be below expectation. In December, on average we discharged 80 patients across the weekend, this is an improvement on previous months, but driven by the pre-Christmas holiday. An operational change in the system used by the Multi-Disciplinary Team (MDT) for weekend discharges has taken place. Feedback has been positive from colleagues.

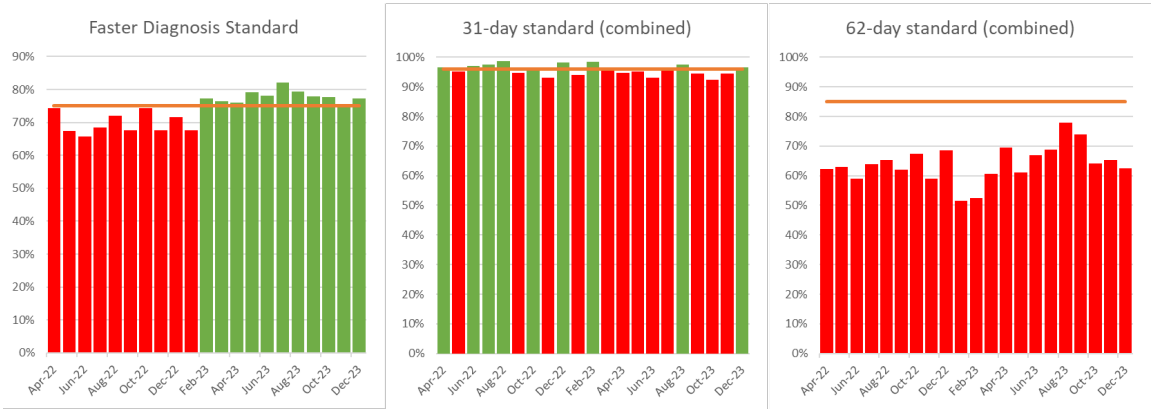


5.0 Cancer

5.1 Cancer Demand

In December, Torbay and South Devon received 1,447 two-week wait referrals (2WW). This represents a 16% increase on the previous December. This month characteristically receives a lower number of referrals (25% less, than the average monthly rate this year).

5.2 Cancer Performance



November and December see Torbay achieving the 28-day Faster Diagnosis Standard at 75.8% and 77.3% respectively, with the later remaining subject to validation. Gynaecology, Colorectal and Urology remain the three sites which are not achieving this standard.

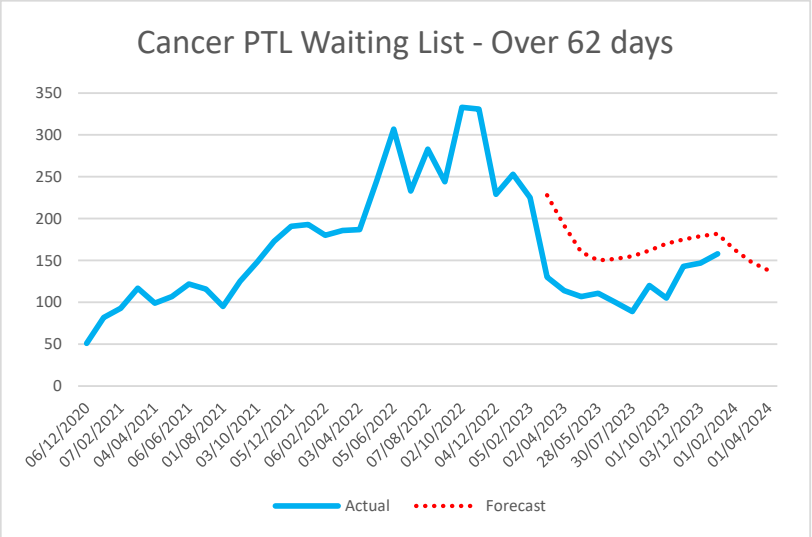
For November, the combined 31-day performance standard is at 94.4% (96% target). Of the 23 breaches, 16 were for patients awaiting first treatment and 7 were for subsequent treatments. In December, the provisional position is 96.6% (96% target). Capacity constraints, rolling over from industrial action in September and October, followed by the festive season and compounded by December's strike action had an impact on the 31-day performance over these two months.

Performance for the combined 62-day standard remained relatively static across November (63.9%) and December (62.5%) against the 85% target. Urology accounted for half of the patient's missing the standard; however, there were delays seen across the majority of tumour sites, which is indicative of the pressures seen across Torbay and South Devon in the past few weeks.

<u>Over 62-day Backlog (Open Pathways)</u>

As of December 31, 2023, our backlog for patient tracking lists (PTL) over 62 days stands at 158, constituting 10.2% of the total PTL. Additionally, there are 22 patients who have been waiting for over 104 days.

While our current position is above the target of 138 patients, we are still below our projected numbers for this point in the year. Torbay remains in the top half of all Trusts nationally regarding the over 62-day backlog.



Outlook

Performance in Quarter 3 (October, November, and December) has remained relatively stable for the three core waiting time targets mentioned above. However, challenges during December, including seasonal holidays and disruption from Junior Doctor strikes, have made it an exceptionally difficult month. The fragility of our medical workforces has compelled us to prioritise on-call provision, resulting in the unfortunate postponement of clinics and theatre lists.

This situation is reflected in the rise of the backlog of patient waiting over 62 days and lower treatment activity numbers in December. It serves as a precursor to a potential decline in our Cancer Waiting Times performance in January and February.

Specific Challenges in Urology Services

Urology remain one of the most fragile services. They are reliant on locum support, which has been reduced throughout December due to the planned leave of one locum and one post currently vacant. This has led to an increase in the backlog of flexi-cystoscopy procedures. The sickness of a consultant and planned leave of a senior nurse have further extended wait times for prostate biopsies. The 62-day backlog for Urology has doubled since October, reaching 70, and the 29-62 day backlog, an early indicator of increasing waiting times, has also seen a sharp increase.

To address these challenges, several initiatives are actively being pursued. We have secured additional funding from the Cancer Alliance to run additional sessions and cover the cost of overtime. The return of one locum this month and the commencement of a new locum in March are anticipated. Furthermore, the regional Acute Sustainability Programme is focused on developing a regional Urology on-call service, aiming to bring stability to the existing team and enhance recruitment prospects for new substantive workforce.

6.0 Referral to Treatment (RTT)

6.1 Long waits (December 2023)

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

- **78 and 65 weeks –** The Trust has submitted an updated forecast for 31st March based on the impact of industrial action up to October 23. This is shown below:

78 week	Forecast Plan	130	130	130	111	92	73	53	35	19	0
	Actual	123	129	156	187	155	180	163			
	Revised Plan IA to Oct only						195	196	198	199	200
		June	July	August	Septembe	October	Novembe	December	January	February	March
65 week	Forecast Plan	1312	1307	1387	1189	991	793	650	397	199	0
	Actual	1196	1169	1296	1180	1018	880	842			
	Revised Plan IA to Oct only						880	823	765	708	650

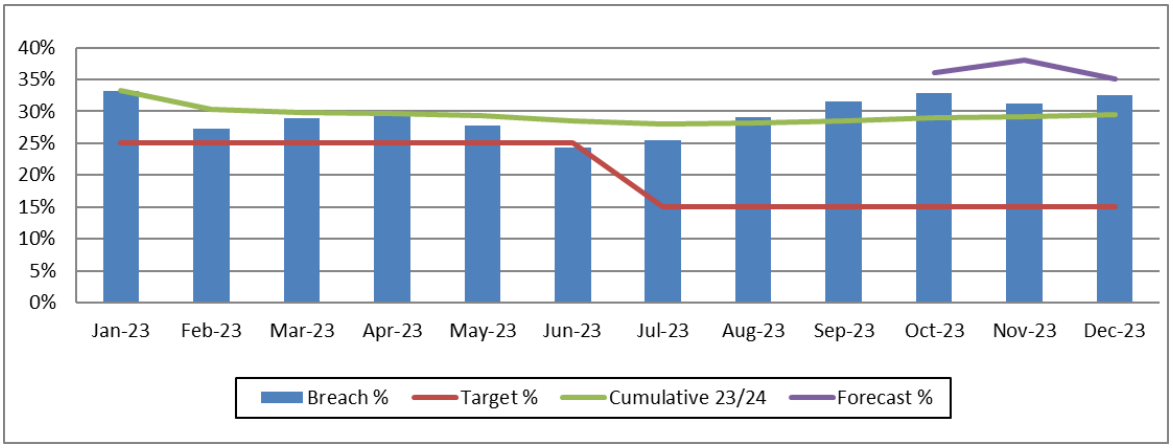
Up to October 2023 c.6k clinical interventions have been lost at Torbay as a result of industrial action across all elective areas including Cancer. Whilst our actuals are below the expectations of our original plan, we are ahead of our revised plan for 78 weeks and just behind plan for 65 weeks. Given the loss of capacity this is a remarkable achievement.

Further plans to improve on our revised position have been shared with the Devon Integrated Care Board, they involve additional activities in Qtr 4 in a small number of specialties. The Trust awaits a response to these plans.

As we enter the planning period for 24/25 the Trust starting position against our overall PTL has significantly improved in the past 12 months. Our overall PTL has reduced from 44K to 34K, a reduction of 23%. Importantly this drop is reflected in our 52-week cohorts meaning our ambitions to clear our longest waits down to 52 weeks in 23/24 is within scope.

7.0 Diagnostics Performance

Our diagnostic performance has been challenged in December 2023. The Trust reported 33% of patients waiting longer than six weeks against the end of November target of 25% (November reported 31%). The expectation is that we will work to meet the amended Target of 15% by end of March 2024 (amended target as demonstrated on the chart below).

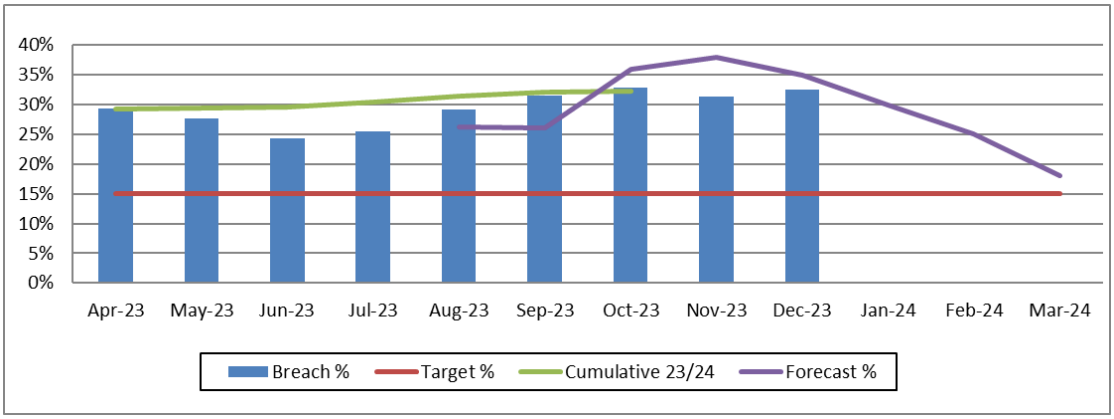


Radiology modalities have been challenged in December owing to a significant increase in acute and inpatient requests which has led to outpatient scan cancellations. This has been further compounded by the junior doctor strike in December. Lost activity over the festive period has also impacted on outpatient capacity.

- MRI has remained static at 34% in December and currently sitting at 1% over trajectory. However, it is unlikely that MRI will recover back to under 25% and unlikely to achieve 15% or lower until the Community Diagnostic Centre (CDC) opens in Summer 2024.
- CT has worsened 19% in November to 29% in December, however, CT remains 11% under trajectory. The second pad at Newton Abbot Hospital (NAH) will be providing a full service in January and will be providing a further 20 days a month for CT examinations.
- Non-obstetric ultrasound scan (NOUS) has worsened 19% in November to 22% in December.
- Colonoscopy remains at 65% of patients waiting over 6 weeks for procedure.
- Flexible sigmoidoscopy has worsened to 72% from an improved November position of 68%.
- Cystoscopy remains at 29% of patients waiting over 6 weeks for procedure.
- Echocardiology continues to hold steady at an improved performance, achieving target at 14% in December 2023.
- Gastroscopy has slightly improved to 51% in December from 54% in November.

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 (purple line = forecast).



Additional capacity plan to meet 15% March 2024

- Work is required to monitor inpatient requests and impact on outpatient services in Radiology, currently Radiology is only able to maintain 2WW scans at acute site.
- Additional CT mobile van at Newton Abbot from December 2023.
- 2 x additional endoscopy rooms to open end November 2023.
- Stress MRI capacity and demand to be undertaken to identify additional sessions.

8.0 Children and Family Health Devon (CFHD)

8.1 Performance

Therapies and Nursing

Please note that data provided for December 2023 is subject to validation.

Mean waiting times and Referral to Treatment (RTT) (non-consultant led)

- Waiting times and RTT remain static in Children's Community Nursing, Special School Nursing, Specialist Learning Disability, Early Childhood Development and Speech and Language Therapy.
- Waiting times and RTT have improved slightly for Occupational Therapy, this is attributed to increased clinical capacity. Delays in workforce panel approval of agreed vacant roles impacts performance as does current planned leave.
- Waiting times and RTT have reduced for Physiotherapy and the Autism Assessment Service.

RTT and mean waits by clinical pathway

Clinical pathway	Mean Wait	% waiting < 18 weeks	Narrative
Community Children's Nursing (including palliative care)	1.1	100%	Mean wait and RTT remains static and children seen promptly based on need.
Specialist School Nursing	4	100%	Mean wait and RTT remains static and children seen promptly based on need.
Specialist Learning Disability	5.6%	100%	Mean wait and RTT remains static and children seen promptly based on need. 20% increase in referrals compared with Q1 -Q3 2022/23
Physiotherapy	13.0	76.1%	Reduction in mean wait and RTT from last month. Recruitment delays and increased number of acute discharges needing prompt access is impacting overall performance.
Occupational Therapy	23.9	46.5%	Slight improvement in RTT based on previous month. Recruitment advertising delays and planned leave in team impacting performance.
Speech & Language Therapy	36.7	31.4%	Mean wait time remains static but RTT has improved on previous month. Waiting list and caseload initiative implemented across county to support longest waits being seen. Onboarding of new staff and recruitment still underway.
Autism Assessment Service	55.0	18%	Reduction in mean wait and RTT from last month. Referral rates continue to increase (37% increase

			on previous year) with a 50% vacancy rate in the pathway.
Early Childhood Development	52.0	24.8%	Mean waits remain static but RTT has improved on previous month. Pathway review with ICB and Acute Paediatrics planned in February 2022 to review specification for the future service scope.
Children in Care Nursing	Assessment completion within 28 days -70%		Assessment performance remains static. Increasing number of children in care placed in Devon and Torbay from other areas impacts on capacity within the team.

Mental Health

Please note that data provided for December 2023 is subject to validation

RTT and mean waits by clinical pathway

Clinical pathway	Mean Wait	% waiting < 18 weeks	Narrative
Children in Care mental health	19.9	37%	The mean wait has shown a decrease of 4 weeks when compared to November.
CAMHS	19.3	52%	A slight increase in mean waits. <18 weeks remains stable given the overall increase of children added to the waiting list in December.

A comprehensive piece of work has commenced in January to increase productivity, which will have an impact on waiting times. A full suite of activity data by locality and clinician has been analysed and new activity standards have been developed and launched. In the next phase we will develop trajectories to set out the expected impact on RTT, wait times, numbers waiting and patient flow.

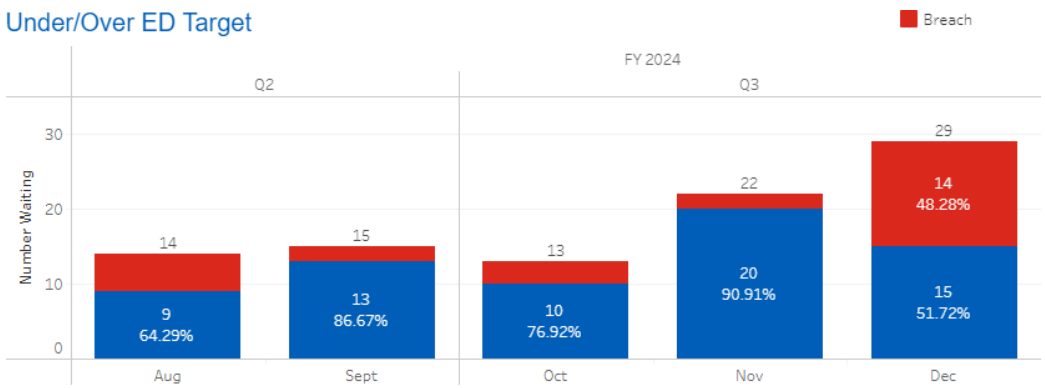
NHS Long Term Plan (LTP) Deliverables: Children / young people's mental health

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 51.72% (15/29) of young people who had their first treatment appointment within December were seen within the 4-week target.



Urgent Referrals

There were no urgent referrals, which should be seen within 7 days, during December.

Child and Adolescent Mental Health Services (CAMHS) Access

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 10,424 which is ahead of the Q3 target. Performance should improve further 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

Our focus service over the last month or so has been on the development and implementation of the new electronic patient record system, SystmOne. This has been resource-intensive, in terms of manager, clinician, informatics, IT and administrative time. The plan is for SystmOne to go live on 31st January. Interoperability challenges between the two organisations have created many and frequent obstacles to the successful development and implementation of SystmOne which have and continue to risk de-railing the project.

Whilst the service works at pace to implement SystemOne, transformation work has slowed. However, the website development continues at pace and should be live by April this year.

8.3 Joint Targeted Area Inspection (JTAI) Torbay

Following the Joint Targeted Area Inspection of children's services in November 2023, the letter from the joint inspectorate team[1] has been received. A joint Local Authority (LA) /Health response to the factual accuracy of the letter was sent on 12th January 2024. Work will now begin on finalising action plans.

8.4 SEND (Special Educational Needs and Disabilities)

Both Torbay LA area and Devon County Council area has been inspected in recent years by Ofsted and CQC, both children's partnerships have improvement plans in place. CFHD are engaged at all levels with these plans which are reported to the partnerships in both areas.

A statutory requirement within SEND is for organisations to contribute to the assessment of need and development of Education Health and Care Plans for children with SEND. During recent months, CFHD has implemented an improvement plan with new systems, processes and quality assurance measures to ensure compliance with these requirements improves.

Education Health and Care Plan (EHCP) Timeliness CFHD			
LA/ County Council	**Contributions due**	**On time** ***(6 weeks)***	**Narrative**
Torbay	48	90%	Increasing percentage each month with dedicated SEND Lead focus. Target 95%
Devon	213	78%	
Total	261		

Torbay Overview and Scrutiny Committee

Torbay Overview and Scrutiny Committee (OSC) held a 'spotlight review of mental health services for children and young people' on 7th December 2023. The review aimed to look at the wider provision of mental health, therapeutic and emotional wellbeing services to provide early support and reduce the number of people meeting the threshold for CAMHS for children and young people in Torbay. The Committee wanted to receive an update on CAMHS and the action being taken to reduce waiting times and explore options for those young people who do not require specialist care and to understand the transitional arrangements for CAMHS for children from 18 years old onwards.

The meeting was streamed live on the Council's YouTube channel and featured on local television news in the evening. Partners were invited to the meeting and members of the public were invited to submit general questions via a press release in the weeks prior to the meeting and to attend on the day.

A number of individual service user stories were collated and circulated to partners attending, before the committee. The stories indicated the following themes:

- CAMHS not correctly commissioned, lack of investment
- Lack specialist staff and inadequate, incorrect mental health support
- Waiting times and access
- Support for transition into adulthood

[1] HMICFRS, CQC and Ofsted

- Organisational failures, lack of transparency and accountability, difficulty in challenging decisions/professionals
- Inequality of access across schools
- Separate services for ADHD and Autism

The Committee required health partners, specifically CFHD, to outline how the lack of CAMHS support and access for young people to CAMHS services would be resolved and required answers to a series of specific questions regarding numbers of children waiting and receiving intervention, those with neurodiversity needs, services for children in care and commissioning arrangements.

The committee was attended by senior leaders from NHS Devon ICB, Torbay and South Devon NHS Foundation Trust, Devon Partnership Trust, Children and Family Health Devon, and Children's Social Care. Members of the public were present but unable to ask questions.

In the meeting, partners presented a summary of the slides that had been circulated with the papers. A number of patient stories were read out by councillors, and one young person told her story in person. A broad range of questions were answered, largely by CFHD. The meeting concluded with a set of recommendations being made by the Committee, which have yet to be received by health organisations. The chair of the committee indicated health partners would be required to return to the OSC in April to present an update. On 11th January, at the invitation of parents, two leaders from CAMHS met with four parents who had attended the committee and the OSC Chair.

9.0 Families Community and Home Care Group Update

9.1 Child Health / Paediatrics

Child Health is on track to clear all 65-week waits by the end of March. The number of children on the waiting list has reduced from a peak of 1,934 at the start of the financial year to 1,524 in December, a reduction of 21%. Both general and community waiting lists are at their lowest for at least two years. Follow ups past their to be seen by date are at 507 a reduction of 41% from a high of 864 in April 2023. This has been the result of lots of improvements as part of the Child Health Sustainability and Transformation Plan over the last 9 months. This will continue over the coming year. Risks to continuing our performance trajectory include ongoing strikes and the delay in works to Elizabeth Ward to create a 5th clinic room that was lost 2 years ago.

There have been a number of Paediatric Awards for Training Achievements (PAFTA) for staff within Child Health and the wider Trust this year, winners are announced in March. Well done to all those who have been nominated.

The Transitional Care Ward within Special Care Baby Unit (SCBU) formally opened last month, this unit is designed to keep Mum and Baby together, promotes breast feeding and reduces early years re-admissions for paediatrics.

9.2 Children's Torbay 0-19 Service

The Family Hub website Home - Family Hub (torbayfamilyhub.org.uk) is now fully functioning and provides a "front door" for families from pregnancy through to young people up to 19 years (or 25 years if they experience SEND).

DadPad was recently launched across Torbay, which is an essential guide for new dads, helping them to get to grips with their new responsibilities, gain confidence, and offers the tools and practical skills to best support their baby and their baby's mum.

The DadPad app will help dads to:

- Reduce their own anxiety by getting involved and gaining in confidence.
- Learn how to create a strong bond and healthy attachment with their baby.
- Build stronger family relationships by sharing the load and learning how to parent together.
- Recognise the signs of postnatal depression, and other signs of mental ill-health, in both them and their partner, and learn how to get help early.

The DadPad is also intended to assist health professionals engage and build relationships with new dads and dads-to-be. Same-sex parent Pad is also available for co-parents and birth partners.

9.3 Torbay Recovery Initiatives (Drug & Alcohol Service)
As part of the service delivery there is support as part of an individual's recovery to find work or develop their career. The Individual Placement and Support (IPS) Service works alongside an individual with an employment focused intervention and works on an individual basis taking into consideration the client's vocational interest, barriers, training, mental health, fiscal health, criminal record, recovery journey and employability skills.

The IPS Torbay worker is part of a team that works within Cornwall and is employed by 'We Are With You Cornwall' working in partnership with Torbay Recovery Initiative (TRI). Integration has developed well and the IPS worker is very much part of the wider team, having an allocation slot in the weekly clinical meetings to give IPS updates and discuss joint clients.

The service is building more connections in the area and have supported clients into new job roles. The IPS is currently supporting 12 individuals, and this will rise to 25 (caseload capacity) when we are fully staffed in Torbay.

9.4 Gynaecology
Obstetrics and Gynaecology Service Review:

An overview of the service has been completed in conjunction with the Transformation team. A briefing paper was presented to the executive team in mid-December with a need to now share the recommendations with the ICB.

There was broad agreement for the principle that we require consultant expansion within Obstetrics and Gynaecology to provide a safe service. It is likely that in the current financial climate that any business case for expansion in clinical staff will require approval from the Integrated Care System and Regionally at NHS Southwest. This is the first step in our journey, the business case will go through the business planning process.

Risks & Challenges:

Obstetrics and Gynaecology capacity – Still have approx. 50 women (needing surgery) who will breach 78 Weeks by the 31st March 2024. We are working on reducing this but with the current financial constraints and ability to operate on our cohort of women at the weekend it is challenging. There are also significant challenges with the 28 day faster diagnostic pathway with several women breaching this standard. Administrative shortage due to sickness, leave and turnover, which is causing a challenge.

9.5 Maternity

Care Quality Commission (CQC) Inspection:

The CQC conducted an inspection of the Trust's maternity service on 22nd November 2023. The inspection was part of the national maternity inspection programme. Two days after the visit, a letter of intent was received notifying the Trust of two serious concerns that they had identified during the visit. These two areas of concern related to Maternity Triage and the provision of a dedicated second emergency Obstetric theatre. A further concern was escalated a week after the visit via email with regard to the resuscitation equipment available on the antenatal/postnatal ward. Details of actions and mitigations were provided to the CQC as requested. They were satisfied with the response and the report is anticipated early in 2024.

Any additional resource has/will be taken through the Care Group governance and escalation processes.

Maternity Incentive Scheme (MIS):

Work is ongoing to provide the necessary evidence for the year 5 MIS submission that is due on 1st February 2024.

The areas of risk are obstetric workforce and the ability to protect compensatory rest and neonatal nursing workforce. These areas may impact on the ability to declare full compliance and thus impact on the receipt of the incentive payment. The local maternity and neonatal system (LMNS) on behalf of the ICB are required to approve certain elements of the evidence submitted and a representative from the ICB will attend the Trust Board meeting in January to jointly approve the submission.

An extraordinary QAC meeting is being held in January 2024 to review the submission evidence prior to the Board meeting.

9.6 Healthy Lifestyles & Personalised Care

The team have been working with the Trust on the review of Care and Health Apps (ORCHA) to develop a digital health campaign to support work around winter pressures. We have developed a digital resource (web page and App library) that will support people to manage their health over winter. The web page also has links to support services available to people across Devon. The link to the ORCHA page (via QR code) will be included within discharge information packs to help people self-manage and reduce the likelihood of readmission. The winter wellbeing resource will be promoted through the Trust communications team as well as through the Devon ICB communications team.

The team have been successful in a bid submission to the Devon ICB South Population Health and Prevention Fund, to assist with the recovery of the strength and balance exercise programme. The programme supports about 600 people per year to improve their strength and balance, reduce the risk of falling and maintain independence. Since the Covid-19 pandemic, waiting times to start the programme have been increasing, with some of the fall's classes having waiting times of between 12 and 17 weeks. The successful bid will provide additional classes to be delivered and this will reduce the number of people waiting for a programme and allow the service to recover by providing an additional 64 spaces on the programme.

9.7 Social Care

Cost Improvement Plans for Adult Social Care (ASC) are on track, contributing £2.7M in 2023/24. The Hospital In-Reach Project has achieved a 60% reduction in discharge pathways, expediting discharges for 483 patients. Additionally, 261 patients transitioned from P2 to P1, enabling them to return home, reducing the length of stay for 483 patients and mitigating the risk of patient deconditioning. In December, 30% of reviews in McCallum ready-to-go wards resulted in 73% reduction rates, with 22 patient reductions.

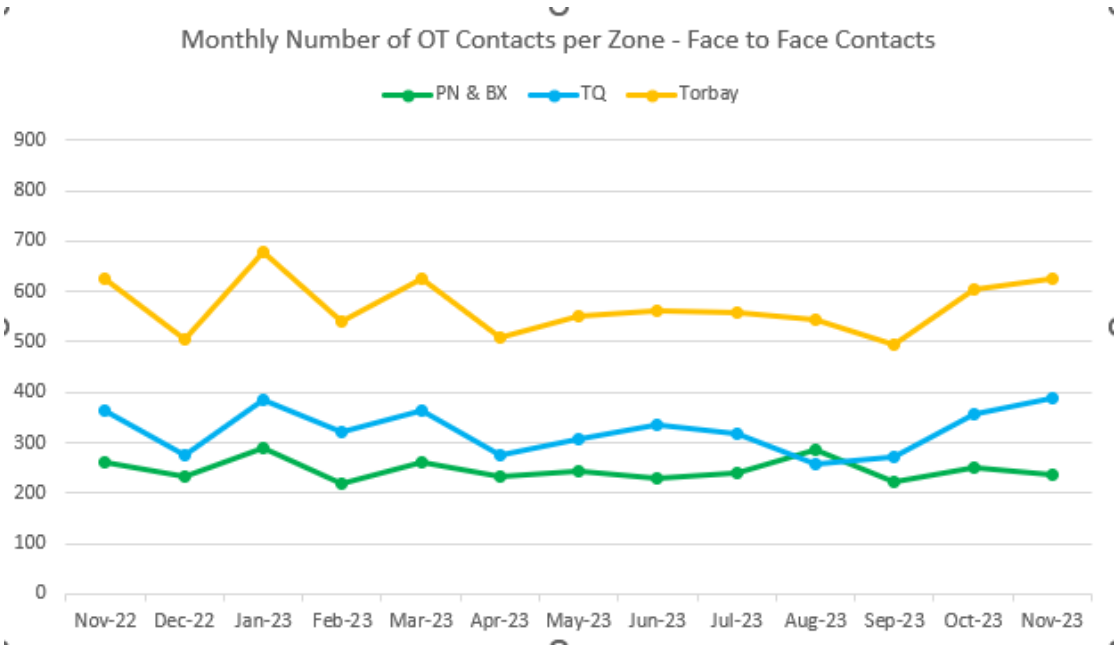
The decline in clients awaiting allocation in M05 and M06 is credited to the Social Care Waiting List Recovery Plan. However, a plateau in M07 through M09, with fluctuations attributed to work allocation, and an upward trend in the complex care waiting list in M09 are observed. The Baywide social care team monitors Recovery Plan performance amidst social care recruitment challenges. The plan will factor into resource planning for 2024/25 transformation activities.

An external partner initiated an ASC IT System options appraisal on January 8, 2024, spanning eight weeks. The partner will also assist in delivering transformations post-Q2 diagnostic activities. Ethnicity recording is recognised as an improvement area; a task group is addressing this, aiming to capture baseline ASC national fields. The social work registration process and responsibilities have been outlined, with active Social Work England (SWE) register checks completed in December 2023. Two staff members finished the Assessed and Supported Year in Employment program in December, with two more scheduled to begin.

9.8 Bay Wide Community Health Services

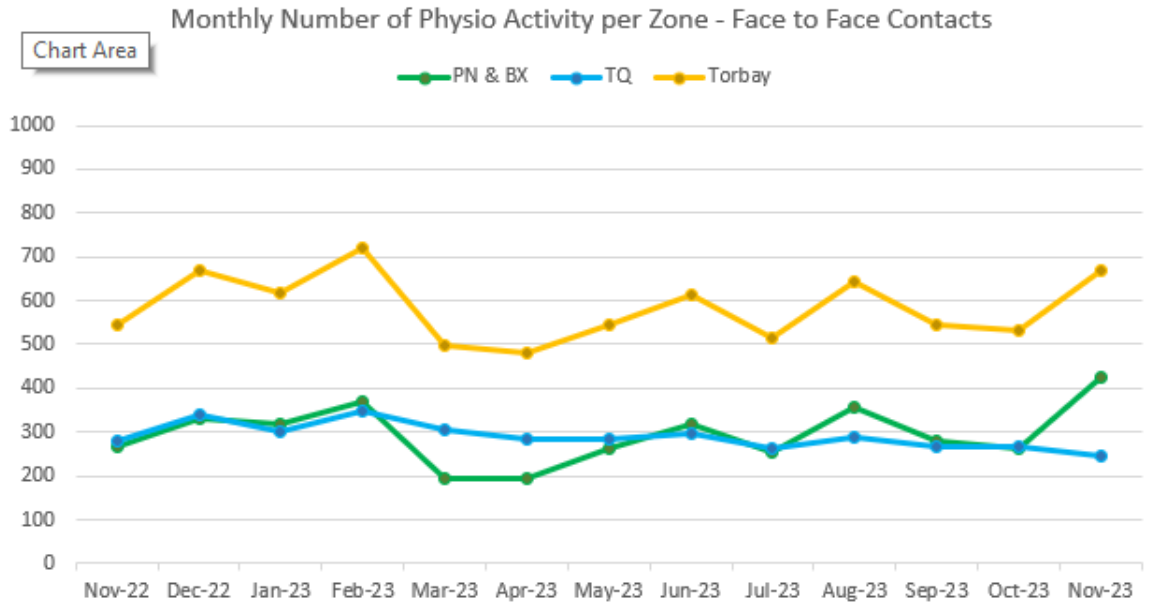
9.8.1 Therapy

The occupational therapy (OT) waiting list is on average 60 in both areas with the oldest wait from June for a referral.



Physiotherapy (PT) team list in Torquay is 45 with a wait of three weeks and Paignton and Brixham is 60 with a 4.5 week wait. The return of an Assistant Practitioner from her training placement will assist in reducing these waiting lists.

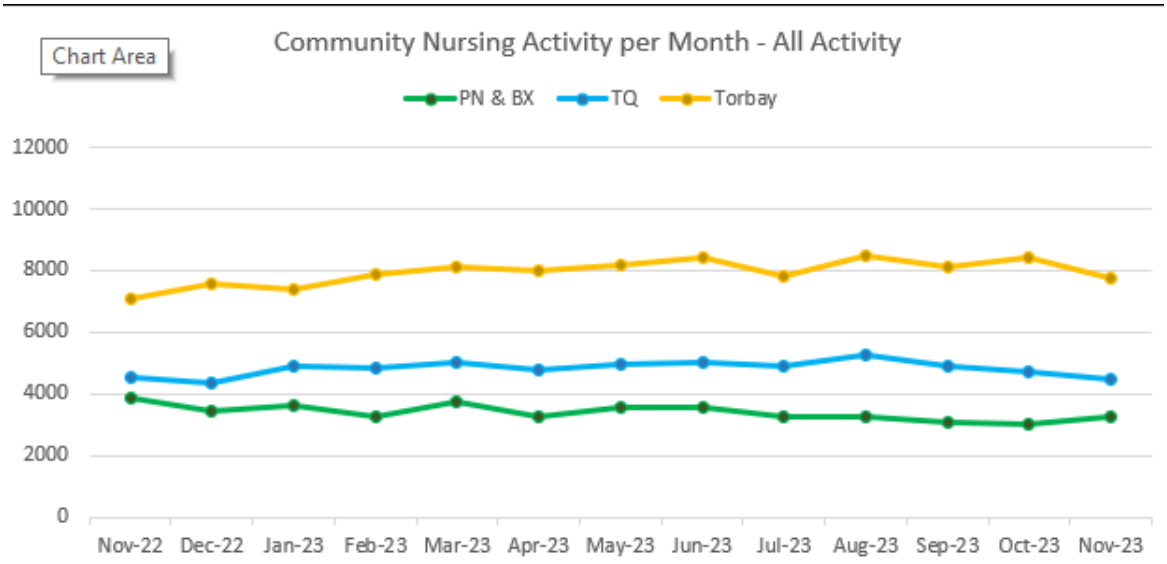
Physio activity



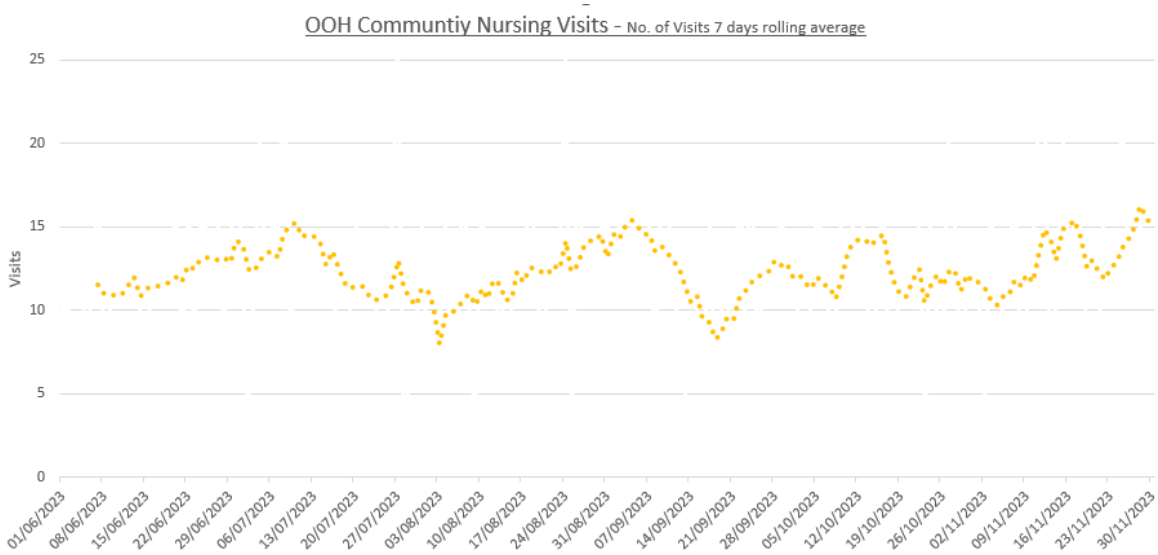
9.8.2 Community Nursing

The Torquay (TQ) community nurses (CNs) have two band 5 vacancies which are out at advert.

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

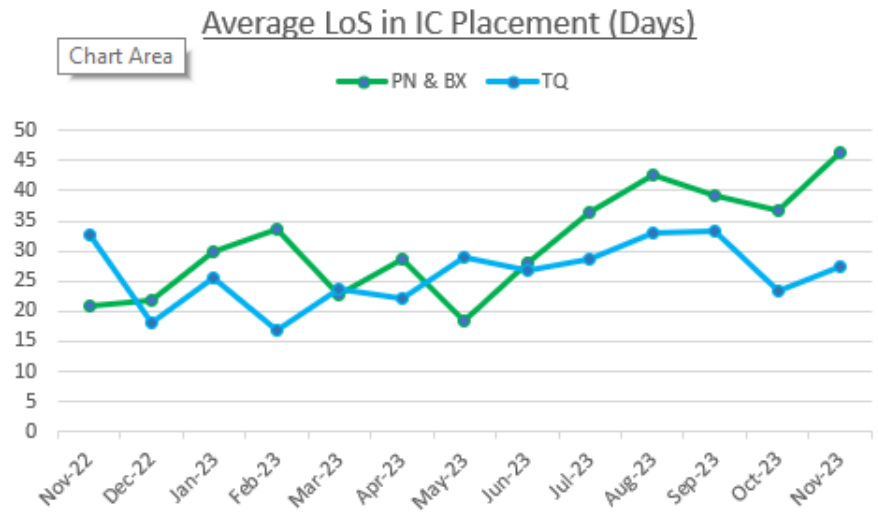


The Out of Hours (OOH) CN team are recording the number of visits and mileage travelled so that we can reskill mix the service in line with productivity. We have moved some budget to support recruitment in busier CN teams.



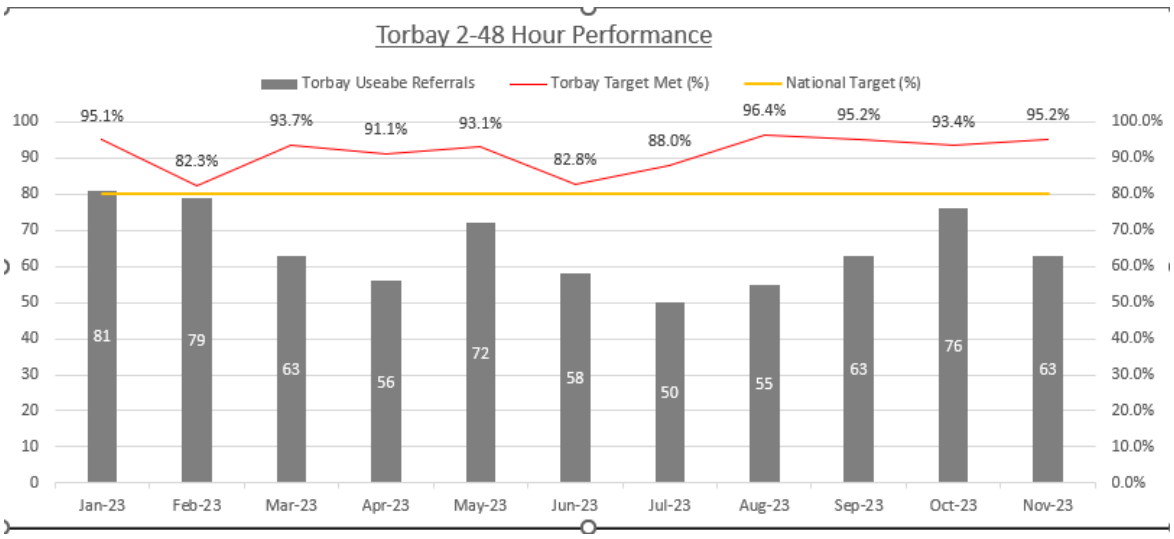
9.8.3 Intermediate Care (IC)

In December 2023, we launched the Baywide Intermediate Care (IC) pilot. It involves one team managing patients in IC placements and another team overseeing IC treatment at patients' homes. The goal is to enhance team productivity and decrease placement duration. While the chart indicates a rise in length of stay (LOS), it highlights areas needing attention, particularly in intermediate care referrals.

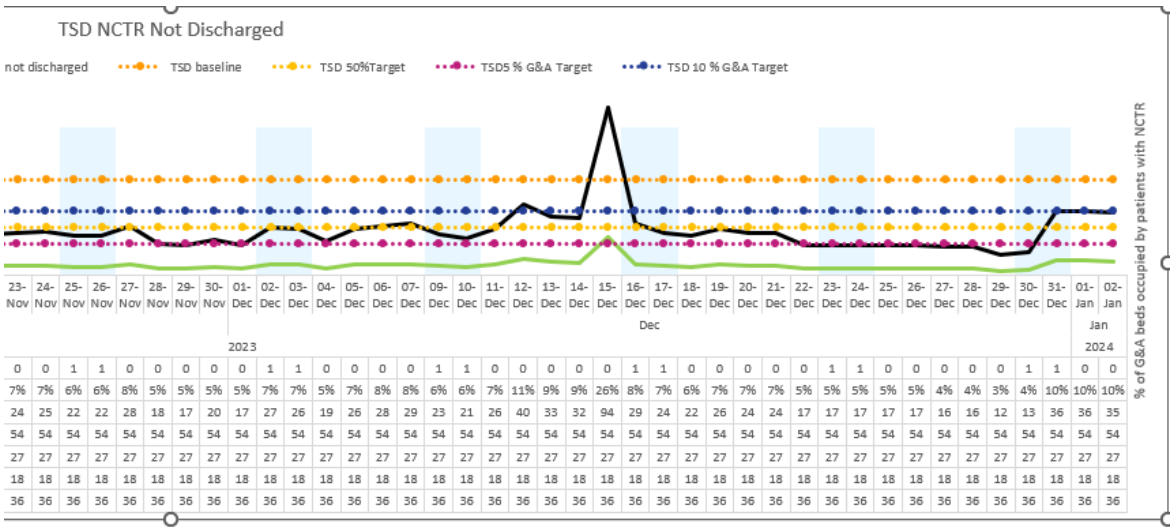


9.9 Urgent Care Response (UCR)

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 organisation submits the data weekly to the ICB. The teams are increasing their referrals into the UCR 2-hour response. The chart illustrates an increase in referrals.



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



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7%	7%	6%	6%	8%	5%	5%	5%	5%	7%	7%	5%	7%	8%	8%	6%	6%	7%	11%	9%	9%	26%	8%	7%	6%	7%	7%	7%	5%	5%	5%	5%	5%	4%	4%	3%	4%	10%	10%	10%	
24	25	22	22	28	18	17	20	17	27	26	19	26	28	29	23	21	26	40	33	32	94	29	24	22	26	24	24	17	17	17	17	17	16	16	12	13	36	36	35	
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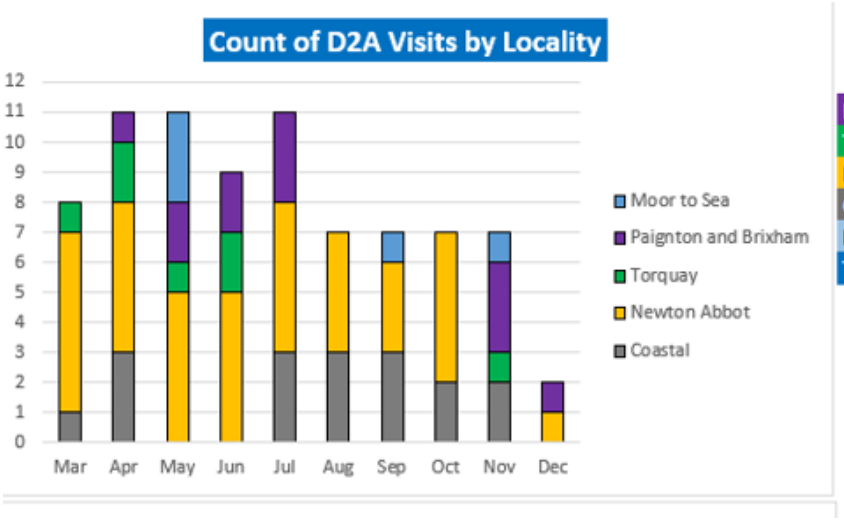
The No Criteria to Reside (NCTR) percentage has varied between 3% and 10% throughout December. There was an increase in NCTR over the last bank holiday in 2023, influenced by staffing challenges in the Arranging Support Team for Devon County Council (DCC), which operated below core numbers, resulting in no discharges from P2-3 for DCC residents. We have established plans to bring the NCTR down to 5% or less.

- Conducting daily reviews of No Criteria to Reside (NCTR) and ensuring accurate recording.
- Implemented twice-weekly meetings to promptly review patients referred for assessment by the Complex Discharge Team, aiming to streamline the process from referral to assessment documentation sent to the Discharge Hub. This initiative aims to minimize deconditioning by reducing the loss of bed days.
- Introduced a second Inreach team member in December, with a specific focus on the Ready to Go unit.
- Ongoing collaboration with clinicians in the Discharge Hub to efficiently complete Functional Discharge to Assess (D2A) assessments.



P & B	12	15%
Tqy	7	9%
NA	39	49%
Cst	17	21%
MtS	5	6%
TOTAL	80	100%

Pathway 1 (P1) - we have movement and good flow. Time to transfer reduced to on average 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 and a further 4 IC block beds in Lake View commenced in December 2023. 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.

Continue to be limited with providers who have the core competencies and skills to manage people with dementia and with behaviours that challenge.

9.11 Continuing Healthcare (CHC)

The Torbay and South Devon Continuing Healthcare (CHC) team is currently exceeding national targets, achieving a 93.5% rate for CHC decisions made within 28 days, surpassing the 80% target. While there has been a slight decline in new CHC referrals and fast track applications, there is a corresponding increase in requests via Short Term Services (STS) and Interim Health Funding (IHF). Additionally, there is a rise in urgent crisis health funding requests from Devon County Council (DCC) and Torbay.

The team has successfully reviewed clients, identifying savings through package and care reviews. Ongoing plans involve further reviews in the coming months. Awaiting approval to recruit a mental health nurse to address resource gaps, especially in handling complex cases with 1:1 support.

The CHC IT system managed by Torbay Council requires detailed enhancements to align with Department of Health (DOH) performance requirements. The current manual data manipulation for accurate reporting poses challenges, and alternative systems with end-to-end solutions are being explored. Mindful of ongoing work within the Trust on alternative IT solutions.

Personal Health Budgets remain a risk area for CHC-funded clients, particularly in Torbay due to the absence of infrastructure for a default offer. Risks involve employment rules, budget calculations, insurances, and legal challenges.

Anticipating new Department of Health guidance on Previously Unassessed Periods of Care (PUPoCs), allowing clients or representatives to request reviews back to 2012. A call on January 12 will further clarify how providers and Integrated Care Boards (ICBs) will manage this, with updates to follow.

10.0 Healthcare of Older People (HOP) and Frailty

Dr Kath Bhatt, GP and Clinical Lead for the Frailty Virtual ward (FVW) has been joined by two colleagues; Laura Anscombe and Rachael Perkins started on the 20th and 27th November respectively as trainee Advanced Clinical Practitioners. This has allowed the FVW to expand the pathways they support with an increase in referrals. They now take both step-up and step-down referrals and are supporting patients from 4 of our 5 localities. Newton Abbot Community team have requested that a roll-out across their locality is deferred whist they resolve some staffing challenges.

We are actively recruiting for additional senior clinical decision-making support in the form of additional GP hours, but discussions are also underway within the HOP team about an expansion of Specialty and Specialist (SAS) grade doctors to support our services and increase bed numbers.

Frailty same day emergency care (SDEC) was due to go live on 11th December. However, due to the inability to secure a nurse to support patients in the SDEC area and then the subsequent industrial action which meant consultant resource had to be diverted to the greatest need, SDEC did not open. We are still hoping to "go live" in January for the pilot, initially until the end of February, and the team are optimistic about what they can achieve for older people living with frailty. The aim of a Frailty SDEC is to identify smaller numbers of patients attending the Emergency Department (ED) or Acute Medical Unit (AMU) and take them through a same day emergency care pathway ensuring they have a holistic, multi-professional Comprehensive Geriatric Assessment which is an evidence-based intervention shown to improve outcomes and prevent reattendance or readmission in this patient cohort.

10.1 Stroke Services

SSNAP Scoring Summary:	*Team type*	*Routinely admitting team*	*Routinely admitting team*
	ISDN	SW Peninsula	SW Peninsula
	Trust	Torbay and South Devon NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust
	Team	Torbay Hospital	Torbay Hospital
	Time period	Apr-Jun 2023	Jul-Sep 2023
	SSNAP level	D	D
Team-centred KI levels:			
Team-centred Domain levels:	1) Scanning	A	B
	2) Stroke unit	E	E
	3) Thrombolysis	D	E
	4) Specialist Assessments	E	E
	5) Occupational therapy	B	C
	6) Physiotherapy	D	D
	7) Speech and Language therapy	E	E
	8) MDT working	C	D
	9) Standards by discharge	A	B
	10) Discharge processes	B	B
Team-centred KI level	Team-centred Total KI level	D	D
	Team-centred Total KI score	56.0	46.0
Team-centred SSNAP level	Team-centred SSNAP level (after adjustments)	D	D
	Team-centred SSNAP score	56.0	46.0

The Q2 (July – September 2023) Sentinel Stroke National Audit Programme (SSNAP) results were released in December. George Earl retained a D but dropped in their points scoring, with four domains dropping from the previous quarter. Once again, the domains that we struggled most with were those describing the hyper-acute pathway, i.e., domains 1-3 plus domain 4 - specialist assessments. The Specialist Stroke Nursing is now at establishment and all nurses have completed their induction. Speech and Language Therapy had positive changes within their workforce at the beginning of

September. It is hoped that these changes will support improvements in domains 4 and 7 which would reflect in the results due for release in March. Occupational therapy has had a fluctuating performance also linked to staffing; this will be discussed at our Stroke Team Meeting.

In Q2 results show that Templar Ward dropped to a D in their SSNAP performance. This was driven by scoring an E for Audit Compliance and a D for Case Ascertainment (which dropped from a B). These scores describe the timeliness and quality of inputting to SSNAP.

The Stroke Performance Co-ordinators started in post at the beginning of January and this role will support the consistency, accuracy, and timeliness of inputting to SSNAP across the whole pathway also releasing clinical time back to patient care.

In November we reported that we had bid to become one of 6 sites nationally to be part of the first Thrombolysis in Acute Stroke Collaborative (TASC). Our bid was successful and in December we had our site visit, and the 12-month programme starts this month. Our aim during the programme is not only to increase the thrombolysis rates for patients admitted to Torbay with stroke but also to improve the timeliness of scanning and admission to the stroke unit. We have the support of our local Integrated Stroke Delivery Network (ISDN) during this project and our project team has been established to include ED, radiology and SWASFT colleagues.

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	Oct-23	Nov-23
Number of patients (N)	42	46	60	47	59	49	54	69	66	72	62	62	65	55	57	44
% 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	49.1	54.4
% 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	89.5	100
% Admitted to Stroke Unit within 4 hours	35	17.4	8.8	27.1	0	14.9	15.1	29.9	33.1	28.2	25	20.3	27	18.5	28.6	20
% of patients spending 90% of their time on the Stroke Unit	65	53.3	59.3	76.1	48.1	61.7	68.5	71	61.5	77.8	59.7	70.5	69.8	69.1	66.7	63.6
% (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)	7 (4)	15.9(7)
% Received Thrombolysis within 1 hr	25	20	50	100	25	60	0	57.1	50	16.7	42.9	75	0	0	75	57.1
SSNAP		A	B	C	D	E										

As previously reported stroke admissions to Torbay are increasing. We have seen a 27% increase in admissions annually in 2023 compared to 2019 and a 45% increase in admissions in the last 12 months. This is in line with a national trajectory predicated pre-Covid which dipped during the pandemic.

The number of strokes in November is believed to be higher than the 44 reported here; this data will refresh later in January. However, the narrative remains the same. Whilst the focus on the ring-fencing of beds on George Earl Ward is improved the increased number of stroke admissions and pressures on flow still means that we are struggling to get patients to the ward in 4-hours. Our thrombolysis performance has improved in the three months since the Q2 results and it is hoped that the work with TASC will support an increased focus on this and help us improve the quality of this element of the pathway for our patients.

We have restructured our Stroke Team meetings to focus on key areas and to try to make them less vulnerable to cancellation due to system pressures. The first of these meetings is at the end of January and this is a key focus for the next month.

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: Chief Executive's report			Meeting date: 31 January 2024
Report appendix:			
Report sponsor:	Chief Executive		
Report author:	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

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 29 November 2023 are as follows:

3.1 Excellent population health and wellbeing

New mobile breast screening unit opens

Our new £240,000 mobile unit was officially opened at Dartmouth Health and Wellbeing Centre earlier this month. The unit has been in operation since December to help us meet the NHS target to offer all eligible woman a screening every three years. The team has already completed around 900 screenings since the new unit was delivered.

Serving such a rural location, mobile screening units help us to reduce inequalities and provide this vital test for breast cancer without having to come to our hospital in Torquay. The mobile unit moved on to Teignmouth on 15 January 2024 and rotates around nine locations in our Torbay and South Devon footprint.

Healthy lifestyles and personalised care

The team have been working on the review of Care and Health Apps (ORCHA) to develop a digital health campaign to support work around winter pressures. A digital resource (web page and App library) has been developed that will support people to manage their health over winter. The web page also has links to support services available to people across Devon. The link to the ORCHA page (via QR code) is included within discharge information packs to help people self-manage and reduce the likelihood of readmission.

The team have also been successful in a bid submission to the Devon ICB south population health and prevention fund, to assist with the recovery of the strength and balance exercise programme. The programme supports about 600 people per year to improve their strength and balance, reduce the risk of falling and maintain independence. Since the pandemic, waiting times to start the programme have been increasing, with some of the fall's classes having waiting times of between 12 and 17 weeks. The successful bid will provide additional classes to be delivered and this will reduce the number of people waiting for a programme and allow the service to recover by providing an additional 64 spaces on the programme.

Spotlight review of children's mental health services
In December, Torbay Council's overview and scrutiny committee (OSC) held a spotlight review of mental health services to look at the provision of mental health, therapeutic and emotional wellbeing services for children and young people in Torbay. The aim of these services is to provide early support and reduce the number of people meeting the threshold for children and adolescent mental health services (CAMHS).

The committee was attended by senior leaders from NHS Devon, ourselves, Devon Partnership Trust, Children and Family Health Devon and Children's Social Care. Members of the public were present also present.

The committee asked to receive an update on CAMHS and the action being taken to reduce waiting times and explore options for young people who do not meet the threshold for formal CAMHS referral or support. Members also wanted to understand the transitional arrangements for CAMHS for children 18 years and older.

The experiences of people who use CAMHS were shared with the committee and themes included commissioning, waiting times, support for transition into adulthood, and accessing services.

While the focus of the meeting was on specialist community CAMHS provision, the discussion demonstrated an awareness of the systemwide responsibilities for children's emotional wellbeing and mental health.

The committee made a set of recommendations which have been shared with health partners. Health partners will return to the OSC in April to present an update.

We remain committed to working together as a joined-up health and care system to support children and young people and their families to receive the help, care and support they need when they need it.

National apprenticeship week event – recruiting our future workforce
A range of professionals from clinical and non-clinical roles will be available at our apprenticeship team careers event to talk to anyone interested in an apprenticeship. The event will run in the Horizon Centre at Torbay Hospital on Thursday 08 February from 9am-4pm.

Support for new fathers
DadPad was recently launched across Torbay, which is an essential guide for new dads, helping them to get to grips with their new responsibilities, gain confidence, and offers the tools and practical skills to best support their baby and their baby's mum.

The DadPad is also intended to assist health professionals engage and build relationships with new dads and dads-to-be. Same-sex parent pad is also available for co-parents and birth partners.

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 eighth consecutive month our urgent and emergency care performance was above 60%. We saw 8,766 attendances in December, an average of 282 patients per day. Our performance remains behind our trajectory for the national oversight framework (NOF) 4 recovery target of 72% at 68.02% for December. Our performance in our urgent treatment centre and minor injuries unit remains consistent at 99.78%.

While we know we have much more work to do on ambulance handover delays, the average time lost per ambulance to handover was 1hr 12 mins in December 2023, a distinct improvement on the December 2022 when the average time was 3hrs 24minutes. We remain committed to working towards the 15 minute handover target.

In terms of getting people home quickly when they are well enough to do so, we remain behind target for our pre-noon discharges at 26.6% against a target of 33%. 74.2% of people went home before 5pm in December. Our discharge lounge supported 681 people in December 2023 and is now open at weekends and will remain so until April 2024 as part of our winter plan.

Our cancer performance has remained relatively stable for our three core waiting time targets. Our performance in planned care services has remained strong and we are meeting our targets for 104 week waits. We continue to see impact of the industrial action 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. However we are ahead of our revised plan for 78 weeks and just behind our plan for 65 weeks which is a remarkable achievement given the challenges our teams have faced. Overall we have reduced our waiting list over 12 months from over 44,000 people to 34,000 people – a reduction of 23%.

Our frailty virtual ward has expanded and is now taking both step-up and step-down referrals and supporting people from four of our five localities. Frailty same day emergency care is due to go live this month.

Our child health teams are on track to clear all 65 week waits by the end of March 2024. The number of children on the waiting list have reduced from a peak of 1,934 at the start of the financial year to 1,524 in December 2023, a reduction of 21%. Both general and community waiting lists are at their lowest for at least two years. This positive progress has been due to the sustainability and transformation plan the teams have implemented over the past nine months.

Industrial action
The British Medical Association (BMA) undertook industrial action during December and January as part of its ongoing dispute with the government over pay and conditions.

This latest round of industrial action was the longest in the NHS' history and took place during one of the busiest periods of the year, coupled with a rise in seasonal infections including norovirus, COVID-19 and flu which impacted on Devon's health and care system.

We had planned for this action and our priority was to ensure that all our services could be delivered safely. I would like to take this opportunity to thank everyone who was involved in planning for this action and delivering care during a challenging two weeks.

This latest action did impact on our services and we worked hard to ensure that disruption was kept to a minimum, but we did have to make the difficult decision to stand down some people's appointments. We do not take these decisions lightly, but safety remains our number one priority and I would like to apologise to anyone whose appointment or procedure was affected.

On 25 January consultant members of the BMA voted 51% against the government's offer in the pay referendum. Consultants have not announced details of any planned industrial action, but we hope that the government and the BMA will reach an agreement as soon as possible.

Maternity hotline
Anyone who is pregnant or has had a baby and lives in Torbay and South Devon can now call an improved maternity hotline if they need urgent medical advice and help from a midwife.

Our improved maternity triage line is available 24 hours, seven days a week for anyone who is more than 12 weeks pregnant or has had a baby in the past 28 days. They will be able to talk to a midwife if they are experiencing cramping, bleeding, reduced baby movements, their waters have broken or labour has begun or they are concerned about anything else related to their pregnancy or recent birth. The number is 01803 656588.

New transitional care ward
Our new transitional care ward within special care baby unit (SCBU) formally opened last month, this unit is designed to keep mother and baby together, promotes breast feeding and reduces early years re-admissions for paediatrics.

Pioneering cancer vaccine research trial
Our research and development department has been selected to take part in a ground-breaking cancer vaccine trial. The study will focus on exploring the safety and efficacy of a personalised cancer vaccine.

People who have had surgery to remove their cancer, but whose blood tests have shown that there may be a risk of the cancer returning, are eligible to take part in the study. They will have their individual tumour mutations studied and sequenced, which will be used to create a bespoke therapeutic vaccine specific to their tumour to delay or stop it from returning.

First patient enrolled in PhEAST study
Katy Gass, speech and language therapist, and the team on George Earle ward who have successfully enrolled the first Torbay and South Devon patient into the PhEAST study.

The study is trialling a nasogastric tube, which delivers electrical stimulation to the nerves at the back of the throat in patients who have had a stroke, to see if it improves their ability to swallow.

Award-winning personalised care
We are proud to have had two winners at last month's South West integrated personalised care awards. Personalised care, or what matters to you, is one of our six strategic priorities as an organisation as we work together to deliver our vision of better health and care for all.

The cancer services team won the choice and control award for their pilot to support people with cancer to self-manage their diagnosis throughout treatment and when they are living with and beyond their treatment. This approach has demonstrated that with the support of our communities and multidisciplinary teams, people's knowledge, skills, and confidence to manage their own care is markedly increased. When treatment is required, they can be part of a shared decision-making conversation with health specialists, to help them make the right choice for them, and with better long-term health outcomes.

Andy Simpson won the delivering best value award for his work to support people to stop smoking with the use of a personalised health budget. This project has had a high success rate and is enabling people to take steps toward healthier lifestyle choices. The innovative use of personal health budgets and personalised care conversations shows a clear cost saving to our health and care system and a lifesaving change for people.

Creating inclusive, compassionate workplaces to deliver safe care
We are committed to ensuring our organisation is a safe and healthy place to work, where our people feel valued and supported, have opportunities to learn and grow, and choose to stay working with us.

Our people priority is to build a healthy culture at work, where our people feel safe, healthy and supported. At the heart of this and one of our three people goals is our compassionate leadership framework which launched in 2023 with a full programme of support that will continue through 2024.

Alongside compassionate leadership is our people goal to build an inclusive culture. Our people have told us that having an inclusive culture is important to them, and we believe it is too. The need to strengthen our equality, diversity and inclusion (EDI) work was also highlighted by the Care Quality Commission (CQC) during its inspection of our services last year. To support this, we have launched our new EDI training module, called It starts with me, this month.

Everyone must complete this training by 22 July 2024, regardless of their role. The training module features the experiences of some of our people of when they felt discriminated due to their race, gender, religion, sexuality or other reasons, had received unwelcome attention or were made to feel uncomfortable because of someone's inappropriate language or behaviour.

We are also finalising our plans to launch our new Patient Safety Incident Response Framework (PSIRF) on 01 February, which will fundamentally change our approach to patient safety incidents and how we investigate them. We will work closely with people who have experienced or been involved in a patient safety incident and involve them in our reviews to make sure we learn from safety events to reduce the likelihood of reoccurrence.

This year we will focus on delays in elective care, elderly and frail care pathways and diagnostic testing to improve safety for patients and to continue to improve our services.

Midgley Ward, our DAISY team award winner
Our annual DAISY team award has gone to Midgley ward who were nominated by a patient's relatives for the incredible care they gave to their father in his last weeks.

The nomination read: "My father was in Midgley ward for just over two weeks in October with fluid on the lung, which was found to be lung cancer. Initially, he underwent active treatment to try and improve his situation but after a few days, it became clear that active treatment was no longer an option and Dad entered the palliative stage.

"I can't fault the care given by the nurses and HCAs. I always felt listened to when I expressed any concerns and they were acted on almost immediately.

"My brother and I were left feeling peaceful and happy and I will carry the experience of that week with me my whole life. It was so special and profound with some extremely precious moments and I have the team at Midgley to thank for that."

The family also presented the ward with a copy of their late father's last painting to display on the ward.

Celebrating our South Asian colleagues
Last month Sanita Simadree (equality, diversity and inclusion lead), Fahida Manby-Rehman (clinical nurse specialist, head and neck cancer) and Alston Owens (assistant director of finance) attended a special event for the Asian Professionals National Alliance (APNA) – a network of South Asian heritage NHS colleagues and allies. The event was hosted by the Rt Hon Preet Kaur Gill MP, shadow MP for primary care and public health at the House of Commons in honour of the NHS 75th birthday.

Ward accreditations
Ten of our wards have undergone accreditation since my last report to Board. EAU4 and Allerton ward maintained their silver award while George Earle, Dawlish hospital and Teign and Templer wards (Newton Abbot hospital) achieved a silver award. Dart ward (Totnes hospital), Cheetham Hill, Cromie ward and McCullum ward achieved bronze awards.

Virtual reality taking carers closer to the action
Ground-breaking Virtual Reality (VR) and 360 training is helping to bring vital training sessions to life and improving the care people receive.

A Train to Restore session was held in the Horizon Centre in November where people who are responsible for the care of the elderly used this technology to improve the response to numerous challenges, including spotting the signs of dehydration in the

elderly.

Due to the number of homes we support, it has become increasingly more difficult to train within each care home. We have created this VR package to put trainers into a real-life scenario highlighting the dangers of deterioration.

The immersive nature of 360 media when used with VR headsets allows users to step into the shoes and experience scenarios from the perspective of someone within the environment.

This training is essential as detecting early deterioration in our care patients and residents is vital; if is spotted and escalated at an early stage, this will prevent hospital admissions and enable people to get the care they need in the place where they live.

3.3 Excellent value and sustainability

New day theatres shortly to open at Torbay Hospital
We are finalising our plans to open our two new day theatres and to begin seeing patients from mid-February.

The two new theatres have benefited from £15million capital investment which will significantly increase capacity and allow an extra 4,500 people who need hip, knee and eye operations to be treated quickly.

The opening will mark another significant milestone in our building a brighter future programme which seeks to improve people's experiences and outcomes of care while reducing waiting times, following the opening of our £4.99million endoscopy unit last November, our £2.8million radiotherapy planning CT suite last October and our £15 million acute medical unit in December 2022.

Earlier this month we welcomed Newton Abbot MP, Anne-Marie Morris, to see the new endoscopy unit and speak to our teams about how they are significantly reducing waiting times for endoscopy services thanks to the new facilities. We also took the opportunity to show Ms Morris the new theatres under construction and she also spent time with our digital futures team looking at how virtual reality, augmented reality and new digital technologies are transforming the way we deliver care, support and information to people of all ages.

New MRI/CT units available at Newton Abbot
In December we welcomed the first patients to use our two new MRI/CT units at Newton Abbot Community Hospital, as part of our focus on early diagnosis and treatment.

The radiology team has had a long-held ambition to install a second MRI/CT pad, and this was made possible thanks to a £412,000 capital investment funding. This new pad will enable us to provide increased capacity for CTs, helping to reduce waiting times for people who are waiting for a vital diagnostic.

Further diagnostic capacity will come to people in Torbay and South Devon when the new community diagnostic centre opens in the spring. Run by In-Health, the new centre will be located in Torquay and provide a wide range of services.

Leadership team changes
Last month we said goodbye to Ian Currie who has retired after many years dedicated NHS service. As I shared with you in my report to November's meeting, Dr Kate Lissett is our new Chief Medical Officer following a competitive recruitment process.

We also said goodbye to our chief nurse, Deborah Kelly, who left us just before Christmas to take up a new role in the new year with Croydon Health Services NHS Trust as its chief nurse. Following robust interviews, we have appointed Nicola McMinn to be our interim chief nurse. Nicola has been with us for two and a half years, first as our head of nursing workforce and latterly as deputy chief nurse.

Recruitment process for a new chair
Our chair, Sir Richard Ibbotson, leaves us at the end of his term in May 2024 after 10 years' dedicated service. Sir Richard will be greatly missed and we are now looking to recruit a new chairman who shares not only our values but has the skills and expertise to help us to deliver our ambitious plans and vision to provide better care for all. The final stage of the selection process took place on 24 January and we will announce our new chair in the coming weeks.

Our electronic patient record (EPR)
We are delighted to announce that, following a competitive tender, Epic is our preferred supplier for our electronic patient record (EPR) system, subject to contracts. Epic has worked with numerous NHS trusts across the UK to deliver their EPR.

Our EPR is pivotal to transforming our acute and community services, embedding clinical good practice and providing better care and outcomes. It will change the way that we use and share information by having real time data about our patients, whenever and wherever we need it. It also brings us a step closer to becoming a digitally-enabled organisation.

This represents a significant programme of work across all of our services and communities. It will impact every colleague and patient and will be replacing up to 25 major systems, as well as many other smaller systems.

The next steps are to detail the implementation plan, finalise our commercial arrangements and submit our final full business case to NHS England with implementation planned for 2025.

Sale of properties no longer needed for healthcare
In late November we completed the sale of the former Bovey Tracey Community Hospital, which closed in 2017. The funds received will help our financial position and support us to deliver best value.

We have completed the sale of the former St Johns ambulance premises adjacent to Brixham community hospital to Brixham Town Council. The Town Council plan to develop the site for their Lengthman Service (who maintain the trees, grass verges and hedgerows at the sides of roads).

We have proceeded to open market disposal for the sites of the former Dartmouth and Kingswear community hospital and Dartmouth Clinic using Montagu Evans – bids will be received by the end of January 2024. We will review bids to ensure we deliver against our commitment to the local community to deliver best value. We have always

been open about our intent to proceed to open market disposal if the community bid was not successful.

Six firms generously sponsor our 2024 our people celebration event
Bailey Partnership and Services Design Solutions have joined PSB Scaffolding, KTA Architects, Kier and Nevada Construction as sponsors for the annual event which celebrates the achievements of our staff who have gone above and beyond to provide compassionate care, supported their colleagues, or improved services.

We are very proud of our people who supporting people to live well across Torbay and South Devon. Our annual celebration is our opportunity to say thank you and celebrate their achievements but without our generous sponsors we would not be able to do this in the way that we would wish.

Little ones remembrance weekend
Two special events were held at the start of December for families who had experienced the loss of a child or a baby during pregnancy. Organised by maternity, chaplaincy and community nursing teams, a craft morning and remembrance service took place.

Many parents, children and other family members attended the craft morning which was held at Torbay Hospital's Bayview Restaurant. Everyone had a great time making Christmas decorations and a variety of star-themed crafts to take home. Face painting and biscuit decorating were also very popular!

The following day, the service was held at All Saints Church, Babbacombe, which provided a more reflective opportunity for people to come together and remember their little one by lighting a candle and writing a message on a star. The stars are then hung on a tree, provided by our grounds and garden colleagues, which they collect after the service and is put on display at the hospital chapel. In the new year, the team then plant the tree on the Torbay Hospital site.

Over a hundred parents, grandparents and other relatives attended. A combined church and hospital choir sang "Count the Stars" and parents contributed readings and poems.

Dunelm delivers joy to Torbay Hospital
We are delighted that Dunelm Torquay chose us to be part of their Delivering Joy campaign again this year.

Thanks to the kindness of Dunelm staff and customers we received 187 bags of gifts, full of thoughtful items to support our most vulnerable patients as they leave hospital over the Christmas weekend.

We also received lovely gifts of sweets, biscuits and hand creams for our teams which have been very much appreciated.

Louisa Cary's festive fixture
In December stars from our favourite football team, Torquay United brought much-needed festive cheer to Louisa Cary ward, as well as gifts for the children. Children and their families enjoyed meeting and talking to the players who kindly took time out of training to pay them a visit.

Torbay Hospital Nurses League help support people in our care with dementia, delirium or a cognitive impairment
We have been trialling a pilot dementia and delirium team that can support and assess people when in hospital to ensure they have a care plan that supports their needs. Our Torbay Hospital Nurses League have generously donated games and activities which the team can provide when they are spending time with people in our care.

Torbay Hospital League of Friends' presidents celebrated in new wallpaper mural
The generosity of Torbay Hospital League of Friends' presidents during the past 70 years has been immortalised on a new commemorative wall.

The wallpaper, located in two locations at Torbay Hospital, recognises the dedication and leadership that the presidents have provided throughout the league's nearly 70-year history.

Current members of League of Friends, family members of presidents and members of our Board attended an opening celebration in December. A plaque records the names of all the league's presidents including Mr Earnest Hutchings, Mr J J Cox, Mr B Venn Dunn, Mrs M Ball and Mr W G Standley. The wallpaper provides more insight into the people behind the names, featuring the current league president Pat Roberts (who has been an active member for more than 60 years) and the three presidents who came before her: Joan Williams, Fred Payne and David Hall.

Torbay Hospital marked its 95th anniversary in November and this year the league will celebrate the 70th anniversary of its formation. Torbay Hospital League of Friends has become one of the leading leagues in the country, raising millions of pounds to benefit local people and receiving the Queen's Award for Voluntary Service in 2012.

4. Chief executive engagement November and December

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
• Long service awards • Breast screening mobile unit opening • Inclusion module launch • League of Friends chairs meeting	• Chief Executive, NHS England south west • Interim Chief Nurse, Integrated Care System Devon (ICSD) • Chief Delivery Officer, ICSD • Chief Executive, University Hospitals 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 • Chief Executive, Torbay Council

	• Council Leader, Torbay Council • Chief Executive, NHS Providers • Anne Marie Morris MP • Kevin Foster MP • Anthony Mangnall MP • South west integrated personalised care enabling Board event

5. Local health and care economy developments

5.1 Partner and partnership updates

5.1.1 New Chief Executive for NHS Devon

NHS Devon has announced the appointment of Steve Moore as its new Chief Executive. Following a competitive national recruitment process, Steve will join NHS Devon on 12 February 2024

Having worked for the NHS for most of the last 30 years, Steve has extensive expertise and knowledge at a senior level, including most recently as the Chief Executive of Hywel Dda University Health Board in Wales, a role he has held since January 2015.

Steve knows our county and the wider South West well, as has led NHS organisations in Devon, Plymouth, Torbay and Cornwall and the Isles of Scilly.

5.1.2 New interim Chief Executive for South Western Ambulance Service NHS Foundation Trust

Dr John Martin has formally taken on the role of Chief Executive at South Western Ambulance Service NHS Foundation Trust (SWASFT).

John joins SWASFT on secondment from his role as Chief Paramedic and Quality Officer and Deputy Chief Executive at London Ambulance Service NHS Trust.

An experienced Executive Board member with a wealth of clinical and operational experience across ambulance, acute, community and mental health NHS services, John is also a Visiting Professor in Paramedic Science at the University of Hertfordshire.

John succeeds Will Warrender CBE who announced his intention to leave SWASFT earlier this year after more than three years as Chief Executive of the organisation. The recruitment process for a substantive Chief Executive is underway.

6 Local media update

6.1 News release and campaign highlights include:

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

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

Key media releases and responses

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

Torbay and Devon NHS Foundation Trust sells pharmaceutical business
Torbay and Devon NHS Foundations Trust is today announcing the sale of its pharmaceutical business, Torbay Pharmaceuticals (TP), to leading regional private equity firm, NorthEdge.

Two firms to honour our people at annual awards
The achievements of hundreds of caring NHS staff from Torbay and South Devon will be celebrated at an awards ceremony next year thanks to the support of Kier Construction Western and Wales, and Nevada Construction.

New £4.99 million endoscopy training centre opens at Torbay Hospital
A new multi-million-pound endoscopy centre has opened at Torbay Hospital to treat more people who are awaiting diagnosis and treatment for cancer and bowel disease. The Torbay endoscopy training centre was opened by Torbay and South Devon NHS Foundation Trust chairman Sir Richard Ibbotson and Lord Julian Darling on Tuesday 14 November.

Torbay and South Devon NHS to host pioneering therapeutic cancer vaccine research trial
Torbay and South Devon NHS Foundation Trust's research and development department has been selected as a hospital for a ground-breaking cancer vaccine trial.

Virtual reality taking carers closer to the action
Ground-breaking Virtual Reality (VR) and 360 training is helping to bring vital training sessions to life and improving the care people receive.

League of Friends presidents celebrated in new wallpaper mural
The generosity of Torbay Hospital League of Friends' presidents during the past 70 years has been immortalised on a new commemorative wall.

More sponsors announced in support of NHS trust's annual awards
Torbay and South Devon NHS Foundation Trust are proud to announce that a further two companies have agreed to support their 'our people celebration event' 2024.

Little ones remembrance weekend 2023
Two special events were held at the start of December for families who had experienced the loss of a child or a baby during pregnancy.

Research funding secured for radiotherapy equipment
Torbay and South Devon NHS research and development and radiotherapy teams have secured over £800,000 of funding to support both research trials and the ongoing care of patients.

Don't visit hospitals if you have diarrhoea and vomiting
The NHS in Torbay and South Devon is seeing an increase in the number of cases of norovirus both in hospitals and out in the community.

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

Festive physio session for MS patients in Torbay and South Devon

Digital engagement

	Linkedin	Facebook	X (Twitter)
Followers (as of 10 January)	7,133 +195	14,309 +35	8,012 +15
Engagement	1,021	6,216	432
Impressions/ reach	38,125	472,861	20,004
Best performing post	Fantastic to see lots of our teams getting into the seasonal spirit for Christmas Jumper Day yesterday. Here are our Planned Care Surgical Admissions and Capital Development teams looking festive! 1,523 impressions 77 reactions 2 reposts	What better way for our maternity teams to celebrate the festive season than with a Christmas Day baby?! Congratulations to Chelsey and George on their beautiful baby girl, born at 4.59pm on Christmas Day Thank you so much to our maternity teams and all of our colleagues who were caring for and supporting our communities this Christmas 44 comments 11,341 impressions 516 reactions 1 share	Congratulations to Stephen, our latest winner of the Primrose award! Stephen was nominated by a patient for his kindness and grace and described him as a big teddy bear who did everything with a smile on his face. Nominate a healthcare support worker https://ow.ly/SBha50Qe2Yb 771 impressions 10 likes 4 reposts

Website activity

50,656 unique views of our website (the number of people viewing our web pages)

142,864 total views of our web pages (including people revisting the same page)

Most popular pages:

- Vacancies: 16, 284 views
- MIU wait times: 14, 403 views
- Physio appointment service: 5, 670 views
- Minor injury units: 2, 670 views.

Engagement

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

We have spoken to more than 75 people from our community and partner organisations to listen to people's experiences and ideas about how we can improve our services, including:

- The third Teignmouth Hospital Stakeholder Group meeting, which ran as a workshop to generate ideas for the future of the Teignmouth Hospital site.
- Coastal Engagement Group.
- Focus group with the Torbay Learning Disability Ambassadors who fed back on the Torbay Adult Social Care webpages. The outcomes of this, alongside further focus groups and a survey, informed a user engagement recommendations report on redevelopment of the webpages.
- Visit to Alice Cross Centre in Teignmouth to further our understanding of the VCSE sector within the integrated care system.
- Friends of Network.
- We have almost concluded the procurement exercise for our child health engagement forums. We will be working with Parental Minds and Young Devon to launch the two forums early this year and are finalising contractual arrangements. These forums will help us to amplify the voices of children, young people and their families and carers within our organisation.

On new hospital programme (NHP) stakeholder engagement we hosted a site visit with NHP development partners, held a briefing with Healthwatch and developed a site enabling communications and engagement plan.

Communications to staff have been issued about our electronic patient record (EPR) preferred supplier, with further information being prepared for circulation this month, including email briefings, ICON pages and FAQs. Face to face engagement activity will commence in the spring and in the meantime we are encouraging staff to help us build the FAQs, develop our EPR vision and invite us to team meetings to present on the programme.

7 Recommendation

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Integrated Performance Report (IPR) M9 2023/24 (December 2023 data)			Meeting date: 31 January 2024
Report appendix:	Appendix 1: IPR Month 9 2023/24 Focus Report Appendix 2: IPR Month 9 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) M9 2023/24 (December 2023 data)		**Meeting date:** 31 January 2024
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 Trust Board of Directors 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.

The Trust remains in National Oversight Framework Section 4 being the highest level of national performance oversight.

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

Quality Headlines

Incidents

In December 2024, 3 incidents were reported as severe harm and one incident reported as death. The incidents related to three patient falls resulting in fractures and one incident reported under the category of clinical assessment.

VTE (Venous Thromboembolism) Assessment

December 2023 (n=5), saw a reduction of 1 in reportable VTEs, when compared with the same period in 2022 (n=6). Over the last 3 months, there has been an overall reduction in VTEs reported, with none reported in November. The VTE steering group will commission a deep-dive review, to understand compliance with VTE risk assessments, at the time of the patient's entry to the service, with a specific focus on those areas outside of bed-based patient care.

Infection, Prevention, and Control

The number of closed bed days due to infection has continued to reduce 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

There have been no reported stillbirths during the year of 2023.
Two incidents were reported in December regarding infants who needed escalated care. One of these cases met the criteria for referral to Maternity and Newborn Safety Investigation Programme (previously HSIB).

Fractured Neck of Femur

47.1% of patients had access to theatre within the recommended time frame in December 2024 against a target of 90%, this is a slight worsening position from November (68.7%) which, due to industrial action theatre capacity was reduced.
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 Registered Nurse (RN) actual CHPPD has been reported as 4.21 in December but remains below the carter recommendation of 4.7.
The actual Healthcare Assistants (HCA) CHPPD was 3.86 in December which remains above the carter recommendation of 2.91. This is due to the increased need for Healthcare Support Worker (HCSW) to provide 1:1 supportive observation care.

Workforce Headlines

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

The Trust's substantive workforce is 122.60 WTE under plan, improving from the previously reported 99.8 WTE under plan in November. This is largely due to the sale of Torbay Pharmacy (TP), without this we would currently be 112.28 over plan.

Areas 'above plan' since November have been seen in the Nursing and Midwifery staff group showing an increase of 8.97 WTE, Medical and Dental staff group have increased by 8.62 WTE with the greatest growth in infrastructure by 25.34 WTE. (Administration and estates staff grew by 4.69 WTE since November, there have been increases in the following areas: Portering, Discharge Team, Patient Access, and Cleaning operations)

Areas 'below plan' have been seen in Registered/ Qualified Scientific, Therapeutic and Technical staff 54.86 WTE (-0.81%) and Support to Clinical staff 108.77 WTE (-0.13%).

Bank usage has decreased by **30.79%** since November, equating to **84.67 WTE**, **6.01 WTE** below plan.

Agency usage has increased by **23.17%** since November equating to **55.71 WTE** and is **124.47 WTE** over plan in December.

Work is currently being undertaken to look at the true workforce baseline in all the ward areas and this will help us understand shortfalls and controls of spend in bank and agency around these areas.

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 has now been replaced by Workforce Control Panels which continue to meet 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 Integrated Care Board (ICB) and there has been a decrease in requests being submitted for review at panel.

So far, the two panels in January 24 have seen the number of vacancies reviewed drop by 30% compared to the first panel on 7th December where we commenced more stringent reporting of panel outcomes.

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 (**11.91%**) and sickness rates (**4.96%**) for December are lower than those forecasted in the operational plan.

There has been a steady upward trend in overall mandatory training compliance over the last 12 months. Compliance is unchanged in December **91.15%** against a target of 85%. However, at a topic level we remain challenged in Manual Handling at **77.29%** and Information Governance at **85.05%.**

Achievement Review – compliance has increased by 0.57% in December to **79.18%** 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

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 and Care Group Directors 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

	Target March 2024	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Operational Plan trajectory Dec 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)	1110	2448	5017	3280	740	2260	796	1630	1569	1223	1707	2579	3591	3141	2141	1213
Percentage of Ambulance handovers greater than 3 hours		18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	3.7%	6.5%	14.7%	23.4%	18.7%	12.5%	No trajectory
Total average time in ED (hours/minutes)		07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	05:41	06:05	05:46	06:15	06:19	05:44	No trajectory
ED attendances where visit time over 12 hours	0	939	1207	823	599	977	568	893	797	637	794	686	822	770	622	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68.4%	66.6%	67.0%	68.0%	75%
% patient discharges pre-noon	33%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	20.5%	21.6%	21.5%	20.3%	22.4%	23.7%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%	11.0%	13.0%	13.0%	12.0%	8.1%	7.6%	6.0%	7.0%	6.0%	7.5%	7.4%	8.3%	7.2%	6.4%	7.5%

2023/24 RAG indicator

Meeting monthly trajectory

Not meeting monthly trajectory

The Trust is not meeting the UEC NOF 4 exit criteria for the following indicators:

- Ambulance handover time lost decreased in December reporting 2141 hours lost waiting over 15 minutes (from 3141 hours lost in November); this does not meet the trajectory of 1213 hours lost.
- The percentage of patients waiting over 3 hours for an ambulance handover decreased to 12.5% in December from 18.7% in November.
- The Trust's Urgent and Emergency Care (UEC) 4-hour performance increased to 68% and did not meet the December trajectory of 75%.
- 23.7% of discharges were achieved before noon against a target of 33%.

Elective Recovery NOF 4 headlines

	Target March 2024	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Operational Plan trajectory Dec 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																
Elective recovery																
RTT 104 week wait incomplete pathway	0	34	29	22	14	0	0	0	0	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	822	923	708	462	183	166	167	123	129	156	187	155	179	165	65
RTT 65 week wait incomplete pathway	0	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1161	1018	871	840	650
RTT 52 week wait incomplete pathway	Reduction	5585	6027	5554	5116	4427	4024	3926	3938	3879	3977	3471	2961	2533	2258	Reduction
Patient waits over 2.5 years	0	17	12	9	6	0	0	0	0	0	0	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	67.3%	71.7%	67.5%	77.3%	76.3%	75.5%	78.0%	77.7%	79.6%	79.3%	78.0%	77.5%	75.7%	77.0%	75%
Number of patients waiting longer than 62 days for treatment	138	229	253	225	130	114	107	111	100	89	120	105	143	147	158	182

2023/24 RAG indicator

Meeting monthly trajectory

Not meeting monthly trajectory

Elective Referral to Treatment (RTT)

Elective recovery against the NOF 4 exit criteria is meeting the planned trajectory for 5 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

The Trust is meeting the Faster Diagnosis performance with 77% achieved against a target of 75% in December. The Trust is ahead of the December 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. There is emerging concern about the growing backlog of 62-day for treatment. Some specialities such as gynae/urology may out at risk our 104-day breaches. The mitigation plan for gynae is around additional investment during business planning and for urology is around regional stabilisation of the service.

Finance headlines

As at M09, the Trust reported an adverse variance to plan of £1.528m. The adverse variance to date primarily relates to Elective Recovery Fund (ERF) estimated clawback due to activity delivery being lower than planned, and other overspends partially offset by other income.

At M09, we have now formally reported a forecast adverse variance to plan of £8.765m for the year in line with the agreed deficit forecast of £41.336m control total with the system. This will enable the system to reach a balance financial position for 23/24.

Our current 2023/24 CIP programme includes 142 schemes in green totalling £40.9m (£27m recurrent CIP) to support the delivery of in year position.

Net year to date CDEL expenditure totals £9.5m against a Plan of £37.9m. Full year forecast CDEL totals £30.7m, of which £2.8m is IFRS16 related. The gross expenditure sum that is forecast to be spent across January 2024 to March 24 totals £21.2, of which £2.8m is IFRS16 related.

Cash balances remain strong at £30.5m at 31st December 2023 compared to a Planned value of £14.3. The positive variable is associated with the sale of Torbay Pharmaceuticals.

Integrated Performance Focus Report (IPR)

Torbay and South Devon NHS Foundation Trust

January 2024: Reporting period December 2023 (Month 9)

Working with you, for you

National Oversight Framework - Introduction

NHS Torbay and South Devon NHS Foundation Trust

NHS National Oversight Framework (NOF)

In December 2022 NHS England rated the Trust at NOF 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.

Exiting NOF 4 is the key system and provider objective 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.

More general operational performance highlighting risks and on-going recovery plans 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

	Accountability framework				Latest month performance	
Metric:	**Senior Responsible Officer:**	**Clinical Lead:**	**Executive Lead:**	**Reporting forum for review of performance**	**Meeting monthly trajectory**	**Meeting NOF 4 exit target**
UEC 4-hour target 76% by March 2024	System Care Group Director (SCGD) - Urgent Care	System Care Group - Medical Director (SCGMD)	Chief Operating Officer	Operational Recovery Group (ORG) Trust Management Group (TMG)	No	No
Ambulance handovers greater than 15 minutes	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	No trajectory	No
Over 12-hour visit time; and ED (type 1) 4-hour target	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	No trajectory	No
Increase in pre-noon patient discharges	SCGD – Urgent Care	SCGMD	Chief Operating Officer	ORG TMG	No	No
Reduction in 'No criteria to reside'	SCGD – Families community and place based	Deputy Medical Director	Chief Operating Officer	ORG TMG	Yes	No
Patient wait over 104 weeks	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	Yes	Yes
Cancer longer than 62-day wait	SCGD – Planned Care	SCGMD	Chief Operating Officer	ORG TMG	Yes	No

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. • TIF 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 and specifically ambulance demand increases. • Capacity of transformation team support to improvement plans. • 62-day cancer backlog is 50th worse in England.	• ECIST support to SHOP on wards • ECIST review of the bed management process and Ambulance Handover Delays. • Review of Transformation support for improvement plans and review of audit of wards to increase medical engagement. • Implementation of the 'Emergency Village'. • Staffing agencies to be engaged to support opening of theatres.
Positive assurances	**Decisions made**
• Whilst RTT control totals have not been met performance against 78 and 65 weeks improved in January against revised trajectories. • UEC 4hr performance above 60% for ninth month in a row and continuing to rise. • NCTR performance is best in Southwest. • Management of Industrial Action becoming business as usual with established playbooks. • GIRFT review of UEC processes complete – follow up session to be planned • Virtual ward occupancy has consistently improved • Frailty unit on track to open	• 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 in place and to support Frailty Team

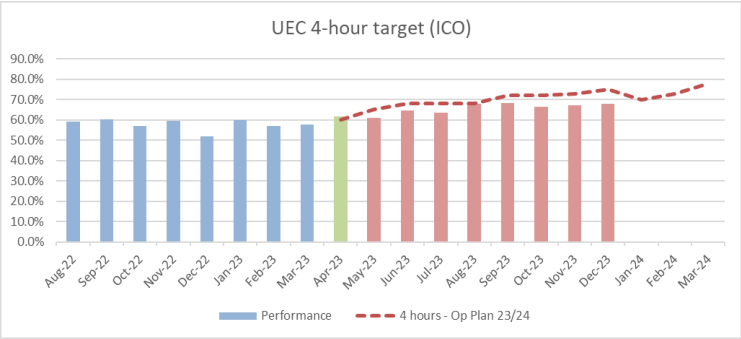
National Oversight Framework (NOF) 4 Exit Criteria – Urgent and Emergency Care Performance Summary

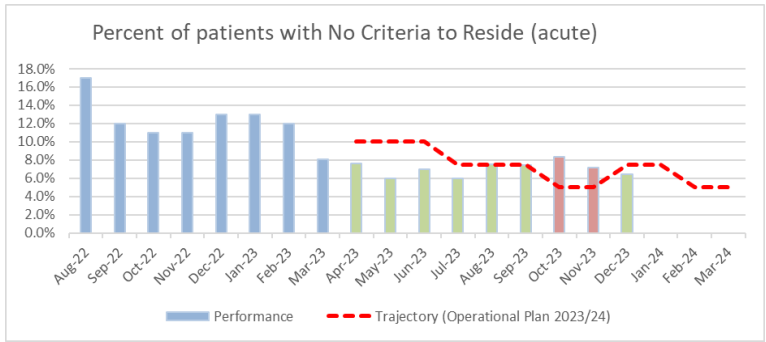
Torbay and South Devon NHS Foundation Trust

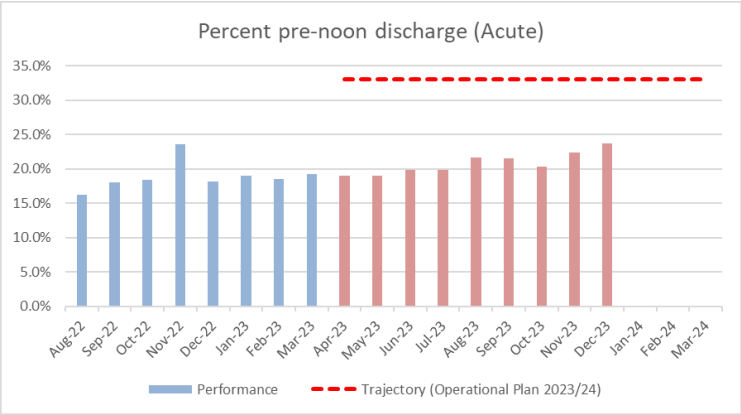
	Target March 2024	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Operational Plan trajectory Dec 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)	1110	2448	5017	3280	740	2260	796	1630	1569	1223	1707	2579	3591	3141	2141	1213
Percentage of Ambulance handovers greater than 3 hours		18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	3.7%	6.5%	14.7%	23.4%	18.7%	12.5%	No trajectory
Total average time in ED (hours/minutes)		07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	05:41	06:05	05:46	06:15	06:19	05:44	No trajectory
ED attendances where visit time over 12 hours	0	939	1207	823	599	977	568	893	797	637	794	686	822	770	622	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68.4%	66.6%	67.0%	68.0%	75%
% patient discharges pre-noon	33%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	20.5%	21.6%	21.5%	20.3%	22.4%	23.7%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%	11.0%	13.0%	13.0%	12.0%	8.1%	7.6%	6.0%	7.0%	6.0%	7.5%	7.4%	8.3%	7.2%	6.4%	7.5%

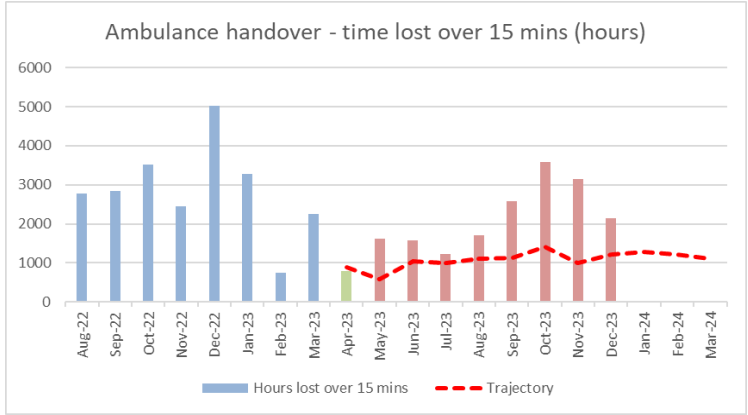
2023/24 RAG indicator
- Meeting monthly trajectory
- Not meeting monthly trajectory

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.









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 decreased in December with 1662 (1937 in November).
The total hours lost due to ambulance delays over 15 minutes decreased to 2141 hours compared to 3141 in November.

Average time lost to ambulance handover delays over 30 minutes (hours per day) – rolling 30 day

Rolling 30-day position as at **21 January 2024**
click on a bar to highlight site on the trend chart

Ambulance Trust	Site Name	
South Western	Derriford Hospital	7041:01:15
South Western	Royal Cornwall Hospital (treliske)	5106:48:36
South Western	Torbay Hospital	2694:45:46
South Western	Gloucestershire Royal Hospital	2195:23:00
South Western	The Great Western Hospital	1886:40:33
South Western	Royal United Hospital	1089:53:50
South Western	Southmead Hospital	1038:02:28
South Western	Royal Devon & Exeter Hospital (w	1015:33:06
South Western	Royal Bournemouth Hospital	611:40:22
South Western	Bristol Royal Infirmary	527:53:17
South Western	Musgrove Park Hospital	496:52:52
South Western	Poole Hospital	456:21:59
South Western	Yeovil District Hospital	267:35:17
South Western	Weston General Hospital	252:45:20
South Western	Salisbury Health Care NHS Trust	152:37:13
South Western	North Devon District Hospital	149:41:33
South Western	Dorset County Hospital	94:24:31

Operational update

In December, the Trust saw a decrease in handover delays despite an increase in ambulance handover demand which has risen 31% comparing December 2022 (1677 handovers) to December 2023 (2211 handovers). This to equates to 18 additional ambulances a day.

The average time lost per ambulance to handover has decreased from 1hr 40min in November 2023 (including the 15 mins) to 1h 12m in December 2023. This remains an improvement from average time lost in December 2022 of 3h 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

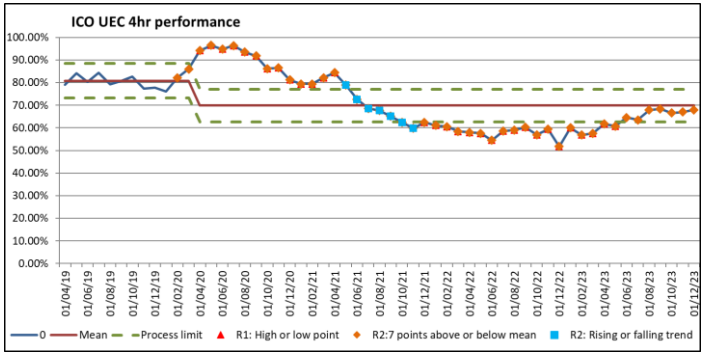
- Further infection control issues
- Further Consultant industrial action
- Combination of the above

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

Torbay and South Devon NHS Foundation Trust

Performance

	December 2022	December 2023
MIU/UTC attendances	3180	2690
MIU/UTC performance	95.1%	99.8%
ED (type 1) attendances	6076	6076
ED (type 1) performance	29.2%	53.9%
ICO attendances	9256	8766
ICO performance	51.9%	68.0%



Operational update

- December recorded a decrease in the average time in ED with 5h 44 m compared to 6h 19m in November.
- Overall ED attendances remained static compared to December 2022, however, the Trust saw in improved position against the 4-hour target. December recorded 68% performance the second highest in year against a backdrop of winter seasonal pressures and industrial action. December is the 9th consecutive month where the ICO 4-hour performance has been over 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 – including Same Day Emergency Care (SDEC), JETS, Frailty 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: Percent of pre-noon discharges: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

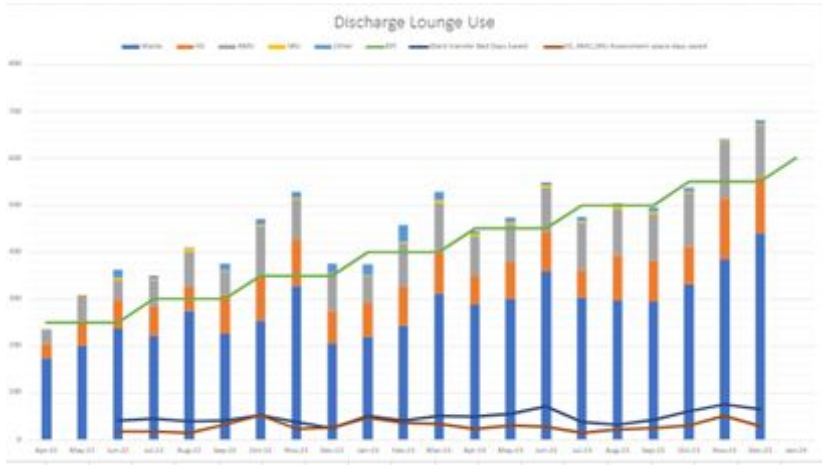
We saw an increase in our overall general and acute discharges in December totalling 1805 compared with 1739 in November. The percentage discharges pre-5pm and pre–noon increased compared with November.

The Flow and Ward Improvement Group seek to continue to drive this improvement, with a focus on pre-noon discharge, 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%
November	22.4%	71.2%
December	23.7%	72.5%

Operational update

The Discharge Lounge (DCL) remains a key part of the strategy for generating timely ward capacity. December saw a new all time high in terms of attendance with 681 patients.



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
- Formalised weekend planning meeting - including surge plans

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

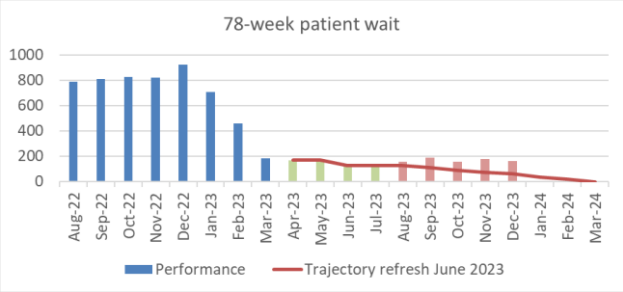
	Target March 2024	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Operational Plan trajectory Dec 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																
Elective recovery																
RTT 104 week wait incomplete pathway	0	34	29	22	14	0	0	0	0	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	822	923	708	462	183	166	167	123	129	156	187	155	179	165	65
RTT 65 week wait incomplete pathway	0	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1161	1018	871	840	650
RTT 52 week wait incomplete pathway	Reduction	5585	6027	5554	5116	4427	4024	3926	3938	3879	3977	3471	2961	2533	2258	Reduction
Patient waits over 2.5 years	0	17	12	9	6	0	0	0	0	0	0	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	67.3%	71.7%	67.5%	77.3%	76.3%	75.5%	78.0%	77.7%	79.6%	79.3%	78.0%	77.5%	75.7%	77.0%	75%
Number of patients waiting longer than 62 days for treatment	138	229	253	225	130	114	107	111	100	89	120	105	143	147	158	182

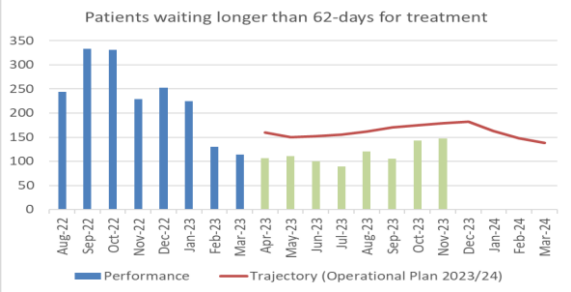
2023/24 RAG indicator

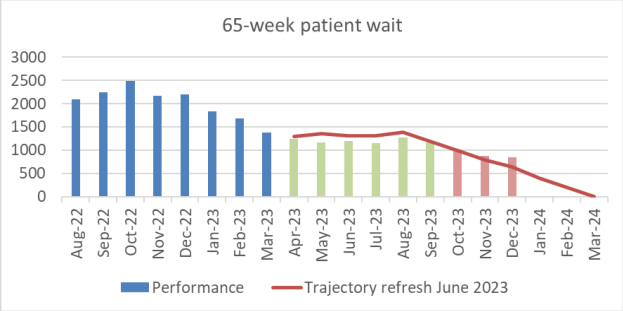
Meeting monthly trajectory

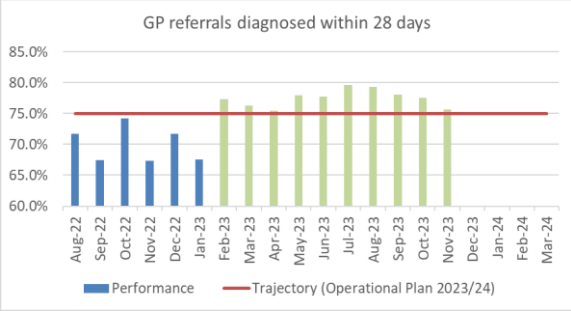
Not meeting monthly trajectory

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. The impact of industrial action being the driving factor, the exception reports describes in more detail the position and actions being taken.









Actions on-going this month

- Engagement with 'Further Faster' work programme.
- Targeted Investment Fund (TIF) day case theatres remains on track for handover end of February 2024.
- 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 December.

Operational update

Failure to deliver the trajectory targets 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. Additional weekend lists in services such as T&O and Gynae will help to recover the position. Some of the additional lists were put on hold due to financial controls imposed in November 2023.

Actions to complete next month

- Assessment of insourcing and outsourcing plans to identify opportunities to compensate for lost capacity from Industrial.
- 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.
- Gynae is becoming an issue and may threaten the 104-week position.
- Urology is also creating pressure in cancer services due to their vulnerable staffing position.

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 December 2024, 3 incidents were reported as severe harm and one incident reported as death. The incidents related to three patient falls resulting in fractures and one incident reported under the category of clinical assessment.

VTE (Venous Thromboembolism) Assessment
December 2023 (n=5), saw a reduction of 1 in reportable VTEs, when compared with the same period in 2022 (n=6). Over the last 3-months, there has been an overall reduction in VTEs reported, with none reported in November. The VTE steering group will commission a deep-dive review, to understand compliance with VTE risk assessments, at the time of the patient's entry to the service, with a specific focus on those areas outside of bed-based patient care.

Infection, Prevention, and Control
The number of closed bed days due to infection has continued to reduce 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
There have been no reported stillbirths during the year of 2023.
Two incidents were reported in December regarding infants who needed escalated care. One of these cases met the criteria for referral to Maternity and Newborn Safety Investigation Programme (previously HSIB).

Fractured neck of femur
47.1% of patients had access to theatre within the recommended time frame in December 2024 against a target of 90%, this is a slight worsening position from November (68.7%) which, due to industrial action theatre capacity was reduced. 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 Registered Nurse (RN) actual CHPPD has been reported as 4.21 in December but remains below the carter recommendation of 4.7.
The actual Healthcare Assistants (HCA) CHPPD was 3.86 in December which remains above the carter recommendation of 2.91. This is due to the increased need for Healthcare Support Worker (HCSW) to provide 1:1 supportive observation care.

CQC update on the Well Led actions, Maternity Inspection and Joint Targeted Area Inspection

CQC 2023 Well Led Inspection

Following the inspection, the Trust was issue with 15 Must Do and 36 Should Do actions. The table, adjacent, highlights the area, number and progress of each. All actions on track and 1 1 achieved and subsequently closed.

CQC Core Service Action Status	No. of Actions		MD On track		SD On Track	
	Must Do	Should Do	Yes	No	Yes	No
Trustwide	2	7	2	0	7	0
Urgent and Emergency	2	6	2	0	6	0
Medical Care	3	6	3	0	6	0
OPD	1	10	1	0	10	0
Diagnostics Imaging	7	7	7	0	7	0
TOTAL	**15**	**36**	**15**	**0**	**36**	**0**

The plan is monitored at the monthly CQC CAG group, where each action is reviewed in relation to the ask and evidence provided to show progress or compliance. A number of actions are Trustwide, namely the requirement to ensure financial pressures are managed so they do not compromise the quality of care and the Equality, Diversity and Inclusion action. These have separate plans, and monitored through appropriate committees, however the CQCAG group receives updates regarding their progress from their leads.

Where an action requires checks to be in place and training levels to be achieved these will be monitored until their compliance is assured

Joint Targeted Area Inspection (JTAI)

This is a partnership Inspection of services for vulnerable children and young people undertaken by Ofsted, Care Quality Commission & Her Majesty's Inspectorate of Constabulary. These inspectorates jointly assess how local authorities, the police, health, probation and youth offending services are working together in an area to identify, support and protect vulnerable children and young people. The unannounced inspection took place in November 2023 with an embargoed draft report circulated for factual accuracy on 15th January 2024 with a released date set for the 28th January. The initial findings are as below:

Areas for Improvement

- The ICB needed to assure itself around the weaknesses found within TSDFT regarding its oversight and professional practice in consistently identifying, and the management of, non-accidental injuries in children
- Potential missed opportunities for child protection medicals
- Safeguarding children teams' advice to professionals as a health representative and specialist advisor to health practitioners
- Capacity of Named Nurse working at an operational level rather than strategically focussed due to capacity challenges in the team

Strengths identified:

- Responsive Maternity and 0-19 service involving a holistic approach to care
- Positive inter-agency working in MASH
- The development of Family Hubs and their accessibility in the community
- Voices of children captured well in safety plans
- Strong multi-agency response for missing and exploitation

A comprehensive action plan is in place, and this is being managed at the weekly JTAI meeting and overseen by the CQCCAG group

Maternity Inspection

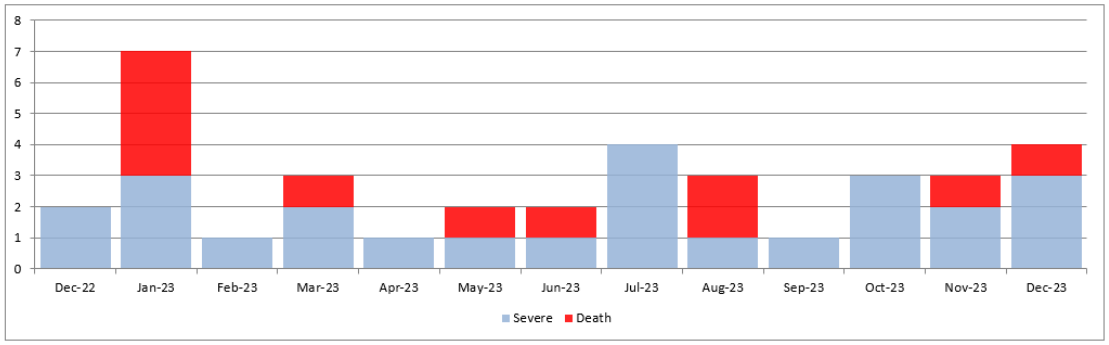
As part of the national, CQC maternity inspection programme, our Maternity services were inspected in November 2023. Whilst we are still awaiting the report, the CQC have asked for several actions to be undertaken. These included enhancing the maternity triage service and risk assessments for the out of hours emergency theatre. These actions have been completed and form part of the monitoring plan whilst we await the formal report.

Quality and Safety exception reports – reported incidents / HSMR

Torbay and South Devon NHS Foundation Trust

Reported Incidents - Severe and Death

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



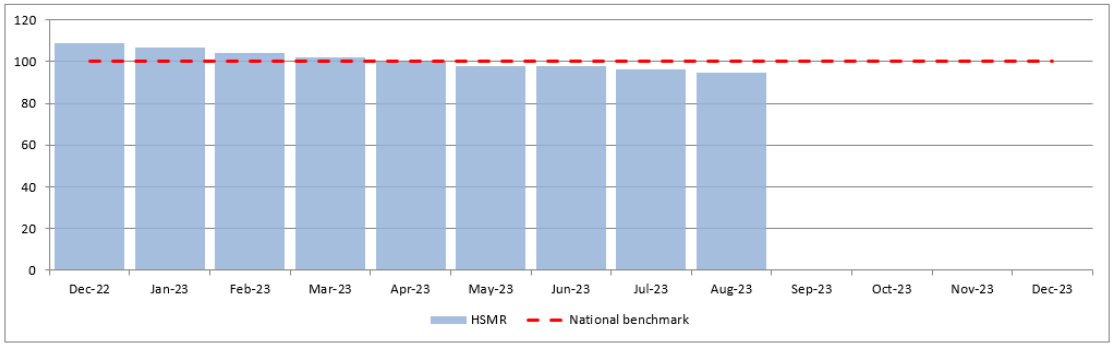
In December 3 incidents were reported as severe and 1 reported as death.

- Death relating to clinical assessment – delay
- All severe incidents were as the result of falls resulting in harm.

All incidents are being investigated managed according to local policy

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
HSMR	108.7	106.8	104.2	101.9	99.9	98.1	98.1	96.2	94.8	0	0	0	0
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



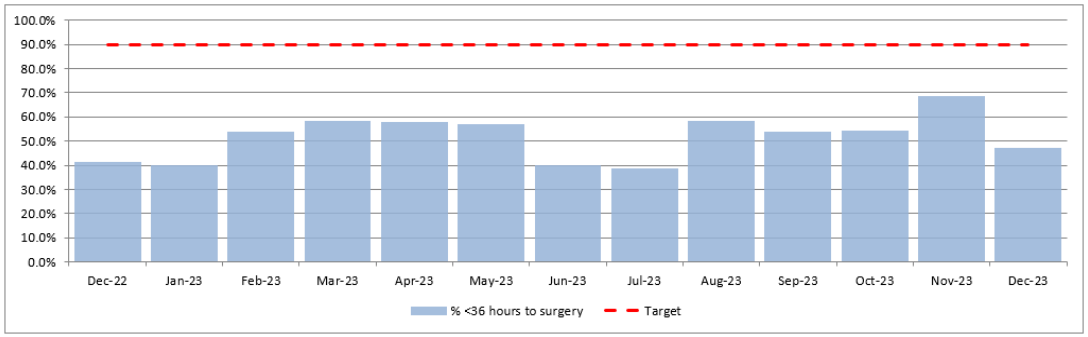
The latest HMSR for August 22 - July 23 is **94.8** (92.4 – 104.0) and is within the expected range compared to hospital trusts nationally (↓). All individual months are also within the expected range.
There has been a steady decline and the HSMR has been with in the expected range for the last six data periods. The Trust's HSMR is one of 12 trusts in our peer comparator statistically within the expected out of 20 Trusts.

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

	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
% <36 hours to surgery	41.5%	40.0%	53.8%	58.3%	58.0%	57.1%	40.0%	38.7%	58.3%	53.8%	54.5%	68.7%	47.1%
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

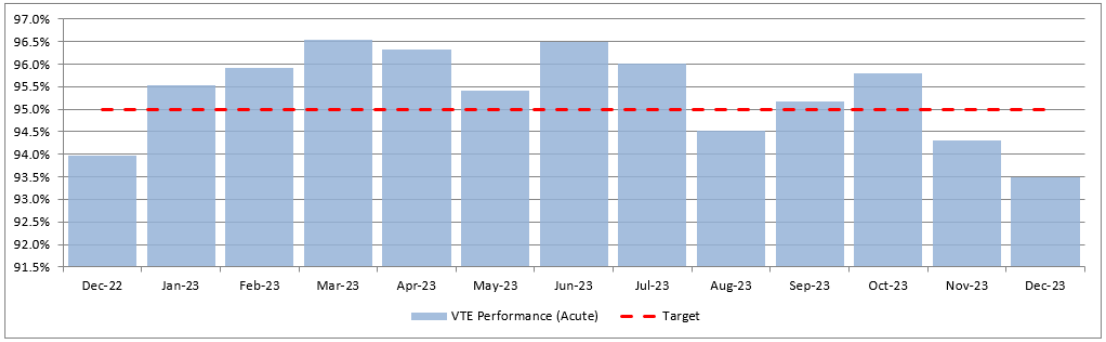
During December 53 patients were admitted with femoral/hip fractures, this is higher than the monthly average.

The time to theatre has reduced to 47.1% of patients this month. Despite increasing theatre capacity, due to Christmas bank holidays and industrial action, only 12 days saw 2 lists running.

The team continue to work with the ED and operational team to ensure timely transfer of patients to the trauma ward as soon as possible.

Acute VTE risk assessment on admission

	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
VTE Numerator	4896	5631	5437	6050	5152	5104	2563	5911	5717	5624	5643	5755	5439
VTE Denominator	5210	5894	5669	6267	5349	5349	2656	6157	6048	5910	5891	6103	5818
VTE Performance (Acute)	94.0%	95.5%	95.9%	96.5%	96.3%	95.4%	96.5%	96.0%	94.5%	95.2%	95.8%	94.3%	93.5%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



VTE assessment

The overall VTE assessment conformity for all relevant in-patients in December 2023 is 93.5%, which is below the 95% national target for the second consecutive month.

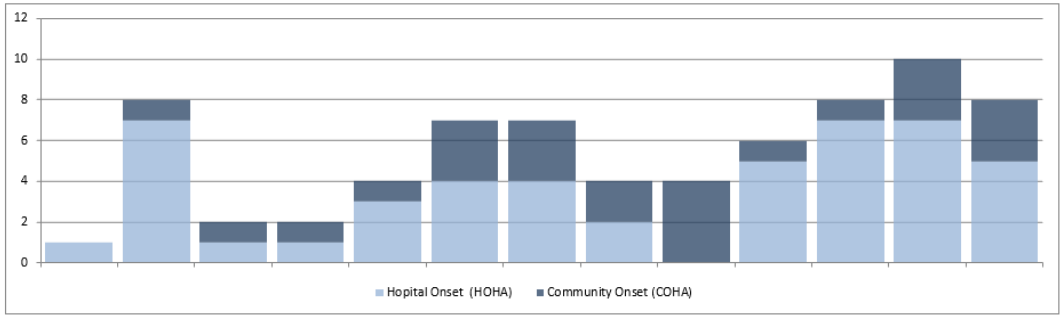
Based on monthly 1-day prevalence safety assessment audit, there is a high level of confidence that, for the inpatient setting, 97.8% of patients in December received a VTE risk assessment and, of these, 96.1% of patients received their assessment within 24hrs.

Quality and Safety exception report - Infection control

Torbay and South Devon NHS Foundation Trust

Number of Clostridium Difficile cases

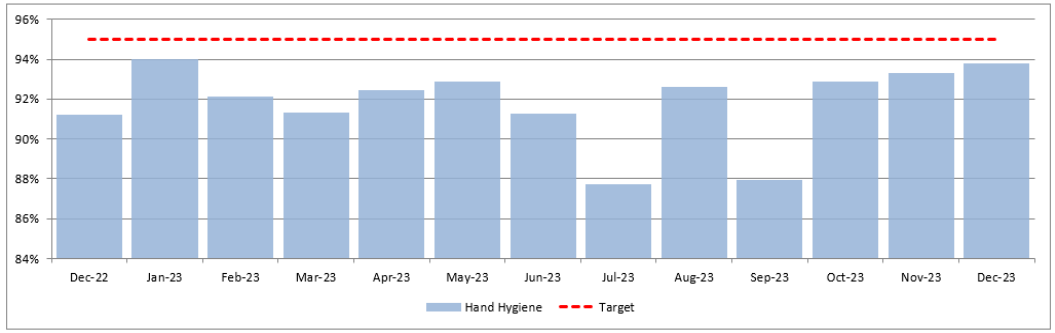
	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Hopital Onset (HOHA)	1	7	1	1	3	4	4	2	0	5	7	7	5
Community Onset (COHA)	0	1	1	1	1	3	3	2	4	1	1	3	3



During December 8 cases of Clostridium Difficile were reported which is a reduction from the previous month. No cluster outbreaks were recorded during the month of December.
Work continues to ensure compliance with antimicrobial prescribing

Hand Hygiene

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

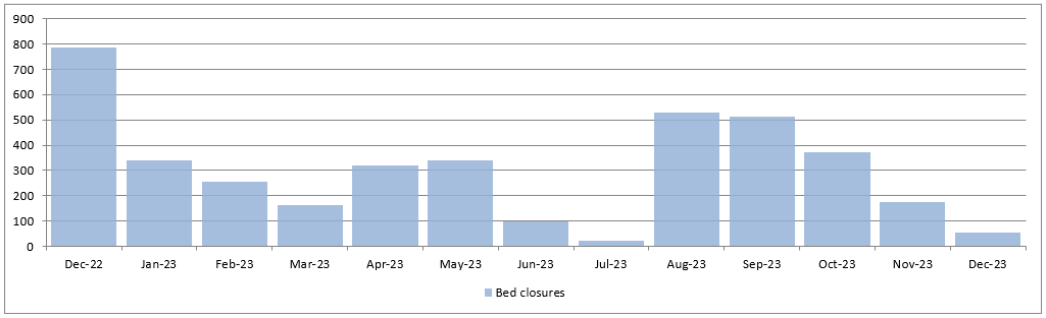


Hand hygiene compliance continues to improve with targeted training in those areas not achieving compliance.

The "Gloves Off" campaign has worked well, and that work continues.

Infection control - Bed days lost (Acute)

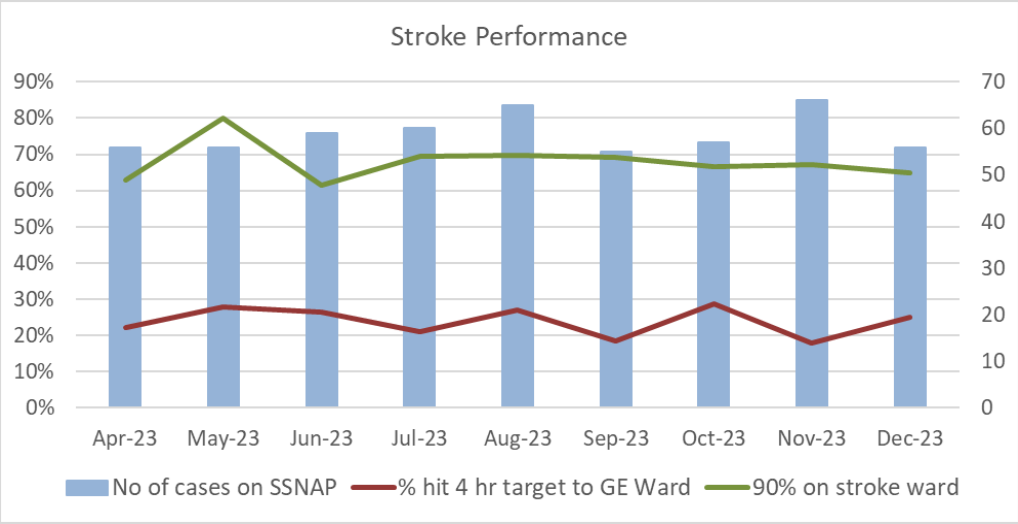
	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Bed closures	786	339	254	164	319	340	99	24	528	514	373	174	56



This month the IPR dashboard of key metrics has been updated from April 2023 to reflect Trust daily sitrep reporting. Originally reporting against closed beds due to diarrhoea and vomiting /norovirus only was required to be reported in the Daily Sitrep; Flu and RSV were then added as an additional breakdown followed by covid reporting. An additional category 'other' has been added to capture issues such as estate/equipment.

Bed closures have decreased in December. 6 beds were closed due to covid Infection, prevention, and control; 50 beds were closed under the 'other' category.

Quality and Safety exception report – stroke care



Time critical stroke standards – November 2023

- 67.2% of patients spent more than 90% of their stay on the stroke unit which is an improved position from October 2023;
- 18% of patients were admitted to the Stroke Unit with 4 hours of admission; this is a reduction from the previous month and the lowest since February 2023;
- 54.5% of patients received a scan within one hour, the highest since June 2023;
- 95.5% of patients received a scan within 12 hours the highest since July 2023.

December 2023 is data is not finalised, it will be refreshed in February 2024.

Q2 SSNAP results for both George Earl and Templar Wards became available in December. George Earl remained at a D but unfortunately scores dropped in 5 domains and domain 2 (time to and time spent on the stroke unit) remained at an E (E is the lowest. We also dropped in thrombolysis, occupational therapy, standards by discharge and MDT working. Domain 4 – specialist assessments remain a challenge. There were positive changes in SALT staffing at the beginning of September and the Specialist Stroke Team is now fully recruited and inducted which should bring improvements. SSNAP Performance Co-Ordinator started in post at the beginning of January and this will over time improve the inputting of data across the pathway and release clinical time back to care.

Templar Ward dropped to an overall D which was almost entirely dependent on audit compliance and case ascertainment which refer to the efficiency and timeliness of inputting data.

We were successful in becoming one of 6 Trusts nationally to be part of the first Thrombolysis in Acute Stroke Collaborative (TASC); an improvement programme aimed at improving thrombolysis rates towards the national ambition of 20%. A multi—professional project team has been formed including ED and SWASFT colleagues and we are hopeful that we will be able to use this group to drive change across the whole pathway.

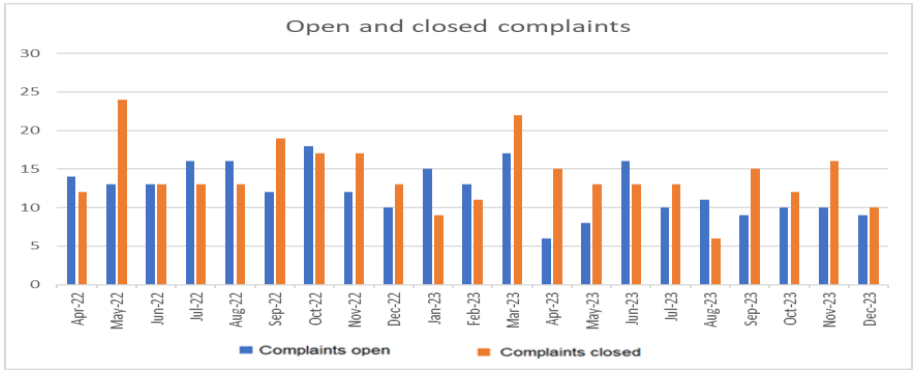
<u>ACTIONS</u>

Meet with therapy leads to discuss the inputting of data on both wards

Deep dive into Domain 4 (outstanding action)

Meet again with ED colleagues to agree the medical processes for stroke patients in the department.

Quality and Safety exception report – Complaints

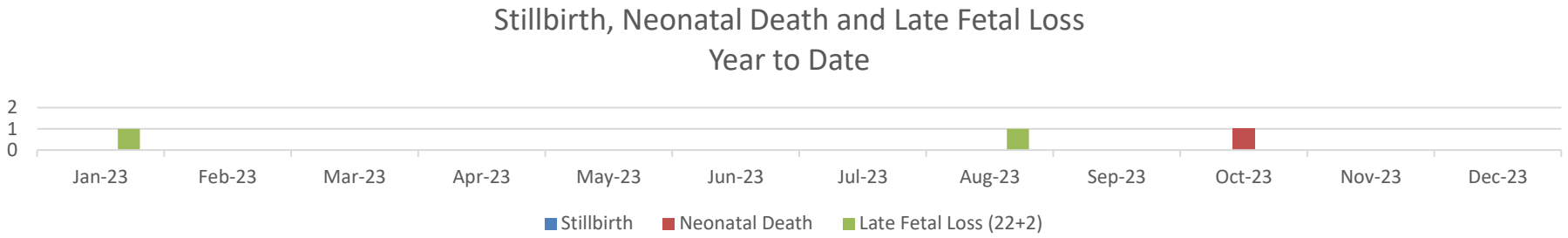


On a month-by-month basis, an average of 11 complaints are received per month between 1st April 2023 – 31st December 2023, with 14 complaints on average being closed per month.
Associate Director of Nursing and Professional Practice (ADNPP's) have been working hard with their teams regarding closing of complaints and this is reflected in the last 10 months where 8 months have seen greater numbers closed than received.
By 31st December 2023 there where 63 complaints that remained active/ongoing. The largest proportion of these are with Surgery, Urgent and Emergency and Medicine. This is reflected of the areas who receive the most complaints which are related to waits in Emergency Department, time to surgery and access to outpatients.

	Admission	Appointment	Assessment	Care	Diagnosis	Discharge	Personal Welfare	Record Management	Referral	Treatment	Total
Not Applicable - (Archived July 2023)	1	3	1	1	4	0	1	0	1	5	17
Urology	0	1	0	0	0	0	0	0	0	0	1
Administration - (Archived July 2023)	0	0	1	0	0	0	0	1	0	0	2
Ear, Nose and Throat	0	0	1	0	0	0	0	0	0	0	1
Estates Operations	0	0	1	0	0	0	0	0	0	0	1
Social Care (ADULT) - (Archived July 2023)	0	0	1	0	0	0	0	0	0	0	1
Cardiology - Inpatient Nursing	0	0	0	1	0	1	0	0	0	0	2
Community Nursing (ADULT) - (Archived July 2023)	0	0	0	1	0	0	0	0	0	0	1
Healthcare of the Older Person - Inpatient Nursing	0	0	0	1	0	0	0	0	0	1	2
Inpatient Nursing (COMMUNITY) - (Archived July 2023)	0	0	0	1	0	0	0	0	0	1	2
Learning Disabilities Adult - (Archived July 2023)	0	0	0	1	0	0	0	0	0	0	1
Paignton HWB	0	0	0	1	0	0	0	0	0	0	1
Torbay Community / District Nursing	0	0	0	1	0	0	0	0	0	0	1
Upper GI - Inpatient Nursing	0	0	0	1	0	0	0	0	0	0	1
Urgent Treatment Centre / Minor Injuries Unit (UTC / MIU) - (Archived July 2023)	0	0	0	0	1	0	0	0	0	0	1
Hospital Assessment and Discharge Team - (Archived July 2023)	0	0	0	0	0	1	0	0	0	0	1
Totnes Inpatient Nursing	0	0	0	0	0	1	0	0	0	0	1
Endocrinology	0	0	0	0	0	0	0	0	1	0	1
Acute Frailty - Inpatient Nursing	0	0	0	0	0	0	0	0	0	1	1
Acute Medicine - Inpatient Nursing	0	0	0	0	0	0	0	0	0	3	3
Inpatient Nursing Adult (ACUTE) - (Archived July 2023)	0	0	0	0	0	0	0	0	0	1	1
Cardiology - Outpatients	0	0	0	0	0	0	0	0	0	1	1
Dermatology	0	0	0	0	0	0	0	0	0	2	2
Emergency Department - Majors	0	0	0	0	0	0	0	0	0	5	5
Inpatient Gynaecology	0	0	0	0	0	0	0	0	0	1	1
Gynaecological Administration	0	0	0	0	0	0	0	0	0	1	1
Midwfiery Administration	0	0	0	0	0	0	0	0	0	1	1
Newton Abbot Inpatient Nursing	0	0	0	0	0	0	0	0	0	1	1
Oncology	0	0	0	0	0	0	0	0	0	1	1
Paediatrics Outpatients	0	0	0	0	0	0	0	0	0	2	2
Respiratory and Thoracic - Inpatient Nursing	0	0	0	0	0	0	0	0	0	1	1
Rheumatology	0	0	0	0	0	0	0	0	0	2	2
Rheumatology - Administration	0	0	0	0	0	0	0	0	0	1	1
Trauma and Orthopaedic - Administration	0	0	0	0	0	0	0	0	0	1	1
Total	1	4	5	9	5	3	1	1	2	32	63

Quality and Safety- Perinatal Clinical Quality Surveillance December 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



There were no stillbirths in 2023.

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Running Total
% of women booked for continuity of carer	61.0%	62.1%	64.8%	74.4%	75.7%	94.0%	96.2%	90.4%	76.9%	93.8%	96.6%	66.4%	79.4%
Number of Stillbirths	0	0	0	0	0	0	0	0	0	0	0	0	0
SATOD	7.10%	11.30%	7.10%	5.8%	6.3%	7.7%	4.8%	8.8%	6.4%	7.3%	12.5%	7.5%	7.7%
% Breastfeeding at Delivery	63.1%	71.8%	71.0%	67.1%	71.7%	69.9%	78.4%	67.6%	75.5%	74.9%	67.3%	71.9%	70.9%
% Robson Group 1	19.4%	0.0%	26.9%	5.6%	17.6%	22.7%	6.7%	26.7%	11.5%	14.3%	8.0%	26.3%	15.5%
% Robson Group 2	42.9%	42.9%	18.5%	37.0%	22.2%	28.0%	23.1%	19.0%	40.9%	30.4%	31.8%	48.4%	32.1%
% Robson Group 5	88.9%	88.9%	87.5%	75.0%	76.5%	81.3%	88.9%	92.3%	94.4%	82.4%	90.0%	88.2%	86.2%

Incidents

November - One moderate incident reported - a women experienced a 3.5 litre Postpartum haemorrhage;

December – Two moderate incidents reported:

1. A neonate required therapeutic cooling in higher tier unit. Maternity and Newborn Safety Investigations - MNSI (previously HSIB) reported.
2. A neonate required admission to SCBU following pathological CTG; they did not require therapeutic cooling

No final MNSI reports received in November /December 2023.

Workforce Status

The report provides an update on progress in delivering the Trust-wide workforce implications of the:

- operational plan
- local workforce factors impacting NHS Oversight Framework (NOF4) exit criteria and mitigating actions and;
- an overview of Trustwide workforce Key Performance Indicators (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 whole time equivalent (WTE)	December 2023 **122.60** WTE under plan	• enhanced vacancy and scrutiny measures have been established
Bank WTE	December 2023 **6.01** WTE under plan	
Agency WTE	December 2023 **124.47** WTE over plan	
Local workforce factors affecting NOF4 exit criteria		
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.		• 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%)	December 2023 **5.21%**	• 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%)	December 2023 **4.96%**	
Achievement review rate (target 90%)	December 2023 **79.18%**	

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 **122.60 WTE** under plan, improving from the previously reported **99.8** WTE under plan in November. This is largely due to the sale of Torbay Pharmacy (TP), without this we would currently be **112.28** over plan.

- Areas 'Above plan' since Nov have been seen in Nursing and Midwifery staff group showing an increase of **8.97 WTE,** Medical and Dental staff group have increased by **8.62 WTE** with the greatest growth in Infrastructure by **25.34 WTE.** (Administration and Estates staff grew by 4.68 WTE since November, there have been increases in the following areas: Portering, Discharge Team, Patient Access and Cleaning operations)
- Areas 'below plan' have been seen in Registered/ Qualified Scientific, Therapeutic and Technical staff **54.86 WTE** (-0.81%) and Support to Clinical staff **108.77 WTE** (-0.13%)

- **Bank usage** has decreased by **30.79%** since Nov, equating to **84.67 WTE**, **6.01 WTE** below plan.
- **Agency usage** has increased by **23.17%**, since Nov equating to **55.71 WTE** and is **124.47 WTE** over plan in December.

Work is currently being undertaken to look at the true workforce baseline in all the ward areas and this will help us understand shortfalls and controls of spend in bank and agency around these areas.

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 has now been replaced by Workforce Control Panels which continue to meet 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 and there has been a decrease in requests being submitted for review at panel.
So far, the two panels in January 24 have seen the number of vacancies reviewed drop by 30% compared to the first panel on 7th December where we commenced more stringent reporting of panel outcomes.

	Plan - As at the end of														
	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	Nov 23 Actual	Plan Dec 23	Dec 23 Actual	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 Workforce	6,522	6707.55	6,531	6727.04	6530	6776.66	6,552	6752.49	6,579	6643.60	6609	6604.86	6,619	6,622	6,644
Total Substantive	6,180	6266.13	6,184	6213.48	6,190	6252.81	6,197	6289.51	6,199	6099.18	6212	6089.4	6,222	6,225	6,241
Registered Nursing, Midwifery and Health Visiting Staff	1387.78	1379.2	1389.03	1390.1	1395.03	1409.2	1399.03	1414.47	1401.03	1421.28	1411.74	1420.71	1414.74	1417.62	1417.67
Registered/ Qualified Scientific, Therapeutic and Technical staff	962.48	974.39	962.48	975.1	962.48	984.467	962.48	987.578	962.48	914.97	962.48	907.62	962.48	962.48	972.87
Support to Clinical Staff	1443.25	1435.83	1443.25	1411.46	1443.25	1423.57	1443.25	1422.49	1443.25	1336.25	1443.25	1334.48	1443.25	1443.25	1440.05
NHS Infrastructure support	1789.33	1836.24	1789.33	1835.37	1789.33	1833.32	1789.33	1853.94	1789.33	1813.28	1789.33	1814.67	1793.18	1793.18	1801.95
Medical and Dental	589.6	633.05	592.6	594.17	592.6	594.967	595.6	604.748	595.6	607.12	597.6	606.22	600.6	600.76	600.76
Total Bank	246	273.16	251	337.19	249	318.07	251	254.26	270	359.66	281	274.99	280	282	281
Total Agency	96	168.26	96	176.37	91	205.78	104	208.727	110	184.76	116	240.47	117	115	122

Service Level – Workforce Implications affecting NOF4 exit

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 two consultant vacancies meaning they are operating 1:4 consultant rota which is unsustainable and poses risk to burnout. However, one post has now filled. **Mitigating action:** A bespoke recruitment video has been developed to enhance marketing and attraction.
Urology	**Issue:** Continue to have two 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:** Full service review has been completed and outcomes shared with Execs, this is now being worked up into a full business case.
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. **Mitigating actions:** Meeting with consultants to agree an hours monitoring review of their out of hours working.
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 ten-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 and four agency workers have been engaged. A programme of international recruitment is piloted, with interviews being held in January 2024. A business case has been approved to support a rolling programme of apprenticeships for ODPs.

Trust Level Workforce – Key Performance Indicators (KPI's)

Torbay and South Devon NHS Foundation Trust

Indicator	Target	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Performance
Month Sickness %	<4%	6.54%	5.26%	4.59%	4.63%	5.07%	4.46%	4.88%	4.98%	4.96%	4.97%	5.24%	4.87%	5.21%	
12 Mth Rolling Sickness %	<4%	5.76%	5.69%	5.58%	5.62%	4.96%	5.29%	5.32%	5.18%	5.19%	5.20%	5.13%	4.89%	4.96%	
Achievement Rate %	>90%	76.70%	77.68%	76.71%	76.87%	77.87%	78.12%	78.08%	78.08%	79.92%	78.93%	78.40%	78.61%	79.18%	
Labour Turnover Rate	10-14%	13.48%	13.33%	13.09%	12.85%	12.92%	12.74%	12.46%	12.71%	12.46%	12.16%	12.19%	11.94%	11.91%	
Overall Training %	>85%	89.70%	89.94%	90.09%	90.45%	90.72%	91.24%	91.74%	91.49%	91.97%	91.59%	91.07%	91.15%	91.15%	
Nuring Staff Average % Day Fill Rate- Nurses		92%	92%	91%	93%	92%	96%	100%	96%	98%	98%	101%	101%	100%	
Nuring Staff Average % Night Fill Rate- Nurses		87%	88%	87%	88%	91%	90%	89%	90%	89%	90%	92%	93%	116%	
Safer Staffing- Overall CHPPD		7.54	7.72	7.83	7.75	7.9	8.05	7.99	8.4	8.17	8.08	8.02	8.15	8.07	

Sickness – The operational plan trajectories reflects revised KPI's for sickness absence based upon the previous 5-years trend data. We have seen a slight increase in the 12 months ending December to **4.96%**, which is below our plan of 5.29% and lower than the same time last year (5.76%). Rolling sickness cost at the end of December was £11.36m which whilst lower than £12.24m in December 2022, represents a significant opportunity for improvement.

Turnover – December turnover is **11.91%**, against a plan of 12.94% and represents a continued improvement from the previous month. Turnover is significantly lower that the same time last year (13.48%). Actions as part of the Integrated Care System (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 is unchanged in December **91.15%** against a target of 85%. However, at a topic level we remain challenged in Manual Handling at **77.29%** and Information Governance at **85.05%.**

Achievement Review – Compliance has increased by 0.57% in December to **79.18%** 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

Torbay and South Devon NHS Foundation Trust

Dec-23

Ward	Day						Night						Total Patients	Day			Night		
	RN / RM		Nursing Associates		Care Staff		RN / RM		Nursing Associates		Care Staff								
	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours		Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)
Ainslie	1783	1917	0	0	1783	1731	1426	1424	0	0	1070	1178	702	107.6%	0.0%	97.1%	99.8%	0.0%	110.1%
Allerton	2895	2594	0	0	1070	1278	1426	1334	0	0	1070	1462	886	89.6%	0.0%	119.4%	93.5%	0.0%	136.7%
Cheetham Hill	1783	1687	0	0	2139	2321	1070	920	0	0	1426	2152	854	94.6%	0.0%	108.5%	86.0%	0.0%	150.9%
Coronary Care	1426	1381	0	0	0	98	1070	1058	0	0	0	46	373	96.9%	0.0%	0.0%	98.9%	0.0%	0.0%
Cromie	1668	1954	0	0	891	1446	1070	1139	0	0	713	1053	727	117.2%	0.0%	162.3%	106.5%	0.0%	147.6%
Dunlop	1426	1381	0	0	1248	1225	1070	1070	0	0	1070	1054	740	96.9%	0.0%	98.2%	100.0%	0.0%	98.5%
EAU4	1783	1934	0	0	1426	1063	1783	1438	0	0	1426	1236	736	108.5%	0.0%	74.5%	80.7%	0.0%	86.6%
Ella Rowcroft	1070	1020	0	0	1426	1275	1012	840	0	0	713	702	332	95.4%	0.0%	89.4%	83.0%	0.0%	98.4%
Warrington	1070	1158	0	0	713	970	713	698	0	0	713	885	478	108.3%	0.0%	136.0%	97.9%	0.0%	124.1%
George Earle	1783	1709	0	0	2139	2320	1070	1048	0	0	1426	1599	816	95.9%	0.0%	108.5%	98.0%	0.0%	112.1%
ICU	3209	2332	0	0	357	136	3209	2196	0	0	0	12	132	72.7%	0.0%	38.0%	68.4%	0.0%	0.0%
McCullum (Escalation)	713	909	0	0	1070	1031	713	677	0	0	1070	1035	516	127.4%	0.0%	96.4%	94.9%	0.0%	96.8%
Louisa Cary	2496	2099	0	0	713	892	2496	1686	0	0	713	868	478	84.1%	0.0%	125.1%	67.5%	0.0%	121.7%
John Macpherson	1070	854	0	0	713	632	713	640	0	0	357	387	394	79.9%	0.0%	88.6%	89.8%	0.0%	108.6%
Midgley	1783	1923	0	0	1783	1590	1426	1472	0	0	1426	1749	785	107.9%	0.0%	89.2%	103.2%	0.0%	122.6%
SCBU	1070	783	0	0	357	267	1070	763	0	0	357	253	176	73.2%	0.0%	74.8%	71.3%	0.0%	71.0%
Simpson	1783	1808	0	0	2139	1901	1070	994	0	0	1426	2105	845	101.4%	0.0%	88.9%	92.9%	0.0%	147.6%
Turner	1426	1398	0	0	1783	1698	713	713	0	0	1426	1415	512	98.0%	0.0%	95.3%	100.0%	0.0%	99.2%
New Forrest Ward	1783	1958	0	0	1426	1477	1426	1437	0	0	1426	1654	878	109.8%	0.0%	103.6%	100.8%	0.0%	116.0%
Total (Acute)	*32013*	*30798*	*0*	*0*	*23172.5*	*23347.75*	*24541*	*21543.25*	*0*	*0*	*17825*	*20839.75*	*11360*	96.2%	0.0%	100.8%	87.8%	0.0%	116.9%
Brixham	868	968.5	434	0	1302	1378.5	682	682	0	0	1023	1145	602	111.6%	0.0%	105.9%	100.0%	0.0%	111.9%
Dawlish	868	961.5	0	0	1085	1122	744	638	0	0	682	769.75	530	110.8%	0.0%	103.4%	85.8%	0.0%	112.9%
NA - Teign Ward	1953	1687.25	0	0	1953	1892.5	1023	1023	0	0	1023	1221	923	86.4%	0.0%	96.9%	100.0%	0.0%	119.4%
NA - Templar Ward	1736	1595.5	0	0	2170	1996	1023	1065	0	0	1116	1395.25	912	91.9%	0.0%	92.0%	104.1%	0.0%	125.0%
Totnes	868	789	0	0	1302	1378	744	668.5	0	0	682	709.5	503	90.9%	0.0%	105.8%	89.9%	0.0%	104.0%
Organisational Summary	38306	36800	434	0	30985	31115	28757	25620	0	0	22351	26080	14830	96.1%	0.0%	100.4%	89.1%	0.0%	116.7%

The Registered Nurse (RN) fill rate for days during December was 96.1% which is a decrease in the November fill rate of 101.6% and for night duty reported as 89.1% which is a decrease on the previous months fill rate of 93.2%.

The fill rate for Healthcare Support Worker (HCSW) for days during December was 100.4% which a decrease in the November fill rate of 103.0%. For night duty reported as 116.7% which is a decrease on the previous months fill rate of 124.7%.
The increase in fill rate for HCSW at night is to mitigate any risks associated with the RN fill rate.

Safer Staffing – planned versus actual

Torbay and South Devon NHS Foundation Trust

CHPPD Monthly Summary

Ward	Planned Total CHPPD	Planned RN / RM CHPPD	Planned NA CHPPD	Planned HCA / MCA CHPPD	Actual Mean Monthly Total CHPPD	Actual Mean Monthly RN / RM CHPPD	Actual Mean Monthly NA CHPPD	Actual Mean Monthly HCA / MCA CHPPD	Total CHPPD days not met in month	RN / RM CHPPD days not met in month	NA CHPPD days not met in month	HCA/MCA CHPPD days not met in month	Total CHPPD % days not met in month	RN / RM CHPPD % days not met in month	NA CHPPD % days not met in month	HCA/MCA CHPPD % days not met in month	Carter Median CHPPD All (September 2016)	Carter Median CHPPD RN (September 2016)	Carter Median CHPPD NA (September 2016)	Carter Median CHPPD HCA (September 2016)
Ainslie	7.52	3.98	0.00	3.54	8.90	4.80	0.00	4.10	1	3	0	4	3.2%	9.7%	0.0%	12.9%	7.74	4.74	0	2.91
Allerton	7.40	5.02	0.00	2.38	7.50	4.40	0.00	3.10	13	28	0	2	41.9%	90.3%	0.0%	6.5%	7.74	4.74	0	2.91
Cheetham Hill	7.39	3.29	0.00	4.11	8.30	3.10	0.00	5.20	1	18	0	1	9.7%	22.6%	0.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.90	6.50	0.00	0.40	1	4	0	0	3.2%	12.9%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.75	3.68	0.00	2.07	7.70	4.30	0.00	3.40	0	0	0	0	0.0%	0.0%	0.0%	0.0%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.40	3.30	0.00	3.10	11	15	0	10	35.5%	48.4%	0.0%	32.3%	7.74	4.74	0	2.91
EAU4	8.63	4.79	0.00	3.83	7.70	4.60	0.00	3.10	30	21	0	27	96.8%	67.7%	0.0%	87.1%	7.74	4.74	0	2.91
Ella Rowcroft	8.63	4.31	0.00	4.31	11.60	5.60	0.00	6.00	2	4	0	3	6.5%	12.9%	0.0%	9.7%	7.74	4.74	0	2.91
Warrington	6.09	3.38	0.00	2.71	7.80	3.90	0.00	3.90	1	3	0	2	3.2%	9.7%	0.0%	6.5%	7.74	4.74	0	2.91
George Earle	7.39	3.29	0.00	4.11	8.20	3.40	0.00	4.80	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	35.40	34.30	0.00	1.10	0	0	0	16	0.0%	0.0%	0.0%	57.1%	7.74	4.74	0	2.91
McCullum (Escalation)	6.76	2.71	0.00	4.06	7.10	3.10	0.00	4.00	7	5	0	12	22.6%	16.1%	0.0%	38.7%	7.74	4.74	0	2.91
Louisa Cary	8.63	6.71	0.00	1.92	11.60	7.90	0.00	3.70	4	10	0	1	0.0%	32.3%	0.0%	3.2%	7.74	4.74	0	2.91
John Macpherson	5.11	3.19	0.00	1.92	6.40	3.80	0.00	2.60	7	11	0	4	22.6%	35.5%	0.0%	12.9%	7.74	4.74	0	2.91
Midgley	7.96	3.98	0.00	3.98	8.60	4.30	0.00	4.30	3	3	0	10	9.7%	9.7%	0.0%	32.3%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	11.70	8.80	0.00	3.00	2	7	0	10	6.5%	22.6%	0.0%	32.3%	7.74	4.74	0	2.91
Simpson	7.39	3.29	0.00	4.11	8.10	3.30	0.00	4.70	3	7	0	0	9.7%	22.6%	0.0%	0.0%	7.74	4.74	0	2.91
Turner	9.58	3.83	0.00	5.75	10.20	4.10	0.00	6.10	8	5	0	13	25.8%	16.1%	0.0%	41.9%	7.74	4.74	0	2.91
New Forrest Ward	6.74	3.57	0.00	3.17	7.40	3.90	0.00	3.60	4	7	0	8	12.9%	22.6%	0.0%	25.8%	7.74	4.74	0	2.91
Brixham	6.95	2.50	0.70	3.75	6.90	2.70	0.00	4.20	20	13	31	3	64.5%	41.9%	100.0%	9.7%	7.74	4.74	0	2.91
Dawlish	6.81	3.25	0.00	3.56	6.60	3.00	0.00	3.60	20	19	0	12	64.5%	61.3%	0.0%	38.7%	7.74	4.74	0	2.91
NA - Teign Ward	6.40	3.20	0.00	3.20	6.30	2.90	0.00	3.40	15	23	0	8	48.4%	74.2%	0.0%	25.8%	7.74	4.74	0	2.91
NA - Templar Ward	6.50	2.97	0.00	3.53	6.60	2.90	0.00	3.70	9	18	0	7	29.0%	58.1%	0.0%	22.6%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	7.00	2.90	0.00	4.20	7	12	0	4	22.6%	38.7%	0.0%	12.9%	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
	7.42	4.12	0.03	3.28	8.07	4.21	0.00	3.86
Total Planned Beds / Day	525							
Days in month	31							

The Registered Nurse (RN) actual CHPPD has been reported as 4.21 in December but still remains below the carter recommendation of 4.7. The actual Healthcare Assistants (HCA) CHPPD was 3.86 in December which remains above the carter recommendation of 2.91. This is due to the increased need for Healthcare Support Worker (HCSW) to provide 1:1 supportive observation care.

During December the Trust was operationally challenged with 4 days in Operational Pressures Escalation Levels (OPEL 4) and 17 days at OPEL 3 The planned CHPPD total was reported as 7.42 with an actual of 8.07 which reflects an increase in escalation areas due to operational challenges.

Community and Social Care Indicators - dashboard of key metrics

Torbay and South Devon NHS Foundation Trust

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

Opiate users - % successful completions of treatment (quarterly 1 quarter in arrears)		
DOLS - Deprivation of Liberty Standard		
Intermediate Care - No. urgent referrals		
Community Hospital - Admissions (non-stroke)		
Community Hospital average Length of Stay (days)		
Urgent Community Response 2 hours		⬇
Urgent Community Response 2 to 48 hours		
Permanent admissions (18-64) to care homes per 100k population (ASCOF) (14)		⬆
Permanent admissions (65+) to care homes per 100k population (ASCOF) (450)		⬇
Proportion of clients receiving direct payments (ASCOF) (25%)		⬇
% reablement episodes not followed by long term SC support (83%)		⬇

Further commentary on key performance indicators for community and Adult Social Care is included in the Chief Operating Officer report.

Operational Performance Indicators - dashboard of key metrics

NHS Torbay and South Devon NHS Foundation Trust

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

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 – Weekday		↑
Care Planning Summaries % completed within 24 hours of discharge – Weekend		↓
Clinic letters timeliness - % specialties within 4 working days		↓

NHS
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Monthly Financial Performance Report

M09 (Period Ended Dec-23)

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Torbay and South Devon NHS Foundation Trust

Torbay and South Devon NHS Foundation Trust

Executive Summary

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	481,963	493,821	11,857		637,940	655,836	19,947	
Operating Expenditure and Financing Cost	(510,334)	(543,602)	(33,268)		(670,513)	(717,141)	(48,680)	
Surplus / (Deficit)	**(28,371)**	**(49,782)**	**(21,411)**		**(32,573)**	**(61,305)**	**(28,733)**	
Remove Donated Assets, Cost on Impairment	(177)	19,705	19,882		2	19,970	19,968	
Adjusted Surplus / (Deficit)	**(28,548)**	**(30,076)**	**(1,528)**		**(32,571)**	**(41,336)**	**(8,765)**	
Capital (CDEL)	37,936	9,458	(28,478)		56,755	30,902	(25,853)	
Cash & Cash Equivalents	14,320	30,510	16,190		14,975	12,913	(2,062)	

As at M09, the Trust reported an adverse variance to plan of **£1.528m**. The revised adverse variance to date primarily relates to Elective Recovery Fund (ERF) estimated clawback due to activity delivery being lower than planned and other pay and non-pay overspends partially offset by other income. However, it is expected that the ERF income position will recovery by end of March.

At M09, we are formally reporting a forecast adverse variance to plan of **£8.765m** in line with the agreed deficit forecast of **£41.336m** set for the year.

* Capital Plan is different to Current Year end forecast as there has been movement in ICB CDEL as a consequence of the sale of TP and movement in National PDC schemes, such as NHP and Digital EPR, where the phasing of expenditure has changed.

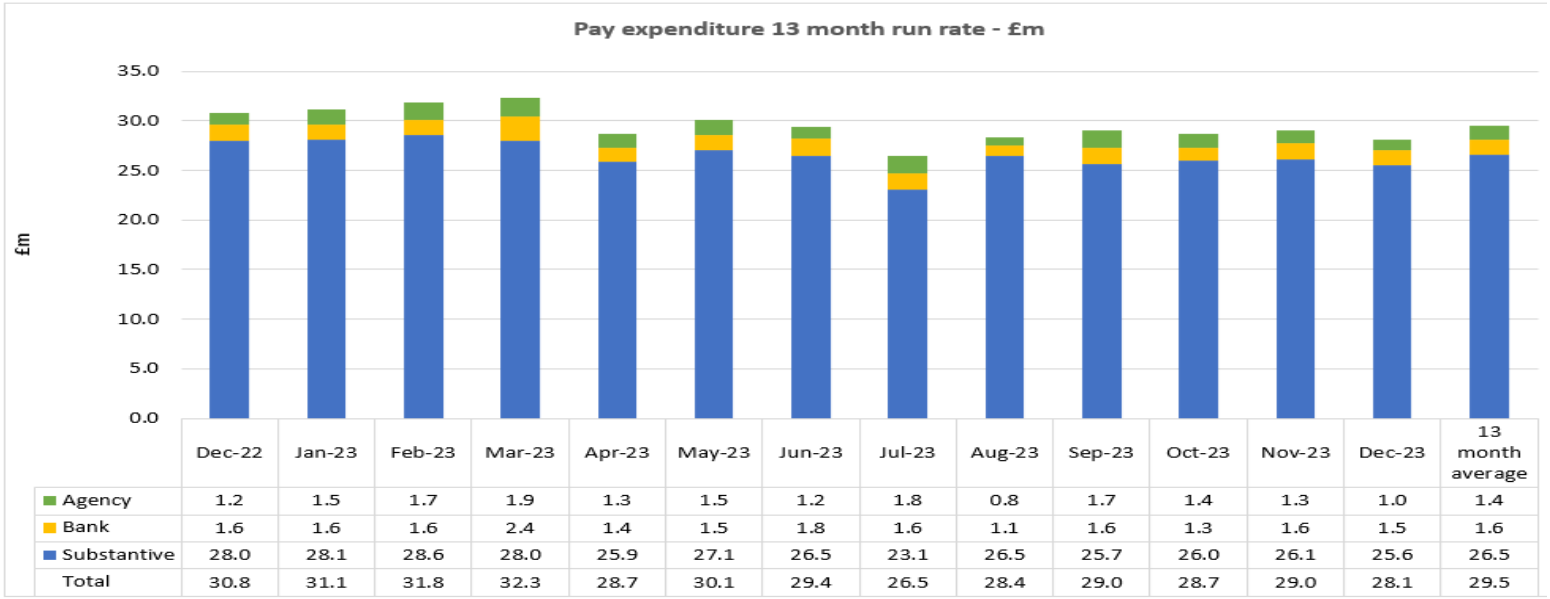
Forecast Position By Care Group

Torbay and South Devon NHS Foundation Trust

The table below provides a snapshot of our Forecast financial position at the end of M09 at Care Group Level, with commentary on key variances that have material impact on our overall performance.

Care Group	Full Year Plan £M	Full Year F'cast £M	Full Year Variance £M	RAG	Commentary
Children and Family Health Devon	0.59	2.18	1.59		Pay YTD is **£0.5m** over budget mainly for externally funded posts and agency costs supporting waiting list work and pilot schemes, offset by income received. Non pay **£5.5m** overspend is mainly for recharge of expenditure incurred (funded via external income) and un-planned risk share. Total Income is reported as a **£6.8m** above budgeted position, mainly to offset non pay and pay expenditure. CIP delivery of **£0.8m** has been processed relating to net surplus position reported in-year.
Families & Communities	(206.57)	(211.68)	(5.11)		Full year overspend is materially driven by overspends on ASC (volume and complexity) and Placed People (Torbay CHC - Dom Care and Nursing activity) packages of care of **£4.4m** In addition to this there are pressures in Child Health (unachieved CIP & medical costs - junior doctor strikes) and Community Hospitals (unachieved CIP) of **£2.0m**. Other Divisions are reporting underspends of **£1.3m** for additional achievement of CIP and vacancy slippages.
Medicine and Urgent Care	(73.75)	(85.37)	(11.62)		The YTD overspend is forecast to continue for the remainder of the financial year, materially driven by: -unachieved CIP across all divisions in the Care Group **£4.2m**, -ward pressures within the Care Group **£1.4m**, -recovery areas that are still fully operational despite reduced budgets **£1.7m**, and -medical cost pressures (includes Junior strikes and locum pressures) **£4.3m**.
Planned Care and Surgery	(143.44)	(145.33)	(1.89)		Forecast overspend of **£1.9m**, includes **£2.5m** under delivery of CIP and **£0.4m** overspends against various under specialties, offset by **£1.0m** ESRF less than planned activity earlier in the year, Theatres consumables, Clinical Engineering and Labs managed service contract.
Shared Corporate Services incl. Reserves & Other Income	390.60	398.86	8.26		Forecast underspend includes: **£0.7m** net Reserves & Other Income plan profiling adjustments, **£1.9m** Energy and other Estate related cost pressures, offset by **£2.3m** underspends against depreciation and interest income received, **£3.4m** Industrial Action funding, **£1.4m** additional forecast CIP delivery, **£0.6m** additional Education income.
Total	**(32.57)**	**(41.34)**	**(8.77)**		

Pay Expenditure – Run Rate



	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	13 month average
Agency	1.2	1.5	1.7	1.9	1.3	1.5	1.2	1.8	0.8	1.7	1.4	1.3	1.0	1.4
Bank	1.6	1.6	1.6	2.4	1.4	1.5	1.8	1.6	1.1	1.6	1.3	1.6	1.5	1.6
Substantive	28.0	28.1	28.6	28.0	25.9	27.1	26.5	23.1	26.5	25.7	26.0	26.1	25.6	26.5
Total	30.8	31.1	31.8	32.3	28.7	30.1	29.4	26.5	28.4	29.0	28.7	29.0	28.1	29.5

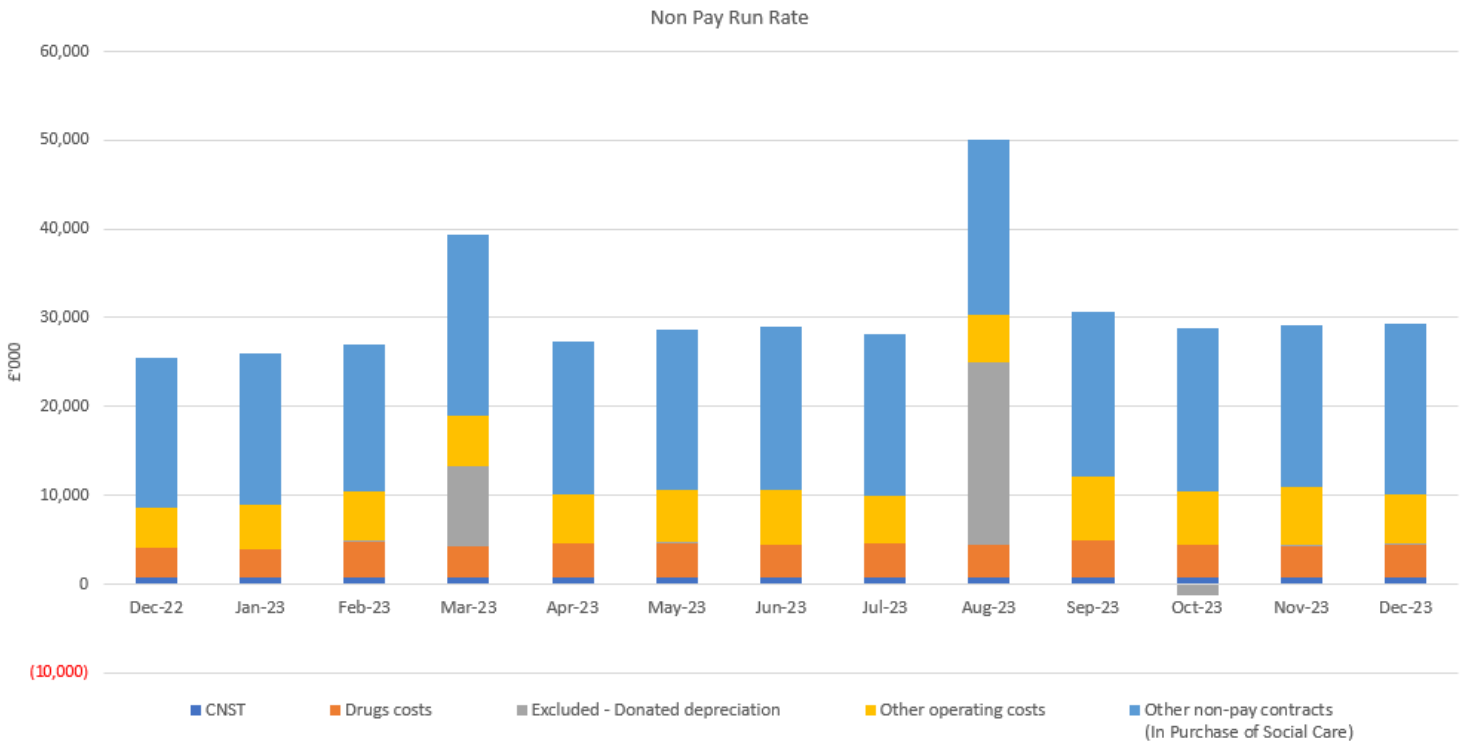
***Periods prior to Mar-23 have been inflated to 23/24 uplift to aid comparison in spend**

The graph above displays the run rate for overall pay expenditure over the previous 13 months* excluding technical adjustments, covering data that includes bank, agency, and substantive pay, along with any overtime hours worked. As at M09, there had been a slight reduction in substantive, bank, and agency expenditure due to reduction in accrual provisions for expected increase in clinical demand.

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

It is imperative to emphasise that within the first nine months of this fiscal year, the trust exceeded the annual agency expenditure limit by 25%, as stipulated by NHSE/I. Corrective measures have been implemented to control agency expenditure including aligning rostering system to budgeted establishment but more still needs to done in reducing shift booking whilst maintaining safe services

Non-Pay Expenditure – Run Rate



The year-to-date figures shows, the Non-Pay expenditure remained adverse to the plan, amounting to **(£28.25m)**. The adverse variance includes **(£20.50m)** impairment relating to the sale of Torbay Pharmaceuticals, while other adverse variances of **(£7.75m)** relate to continued escalation of Purchase of Social Care and Other non-pay operating expenses.

Torbay and South Devon NHS Foundation Trust

ERF Income and Activity Position

Setting	YTD 19/20 Activity	YTD 23/24 Activity	YTD Var	YTD Var %	YTD 100% of 19/20 Income £'000	YTD 23/24 Income £'000	YTD Income Var £'000	YTD Income Var %
Day Cases	21,423	20,596	(827)	96%	18,255	18,782	526	103%
Electives	2,698	2,220	(478)	82%	11,320	8,806	(2,514)	78%
APC TOTAL	**24,121**	**22,816**	**(1,305)**	**95%**	**29,576**	**27,588**	**(1,988)**	**93%**
Firsts	63,581	66,966	3,385	105%	12,807	13,400	593	105%
First Procedures	13,904	16,594	2,690	119%	2,475	2,941	466	119%
Follow-Up Procedures	40,096	39,666	(430)	99%	5,814	5,984	170	103%
OPA TOTAL	**117,582**	**123,226**	**5,644**	**105%**	**21,097**	**22,325**	**1,229**	**106%**
Total ESRF Performance	141,703	146,042	4,339	103%	50,672	49,913	(759)	98.5%

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 Industrial Action, NHSE/I has reset the target to 100% to take 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.

The bottom-line position of 98.5% has increased slightly since last month but the profiling of the 19/20 baseline by NHSE/I has a higher % of the baseline at the end of the year to reflect less expected Industrial Action. The reason for activity being at 103% and finance at 98.5% is due to more electives and less outpatients being cancelled for Industrial Action and a change to the case mix of the electives being outsourced since M3.

The above does not include a known data issue that is currently being fixed and should significantly improve the position by approx. £500k to £1m over the coming months. If data quality not improved in-time for year-end, the FOT would show an underperformance against 19/20 of £1.1m (98%).

Please note M1 to 7 are based on SUS freeze submission and M8 & M9 are at Flex Submission.

Bed Utilisation

Point of Delivery	Dec 22 Actual	Jan 23 Actual	Feb 23 Actual	Mar 23 Actual	Apr 23 Actual	May 23 Actual	Jun 23 Actual	Jul 23 Actual	Aug 23 Actual	Sep 23 Actual	Oct 23 Actual	Nov 23 Actual	Dec 23 Actual
Occupied Beds DGH	10,939	11,221	9,992	11,195	10,576	11,044	10,625	10,600	10,715	10,542	11,126	10,748	10,578
Available Beds DGH	11,375	11,598	10,376	11,559	11,092	11,460	11,125	11,385	11,342	10,999	11,534	11,233	11,326
Occupancy	96%	97%	96%	97%	95%	96%	96%	93%	94%	96%	96%	96%	93%

In M09, the overall bed occupancy for Acute beds is **93%**. Occupancy below **95%** is considered a minimum to support timely patient flow.

The increase in overall bed occupancy has coincided with onset of winter pressures and increased demand on services. The challenges in maintaining patient flow impact on Handover delays in the Emergency Department and levels of escalation.

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. Further work is being done across the wider ICB to support system schemes including care coordination Hub and out of hours falls prevention Falls prevention to help manage demand on hospital bed capacity.

The key areas of improvement this winter 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 M9 the Trust reported 6.4**%** of occupied beds as "No Criteria to Reside". This is against the plan to deliver 5% by March 2024.

Torbay and South Devon NHS Foundation Trust

CIP Programme 23/24 Pipeline

For the financial year 2023/24, the total CIP delivery requirement was £46.6m. As of 8th January, the 2023/24 CIP programme includes 145 schemes, of which 142 schemes (98%) totalling £41.2m are assessed as Green and have been confirmed in the Plan.

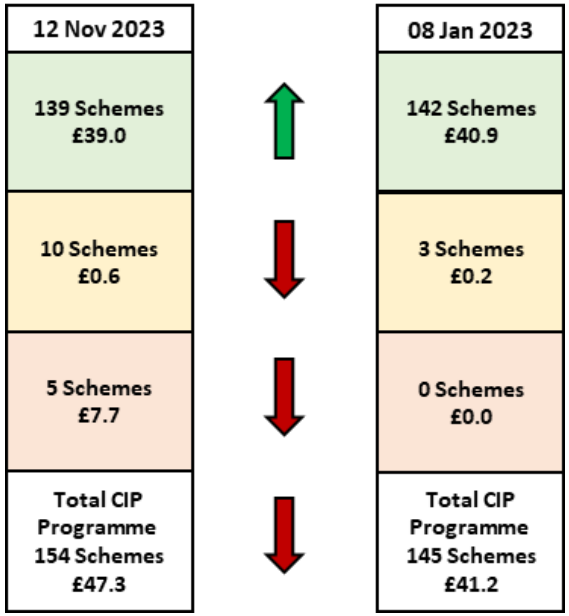
Divisions and workstreams are working through 3 new schemes that have a value of £0.2m.

Scoping work continues to be developed whilst maintaining a balance with ensuring the delivery of existing schemes. Considerable focus must be placed on Amber schemes to reach the in-year target and more schemes need to be generated for the remaining 3 months of the financial year.

The Strategic ICB Collaborative schemes totalling £10.5m have been reduced in line with the final information provided by the ICB to £0.07m assessed as Green, with the remainder of schemes being either closed due to no delivery or counted as run rate reduction initiatives only, by the PMO. The CIP delivery from the ICB Collaborative schemes has been negligible.

Currently, if all the schemes included in the pipeline were to be developed and pass through the governance process, the total programme will be in the region of £41.2m.

2023/24 Scheme Development (£m)



Cash Position

Torbay and South Devon NHS Foundation Trust

Description	YTD Bud £000	YTD Act £000	YTD Var £000
Opening Cash Balance	**14,961**	**34,734**	**19,773**
Capital Expenditure (Accruals Basis)	(39,164)	(9,405)	29,759
Capital Loan/PDC Drawn Down	22,952	16,055	(6,897)
Capital Loan Repayment Principal	(2,282)	(6,559)	(4,277)
Proceeds on Disposal of Assets	0	3	3
Movement in Capital Creditor	0	(10,735)	(10,735)
Other Capital-related Elements	1,086	(1,667)	(2,753)
Sub Total – Capital Related Elements	**(17,408)**	**(12,307)**	**5,101**
Cash Generated From Operations	(3,047)	(10,070)	(7,023)
Revenue PDC Drawn Down	29,918	28,548	(1,370)
Working Capital Movements – Debtors	(1,719)	3,457	5,176
Working Capital movements – Creditors	(51)	(8,120)	(8,069)
Net Interest	(1,888)	(768)	1,120
PDC Dividend Paid	(4,106)	(3,839)	267
Other Movements	(2,338)	(1,124)	1,214
Sub Total - Other Elements	**16,768**	**8,083**	**(8,685)**
Closing Cash Balance	**14,321**	**30,510**	**16,189**

- Unlike in previous years, the plan had to be submitted to NHSE prior to the end of the last 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 M09 is **£16.2m** ahead of plan.
- Access to capital and revenue PDC support prior to the sale of Torbay Pharmaceuticals Ltd (TP), remained 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 **£52.2m,** 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. Please refer to the supplementary Capital and Cash paper for further details.
- Capital-related cashflow is **£5.1m** favourable. A movement can now be seen against capital expenditure in terms of the sale of TP and general delays in capital expenditure requirement **£29.8m**. An offset to this is pay down of the capital creditor **£10.7m**, the plan assumed that this would have happened at the end of the prior year. PDC capital drawn down **£6.9m** adverse due to delays in national programmes and loan repayment **£4.3m** adverse due to early settlement of a loan.
- Cash generated from operations is **£7.0m** adverse due to the adverse operational elements within in the I&E position. Due to cash generated from the sale of Torbay Pharmaceuticals, it is now anticipated that there will be no further revenue PDC drawdown hence the adverse position on planned cash flow. Cash flow forecasting will be updated on a regular basis to ensure the current planned year end cash balance of circa **£13.0m** remains as expected.
- Debtor movement is **£5.2m** favourable, largely due to the removal of TP debtors and inventories
- Creditors are higher than planned **£8.1m** due to higher than planned value for provider-to-provider recharges and general provisions as explained on the balance sheet movement.

Balance Sheet

Torbay and South Devon NHS Foundation Trust

	YTD Bud £000	YTD Act £000	YTD Var £000
Intangible Assets	14,067	13,179	(888)
Property, Plant & Equipment	266,985	216,344	(50,641)
On-Balance Sheet PFI	17,083	19,907	2,824
Right of Use assets	20,100	18,923	(1,177)
Other	1,843	1,628	(215)
Non-Current Assets Total	**320,078**	**269,982**	**(50,096)**
Cash & Cash Equivalents	14,321	30,510	16,189
Other Current Assets	42,380	50,840	8,460
Current Assets Total	**56,701**	**81,349**	**24,648**
Total Assets	**376,779**	**351,331**	**(25,448)**
Loan - DHSC ITFF	(2,917)	(2,507)	410
PFI and Leases	(3,914)	(3,950)	(36)
Trade and Other Payables	(54,872)	(63,390)	(8,518)
Other Current Liabilities	(5,267)	(9,506)	(4,239)
Current Liabilities Total	**(66,970)**	**(79,353)**	**(12,383)**
Net Current Assets/(liabilities)	**(10,269)**	**1,997**	**12,266**
Loan - DHSC ITFF	(20,010)	(16,143)	3,867
PFI and Leases	(31,118)	(30,509)	609
Other Non-Current Liabilities	(4,615)	(4,667)	(52)
Non-Current Liabilities Total	**(55,743)**	**(51,320)**	**4,423**
Total Assets Employed (Assets + Liabilities)	**254,066**	**220,659**	**(33,407)**
Reserves			
Public Dividend Capital	246,194	240,218	(5,976)
Revaluation	61,351	60,112	(1,239)
Income and Expenditure	(53,479)	(79,671)	(26,192)
Total	**254,066**	**220,659**	**(33,407)**

- Non-Current Assets are **£50.1m** lower than plan. This is largely due to the sale of TP related assets **£36.1m** . In addition a FY22/23 property revaluation was lower than planned **£4.7m** and year to date capital expenditure behind plan **£12.2m**, which is partly offset by reduced depreciation **£3.1m** due to delays in bringing assets into service.

- Cash & Cash Equivalents is **£16.2m higher** than plan, as explained in the commentary to the Cash Flow Statement.

- Other Current Assets are **£8.5m** higher than planned. This is mainly due ASC debtors **£4.6m,** accrued income **£10.5m** higher than planned and prepayments higher than planned **£1.2m** . This is partly offset by the removal of current assets **£8.4m,** again linked to the Torbay Pharmaceuticals sale.

- Trade and Other Payables are **£8.5m** higher than plan. Principally this value is due to **£8.3m** provider to provider recharges such as CFHD, **£1.2m** general provisions including placed people and **£1.3m** payroll creditors. This is partly offset by PDC being lower than planned **£1.0m.**

- Other Current Liabilities are **£4.2m** higher than planned, mainly due to income received ahead of time and being deferred to match expenditure.

- Loans are lower than planned **£4.3m** due to the early repayment of a loan linked to the recent sale of an asset.

- PDC reserves are behind plan **£6.0m** , due to a delay in projects linked to Capital PDC.

- The Income and Expenditure reserve is **£26.2m** 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 **£1.5m**

Capital Position

- M9 ICB CDEL expenditure is £10.8m against the planned £21.2m for the year, if is expected significant expenditure increase in the last quarter.
- Asset disposal mainly relates to TP sale
- We are forecasting the ICB CDEL will be fully spend at year-end however some delayed relating to Nationally funded projects.

Combined ICB and National CDEL	Capital Full year Plan for 23/24 £'000	Capital F'cast for 23/24 at 31 Dec £'000	Variance Plan to F'cast M09 £'000	Capital YTD M09 £'000
ICB CDEL	21,237	21,719	482	10,800
National CDEL	32,717	23,485	(9,232)	15,967
CDEL asset disposal	0	(17,309)	(17,309)	(17,309)
IFRS 16 CDEL	2,800	2,800	0	0
CDEL total	**56,754**	**30,695**	**(26,059)**	**9,458**
Other - Charitable Funds and PFI	1,382	522	(860)	202
Grand total	**58,136**	**31,217**	**(26,919)**	**9,660**

	Target March 2024	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Operational Plan trajectory Dec 2023
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)	1110	2448	5017	3280	740	2260	796	1630	1569	1223	1707	2579	3591	3141	2141	1213
Percentage of Ambulance handovers greater than 3 hours		18.1%	36.0%	18.9%	3.7%	13.8%	2.7%	8.2%	7.5%	3.7%	6.5%	14.7%	23.4%	18.7%	12.5%	No trajectory
Total average time in ED (hours/minutes)		07:44	08:59	07:49	06:35	07:34	05:57	06:48	06:20	05:41	06:05	05:46	06:15	06:19	05:44	No trajectory
ED attendances where visit time over 12 hours	0	939	1207	823	599	977	568	893	797	637	794	686	822	770	622	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	76%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68.4%	66.6%	67.0%	68.0%	75%
% patient discharges pre-noon	33%	23.6%	18.1%	19.0%	18.5%	19.2%	18.9%	18.9%	19.9%	20.5%	21.6%	21.5%	20.3%	22.4%	23.7%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%	11.0%	13.0%	13.0%	12.0%	8.1%	7.6%	6.0%	7.0%	6.0%	7.5%	7.4%	8.3%	7.2%	6.4%	7.5%
Elective recovery																
RTT 104 week wait incomplete pathway	0	34	29	22	14	0	0	0	0	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	822	923	708	462	183	166	167	123	129	156	187	155	179	165	65
RTT 65 week wait incomplete pathway	0	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1161	1018	871	840	650
RTT 52 week wait incomplete pathway	Reduction	5585	6027	5554	5116	4427	4024	3926	3938	3879	3977	3471	2961	2533	2258	Reduction
Patient waits over 2.5 years	0	17	12	9	6	0	0	0	0	0	0	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	67.3%	71.7%	67.5%	77.3%	76.3%	75.5%	78.0%	77.7%	79.6%	79.3%	78.0%	77.5%	75.7%	77.0%	75%
Number of patients waiting longer than 62 days for treatment	138	229	253	225	130	114	107	111	100	89	120	105	143	147	158	182

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - December 2023

	ISU	Target	13 month trend	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		2	3	1	2	1	1	1	4	1	1	3	2	3	17
Reported Incidents - Death	Trustwide	<1		0	4	0	1	0	1	1	0	2	0	0	1	1	6
Medication errors resulting in moderate harm	Trustwide	<1		0	0	0	0	0	1	2	2	2	0	0	0	0	7
Medication errors - Total reported incidents	Trustwide	N/A		48	47	44	62	68	72	76	70	74	58	53	33	49	553
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		2	0	3	1	0	0	2	1	1	0	0	0		4
Never Events	Trustwide	<1		0	0	2	0	0	0	0	0	0	0	0	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		6	13	3	13	5	7	8	11	7	7	5	5	7	62
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	1	0	0	2	1	2	1	0	0	1	0	0	7
Formal complaints - Number received	Trustwide	20		10	14	12	12	5	7	6	8	8	7	9	8	9	67
VTE - Risk Assessment on Admission (acute)	Trustwide	>95%		94.0%	95.5%	95.9%	96.5%	96.3%	95.4%	96.5%	96.0%	94.5%	95.2%	95.8%	94.3%	93.5%	95.2%
Hospital standardised mortality rate (HSMR) (4 months in arrears)	Trustwide	<100		108.7	106.8	104.2	101.9	99.9	98.1	98.1	96.2	94.8					
Safer staffing - ICO - Day time	Trustwide	90% - 110%		91.6%	92.1%	91.3%	93.1%	92.4%	96.0%	100.1%	96.1%	97.6%	98.1%	101.4%	101.6%	96.1%	96.1%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		87.4%	87.9%	87.0%	88.4%	91.3%	90.0%	89.0%	90.1%	88.7%	90.1%	92.3%	93.2%	89.1%	89.1%
Bed capacity impacted by Infection Control (Acute beds closed in month)	Trustwide	<100		786	339	254	164	319	340	99	24	528	514	373	174	56	2427
Hand Hygiene	Trustwide	>95%		91.2%	94.0%	92.1%	91.3%	92.5%	92.9%	91.3%	87.7%	92.6%	87.9%	92.9%	93.3%	93.8%	91.9%
Number of Clostridium Difficile cases (COHA+HOHA)	Trustwide	<3		1	8	2	2	4	7	7	4	4	6	8	10	8	58
CDiff - Hospital Onset Healthcare Associated (HOHA)	Trustwide			1	7	1	1	3	4	4	2	0	5	7	7	5	37
CDiff - Community Onset Healthcare Associated (COHA)	Trustwide			0	1	1	1	1	3	3	2	4	1	1	3	3	21
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		41.5%	40.0%	53.8%	58.3%	58.0%	57.1%	40.0%	38.7%	58.3%	53.8%	54.5%	68.7%	47.1%	
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		28.0%	54.5%	67.4%	70.7%	63.0%	80.0%	61.4%	69.5%	69.8%	69.1%	66.7%	67.2%	64.8%	
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		21452	20030	20048	19979	19618	19609	18738	18842	19582	20140	19265	19082	19673	
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.6%	4.7%	5.7%	5.6%	5.0%	5.3%	5.3%	5.2%	5.2%	5.2%	5.1%	4.9%	5.0%	
Appraisal Completeness	Trustwide	>90%		76.7%	77.7%	76.7%	76.9%	77.9%	78.1%	78.1%	78.1%	79.9%	78.9%	78.4%	78.6%	79.2%	
Mandatory Training Compliance	Trustwide	>85%		89.7%	89.9%	90.1%	90.4%	90.7%	91.2%	91.7%	91.5%	91.8%	91.6%	91.0%	91.2%	91.1%	
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		13.5%	13.3%	13.1%	12.8%	12.9%	12.7%	12.5%	12.7%	12.5%	12.2%	12.2%	11.9%	11.9%	

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	ISU	Target	13 month trend	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-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%			5.5%			5.5%	
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		756	755	781	814	784	804	817	823	852		834	768	757	
Intermediate Care - No. urgent referrals	Trustwide	NONE SET		299	318	307	298	288	323	327	308	323	335	327	305		2536
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		208	198	200	251	224	219	228	281	234	208	241	254	216	2105
Urgent Community Reponse (2-hour) - Referrals	Trustwide	NONE SET		40	34	34	30	25	34	37	38	44	49	40	50	58	375
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	70%		77.5%	79.4%	94.1%	90.0%	92.0%	88.2%	89.2%	97.4%	95.5%	95.9%	92.5%	100.0%	98.3%	94.9%
Urgent Community Reponse (2-48 hour)- Referrals	Trustwide	NONE SET				171	160	138	162	151	124	128	133	157	140	127	1260
Urgent Community Reponse (2-48 hour) - Target achievement	Trustwide	NONE SET				83.3%	86.3%	86.2%	85.8%	85.4%	84.7%	87.5%	85.7%	87.9%	90.0%	85.8%	86.6%
ADULT SOCIAL CARE TORBAY KPIs																	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		32.6	32.6	28.5	29.9	32.6	27.2	24.5	27.2	16.3	24.5	32.6	34.0	30.0	30.0
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		915.4	840	802.3	826.5	805	748.5	729.6	729.6	735	740.4	775.4	748.5	749.8	749.8
Proportion of clients receiving direct payments	Trustwide	25%		20.3%	20.0%	20.2%	19.5%	20.1%	20.1%	20.0%	20.6%	21.1%	20.7%	20.7%	20.6%	19.8%	19.8%
% reablement episodes not followed by long term SC support	Trustwide	83%		85.4%	86.6%	86.4%	86.4%	85.3%	88.3%	88.9%	87.7%	87.9%	88.3%	88.6%	88.3%	88.2%	93.0%

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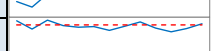
LOCAL PERFORMANCE FRAMEWORK 1																	
Cancer - Two week wait from referral to date 1st seen - regional reporting	Trustwide	>93%		67.4%	76.3%	82.6%	76.0%	55.9%	74.1%	76.3%	68.6%	69.5%	70.7%	67.3%	68.3%	71.0%	
Cancer - 28 day faster diagnosis standard - national reporting	Trustwide	75%		71.7%	67.5%	77.3%	76.3%	75.5%	78.0%	77.7%	79.6%	79.3%	78.0%	77.5%	75.7%	77.0%	
Cancer - 31-day wait from decision to treat to treatment - national reporting	Trustwide	>96%		98.1%	93.9%	98.4%	95.7%	94.8%	95.1%	93.2%	95.3%	97.5%	94.4%	92.5%	94.1%	96.6%	
Cancer - 62-day wait for treatment - national reporting	Trustwide	>85%		68.5%	51.1%	52.5%	60.8%	69.5%	61.5%	67.0%	68.4%	77.9%	73.3%	64.6%	68.4%	62.4%	
Cancer - Patient waiting longer than 104 days from 2ww - regional reporting	Trustwide	20		69	68	53	24	20	11	7	10	11	14	21	22	22	
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		43.3%	43.9%	44.3%	48.1%	49.7%	49.8%	51.2%	53.1%	52.0%	54.1%	54.8%	55.8%	55.8%	
RTT 65 week wait incomplete pathway	Trustwide	1091		2203	1828	1679	1372	1244	1163	1196	1136	1274	1161	1018	871	840	
RTT 78 week wait incomplete pathway	Trustwide	178		923	708	462	183	166	167	123	129	156	187	155	179	165	
RTT 104 week wait incomplete pathway	Trustwide	0		29	22	14	0	0	0	0	0	0	0	0	0	0	
On the day cancellations for elective operations	Trustwide	<0.8%		2.1%	1.4%	1.5%	1.5%	0.8%	1.4%	1.8%	1.4%	1.6%	1.7%	2.1%	1.0%	1.2%	1.5%
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		6	11	10	7	7	10	14	13	23	37	13	2	8	127
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		16.1%	16.5%	15.3%	14.6%	15.8%	15.2%	15.0%	15.3%	15.9%	15.4%	15.3%	15.3%	15.4%	
Bed Occupancy	Acute	90.0%		94.9%	96.3%	96.2%	96.3%	95.3%	96.4%	95.5%	93.1%	94.0%	96.0%	96.5%	95.7%	93.0%	
Percentage of inpatients with No Criteria to Reside (acute)	Trustwide	<5%						7.6%	6.0%	7.0%	6.0%	7.5%	7.4%	8.3%	7.2%	6.4%	
% patient discharges pre-noon	Acute	33%								19.9%	20.5%	21.6%	21.5%	20.3%	22.4%	23.7%	20.80%
% patient discharges pre-5pm	Acute	75%								67.7%	67.9%	70.6%	70.9%	69.4%	71.2%	72.5%	69.6%
Number of patients >7 days LoS (daily average)	Trustwide			172.6	183.5	166.1	167.0	154.2	159.8	156.2	129.9	156.0	159.8	169.4	158.0	151.5	
Number of extended stay patients >21 days (daily average)	Trustwide			42.3	57.1	40.7	38.6	39.3	33.2	35.2	30.6	35.9	38.3	49.6	38.5	31.4	

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LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide			1232	865	534	1043	598	1025	1002	936	1098	1346	1508	1407	1014	9934
Ambulance handover delays > 60 minutes	Trustwide	0		983	623	263	687	277	595	615	490	629	907	1070	965	713	6261
UEC - patients seen within 4 hours (23/24 plan target 76%)	Trustwide	76%		51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68.4%	66.6%	67.0%	68.0%	65.4%
ED - patients with >12 hour visit time pathway	Trustwide			1207	823	599	977	568	893	797	637	794	686	822	770	622	6589
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute				46%	44%	41%	52%	53%	55%	59%	61%	71%	68%	74%	73%	
Clinically Ready to Proceed delay over 1 hour - Emergency Department	Acute								40%	29%	26%	28%	29%	29%	28%	30%	
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute				05:02	04:53	05:08	04:24	04:42	04:22	04:17	04:03	03:59	04:15	04:15	04:00	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute				13:42	10:06	12:47	09:10	11:15	10:55	08:47	11:19	09:53	10:58	10:22	09:04	
Diagnostic tests longer than the 6 week standard	Trustwide	15%		29.0%	34.0%	26.1%	29.7%	29.8%	27.7%	24.3%	25.5%	29.1%	31.5%	32.9%	31.3%	32.6%	29.4%
Dementia - Find - monthly report	Trustwide	>90%		91.6%	87.9%	84.5%	87.1%	83.6%	90.7%	85.2%	86.1%	87.8%	81.7%	94.2%	91.4%	84.0%	87.2%
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%			72.3%		58.1%		61.5%	71.7%	70.3%	73.0%	78.3%	72.6%	79.6%	77.1%	72.2%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%			48.1%		39.4%		55.5%	52.7%	58.5%	46.2%	62.4%	59.0%	61.0%	57.8%	55.9%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		68.0%	73.9%	69.2%	62.8%	67.7%	64.4%	63.7%	61.9%	71.6%	73.9%	73.1%	77.3%	70.3%	69%

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NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from PBR Plan - cumulative (£'000's)	Trustwide			-13434	-16118	-19884	-21358	-394	-342	-761	-1254	-3116	-5341	-8279	-5554	-7016	
Agency - Variance to NHSI cap	Trustwide			-1.80%	-1.80%	-1.90%	-1.90%										
Agency - Spend in month against budget value	Trustwide							38.22%	55.00%	-22.78%	141.06%	155.12%	159.29%	162.70%	164.29%	161.52%	
CIP - Variance from PBR plan - cumulative (£'000's)	Trustwide			-5874	-5328	-5512	-3390	-449	17	2478	2486	2529	2529	464	2018	2117	
0	Trustwide			3280	4076	944	-18162	-993	3619	1616	-515	1517	3267	6240	23869	28478	
Distance from NHSI Control total (£'000's)	Trustwide			-9995	-12182	-15796	-17186	22	307	300	300	-1293	2389	-4861	-1017	1528	
ACTIVITY VARIANCE vs 2019/20 BASELINE* (* March 2023 compared to March 2022)																	
Outpatients - New	Trustwide			-2.0%	-5.2%	-0.6%	16.1%	-10.0%	7.7%	11.2%	-5.6%	7.0%	14.8%	11.1%	19.0%	6.0%	6.7%
Outpatients - Follow ups	Trustwide			-4.1%	-6.9%	-2.4%	9.0%	-8.0%	5.7%	9.0%	-3.0%	7.2%	-1.2%	-5.8%	9.4%	-7.4%	1.1%
Daycase	Trustwide			-5.5%	-1.7%	5.1%	21.7%	-12.8%	-5.5%	8.4%	-4.0%	-2.0%	3.1%	-7.2%	-0.8%	-1.8%	-2.5%
Inpatients	Trustwide			-21.4%	-18.1%	-16.4%	42.0%	-16.2%	-1.3%	-1.4%	-20.8%	0.7%	-0.4%	-23.7%	-13.2%	-23.3%	-12.3%
Non elective	Trustwide			-18.1%	-5.7%	-11.2%	-0.2%	-7.1%	-8.9%	0.4%	0.4%	12.3%	9.1%	2.1%	10.8%	8.0%	2.6%

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Torbay and South Devon
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Report to the Trust Board of Directors			
Report title: NHS Resolution Maternity Incentive Scheme – Year 5			Meeting date: January 31st 2024
Report appendix:			
Report sponsor:	Chief Nursing Officer (Interim)		
Report author:	Director of Midwifery and Gynaecology Transformation Lead Midwife		
Report provenance:	This report provides a summary of the Trust's status and evidence in relation to compliance with NHS Resolution's Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 5 standards. Achievement of the 10 Safety Actions will result in a minimum rebate of the Trust's contribution to the incentive fund (calculated at 10% of our maternity premia). The Devon Local Maternity and Neonatal System (LMNS) has reviewed the evidence pertaining to each of the 10 Safety Actions. Following a comprehensive second review, additional evidence corroborated the Trusts self-assessment, confirming our capability to demonstrate compliance in 9 out of the 10 Safety Actions.		
Description/Purpose of the report and key issues for consideration/decision:	The purpose of the report is to provide the Trust Board with a self-assessment of the Trust's position in relation to achieving the standards set out within the CNST Maternity Incentive Scheme (MIS). A summary of the evidence that supports the self-assessment can be provided to enable the Trust Board to complete the declaration form to be submitted to NHS Resolution. The paper sets out specific action for the Trust Board to consider compliance with the 10 standards. The recommendation is that the evidence provided will allow the Trust to be able to declare compliance with nine out of ten safety actions.		
Action required:	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendation:	The Trust Board is asked to: i) Review the report and evidence that supports declaration of compliance with Maternity Incentive Scheme Standards. ii) To agree with our assessment of non-compliance with Safety Action 4, workforce requirements for Obstetrics medical workforce.		

	iii) Confirm the Trust position of compliance against nine out of ten Safety Actions that enables the Chief Executive to sign the declaration form on behalf the Trust.
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 describes the quality of maternity care that is accessible and available to the pregnant population and their families in Torbay and South Devon. It also describes the mechanisms that are in place that monitors this care.
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided This report supports the aims described by demonstrating best practice guidance in the delivery of care to promote the health and wellbeing of pregnant people and babies.
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People
Risk: Risk ID: *As appropriate*	*NA*
External standards affected by this report and associated risks	The maternity Incentive scheme sets clear safety standards for Trusts in relation to maternity services. Demonstration that these standards have been met result in the Trust being eligible for a rebate on their maternity incentive scheme contribution and a share of any unallocated funds.

Report title: NHS Resolution Maternity Incentive Scheme – Year 5		**Meeting date**: 31st January 2024
Report sponsor	Chief Nurse (Interim)	
Report author	Director of Midwifery and Gynaecology Transformation lead midwife.	

1.0 Introduction

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year five: conditions

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution nhsr.mis@nhs.net by **12 noon** on **1 February 2024** and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
    - The Trust Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
- The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document.
- There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g., Care Quality Commission (CQC) inspection report,

Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before **1 February 2024**.

- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.
- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all the ten safety actions, then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

2.0 CNST Self-Assessment Summary of 10 Maternity Safety Action

2.1 **Table 1** sets out the Trust position regarding compliance against the 10 core standards.
The evidence to support the 10 safety actions is stored electronically within the Maternity Services Shared Drive Dir Man (\\sdhfs03): CNST 2023 year 5. This can be accessed by the senior staff within the maternity services to demonstrate compliance as required. The Chief Nurse also has access to this evidence.
NHSR have provided technical guidance and conditions to support collation of evidence and completion of declaration. These can be accessed via the following link: This includes a link to the self-declaration form.

Maternity incentive scheme - NHS Resolution

2.2 Following the maternity inspection by the CQC in November 2023, clarification was obtained from the maternity advisor within NHS Resolution about the areas of concern identified during the visit. The advice was that triangulation between the CQC and NHS Resolution will take place to ensure that there is no conflicting evidence in the CQC key lines of enquiry and the ten safety actions. The three areas of risk highlighted formally by the CQC, do not have a direct implication on the ten safety actions. These risks have been described in a separate paper presented to the Quality Assurance Committee. However, verbal feedback at the CQC high level highlight meeting, referred to medical workforce. This is pertinent to safety action four and is described in more detail with this paper.

2.3. The other two providers within Devon utilise an Internal Audit process to review the evidence submitted thus providing an objective oversight. To provide a similar degree of assurance around the evidence provided and to demonstrate compliance at Torbay and South Devon NHS FT, the LMNS was asked by the Director of Midwifery to review the evidence. In response to their review additional evidence has been supplied to strengthen our compliance. An extraordinary Quality Assurance Committee meeting was also held 18th January to enable sufficient scrutiny of the compliance position.

Separate to the Trust oversight, the LMNS were required to approve specific pieces of evidence for all Devon Providers. These were approved by the LMNS Strategic Board meeting on January 8th, 2024.

Table 1: Summary of Trust Position Against 10 Maternity Safety Actions

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Y
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Y
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Q2 ATTAIN report and action plan approved by Quality Assurance Committee (QAC) 18/1/24
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Workforce requirements Neonatal medical and nursing and the Neonatal Nursing Workforce Action Plan approved by QAC 18/1/24. Workforce requirement for Obstetric workforce not met
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Y
6	Can you demonstrate that you are on track to fully implement all five elements of the Saving Babies' Lives care bundle version three (SBLV3)?	SBLV3 implementation tool approved by QAC 18/1/24
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Y
8	Can you evidence that a **local training plan** is in place for implementation of Version 2 of the Core Competency Framework? In addition, can you evidence that at least 80% of each relevant maternity unit staff group has attended an 'in house', **one-day, multi-professional training day** which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new-born life support from December 2023 – December 2024. Where declaring compliance of 80-90% can you confirm that an action plan had been approved by your Trust Board to recover this position to 90% within a 12-week period within a maximum 12-week period form the end of the MIS compliance period	Local Training Plan and action plan for training compliance approved by QAC 18/1/24
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Y
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 6th December 2022 to the 7th December 2024	Y

3.1 Quality Assurance Committee (QAC) approval of standards.

The Quality Assurance Committee met on the 18th of January 2024. During this meeting the Director of Midwifery and the Clinical Director for Obstetrics presented the evidence to support the submission. The Committee were satisfied with the evidence presented to approve safety actions (SA) 3, 6 and 8. However, following discussion and after further consideration, the Committee accepted the recommendation that the service is non-compliant with safety action 4 due to the inability to provide protected compensatory rest for obstetric medical staff. The Committee also reviewed and approved three documents that were required to meet the compliance standards. These were:

SA3 ATAIN - Sign off and oversight of progress with the Avoiding Term Admissions into Neonatal units (ATAIN) action plan by the Trust Board.
SA6 Saving Babies Lives - Confirmation that the SBLV3 implementation tool demonstrates our current compliance of 77%. This has been signed off by the LMNS and demonstrates that the Trust is on target to be 100% compliant by the end of March 2024.
SA8 - Training Sign off the Maternity Training plan to meet compliance with the Core Competency Framework V3 and the action plan to achieve 90% compliance for training of all staff within 12 weeks of the compliance period.

3.2 Safety Action Four - Clinical workforce standards

Obstetric medical workforce
The Trust are required to demonstrate that all locum staff are adequately trained and have maintained their skills. A guideline for the employment of locum medical staff in obstetrics has been developed and there has been no locum Obstetric staff employed by the Trust in the qualifying period.

The Trust also requires an action plan to show how it will implement the Royal College of Obstetricians and Gynaecologists (RCOG) guidance on compensatory rest and attendance out of hours. The Trust can demonstrate that consultants are attending all clinical situations when required, however where this happens overnight consultants are not always able to take 11 hours compensatory rest the next day, due to service demands. The operational manager liaises with consultants to ensure compensatory rest for significant overnight disruptions however this is not also possible for all disruptions.

A complete review has been undertaken of the job plans for Obstetrics and Gynaecology which was presented to the executive directors on 12th December 2023. The recommendation from the review, to achieve compliance with national compensatory rest guidance, is that the Trust implement, a 1:12 on call rota with a fixed-on call and a buddy system. This will require an additional 4.0 WTE consultants. The next steps are to gain approval for the recommendations from the ICB and the Southwest Regional Maternity & Perinatal Team. Although in principle the technical guidance around compensatory rest has been achieved, this is difficult to initiate in practice due to the workforce challenges identified. The Trust will need to seek approval for the funding of additional posts prior to be able to initiate an on-call rota that facilitates compensatory rest.

4.0 Conclusion

The Maternity Service has worked hard to ensure that processes and systems are in place to meet the requirements set by NHS Resolution. These 10 key actions are designed to drive safety improvements within maternity and neonatal care.
This report provides a summary of the evidence of achievement of nine out of ten of the safety actions.

The Board are now required to review the evidence provided to assure themselves of achievement of the standards and to confirm the decision around non-compliance with safety action four. The Chief Executive will need to sign the Board declaration on behalf of the Board. This declaration will also need to be countersigned by the Accountable Officer for Devon LMNS.

An action plan will need to be submitted to NHS resolution along with the self-deceleration form to provide objectives that will demonstrate a plan to achieve compliance in this safety action. This could result in a small amount of funding to support the actions but would be less than the 10% incentive rebate.

5.0 Recommendations

- Review the report and evidence that supports declaration of compliance with MIS Standards
- Note that there is an action plan in place to demonstrate that the Trust is working to ensure compensatory rest can be taken by Obstetric medical staff.
- Confirm the Trust position of compliance against 9 of the 10 Safety Actions that enables the Chief Executive to sign the declaration form on behalf the Trust.

NHS
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Maternity Incentive Scheme CNST – year 5

Joanna Bassett Director of Midwifery

Katie Cresswell Clinical Director Consultant

Obstetrics and Gynaecology

Working with you, for you

Governance and Oversight

Torbay and South Devon NHS Foundation Trust

- All 10 safety actions have a designated lead who has responsibility and oversight
- All evidence is uploaded onto shared drive into relevant safety action folders
- Multi-disciplinary monthly assurance meetings chaired by DOM/Deputy DOM to review progress
- Progress and areas of risk shared within organisation via Care Group Escalation. Reviewed at Speciality Governance groups and Clinical Directorate meetings
- Quarterly update on progress presented to Trust Board via Quality and Safety report
- Evidence reviewed by DOM – benchmarked against standards and technical guidance. Oversight by CNO
- Evidence reviewed by the LMNS to ensure compliance.
- Board paper contains summary of each standard and details of areas requiring board approval
- Presented to QAC and Trust Board of Directors for final approval

Year 6 – evidence review and process – consistency across ICB. Consideration of SW Internal Audit providing the oversight (RDUH and UHP process)

Context of national position for full compliance

CNST – Safety Actions

Torbay and South Devon NHS Foundation Trust

NHS Resolution

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Y
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Y
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Q2 ATTAIN report and action plan approved by Quality Assurance Committee (QAC) 18/1/24
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Workforce requirements Neonatal medical and nursing and the Neonatal Nursing Workforce Action Plan approved by QAC 18/1/24 Workforce requirement for Obstetric workforce not met
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Y

CNST – Safety Actions

Torbay and South Devon NHS Foundation Trust

NHS Resolution

6	Can you demonstrate that you are on track to fully implement all five elements of the Saving Babies' Lives care bundle version three (SBLV3)?	SBLV3 implementation tool approved by QAC 18/1/24
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Y
8	Can you evidence that a **local training plan** is in place for implementation of Version 2 of the Core Competency Framework? In addition, can you evidence that at least 80% of each relevant maternity unit staff group has attended an 'in house', **one-day, multi-professional training day** which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new-born life support from December 2023 – December 2024. Where declaring compliance of 80-90% can you confirm that an action plan had been approved by your Trust Board to recover this position to 90% within a 12-week period within a maximum 12-week period form the end of the MIS compliance period	Local Training Plan and action plan for training compliance approved by QAC 18/1/24

CNST – Safety Actions

NHS
Torbay and South Devon
NHS Foundation Trust

NHS
Resolution

9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Y
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 6th December 2022 to the 7th December 2024	Y

CNST – SA4 Workforce

Torbay and South Devon NHS Foundation Trust

Obstetric medical workforce

Assurance required to show how Trusts will implement the RCOG guidance on compensatory rest and attendance at 'MUST' attend clinical situations.

A complete review has been undertaken of the job plans for Obstetrics and Gynaecology - presented to the executive directors on 12th December 2023.

The recommendation from the review, to achieve compliance with national compensatory rest guidance, is that the Trust implement, a 1:12 on call rota with a fixed-on call and a buddy system. This will require an additional 4.0 WTE consultants.

Although in principle the technical guidance around compensatory rest has been achieved, this is difficult to initiate in practice due to the workforce challenges identified.

Discussion/ Recommendation to Trust Board

Torbay and South Devon NHS Foundation Trust

- **SA4-** The action plan that is in place to support the requirement can only be enacted with significant investment that will require business planning and System/Regional signoff.
- Even with investment to secure recruitment of the 4.0 posts, there is a potential risk that the national workforce shortfall will not address the gap and therefore further risk to enacting the actions to ensure compensatory rest is achieved.
- On the 18th January 2024, the Committee accepted the recommendation that the service is non-compliant with safety action 4 due to the inability to provide protected compensatory rest for obstetric medical staff.
- If not declaring compliance Trusts may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.
-

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Report to the Trust Board of Directors			
Report title: Maternity Governance & Safety Report (1 October 2023 – 31 December 2023).			Meeting date: 31st January 2024
Report appendix:			
Report sponsor:	Chief Nursing Officer		
Report author:	Deputy Director of Midwifery and Gynaecology Director of Midwifery Clinical Governance Co-ordinator Digital & Quality Improvement Midwife Inpatient Matron		
Report provenance:	The content of this report is a summary of the safety improvement activities implemented by the Maternity Governance Group within the Trust to meet the national priority to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025. This is informed by the Safety workstream of the Devon Local Maternity & Neonatal System (LMNS). The report reflects the mandatory reporting requirements of the Perinatal Quality Surveillance Model & the Three-Year Delivery Plan. It is also required as part of the maternity reporting framework for NHS England (NHSE)		
Description/Purpose of the report and key issues for consideration/decision:	The purpose of this report is to provide assurance to the board around key aspects of the maternity safety agenda, specifically relating to: • Setting out the Trust position in relation to perinatal mortality and morbidity. • To provide an update on the recent unannounced CQC maternity inspection and immediate actions taken in response to this • To provide an update to the board on the maternity service's compliance with Saving Babies Lives Version 3		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	• Note the progress and compliance position regarding the priority areas. • Note the key quality and safety issues identified in the report. • Note the initial feedback received from the maternity CQC inspection and immediate actions taken in response to this. • To provide an update to the board on the maternity service's compliance with Saving Babies Lives Version 3. • To note the challenges associated with the Obstetrics and Gynaecology medical staffing capacity. • To note the increasing gap in neonatal nursing workforce and that there is an action plan to mitigate the risk of the vacancies		

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 describes the quality of maternity care that is accessible and available to the pregnant population and their families in Torbay and South Devon. It also describes the mechanisms that are in place that monitor this care.
How does the report support the Triple Aim:	1) Population health and wellbeing 2) Quality of services provided This report supports the aims described by demonstrating best practice guidance in the delivery of care to promote the health and wellbeing of pregnant people and babies.
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People
Risk: Risk ID: *As appropriate*	*NA*
External standards affected by this report and associated risks	NHS England licence and regulations National policy, guidance

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Devon

NHS
University Hospitals
Plymouth
NHS Trust

NHS
Royal Devon
University Healthcare
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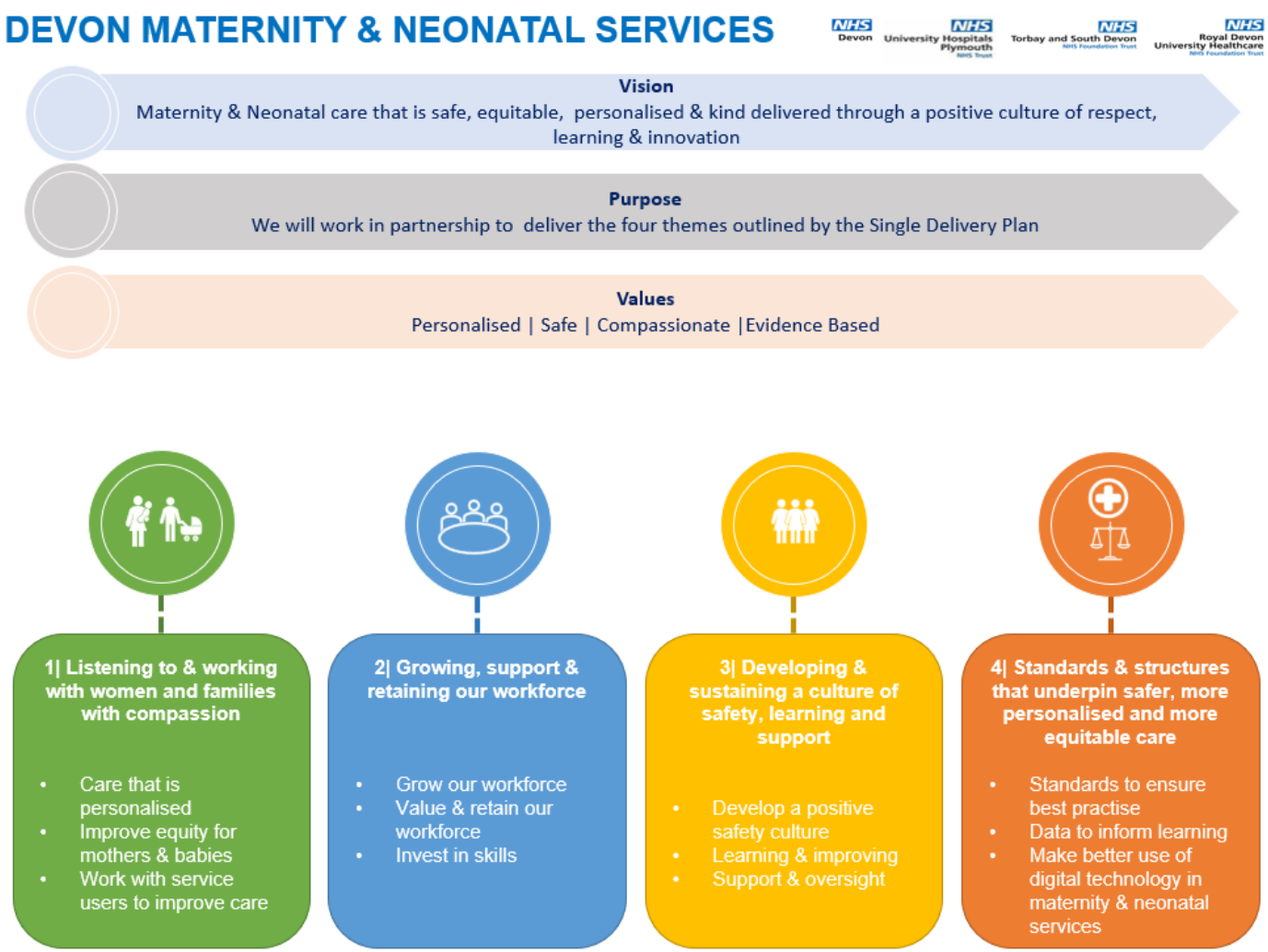
Torbay and South Devon NHS FT MATERNITY BOARD REPORT

OCTOBER 2023- DECEMBER 2023 Q3

Control
The master copy of this document is held by the Devon LMS. To obtain the most recent version of this document, please contact Devon LMNS.



Contents

Introduction

Purpose

To align the required reporting as set out by NHS England Perinatal Quality Surveillance Model (2020) and Three-Year Delivery Plan (2023). This will strengthen Trust Board and Local Maternity and Neonatal System oversight into the operational safety and quality of the maternity service provided, ensuring intelligence and learning is shared and concerns are addressed.

The report reflects the mandatory reporting requirements of the Perinatal Quality Surveillance Model & the Three-Year Delivery Plan.

Information is colour coded for expected frequency of reporting.
Monthly- **Green** (where reporting is quarterly, report as quarterly)
Quarterly- **Yellow**
Annual- **Amber**

RAG ratings as follows:

Complete	On Track	Off Track- Plan in place	Off Track- At Risk, No Plan

Glossary

Healthcare Safety Investigation Branch (HSIB)

- HSIB undertake independent investigations of cases which meet certain criteria, these are.
  - Intrapartum Stillbirth
    - Where a baby, thought to be alive at the start of labour, was born with no signs of life.
  - Early Neonatal Death
    - When the baby died within the first week of life (0-6 days) of any cause
  - Potential Severe Brain Injury
    - Potential severe brain injury diagnosed in the first 7 days of life.
  - Maternal Deaths
    - Deaths of women while pregnant or within 42 days of the end of pregnancy

Clinical Negligence Scheme for Trusts (CNST)

- The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. This is achieved through the "Maternity Incentive Scheme", which is part of the CNST. The Maternity Incentive Scheme sets out 10 safety actions which trusts need to demonstrate compliance against.

Avoiding Term Admissions into Neonatal Units (ATAIN)

- ATAIN is collaborate work between maternity and neonatal to reduce unnecessary admissions with strategies that support services and staffing to keep mothers and babies together and reduce harm caused by separation.

Perinatal Mortality Review Tool

- PMRT is a standardised framework used to review and analyse perinatal deaths, which are deaths that occur during pregnancy, labour, or in the first month of life. The tool is used by the multidisciplinary team to identify gaps in care and opportunities for quality improvement.

Essential Reporting: Trust Board & LMNS Oversight

Item	Source	Frequency (Min.)
Minimum Data Set 1. CQC rating (as updated) 2. MSSP status 3. Findings of PMRT & HSIB reviews 4. Incident reports moderate & above 5. Training compliance 6. Minimum safe staffing 7. Service user feedback 8. Staff feedback	Implementing a Revised Perinatal Quality Surveillance Model	Monthly

9. HSIB/NSHR/CQC concerns or requests for action. 10. Coroner Reg 28 11. CNST progress 12. Staff survey (Midwives & Obstetricians)		
All Maternity SI Reports	Ockenden Interim (IEA1)	Quarterly
Maternity Dashboards	Ockenden Interim (IEA1)	Quarterly
Multidisciplinary training	Ockenden Interim (IEA3)	Quarterly
Minimum staffing levels (if not nationally agreed levels)- to be locally agreed with LMNS	Ockenden Final (IEA1)	As required
Sustained inability to meet staffing levels	Ockenden Final (IEA2)	As required
Learning from reviews of maternal deaths	Ockenden Final (IEA6)	As Required
Content of Human Factor Training	Ockenden Final (IEA7)	Annually
Neonatal care outside agreed pathways- *including births <27 weeks at units <Level 3 NICU* Care outside agreed pathways must be monitored & reviewed by Trusts, the LMNS & the ODN	Ockenden Final (IEA14)	Quarterly
Trusts to ensure that there is proper representation of maternity care on their boards	Reading the Signals	Ongoing
SDP Outcomes: 1) Staff Survey	Single Delivery Plan	
SDP Progress	Single Delivery Plan	As required
SDP Evidence	Single Delivery Plan	As required
SDP Regulation & Incentivisation: 1) CQC 2) CNST	Single Delivery Plan	

Trust Summary

Key messages within reporting timeframe
• A Joint Targeted Area Inspection (JTAI) of safeguarding services including CQC was undertaken in November. The inspection included Maternity Services and looked at the multi-agency response to the identification of initial need and risk of children and young people – good feedback received for maternity service. • A CQC inspection of maternity services was undertaken on 22 November 2023. Ratings will be provided in the domains of well led and safe. 3 immediate areas of concern were raised by the CQC following the visit. These were: No dedicated obstetric theatre team and second theatre, the absence of a specific maternity triage service and no designated resuscitation area on

antenatal/postnatal ward. An action plan to address the 3 areas was submitted within the required timeframes and the CQC have confirmed that they were satisfied with the action plan and assurance provided.
- Preparation for the upcoming CNST (Maternity Incentive Scheme) assessment is in progress. A separate Board paper summarising this work has been written and presented to the Board in January 2024.

Areas of good practise/ achievement

- There were no stillbirths from January to December 2023. This compares to 5 stillbirths in the same period in 2022. This is likely to reflect the influence of the interventions initiated through the Saving babies Lives care bundle.
- Low numbers of complaints: No formal complaints and only 5 informal complaints in this reporting period.
- Good feedback regarding inter-agency working received from JTAI CQC inspection into safeguarding services and a deep dive audit undertaken as part of the inspection demonstrated good relationship between the community midwife and mother and excellent professional tenacity demonstrated by the midwife.
- Highest compliance of all maternity services in Devon with the Saving Babies Lives care bundle (81%)

Risks/ concerns

- Challenges with Obstetrics and Gynaecology medical staffing capacity. This is impacting on the ability to perform all roles and responsibilities that are required as well as preventing the implementation of compensatory rest following a period of on call. A full-service review has been completed with a recommendation that an uplift of 4.0 WTE Consultants is required. This will now form part of a business case. These workforce pressures also are likely to impact on ability to declare CNST compliance as well as create challenges in other areas of assurance (updating clinical guidelines and completion of mandatory training).
- Potential impact of a gap in neonatal nursing workforce. The service has the required level of nursing within the budgeted establishment however due to a few unconnected recent resignations, there is a vacancy gap. The senior leadership team from both maternity and child health have met to develop an action plan to mitigate any nursing vacancies. This plan has been shared with the SW Neonatal Network.

Escalation & support required – For information only

- Obstetrics and Gynaecology medical staffing capacity – this will be managed through Care Group governance processes.
- Increasing gap in neonatal nursing workforce - will be managed through Care Group governance processes.

Listening to Women & Families with Compassion

User Feedback

FEEDBACK	Comments	Impact	Ongoing Actions	Timescales
Service User Feedback: 1) Compliments	Excellent formal feedback on the Infant Feeding Team service provided.	This was shared with the Infant Feeding Team and the Senior Management Team to ensure all aware of this and ensure all know how appreciated their work is.	Identify funding to make Infant Feeding Team Maternity Support Worker post substantive so the team can continue to operate at this level.	October 2024
2) Themes of complaints	Due to the small number of concerns raised it is difficult to identify themes. Some detail is provided below: • Inability to provide out of hospital birth. • Feedback from a family following a maternal death. • Some concerns regarding postnatal care on Antenatal/postnatal Ward	All were dealt with in line with Trust procedures. Learning has been shared with relevant departments. Place of birth not being able to be facilitated has a clinical impact on women as well as their confidence in the service to care for them.	Continue to recruit into existing midwifery vacancy to ensure we have the optimum workforce numbers to meet this requirement. Women's expectations set so they are always aware that there is the possibility of staff not being available to staff out of hospital birth.	Closed

3) Maternity & Neonatal Voice projects/ additional comments	• Real time feedback is collected from women and their families ensuring maternity can be responsive to service user needs.	Safety is maintained by ensuring the service user voice is heard on a regular basis.	Continue to collect and meet.	Ongoing
	• Work around a visitor agreement for staying overnight on wards to ensure clear expectations are set.	Strengthening the contract between staff and partners on staying on ward effecting safety of environment.	Continue to develop across the region.	March 2024
	• Disparity between trusts in Devon regarding sonographers providing baby gender in a sealed envelope.	Ensure consistent service to all families in Devon.	To be discussed through the LMNS operational group	March 2024

FEEDBACK	Comments	Impact	Ongoing Actions	Timescales
4) CQC Survey	The results of the national maternity survey are embargoed at present. The anticipated release date is early 2024. The results and action plan will be shared with the Feedback and			

	Engagement group before being presented to the Quality Assurance Committee in March 2024			

Growing, Supporting & Retaining our Workforce and Developing & Sustaining a Culture of Safety, Learning & Support
Staff Feedback

FEEDBACK	Comments	Impact	Ongoing Actions	Timescales
Staff Feedback: 1) Key themes of frontline Champions and Walkabout	Designated resuscitation area needed on Ante /post-natal ward.	Remove the need for current mitigations and ensure the right equipment in all places.	Estates works for storage of equipment as well as business case for additional resuscitaire.	Early 2024
	Issues raised around induction of Obstetric rotational staff and their introduction to procedures as well as Paediatric rotational staff and the lack of shared language with maternity.	Greater clarity needed around expectations with some communication challenges between maternity and paediatric staff on occasions.	Discussion with leads for clinical induction in Obstetrics and Paediatrics.	Feb 2024
	Issue raised about band 5 and band 6 midwifery skill mix at times on Antenatal /postnatal ward.	Staff feeling under pressure as needing to provide enhanced support to the band 5 midwives.	Introduce new skill mix daily sheet for ease of understanding issues. Ensure staff are aware of ways of escalating issues in real time. Introduction of fulltime band 6 clinical education	Feb 2024

			midwife who can work alongside the band 5 midwives to support development	
2)SCORE Survey (as available- *to note, phased roll out of survey in 23/24)*	The Score culture survey is an internationally recognised tool to measure and understand culture within organisations. This is being utilised within maternity and SCBU as part of the Perinatal Culture and Leadership Programme that the Quadrumvirate are participating in. Data collection is completed, and the initial results will be shared with the team in early February 2024. Cultural conversation champions have been identified in each area. They will receive training externally to support the work needed to embed actions and learning.			

Minimum Safe Staffing Exception Reporting-

Minimum safe staffing events	Occurrence	Actions taken
Midwifery (CNST Safety Action 5 Red Flags)		
Redeployment of staff to other services/sites/wards based on acuity.	0	There were no red flags for redeployment of staff however supernumerary ward managers regularly back fill in times of high acuity
Delayed or cancelled time critical activity.	0	
Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing).	3	Most of these occasions were on night shifts prior to a change in shift patterns to move from on-call night staffing to rostered night shifts. There will be close monitoring going forward to ensure this has improved the situation. There was one red flag during the day when staffing was particularly challenging. Delivery Suite Coordinator's will be reminded to escalate these issues in a timely manner. A quarterly acuity report will be monitored via the Maternity Quality Group.
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).	0	
Delay of more than 30 minutes in providing pain relief.	0	

Delay of 30 minutes or more between presentation and triage.	0	
Full clinical examination not carried out when presenting in labour	0	
Delay of two hours or more between admission for induction and beginning of process.	0	
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).	0	
Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.	0	
Delivery suite coordinator is not supernumerary	7	Most of these occasions were on night shifts prior to a change in shift patterns to move from on-call night staffing to rostered night shifts. There will be close monitoring going forward to ensure this has improved the situation. On the occasions recorded, the Delivery Suite Coordinator was not providing 1.1 care in labour. A quarterly acuity report will be monitored via the Maternity Quality Group.
Retention Issues		Work continues through the retention midwives to support the workforce to strengthen retention. All the band 5 midwives employed in 2022 obtained band

		6 jobs within Torbay and South Devon NHS FT.
Obstetric cover on delivery suite	0	All gaps including during those affected by industrial action were filled within the existing Obstetric workforce.
Gaps in obstetric rota	All gaps covered in period using existing staffing	

Multidisciplinary Training Compliance

TRAINING COMPLIANCE	PROMPT	Fetal Monitoring	Safeguarding
Midwives	100%	99%	93%
Maternity Support Workers	94%	NA	92%
Obstetric Consultants/Registrars	86%	81%	63%
Anaesthetists	84%	NA	NA
Actions required	To continue to book all staff on training in advance and closely monitor compliance. Liaise closely with the medical team and anaesthetic consultant lead for Obstetrics to ensure staff attend within a 12-month timeframe.	From 2024 this training is now a full day's training with assessments as per the new competency standards. All staff are booked on in advance and attendance closely monitored to ensure compliance levels.	Staff are notified when their training is due – allowing them to re-book in a timely manner and ensuring they attend within a 3-year period. Unfortunately training dates in early 2024 have either been cancelled or are full. Staff have also been unable to book onto future dates as these are not being released until the new financial year. This has had a significant impact on compliance rates. This will be highlighted to the Trust Education team at the Education meeting being held this month.

Standards That Underpin Safer, More Personalised & More Equitable Care

Activity Dashboard

Insert dashboard data for live births-

Maternity Dashboard 2023

	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Running Total
Number of new pregnancies (All CCG's)	177	177	213	182	168	205	212	177	175	216	180	152	**2234**
% of women booked for continuity of carer	61.0%	62.1%	64.8%	74.4%	75.7%	94.0%	96.2%	90.4%	76.9%	93.8%	96.6%	66.4%	79.4%
% of women booked from ethnic minorities groups & COC	83.3%	88.9%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% of women booked from low deprivation postcodes & COC	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Births (TOTAL)	156	115	155	138	144	144	146	136	141	164	152	134	1725
Number of Stillbirths	0	0	0	0	0	0	0	0	0	0	0	0	0
% Cat 1 within 30 minutes									75.0%	54.5%	100.0%	66.7%	74.1%
% Cat 2 within 75 minutes									65.2%	46.7%	64.7%	85.7%	65.6%
% Cat 3 within 24 hrs.									72.7%	90.0%	60.0%	82.4%	76.3%
% Robson Group 1	19.4%	0.0%	26.9%	5.6%	17.6%	22.7%	6.7%	26.7%	11.5%	14.3%	8.0%	26.3%	15.5%
% Robson Group 2	42.9%	42.9%	18.5%	37.0%	22.2%	28.0%	23.1%	19.0%	40.9%	30.4%	31.8%	48.4%	32.1%
% Robson Group 5	88.9%	88.9%	87.5%	75.0%	76.5%	81.3%	88.9%	92.3%	94.4%	82.4%	90.0%	88.2%	86.2%
Total Inductions %	32.7%	29.6%	34.2%	35.5%	29.2%	25.0%	37.7%	38.2%	31.2%	32.3%	31.6%	38.8%	33.0%
% PPH >1500	3.8%	0.0%	1.9%	2.9%	2.1%	2.8%	4.1%	2.9%	5.0%	3.7%	5.9%	2.2%	3.1%
% 3rd and 4th degree tears (total)	3.1%	6.5%	9.1%	6.0%	6.2%	3.4%	3.0%	2.6%	2.5%	2.1%	5.4%	4.5%	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	7.1%	11.3%	7.1%	5.8%	6.3%	7.7%	4.8%	8.8%	6.4%	7.3%	12.5%	7.5%	7.7%
% Breastfeeding at Delivery	63.1%	71.8%	71.0%	67.1%	71.7%	69.9%	78.4%	67.6%	75.5%	74.9%	67.3%	71.9%	70.9%

Narrative

Births for the calendar year 2023 were 1725 which is lower than the previous year of 1883. The projected births for the financial year 2023/2024 reflect this drop slightly less potentially being 1817 compared to 1847 for 2022/2023.

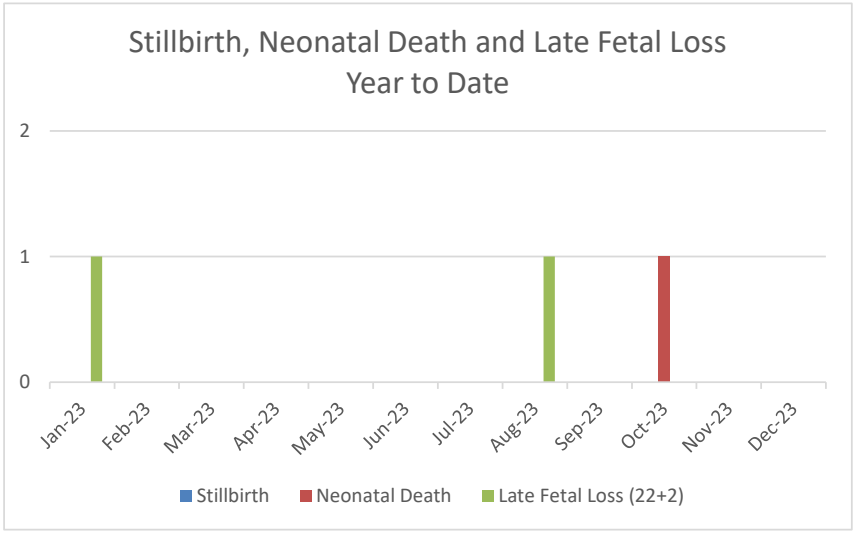
The number of women booking for maternity care remains on average 185 per month.

There were no stillbirths from January to December 2023. This compares to 5 stillbirths in the same period in 2022. This is likely to reflect the influence of the interventions initiated through the Saving babies Lives Care Bundle. This is a remarkable achievement and is testament to collaborative working as well as education and engagement with pregnant people.

The dashboard now provides specific data on the compliance rate of timings around the decision to delivery data. This metric is recommended as part of maternity reporting and was a dataset as requested by the CQC. Any incidences where there has been a delay in the delivery time interval are being reviewed by the inpatient matron to identify any themes.

The smokefree pregnancy team are continuing with their engagement work with women and their families which is demonstrated by the smoking at time of delivery data.

Insert dashboard data for stillbirths, neonatal death, and late fetal loss.



Narrative

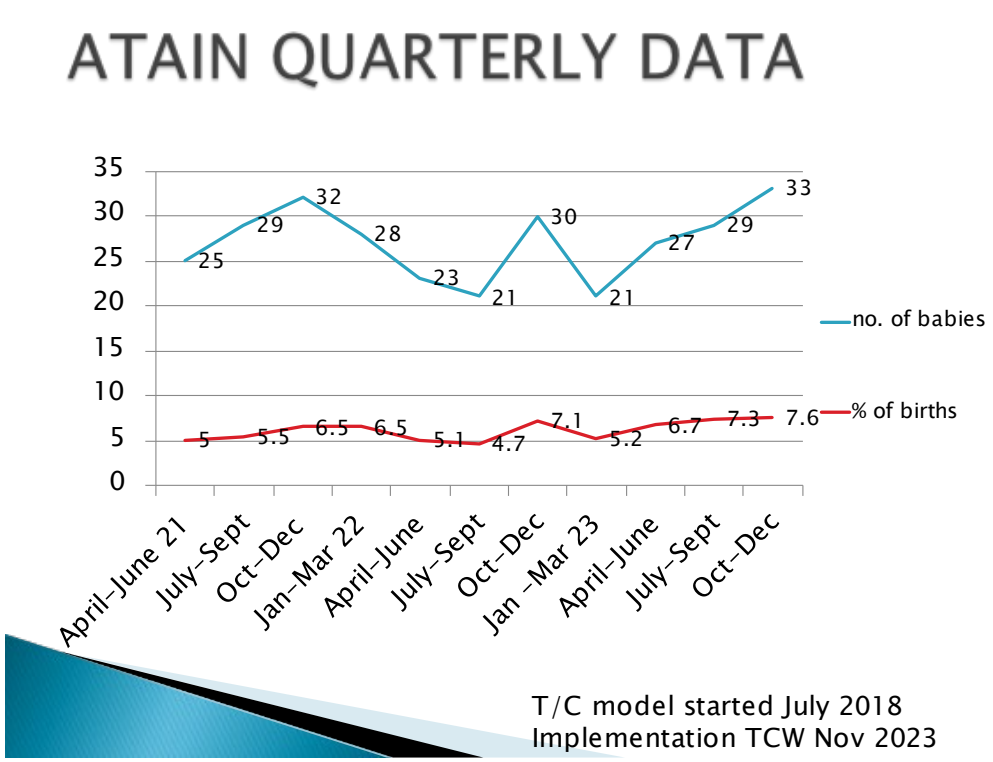
2023 Summary

January - One late fetal loss (LFL > 22+0 weeks gestation) at 23 weeks + 6 days Gestation

August – One late fetal loss at 22 weeks + 2 days

October – Neonatal death of a baby at 37 weeks and 4 days diagnosed antenatally with a life limiting condition. Pre delivery decision had been made to provide palliative care to the baby.

ATAIN data



Narrative

This graph illustrates the rate of babies who are born at full term that require admission to the neonatal unit. The aim is to have an admission rate <5%.
In Q3 the rate was 7.6%
The ATAIN figures have yet to show the impact of the introduction of our Transitional Care Ward. (TCW) This is a setting that will care for babies who require more nursing care or monitoring than routine maternity care. This was launched in November 2023 so we anticipate a reduction on the ATAIN rate as some babies will be admitted to TCW rather than to SCBU.

Whilst incidents remain low in number themes are difficult to identify, however thermoregulation is more common. An action plan for implementation of the BAPM guidelines on thermoregulation has been produced.

The process for review of ATAIN has been strengthened and includes full multidisciplinary discussion and review which will ensure that actions are truly targeted at local issues.

Patient Safety-

PATIENT SAFETY	Number	Key themes/ trends/ escalations
Serious Incidents	2	**November** - A maternal death at home, 9 days following delivery, with a suspected substance overdose. The unborn baby was on a child protection plan, and following delivery, the Local Authority decided to remove the baby from the mother's care prior to her transfer home. Once the mother was home concerns had been raised to the police by the maternity services in the postnatal period as the midwives had not been able to access the mother. The mother was discovered deceased in her home by the police and the case has been referred to the coroner. A meeting has been held with the family and senior members of the maternity Team. A cause of death will form part of the coroner's investigation report. This case was reported to MNSI but rejected by them based on the cause of death at the time. **December -** Baby born requiring advanced resuscitation and transfer to a level 3 neonatal unit for ongoing care including therapeutic cooling. (MNSI investigating)
Moderate Incidents	3	**October -** Issues with the emergency bleep system and the late arrival of blood products during a major obstetric Haemorrhage. Bleep system investigated and learning incorporated into mandatory emergency skills drills. There was no harm identified. **November -** Postpartum haemorrhage of 3500mls. No concerns raised around management of this obstetric emergency. **December -** Baby was transferred to the special care baby unit (SCBU) following a category 1 caesarean section and subsequently required an uplift in care to RDUH. A review is being undertaken of the electronic fetal monitoring prior to delivery by the fetal monitoring lead midwife and the Consultant Lead for fetal monitoring. The case is to be discussed at our monthly perinatal meeting to share learning.
Learning from reviews of maternal deaths	1	Maternal death of a mother on day 9 postnatally. Concerns had been raised to the police by the maternity services as not able to access the mother. Initial learning identified a review of the guideline that details action to take in the case of "no access" visits to mothers in the postnatal period. A Meeting has been held with the family and senior members of the Maternity Team.

PATIENT SAFETY	Number	Key themes/ trends/ escalations
New referrals to MNSI	1	**December -** 1 Case that met the criteria for a baby that was born who met the criteria for therapeutic cooling in a Level 3 neonatal unit. The Baby's scan result demonstrated mild birth hypoxia. The family consented to MNSI undertaking the review of their care. A Duty of Candour letter sent was to the family containing details of MNSI and the Early Notification Scheme (ENS Number EN2304/M23CT173/015) referral. The Trust Litigation team and Maternity team met in December 2023 to discuss the triangulation of cases, MNSI referrals, complaints, and litigation. The Litigation team gave an update on the progress of MNSI cases and outcome of other claims. The latest CNST Trust score card was discussed.
Findings of final MNSI reports returned (themes only)	0	No finalised reports returned this quarter.
Care outside agreed neonatal pathways. • <27-week births (excl. UHP)	0	No babies delivered at Torbay less than 27 weeks gestation.
Findings of cases reviewed under PMRT. (themes only)	1	One Perinatal Mortality Tool (PMRT) completed during the reporting period of a neonatal death of baby who had known lethal genetic condition. There were no actions or safety recommendations in response to the review of this case.

Saving Babies Lives Care Bundle V3

RAG Rating

Element 1 Reducing smoking in pregnancy	Element 2 Fetal growth- risk assessment, surveillance & management	Element 3 Raising awareness of reduced fetal movement	Element 4 Effective fetal monitoring during labour	Element 5 Reducing preterm births and optimising perinatal care	Element 6 Management of pre-existing diabetes in pregnancy
On Track	**On Track**	**Complete**	**On Track**	**On Track**	**On Track**

Complete	On Track	Off Track- Plan in place	Off Track- At Risk, No Plan

Narrative by exception

Element	Areas of non-compliance	Actions Required
1	Data for CO monitoring at booking all women. Data for CO monitoring and smoking status for pregnant smokers at each AN appt Data on opt out referrals. Data on quit dates	Changes made to SystmOne to capture CO & smoking status at each appt for all future entries. DDOM to facilitate meeting with community team leads to look at ways to improve CO measurement within 3 days of booking appt.
2	Update multiple pregnancy guideline in line with latest NICE guidance. Data on Uterine Artery doppler	Multiple birth policies from across Devon requested. New USS clinics in place from 08/01/24 to facilitate sonographer training. Process in place with ANC lead to enable data to be captured.
3	N/A	N/A
4	Data on onset of labour risk assessment	Education of use of risk assessment on mandatory training. Ongoing work with SystmOne BAU team to make this mandatory to complete.
5	Data on MSU at booking Data on paediatric discussion in preterm labour Data on overall PeriPrem optimisation elements Data on antibiotics in labour for preterm birth	PeriPrem meeting to be arranged with Child Health team to improve documentation within Badgernet and Periprem metrics.

	Data on temperature measurement for preterm babies Data on volume targeted ventilation Data on caffeine	Ongoing training for staff on Optimisation elements on mandatory training.
6	Data on HbA1C between 24-30 weeks for Type 1&2 diabetic women	Midwife supporting diabetes clinic to review women attending & flag requirement for bloods at appropriate gestation. Requirement highlighted at diabetes team MDT meeting

Clinical Negligence Scheme for Trusts-

Full details and a report around compliance for the Maternity Incentive Scheme presented to the Quality Assurance Committee at an extraordinary meeting on the 18th of January 2024. The final declaration will be approved at the Trust Board meeting on the 31st of January 2024.

Achievements within period.

A Joint Targeted Area Inspection (JTAI) of safeguarding services by CQC, Ofsted and HMICFRS (His Majesty's Inspectorate of Constabulary and Fire & Rescue Services) was undertaken in November 2023. The inspection included Maternity Services and looked at the multi-agency response to the identification of initial need and risk of children and young people. Interviews were held with maternity safeguarding leads and midwifery staff and a deep-dive audit undertaken of a maternity safeguarding case. Excellent feedback was received from the audit team regarding this case, highlighting the good relationship between the community midwife and the mother and the professional tenacity demonstrated by the midwife. Positive feedback was also received regarding good inter-agency working and communication between Maternity Services and Health Visiting, Drug & Alcohol Services, and the Perinatal Mental Health Team.

The Maternity Service has recently had its compliance with the Saving Babies Lives care bundle assessed, with a result of 81%. This is the highest compliance rating currently for the Devon maternity providers. The Saving babies' lives care bundle provides evidence-based best practice for providers and commissioners of maternity care across England to reduce perinatal mortality. Version 3 of the care bundle (published in May 2023) has been co-developed with clinical experts and includes a refresh of all existing 5 elements and a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) audit. The Trust must demonstrate 100% compliance with all elements of the care bundle by the end of March 2024. The national implementation tool is used to demonstrate compliance, and this was audited and confirmed by the LMNS and ICB at the LMNS board meeting on 8th January 2024.

There were no stillbirths from January to December 2023. This compares to 5 stillbirths in the same period in 2022. This is likely to reflect the influence of the interventions initiated through the Saving babies Lives Care Bundle.

Issues within period-

The CQC conducted an inspection of the Trust's maternity service on 22 November 2023. Ratings will be provided in the domains of well led and safe, with the ratings for caring and responsive being carried forward from the previous inspection. For context, within the national programme, approximately two thirds of maternity services are rated either inadequate or requires improvement. No immediate feedback was provided to the service by the inspection team on the day, but a letter of intent was received by the Trust two days after the visit. The letter identified two areas of serious concern and requested an action plan summarising how the service would address each area of concern. A further area of concern was then highlighted to the Trust on 4 December 2023, this had been identified as part of the data review process that the CQC were conducting. The three areas of concern are as follows:

- Theatres – Ineffective processes for the provision of a dedicated obstetric theatre team and second theatre
- Maternity Triage - Ineffective assessment process within the Maternity Unit at Torbay Hospital
- No designated resuscitation area on footprint of mixed antenatal/postnatal ward

An action plan addressing these concerns was submitted within the required timeframes and the CQC provided feedback to the Trust confirming that they were satisfied with the action plan and assurance provided and that they would not be seeking to issue a legal notice at this time.

High-level feedback was provided by the Lead Inspector on 5 December 2023 to executive colleagues and senior representatives of the service. Positive finding included:

- The team were welcoming and hospitable on the day of their visit.
- Staff were open and non-defensive and motivated to learn and improve.
- A very positive relationship noted between the MNVP and the maternity service. Examples of the work being undertaken to engage with women and birthing people from deprived backgrounds, such as the freephone access and smoking cessation improvements. Some very positive feedback through their survey "give feedback on care" around support with mental health and baby loss.
- Leaders were passionate and focused on improving outcomes for women and birthing people and staff.
- Acknowledgement of the improvement journey within the maternity service around strengthening culture and leadership.

The service is now continuing to work through and monitor the actions that have already been initiated. An improvement huddle has been instigated and a weekly CQC assurance checkpoint with the leads for the areas to support the identified action areas. The CQC advised that they anticipate that their report will be sent early in 2024 for our initial review.

Conclusion

The maternity and neonatal teams continue to ensure that systems are in place to provide assurance in relation to safe midwifery care. They continually review and can evidence progress against several trajectories to improve the quality of care delivered. The perinatal team will embed the strategic aims of the Devon LMNS to ensure that care is personalised and responsive to the needs of women, families, and staff. The utilisation of the single board reporting template for Devon will assist in providing evidence of assurance and monitoring.

Recommendations

- Note the progress and compliance position regarding the priority areas.
- Note the key quality and safety issues identified in the report.
- To provide an update on the recent unannounced CQC maternity inspection and immediate actions taken in response to this
- To provide an update to the board on the maternity service's compliance with Saving Babies Lives Version 3
- To note the challenges associated with the Obstetrics and Gynaecology medical staffing capacity.
- To note the increasing gap in neonatal nursing workforce and that there is an action plan to mitigate the risk of the vacancies.

NHS
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Report to Trust Board of Directors	
Report title: Draft Patient safety Incident Response Plan (PSIRP)	Meeting date: 31st January 2024
Report appendix:	
Report sponsor:	Nicola McMinn- Chief Nursing Officer (interim)
Report author:	Maria Patterson- Associate Director of patient safety and Quality
Report provenance:	Trust PSIRF expert advisory (PEAP) panel members. ICB on 17th January 2024 (subject to minor additions which have been updated). Quality Assurance Committee (QAC) 29th January 2024.
Description/Purpose of the report and key issues for consideration/decision:	A national requirement of NHS England which is stated within the NHS standard contract 2023/24 is that organisations must transition from the Serious Incident Framework (SIF, 2015) to the Patient Safety Incident Response Framework (PSIRF). The target date for transition was autumn 2023 with a final deadline of 31st March 2024. A requirement of the transition to PSIRF is that each organisation must develop and publish a safety incident response plan (PSIRP) which is agreed by the Trust board and ICB. Both documents describe the organisations approach towards improving patient safety and details the learning responses we will undertake when a patient safety incident occurs. It is important to note that all incidents will continue to be reported, it is the level of review that will change. All incidents of moderate and above will be reviewed at our weekly executive review panel to ensure robust oversight. The PSIRP details the nationally defined incidents requiring investigation e.g., never events, child death overview panel and other incidents which require national reporting and a specific learning response. The PSIRP also notes 3 locally defined safety priorities for patient safety incident investigation (PSII) which have been identified following a detailed analysis of our safety intelligence data and in consultation with staff and Health Watch. These priorities for PSII are: 1. Harm related to delays in access to elective or planned care. 2. Delays across our urgent and emergency care pathway related to frailty/ the elderly. 3. Errors or delays in diagnostic tests testing 4. Incidents of violence and aggression. Both documents describe our compassionate and approach towards supporting patients and families in the event of a patient safety incident and our drive and ambition towards supporting our staff via within a restorative just learning culture.

	Our future model for safety investigation and safety resource is described. This model is anticipated to evolve over the first year of transition to PISRF as our care group governance structure matures.		
Action required:	**For information ☐**	**To receive and note ☐**	**To approve ☒**
Recommendation:	The Trust Board is asked to: 1. Approve the patient safety incident response plan (PSIRP) and the 'go live' date of 1st February for transition to PSIRF. 2. Note that the patient safety incident response policy has been shared at QAC and is being ratified via the Trust usual process for policy ratification.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	This PSIRP details the proactive approach that the Trust will take towards responding to patient safety incidents and details our ambition to learn and improve following a patient's safety event. The plan references and links to our existing quality improvements programmes services to support and deliver effective and sustained improvement in outcomes for our patients. The impact of healthcare inequalities and noted as is our ambition to consider this impact as part of our patient safety learning. Our ambition to support staff wellbeing is also noted.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided		
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience		
Risk: Risk ID: *As appropriate*	*N/A*		
External standards affected by this report and associated risks	*NHS England licence and regulations- PSIRF is a requirement of compliance with NHS standard contract from April 2024.* *National policy (patient safety incident response framework), guidance*		

Torbay and South Devon NHS Foundation Trust

Torbay and South Devon NHS Foundation Trust

Patient Safety Incident Response Plan

Effective date:

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author	**Maria Patterson**	**Associate Director of Quality and Patient Safety**		
Reviewer				
Authoriser				

On completion of your final report, please ensure you have deleted all the blue information boxes.

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Foreword from our Chief Nurse

To be completed

Torbay and South Devon NHS Foundation Trust

1.0 Introduction

Patient safety has been recognised as a health priority and is seen as fundamental to the delivery of quality health services. The World Health Organisation highlights that clear policies, leadership capacity, appropriate data to drive safety improvements, skilled healthcare professionals and effective involvement of patients in their care are key in the realisation and implementation of patient safety strategies.

These requirements are reflected in actions taken by the NHS nationally, changing the way in which healthcare organisations and Torbay and South Devon NHS Foundation Trust thinks about safety.

The NHS Patient Safety Strategy (2019) builds on the two foundations of a patient safety culture and a patient safety system by defining the three following aims:

1. Improving an understanding of safety by drawing intelligence from multiple sources of patient safety information (insight)
2. Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (involvement)
3. Designing and supporting programmes that deliver effective and sustainable change in the most important areas (improvement).

1.1 The Patient Safety Incident Response Framework (PSIRF)

The NHS Patient Safety Incident Response Framework (2022) replaces the NHS Serious Incident Framework (2015). The Serious Incident Framework (SIF) provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

PSIRF supports the development and maintenance of an effective safety incident response system that integrates four aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement.

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associate policies and guidelines will describe how it all works in practice. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

Carrying out investigations for the right reasons can and does identify learning. Removal of the serious incident process does not mean “do nothing”, it means respond in the right way depending on the type of incident and associated factors.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety insights.

PSIRF recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents, part of which is the fostering of a psychologically safe culture shown in our leaders, our trust-wide strategy and our reporting systems.

1. 2 Patient Safety Incident Response Plan (PSIRP) scope

This patient safety incident response plan (PSIRP) sets out how Torbay and South Devon NHS Foundation Trust intends to respond to patient safety incidents over the next 12 to 18 months. The PSIRP is a ‘living document’, meaning the PSIRP can be reviewed and refreshed as new safety intelligence is identified to inform the safety priorities for the Organisation. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This PSIRP explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities, our analysis of which is explained later within this document. There are many ways to respond to an incident. This plan will detail how different types of incidents will be responded to, based on the potential for learning and being mindful of existing improvement work.

This document covers responses conducted solely for the purpose of systems-based learning and improvement. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, HR matters, legal claims and inquests.

This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

a. refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues

b. focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents

c. transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders’ (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents

d. demonstrating the added value from the above approach.

This plan is underpinned by the national Patient Safety Incident Response Framework and should be read in conjunction with the TSDFT Patient Safety Incident Response Policy (**Policy number to be added once ratified**) and TSDFT Incident Reporting and Management Policy (**Policy number to be added once ratified**).

1. 3 PSIRF alignment to Torbay and South Devon vision and purpose

The vision of Torbay and South Devon NHS Foundation Trust is better health and care for all, and our purpose is to support our people to live well. The PSIRF strategic aims will support the Trust to realise our vision and purpose and ensure closer alignment with our Trust values.

PSIRF strategic aims are to:

- Improve the safety of the care we provide to our patients
- Improve the experience for patients, their families and carers when the need for a patient safety review or investigation is identified
- Improve the use of valuable healthcare resources
- Improve the working environment for staff in relation to their experiences of patient safety incident investigations.

Our Trust values are:

This PSIRP has been developed to complement the Torbay and South Devon vision to deliver outstanding care, ensuring excellence in experience and outcomes for our patients and the wider community we serve.

Our quality goals have also been considered to inform and shape this PSIRP:

1. 4 Trust 'Regain and Renew' plan

This PSIRP recognises that Torbay and South Devon NHS Foundation Trust is in special measures (NOF4), both as an Organisation and as part of the Devon Health and Care system. We are the only Integrated Care System in England where every acute trust is in special measures – this means we are in the national spotlight and are the focus of intensive attention from the national and regional teams at NHS England and NHS Improvement (NHSEI).

The Trust is receiving external support, scrutiny and challenge to maximise delivery against key areas of improvement for the benefit of those who access our services and our staff; PSIRF will help us to achieve these improvements. By identifying and focusing on our key safety and quality priorities, PSIRF will also support the Trust to deliver against our 'Regain and Renew' plan maximising improvements across patient pathways and ensuring that staff are supported via a restorative just and learning culture.

Figure 1: Regain and Renew Plan

2.0 Our services

2. 1 Our population

We serve our local people by providing community care, including adult social care (Torbay), and acute care, from Torbay Hospital and a range of community sites. We are the lead organisation in the alliance of Children and Family Health Devon (CFHD) which is one of our 5 care groups. Increasingly, we are providing more care as close to home as possible for our people, reducing their need to travel and helping to keep them safe and live well. Increasingly, we are delivering care directly into people's homes either through visits, online or telephone appointments and offering as many appointments as we can at local health and wellbeing centres and community hubs.

The Trust covers a wide geographical area, including parts of Dartmoor (Newton Abbot, Ashburton and Bovey Tracey) along with Torbay (Torquay, Paignton and Brixham), and the South Devon areas around Totnes and Dartmouth. We employ over 6,700 staff across a variety of roles. We are very proud to employ a workforce which affords local people employment along with highly regarded career opportunities in the NHS.

We provide emergency care at Torbay Hospital and urgent care (for minor injuries and illnesses) in several community locations. We support around 500,000 face-to-face contacts with patients in their homes and communities each year and see over 78,000 people in our Emergency Department annually. We serve a resident population of approximately 286,000 people, plus about 100,000 visitors at any one time during the summer holiday season.

Our maternity service at Torbay Hospital offers Midwifery-Led and Consultant-Led care for approximately 2,000 women and birthing people per annum, The service is provided by midwifery teams based in the community giving antenatal, intrapartum and postnatal care both at home, children's centres and in the hospital. We also have a Special Care Baby Unit with 10 cots and provide care for babies born from 30 weeks' gestation (depending on care needs).

The Torbay Recovery Initiatives (TRI) drug and alcohol service provides support and treatment interventions for people in Torbay who have issues related to substance use. TRI is part of an Alliance which includes the Torbay Domestic Abuse Service (TDAS) and the Homelessness Hostel – Leonard Stocks Centre. TRI provides a range of psychosocial and pharmacological interventions. Alongside these interventions TRI also provides Groupwork Programmes, Peer Support, Online Self-Management Support through SilverCloud and has a strong connection with our local Recovery Network. Mental Health services are provided by the Devon Partnership Trust. The TRI service has engaged in the development of this plan.

The Integrated Care Organisation (ICO) is responsible for the delivery and quality assurance of adult social care services via a s75 agreement with Torbay Council. All Trust staff including members of the adult social care (ASC) workforce adhere to the 'reporting and responding to incidents' requirements within the ICO's policies and procedures. As such, ASC staff will participate in safety reviews and investigations when requested and report incidents onto the DCIQ system. Further discussions are planned to explore how this transition will impact the frontline workforce going forward. It is the intention to adapt this plan as these conversations evolve.

2.2 The impact of health inequalities for our population

This PSIRP has considered and been informed by health inequality data for our local population. The Trust serves the coastal population of Torbay which is referenced in the Chief Medical Officer's Health in Coastal Communities report 2021. This report demonstrates that coastal communities have a higher burden of disease across a range of physical and mental health conditions (for example coronary heart disease). Life expectancy (LE), healthy life expectancy (HLE) and disability free life expectancy (DFLE) are all lower in coastal areas and the Standardised Mortality Ratios (SMRs) for a range of conditions, including preventable mortality, are significantly higher in coastal areas compared with non-coastal. Torbay is highlighted within this report to have worse admissions for alcohol related conditions than the average population. Factors which impact upon health outcomes such as housing quality, educational attainment, employment and crime are either comparable to, or significantly worse for the population of Torbay than the England average.

The Trust recognises that health inequalities and deprivation can shorten life expectancies and have a negative impact upon health and wellbeing. The Trust is taking steps to reduce the negative impact of inequalities in health outcomes for our population. We are currently working with local partners to finalise a waiting list equality action plan to ensure parity of access to elective treatment for members of our community with learning disability, a complex mental health illness or those living in areas of the highest social deprivation. We also note the impact that being an older aged carer can have upon

an individual's own health. Torbay has higher than average rates of children who are in care which impacts upon their health and wellbeing.

The Trust is also working closely with the ICB and local partners to deliver the Core20PLUS5 strategy which seeks to reduce health care inequalities for the 5 key areas of national focus. The Trust and local partners are also working to identify and agree our local population groups to be prioritised under the PLUS agenda.

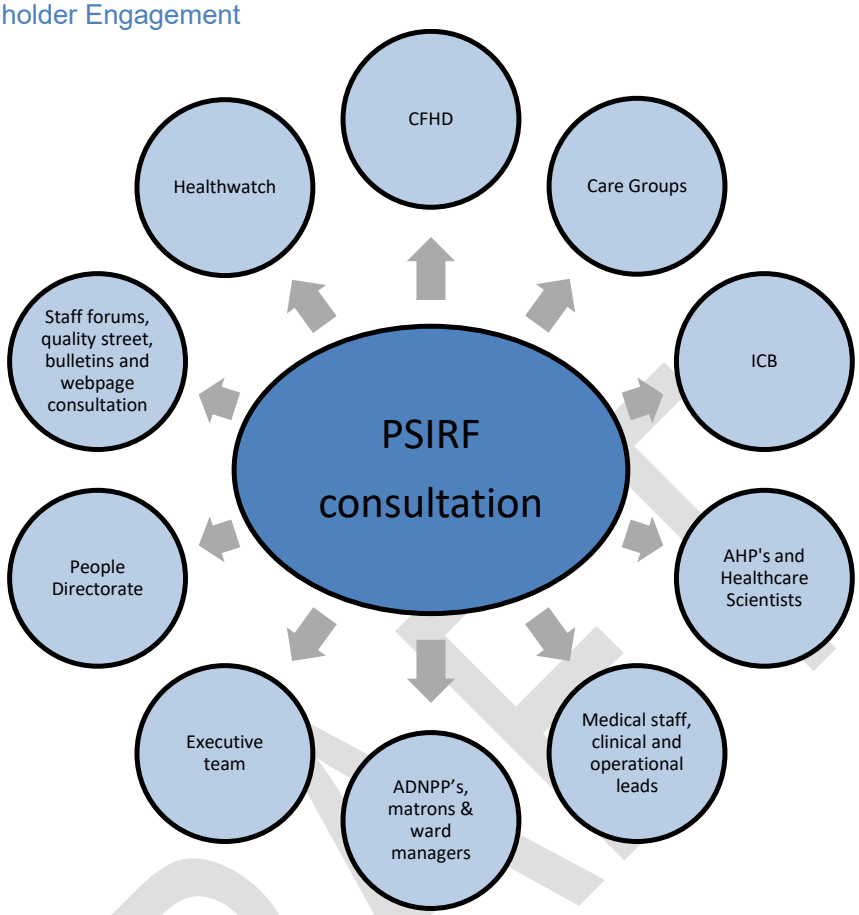
We will seek the support of our patient safety partners once in post to look to improve how we engage compassionately and equitably with patients from all back grounds and progress will be updated at the next revision of this plan.

3.0 Stakeholder engagement

The Patient Safety team commenced planning for PSIRF in November 2022 via the establishment of a PSIRF Expert Advisory Panel (PEAP) which was supported by a number of key pillar working groups. The voice of care groups has been represented at PEAP and PSIRF transition has been discussed in local forums including CFHD, Infection Prevention and Control, and with medicines leads. Our local Healthwatch member has been present at these meetings to collaborate and represent the voice of patients. Our Patient Safety Specialist has engaged with PSIRF early adopters to enable us to understand the practicalities of planning for and implementation of PSIRF; their assistance has been invaluable. We have also reached out to engage with different staff groups via their key meetings (see Figure 2) and supported Trustwide conversations via our Chief Executive Officer briefings, Trust Talk, Clinical Senates and Quality Street meetings. Patient safety data and intelligence was shared during these forums and staff views were sought to ascertain the priority focus via online surveys and focus groups. The proposed Patient Safety Incident Investigation (PSII) priorities were shared on the TSDFT webpage seeking staff feedback and informing the choice of our 3 priorities.

We recognise that the changing nature of oversight under PSIRF and the move to a systems-based investigation approach requires collaboration and we have engaged with Devon ICB, NHS England regional and national colleagues and the Southwest Academic Health Science Network to support, inform and enhance transition.

Figure 2: Stakeholder Engagement



4.0 Patient safety resource analysis

As part of preparation for PSIRF transition we have considered the resource we need to respond to incidents and how this can be organised to ensure a safe implementation of PSIRF across the Trust. Under PSIRF, our central Patient Safety and Quality team will continue to monitor all patient safety incidents and act as a core resource in supporting staff across the organisation with incident reporting and management. The coordination and review of all PSII's will be the responsibility of the central team; local level reviews (it is anticipated that the majority of safety reviews will be managed locally) will be supported by the central Patient Safety and Quality team. Under PSIRF, we will continue to maintain the high profile for patient safety across all services.

Given that the Trust has finite resources available for patient safety incident response, we intend to use this resource to maximise the impact on learning to improve patient safety and quality of care. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

A review of the resource associated with the current Serious Incident Framework for the 12 months leading up to October 2023 has been completed. We have also correlated and reviewed our patient safety data based on the national PSII criteria to provide an

indication of the PSII workload under PSIRF and to determine how many PSII's can be supported during a 12-month period. This review has been undertaken noting the Patient Safety Incident Response Standards to ensure that all future PSIIs are compliant with these standards. In addition, a review has been undertaken to determine our current level of resource for non-PSII related activity which will include Hot Debriefs, After Action Reviews (AAR), Case Note Reviews, Thematic Review, MDT meetings and 'Being Open' conversations, to name a few. This supports planning of appropriate responses and the application of different review techniques where PSII is not indicated.

The number of SI investigations undertaken over the previous five years has been reviewed (Table 1), along with the resource allocated to patient safety investigations, both within the central patient safety team and job plans for clinical staff in all care groups.

In summary, TSDFT has identified that it will undertake 20 PSII's per year. Each lead investigator will be supported by an investigator 'buddy' and the central patient safety team. Lead investigators will not be expected to lead any more than one full PSII at any one time to ensure the quality of the review is maintained; they will however be able to act as a buddy for other lead investigators. We recognise that the Organisation currently has a backlog of Serious Incidents and that these are and will continue to be the focus once the transition to PSIRF has occurred. This workload is likely to impact upon the ability of the Organisation to undertake PSII's within the stipulated timeframe, therefore a plan will be shared at the Incident Review Group (IRG) to agree a deadline for the completion of PSII's.

To improve our ability to deliver against PSII standards, we plan to:

- Assign an appropriately trained Board member, supported by the Associate Director of Patient Safety and Quality, to oversee delivery of the PSII standards and support the sign off of all PSIIs
- Provide a PSIRF oversight session for all Board members
- Train staff in system-based investigation training to support leading or reviewing an investigation – to date, over 20 members of staff have been through this training
- Work with senior clinicians, nursing and AHP staff to review the existing tools for Patient Safety Reviews (PSRs) to ensure they fit the requirements of PSIRF and a system approach to patient safety
- Continue to deliver our internal patient safety curriculum which is designed to touch all colleagues in the organisation from Board to floor

Table 1: Patient safety incident investigation activity 2018 - 2023

Activity Type	2018/19	2019/20	2020/21	2021/22	2022/23	Average
Never Events	2	3	5	0	3	2.6
Serious Incident Investigations (i.e., StEIS reportable and including IMRs submitted to DHR, SCR etc.)	3	10	69	90	62	46.8
Patient/Family/Carer complaint-initiated patient safety investigations	1	2	0	0	0	0.6
Other PSIIs (currently classed as ward, department or directorate-level root cause analyses)	0	0	20	68	228	105
Child death overview panel (CDOP)			2	1		
Independent PSIIs sourced and funded directly by the local provider	0	0	0	3	0	0.6
Incidents referred (to HSIB/regional independent investigation team (RIITs)/PHE, etc.) for independent PSII	3	3	3	2	4	3
Independent PSIIs commissioned nationally or regionally on behalf of the local provider	0	0	0	0	0	0

4.1 Current patient safety resource

The current structure relies on Clinical Governance Coordinators (CGC's) to undertake reviews supported by senior clinicians, nurses and AHP's in their allotted management / administration. Currently the central governance team does not have any line management responsibilities for the CGC's with regards to investigations and thus limited influence over how investigators prioritise their time for investigations. It has been proposed that the CGC's line management responsibility move to the central governance team to support oversight and planning of patient safety work. These discussions are ongoing.

Torbay and South Devon NHS Foundation Trust has the following existing substantive resources dedicated to patient safety and quality improvement:

- 1 WTE Associate Director of Patient Safety and Quality
- 1 WTE Patient Safety Specialist
- Medical Director of Patient Safety (2 sessions per week)
- 2 WTE Quality and Patient Safety Facilitators

In addition, the Trust has 6.4 WTE resource comprised of both Clinical Governance Coordinators and Governance Support Nurses/Radiographer who are in post to support patient safety at care group level, including incident investigation support and oversight. Each care group is also supported by a medical clinical governance lead at 1 session per week. All CGC'c have undergone 4-day PSII training, which was undertaken by over 20 members of staff. A further 20 staff members will undertake training in PSIRF alternative learning methodologies in January 2024.

The Trust will follow the recommendations detailed in the Patient safety incident response standards where possible. The Trust has not elected to have 'stand-alone' lead PSII investigator roles due to current financial constraints, therefore any PSII will be undertaken by staff as part of their existing role (it is anticipated that staff will have capacity to deliver the PSIRF requirements due to the mapping of existing safety workload detailed above). It is acknowledged that due to the recent implementation of the new care group structure, the level of clinical governance support for each care group is variable meaning that capacity and capability will need to be monitored and reviewed regularly as part of this plan.

The Trust notes that the PSIRF standards recommend that learning responses are led by staff who have an 'appropriate level of seniority and influence' within the organisation likely to be at grade 8a or above. We acknowledge that our investigators are not employed at this level and to mitigate this risk the investigator will work with a peer for support. In addition, the Trust will provide support and coaching for learning responses (such as PSII's) by the Patient Safety Specialist and Associate Director of Patient Safety and Quality. We will adopt a panel approach when agreeing terms of reference and at further touchpoints during the investigation to discuss findings and recommendations. The final report will have executive oversight at the Incident Review Group and at the soon-to-be-established Patient Safety Group.

The effectiveness of this approach will also need to be reviewed as part of the plan to ensure that high quality safety investigations are completed in a timely manner for patients, families and staff. The members of staff detailed above, and senior members of each care group have been trained in the PSII methodology.

5.0 Defining our patient safety incident profile

5.1 Analysis of Trust patient safety intelligence

PSIRF sets no rules or thresholds to determine which safety incident should be investigated to generate learning and improvement apart from the national requirements for external and local PSII (detailed further in this plan) A significant risk to the successful implementation of PSIRF is continuing to investigate all 'serious incidents' to the same level as previously under SIF but calling them something else.

A key focus of the Trust approach to transition to PSIRF is to understand our Trust safety profile. To support this, we have reviewed the patient safety activity within the Trust over the last 5 years (an extended time was selected to allow for a change in safety profile during the COVID-19 lockdowns). To support us to further define and understand our patient safety profile, we have analysed data from a variety of sources including the Datix incident reporting systems. Data has been collated and reviewed from the actual incidents that had occurred over the previous 5-year period from 2018 – September 2023. Data and information (both qualitative and quantitative) have been received and reviewed from the following sources:

- Incidents recorded on Datix related to patient safety
- Serious incidents and never events
- Complaints and concerns relating to clinical care and treatment
- Freedom to Speak Up themes
- Safeguarding reviews
- Bi-monthly mortality scorecard data
- Staff survey results and focus groups
- Legal claims and inquests
- Trust-level risks relating to patient safety
- Intelligence and feedback from Quality Improvement programmes
- Mortality reviews, though further work will be needed here to address challenges in accessing non-electronic data
- CQC inspection findings, published November 2023

Where possible we have considered what elements of the data tells us about inequalities that may adversely affect outcomes or the health and wellbeing of our population. As part of our engagement, we have also considered any new and emergent risks relating to changes in demand that the historical data does not reveal. Feedback and information provided by internal stakeholders and subject matter experts has also been considered as part of the diagnostic and discovery planning phase of PSIRF implementation. We have also consulted our ICB colleagues for their perspective on patient safety themes to inform the plan.

Our approach has also considered the Quality Account annual report, the quality of services offered by Torbay and South Devon NHS Foundation Trust and our ability to demonstrate improvements in the services we deliver. The quality of services is measured by considering patient safety, the effectiveness of treatments that patients receive and patient feedback about their experience of the care provided.

We have also consulted with and sought the views of staff to obtain their views on our patient safety profile and priorities as detailed earlier. The PSIRP has also been informed by the Devon system being in NOF4 and the associated improvement priorities, in particular reducing elective waiting lists and delays across the urgent and emergency care pathway.

5. 2 TSDFT Patient Safety Incidents

The Trust reported 52,971 patient safety incidents from July 2018 to June 2023 via the DatixCloudIQ (DCIQ) incident and risk management system. The majority of the reported incidents were no harm, low harm and near miss, however 4% of incidents led to more significant moderate harm to the those involved.

The highest recurring harm in incidents reported as moderate or above harm related to infection prevention and control, falls and pressure ulcer incidents; this correlates with the pandemic and COVID-19 cases reported through the Trust, and the national picture on pressure ulcer prevalence and falls where harm occurs which is linked to an ageing population. Existing quality improvement projects are underway for falls and specific learning and improvement tools are utilised when pressure ulcer incidents occur. Feedback from the falls and pressure ulcer groups, including number of incidents will be shared at the Incident Review Group to monitor trends and to seek assurance regarding improvements.

Serious Incident data for the past 5 years has been reviewed as part of our safety intelligence. The top 10 categories are detailed below.

Table 2: Highest reported Serious Incidents 2018 – 2023

Serious incident Category	Total
Accident/Injury (Including slips, trips and falls)	85
Pressure ulcer	34
Clinical assessment (including diagnosis, scans, tests, assessments)	26
Implementation of care and ongoing monitoring / review	16
Access, admission, transfer, discharge (including missing patient)	15
Obstetrics related issue	12
Treatment, procedure	12
Medication related issue	8
Never Events List	7
Cardiac / Respiratory Arrest	6

Table 3: All incidents 01/04/2020 - 31/03/2023

Criteria	Moderate	Death	No harm	Severe	Low harm	Near miss	Total
Pressure ulcer	1122	1	3441	8	3452	27	8051
Access, admission, transfer, discharge (including missing patient)	66	3	5006	9	246	460	5790
Accident/Injury (Including slips, trips and falls)	47	7	2182	41	1236	199	3712
Security / Crime related incident	18	0	1643	0	249	286	2196
Medication related issue	16	4	1570	0	228	275	2093
Blood Transfusion and Blood Sample incident	4	0	288	0	23	1228	1543
Implementation of care and ongoing monitoring / review	27	12	801	4	223	220	1287
Documentation (including electronic & paper records, identification and charts)	1	0	867	0	57	356	1281
Infection Control Incident	2	3	530	4	341	113	993
Clinical assessment (including diagnosis, scans, tests, assessments)	24	7	522	6	145	219	923
Total	1327	37	16850	72	6200	3383	27869

As part of our data analysis, a review of the top safety themes from our corporate risk register where considered. These related to patient flow pressures resulting in delays, non-compliance with waiting times, delayed follow-up across surgical care, incorrect labelling of samples and delays in intervention for stroke patients. Treatment delay and delayed diagnosis are our highest volume of claims. Wait times and access to pathways are also reflected in our top 3 complaints and concerns from patients for quarters 1 and 2 of 2023/24. Mortality data nationally indicates that delays across emergency care and for those waiting for elective care correlates to a rise in mortality. Mortality data for the Trust indicates a higher mortality rate associated with delays accessing emergency and elective care in particular for our older population; this data requires further analysis.

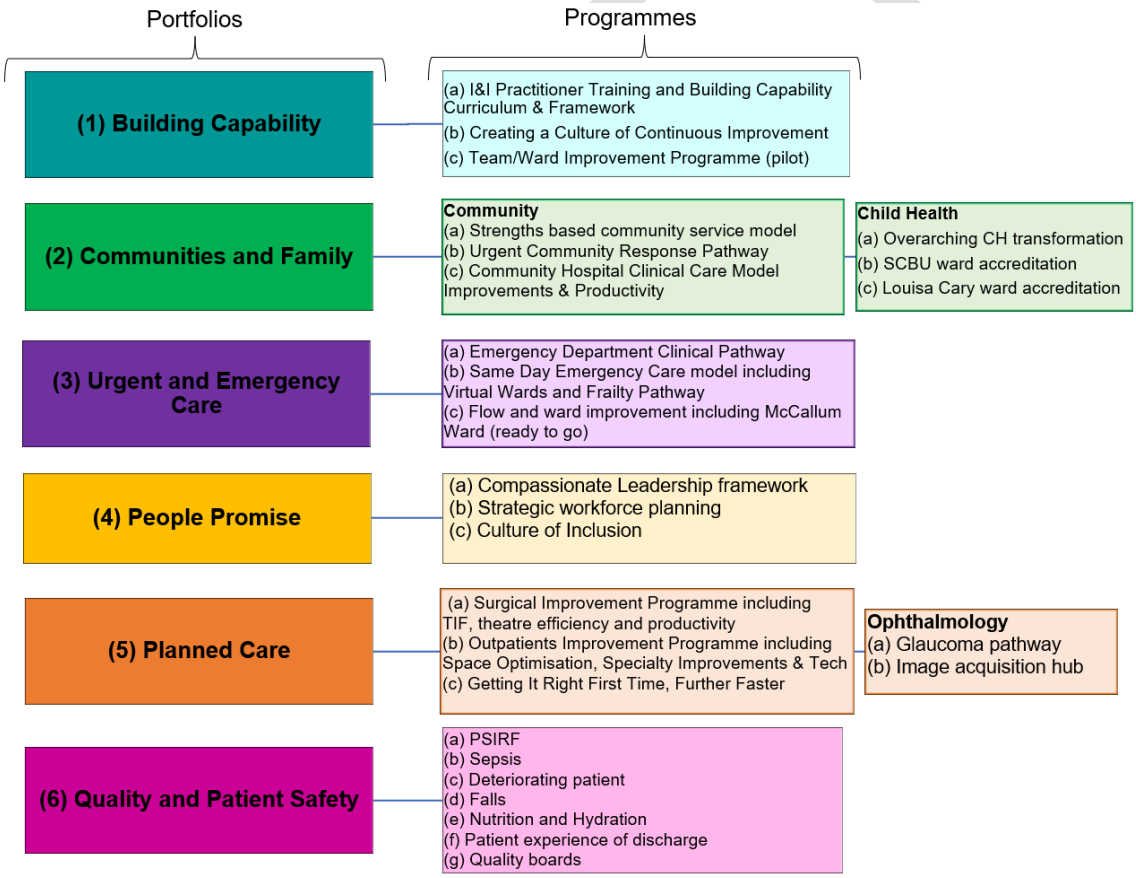
This patient safety intelligence has been complied to form a patient safety profile for the Trust which has considered incidents which present the greatest risk (severity, likelihood, concern, cost) and an opportunity for new knowledge and improvement. This indicated that delayed access to emergency and elective care was a theme of concern for patients in terms of litigation and complaints, which correlates with safety concerns shared by our staff and with a likely increase in mortality. Whilst delays are realised across the System, the Trust considers there is value in these areas being priorities for PSII to realise local learning and improvement. Consultation with our staff has informed this PSIRP and staff have advised us that there was still learning to be found across emergency and planned care pathways related to access to services for specific patient pathways (such as stroke, frailty) and access to those who may be impacted by inequalities.

These discussions have further informed the selection of our local safety priorities alongside our patient safety intelligence. The safety intelligence was shared across the

Trust in key staff meetings and through circulation and dissemination at key meetings via Associate Directors, care groups and Clinical Leads. The priorities were also shared on our webpage in survey format for staff to comment upon. Feedback from staff is that they identified with elective care, access to emergency care (in particular for frail/ elderly patients) and gaps in our diagnostic/results pathways as key safety priorities.

This safety intelligence has been analysed and cross referenced against existing Quality Improvement (QI) and patient safety transformation programmes. There are currently a number of QI programmes (Figure 3) underway within the Trust which are directly linked to improving patient safety, in particular elective and emergency care. It is envisaged that the learning and recommendations from any safety investigations or reviews will feed into the relevant Quality Improvement workstream to further enhance this work by a representative of the Improvement & Innovation team attending the Patient Safety Group, also allowing for QI methodology coaching and support to be provided to project leads.

Figure 3: Existing Quality Improvement portfolios



6.0 National safety priorities

PSIRF stipulates that some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident Investigation (PSII) to learn and improve. These criteria have been determined

nationally, and the Trust fully endorses this approach as it fits with our aim to learn and improve within a restorative just and learning culture. As well as PSII, some incident types require specific reporting and/or review processes to be followed.

For clarity, all types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the suggested methods and are detailed in Table 4 below. For other types of incidents which may affect certain groups of our patients, a PSII will also be required.

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 6 PSII reviews (where national requirements have been met) per annum.

Table 4: Nationally required patient safety incident investigations

Patient Safety Event Occurs	Patient Safety Incident Investigation	National Priorities	Event	Approach	Improvement
			Maternity and neonatal incidents meeting HSIB and Special Healthcare Authority referral criteria	Work with partners to ensure cases are referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
			Child death	Refer for Child Death Overview Panel (CDOP) and liaise with panel as locally led PSII may be required	
			Death of a person who has lived with a Learning Disability or autism	Refer for Learning Disabilities Mortality Review (LeDeR) liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required	
			Safeguarding incidents in which: Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. Adults over 18 years old are in receipt of care and support needs from their local authority. The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery	Refer to local authority safeguarding lead via TBSD named safeguarding lead TBSD will contribute to domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by	

			and human trafficking or domestic abuse/violence.	the local safeguarding partnership (for children) and the local safeguarding adults boards	
			Domestic homicide	Identified by the police usually in partnership with the local community safety partnership with whom the overall responsibility lies for establishing review of the case. Where the CSP considers that the criteria for a domestic homicide review are met and establishment of a DHR panel, TBSD will contribute as required by the DHR panel.	
			Incidents in screening programmes	Work with partners to ensure cases are referred to Public Health England (PHE)	
			Death of patients in custody/prison/probation	Refer to Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC)	
			Mental health-related homicides	Refer to the NHS England Regional Independent Investigation Team for consideration for an independent PSII, locally led PSII may be required	
			Patient Safety incidents meeting the Never Event criteria 2018 or its replacement	Local Patient Safety Incident Investigation	Create local organisational recommendations and actions and feed these into the quality improvement strategy
			Deaths of patients detained under the MHA (1983) or where the MCA (2005) applies, where there is reason to think that the death may be linked to problems in care		

			Patient Safety incidents resulting in death where the death is thought more likely than not to be due to problems in care		

7.0 TSDFT local safety priorities

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. To decide upon our local priorities, we used the 'Guide to responding proportionately to patient safety incidents'.

Based on our analysis (Appendix 1) and the selection criteria described above, the Trust has identified 3 patient safety priorities for PSII which will be the focus for the next 18 months and the remainder of 2023/2024. We will aim to undertake 3 PSII's for each local priority in line with national guidance. We have selected this number based on consultation with and feedback from early adopters who advised that a higher number of PSII per priority was overambitious and unachievable and that 3 PSII's alongside other review methods realised learning and improvement. We consider this number of PSII's will allow us to apply an in-depth systems-based approach to learning from these incidents, exploring multiple interacting contributory factors to maximise the potential for learning and improvement.

We also recognise that this is a period of transition for the Trust, and we want to be realistic about what we can achieve whilst seeking to learn and improve our processes. The priorities have been discussed and agreed with Devon ICB. Attempting to undertake more than this number will impact upon our ability to focus upon learning and improvement.

Table 5: Local priorities for PSII

Priority number	Incident type	Description	Response type and number	Anticipated improvement route
1.	Delayed access to elective/ planned care	There are currently prolonged waits for access to elective and planned care which is contributing to patient harm. This risk is exacerbated by a lack of understanding regarding the prioritising of patients for specific pathways and the impact of health inequalities.	PSII - anticipate 3 PSII's will be required to realise new learning and improvement	Create local organisational and / or system actions and feed these into quality improvement groups and the quality strategy. Build case for new improvement if required.

2.	Delays across our urgent and emergency care pathway related to frailty/the elderly	Incidents related to delay across our urgent and emergency pathway inform that our elderly and frail population are at higher risk of harm.	PSII - anticipate 3 PSII's will be required to realise new learning and improvement	Create local organisational and / or system actions and feed these into quality improvement groups and the quality strategy. Build case for new improvement if required.
3	Diagnostic tests and testing	Safety incidents related to errors or delays across diagnostic and testing pathways	PSII - anticipate 3 PSII's will be required to realise new learning and improvement	Create local organisational and / or system actions and feed these into quality improvement groups and the quality strategy. Build case for new improvement if required.

7.1 Investigations requiring a multi-agency approach

The aim of the PSIRF is to create a safety system where learning responses are managed as locally as possible to facilitate the involvement of those affected by the event and those responsible for delivery of the service. Where more than 1 service or provider is involved, the Trust may seek to initiate a system response to maximise learning across pathways.

Where a patient safety incident is identified by the Patient Safety team as requiring a coordinated multi agency response, a member of the team will contact the ICB to advise of the incident and to request support to engage other services. Initial scoping with the ICB and partners will agree the role and responsibilities of the different agencies involved, including who should undertake the responsibility of lead agency for the purposes of family and staff liaison.

The Trust is committed to collaborative working with our partner Organisations and patient groups. We will engage in cross system investigations and are committed to sharing learning across our system and wider. Further detail can be found in our PSIRF policy.

7.2 Timescales for PSII's

Where a PSII is required (as defined in this plan for both local and national priorities), the investigation will start as soon as possible after the patient safety incident is identified as meeting the PSII inclusion criteria. Whilst there is no formal timescale, PSIIs should ideally be completed within six months of their start date. In exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended

timeframe will be agreed between the Trust and the patient/family/carer. Where the processes of external bodies delay access to information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity. The outcomes of PSII's will be used to inform our patient safety improvement planning and work as agreed at the Trust Quality Assurance Committee (QAC).

7.3 Patient safety review methodology (non-PSII safety activity)

For any incident not meeting the PSII criteria, or any other incident, we will use a specific patient safety review tool to enable a learning response. For lesser harm incidents, we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work. Oversight of patient safety reviews categorised as 'moderate harm' or above will be monitored via the Incident Review Group (IRG).

We have explored the toolkit methods suggested for reviewing other incidents and decided that we will principally use the following tools for Patient Safety Reviews.

- Hot Debriefs
- After Action Reviews
- Case note reviews
- Thematic analysis
- MDT Roundtables
- Multi-agency review/panel

It is envisaged that under PSIRF, the care groups supported by the central team and CGC's will identify the most appropriate methodology to review non-PSII incidents, this process will be closely monitored and supported during transition to PSIRF. For certain patient safety incidents, such as falls and pressure ulcers, the Trust has defined the best tool to achieve learning as an After Action Review. These incidents and the selected learning methodology are detailed below (Table 6).

The Trust is committed to ensuring that staff will be well prepared for their role in undertaking and facilitating these reviews, and we have worked with our education lead to develop a patient safety training plan for our workforce as part of a wider vision to achieve an integrated quality education framework. This process will be supported by robust 'ward to board' governance mechanisms and subsequent reporting to ensure that patient safety incidents and improvements are overseen effectively.

Table 6: Non-PSII activity

Patient safety incident type or issue	Planned PSR methodology	Anticipated improvement route
Patient safety concern associated with patient harm and identification of a new area for learning	Initial patient safety review to inform decision to be considered as PSII.	Incident review group
Death	Review by Mortality process including medical examiner. Possible Structured judgment review (SJR) and Mortality and morbidity meeting discussion. If concerns regarding care are raised during SJR */ mortality review, consider for review as PSII where index case or meets national priority criteria	Create local safety actions and feed these into the quality improvement strategy
Falls	After Action Review all falls Thematic review of falls resulting in fractured neck of femur.	Quarterly report shared to Executive quality group/ patient safety committee. Oversight of incidents with moderate and above harm to the incident review group. Annual thematic report (can focus on specific safety areas i.e.) to demonstrate improvement trajectory and inform revised PSIRP.
Pressure ulcer	Pressure Ulcer review tool	Quarterly report shared to Executive quality group/ patient safety committee Oversight of incidents with moderate and above harm to the incident review group. Annual report to demonstrate improvement trajectory and inform revised PSIRP.
Infection Prevention Control (IPC)	To report as per national standards for IPC incidents. Use of PSIRF alternative methodology tools and templates to be utilised were appropriate.	

Maternity	National maternity PSII's conducted via HSIB in line with national criteria. Other incidents meeting local PSII threshold Will continue to report and review incidents via the perinatal mortality review tool in line with national standards	Review at incident review group / patient safety committee.

7.4 PSII review and sign off

Once completed, all draft PSII reports will be reviewed at the Incident Review Group (IRG) for discussion and agreement of the safety recommendations. The IRG members will consider the quality and content of the PSII or safety review including the inclusion of systemic factors and to ensure that a restorative just and learning culture approach is evident. Identified areas for learning and improvement will be considered to ensure gaps in safety are addressed (please see PSIRF policy for more detail).

8.0 Supporting those affected by patient safety incident

8.1 Incidents that meet the duty of candour threshold

There is no legal duty to investigate a patient safety incident, however once an incident is identified that meets the statutory duty of candour threshold, our legal duty, as described in regulation 20, says we must:

- Inform the person or people involved, including the family where appropriate, that a patient safety incident has taken place.
- Apologise – 'we are very sorry this has happened.'
- Provide an account of what happened and explain the details you know at that point.
- Explain what you are going to do to understand the events.
- Follow up by providing a summary of events, a further apology, and an update in writing.
- Keep secure records of all meetings and communication

These incidents would have previously automatically been reported as serious incidents under the serious incident framework. It is crucial these incidents are not routinely investigated using the PSII process, as PSIRF steers us away from this routine approach to a more individual local approach. Incidents that result in severe harm will still fall within the duty of candour requirements. Any safety review undertaken should enable the provision of information about events to be shared with those involved, the patient, their family, and staff.

8.2 Supporting patients, families, and carers

PSIRF asks that we engage in a meaningful way with those affected by any incident, this means showing compassion and involving them to understand and answer any questions they have in relation to an incident. The Trust is committed to supporting and involving patients and families in line with the Patient Safety Incident Response Standards and the PSIRF national guidance on engagement and involvement – NHS England » Engaging and involving patients, families and staff following a patient safety incident

During a patient safety incident investigation, the patient, family or carer will be provided with a dedicated point of contact from the Trust who will explain the investigation process and discuss the level of involvement and support preferred by the family, which will include agreeing the terms of reference for the investigation and factual accuracy review of the report should the family wish to be involved.

This will aid our learning and improvement but, more importantly, allow us to support patients, service users, families and carers effectively. We want to be open and transparent with those affected by a patient safety incident because it is the right thing to do, regardless of the level of harm caused by an incident.

A patient, family member or carer is asked to contribute to a patient safety review (regardless of the methodology being used) in several ways. By fostering a collaborative and open approach to patient safety reviews, we will ensure they have the opportunity to share their experience and ask questions. Our ambition is to ensure that patients, families and carers have a voice throughout patient safety reviews and have the right level of support through the process and receive appropriate feedback about the outcome of any review.

On completion of a patient safety review the Trust will actively encourage feedback from patients, families or carers to continually improve the experience of patient involvement in the patient safety review process and to improve standards and quality of care. The Trust is committed to being open and honest with patients and their families/carers in line with our responsibilities under duty of candour and we are continually trying to improve our approach.

8.3 Supporting staff: Restorative Just and Learning Culture work

The Trust is committed to ensuring that patient safety incident responses are conducted for learning and improvement purposes only. Improving safety relies on a culture where staff feel safe to speak up, where there is a balance between fairness, learning and supportive accountability and where fear, blame and reprisal no longer exist. Staff need to know that when they speak up, they will be treated fairly, with compassion and be supported, and their concerns acted on.

The Trust recognises the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place. We value our staff, who can give us key insight into ‘work as done’ rather than ‘work as imagined’ and move towards a true safety culture. We want everyone’s voice to be encouraged, valued and listened to, helping us to continually learn, inspire change and improve.

Staff, through involvement in care-group led incident review groups, can share their concerns and discuss incidents openly, contributing to the overall decision-making process for learning responses. Staff are actively involved in patient safety reviews and investigations and their engagement and contributions are encouraged. We will seek staff feedback about their experience of our patient safety review/investigation process to ensure that we continually review the support available and as a cultural measure of psychological safety.

An anonymous just culture survey was undertaken, alongside facilitated staff focus groups, by the Freedom to Speak Up (FTSU) Lead, Improvement & Innovation Project Support Lead and the Associate Director for Education and Workforce Development. The survey showed that further work is needed to improve safety culture with approximately 50% of respondents fearing disciplinary action when involved in an incident. This is concerning and indicates that staff may be hesitant to raise an incident for fear of reprisal. However, the survey also found that people recognised reporting an incident is important for improving patient safety. Staff were also concerned that a fair and balanced system would not be applied when they were involved in an incident. The NHS staff survey also found that staff scored lower than the national average in terms of being confident that the organisation would address concerns. We have taken this feedback on board and are committed to embedding a restorative just and learning culture, where staff feel able to speak up and are listened to.

To support the embedding of a restorative just and learning culture, members of the People Directorate and the Patient Safety Specialist attended Just Culture training at Merseycare, following which the Employee Relations (ER) team will be leading on a just culture steering group, as well as having wider conversations to engage people across the Organisation. Key policies are being reviewed and reframed through a Just Culture lens in partnership with Staff Side and training and guidance will be developed for managers, both new and current, to support the use of consistent approaches and ensure principles are translated into practice. By ensuring that staff who raise concerns are supported and protected, we will create and embed a culture where staff feel able to speak up to raise concerns.

The Trust will have dedicated resources such as webpages for support and signposting, including the current Work In Confidence anonymous platform and Just Culture ambassadors. The Patient Safety team will continue to work with our People Directorate colleagues, Improvement & Innovation team, and the Freedom to Speak Up Lead to ensure we continue to develop and embed psychological safety and a restorative just and learning culture across the Organisation.

9.0 Our patient safety partners

We are excited to have recruited two volunteer Patient Safety Partner (PSP) roles. We see their role as a true partnership, drawing on their experience and having an active role in highlighting good practice and challenging where care, treatment or our processes are not as we would hope for, to ensure that the patient voice is heard throughout.

PSP’s are patients, carers, family members or other lay people (including NHS staff from another organisation working in a lay capacity) who will work in partnership with staff to

influence and improve the governance and leadership of patient safety within the Trust. They will represent the voice of the wider community and provide the Trust with a real opportunity for building on the vision of developing a collaborative approach, supporting a leadership culture that initiates and facilitates the opportunity for co-production and co-design in service improvements and patient safety. This will be facilitated through their participation in safety and quality committees, involvement in patient safety projects, working with the Board to consider how to improve safety, involvement in staff patient safety training and participation in investigation oversight groups. Staff feedback in the NHS staff survey scored lower than the national average in terms of staff feeling that the organisation would act on concerns raised by patients or that patient care was the top priority – our patient safety partners will challenge us to improve this.

We will be supporting our selected PSPs with training and mentoring to ensure that they are able to fully contribute to the further developments of our PSIRF responses, safety improvement work and to codesigning our future processes with the patient voice at the forefront of what we do. PSP's will; be supported and coached during key meetings to be confident and supported to contribute. PSP's will be asked to share their reflection's as to how the team can best support them to best deliver and achieve in their role.

10.0 Sharing learning to support safety improvement

The Trust has a number of ways to ensure that learning from safety reviews, including learning from excellence, is shared across the Organisation to support safety improvements. The Patient Safety Specialist and central team, supported by the Trust Communications team, will facilitate cascade of relevant content across the organisation through a range of media including safety bulletins, social media streams, videos and podcasts. Staff are currently asked to report examples of what went well to ensure learning from excellence, these examples will be shared regularly at the incident review group and incorporated into the terms of reference. Examples of Good Care are also reported on DCIQ under LfPSE.

Monitoring through Clinical Audit should be undertaken when improvement plans are complete to ensure that changes are embedded and continue to deliver the desired outcomes. When changes have led to measurable improvements then these will be shared, adapted and adopted with other areas of the Organisation and peer Organisations via the Patient Safety Specialist to the ICB Patient Safety Specialist Network and/or System Quality Group.

10.1 Evaluating and monitoring outcomes of PSIIs and Safety Reviews

Each of the care groups and agreed Trust Quality Improvement Programmes will receive the learning and recommendations from PSII's and local reviews to inform the improvement work as well as evidence improvement and impact learning. Close working between the Patient Safety team and Improvement & Innovation Team is central to this plan to ensure that data and learning is used to inform and align with Quality Improvement projects. Large scale improvement projects are underway in relation to elective and emergency care and recommendations and learning from these safety priorities will feed into these workstreams via Improvement & Innovation team representation at Patient Safety Group.

Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story. Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

The following mechanisms are used to develop and support improvements following PSIIs:

- The Trust uses a stepped Quality Improvement methodology as the way we do business across the Trust, constantly evaluating our work processes and making changes to improve services for patients and the working environment for staff.
- Our processes for improvement are described in our Building Capability Framework and our Quality and Patient Safety Strategy. The recommendations from PSII's and other reviews will flow through these processes linking them in directly to the Trusts Quality Improvement and Transformation work.

Projects will follow Quality Improvement methodology, supported by members of the Improvement & Innovation team, to ensure consistency and careful monitoring of outcome, process and balancing measures. Work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents. Improvement plans will be shared with the relevant teams to enable delivery of actions, monitoring and evaluation of improvement outcomes. Clinical/operational project leads, supported by the Improvement & Innovation team, will provide update reports on progress to the Quality Assurance Committee.

Reports to the Quality Assurance Committee will be bi-monthly and will include aggregated data on:

- patient safety incident reporting
- audit and review findings
- findings from PSIIs
- progress against the PSIRP
- results from monitoring of quality and safety improvement plans from an implementation and efficacy point of view
- results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents will be reported and disseminated via the feedback and engagement group.
- results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents will be reported and disseminated via the feedback and engagement group

10.2 Safety improvement plans

It is an ambition of the Trust that once the transition to PSIRF has been completed, the Trust will develop an Organisational safety improvement plan, the oversight of which will sit with Patient Safety Group. The safety improvement plan will reference and incorporate existing safety improvement work and will also review output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues. The Organisational safety improvement plan will also seek to incorporate any broader areas for improvement which require systemic change and commitment from the executive team.

11.0 Complaints and appeals

The Trust fully upholds the NHS Constitution, aspiring to put the patient at the heart of everything it does. Any concerns or complaints raised about a service provided by the Trust will be taken seriously and will be managed in a way that reflects the Trusts' values. If following completion of a patient safety incident response there are concerns that a service user, family member or carer wished to raise, we would welcome the opportunity to review and discuss these. If, however we are unable to resolve these concerns a complaint can be raised by contacting our Patient Advice and Liaison Service (PALS).

12.0 Governance, Roles and Responsibilities with the PSIRF approach

It is important that the Trust governance structures are robust to support the implementation and progression of PSIRF. The Trust core meetings and committees which represent our governance approach are detailed in the Trust PSIRF policy alongside core roles and responsibilities.

Torbay and South Devon NHS Foundation Trust

Appendix 1 – Data and Intelligence

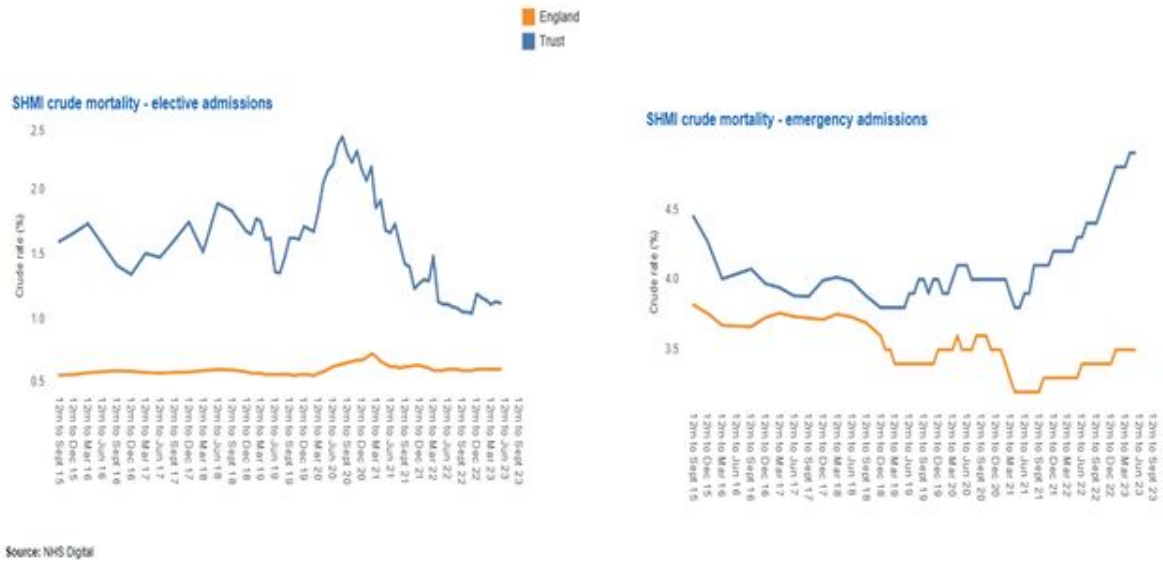
The information contained within this section focuses on the information and intelligence used to inform the development of the patient safety incident response plan.

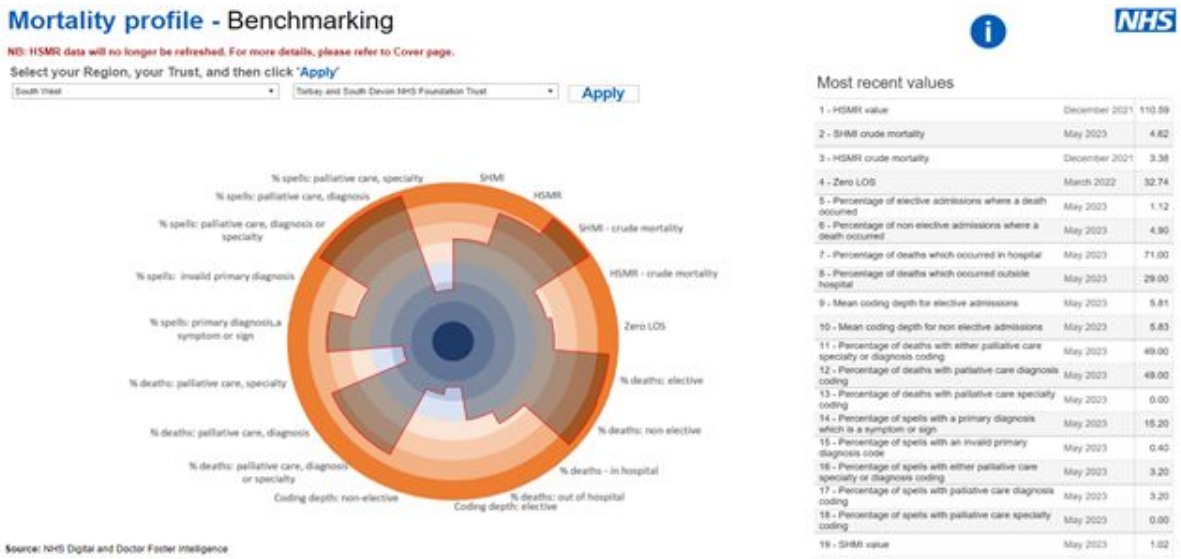
Top corporate risks related to patient safety

- Trust Patient Flow Pressures Resulting in Ambulance Handover Delays, Poor Levels of Care and Performance for 12hr & 4hr Standard - rated @ 20
- Failure to Achieve Constitutional Target Regarding RTT Resulting in Poor Patient Experience and Quality of Care - rated @ 20
- Non-Compliance with the National Cancer Waiting Time Target - rated @ 20
- Incorrect labelling of samples for blood transfusion - rated @ 20
- Lack of/delayed follow up across surgical care - all departments - rated @ 20
- Stroke Services (overarching risk) - rated @ 20

Learning from deaths

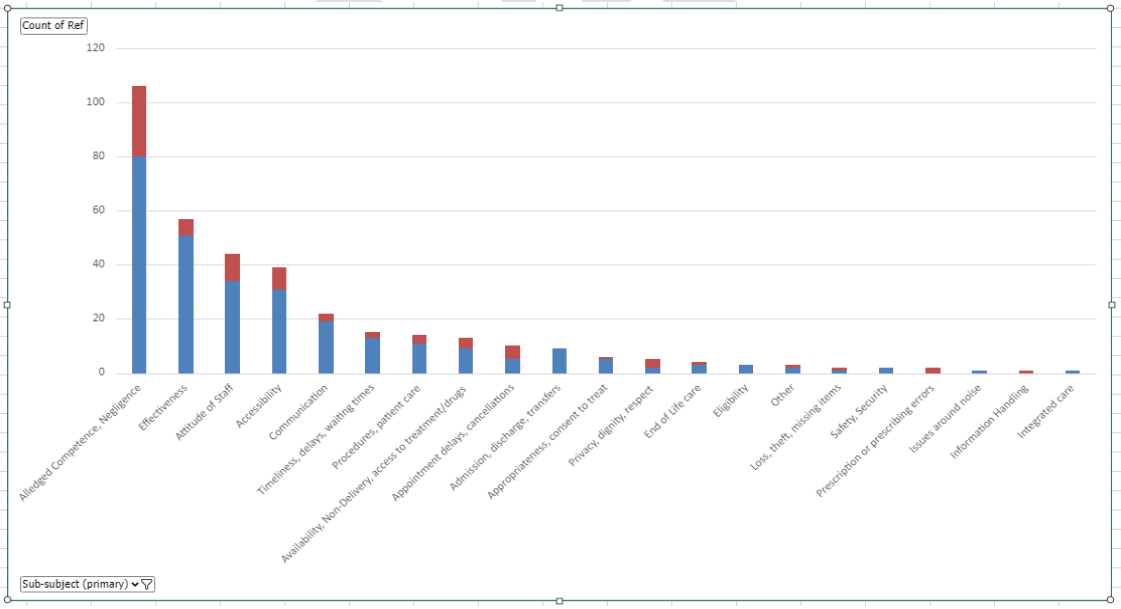
Themes from patient safety reviews, inquests and mortality reviews have identified the following themes:



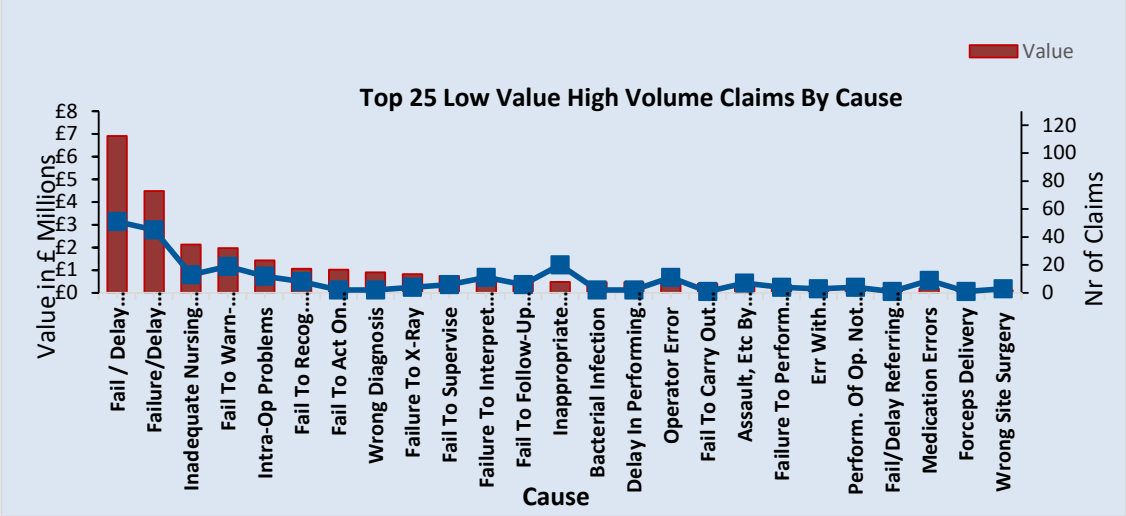


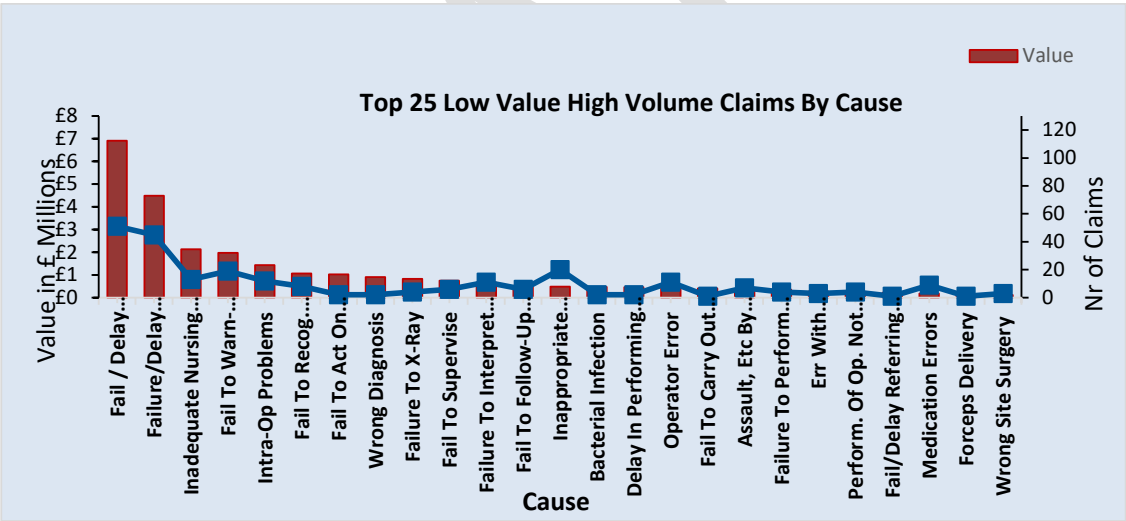
Patient Experience

TSDFT complaints



Litigation


Value
Top 25 Low Value High Volume Claims By Cause
Value in £ Millions
£8
£7
£6
£5
£4
£3
£2
£1
£0
120
100
80
60
40
20
0
Nr of Claims
Fail / Delay...
Failure/Delay...
Inadequate Nursing...
Fail To Warn-...
Intra-Op Problems
Fail To Recog...
Fail To Act On...
Wrong Diagnosis
Failure To X-Ray
Fail To Supervise
Failure To Interpret...
Fail To Follow-Up...
Inappropriate...
Bacterial Infection
Delay In Performing...
Operator Error
Fail To Carry Out...
Assault, Etc By...
Failure To Perform...
Err With...
Perform. Of Op. Not...
Fail/Delay Referring...
Medication Errors
Forceps Delivery
Wrong Site Surgery
Cause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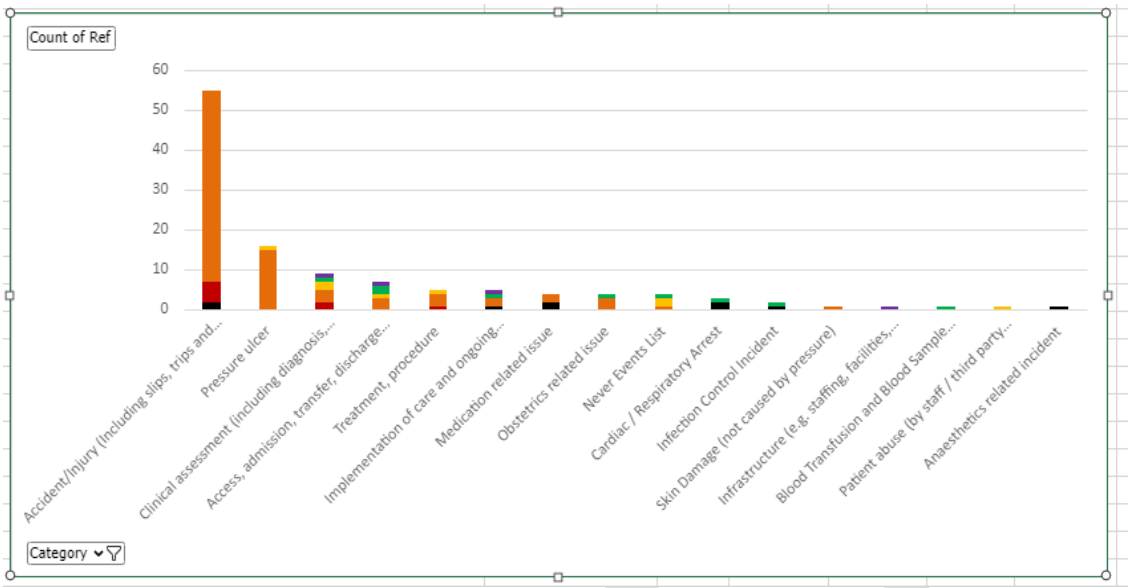
80
60
40
20
0
Nr of Claims
Fail / Delay...
Failure/Delay...
Inadequate Nursing...
Fail To Warn-...
Intra-Op Problems
Fail To Recog...
Fail To Act On...
Wrong Diagnosis
Failure To X-Ray
Fail To Supervise
Failure To Interpret...
Fail To Follow-Up...
Inappropriate...
Bacterial Infection
Delay In Performing...
Operator Error
Fail To Carry Out...
Assault, Etc By...
Failure To Perform...
Err With...
Perform. Of Op. Not...
Fail/Delay Referring...
Medication Errors
Forceps Delivery
Wrong Site Surgery
Cause



Freedom to Speak Up concerns

2 FTSU 6 monthly report were analysed for the year 2023.

The Nov 2022 reported noted the highest number of cases related to bullying and harassment (in 2 cases directly impacting upon pt safety), with failure to follow processes being a consistent theme.

The May 2023 FTSU report noted a rise in reported cases with the top themes being bullying and harassment, patient safety (5) and failure to follow process.

NHS
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NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: End of Life (EOL) Annual Report 2022/23			**Meeting date:** 31 January 2024
Report appendix:	End of Life Annual Report 2022/23 Appendix 1: EOL National and Regional Ambitions Appendix 2: National Audit EOL Case Review 2022/23 - Published in 2023 Appendix 3: Summary of findings Round 4 National Audit of Care at the EOL (NACEL) Family and Carer Feedback 2022/23: - Published 2023 Appendix 4: Palliative Care and End of Life Survey Analysis for 22/23		
Report sponsor:	Chief Nurse (Interim)		
Report author:	Interim Deputy Chief Nurse		
Report provenance:	ICO EOL Group		
Description/Purpose of the report and key issues for consideration/decision:	The report covers the period of 1 April 2022 – 31 March 2023. It will highlight the work streams aimed at delivering high quality care to individuals and their families at end of life. The Report demonstrates the trust position regarding: • Key measures of quality and performance (section 6 page 5) • Monitoring care provided with a view to specifically providing assurance around End-of-Life Care (EoLC) quality standards (6.3 page 6) • Trends in Patient Safety Incidents (section 7 page 10) • Themes from Patient Family and Carer Experience (section 9.4 page 14) and actions in place		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Board is asked to: • Receive the report and note the breadth of end-of-life work across the trust. • Note the successful partnerships built across the health and social care system • Note the Improvement work for 2022/23 planned in relation to Advance Care Planning		
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 to improve the care provided to patients in relation to EoLC.		
How does the report support the Triple Aim:	*1)* population health and wellbeing. 2) quality of services provided.		

Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience
Risk: Risk ID: *As appropriate*	ID 3434 Delays in Providing MCCD to Next of Kin Following Patient Death (EOL) ID 3500 Potential Delay to Appropriate Spiritual Support at End of Life (EOL Risk)
External standards affected by this report and associated risks	Care Quality Commission

Report title: End of Life Annual Report 2022/23		Meeting date: 31 January 2024
Report sponsor	Chief Nurse (Interim_	
Report author	Deputy Chief Nurse	

1.0 Introduction

The paper provides the Board with assurance around the programme of work aligned to End of Life Care (EoLC) across the organisation and includes the achievements and challenges for the period 1 April 2022 – 31 March 2023. The report sets out the current position relating to quality standards and our overall improvement priorities.

End of life care is delivered across the whole organisation by our nurses, support workers, doctors and allied health professionals in a range of care settings from people's own home to the acute hospital.

The strategic leadership for palliative and end of life care in the year 2022/23 was aligned to Paignton and Brixham Integrated Service Unit (ISU) alongside long term conditions, cancer care services and Specialist Palliative Care.
In July 2023 the trust transitioned into a care group structure which EoLC was aligned to the Planned Care Care Group whose focus is on Cancer and Surgical Services. The change from ISU to care group will not change the strategic focus but will enhance the support provided by having a designated Associate Director of Nursing and Professional Practice (ADNPP) aligned to cancer services. The ADNPP will work closely with their ADNPP colleagues to ensure all EOL patients across the trust receive the same standard of care. The delivery model supports the aim to provide seamless care across the whole pathway, achieved through collaborative working across services and teams within the organisation and our local health and care partners.

2.0 Context of EoLC

The impact of COVID-19 on the end-of-life pathway has been significant. In the first year of the pandemic, much work was focused on adapting service delivery models and pathways to ensure patients were best placed to access services within the context of extreme restrictions, ensuring the service remained responsive, compassionate and safe. As the pandemic has lifted the EoLC Team have been able to refocus on EOL priorities, and actions as evidenced within this report.

3.0 The National Strategic, Regional and Local Priorities

3.1 Torbay and South Devon Foundation Trust's (The Trust) End of Life Strategy for 2021-2024 is based on the National and Regional ambitions (Appendix 1). It sets out the overarching ambitions and direction of travel for integrated care across the trust in how EoLC is provided.

The trusts strategic goals:

- Provide high quality care to people approaching end of life (EOL)
- Work in partnership to establish and support preferences for individual's end of life care
- Promote living well and as independently as possible
- Support people who are important to each patient

- Ensure equitable care to everyone at the end of their life regardless of their life limiting condition, care setting, social circumstances, life choices, culture and religion
- Work with specialist, acute, primary and community care providers to provide seamless patient journey
- Provide support & education to all our staff providing EOL care

3.2 From these goals the trust has established a set of priorities to deliver against both the national and regional objectives. Progress has been made across the priorities but in some areas, this has been limited due to the pandemic and sustained operational challenges.

- Promote the provision of high-quality care to people approaching the end of their life. Working in partnership to establish and support preferences for everyone in EoLC.
- Roll out EOL documentation to community hospitals and community teams.
- Develop EOL audit programme to include participation in national audits, and locally driven audits.
- Develop a plan to improve recognition of patients likely to be in the last year of life
- Understand the patient/carer and family experience of EOL care delivered by the Integrated Care Organisation (ICO)
- Understand the perspective of staff who provide care at patients' EOL.

4.0 Governance and Leadership

- The Deputy Chief Nurse provides strategic leadership of the EOL agenda and delivery is supported by the Consultant in Palliative Medicine and EOL Lead Nurse.
- Externally the EOL ICO group feeds into South Devon and Torbay End of Life Committee chaired by Macmillan GP Facilitator.
- This structure allows for shared learning and a collective approach to achieve priorities set nationally and regionally.
- The EOL Trust Group provides regular updates to the Executive Quality Group and then the Quality Assurance Committee

5.0 End of Life Activity.

EOL care is delivered in various settings including the persons own home, which may be a care home, the local hospice, Rowcroft (a unit providing specialist EoLC), or within the acute or community hospital setting. Between 1st April 2022 and 31st March 2023:

- **839** people received EoLC in our hospitals in 2022/23 an increase from 2021/22 of 185 people. It is thought the increase in numbers relate to the bespoke education training sessions around recognising EOL and therefore an increase in referrals to the Palliative Care Team.

6.0 Performance and quality

6.1 Community End of Life Care

The end-of-life care provision was last inspected by the Care Quality Commission for community (CQC) and acute services in 2018. The community end of life care was rated “requires improvement” overall which included requires improvement for safe, effective and well led and good for caring and responsive. Areas identified for improvement include the following:

- Insufficient evidence of training records
- Lack of documentation and decision making around those EOL patients who lacked capacity
- Mobile phones not fit for purpose which could impact on patient care
- Care plans reviewed were generic not individual to need
- Insufficient information on governance process regarding EOL

There is an action plan held by the EOL Trust Group that provides assurance around the work that is being undertaken across the trust to address such issues and ensure ongoing monitoring is in place. A further audit and review was undertaken in November 2022 to ensure continued compliance against the above. Outcomes are as follows:

- Training is now captured centrally on The HIVE for syringe pumps and Verification of Expected Death (VOED)
- Butterfly packs have been introduced to support documentation and decision making, however, further work is required in 2023/24 around how these packs can be supported in the community setting through monthly documentation audits that will include the review of EOL Care as appropriate.
- All community nurses now have smart phones and access to laptops.
- Robust governance structure in place that supports both acute and community through the trust EOL Group, which meets monthly and the ICO EOL Group which includes external stakeholders which meet bi-monthly.

6.2 Acute Services End of Life Care

End of Life Care in acute services achieved “Good” overall in the 2018 CQC inspection. Across the five key lines of enquiry the acute services achieved requires improvement for safe, and good for the other four domains, effective, caring, responsive and well led. There were two ‘Must Do’ requirements:

- To ensure care planning documentation is used consistently to assess and plan the needs of palliative care and end of life patients.
- To ensure Mental Capacity Act (MCA) 2005 was complied with, and that the trust continues to strive to ensure staff complete the required training and enact the requirements of the Mental Capacity Act within their practice when required.

Actions taken:

- Monthly audits on butterfly packs evidence they are well completed, including decisions around EOL, individualised plan, symptom control – spirituality improving but remains a focus for 23/24
- MCA update table below and trajectory plan

Table 1 sets out the compliance performance for the period of this report (1 April 22 – 30 March 23) at 31 March 2023 against the target of 90% for level 1 and 85% for levels 2 – 6.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Mental Capacity Act L1	87.58%	88.27%	89.28%	89.78%	89.51%	89.76%	91.12%	91.13%	91.21%	91.65%	92.30%	93.04%
Mental Capacity Act L2	81.88%	83.72%	84.87%	84.72%	84.19%	84.11%	84.00%	85.38%	85.31%	86.73%	87.75%	89.14%
Mental Capacity Act L3	61.15%	62.62%	64.32%	64.76%	65.70%	66.13%	66.46%	66.78%	68.31%	70.05%	71.18%	72.57%
Mental Capacity Act L4	100.00%	100.00%	100.00%	100.00%	80.00%	57.14%	66.67%	100.00%	100.00%	100.00%	100.00%	100.00%
Mental Capacity Act L5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	83.33%	71.43%
Mental Capacity Act L6	83.33%	71.43%	71.43%	83.33%	83.33%	83.33%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%

Table 1: MCA compliance and trajectory TSDFT

A recovery plan is in place for all Statutory and Mandatory training, to which the organisation has established improvement trajectories. Table 2 provides a current compliance position as of 18 January 2024.

Level	Target	Compliance	Improvement target for April 24	Target for full compliance April 2024
1	90%	95.8%	N/A	Compliant
2	85%	93.5%	N/A	Compliant
3	85%	79.08%	76%	On Track
4	85%	75%	76%	On Track
5	85%	100	85%	Compliant
6	85%	N/A	N/A	Delay in system update due to change in Executives

Table 2: MCA trajectory TSDFT

Level 4 training compliance has dropped from 100% in April 23 to 75% January 24 however, this is a result of having small staff numbers required to complete this level of training. Having just two members of staff as noncompliant will automatically drop the overall compliance to 75%.

Level 6 training compliance is not available due to the system not reflecting a change in Executives. This is currently being adjusted to reflect current performance.

Where compliance is below the expected target managers are working with staff to ensure their training is booked and undertaken. Assurance is provided to the Mandatory Training Sub Group and Integrated Safeguarding Inclusion Group for oversight and scrutiny.

6.3 End of Life Quality Standards

6.3.1 National Audit of Care at the End of Life (NACEL) 2022/23 – Round 4

The trust is currently reporting against the 2022/23 national standards, published in February 2023. The National Audit sets out a range of quality standards that are monitored through an annual review process that includes:

- Case note review
- Online survey for next of kin/families/carers
- Staff feedback

The standard areas reviewed at trust level are set out below:

- Recognising the possibility of imminent death
- Communication with the dying person
- Communication with families and others

- Involvement in decision making
- Individualised plan of care in place
- Needs of families and others documented
- Families' and others' experience of care
- Governance
- Workforce / specialist palliative care
- Staff confidence
- Staff support
- Care and culture

Performance from Case Note Review

Appendix 3 sets out our position in detail against the national standards for acute and community inpatient bed-based care. In summary, the trust is performing better than the national average against 9 out of 17 questions in acute inpatients and 12 out of 17 questions for community inpatients. These include:

Above National average

- ✓ Recognising dying early
- ✓ Responding to practical needs of patients and families
- ✓ Healthcare staff monitoring hydration and nutrition
- ✓ Prescribing anticipatory medications

Below National Average

- Do not regularly discuss preferred place of care

The results of the 2022/23 Round 4 NACEL audit have been presented to the grand round in September 2023 with an action to improve how we have conversations with patients around preferred place of death. This has been enhanced further through teaching sessions with medical students and junior doctors around the importance of these conversations. The palliative care team have also taken an action to undertake further work regarding education across their team and the trust. This work will be monitored over the coming year to ensure that improvements are made. A pilot is also underway regarding conversations with patients, families, loved ones to ensure we understand what's important to the patient. Further details can be found in section 9.2.

Performance from family/carer feedback

Feedback was received between 1 April 2022 – 31 August 2022 (part of the 2022/2023 NACEL audit) from a 'nominated person' (relative/loved one) for patients who died in acute / community settings from an online survey.

- Acute services received feedback from 14 'nominated persons', a response rate of 19% of the 70 surveys sent was received.
- Community services received feedback from 3 'nominated persons', a response rate of 50% of the 6 surveys sent was received.

To limit any sampling bias, a good response rate is required. According to SmartSurvey (2023) a good response rate should be around 20%. The national average response rate for the quality survey component of the NACEL audit was 22%, this demonstrates as an acute service we were in line with the national average and that of a good response rate, and our community services exceeding that of both.

Processes regarding requesting of relative/loved one's contribution to the survey are being reviewed through 2023/24 to ensure we maximise the opportunity to receive feedback through the ongoing surveys.

Appendix 4 sets out our position in detail against the national standards for acute and community inpatient bed-based care. In summary, areas the trust is performing better than the national average include:

Above national average

- ✓ Families/carers felt they were well informed about their loved one's condition and were given enough opportunities to discuss their conditions and treatment
- ✓ Families/carers felt care provided to their loved ones was 'outstanding' and 'excellent', especially in the acute hospital
- ✓ 71% patients received care within a side room, compared to the national average of 57%

Below National Average

- Family/carers reported they received less emotional support

The palliative care team and EOL education team are developing a workplan which they aim to have in place by summer 2024 that will support the development of staff regarding supporting patients emotionally through what can be difficult time regarding EOL conversations. The chaplaincy team are also exploring the possibilities of an EOL chaplaincy role funded by Macmillan to support patients and their families further by spring 2024.

Performance from Staff feedback

The online survey was aimed at all staff (doctors, nurses, allied healthcare professionals, ward-based receptionists, pharmacists, domestics) working in all hospital wards except maternity, paediatrics and the Emergency Department.

The national audit program sets a target for completion with the trust target being set at 100 for acute services 20 in community hospitals.

The results show:

- The trust uptake to be below what is set nationally with **28** completed surveys in acute services, 30 less than last year and 72 less against our set national target.

- Community hospitals received **3** responses, an increase from 0 last year, however 17 less than our national set target. There was an expectancy for a higher response rate given the work that took place through the Palliative Care Teams engagement with each Community Hospital, Ward Manager and Matron to advertise the audit and encourage staff feedback. Therefore, processes are being reviewed through 2023/24 in how Community Hospitals can be supported further to improve response rates through site visits, posters and discussions with the ward teams.

The team have not been able to identify why less people took part in the survey but what has been agreed is a clear communications package needs to be aligned to and leading up to the launch of the next survey to prevent nonresponsive bias. Nonresponsive bias carries

a risk as error comes from an absence of respondents instead of the collection of erroneous data. which may provide the trust with a false view of how the staff see the service and the care provided. As a result, throughout 2023 the palliative care team visited areas to gain feedback from staff to ensure their views were heard. Reassuringly, nothing new was identified through this process.

Most agreed or strongly agreed that they were confident in:

- ✓ Recognising when a patient maybe dying imminently
- ✓ Were confident in their skills to communicate clearly and sensitively to dying patients and their loved ones and to involve them in end-of-life discussions
- ✓ Knew how to access help from the specialist palliative care team and felt well supported by them when they did so
- ✓ Felt able to respond to requests to die outside of the hospital setting, although those working in the community hospitals felt most confident here
- ✓ Felt confident in discussing hydration options with dying patients and their loved ones, in assessing and managing pain and other physical symptoms at end of life, responding to practical and social needs of the dying person and their families
- ✓ Most felt able to raise a concern about end-of-life in the hospital
- ✓ Most felt they worked in a culture that priorities care, compassion, respect and dignity
- ✓ Staff surveyed also felt they had not had end of life training in the last 3 years

To improve the offer of EoLC the Palliative Care Team are now providing regular bite size teaching sessions to nursing staff within their clinical areas, they have committed to attending Emergency Department each weekday providing palliative care and EOL teaching. A programme has been introduced to teach Junior Doctors yearly, along with a presentation of the NACEL results at the Grand Round to scope EOL training needs.

6.3.2 Local audit of EOL care (2022/23)

The documents reviewed as part of this audit are the Individualised EOL care plans (butterfly packs) and syringe pump administration checklists. In 2021/22 audits were not undertaken due to the impact of COVID-19 pandemic on staff and access to records. However, in 2022/23 these audits have gradually been reintroduced monthly.

Key themes from 2022/23 include:

- Documentation: multi-professional communication pages are not being used. This has been highlighted to Medical Colleagues/Ward Managers as an area for improvement.

- Documentation: the current Community Hospital Syringe Pump Administration Record is now consistent with those used within the acute setting. When a care plan or syringe pump checklist is noted to not be complete it is brought to the attention of the practitioner straight away to allow real time learning.

- Spirituality: it has been noted the quality of the care plan continues to improve however this will remain a focus for 23/24. Ward staff and managers receive real time feedback on specific detail regarding the quality of the care plan reviewed and support is offered and bespoke training supplied as needed.

During 2021/22 it was identified different paperwork was in place across the inpatient setting so this was reviewed through 2022/23 and changes piloted. In 2023 standardised documentation for syringe pumps was introduced across all inpatient sites to improve quality and safety for patients and staff alike. EOL care plans have also be standardised across all inpatient sites (acute and community), to allow for a seamless journey.

There is ongoing work to create a seamless care plan that can be used in both the acute and community setting. The “Butterfly pack” was piloted in the community in 22/23 however it has not been successful in its launch due to the form being very acute focused, therefore ongoing work continues in 23/24 to enhance continuity for our patients. To support transfers in the absence of a community butterfly pack the SBAR system has been altered to include a butterfly symbol to recognise EoLC and highlight patients who are in the last hours to days of life. This has been received well by staff and has improved handovers. Therefore, it will continue to be used to further improve continuity and standardisation of care.

7.0 Incidents

EOL Incidents by Severity and Reported date (Month and Year) 1 April 2022 to 31 March 2023

	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total
No harm	9	11	8	8	20	8	20	17	18	13	6	14	152
Near miss	0	0	1	1	0	0	1	0	0	1	1	1	6
Low harm	0	0	0	1	2	1	1	0	1	3	3	2	14
Death	0	0	0	0	0	0	0	0	0	1	0	1	2
Moderate	0	0	0	0	0	0	0	0	0	0	0	1	1
Total	9	11	9	10	22	9	22	17	19	18	10	19	175

Table 3: EOL incidents reported by severity 1st April 2022 – 31st March 2023 for TSDFT

The trust reported 175 incidents related to EOL care over the period 1st April 2022 – 31st March 2023 (Table 3), this is an increase of 62% from 21/22. This increase relates to a further 108 (↑ 65%) incidents being logged within the no harm category with a large proportion of these relating to care after death. This refers to delays in medical death certificates being released to families due to a change in national timescales and the availability of doctors due to rotas/annual leave to complete within the designated timeframe. Work is taking place in 23/24 to improve this process and review the timelines.

A proportion of incidents related to *Just In Case Bags* regarding prescribing, prescriptions, access to medications. Work has already started to align policies and processes to support our Community Teams and prevent unnecessary delays. This work continues through 2023/24 with the hope to have it completed by summer of 2024. These trends are illustrated further within Table 4. All incidents received have been reviewed and where appropriate in-depth reviews undertaken with actions and learning identified, 95% of the incidents logged related to EOL care fall within the no or low harm category. This assures the trust that no significant harm is coming to those who are receiving EoLC.

EOL Incidents by sub-category and reported date (Month and Year) 1 April 2022 to 31 March 2023

	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total
EOL - Symptom Control	1	1	2	1	2	0	3	0	4	6	4	4	28
EOL - Medication Issue	1	1	0	1	0	1	0	0	1	0	0	3	8
EOL - Care after death	4	7	5	0	4	2	4	9	6	4	1	3	49
Delay with MCCD	3	0	0	6	14	6	14	7	7	5	3	7	72
EOL - Pain Relief	0	1	1	0	2	0	0	1	0	1	2	1	9
EOL - TEP Issue	0	1	0	0	0	0	0	0	0	0	0	0	1
EOL - Medical Device Issue	0	0	1	1	0	0	0	0	0	1	0	1	4
EOL - Rapid discharge issue	0	0	0	1	0	0	1	0	1	1	0	0	4
Total	9	11	9	10	22	9	22	17	19	18	10	19	175

Table 4: EOL incidents reported by sub-category 1st April 2022 – 31st March 2023 for TSDFT

8.0 Education and Training

From September 2022 the Hospital Palliative Care Team have been providing ward-based bite sized teaching sessions of 20-30mins on a rolling programme to cover all aspects of Palliative and EoLC. This programme consists of training related to:

- EOL individualised care plan
- Recognising dying
- Fluid management at EOL
- Pain management
- Management of respiratory symptoms
- Nausea and vomiting
- Agitation/terminal restlessness
- Bowel management
- Advanced care planning and difficult conversations/after death care and signposting relatives
- Rapid discharge
- Syringe pump management and paperwork completion
- Spirituality
- Just in case medication and community syringe pump prescriptions.

There are also a range of e-learning courses available on the HIVE for staff to access and utilise for Continual Professional Development. This training is offered to both community hospital teams, Care Home staff, and Community Nurses.

The Hospital Palliative Care Team are also now providing some supportive training regarding Palliative and End of Life Care to the international nurses as part of their introductory period into The Trust because of international nurse feedback**.**

8.1 Staff syringe pump training and Verification of Expected Adult Death (VoED) training and compliance

For the period 1 April 22 to 30 March 2023, there were 1763 Registered Nurses employed by the trust working in the Acute and Community setting. 883 are required to be competent in the use of Syringe Drivers either because of their role or their place of work. 60% of staff had completed training and compliant with Syringe pump training for the period the report covers.

46% of the community staff were trained in VoED for the same period. These figures are subject to variation due to staff movement. However, work continues to increase the number of staff able to support patients with syringe drivers by offering wards and

community teams bespoke training as well as training accessed through the HIVE. In 23/24 there will be a further focus on train the trainers to allow for individual on the job training which is thought will improve compliance further. To gain assurance that these figures continue to improve they are now reported into the Trust EOL Group.

The trust has a rolling education plan to ensure all staff who require training in VoED and syringe pump training have completed as needed. The training programme has set a compliance target of 75% by summer 2024 and 95% by spring 2025 for both VoED and syringe pump compliance. To support this, training has now returned to face-to-face teaching sessions for both V0ED and Syringe Pumps at the Horizon Centre. The team continue to provide ad-hoc training sessions in Community Hospitals and Community Nursing Teams offices to maximise accessibility and ensure staff are compliant.

Spring 2023 saw the role out of 100 new syringe pumps to support EoLC. The new devices have an increased battery life of > 50hours and can deliver medication up to 35hours improving patient care and outcomes. A training programme was implemented and a working group set up to produce a policy and Standard Operating Procedure to support the responsibility of the devices as each acute inpatient area has receive their own stock to support their patient cohort. This approach will improve access to devices improving patient outcomes.

8.2 Ambassadors

An EOL Ambassador is a member of the nursing or allied health professional teams who has completed the ambassadors training programme delivered jointly by Rowcroft Hospice and the Hospital Palliative Care Team Leads. Their role is to support the successful implementation of The Trust End of Life Care Strategic Board Plan in relation to:

- Promoting recognition of people at the end of life (defined as anticipated to be in the last 12 months of life), to identify what matters to the person and their family
- Maximise and effectively use all available resources for service provision of end-of-life care across the whole health and care community
- Provision of education and training to the workforce to deliver high quality end of life care to build a commonality of understanding of why end of life is important in our system
- To promote the Six National Ambitions for Palliative and End of Life Care and the five priorities of care

Since COVID-19 the ambassador leads have continued to maintain communication via MS teams which supports effective communication and support for staff working across the trust footprint. Ongoing support for the EOL Ambassadors programme, in partnership with Rowcroft Hospice, continues to focus on maintaining the knowledge, skills and momentum of the graduates of previous cohorts. The Ambassador role has supported areas to improve the knowledge, care, skills and understanding when looking after EOL patients. A third cohort commenced in September 2022 with 24 successful applicants which will improve the care provided further. The expression of interest was above expectation and the successful candidates come from a wide area of expertise, including nurses, rapid response, care home staff, social workers, Paramedics. The number of EOL ambassadors across the trust on 31 March 23 was 39, with a further 15 due to graduate later in 2023.

9.0 Projects and Initiatives

9.1 Hospital Specialist Palliative Care Team 7 day working

NICE guidance and CQC have recommended 7-day face to face working for the Hospital Specialist Palliative Care Team. A change in working patterns allowed this to be achieved from March 2020 to May 2020 due to the Covid-19 pandemic changing the way services functioned and was beneficial and welcomed across the trust with better outcomes for patients.

In July 2022, 7-day working was reintroduced again using the existing workforce based on 2020 findings. This was kept in place up until April 2023 at which time it was felt that it was not sustainable with the current workforce and increased clinical demand, for this to be fully achievable extra resource would be required. The team will be raising this in 23/24 through the relevant Care Group Governance Meeting. However, while we await this to take place patient care continues to be supported with by Rowcroft Hospice who provide specialist palliative care advice and support via a 24/7 telephone service.

9.2 TEP Action and Delivery Group

In 2021/22 we introduced the latest version of the Treatment Escalation Plans (TEP), supported by frequently asked questions and completion guidelines. Compliance as a trust was 78.2% fully/partially completed for March 2023 of which 74.1% were completed fully. The aspiration is for 100% completion across the trust. To support this and understand the reasons behind not achieving this to date an audit of their quality took place in Q4 of 22/23. The audit reinforced that the TEP form completion was variable. The audit results were feedback to doctors in spring 23 where compliance rates then started to improve. The last three months have seen compliance rates on a downward trend with December 2023 being 76.1% fully completed and 82.1% fully or partially completed.

A task and finish group has been set up to include Advanced Nurse Practitioners, Nurse Consultants, Consultants and Primary Care General Practitioners looking at TEP form completion. The role of this group is to identify what training and actions are needed to support these practitioners in undertaking sensitive conversations, capturing what matters to the people and can adjust the TEP form to reflect individuals wishes. The group has ensured the correct governance processes are in place regarding escalation of compliance. The work is in the pilot phase and in phase one will have five senior professionals who are not Doctors undertaking the role of TEP completion. A register of competent practitioners who are undertaking TEPs will be held. A TEP policy has been worked on through 2022/23 alongside the Resus Committee Steering Group which show the publication of the policy October 2023. There are also plans for a representative from the TEP action and delivery group to join the Resus Committee Steering Group to work closely on these policies.

The aim for the TEP Action and Delivery Group in 2023 was to write/develop competencies alongside a training package to support staff undertaking the role of TEP completion. The training package was completed by Winter 2023 by the 5-pilot staff and is currently in its pilot phase across the trust. Next steps will be to review in 2024 the outcome and look to expand to a further group of staff.

9.3 Dying Matters campaign

Every year, people around the country use ‘Dying Matters Awareness Week’ as a moment to encourage all communities to hold conversations around death and dying. In 22/23

'Dying Matters Awareness Week' took place from 2 - 6 May 2022 with a focus on the importance of being 'In A Good Place to die'.

A stand in the main entrance gathered feedback from staff and the public on experiences, information was on display and leaflets were provided to staff and public. The general feeling was the stand was well received by all, it included supportive conversations and signposting. Community hospitals also did stalls, displayed information in their staff rooms and offered coffee mornings raising awareness.

9.4 Patient, Family and Carer Experience

The voice of the patients, carers and loved ones is a critical area of focus on our quality improvement journey. Although the last 2 years has impacted on the pace of our improvement we have continued to adapt and modify interventions to ensure we are listening to patients, families and carers, compassionately responding to their care needs.

9.4.1 Complaints, Concerns 1st April 2022 to 31st March 2023

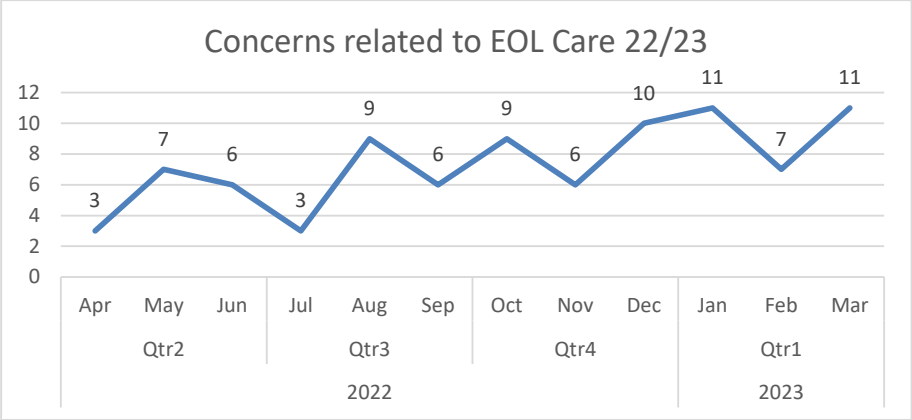


Figure 1: Concerns logged relating to EOL Care 22/23

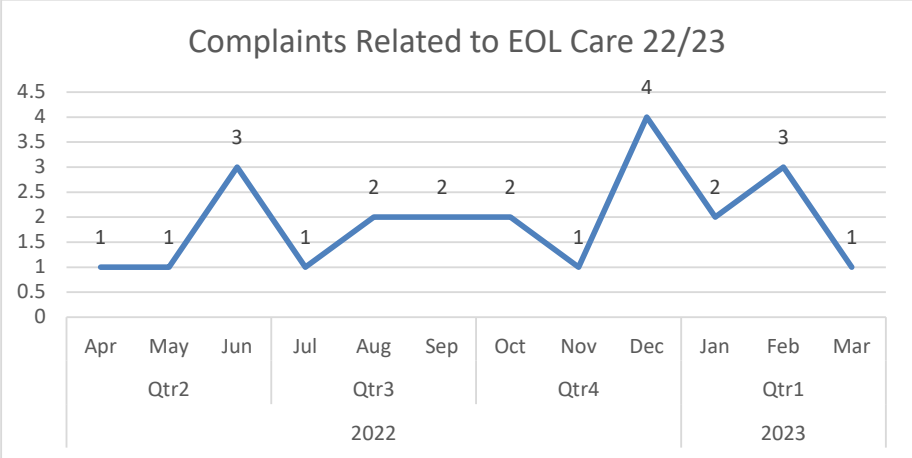


Figure 2: Complaints logged relating to EOL Care 22/23

In 2022/23 we received 23 complaints over the period of 1st April 2022 – 31st March 2023, shown in figure 1 and figure 2. Themes related to care experienced and treatment provided all of which have been investigated and responses feedback to the complainant. Where learning has been identified plans have been put in place to embed change moving forward. Of the 88 concerns raised the medical workforce had the largest concerns received with 42%. The largest themes related to communication and access to treatment.

23% of the concerns received related to the Nursing, Midwifery and Health Visiting. Themes included communication, attitude of staff and EoLC. Individual learning has taken place where required and wider learning

9.4.2 Torbay Survey for Feedback

In 2022/23 we implemented a survey aligned to the friends and family model (Palliative Care and End of Life Feedback Survey). The survey is similar to that of our local hospice and has been successfully rolled out over the past 12 months.

Key messages from patients and carers

The annual report has taken place for 2022/23:

- 664 surveys were sent out with a return rate of 12% (80)
- Of the 12% (80), 65 died within the acute trust, 6 died within the community hospital setting and a further 9 died e.g., Hospice, Care Home or home
- An average response rate is 5%-30% (SmartSurvey, 2023). Therefore, the trust response rate is suggestive of a good sample data

The next of kin were asked questions about the care received by their loved one on a scale from very satisfied to very dissatisfied.

Data shows overall most were satisfied with the service that was provided for their friends and family. As this is an independent tool it is not possible to benchmark ourselves locally or nationally to compare our findings.

The main areas of dissatisfied included:

- Lack of communication or understanding of the process of being on palliative care
- Lack of compassion or empathy

There is an ongoing rolling programme of training to focus on these findings via TEP working group and ACP work. The hope is with the introduction of the TEP pilot and its expansion we will address the concerns raised regarding communication, and the training will enhance staff's knowledge regarding compassion and empathy.

The main areas of satisfaction included:

- The importance of communication from and between staff members regarding their friend/family's care was event and mention with many positive comments
- Friends and family feeling safe
- Response to change in care needs (this remains for a second year in the very satisfied category)
- Respect for patient dignity (this remains for a second year in the very satisfied category)
- Practical assistance for patients' personal care and attention to patients' symptoms (this remains for a second year in the very satisfied category)

Fully survey results can be found in Appendix 5.

9.4.3 Family and loved one support.

We know that talking about dying, death and bereavement is not easy. In response to this we continue to provide a range of resources to help patients and their significant others to start a conversation. These resources include:

- ✓ **Memory boxes:** holds special things belonging to that person. It can help a person approach their final days with a sense of accomplishment and completeness, content and peace.
- ✓ **Support for individuals to record a message:** a message from the patient to their family, friends, we have helped patients make a collection of short videos using their phone.
- ✓ **Putting together a favourite music playlist:** onto a CD or save them to a USB memory stick.
- ✓ **Wedding planners**: The Cancer Nurse Specialist teams and Ward managers have helped to arrange short notice weddings using the use of the rose garden and day rooms
- ✓ **Visiting pets:** last days of life spent with beloved pets, bringing comfort to the patient as their last wishes are fulfilled, treasured memories of last days of life for their family & friends
- ✓ **Prompt cards:** Small cards with messages on them could include details of your favourite things. Examples include: 'I love you because...', 'Thank you for…', 'When we are not together, what I miss most about you is…', or 'Remember when…'.
- ✓ **Compassionate hearts:** started as part of the COVID-19 response support and has been continued as a support for patients and bereaved relatives.
- ✓ **Handprints:** handprints for loved ones
- ✓ **Reading Material:** supplied to support teenagers and younger children around death, illness and loss

We will continue to build on the resource and ideas to support patients and their families and friends in the last phase of their life. Funding for these initiatives relies on donations, use of trust funds and support from the Nurses League.

10.0 Spiritual Care at the End of Life

The Chaplaincy and Pastoral Care Department have continued to provide spiritual support at the end of life for those patients and their families who require it. The team are available 24/7, with an on- call service provided for out of hours and to our community hospitals. In the 12 months from April 2022 to March 2023 chaplains recorded 483 visits to patients on an end-of-life care plan, representing 12.5% of our total visits. The vast majority of these were at Torbay Hospital, with only a handful of EOL visits taking place in our community hospitals. These were spread evenly through the year, with an expected slight increase during November, December and January.

Patients were offered a variety of sacramental, prayer and emotional support, according to their needs. For some, a Chaplain simply provided a safe space to look back over their life, talk through their decisions about care or express their fears for the future. The care offered is always spiritual, but not always religious. However, they always endeavour to ensure that appropriate rites from their own tradition are provided for patients identifying with a faith community.

The best care always includes support for families and friends, as well as the patient themselves, and this remains a significant part of our work.

11.0 Staff feedback and experience on EOL

The EOL staff feedback has been an initiative in place for three years and provides staff the opportunity to give timely feedback about their experience of end-of-life care, the team, the environment, overall thoughts. Despite continued efforts to encourage staff to provide feedback the return of previous use of the post cards was low.

Staff have requested an easier way to feedback hence the low returns rate. The Postcard has now been replaced with QR Codes to aid accessibility and completion. Feedback will be shared locally and with the EOL ICO Meeting to ensure any learning or great practice can be shared and actioned accordingly.

The use of the QR code is under review as part of the 2022/23 work plan and is intended to run alongside the roll out of Palliative Care and End of Life Feedback Survey to provide focused completion and comparable data, themes and then supported actions. The 2022 NACEL audit includes a staff feedback element which is included in this year's report (Section 6.3.1).

12.0 Conclusion

The report demonstrates the breadth of work that supports end of life care across the trust and the importance of working collaboratively with several organisations, services and teams to facilitate competent and confident staff to deliver high-quality end of life care to our local population in various settings. This has been a challenging twelve months however we continue to make progress against our quality improvement priorities.

Ultimately, we have one opportunity to ensure the end-of-life experience for the individual, their family and loved ones is delivered with compassion and dignity. This includes the care of, family and loved ones during and after their bereavement.

Participating in and learning from the findings of the National Audit of Care at the End of Life across the acute and community settings recently published provides a wealth of data on what works well and where we can improve as set out in the report. To ensure that everyone has access to good quality end of life care, wherever it is accessed, being able to meet their needs is pivotal.

The Covid-19 pandemic strengthened our collaborative working with our external partners to support individuals at end of life, their families and loved ones along with our workforce. Throughout 2022/23 this collaboration has continued enhancing these relationships further.

13.0 Key Learning

The report has provided insight into the positive work that is currently taking place across the trust such as:

- The standardisation of bed-based paperwork has enhanced the care of those requiring EoLC and allows a seamless move within bed-based care.
- Review of incidents and complaints has provided rich information regarding any learning to develop EoLC for our patients.
- Recognition of the benefits of 7-day working has resulted in a want to develop the service further.

- The introduction of the TEP pilot will improve patient outcomes regarding their EoLC.
- Audits are being undertaken and action plans and learning are developed and monitored to improve patient and family outcomes throught the EOL Trust Group.
- The EOL Trust Group is monitoring TEP compliance, Syringe Pump and VoED training compliance to gain assurance on compliance.
-

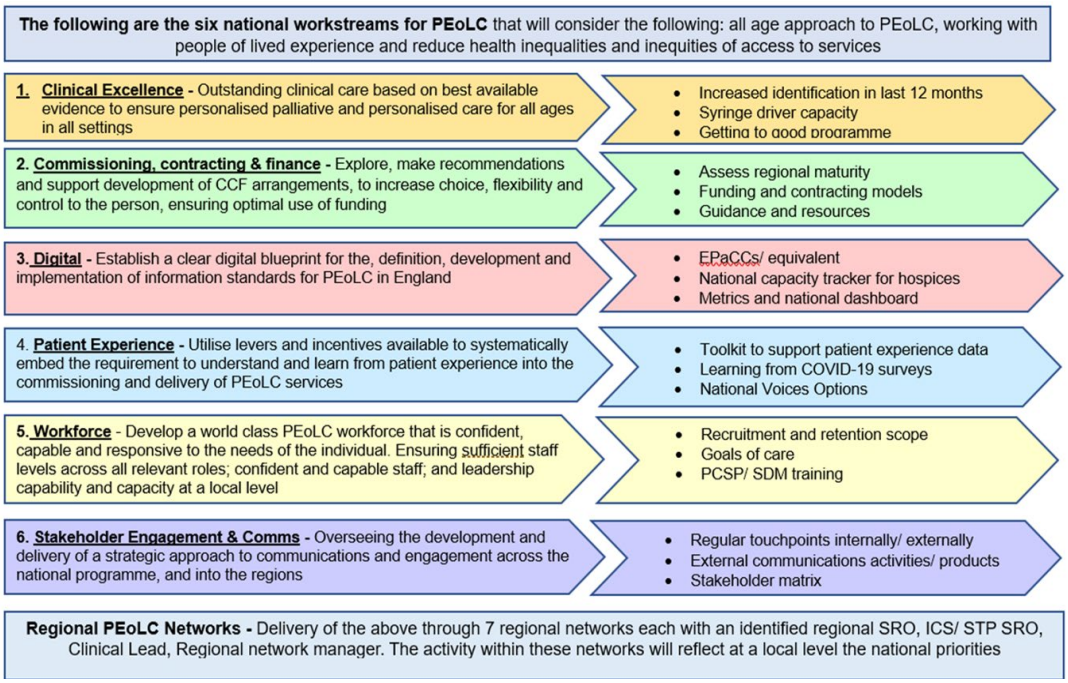
14.0 Recommendations

The Board is asked to:

- Receive the report and note the breath of end-of-life work across the trust
- Note the successful partnership built across the health and social care system
- Note the improvement work for 2023/24 planned

Appendix 1: EOL National and Regional Ambitions

National ambitions for Palliative and End of Life Care is based on 6 workstreams:



The Integrated Care System EOL care ambitions for 2021/2026 are aligned to the National Palliative and End of Life Care framework (as above) set out below:

Appendix 2: National Audit of EOL Case Review 2022/23 - Published February 2023

Audit Question	Acute Inpatient Beds %	Community Inpatient Beds %	National Average
Healthcare staff in Torbay and Community Hospitals are excellent at recognising dying early	88	88	49
Torbay and Community Hospital staff are excellent in informing families that their loved one may die	87	100	96
Communication of impending death does not occur as often with patients themselves However, patients are often confused / less awake by this stage (reason for not discussing with patients	28 51	13 75	26 64
EOL care plans are used regularly	63	88	76
Crisis medications are almost always written up indication for use not always given – no improvement from last year and their potential to cause drowsiness is not often discussed with patients	92 62 5	100 75 0	89 79 6
Healthcare staff are excellent at assessing psychosocial needs :- - Anxiety and distress - Emotional needs - Social needs but not as good at assessing spiritual / religious needs, although an improvement from last year	71 54 62 51	75 50 50 13	51 36 42 40
Healthcare staff monitor hydration and nutrition regularly during the dying process but do not always discuss risks and benefits of food and fluids	86 86 22 24	88 86 50 50	79 73 32 39
Preferred place of care not always documented	13	25	30

Appendix 3: Summary of findings Round 4 National Audit of Care at the EOL (NACEL) Family and Carer Feedback 2022/23: - Published February 2023

Audit Question	Acute Inpatient Beds % N= 14	Community Inpatient Beds % N = 3	National Average %
Most agreed or strongly agreed that they were asked about their needs, were given emotional support, although were less sure about spiritual / religious support ('not sure')	72	33	54
Most agreed they had been given enough practical support	50	67	51
Most agreed or strongly agreed they were well informed about their loved one's condition and had enough opportunity to discuss their conditions / treatment,	64	33	61
that they were involved in decision making for their loved one's care	71	67	65
that staff communicated sensitively with their loved one	79	67	68
and with themselves	93	67	76
They rated the care and support provided to their loved one as *outstanding*	7	33	24
They rated the care and support provided to their loved one as *excellent*	36	33	28
They rated the care and support provided to their loved one as *good*	57	0	20
They rated the care and support provided to their loved one as *fair*	0	0	10
They rated the care and support provided to their loved one as *poor*	0	33	2
They rated the care and support provided to their loved one as *not sure*	0	0	2
Nominated persons were asked if they felt that the hospital was the right place for their loved one to die as *strongly agree*	29	33	42
agree	50	0	31
Nominated persons were asked if they felt that the hospital was the right place for their loved one to die as *disagreed*	7	33	9
Nominated persons were asked if they felt that the hospital was the right place for their loved one to die as *neither agreed nor disagreed*	14	33	9
Their loved one died in a side room	71	100	57
Visiting restrictions in place due to Covid	57	0	44

Appendix 4: Palliative Care and End of Life Survey Analysis for 22/23

NHS
Torbay and South Devon
NHS Foundation Trust

Palliative Care and End of Life Survey Analysis

Analysis for 2022/23

The Palliative Care and End Of Life scale is intended to assess the experience of next of kin with palliative care given to patients.

Palliative Care & End of Life Survey Analysis

In the first part of the survey questionnaire, the next of kin were asked to disclose information about themselves and the patient.

Survey responders are then asked 14 questions regarding the different aspects of care, including consideration of spirituality, to measure satisfaction with service provision. Each statement is scored with options for very satisfied, satisfied, neither satisfied or dissatisfied, very dissatisfied, or not relevant.

The survey then asks for comments from the next of kin, for qualitative analysis.

Key Facts

Overall surveys distributed: 664

Overall Returns: 80

Overall response rate: 12%

Figures for each quarter:

Q1&2 (collated together):

Surveys sent out- 292

Responses- 28

Response rate- 9.5%

Q3:

Surveys sent out- 191

Responses- 15

Response rate- 7.8%

Q4:

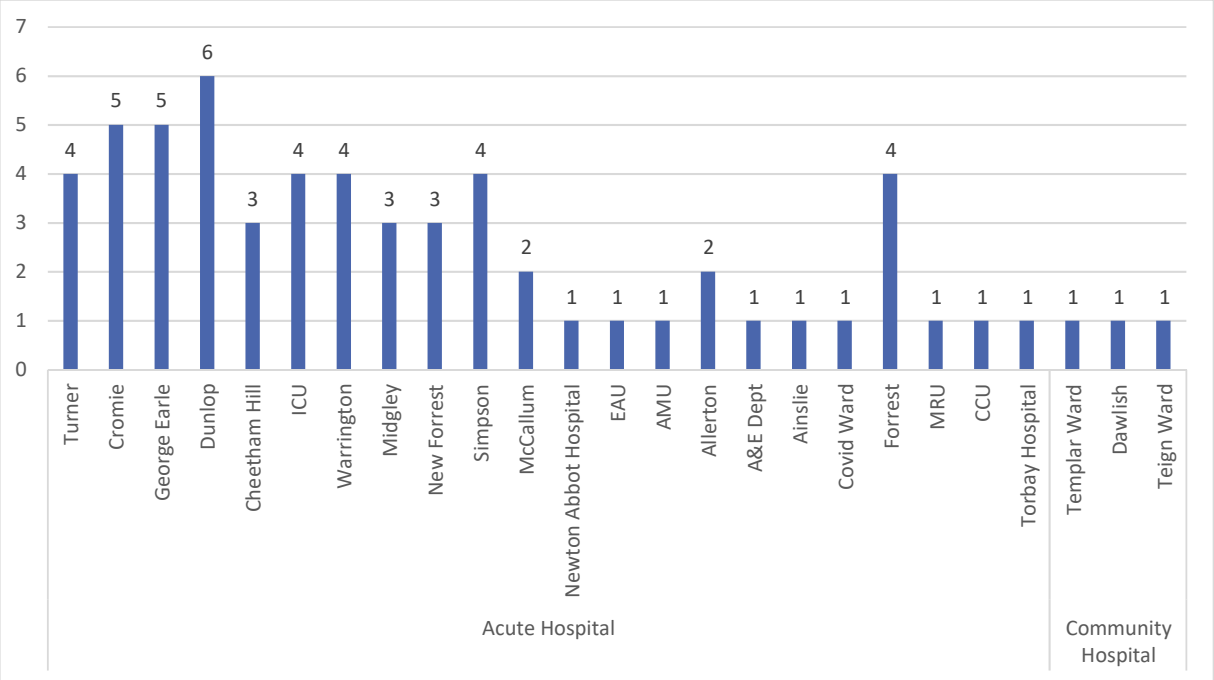
Surveys sent out- 181

Responses- 37

Response rate- 20%

Produced by The Patient Experience Team,
Torbay Hospital.

Locations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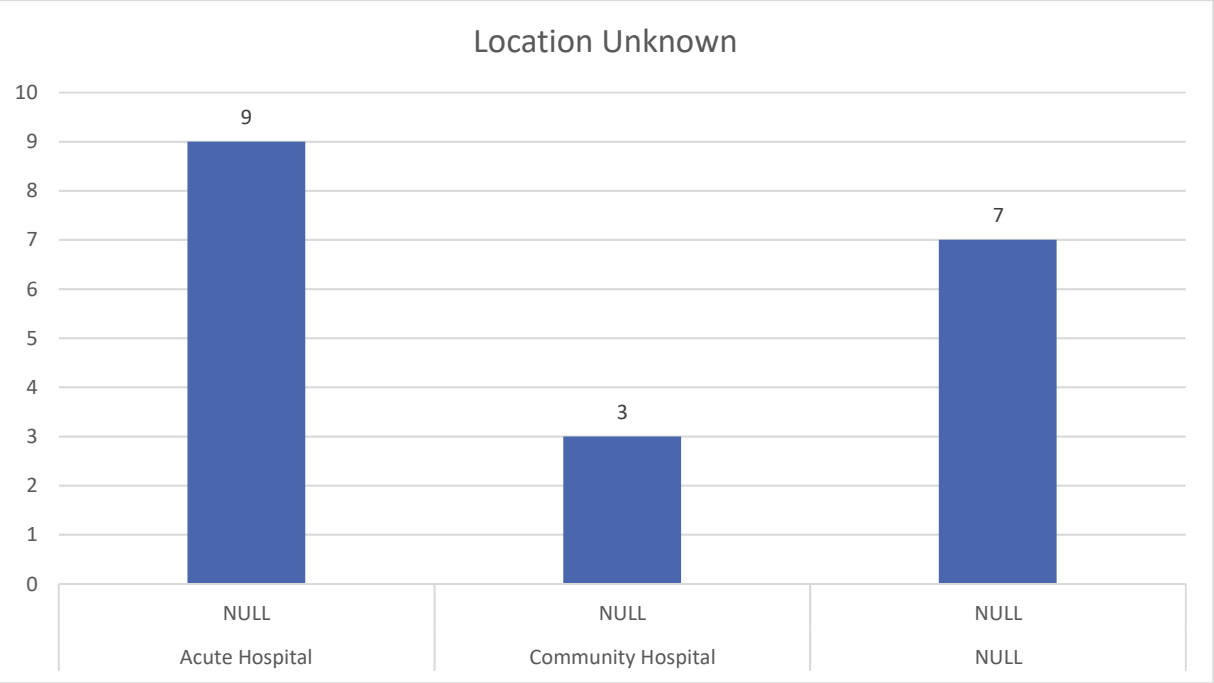
Turner
Cromie
George Earle
Dunlop
Cheetham Hill
ICU
Warrington
Midgley
New Forrest
Simpson
McCallum
Newton Abbot Hospital
EAU
AMU
Allerton
A&E Dept
Ainslie
Covid Ward
Forrest
MRU
CCU
Torbay Hospital
Templar Ward
Dawlish
Teign Ward
Acute Hospital
Community Hospital


Location Unknown
10
9
8
7
6
5
4
3
2
1
0
9
3
7
NULL
Acute Hospital
NULL
Community Hospital
NULL
NULL

Analysis:

Acute Hospital	**65**
Turner	4
NULL	7
Cromie	5
George Earle	5
Dunlop	6
Cheetham Hill	3
ICU	4
Warrington	4
Midgley	3
New Forrest	3
Forrest	3
Simpson	4
McCallum	2
Newton Abbot Hospital	1
EAU	1
AMU	1
Allerton	2
A&E Dept	1
Ainslie	1
Covid Ward	1
Forrest	1
MRU	1
CCU	1
Torbay Hospital	1
Community Hospital	**6**
NULL	3
The Stroke Ward- Newton Abbot Hospital	1
Templar Ward	1
Dawlish	1
NULL	**9**
NULL	9
Grand Total	**80**

Palliative Care & End of Life Survey Analysis

NHS
Torbay and South Devon
NHS Foundation Trust

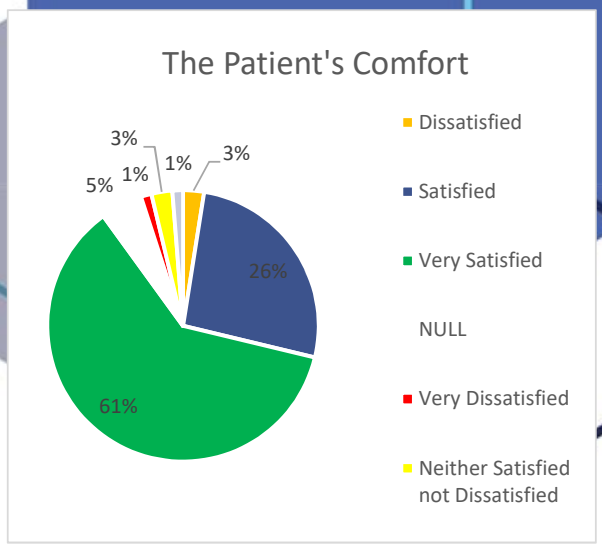
Results

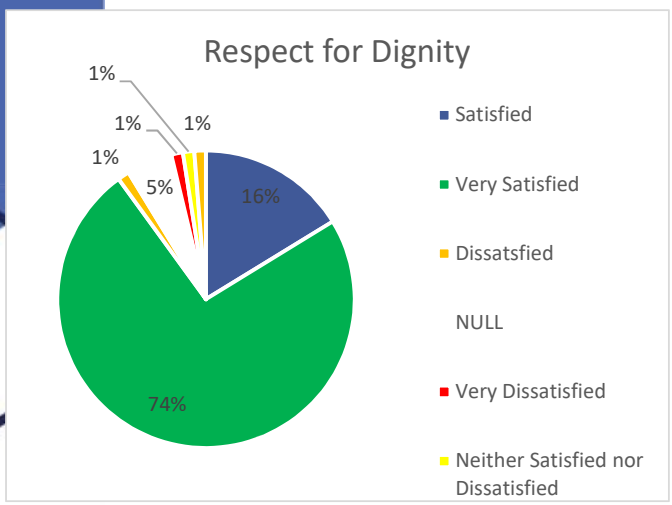
Were you satisfied with...	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied	Not Relevant to my Situation
Patient's Comfort	47	21	3	2	1	0
Respect for Patient's Dignity	59	13	1	2	1	0
Patient Feeling Safe	48	15	5	1	2	2
Family/Friends Feeling Safe	52	16	3	0	1	1
Patient's Physical Needs for Comfort	51	20	0	3	2	0
Practical Assistance to Patient with Personal Care	56	13	3	2	2	0
Discussions about Patient's Condition/ Plan of Care	47	21	2	3	3	0
Family/Friends Included in Treatment and Care Decisions	46	21	4	1	2	1
Attention to Patient's Symptoms	48	19	4	2	2	0
Management of Patient's Symptoms	48	21	1	3	3	0
Response to changes in Care Needs of Patient	50	17	3	2	4	0
Emotional Support for Patient	42	19	8	2	1	3
Emotional Support for Family	49	14	10	1	2	0

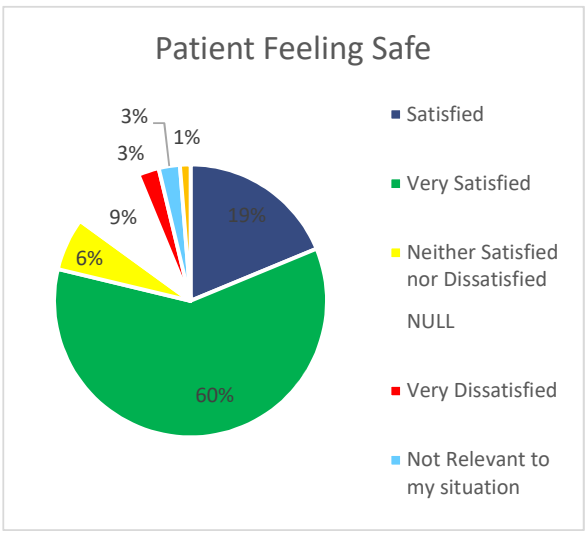
Analysis:

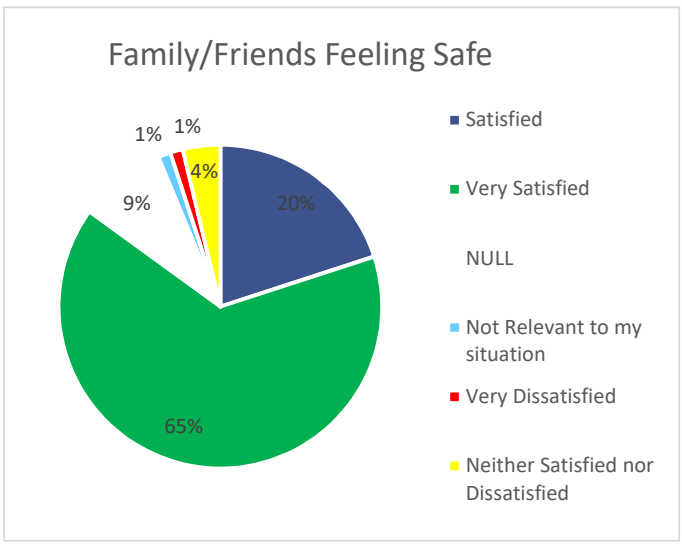
Feedback overall positive

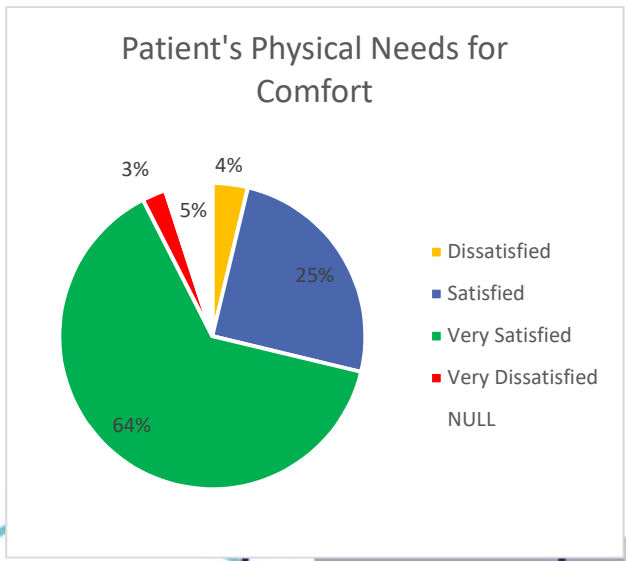
Produced by The Patient Experience Team,
Torbay Hospital.

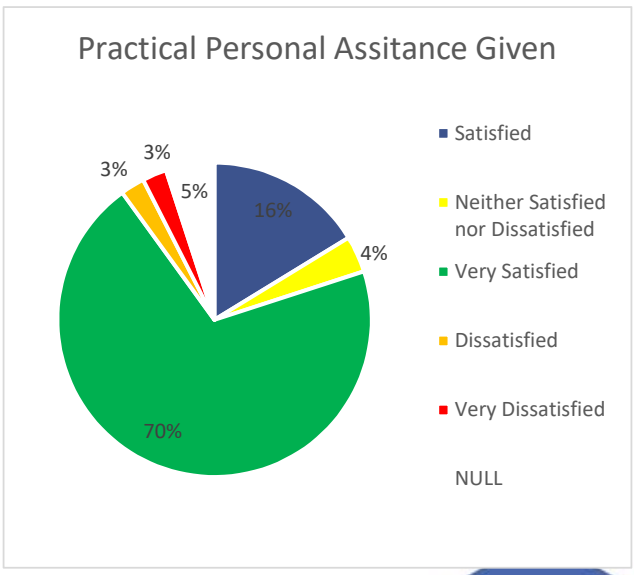

The Patient's Comfort
3%
1%
1%
3%
5%
26%
61%
Dissatisfied
Satisfied
Very Satisfied
NULL
Very Dissatisfied
Neither Satisfied not Dissatisfied


Respect for Dignity
1%
1%
1%
1%
5%
16%
74%
Satisfied
Very Satisfied
Dissatsfied
NULL
Very Dissatisfied
Neither Satisfied nor Dissatisfied


Patient Feeling Safe
3%
1%
3%
9%
6%
19%
60%
Satisfied
Very Satisfied
Neither Satisfied nor Dissatisfied
NULL
Very Dissatisfied
Not Relevant to my situation


Family/Friends Feeling Safe
1%
1%
4%
9%
20%
65%
Satisfied
Very Satisfied
NULL
Not Relevant to my situation
Very Dissatisfied
Neither Satisfied nor Dissatisfied

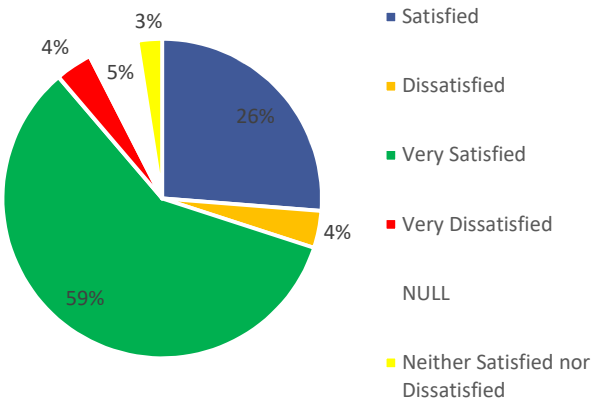

Patient's Physical Needs for Comfort
3%
4%
5%
25%
64%
Dissatisfied
Satisfied
Very Satisfied
Very Dissatisfied
NULL


Practical Personal Assitance Given
3%
3%
3%
5%
16%
4%
70%
Satisfied
Neither Satisfied nor Dissatisfied
Very Satisfied
Dissatisfied
Very Dissatisfied
NULL

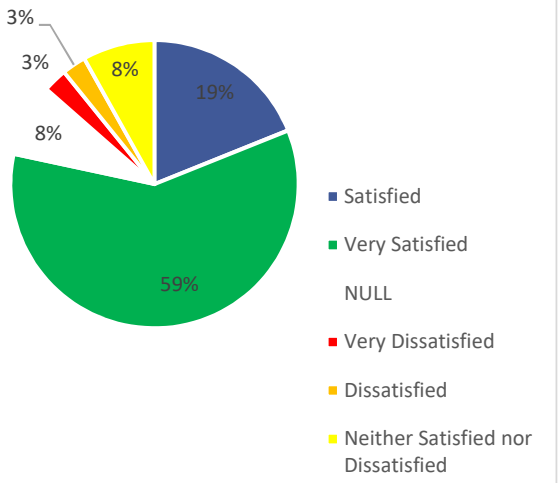
Palliative Care & End of Life Survey Analysis

Torbay and South Devon NHS Foundation Trust

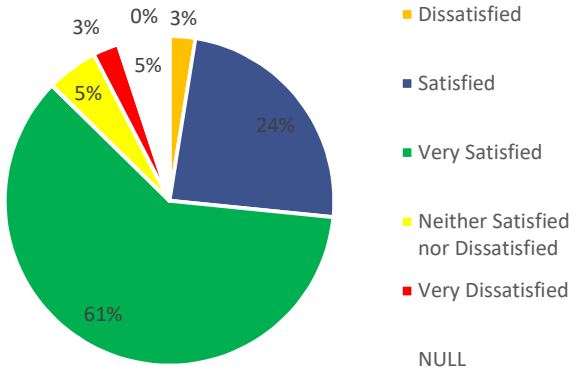
Discussions about Patient's Condition/ Plan of Care



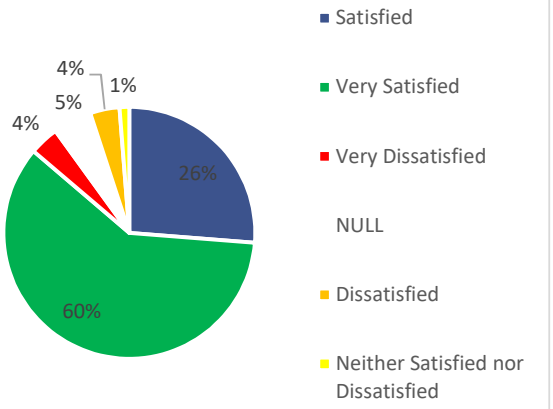
Family/Friends Included in Treatment and Care Decisions



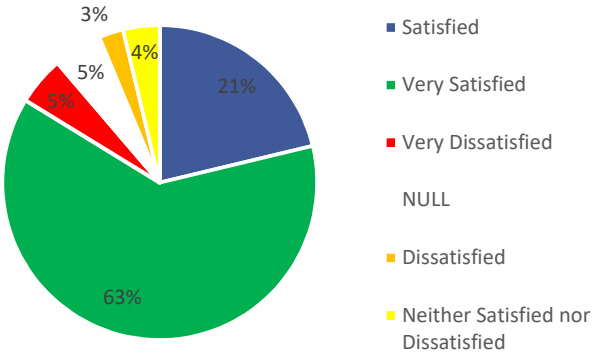
Attention to Patient's Symptoms



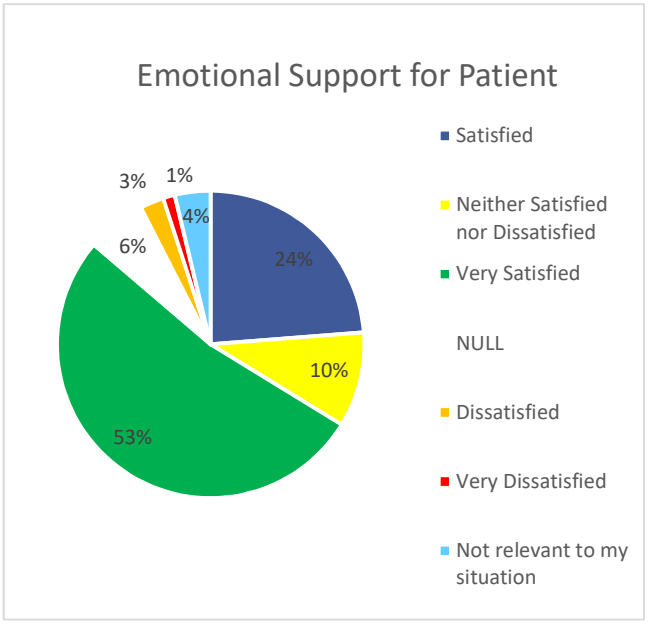
Management of Patient's Symptoms

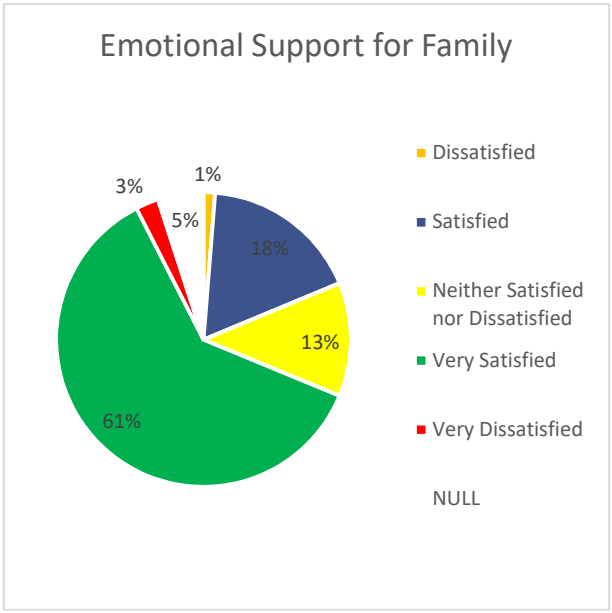


Response to changes in Care Needs of Patient

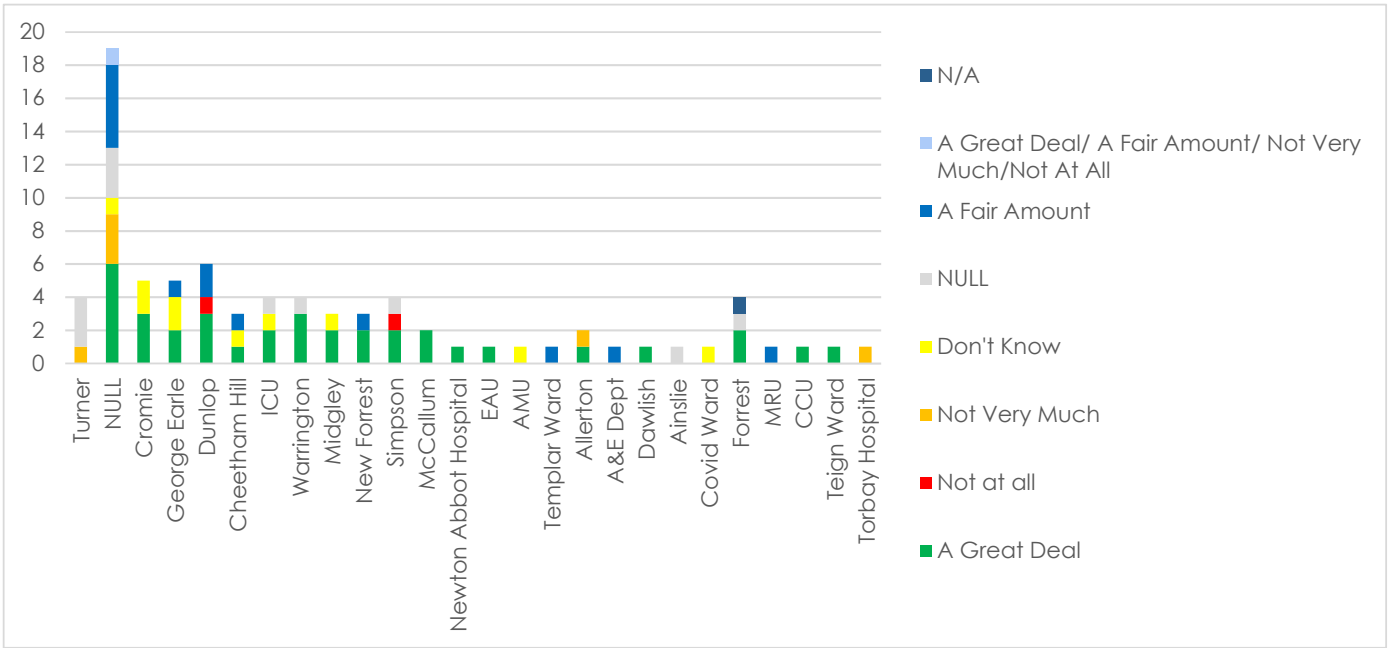


Produced by The Patient Experience Team, Torbay Hospital.





Spirituality



Analysis:

Overall positive response

Comments

The family and friends who completed the questionnaires were invited to add any comments that they wished to share. The below comments have been selected from each of the reports from Quarter 1 to 4 and relate to the most common themes of **compassion** and **communication.** Both positive and negative feedback has been included.

Please Note: Some comments have been taken from a larger source and some names have been removed.

A&E

I would like to take this opportunity to thank all concerned with my brother's treatment and care. In every department he was seen with kindness and consideration.

Allerton

Staff laughing and joking outside the room where my wife was dying.

Allerton

The whole Nursing team provided the highest level of care and support to my wife, sometimes under extreme working conditions. There is no question in my mind that these Nurses dedicated their professional lives to helping their patients.

CCU

Very caring, we found the staff helpful and caring.

Ainslie

Sister and staff on Ainslie excellent Mr. Higgins and orthopedic team excellent but ambulance and AE a difficult experience happy to discuss further.

Cheetham Hill

What I did find unacceptable was the fact that we were on a busy ward which was unavoidably very noisy

…

So, I had to take his hearing aids out and then he could not hear me

…

All end of life patients deserve peace.

AMU

Staff very helpful and thoughtfully advised us which steps to take after our friend passed away thank you.

Cromie

I and my brother would like to say a very very big thank you to all nursing staff, docs and meal people that all helped our dad and made me feel really relaxed as I was the only one down here. Thank you all. Keep up the good work you all working through hard times.

Cheetham Hill

His passing away was peaceful pain free and dignified. Thank you.

Covid Ward

We were a bit concerned that mum got taken off the OBS monitoring by the nurses without being discussed with us. Also, mum was put on nil by mouth without this being explained.

…

The end of life nurse young gentleman from palliative care was amazing and so kind.

Palliative Care & End of Life Survey Analysis

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Cromie

The care that my husband received couldn't have been any better and the staff of Cromie ward AE ambulance team were excellent showed kindness and compassion to me and my family.

Cromie

Changeover of shift occurred at 8am and in walked a surgeon (lady) who bluntly told Mum she was not prepared to operate and that she was going to die and have a horrific death in one to two days! I tried to question this and was bluntly told that she was here to speak to Mum and not me.

…

This will stay with us for the rest of our lives!

Dunlop

All my family and friends that visited over those three weeks all agree the staff were very professional and were always available to Heidi's needs.

EAU

I wrote to the hospital after Martins death to say how wonderful the affectionate care he and his family had received.

Dunlop

The Doctor Consultant which now has left Torbay Hospital was totally disrespectful of myself and wife as not giving us any information about Olives care also the Junior, was just as bad and needs training on how to speak and deal with family members.

George Earle

If I had known it was palliative care he was going to get, I would have kept him at home. I would have wanted to have had a chance to do this.

George Earle

Very pleased with care especially with Nurse Kelly on nights who sat with my late wife on her breaks. A credit to her profession.

Forrest

Amazing people amazing support.

McCallum

I was allowed to stay in the ward and I was able to help the nurse wash and change everything with my husband this was a great comfort to me and also to be with him when he died. Thank you to everyone.

ICU

The team were professional in their work with empathy.

New Forrest

The staff on the ward kept an eye on me with cups of tea etc. ensuring I was ok.

Midgley

Cups of tea and kindness do make a difference.

Simpson

Very sympathetic and supportive my thanks and gratitude to all of them.

Turner

Few instances where the patients was dealt with in what I felt to be an inappropriate manner e.g. being told not to bother asking for a bedpan, because the bed was made up with a 'bluey' totally dehumanising for a patient who was still continent and cognitive.

Teign Ward

My sister in Spain would ring the ward mobile phone and the staff would hold the phone so that my father could hear it.

Warrington

My Son and I were kept informed and lots of care too in-between other duties.

4

…ced by The Patient Experie…
Hospital.

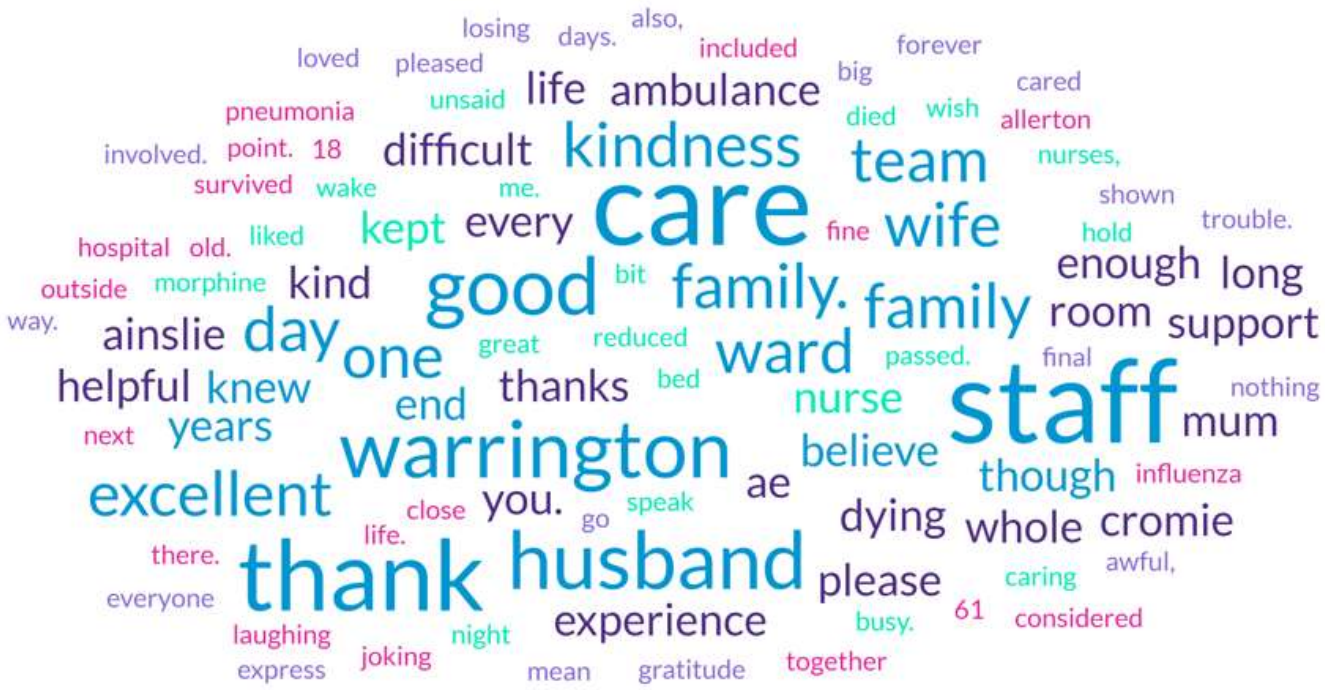
Key Themes

Positive Feedback

Overall, most were satisfied with the service that was provided for their friends and family on End of Life care. The importance of communication from and between staff members is highlighted in many positive comments.

Negative Feedback

Many Negative comments suggest feelings of lack of communication or understanding of the process of being on Palliative care. Some comments also highlight a lack of compassion or empathy.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outside
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helpful
wife
team
experience
hospital
wake
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warrington
excellent
gratitude
cared
forever
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nothing

Actions

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Update on our Culture plans: Creating a culture at work where people feel safe, healthy and supported.			Meeting date: 31 January 2024
Report appendix:	Appendix 1: Board's Culture Charter		
Report sponsor:	Chief People Officer		
Report author:	Chief People Officer		
Report provenance:	People Committee December 2023		
Description/Purpose of the report and key issues for consideration/decision:	This report provides an update on the 2 priorities of our people promise that directly impact on our culture: Priority 1: Define and deliver a consistent, compassionate and inclusive Leadership & Management approach, that is motivating, empowering and encourages accountability. This includes an update on: • progress of phase 1 delivery of embedding our compassionate leadership framework; Include, Listen, Act • an update of the care group development plan, including principles, the three areas of development focus and current progress Priority 3: Creating and embedding a culture of Inclusion. This includes updates on key actions within our plan; also within the appendix is a summary of the actions within the CQC (EDI) action plan. The date for Board development on the Compassionate Leadership approach is yet to be agreed, recommitment from the Board is sought to set a date where the only agenda item is the compassionate leadership approach. Key Messages: **Include, Listen, Act** **It Starts With Me**		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Trust Board is asked to note the update of progress on delivery of our plan to improve our culture, including CQC (EDI) action 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 priorities and deliverables of Our People Promise is the People enabling strategy for our organisational strategy and the aim is to create a culture at work where are people feel safe, healthy and supported, which is fundamental to furthering our purpose. This report updates Trust Board on our progress and planned next steps in delivering on our culture plans.		
How does the report support the Triple Aim:	In the main, this report supports all of the Triple aim elements, mostly through the underlying aim of promoting a positive experience of work- which underpins all three. 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) Risk 3547 (Upwards trend in EDI related investigations)
External standards affected by this report and associated risks	Care Quality Commission NHS People Promise and Plan National Oversight Framework

Report title: Our People Promise – progress update		Meeting date: 31 January 2024
Report sponsor	Chief People Officer	
Report author	Chief People Officer	

1.0 Introduction

A progress report against Our People Promise, including all three priorities, was provided to the People Committee in October 2023 and follow up paper in December 2023, focussing in particular on:

- Priority 1: Define and deliver a consistent, compassionate and inclusive Leadership & Management approach, that is motivating, empowering and encourages accountability- particularly in relation to the care group development
- Priority 3: Embedding a culture of inclusion

Since the leadership framework, management development plan, and culture plan were approved by Trust Board, the report following the CQC Well Led inspection has been published. The findings highlighted the importance of Our People Promise, particularly in relation to culture and EDI (must-do actions) and leadership.

2.0 Priority 1: Define and deliver a consistent, compassionate and inclusive Leadership & Management approach, that is motivating, empowering and encourages accountability

Current phase: Phase 1: Raise awareness and build capability (29 Sep 23 – 29 Mar 24)

We are over halfway through our first phase which is focusing on raising awareness and building capability through targeted communications and development interventions; particularly focused at the middle, senior and VSM management level to role model the Compassionate Leadership Approach (CLA).

2.1 Our 6 countermeasures to embed a Compassionate Leadership Approach and their key highlights and updates:

1) Co-created Compassionate Leadership framework and descriptors – **completed in 2023**

2) Recruit and onboard compassionate leaders through embedding our Compassionate Leadership Framework into our recruitment and onboarding process **– to start in April 2024**

3) Raise awareness and increase the engagement with our compassionate leadership approach to ensure everyone understands the importance of self-awareness, compassion and accountability

- **New People Promise Communications Plan** in draft with SPP and Communications Team. Next steps: relaunch communications plan containing the wider People Promise agenda

4) Enhance our leaders' and mangers' (at all levels including Board) capability through a multifaceted approach to developing knowledge and skills (informal, formal and self-directed learning)

- **Introduction to Compassionate leadership day**
  In cohort 1 (B7+ and consultants):
  >300 booked onto future sessions plus >250 have attended a session
  The course has achieved a rating of 4.48 out of 5 star review from 250 ratings
  Next steps: roll out to cohort 2 (the rest of the Trust)
- Awaiting dates for **Board Development Programme** with new COO, interim CNO and CMO in place.
  Next steps: confirm dates
- **Care Group Development** overview shared at People Committee for reference. Final draft for socialisation being drafted Jan 2024 to start in Q4 of 2024.
- **New Managers Induction** launched within expected timescales and 10 cohorts are booked in- cohort 4 is about to begin (16th January 24) and cohorts 4-6 are fully booked. 37 managers have completed the induction programme and a further 85 are booked on. Ratings to date average 4.29 out of 5 stars. Topics covered are Compassionate Leadership, People Management, Resourcing adn Recruitment, Trust wide responsibilities (Health and Safety, Finance). Inclusion and Well Being.
  Next steps: continue as a part of BAU
- **Formal and Informal Leadership and Management Development -** The role out of the Specialist Skill Sessions have been paused as underpinning management/leadership competency frameworks are developed, which are in progress. This will inform how we will develop our managers competencies, including any gaps. A plan for how we will deliver this development (including specialist skills sessions), will identify internal delivery, online resources (e.g. iManage), what we need to outsource to external providers (including existing partnership arrangements and contracts) and how we use CPD funding.
  Next steps: The competency framework will be complete in March 24 and launched with the specialist sessions from April to September 2024.

5) Develop and embed a culture of accountability where people feel able to recognise and speak up in relations to behaviour. Including methods of recognising colleagues and teams who embody the Compassionate Leadership approach

- **Development workshops** have come to an end and a final approach is being developed to share with a reference group in February.
  Next steps: Post February 2024 these will be refined into a strategy ready for March 2024 launch.

6) Develop a cohesive package of progression and talent management products for colleagues, to encourage the growth and development of our colleagues.

- **Compassionate Leadership 360 Survey** is being piloted by a few select stakeholders to check for user friendliness, effectiveness, and any system errors.

A risk around the debriefing was identified during the technical pilot. To maintain strict confidentiality, we need a process that restricts debriefer access to only 360s that they are debriefing for. Therefore, the options are either a heavily administrative process in a team with no administrative support or building a system that protects confidentiality and eliminates the heavy administrative burden. This alternative is currently being put forward for investment and scope. Next steps: confirm the debriefing process.

3.0 Priority 3: Creating and embedding a culture of Inclusion.

The delivery of our culture and inclusion plan forms an integral part of our 'must-do's' from the recent CQC report. A full action plan to address the CQC Must do, which aligns with activities within our Priorities 1 and 3 of our People Promise, exists and is being monitored. It has not been included in this update as it is a full Excel document but can be available on request.

The CQC highlighted:

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.

3.1 Countermeasures within this priority include:

- To create an environment free of discrimination, where difference and diversity is encouraged and celebrated giving people a sense of belonging and ability to perform at their best
- Creating an environment where our people are able to be healthy and well (physically and mentally) to be themselves and perform at their best
- JUST CULTURE - Introduction of Just and Learning HR polices, systems, processes and practice.
- To embed inclusion throughout the employee lifecycle: onboarding, induction, training, talent management, appraisal (via Leadership Framework Include, Listen, Act)
- To be recognised as an inclusive and equitable employer committed to ensuring our workforce reflects the community it serves and eliminates pay gaps
- To develop staff networks to gain confidence in sharing their lived experience to inform organisational decision -making and improvements and create a sense of belonging
- To create and utilise a People dashboard for TSD to understand areas requiring cultural development to improve workforce lived experience and patient safety

3.2 Summary of Progress in Delivery of Countermeasures:

3.2.1 EDI Inclusion Module Launch – It Starts With Me

The mandatory EDI inclusion module launched on 22nd January 2024 – it is mandatory training and the whole workforce are expected to complete within six months of its launch. Working with our communications team, the promotion of this module will ensure that it has maximum visibility, and nudge's people to remember that all

behavioural change ‘It Starts With Me’. The People Directorate will advocate and raise awareness of the training module and how it aligns to our People Promise delivery and complements the Compassionate Leadership framework.

This course has been tested to ensure all users can navigate the course, and all accessibility is 100% accurate, as well as testing it across a diverse range of learners. e.g. where English may not be their first language.

Impact of the module will be assessed through assessment at the beginning and end of the course. This will enable us to gather baseline data around each topic and compare if there has been an improvement in understanding at the end of the course. There will also be a free text box to enable the learner to add any further comment and will help inform improvements and the addition of new material.

A 12-month campaign, that will promote each topic, will continue to raise awareness and expand knowledge of each topic across our organisation. The aim will be to encourage teams across the trust to use the content in their delivery, using various methods from podcast to frameworks etc. ensuring consistency around language and messaging. The campaign will include the launch of the Board’s statement of commitment, Culture Charter, towards an Inclusive Culture.

In addition, ‘Culture change agents’ will be identified across the organisation; people who are passionate about Inclusion to become the much-needed allies and active bystanders, supporting and embedding the changes identified in our culture plan- bringing the changes alive throughout the Trust.

3.2.2 Restorative Just and Learning Culture

The first task and finish group has taken place around the Restorative Just and Learning Culture (RJLC) with representatives from staff side, employee relations, Medical HR and PSIRF. A priority identified by the group was the key policies: Disciplinary, Grievance, Bullying and Harassment, Acceptable Behaviour, and a review of the principles of the two polices produced by RDUH. The importance of competence and confidence of our managers, leaders, and teams in RJLC, built on the foundations of civility, respect, and psychological safety, was highlighted. The delivery of our compassionate leadership programme and managers induction are all part of these foundations.

A detailed action plan to include timelines will be developed with this task and finish group, following our JLC lead (our substantive Employee Relations Service Manager) starting in post in February 2024.

3.2.3 Flu and Covid Vaccination Programme

This year’s autumn Vaccination programme for Flu and Covid, based in the vaccination hub located in Bay View closed on 15 December 2023. At the time of writing, 45.21% of our staff (incl. bank) having been vaccinated, of which 36.20% have received both Flu and COVID. The vaccination team visit our community sites and regularly rove the hospital to provide as many staff as possible who wish to be vaccinated are able to do so.

3.2.4 Adverse Incident Support

To support our people following an adverse incident, our Clinical Health Psychology and Wellbeing teams have developed a training programme to teach senior team leads how to effectively support their teams following a critical incident. It aims to support shift leaders to feel skilled and confident in delivering debriefs following shifts and critical incidents. The training is based on critical incident stress management, a peer led approach, up to date literature and learnings from COVID. Two successful pilots have already been undertaken and the programme is now ready for a soft launch with ED and the main launch being in the spring of 2024. A more detailed update will be provided at a future People Committee.

4.0 Measuring the Delivery and Impact of Our People Promise: People Promise Dashboard

As we progress with the delivery of Our People Promise, we will be monitoring the impact through our People Promise Dashboard. The Workforce Information & ESR team are developing a visually engaging dashboard with both Lead and Lag metrics for all three priorities, providing a meaningful measurement of both the delivery and impact of our People Promise. Due to the organisational re-shaping process, this dashboard (and ESR hierarchy) had to be re-built; in addition the delay to fully introducing Tableau means that a live and final version has been delayed.

In terms of timelines, draft versions of the dashboard will have been shared with key stakeholders and a final version submitted to the next meeting of the People Committee (26th February 2024). A live version (built within Tableau) enabling Care Group Directors to interrogate the data for their area is planned by April 2024.

A group to support both understanding and acting on the data (reviewing hotspot areas and identifying relevant support, intervention) is due to be established. An initial meeting of key stakeholders is scheduled on 5th February 2024. The outputs of this group will report to the Executive Quality Committee.

5.0 Programme Delivery Risks

Priority no.	Risk	Impact	Mitigation	Risk mitigated?
1 – CLA	Lack of administration/coordination provision for the programme has led to delays of timeline of delivery and reduction of quality of some aspects of the programme. The timelines will need to be reviewed and monitored in line with this risk, or administration support identified.	Delays in timeline, reduction of impact due to slower deployment, part of CQC must dos	Internal people team support explored but unsuccessful. Redeployment explored but unsuccessful. Currently exploring establishment of non-clinical workforce development cell	No – progress at risk to delivery.
1 – CLA	Risk to booking Board Development dates – currently overdue	Delays in timeline and feedback from Intro to CLA sessions	Awaiting confirmation of date of full day Board Development Session	No – progress at risk to delivery
3 – Inclusion	Capacity within both EDI and ER Services	Delays to delivering Priority 3 actions	Additional resource has been identified to increase capacity with new roles starting Feb 24 (1 x EDI band 6, 1 x ER Band 8a, 2 x ER Band 7 in recruitment, 1 x F2SU Band 6 in recruitment)	Yes- going forward

6.0 Recommendation

The Trust Board is requested to note the update of progress in delivery of our Culture Plan- in particular priorities 1 and 3 of Our People Promise, including the CQC (EDI) action plan. The date for Board development on the Compassionate Leadership approach is yet to be agreed, recommitment from the Board is sought to set a date where the only agenda item is the compassionate leadership approach.

NHS
Torbay and South Devon
NHS Foundation Trust

Our culture charter

Our NHS values underpin not only how healthcare is provided to our patients and carers but also how we behave towards our colleagues and our people.

We are one big, diverse team, united by a desire to provide better health and care for all. Our people priority is to build a culture at work where our people feel safe, healthy and supported. Our people promise is how we work together to improve the experience of working in the NHS.

Our Board's pledge to our people*

- We do not tolerate any form of discrimination, harassment, bullying or violence
- We each have a responsibility and role to play in making the NHS a place where we all feel we belong
- We will promote a culture that fosters openess and transparency and does not tolerate unwanted, harmful and/or inappropriate behaviours

* our people includes all our staff, bank staff, contractors and students on placement

What our people can expect from us

- We lead our people and manage our processes in line with our compassionate leadership approach: we include with care, we listen with genuine curiosity, we act with courage
- We listen with respect to the voices and lived experience of colleagues, patients, and all individuals and groups who experience discrimination or lack of fair representation.
- We work together with our people to identify, reduce and remove inequalities within our organisation
- We use our influence and our voice to assist others within our local communities to address discrimination, inequality and unfairness
- We acknowledge that past action has failed to bring about the change we need to see and we recognise and are accountable for our own role in creating a fairer and more inclusive environment in and at work

Our values

Everyone counts · Commitment to quality · Improving lives
Working together for patients · Dignity and respect · Compassion

NHS
Torbay and South Devon
NHS Foundation Trust

Our culture charter

What we expect from our people

- We all recognise that people are different and value people for their difference
- We all treat people fairly, with respect and without bias
- We all take personal responsibility for our own words, behaviour and actions and understand our role in creating a fairer and more inclusive workplace
- We all challenge bullying and harassment when we see or hear it, and report concerns
- We all listen and learn from the experiences of others. We listen with care and with curiosity and are respectful of people's lived experience

What we will do together

- Through our actions, words and behaviour, we create a workplace where everyone feels safe and confident to speak up
- We work together to reduce and remove unfairness and discrimination within our communities, within the NHS and our partner organisations and within society as a whole

How to report concerns

It is important that we lead through including, listening and acting and behave in accordance with our culture charter.

If you're concerned that someone's actions are not in line with our charter or you need advice on a related issue, you can seek help from:

- your line manager and immediate team members , or your line manager's line manager
- our employee relations team
- your trade union representative or professional body
- our freedom to speak up guardian
- the occupational health, employee assistance programme, chaplaincy and other wellbeing services
- staff networks including our wellbeing buddies, the ethnic minority network, LGBTQ+ network, carers network, mental health forum, business equality forum
- mediation
- our whistleblowing policy.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board			
Report title: Freedom To Speak Up Guardian Six Monthly Report			Meeting date: 31st January 2024
Report appendix:	National Guardian Office Annual Report		
Report sponsor:	Chief People Officer		
Report author:	Lead Freedom to Speak Up Guardian		
Report provenance:	People Committee December 2023		
Description/Purpose of the report and key issues for consideration/decision:	The Freedom to Speak Up Guardian report is submitted every six months to enable the Board to maintain a good oversight of Freedom to Speak Up matters and issues.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Trust Board of Directors is asked to receive and note the Freedom To Speak Up Guardian Six Monthly Report.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	There is a direct correlation between staff satisfaction and engagement with patient safety and experience.		
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 11 – Equality, Diversity and Inclusion		
Risk: Risk ID: *As appropriate*	Held with Corporate EDI risk 3547		
External standards affected by this report and associated risks	Laws or regulations Care Quality Commission National policy, guidance		

Report title: Freedom to Speak Up Guardian Six Monthly Report	**Meeting date: 31st January 2024**
Report sponsor	Chief People Officer
Report author	Lead Freedom to Speak Up Guardian

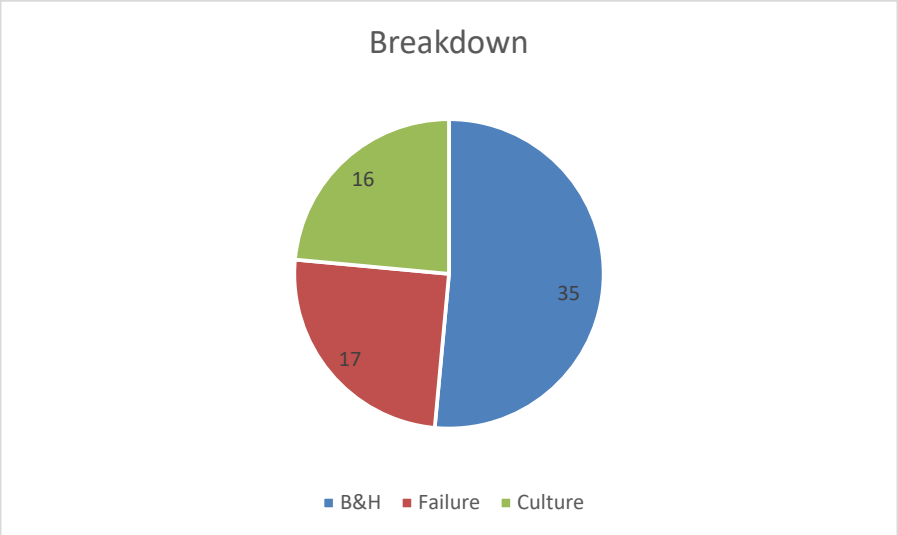
Introduction

1. Speaking up protects patients and workers, but is only effective if leaders listen up and follow up with leaders setting the tone from the top. Freedom to Speak Up is about more than the ability to raise concerns about patient safety. It is about being able to speak up about anything which gets in the way of doing a great job. That can be about ideas for improvement, ways of working or behaviours. This routine report highlights the number of Freedom to Speak Up cases that have presented in the past six months.

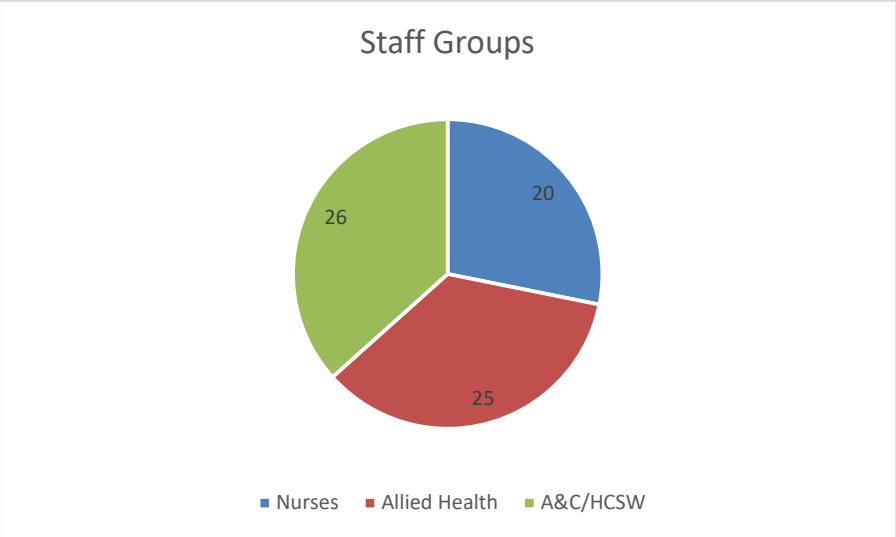
Cases

2. There has been a significant increase in concerns raised to the Freedom to Speak Up Guardian between May 23 and October 23, 83 via email and mobile phone and 41 concerns through the anonymous communication platform WorkinConfidence.

Breakdown of cases:
Bullying and Harassment – 35
Patient Safety – 4
Failure to follow process - 17
Diversity and Inclusion - 3
Staff Safety - 6
Culture of organisation – 16
Fraud – 1
Other – 1



Staff group speaking up:
Medical - 1
Nurse - 20
Midwife - 2
AHP - 25
Senior Manager - 8
HCSW/AP - 13
A&C – 13
EFM – 1
Other -0



4. The highest staff number speaking up were Allied Health Professionals, followed by Nurses, then Admin and Clerical/Additional Clinical Services.

5. Bullying and Harassment concerns including poor behaviour and breakdown in relationships remains the main reason staff make contact. The consistent theme from conversations is a lack of interest in trying to find an early resolution and managers minimizing the impact this may be having on the individual or team as a whole.

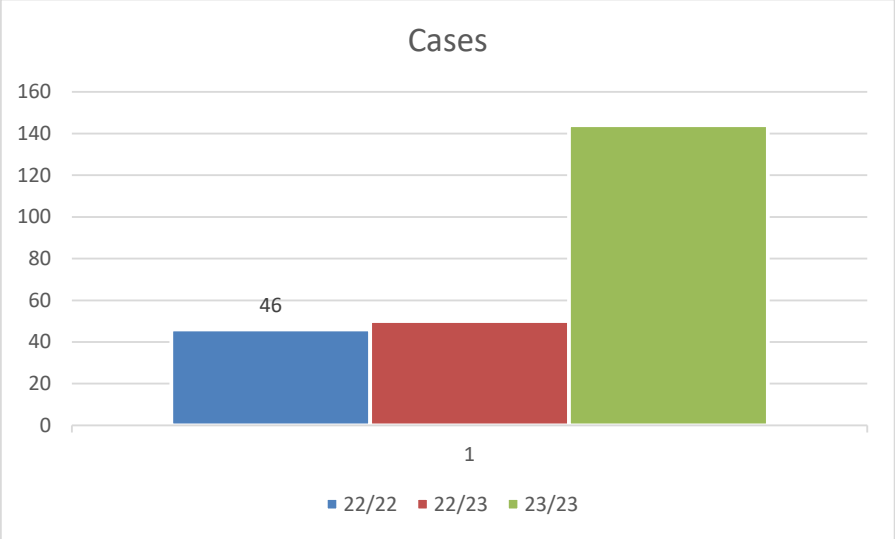
6. Failure to follow process is related to recruitment, which continues to be a consistent theme, culture of the organisation relates to slow referral to occupational health and lack of response to any concerns raised.

7. Patient safety concerns relate to inappropriate communication by Consultants and lack of provision in services. Diversity and Inclusion concerns relate to lack of support for reasonable adjustments in the workplace.

8. Staff safety refers to lack of support and communication in disciplinary and grievance processes.

Case numbers

April 22 – October 22 - 46 cases
October 22 – April 23 – 50 cases
April 23 – October 23 – 124 cases



Awareness

9. Promotional awareness of how to speak up is part of Corporate Induction including a revamped personal video and interactive session from the National Guardian Office that has to be completed by every new worker.

   Two interactive modules for Managers and Senior Leaders on listening and acting on speaking up is to be incorporated into the Compassionate Leadership programme.

10. Bespoke speak up sessions for the Preceptorship programme, International Educated Nurses F1 and F2 Induction and Health Care Support Worker Induction are now in progress. Work continues to offer these sessions to all bank and agency workers, and area which was highlighted by the CQC as a must do. A bespoke training package for the Wellbeing Buddies has been delivered with good feedback.

11. Additional awareness sessions and support has been undertaken with student nurses and clinical staff at Newton Abbot Hospital where there has been a reluctance to speak up in a timely way.

Feedback from speaking up

12. These are an example of quotes from individuals who have received support from the Freedom to Speak Up Guardian, demonstrating the positive impact of the role:

    I really can't thank you enough for all your support throughout this and encouragement to carry on. You gave me the confidence and courage to do so. Thank you so much Sarah.

    You have been such a help and constant reassurance to me over the last year, I really do appreciate it.

I very much doubt I would have done anything without your support, so thank you!

Thank you, Sarah, without all your support and help I wouldn't be in this position today.

I just wanted to say a big thank you for taking the time to meet with me last week and to actually listen to my concerns.

National Guardian Office Annual Report

13. In December 2023, the NGO Annual Report was laid before Parliament. In her forward to the report, the Parliamentary Under Secretary for Mental Health and Women's Health Strategy, Maria Caulfied MP, said:

"The events surrounding the terrible crimes of Lucy Letby are an important reminder of how vital it is for organisations to have a culture in which workers feel safe to speak up about anything that gets in the way of delivering safe and high-quality care. Managers and senior leaders must be welcoming of speaking up and be ready to listen and act on what they hear.

"Freedom to Speak Up must be at the heart of our efforts to improve the culture, leadership and wellbeing of our healthcare workers."

Assurance

14. The South West Audit and Assurance team are currently auditing the Freedom to Speak Up capability within the Trust, with the report expected by Easter. Internally, the Chief People Officer and F2SU Guardian are completing the national F2SU reflection and planning tool, due by end of January 2024, regarding the maturity of our F2SU service against national framework. The result will inform an improvement plan, as required.

15. The CQC Must Do instruction for EDI included reference to the requirement to bolster the F2SU capacity. As a result, utilsiing funding released from posts within the Transformation team, a 0.5 WTE Band 6 is being recruited for.

National Guardian
Freedom to Speak Up

Making Speaking Up business as usual

National Guardian's Office
Annual Report / April 2022 – March 2023

CP 959

National Guardian's Office

Annual Report April 2022 – March 2023

Presented to Parliament by the Parliamentary Under Secretary of State for Mental Health and Women's Health Strategy by Command of His Majesty

November 2023

CP 959

This publication is available at **www.gov.uk/official-documents.**

Any enquiries regarding this publication should be sent to us at **enquiries@nationalguardianoffice.org.uk.**

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Contents

About Freedom to Speak Up

What is Freedom to Speak Up?

In healthcare, Freedom to Speak Up is about feeling able to speak up about anything that gets in the way of doing a great job. That could be a concern about patient safety, a worry about behaviours or attitudes at work, or an idea which could improve processes or make things even better.

About us

The National Guardian's Office

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015).

These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

This Annual Report is the sixth from the National Guardian's Office, which is required to be laid before Parliament as a commitment made by the Government's response to the Gosport Independent Panel: "To further increase transparency, accountability and to promote culture change the Government has requested the National Guardian to produce an annual report to be laid before Parliament."[1]

What we do

The National Guardian's Office leads, trains and supports a network of Freedom to Speak Up guardians in England. There are over 1,000 guardians in NHS and independent sector organisations, hospices and national bodies who provide an additional way for workers to speak up when they feel that they are unable to in other ways. They also support their organisations to help address the barriers to speaking up.

The Office also provides challenge and learning to the healthcare system as a whole as part of its remit. We conduct Speak Up reviews to identify learning and support improvement of the speaking up culture of the healthcare sector.

Our vision: that speaking up is business as usual in the healthcare sector in England.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/758062/government-response-to-gosport-independent-panel-report.pdf

Ministerial Foreword

Maria Caulfield MP
Parliamentary Under Secretary of State for Mental Health and Women's Health Strategy

Embracing Freedom to Speak Up by listening to and acting on the suggestions and concerns of workers is critical for learning and improvement. The events surrounding the terrible crimes of Lucy Letby are an important reminder of how vital it is for organisations to have a culture in which workers feel safe to speak up about anything that gets in the way of delivering safe and high-quality care. Managers and senior leaders must be welcoming of speaking up and be ready to listen and act on what they hear.

It is clear from the National Guardian's annual report, which I am placing before Parliament, that Freedom to Speak Up Guardians continue to be a valuable additional route for NHS workers through which workers can speak up if they feel they cannot do so in other ways. There are now over 1,000 Freedom to Speak Up Guardians available, not just in NHS trusts, but in primary medical services, the independent sector, hospices and national bodies. I am grateful to the National Guardian, Dr Jayne Chidgey-Clark, for the leadership and support she provides for this important network.

Freedom to Speak Up Guardians have supported over 25,000 cases this year, the highest number recorded. This shows how valued and trusted they are by the workforce.

I would like to see this value replicated by their leadership as well. The independent review, commissioned by DHSC, into the leadership of health and social care organisations, led by former Vice Chief of the Defence Staff General Sir Gordon Messenger and supported by Dame Linda Pollard, Chair of Leeds Teaching Hospital Trust, found there to be a lack of consistency in leadership support for speaking up.

The Review noted: "In the NHS, we sensed a lack of psychological safety to speak up and listen, despite the excellent progress made since the Francis Report. We would observe that the Freedom to Speak Up initiative can be narrowly perceived through the lens of whistleblowing rather than also organisational improvement, and we would encourage a broader perspective."

The National Guardian's Speak Up Review of ambulance trusts made similar findings. I am pleased to support the recommendations, and to update that the recommended independent review of broader cultural matters in ambulance trusts is now underway.

Workers are our greatest asset – and they hold the key to provide us with the information we need to make the NHS the best place to work. The long-term workforce plan, developed by the NHS and backed by Government, places a renewed focus on retention. Freedom to Speak Up must be at the heart of our efforts to improve the culture, leadership and wellbeing of our healthcare workers.

Foreword

Dr Jayne Chidgey-Clark, National Guardian

This Annual Report is an opportunity for me to reflect on a year of challenges and successes.

It is an honour to lead the network of Freedom to Speak Up guardians who do so much to support workers within the healthcare sector to speak up, and to encourage their organisations to listen and follow up.

The network has grown to over 1,000 guardians supporting organisations across healthcare, from trusts, to Integrated Care Boards, primary medical services, hospices, independent sector and national bodies. This year, I have welcomed the opportunity to meet many of them face to face, whether at site visits, network meetings or at our annual Freedom to Speak Up conference for guardians.

It is ten years since Sir Robert Francis published his report into the failings at Mid Staffordshire NHS Trust, which lit the touch paper for cultural change and led to the Freedom to Speak Up Review and the recommendation of my role and that of Freedom to Speak Up guardians. This year, we bade farewell to Sir Robert as he stood down as a founding member of our Accountability and Liaison Board.

We celebrated Sir Robert's incredible legacy with a special edition of my Speak Up, Listen Up, Follow Up podcast[2] where he reflected on the impact of Freedom to Speak Up and his thoughts on priorities for the future. He spoke of the need for those who speak up to be "respected, supported and celebrated". Within this report you will find examples of the good practice which is being shared to help change the conversation of what it means to speak up in healthcare.

This year, Freedom to Speak Up guardians supported more workers than ever before. Over 25,000 cases were raised to them; that is 25,000 opportunities for leaders to learn what is getting in the way of people doing a great job; 25,000 opportunities for improvement. In a system which is stretched and under pressure, leaders need to take heed. Listening could make the difference to patient safety, worker wellbeing, staff retention, organisational risk and reputation.

The importance of Freedom to Speak Up

This year we have had stark reminders of why all efforts to improve the Speak Up culture in health, including the Freedom to Speak Up Guardian route, are so essential for patient safety.

It is chilling to think of the harm that might have been prevented and/or lives which might have been saved if colleagues felt able to raise concerns, or had been listened to and appropriate action taken swiftly when they did.

Reports from the Lucy Letby case, Donna Ockenden[3] and Bill Kirkup[4], and inquiries into University Hospitals Birmingham and others have shown why Freedom to Speak Up has never been more important.

[2]https://nationalguardian.org.uk/2022/06/09/listen-to-the-new-ngo-podcast/
[3]https://www.ockendenmaternityreview.org.uk/
[4]https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

Dr Jayne Chidgey-Clark
National Guardian for the NHS

The silence of missing voices

A quote which has been much on my mind this year is from Megan Reitz from Ashridge Business School, who spoke at this year's Freedom to Speak Up Guardian Conference: "The silence of missing voices costs careers, relationships and lives"[5]. Because for all the people who feel they can speak up, whether to their line manager, patient safety team, or their Freedom to Speak Up Guardian, I am concerned for those who still feel they cannot – that speaking up is not worth the risk.

We have begun work to understand and help remove barriers to speaking up for these people, for example, rolling out training for Freedom to Speak Up guardians working with the NHS Workforce Race Equality Standard team at NHS England.

The Freedom to Speak Up sub-score has declined from 6.5 in 2021 to 6.4 in this year's NHS Staff Survey. This fall equates to a 1.5% change. Given the size of the survey (over 600,000 workers) this equates to a declining perception of over 9,000 workers in how safe and supported they feel to speak up about anything which gets in the way of them doing their job[6]. High profile cases this year contribute to this silencing effect. These cases where people have experienced detriment for speaking up have the potential to undo much of the progress being made.

The wellbeing of workers must be paramount in order to maintain patient safety, which the recently published workforce plan acknowledges[7].

25,382 cases raised with Freedom to Speak Up guardians
(1 April 2022 to 31 March 2023).

(25% increase on the previous year).

[5]Megan Reitz & John Higgins (2019) Speak Up: say what needs to be said and hear what needs to be heard
[6]https://nationalguardian.org.uk/2023/06/08/fear-and-futility/
[7]https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

Foreword – Continued.

Working in partnership

This year, we worked with NHS England to publish the new and updated Freedom to Speak Up policy and guidance for the NHS and leaders of organisations providing NHS services. This is an opportunity for leaders to look afresh at their arrangements to assure themselves that their workers have supportive routes available to them to speak up, and that, as leaders, they are listening and acting. I am grateful to the leaders who are working hard to improve their organisation's culture in stretched and stressful circumstances. If we can get the culture right, benefits will follow, including innovation for improvement, retaining workers and making the NHS a great place to work.

For these benefits of Freedom to Speak Up to be realised, we need a whole system approach. Supportive regulatory frameworks can be a facilitator for this work. Our Speak Up review into ambulance trusts[8] identified the need for the Care Quality Commission, England's health and social care regulator, to treat workers' voices on a par with patients'. I have welcomed the opportunity to work with the Care Quality Commission on their new regulatory framework and improving the effectiveness of their assessments of the Speak Up culture in the organisations they regulate and inspect. This is especially important as regulators are the place where concerned workers go when they are desperate for action to be taken. We look to build on this work further with the Speak Up Partnership Group, which brings together regulators to facilitate a consistent approach to listening up.

Speaking Up in an evolving healthcare landscape

Looking to the future, further integration brings with it the opportunity to embed Freedom to Speak Up more fully into integrated care and primary medical services to give everyone a voice. We have seen that this culture change cannot be successful in silos – it requires a joined-up approach. As Rt Hon Patricia Hewitt said in her independent review of integrated care systems: "while structures matter, culture, leadership and behaviours matter far more"[9].

This also includes our colleagues in social care. I was disappointed that following an earlier commitment by the Government, Freedom to Speak Up in Adult Social Care is not being taken forward at this stage[10].

This report shares some of our learning. Freedom to Speak Up is more than an 'initiative', it is a social movement. Our Pan-Sector network which is made up of an ever-growing variety of organisations, illustrates that all sectors can benefit from the gift which speaking up brings, and in healthcare we have much to learn from others such as the aviation and financial industries.

All leaders must make it their mission to instil confidence in their workers to speak up. As Sir Robert said, to "feel pride, not fear" when workers want to speak up – whether that is to voice a concern, or an idea for improvement. Confidence to speak up comes from knowing that when you speak up, what you raise will be actioned appropriately. If speaking up feels futile, workers may remain silent, and we have seen too often that silence can be dangerous.

[8] https://nationalguardian.org.uk/case-review/speak-up-review-of-ambulance-trusts-in-england/

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1148568/the-hewitt-review.pdf

[10] https://www.gov.uk/government/publications/adult-social-care-system-reform-next-steps-to-put-people-at-the-heart-of-care/next-steps-to-put-people-at-the-heart-of-care

Chair

Suzanne McCarthy, Accountability and Liaison Board

I was delighted to take up my role as the first Independent Chair of the National Guardian's Office Accountability and Liaison Board in May 2023.

Effective governance is essential to ensuring the National Guardian's Office effectively supports its staff and Freedom to Speak Up guardians allowing both to continue to do excellent work.

The Accountability and Liaison Board seeks assurance and gives strategic advice to the National Guardian to promote her mission to make speaking up business as usual throughout healthcare. Members of the Board are representatives of the funding bodies of the National Guardian's Office, and it is my role as Independent Chair, unaffiliated to any of these bodies, to provide leadership to the Board, and bring together the views of each of its members.

The Board holds the National Guardian to account, but it is also a two-way street. As Independent Chair I can act as the liaison with the Board working constructively with our funding bodies.

I am very grateful to everyone for the immersive induction I have had into the role; meeting both the small and committed National Guardian's Office team and Freedom to Speak Up Guardian Network Chairs, and getting to know Jayne, the National Guardian.

My induction included time spent with a Freedom to Speak Up Guardian in a busy London trust, enabling me to gain insight into the reality of being a Freedom to Speak Up Guardian and understand how crucial this role is for patients and workers.

Suzanne McCarthy
Independent Chair of the National Guardian's Office Accountability and Liaison Board

I see Freedom to Speak Up as an essential tool for ensuring a positive organisational culture. The same is true for all who provide over-sight of their organisations – whether chairs, non-executive directors, trustees, partners, governors, or lay-members. Freedom to Speak Up can help provide the information needed to ensure our organisations are well run and our people are well supported.

I am looking forward to working with all the National Guardian's Office's stakeholders. Together we can achieve a Speak Up culture that is supported at all levels within the healthcare sector and possibly even beyond.

Overcoming fear and futility

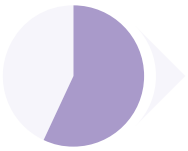
Do workers in the NHS feel safe to speak up?

71.9% ↓Drop from 75%

"I would feel secure raising concerns about unsafe clinical practice."

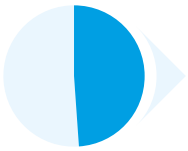
61.5% ↓Drop from 62.1%

"I feel safe to speak up about anything that concerns me in this organisation."



56.7% ↓Drop from 59.5%

"I am confident that my organisation would address my concern."



48.7% ↓Drop from 49.8%

"If I spoke up about something that concerned me I am confident my organisation would address my concern."

Source: 2022 NHS Staff Survey results[11]

Perceptions of Freedom to Speak Up guardians

59% Said there had been **an improvement in. the speaking up culture in their organisation** over the last 12 months. 12% said it had deteriorated.

66% 66% perceived the **fear of detriment** as having a noticeable or very strong impact as a barrier to workers in their organisation speaking up.

67% Identified **futility** (i.e., the concern that nothing will be done) as being a 'noticeable' or 'very strong' barrier to workers in their organisation speaking up.

This was an 8-percentage point increase compared to responses to the previous survey (58% 2021).

84% Said their organisation was **taking action to tackle barriers to speaking up.**

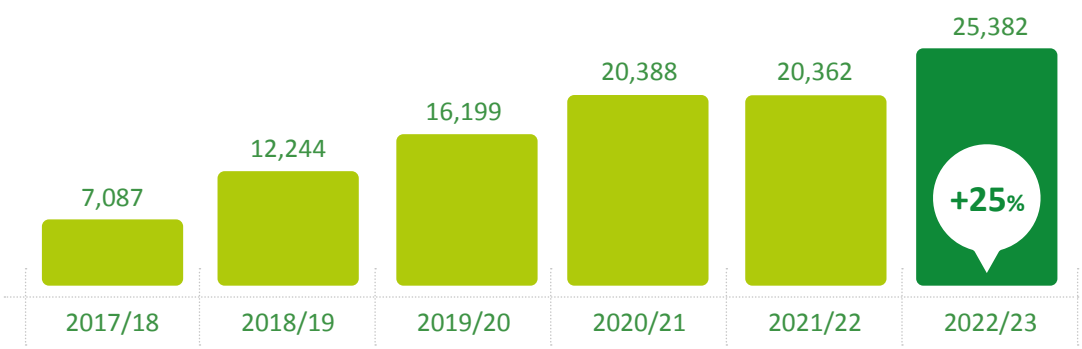
(a nine-percentage point increase compared to the previous survey's results (75%, 2021).

[11]We encourage organisations not included in the NHS Staff Survey to consider incorporating the questions asking whether people feel safe to speak up about anything, and confident that their concerns will be addressed into their own staff surveys.

Speaking up to Freedom to Speak Up guardians

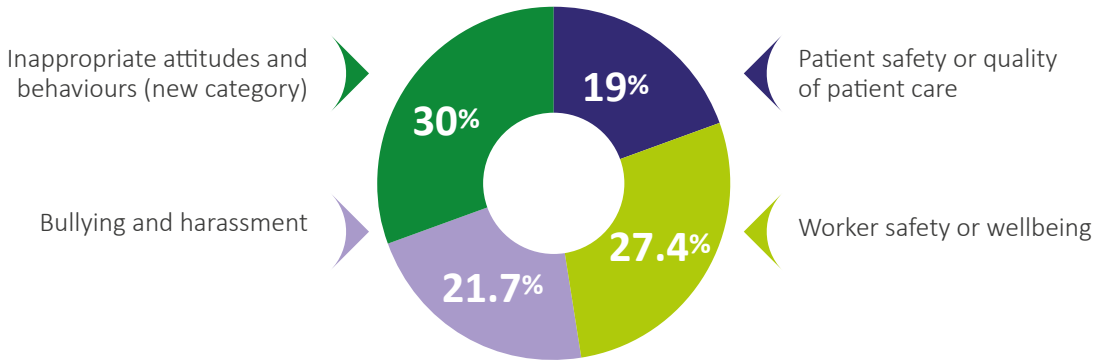
25,382 cases raised with Freedom to Speak Up guardians.

(1 April 2022 to 31 March 2023 / 25% increase on the previous year).



101,662
Total cases raised with Freedom to Speak Up guardians

What are people speaking up about to guardians?



Anonymous cases[12]

9.3%

This continues the downward trajectory from 2019, when 17.7% of cases were raised anonymously.

Detriment

3.9%

Detriment for speaking up[13] was indicated in 3.9% if cases.

Although there has been a drop in percentage given the rise in numbers, this equates to 1,000 cases.

Would you speak up again?

82.8%

Over four-fifths of those who gave feedback to their Freedom to Speak Up Guardian said they would speak up again.

[12]Anonymous cases are where the person speaking up is unwilling or feels unable to reveal their identity to you. Their identity is unknown. Where someone speaks up confidentiality, they reveal their identity to someone on the condition that it will not be disclosed further without their consent (unless legally required to do so).

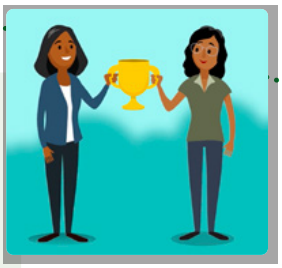
[13]Detriment refers to disadvantageous and/or demeaning treatment as a result of speaking up

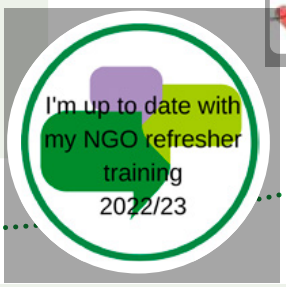
Overview of the year

1 April 2022 – 31 March 2023

Spring 2022

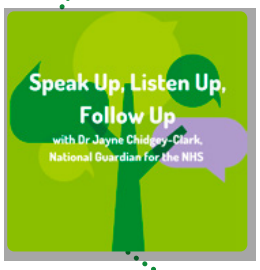
- Launch of Follow Up elearning for leaders
- Launch of Speak Up, Listen Up, Follow Up – the National Guardian's podcast
- Publication of Freedom to Speak Up Guardian survey report on supporting the wellbeing of guardians
- Publication of revised Freedom to Speak Up national policy and updated Freedom to Speak Up guidance and reflection and planning tool
- Roll out of new Foundation Training for new Freedom to Speak Up guardians and refresher training for established guardians
- Review of our governance processes, updated documents and procedures





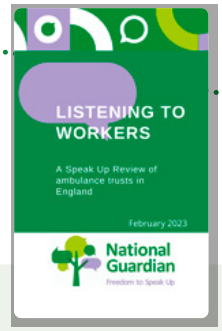
Summer 2022

- Publication of Annual Data summary – Freedom to Speak Up guardians handled 20,362 cases in 2021/22
- First mentor conversations for new guardians
- Publication of employment tribunal findings in the case of Dr Kumar v the Care Quality Commission



Autumn 2022

- Annual Speak Up Month
- Health Service Journal Awards for Freedom to Speak Up organisation of the year
- Farewell to Sir Robert Francis
- Reading the signals: Maternity and neonatal services in East Kent independent investigation report by Dr Bill Kirkup published



Winter 2022/2023

- Speak Up review of ambulance trusts
- Reviews into the culture at University Hospitals Birmingham NHS Trust begun
- National Guardian's Office Freedom to Speak Up Conference
- New 3-year Memorandum of Understanding agreed. This sets out funding and governance arrangements with our funding bodies.

Delivery of our Strategic Framework

Our mission to make speaking up business as usual is ambitious. Our Strategic Framework sets out the intention of the National Guardian's Office to obtain greater assurance about speaking up cultures and the quality and consistency of how the Freedom to Speak Up Guardian role is implemented.

We themed our strategic framework into four core pillars of support: **workers; Freedom to Speak Up guardians; leadership;** and the **healthcare system**. This Annual Report shares the 12 outcomes we have sought to achieve in our work programme in 2022/23.

Workers

- There will be a more consistent understanding of speaking up and how it can support learning and improvement through consistent championing of speaking up messages
- The voice of workers will be reflected in speaking up reviews to promote learning and improvement across the system
- Protection of those who speak up will be furthered through engaging with partners
- Worker's knowledge of, and ability to, speak up will be improved by providing training tools for workers and leaders

Freedom to Speak Up Guardians

- The training, guidance and support we provide Freedom to Speak Up guardians will be improved by the regular review of this material
- There will be greater assurance of the quality and consistency in the Freedom to Speak Up Guardian role through enhancements to the National Guardian's Office's registration and training processes
- There will be clear expectations for the Freedom to Speak Up Guardian role from the development of standards and improved quality assurance mechanisms

Healthcare System

- Universal principles for speaking up will be promoted
- Speaking up culture will be more easily understood through the establishment of a consistent set of metrics at the organisational, system, and national level
- A more consistent and supportive response when workers speak up will be developed through bringing national bodies together to develop consistent, coherent and complementary processes

Leadership

- Leaders will be more able to improve their speaking up culture as a result of the supportive guidance and training tools we offer
- Good practice will be identified and informed through the improved use of data and intelligence

Workers

Strategic aim: to champion and support workers to speak up

Overcoming fear and futility

We want everyone who works in healthcare to feel safe and supported when they speak up. Yet too many workers still do not feel they can speak up about anything which gets in the way of them doing their job.

For these people, the potential risks of speaking up do not outweigh the benefits. They may feel nothing changes when they do speak up or they fear experiencing negative consequences if they do.

We are working in partnership across the healthcare system to overcome these barriers of fear and futility to make speaking up business as usual.

One of our key aims is to ensure all workers have knowledge of, and ability to, speak up, with training and tools for workers and leaders We also publish 100 Voices stories on our website where people have spoken up, and the positive change which has happened as a result.

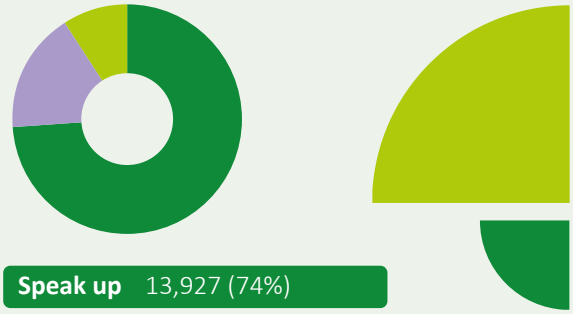
Supporting workers with knowledge of how to speak up

The Freedom to Speak Up eLearning package which we developed with Health Education England has now been rolled out across the country, with many organisations making the training mandatory.

This eLearning is divided into three modules – 'Speak Up, Listen Up, Follow Up'. It helps learners understand the vital role they can play in a healthy speaking up culture which protects patient safety and enhances worker experience.

13,927

Workers completed the speak up module on the elearning to health platform, with many more completing it within their organisations.



Speak up 13,927 (74%)

Listen up 3,085 (17%)

Follow up 1,7495 (9%)

Training completions on the elearning for health platform.

1,719

People made Speak Up Pledges on our website following the training.

"To make time to actively listen to anyone who tells me they need to talk; to thank them, and to take action to help create a safe, high trust environment for everybody."

Director of People, Engagement & Performance

"To ensure that I give the opportunity to staff to speak up as part of their regular 1:1 supervision sessions."

Physiotherapist

"I pledge to be a listening ear, source of direction and advocate those who need it. I will say "thank you" and not make the person feel stupid or belittled when they wish to tell me."

Staff Nurse

"I now feel confident enough to speak up if the need arises without hesitation."

Medical Laboratory Assistant

"I will always speak up, to make not only the workplace but the world a better place. I will support my peers in speaking up and help in any way that I can, we are stronger together and can really make change happen!"

Team Administrator

"My pledge is to always listen for what is being and not being said from colleagues and to always been caring and supportive."

OD Facilitator

"I will aim to overcome barriers and find the correct person to talk to if I have any concerns."

Physiotherapist

"My pledge is that I will not shrink from making my manager aware of unfair treatment of colleagues and service users; nor from unhealthy and unhygienic handling of patients' feeding facilities."

Healthcare Assistant

"I pledge to speak up not just for myself for everybody who needs to be heard. I will use my voice to encourage and motivate everyone to speak and reach out. It is okay to speak out and there are many to help and support."

Nurse

"To be accessible to all staff where possible, listen to their views and use these views as potential intelligence for improvement.

To let staff know what has happened as a result of sharing their views with me."

Non-Executive Director

Workers – Continued.

100 Voices story: **Incivility in the workplace**

A worker raised concerns with Sylvia Gomes, the Freedom to Speak Up Guardian at East and North Hertfordshire NHS Trust, describing incivility they experienced during procedures. These were specialised procedures carried out by highly skilled interventionists with the support of a multidisciplinary team.

Sylvia met with the manager and team leaders to better understand the experiences of the team as a whole. It became clear that the multidisciplinary team frequently experienced incivility during procedures. Examples included sarcastic remarks, rudeness, sharp and overly critical comments, rolling of eyes, tutting. This behaviour was not consistent and there were many occasions when the same professionals would be kind and professional.

To assess the level of incivility being experienced, Sylvia invited all the multidisciplinary team members, including the interventionists, to complete an anonymous survey on workplace incivility.

This survey results showed that 70% of respondents had either experienced or witnessed incivility. Team members shared that they felt anxious and reported poor psychological safety within the team. This highlighted that incivility was increasing patient safety risk as it increased fears of speaking up. This was escalated to the Trust patient safety team.

The survey response was also shared with the interventionists, and a senior member of the patient safety team met with them and shared the Trust's kindness and civility matters video (https://www.youtube.com/watch?v=o6apzHxts-Y), facilitating a reflective discussion. They agreed a change in behaviour, to a more civil and kind approach.

While there was some improvement, this had limited impact and behaviour was not consistently in line with Trust values to Include, Respect and Improve. This absence of meaningful change resulted in Sylvia escalating the concerns about incivility to the Trust executives responsible for patient safety including the Chief Nurse, Medical Director and CEO.

Sylvia Gomes
Freedom to Speak Up Guardian, East and North Hertfordshire NHS Trust

The Responsible Officer informed the interventionists of expected standards of behaviour and the likely impact of not meeting these standards. This message from all levels of leadership within the Trust, including executives, that incivility is unacceptable played a crucial role in changing behaviours which resulted in meaningful change that continues to be sustained.

Teams that experience incivility need additional support to rebuild psychological safety over several months.

As the interventionists' behaviour changed, the team leaders worked on improving the multidisciplinary team members' confidence by giving them opportunities to lead pre- procedure briefings with support. The team leader role for each room was implemented within the allied health care professional team which improved team working and gave team members leadership and management skills, increasing their confidence to challenge. Team members reported improvement in work environment and reduction in anxiety.

Sylvia said: "Whilst the incivility reported was a mild form of poor behaviour, because of its impact on patient safety and worker wellbeing, it could not be ignored.

"Workers who experience or witnessed incivility are less likely to Speak Up. It is therefore important when a concern regarding incivility is raised, it is taken seriously and explored further as it is likely to be affecting more than one individual.

"When dealing with complex issues, it is vital that the right people with authority and influence are involved as this drives action for change."

Raising awareness

We aim to ensure there is a consistent understanding of speaking up and how it can support learning and improvement, through raising awareness of the importance of speaking up and the benefits that Freedom to Speak Up can bring.

The National Guardian is an independent voice, championing workers to speak up. We raise awareness and challenge leadership and the healthcare system by engaging with national bodies, speaking to the media and appearing as a guest speaker at events and conferences.

1,186
Podcast listens

This year we launched a podcast channel to bring Freedom to Speak Up to a new audience. The National Guardian talked to leaders from across health and care about what Freedom to Speak Up means to them. We created 11 episodes with 194 minutes of new content.

111,721
Find my guardian page views

Our website provides information for workers, resources for Freedom to Speak Up guardians and resources and data for leaders and system partners.

Workers can use the website to find their local Freedom to Speak Up Guardian. This year the find my guardian tool has been used over 100 thousand times.

Speak Up Month

Our annual Speak Up Month, held in October, is an opportunity for Freedom to Speak Up guardians to raise awareness locally and for the National Guardian's Office to do so nationally.

The theme for our fifth Speak Up Month in 2022 was "Freedom to Speak Up for Everyone". Each week we highlighted key themes and the impact which speaking up can bring for patient safety, inclusion and worker wellbeing.

We shared blogs, videos and four podcasts exploring the themes, and our social media channels turned green as people across the sector took part in Wear Green Wednesdays to show their visible support of Freedom to Speak Up.

Workers – Continued.

Listening to workers – Speak Up Review of Ambulance Trusts

The voices of workers are central to our Speak Up Reviews, where we seek to identify learning, recognise innovation and support improvement in the speak up culture of the healthcare sector.

Stories about poor culture in ambulance trusts have been well documented in the media. We proposed this review in response to consistent findings that the speaking up culture in NHS ambulance trusts appeared to be more challenged compared to other NHS trust types.

During our review, we heard from workers, ex-workers, managers and senior leaders that fear of consequence was a main barrier to speaking up.

Culture of silence

We heard from workers that the culture in ambulance trusts was having a negative impact on their ability to speak up. We heard about experiences of bullying, harassment and discrimination and a culture of silence where workers would often not speak up, and concerns were often unheard. When people told us about their experiences of speaking up, we heard a range of ways that people had suffered detriment as a result.

We made four recommendations in this Speak Up Review and chair the implementation group made up of colleagues from Department of Health and Social Care, NHS England, Care Quality Commission and Association of Ambulance Chief Executives to ensure follow through with recommendations. One of our recommendations was for an independent cultural review to look at broader cultural matters in ambulance trusts, with Ministerial oversight. We are pleased that this review, led by NHS England, is now underway. The National Guardian is conducting board development sessions for each ambulance trust in England and we look forward to supporting ambulance trusts in their learning and improvement journey.

> “People are too scared to say, ‘that’s not right’ because of potential consequences.”
>
> **– Worker**

Case Study: **East of England Ambulance Service**

Janice Scott joined the East of England Ambulance Service trust as the Lead Guardian in 2020, at a time when the executive leadership team had acknowledged there were deep-rooted issues within the service, following a CQC inspection. The number of concerns raised increased by approximately 90% within the first reporting quarter and she spent her first year actively listening and speaking to staff about their experiences.

Within three years of the full time Guardian starting, the trust had one of the most overall improved scores for the speaking up questions in the NHS Staff survey.

"This is a result of commitment from staff, volunteers and the executive leadership team" said Janice. "When you are faced with a culture of distrust and fear based on workers' previous negative experiences of speaking up and an environment where bullying and harassment was the norm, you have to go back to the basic principles of engagement. At EEAST, this meant committing to physically visiting as many of the 120 sites and stations to talk to staff and volunteers, whether that be the early hours in the morning, during lunch breaks or late at night. It meant meeting with managers to understand their frustrations and successes. More importantly, it meant holding honest, realistic and sometimes painful conversations with workers and managers."

This work has been led by the Executive and Non-Executive Freedom to Speak Up leads who, together with the rest of the Board and the executive, have taken ownership of the cultural problems within EEAST. Their focus was on the potential irreparable negative consequences for workers of not tackling the challenges head-on.

The Lead Guardian feels encouraged and supported by the leadership team and has regular meetings to discuss themes and barriers to resolving concerns. This work has highlighted issues such as timely employee relations case handling and lengthy suspension times. Ensuring that core HR systems and processes worked effectively helped to build staff confidence.

Janice Scott
Lead Freedom to Speak Up Guardian

Janice also presents a quarterly board report which shares the speak up data along with the current themes and patterns. She recently delivered a board development session on workers' fear of suffering detriment for speaking up, which led to innovative solutions which are currently being implemented.

The trust also developed a "Raising Concerns Forum" which collates and triangulates data from Freedom to Speak Up, employee relation cases, sickness and leavers data to identify themes, emerging issues, hot spots and potentially high-risk issues to patient and/or staff safety.

A number of the recommendations from the National Guardian's Office Speak Up Review of ambulance trusts[14], have already been implemented in the trust. This included making the three speak up training modules mandatory, the recruitment of 3 full time Guardians through open, fair and transparent processes and the recruitment of ambassadors to further extend the reach of Freedom to Speak Up.

Tom Abell, CEO and Executive Lead for Freedom to Speak Up said: "This has fostered a sense of unity within the trust, where staff feel able to voice their ideas, challenges, and concerns, without fear of negative consequences or overall inaction. We recognise and celebrate our achievements but know we still have a way to go, particularly with reducing the fear of detriment when speaking up."

As a result of this improved culture, the staff attrition rate has turned around, so that between 2021 and 2022 there was more than a 30% drop in staff leaving the trust in the same year they joined.

[14] "Listening to Workers" review of speaking up in an ambulance service

Freedom to Speak Up Guardians

Strategic aim: To enhance the Freedom to Speak Up Guardian role

1,006 **Total number of guardians**

Trusts	396
Independent Provider	258
Hospice	93
Primary Medical Services	93
National Body	78
ICS/ICB	39
Other	42

An evolving network

The Freedom to Speak Up Guardian role is complex, and the landscape in which they operate is constantly evolving. The network has grown from just 200 guardians in NHS Trusts in 2017 to over 1,000 guardians supporting a wide range of organisations.

This year, Freedom to Speak Up guardians handled a record number of cases which highlights how trusted guardians are as a valuable additional route to speaking up. It is clear that the role is valued by workers- over four-fifths (82.8%) of those who gave feedback to their Freedom to Speak Up Guardian said they would speak up again. It is essential that all leaders recognise its importance, and that all provide sufficient time and resources for their guardians to meet the demand of this unique and far-reaching role.

Our survey of Freedom to Speak Up guardians revealed the impact which insufficient protected time has, both on the execution of the role and the Freedom to Speak Up culture, as well as on guardian wellbeing.

Just over half of guardians who responded to our survey felt they had enough time to carry out their Freedom to Speak Up Guardian role. In addition to supporting workers who speak up, guardians also need time for the proactive part of their role, identifying and tackling barriers to speaking up. Yet half of guardians spent the majority of their time responding to workers. This is perhaps a reflection on the increased number of cases being raised to them and reinforces the need for leaders to review the time and resources for the role to ensure guardians can undertake its proactive elements as well as reactive. Guardians told us this is having an impact on their wellbeing, and they feel that they are not always meeting the needs of the workforce.

Some of the cases which guardians hear are complex and emotional; people may be feeling angry and distressed. Sometimes there are complex mental health issues involved, feelings of suicide, experiences of sexual harassment. Clinical supervision and adequate support is essential.

54%
Have enough time to do their guardian role

48%
Majority of time responding to workers

65%
Feel they are meeting the needs of the workforce

44%
Said the role had reduced their health and wellbeing

Source: 2023 Freedom to Speak Up Guardian Survey

108 Support calls held for Freedom to Speak Up guardians

Themes*

- **38** Case support
- **25** Freedom to Speak Up Guardian role clarity
- **38** Support in role
- **13** Data
- **7** Detriment
- **4** Wellbeing

*Some calls include multiple themes

Despite these challenges, eight out of ten guardians who responded said they would recommend the role to a friend or colleague.

"I feel satisfied that I am helping others, especially when they have no one else to turn to. The job can be difficult and draining sometimes but knowing that people can come to us for support makes it worthwhile."

Freedom to Speak Up Guardian

Freedom to Speak Up Guardians – Continued.

Bringing guardians together for networking and shared learning

For the first time since the pandemic, we were able to meet in person for our annual Freedom to Speak Up Conference.

Held in London, but with the ability to join virtually, over 300 people attending live, with many more able to watch the recordings of the conference if they were unable to join on the day.

In addition, we held three Communities of Practice sessions. Freedom to Speak Up guardians came together with common problems, explored ways of working and shared ideas, promoting good practice. These were attended by 76 guardians attending over 3 dates.

Following the BBC Panorama programme – Undercover Hospital – we held two roundtables with Freedom to Speak Up guardians supporting mental health trusts. These sessions explored the challenges they face in their setting and were an opportunity to share practice and experiences. The NHSE Clinical Director for Mental Health, Claire Murdoch, joined for one session to listen to Freedom to Speak Up guardians feedback.

My journey from mental health nurse to Guardian

Leeds and York Partnership Foundation Trust (LYPFT) is the main provider of mental health, learning disability and neurodiversity services in Leeds, as well as more specialist services across the North of England. I became their first Freedom to Speak Up Guardian in October 2017 because I felt I could make a difference and help people safely raise matters.

I started my NHS career in mental health nursing as a staff nurse in our rehabilitation and recovery services after qualifying in 1998. I then progressed to roles in different settings including a forensic mental health team and experience in a private medium secure hospital and by 2015 I had worked my way up to be the Bed Manager.

One of my first tasks as a Guardian was to raise awareness of how I could help people. I needed to encourage them to put their trust and faith in me.

Making sure I reached all staff including bank, agency, contractors and other seldom heard colleagues was a huge job. Engagement is key, and working closely with our Communication Team helped me to promote myself and my role when it was brand new. We did this through displays in clinical services, drop in events, blogs, and also some more informal use of Twitter. Our staff networks have been invaluable, providing a rich insight from different perspectives.

Within mental health services there are units which by their very nature are closed access. This can be a concern that negative 'closed cultures' develop. Because of the integrity of my experience as a long-standing member of staff at LYPFT, and the trust I have built up, I have open access to these units, so that I can visit freely and am available to all workers to speak up to.

John Verity
Outgoing Freedom to Speak Up Guardian at Leeds and York Partnership NHS Foundation Trust

As with most roles within the NHS, good quality supervision is a core requirement as some of the concerns can be very effecting. I have high levels of support from the Trust Board Chair, Chief Executive and Chief Operating Officer. LYPFT were also able to provide a psychologist to offer regular supervision to the regional network too.

We have appointed five Freedom to Speak Up Ambassadors. These are voluntary roles and are fulfilled by a mixture of clinical and non clinical colleagues alongside their day jobs. They contribute to creating a culture of speaking up where all staff feel safe and confident to raise concerns.

Our core values are Caring, Simplicity and Integrity, and throughout my career and extended through the Guardian role these are always upheld with civility, dignity and respect for any colleagues raising concerns. Speaking up leads to improvements, and at all times I have remained solution-focused. Anyone raising a concern has always been thanked for speaking up.

Together we've managed over 320 concerns since I came into post in 2017. I'd like to think that's 320 people we've helped find support for a problem they couldn't solve on their own.

Freedom to Speak Up Guardians – Continued.

Greater assurance of Freedom to Speak Up Guardian Training

As the Freedom to Speak Up Guardian network develops, we are seeing an increased professionalisation in the role. There are movements in terms of investment in time and banding, however, we would like to see this considered more consistently across the sector.

One of our strategic aims is to gain greater assurance of the quality and consistency of the performance of those in a Freedom to Speak Up Guardian role, through enhancements to our training and registration processes.

Freedom to Speak Up guardians are employed by the organisation they support, either directly or indirectly. In order to be placed on the National Guardian's Office directory, they are required to complete our training.

The training is in two parts – Foundation training delivered by elearning modules, followed by a reflective conversation with a Freedom to Speak Up Guardian mentor.

Mentors

Volunteer Freedom to Speak Up Guardian Mentors are experienced guardians who help newly appointed Freedom to Speak Up guardians reflect on their experience, helping them to identify any learning and support needs through discussion and guidance as they progress in their role.

24
Freedom to Speak Up Guardian Mentors

108
New Freedom to Speak Up guardians supported

Annual Refresher Training

To give assurance that all guardians were trained to the same level of knowledge and understanding of the expectations of this unique and far-reaching role, in 2021/22 all Freedom to Speak Up guardians were asked to complete the newly devised Foundation eLearning modules. This served as Refresher Training for that year.

569
Guardians completed the training

Each year, we will develop new training modules to refresh Freedom to Speak Up guardians' knowledge and skills. Annual Refresher training is now mandatory. We have established compliance mechanisms, and from 2022/23 guardian details may be removed from the National Guardian's Office's Find My Guardian page, if we cannot be assured that they have the necessary training to carry out this important role.

Supporting inclusivity

Following a commitment in the NHS People Plan for training to be provided for Freedom to Speak Up guardians to help improve the Speak Up culture for minority ethnic colleagues, we worked in partnership with the Workforce Race Equality Standards Team at NHS England to deliver 13 sessions for 214 Freedom to Speak Up guardians.

It is vital that Freedom to Speak Up guardians are sensitive and knowledgeable about diversity, inclusion and belonging. The National Guardian's Office is looking to embed this into next year's Refresher Training for all Freedom to Speak Up guardians.

The role of a Guardian Mentor

When I heard about the role of becoming a Mentor for the National Guardian Office, I was delighted to offer my support.

For a newly appointed Guardian it can seem very daunting starting out, so each session offered is unique to them. New mentees come from various backgrounds including NHS trusts, hospices, primary care and private health organisations.

Mentees say that these sessions are invaluable as I share examples of case studies where workers have raised concerns, discuss processes regarding signposting, address policy information and give information about resources available from the National Guardian's Office. We also share reflections of the actual day-to-day role. I provide information regarding support mechanisms that they can access to ensure their health and well-being are addressed and information about buddies and attending regional network meetings for additional support and information.

For myself as a Guardian, I am passionate in being able to impart my 5 years' experience and knowledge of the Guardian role. I also enjoy meeting new workers and using examples of my 35 years' experience in the NHS in discussing how the Guardian role impacts and improves both patient and worker safety for the future.

So far I have met over 40 new guardians, and I have had the privileged opportunity to discuss their new position, and ensuring they as a Guardian are equipped to provide the psychologically safety for their workers to speak up.

Sue Fogg
Freedom To Speak Up Guardian
Mersey Care NHS Foundation Trust
and Volunteer Guardian Mentor

Networks

Being a Freedom to Speak Up Guardian is a challenging, rewarding and sometimes isolating role. One vital source of support is the regional and national Freedom to Speak Up Guardian networks.

National Networks

Ambulance 47

Hospice 93

Non-providers 78

Regional Networks

North West

North East and Yorkshire

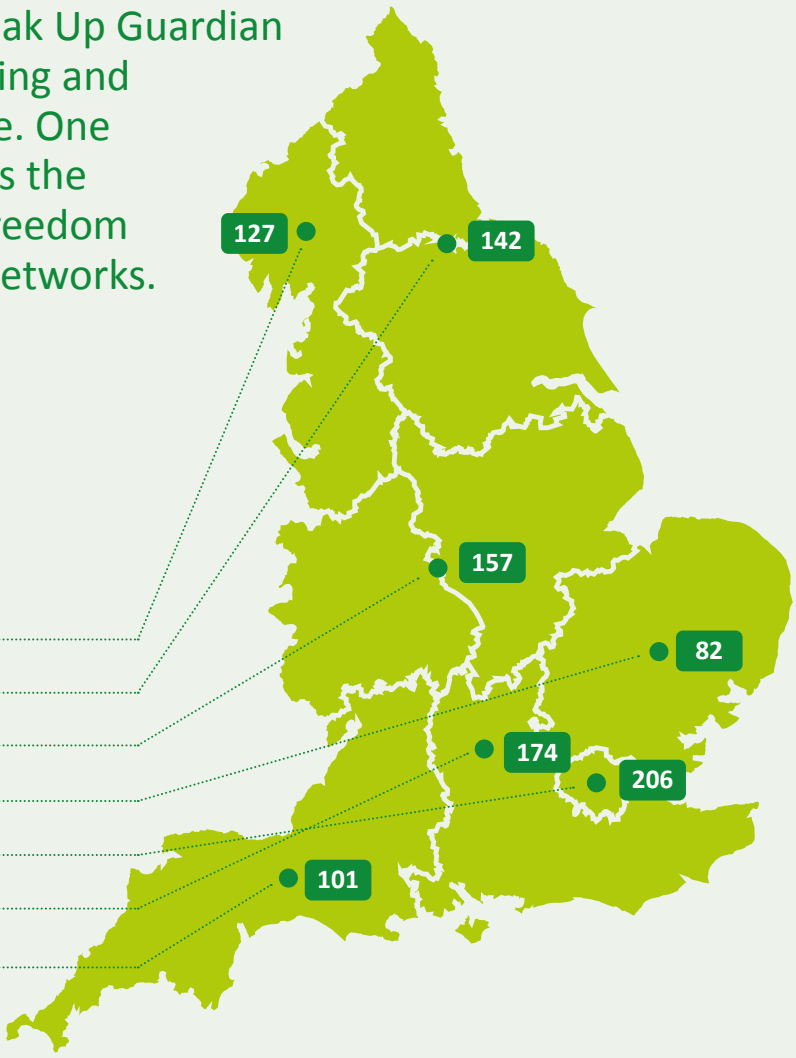
Midlands

East of England

London

South East

South West



We wanted to ensure that all networks were supportive and inclusive of all Freedom to Speak Up guardians, whatever the type of organisation they support. In 2022 we launched a project to enhance network effectiveness. This included updating expectations of network chairs and establishing a fair and open network chair recruitment process. We provide a survey function for network members to feedback on the meeting and whether they felt supportive and provided opportunity to share learning.

Regional Networks

Northeast and Cumbria

Chair: **Amanda Sutton**

Here in the North East Region our regional network continues to grow. As well as being a very friendly network colleagues are always a very supportive network helping each other when facing the day-to-day challenges that we all inevitably face as guardians.

Last year saw our first face to face post pandemic meeting hosted by our colleagues at South Tees and we are hoping to hold another during Speak Up Month.

We are now looking forward to 2024 when we will be merging with our colleagues in Yorkshire and Humberside to see what the future holds.

Yorkshire and Humber

Chair: **Estelle Myers**

Each meeting we share good practice and how we can all learn as a community of practice.

Over the year we have discussed the Ockenden report, guardian hours and training, the updated national Freedom to Speak Up policy, and how the integrated care Freedom to Speak Up Guardian role is set up.

We have discussed dealing with anonymous concerns, wellbeing support, private companies on NHS premises, Care Quality Commission and Freedom to Speak Up, the Public Interest Disclosure Act, and the collection of diversity information.

North West

Chair: **Phil Gordon**

The North West network meets once a month. We regularly discuss external developments and hot topics, and are joined regularly by the National Guardian's Office and external guest speakers. After every meeting, all members are invited to stay as long as is needed to seek for and offer informal peer support.

In December 2022 we had a regional conference where several colleagues shared progress and developments in their organisation, and we were joined by the National Guardian.

Midlands

Chair: **Sue Pike**

The network continues to go from strength to strength, and has welcomed many new guardians during the year, with a notable increase in those from outside NHS trusts.

The network combines an informal and formal approach with fortnightly check ins and quarterly regional meetings (with the inclusion of training and development).

Speak Up month is supported with a range of varying activities in different trusts and access to a day-long virtual conference hosted by the network chair's organisation.

Guardians from within the network openly share resources and ideas to support each other. A particular area of review and focus during the year has been in relation to detriment with the evolution of a 'Best Practice Guide' from a task and finish group within the network.

Regional Networks – Continued.

East of England

Chair: **Annie Ng**

We strive to focus on promoting learning, sharing and continuous development among guardians. Over the last year we have implemented monthly Community of Practice sessions, which have been extremely well received.

We have explored a number of themes including: leading and engaging inclusively with cultural intelligence; reflections from a former Non-Executive Director on the role of Non-Executive Director Lead for Freedom to Speak Up; networking with the GMC Regional Liaison Advisor; and looking at the Eastern Region Trainee's survey.

Guardians in the region have shared their learning, for example we heard from the Lead Guardian of the East of England Ambulance Service following the National Ambulance service Speak Up Review; West Hertfordshire Hospitals NHS Trust Guardian shared their Difference Matters project that looked at the impact of ethnicity on speaking up.

South East

Chair: **Mike Craissati**

We celebrated two organisations being shortlisted at this year's prestigious Health Service Journal awards. We have done a lot of work to help ensure the wellbeing of our guardians, especially those whose organisations may have been in the media spotlight or under review.

We always ensure that good practice is shared amongst guardians. We have a diverse membership representing a wide range of healthcare organisations, from NHS trusts to primary care, commissioners and private healthcare providers.

London

Chair: **Karyn Richards-Wright**

As chair of the London Network we feel very proud of the progress the network has made, which has gone from strength to strength this year. Jacqui Coles, vice chair and I regularly receive feedback from our guardians who say their highlights are the regional catch ups that we have on a fortnightly basis and quarterly meetings which are very well attended. We have seen the network grow and have guardians from different sectors within our region, enhancing the experiences and conversations that we bring to the meetings. Guardians have a safe place to speak and discuss their experiences but also to discuss learning which is our main focus. The main topics for this year have been detriment, barriers to speaking up, the Patient Safety Incident Response Framework and the wellbeing of guardians. We look forward to re-introducing face to face quarterly meeting in the very near future and continue the strong London Network links that have been formed.

South West

Chair: **Elizabeth Bessant**

We have such an inclusive and supportive network in the South West, sharing the highs and lows of being a Freedom to Speak Up Guardian.

There are many highlights to share, and one is our previous Chair, Sonia Pearcey, receiving the MBE in June 2022. Inspirational speakers have been a consistent focus for our sessions although the peer support we offer, supporting the health and wellbeing of each other, is pivotal.

Themes from guardians continue around capacity challenges, future growth and direction of the role, and an improved Well Led Care Quality Commission inspection framework valuing speaking up.

National Networks

Ambulance

Chair: **Carmen Peters**

A highlight for the year for the National Ambulance Network is that under extreme pressures, how resilient the members are. Although we provide a safe space, and listening ear to all workers within our organisation, the National Ambulance Network provides a safe confidential non-judgemental empathic space for guardians to express their worries, share experiences and provide each other with good practice advice.

This year the Ambulance sector welcomed the National Guardian's Office Speak Up Review. The whole network pulled together to support each Guardian of the chosen five Trusts with comfort, support, reassurance and guidance. I am proud of each member of the network for encouraging all workers to voice anything that is a concern to them, but also allowing the network to provide that environment for guardians at our catch ups.

National Non-Providers

Chair: **Nick Hodgetts**

The network's numbers are growing due to the increase in guardians being appointed within Integrated Care Boards, and we now number approximately 130 Guardians serving organisations of all sizes.

Now the network is fully active, we are recruiting Deputy Chairs and are helping and supporting new guardians with challenges (especially where people are the only Guardian in their organisation). We are beginning to help shape Freedom to Speak Up in ICBs in conjunction with NHS England's guidance.

We are introducing a debate topic slot which enables us to discuss and debate an element of Freedom to Speak Up, with a view to sharing views and expertise with the ultimate goal of making things even better.

Hospice

Chairs: **Janet Simkins, Jane Naismith, Sophie Cowan**

The network has seen a growth in the number of hospices attending network events and indeed in training guardians. Hospices are at various stages of developing their Speak Up work which means that the network meetings include a lot of sharing of experience and claiming learning, sharing good practice. Recently topics of conversation have included having champions to support guardians, recording cases, promoting a Speak Up culture and overcoming barriers and preparations for Speak Up Month.

We are pleased to have a regular update from the National Guardian's Office and were delighted to welcome Dr Jayne Chidgey-Clark to a network meeting.

Leadership

Strategic aim: To support and encourage leadership at all levels to foster a Speak Up, Listen Up, Follow Up culture

Leaders at all levels set the tone when it comes to fostering a healthy organisational culture. A supportive speaking up culture, led from the top, improves workers' experience and enhances organisational performance.

The role of leadership in influencing organisational culture is well documented. Yet, high profile cases reported in the media underline how the pressure which the healthcare sector is under can mean that this work is not given the priority it needs. A focus solely on targets can – especially under pressure – make us blind to how those measures are achieved and at what cost.

As one senior leader of an ambulance trust told our Speak Up review: "When I first started, everyone I spoke to said we have a culture problem. Sexism, racism, homophobic, cliquey. We are going to fix it but not yet. We need to sort out other things like wait times."

74%

Of Freedom to Speak Up guardians said that senior leaders supported workers to speak up, a 3-percentage point decrease compared to the results of the previous survey (71%, 2021).

51%

Said managers supported workers to speak up.

Source: 2023 Freedom to Speak Up Guardian Survey

"Problem-sensing versus comfort seeking": leadership approaches to Freedom to Speak Up

Researchers from University of Cardiff found that curiosity (in the form of reflexive monitoring and a problem-sensing approach to Freedom to Speak Up) could be recognised as a barometer of speaking up culture.

Curious leaders of trusts demonstrated a problem-sensing approach to Freedom to Speak Up and the Guardian role. They consistently monitored the contribution of speaking up to the organisation and normalised rigorous analysis of Freedom to Speak Up data, triangulating with other data sources.

Researchers found that achieving change beyond the surface level was dependent on leaders being comfortable "with the idea of being challenged, not comfort-seeking all the time".

Demonstrable benefits of curiosity included improving the experiences of minority communities and workers who may otherwise be seldom heard from, alongside learning that fed into service improvements.

By contrast, where incuriosity was normalised, Freedom to Speak Up guardians often worked within restrictive boundaries and practices in which senior leaders were disengaged and limited data were collected and 'reported', rather than analysed, triangulated and integrated, into routine organisational processes of reflection and improvement.

Source: Implementation of 'Freedom to Speak Up guardians' in NHS acute and mental health trusts in England: the FTSUG mixed-methods study https://www.ncbi.nlm.nih.gov/books/NBK583156/

Leadership – Continued.

Increased focus on leadership

This year we have welcomed the focus on leadership through important reviews.

The independent review of health and adult social care leadership by General Sir Gordon Messenger and Dame Linda Pollard[15] noted that "the Freedom to Speak Up initiative can be narrowly perceived through the lens of whistleblowing rather than also organisational improvement, and we would encourage a broader perspective."

The proposed training, accreditation and appraisal implementation is a golden opportunity to ensure that fostering a healthy Speak Up, Listen Up, Follow Up culture is at the core of future leadership requirements. How managers and leaders listen and respond to speaking up should also be included in appraisal and performance management frameworks.

To support these future improvements, the National Guardian's Office has worked with Health Education England to develop Freedom to Speak Up eLearning.

The last of the three modules – **Follow Up** – was launched this year and completes the package. Developed for senior leaders throughout healthcare – including executive and non-executive directors, lay members and governors – to help them understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement.

We contributed to the Committee on Standards in Public Life report Leading in Practice[16] with a case study. Freedom to Speak Up guardians also shared their thoughts with the Committee. We were delighted to welcome Lord Evans, Chair of the Committee, as a plenary speaker at our Freedom to Speak Up Guardian Conference.

"If leaders are serious about creating a culture where people are willing to speak up, they must identify and dismantle the barriers to doing so"

Committee on Standards in Public Life

[15]Leadership for a collaborative and inclusive future https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future#recommendations

[16]Leading in Practice https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1130992/CSPL_Leading_in_Practice.pdf

Case Study: **First Community Health and Care**

In the 2022 NHS Staff Survey, 83% of workers at First Community Health and Care agreed with the question "I feel confident to speak up about anything that concerns me in my organisation." This is the highest score across all NHS organisations, with the national average being 61.5%.

Talking about First Community's positive speaking up culture, Florence Barras, Chair of the Board says: "As an employee-owned social enterprise we are committed to listening to each other, learning lessons and improving patient care. It's who we are and these principles are fully embedded in our organisations culture and DNA.

"I'm really proud of the open, compassionate and inclusive culture we have at First Community and we have several speaking up mechanisms in place for colleagues to share their views and be heard.

"Our Floor to Board process allows employees to contact an executive or non-executive Board member directly within five minutes if they have a concern.

"Our Council of Governor's are elected representatives who meet regularly with myself and Sarah Tomkins, Chief Executive to address issues of importance.

"We also have two Freedom to Speak Up guardians who provide a confidential safe space to raise concerns, along with a comprehensive Raising Concerns policy and additional guidance to support our workforce.

Florence Barras
Chair of the Board – First Community Health and Care

"We continually encourage our employees to have conversations when they feel that something isn't right, and this is reflected in the 83% response rate which has significantly improved from 75% the previous year.

"Our speaking up approach is an integral step towards learning and improvement and means that everyone is empowered to raise concerns, lead change and celebrate learning."

First Community delivers community healthcare services in East Surrey and the surrounding area, providing nursing and therapy services, children and family services as well as a Community Inpatient Ward and Minor Injury Unit at Caterham Dene Hospital.

Healthcare system

Strategic aim: to support health system alignment and accountability

For these benefits of Freedom to Speak Up to be realised, we need a whole system approach. Regulators with a deeper understanding of Freedom to Speak Up can better support organisations to use the voices of workers as a tool for improvement.

Our Speak Up review into ambulance trusts[17] identified that partners in the healthcare system did not always communicate effectively regarding concerns about the speaking up culture in ambulance trusts.

Partnership Working

Updated Freedom to Speak Up Policy & Guidance for the NHS

The publication of the updated universal Freedom to Speak Up Policy for the sector is an opportunity for organisations to refresh their Freedom to Speak Up arrangements.

We worked together with NHS England, to publish new and updated Freedom to Speak Up guidance and a Freedom to Speak Up reflection and planning tool to work alongside the new policy.

These will help organisations apply the policy and deliver the People Promise for workers, by ensuring they have a voice that counts. This will help organisations develop a Speak Up culture where leaders and managers value the voice of their workers as a vital driver of learning and improvement.

NHS England is asking all trust boards to be able to evidence their application of the policy and guidance by the end of January 2024.[18]

In the coming year we will be seeking to understand what mechanisms there are to ensure compliance with national guidance and policy on speaking up.

[17] https://nationalguardian.org.uk/case-review/speak-up-review-of-ambulance-trusts-in-england/

[18] https://www.england.nhs.uk/ourwork/freedom-to-speak-up/developing-freedom-to-speak-up-arrangements-in-the-nhs/

Well led domain

We have been working with the Care Quality Commission on their single assessment framework and increasing the depth of well-led domain inspections around Speak Up culture. We are also assisting them as they develop inspections for integrated care systems and primary care.

Following our findings during our Speak Up Review of ambulance trusts, we are supporting the Care Quality Commission to deepen the understanding of Freedom to Speak Up for all those involved in the regulation, inspection, and improvement support of organisations, including senior leaders.

Emerging Concerns

The emerging concerns protocol provides a process for health and social care regulators to share information that may indicate risks to people using services, their carers, families or professionals. Over the past year the National Guardian's Office has escalated concerns to members of the emerging concerns protocol. While not a regulator, the National Guardian's Office receives data and information which can provide vital intelligence which provides early indications under the protocol and is seeking an inclusion within the group's communications.

Speak Up Partnership Group

Concerned workers turn to regulators when they are desperate for action to be taken and have exhausted other routes. We continue to build on this work further with the Speak Up Partnership Group, which brings together regulators to ensure a consistent approach to listening up.

NHS England is committed to improving the experience for all NHS workers who speak up to us as a national body. Being a member of the Speak Up Partnership group has given us an invaluable opportunity to learn from and to work with other national bodies in healthcare and to consider those when making improvements to what we do.

Just one example of this is when we recently updated our speaking up policy and in doing so, we made sure we incorporated all the principles which the group had jointly identified were important for workers speaking up.

Alison Bell,
NHS England

Speaking up can be incredibly difficult. It's crucial that system partners work together to support whistleblowers and that's why I really value the partnership group. We've collaborated on shared principles, so all those speaking up to our organisations receive a consistent, compassionate response. We've learnt from each other, sharing expertise and promoting initiatives, such as the GMC confidential helpline. And we've agreed areas for focus; one of the most important of these is Equality, Diversity and Inclusion. We know minoritised colleagues face even greater barriers when speaking up and I'm looking forward to working together to help tackle this.

Tista Chakravarty-Gannon,
General Medical Council

Learning from others

Sharing good practice

Sussex Community Foundation Trust was awarded the Freedom to Speak Up Organisation of the Year award at the HSJ Awards 2022. Oxford University Hospitals Foundation Trust was highly commended by the panel.

The submission from Elizabeth Bell, Freedom to Speak Up Guardian, titled 'Caring for Speak Up Ambassadors – Improving our Speak Up culture', demonstrated how speaking up has been embedded across the organisation.

The judges commented that they would feel safe in an organisation that had this level of focus, professionalism, and care. They commended the Freedom to Speak Up Ambassadors for speaking up about their experiences and how the role has supported speaking up in the trust and patient safety.

There were eight finalists this year and all finalists demonstrated good practice which has been shared as case studies for further learning on our website. Finalist Freedom to Speak Up guardians shared their learning at a panel during the Freedom to Speak Up Guardian Conference looking at ways to overcome futility and promote confidence that actions will be taken if people speak up.

Learning from other sectors

All sectors have experienced tragedies which could have been prevented if staff had been supported in speaking up. We have much to learn from one another about how to embed a culture where people feel they can speak up about anything which gets in the way of them doing their job.

For these reasons, the National Guardian's Office set up the Pan-Sector Network to enable cross-sector sharing and learning. Attendees are from 31 different sectors, ranging from armed forces, financial services, academia, public and third sectors, all with an interest in making speaking up business as usual.

This year we have held events exploring the themes of leadership; compassionate and effective investigations of Speak Up concerns; and an exploration of different models of roles which operate as a route for people to speak up at work, like the Freedom to Speak Up Guardian role.

Case study: **Dudley Integrated Health and Care NHS Trust**

In the 2022 NHS Staff Survey, Dudley Integrated Health and Care NHS Trust had the most improved Freedom to Speak Up subscore.

I was appointed Dudley Integrated Health and Care NHS Trust Freedom to Speak Up Guardian in November 2021. Our Trust is small with approximately 450 staff working across a diverse range of services. It is relatively new in the NHS having launched in April 2020. At that time the country was experiencing the first COVID-19 pandemic lockdown and most staff were working remotely where it was clinically effective to do so.

From the start the Trust encouraged open and regular engagement through meetings with the Executives and CEO. Staff transferred from several NHS and non-NHS organisations, and I was part of staff transferred from Dudley CCG. We were all warmly welcomed into this new Trust. Those first few months set the tone for the culture of the organisation. So, when the opportunity arose to take on the role of Freedom to Speak Up Guardian, though nervous, I felt supported and encouraged by the Trust.

Prior to my appointment, the Trust accessed the Freedom to Speak Up Guardian Services from Black Country Healthcare NHS Foundation Trust who also provided much needed guidance to me. I also receive support from the West Midlands Guardians Network.

Mwamba Bupe Bennett
Freedom to Speak Up Guardian

In those first few months my priority was clear, to raise awareness of what Speaking Up is and work with others to create a culture where staff felt safe to raise concerns. Over the next year, I met with teams and individuals face to face and online to explain the role of Speaking Up using the helpful National Guardian's Office resources. I also attend the induction meetings for new staff and all staff meetings where I anonymously and appropriately share the concerns, learning and actions that I had or that were brought to me. It is a privilege that staff trust me with the concerns or suggestions for improvement.

I am grateful that our Trust Board and Senior Executives have embraced the Freedom to Speak up principles. Our Communications and Engagement team encourage staff to attend the Staff Forum, Staff Voice Groups, and other Listening Events which I also attend. A representative from our Executives is also present at the Staff Forum to receive feedback from staff directly.

We have all worked hard to create this culture that led to the improvement in our NHS Staff Survey results, and it is something we are deeply proud of and will continue to work on.

Future priorities

Alongside our work supporting Freedom to Speak Up guardians, four core themes are directing our work programme for the next year. These are:

- Improving our systems to better support our offer to **Freedom to Speak Up guardians**
- Ensuring all workers have a voice wherever they work, including in **primary medical services**
- Exploring how we can support the knowledge and skills of **Non-Executive Directors** and those with organisational oversight
- Building on insights from our first **Speak Up review**, initiating our next review and establishing the framework for future assessments.

Improving our systems to support Freedom to Speak Up guardians

Upgrading our systems is an operational priority for the forthcoming year.

As the Freedom to Speak Up network has grown and diversified, we have improved our training and assurance of Freedom to Speak Up guardians, and developed resources to support them in their work, including communications resources. These improvements have meant that our guardian portal, website and learning management systems need to be upgraded to provide integrated support, data collection and security, and enhanced learning provisions.

Freedom to Speak Up for Primary Medical Services

Freedom to Speak Up can support the successful delivery of healthcare in England as it becomes more integrated. Integrated care boards are an opportunity to ensure speaking up routes are available for all workers in NHS healthcare providers across the Integrated Care System.

Working in partnership with NHS England, we are building on our report in 2021[19] looking at Freedom to Speak Up models in primary care. This includes working with guardians to better understand the practical challenges of Freedom to Speak Up in primary medical services and integrated care boards.

[19]https://nationalguardian.org.uk/2021/06/03/exploring-freedom-to-speak-up-in-primary-care-and-integrated-settings/

Non-executive Directors

The new code of governance for NHS provider trusts states:

"The board of directors should ensure that workforce policies and practices are consistent with the trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern."[20]

A key element of the Freedom to Speak Up Guardian role is to work proactively with their leaders to address the barriers to speaking up. However, our Speak Up Review of ambulance trusts found that senior leaders and boards did not always understand the benefits which fostering an open speaking up culture can bring. Listening to Freedom to Speak Up guardians in different settings, it is clear that developing the understanding of those in organisational oversight roles (not just non-executive directors, but trustees, governors, council leaders) will be a key lever in improving the culture of healthcare organisations.

Building on the Speak Up, Listen Up, Follow Up elearning[21] packages we produced in association with Health Education England, we would like to see a shift from a position of 'comfort seeking' to curiosity about speaking up, where leaders and board members are inquisitive about the data that is presented to them and are keen to embrace the learning which listening to those who speak up can bring.

We will be exploring ways we can support the development and understanding of non-executive directors in this area, working in association with NHS England and NHS Confederation, and cross sectors.

Speak Up Reviews

The drive to make speaking up business as usual operates in a continuous improvement cycle. To facilitate this cycle, we carry out Speak Up Reviews to identify and promote learning and innovation to ultimately enhance the experience of workers, patients, and the public.

With the knowledge garnered from our first Speak Up Review, we are finalising the framework which will guide our assessment methodologies for future thematic reviews, grounded in good practice. We have started work to pinpoint the focus of our next Speak Up Review, which we aim to launch in Q1 2024/25.

83%

83 per cent of respondents said they had direct access to the non-executive director (or equivalent).

78%

78 per cent said they had sufficient access to the board (or equivalent), down five percentage points year-on-year (83%, 2021).

Source: Freedom to Speak Up Guardian Survey 2023

[20] NHS England (2022) Code of Governance for NHS Provider Trusts
[21] https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/

Governance

The National Guardian's Office is funded by the Care Quality Commission and NHS England. Senior representatives from our funders form the Office's Accountability and Liaison Board, led by an independent Chair.

Current Accountability and Liaison Board members are:

- **Suzanne McCarthy** – Independent Chair (appointed May 2023)
- **Dr Ronke Akerele** – Director of Culture Transformation, NHS England
- **Adam McMordie** – Deputy Director Quality, Patient Safety and Maternity, Department of Health and Social Care
- **Stephen Marston** – Vice-Chancellor, University of Gloucestershire.
- **Sir Andrew Morris OBE** – Deputy Chair, NHS England
- **Mark Sutton** – Chief Digital Officer, Care Quality Commission

The Board meets four times a year. Its overarching purpose is to provide strategic advice to the National Guardian on all matters related to their work portfolio, acting as a link to the boards of the sponsoring organisations.

The National Guardian reports at least annually to the boards of Care Quality Commission and NHS England on the work of the Office.

The Office also receives advice and support from the Partnership Working Group, whose members are senior leaders drawn from the Office's funding bodies, as well as the Department of Health and Social Care. The Partnership Working Group's purpose is to support the implementation of the National Guardian's work programme by providing insight and advice on emerging priorities and acting as a sounding board for ideas.

Liaison between the Office and Partnership Working Group members helps ensure the co-ordination of the organisations' respective work to support speaking up in healthcare.

Finances

The National Guardian's Office was allocated an annual budget of £1,650,333 and spent a total of £1,445,893. Expenditure on pay was £1,081,445.

Prescribed Person

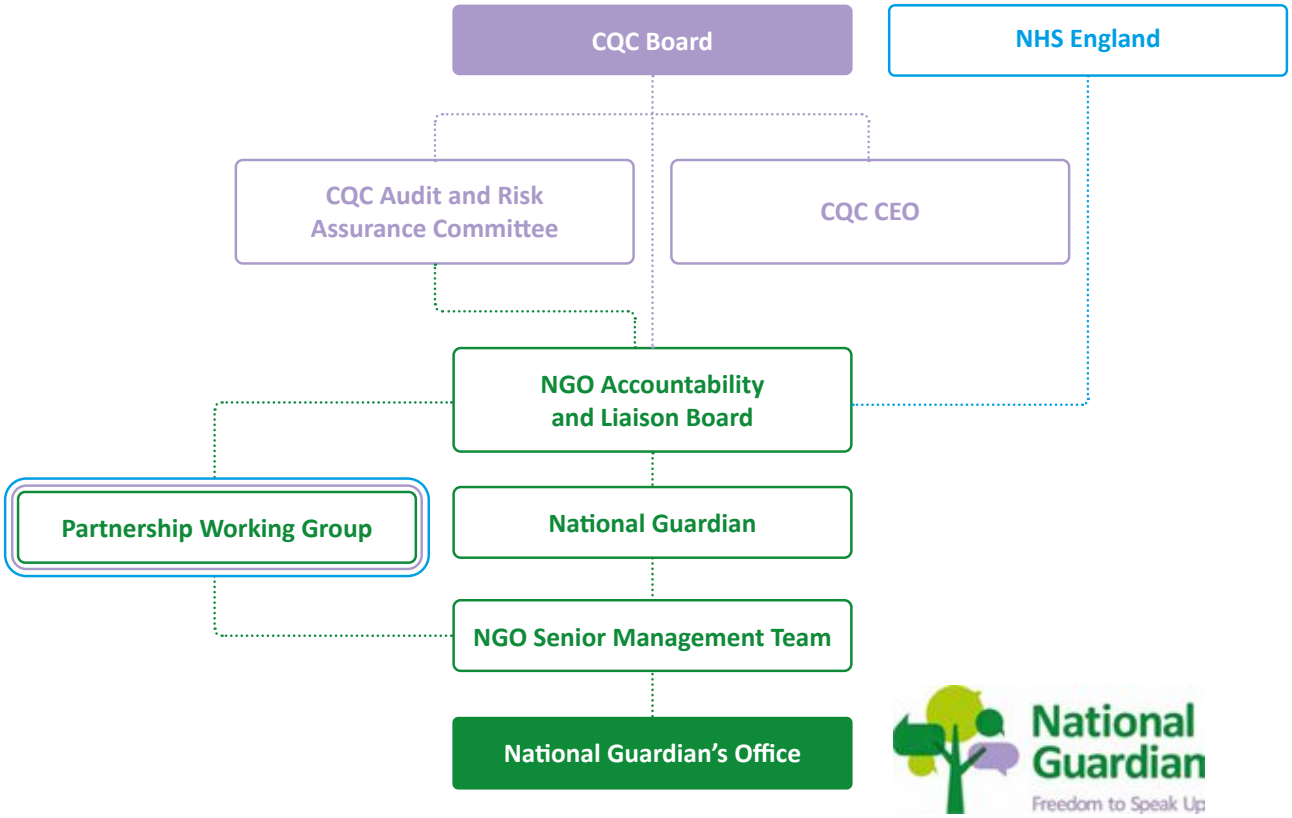
The National Guardian's Office is a 'prescribed person' for the purposes of s.43F of the Public Interest Disclosure Act 1998. In total, 32 'qualifying disclosures' were made to the Office, and 50 actions were taken as a result.

The National Guardian's Office annual prescribed person's report is available here.

https://nationalguardian.org.uk/about-us/prescribed-persons-report/

Structure

The National Guardian for the NHS is supported by a team consisting of 17 London or home-based members of staff at 31 March 2023.



Enquiries to the National Guardian's Office

3,303

Of these, 40% were responded to on the same day and a further 42% within 5 working days.

We are working to further improve our response times in line with our quality improvement approach

National Guardian's Office
Annual Report / April 2022 – March 2023

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National Guardian
Freedom to Speak Up

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Board of Directors			
Report title: Board Assurance Framework and Corporate Risk Register			Meeting date: 31 January 2024
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 December and January Board Sub-Committees have reviewed those risks where they have been designated as the overseeing committee. The Risk Group also reviewed the BAF and Corporate Risk Register ('CRR') at its most recent meeting. The Corporate Risk Register ('CRR') is presented alongside the BAF as assurance that the Trust's risk management system and the risk registers adequately underpin the BAF providing linkage between operational and strategic risks. Since the last meeting amendments have been made to Objectives 1, 2, 3, 7, 8 and 11		
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

NHS
Torbay and South Devon
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	Minor updates
2.	People	CPO	20	16	Minor Updates
3	Financial Sustainability	CFO	25	15	Updates in particular to reflect discussion in respect of control total
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	Minor updates
8	Transformation and Partnerships	DTP	16	9	Minor updates
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	Minor updates

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 2023/24 ensuring consistency of methodology both internally and with the ICB.

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	6, 4, 2, 3
4 - Likely	4	8	10, 12	8, 9, 16, 1, 11	20, 2
3 - Possible	3	6	9	12	5, 15, 7
2 - Unlikely	2	4	6	8	10
1 - Rare	1	2	3	4	5

Risk Summary

BAF Reference: 1. QUALITY & PATIENT EXPERIENCE

Objective: To deliver high quality health and care services, achieving excellence in health and wellbeing for patients and local community

Internally Driven: ✓ Externally Driven:

Responsible Executive: Chief Nurse supported by CMO	**Committee:** Quality Assurance Committee	**Last Updated:** January 2024

BAF Risk Scoring

Current Position					**Target**	**Year on Year**	**Rationale for Risk Level**
	Jul 23	**Sept 23**	**Nov 23**	**Jan 24**	**April 24**	**Jan 23**	There are a range of factors that present a risk to delivering high quality health care. These include the ongoing and accumulate impact of the following: • The CQC (Care Quality Commission) inspection gave a rating of Requires Improvement and therefore has a significant improvement plan that needs scoping in terms of QI a 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 yet 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 • 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	3	
Risk Score	16	16	16	16	12	12	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
1.1 A	Pace and scale of change required to minimise harm and poor patient experience & meet NOF 4 exit criteria is a significant challenge.	1.1B	Setting out medium to long term plan for reconfiguration of services to meet risk/demand Recovery and Restoration plan with agreed targets as set out in Performance framework and operating plan for planned and emergency Care Regular review Mortality and Morbidity through to Board incorporated into overall Harm review framework and through QA Governance framework	1.1C	Inequities and inequalities in access resulting in increase in Mortality& Morbidity across Torbay and South Devon Performance and operational resilience remained constrained with ongoing impact of: a) Delays in diagnostics and access to treatment - analysis of harm in key high-risk service areas shows an increase in harm in Ophthalmology, Urology, Cancer Services b) Failure to achieve recovery and restoration targets set out in the Recovery Plan c) Delayed ambulance handovers d) Adverse Mortality and Morbidity
1.2 A	Clinical Leadership Capacity to lead change	1.2B	Acute Service Sustainability Plan in development	1.2C	Failure to deliver fundamental standards of care as set out in regulatory/statuary frameworks

1.3 A	Gaps in Leadership Capacity and Capability across new Care Group Structure	1.3B	TSDFT Leadership Strategy Active recruitment to key leadership roles	1.3C	Failure to deliver against Single Improvement Plan targets – Regain and Renew
1.4 A	Capacity and capability to monitor /interrogate business/clinical Intelligence data including workforce, operational performance, quality and safety immature and sub optimal	1.5B	Quality Metrics being reviewed to ensure focus on appropriate quality and patient safety issues and ensure alignment with risks and SOF 4 criteria	1.4C	Failure to intervene and prevent patient Harm issues and underperformance around NOF 4
1.5 A	Maturing quality /governance systems across organisation and within the newly emerging Care Group structure - impacting effectiveness of quality systems – assurance /improvement	1.6B	Broader Corporate Governance Review including strengthened Clinical Governance Framework in line with GGI recommendations	1.6C	Sub-Optimal Quality Assurance framework - Failure to address quality and patient safety risk and to effectively drive up quality improvement a) Continuous review of NICE recommendations and communication of new/changing requirements by the Quality Effectiveness Team. b) Monitoring framework of concerns and feedback from patients and service users c) Embedding key programs of work to ensure fostering of Safety Culture work

Gaps in control/assurance

Internal		**External**	
Risk Analysis reference:		**Risk Analysis Reference:**	
1.3A	Operating structure Maturing	1.1C	System /ICS around plans to address inequalities in access and treatment
1.3A	Strengthen accountability and improvement through new Care Group Structure	1.1C	Central government control restricting ability to prioritise local needs
1.3A	Need to strengthen and Mature Governance and oversight through new divisional structure and monitoring outside Board Sub- Committee	1.1C	Collaboration with Devon system to ensure joined up response to increasing pressures
1.6A	Quality of clinical data variable	1.6A	CQC new regulatory approach not yet tested.
1.3A	Need comprehensive Organisational development plan to support system wide leadership capacity	1.1C	System /ICS around plans to address inequalities in access and treatment

Action Log: (actions identified to achieve target risk score)

Risk analysis reference:	**Action required:**	**Executive Lead:**	**Due Date:**	**Progress Report:**
1.2B	Continue acute service collaborative and delivery of the Acute Service Sustainability Plan	CEO	Ongoing 2024	• 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	April 2024	• 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 2024	• 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 2024	• 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 2024	• 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 2024	• 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:** January 24

BAF Risk Scoring

Current Position	Jul 23	Sept 23	Nov 23	Jan 24	Target: Aug 24	Year on Year Jan 23	Rationale for Risk Level
Likelihood	5	5	5	5	4	4	NOF4 has highlighted the improvements required in reducing waiting list times and improving financial efficiency. Whilst improvements in processes can alleviate both, people remain the key deliverers of all services, often doing so against competing demands and priorities. Our cultural dashboard data (sickness, rolling sickness, long term sickness, age profile, holiday taken, overtime hours, bank and agency spend, and turnover) highlights areas that 6 out of 9 are in red RAG status. The difficulty in analysing the impact of this is compounded by poor vacancy data quality. All of these categories, as well as ongoing industrial action, 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 report following Well-led inspection highlighted the level of work to do regarding EDI. The link between this culture and patient safety is actively being investigated, with the full degree of risk to patient safety yet to be understood.
Consequence	4	4	4	4	4	4	
Risk Score	20	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 (including industrial action cover) is leading to staff burnout. The requirement to improve performance to reduce long waiting lists will likely add workload and mental load/emotional labour 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. This is compounded by the restrictions associated with the financial recovery plan on wte growth. 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, Finance 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. Also, the immediate requirement for financial recovery requires tight short-term pay controls, challenging the opportunities for developing longer-term workforce redesign.

2.4A	Lack of leadership/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/management framework will used to identify leadership expectations, standards & behaviours. Evaluate (through a 360 approach), recruit and develop leaders to improve effectiveness and consistency in leadership.	2.4C	Continued poor leadership and management behaviours will exasperate an already fragile workforce and reinforce that their concerns are not listened to, further compounding fragility challenges.
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 and widening participation 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, impacting negatively on both financial run rate and team health/wellbeing	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. Plan to purchase e-rostering system for medical workforce in 2024 will see additional reduction in spend on temporary staff.	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. These will compete for limited resource and capacity and can cause confusion/stress as workload is not robustly prioritised.	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.
2.10A	Lack of accurate vacancy data and correlation with financial data impede the process of operational and workforce planning, budget setting as well as financial recovery.	2.10B	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 and refining the accuracy of occupational codes within financial systems/budgets. Should result in clearer/more accurate vacancy data.	2.10C	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 d) inaccurate reporting outside of the organisation, impacting on our reputation

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 organisational/workforce ill health 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.		
2.4A	2. Skillset of managers to compassionately and consistently 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 pay controls have been introduced, with aim to reduce spend/run rate and to meet workforce plans in line with financial recovery. Strategic Workforce Planner and Head of Resourcing working closely with finance and operational teams to work towards consistent/visible data and processes	CPO	Mar 24	Agency use monitored through Nursing & Midwifery Workforce Transformation Council and Medical Workforce CIP group and reported into Recovery group.
2.1 - 2.4A	~~1 & 2~~ As part of our People Promise (priority 1), a new TSD Leadership and Management framework and resources was launched from September 2023 that focus on a leadership responsibility of all to include listen and act, as well as developing management capability. Our People Promise priority 3 (embedding a culture of inclusion) is aligned to this, and includes mandatory Inclusion training for all	CPO	Sep 23 rollout – ongoing	Leadership framework approved by Trust Board. All products – based on the framework- including a 360 and leadership & management induction programme **Complete** - launched at the end of September 2023. A process of rolling out and embedding commences from now, including using the framework to recruit future managers. Mandatory Inclusion module and campaign launches January 24
2.8-2.10 A	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	March 24	Interim Employee Relations Service manager has now left the organisation and uplift to resources now in place. Additional resource uplift secured in key risk areas of ER Team, EDI, Medical Workforce and Workforce Data analysis. Roles in recruitment process currently.

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: January 24**

BAF Risk Scoring

Current Position					**Target**	**Year on Year**	**Rationale for Risk Level**
	Jul 23	**Sept 23**	**Nov 23**	**Jan 24**	**April 24**	**Jan 23**	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. CQC Report dated 3/11/2023 (Extracts as below) • The Trust and Devon were in NHS system oversight framework segment 4 due to financial performance and delivery against performance targets. • The trust had a challenging financial position but had a plan to address this. Action the trust MUST take to improve: • They 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).
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 and overall run rate in excess of 2023/24 budget.	3.7B	On the 28th November 2023, it was agreed at ICB F&PB that there would no longer be separate reporting on strategic CIP schemes and going forwards the identified savings would be incorporated into local plans / reporting. External Recovery Support and the PMO continue to work towards delivery of the recovery action plan. Recovery action plan updated to reflect adjusted	3.7B	Deterioration in financial performance and failure to deliver NOF 4 exit requirements

			control total following Regional and National review of forecast outturn. Control total now confirmed as £41.3m deficit including impact of industrial action for Dec 23 and Jan 24. Current run rate to deliver the year end position of £41.3m deficit (in line with the 2023/24 Recovery Plan).		
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	Ongoing	Underway with risk of slippage
3.2A	Ensure full reconciliation of workforce and financial data	DOpFin	Ongoing	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	Ongoing	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	Ongoing	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	Feb 24	

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:** December 2023

BAF Risk Scoring							
Current Position					**Target:**	**Year on Year**	**Rationale for Risk Level**
	Jul 23	**Nov 23**	**Sep 23**	**Jan 24**	**2030**	**Jan 23**	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	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.

	risk through to the completion of Building a Brighter Future			
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:** December 2023

BAF Risk Scoring

Current Position					Target	Year on Year	Rationale for Risk Level
	Jul 23	Sep 23	Nov 23	Jan 24	April 24	Jan 23	Consequence: Performance Risk - Failure to meet professional standards or statutory requirements. Likelihood: If the activity continues without controls in place, there is a strong possibility the event will occur as there is a history of frequent occurrences.
Likelihood	4	5	5	5	3	3	
Consequence	4	3	3	3	4	4	
Risk Score	16	15	15	15	12	12	

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. Weekly PLT review meetings to progress patient pathway for Cancers and Electives. Tier 1 Regional Support .	5.4.C	Failure to deliver on NOF4 exit criteria resulting in reduced organisational control

			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:** December 2023

BAF Risk Scoring

Current Position	Jul 23	Sept 23	Nov 23	Jan 24	Target: April 24	Year on Year Jan 23	Rationale for Risk Level
Likelihood	5	5	5	5	5	5	Current IT systems and supporting infrastructure will not meet the current of future business need. The current likelihood remains the same and is driven by two main 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 are significant threats to IT systems globally. The Summer cyber-attacks against the Ortivis provider used by SWAST took several months to be resolved and restored and is the second within a calendar year (the other being against Advanced which affected CAHMS and CFHD). 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)
Consequence	5	5	5	5	5	5	
Risk Score	25	25	25	25	25	25	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		Mitigating Factors (internal controls):		Impact of risk occurring:	
6.1A	Failure to meet cyber security or information governance standards Cyber-attack – local or global e.g. malware / ransomware / zero-day threats	6.1B	Data Security and Protection Toolkit in place with Standards Met which include compliance to Cyber Essentials. 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 2023/24 £4.5m capital funding from Frontline Digitisation, and being implemented through 2024 IM&T Prioritisation with risk mitigation as a significant criteria 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 EPR procurement due to identify a Preferred Bidder in December 2023 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 The financial risk of the LIMS Preferred Bidder is being assessed by the Finance Team, and potential alternate LIMS approaches should this risk be un-mitigatable will be assessed IM&T Prioritisation with risk mitigation and 'end of life' business critical IT systems as two significant criteria in place to ensure that investment is made into the most critical areas	6.4C	A shut down of business-critical IT systems would have a significant detrimental impact on patient care and access. Loss of certain IT systems for more than 18 hours would require the Trust to not only stop UEC pathways for new patients, but also displace current inpatients and planned care to neighbouring trusts
6.5A	Prohibitive cost of software licensing Increasing change of software licensing to subscription models	6.5B	2024/25 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	2024/25 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	2024/25 capital plan, including external Frontline Digitisation funding Implementation of new capabilities included in the business case and implementation of the N365 technologies	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 although there has been agreement that future capital following the sale of TP will be available	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 1.8.2024	Secured – subject to FBC but all key criteria including affordability now met and regional/national approval for OBC received. FBC being drafted to submit for approval.
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	1.4.2024	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	1.3.2024	Database migration suspended following unintended consequences of doing so in Cornwall. Focus is now on re-procurement of LIMS. Finance colleagues assessing the financial risk of the LIMS Preferred Bidder due to their failure to meet the procurement financial assessment of that bidder. Parallel activity to assess the achievability within timescale of the Epic LIMS (Beaker) underway should the reprocurment option not progress.

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: January 2024**	

BAF Risk Scoring							
Current Position					**Target**	**Year on Year**	**Rationale for Risk Level**
	Jul 23	**Sep 23**	**Nov 23**	**Jan 24**	**May 24**	**Jan 23**	
Likelihood	3	3	3	3	3	2	The availability of a national funding for cohort 4
Consequence	5	5	5	5	5	5	
Risk Score	15	15	15	15	15	10	

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
7.11A	Ability of the Trust to deliver a robust long term car parking strategy for the Torbay Hospital site	7.11B	The capital development team are working with the local planning authority in relation to the completion of master planning exercise for the site, this will need to include an agreed position on car parking capacity.	7.11C	The risk associated with not being able to agree long term car park strategy would impact on the ability of the trust to secure full planning permission for the main constrcution project.

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 have now been presented to the BBF committee. A final report will be available in February 2024 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: January** 2024

BAF Risk Scoring

Current Position					**Target**	**Year on Year**	**Rationale for Risk Level**
	Jul 23	**Sep 23**	**Nov 23**	**Jan 24**	**March 24**	**Jan 23**	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	3	
Consequence	4	4	4	4	3	3	
Risk Score	16	16	16	16	9	9	

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	December 2023	Year 2 investment approved as part of original Business Case not available. Full recruitment to Year 1 funding envelope achieved. Deep dive to look at impact and mitigations of reduced improvement resource due January 24' BBF Committee.
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	Ongoing	To be linked to COO/CNO workplan
1.2B	Produce business case for ICS fragile services engine room of capacity	DTP	Ongoing	Business case presented – PAPC required further review, case presented in August 2023 with updates given at subsequent Board meetings.

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:** December 2023

BAF Risk Scoring

Current Position	Jul 23	Sep 23	Nov 23	Jan 24	Target April 24	Year on Year Jan 23	Rationale for Risk Level
Likelihood	4	4	4	4	2	4	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.
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	Ongoing	Board briefings provided during 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:** December 2023

BAF Risk Scoring

Current Position	Jul 23	Sep 23	Nov 23	Jan 24	Target Apr 24	Year on Year Jan 23
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

Rationale for Risk Level

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.

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:** December 2023

BAF Risk Scoring

Current Position				Target	Year on Year	Rationale for Risk Level
	Jul 23	Sep 23	Nov 23	Jan 24	Sept 25	Jan 23	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 including 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 and widening participation 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 inclusive. This was highlighted in the recent CQC ~~i~~report following the Well led inspection.	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 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.	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.

			Formal reports are completed, published with robust action plans, as well as CQC action plan, 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 EDI 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	Robust onboarding and induction for our internationally recruited staff is required		
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:**
11.1- 11.3A	Develop a CQC action plan that is aligned to our People Promise priority 3 (Embedding a culture of inclusion) and promise 1 (Compassionate leadership and management). Items below are taken from this plan.	CPO	Jan 24	CQC action plan draft shared with CQC group, People Directorate service leads and People Committee, and is being refined based on feedback.
11.1A	EDI Trust Board development sessions to be identified.	CPO	March 24	EDI Trust Board development sessions have been identified 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 coordinator of the induction to ensure a more robust follow up. Culture ambassador training has been offered to our nurse managers. **Complete**
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	CPO	March 24	

	decision making and improvements with a particular focus on our Disability network.			
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 and is being finalised. The creation of the enhanced module began in Nov 23.

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DATIX RISK MODULE REPORT

(Exceptions highlighted in Yellow.)

ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	Specialty	Risk Location	Title	Description Cause: Effect:	Consequence (Inherent / Initial)	Likelihood (Inherent / Initial)	Rating (Inherent / Initial)	Controls in place	Gaps in Control	Review due date	Consequence (Current)	Likelihood (Current)	Rating (Current)	Risk Progress Notes Last 3 entries minimum.	Consequence (Residual)	Likelihood (Residual)	Rating (Residual)	Action Point/Plans relating to Risk Synopsis of Open Action Point/Plan	Action Point Owner	Review due date (Action Plan)	Completed by	Completed on	Action Plan Progress Notes Last 3 entries minimum.
1083	01/01/2016	Corporate Level Risk	Estates	Jake O'Donovan	Jake O'Donovan	Chief Finance Officer (Mark Bvoe)	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	19/09/2012	Corporate Level Risk	All Departments (Risk Only)	Gary Hotine	Adé Jones	Director of Transformation and Partnership (Adel 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).	01/08/2024	Catastrophic	Almost Certain	25	[29/11/2023 11:14:46 Gary Hotine] Reviewed and updated residual risk following EPR procurement/implementation action [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	Catastrophic	Rare	5	Support the activities described in the Trust's Digital Strategy regarding the priority action to procure an EPR	Gary Hotine	21/07/2024			[14/06/2023 09:04:44 Gary Hotine] OBC with national team for approval
3309	03/11/2021	Corporate Level Risk	IT Operations	Gary Hotine	Adé 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. Obtain formal extension for support from supplier, including for the Microsoft and Intersystems components upon which the PAS is built.	Adé Jones Gary Hotine	01/02/2024 01/01/2025			[26/09/2022 18:31:33 Gary Hotine] Taken to Execs and FPDC twice but no funding solution available [02/05/2023 13:15:48 Gary Hotine] Supplier has agreed that at least 2 years notice will be provided [08/03/2023 10:48:17 Gary Hotine] Supplier maintains the agreed position. [07/03/2023 08:22:45 Gary Hotine] Daedalus have confirmed that 2 years' notice will be provided when the platforms from ISS are to become unsupported, but cannot put in writing.

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3684	12/12/2023	Corporate Level Risk	Estates	Jake O'Donovan	Jake O'Donovan	Chief Finance Officer (Mark Brice)	Operational Risk	Estates Operations	HOS: Torbay Hospital Tower Block	Tower Block Building Fabric Weakened - (cracked pillars and core samples contain ASRs)	Cause. 1. At a recent survey cracking was noted in the structural elements of the concrete frame of the Tower block. Following this, laboratory tests were carried out on the Tower concrete structure inside and outside which showed high levels of Alkali-Silica Reaction (ASR) which weakens the integrity of the concrete. Case structural engineers had a report carried out by Birmingham City Laboratories which showed disturbingly high levels of ASRs. Effects. 1 The presence of ASRs is a chemical reaction between the cement and the aggregate with weakens the concrete strength to the point where it becomes crumbly and collapses. 2 The long term effect is to place a limited life span on the building. 3 The short term effect is that it is not yet possible to quantify what the remaining useful life of building might be. 4 The Podium Block was also constructed at the same time, and fractures have already been detected in the Fracture Clinic area.	Catastrophic	Almost Certain	25	1. Scaffolding in place (to address the Falling Tiles and spalling concrete Risk 3621) will permit a more detailed survey of the cracking and allow monitoring of any further deterioration. 2. Option to consider viability of short term life extension within the context of the Building a Brighter Future development control plan. 3. Monthly review in place to consider next steps.	1. The short term effect is that it is not yet possible to quantify what the remaining useful life of building might be.	31/01/2024	Catastrophic	Almost Certain	25	[15/01/2024 08:09:11 Amanda Anders (Risk Officer)] Risk discussed at Jan Risk Group and agreed to add to the CRR	Catastrophic	Rare	5						
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 12. the Delivery Director for improvement are now post (Jan 2023)	1. Lack of regular and coherent productivity reviews of clinical services and action plan to address the issues 2. Interruptions to meetings cycles (routine governance) due to operational pressures. 3. Governance and delegation compliance rate following spending protocols requires monitoring and addressing	30/11/2023	Catastrophic	Almost Certain	25	[23/08/2023 14:08:07 Tian Ze Hao] Risk still remain the same driven by unidentified / under-delivery of CIP schemes and the increasing cost pressure in Adult Social Care. This is not just for 23/24, for the medium term we are developing a joint understanding with ICB on interventions required. [26/05/2023 09:29:27 Dave Stacey] Updated DS May 2023 [30/01/2023 13:34:45 Tian Ze Hao] Risk updated for the current and coming financial year (23/24). We are in the process of submitting a joint acceptable operational plan with the ICB in Feb 2023.	Catastrophic	Likely	20						
1070	29/05/2014	Corporate Level Risk	Emergency Department (ED)	Joann Hall	Lisa Houlihan	Chief Operating Officer	Performance Risk		HOS: Torbay Hospital ED (A&E)	Trust Patient Flow Pressures Resulting in Ambulance Handover Delays, Poor Levels of Care and Performance for 12hr & 4hr Standard	Cause: Patient demand exceeding capacity within the ED department. Effect: Failure of the 95% standard, poor patient experience and possible adverse clinical outcomes as patients not cared for in the correct environment. Linked to other ED CLR: DRM ID No 1095 Overcrowding In Emergency Department.	Catastrophic	Almost Certain	25	1. Good data analysis available - ED dashboard linked with control room - good and accurate weekly data sheets produced to monitor performance. 2. New medical "O" drive - to allow other specialities (Medicine) to be monitored in same way as ED - pressures easier to identify earlier. 3. Escalation policy in place. 4. 3 x daily control meetings with real-time information and appropriate management responses. 5. Ward discharge coordinators have daily meetings to review ward discharges. 6. AMU re-provided on Level 2 from 21/03/16 to divert medically expected patients from ED. 7. "See & Treat" trial in 2017 was successful and is now used during periods of escalation. 8. JET Team now fully operational to provide support for early discharge. 9. Acute Care Model in Bay 5 to accept direct HCP referrals from 10th April 19. Prioritise use of EAU3 as assessment space, additional push from Jan 2020. 10. There are 3 improvement work streams in place with project plans for each; Emergency floor programme, ward processes, and Home First. We also have support from ECIST who are actively supporting a range of improvements. Governance structure in place to support these and currently looking to source additional project support. 11. Increased robustness of internal ED escalation. 12. Improvements to RAR space to enable additional capacity when unit is full. 13. Changes to corridor traffic to prevent thoroughfare use. 14. Creation of an Medical Receiving Unit in DSU as part of the COVID response. 15. Creation of a Surgical Receiving Unit on level 5 opening on 29/06/2020.	1. Linkage of the overcrowding risk score not formally linked to the escalation policy. Need for better OPEL linked escalation. 2. Patient flow out of the ED and other assessment spaces (MRU/SRU)	30/10/2023	Catastrophic	Likely	20	[29/03/2023 11:27:49 Amanda Anders (Risk Officer)] Title changed by COO [22/11/2022 17:30:40 Melody Andrews] Risk reviewed and no change at present. [10/06/2022 10:36:11 James Merrell] Risk reviewed and no changes at present.	Catastrophic	Unlikely	10	To support improvements an urgent care board has been established to monitor the workstreams affecting flow and process issues across ED, medicine , frailty , bed management and discharge processes. Each workstream holds a specific action plan for improvement measures which is monitored weekly with oversight weekly at the urgent care board .	Joann Hall	29/03/2024			[16/07/2023 13:37:34 Joann Hall] Minutes and action log available in shared teams drive
2416	23/04/2019	Corporate Level Risk	PMU Finance	Emma Rodin	Emma Rodin	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. Gain clarity on strategic direction of TP	Emma Rodin Emma Rodin	31/01/2024 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.

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3547	05/04/2023	Corporate Level Risk	Human Resources	Sarah Lohmann	Michelle Westwood	Chief Peoples 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 staff with additional training to be launched on 22 January 2024. 2. Board signed off Culture Charter, to be launched on 22 January 2024, detailing commitment to upholding expected behaviours.	1. EDI training is not part of induction - Induction review underway 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	01/04/2024	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	New Culture and Workforce Working Group being established to proactively identify where in TSD there are trends in Absence/Grievance/Turnover/F2SU/EDI/Patient Safety to enable targeted treatment to improve employee experience and managers confidence to treat.	Sarah Lohmann	01/06/2024			[04/01/2024 08:12:46 Sarah Blacoe] [3/1/24] Band 7 in place in EDI team, Band 6 recruited for, Band 8 solution in unison with RDUH being developed. CQC Action plan to address EDI Must do in progress and being assured by People Committee. [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.					Michelle Westwood	31/03/2024			[04/01/2024 08:16:24 Sarah Blacoe] People Promise programme of work reviewed December 2023 with new approach so that solid projects are removed and it incorporates the CQC EDI Action Plan, the roll out of the Compassionate Leadership programme, Management Development, and the Just and Learning Culture change. This will monitor progress and measure improvement in behaviours.
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 decsion making groups 3.Development of ICS governance arrangements to include ICB, ICP Local Care Partnerships and Provider Collaboratives 4. ICS Board appointments, Executive Team and Programme Director capacity 5. Provider Collaboratives- Acute, MHLDN and plans for Primary Care and Community 6.Regular TSDFT executive engagement and attendance at ICS Board and Place Based/ICP planning meetings. 7.TSDFT CEO leads the Acute Provider Collaborative and Chair, DCEO and CMO also members 8.Influence at Strategic/Clinical networks: ICS Executive, Finance Working Group and HRD Executive Forum 9.Stakeholder engagement: proactive relationship management at CEO level with ICSs and other Provider CEOs. Focus on primary care leaders and stakeholders, and ensure attendance at key primary care engagement events. 10. System Recovery Board. 11. Trust internal governance.	Internal 1.Lack of robust planning arrangements 2.Operational capacity and governance External 3.Financial Plan/Devon System Health and Care Strategy 4.Lack of of engagement from partnership providers to impact positively on pace of change 5.ICS governance structures are emerging and decision making at organisation, place and ICS level is ambiguous at times. 6.Implications of revised governance arrangements on FT governance and decision making	01/02/2024	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	01/02/2024			
																					System Operating Plan	Liz Davenport	01/03/2024			
																					Trust Governance Process - Recovery Board	Liz Davenport	01/03/2024			
																					Leadership Capacity and Capability	Michelle Westwood	04/12/2023			
																					Regain and Renew (SOF4 Exit plan)	Adel Jones	04/12/2024			
1815	05/08/2014	Corporate Level Risk	Cancer Waits 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	31/01/2024	Major	Almost Certain	20	[24/11/2023 14:38:31 Nick Hughes] Reviewed by AA and NH [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 AA/JR - 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.	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	16/02/2024			[03/01/2024 12:34:57 Jacqui Robinson] The Trust continues to maintain their position outside of Tier 1 and achieved 28 day standard for the past 11 months. Gynae, Colorectal and Urology performance continues to be our main areas of concern with all sites failing the 28 day target. Clinic teams are also working closely with cancer managers to improve performance across 31d and 62d targets across numerous sites. Strikes, staffing and diagnostics having the biggest impact. [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 currently 25th highest performing trust across the
																					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 Plet	08/07/2022			[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 [05/05/2022 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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1266	01/10/2015	Corporate Level Risk	All Departments (Risk Only)	Derren Westacott	Kevin Pike	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 lists 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)	30/01/2024	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	07/11/2016	Corporate Level Risk	Human Resources	Michelle Westwood	Michelle Westwood	Chief People 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 Inability To Keep Services Open. DRM 1652 Vulnerability Of The Junior Doctors Rota In Medicine. DRM 2928 Inadequate Medical Physics Resources Impacting on Service Provision DRM 2528 Reduced Staffing Numbers Resulting In Inability To Keep Services Open (Workforce Risk). DRM 2602 Recruitment and Retention of Staff. (TP) (Workforce Risk) DRM 2576 Lack Of Anaesthetic Cover To Cover 85% Of Scheduled Lists. DRM 3286 Physiology Workforce (Workforce Risk) DRM 3231 Critical Staff Shortages in Radiotherapy Physics (workforce risk) DRM 3362 ED Medical Workforce (Workforce Risk)	Major	Almost Certain	20	1. Recruitment updates are reported to Board bi-monthly as part of Workforce Report. 2. Medical Recruitment is being looked at as part of the Trust's Recruitment Strategy working groups. 3. Performance Report identifies where compliance with RTT/ED/STC impacted by workforce shortage. 4. Nursing workforce strategy in place including capacity plan that identifies demand and supply routes (including overseas nursing, redesign and vocational career pathways) monitored by Workforce and OD group. 5. E-Rostering system in place for nursing staff. 6. Restricted use of agency staff. 7. Use of bank staff wherever possible. 8. Additional support from current staff. 9. Risk discussed at Local level with escalation process for risks. 10. 15+ being linked to this risk. 11. Risk discussed at HR SDU meetings. R+R Groups. Workforce OD Group, Quality & SDU Performance meeting, Nursing working board group meeting, Risk Group meeting, Executive Directors meeting, Audit committee meeting and Trust Board. 12. STP Workforce and Clinical network development. 13. Trust now part of ICS Retention Project for late stage career nurses and early stage career support to improve nursing retention.	Lack of strategic workforce planning capability and capacity. Ctrl 2. Link 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 Routh	Emma Routh	Chief Finance Officer (Mark Brist)	Financial Risk		Torbay Pharmaceuticals	Insufficient Access to Capital.(TP)	Cause: TP could be requested to reduce its capex budget in order to support the Trusts CDEL. Effect: Inability to invest in items linked to Torbay Pharmaceuticals Strategic Plan and requirements by MHRA if capex is reduced.	Catastrophic	Likely	20	1. Within year Capital plan in place. 2. Reviewed at TP Board meetings. 3. Meetings with Trust FD and TP Chairman. 4. Raised at Trust Board Meetings for assurance.	1. Potential for change in financial requirements of the Trust/NHSE. 2. No long term capital budget visibility (>1 year) from NHSE for Trust/TP.	31/01/2024	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						
3536	14/03/2023	Corporate Level Risk	Human Resources	Michelle Westwood	Michelle Westwood	Chief People Officer	Operational Risk		HOS Torbay Hospital Regents House	Pressure in Employee Relations Team due to a Combination of Increase in Demand on Services and Personnel Churn (Workforce Risk)	Cause: There is considerable pressure in the Employee Relations Team due to a combination of increase in demand on services (especially grievances) and personnel churn (change of Employee Relation Team Manager and the long term sick of one full time member of ER Team and the absence of the Associate Dir of People Ops). Effect: There is a risk of reduced output and productivity from the ER Team, with the inability to address long term absence (£11.6m a year), 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. Org design of Employee Relations team has been reviewed against demand and KPIs - permanent team leader recruited to due to start 1 Feb 24; 2 x Band 7 created but awaiting ICS approval to recruit. 2. Roll out of Management Induction is increasing confidence of managers to act in line with policies. 3. Revised Employee Relations metrics are identifying where prioritisation is required and where capacity could exist.	1.. Employee Relations team leader role gapped 4/1/24-1/2/24; one person on long term sick; one person on annual leave means depleted team is further depleted until 1/2/24. 2. ICS approval to recruit 2 x band 7 is beyond TSD control. 3.Lack of triage and prioritisation of Trust wide projects that impact on Employee Relations	01/06/2024	Major	Almost Certain	20	[04/01/2024 08:30:02 Sarah Blacoe] Band 8a permanently recruited to, starts 1/2/24. 2 x Band 7 roles approved by Vacancy Control at TSD, awaiting ICS approval. 1. New Manager to focus on workplan for the ER team, including role out of Just Learning Culture policies, and KPI monitoring. 2. New Culture and Workforce Working Group being established to proactively identify where in TSD there are trends in Absence/Grievance/Turnover/F2SU/EDI/Patient Safety to enable targetted treatment to improve employee experience and managers confidence to treat. 3. New Management Induction Training commenced 1 Oct 23 covering ER." [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	Major	Possible	12						

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3546	18/03/2023	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	31/01/2024	Major	Almost Certain	20	[14/12/2023 10:43:42 Cheryl Vidall] No change since last update. Awaiting approval of amended business case from ICB for additional resourcing. Health in MASH continues to have too many cases each day to complete, resulting in some health enquiries each day not getting actioned. [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	Major	Possible	12	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.
3030	12/03/2021	Corporate Level Risk	Human Resources	Michelle Westwood	Michelle Westwood	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						
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	29/02/2024	Major	Likely	16	[11/12/2023 14:04:58 Anthony Lowe] We failed to appoint to the Histology 8b role. This went back out to advert. Haem and BT role - successful internal candidate. However, this will now lead to vacancy at 8a level In lab mangers meeting other operational models were asked to be considered by ADO in the event of further failed recruitment Ongoing Network meetings for fragile Micro and Histo services [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 silesia n, BCHD under pressure. Both histo and	Major	Unlikely	8						
3195	19/06/2021	Corporate Level Risk	PMU Finance	Leon Rudd	Emma Routh	Torbay Pharmaceuticals	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						
3287	11/10/2021	Corporate Level Risk	Stroke Medicine	James Hobbs	Tracey McKenzie	Chief Nurse (Deborah Kelly)	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.	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

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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.
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	Major	Likely	16							
3437	09/09/2022	Corporate Level Risk	PMU Operations	ARI	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			
2948	13/11/2020	Corporate Level Risk	Emergency Department (ED)	Lisa Houlihan	Nicola McMinn	Chief Nurse (Deborah Kelly)	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.	31/05/2024	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)	Katie 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	14/01/2024	Major	Likely	16	[24/07/2023 16:42:20 Tim Simpson] arranging meeting with RPA asap [06/04/2023 11:14:58 Nick Rowles] I have reviewed this risk today. Whilst there have been improvements in radiation safety and compliance, there are still significant gaps. Risk assessment in key areas of Nuclear Medicine and Radiotherapy are being drafted and identify actions required to improve safety and complaince. These actions will require implementation through Local Rues (instructions for safe work) on completion of the risk assessments. There is still no suitable and sufficient risk assessment in place for cardiac catheter laboraties and there are a number of indicators of concern regarding radiation safety and culture arising in this area. There remain other gaps in risk assessments. In terms of Nuclear Medicine (ref external review), there has been progress around management of radioactive waste, and additional staff in Clinical Nuclear Medicine. Recruitment into the senior medical physics role at 8B however remains challenging and the position remains unfilled after 4 adverts. An alternative solution is being investigated. Actions around this risk warrant review and updating	Major	Rare	4	To formally review this risk with KdB. Risk description is very broad and general, review to ? close and create new risks for remaining items	Tim Simpson	14/01/2024			[06/12/2023 14:39:41 Tim Simpson] Met with KdB/JR. Risk to be reviewed and revised [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
2920	12/10/2020	Corporate Level Risk	Finance	Neil David Elliott	Abi Jones	Director of Transformation and Partnership (Adel Jones)	Performance Risk	Business Intelligence	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.	28/12/2023	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	28/06/2024			[09/01/2024 08:33:18 Neil David Elliott] The situation is the same as on 07/07/2023. The work to make the PARIS system compatible is progressing, data from the Community Physiotherapy teams may be available for testing in February 2024. [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.

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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.
2965	30/11/2020	Corporate Level Risk	Maternity Services	Jonathan Hindley	Joanna Bassett	Chief Nurse (Deborah Kelly)	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 24 hours a day. Where treatment has been delayed due to lack of availability of access to an emergency theatre. There is a dedicated obstetric theatre in hours but this used four elective sessions leaving six sessions available for emergencies. During the four elective sessions if an additional theatre is required for an emergency, the theatre coordinator will identify the next immediately available theatre. Out of hours there is one emergency theatre available that is fully staffed with a second on call team available to staff an additional theatre if the staffed theatre is already in use. a second on call team would take 20-30 minutes to be onsite and the theatre operational. Effect: 1) Inability to provide care within nationally recommended timescales, eg Category 1 LSCS within 30 mins and Category 2 within 75 minutes. 2) Any delay may result in life threatening harm to mother or baby.	Catastrophic	Possible	15	1) Daily morning safety huddle involving obstetrics, anaesthetics and theatre, to include which theatres are available, which theatre could be utilised. 2) Review of clinical risk as identified by the delivery suite coordinator and on call obstetrician at each handover 3) Early identification and communication with the MDT of potential requirement of need to access theatre. 4)Theatre 10 (Griffin Suite) available Monday all day, Tuesday-Friday pm for emergency obstetric use. 5) In the event of needing a theatre outside of these hours ceasing the elective list if no alternative theatre free. 6) SOPS in place to support obstetric MDT in activating the emergency theatre team, theatre and enabling access to theatre in and out of hours. 7) Weekly audit of Cat 1 and 2 decision to delivery times.	1) Unable to recruit the additional ten required ODP's to be able to have a dedicated on site out of hours obstetric theatre fully staffed. (In total our current workforce is 20 ODPs for in patient theatres. who are deployed to manage the current in patient activity, this includes one emergency theatre at night).	31/01/2024	Catastrophic	Possible	15	[27/12/2023 11:12:10 Claire Jones] New SOPs and pathways in place, Plans for timings review, audit and skills drills. Joint working group with theatres and maternity to drive this forward. [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	Catastrophic	Rare	5						
3293	14/10/2021	Corporate Level Risk	PMU Finance	David Houghton	Emma Rodh	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. Andrew advised that ITH Pharma have had the full support of their bankers and insurers since the incidents in May 2014, and no restrictions have been placed on them (including the MHRA). He is going to share with Dave a redacted letter between ITH and their bankers that should provide some reassurance of this position. The directors of ITH Pharma do not envisage any impact on day-to-day trading of the company, despite the admissions of guilt in relation to the Crown Court case. (1 x Insufficient risk assessment in place and 2 x supplying medicinal products not of nature or quality specified in the prescription). They have had almost 8 years of continued trade with the NHS since 2014 with no repeat issues and their business has continued to grow. The directors are also advised that, should any civil claims arise in the future (and they are expecting them), their insurers will continue to defend their	Catastrophic	Possible	15						

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Board of Directors		
Report title: Fit and Proper Persons Test for Board Members		Meeting date: 31 January 2024
Report appendix:	Privacy Notice Updated Fit and Proper Persons Test (FPPT) Standing Operating Procedure (SOP)	
Report sponsor:	Director of Corporate Governance and Trust Secretary	
Report author:	Corporate Governance Manager	
Report provenance:		
Description/Purpose of the report and key issues for consideration/decision:	As reported to the Board in September 2023, NHSE published a new Fit and Proper Person Test (FPPT) Framework (the "Framework") on 2nd August 2023 alongside guidance for Chairs and staff on implementation. The revised Framework applied to new appointments from 30th September 2023 and must be implemented fully for all new and existing officers by 31st March 2024. The Framework was revised in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also took into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles. The Trust's Fit and Proper Person Standard Operating Procedure (SOP) and processes have now been reviewed and revised in conjunction with new guidance. The revised Trust SOP is appended for Board of Directors' review and approval. The principal changes relate to the use of and access to ESR (our electronic record system) as the mechanism by which we store and process the FPPT as well as the creation of and utilisation of standard form references for Trust officers. These are summarised in more detail below: • The Electronic Staff Record (ESR) will be used to store information related to FPPT checks and references. This will provide a standard way to record and report compliance internally. Retrospective population of data is not proposed. • FPPT good character assessment checks: To evidence appropriate care, skill and knowledge, the FPPT introduces a requirement to store training records as well as any complaints or investigations, even if unfounded, for a period of six years. DBS checks will also be required at a three-year frequency. Other checks required annually: social media and employment tribunal (new)/ directorship/trustee registers and insolvency checks(existing). At recruitment a medical clearance for fitness to hold the role will continue to be required. • The framework introduces a new NHS standardised board member reference. These should be created and stored whenever a board member leaves an NHS organisation, regardless of whether they are moving immediately to another	

	NHS role and should be sought by employing NHS organisations when making a Executive or Non-Executive role offer. The template has been included within the Trust's revised Standing Operating Procedure, as appended. • The framework provides a new template for the self-attestation (declaration); we have adopted the additional fields in our self-declaration template, as appended. • There is a stronger emphasis on the responsibilities of the Chair more broadly and Senior Independent Director in respect of the former, noting the role of appraisals as part of the ongoing nature of the FPPT. • There is a requirement for an annual submission to be made to the NHS England Regional Director confirming that the FPPT has been completed and the outcome of it which must be signed by the Chair; for 2024 the deadline is June 2024 but going forward this is expected to align with appraisals in Q1 of the following year. The FPPT Framework asks organisations, from the end of Q1 in 2024/2025, to incorporate the Leadership Competency Framework (LCF) into annual appraisals of all board directors. Where the FPPT Framework refers to appraisal, it means the annual performance appraisal. In future years, the appraisal/LCF and FPPT assessment should all align. The full implementation of the framework is reliant on NHSE support and roll-out, notably: • National changes to ESR, which have now been implemented and are available for local use. • A DPIA for ESR (data protection impact assessment), which has been completed by the NHS Business Services Authority (NHSBSA) who host ESR and NHS England. • Publication of the forthcoming NHS Leadership Competency Framework and the Board Appraisal Framework (expected later in 2023/24). Please note: NHS organisations, as data controllers, must communicate to all directors whose details will be included in ESR and local records. Directors are therefore asked to raise any concerns regarding the proposed use of their data, to enable NHS England and participating data controllers (i.e. The Trust) to consider these concerns and amend their approach if necessary. A link to the full framework and supporting guidance is provided here: NHS England » NHS England Fit and Proper Person Test Framework for board members		
Action required:	**For information** ☐	**To receive and note** ☐	**To approve** ☒

Recommendation:	The Board of Directors is asked to: i.) Note the changes as set out by NHS England in the new Fit and Proper Persons Framework ii.) Confirm and acknowledge that information for all Board members will be held on ESR. Board members should object if they have data privacy concerns so that these can be considered and the approach amended if necessary. iii.) Review and approve the revised Trust Fit and Proper Persons SOP
Summary of key elements	
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	Compliance with the FPPT guidelines will ensure regulatory compliance, that all new and existing Board Director appointments meet the FPPT and will support the Trust in meeting its objectives.
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 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	National policy, guidance

Torbay and South Devon NHS Foundation Trust

Fit and Proper Persons Test (FPPT) Privacy Notice

Torbay and South Devon NHS FT is required to provide you with details on the type of personal information which we collect and process. In addition to any other privacy notice which we may have provided to you, this notice relates to the information collected and processed in relation to the FPPT.

The FPPT in ESR is commissioned by NHS England.

Contact:	Adel Jones, Deputy Chief Executive/Director of Transformation and Partnerships
Address:	Torbay Hospital, Lowes Bridge, Torquay, TQ2 7AA
Phone Number	01803 614567
E-mail:	tsdft.siro@nhs.net

The type of personal information we collect is in relation to the FPPT for board members and is described below, much of which is already collected and processed for other purposes than the FPPT:

1. Name, position title (unless this changes).
2. Employment history – This would include detail of all job titles, organisation, departments, dates, and role descriptions.
3. References.
4. Job description and person specification in their previous role.
5. Date of medical clearance.
6. Qualifications.
7. Record of training and development in application/CV.
8. Training and development in the last year.

9. Appraisal incorporating the leadership competency framework has been completed.
10. Record of any upheld, ongoing or discontinued disciplinary, complaint, grievance, adverse employee behaviour or whistle-blow findings.
11. DBS status.
12. Registration/revalidation status where required.
13. Insolvency check.
14. A search of the Companies House register to ensure that no board member is disqualified as a director.
15. A search of the Charity Commission's register of removed trustees.
16. A check with the CQC, NHS England and relevant professional bodies where appropriate.
17. Social media check.
18. Employment tribunal judgement check.
19. Exit reference completed (where applicable).
20. Annual self-attestation signed, including confirmation (as appropriate) that there have been no changes.

Processing of this data is necessary on the lawful basis set out in Article 6(1)(e) UK GDPR as the foundation for the database. This is because it relates to the processing of personal data which is necessary for the performance of the fit and proper person test which is carried out in the public interest and/or in the exercise of official authority vested in the controller.

For CQC-registered providers, ensuring directors are fit and proper is a legal requirement for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and organisations are required to make information available connected with compliance to the CQC.

How we get the personal information and why we have it

Most of the personal information we process is provided to us directly by you as part of your application form and recruitment to satisfy recruitment checks and the FPPT requirements.

We may also receive personal information indirectly, from the following sources in the following scenarios:

- References when we have made a conditional offer to you.
- Publicly accessible registers and websites for our FPPT.
- Professional bodies for FPPT to test registration and or any other 'fitness' matters shared between organisations.
- Regulatory bodies, eg CQC and NHS England.

We use the information that you have given us to:

- conclude whether or not you are fit and proper to carry out the role of board director
- inform the regulators of our assessment outcome.

We may share this information with NHS England, CQC, future employers (particularly where they themselves are subject to the FPP requirements), and professional bodies.

Under the UK General Data Protection Regulation (UK GDPR), the lawful bases we rely on for processing this information are:

- We need it to perform a public task.

How we store your personal information

Your information is securely stored. We keep the ESR FPPT information including the board member reference, for a career long period. We will then dispose of your information in accordance with our policies and procedures (Retention of Corporate Records Policy and Personal Files Procedure).

Your data protection rights

Under data protection law, you have rights including:

- Your right of access – You have the right to ask us for copies of your personal information.
- Your right to rectification – You have the right to ask us to rectify personal information you think is inaccurate. You also have the right to ask us to complete information you think is incomplete.
- Your right to erasure – You have the right to ask us to erase your personal information in certain circumstances.
- Your right to restriction of processing – You have the right to ask us to restrict the processing of your personal information in certain circumstances.
- Your right to object to processing – You have the right to object to the processing of your personal information in certain circumstances.
- Your right to data portability – You have the right to ask that we transfer the personal information you gave us to another organisation, or to you, in certain circumstances.
- You are not required to pay any charge for exercising your rights. If you make a request, we have one month to respond to you.

Please contact us at [insert email address, phone number and or postal address] if you wish to make a request.

How to complain

If you have any concerns about our use of your personal information, you can make a complaint to us at:

Data Access and Disclosure Office
Belmont Court
Torbay Hospital
Torquay
TQ2 7AA
Tel: 01803 654868
Email: dataprotection.tsdft@nhs.net.

You can also complain to the ICO if you are unhappy with how we have used your data.

The ICO's address

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Helpline number: 0303 123 1113 ICO website: https://www.ico.org.uk

NHS
Torbay and South Devon
NHS Foundation Trust

The Fit and Proper Persons Regulations Standard Operating Procedure

This procedure outlines the requirements and responsibilities for ensuring that all Executive Director and Non-Executive Director appointments are compliant with The Fit and Proper Persons Regulations both on appointment and during ongoing employment.

If you require further help in the interpretation of this document please contact the Trust Secretary

If this document has been printed please note that it may not be the most up-to-date version. For current guidance please refer to the Trust Website.

Document Control	
Procedure Ref No & Title:	The Fit and Proper Persons Regulations Procedure
Version:	V4.0
Replaces / dated:	n/a
Author(s) Names / Job Title	Trust Secretary
Ratifying committee:	Board of Directors
Director / Sponsor:	Trust Secretary
Primary Readers:	Executive and Non-Executive Directors Members of the Chief Executive Office Office of the Chair and CEO Senior members of the People Directorate Communications Team
Date approved:	31 January 2024
Date for review:	January 2026

Contents

1. Introduction

1.1. The Fit and Proper Persons Regulations (FPPR) were introduced in response to concerns raised following investigations into Mid Staffordshire NHS Foundation Trust and Winterbourne View Hospital.

1.2. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 require all Trusts to ensure that "Directors of the service provider" (or anyone performing similar or equivalent functions) are individuals who meet the requirements of FPPR. These regulations were introduced in November 2014 and the fundamental standards came into force in April 2015. Further details can be found on the Care Quality Commission's (CQC) website: http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-5-fit-proper-persons-directors

1.3. The regulations stipulate that Trusts must not appoint or have in place Directors unless they meet the FPPR standards. While it is the Trust's duty to ensure that they have fit and proper Directors in post, the CQC has the power to take enforcement action against the Trust if it considers that the Trust has not complied with the requirements of the FPPR. This may come about if concerns are raised to the CQC about an individual or during the annual well-led review of the appropriate procedures.

1.4. In response to the Kark Review in 2019, NHS England published in 2023 a Fit and Proper Persons Test Framework for Board Members, NHS England » NHS England Fit and Proper Person Test Framework for board members which needs to be complied with in conjunction with CQC regulation.

1.5. For Torbay and South Devon NHS Foundation Trust ('the Trust'), "Directors of the Service Provider" are defined as all members of the Trust Board, being all Non-Executive Directors, voting and non-voting Executive Directors and the Trust Secretary.

1.6. This procedure outlines the application of FPPR for all Directors of the Service Provider as outlined in section 1.5, including interim appointments.

2. Purpose

2.1. The purpose of this procedure is to ensure the Trust complies with 'The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons: Directors'. As noted above, further details are provided in the CQC Guidance for NHS Bodies: Fit and Proper Persons: Directors, November 2014 and can be found on their website: http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-5-fit-proper-persons-directors

2.2. The purpose of this procedure is to ensure its Directors are at appointment and remain fit and proper persons to lead an NHS Trust, with the appropriate knowledge and skills, as well as enabling the Trust to operate in line with legal and regulatory requirements.

3. Definitions

3.1. **CQC** -Care Quality Commission

3.2. **FPPR** - The Fit and Proper Persons Regulations

3.3. **NEDs** - Non-Executive Directors

4. Duties within the Organisation

4.1. **Chair –** The Chair is the Responsible Officer for discharging the FPPR requirement placed on the Trust, to ensure that all relevant post holders meet the fitness test and that they do not meet any of the 'unfit' criteria set out in the FPPR. For new appointees, the Chair will be presented with information setting out the individual's compliance with the FPPR requirements.

4.1.1. Should the Trust wish to proceed with the recruitment of a Director to the Board before all of the FPPR checks have been completed, or in circumstances where an individual does not meet the FPPR, the Chair must take responsibility for this decision which must be documented in writing and the reasons reported to the Board.

4.1.2. In respect of the Chair's appointment the aforementioned responsibilities (4.1 and 4.1.1 inclusive) fall upon the Senior Independent Director.

4.2. **Voting Board Directors and regular Board attendees who are direct reports to the Chief Executive –** To comply with the Trust's FPPR procedure in order to ensure that the annual requirement for each individual's FPPR assurance is delivered.

4.3. **Trust Secretary** - To act as the main point of contact in relation to the FPPR process and to provide regular FPPR documentation updates, for administering by the Corporate Governance Manager, and to oversee the administration of the FPPR process from start to finish for those to whom the FPPR applies.

4.4. **Resourcing Hub –** To support the Trust Secretary with the compliance checks for FPPR, including a check of the FPPR paper and electronic files at least annually, and whenever a new appointment is made.

4.5. **Corporate Governance Manager –** To coordinate the annual FPPR declaration process and ensure that all documentation is received and recorded (See Appendix 2). To receive updated FPPR documentation for Directors of the Board and to oversee the administration of their Fit and Proper Person files, ensuring that files are in good working order.

4.6. The Trust will take steps to ensure the continued compliance with FPPR of the Chair and NEDs by undertaking annual checks.

5. Meeting the FPPR Requirements

5.1. The Trust will make every reasonable effort to assure itself about existing post holders, including interim appointments and new applicants and to make information about the compliance of Directors of the Board available to the CQC on request. The following is a summary of the FPPR requirements:

- Are of good character
- The individual has the qualifications, competence, skills and experience that are necessary for the relevant office or position or the work for which they are employed

- The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed

- Can supply relevant information as required by Schedule 3 of the Act, i.e. documentation to support the FPPR.

- The individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity

- Are prohibited from holding the office in question under other laws such as the Companies Act 2006 or Charities Act 2011

- As the Trust is an apolitical organisation, to meet the FPPR requirements an individual cannot be a serving Member of Parliament (MP) or a candidate for election as MP.

- In addition, individuals cannot be a Chair or Member of the Integrated Care Board or employee of such organisation or similar.

- In the case of Non-Executive Directors only, NEDs cannot be an employee of the Trust.

- None of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual.

5.2. In accordance with Schedule 4, Part 2, of the Act a person will fail the 'good character' test if they have been:

- Convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence.

- Erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

5.3. The table below sets out how the Trust makes these compliance checks:

FPPR Requirement	Check	Regularity
The individual is of good character.	References Board Member Reference Template	On appointment
	Social media check	On appointment, annually and with ongoing internet alerts
	Interview	At recruitment stage
	DBS if applicable and in line with the DBS guide lines	On appointment and annually thereafter
	Declarations of Interest Form	
	Professional Standards Authority Form	

The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed.	Application	At recruitment stage
	Interview	At recruitment stage
	References	On appointment
	Qualifications	On appointment
	Professional registration	On appointment and annually thereafter
The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed.	Occupational Health Assessment	On appointment
	References	On appointment
	DBS	Three yearly
	Search of registers: Companies House Disqualified Directors Insolvency Registers Removed Trustees CCJ or High Court Judgements Employment Tribunal Judgements	On appointment and annually thereafter
	Director Code of Conduct Self Declaration	
	FPPR Self-Declaration Form	
None of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.	Professional Standards Authority Form	On appointment and annually thereafter
	Director Code of Conduct Self Declaration	
	FPPR Self-Declaration Form	
	Secondary Employment Form (Executive Directors)	

5.4. Directors of the Board will not be able to commence in post unless the FPPR requirements have been met. However, there may be exceptional circumstances where, in the interests of the efficient running of the organisation and/or to ensure that the requirements of our licence are fulfilled, an Executive Director or NED may start work before all components of the FPPR have been met. The Chair is the Responsible Officer for making an informed decision regarding the course of action to be followed and will confirm their authorisation for the Executive Director or NED to start prior to the FPPR being met. This has to be documented in writing and the reasons reported to the Board.

5.5. Please note that commencement of an appointment is subject to the expectation of the appointee successfully meeting the FPPR requirements. If they do not meet the requirements then their appointment may be terminated with immediate effect.

6. **FPPR at the Recruitment Stage and Ongoing Basis**

6.1. The document ‘Complying with FPPR at the Recruitment Stage’ sets out the Trust’s requirements for ‘Complying with FPPR at the recruitment stage’. The People Directorate is the lead department for conducting and completing the FPPR checks as part of the recruitment process. Once completed, the information should be sent to the Office of the CEO and Chair for storage and ongoing FPPR checks

6.2. The 'Complying with FPPR on an Ongoing Basis' document sets out the Trust's requirements for 'Complying with FPPR on an ongoing basis'. The Trust Secretary, with the support of the Resourcing Hub and the Corporate Governance Manager, is the lead for conducting and completing the FPPR checks on an ongoing basis.

6.3. The NHS Employment Check standards apply to applications for NHS positions, including permanent staff, staff on fixed-term contracts, volunteers, students, trainees, contractors, highly mobile staff, temporary workers (including locum doctors), those working on a Trust bank, and other workers supplied by an agency. The checks are intended to provide assurances that staff working in the NHS are appropriately registered, qualified, experienced and do not pose a risk to patients. NHS organisations are required to show evidence of their compliance with these standards as part of the CQC's regulatory framework. These checks will be conducted for all new Directors of the Board, including interim positions.

6.4. The NHS Employment Check standards are on the NHS Employers website and checks will be taken out in line with these. Currently the NHS Employment checks are as set out below though they change from time to time:

- Identity Checks – reducing the risk of employing illegal workers and impersonators
- Right to Work in the UK Check
- Professional Registration (where appropriate) and Qualification Checks
- Criminal Record and Barring Checks – reducing the risk of employing criminals
- Employment History and Reference Checks – reducing the risk of employing staff with unsuitable or unsatisfactory employment records
- Work Health Assessments – reducing the risk of employing staff that are not correctly immunised or not fit for work (pending reasonable adjustments).

6.5. In addition to the NHS and NHSE pre-employment checks, the following checks will be conducted for all new Directors of the Board, including interim positions:

- Search of insolvency and bankruptcy register
- Search of disqualified directors register
- Charity Commission Register of Removed Trustees
- County Court or High Court Judgements
- Employment Tribunal Judgements
- The Director completes a self-declaration of interests form and a FPPR self-declaration form
- An appropriate media, social media and news search is conducted.

6.6. The process for assurance includes a check of personal files to ensure there is a complete employment history and, where there are any gaps or omissions, the post holder will be asked to provide a written explanation for this. Where the Trust has no record of mandatory qualifications or mandatory professional registration, the individual will be asked to produce the original for inspection and verification. Where documentation against FPPR checks is not available due to historical timescales, the Trust will make every effort to obtain relevant, alternative records where appropriate. "Historical" is defined as instances where documentation is not available, whether due to having been mislaid or not having been requested at the appropriate time; instances, for example, where interview panel paperwork has been mislaid or where reference checks were stored electronically and subsequently mislaid due to staff changes. Alternative documentation may include, for example, requesting a letter of endorsement where a reference check has been

mislaid and contacting the awarding institution for proof of qualification where original certificates of qualification have been mislaid.

6.7. If the appointment is a joint appointment with another Trust, the host organisation is required to undertake the FPPR checks and provide assurance to the other organisation that they have been completed satisfactorily. If an individual holds a Board level position at two organisations, both are required to undertaken FPPR checks to their satisfaction.

6.8. On leaving the Trust, there is now a requirement to complete a Board member reference to retain on the individual's file. Ideally this should be completed in conjunction with the departing individual.

6.9. If any issues arise as a result of the FPPR process, an interview may be conducted by the Chair or their nominated Deputy. Further documentary evidence may be required to support this process and should be provided on request.

6.10. An FPPR self-declaration form and all associated documentation regarding FPPR will be retained on the individual's personal file.

6.11. The Chair will be notified of specific issues of non–compliance with the FPPR and is the Responsible Officer for making an informed decision regarding the course of action to be followed.

6.12. New fields have been added to the Trust's Electronic Patient Record (ESR) to enable it to comply with the need for ESR to hold FPPR information for board members, in line with the new guidance. The guidance states that the following can have access to this data on ESR if necessary:

- Chair
- Chief Executive Officer (CE)
- Senior Independent Director (SID)
- Vice Chair
- Trust Secretary
- Chief People Officer

7. FPPR Monitoring and Review

7.1. The Board of Directors is required to review, check and agree the outcome of the annual FPPR assessment of continued fitness and to record in the minutes of the meeting that due process has been followed. FPPR annual assurance will be formally addressed by the Board of Directors in the Quarter 4 meeting.

7.2. Assurance that FPPR assessments have been undertaken for Non-Executive Directors will be provided to the Council of Governors in Quarter 4.

7.3. Assessment of all Directors' continued fitness is to be undertaken each year as part of their appraisal process and overseen by the Trust Secretary.

7.4. On an annual basis a report will be provided to the Board of Directors to provide assurance that the 'Directors of the Service Provider' remain Fit and Proper people.

7.5. A FPPR process and review of all Director FPPR files will be undertaken at Quarter 4 each year.

7.6. Following the annual FPPT assessments, the Chairman is required to submit a report to NHSE to confirm the annual process has been completed satisfactory and also to provide assurance on the FPPT process for starters and leavers in the reporting period.

8. References

Care Quality Commission, (January 2018). *Regulation 5: Fit and proper persons: directors, Guidance for providers and CQC inspectors*.

Care Quality Commission, *Regulation 5: Fit and proper persons: directors.*

NHS Employment Standards.

NHS England Fit and Proper Persons Test Framework for Board Members

The following documents, referenced above, will be available in the Corporate Documents Library on ICON, as issued from time to time:

- Annual NHS FPPT Submission Reporting Template
- Board Member Reference template
- Complying with FPPR at the Recruitment Stage
- Complying with FPPR on an Ongoing Basis
- Confirmation letter re joint board member post
- Declaration of Interest Form
- Departing Board Member Reference template
- Director Code of Conduct
- FPPR Self-Declaration Form
- Professional Standards Authority Form
- Secondary Employment Form (Executive Directors)