Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors

Date: **Wednesday 27th March 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

27/03/2024 11:30

Torbay and South Devon NHS Foundation Trust

	6.2	Chief Executive's Report Receive and Note	CEO	12:10-12:25	59
7.	Safe Quality Care and Best Experience				73
	7.1	Integrated Performance Report (IPR): Month 11 2023/24 (February 2024 data) Receive and Note	CMO	12:25-12:40	73
	7.2	Care Quality Commission Maternity Inspection Report and Action Plan Receive and Note	ICNO	12:40-12:50	126
	7.3	The improvement plans developed in response to the results of the Care Quality Commission (CQC) NHS Patient Experience Survey programme for 2023 Receive and Note	ICNO	12:50-13:00	132
	7.4	Maternity Workforce Oversight Report Receive and Note	ICNO	13:00-13:10	147
	7.5	Safe Staffing 6-month Review (July 23 – December 2023) Receive and Note	ICNO	13:10-13:20	161
	7.6	BREAK		13:20-13:30	
	7.7	Torbay Carers' Interagency Strategy Approve	ICNO	13:30-13:40	179
8.	Valuing our Workforce				207
	8.1	Board member EDI Objectives Approve	CPO	13:40-13:50	207
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	9.1	Fundraising Strategy Receive and Note	DCEO/CSTO	13:50-14:00	209
	9.2	Sustainability Position and Green Plan Implementation Receive and Note	ICFO	14:00-14:10	224
	9.3	Board Assurance Framework and Corporate Risk Register Receive and Note	DCG	14:10-14:15	303
10.	Compliance Issues				
11.	Any other business notified in Advance				

12. Date and time of Next Meeting - 11.30am, Wednesday 24 April 2024

NHS
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NHS Foundation Trust

OUR STRATEGY AND PURPOSE

Our Vision

- Our vision is better health and care for all

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'
- Reduce inequity and build a healthy community with local partners
- Relentless focus on quality improvement underpinned by people, process and technology
- Build a healthy culture at work everyone feels safe, healthy and supported
- Improve access to specialist services through partnerships across Devon
- Improve financial value and environmental sustainability

Our Enabling Plans:

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

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MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARDROOM, HENGRAVE HOUSE
AT 11:30AM ON 28 FEBRUARY 2024

Present:	Sir Richard Ibbotson	Chairman
	Mrs Liz Davenport	Chief Executive Officer
	Dr M Beaman	Non-Executive Director
	Mr M Brice	Interim Chief Finance Officer
	Mr A Chandran	Chief Operating Officer
	Mr R Crompton	Non-Executive Director/Vice Chairman
	Ms B Gregory	Non-Executive Director
	Dr C Lissett	Chief Medical Officer
	Ms A Jones	Deputy Chief Executive Officer/Chief Strategy and Transformation Officer
	Mrs E Long	Director of Corporate Governance and Trust Secretary
	Mrs V Matthews	Non-Executive Director
	Mrs N McMinn	Interim Chief Nurse
	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
	Mr R Williams	Associate Non-Executive Director
In attendance:	Mrs S Fox	Corporate Governance Manager
	Mrs A Hall	Governor
	Mr S Hughes	Mortuary Manager (for item 35/02/24)
	Ms R McCoy	Associate Director of Operations (for item 35/02/24)
	Mr P Milford	Lead Governor (part meeting)
	Mr A Postlethwaite	Governor

022/02/24 **Welcome and Introductions**

The Chairman welcomed all those in attendance to the meeting.

Preliminary Matters

023/02/24 **Apologies for Absence and Quoracy**

An apology for absence was received from Professor Chris Balch, Non-Executive Director who was at a National NHSE meeting on behalf of the Trust.

024/02/24 **Declarations of Interest**

The Board did not receive any declarations of interest.

025/02/24 **Patient Story**

The patient story was presented by a patient (George) who had been part of the Cancer Prehabilitation Pilot. The pilot aimed to prepare patients both physically and mentally for cancer treatment and surgery.

Both George and his wife, Sheila, told the Board about the benefits of the pilot not just in terms of physical and mental wellbeing, but the support from the team who delivered the classes.

It was noted that, in some cases, the classes had enabled patients who were originally declared not fit for surgery to be able to have their surgery.

As a measure of the success of the pilot, the Prehabilitation Team had been presented with a South West Integrated Personalised Care Award for patient choice.

The Board reflected on the importance of personalised care, how this type of work supported the wellbeing of patients and in the long run reduced dependency on the Trust services by achieving more successful medical interventions.

026/02/24 **Board Corporate Objectives**
The Board received and noted the Board Corporate Objectives.

For Approval

027/02/24 **Minutes of the meeting held on 31 January 2024**

The Board approved the minutes of the meeting held on 31 January 2024. The action log was reviewed and updates received on outstanding actions.

Consent Agenda (Pre-notified questions)

Reports from the Executive Directors (for noting)

028/02/24 **Chief Operating Officer's Report - February 2024**
The Board received and noted the Chief Operating Officer's Report – February 2024.

Reports of the Chairman and Chief Executive

029/02/24 **Report of the Chairman**

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

- The Non-Executive Directors Nominations and Remuneration Committee had met and approved appointing Ms Jones substantively to the position of Deputy Chief Executive. In addition, it had been agreed to amend her job title to 'Chief Strategy and Transformation Officer' to more accurately reflect the portfolio of her work.
- Professor Balch would begin to shadow the current Chair from 1 May, so that a seamless handover could be achieved.
- Both the Chair and Chief Executive had recently visited the Shrublands Drug and Alcohol Unit which provided them with a better understanding of the complexity of the service provided and its importance in the community.
- The new Urology Centre at Paignton Hospital opened on 2 February. A lot of positive feedback was already being received from both colleagues and patients.

- The new Targetted Investment Fund theatre opened on 9 February. It would deliver an additional 3,000 Ophthalmology and 1,500 general day surgery procedures in its first year of operation.
- The Chairman recently visited Brixham Hospital. He reported that colleagues and patients he spoke to were happy and content.
- The Chairman would be representing the Trust at an event in Brixham on 4 March to celebrate 200 years of the Royal National Lifeboat Institute.

030/02/24 **Chief Executive's Report**

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

- There continued to be pressure in the hospital, however progress had been made around elective care performance and cancer pathways. The benefits of the Trust as an integrated organisation had helped to realise improvements in urgent and emergency care performance.
- There was a national expectation that Trusts met the 76% 4-hour emergency department target by the end of the financial year. Work continued to support delivery of this target.
- The Care Quality Commission (CQC) had published its report following an unannounced inspection of the Trust's maternity services towards the end of 2023. The CQC assessed the service as 'requires improvement'; they did however acknowledge the significant work already undertaken by the maternity team. In addition, the output of a recent CQC patient experience survey of maternity services had been very positive. The Trust's maternity team would work with its partners to continue to improve delivery of services and ensure wider learning was implemented at the Trust.
- Junior Doctors were undertaking a further period of industrial action. The Trust was working to ensure that the impact of this was minimised.
- Work was taking place to understand the implications of, and support delivery, of Martha's Rule.
- Ann James, the Chief Executive of Plymouth Hospitals Trust, would be retiring at the end of March. Ann had worked for the NHS for over 35 years. Ms Davenport would write to Ms James, on behalf of the Board, to thank her for her leadership, support and compassion, wishing her well for her retirement.

Safe Quality Care and Best Experience

031/02/24 **Integrated Performance Report (IPR): Month 10**

Ms Jones presented the Integrated Performance Report for Month 10 2023/24, as circulated, and asked the Board to note the following:

Quality

- During January there had been an increase in the number of closed beds compared to the previous month. This was due to the impact of cases of flu and norovirus. The increase was expected at this time of year and was a national trend.
- There had sadly been one neonatal death and one incident reported relating to a baby born with undiagnosed limb abnormalities in the reporting period.
- The Trust's performance in respect of patients with a fractured neck of femur had slightly deteriorated as a result of theatre activity needing to be reduced due to industrial action.

Workforce

- The Trust's substantive workforce was below plan due to the transfer of staff in Torbay Pharmaceuticals (TP). The underlying position remained above plan. Work continued to align finance, activity and workforce data.
- Workforce control measures that had been put in place were having a positive effect in supporting delivery of the Trust's financial targets.

Performance

- The Trust's performance in respect of ambulance handover times had deteriorated and was below the target of 1,284 hours lost, with reported lost hours being 1205. Performance had been challenged due in part to the loss of beds as a result of flu and norovirus.
- The Trust's 4-hour performance decreased in the month to 65.1% against a target of 70%.
- No criteria to reside performance continued to be positive.
- Planned care targets had been affected by industrial action, in particular 65 and 78 week waits.
- Cancer faster diagnostic targets were being met.

Finance

- At Month 10 the Trust was reporting a variance to plan of £3.81m.
- A forecast outturn adverse variance to plan of £8.95m was being reported, in line with the agreed revised control for the end of the financial year.
- The CIP target for 2023/245 was £46.6m and, to date, schemes with plans in place for delivery totalled £40m.
- The overall cash position was ahead of plan, largely due to the sale of TP.
- The Board wished to place on record its thanks to the finance team for the work undertaken to ensure the Trust's financial position was transparent and for delivery of the year end revised control total.
- The Board also welcomed the report and level of detail it contained, which would support the Trust in identifying its priorities for the coming year.
- Attention was drawn to the National Oversight Framework 4 exit criteria and the Trust's progress in meeting those criteria.

032/02/24 **Mortality Safety Scorecard - January 2024**

The Board received the Mortality Safety Scorecard, circulated with the agenda pack. The following was discussed:

- The Trust's Hospitalised Standardised Mortality Rate (HSMR) was below the expected mortality rate for the Trust.
- The HSMR rolling position presented a downward trend.
- It was noted that significant improvements had been made to the coding of patients who presented with co-morbidities and that this would further improve once the electronic patient record was implemented.
- The Trust's Summary Hospital Mortality Index looked at mortality in hospital and 30 days after discharge and was within expected ranges. This supported the work that the Trust had undertaken around discharge of patients and provided assurance that, where medically appropriate, earlier discharges did not affect mortality.
- The Trust was performing well compared to its peers.
- It was acknowledged that the influence of Covid was no longer being seen in the data presented.
- The benefits of patients having clear treatment plans in case of admission was discussed and that these were best completed before someone was admitted to hospital. It was suggested that agencies such as Age UK or GPs could support patients to formally articulate their wishes.

- It was agreed that further information would be provided to the Quality Assurance Committee with regard to cardiac arrest performance data. **Action: K Lissett**

033/02/24 **Assurance Framework for Seven Day Hospital Services**

The Board received the Assurance Framework for Seven Day Hospital Serviecs report, circulated with the agenda pack.

The seven-day standard framework which was published in 2013 was updated in 2016. The framework included a number of clinical standards that needed to be met and the report detailed the Trust's performance against these standards.

The benefits of implementing a full seven-day working model and whether the benefits that would bring would outweigh the cost of implementing the model will be reviewed on an ongoing basis.

Nationally, it was noted that long-term workforce planning would need to be put in place to ensure colleagues were available to enable hospitals to deliver a 7 day a week service. In addition, a social care workforce plan would also be required.

Adel Jones left the meeting and Peter Milford joined the meeting.

034/02/24 **Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training**

The Board received the Report of the Guardian of Safe Working Hours – Doctors and Dentists in Training report, circulated with the agenda pack. The following was highlighted:

- In the last three months 97 exception reports had been submitted. This was an increase of 37 compared to the previous quarter. This increase was expected following a new cohort of junior doctors joining the Trust in August of last year.
- One report related to a junior doctor working late and then being asked to return to the Trust early the next day. In respect of this case learning had been shared with the team around safe working hours and escalation processes if additional cover was required.
- The culture, which was becoming normalised, of working additional hours over those contracted was discussed, and the need for the Board to hold itself to account in this respect. It was also noted that colleagues joining the workforce would not tolerate working outside of agreed hours regularly, seeking a greater work-life balance and that the employment offer needed to account for that.
- The data helped to provide a heat map to identify any areas of concern. It was agreed work would take place to compare and triangulate this data to other data held by the Trust such as freedom to speak up concerns etc. **Action: KL/MW**

035/02/24 **Fuller Inquiry Brief and Outcomes**

Mr S Hughes , Mortuary Manager and Ms R McCoy, Associate Director of Operations, joined the meeting.

The Board received the Fuller Inquiry Brief and Outcomes Report, circulated with the agenda pack.

The Fuller Report (Phase 1) made recommendations, relating to mortuary management, specifically for the Trust where David Fuller had worked following an inquiry into issues raised by his case. A second, Phase 2 report, would be published that would contain recommendations for all providers of mortuary care.

Although the Phase 1 report did not contain any general recommendations for providers of mortuary care, the Trust had reviewed the recommendations to ascertain if it was compliant with them or not. The report detailed the Trust's compliance with those recommendations and where action had needed to be taken.

Mr Hughes provided assurance to the Board that there were no areas of concern in terms of mortuary practice. There had, however, been some concerns in respect of the capacity of the mortuary team and a business plan was in the process of being developed to support additional capacity. This was a risk that was well-articulated and included on risk registers.

It was noted that the services provided by the team were exemplary, for example members of the team being available to support bereaved families late at night to see a deceased family member, if requested.

Well Led

036/02/24 **Board Assurance Framework (BAF) and Corporate Risk Register (CRR)**

The Board received the BAF and CRR circulated with the agenda pack.

The Board had met earlier in the month to review the BAF and proposed objectives for 2024/25 to ensure they reflected the Trust's strategy. Board Sub-Committees would now review the objectives and consider risk appetite and tolerance for those aeras within their remit. Work would also be taking place ensure consequences and risks were aligned to provide a robust picture of the Trust's risk position and were aligned to strategic delivery.

The need to have separation between risks and actions was discussed and the need to ensure risks were addressed and closed down when appropriate. The Board was reminded that the Trust would always need to articulate and carry a level of risk as part of its business and this was acknowledged.

037/02/24 **Building a Brighter Future (BBF) Progress report – January 2024**

The Board received the BBF Progress Report, circulated with the agenda pack. The following was discussed:

- An update was provided to the Board on the progress made in respect of the site enabling business case and work, in conjunction with the national team, to agree a set of mitigating actions to reduce the timetable risk attached to the programme of works.
- Engagement with the National Hospitals Programme team was starting to accelerate, which was positive.
- A request for funding to cover fees for 2024/25 had been submitted to the national team.

- The increased focus by the national team on the Trust's progress was welcomed and it was hoped that this would support the Trust's position in the New Hospitals Programme timetable and receipt of funding.

038/02/24 **Compliance Issues**
None reported.

039/02/24 **Any other business notified in advance**
None discussed.

040/02/24 **Date and Time of Next Meeting:**
11.30 am, Wednesday 27 March 2024.

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
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. January Update – an executive to executive meeting would take place with Devon Partnership Trust prior to a Board to Board being arranged. February Update – an executive to executive meeting prior to a Board to Board meeting had been requested by Devon Partnership Trust and was in the process of being arranged. It was agreed this action could now be closed.	26.04.23
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	February Update – it was noted that this action related to the timeliness of assessments for people with mental health issues and learning disabilities. The Integrated Care Board had provided data detailing current performance and plans for 2024/25. The data showed that targets would be met both in 2023/24 and 2024/25. It was noted that learning disability clients were also being encouraged, and support provided, to write to their GPs to request improvement plans. Action closed.	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	February update – if a trial was conduced with patients as part of normal care, no payment would be provided. If additional clinical time was required it would not be taken from normal clinical activity. Action closed.	29.11.23
013/01/24	The need to ensure information from the community was captured within PSIRP and learning shared with community settings was acknowledged.	Ms McMinn	February update – assurance was provided that the plan included community services. Work would take place to ensure adult community services were also included. Action closed.	31.01.24
014/01/24	Provide report from the Community End of Life Group.	Ms McMinn	February update – to be included as an agenda item on the March Board agenda.	31.01.24
032/02/24	Provide information to the Quality Assurance Committee around mortality data associated with cardiac arrests.	Dr Lissett	March Update - Katherine Mellor to prepare a resuscitation report to come to QAC yearly in October. ACTION: Closed	28.02.24
034/02/24	Triangulate data from Junior Doctor exception reports with that obtained from freedom to speak up issues and other sources.	KL/MW	March Update – This would be key work of the Guardian of Safe Working Hours and will be ongoing.	28.02.24

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

The prolonged operational pressure experienced in February was attributed to a combination of industrial action, increased infection outbreaks, rise in acuity levels, and overall attendance rates. These challenges required the organisation to implement ongoing escalation measures to manage the surge of patients effectively, while ensuring the delivery of high-quality care.

Month	OPEL 1	OPEL 2	OPEL 3	OPEL 4
Apr-23	0	8	17	5
May-23	0	7	10	12
Jun-23	0	7	17	6
Jul-23	12	7	12	0
Aug-23	0	10	16	5
Sep-23	0	1	19	10
Oct-23	0	3	15	11
Nov-23	0	4	14	10
Dec-23	2	8	17	4
Jan-24	0	0	11	18
Feb-24	0	2	10	17

3.0 Winter Plan

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

- The frailty unit opened on 8th January, and they have made progress in the admissions avoidance pathway.
- Virtual ward continues to treat over 50 patients. Work is being done to extend the service to other specialities.
- The Families and Communities care group supported by the Medicine and Urgent Care group are progressing well with the care coordination hub initiative and are looking to extend the service further to include care homes.

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

February saw 8,346 attendances for the integrated care organisation (ICO). This was an average of 287 patients per day. This represents an increase of 696 attendances compared to February 2023.

Performance was behind the trajectory for the National Operating Framework (NOF4) recovery target of 72% at 63.29%. This a further drop of 2% on the previous month and can be attributed to a deterioration in non-admitted performance. In February 2023 4hr performance was 56.99%

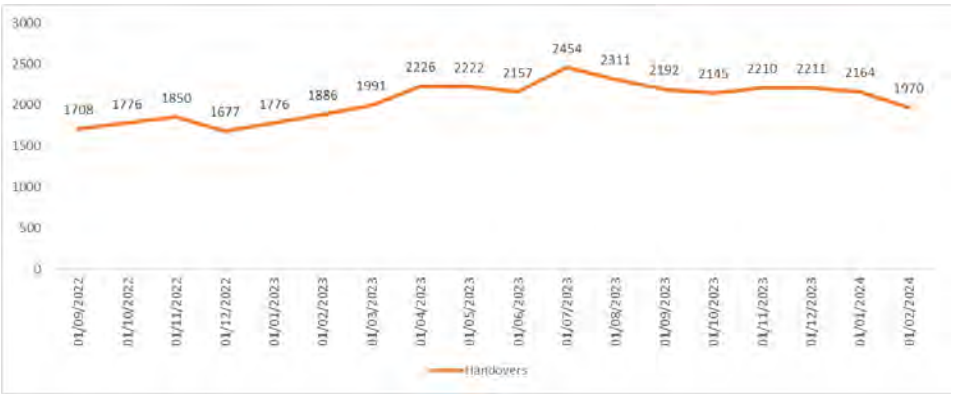
Community Urgent Care - Urgent Treatment Centre (UTC) and Minor Injuries Unit (MIU) performance remains consistently above 99%.

4.1 Ambulance Handovers

The volume of ambulance handovers shows a decrease in February 2024 of 194 episodes compared to January 2024 at 1,970. This is an increase of 84 from February 2023.

Thursday 1 September to Sunday 31 December - Monthly data

Month starting 1st September 2022 - Total handovers 1708



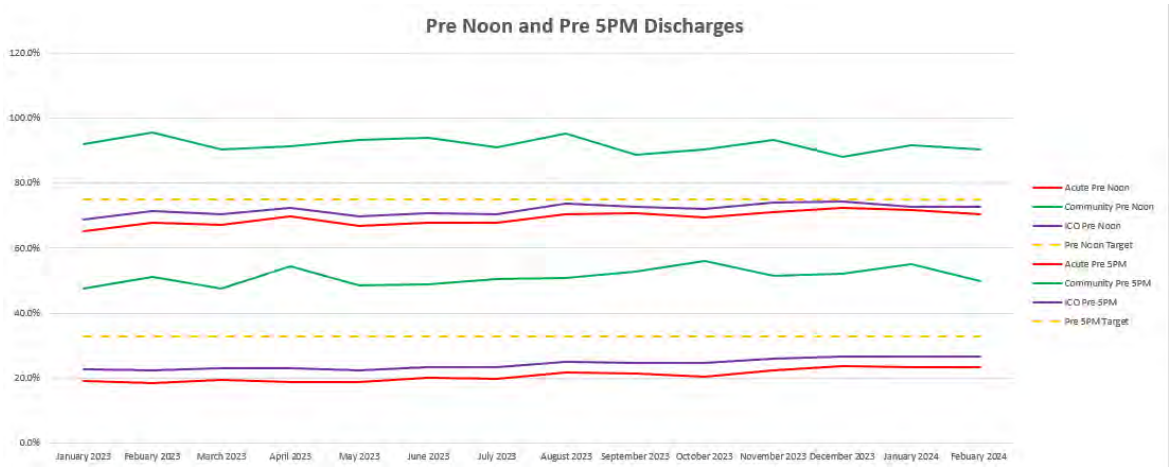
The average time lost per ambulance to handover, is 1hr 53 minutes (incl. the 15 mins) in February 2024, this is a marginal improvement from January's reported position where the average handover time was 1hrs 55 minutes. This is a significant increase from February 2023 where the average handover time was 35 minutes 47 seconds.

Thursday 1 September to 29/02/2024 - Monthly data

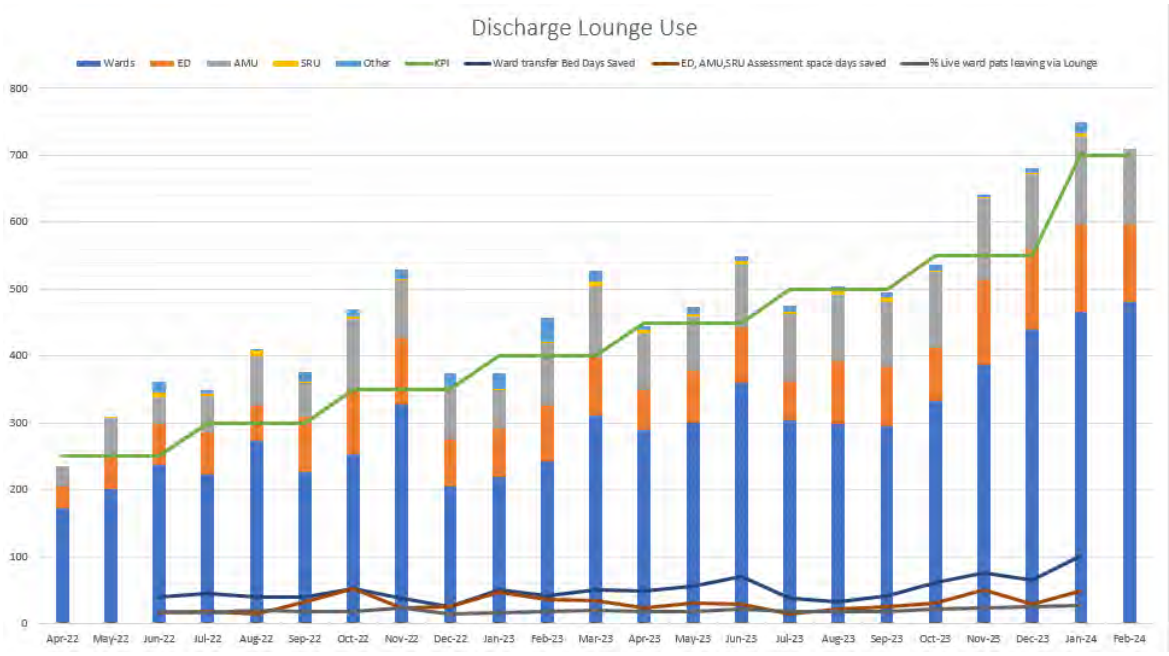
Month starting 1st September 2022 - Average handover time - 01:52:53

4.2 Inpatient Flow

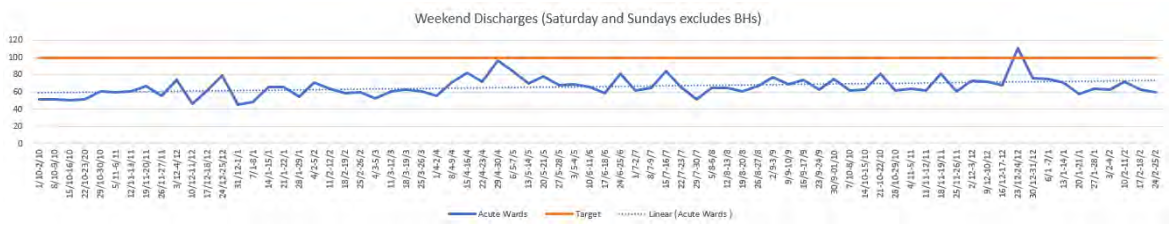
Across the Integrated Care Organisation (ICO) (including our community hospitals), there were 1,850 discharges from our adult inpatient areas. Of which 26.5% of patients were discharged by noon and 72.8% pre-5 PM. The efficient discharge processes in place continues to help ensure that our patients are able to return home or continue their care in a different setting in a timely manner, which supports better outcomes and satisfaction for both patients and staff.



The discharge lounge supported 709 patients in February. Expanding the lounge's availability to weekends and overnight from Sunday to Wednesday are positive steps towards optimising bed turnover and delivering timely patient care.



Weekend discharges continue to be below expectation. In February, on average we discharged 65 patients across the weekend from our adult inpatient base wards. With the support of the wider organisation, we continue to scope out workstreams to improve the number of discharges at the weekends. This includes the recent increase in senior medical decision making at the weekends with a focus on admission avoidance from the emergency department (ED) and the assessment units.

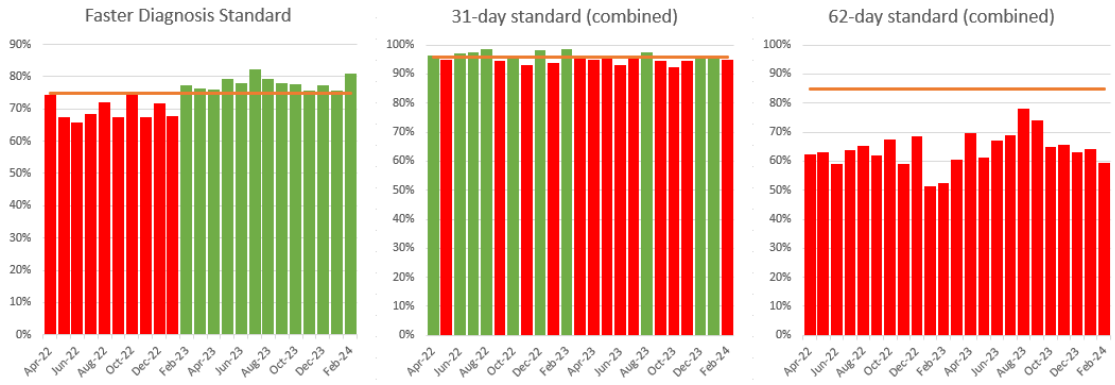


5.0 Cancer

5.1 Cancer Demand

In February, Torbay and South Devon NHS Foundation Trust (TSDFT) received 1,887 urgent suspected cancer referrals. Since April 2023 our referral growth is at 7.5%, which equates to an additional 133 referrals per month, compared to the equivalent period last year.

5.2 Cancer Performance



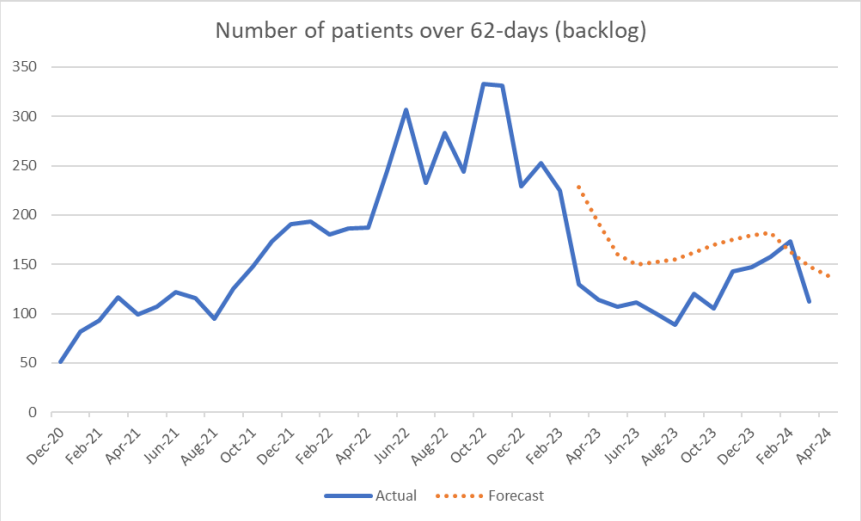
February's performance against the 28-day Faster Diagnosis Standard (FDS) is projected to reach 81.0%. Notably, we have recently completed the final submission of January's position, marking us as one of only 20 trusts nationwide (and the only trust in the South West) to sustain this standard for an entire year.

31-day performance remains consistent, but currently not achieving the standard, at 94.9% in February (96% target). Among the 20 patients who missed the target, the majority experienced delays of under 10 days. Plastic surgery (9) and Colorectal (8) delays accounted for the largest proportion of the breaches. A comprehensive review of theatre allocation is nearing completion, guided by the evaluation of specialty demand and clinical availability. This strategic initiative aims to address the root causes of delays and support the reduction of 31-day waiting times.

The 62-day standard for February is currently at 59.3%, against the 85% target. This seasonal decline is not uncommon, as all these patients were referred before Christmas. Additionally, we have encountered challenges due to multiple Junior Doctor strikes over the past two months. Despite these obstacles, we have observed a smaller deterioration compared to previous years. Moreover, the reduction of the 62-day backlog during this period signals a positive trajectory for recovery.

Over 62-day Backlog (Open Pathways)

As of March 3rd, 2024, our backlog for patient tracking lists (PTL) over 62 days has reduced to 112, constituting 7.2% of the total PTL. Additionally, there are 24 patients who have been waiting for over 104 days. The Trust is on track to achieve our end of year forecast.



Outlook

The reduction in the 62-day backlog provides us confidence to have a positive outlook into March. Initial signs point towards a promising trajectory for the 62-day Referral to Treatment (RTT) performance, with expectations of exceeding 70% in March. Improvements in diagnostic waiting times, particularly across Urology, Gynaecology and Colorectal services have had the biggest contribution to this, coupled with the absence of any planned industrial action.

However, increases in diagnostic activity inevitably impact other clinical services, especially histopathology. The resilience and swift turnaround times of our pathology team is recognised regionally, however the additional biopsies from surgical teams has increased the pressure on their scarce physical and workforce resources. To mitigate this strain, the Trust has expanded our outsourcing practices to uphold the resilience of the service.

The introduction of home-reporting equipment in our radiology department is another positive development in the last month. This innovation offers greater flexibility and adaptability in reporting processes, allowing radiologists to work remotely. As a result, it will foster a better working environment and boost productivity within the department.

The NHS operational planning guidance for 2024/25 has yet to be finalised. However, we anticipate being tasked with maintaining a performance level of 70% for the 62-day standard. This will necessitate us to sustain our backlog position at its current levels. Additionally, for the 28-day Faster Diagnosis Standard, we foresee being assigned a more challenging target of 80%, up from the current 75%, to be achieved by March 2025. As well as the introduction of site-specific targets; with Breast and Skin aiming for an 85% target, while Urology and Gynaecology are expected to aim for a 60% target. Although the national steer is not formally confirmed, we are aligning our recovery plans to these metrics.

6.0 Referral to Treatment (RTT)

6.1 Long waits (February 2024)

- **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 Feb 2024. This is shown below:

		Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
78w	Actual	162	123	127			
	Forecast	153	129	85			

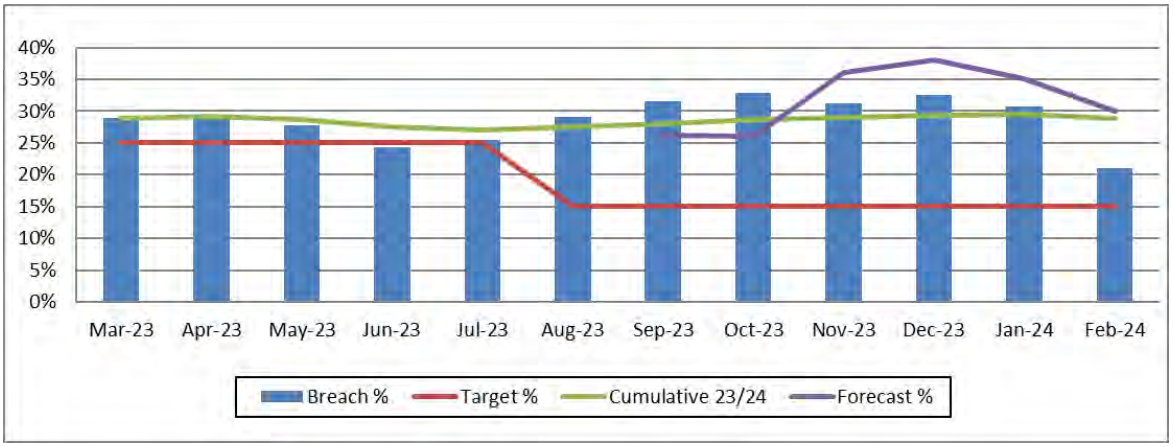
		Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
65w	Actual	836	740	694			
	Forecast	766	628	489			

		Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
52w	Actual	2,085	2,057	1,998			
	Forecast	2,177	2,049	1,882	1,714	1,547	

The Trust was on track to deliver the revised 78 week forecast of 85 in March 2024.

7.0 Diagnostics Performance

Our diagnostic performance has significantly improved in February 2024 and we are now compliant with the 25% target as a Trust. The Trust reported 21% of patients waiting longer than six weeks against the end of February target of 25% (step change to 15% end of March-24). 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).



- MRI still remains challenged but has improved from 40% in January to 31% in February. However, it is unlikely that MRI will recover back to under 25% and will not achieve 15% or lower until the Community Diagnostic Centres (CDC) opens in Summer 2024

- CT has significantly improved to 11% (January position 24%) which is compliant with the March target of 15%.

- Non obstetric ultrasound (NOUS) has significantly improved to 10% in February from 21% in January. This has also bought this modality into a compliant position with the March target of 15%.

- DEXA scans have significantly improved to 5% in February from 22% in January, ensuring compliance with the March target of 15%

- Neurophysiology remains challenged as a specialty with long waits but shows a slight improvement of 60% in February (66% in January)

- Colonoscopy has improved to 47% in February from 59% in January, this trajectory continues to improve month on month.

- Flexi-sig has improved to 56% in February from 67% on January. This trajectory continues to improve month on month.

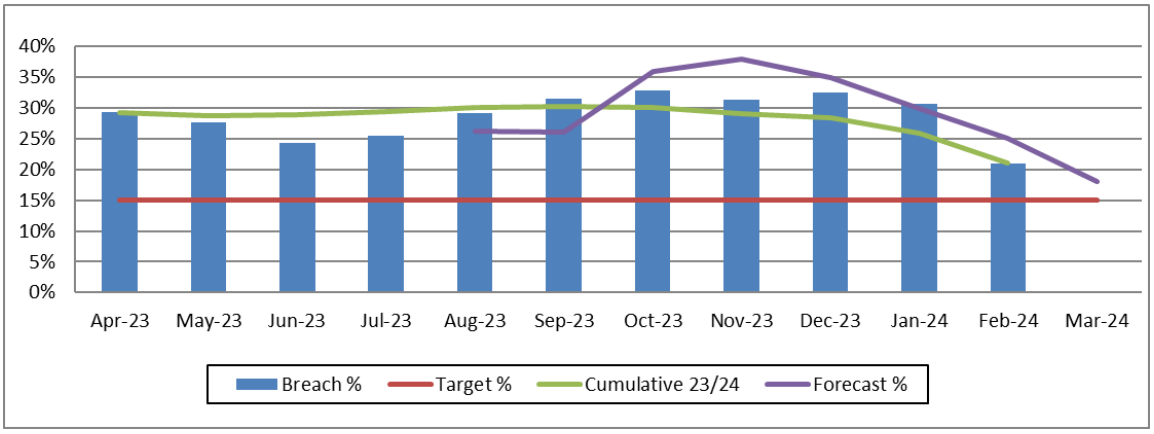
- Cystoscopy has significantly improved in February at 27% (49% in January).

- Echocardiology continues to hold steady at an improved performance, achieving target at 11% in February.

- Gastroscopy has significantly improved in February at 32% (40% in January).

DM01 Forecast – March 2024, target 15%

The overall trust DM01 prediction is 18% by end of March-24 against a 15% target.



8.0 Children and Family Health Devon (CFHD)

8.1 Performance

Due to SystmOne implementation on the 1st February 2024, there is no available service specific data for CFHD for the month of February 2024. Data shown below is for January 2024. **Narrative has been updated to reflect February 2024.**

January-February 2024 Integrated Nursing & Therapies *Data not validated at this point in the month*				
Service	**Number Waiting**	**Longest Wait**	**Over 18 weeks**	**Comments (Feb 24)**
Community Children's Nursing (inc Palliative)	8	3	0	Mean wait and RTT remains static, and children seen promptly based on need. Maternity leave in 2024 will have impact on performance, 3.6 WTE Band 6 nurses on M/L between Feb – Dec 24 (22% of workforce). Replacement costings only allow for 1.9 WTE fixed term contracts.
Specialist School Nursing	0	1	0	Mean wait and RTT remains static, and children seen promptly based on need.
Specialist Learning Disability	50	22	2	Mean wait remains static, slight decrease in RTT from 100% to 96%. Long term sickness in team, staff supported and on phased returns with OH guidance.
Physiotherapy	154	68	36	Mean wait and RTT remains static on previous month. New Physiotherapist started in January and interviewing for FTC and Band 4 in Feb 2024.
Occupational Therapy	694	75	400	Increase in mean wait and decrease in RTT from previous month. Planned leave impacting team and vacancies, agreement from COO to seek agency staff. Successful interviews January 23 and planned interviews in Feb 24.
Speech & Language Therapy	3387	132	2280	Mean wait and RTT remains static on previous month. Waiting list and caseload initiative implemented across county to support longest waits being seen. Onboarding of new staff and development of rotational post to attract new qualified staff.
Autism Assessment Service	4611	189	3766	Mean wait and RTT remains static on previous month. Referral rates continue to increase (37% increase on previous year) with a declining vacancy rate in the pathway (45%)
Early Childhood Development (Previously SCAC)	869	163	660	Mean wait and RTT remains static on previous month. Pathway review with ICB and Acute Paediatrics planned in February 2022 to review specification for the future of service delivery.
Children in Care Nursing	878	312	787	Decrease in review health assessments (RHA) completion for Children in Care Team, however caution is noted as data pulled on 1/2/24 and completion rate to

				increase as nurses complete and submit complex reports.

January-February 2024 CAMHS *Data not validated at this point in the month*				
Service	**Number Waiting**	**Longest Wait**	**Over 18 weeks**	**Comments (Feb 24)**
CAMHS overall Total	1389	49 weeks	467	This is the combined total of children waiting across Devon and Torbay for all child and adolescent mental health services (CAMHS) core services.
MERS Countywide	862	49 weeks	413	This is the Combined total of children waiting countywide for initial assessment for mood, emotions, and relationships (MERS). Improvement work around caseload management, standard levels of activity and assessment clinics is underway in the MERS pathway
MERS North	173	48 weeks	91	The smallest of the three MERS teams with highest staff vacancies has a longest wait of 48 weeks.
MERS Exeter, East and Mid	296	49 weeks	142	This team has significant staffing vacancies and has the longest wait time of 49 weeks. Focussed work to review children waiting is in place.
MERS Torbay and South	393	44 weeks	180	This is the largest of the MERS teams with a longest wait of 44 weeks.
Eating Disorders	39	14 weeks	0	Longest wait of 14 weeks now closed.
MHST and CWP	391	31 weeks	24	A number of children waiting over 18 weeks are waiting for a group and significant reductions are expected in February after this has been completed.
Urgent Care (Crisis Team)	5		0	No waits outside of target time to be seen.
Urgent Care (AOT)	13		0	No children waiting over 18 weeks these have been errors in recording and being closed for next reporting run.
CiC	79	46 weeks	47	Data validation and increased case allocation has seen a reduction in the number of children and young people waiting for assessment and the longest wait reduced from 80 weeks to 46.

8.1.2 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

Urgency	Seen within 4 weeks		Breached	
	Number	Percentage	Number	Percentage
Routine Referrals	7	53.8%	6	46.2%
Urgent Referrals	3	100% (7 days)	0	0%

Narrative:

Urgent referrals in the eating disorder pathway are addressed within 7 days, achieving 100% compliance aligned with LTP objectives. However, routine appointments for children and young people within 28 days need improvement, currently at 53.8%. January's data is unvalidated, but past trends reveal a higher number of initial assessments, not recognized as "stop the clock activity" if not meeting NICE guidelines. Thus, an accurate representation of access within the 28-day target is lacking. This issue will be addressed with new guidance expected in Spring 2024.

Children and Adolescent Mental Health Services (CAMHS) Access performance
(number of children within the year who have attended one appointment within an NHS-funded service to address their mental health condition)
For CAMHS access performance, the national target measures children attending one NHS-funded appointment for mental health conditions, aiming for 11,801 by year-end. Current data, including CAMHS, Kooth, and Young Devon, reports 10,173 appointments, exceeding the Q3 target.

Mental Health Access Targets 2023/2024 (rolling 12-month figure – 1 contact)				
	Q1	Q2	Q3	Q4
Target		9,876	9,944	11,801
CFHD	5773	5917	6243	9877 up to end January
Kooth	921	1355	1535	
Young Devon (have requested latest data)	2395	2395	2395	
Actual	9089	9677	10173	predicted

Quality

Project launch for both Autism Wait List elective recovery and Capacity, Activity and Demand for each pathway. Capacity and demand for MERS to be completed by the Integrated Governance Board (IGB) March 2024.

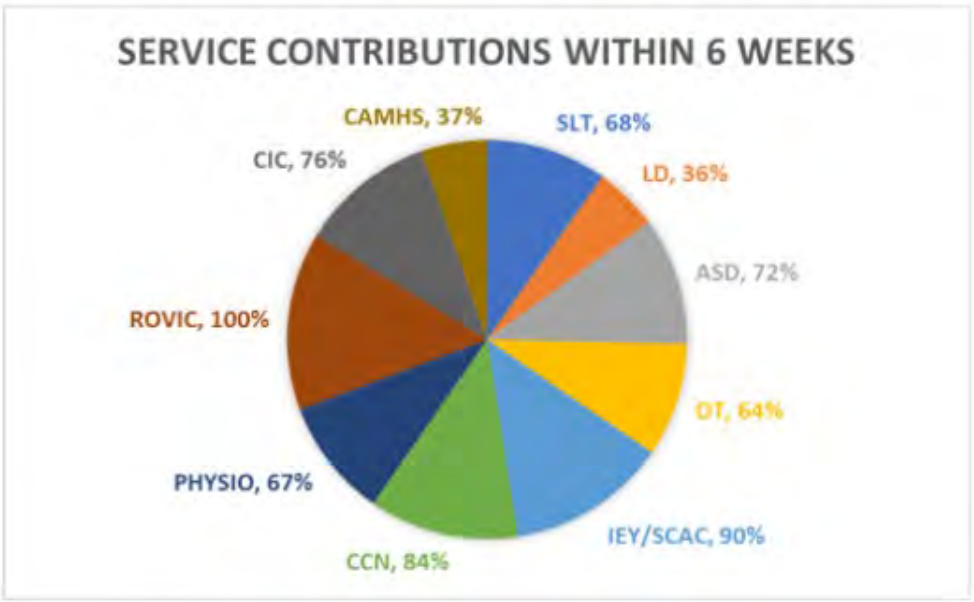
8.2 Transformation

8.2.1 New Model Mobilisation

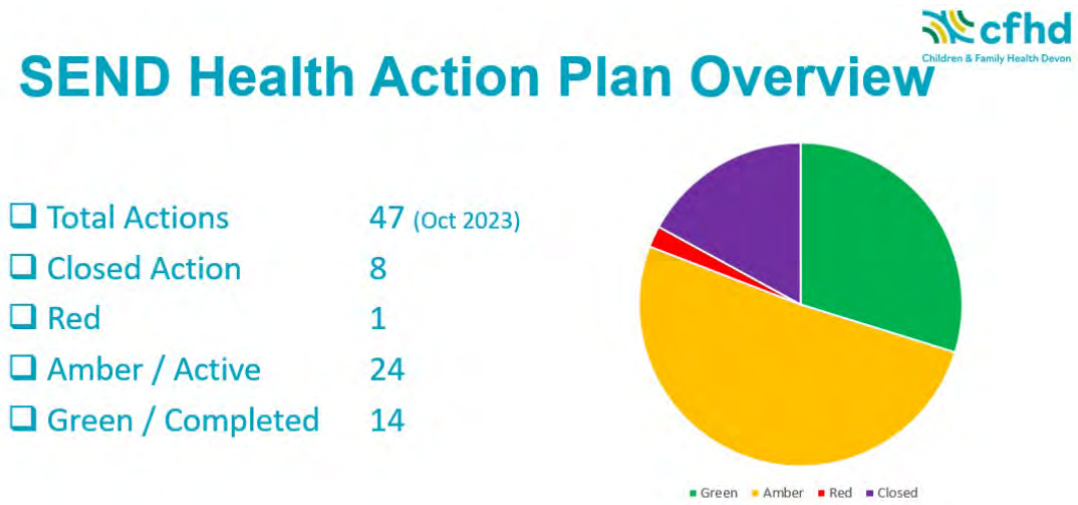
The plan has been reviewed (being finalised by Devon Partnership Trust (DPT) Project Management Office) to provide clarity and assurance (blue, red, amber, green RAG rating) on the pathway mobilisation underway. Senior Responsible Officer (SRO) re-allocation in Director's absence to ensure progress is maintained. Hope to have trial of integrated triage and screening session in place from 1st June 2024.

8.3 SEND (special educational needs and disabilities)

Each area of Devon has been inspected in recent years by the Office for Standards in Education (OFSTED) and Care Quality Commission (CQC) and all have improvement plans in place. CFHD are engaged at all levels with these plans in Torbay and Devon. CQC are visiting Devon 5/6 March.



Education Health and Care Plan (EHCP) Timeliness CFHD December 23			
County Council	Contributions Due	On time *(6 weeks)*	Narrative
Torbay	59	49%	Reduction in improvement with delay in quality assurance of advice written by clinicians. SEND Leads prioritising training for more QA clinicians.
Devon	447	59%	
Total	506		
SEND Improvement Update	SEND now included in CFHD Induction Pack SEND Standard Operating Procedures being reviewed Updated QA process to begin for each pathway 1.4.24		



8.4 Finance

- 2023/24 year-to-date spend for CFHD is £26.8m. Month-on-month run rates are stable.
- Year-to-date underspend of £4.4m and forecast underspend of £4.9m, before applying the risk/gain share agreement and assuming that Strategic Development Fund (SDF) funds are fully utilised.
- Work to be undertaken to assess revenue and capital implications of the IT and Informatics transfer between DPT and TSDFT.
- Review of corporate costs to be undertaken. It was recommended for 23/24 CIP planning.

9.0 Families Community and Home Care Group Update

9.1 Child Health / Paediatrics

Waiting lists for new Child Health appointments have decreased by 22% since the year began, with follow-ups past their scheduled dates dropping by 42%. By the end of March, we anticipate 13 instances of breaching the 65-week wait threshold for our community paediatrics under-5 service, jointly managed by Paediatrics and the Infant and Early Years team.

The team's participation in Getting It Right First Time (GIRFT) initiatives has identified opportunities for ongoing enhancement.

Over the next year, our focus includes expanding non-face-to-face clinics and reducing the new-to-follow-up appointment ratio. Additionally, the splitting of a large clinic room in paediatric outpatients, starting April 3rd, will restore our clinic space capacity to pre-relocation levels, aiding in achieving our 52-week wait target by March 31st, 2025.

Despite ongoing risks to the paediatric nursing workforce, efforts such as non-clinical staff working clinically and agency nurse support for specific units are mitigating concerns. Leadership capacity may be temporarily reduced due to managerial staff involvement in clinical duties, but recruitment efforts are underway to address this issue.

Lastly, the upcoming Paediatric Awards for Training Achievements (PAFTA's) will recognize outstanding individuals from Torbay and South Devon. Best wishes to all nominees.

9.2 Children's Torbay 0-19 Service
The team have been awarded an "our people" award for their work around Safer Sleep. The team, alongside Child Health colleagues and the Joint Agency Response team, developed a safer sleep assessment tool following a high incidence of sudden infant deaths during 2021/22.

"The work has been completed in an inclusive way, encouraging debate, and presented to a high standard with evident passion for improving outcomes. These tragic deaths have had a life-changing effect on families and emotional wellbeing impact on staff who were involved in their care. Health visitors visiting families after the baby's deaths heard how devastating their losses have been, and it was felt as a service visiting antenatal parents in their homes, public health nursing was in an excellent position to bring safer sleep to the forefront of their professional practice."

9.3 Torbay Recovery Initiatives (Drug & Alcohol Service) (TRI)
TRI will close its Walnut Lodge location by the end of March, consolidating its operations into Shrublands House as part of the Growth In Action Alliance (GIA) integration efforts. Our partners include Leonard Stocks Hostel and Torbay Domestic Abuse Service (TDAS), with TRI workforce evolving to include specialists in homelessness, domestic abuse, and sexual violence. Several staff are already engaging regularly with the Hostel, and one member is now trained as an Independent Domestic Violence Adviser (IDVA). The GIA branding has been finalized through a consultative process involving staff, volunteers, and service users, ensuring direct feedback integration from the co-production group.

9.4 Gynaecology
We're currently advertising for an Obstetrics & Gynaecology Consultant post, with the Cancer Alliance committing £63,000.00 in funding support. We've made significant progress in reducing our backlog of 78-week breaches, currently down to 10.

However, we're facing ongoing challenges:
- Long-term sickness among consultants persists.
- Administrative shortages due to sickness, leave, and turnover are placing significant strain on remaining staff

9.5 Maternity
The Maternity Care Quality Commission (CQC) inspection report was published on 21 February 2024, work has been ongoing to address the 3 immediate areas of concern that were raised by the CQC at the time of inspection: No dedicated obstetric theatre team and second theatre, no formal separate maternity triage service and no designated resuscitation area on antenatal/postnatal ward. An action plan is being written to address all areas of improvement and progress against this will be monitored closely within the department.

The CQC national maternity survey results were published in February 2024 covering data collected in February 2023. The CQC survey asked about experiences of antenatal, intrapartum and postnatal care. The response rate for the survey was good with a rate of 51% (above average). Overall responses suggest that experiences of care are positive, Torbay scored in the top 20% of trusts in 44% of the questions asked. Areas of Torbay Maternity services that were rated highly by women were:

- Information and advice around discussing induction of labour
- Partners being involved during labour and birth
- Being treated with kindness respect and dignity
- Cleanliness of the room or ward area

In addition, TSDFT Maternity Services scored the highest in the country in the following areas:

- If you raised a concern during your antenatal care, did you feel that it was taken seriously? **Score=9.7**
- Your labour and birth (overall responses to Questions C4-C9) **Score=9.2**
- And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour? **Score=9.4**

We continue our work with the Maternity and Neonatal Voices Partnership (MNVP) to address feedback narratives and those areas we could improve on by co-producing our action plan.

9.6 Healthy Lifestyles & Personalised Care

Connect Plus Type 2 diabetes education pathway is now live and accepting self-referrals as per the new service specification. Promotional materials are being distributed to Primary Care.

The FLEXI study results show Devon is providing a high-quality FaME (strength and balance exercise programme), which is excellent news for the service delivery team.

The service has recruited 3 new volunteers who are supporting with administrative duties (photocopying, printing, resource collation). The volunteers are also providing support to the education groups by welcoming participants and taking the register. This is proving very helpful as the administrative capacity in the team is very small.

9.7 Sexual Health

Market warming event held for the procurement of the Sexual Health & Reproductive Health Service. A series of listening and engagement exercises have been undertaken by Torbay and Devon County Council to help inform a new service specification. Examples of the themes include collaboration, resilience accessibility and service development and data.

The invitation to tender (ITT) is likely to be issued in July 2024.

9.8 Social Care

Cost Improvement Plans progressing well and verification complete with £2.8M contributed in 2023/24 to Cost Improvement Plans for Adult Social Care (ASC). Planning for cost improvement plans for 2024/25 were submitted on 29th February 2024.

An external delivery partner, to support the options appraisal for an ASC IT System began 8th January 2024. Following a series of engagement workshops across January an options appraisal was drafted and scored with stakeholders through February and is scheduled to be presented 1st March 2024 to the project steering group for confirmation of the preferred option.

External partner Channel Three, will support planning for transformation following diagnostic activity completed by Newton in Q2 23/24. The planning is scheduled to be completed across March 2024. A tender is currently in progress to procure an external partner for delivery of transformation which is scheduled to begin April 2024.

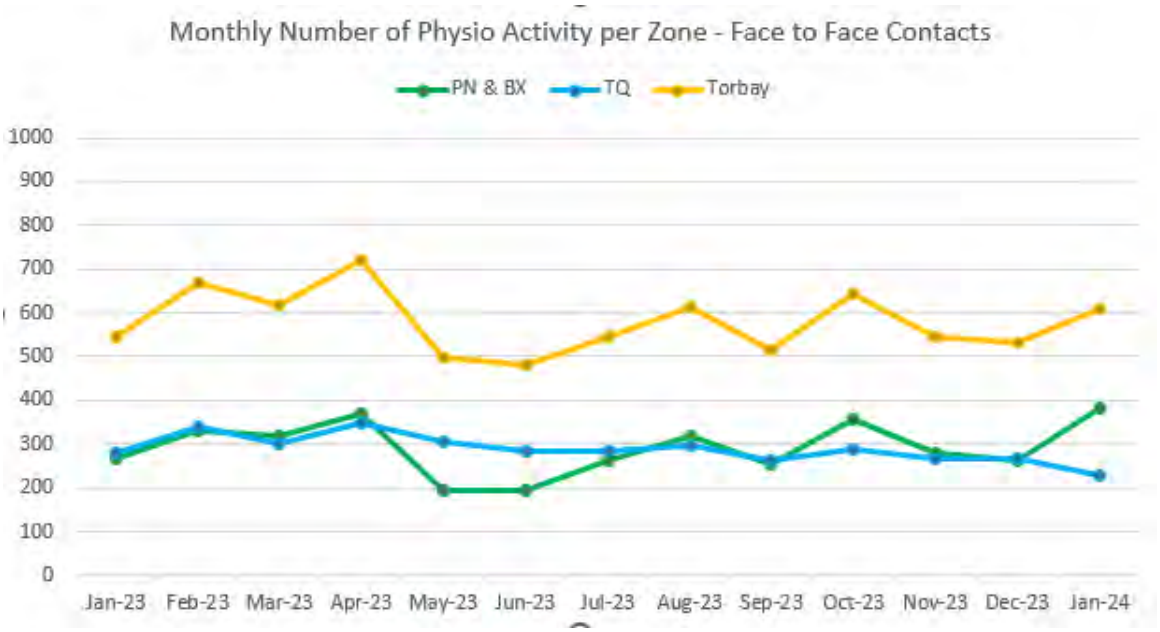
Recording of ethnicity has been identified as an area for improvement, a task and finish group is in place to support the work to move forward and capture baseline ASC national fields as a starting point. The need for recording Equality, Diversity, and Inclusion (EDI) data has been included in the ASC IT System work.

9.9 Bay Wide Community Health Services

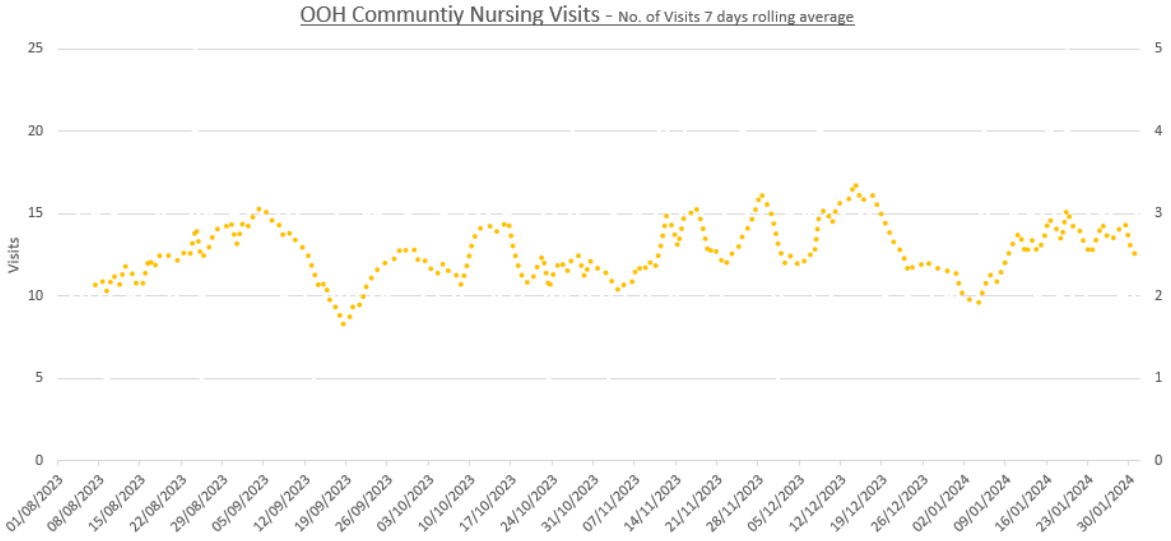
9.9.1 Therapy

The social care occupational therapy team is now managed by the Baywide Adult Social Care Community Service Manager

Physiotherapy (PT) team in Torquay is 50 with a wait of 4 weeks. Paignton and Brixham (P&B) is 60 with a 5 week wait (static). P&B's waiting list is higher due to vacancy factor and a team member redeployed to Brixham hospital temporarily on Occupational Health advice and over 32 hours per week of sickness in the team We are carrying 30 hours vacancy for an Assistant Practitioner (AP). Just recruited to 0.6 WTE for Band 6 physio.



Community Out of hours (OOH) activity

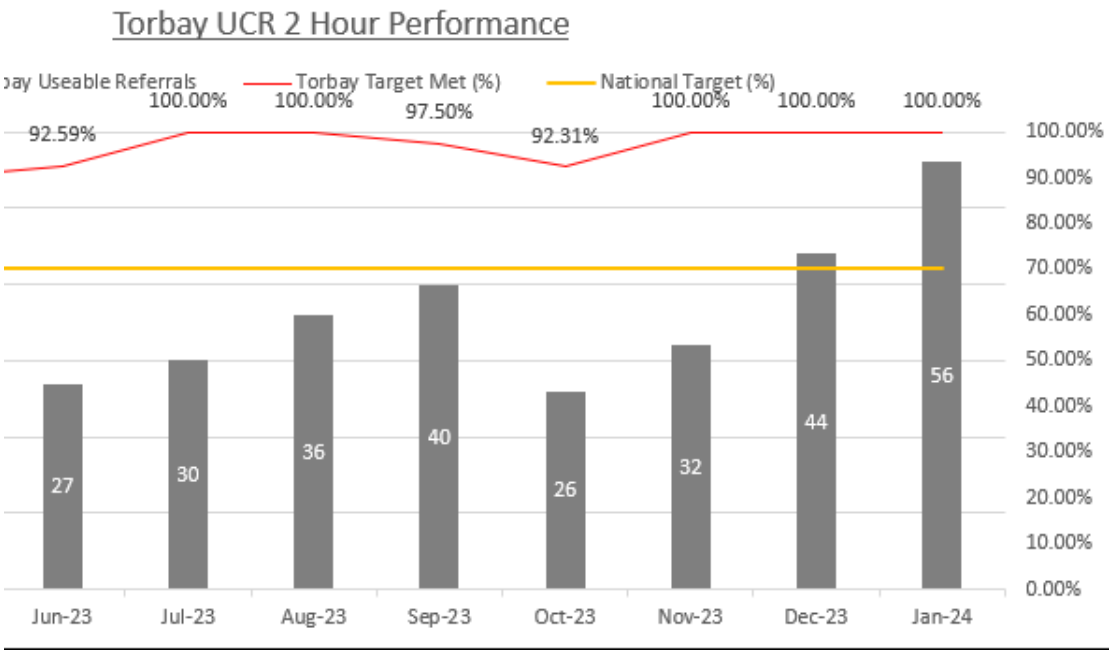


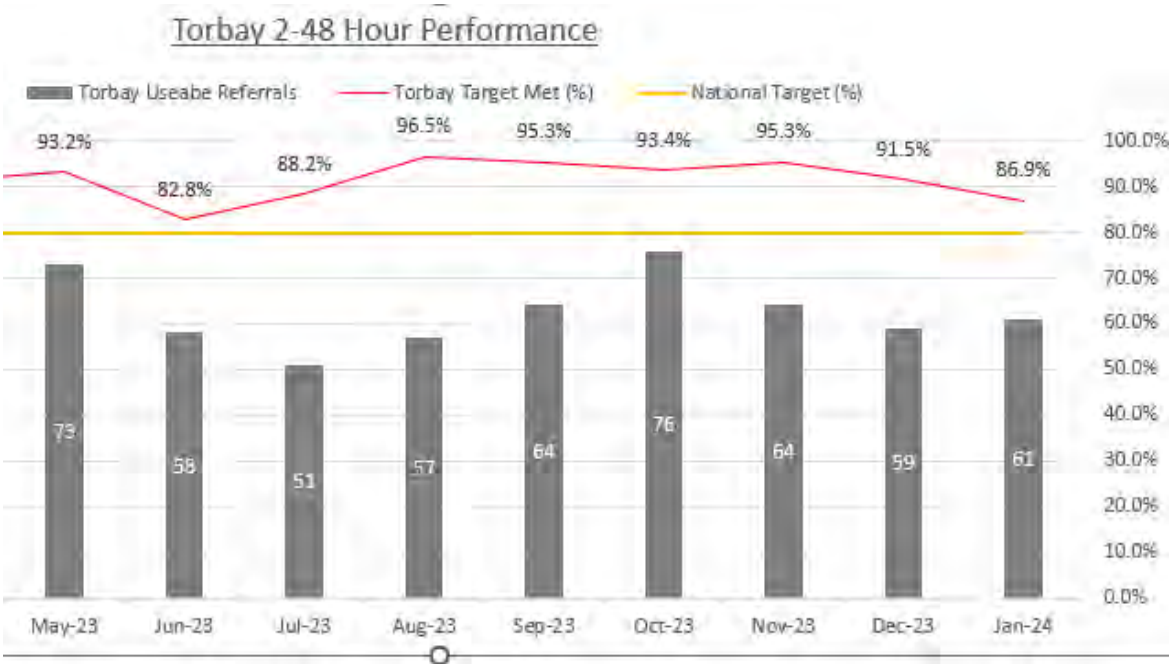
9.9.2 Intermediate Care (IC)

We have continued with the Baywide IC pilot in December 2023. This is to manage the patients that are treated in IC placements by one Baywide team and another Baywide team managing IC treatment in their own homes. The aim is to increase the team's productivity and reduce the length of stay in placements. The below chart demonstrates an increase in length of stay (LOS) but this has demonstrated areas that we need to focus on.

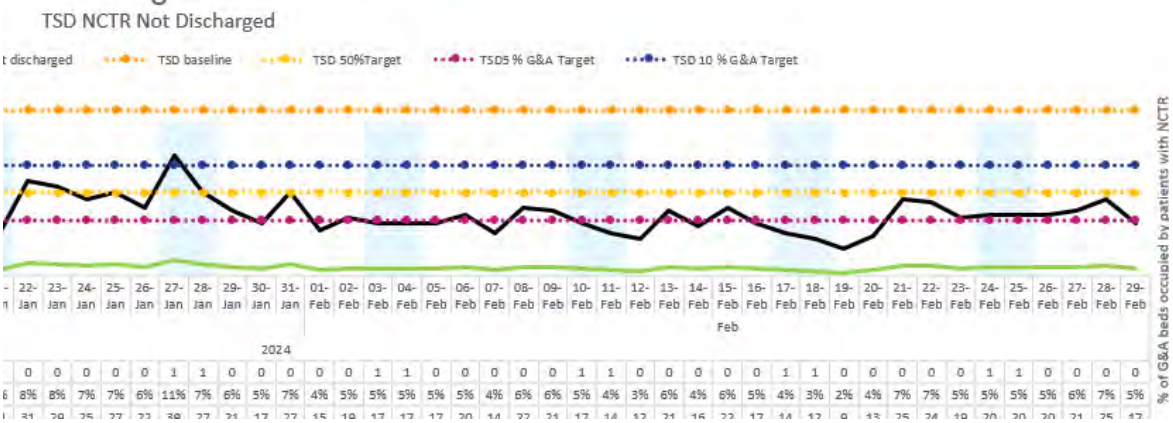
9.10 Urgent Care Response (UCR)

Below is the UCR response for TSDFT footprint: Referrals are increasing





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



NCTR fluctuated between 3% and 7% in February, averaging at 5%. Increased over a weekend in January due to ward processes, but reduced once validated. Plans in place to maintain 5% or less:

- Daily NCTR review and validation.
- Twice-weekly meetings to expedite assessment documentation for Complex Discharge Team referrals.
- Second Inreach team member focusing on Ready to Go unit.
- Clinicians in Discharge Hub continue D2A assessments.
-

Pathway 1 (P1) has good flow with reduced transfer time to an average of two days. Block contract hours extended in Torbay and South Devon until April 2024 and June 2023, respectively, with utilization and workload scheduling monitored.

Pathway 2 (P2) utilizing all 17 block beds in Torbay; MDT reviews influencing positively, though triage improvement needed. Mapleton in South Devon providing 10 block IC

beds with LOS and support monitored. Pilot started with OT Inreach team member for P2 rehab referrals in Newton Abbot hospital.

Pathway 3 (P3) sees reduced transfer time but faces challenges with bariatric and LD placements.

Limited providers for dementia patients; weekly meetings held with EMI providers to prioritize admissions and flow.

9.12 Continuing Healthcare (CHC)

- Torbay and South Devon CHC team are currently achieving 84% against a national target (80%) for CHC decisions made within 28 days. January has seen an increase in our referrals for standard assessment and Fast track applications.

- CHC and individual patient placement (IPP) have delivered £2.2m in CIP savings. Plans for next year are being worked up. Team is also involved in the provider collaborative placements work streams and planning.

- There have recently been some complex cases moved into the South Devon area into supported living accommodation. Under responsible commissioner rules the Trust becomes responsible for their care and funding arrangements. Some of these cases are under the court of protection meaning that the trust is also responsible for legal fees relating to these cases. They are flagged with the Trusts Head of Litigation as soon as we become aware.

- Staff continue to manage new assessments alongside undertaking reviews of care and eligibility and case management for South Devon.

- Personal health budgets and direct payments continue to be an area of risk for the Trust. We are currently managing several cases where governance arrangements are not in place. There are several risks relating to employment legislation and rights, budget calculation and right to have. We currently have no infrastructure to deliver and monitor budgets and outcomes. We are working with partners to try and address some of these risks.

9.13 South Devon

New Risks

- Multiple changes in initiatives and referral routes e.g., immedicare /medvivo/apello/Virtual Wards has created some instability and anxiety in teams – Medvivo invited to team meetings and review of any quality issues taking place jointly with Medvivo.
- On call rota set up to support complex weekend risk / prioritisation discussion and decisions up to end March 2024– (funded from 23/24 ICB UCR monies)
- Offer of additional hours for weekend staff to build additional capacity and coordination utilising UCR 23/24 monies.
- Newton Abbot (NA) Community and IC staffing situation to be added to risk register – absence/sickness. Cross cover from other South Devon Locality teams being implemented where possible.

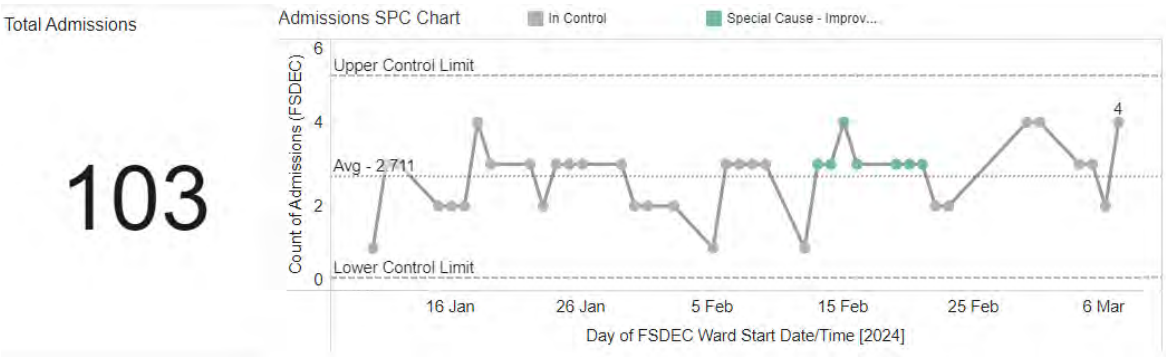
Increase in community therapy waiting lists as summarised below:

- Longest OT waiting list now 13 weeks (was 19 weeks – improved due to Data Quality (DQ) exercise).
- Longest physio waiting list now 19 weeks (was 21 weeks).

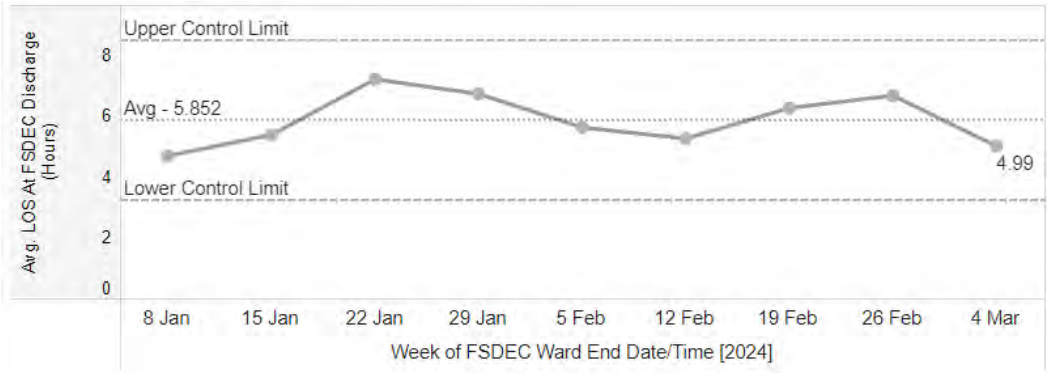
10.0 Healthcare of Older People (HOP) and Frailty

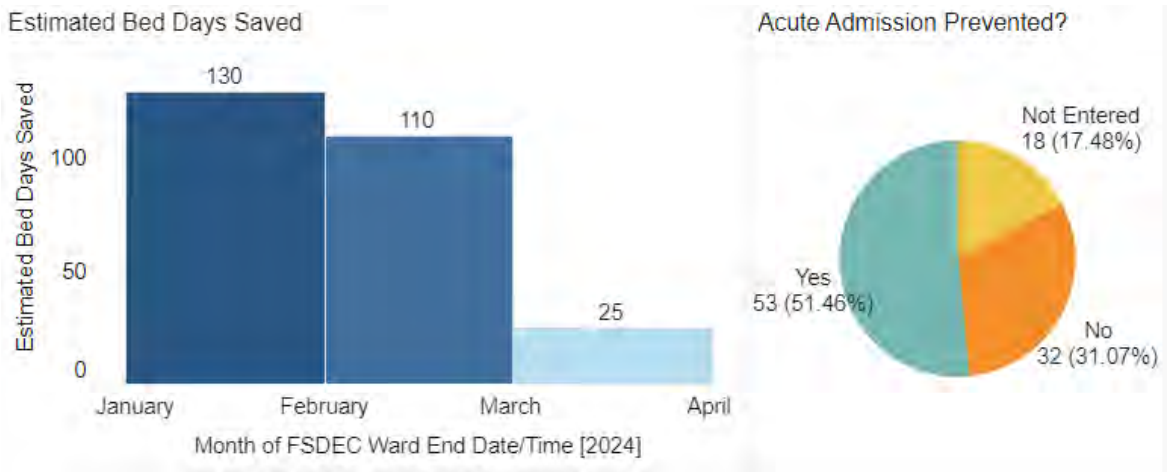
The Frailty Virtual Ward (FVW) closed to new admissions for one week in February due to annual leave coinciding with industrial action opening again on 19th February. A total of 54 patients have been through the ward and as the dashboard demonstrates 68.5% of these have been "step-up" or admission avoidance with only 5 patients admitted or readmitted to acute care whilst on the ward. The greatest vulnerability of the FVW is staffing, particularly medical cover. An advert is out currently for additional GP hours and workforce planning within HOP is focussed on resilience across FVW and Frailty same day emergency care (SDEC).

Frailty SDEC has now seen over 100 patients since opening on January 10th. Launched as a pilot, Frailty SDEC is open Monday – Friday 08:00-17:00 with the aim initially of seeing 3 patients per day and growing from there. There has also been a focus on identifying how best to use the space – which had previously been a discharge lounge and bedded decant area - as a multi-disciplinary team (MDT) assessment area for older people with frailty, refining the triage process and criteria and identify alternative entry and exit pathways to the unit. SDEC was stood down due to industrial action and there have been challenges maintaining core staffing. A dashboard has been published in Tableau and an evaluation being prepared. A further development session is planned with a focus on identifying how to achieve increased numbers consistently and increase admission avoidance pathways including developing a co-ordinated response to Care Co-ordination Hub referrals working with Urgent Community Response Teams and our Frailty Virtual Ward.



The average length of stay on the unit is just under 6 hours, which means bringing people in as early in the day as possible is essential if admissions are to be avoided, however the proactive use of community hospital beds, Frailty Virtual Ward, the Discharge Lounge, McCullum Ward and HOP wards is already being seen for patients who cannot return home the same day. This retains a focus on right care, right place, right time. Acute admission has been avoided in 53 cases and a total 265 occupied bed days saved. This number does not include people who were sent to the Discharge Lounge or McCullum Ward overnight to await the start of a care package.





10.1 Stroke Services

The number of stroke patients admitted in January dropped to 44. Alongside this there was an improvement in other time critical standards including:

- The percentage of patients scanned within 1 hour and the percentage of patients thrombolysed within 1 hour (72.7%). The team are working towards improving this further.
- The percentage of patients admitted to the stroke unit in 4 hours (31.7%), indicating improvement. Operational pressure remains a key factor hindering further progress in this metric.
- Significant improvement in the percentage of patients spending 90% of their time on a stroke unit 81.4%), credited to the commitment and dedication of the entire team involved in the stroke pathway

Time critical Stroke Standards						
	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Number of patients (N)	65	55	57	65	53	44
% Scanned within 1 hour	55.4	52.7	49.1	55.4	64.2	72.7
% Scanned within 12 hours	92.3	85.5	89.5	96.9	98.1	97.7
% Admitted to Stroke Unit within 4 hours	27	18.5	28.6	18.3	23.9	31.7
% of patients spending 90% of their time on the Stroke Unit	69.8	69.1	66.7	66.7	62.7	81.4
% (No.) Patients that received Thrombolysis	3.1 (2)	5.6 (3)	7 (4)	11.9 (7)	12.8 (6)	16.7 (7)
% Received Thrombolysis within 1 hr	0	0	75	57.1	16.7	42.9

Work as part of Thrombolysis in Acute Stroke Care (TASC) continues. There have been two meetings reviewing our data with the support of the TASC data analysts which has highlighted areas in which we seem to do well (time to CT scanning) and where there might be opportunity (time from scanning to thrombolysis). Additionally, a review of patient cases with TASC support has shown that confidence in decision making and out of hours could give further opportunity for improvement. The support of TASC and the programme has been very positive thus far and the stroke team and wider stakeholders are very engaged.

A networked approach to out-of-hours support for thrombolysis decision making as part of the Integrated Stroke Delivery Network (ISDN) has unfortunately stalled. Neighbouring Trusts were unable to support the founding of a local network for Devon and Cornwall and unfortunately the next nearest network did not wish to expand further to include TSDFT and Royal Cornwall Hospitals NHS Trust (RCHT).

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			
Report title: Workplace Team Strategic Performance Update			Meeting date: 27th March 2024
Report appendix:	Appendix 1: Trust Health & Safety Report by the Committee Chair to the Risk Group Appendix 2: Workplace Compliance Dashboard		
Report sponsor:	Interim Chief Finance Officer		
Report author:	Workplace Director		
Report provenance:	Workplace Performance and Compliance Group		
Description/Purpose of the report and key issues for consideration/decision:	The purpose of this report is to brief the Trust Board on strategic Workplace Team performance and compliance exceptions for December 2023 and January 2024.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	To note the current performance and compliance of Workplace Team and headline summary of key exceptions and activities		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	This report outlines the work being undertaken by the Trust to enable the delivery of patient care through the provision of compliant and safe environments, services and people. This report also covers the work being undertaken to reduce the Trust's carbon footprint to the benefit of the local environment.		
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources		
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 4 - Estates Objective 5 - Operations and Performance Standards Objective 10- Green Plan/Environmental, Social and Governance Objective 11 – Equality, Diversity and Inclusion		
Risk: Fit for Purpose Estate Risk ID: 2179	Risk is already included in DATIX and outlined on the corporate risk register		
External standards affected by this report and associated risks	Laws or regulations Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance		

Report title: Workplace Team Strategic Performance Update		**Meeting date:** 27th March 2024
Report sponsor	Interim Chief Finance Officer	
Report author	Workplace Director	

1.0 Introduction

1.1 This report sets out performance and compliance exceptions within the Workplace Team for the months of December 2023 and January 2024. In addition to this, some strategic updates relating to Workplace activities and business projects are included.

2.0 Discussion

2.1 Corporate Health & Safety

Focus on ensuring the Trust delivers continued culture improvement in relation to corporate health and safety continues.

There are currently 68 health and safety risks open of which 30 are scoring 12 and above, and the number of incidents recorded in January increased from 157 to 224 (an increase of 42%). Whilst any increase in incidents is a concern, that these are being appropriately reported demonstrates a strong cultural improvement in this space.

Slips, trips and falls saw an increase in January from 26 to 43 with Simpson Ward and Cheetham Hill ward being the key areas of concern in this respect. Work continues, via the Health and Safety Committee, to use data and the lived experience of our people in order to drive improvements and a reduction in slips, trips and falls.

Improvements continue to be realised in relation to fire safety compliance, particularly where fire risk assessments (FRAs) are concerned, where the post-COVID recovery work is nearing conclusion, and all FRAs will be reviewed and updated by the end of the 23/24 financial year.

2.2 Compliance and Performance

Appendix two sets out the Workplace Team's operational compliance and performance for the months of December and January.

Demonstrable improvements in relation to Workplace performance and compliance were realised in January 2024. Planned preventative maintenance (PPM) saw an average SLA performance of 96%, up from 94% in December and 89% in January. This was largely due to the onboarding of candidates for vacant technical positions, particularly in the electrical discipline.

Reactive performance also saw a month-on-month improvement, with an average SLA score of 89%, up from 87% in December. Again, this is primarily as a result of appointment of candidates to electrical vacancies within the Estates Delivery function.

Water Risk Assessments (WRAs) are currently being reviewed and updated but in several cases are past review date. This was predominantly due to the available of the specialist contract resource required to undertake this work. All WRAs will be reviewed and updated by the end of May. The Trust's Authorising Engineer for Water Safety is aware of this situation and is content with the plan being executed.

The delivery of the updated generator service and load bank test plan is on track, with a 21% compliance improvement in January. There are a small number of monthly load tests on generators which cannot be completed, due to access issues as a result of project works. This is a managed risk and there are no concerns about the ability of the generators to operate where required. To help mitigate this risk, off-load tests continue to be conducted.

All other areas of Workplace Performance and Compliance remain consistently strong.

2.3 Car Parking and Traffic Management

The new approach to car park management on the acute site in partnership with SABA is now fully mobilised. Much of the adverse feedback received through the various phases of mobilisation has now settled down and the Workplace team has seen a significant reduction in the number of staff complaints and concerns raised. The number of staff permits per space issued remains high at 2.8 and whilst the refreshed approach to operating Trust car parks on the acute site has improved the efficiency of use of staff parking spaces, capacity remains a challenge, particularly on Tuesdays and Wednesdays.

The installation of vehicle messaging systems at the two entrances to site has been well received and has improved patient and staff experience, allowing drivers to identify the location of any free spaces in advance of entering site, negating the need to drive around searching. The number of patient complaints relating to the availability of parking spaces has declined significantly since the implementation of the revised approach, although patient parking capacity remains a challenge. The new approach to car park management is being extended to the Trust's Regent House site, this will include the installation of automatic number plate recognition technology and electrical vehicle charging points for the Trust's IT fleet.

The Workplace Team continue to collaborate with capital development colleagues in order to identify strategic opportunities to enhance the provision and capacity of staff and visitor parking. Born out of this collaboration has been the purchase of the former Natwest Bank site on Newton Road on the boundary of the acute site. This will provide an additional 26 staff parking spaces, no additional permits will be issued.

2.6 Catering

The financial subsidy on hot meals sold within Bayview restaurant will be removed effective 1st April 2024, staff communications have been shared and engagement with both the JLNC and the Trust's staff side partnership have taken place in relation to this change. Whilst the subsidy is being removed, a wider range of hot food options will be made available to ensure colleagues can access nutritious, affordable hot meals. This change will result in an estimated saving of £100k per annum.

2.7 Patient Led Assessment of the Care Environment (PLACE)

The results of the national 2023 PLACE inspection have been released and the Trust did exceptionally well for the second year in a row. PLACE inspections involve people from our local community (known as patient assessors) each year, going into our community and acute hospitals to assess how our environments support the provision of care (they don't assess the quality of care given by staff).

Assessment Category	Score	National Ranking (out of 189 NHS Trusts)
Cleanliness	100%	1
Food Quality	98.54%	5
Condition, Appearance & Maintenance	99.74%	8
Dementia Support	97.99%	4
Disability Support	97.49%	6
Privacy, Dignity & Wellbeing	99.03%	4

These results reflect the capacity and diligence of colleagues within the Workplace Team who, despite the challenge posed by the condition of our estate, continue to deliver a high-quality service in support of the delivery of excellent patient care.

2.6 CIP Delivery and Financial Performance

As at month ten, the Workplace Team reported a year-to-date adverse variance of £3.3m including undelivered CIP of £2.3m, the remaining balance of £1m is caused mainly by further utility and business rate increases which were higher than predicted along with repairs and maintenance and food costs.

The total forecast outcome compared to budget is an overspend of £3.8m which is an improved position of £489k on month nine.

Year End Forecast Position (by Dataset)

- Pay £13k (positive)
- Non-Pay £2.0m (adverse)

- Income (£631k) (favourable)

The Workplace Team will continue to focus on all elements of spend within its control to identify sustainable financial efficiencies and recover the current forecast position as best as is reasonably practical. A further reduction in run rate is anticipated in month 11.

3.0 Conclusion

December 2023 and January 2024 have seen significant improvements in relation to compliance and performance within the Workplace Team.

The challenging mobilisation of the new approach to car park management is beginning to bear fruit and there has been a significant reduction in the number of patient and staff complaints in this area. Whilst the new approach has enhanced and modernised the car parking operation, capacity in all areas remains a significant challenge.

For the second year in a row, the Trust performed exceptionally well in its PLACE assessments and finished in top five for most categories and top ten for all categories when compared with all other NHS Trusts.

The scale of the financial challenge remains significant largely due to factors beyond the direct control of the Trust, although significant improvements to the Workplace Team’s financial run-rate have been made, and further improvements in month 11 are anticipated.

4.0 Recommendations

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

NHS
Torbay and South Devon
NHS Foundation Trust

Report of Health and Safety Committee Chair to the Risk Group

Health and Safety Committee meeting date:	14th February 2024
	Arun Chandran
This report is for: *(please select one box)*	Information☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Excellent population health and wellbeing ☒ 2: Excellent experiencing, receiving, and providing care ☒ 3: Excellent value and sustainability ☒
Public or Private *(please select one box)*	Public ☐ or Private ☒

Key issues discussed at H&S Committee:

Health & Safety and Fire:

- There are 68 Health & Safety risks currently open of which 30 are scoring 12 and above.
- The number of incidents recorded in January increased from 157 to 224, an increase of 42%.
- Slips, trips and falls saw an increase in January from 26 to 43.
- Simpson Ward and Cheetham Hill remain two areas of concern.
- 2 RIDDORS were reported to the HSE in January.
- A reporting issue has been identified relating to reporting fire incidents on DATIX. The Security team have been informed who input this data.

Litigation:

- The next report is due in March.

Trust Security Report:

- An action plan is in place to manage a significant increase in anti-social behaviour at Paignton Health & Wellbeing Centre.
- Colleagues at RDUH have been contacted regarding their experience with the Crisis Café next to Wonford House. They have not seen any increase in activity for their security officers since it opened. The Trusts Security Management Team will monitor if there is an increase in call outs following the Crisis Café opening in Salus/Haytor.
- Health & Safety Executive (HSE) – Recommendations for managing violence and aggression and musculoskeletal disorders in the NHS – March 2023. Issues were identified for two areas during the visit. See below what action has been taken:

  Risk Assessments:

Torbay and South Devon NHS Foundation Trust

- **Assessment too generic, with high-risk areas not being identified.** High risk areas highlighted on the risk assessment spreadsheet. Assessments were reviewed in 2023 and new areas added.
- **Assessments not including non-clinical workers who were exposed to the risk.**
  Risk assessment document reviewed (13/2) and non-clinical workers are included.
- **Inconsistencies in the approach to risk assessment across the same organisation.**
  Security management team are using the same risk scoring matrix as highlighted in the new Trust Risk Management policy.

Training (training on controlling risk from MSDs and V&A provided to employees):

- **Training too generic and lacked evidence it was based on a training needs analysis.**
  Supportive observations and safe approaches to be added as essential training for high-risk wards. Information sent to mandatory training group to enable “essential” training to be added.
  Digital lone worker training to be planned, designed, and implemented by April 2024. Security management team to work alongside community staff and digital education regarding content. (Meeting held 16/2/24)
- **Where training was identified as being mandatory, in practice it was optional for relevant workers to attend.**
  Ensure reporting compliance rates for supportive observations and safe approaches linked to bank staff. All HCA and Nurses are required to complete. Information sent to mandatory training group to enable “essential” training to be added.
  Clinical safety manager to liaise with the Hive team to implement compliance figures for ED breakaway / bank supportive observations and safe approaches.
  Security management team to liaise with bank team to ensure compliance levels are acceptable and RAG rated. (Meeting held on 7/2/24)

Radiation Committee:

- No representative at the meeting

EFM Performance Report

Domain	Workplace Services Performance Data January 2024 for February 2024 Report	2022-23 Quarter Four			2023-24 Quarter One			2023-24 Quarter Two			2023-24 Quarter Three			2023-24 Quarter Four			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Estates - Planned work Performance	Total PPMs planned per month (not KPI)	887	694	747	619	643	913	1006	895	870	982	877	858	960	#N/A	#N/A		10951	842	Variable				Not a KPI - an indicator of planned work volumes
	Statutory PPMs planned per month	415	280	307	263	229	372	428	371	359	426	383	380	417				4630	356	Variable				
	Statutory PPM % success against plan	100%	99%	100%	100%	100%	100%	97%	99%	96%	76%	98%	99%	99%					97%	97%	85%	85%	97%	2 weekly fire alam PPMs cancelled as B/H. I quarterly shower head clean nor achieved in month
	Mandatory PPMs planned per month	217	163	154	171	214	259	317	261	235	289	236	237	259				3012	232	Variable				
	Mandatory PPM % success against plan	100%	100%	100%	100%	100%	100%	100%	94%	94%	94%	92%	94%	96%					97%	97%	85%	85%	95%	
	Routine PPMs planned per month	255	251	286	185	200	282	261	263	276	267	258	241	284				3309	255	Variable				
	Routine PPM % success against plan	100%	100%	100%	100%	100%	96%	94%	85%	97%	81%	78%	89%	92%					93%	90%	70%	70%	80%	
Estates - Reactive work Performance	Total Reactive Requests per month (not KPI)	1074	837	832	748	693	1013	1005	928	922	1007	922	749	1010	#N/A	#N/A		11740	903	Variable				Not a KPI - an indicator of reactive work volumes
	Emergency - P1 - requests per month	143	108	83	111	107	143	143	140	141	130	80	94	130				1553	119	Variable				
	Emergency - % P1 completed in < 2hours	99%	93%	98%	96%	97%	85%	97%	100%	99%	98%	100%	98%	98%					97%	97%	90%	90%	95%	
	Urgent - P2 - requests per month	217	163	175	164	166	219	210	238	242	229	214	172	234				2643	203	Variable				
	Urgent – % P2 completed in < 1 - 4 Days	90%	86%	88%	88%	88%	84%	86%	82%	88%	85%	85%	83%	85%					86%	97%	85%	85%	90%	
	Routine - P3 - requests per month	525	428	431	357	317	539	482	420	409	522	508	382	535				5855	450	Variable				
	Routine - % P3 completed in < 7 Days	85%	84%	80%	79%	77%	73%	72%	80%	82%	77%	85%	80%	84%					80%	97%	75%	75%	85%	
	Routine - P4 - requests per month	189	138	143	116	103	112	170	130	130	126	120	101	111				1689	130	Variable				
	Routine - % P4 completed in < 30 Days	72%	75%	71%	75%	88%	93%	62%	78%	85%	83%	88%	74%						79%	97%	65%	65%	75%	P4 Routine will always be a month in arrears.
	Trust Critical Infrastructure Failures per month	0	1	0	1	0	1	1	2	0	1	1	2	1				11	0.8	0	2	1	0	Hot Water System fault in Beech Ward
Progress Desk - Requests	Total Requests open at end of reporting month	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	1088	980	1002	893	1016	#N/A	#N/A			996	Variable				Added September 2023
	Workplace Delivery Work Requests over 120 days old									354	332	377	365	356					357	Variable				Inc 113 Requests to Contractors
	Workplace Delivery Work Requests over 60 days old									176	122	112	153	160					145	Variable				Inc 70 Requests to Contractors
	Workplace Delivery Work Requests less than 60 days old (to the end of the reporting month)									558	526	513	375	500					494	Variable				Inc 184 Lorne Stewart,
Estates - Fire Engineering Compliance	Fire Alarm Testing - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	97%	85%	85%	97%	126 Fire Alarm systems
	Fire Alarm Remedials Outstanding	263	263	263	263	263	263	263	263	263	257	257	257	167				3305	254	Variable				45% Room ID completed, 32% ready for uploading, 23% In progress. Due to be completed in March 2024
	Emergency Lighting - % In date	100%	100%	100%	100%	100%	100%	100%	100%	90%	54%	100%	100%	100%				Stat	96%	97%	85%	85%	97%	139 Locations
	Emergency Lighting Remedials Outstanding	6	9	0	0	6	0	19	35	51	62	62	66	93				409	31	Variable				Acute - lights to be replaced represent 2% of total lights. plan in place to carry out backlog of remedials with outstanding upto Dec 2023 planned to be completed by March 29th. (Acute
	Fire Extinguisher - % In date	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%				Stat	99%	97%	85%	85%	97%	
	Fire Extinguisher Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0	Variable				
	Fire Dry Risers - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	
	Fire Dry Risers Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0	Variable				
	Fire Hydrants - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	12 Hydrants
	Fire Hydrants Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0	Variable				
	Fire Dampers - % In date	85%	86%	86%	86%	86%	86%	87%	87%	87%	87%	87%	87%	87%				Stat	86%	97%	85%	85%	97%	1177 dampers inspected, 1025 passed
	Fire Dampers Remedials Outstanding	167	156	156	156	156	156	152	152	152	152	152	152	152				2011	155	Variable				
	Fire Supression - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	3 Systems
	Fire Supression Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0	Variable				
	Fire Doors Inspections - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	98%	100%	100%				Stat	99%	97%	85%	85%	97%	127 Locations (989 Fire Doors)
	Fire Doors Compliance - % In date	11%	19%	29%	29%	29%	29%	29%	29%	29%	29%	10%	10%	10%					23%	97%	85%	85%	97%	% of doors with Remedials compared to known asset base -(ongoing PRIME inspection programme will provide updated asset base by June 2024.
	Fire Doors Inspections - % In date - from PRIME						100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	% of Fire Doors Inspected to PRIME plan
	Fire Doors Compliance - % In date - From PRIME						56%	43%	36%	44%	44%	47%	43%	43%					45%	97%	85%	85%	97%	1424/ 810 8/12
	Fire Doors with Remedials Outstanding	940	853	746	0	8	142	362	451	536	550	618	810	810				6826	525	Variable				
	Fire Risk Assessments - % plan to date								80%	82%	84%	84%	84%	88%				Stat	84%	97%	85%	85%	97%	New Metric from September 2023
	Fire Risk Assessments - Remedials Outstanding								22	22	22	22	22	19				129	22	Variable				FRA programme undergoing thorough review - expected to be completed end Jan 2024.
Estates - Mand Compliance	Fixed Wire Testing - % In date	90%	90%	91%	92%	93%	93%	93%	93%	94%	94%	94%	95%	95%				Stat	93%	97%	85%	85%	97%	Sub 6 requires tower fire works to complete prior to EICR inspections
	Fixed Wire Remedials Outstanding	895	895	895	895	895	895	895	895	895	895	895	895	895				11635	895	Variable				Packaging work, PO's raised to commence work.
	Portable Appliance Testing - % in date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Mand	100%	97%	85%	85%	95%	
	Portable Appliance Testing Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0	Variable				
	HV Equipment Testing - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	HV Substation rolling programme, coinciding with Gen Testing
	HV Equipment Remedials Outstanding	1	1	1	1	1	1	1	1	1	1	1	1	1				13	1	Variable				Change of scope due to New Theatre programme, new Transformer will be installed in January 2024
	Generator Service & Load Bank Test - % In date	100%	100%	100%	100%	100%	100%	100%	12%	12%	12%	41%	50%	71%				Mand	69%	97%	85%	85%	95%	

EFM Performance Report

Domain	Workplace Services Performance Data January 2024 for February 2024 Report	2022-23 Quarter Four			2023-24 Quarter One			2023-24 Quarter Two			2023-24 Quarter Three			2023-24 Quarter Four			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Estates - Electrical - St	Generator Service & Load Bank Remedials O/S	1	1	1	1	1	1	1	1	1	1	1	1	1				13	1	Variable				Gen 7 exhaust stack split - Remedial to be covered under warranty
	Generator Monthly Load Test - % In date	77%	100%	100%	100%	100%	100%	100%	38%	100%	100%	100%	83%	67%				Mand	90%	97%	85%	85%	95%	Contractor will address under maintenance visit. Monthly Testing - 12 Generator's (Plus 2 PFI & 1 DPT). Gen Set 3 Off Line for LV Works (2 x Temp Gen Set in place - Off load test only).
	Generator Monthly Load Test Remedials O/S	0	0	2	2	2	2	1	1	1	2	2	1	0				16	1	Variable				
	Lightning Protection - % In date	95%	95%	95%	95%	95%	95%	95%	97%	97%	97%	97%	97%	97%				Stat	96%	97%	85%	85%	97%	
	Lightning Protection Remedials Outstanding	3	3	3	3	3	3	3	2	3	2	2	2	2				34	3	Variable				Awaiting completion reports for AMU (Snagging) and Main Entrance, Salus.
	Auto Door Inspection - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Mand	100%	97%	85%	85%	95%	
	Auto Door Remedials Outstanding	1	1	1	1	0	0	1	0	1	1	0	1	1				9	1	Variable				Main Entrance - Inner Door. KONE to provide update.
Estates - Mechanical - Stat / Mand Compliance	LEVs Testing - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	All known LEV's Inspected & Tested
	LEVs Testing Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0	Variable				
	Critical Vent Verification - % In date	96%	98%	98%	100%	100%	100%	100%	100%	98%	96%	100%	98%	100%				Stat	99%	97%	85%	85%	97%	Next ventilation Verifications for Special Theatre C & General Theatre 6 booked to be completed on 21/2/2024
	Critical Vent Remedials Outstanding	74	55	52	50	48	46	53	47	24	26	38	36	28				577	44	Variable				Outstanding ventilation critical remedials now 28 -(8 completed in January) 0 - Added Remedials in Januarv
	Kitchen + Extract Duct Cleaning - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	Next Inspection & Clean due June 2024.- Kitchen Extract Hood upgraded to a 6 monthly inspection.
	Kitchen + Extract Duct Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0	Variable				
	Gas Protection systems - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	
	Gas Protection Remedials Outstanding	0	0	0	0	0	0	0	0	0	1	0	0	0				1	0	Variable				
	Gas Appliance - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	
	Gas Appliance Remedials Outstanding	0	0	0	0	0	0	0	0	0	1	0	5	0				6	0	Variable				Ashburton running on hire unit as part of replacment project.
	Landlord Gas Appliances - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	68%	100%	100%	100%				Stat	98%	97%	85%	85%	97%	
	Landlord Gas Appliance Remedials Outstanding	18	18	18	18	11	0	0	0	0	0	0	0	0				83	6	Variable				
	Pressure Systems inspection - % In date	100%	100%	98%	98%	98%	98%	98%	98%	99%	99%	100%	100%	100%				Stat	99%	97%	85%	85%	97%	Main Steam Boiler No.1 now awaiting working PSSR inspection - Booked for 21/02/2024
	Pressure Systems Remedials Outstanding	0	0	0	0	1	1	1	2	2	3	2	2	0				14	1	Variable				No outstanding PSSR remedials - Awaiting PSSR certficates from Main Entrance Coffee Bar for 2 X Coffee Boilers.AE PSSR aware.
	LOLER Lifts Safety Checks - works % in date	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	99%	100%				Stat	100%	97%	85%	85%	97%	
	LOLER Lifts Safety Remedials Outstanding	0	1	0	0	0	0	0	1	1	1	1	1	0				6	0	Variable				
	LOLER Lifting Appliances - works % in date	94%	94%	95%	95%	95%	96%	96%	98%	100%	98%	98%	98%	98%				Stat	97%	97%	85%	85%	97%	
	LOLER Lifting Appliances Remedials Outstanding	0	0	1	1	1	0	0	1	5	50	50	50	50				209	16	Variable				29 Hoist Remedials sent to Clinical Engeering (awaiting Confirmation of completion of defects) - 21 Defects Currentlv under TCOE
	Water Safety Risk Assessments - % plan to date								100%	99%	86%	51%	29%	29%				Stat	66%	97%	85%	85%	97%	Pre-start meeting on 20th February
	Water Safety Risk Assessments - Remedials Outstanding								0	0	278	278	278	278				1112	185	Variable				
	Water Safety Checks - works % in date	99%	97%	97%	100%	100%	100%	100%	100%	95%	90%	100%	100%	100%				Stat	98%	97%	85%	85%	97%	
	Water Safety Remedials Outstanding	268	238	317	284	136	158	245	227	248	284	241	231	135				3012	232	Variable				Decemnber updated to include Acute site (information not availble at time of report)
Estates - Buildings - Stat / Mand Compliance	Window & Restrictor Insp - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Mand	100%	97%	85%	85%	95%	Inspections only, window condition survey is independent to this functional test
	Window & Restrictor Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0	Variable				
	Asbestos Inspections - % in date	100%	93%	88%	98%	98%	98%	95%	94%	94%	89%	98%	98%	100%				Stat	95%	97%	85%	85%	97%	1020 separate reinspection areas in RfB.
	Asbestos Inspection Remedials Outstanding	0	6	5	5	2	2	4	1	0	1	1	0	12				39	3	Variable				
	Edge Protection inspection - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	Edge Protection condition and requirements
	Edge Protection Remedials Outstanding	0	0	0	0	10	10	10	10	10	10	10	10	10				90	7	Variable				
	Fixed Ladder Inspection - % In date	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				Stat	100%	97%	85%	85%	97%	Fixed ladder Inspections
	Fixed Ladder Inspection Remedials Outstanding	0	3	3	2	2	2	2	2	2	2	2	2	2				26	2	Variable				Carried out by external contractor
	Site Safety Audits - % in date		68%	76%	82%	92%	76%	88%	80%	87%	87%	92%	95%	93%				Stat	85%	97%	85%	85%	95%	
	Current Red Status Safety Reports Outstanding		3	1	0	0	6	4	1	1	1	1	1	1				20	2	Variable				New residences.
	Site Safety Audits Remedials Outstanding		118	119	113	113	89	89	86	84	80	98	106	106				1201	100	Variable				Expecting more remedial work to arise from Community sites in 2024.

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Domain	Workplace Services Performance Data January 2024 for February 2024 Report	2022-23 Quarter Four			2023-24 Quarter One			2023-24 Quarter Two			2023-24 Quarter Three			2023-24 Quarter Four			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
	Metrics	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24					Constant Review	Cause for Concern	No Concerns	
		Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Facilities - National Cleaning Standards (from April 2022)	FR1 - Weekly - Torbay Hosp ICU, ED, Oncol, Thtrs	4.90	5.00	5.00	4.90	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00					4.98	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR1 - Weekly - Torbay Hosp OPD	4.80	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00					4.98	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR1 - Weekly - Dawlish Hosp MIU	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00					5.00	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR1 - Weekly - Newton Abbot Oncology, UTC	4.70	5.00	5.00	4.80	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00					4.96	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR1 - Weekly - Totnes Hosp MIU	4.70	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00					4.98	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR1 - Weekly - Teignmouth Hosp Theatre	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00					5.00	5	3	3	4	Weekly Audits - Target - 98% completed each week
	FR2 - Monthly - Torbay Hosp Wards, CCU, Xray	4.90	5.00	5.00	5.00	5.00	5.00	5.00	4.90	5.00	4.97	4.75	4.90	5.00					4.96	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Torbay Hosp OPD Phrmcy, Eye Cl	4.80	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	4.90	5.00					4.98	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Newton Abbot Wards, Maternity	4.30	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	4.79	5.00	5.00					4.93	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Dawlish Hosp Ward	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	4.90	5.00	4.93	5.00					4.99	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Brixham Hosp Ward	4.10	5.00	5.00	4.50	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00					4.89	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Totnes Hosp Ward	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00					5.00	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Paignton H+WBC Oncology	4.70	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00					4.98	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR2 - Monthly - Ashburton Hosp Treatment Room	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00					5.00	5	3	3	4	Monthly Audits - Target - 95% completed each Month
	FR3 - Bi-Monthly - Torbay Hosp Dental, Day Units		5.00		5.00	4.00		5.00		5.00		5.00		5.00					4.86	5	3	3	4	Bi-Monthly Audits - Target - 90% completed each 2 Month period
	FR3 - Bi-Monthly - Torbay Hosp, OPD Pharm,		5.00		5.00		5.00		5.00		4.90		5.00						4.98	5	3	3	4	Bi-Monthly Audits - Target - 90% completed each 2 Month period
	FR4 - 4-Monthly - Torbay Hosp - Rms, Audiology		5.00		5.00	5.00				5.00		4.35							4.87	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Torbay Hosp access wait areas	5.00	5.00		5.00	5.00			5.00		5.00			5.00					5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Newton Abbt access wait areas				5.00		5.00			5.00		5.00							5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Dawlish Hosp access wait areas				5.00				5.00				4.88						4.96	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Brixham Hosp access wait areas				5.00				5.00			5.00							5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Totnes Hosp access wait areas				5.00				5.00			5.00							5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Teignmth Hosp access wait areas				5.00				5.00			5.00							5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Paigntn H+WBC access wait areas				5.00				5.00			5.00							5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR4 - 4-Monthly - Ashburton Access Waiting Areas				5.00				5.00			5.00							5.00	5	3	3	4	4 Monthly Audits - Target - 85% completed each quarter
	FR5 - 6-Monthly - Torbay, MDSS, Chapel, PTS Vehs				5.00	5.00				5.00									5.00	5	3	3	4	6 Monthly Audits - Target 80% completed each 6 months
	FR5 - 6-Monthly - Torbay, OPD	5.00						5.00	5.00				5.00						5.00	5	3	3	4	6 Monthly Audits - Target 80% completed each 6 months
	FR6 - Annual - Torbay Admin, Training, Stores				5.00							4.41							4.71	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Torbay OPD Admin Offices, Stores	5.00			5.00					5.00			5.00						5.00	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Newton Abbot, Admin Offices, Stores									5.00				5.00					5.00	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Dawlish, Admin Offices, Stores				5.00														5.00	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Brixham, Admin Offices, Stores										5.00								5.00	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Totnes, Admin Offices, Stores											5.00							5.00	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Paignton, Admin Offices, Stores											5.00							5.00	5	3	3	4	Annual Audits - Target 75% completed each year
	FR6 - Annual - Ashburton, Admin Offices, Stores										5.00								5.00	5	3	3	4	Annual Audits - Target 75% completed each year
	HPV Cleans per month	6	6	17	31	12	13	58	31	22	34	67	34	31					362	28	Variable				From Porter HPV data to 21st Nov 22 then Navenio, back to Backtraq 17th March 23.
	Deep Cleans per month	1036	1146	994	852	938	778	782	899	861	896	735	900	1096					11913	916	Variable				From Porter Deep Clean data to 21st Nov 22 then Navenio, back to Backtraq 17th March 23.
Facilities - Catering	EHO Audit Scores - Acute	5	5	5	4	4	4	4	4	4	4	4	4	4					4.2	5	2	2	4	EHO Audit score back to 5 following audit in January 2022. Routine EHO Audit could be at any time.
	EHO Audit Scores - Brixham Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5					5.0	5	2	2	4	
	EHO Audit Scores - Dawlish Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5					5.0	5	2	2	4	
	EHO Audit Scores - Newton Abbot Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5					5.0	5	2	2	4	EHO Visit in November - no change
	EHO Audit Scores - Totnes Hospital	5	5	5	5	5	5	5	5	5	5	5	5	5					5.0	5	2	2	4	
	Catering Audits	22	22	22	22	22	22	22	22	21	21	22	22	22					21.8	5	19	19	19	
	Catering Audit Remedials Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0					0	0	Variable				
	Total Tonnage all waste streams per month	144.6	140.5	172.1	128.2	146.5	132.5	133.4	132.3	126.9	176.1	159.4	126.8	152.5	#N/A	#N/A	#N/A		1871.8	144.0	Trend				TP removed from waste figures
	% of Total tonnage Recycled Waste per month	35.7%	35.3%	36.1%	34.5%	42.8%	30.1%	31.8%	34.3%	44.1%	39.5%	32.5%	35.5%	38.2%						36%	Aim is ↑	25.0%	25.0%	30.0%	
	Tonnage Recycled Waste per month	51.6	49.6	62.1	44.2	62.7	42.9	43.3	45.3	56.0	69.6	52.1	45.5	58.2					683	52.5	Trend				
	% of Total tonnage Landfill Waste per month	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						0%	Aim is Zero	5.0%	5.0%	2.0%	
	Tonnage Landfill Waste per month	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0					0	0.0	Trend				

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Domain	Workplace Services Performance Data January 2024 for February 2024 Report	2022-23 Quarter Four			2023-24 Quarter One			2023-24 Quarter Two			2023-24 Quarter Three			2023-24 Quarter Four			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
	Metrics	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24					Constant Review	Cause for Concern	No Concerns	
		Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Facilities - Waste	% of Total tonnage of Clinical Non-Burn waste / month	18.6%	14.1%	15.6%	17.0%	11.6%	15.4%	13.7%	13.6%	9.9%	13.3%	13.6%	13.0%	15.2%					14%	Aim is ↓	22.0%	22.0%	18.0%	
	Tonnage of Clinical Non-Burn waste per month	26.8	19.5	26.8	21.8	17.0	20.4	18.7	18.0	12.6	23.4	21.8	16.7	23.1				266	20.5	Trend				
	% of Total tonnage of Clinical Burn waste per month	14.0%	11.4%	12.7%	12.3%	6.2%	6.7%	7.9%	9.5%	6.8%	10.3%	11.0%	8.6%	7.1%					10%	Aim is ↓	18.0%	18.0%	14.0%	
	Tonnage of Clinical Burn waste per month	20.2	15.7	21.9	15.8	9.1	8.9	10.8	12.5	8.6	18.1	17.6	11.0	10.8				181	13.9	Trend				
	% of Total tonnage of Clinical Offensive waste / month	14.9%	17.0%	15.6%	16.0%	19.9%	17.0%	15.2%	16.2%	16.6%	18.2%	15.5%	19.9%	15.3%					17%	Aim is ↑	12.0%	12.0%	15.0%	
	Tonnage of Clinical Offensive waste per month	21.6	23.4	26.8	20.5	29.2	22.5	20.8	21.5	21.0	32.0	24.9	25.5	23.4				313	24.1	Trend				
	% of Total Tonnage Waste to Energy (General Waste)	16.9%	23.3%	20.1%	20.3%	19.5%	28.5%	29.2%	27.0%	22.7%	18.7%	26.9%	21.9%	24.3%					23%	Aim is ↑	15.0%	15.0%	18.0%	
	Tonnage Waste to Energy (General Waste)	24.5	32.2	34.5	26.0	28.6	37.7	39.9	35.0	28.8	33.0	43.1	28.1	37.0				428	32.9	Trend				
	Statutory Waste Audits - % completed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	Trend	90%	90%	95%	
Workplace Incidents and Safety	Workplace Serious/RIDDOR incidents	0	0	1	0	1	2	1	1	0	0	0	1	0				7	0.5	0	2	1	0	2 pending - RIDDOR status to be confirmed
	Workplace incidents resulting in moderate harm	2	0	0	0	0	1	1	1	0	1	1	0	1				8	0.6	0	3	3	1	General Waste Bin fell on head - precautionary ED visit - no time off work.
	Workplace incidents resulting in minor harm	3	0	0	2	4	5	1	3	5	1	6	7	2				39	3.0	0	10	10	5	Slip on wet floor - right wrist, Fire Door closed on left Wrist
	Workplace incidents resulting in no harm	19	5	6	4	13	54	12	44	79	36	28	29	45				374	28.8	0	50	50	15	30 Aggressive Patients, 6 False Fire Alarms, 2 Parking Space availability
	Workplace Incidents resulting in Near Miss	2	1	2	0	5	6	2	7	4	2	4	6	2				43	3.3	0	20	20	5	Welfare Check on colleague in Accom, 1 Aggressive Patient.
	Workplace Datix incidents open for > 8 weeks	77	53	46	42	38	36	35	38	50	44	46	55	34				594	45.7	0	50	50	15	
	Workplace Teams Safety Walks - % Completed	40%	78%	80%	80%	90%	60%	67%	63%	75%	94%	100%	100%	75%					77%	Trend	75%	75%	90%	8 Meetings per month.
	Workplace Safety Action Group Mtgs - % Completed	30%	78%	70%	70%	90%	60%	67%	63%	75%	88%	100%	100%	85%					75%	Trend	75%	75%	90%	8 Meetings per month.

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Domain	Workplace Services Performance Data January 2024 for February 2024 Report	2022-23 Quarter Four			2023-24 Quarter One			2023-24 Quarter Two			2023-24 Quarter Three			2023-24 Quarter Four			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Lorne Stewart Planned Work	Total PPMs planned per month (not KPI)	94	109	73	156	131	89	45	83	86	111	90	172	163	#N/A	#N/A		1402	108	Variable				Not a KPI - an indicator of planned work volumes
	Statutory PPMs planned per month	67	27	19	38	45	29	29	21	21	36	19	28	18				397	31	Variable				
	Statutory PPM % success against plan	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	97%	85%	85%	97%	
	Routine PPMs planned per month	27	82	54	118	86	60	16	62	65	75	71	144	145				1005	77	Variable				
	Routine PPM % success against plan	100%	100%	100%	100%	100%	100%	100%	100%	98%	96%	100%	100%	97%					99%	90%	60%	60%	70%	
	Grand Total Reactive Work (not KPI)	107	108	154	113	120	130	129	128	120	159	153	85	217	#N/A	#N/A		1723	133	Variable				
Lorne Stewart Class A - Reactive	Total Class A Reactive Requests per month (not KPI)	38	40	69	47	63	62	87	62	41	62	59	33	87	#N/A	#N/A		750	58	Variable				Not a KPI - an indicator of reactive work volumes
	Class A - Emergency - LD1A - requests per month	3	1	5	4	2	8	10	6	2	8	10	6	6				71	5	Variable				Note LD1A is 1hr response, LD1B is 2hr Response
	Class A - Urgent - LD2 - requests per month	17	14	32	22	15	19	25	23	17	21	24	17	36				282	22	Variable				
	Class A - Routine - LD3 - requests per month	8	22	30	21	37	31	30	28	20	32	19	8	34				320	25	Variable				
	Class A - Routine - P4 - requests per month	10	3	2	0	9	4	22	5	2	1	6	2	11				77	6	Variable				
Lorne Stewart Class B - Reactive	Total Class B Reactive Requests per month (not KPI)	69	68	85	66	57	68	42	66	79	97	94	52	130	#N/A	#N/A		973	75	Variable				Not a KPI - an indicator of reactive work volumes
	Class B - Emergency - LD1B - requests per month	3	6	6	4	2	6	4	1	0	6	5	2	7				52	4	Variable				Note LD1A is 1hr response, LD1B is 2hr Response
	Class B - Urgent - LD2 - requests per month	24	32	25	22	24	24	11	25	37	28	35	20	45				352	27	Variable				
	Class B - Routine - LD3 - requests per month	32	28	46	30	26	32	21	28	38	53	49	25	60				468	36	Variable				
	Class B - Routine - P4 - requests per month	10	2	8	10	5	6	6	12	4	10	5	5	18				101	8	Variable				
KPIs	Attendance KPI - % Completed on Time	100%	98%	98%	99%	100%	100%	98%	98%	99%	97%	88%	94%	93%					97%	97%	65%	65%	75%	Reactive
	Completion KPI - % Completed on Time	95%	97%	98%	96%	91%	90%	90%	87%	91%	90%	86%	92%	93%					92%	97%	65%	65%	75%	Completion due - 15 jobs within KPI target, 30 day jobs
Other Contract KPIs	Health and Safety Incidents per month	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0.0	0	2	2	0	
	Service Level - provide Financial Report within 10wkg days of month end	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%		95%	95%	100%	
	Service Level - Provide Contract Report within 10wkg days of month end	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	100%					92%		95%	95%	100%	
	Building Maintenance Statutory Compliance	100%	100%	99%	100%	99%	100%	100%	100%	100%	99%	100%	100%	100%					100%	Trend	95%	95%	100%	
	Building Maintenance Routine Priority	100%	100%	98%	99%	99%	100%	100%	100%	99%	99%	99%	99%	99%					99%	Trend	95%	95%	100%	

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Domain	Workplace Services Performance Data January 2024 for February 2024 Report	2022-23 Quarter Four			2023-24 Quarter One			2023-24 Quarter Two			2023-24 Quarter Three			2023-24 Quarter Four			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
Community Cleaning Contract - Quality Control	Number of Cleaning Audit Scores			10	11	11	11	11	11	11	11	11	11	11				120	11	Variable				
	Average % of Cleaning Audit Scores			97%	95%	97%	97%	96%	96%	95%	96%	97%	96%	96%					96%	97%	85%	85%	95%	
	Belmont Court			97%	80%	98%	97%	97%	96%	96%	95%	96%	96%	96%					95%	97%	85%	85%	95%	
	Castle Circus Health Centre			95%	88%	92%	95%	95%	95%	93%	91%	100%	95%	96%					94%	97%	85%	85%	95%	
	Dartmouth Clinic			98%	98%	98%													98%	97%	85%	85%	95%	Removed from June 2023
	Dartmouth H+WBC					98%	95%	97%	96%	97%	97%	98%	96%	95%					97%	97%	85%	85%	95%	Added from May 2023
	Hollacombe CRC			97%	98%	97%	98%	95%	97%	97%	97%	96%	97%	97%					97%	97%	85%	85%	95%	
	Kings Ash House			97%	96%	97%	96%	97%	96%	96%	97%	96%	98%	95%					96%	97%	85%	85%	95%	
	Sherbourne House			98%	98%	97%	97%	98%	98%	97%	98%	97%	98%	98%					98%	97%	85%	85%	95%	
	Shrublands			96%	97%	97%	97%	96%	94%	89%	97%	96%	95%	96%					95%	97%	85%	85%	95%	
	Teignmouth Clinic			97%	97%	95%	95%	95%	93%	95%	95%	95%	95%	95%					95%	97%	85%	85%	95%	Jan2024 - 94.9% - 0.1% below green rating
	Union House			98%	98%	96%	97%	95%	98%	98%	98%	97%	95%	97%					97%	97%	85%	85%	95%	
	Unit 7			96%	96%	98%	97%	97%	94%	96%	97%	98%	99%	98%					97%	97%	85%	85%	95%	
	Walnut Lodge			96%	98%	98%	99%	97%	97%	96%	98%	97%	97%	97%					97%	97%	85%	85%	95%	
Community Cleaning Contract - Re-Audit Scores (as required)	Number of Re-audits required			0	2	0	0	0	0	1	0	0	0	0				3	0.3	0	3	3	0	Under 90% for re-audit
	Belmont Court				97%														97%	97%	85%	85%	95%	
	Castle Circus Health Centre				91%														91%	97%	85%	85%	95%	
	Dartmouth Clinic																		#DIV/0!	97%	85%	85%	95%	
	Dartmouth H+WBC																		#DIV/0!	97%	85%	85%	95%	
	Hollacombe CRC																		#DIV/0!	97%	85%	85%	95%	
	Kings Ash House																		#DIV/0!	97%	85%	85%	95%	
	Sherbourne House																		#DIV/0!	97%	85%	85%	95%	
	Shrublands									97%									97%	97%	85%	85%	95%	
	Teignmouth Clinic																		#DIV/0!	97%	85%	85%	95%	
	Union House																		#DIV/0!	97%	85%	85%	95%	
	Unit 7																		#DIV/0!	97%	85%	85%	95%	
	Walnut Lodge																		#DIV/0!	97%	85%	85%	95%	
Community Cleaning - Health & Safety	Accidents			0	0	0	0	0	0	0	0	0	0	0				0	0.0	0	3	3	1	
	Near misses			0	0	0	0	0	0	0	0	0	0	0				0	0.0	0	8	8	5	
	RIDDORs			0	0	0	0	0	0	0	0	0	0	0				0	0.0	0	3	3	1	
	Health & Safety breaches			0	0	0	0	0	0	0	0	0	0	0				0	0.0	0	30	30	15	
	New starters			0	0	2	0	4	1	0	2	0	0	0				9	1	Variable				Not a KPI - for info only.
	New starter inductions within 7 days of start date			0	0	2	0	4	1	0	2	0	0	0				9	1	Variable				
Feedback	% Feedback from completed Satisfaction Certificate																	0	#DIV/0!	Trend	75%	75%	90%	
	Client Compliments			1	0	0	1	0	0	0	2	0	0	0				4	0.4	0	0	0	1	Not a KPI - for info only.
	Client Complaints			1	1	2	2	1	0	1	1	0	2	2				13	1.2	0	2	2	0	Distrubing Gp apointments at Dartmouth HWBC, clinical waste bins emptying at Sherborune
	Complaints resolved within 5 days			1	1	1	2	1	0	1	1	0	1	2				11	1.0	0	10	10	0	

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Domain	Workplace Services Performance Data January 2024 for February 2024 Report	2022-23 Quarter Four			2023-24 Quarter One			2023-24 Quarter Two			2023-24 Quarter Three			2023-24 Quarter Four			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
PFI Dawlish	PPMs planned per month	66	43	38	44	44	37	51	65	35	44	42	38	69				616	47	Variable				
	PPM % success against plan	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%					99%	97%	85%	85%	97%	
PFI Dawlish - Reactive work Performance	Total Reactive Requests per month (not KPI)	29	20	37	22	21	38	19	21	21	17	31	21	24	#N/A	#N/A		321	25	Variable				Not a KPI - an indicator of reactive work volumes
	Emergency - P1 - requests per month	2	0	3	5	3	5	4	1	1	2	0	1	2				29	2	Variable				
	Emergency - % P1 completed in < 3hours	100%	100%	100%	80%	100%	100%	100%	100%	100%	100%	100%	0%	100%					91%	97%	90%	90%	95%	
	Primary Important - P2 - requests per month	3	4	3	5	1	5	7	2	4	0	2	0	3				39	3	Variable				
	Primary Important - % P2 completed in < 24 Hours	100%	100%	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%					98%	97%	75%	75%	85%	
	Very Important - P3 - requests per month	3	2	2	1	5	8	2	4	2	0	4	13	1				47	4	Variable				
	Very Important – % P3 completed in <48 hours	100%	100%	100%	100%	80%	88%	100%	100%	100%	100%	100%	100%	100%					98%	97%	85%	85%	90%	
	Important - P4 - requests per month	21	14	29	11	12	20	6	14	14	15	25	7	18				206	16	Variable				
	Important - % P4 completed in < 60 hours	100%	100%	96%	100%	100%	100%	100%	100%	93%	87%	100%	100%	100%					98%	97%	65%	65%	75%	
	Routine - P5 - requests per month	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0	Variable				
	Routine - % P5 completed in < 6 Business Days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	97%	65%	65%	75%	
PFI Dawlish	PFI Paymech Report	0	1	2	4	1	1	0	0	1	2	0	0	3				15	1.2	0	5	5	2	1 P1 failure (from December 23, failed in January 24) One Failure Deduction - £50 - 3 default points for emergency jobs. 1 for routine
	Energy Performance (GJ / 100m3)	4.62	3.95	4.14	3.04	2.35	1.64	1.28	1.47	1.46	2.61	4.14	4.65	4.85				40	3.09	0	5	5	3	

EFM Performance Report

Domain	Workplace Services Performance Data January 2024 for February 2024 Report	2022-23 Quarter Four			2023-24 Quarter One			2023-24 Quarter Two			2023-24 Quarter Three			2023-24 Quarter Four			Trend	Totals to date	Average to date	Target 2023-24	RAG Threshold			Comments
		Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24					Constant Review	Cause for Concern	No Concerns	
	Metrics	Month 10	Month 11	Month 12	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12								
PFI Newton Abbot - Planned work	Total PPMs planned per month (not KPI)	69	74	59	79	91	72	94	78	92	84	84	89	89	#N/A	#N/A		1054	81	Variable				Not a KPI - an indicator of planned work volumes
	Statutory PPMs planned per month	16	21	20	18	21	20	19	24	25	19	26	22	20				271	21	Variable				
	Statutory PPM % success against plan	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	97%	85%	85%	97%	
	Routine PPMs planned per month	53	53	39	61	70	52	75	54	67	65	58	67	69				783	60	Variable				
	Routine PPM % success against plan	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	90%	60%	60%	70%	
PFI Newton Abbot - Reactive work	Total Reactive Requests per month (not KPI)	166	121	181	167	116	94	105	111	104	98	93	83	103	#N/A	#N/A		1542	119	Variable				Not a KPI - an indicator of reactive work volumes
	Emergency - requests per month	4	9	9	3	8	9	6	21	21	8	9	4	8				119	9	Variable				
	Emergency - % completed in < 24hours					100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	97%	90%	90%	95%	
	Non- Emergency - requests per month	81	56	86	82	108	85	99	90	83	90	84	79	95				1118	86	Variable				
	Non-Emergency – % completed in < 1 - 5 Days					100%	99%	100%	100%	99%	100%	100%	100%	99%					100%	97%	85%	85%	90%	
PFI Newton Abbot - KPIs	PFI Contract 1 - User Satisfaction	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	Trend	84%	84%	95%	
	PFI Contract 2 - Absenteeism & Sickness	0%	0%	6%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%					0%	Trend	16%	16%	10%	
	PFI Contract 3 - Complaints per month	0	0	0	0	0	0	0	0	0	0	0	0	0				0	0.0	0	3	3	1	
	PFI Contract 4 - % downtime of assets affecting operations	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%					0%	Trend	6%	6%	1%	
	PFI Contract 5 - Meeting Annual Energy Targets	100%	110%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%	Trend	113%	113%	103%	
	PFI Contract 6 - Energy Performance (GJ / 100m3)	4.55	4.18	4.57	3.64	3.00	2.47	2.22	2.47	2.12	2.97	4.21	3.90	5.30				46	3.51	0	5	5	3	

Workplace Services Performance Data
January 2024 for February 2024 Report

22-Mar-24

Workplace Policies, Procedures and Meeting Group Terms of Reference reviews

TITLE	Procedure	Lead	Group Developing Doc	Group ToRs Review date	Pre-ratification Route	Ratification Group / Committee	Policy / Procedure review cycle	Date to begin next review	Next Review date	Notes & Target Date for completion
Water Safety Policy	Policy	Head of Estates Delivery	Water Safety Group	tbc	DIPC	Infection Control Committee	3 Yearly	Mar-24	May-24	
Water Safety Plan	Procedure	Head of Estates Delivery	Workplace Senior Leadership Team		Workplace Director	WPCG	Annual	Oct-25	Jan-26	
Management of Fire Safety and Evacuation Including Trust Fire Safety Policy Evacuation Including Trust Fire Safety Policy	Policy	Workplace Director / Corporate H&S Mgr	Fire Safety Group	tbc	WPCG	Health and Safety Committee	2 Yearly	Jul-24	Oct-24	
Control and Management of Contractors, Professional Consultants and Third Parties Policy	Policy	Head of Estates Delivery	Workplace Senior Leadership Team		Workplace Director	H&S Committee	2 Yearly	Sep-24	Dec-24	
Medical Gases	Policy	Head of Technical Services	Medical Gas Committee	tbc	Head Pharmacy . Workplace Director	H&S Committee	1 Yearly	May-24	Aug-24	
Electrical Safety	Policy	Head of Technical Services	WPCG	Sep-24	AE	H&S Committee	3 yearly	Apr-23	Jul-23	A Corporate Policy. Will be presented at February 2024 H+S Committee - following HTM update in late 2023. Amendments to be agreed in Electrical Safety Group prior to H&S Meeting. To go to March meeting
Electrical Safety	Procedures	Senior Electrical Engineer	Electrical Safety Group		AE	WPCG	3 yearly	Apr-23	Jul-23	A Corporate Procedure. Will be presented at February 2024 H+S Committee - following HTM update in late 2023. Amendments to be agreed in Electrical Safety Group prior to H&S Meeting.
Ventilation Systems Policy	Policy	Head of Technical Services	Workplace Senior Leadership Team	Nov-25	AE	H&S Committee	2 Yearly	Jan-25	Apr-25	
Lifting Operations & Lifting Equipment Management	Policy	Head of Technical Services	Workplace Senior Leadership Team		Manual Handling Group	H&S Committee	2 Yearly	Aug-24	Nov-24	
Lift Management Plan	Procedure	Head of Estates Delivery	Workplace Senior Leadership Team		Workplace Director	WPCG	2 Yearly	Sep-23	Dec-23	Ratified at Jan 2024 WPCG, to be issued to H&S Committee. To go to H+S - but Fire Service SLA has changed - plan to reflect new arrangements.
Pressure Systems Policy	Policy	Head of Technical Services	Workplace Senior Leadership Team		AE	H&S Committee	2 Yearly	Jan-25	Apr-25	
Asbestos Policy	Policy	Head of Technical Services	Workplace Senior Leadership Team		Workplace Director	H&S Committee	3 Yearly	Jun-24	Sep-24	
Asbestos Management Plan	Procedure	Asbestos Coordinator	Workplace Senior Leadership Team		Workplace Director	Asbestos Safety Group, WPCG	6 Monthly	Jun-24	Jul-24	6-monthly review through ASG/ WPCG
Cleaning Policy	Policy	Head of Facilities Operations	Environment Gp	tbc	DIPC	Infection Prevention Control Gp	3 Yearly	Jan-24	Apr-24	On track
Linen & Laundry Policy	Policy	Head of Facilities Operations	Workplace Senior Leadership Team		DIPC	Infection Prevention Control Gp	3 Yearly	Jul-23	Oct-23	Under review by SLT as of 30th Oct 2023. To be ratified in November 2023 to ICG Dec 2023 (cancelled) Jan 2024 (cancelled). To next IPC Meeting (March 2024.
Waste Management Policy	Policy	Head of Facilities Operations	Environment Gp		DIPC	H&S Committee	3 Yearly	Apr-25	Jul-25	
Food Hygiene Policy	Policy	Head of Facilities Operations	Workplace Senior Leadership Team		Nutritional Steering Gp	Infection Prevention Control Gp	3 Yearly	Jan-24	Apr-24	On track - need consultant input
Pest Control Policy	Policy	Head of Facilities Operations	Workplace Senior Leadership Team		Environment Group	Infection Prevention Control Gp	3 Yearly	Dec-23	Mar-24	
Transport of Dangerous Goods and the Accompanying Procedures for the Transport of Various Items classified under ADR 2019	Policy	Head of Facilities Operations	Workplace Senior Leadership Team		Workplace Director	H&S Committee	3 Yearly	May-26	Aug-26	
Confined Space Management	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Sep-24	Dec-24	
Control of Substances Hazardous to Health (COSHH), The	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Jan-24	Apr-24	Being Review at Present - on track
Display Screen Equipment (DSE) Eyesight Reimbursement	Procedure	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	May-24	Aug-24	
Display Screen Equipment (DSE) Procedure	Procedure	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	May-24	Aug-24	
Display Screen Equipment User Self Assessment Form	Form	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	May-24	Aug-24	
Electronic Cigarette Management Policy	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	3 yearly	Jul-24	Oct-24	
First Aid Management	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	3 yearly	Sep-25	Dec-25	
Health and Safety Action Plan Template	Form	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Oct-24	Jan-25	
Health and Safety Policy	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Feb-24	May-24	On Track
Health and Safety Representatives	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Jan-24	Apr-24	
Health and Safety Risk Assessment Form- excel	Form	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	3 Yearly	Dec-23	Mar-24	
Health and Safety Risk Assessments	Form	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	3 Yearly	Dec-23	Mar-24	
Hot Desking SOP	Procedure	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	Annual	Aug-23	Nov-23	Sent to Amanda. (Reformatted) awaiting confirmation of ratification.
Ladders Checklist- EFM-SO18	Form	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	3 yearly	Jul-25	Oct-25	
Latex Management	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Oct-24	Jan-25	
Latex Product Use Authorisation Form	Form	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Oct-24	Jan-25	
Ligature Points, Assessing and Managing	Procedure	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Jul-25	Oct-25	SE verifying current copy is published to ICON.
Ligature Risk Assessment, Environmental Blank Form - Excel	Form	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Jan-25	May-25	Ratified by H&S Group.
Management of Confidential Waste	Policy	Environment and site Services Manager			Corporate H&S Manager	H&S Committee	3 Yearly	May-26	Aug-26	Ratified at IGSG on 21st Dec 2023.
Management of Liquid Nitrogen Procedure	Procedure	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Mar-24	Jun-24	
New and Expectant Mothers Risk Assessment Form'	Form	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	3 yearly	Jan-25	Apr-25	
New and Expectant Mothers Risk Assessment Procedure	Procedure	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	3 yearly	Jan-25	Apr-25	
Noise at Work, Management of	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Mar-24	Jun-24	
Personal Protective Equipment Management	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Mar-24	Jun-24	
Preliminary Noise Assessment Form	Form	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Mar-24	Jun-24	
Sharps Management Procedure	Policy	Corporate H&S Manager	Sharps Committee		Corporate H&S Manager	H&S Committee	2 Yearly	Mar-25	Jun-25	
Sharps, Authorisation form for the use of non-safer sharps	Form	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Mar-25	Jun-25	
Sharps/Contamination Incident Investigation	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Mar-25	Jun-25	
Working at Height Procedure	Procedure	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	3 Yearly	Jul-25	Oct-25	
Workplace Health and Safety Audit Procedure	Procedure	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Jan-24	Apr-24	On track
Workplace Management	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	3 Yearly	Jan-24	Apr-24	On track
Workplace Slips Trips and Falls Management Procedure	Procedure	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	Jun-25	Sep-25	
Young Persons and Work Experience, Management of Health and Safety	Policy	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	3 Yearly	Jul-26	Oct-26	Ratified at H&S 17th Oct 2023

CCTV & Body Worn Video Policy	Policy	Trust LSMS			Workplace Director	H&S Committee	2 Yearly	**May-24**	**Aug-24**	
Management of Lone Working Policy	Policy	Trust LSMS			Workplace Director	H&S Committee	2 Yearly	**Oct-23**	**Jan-24**	Approved - obtain dates
Violence Prevention and Reduction Policy	Policy	Trust LSMS			Workplace Director	H&S Committee	2 Yearly	**Jan-25**	**May-25**	
Water Cooler and Vending Machine Management Procedure	Procedure	Corporate H&S Manager			Corporate H&S Manager	H&S Committee	2 Yearly	**Jul-25**	**Oct-25**	Ratified at H&S 17th Oct 2023
Security Procedures Policy	Policy	Trust LSMS			Workplace Director	H&S Committee	2 Yearly	**Aug-24**	**Nov-24**	
Zero Tolerance to Harrassment	Policy	Trust LSMS			Workplace Director	H&S Committee	2 Yearly	**Oct-24**	**Jan-25**	

Workplace Services Performance Data
January 2024 for February 2024 Report

Workplace Roles and Responsibilities

Compliance area	Authorising Engineer	Responsible Persons	Authorised Persons	Competent Persons / Other Competent Persons	Other Key Personnel	Notes
Water	Neil Edmonds	Rae Calicut	John Armstrong Emma Hughes	Churchill Services, PFI Contractors	Trust DIPC – Dr Joanne Watson	
Fire	Darren Kirk	Fire Safety Manager – Jake O'Donovan.	Fire Safety Advisor - Kevin Wood/ Neil Faulkner	Suzanne Ellis, Neil Faulkner	Estates Team - Weekly Testing AlarmTec - Periodic Maintenance Chubb - Periodic Maintenance, Hydrant & Dry Riser Inspections Westcountry Fire Alarms - Fire Extinguisher Maintenance	
Medical Gases	Malcolm Thompson		Paul Morgan Tim Coysh Vacant	Mark Fahy Medical Gas Pipelines Ltd M&M Medical – Newton Abbot PFI. Quality Controller (MGPS) Accredited External Contractor as required. Porters - Cylinder Handling Mechanical Team - First Response and Cylinder Handling	Designated Medical Officer (MGPS) and Designated Nursing Officer (MGPS) to be appointed.	
Electrical Systems	Alex Bray (HV/ LV)		Paul Morgan (HV/ LV) Richard Coombes (HV/ LV)	Steve Thompson (HV Res/ LV), Richard O'Reilly (HV Res/ LV), Andy Maddock (HV Res/ LV), Mark Hodges (HV Res/ LV), Declan Pearson (HV Res/ LV), Richard Hicks (LV - Gas safe) Contractors: Enerveo, HV Power Services (HV/ LV), MEC Engineering, DD Electrical, Addicott Electrics, Bender, Starkstrom, Levcet (HPD)	External Specialist Consultants (ETA Projects Ltd)	
Ventilation Compliance	**Graham Taylor filling in in short term.**		Vacant Tim Coysh	Mechanical Team trained in November 2021(3 year term). Sollus-Solutions, Dan Clarke Howorth Air Technology Ltd Camfil ltd Medical Air Technologies	Trust DIPC – Dr Joanne Watson	AE(Vent) TBC
Lifts / LOLER	Mottram Associates (Competence for Lift systems but not AE)		Mottram Associates Ltd	Lift Release DEL Staff (Lifts) Specialist contractor - Kone Lifts	LmP (examination systems), Allianz Insurance Inspectors for Lift and Fixed / Portable hoist and Lifting beams LOLER. Declan Pearson, Emma Hughes to Lift AP level for day to day management Tim Coysh, Paul Morgan, Richard Coombes (Electrical)	
Pressure Systems	LmP - Corporate AE		Tim Coysh - (AE has assessed) Paul Morgan - (AE has assessed)	CP Examination is Allianz CP Written Schemes prepared by LmP Technical Services Mechanical Team	Emma Hughes - Operational Support	
Decontamination Engineering Systems	Jim Tinsdale		Richard Coombes Paul Morgan	Ben Armstrong (Weekly Testing) Serve Medical MMM Limited Gelinge		
Asbestos	N/A	Asbestos Coordinator – Ian Hackney		All EFM Staff trained in Asbestos Awareness Contractors as appointed, (Tony Mayne for Environmental Services)	Asbestos Removal Projects - Controlled by Capital projects	
Cleaning	N/A	Infection Control – Tony Hopkins, Cleaning in IPC – Rachel Russell		Alan Stephens, Lynn Northcott, Matt Acton Lucy Woodward – Community Inpatient Norse Cleaning - Community Non-Inpatient	Norse Cleaning – Non-Inpatient Areas, managed by Matt Acton	
Waste Management	N/A	tbc.		Tony Hopkins, Matt Acton, Ryan Evans	Catalyst IPC - Rachel Russell	
Catering	N/A	Tony Hopkins		Nathan Simms Kathryn Sherlock		
Security	N/A	LSMS - Andrew Chorlton		Chris Sparks Tom Holland		

Workplace Services Performance Data
January 2024 for February 2024 Report

Workplace Business Continuity Plans

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

Notes

Workplace Services Performance Data
January 2024 for February 2024 Report

Ref	Comments	Date
1	Staff numbers are FTE	30-Apr-19
2	For Workforce stats - use average of the 5 Pink rows - Estates, Facilities Management, and the three Hotel Services groups.	22-May-19
3	Porter data from 'Porter Requests' and 'Request Analysis' for the completed requests for the month being reported. Extract the data and pivot by urgent routine and planned and for top three categories	11-Jun-19
4	Cleaning data added for community sites	11-Jun-19
5	Added SSEP Trust wide metrics - not required for the CIEG Report	12-Jul-19
6	Incidents table added as a tab monthly, Annual Deep Cleans + Incidents added.	13-Sep-19
7	Facilities Essential Training and Catering Cleaning Audits added	18-Oct-19
8	Catering costs and community cleaning scores added.	15-Nov-19
9	To preserve Conditional Formatting when adding the next quarter: **Ensure the new quarter column is inserted to the left** of columns O, P & Q, **before** deleting columns C, D & E. Clear contents of Columns O, P & Q ready for the new months, taking care not to erase the average figures. Update the Quarter and Month names at the top of the new columns, and the Dashboard month info in Cell B1. Check the Sparklines updated too. Save!	22-Apr-20
10	Used Bold borders to denote Reactive and Planned PPM data incomplete - used for Board Reports on odd-numbered Months	21-Sep-20
11	Added Fire Doors and Fire Safety Engineering to Estates	01-Feb-21
12	Draft version for Apr 21 - added remedial count tallys with trends. First version to capture the Compliance area remedials. Really needs a comprehensive set of subgroups, with the time ringfenced to agree planning for all remedials.	25-Feb-21
13	Added If(reactive number cells)=0, N/A)(reactive number cells) to show N/A if no value, so the Sparklines don't show zero for a null. Also removed Porters info - never used.	31-May-22
14	Added EFM Incidents > 8wks old	28-Sep-22
15	Total revision of Waste KPI thresholds following review of invoice tonnages.	03-Oct-22
16	Changed cleaning KPIs to National Cleaning Standards	06-Oct-22
17	Split Estates and Facilities Ops Dashboards into two tabs	27-Oct-22
18	Added All Risks from CRR and added MDSS KPIs	14-Nov-22
19	Added Estates and Cleaning Contracts tabs, plus DAW and NAb PFI Tabs. Note that 'normal' estates and facilities Dashboards are for the whole Trust performance and compliance (where possible), whereas tabs with the two contracts and PFIs are intended to be for reporting the performance of the Contracts and any KPIs set in the Contract documents.	10-Jan-23
20	Removed CES (was MDSS) as they have transferred to the Planned Care Group.	01-Aug-23
21	Added Contracts and No of Progress Desk requests older than 60 / 120 days.	04-Oct-23
22	Added Terms of Reference review dates to Policies Tab	14-Nov-23
23		
24		
25		
26		

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the board of directors			
Report title: Chief Executive's report			Meeting date: 27th March 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 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 28 February 2024 are as follows:

3.1 Excellent population health and wellbeing

Celebrating our unsung young heroes

There are at least 755 children and young adults who are providing unpaid care to look after a family member, although this figure may be higher as many people may not see themselves as a carer. They provide invaluable support for their loved ones including cooking and cleaning, helping them to get out of bed, attending appointments, and collecting medication.

I have been invited to spend time with a group of young carers to learn more about the work they do and the support they need from our people working across health and care services. They have such an important job looking after others, but they have told me that they don't always feel our people trust them to handle sensitive and personal information about their parent's health, or feel they are listened to.

To coincide with Young Carers' Day on 13 March some of our young carers created a film to shine a light on their world and the support they need. I was inspired by their message and promised to share it with our people to remind them to ask carers what help they might need. I am pleased to share their film with our Board of Directors to watch here.

Our carers service does a fantastic job making sure carers are identified, supported and are aware of the help that's available. For more details about the Torbay Carers' Service, visit Torbay Carers Service - Torbay and South Devon NHS FT

Nutrition and Hydration Week 2024
Making sure our patients and staff take regular meal and drink breaks is important to maintain good health and wellbeing, and our wards work so hard to protect mealtimes, understand people's dietary needs and encourage people's choices.

We also encourage our people to take their breaks as we know it's not always easy to forget to look after yourself when you're busy caring for others.

Nutrition and hydration week is one of the highlights of our annual events calendar and helps raise awareness of an important issue. This year our people organised a range of events to promote protected mealtimes, and to learn what support is available from our dieticians. Wards hosted tea parties, and shared information about nutrition and swallowing awareness, and I was proud to present the winning award to the discharge lounge for its Mad Hatter's themed tea party. McCallum ward was the runner-up with its harvest festival-themed ward celebration.

Raising awareness of delirium
For World Delirium Awareness Day members of our intensive care team visited lots of departments and wards at Torbay Hospital. They had a great reception from teams as they raised awareness of delirium, the effects it has on people and their families and the education and advice available.

No smoking day
Smoking is still the single largest preventable cause of death in England – estimated to account for 64,000 deaths annually. In 2022-23, there were an estimated 408,700 smoking-related hospital admissions in England.

Our dedicated tobacco dependence service provides support and access to medication to help people to stop smoking, and the team visited wards on No smoking day to raise awareness of the help that's available. It also created an e-learning programme to help our people have conversations with patients and colleagues about their smoking.

Smoking in pregnancy accounts for one in 12 premature births, one in five low birth weight babies and one in three sudden unexpected deaths in infancy. There has been a significant reduction in stillbirths within our maternity service, to the extent there were no stillbirths from January to December 2023. This evidences the efficacy of our award-winning smokefree pregnancy team and its work to reduce smoking rates of people under their care. The team also spent no smoking day talking to people at Torbay Hospital about the range of support that's available to them and their families to protect themselves and the health of their unborn child.

3.2 Excellent experience receiving and providing care

Current pressures
Devon's health and care system remains under pressure, resulting in ambulance handover delays, increased pressure in our emergency departments, and the growing number of people in our hospitals who are unable to return home when they no longer need acute care.

A fortnight ago, NHS Devon declared a system critical incident to provide greater support to manage demand, and to de-escalate our services within two days. I would like to pay tribute to our people who worked so hard and under such challenging circumstances to provide safe care for our patients.

Despite our best efforts, our urgent and emergency care service remains under significant pressure, and people in ambulances are still waiting longer to be admitted to our emergency department than any of us would like.

NHS England has told all trusts that by the end of March 76% of people needing care from our emergency department must be seen and treated within four hours of arriving. We are reviewing the pathways across all of our services to identify where we can make further sustainable improvements in the way we provide care and how, as a system, primary, secondary, acute and community services can work together to make sure our region's ambulances can get back on the road as quickly as possible to respond to calls from people who need life-threatening care, and that people receive the care they need, in the right place and at the right time.

Staff survey results

Every year we encourage our people to complete the annual NHS staff survey to tell us what it's like to work here and how we need to improve what we do. This year 2,706 of our people took part and shared their views.

This year's results are aligned to the NHS People Promise, which is based on the things that matter to most to our people. The seven promises are:

- we are compassionate and inclusive
- we are recognised and rewarded
- we each have a voice that counts
- we are safe and healthy
- we are always learning
- we work flexibly
- we are a team.

Our people also shared feedback on how we listen and engage with them, and what it feels like to work with us. Due to a national issue, not all our data is available, but we hope to receive responses to the we are safety and healthy section next month.

I continue to be overwhelmed by everyone's enthusiasm to deliver our vision of better health and care for all, and to work together to build a culture where our people feel safe and supported.

I am pleased to report that our score for we are compassionate and inclusive has improved and we have scored higher than the national average in this year's staff survey results. These are areas we have focused on improving following feedback in last year's staff survey that we needed to do more to make our organisation an inclusive and compassionate place to work. In response we co-designed our compassionate leadership programme with our people, which has now been completed by more than 500 of our senior leaders and consultants.

We also created It starts with me, our new equality, diversity and inclusion training which has been completed by 3,660 people since it launched in January.

People also told us that they have opportunities to work flexibly, and they feel part of a team, which is really encouraging, but they have told us that we need to do more to improve morale and staff engagement. We still have much more to do to make this an organisation where everyone feels they belong, but we are on the right path.

We are scrutinising the findings and developing a plan to respond to the areas where we must do better. We will continue to develop our improvement plans with our people to ensure any changes reflect what they tell us are important to them.

It starts with me – creating a culture at work where people feel safe, healthy and supported

Through our compassionate leadership approach we commit to include with care, listen with genuine curiosity and act with courage to make Torbay and South Devon not only a great place to work but also a great place to receive care and treatment.

It starts with me underscores our collective responsibility to creating a culture where people feel seen, heard and included, where all are treated with dignity and respect and everyone is welcome. We all have a responsibility to make the NHS a place where we all feel we belong.

We are currently awaiting our individual organisational reports for the NHS Workforce Disability Equality Standard (WDES) 2023 data report and the NHS Workforce Race Quality Standard (WRES) 2023 data report which will further inform our inclusion plan.

The NHS Workforce Disability Equality Standard (WDES) aims to ensure disabled colleagues have equal access to career opportunities and receive fair treatment in the workplace. This is the third WDES data report which provides comparable data against ten metrics on which to build future improvements.

The ten metrics measure career progression, staff perceptions of how they are treated by colleagues, employing organisations and patients and one highlights board representation.

The NHS Workforce Race Equality Standard (WRES) was mandated in April 2015. It aims to ensure employees from ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The 2023 WRES report is the eighth publication and covers all nine indicators. It provides a national picture of WRES in practice and the developments on the workforce race equality agenda.

Of the nine indicators, eight cover ethnic minority appointments and career progression, experiences in bullying; by colleagues, managers, patients and the public, disciplinary action and one measures board representation.

Ward accreditations

Eight of our wards have undergone accreditation since my last report to Board. Dunlop and Ella Rowcroft maintained their silver award while Cromie, Midgley and EAU4 also achieved a silver award. Dart ward at Totnes Community Hospital improved from a bronze award two months ago to a silver award. The Medical Receiving Unit achieved a bronze award while Cheetham Hill achieved a white award.

Voting opens to decide the winner of the Our People's Choice award
Each year patients, carers and the public can nominate an individual or a team for our annual People's Choice award. The amazing things our colleagues do every single day can't be underestimated, and these awards are a wonderful way to recognise their incredible hard work, care and support.

We have created two People's Choice awards this year; one for individuals and one for teams. 45 individuals and 23 teams were nominated, with Nicola McMinn, Interim Chief Nurse, shortlisting the finalists.

People were able to vote to decide the winner of the People's Choice individual award until Monday 25 March from a shortlist of four finalists:

- Tessa Clark, acute oncology nurse practitioner, cancer support team
- Fay Martin, midwife
- Dr Freddie Sweeting, junior doctor
- Faye Drinkwater, eating disorder specialist

Voting for the team award closes on Monday 08 April; the nominees are:

- Breast Care team
- Ricky Grant Day Unit
- Physiotherapy department, Torbay Hospital

The winner will be announced at our award celebration at the Riveria Centre, Torquay, in May. I would also like to thank Nevada Construction, and Kier Construction which have generously sponsored our two People's Choice awards this year.

Celebrating our junior doctors
Our junior doctors play a vital role in being able to provide better care for our patients. To celebrate their outstanding contribution, we have launched a new award scheme to recognise their achievements.

Nominations for this bi-monthly award will be considered by a panel with representatives from the Junior Doctor Representative Committee, Education and People Directorate, Medical Education and our Board of Directors.

All winners will receive a pin badge and will be invited to our annual People Award Celebration in May.

Celebrating and sharing the work of our retention midwives
Jacquelyn Crow and Josephine Ash, our retention midwives, have done a phenomenal amount of work to improve the retention of our midwives. This month they attended the Houses of Parliament to share the findings of their work with the All Party Parliamentary Group on maternity. They were invited to attend by the Royal College of Midwives, which generously paid their expenses to attend.

We are very proud that their innovative and compassionate work is being recognised nationally and were told they gave a 'brilliant presentation' about their ground-breaking approach which the Royal College hope will be adopted more widely.

Thank you, Jacquelyn and Josie for your hard work.

Nicky Richardson wins bronze at Journal of Wound Care Awards
Congratulations to Nicky Richardson, our lead tissue viability clinical nurse specialist, who won a bronze award for cost effective care at the Journal of Wound Care awards.

The annual awards ceremony was held at the Imperial War Museum in London, and Nicky won the award for the weekly drop-in wound care clinic she runs at the Leonard Stocks Homeless Hostel which was set up two-and-a-half-years ago for anyone who is homeless, vulnerably housed or has addiction issues.

Nicky can refer people to hospital if they need medical or surgical treatment and supports people if they are admitted to hospital to support their recovery and avoid a hospital re-admission. Congratulations, Nicky.

Our PAFTA winners
The Paediatric Awards For Training Achievements, or PAFTAs, is a region-wide award scheme recognising the incredible hard work and dedication of all the staff working with children and young people across the south west.

The winners were announced at the peninsula event on 16 March 2024. We had two winners:

- The Kate Westwood memorial award for senior doctor: Dr Jane Baker
- Consultant of the year: Dr Esther Morris

Unsung Hero Awards 2024
San Boosey, our head of improvement and innovation, was a finalist in this year's Unsung Hero Awards, the only national platform dedicated to honouring the NHS' non-medical and non-clinical staff. San was nominated by a member of her team for being a compassionate, skilled and approachable facilitator, and for driving improvement across our organisation.

Although San did not win the award, it is a huge honour that her work and commitment to improving the quality of care was recognised. Congratulations, San.

Supporting our people during Ramadan
We continue to support our Muslim colleagues who are observing the holy month of Ramadan, a period of deep spiritual reflection, fasting during daylight hours and prayer.

We encourage our people to ensure they are taking breaks and to support colleagues who are fasting and that they are able to break for prayer throughout the day.
Our teams are incredibly supportive and respectful of their colleagues during Ramadan, including one ward manager who supports her team to use her office for prayer when required.

3.3 Excellent value and sustainability

Delivering best value
We are working in very challenging times. Devon's ICB and the three acute providers are in segment 4 of the NHS operating framework (NOF4) due to performance and financial challenges.

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

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

We are on plan to deliver our forecast deficit of £43.3million as a result of the hard work of our people. We have delivered more than £33m in cost improvement programme savings. We are also on plan to meet the majority of our planned care performance targets while recognising that challenges remain in our urgent and emergency care services.

Our operating plan for 2024/25 was shared with the regional team on 21 March and we will be submitting our final plan for 2024/25 on 02 May 2024. Our plan includes having no one waiting more than 52 weeks for treatment and care by the end of March 2025 as well as a cost improvement programme saving target of 39.9m. We will maintain our focus on delivering best value, checking and challenging ourselves around both pay and non-pay spend and protecting and maintaining patient safety.

Reconfirming our commitment to provide integrated adult social care in Torbay
In 2005 we signed an agreement with Torbay Council to become the first area in the country to provide a joined-up NHS and adult social care service to help improve the lives of people in Torbay. This has allowed us to collaborate to ensure people receive seamless health and social care, improve preventative care, reduce hospital admissions, manage acute care, and support independent living.

We remain committed to working with our partners at Torbay Council and NHS Devon Integrated Care Board and have made the commitment to sign a new tri-partite Section 75 agreement to deliver integrated adult social care services in Torbay from April 2025 to March 2030.

The new agreement will see Torbay Council committing to a £1.7million increase in all years of the contract, and an additional £0.85million increase in the first two years of the contract to recognise the transformation activity that is required to take place. This will result in an overall increase of £10.2million during the five-year contract, funded through an increase in council tax.

We will continue to transform our service to embed an independence-led culture, and this new agreement will underpin our collective agreement to continue responding to the demand, outcomes, and financial challenges our integrated care organisation (ICO) is facing.

Dawlish minor injuries unit to reopen
In March 2020 we closed the minor injuries unit (MIU) at Dawlish Community Hospital in response to the COVID-19 pandemic due to staffing levels and demand for services. I am pleased to announce that the MIU will reopen on Tuesday 02 April 2024.

It will be open Monday to Friday, 8am to 5pm via same day bookable appointments. Walk-in appointments will be available, but appointments will be prioritised and people may be redirected. The telephone number to book appointments will be promoted widely ahead of the opening.

This system follows our model at Totnes Community Hospital's MIU which has helped protect the service and maintain consistency. The unit will reopen without x-ray facilities at this time due to radiology workforce constraints.

We know how much the service means to people, and our teams have worked incredibly hard to reach this point. I would like to thank everyone for their patience and support.

Recognition for our cleanliness and food
For the second year in a row, we have been identified as one of the leading trusts in the country for cleanliness and our food.

Thanks to the hard work of our catering, cleaning and the many other teams looking after workplaces and environments, the Patient-Led Assessments of the Care Environment (PLACE) identified our organisation as being in the top five for both categories.

For cleanliness, which looked at the condition of objects and facilities including patient equipment, furniture and toilets, we scored full marks (100%). In food and hydration, which looked at choice, availability and quality, we were placed in the top five trusts in the country.

We also scored highly in seven other areas:

98.54% for combined food (top 10)
98.84% for organisation food (top 10)
98.6% for ward food (33rd)
99.03% for privacy and dignity (top 6)
99.74% condition and maintenance (top 25)
97.99% for dementia (top 6)
97.49% for disability (top 10)

These results demonstrate the commitment and energy of our workplace team which remain focused on delivering an excellent experience for our patients. I would like to thank them for everything they do to achieve these scores.

5* ratings for Torbay Hospital and Brixham Hospital
I am delighted to report that our food hygiene standards at Brixham and Torbay hospitals have been rated as very good (5), following an inspection by the council's environmental health team.

Congratulations to everyone involved at Torbay and Brixham Hospitals, and our workplace team.

New medical leadership roles announced

I am pleased to announce Dr Catherine Blakemore and Dr Rachel Winfield have been appointed as our two medicine and urgent care group Associate Medical Directors.

Catherine, a consultant cardiologist, and Rachel, a consultant rheumatologist, are well-known across our services and will be responsible for ensuring the delivery of high-quality, clinically-led leadership. They will also help ensure our communities continue to receive swift and safe care. They will start their new roles in April.

League of Friends' donation supports surgery experience
Thank you to Torbay Hospital's League of Friends for its incredibly generous donation of more than £130,000 to provide equipment that will improve the experience of people having surgery.

The donation has funded 15 operating trollies which can transport people into theatre, with most operations being carried out on the trolley. Previously, people would have been needed to be transferred to different units multiple times. The new trolleys will provide a comfortable experience and reduce transfer time, which has become more important as the number of day surgeries our teams support has increased.

4. Chief executive engagement March

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
• Torbay Hospital League of Friends • Meeting with Staffside • Quarterly League of Friends Chairs meeting • Nutrition and Hydration event • Governor induction • Head of Personalised Care • Bales Buddies event	• Chief Executive Officer, Royal Devon University Healthcare • Devolution stakeholder engagement • Chinese delegation • CEO, SWASFT • Young Adult Carer's session

5. Local health and care economy developments

5.1 Partner and partnership updates

5.1.1 Substantive Chief Executive appointed for South Western Ambulance Service NHS Foundation Trust

Dr John Martin has been formally appointed as the substantive Chief Executive at South Western Ambulance Service NHS Foundation Trust (SWASFT).

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

January 2024 and was formally appointed as the substantive Chief Executive earlier this month.

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.

5.1.2 Leadership arrangements at University Hospitals Plymouth NHS Trust

Earlier this month, it was announced that Mark Hackett will join University Hospitals Plymouth NHS Trust as Interim Chief Executive.

Mark is an experienced NHS leader, with more than 30 years' experience at Board level, including as Chief Executive of Southampton University Hospital NHS Foundation Trust, North Staffordshire NHS Trust and latterly, Swansea Bay University Health Board.

With Ann James' tenure as Chief Executive finishing at the end of March, Mark will pick up the reins from the start of April. We welcome Mark to the Integrated Care System for Devon and look forward to working alongside him to deliver better health and care for all.

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

Key media releases and responses

Torbay and South Devon NHS Foundation Trust announce appointment of new Chair

Professor Chris Balch has been appointed as the new Chair for Torbay and South Devon NHS Foundation Trust. He will begin the role on 1 May 2024 to ensure a smooth transition ahead of the end of current Chair Sir Richard Ibbotson's 10-year term on 31 May 2024.

Two new operating theatres open at Torbay Hospital

A £15million operating theatre building has been opened at Torbay Hospital which will help reduce the time people are waiting for surgery. The new building has two operating theatres and additional pre-operative assessment and recovery spaces which will support 4,500 more people each year.

Maternity services rated highly by local families

Maternity services at Torbay and South Devon NHS Foundation Trust have been rated highly by local people in the 2023 National Maternity Survey.

Care Quality Commission maternity services inspection
In November 2023, the Care Quality Commission (CQC) carried out a short-notice inspection of maternity services at Torbay Hospital. Its report acknowledges areas of good practice and one area of outstanding practice.

International Women's Day – Caroline Cozens
To celebrate International Women's Day, Caroline Cozens, Torbay and South Devon NHS Foundation Trust's director of capital development, shares what it's like being a woman at the top of her game in a traditionally male industry, and why she wants to see more girls and women wearing hard hats on building sites.

Dawlish minor injuries unit to reopen in April
The minor injuries unit (MIU) at Dawlish Community Hospital will reopen next month.

Torbay and South Devon NHS recognised for high standards in cleanliness and food
For the second year in a row, Torbay and South Devon NHS Foundation Trust has been identified as one of the leading trusts in the country for cleanliness and food.

Voting now open for local NHS staff award
Members of the public can vote for their winner of Torbay and South NHS Foundation Trust's People's Choice individual award.

Coverage
Thank you, BBC Spotlight, Channel 5 News, Totnes Today, and Torbay Weekly for covering our work during March. We are grateful for your support.

New Hospital Programme
BBC Spotlight talks to Adel Jones, our Deputy Chief Executive and Director of Transformation and Partnerships, about our plans for a new hospital which will help transform the way health care is provided.

Channel 5 chronic pain feature
Dr Andrew Gunatilleke, one of our pain specialists, talks to Channel 5 News about a campaign to reduce the use of opioids to manage chronic pain conditions.

Please support our NHS
Our Chief Operating Officer, Arun Chandran, asked people to help our NHS manage high levels of demand by using the most appropriate service and to collect loved ones when they are ready to leave hospital.

Digital engagement

	Linkedin	Facebook	X (Twitter)
Followers (as of 08 March)	7,511 +126	14,390 +46	8,025 +6
Engagement	345	1,833	131
Impressions/ reach	19,910	196,772	8,046
Best performing post	We are pleased to announce that Professor Chris Balch has been appointed as our new Chair. Chris will begin the role on 01 May to ensure a smooth transition ahead of the end of current Chair Sir Richard Ibbotson's 10-year term on 31 May 2024. Chris is no stranger to Torbay and South Devon, having served as a Non-Executive Director since April 2019. Read more on our website https://ow.ly/Nak850QAiCj 10 comments 6,245 impressions 90 reactions 2 reposts	Huge congratulations to Nicky Richardson, Lead Tissue Viability Clinical Nurse Specialist, who won a bronze award for cost effective care this week at the Journal of Wound Care awards. Nicky won the award for the wound care clinic she runs at the Leonard Stocks Homeless Hostel every Tuesday morning. 46 comments 6,865 impressions 239 reactions 4 shares	We are pleased to announce that Professor Chris Balch has been appointed as our new Chair. Chris will begin the role on 01 May to ensure a smooth transition ahead of the end of current Chair Sir Richard Ibbotson's term on 31 May 2024. Read more https://ow.ly/Nak850QAiCj 223 impressions 4 likes 1 repost

Recruitment activity

Facebook

| We have an exciting opportunity for an apprentice operating department practitioner (ODP) to work towards becoming a registered ODP!

The successful candidate will gain a BSc in operating department practice over three years while working in our theatres with our amazing team.
Find out more and apply
https://ow.ly/vIG850QFhCn

0 comments
6,164 impressions
16 reactions
29 reposts
129 link clicks

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) M11 2023/24 (February 2024 data)			Meeting date: 27 March 2024
Report appendix:	Appendix 1: IPR Month 11 2023/24 Focus Report Appendix 2: IPR Month 11 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) M11 2023/24 (February 2024 data)		**Meeting date:** 27 March 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 FPDC 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 February 2024, 4 incidents were reported as severe, and 4 incidents were reported as death. The deaths included 2 patients receiving care from the Drug and Alcohol team, and 1 child, and 1 neonate.

VTE (Venous Thromboembolism) Assessment
February 2024 (n=10), saw an increase of 2 in reportable VTEs, when compared with the same period in 2023 (n=8). Q4 to date has seen 20 reportable VTEs an increase of 5 compared to the same time for year 22/23. Year to date 90 VTEs have been reported, compared to 22/23 this is already an increase of 11. The VTE steering group review the compliance and review any themes or issues related to compliance.

Eliminating Mixed Sex Accommodation
In February 2024, 2 incidents of mixed sex breach occurred. Both incidents were at night and involved patients being transferred to SRU mixed sex assessment area. As the patients were inpatients this is in breach of the national guidance, although carried out to support the off-loading of ambulances in the Emergency Department.

Infection, Prevention, and Control
The number of closed bed days due to infection has seen a significant reduction in February from 710 to 164.
A visit was hosted from the regional Lead IPC nurse to review the use of clinical side rooms and reasons to isolate patients. This was a welcomed visit, and the clinical teams were fully engaged. Some actions were agreed and work is in progress to update guidelines and some policies.

Maternity
In February 2024 2 moderate and above incidents were reported: 1 neonatal death at a hospice in Plymouth following precipitous delivery at 34/40 in Torbay (harm grading: severe1 maternal postnatal VTE (harm grading: moderate) and 1 maternal post-natal VTE (Anti D administered late).

Safer Staffing
The Registered Nurse fill rate for days during February was 97.8% which is a slight decrease in the January fill rate and for night duty reported as 90.9% which is comparable with the previous month.
The fill rate for Health care support workers for days during February was 99.7% which is comparable with the January. For night duty reported as 118.4% which is a slight increase on the previous months fill rate of 117.4%
The increase in fill rate for Health Care support workers at night is to mitigate any risks associated with the registered nurse fill rate.

Workforce Headlines

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

The Trusts **substantive workforce** is 90.81wte under the original workforce plan in M11 (due to the sale of Torbay Pharmacy (TP) and is on track to achieve the M12 forecast outturn position of 6155.77wte. Since M10, we have seen an increase of 4.08wte, all within Community nursing and Reg/qualified scientific, therapeutic and technical staff groups.

Bank usage has increased marginally between M10 and M11 by 7.06wte but at 363.53wte is significantly higher than the original workforce plan and the revised M12 forecast outturn position of 235.95wte.

Agency usage has increased by 65.95wte between M10 and M11 and at 199.9wte is higher than the original workforce plan and the revised M12 forecast outturn position of 150.13wte. The largest proportion of agency growth at 40.84wte is within our Medicines and Urgent Care Group. The drivers for this growth are largely within our safer staffing wards - 18.00wte due to increase in vacancy cover, 8.98wte due to increase in specialling, 4.25wte due to increase in sickness/maternity cover, 2.94wte due to increased demand and escalation. Much smaller levels of growth have been seen across our other care groups and again are largely due to vacancies, specialling and maternity leave.

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. Workforce Control Panels continue to meet weekly, and all requests received in recruitment are thoroughly checked ahead of this meeting. Vacancy requests require care group director or corporate director approval when the vacancy is added to Trac. The number of vacancy requests received and reviewed at panel has reduced from 224 (Jan-24) to 183 (Feb-24) with a steady decline week on week for non-clinical roles with an overall declining trend.

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 (11.65%) and sickness rates (5.01%) for February are lower than those forecasted in the operational plan.

Mandatory Training - there has been a steady upward trend in overall compliance over the last 12 months. Compliance has increased slightly in February to 90.86% against a target of 85%. However, at a topic level we remain challenged in Manual Handling at 78% and Information Governance at 84.72%.

Achievement Review – compliance has increased by 1.12% in February to 78.67% 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	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Operational Plan trajectory Feb 2024
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA													
Urgent and Emergency Care													
Ambulance handovers - time lost over 15 mins - Actual (hours)	1310	2446	5017	3280	740	2260	796	1600	1048	1221	1397	2979	3091	3141	2141	3634	3217	1205
Percentage of Ambulance handovers greater than 3 hours		18.1%	46.0%	18.9%	3.3%	13.8%	7.7%	8.3%	7.5%	8.3%	6.5%	14.2%	23.4%	18.7%	17.5%	22.3%	20.0%	No trajectory
Total average time in ED (hours/minutes)		07:44	08:58	07:49	06:35	07:14	05:57	06:48	06:20	05:41	06:05	05:46	06:15	06:19	05:44	06:33	06:39	No trajectory
ED attendances where wait time over 12 hours	0	989	1207	823	699	947	568	692	697	637	794	980	922	747	622	936	824	No trajectory
UEC 4-hour target (RAG against local trajectory on national target)	76%	59.4%	51.8%	60.0%	56.9%	57.6%	61.7%	60.8%	64.0%	63.5%	67.9%	68.4%	66.6%	67.2%	68.0%	65.1%	63.2%	73%
% patient discharges pre-noon	33%	21.6%	16.1%	19.0%	18.5%	19.2%	18.9%	19.9%	19.0%	20.1%	21.6%	23.5%	20.3%	22.4%	23.7%	22.6%	23.3%	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%	6.6%	4.9%	5.0%

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 February reporting 3217 hours lost waiting over 15 minutes (from 3634 hours lost in January); this does not meet the trajectory of 1205 hours lost.
- The percentage of patients waiting over 3 hours for an ambulance handover decreased to 20% in February from 22.2% in January.
- The Trust's Urgent and Emergency Care (UEC) 4-hour performance decreased to 63.2% and did not meet the February trajectory of 73%.
- 23.3% of acute 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	Jan-24	Feb-24	Operational Plan trajectory Feb 2024
NATIONAL OVERSIGHT FRAMEWORK (OF) 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	0	0
RTT 78 week wait incomplete pathway	0	822	923	708	482	183	166	187	123	129	156	187	155	170	165	136	125	19
RTT 65 week wait incomplete pathway	0	2179	2203	1878	1679	1372	1244	1165	1196	1136	1274	1161	1018	971	840	767	695	199
RTT 52 week wait incomplete pathway	Reduction	5585	6077	5554	5116	4437	4024	3926	4048	4079	4377	3421	2961	2583	2258	2007	1806	Reduction
104wks waits over 2.5 years	0	17	12	9	6	0	0	0	0	0	0	0	0	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	67.9%	71.7%	67.5%	77.3%	76.9%	75.0%	70.3%	78.1%	81.7%	79.6%	77.8%	77.5%	75.7%	77.0%	75.4%	80.9%	75%
Number of patients waiting longer than 62 days for treatment	138	229	253	225	120	114	107	111	100	89	120	109	143	147	158	173	112	148

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

Cancer standards

The Trust is meeting the Faster Diagnosis performance with 80.9% achieved against a target of 75%. The Trust achieved the 62-day backlog trajectory for February with 112 against a year-end target of 138. Torbay is no longer included in Tier 1 performance oversight for cancer standards.

Finance headlines

As at M11, the Trust reported an YTD adverse variance to plan of **£5.7m**. We are formally reporting a forecast outturn adverse variance to plan of **£7.6m** in line with the agreed Deficit control total of **£27.024m** which the trust in on track to achieve for the end of the financial year.

Against our in-year CIP target of **£46.6m**, the number of schemes marked delivered total **£39.8m** for the whole year, leaving a gap of **£6.8m.** This position may further improve next month at year-end if all green schemes under development (**£41.1m)** are delivered by M12.

Please note the original budget had been adjusted by **£13.2m** for the year due to additional NHSE funding support in M11 and 12.

Capital Plan had been adjusted for ICB CDEL due of the sale of TP and movement in National PDC schemes, such as NHP and Digital EPR, where the phasing of expenditure has changed. We are forecasting no significant underspend on ICB CDEL capital allocation at year-end.

Our overall cash position at M11 is **£16m** ahead of plan largely due to NHSE additional funding support mentioned above (£13.2m) and the cash benefit of the TP sale. We are not anticipating any further Revenue PDC drawdown for the year.

Integrated Performance Focus Report (IPR)

Torbay and South Devon NHS Foundation Trust

March 2024: Reporting period February 2024 (Month 11)

Working with you, for you

National Oversight Framework - Introduction

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

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

Devon System Overview Framework Criteria Report - TSDFT

Exit Criteria Measures													
Key Measures		Apr - 23	May - 23	Jun - 23	Jul - 23	Aug - 23	Sep - 23	Oct - 23	Nov- 23	Dec – 23	Jan – 24	Feb - 24	Mar - 24
UEC													
Month on month improvements, over two quarters, in ambulance handover delays (>15 minutes) against the agreed baseline and trajectories (hours lost)	Target	894	582	1038	992	1111	1137	1416	996	1213	1287	1205	1110
	Actual	1233	1605	1555	1223	1707	2579	3591	3141	2141	3634	3217	
Improvements in line with agreed baseline and plan over two quarters, 4-hour performance (Trajectory to achieve 76% by 23/24)	Target	59.99%	65%	68%	68%	68%	72%	72%	73%	75%	70%	73%	78%
	Actual	61.75	60.83%	64.63%	63.52%	67.9%	68.4%	66.6%	67.0%	68.03%	65.1%	63.2%	
Improvements in line with agreed baseline and plan over two quarters, 12-hour breaches. (time in department)	Actual	568	893	797	636	794	686	822	770	622	836	824	
Month on month improvements, over one quarter, in pre-midday discharges against agreed baseline and trajectories	Target	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	
	Actual	17.35%	18.59	19.9%	20.5%	21.6%	21.5%	20.3%	22.4%	23.7%	22.5%	23.3%	
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%	Target	10.15%	10.15%	10.15%	7.51%	7.51%	7.51%	5.16%	5.16%	7.45%	7.5%	5.0%	5.0%
	Actual	7.62%	7.48%	7.0%	6.0%	7.5%	7.4%	8.3%	7.2%	6.4%	6.6%	4.9%	
Elective Recovery													
Reduction in waits over 104 weeks in line with agreed plan, against agreed baseline	Target	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	0	0	0	0	0	0	
Reduction in waits over 78 weeks, in line with agreed operating plan trajectory following NHSE review June 22023	Target	173	208	130	130	130	111	92	73	65	35	19	0
	Actual	173	173	130	129	156	187	155	179	163	141	125	
Significant reduction in 65 weeks by March 2024, in line with agreed operating plan trajectory following NHSE review June 2023	Target	1,292	1,362	1,312	1,307	1,387	1,189	991	793	650	397	199	0
	Actual	1,244	1,197	1221	1155	1274	1161	1018	871	842	788	695	
75% of GP referred patients diagnosed within 28 days	Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
	Actual	75%	79.3%	78.1%	81.7%	79%	77.8%	77.5%	75.7%	77%	75.4%	80.9%	

Devon System Overview Framework Criteria Report - TSDFT

Exit Criteria Measures													
Key Measures		Apr - 23	May - 23	Jun - 23	Jul - 23	Aug - 23	Sep - 23	Oct - 23	Nov- 23	Dec – 23	Jan – 24	Feb - 24	Mar - 24
Elective Recovery													
To exit Tier1: 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.	**Target**	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	12.8%	
	Actual	6.5%	6.2%	5.8%	5.3%	6.9%	5.4%	7.2%	7.9%	10.2%	11.0%	7.2%	
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.	**Target**	160	150	152	155	162	170	175	179	182	163	148	138
	Actual	107	111	100	89	120	105	143	147	158	173	112	
Finance													
Performance against system savings trajectory	**Target**	625	625	623	3,083	3,082	3,082	8,898	3,900	3,898	6,256	6,256	6,250
	Actual	0	0	4,351	3,091	3,125	3,082	6,833	5,456	3,995	3,071	3,475	
Significant improvement in underlying recurrent position (£ms) - monthly monitoring of CIP delivery	**Target**	281	281	280	2,167	2,165	2,167	2,732	2,734	2,732	5,090	5,090	5,086
	Actual	0	0	3,715	1,776	2,198	2,486	2,333	3,110	3,009	2,362	2,388	
Productivity back to 2019/20 levels as a minimum	**Target**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Actual	As per NH SE&I	As Per NHS E&I	As Per NHS E&I	As Per NHS E&I	As Per NHS E&I	As Per NHS E&I	As Per NHS E&I	As Per NHS E&I	As Per NHS E&I	As Per NHS E&I	As Per NHS E&I	
Meet the financial plan every month for the quarter	**Target**	(4,883)	(5,215)	(4,853)	(2,446)	(2,601)	(2,537)	1,275	(3,404)	(3,707)	(1,577)	11,211	(466)
	Actual	(4,861)	(4,764)	(4,843)	(2,699)	(4,273)	(3,546)	(1,089)	393	(4395)	(3,850)	9,406	
Reconfirm the underlying exit run-rate	**Target**	(5,144)	(5,476)	(5,179)	(3,614)	(3,597)	(3,356)	(4,796)	(4,614)	(5,049)	(2,739)	(2,050)	(2,730)
	Actual	(5,528)	(5,430)	(5,509)	(5,189)	(5,478)	(4,213)	(4,261)	(4,414)	(4,766)	(4,384)	(2,689)	

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

Matters of concern/key risks to escalate	Major actions commissioned/work underway
• Future Industrial Action. • TIF Theatre recruitment of workforce and delivery of activity. • TIF theatre recovery work will not be 100% complete until June; potential impact on projected 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. • Scale and pace of scheduling ESFR activities from the 1st April 2024.	• ECIST support to SHOP on wards. • ECIST review of the bed management process, ambulance handover delays and validation process. • Continued focus on process issues to improve 4-hour performance. • Workforce review to match demand. • Review of Transformation Team 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 February. • UEC 4-hour performance above 60%. • NCTR performance is best in Southwest. • Management of Industrial Action becoming business as usual with established playbooks.	• 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. • Review of Pathway 1-3 processes report completed and under review. • Locums employed to support Front door frailty and ED. • Level 2 decant in place and to support Frailty Team.

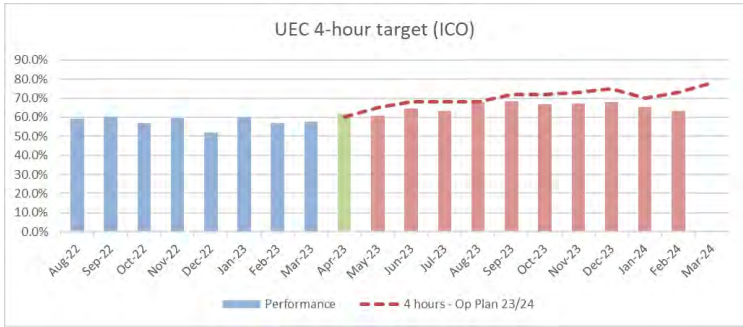
National Oversight Framework (NOF) 4 Exit Criteria – Urgent and Emergency Care Performance Summary

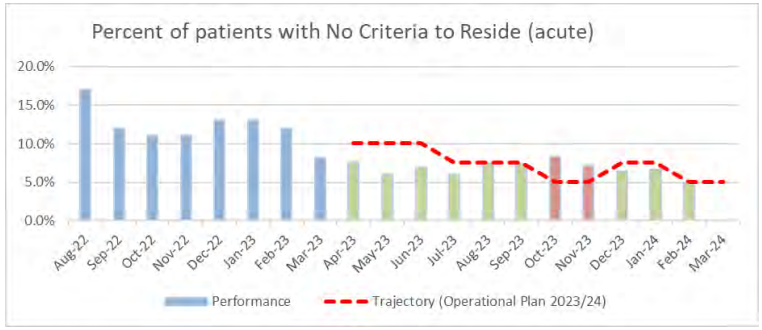
NHS Torbay and South Devon NHS Foundation Trust

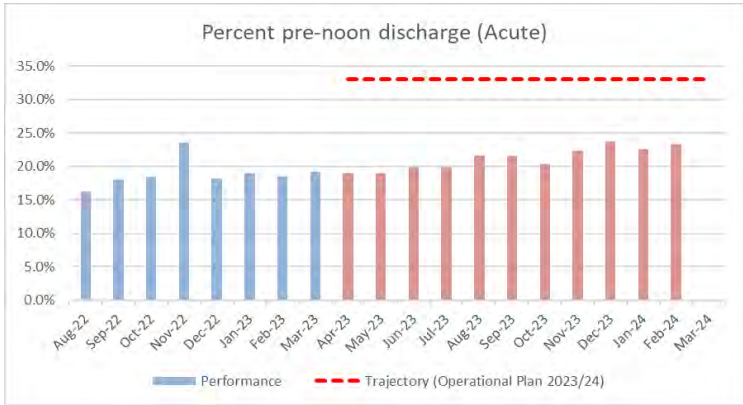
	Target March 2024	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Operational Plan trajectory Feb 2024
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																		
Urgent and Emergency Care																		
Ambulance handovers - time lost over 15 mins - Actual (hours)	1110	2448	5017	3280	740	2260	796	1630	1569	1223	1707	2579	3591	3141	2141	3634	3217	1205
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%	22.2%	20.0%	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	06:33	06:39	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	836	824	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%	65.1%	63.2%	73%
% 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%	22.6%	23.3%	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%	6.6%	4.9%	5.0%

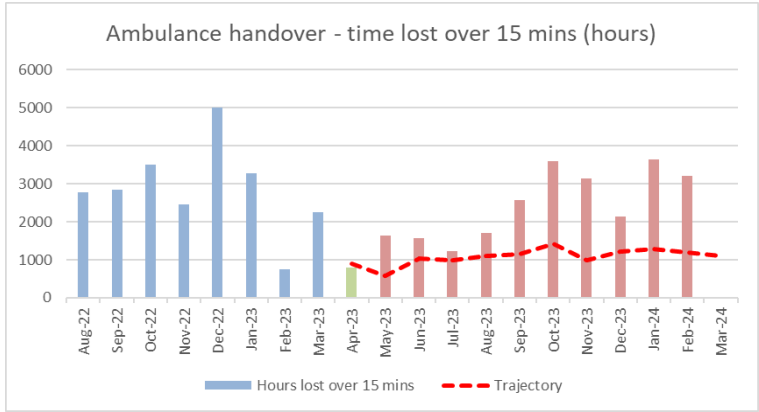
Trajectories have been agreed as part of the 2023/24 Operational Plan submission. The latest month trajectory, where applicable, is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories.

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









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

Torbay and South Devon NHS Foundation Trust

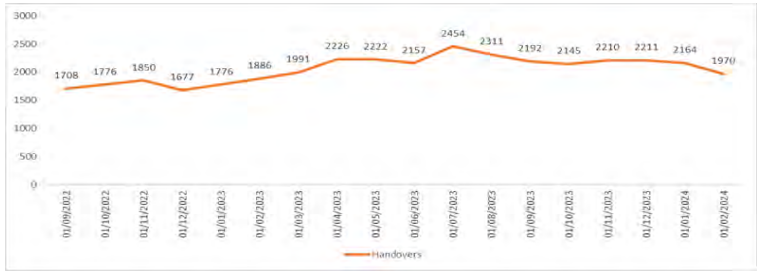
Performance

The number of ambulance handover delays over 15 minutes decreased in February with 1803 (1910 in January).
The total hours lost due to ambulance delays over 15 minutes decreased to 3217 hours compared to 3634 hours in January.

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

Operational update

The ambulance numbers have decreased in February. The numbers of higher acuity majors who present to the waiting room has increased.



The average time lost per ambulance to handover, is 1hr 53 minutes (incl. the 15 mins) in February 2024, this is a marginal improvement from January's reported position where the average handover time was 1hrs 55 minutes. The primary cause for delay remains flow

Actions to complete next month

1) Maintain improvement with SWAST and ED following the launch of XCAD to ensure accurate time stamps recorded.
2) Conduct joint improvement week with SWAST 20th April 2024.
3) Maintain focus on pre-noon and weekend discharge.

Risks/issues

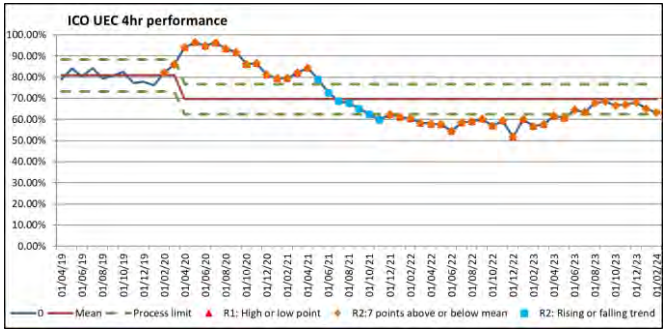
- Further infection control issues
- Further Consultant industrial action
- Combination of the above
- Planning to manage capacity for 4-day weekend

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

Torbay and South Devon NHS Foundation Trust

Performance

	February 2023	February 2024
MIU/UTC attendances	2446	2620
MIU/UTC performance	98.1%	99.2%
ED (type 1) attendances	5212	5758
ED (type 1) performance	37.6%	46.9%
ICO attendances	7658	8378
ICO performance	56.9%	63.2%



Operational update

- February recorded an increase in the average time in ED with 6h 39m compared to 6h 33m in January.
- Attendances spending longer than 12hrs in ED increased from February 2023 representing 8% of attendances.
- February 2024 ED attendances increased compared to February 2023 and the Trust delivered an improved position against the 4-hour target. The ICO 4-hour performance remains over 60%.
- Non admitted performance has improved across the year by 12%

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.

Other actions to ensure processes are robust:

- Minor Injury Unit (MIU) plans to open Dawlish.
- Deep dive into non-admitted pathway in ED to sustain improvement
- PPG pilot of onsite GP
- Tracker role project -identifying barriers to improving 4- hour target.
- Establishing ED SDEC Pathway

Risks/issues

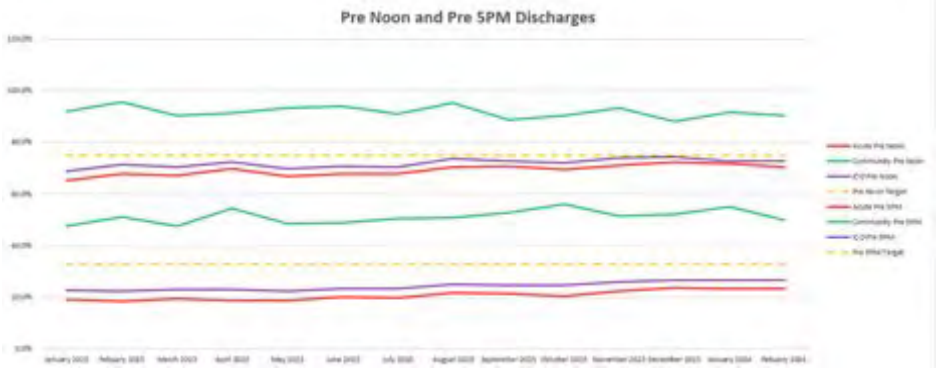
- Further infection issues.
- Further Consultant industrial action.
- Combination of the above.
- Conflicting priorities for Radiology reduce the opportunities to fully support UTC/MIU.

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

Torbay and South Devon NHS Foundation Trust

Performance

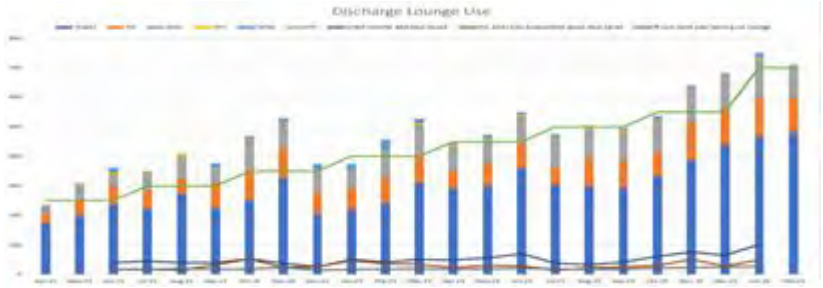
Across the Integrated Care Organisation (ICO) (including our community hospitals), there were 1,850 discharges from our adult inpatient areas; of which 26.5% of patients were discharged by noon and 72.8% pre-5 PM. The efficient discharge processes in place continues to help ensure that our patients are able to return home or continue their care in a different setting in a timely manner, which supports better outcomes and satisfaction for both patients and staff.



Operational update

The discharge lounge supported 709 patients in February. Expanding the lounge's availability to weekends and overnight from Sunday to Wednesday are positive steps towards optimising bed turnover and delivering timely patient care.

Weekend discharges continue to be below expectation. In February, on average we discharged 65 patients across the weekend from our adult inpatient base wards. With the support of the wider organisation, we continue to scope out workstreams to improve the number of discharges at the weekends. This includes the recent increase in senior medical decision making at the weekends with a focus on admission avoidance from the emergency department (ED) and the assessment units.



Actions to complete next month

- Build on SHOP project , rolling out across HOP wards.
- Re-focus ward teams around pre-noon discharge , reinforcing benefits to patients of being home for lunch.
- Review the role of the discharge coordinators.
- ECIST support to initiate 21day LOS meetings weekly
- 10-day Formal Length of Stay reviews

Risks/issues

- Further infection issues.
- Consistent additional staffing support to the discharge team at weekends and senior cover.
- Manual validation of NCTR- time consuming and requires digital support

National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

Torbay and South Devon NHS Foundation Trust

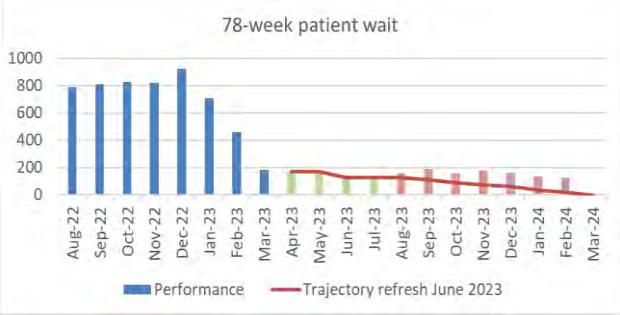
	Target March 2024	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Operational Plan trajectory Feb 2024
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																		
Elective recovery																		
RTT 104 week wait incomplete pathway	0	34	29	22	14	0	0	0	0	0	0	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	822	923	708	462	183	166	167	123	129	156	187	155	179	165	138	125	19
RTT 65 week wait incomplete pathway	0	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1161	1018	871	840	767	695	199
RTT 52 week wait incomplete pathway	Reduction	5585	6027	5554	5116	4427	4024	3926	3938	3879	3977	3471	2961	2533	2258	2007	2006	Reduction
Patient waits over 2.5 years	0	17	12	9	6	0	0	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%	75.0%	79.3%	78.1%	81.7%	79.0%	77.8%	77.5%	75.7%	77.0%	75.4%	80.9%	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	173	112	148

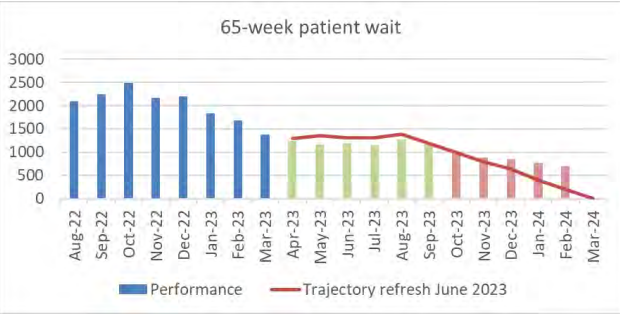
2023/24 RAG indicator

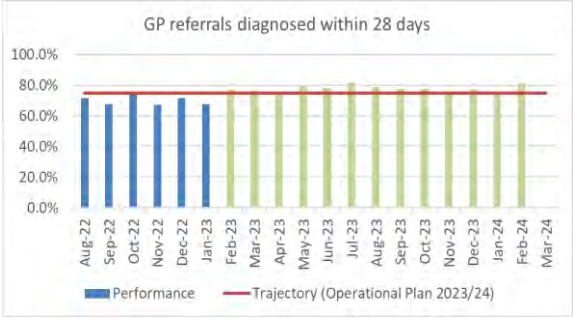
Meeting monthly trajectory

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 exception reports describe 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
- Workforce – clinical, nursing, admin insourcing supporting gaps in clinical workforce capacity. HR programme to support recruitment and retention with ICS system support.
- Endoscopy lift estates works will impact on theatres.

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 February.

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 have now been approved and helping to address the backlog.

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.

Risks/issues

- Further Industrial Action 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 but controls in place have helped.
- 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%) - one month in arrears		⬇
Stroke patients spending 90% of time on a stroke ward (>80%) - one month in arrears		⬇
Mixed sex accommodation breaches (0)		⬆

Quality and Patient Safety Summary

Incidents
In February 2024, 4 incidents were reported as severe, and 4 incidents were reported as death. The deaths included 2 patients receiving care from the Drug and Alcohol team and 1 child and 1 neonate.

VTE (Venous Thromboembolism) Assessment
February 2024 (n=10), saw an increase of 2 in reportable VTEs, when compared with the same period in 2023 (n=8). Q4 to date has seen 20 reportable VTEs an increase of 5 compared to the same time for year 22/23. Year to date 90 VTEs have been reported, compared to 22/23 this is already an increase of 11. The VTE steering group review the compliance and review any themes or issues related to compliance.

Eliminating Mixed Sex Accommodation
In February 2024 2 incidents of mixed sex breach occurred. Both incidents were at night and involved patients being transferred to SRU mixed sex assessment area. As the patients were inpatients this is in breach of the national guidance, although carried out to support the off-loading of ambulances in the Emergency Department.

Infection, Prevention, and Control
The number of closed bed days due to infection has seen a significant reduction in February from 710 to 164.
A visit was hosted from the regional Lead IPC nurse to review the use of clinical side rooms and reasons to isolate patients. This was a welcomed visit and the clinical teams were fully engaged. Some actions were agreed and work is in progress to update guidelines and some policies.

Maternity
In February 2024 2 moderate and above incidents were reported: 1 neonatal death at a hospice in Plymouth following precipitous delivery at 34/40 in Torbay (harm grading: severe1 maternal postnatal VTE (harm grading: moderate) and 1 maternal post-natal VTE (Anti D administered late).

Safer Staffing
The Registered Nurse fill rate for days during February was 97.8% which is a slight decrease in the January fill rate and for night duty reported as 90.9% which is comparable with the previous month.
The fill rate for Health care support workers for days during February was 99.7% which is comparable with the January. For night duty reported as 118.4% which is a slight increase on the previous months fill rate of 117.4%
The increase in fill rate for Health Care support workers at night is to mitigate any risks associated with the registered nurse fill rate.

CQC Update on the Well Led Actions, Maternity Inspection and Joint Targeted Area Inspection

CQC 2023 Well Led Inspection May – Sept 2023
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. Since the release of the report in late November, much work and focus has been put into the action plan.

CQC Core Service	No. of Actions		Completed		MD On track		SD On Track	
	Must Do	Should Do	Must Do	Should Do	Yes	No	Yes	No
Trustwide	2	7	0	1	2	0	6	0
Urgent and Emergency	2	6	1	2	2	0	4	0
Medical Care	3	6	0	0	3	0	6	0
OPD	1	10	0	0	1	0	10	0
Diagnostics Imaging	7	7	0	2	7	0	5	0
TOTAL	**15**	**36**	**1**	**5**	**15**	**0**	**31**	**0**

At the February 2024 CQC CAG meeting a further 2 Should Do actions were closed as U&E completed their PGD review and rehoused their oxygen storage area. This brings the number of should do actions closed to 5.
Radiology and Imaging, Medical Care and Outpatients presented their action plans reporting all on are track. There were no exceptions to report.
All evidence regarding each action is saved to the CQC drive for later scrutiny by Internal audit.

The two trust wide actions are regarding finance, which falls under the NOF 4 management and equality diversity and inclusion. This action has a large and wide-reaching plan which is managed through the People Committee.

Joint Targeted Area Inspection (JTAI) Nov 2023
Following its January 2024 release, the Trust is working on 9 action points covering: professional curiosity, child protection medicals, capacity challenges, performance dashboard, safeguarding supervision, and CAMHS signposting . The teams have come together for a successful away day to further agree the plan and way forward and all actions are on track with the evidence being collated on the shared team's drive.

The actions are being managed and monitored via a bi-weekly meeting, led by the Chief Nurse, with any exception reports taken to the Board. The CQC CAG Group has an oversite view of the Action Plan and its management for assurance. An ICB visit has been arranged for 26th March 2024 to work together on addressing some of the actions.

Maternity Inspection December 2023
The report was released on the 21st February 2024 via a planned release between the Trust and the CQC. The inspection resulted in the Trust remaining Requires Improvement for Maternity, but with much improvement seen in the areas of Safe and Well led. The other domains remined as Good.

The CQC commented that the leaders were visible and the unit had an open culture with staff able to speak up. They saw good engagement with the service users and dignity and respect were intrinsic to the care provided.

The CQC inspection resulted in 8 Must Do actions : Ensuring a second dedicated emergency theatre, improving the triaging and assessing of women and birthing people, improving compliance with the early warning scores, reviewing the provision of equipment, including the number of cardiotocographs (CTG) and resuscitaires, review the process of 'Fresh Eyes' and mandatory training as well as reviewing the governance and oversight of audits and actions plans.

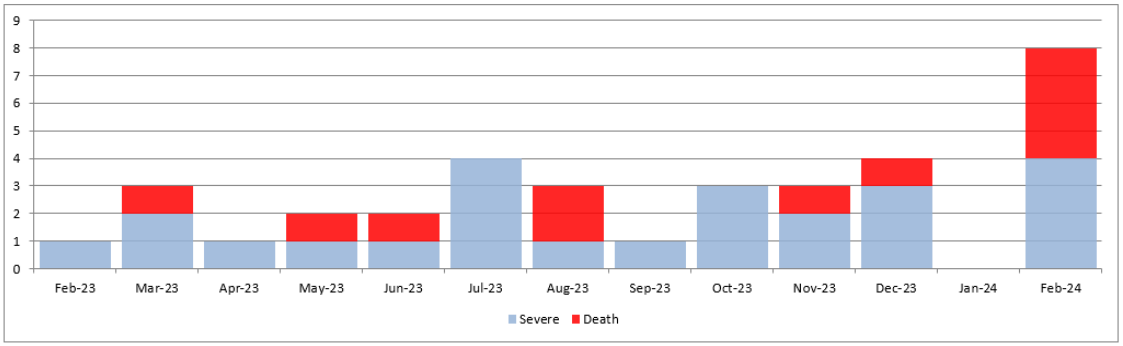
To date a process to always have a second theatre available has been implemented , an enhanced triage process is in place with a dedicated phone line an experienced midwife and additional CTG machines and resuscitaires have been ordered. A comprehensive action plan has been completed will be monitored at the Care Group governance meeting as well as at the CQC CAG.

Quality and Safety exception reports – reported incidents / HSMR

Torbay and South Devon NHS Foundation Trust

Reported Incidents - Severe and Death

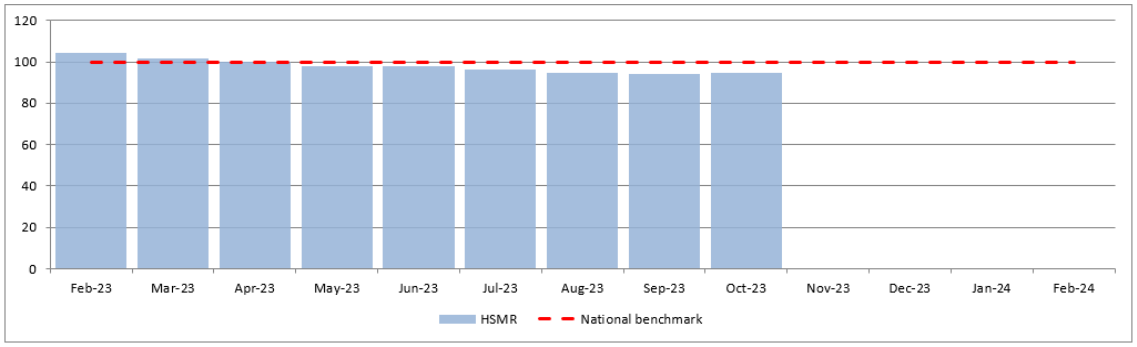
	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Severe	1	2	1	1	1	4	1	1	3	2	3	0	4
Death	0	1	0	1	1	0	2	0	0	1	1	0	4



In February 2024 there were 4 reported incidents meeting the criteria for severe or resulting in death, and 4 meeting the criteria for severe.

Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
HSMR	104.2	101.9	99.9	98.1	98.1	96.2	94.8	94.4	94.8	0	0	0	0
National benchmark	100	100	100	100	100	100	100	100	100	100	100	100	100



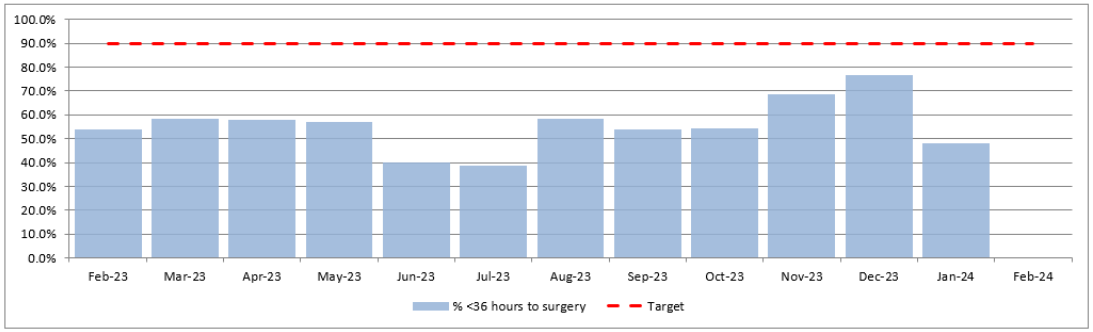
The latest **HMSR for November 22 - October 23 is 94.8** (89.7 – 101.0), this is within the expected range compared to hospital trusts nationally (↓). Emergency weekday HSMR remains statistically lower than expected. Emergency weekend HSMR also remains within the expected range.
Depth of coding continues to improve and the proportion of superspells with a co-morbidity score of 20+ has increased over the last three reporting periods. This is slightly higher than regional peers and slightly lower than national.

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

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
% <36 hours to surgery	53.8%	58.3%	58.0%	57.1%	40.0%	38.7%	58.3%	53.8%	54.5%	68.7%	76.7%	48.1%	
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%

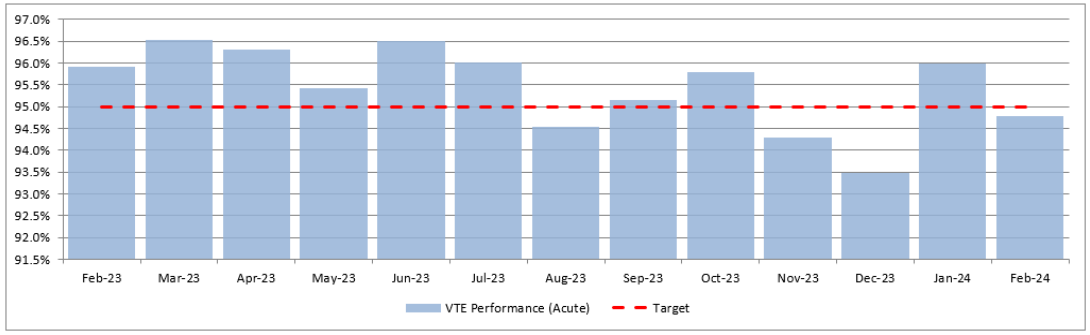


Fractured Neck of Femur

February 2024 data was not available at the time of this report.

Acute VTE risk assessment on admission

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
VTE Numerator	5437	6050	5152	5104	2563	5911	5717	5624	5643	5755	5439	5828	5739
VTE Denominator	5669	6267	5349	5349	2656	6157	6048	5910	5891	6103	5818	6072	6055
VTE Performance (Acute)	95.9%	96.5%	96.3%	95.4%	96.5%	96.0%	94.5%	95.2%	95.8%	94.3%	93.5%	96.0%	94.8%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



VTE assessment

February a 1.2% reduction compared to January 24 figures in risk assessment compliance with 94.8% achieved against the 95% target. Year to date the compliance fall above the 95% target at 95.1%.

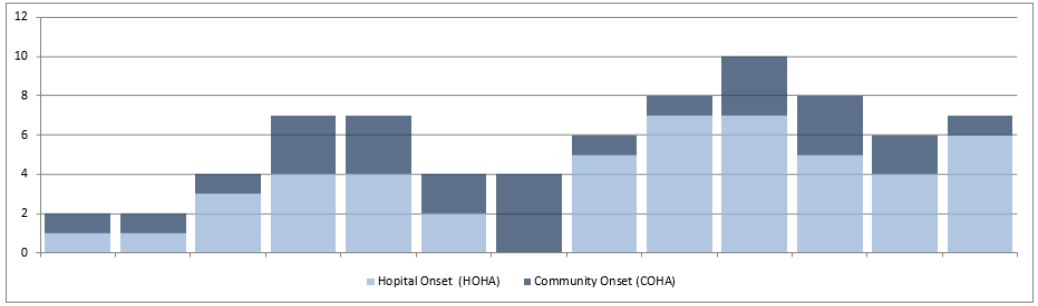
Based on monthly 1-day prevalence safety assessment audit, there is a high level of confidence that, for the inpatient setting, 99.5% of patients in February received a VTE risk assessment and, of these, 99.5% of patients received their assessment within 24hrs. this is an improvement on January 24 figures with a 0.6% increase in over-all compliance and a 2.4% increase completed within 24-hours.

Quality and Safety exception report - Infection control

Torbay and South Devon NHS Foundation Trust

Number of Clostridium Difficile cases

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Hopital Onset (HOHA)	1	1	3	4	4	2	0	5	7	7	5	4	6
Community Onset (COHA)	1	1	1	3	3	2	4	1	1	3	3	2	1



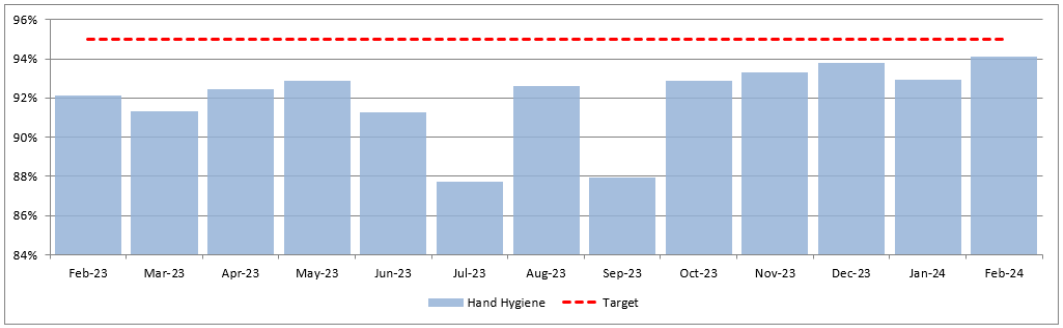
ebruary 7 cases of Clostridium Difficile were
d which is a slight increase from the previous

ter outbreaks were recorded during the month of
y.

ntinues to ensure compliance with antimicrobial
ing.

Hand Hygiene

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Hand Hygiene	92%	91%	92%	93%	91%	88%	93%	88%	93%	93%	94%	93%	94%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

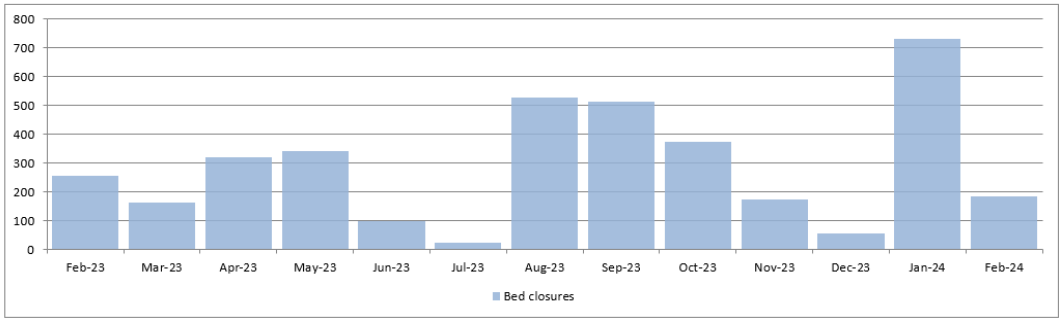


Hand hygiene compliance has remained consistent for the month of February 2024, work continues to improve compliance with targeted training in those areas not achieving compliance.

The "Gloves Off" campaign has been introduced and continues to provide education and training to staff.

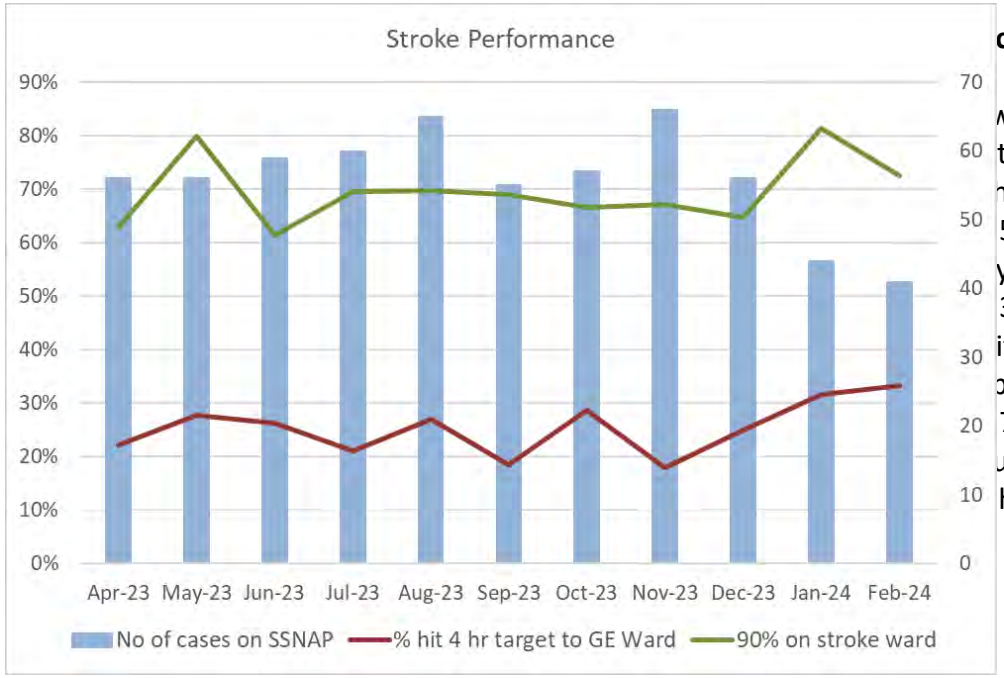
Infection control - Bed days lost (Acute)

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Bed closures	254	164	319	340	99	24	528	514	373	174	56	730	184



Bed closures has decreased significantly in February from 710 days to 164.
The number relates to wards/bays being closed where isolation has not been possible or where delays have occurred.

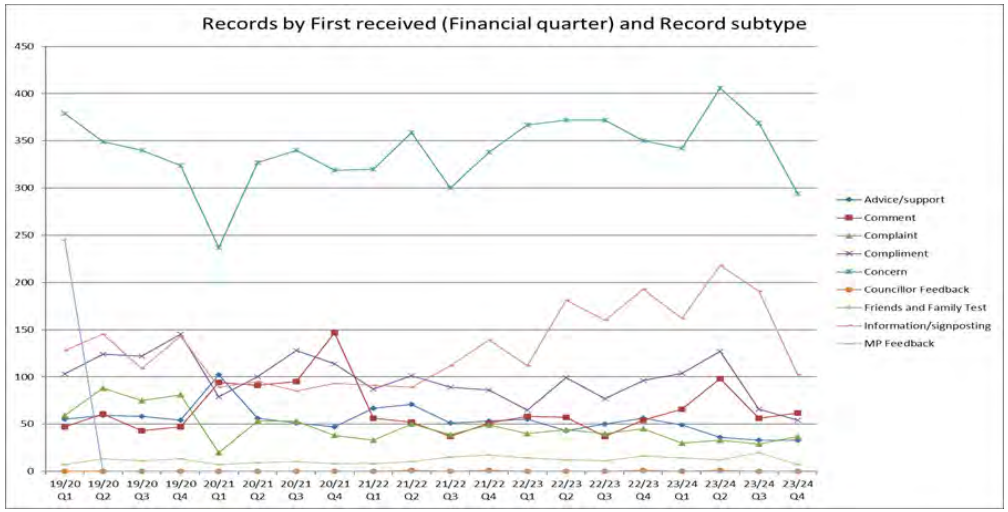
Quality and Safety exception report – stroke care

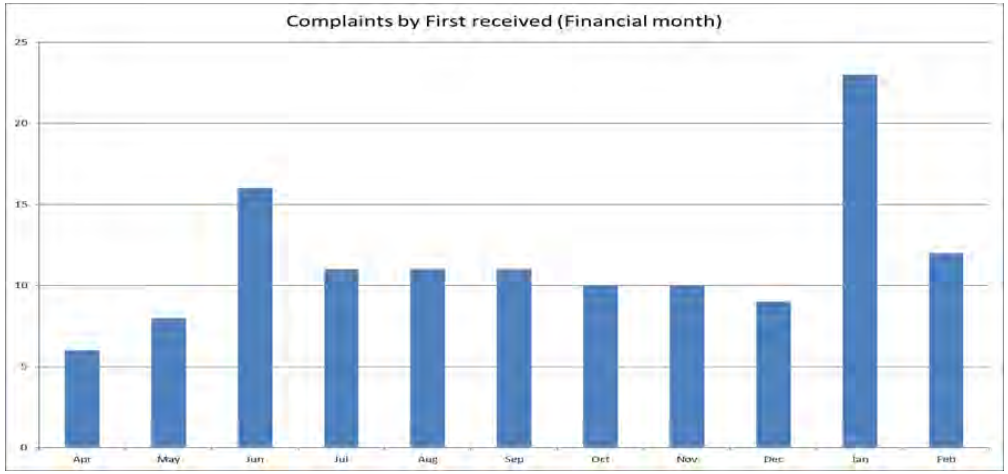


critical stroke standards – February 2024

was entered for 41 patients in February, the
t number of patients reported for the past 9
ns.
5% of patients spent more than 90% of their
y on the stroke unit.
3% of patients were admitted to the Stroke
it with 4 hours of admission; an
provement of 31.7% on January.
7% of patients received a scan within one
ur, and 100% of patients received a scan within
hours.

Complaints





In the 23/24 financial year to date (April 1st – Feb 29th), there have been a total of 3051 (303 in February) contacts to the PALs and Complaints Department recorded on Datix. q.2 saw the largest number of contacts to date with 931.

The number of complaints received since 1st April 23 to date stands at 129; this is lower than the same period last year by 27 complaints which equates a 16% decrease. The numbers received are consistently below the lower control limit (13) apart from Jun 23 and Jan 24, with an average of 11 complaints a month, this has remained so since the beginning of 23/24 financial year.

Concerns received in February have decreased for a second month by 13.5% compared to January, from 170 in January to 147 in February.

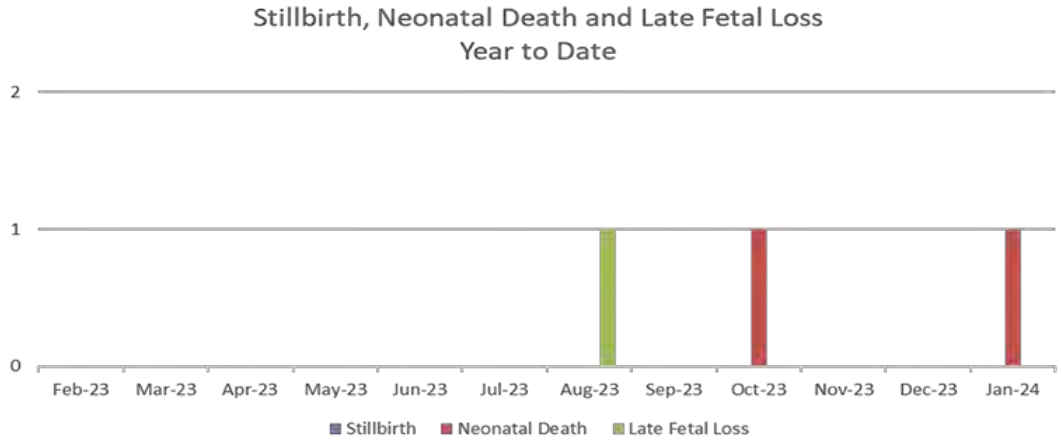
100% compliance with 3-day acknowledgment on receipt of complaints

The largest number of reported complaints and concerns within q.4of 23/24 relate to the surgical division. The top three themes are:
-Wait times
-Access to pathways
-Poor communication

Actions taken:
-Activity has been stood up, outsourcing is in place, performance is monitored and planned reductions for time to surgery is to be less than 62wks by spring 2024
-New builds to improve capacity (Endoscopy/Day Surgery)

Quality and Safety- Perinatal Clinical Quality Surveillance February 2024

National guidance, following publication of the Ockenden Report (Dec 2020), sets out the requirement to strengthen and optimise board oversight for maternity and neonatal safety. Review of maternity and neonatal safety and quality is a monthly the Trust board requirement.



February 2024 one stillbirth at 29+1 weeks gestation (figure 3 below)

	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Running Total
% of women booked for continuity of carer	62.1%	64.8%	74.4%	75.7%	94.0%	96.2%	90.4%	76.9%	93.8%	96.6%	93.2%	83.7%	83.5%
Number of Stillbirths	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Smoking at time of Delivery (SATOD)	11.30%	7.10%	5.8%	6.3%	7.7%	4.8%	8.8%	6.4%	7.3%	12.5%	7.5%	10.4%	8.0%
% Breastfeeding at Delivery	**71.8%**	**71.0%**	**67.1%**	**71.7%**	**69.9%**	**78.4%**	**67.6%**	**75.5%**	**74.9%**	**67.3%**	**71.9%**	**71.1%**	**71.5%**
% Robson Group 1	0.0%	26.9%	5.6%	17.6%	22.7%	6.7%	26.7%	11.5%	14.3%	8.0%	26.3%	12.5%	14.9%
% Robson Group 2	**42.9%**	**18.5%**	**37.0%**	**22.2%**	**28.0%**	**23.1%**	**19.0%**	**40.9%**	**30.4%**	**31.8%**	**48.4%**	**44.8%**	**32.3%**
% Robson Group 5	88.9%	87.5%	75.0%	76.5%	81.3%	88.9%	92.3%	94.4%	82.4%	90.0%	88.2%	78.9%	85.4%

Quality and Safety - Perinatal Clinical Quality Surveillance February 2024

Maternity Incidents

In February 2024 two moderate and above incidents were reported:

- 1 neonatal death at hospice in Plymouth following precipitous delivery at 34/40 in Torbay (harm grading: severe)
- 1 maternal postnatal VTE (harm grading: moderate)

One new MNSI case has been identified for an 'Undiagnosed Breech Homebirth' with an independent midwife, which required a transfer-in (to hospital) post-delivery. The baby was transferred to Bristol for cooling.

No final MNSI reports have been received for existing cases under MNSI review.

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 Trust wide workforce Key Performance Indicators (KPI's)

As part of the iterative process of on-going improvement future 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)	February 2024 **90.81** WTE under plan	• enhanced vacancy and scrutiny measures have been established
Bank WTE	February 2024 **169** WTE over plan	
Agency WTE	February 2024 **84.9** 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%)	February 2024 **5.16%**	• 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%)	February 2024 **5.01%**	
Achievement review rate (target 90%)	February 2024 **78.67%**	

Trust Level Operational Plan – Workforce Implications

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 **90.81 WTE** under the original workforce plan in M11 (due to the sale of Torbay Pharmacy (TP) and is on track to achieve the M12 forecast outturn position of 6155.77wte. Since M10, we have seen an increase of 4.08 wte all within Community nursing and Reg/qualified scientific, therapeutic and technical

- **Bank usage** has increased marginally between M10 and M11 by **7.06wte** but at 363.53wte is significantly higher than the original workforce plan and the revised forecast outturn position of 235.95wte

- **Agency usage** has increased by 65.95 wte between M10 and M11 and at 199.9wte is higher than the original workforce plan and the revised M12 forecast outturn position of 150.13 wte. The largest proportion of agency growth at 40.84wte is within our Medicines and Urgent Care Group. The drivers for this growth are largely within our safer staffing wards - 18.00wte due to increase in vacancy cover, 8.98wte due to increase in specialling, 4.25wte due to increase in sickness/maternity cover, 2.94wte due to increased demand & escalation. Much smaller levels of growth have been seen across our other care groups and again are largely due to vacancies, specialling and maternity leave.

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. Workforce Control Panels continue to meet weekly, and all requests received in recruitment are thoroughly checked ahead of this meeting. Vacancy requests require care group director or corporate director approval when the vacancy is added to Trac. The number of vacancy requests received and reviewed at panel has reduced from 224 (Jan-24) to 183 (Feb-24) with a steady decline week on week for non-clinical roles with an overall declining trend.

Yellow denotes adjusted figures following the identification of accrual issue

	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	Jan 24 Actual	Plan Feb 24	Feb 24 Actual	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 Workforce	6530	6776.66	6,552	6752.49	6,579	6643.60	6609	6528.86	6,619	6620.53	6,622	6697.62	6,644
Total Substantive	6,190	6252.81	6,197	6289.505	6,199	6099.18	6212	6089.4	6,222	6130.11	6,225	6134.19	6,241
Registered Nursing, Midwifery and Health Visiting Staff	1395.03	1409.205	1399.03	1414.469	1401.03	1421.28	1411.74	1420.71	1414.74	1421.41	1417.62	1421.62	1417.67
Registered/ Qualified Scientific, Therapeutic and Technical staff	962.48	984.467	962.48	987.5781	962.48	914.97	962.48	907.62	962.48	909.56	962.48	911.21	972.87
Support to Clinical Staff	1443.25	1423.574	1443.25	1422.486	1443.25	1336.25	1443.25	1334.48	1443.25	1365.61	1443.25	1361.11	1440.05
NHS Infrastructure support	1789.33	1833.32	1789.33	1853.944	1789.33	1813.28	1789.33	1814.67	1793.18	1822.98	1793.18	1826.14	1801.95
Medical and Dental	592.6	594.9668	595.6	604.7481	595.6	607.12	597.6	606.22	600.6	604.85	600.76	608.41	600.76
Total Bank	249	318.07	251	254.2601	270	359.66	281	274.99	280	356.47	282	363.53	281
Total Agency	91	205.78	104	208.7269	110	184.76	116	164.47	117	133.95	115	199.9	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
Endocrinology	**Issue: LIPID** – increase in referrals due to GP incentive to identify patients with high cholesterol as part of Long Term Plan. **Weight Management Service (WM) -** service suspended during COVID. Backlog accumulated. New implementation of NICE pathway to treat more WM patients – increase in referrals and additional follow up over 2 years once commenced. **Blood pressure service (BP) -** reduction in BP clinic capacity due to Consultant Nephrologist dropping session. **10 PA Consultant vacancy –** advertised x 2, appointed but candidates declined offer. **Mitigating action: LIPID -** Appointment of 12-month fixed term Clinical Pharmacist December 23 - December 24. Three days/week funded by Cardiovascular Disease and Respiratory (CVD) Network. Substantiating post to be submitted. Re-triaging of long waiters. Nurse-led LIPID clinic capacity for new patients now in place. Additional clinics provided by Consultants who provide service **Weight Management** – Additional ad-hoc clinics provided, but not sustainable **BP** – 3 month appointment of Acting Consultant October 23 - January 24. Is timetabled in Job Plan for vacant consultant. Review of all demand and capacity in diabetes and endocrinology.
Clinical Neurophysiology	**Issue:** This service is run by Royal Devon University Hospital (RDUH) with a service level agreement (SLA) in place to run 3 sessions per week. Only 2 staff to cover both Trusts. Nationwide recruitment issues. **Mitigating actions:** Meeting with RDUH to discuss bringing service in house at some point in the future.
Maxillofacial & Oral Surgery	**Issue:** One consultant and two speciality doctor vacancies; Shortage of nursing hours. **Mitigating actions:** Currently out to advert for all clinical posts – interviews during March 2024
Paediatrics	**Issues:** One consultant vacancy – due to go back to advert shortly. **Mitigating actions:** Consultants have temporarily reduced to a 1:13 rota to reduce agency spend, with minimal impact on clinics. Since April, total paeds new waiting lists have reduced by 23% follow ups (FUPS) and past to be seen (PTBS) have reduced by 42%. Due to an ongoing improvement and transformation plan.
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 4 agency workers have been engaged. A programme of international recruitment is piloted. A business case has been approved to support a rolling programme of apprenticeships for ODPs.

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

Indicator	Target	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Performance
Month Sickness %	<4%	4.63%	5.07%	4.46%	4.88%	4.98%	4.96%	4.97%	5.24%	4.87%	5.21%	5.28%	5.16%	
12 Mth Rolling Sickness %	<4%	5.62%	4.96%	5.29%	5.32%	5.18%	5.19%	5.20%	5.13%	4.89%	4.96%	4.96%	5.01%	
Achievement Rate %	>90%	76.87%	77.87%	78.12%	78.08%	78.08%	79.92%	78.93%	78.40%	78.61%	79.18%	77.55%	78.67%	
Labour Turnover Rate	10-14%	12.85%	12.92%	12.74%	12.46%	12.71%	12.46%	12.16%	12.19%	11.94%	11.91%	11.68%	11.65%	
Overall Training %	>85%	90.45%	90.72%	91.24%	91.74%	91.49%	91.97%	91.59%	91.07%	91.15%	91.15%	90.49%	90.86%	
Nuring Staff Average % Day Fill Rate- Nurses		93%	92%	96%	100%	96%	98%	98%	101%	101%	100%	99%	98%	
Nuring Staff Average % Night Fill Rate- Nurses		88%	91%	90%	89%	90%	89%	90%	92%	93%	116%	91%	91%	
Safer Staffing- Overall CHPPD		7.75	7.9	8.05	7.99	8.4	8.17	8.08	8.02	8.15	8.07	8.07	7.83	

Sickness – The operational plan trajectories reflects revised KPI's for sickness absence based upon the previous 5 years trend data. We have seen little change in the 12 months ending February at **5.01%**, which is below our plan of 5.21% and lower than the same time last year (5.58%). Rolling sickness cost at the end of February was £11.562m which whilst lower than £12.41m in February 2023, represents a significant opportunity for improvement.

Turnover – February turnover is **11.65%**, against a plan of 12.84% and represents a continued improvement from the previous month. Turnover is significantly lower that the same time last year (13.09%). 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 has increased slightly in February to **90.86%** against a target of 85%. However, at a topic level we remain challenged in Manual Handling at **78%** and Information Governance at **84.72%.**

Achievement Review – Compliance has increased by 1.12 % in February to **78.67%** 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

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	8.50	4.30	0.00	4.20	1	6	0	1	3.4%	20.7%	0.0%	3.4%	7.74	4.74	0	2.91
Allerton	7.00	4.62	0.00	2.38	7.80	5.30	0.00	2.50	0	1	0	12	0.0%	3.4%	0.0%	41.4%	7.74	4.74	0	2.91
Cheetham Hill	7.39	3.29	0.00	4.11	8.70	3.40	0.00	5.30	0	11	0	0	0.0%	13.8%	0.0%	0.0%	7.74	4.74	0	2.91
Coronary Care	5.75	5.75	0.00	0.00	6.70	6.50	0.00	0.20	0	6	0	0	0.0%	20.7%	0.0%	0.0%	7.74	4.74	0	2.91
Cromie	5.75	3.68	0.00	2.07	8.00	4.00	0.00	4.00	0	1	0	0	0.0%	3.4%	0.0%	0.0%	7.74	4.74	0	2.91
Dunlop	6.47	3.35	0.00	3.11	6.80	3.60	0.00	3.20	5	7	0	7	17.2%	24.1%	0.0%	24.1%	7.74	4.74	0	2.91
EAU4	8.63	4.79	0.00	3.83	8.60	4.70	0.00	3.90	13	18	0	8	44.8%	62.1%	0.0%	27.6%	7.74	4.74	0	2.91
Ella Rowcroft	8.63	4.31	0.00	4.31	11.90	5.80	0.00	6.10	5	7	0	3	17.2%	24.1%	0.0%	10.3%	7.74	4.74	0	2.91
Warrington	6.76	3.38	0.00	3.38	7.40	3.70	0.00	3.70	4	2	0	6	13.8%	6.9%	0.0%	20.7%	7.74	4.74	0	2.91
George Earle	7.39	3.29	0.00	4.11	7.20	3.20	0.00	4.00	16	13	0	14	55.2%	44.8%	0.0%	48.3%	7.74	4.74	0	2.91
ICU	21.85	20.70	0.00	1.15	26.60	25.80	0.00	0.70	4	3	0	19	13.8%	10.3%	0.0%	65.5%	7.74	4.74	0	2.91
McCullum (Escalation)	6.76	2.71	0.00	4.06	7.30	3.40	0.00	3.90	5	1	0	14	17.2%	3.4%	0.0%	48.3%	7.74	4.74	0	2.91
Louisa Cary	8.63	6.71	0.00	1.92	8.30	5.70	0.00	2.70	17	21	0	3	0.0%	72.4%	0.0%	10.3%	7.74	4.74	0	2.91
John Macpherson	5.11	3.19	0.00	1.92	6.30	3.80	0.00	2.50	3	5	0	5	10.3%	17.2%	0.0%	17.2%	7.74	4.74	0	2.91
Midgley	7.96	3.98	0.00	3.98	8.20	4.40	0.00	3.80	7	1	0	17	24.1%	3.4%	0.0%	58.6%	7.74	4.74	0	2.91
SCBU	9.20	6.90	0.00	2.30	12.00	0.30	0.00	4.50	6	8	0	5	20.7%	27.6%	0.0%	17.2%	7.74	4.74	0	2.91
Simpson	7.39	3.29	0.00	4.11	8.40	3.60	0.00	4.90	0	4	0	0	0.0%	13.8%	0.0%	0.0%	7.74	4.74	0	2.91
Turner	9.58	3.83	0.00	5.75	9.30	3.90	0.00	5.30	15	6	0	18	51.7%	20.7%	0.0%	62.1%	7.74	4.74	0	2.91
New Forrest Ward	6.74	3.57	0.00	3.17	6.90	3.50	0.00	3.40	8	7	0	9	27.6%	24.1%	0.0%	31.0%	7.74	4.74	0	2.91
Brixham	6.95	2.50	0.70	3.75	7.50	2.80	0.00	4.80	6	11	29	1	20.7%	37.9%	100.0%	3.4%	7.74	4.74	0	2.91
Dawlish	6.44	2.89	0.00	3.56	7.10	2.70	0.00	4.40	3	22	0	0	10.3%	75.9%	0.0%	0.0%	7.74	4.74	0	2.91
NA - Teign Ward	6.40	3.20	0.00	3.20	6.20	3.10	0.00	3.10	16	16	0	15	55.2%	55.2%	0.0%	51.7%	7.74	4.74	0	2.91
NA - Templar Ward	6.50	2.97	0.00	3.53	6.10	2.90	0.00	3.10	24	15	0	25	82.8%	51.7%	0.0%	86.2%	7.74	4.74	0	2.91
Totnes	6.44	2.89	0.00	3.56	6.60	2.90	0.00	3.70	8	13	0	8	27.6%	44.8%	0.0%	27.6%	7.74	4.74	0	2.91

	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
Organisational CHPPD	7.42	4.09	0.03	3.30	7.83	4.09	0.00	3.74
Total Planned Beds / Day	527							
Days in month	29							

The Registered Nurse (RN) actual CHPPD has been reported as 4.09 in February but remains below the carter recommendation of 4.7.
The actual Health Care Assistant (HCA) CHPPD was 3.74 in February 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 February, the Trust was operationally challenged with 17 days in Operational Pressures Escalation Levels (OPEL 4) and 10 days at OPEL 3
The planned CHPPD total was reported as 7.42 with an actual of 7.83 which reflects an increase in escalation areas due to operational challenges.

Safer Staffing – planned versus actual

Torbay and South Devon NHS Foundation Trust

Feb-24

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	1668	1671	0	0	1668	1685	1334	1379	0	0	1001	1298	713	100.2%	0.0%	101.0%	103.4%	0.0%	129.8%
Allerton	2492	2828	0	0	1001	942	1334	1564	0	0	1001	1132	834	113.5%	0.0%	94.1%	117.2%	0.0%	113.1%
Cheetham Hill	1668	1678	0	0	2001	2282	1001	1039	0	0	1334	2044	810	100.6%	0.0%	114.0%	103.8%	0.0%	153.2%
Coronary Care	1334	1466	0	0	0	69	1001	1001	0	0	0	23	382	109.9%	0.0%	0.0%	100.0%	0.0%	0.0%
Cromie	1576	1835	0	0	834	1427	1001	1047	0	0	667	1446	719	116.5%	0.0%	171.2%	104.6%	0.0%	216.8%
Dunlop	1334	1497	0	0	1167	1025	1001	1012	0	0	1001	1194	698	112.2%	0.0%	87.8%	101.1%	0.0%	119.4%
EAU4	1668	1876	0	0	1334	1392	1668	1414	0	0	1334	1381	704	112.5%	0.0%	104.3%	84.8%	0.0%	103.5%
Ella Rowcroft	1001	1010	0	0	1334	1173	955	736	0	0	667	667	302	101.0%	0.0%	87.9%	77.1%	0.0%	100.0%
Warrington	1001	1098	0	0	1001	1017	667	667	0	0	667	773	479	109.8%	0.0%	101.7%	100.0%	0.0%	115.9%
George Earle	1668	1528	0	0	2001	1801	1001	1046	0	0	1334	1449	805	91.6%	0.0%	90.0%	104.5%	0.0%	108.6%
ICU	3002	2359	0	0	334	129	3002	2133	0	0	0	0	174	78.6%	0.0%	38.7%	71.0%	0.0%	0.0%
McCullum (Escalation)	667	988	0	0	1001	890	667	679	0	0	1001	1002	489	148.1%	0.0%	89.0%	101.7%	0.0%	100.1%
Louisa Cary	2335	1794	0	0	667	924	2335	1599	0	0	667	663	597	76.9%	0.0%	138.5%	68.5%	0.0%	99.4%
John Macpherson	1001	830	0	0	667	712	667	655	0	0	334	288	393	82.9%	0.0%	106.7%	98.2%	0.0%	86.2%
Midgley	1668	1840	0	0	1668	1496	1334	1461	0	0	1334	1366	751	110.4%	0.0%	89.7%	109.5%	0.0%	102.4%
SCBU	1001	23	0	0	334	405	1001	23	0	0	334	403	180	2.3%	0.0%	121.5%	2.3%	0.0%	120.7%
Simpson	1668	1862	0	0	2001	1976	1001	1024	0	0	1334	1945	806	111.6%	0.0%	98.7%	102.3%	0.0%	145.8%
Turner	1334	1407	0	0	1668	1449	667	667	0	0	1334	1352	527	105.5%	0.0%	86.9%	100.0%	0.0%	101.3%
New Forrest Ward	1668	1608	0	0	1334	1363	1334	1374	0	0	1334	1464	840	96.4%	0.0%	102.1%	103.0%	0.0%	109.7%
Total (Acute)	*29747*	*29194.75*	*0*	*0*	*22011*	*22154.35*	*22965.5*	*20517*	*0*	*0*	*16675*	*19887.5*	*11203*	98.1%	0.0%	100.7%	89.3%	0.0%	119.3%
Brixham	812	892.75	406	0	1218	1438.75	638	651	0	0	957	1231.5	559	109.9%	0.0%	118.1%	102.0%	0.0%	128.7%
Dawlish	812	738	0	0	1218	1309.5	696	649	0	0	638	924	512	90.9%	0.0%	107.5%	93.2%	0.0%	144.8%
NA - Teign Ward	1827	1699.75	0	0	1827	1660	957	968	0	0	957	1023	859	93.0%	0.0%	90.9%	101.1%	0.0%	106.9%
NA - Templar Ward	1624	1538.75	0	0	2030	1679.5	957	990	0	0	1044	1035	863	94.8%	0.0%	82.7%	103.4%	0.0%	99.1%
Totnes	812	803.5	0	0	1218	1201.5	696	685	0	0	638	717	517	99.0%	0.0%	98.6%	98.4%	0.0%	112.4%
Organisational Summary	35634	34868	406	0	29522	29444	26910	24460	0	0	20909	24818	14513	97.8%	0.0%	99.7%	90.9%	0.0%	118.7%

The Registered Nurse fill rate for days during February was 97.8% which is a decrease in the January fill rate of 99% and for night duty reported as 90.9% which is a slight decrease on the previous months fill rate of 91%.

The fill rate for Health care support workers for days during February was 99.7% which is a decrease in the January fill rate of 102.7%. For night duty reported as 118.7% which is an increase on the previous months fill rate of 117.4%
The increase in fill rate for Health Care support workers at night is to mitigate any risks associated with the registered nurse fill rate.

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

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

M11 (Period Ended Feb-24)

NHS
Torbay and South Devon
NHS Foundation Trust

Contents Page

Executive Summary

Description	YTD Plan £'000	YTD Act £'000	Var £'000	YTD R.A.G	F'cast Plan * £'000	F'cast Exp £'000	Var £'000	F'cast R.A.G
Operating Income	(598,049)	(614,316)	16,267		(651,134)	(671,530)	20,396	
Operating Expenditure and Financing Cost	616,878	661,063	(44,185)		670,513	722,046	(51,533)	
Surplus / (Deficit)	**18,829**	**46,747**	**(27,918)**		**19,379**	**50,516**	**(31,137)**	
Remove Donated Assets, Cost on Impairment	81	(22,147)	22,228		(2)	(23,493)	23,491	
Adjusted Surplus / (Deficit)	**18,910**	**24,600**	**(5,690)**		**19,377**	**27,023**	**(7,646)**	
Capital (CDEL)	52,392	17,462	34,930		56,755	27,757	28,998	
Cash & Cash Equivalents	17,382	33,365	(15,983)		14,975	37,981	(23,006)	

As at M11, the Trust reported an YTD adverse variance to plan of £5.7m. We are formally reporting a forecast outturn adverse variance to plan of £7.6m in line with the agreed Deficit control total of £27.024m which the trust in on track to achieve for the end of the financial year.

Against our in-year CIP target of £46.6m, the number of schemes marked delivered total £39.8m for the whole year, leaving a gap of £6.8m. This position may further improve next month at year-end if all green schemes under development (£41.1m) are delivered by M12.

Please note the original budget had been adjusted by £13.2m for the year due to additional NHSE funding support in M11 and 12.

Capital Plan had been adjusted for ICB CDEL due of the sale of TP and movement in National PDC schemes, such as NHP and Digital EPR, where the phasing of expenditure has changed.

* Cash 31st March 2024 forecast: please note this now include NHSE additional funding support mentioned above therefore our cash position exiting the financial year is significantly better than initially planned.

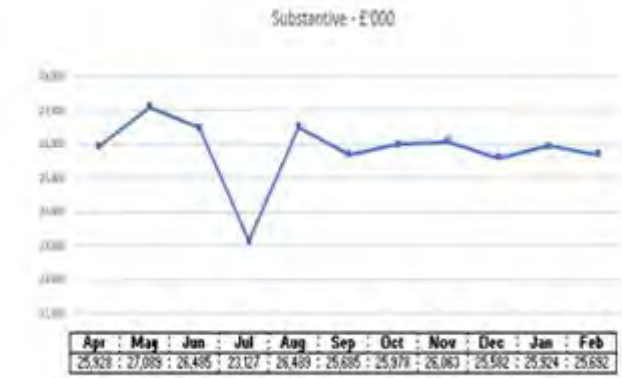
Forecast Position By Care Group

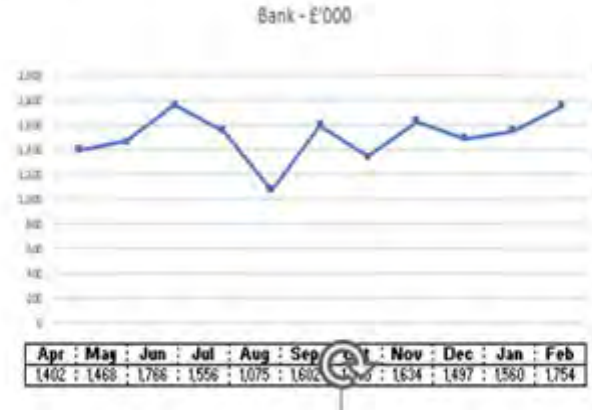
The table below provides a snapshot of our Forecast financial position at the end of M11 at Care Group Level, with commentary on key variances that have material impact on our overall performance.

Care Group	M11 YTD Var £'000	RAG	Commentary
CFHD	1,721		Pay YTD is over budget for externally funded posts and agency costs supporting waiting list work and pilot schemes, offset by income received. Non pay overspend is for recharge of expenditure incurred (funded via external income) and un-planned risk share. Total Income is reported above budgeted position, to offset non pay and pay expenditure.
Families & Communities	(3,218)		YTD position is driven by adverse variance in ASC due to increased volume and complexity and Placed People (Torbay CHC - Dom Care and Nursing activity) packages of care of. Other Divisions are reporting underspends for vacancy slippages.
Medicine and Urgent Care	(11,080)		The YTD adverse variance continues to be driven by: -Ward pressures within Emergency Services, Cardiology, Acute Medicine and Respiratory. -Recovery areas that are still fully operational despite reduced budgets -Medical temporary staffing costs (includes Junior strikes)
Planned Care and Surgery	597		YTD Favourable variance due to ERF spending is less than planned earlier in the year, Theatres consumables, Clinical Engineering and Labs managed service contract.
Shared Corporate Services	18,293		YTD favourable variance forecast underspend includes: Energy and other Estate related cost pressures, offset by underspends against depreciation and interest income received, Industrial Action funding, and additional Education income.
Total	6,351		

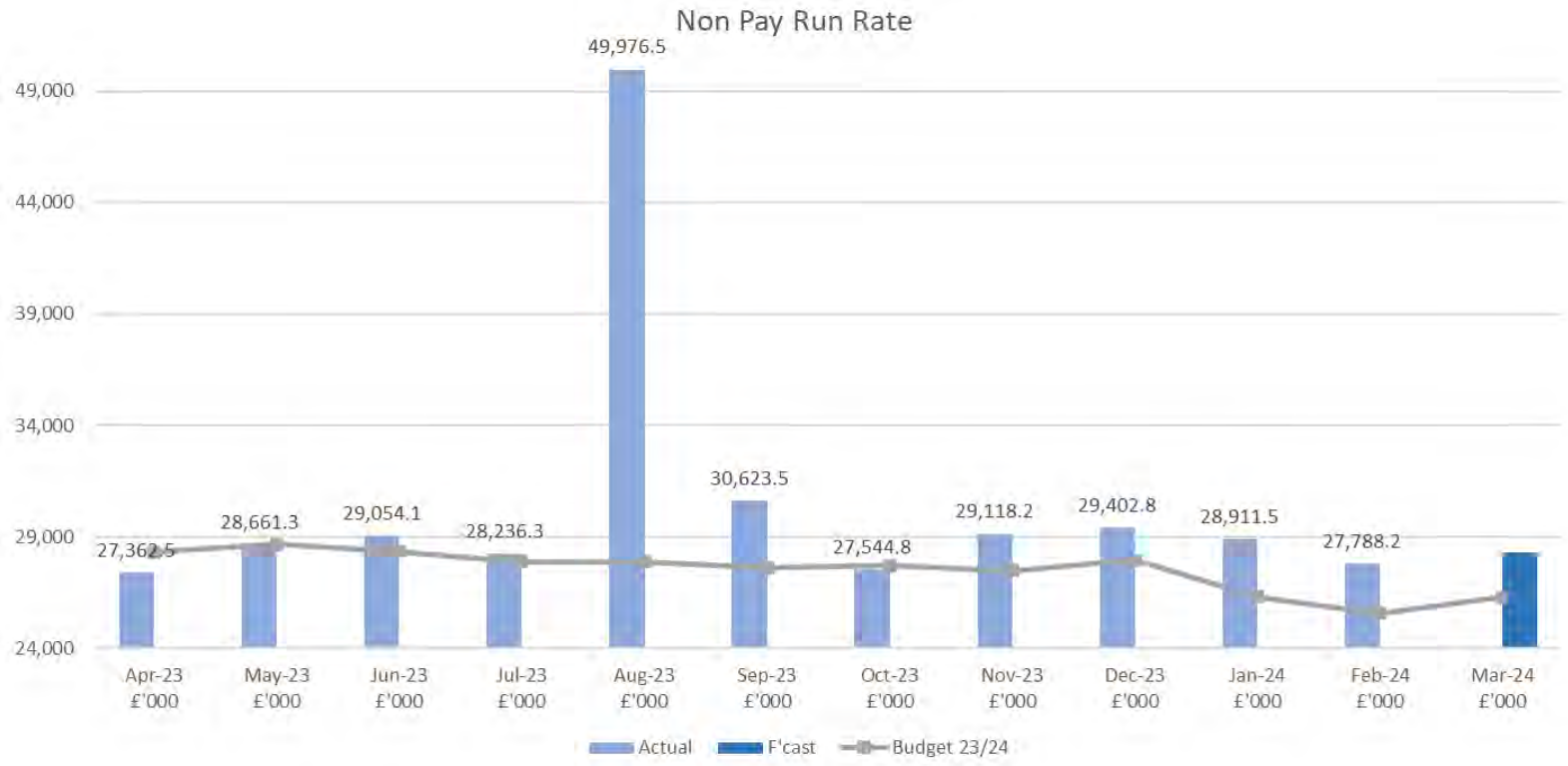
WTE and Pay Run Rate – Substantive, Bank & Agency

Substantive headcount remains consistent due to vacancy review measures. Agency cost and WTE had increased in February largely driven by ward demands particularly in ED.





Non-Pay Expenditure – Run Rate



Overspend trend continues throughout the year. Primary drivers of this variance include increased costs for clinical supplies, drugs, and the purchase of social care (volume and increased complexity). The sharp increase in expenditure in August was due to the impairment relating to Torbay Pharmaceutical sale.

ERF Income and Activity Position

Setting	YTD 19/20 Activity	YTD 23/24 Activity	YTD Var	YTD Var %	YTD 100% of 19/20 Income	YTD 23/24 Income	YTD Income Var	YTD Income Var %
Day Cases	26,607	26,633	26	100%	22,814,460	24,137,584	1,323,124	106%
Electives	3,320	2,721	-599	82%	14,109,749	10,852,688	-3,257,061	77%
APC TOTAL	29,927	29,354	-573	98%	36,924,210	34,990,272	-1,933,937	95%
Firsts	78,405	84,783	6,378	108%	15,786,222	17,031,781	1,245,559	108%
First Procedures	17,132	20,853	3,721	122%	3,032,145	3,704,219	672,074	122%
Follow-Up Procedures	49,922	50,247	325	101%	7,249,249	7,569,105	319,856	104%
OPA TOTAL	145,459	155,883	10,424	107%	26,067,616	28,305,105	2,237,489	109%
Total ESRF Performance	**175,385**	**185,237**	**9,852**	**106%**	**62,991,825**	**63,295,377**	**303,552**	**100%**

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 consider its impact.

The bottom-line position has continued to be at 100% of 19/20 in M11 (£303k above plan), an improved position since M10 due to data quality issues (£0.85m) that have now been resolved. We currently liaising with NSHE to ensure that they can confirm that these changes will be reflected in their record and analysis at year-end.

In M11 the Trust achieved actuals of **£5.8m** against a plan of **£6.1m,** however M10 and M11 are still at Flex position and both months are likely to increase and improve once coding is Frozen and finalised.

Bed Utilisation

Point of Delivery	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	Jan 24 Actual	Feb 24 Actual
Occupied Beds DGH	10,576	11,044	10,625	10,600	10,715	10,542	11,126	10,748	10,578	11,153	10,946
Available Beds DGH	11092	11460	11125	11385	11342	10999	11534	11233	11326	11719	11377
Occupancy	95.3%	96.4%	95.5%	93.1%	94.5%	95.8%	96.5%	95.7%	93.4%	95.2%	96.2%

In M11, the overall bed occupancy for acute beds is 96.2%. Occupancy below 95% is considered a minimum to support timely patient flow. The High Bed Occupancy has impacted in delays in getting patients admitted and overall ED waiting times with a deterioration in ED performance down on previous months. Access to a hospital bed in a timely way is a key driver in this performance deterioration. Initiatives to improve patient flow continue to be supported by the Transformation and Improvement Team reporting through the Unscheduled Care Board meeting every two weeks. The Winter Plan describes actions to increase capacity for winter to meet the expected increase in demand for admission to a hospital bed. Post implementation reviews are being conducted to describe effectiveness of these actions and help design the next set of plans for 2024/25. The ICB is working across the system to support schemes including care coordination hubs and out-of-hours falls prevention to help manage demand on hospital bed capacity and conveyance to ED.

The key areas of improvement this winter have been:

- 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 M10 the Trust reported an increase in beds occupied as 'No Criteria to Reside' with 7% reported in M10. This is against the plan to deliver 5% by March 2024.

CIP Programme Delivery and Pipeline

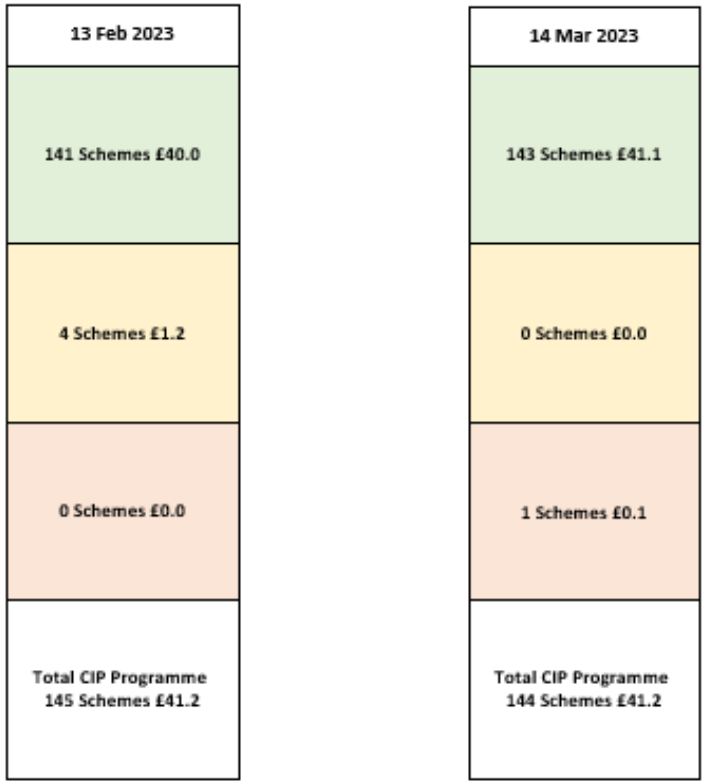
For the financial year 2023/24, the total CIP delivery requirement is £46.6m. As of 14th March, the 2023/24 CIP programme includes 144 schemes, of which 143 schemes (99%) totalling **£41.1m** are assessed as Green and have been confirmed in the Plan. The currently transacted and confirmed delivery sum in the financial system is **£39.8m.**

Divisions and workstreams are working through 1 new scheme that has a value of £0.1m.
Work continues to ensure the delivery of existing schemes.

The Strategic ICB Collaborative schemes have delivered in total £66k (0.063%) against a plan totalling £10.5m.

Currently, if all the schemes included in the pipeline were to be developed and pass through the governance process, the total programme would be in the region of £41.2m (non-risk-adjusted value).

2023/24 Scheme Development (£m)



Torbay and South Devon NHS Foundation Trust

Cash Position

Description	YTD Bud £000	YTD Act £000	YTD Var £000
Opening cash balance	**14,961**	**34,734**	**19,773**
Capital Expenditure (accruals basis- excld. New leases and charitable funds))	(49,927)	(35,032)	14,895
PDC Draw Down	35,034	20,215	(14,819)
Capital Loan/ Lease/ PFI Principal Repayment	(6,704)	(7,042)	(338)
Proceeds on disposal of assets	0	17,572	17,572
Movement in capital creditor	0	(10,663)	(10,663)
Other capital-related elements	0	(0)	(0)
Subtotal - capital-related elements	**(21,597)**	**(14,951)**	**6,646**
Cash Generated From Operations	458	202	(256)
Revenue PDC drawndown	31,005	28,548	(2,457)
Working Capital movements - debtors	(953)	(12,881)	(11,928)
Working Capital movements - creditors	(63)	(2,286)	(2,223)
Net Interest	(2,308)	(3,269)	(962)
PDC Dividend paid	(4,106)	(3,839)	267
Other movements	(14)	7,109	7,123
Subtotal - other elements	**24,019**	**13,584**	**(10,435)**
Closing cash balance	**17,383**	**33,367**	**15,984**

- The opening cash balance at the beginning of the financial year was originally **£19.8m** higher than planned due to the timing difference between the actual Capital Creditor balance at previous year-end and the planned figure estimated before year-end during 23/24 operational planning cycle.
- Our overall cash position at M11 is currently **£16.0m** ahead of plan. Please note this include NHSE additional **£13.2m** funding support for M11 &M12 and the benefit of TP sale in year.
- Access to capital and revenue PDC support prior to the sale of Torbay Pharmaceuticals Ltd (TP), remained 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 **£52.4m,** this reflects the phasing in completing of the national funded programme e.g. EPR and NHP and sale of TP. TP sale concluded on 16th November 23 and the cash inflow had been included in the position.
- Capital-related cashflow is **£6.7m** better than plan. The capital programme is underspent against plan by **£14.9m**, PDC drawdown is **£(14.8)m** lower than planned draw down, this being in part due to slippages on the capital programme and the cash benefit of the TP sale. The disposal proceeds of assets of **£17.6m** mostly relates to the TP sale. Movement in capital creditors is lower than plan **£(10.7)m**.
- Cash generated from operations is **mostly on target.** Operational elements within in the I&E position have significantly improved from M10 due to non-recurrent income support from the ICB circa **£12.1m** and a further **£1.1m** due in M12. Due to additional 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 **£37.9m** remains on target.
- Other movements of **£7.2m** predominantly relates to the sale of stock that was held by TP.

Balance Sheet

	YTD Bud £000	YTD Act £000	YTD Var £000
Intangible Assets	20,634	13,222	(7,412)
Property, Plant & Equipment	271,177	221,109	(50,068)
On-Balance Sheet PFI	17,041	20,154	3,113
Right of Use assets	19,633	18,258	(1,375)
Other	1,843	1,666	(177)
Non-Current Assets Total	**330,328**	**274,408**	**(55,920)**
Cash & Cash Equivalents	17,383	33,367	15,984
Other Current Assets	41,614	60,279	18,665
Current Assets Total	**58,997**	**93,646**	**34,649**
Total Assets	**389,325**	**368,054**	**(21,271)**
Loan - DHSC ITFF	(2,917)	(2,506)	411
PFI and Leases	(3,752)	(3,950)	(198)
Trade and Other Payables	(56,240)	(71,009)	(14,769)
Other Current Liabilities	(5,267)	(9,050)	(3,783)
Current Liabilities Total	**(68,176)**	**(86,516)**	**(18,340)**
Net Current Assets/(liabilities)	**(9,179)**	**7,130**	**16,309**
Loan - DHSC ITFF	(19,844)	(16,144)	3,700
PFI and Leases	(30,638)	(40,391)	(9,753)
Other Non-Current Liabilities	(4,615)	(4,679)	(64)
Non-Current Liabilities Total	**(55,097)**	**(61,213)**	**(6,116)**
Total Assets Employed (Assets + Liabilities)	**266,052**	**220,325**	**(45,727)**
Reserves			
Public Dividend Capital	260,733	244,378	(16,355)
Revaluation	61,351	60,124	(1,227)
Income and Expenditure	(56,032)	(84,177)	(28,145)
Total	**266,052**	**220,325**	**(45,727)**

- Non-Current Assets are **£(55.9)m** lower than plan. This is largely due to the sale of TP related assets **£(36.1)m** . In addition, a FY22/23 property revaluation was lower than planned **£(4.7)m** . Year to date capital expenditure, inclusive of IFRS16 leases and charitable fund expense is also lower than plan by **£(17.9)m**, which is partly offset by reduced depreciation **£3.8m** due to delays in bringing assets into service.
- Cash and Cash Equivalents is **£16.0m higher** than plan, as explained in the commentary to the Cash Flow Statement.
- Other Current Assets are **£18.7m** higher than plan. This is mainly due to accrued income **£21.3m** and other receivable components **£5.0m** (such as ASC) being higher than plan . This is partly offset by the removal of current assets **£(8.4)m,** again linked to the Torbay Pharmaceuticals sale.
- Trade and Other Payables are **£14.8m** higher than plan. Principally this value is due to provider-to-provider recharges such as CFHD and trade creditors awaiting payment.
- Other Current Liabilities are **£3.8m** higher than planned, mainly due to income received ahead of time and being deferred to match expenditure.
- Loans are lower than planned by a total of **£4.1m** due to the early repayment of a loan linked to the sale of TP.
- PDC reserves are behind plan **£(16.4)m** , as described in the cash flow statement.
- The Income and Expenditure reserve is **£28.2m** lower than plan principally due to the year-to-date revenue variance to plan relating to PFI liability remeasurement (in year) and TP impairment £ 21.0m, and the PFI liability restatement prior to 23/24 **£7.7m**.

Capital Position

Combined ICB & National CDEL	Capital Full year Plan for 23/24 £'000	Capital F'cast for 23/24 at 28th Feb £'000	Variance Plan to F'cast M11 £'000	Capital YTD M11 £'000
ICB CDEL	21,237	22,119	882	14,766
National CDEL	32,718	23,826	(8,888)	20,005
CDEL asset disposal	0	(17,709)	(17,709)	(17,309)
IFRS 16 CDEL	2,80	(479)	(3,279)	0
CDEL total	**56,755**	**27,757**	**(28,998)**	**17,462**
Other - Charitable Funds and PFI	1,382	557	(825)	244
Grand total	**58,137**	**28,314**	**(29,821)**	**17,706**

- Full year forecast net CDEL has reduced by £(29.0)m against Plan. The main drivers to this relate to the TP sale totalling £(17.0)m, reduced expense across planned NHP enabling works totalling £(5.0)m, reduced expense on the Digital EPR project totalling £(4.2)m and IFRS16 CDEL £(3.3m) due to Dartmouth Clinic sub-lease.
- Asset disposal mainly relates to TP sale
- We are forecasting the ICB CDEL will be fully spent at year-end.
- A significant proportion of the Trust's CDEL is currently forecast to be delivered in M12. Scheme budget holders have reviewed confidence levels and are pushing forward to close the in-year position over the coming weeks, with regular ongoing reviews between scheme leads and finance.

Torbay and South Devon NHS
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Performance Report - April 2023

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	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	Jan-24	Feb-24	Operational Plan trajectory Feb 2024
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	3634	3217	1205
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%	22.2%	20.0%	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	06:33	06:39	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	836	824	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%	65.1%	63.2%	73%
% 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%	22.6%	23.3%	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%	6.6%	4.9%	5.0%
Elective recovery																		
RTT 104 week wait incomplete pathway	0	34	29	22	14	0	0	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	138	125	19
RTT 65 week wait incomplete pathway	0	2174	2203	1828	1679	1372	1244	1163	1196	1136	1274	1161	1018	871	840	767	695	199
RTT 52 week wait incomplete pathway	Reduction	5585	6027	5554	5116	4427	4024	3926	3938	3879	3977	3471	2961	2533	2258	2007	1985	Reduction
Patient waits over 2.5 years	0	17	12	9	6	0	0	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%	75.0%	79.3%	78.1%	81.7%	79.0%	77.8%	77.5%	75.7%	77.0%	75.4%	80.9%	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	173	112	148

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	ISU	Target	13 month trend	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		1	2	1	1	1	4	1	1	3	2	3	0	4	21
Reported Incidents - Death	Trustwide	<1		0	1	0	1	1	0	2	0	0	1	1	0	4	10
Medication errors resulting in moderate harm	Trustwide	<1		0	0	0	1	2	2	0	1	0	0	0	2	3	11
Medication errors - Total reported incidents	Trustwide	N/A		44	79	75	81	88	82	85	58	57	33	49	59	58	725
Avoidable New Pressure Ulcers - Category 3 + 4 (1 month in arrears)	Trustwide	9 (full year)		3	1	0	0	2	1	1	0	0	0	0	0		4
Never Events	Trustwide	<1		2	0	0	0	0	0	0	0	0	0	0	0	0	0
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		3	13	5	7	8	11	7	7	5	5	7	7	0	69
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	2	1	2	1	0	0	1	0	0	1	2	10
Formal complaints - Number received	Trustwide	20		12	12	6	8	15	12	11	11	10	10	9	25	12	129
VTE - Risk Assessment on Admission (acute)	Trustwide	>95%		95.9%	96.5%	96.3%	95.4%	96.5%	96.0%	94.5%	95.2%	95.8%	94.3%	93.5%	96.0%	94.8%	95.2%
Hospital standardised mortality rate (HSMR) (4 months in arrears)	Trustwide	<100		104.2	101.9	99.9	98.1	98.1	96.2	94.8	94.4	94.8					
Safer staffing - ICO - Day time	Trustwide	90% - 110%		91.3%	93.1%	92.4%	96.0%	100.1%	96.1%	97.6%	98.1%	101.4%	101.6%	96.1%	99.0%	97.9%	97.9%
Safer Staffing - ICO - Nightime	Trustwide	90% - 110%		87.0%	88.4%	91.3%	90.0%	89.0%	90.1%	88.7%	90.1%	92.3%	93.2%	89.1%	91.0%	90.9%	90.9%
Bed capacity impacted by Infection Control (Acute beds closed in month)	Trustwide	<100		254	164	319	340	99	24	528	514	373	174	56	730	184	3341
Hand Hygiene	Trustwide	>95%		92.1%	91.3%	92.5%	92.9%	91.3%	87.7%	92.6%	87.9%	92.9%	93.3%	93.8%	93.0%	94.1%	92.2%
Number of Clostridium Difficile cases (COHA+HOHA)	Trustwide	<3		2	2	4	7	7	4	4	6	8	10	8	6	7	71
CDiff - Hospital Onset Healthcare Associated (HOHA)	Trustwide			1	1	3	4	4	2	0	5	7	7	5	4	6	47
CDiff - Community Onset Healthcare Associated (COHA)	Trustwide			1	1	1	3	3	2	4	1	1	3	3	2	1	24
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		53.8%	58.3%	58.0%	57.1%	40.0%	38.7%	58.3%	53.8%	54.5%	68.7%	76.7%	48.1%		
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		67.4%	70.7%	63.0%	80.0%	61.4%	69.5%	69.8%	69.1%	66.7%	67.2%	64.8%	81.4%	72.5%	
Mixed Sex Accommodation breaches	Trustwide	0		0	0	0	0	0	0	0	0	0	0	0	1	2	0
Follow ups 6 weeks past to be seen date	Trustwide	6400		20048	19979	19618	19609	18738	18842	19582	20140	19265	19082	19673	19704	19120	

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	ISU	Target	13 month trend	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Year to date
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.7%	5.6%	5.0%	5.3%	5.3%	5.2%	5.2%	5.2%	5.1%	4.9%	5.0%	5.0%	5.0%	
Appraisal Completeness	Trustwide	>90%		76.7%	76.9%	77.9%	78.1%	78.1%	78.1%	79.9%	78.9%	78.4%	78.6%	79.2%	77.5%	78.7%	
Mandatory Training Compliance	Trustwide	>85%		90.1%	90.4%	90.7%	91.2%	91.7%	91.5%	91.8%	91.6%	91.0%	91.2%	91.1%	90.5%	90.9%	
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		13.1%	12.8%	12.9%	12.7%	12.5%	12.7%	12.5%	12.2%	12.2%	11.9%	11.9%	11.7%	11.6%	
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%			6.5%			5.5%			5.5%			6.1%			
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET		781	814	784	804	817	823	852			768	757			
Intermediate Care - No. urgent referrals	Trustwide	NONE SET		307	298	288	323	327	308	324	335	329	311	296	336	313	3499
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		200	251	224	219	228	281	234	208	241	254	221	240	230	2581
Urgent Community Reponse (2-hour) - Referrals	Trustwide	NONE SET		34	30	25	34	37	38	44	49	40	50	59	80		456
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	70%		94.1%	90.0%	92.0%	88.2%	89.2%	97.4%	95.5%	95.9%	92.5%	100.0%	98.3%	97.5%		95.4%
Urgent Community Reponse (2-48 hour)- Referrals	Trustwide	NONE SET				139	162	151	124	130	134	158	140	129	166		1433
Urgent Community Reponse (2-48 hour) - Target achievement	Trustwide	NONE SET				85.6%	85.8%	85.4%	84.7%	87.7%	85.8%	87.3%	90.0%	86.0%	88.6%		86.7%
ADULT SOCIAL CARE TORBAY KPIs																	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		28.5	29.9	32.6	27.2	24.5	27.2	16.3	24.5	32.6	34.0	30.0	30.0	33.9	33.9
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		802.3	826.5	805	748.5	729.6	729.6	735	740.4	775.4	748.5	749.8	749.8	776.4	776.4
Proportion of clients receiving direct payments	Trustwide	25%		20.2%	19.5%	20.1%	20.1%	20.0%	20.6%	21.1%	20.7%	20.7%	20.6%	19.8%	19.7%	19.0%	19.0%
% reablement episodes not followed by long term SC support	Trustwide	83%		86.4%	86.4%	85.3%	88.3%	88.9%	87.7%	87.9%	88.3%	88.6%	88.3%	88.2%	88.4%	89.1%	89.1%

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	ISU	Target	13 month trend	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Year to date
LOCAL PERFORMANCE FRAMEWORK 1																	
Cancer - Two week wait from referral to date 1st seen - regional reporting	Trustwide	>93%		82.6%	76.0%	56.7%	73.9%	76.8%	68.4%	69.5%	70.9%	67.3%	68.3%	71.0%	69.4%	79.3%	
Cancer - 28 day faster diagnosis standard - national reporting	Trustwide	75%		77.3%	76.3%	75.0%	79.3%	78.1%	81.7%	79.0%	77.8%	77.5%	75.7%	77.0%	75.4%	80.9%	
Cancer - 31-day wait from decision to treat to treatment - national reporting	Trustwide	>96%		98.4%	95.7%	92.1%	93.2%	93.4%	98.1%	97.8%	91.5%	92.5%	94.1%	96.6%	97.0%	94.8%	
Cancer - 62-day wait for treatment - national reporting	Trustwide	>85%		52.5%	60.8%	67.2%	57.9%	65.7%	67.0%	81.8%	75.0%	64.6%	68.4%	62.4%	62.5%	59.3%	
Cancer - Patient waiting longer than 104 days from 2ww - regional reporting	Trustwide	20		53	24	20	11	7	10	11	14	21	22	22	33	24	
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		44.3%	48.1%	49.7%	49.8%	51.2%	53.1%	52.0%	54.1%	54.8%	55.8%	55.8%	58.7%	58.5%	
RTT 65 week wait incomplete pathway	Trustwide	1091		1679	1372	1244	1163	1196	1136	1274	1161	1018	871	840	767	695	
RTT 78 week wait incomplete pathway	Trustwide	178		462	183	166	167	123	129	156	187	155	179	165	138	125	
RTT 104 week wait incomplete pathway	Trustwide	0		14	0	0	0	0	0	0	0	0	0	0	0	0	
On the day cancellations for elective operations	Trustwide	<0.8%		1.5%	1.5%	0.8%	1.4%	1.8%	1.4%	1.6%	1.7%	2.1%	1.0%	1.2%	0.8%	0.4%	1.3%
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		10	7	7	10	14	13	23	37	13	2	8	19	2	148
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		15.3%	14.6%	15.8%	15.2%	15.0%	15.3%	15.9%	15.4%	15.3%	15.3%	15.4%	16.5%	17.1%	
Bed Occupancy	Acute	90.0%		96.3%	96.9%	95.3%	96.4%	95.5%	93.1%	94.5%	95.8%	96.5%	95.7%	93.4%	95.2%	96.2%	
Percentage of inpatients with No Criteria to Reside (acute)	Trustwide	<5%						7.0%	6.0%	7.5%	7.4%	8.3%	7.2%	6.4%	6.6%	4.9%	
% patient discharges pre-noon	Acute	33%								21.6%	21.5%	20.3%	22.4%	23.7%	22.6%	23.3%	21.08%
% patient discharges pre-5pm	Acute	75%								70.6%	70.9%	69.4%	71.2%	72.5%	70.1%	70.4%	69.7%
Number of patients >7 days LoS (daily average)	Trustwide	153		166.1	167.0	154.2	159.8	156.2	129.9	156.0	159.8	169.4	158.0	151.5	162.6	157.2	
Number of extended stay patients >21 days (daily average)	Trustwide	35		40.7	38.6	39.3	33.2	35.2	30.6	35.9	38.3	49.6	38.5	31.4	40.1	35.1	

Torbay and South Devon NHS
NHS Foundation Trust

Performance Report - February 2024

	ISU	Target	13 month trend	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Year to date
LOCAL PERFORMANCE FRAMEWORK 2																	
Ambulance handover delays > 30 minutes	Trustwide			534	1043	598	1025	1002	936	1098	1346	1508	1407	1014	1405	1337	12676
Ambulance handover delays > 60 minutes	Trustwide	0		263	687	277	595	615	490	629	907	1070	965	713	1068	997	8326
UEC - patients seen within 4 hours (23/24 plan target 76%)	Trustwide	76%		56.9%	57.6%	61.7%	60.8%	64.6%	63.5%	67.9%	68.4%	66.6%	67.0%	68.0%	65.1%	63.2%	65.2%
ED - patients with >12 hour visit time pathway	Trustwide			599	977	568	893	797	637	794	686	822	770	622	836	824	8249
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute				41%	52%	53%	55%	59%	61%	71%	68%	74%	73%	70%	68%	
Clinically Ready to Proceed delay over 1 hour - Emergency Department	Acute								26%	28%	29%	29%	28%	30%	34%	35%	
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute				05:08	04:24	04:42	04:22	04:17	04:03	03:59	04:15	04:15	04:00	04:26	04:30	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute				12:47	09:10	11:15	10:55	08:47	11:19	09:53	10:58	10:22	09:04	10:41	10:59	
Diagnostic tests longer than the 6 week standard	Trustwide	15%		26.1%	29.7%	29.8%	27.7%	24.3%	25.5%	29.1%	31.5%	32.9%	31.3%	32.6%	30.8%	21.0%	28.9%
Dementia - Find - monthly report	Trustwide	>90%		84.5%	87.1%	83.6%	90.7%	85.2%	86.1%	87.8%	81.7%	94.2%	91.4%	84.0%	97.0%	87.7%	88.1%
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		65.7%	58.1%	65.0%	61.5%	71.7%	70.3%	73.0%	78.3%	72.6%	79.6%	77.1%	77.7%	75.0%	73.0%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		45.1%	39.4%	49.1%	55.5%	52.7%	58.5%	46.2%	62.4%	59.0%	61.0%	57.8%	57.1%	49.8%	55.5%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		69.2%	62.8%	67.7%	64.4%	63.7%	61.9%	71.6%	73.9%	73.1%	77.3%	70.3%	69.2%	69.4%	69%
NHS I - FINANCE AND USE OF RESOURCES																	
EBITDA - Variance from Plan - cumulative (£'000's)	Trustwide			-19884	-21358	-394	306.9	300.2	300.3	-1292.5	-2397.4	-4860.6	-1016.8	-1528.8	-3805.7	-5610.5	
Agency - Variance Full Year Budget/spend cap (%)	Trustwide						159.3%	149.4%	161.7%	147.5%	155.3%	155.1%	154.0%	149.4%	145.5%	144.7%	
CIP - Variance from plan - cumulative (£'000's)	Trustwide			-5512	-3390	-449	17	2478	2485	2528	2528	463	2019	2117	-1068	-4202	
Capital spend - Variance from Plan - cumulative (£'000's)	Trustwide			944	-18162	-993	3619	1616	-515	1517	3267	6240	23869	26059	25718	28996	
Distance from NHSI Control total (£'000's)	Trustwide			-15796	-17186	22	0	0	0	0	0	2	3064.2	2060	2017	-30	

NHS
Torbay and South Devon
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Report to the Board of Directors			
Report title: Care Quality Commission Maternity Inspection Report and Action Plan			Meeting date: March 27th 2024
Report appendix:			
Report sponsor:	Chief Nurse		
Report author:	Director of Midwifery and Gynaecology		
Report provenance:	CQC report shared with Care Group and within the specialty. Full report shared with Executive team. Verbal briefing given at private Board meeting in February 2024		
Description/Purpose of the report and key issues for consideration/decision:	The aim of the report is to advise the Board of Directors on the current CQC Maternity inspection report and the Trust processes that have followed in the creation, monitoring, and management of the subsequent action plan.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The summary of the report is for information .		

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 is an external window, by our regulators into our compliance with the CQC fundamental standards, and progression against our strategies and targets in how we support the people of Torbay & South Devon to live well
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 and processes are a key facet in our regulatory requirements to meet the above triple aims.
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 4 - Estates Objective 5 - Operations and Performance Standards Objective 6 - Digital and Cyber Resilience Objective 7 - Building a Brighter Future Objective 8 - Transformation and Partnerships Objective 9 - Integrated Care System Objective 11 – Equality, Diversity and Inclusion
Risk: Risk ID: *As appropriate*	Risks regarding Maternity Triage, Theatre provision and Resuscitation equipment are already on the Risk register

External standards affected by this report and associated risks	Care Quality Commission report into the Trusts Maternity services via the fundamental standards and CQC regulations

Report title: Care Quality Commission Maternity Inspection Report and Action Plan		**Meeting date: 27th March 2024**
Report sponsor	Chief Nurse	
Report author	Director of Midwifery and Gynaecology	

1 Introduction

1.1 Aim

This paper's aim is to provide:

- An update on the recently published Maternity inspection
- An update on the CQC requirements regarding each Must do and Should do actions contained within the report.
- Identify the governance routes the action plan, and any exception reporting will follow.

1.2 Purpose

The purpose of this report is to advise the Trust Board on the CQC's Maternity inspection report and provide early signalling of the areas that are requiring actions to improve the care provided by them.

2 Background and Discussion

2.1 CQC Maternity inspection: November 2023

The CQC gave a 'short notice announcement' of 2 days, on the 17th of November 2023 of their intention to inspect the Trusts Maternity Services via an onsite inspection.

The rationale for the visit was as a requirement of the CQC's planned visits, of all the Maternity services within England, as part of their national inspection plan.

The CQC visited the Trust with 4 Inspectors and a specialist Obstetrician. The Inspection team talked to patients and staff, visited the ward/Outpatient/Theatre areas, observed care, and requested relevant data for the areas visited.

At the end of the inspection, the CQC lead Inspector Manager gave verbal feedback to the Executive team on their findings. This was then documented in a letter to the Chief Executive and included concerns around the provision of a dedicated second theatre team, triage risk assessment processes, resuscitation equipment and medical staffing levels.

The Trust called an extraordinary Board meeting and progressed its plans to immediately answer and address the issues the CQC identified through this meeting. The CQC accepted our action plan and mitigation to address the risks identified.

2.2 CQC Draft Report

On the 19th of January 2024, via the Chief Executive's office, the Trust received its embargoed draft CQC report. The report then underwent a period of factual accuracy

checks within the Trust, with the Trust checking and challenging several points of order, returning the document to the CQC on the 1st of February 2024.

Whilst embargoed, the Trust started to action plan any findings and requirements within the report. The Director of Midwifery and their management teams led this process.

The CQC, after discussions with the Trust and following factual accuracy changes released the final version of the report on the 21st of February 2024.

2.3 Findings by the CQC Inspectors

The CQC had not rated the Trust's Maternity services since 2020, when it was rated as requires improvement. Following the November 2023 inspection, the rating remained the same, but the CQC noted many improvements with the service since the last inspection.

The CQC rated Maternity well led as requires improvement because:

- Arrangements for a second theatre for emergency obstetric surgery and provision of an emergency theatre team may lead to delays for women and birthing people requiring emergency surgery.
- Not all equipment was in place or fit for purpose.
- Systems and processes for triage did not meet best practice guidance because there was no dedicated triage phone and no prioritisation tool to indicate the required clinical response and treatment.
- Staff did not consistently follow the trust's policies for 'fresh eyes' checks of cardiotocography (fetal heart rate) monitoring or modified early obstetric warning scores to identify and escalate women and birthing people at risk of deterioration.
- There were not always enough medical staff deployed to keep women, birthing people, and babies safe.
- Leaders, (Executive) did not always take swift action to address known risks in a timely way or take enough action to mitigate known risks.

However, the CQC also said:

- ✓ Staff had training in key skills and worked well together for the benefit of women and birthing people.
- ✓ Action was taken to retain and develop the existing workforce.
- ✓ Leaders used reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent.
- ✓ They were focused on the needs of women and birthing people receiving care.
- ✓ Staff were clear about their roles and accountabilities.
- ✓ The service engaged well with women and birthing people and the community to plan and manage services.

Maternity Must Do Enforcement Actions

As a result of the above, the CQC issued 8 Must Do improvement notices, this being a relatively small number of actions for a 'requires improvement' rating:

1. The service must operate clear triage processes to ensure the safety of women, birthing people, and babies. Regulation 12 (1)(2)(a)(b)

2. The service must ensure an on-site obstetric emergency theatre team are available to ensure women and birthing people have access to emergency surgery without delay. Regulation 12 (1)(2)(a)(b)

3. The service must ensure 'fresh eyes' checks of cardiotocography (fetal heart rate) monitoring are carried out. (Regulation 12 (2) (a) (b))

4. The service must ensure staff accurately complete, and document modified early obstetric warning scores to identify and escalate women and birthing people at risk of deterioration. (Regulation 12 (2) (a) (b))

5. The service must ensure there are enough medical staff deployed to keep women, birthing people and babies safe. (Regulation 18 (1)

6. The service must ensure the provision of enough equipment such as resuscitaires and cardiography machines Regulation 15 (1)(b)(c)(e)

7. The service must ensure all medical staff have up to date training compliance with safeguarding training. (Regulation 18 (2)(a))

8. The service must ensure effective governance and oversight of audits and action plans to improve performance and manage risks in the maternity service. (Regulation 17 (1) (2) (a) (b))

And 6 Should Do Actions:

- The service should ensure staff practise baby abduction drills.
- The service should ensure all equipment is cleaned, maintained, and stored in line with best practice infection and prevention and control policies.
- The service should ensure records of women and birthing people's care and treatment are accurate and accessible.
- The service should ensure medicine records are completed and storage temperatures are monitored.
- The service should ensure all staff must receive annual appraisals.
- The service should use data to identify when ethnicity or disadvantage affected treatment and outcomes.

2.4 Action Plan Oversight and Assurance

Maternity Services have created an informed and comprehensive action plan which has been agreed by the Families and Community Care Group and will be monitored by their governance and Quality group. The actions and action plan will also be monitored by the CQC Assurance Group for progression to closure and monitoring of exception

reports or deviation from agree time scales with reporting upwards to the board of any concerns.

2.5 Actions Taken to date.

- Dedicated triage telephone line in place. Improved pathways around assessment of risk embedded within electronic record.
- Allocated emergency theatre always identified.
- New CTG machines delivered in Dec 23 and in use.
- Delivery of new/replacement resuscitaire arrived on site in early March 2024
- Advert out for recruitment of 1 FTE consultant with business case progressing for recruitment of the additional posts.
- Audit frequency for assessment of “fresh eyes “altered and additional full day training on electronic fetal monitoring commenced in January 2024
- Actions completed from the 2023 Internal audit review of maternity governance processes – this will strengthen oversight and assurance.

3 Conclusion

This report has provided an update to the Board on TSDFT’s recent CQC maternity inspection activity, resultant report, and action plan by the Maternity service.

4 Recommendations

This summary Board report is for information only.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: The improvement plans developed in response to the results of the Care Quality Commission (CQC) NHS Patient Experience Survey programme for 2023.			Meeting date: March 27th 2024
Report appendix:	CQC Maternity Survey Action Plan 2023		
Report sponsor:	Chief Nurse		
Report author:	Director of Midwifery and Gynaecology		
Report provenance:	Feedback and Engagement Group Feb 2024 Quality Assurance Committee March 2024		
Description/Purpose of the report and key issues for consideration/decision:	The purpose of the report is to share with the Board of Directors areas of good practice and update on the improvement plans currently progressing to address the identified areas for development following publication of the Care Quality Commission (CQC) National Maternity Survey. The Board is asked to note that the Maternity Service achieved results that were the highest in the country for certain questions.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Board is asked to support the following recommendations: • To support the improvement plan aligned to the Maternity Survey 2023 and the areas for focused improvement. • To support the recommendation that the Feedback and Engagement Group will oversee and monitor the progress of both plans.		
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 details service user feedback and the action plan demonstrates the commitment of maternity services to listening and acting. Co-production of services including the voice of users is vital to enable the provision of safe care within maternity to support the people of Torbay and South Devon to live well		
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 women 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

Report title: Care Quality Commission (CQC) NHS Patient Experience Surveys Programme 2023 Reports. Namely the Maternity Survey	**Meeting date: 27th March 2024**
Report sponsor	Chief Nurse
Report author	Director of Midwifery and Gynaecology

1.0 Introduction

1.1 The Care Quality Commission (CQC) undertake several Patient Experience Surveys to support their programme of regulation, monitoring, and inspection of NHS acute Trusts in England. The survey field work for the Maternity Survey was focussed on all women receiving maternity care during January and February 2023 and is split into three key areas:

- Antenatal Care
- Labour and Birth
- Postnatal Care

Results were published in February 2024.

1.2 The aim of this report is to acknowledge where the maternity service has performed 'better than expected' and celebrate success, whilst also providing assurance to the board on the improvement plans being progressed in the areas as indicated. The Trust survey results provide an opportunity to gain greater insight and understanding of the experiences of women who use our maternity services and utilises this valuable feedback to reflect on services provided.

1.3 The detailed analysis of the survey was shared with the Patient Feedback and Engagement Group in February 2024 and this paper will focus on areas for improvement and the work planned and progressed to date to address these areas.

1.4 The Trust level benchmarking report which sets out the results of the Maternity Survey for 2023 was published on the 9th of February 2024. This is commissioned by the CQC, the independent regulator of health and adult social care in England. The CQC use the results from the survey in the regulation, monitoring, and inspection of NHS acute Trusts in England.

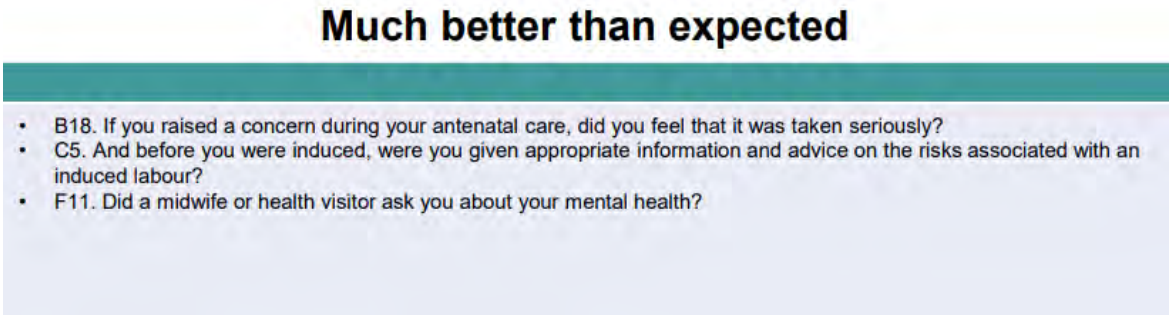
1.5 272 women who had experienced maternity services provided by Torbay and South Devon NHS Foundation Trust (TSDFT) in January and February 2023 were invited to take part. 131 responses were completed and submitted to CQC. The response rate was 51% which was higher than the 2022 response rate of 47% and the national response rate of 41%.

2.0 Summary of findings

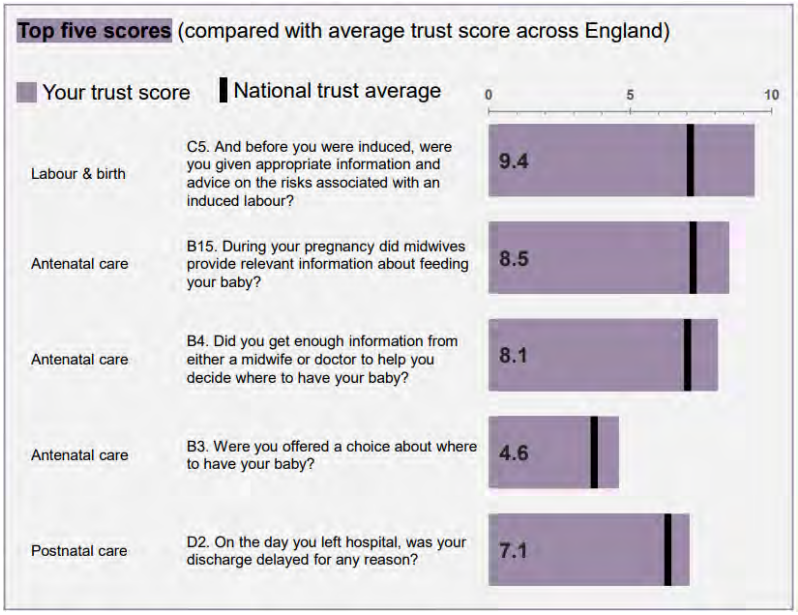
2.1 The table below indicates that in 16 of the 54 questions (30%) the maternity service performed better than other Trusts, with 37 (68%) answers aligning with other Trust responses and only 1 question (2%) where we performed worse than others.

2.2 In areas where care has been identified as 'Much better than expected', this is likely to be a result of the model of care our midwives provide, in that, the aim and philosophy of care is to build positive relationships with women and their families. This also reflects the positive achievement of relational care, women feeling they have informed choice about their care and feel able to raise any concerns. They also feel that their mental health was valued in the postnatal period.

For questions B18 and C5 (see below) we had results that were highest in the country.



2.3 Below is reflected the top five scoring questions compared to the rest of England. These questions include choice about where to have baby, information about infant feeding, induction of labour and timely discharge from hospital.

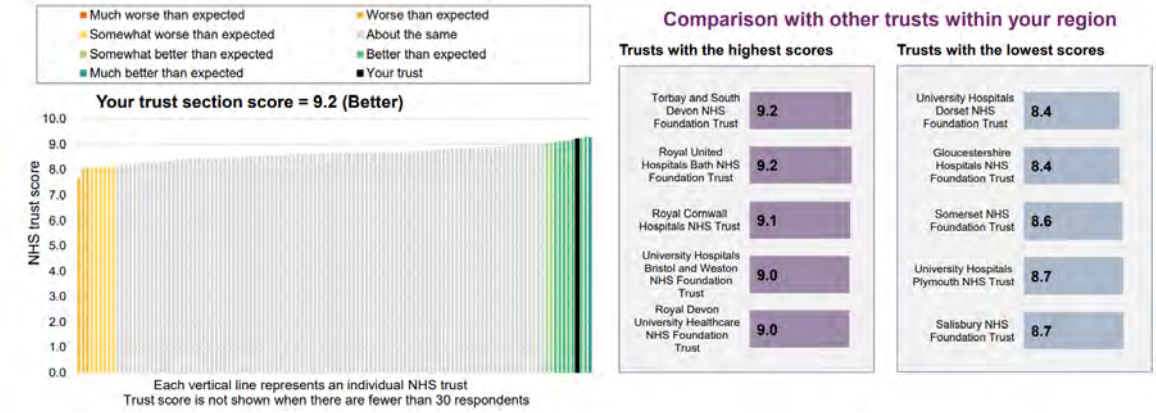


3.0 Antenatal Care

3.1 The antenatal care section of the survey is divided into three and the Trust was in the top 5 performers within our region for all sections.

- The start of your care during pregnancy (3rd)
- Antenatal check-ups (4th)
- During your pregnancy (1st)

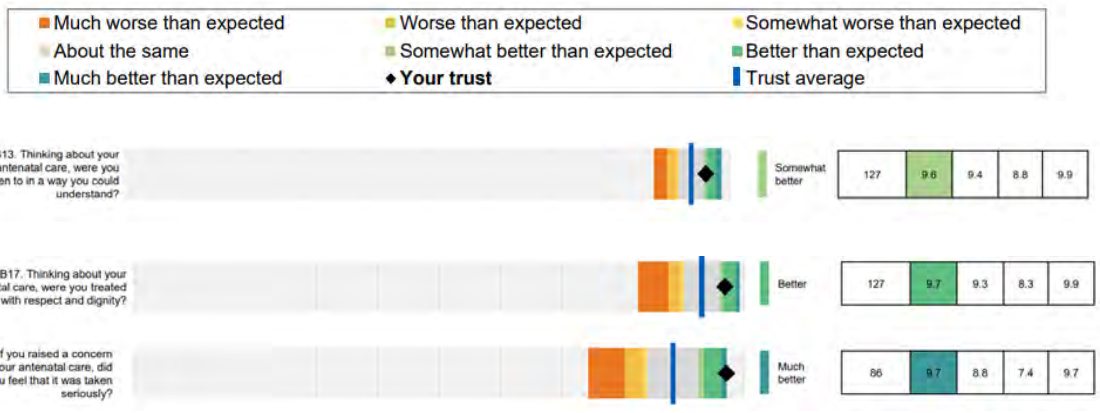
3.2 Survey results for the 'During your pregnancy' is seen below, each vertical line represents an individual NHS Trust across England, and demonstrates that TSDFT (Black, bold line) is with the highest score range and that we are the top performing Trust within our region.



3.3 Of the 14 antenatal questions, the trust scored higher than the national average in half of the questions and around the national average in the other half of the questions.

The Trust was rated highly in providing women and families with quality information and choices in the antenatal period which reflects our continued focus on personalised care and informed choice.

The Trust performed very well in our compassionate care, with women and families reflecting that their concerns were listen to, they were spoken to in a way they could understand and were treated with dignity and respect.

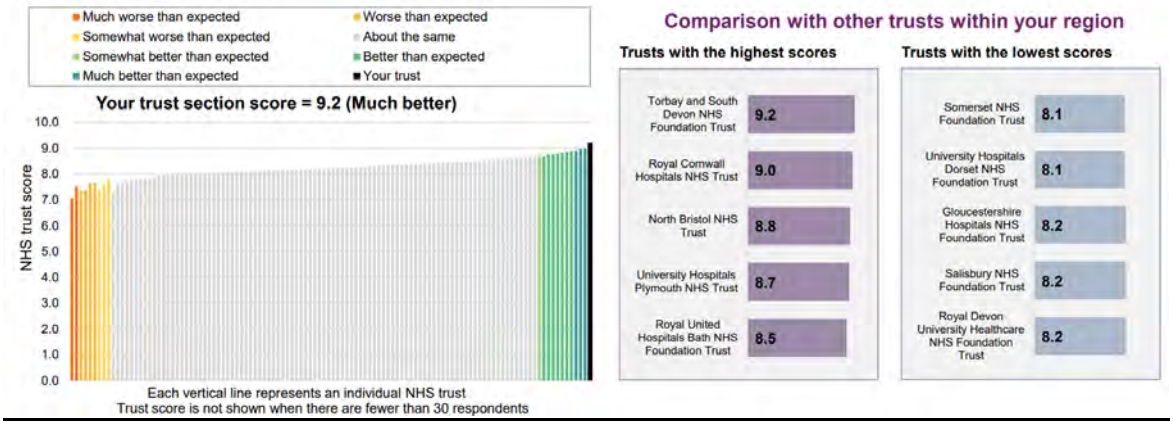


4.0 Labour and Birth

4.1 The labour and birth domain of the maternity survey is divided into three sections, and TDSDFT were in the top 5 trusts within our region for two sections.

- Your labour and birth (1st)
- Staff caring for you.
- Care in hospital after birth (5th)

4.2 Scores for 'Your labour and birth', were 9.2 the highest across the region and within England. Below is demonstrated the range of scores in our region and the TSDFT position.



4.3 Of the 24 Labour questions the trust scored higher than the national average in a third and in line with the national average in the other questions.

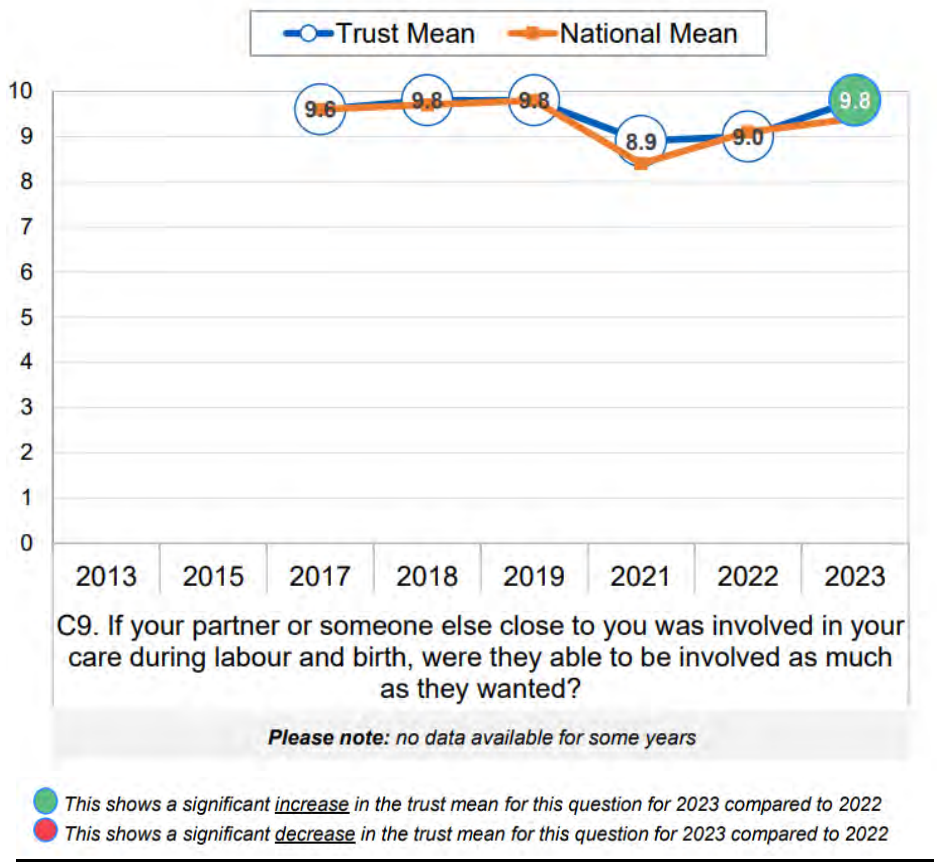
The same themes as in the antenatal care were reflected in the responses, with women and families feeling that they could make informed choices around their care. In all three questions relating to induction of labour the trust scored above average with the highest scoring in England for information about the risks of induction, a significant improvement on our 2022 results.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Your labour and birth											
C5.	And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?							9.4	7.6	43	▲
C6.	Were you involved in the decision to be induced?							9.6	8.9	43	
▼▲	Significant difference between 2023 and 2022										
Blank	No Significant difference between 2023 and 2022										

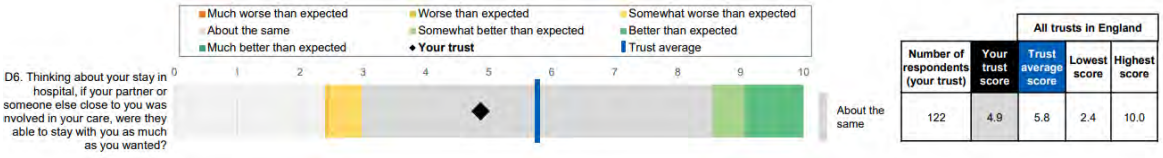
4.4 The Trust also scored highly for management of pain in labour and after birth which could be reflective of the introduction of self-administration of pain relief following birth which has been well received by service users.

D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?					Better	108	8.6	7.8	6.8	8.7

4.5 The table below shows the trend over time for the last six years for partners being involved in labour and birth care. For 2023 the maternity service was back to pre-pandemic levels for satisfaction for women having their chosen supporter in labour and birth.



4.6 The lowest scoring area in the survey relates to women being able to have their birthing partners stay with them on the ward.



	All trusts in England			
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
122	4.9	5.8	2.4	10.0

black diamond = TSDFT

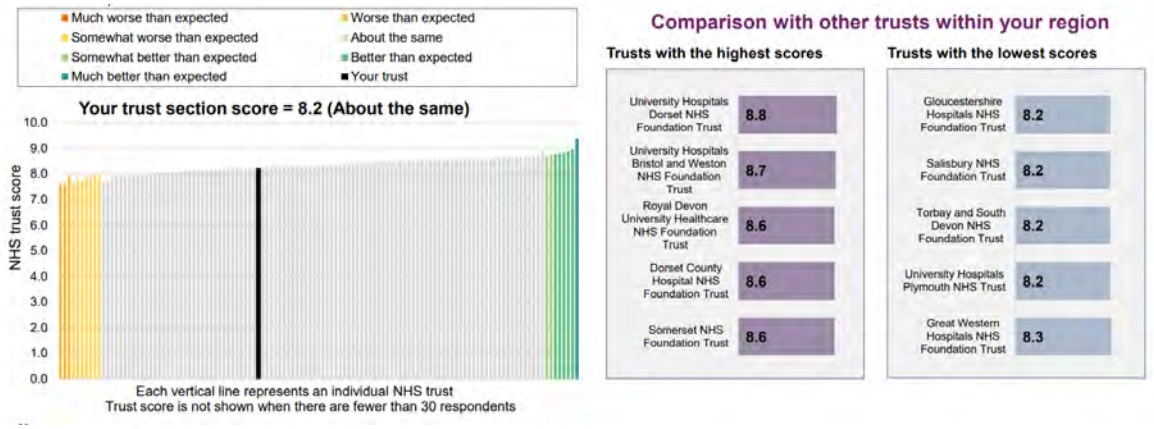
The visiting polices on the postnatal ward are continuously under review in collaboration with the Devon Maternity and Neonatal Voices Partnership (MNVP). Partners can stay 24hrs a day whilst in the side rooms, but this is not possible in the multi bedded bays. Further work is needed to prepare women in the antenatal period for a stay on the ward, so they feel more comfortable and supported.

5.0 Postnatal Care

5.1 The postnatal care section of the maternity survey covers two areas, and we were in the bottom 5 trusts within our region for feeding you baby.

- Feeding your baby
- Care at home after birth

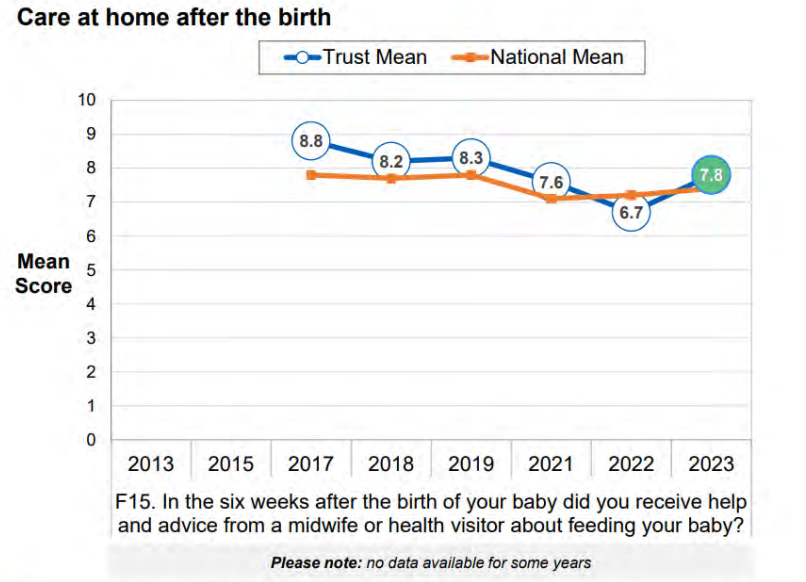
This section of the survey shows some positive survey scores but also some areas for the focus of our improvement plan.

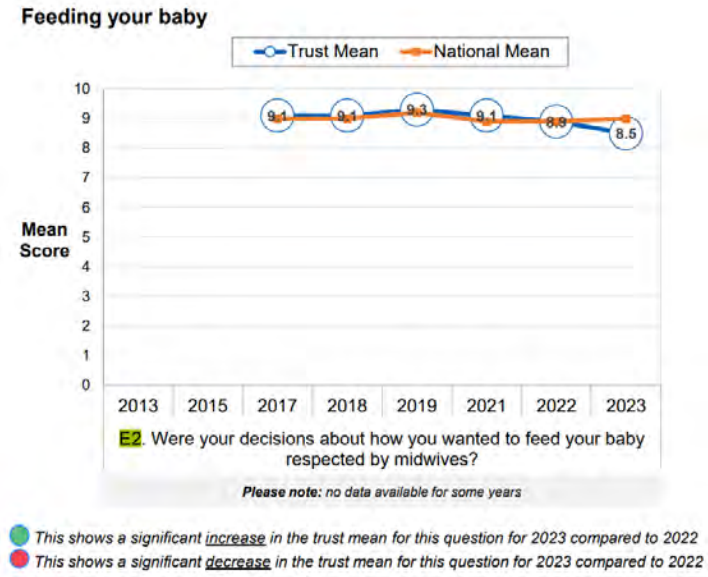


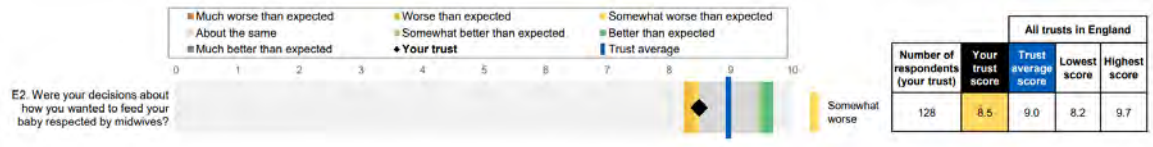
5.2 The following data refers to the questions that relate to infant feeding. There has been an improvement since last year on the feeding advice given in the six weeks after birth reversing the decline from the last 2 previous years. However, women did not feel their decisions about how to feed their babies were respected. This is a decline on last year, although not statistically significant, and below the national average.

The compliance with Infant feeding training declined during the pandemic due to restriction on face-to-face training. Since the survey in early 2023 the training compliance for infant feeding has increased significantly with now over 80% of all staff having received training and 100% of new starters undergoing training within 6 months of starting.

The latest Baby Friendly Initiative (BFI) survey of women in September 2023 shows that women were satisfied with the feeding support they received regardless of the Infant feeding choice. The Infant feeding lead midwife has worked with the Torbay Family Hub team to co-produce their Infant feeding strategy to ensure families continue to feel supported in the community with their feeding choices.

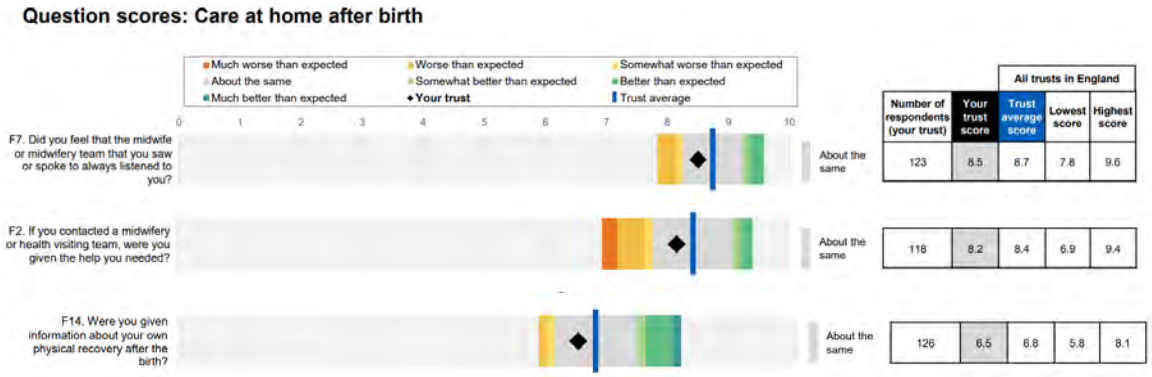


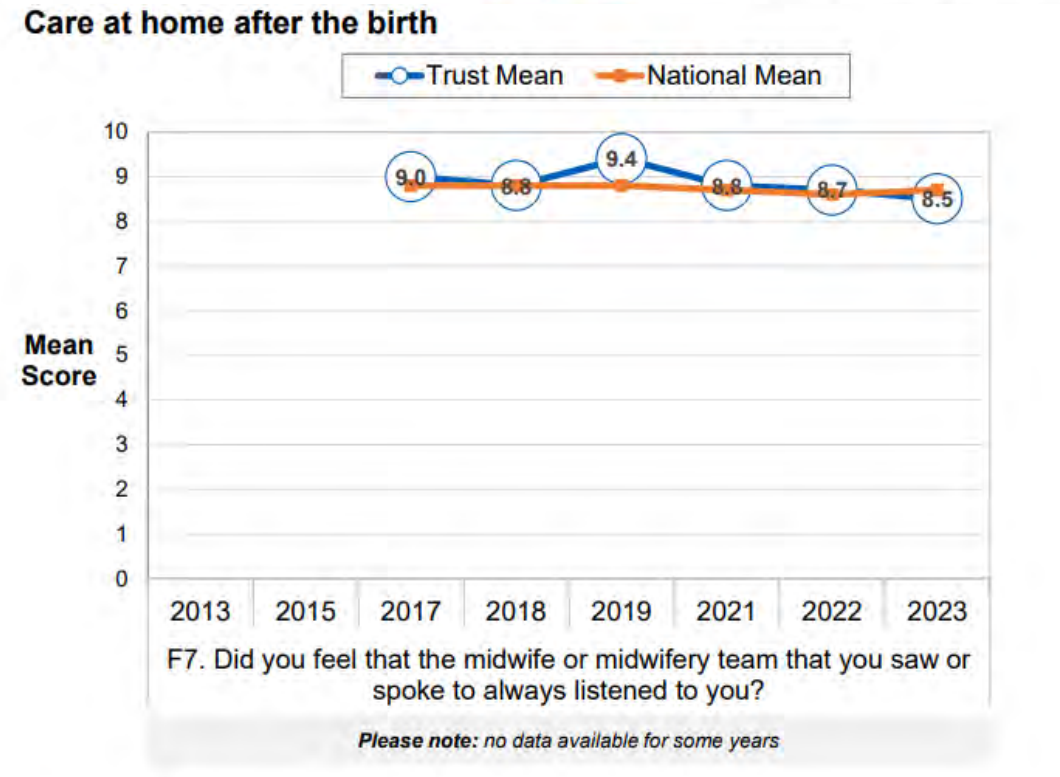




5.3 The Trust scored much better than the national average for enquiring about mental health in the postnatal period. This reflects the impact of bespoke mandatory training session delivered by the Perinatal Mental Health team in Devon. This has increased knowledge and understanding for all staff who then feel more confident to guide and signpost those needing additional support. The Torbay 0-19 team is also doing extensive work with improving access and support for both parents in addressing mental health needs after birth.

5.4 There are three areas of postnatal care at home that the Trust scored below the national average. The Trust model of midwifery care allows for excellent levels of continuity of carer in the antenatal periods leading to good outcome for women, however it has challenges in being able to offer that same level of care in the postnatal period. There needs to be a focus on improving continuity of carer into the postnatal period to see the benefits gained from building positive relationships with women and their families.



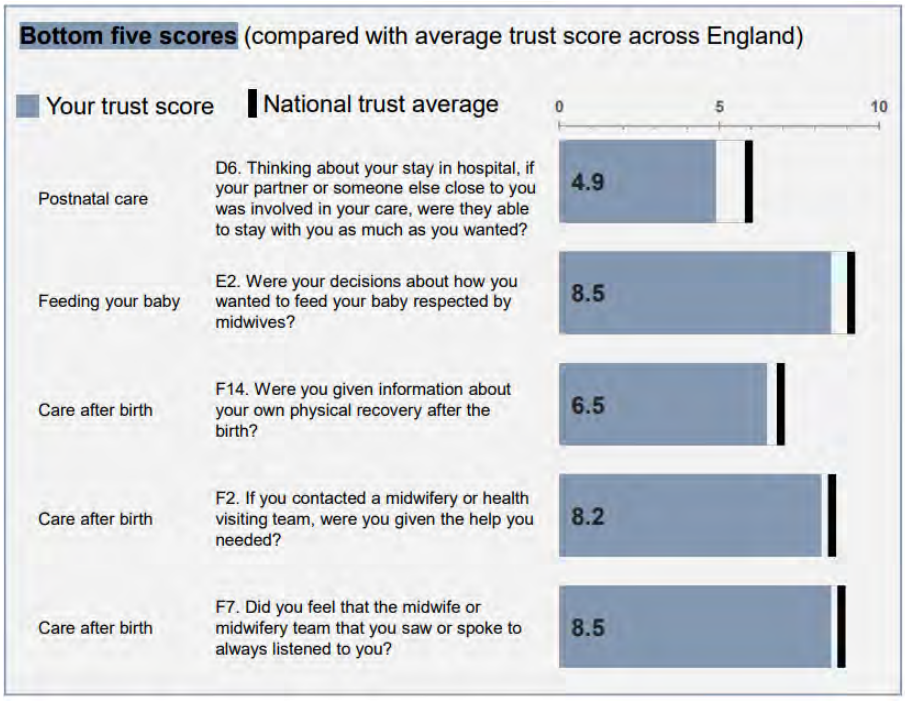


This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

6.0 Maternity Survey Improvement Plan

6.1.1 The improvement plan focuses on the five areas where the results were below the national average. The action plan is included as appendix 1. The action plan includes details of how we are planning to address and monitor these actions.



6.1.2 In the spirit of working collaboratively with users of our maternity service, we co-produced the CQC maternity survey improvement action plan with the Devon Maternity and Neonatal Voices Partnership (MNVP). We are working with them on several projects such as launch of a discharge video and an induction of labour consent form, information leaflet and video.

6.2 How will we measure improvement?

6.2.1 The action plan will be monitored and reviewed in collaboration with the maternity senior leadership team and MNVP.

6.2.2 Triangulation of feedback from concerns, compliments and complaints will occur as well as reviewing the feedback from the Friends and Family Test and the MNVP feedback questionnaire.

6.2.3 The midwives leading the Birth Afterthoughts clinic are collating feedback to review any themes or learning. Any additional actions to come from this review can be added to the action plan.

6.2.4 Involvement of the MVNP and senior walkabouts with operational matron, Deputy Director of Midwifery, Director of Midwifery and Maternity Safety Champions are in place to ensure informal and ad hoc contact with women to gain feedback.

7.0 Conclusion

7.1 The Maternity Survey 2023 provides the Trust with an opportunity to hear the voice of those using our services and understand their lived experience. The improvement plan will facilitate the Trust to enhance these services going forward.

8.0 Recommendations

8.1 The Trust Board is asked to support the following recommendations:

- To support the improvement plan aligned to the Maternity Survey 2023 and the areas for focused improvement.
- To support the recommendation that the Feedback and Engagement Group will oversee the progress of plans.

MNVP and Maternity Co-Produced CQC Maternity Survey 2024 Improvement Action Plan

Ref	Date created	Issue		TSDFT Score 2024	National Trust Average	Action	Lead	Deadline	RAG status	Governance Reporting Route	Monitoring and Evidence	Update
F14	07.03.24	Were you given information about your own physical recovery after the birth?	Care after birth	6.5	7	New QR tree's with all information launched. Ensure that there is a mechanism for these to be accessible away from the hospital so that information can be referred back to. Investigate the use of 'pagetiger' in maternity for additional information in a variety of formats.	Maternity Leadership Team, Transformation Midwives, Integrated Team Leads	30.06.24		Maternity Clinical Governance. Feedback and Engagement Meeting	Triangulate with any themes coming from feedback - concerns/complaints	
D6	07.03.24	Thinking about your stay in hopsital , if your partner or someone else close to you was involved in your care , were they able to stay as much as you wanted?	Postnatal care	4.9	6	We will improve communications antenatally via a targeted campaign to women and families to ensure we set expectations realisitically on visiting availibility. We will instigate a process to ensure that those those with greatest are offered a single room where clincial circumstances allow.	Maternity Leadership Team, named midwives, JM Manager, Integrated Team Leads, Comms department	30.06.24		Maternity Clinical Governance. Feedback and Engagement Meeting	Triangulate with any themes coming from feedback - concerns/complaints	
F2 / F7	07.03.24	Did you feel that the or midwifery team that you saw or spoke to always listened to you? / If you contacted a Midwife or health visiting team, were you given the help you needed?	Care after birth	6.5	7	Targeted support from band 4 Maternity Support Workers (MSW's) in the community will both free Midwives time to spend with women and listen to them whilst also increasing support for vulnerable families. Increased the amount of home visiting available in the post natal period to enable Midwives to provide care in settings conductive to listening and sharing information. The Health Visiting team are undertaking additional support for families via the Torbay Family Hub.	Maternity Leadership Team, named midwives, JM Manager, Integrated Team Leads, Comms department	30.06.24		Maternity Clinical Governance. Feedback and Engagement Meeting	Triangulate with any themes coming from feedback - concerns/complaints	
E2	07.03.24	Were your decisions about how you wanted to feed your baby respected by midwives?	Feeding your baby	8.5	9	The compliance with Infant feeding training declined during the pandemic due to restriction on face-to-face training. Since the survey in early 2023 the training compliance for infant feeding has increased significantly with now over 80% of all staff having received training and 100% of new starters undergoing training within 6 months of starting. Continue regular baby friendly initiative audits to ensure women continue to ensure families feel supported with their feeding choices.	Maternity Leadership Team, named midwives, JM Manager, Integrated Team Leads, Comms department	Closed		Maternity Clinical Governance. Feedback and Engagement Meeting	Triangulate with any themes coming from feedback - concerns/complaints	

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Maternity Workforce Oversight Report			Meeting date: 27th March 2024
Report appendix			
Report sponsor	Interim Chief Nurse		
Report author	Deputy Director of Midwifery and Gynaecology/Director of Midwifery		
Report provenance	This report is a summary of Midwifery and Obstetric Workforce within the maternity service. This reflects NICE guidance around safe staffing levels as well as recent Ockenden recommendations. This is monitored by the Maternity Governance and Service Group. Quality Assurance Committee – March 2024		
Description/Purpose of the report and key issues for consideration/decision	The purpose of the report is to provide an update to the Trust Board of Directors and provide assurance around systems and processes to ensure continuous monitoring and oversight around safer staffing levels as per NICE guidance, NG4 (2015). The guidance recommends that the maternity establishment is reviewed at Board level at least every 6 months. The Trust Board of Directors should note that following key issues: • The birth to midwife ratio falls well within the national recommendation of 1:28 • Excellent position in relation to % of women receiving one-to-one care in labour. • Good compliance with staffing levels meeting acuity levels (>90% of the time • There has been a reduction in the midwifery vacancy rate. • A service review has identified a shortfall of 4.0 WTE in the obstetric workforce.		
Action required. (choose 1 only)	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation	The Trust Board of Directors is asked to: • Note the ongoing improvements in midwifery workforce metrics and the influence of the retention midwifery role. • Note the mitigations to ensure safety and quality. • Note the ongoing service review of the Obstetrics and Gynaecology team. • Note the conclusion of the midwifery organisational change staff consultation regarding shift pattern alignment. • Note the impact that externally funded posts can have on the headcount within the establishment.		

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

2

Report title: Maternity Workforce Oversight Report		**Meeting date: 27th March 2024**
Report sponsor	Interim Chief Nurse	
Report author	Director of Midwifery and Gynaecology	

1.0 Introduction

This report covers the period from 1 July 2023 to 31 December 2023 and details compliance with the standards set out in national and regulatory frameworks (as set out below).

2.0 Context and Standards

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

The three-year delivery plan for maternity and neonatal services also includes workforce as one of its 4 key pillars (2023)

'Growing, retaining and supporting our workforce.'

The Clinical Negligence Scheme for Trusts (CNST) maternity incentive, Year 5, set out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows:

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

3.0 Midwifery Staffing Establishment

3.1 Birthrate Plus®

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

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

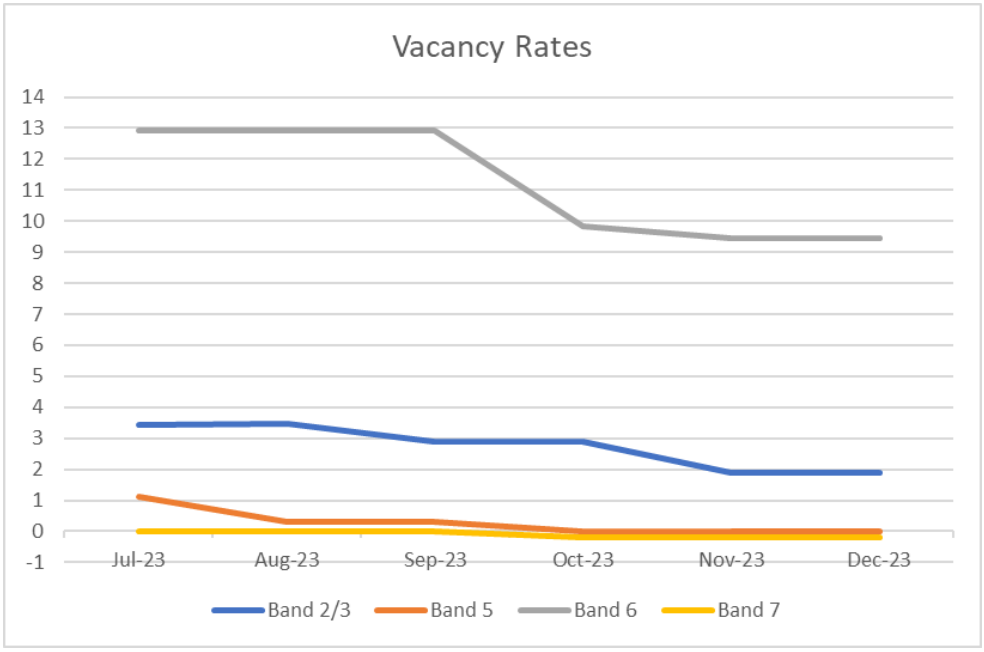
3.2 Monthly Establishment Review.

The midwifery establishment is reviewed monthly by the senior midwifery leadership team. Reviews are undertaken with the relevant team leaders within the maternity service to ensure that appropriate plans are made to recruit to vacant posts and identify teams with staffing issues, so that support can be provided where it is needed. Levels of long-term sickness and staff working non-clinical duties are also monitored to ensure efficient staffing cover in all areas of the service.

3.3 Recruitment

During the 6-month period covered within this report, we have seen a fall in the monthly vacancy rate, especially within the Band 6 Registered Midwives, from 12.93 in July to 9,46 in December 2023. The table below shows the rate across different bands of staff. (WTE vacancy rate is on left axis)

Chart 1



We had undertaken work with our People Business Partner to formulate a robust action plan for recruitment and retention, particularly of band 6 midwives. We had completed forward projections with an aim of reducing our midwifery vacancy factor to 8.64wte at the end of Quarter 2. At the end of this reporting period, in December 2023, the vacancy factor for band 6 midwives was 9.46wte, compared to a vacancy factor of 13.23wte in June 2023. Whilst slightly behind the projected timescale, this demonstrates that we have achieved a reduction very close to our original target.

The vacancy rate reflects the national picture of midwifery establishment and difficulties recruiting into midwifery posts, in particular band 6 midwifery posts.

In Torbay and South Devon NHS Foundation Trust, work has been ongoing to recruit to Band 5 preceptorship posts with the aim of growing the future workforce and readying them for band 6 midwifery positions. This group of staff have been provided with additional support from the Retention and Education Lead Midwives, to support them early in their career and, therefore, avoid attrition. This includes Resourcefulness Adaptability and Wellbeing (RAW) training which is funded in work time for all early career midwives. In addition, a Preceptee away day is planned for February 2024, which includes a relaxation/wellbeing morning and team building afternoon with a psychotherapist from Devon Wellbeing Hub.

Chart 1 shows the ongoing stability within the band 5 workforce which may be a direct result of the support that has been provided to them.

Maternity services nationally continue to receive additional funding for specialist posts. This creates further temporary vacancies locally, by the provision of fixed term specialist midwifery posts that have been filled by internal staff. In addition, we have faced challenges in backfilling these roles, due to their temporary nature. For this reason, temporary vacancies resulting from these fixed term posts have had to be covered using bank staff and staff working additional hours. Most of this funding is provided on a fixed term 12 monthly basis, and, currently, we are unable to obtain further information regarding the long-term provision of these funds.

Of note this can also result in an increase in overall headcount within this establishment. This may impact on the requirement for the Trust to reduce headcount as part of the NHS oversight framework.

3.4 Retention

NHSE have confirmed that funding will be provided for the retention lead midwife post until March 2025, please note, with effect from January 2024, this role will be taken over by one post holder working 0.8wte.

A large focus of the work of the retention midwives during this reporting period has been on culture and civility work, this has included oversight of the Maternity and Neonatal SCORE survey, which was completed in December 2023. A ‘change team’ have been identified to lead any work required after the results have been received and training has been planned for this team. The retention midwife will also work alongside the Quadrumvirate in planning and disseminating any learning from the survey.

A major part of the retention work is developing the A-Equip programme within maternity. There are a group of 10 PMAs (Professional Midwifery Advocates) and a Lead PMA has now been nominated.
The PMA team are now providing support for the whole maternity team not just midwives, through the provision of:

- Group RCS (Restorative Clinical Supervision)
- Monthly themed RCS

- Providing regular group RCS for teams such as: admin, junior doctors, community teams.
- Individual RCS.
- Social activities including group walks.

Work is commencing to introduce a behaviour charter within the maternity service. This will involve a charter containing a set of behaviour standards that everyone agrees and has been inspired by a charter developed in Salisbury, this will be developed with the involvement of all staff in maternity. The plan is to pilot this scheme within maternity and then roll it out across the Trust. This is being facilitated in collaborative with the Trust work around compassionate leadership.

There has been ongoing work by the retention midwives to provide additional support to service users, including the development of a 'Birth Afterthoughts Clinic', which runs weekly and provides women with the opportunity to discuss their birthing experience and ask any ongoing questions they may have and the creation of a Free birthing film which involves women who have chosen to freebirth, talking about their experiences and decision making. The aim is that this video will be used as an educational tool for maternity staff and university midwifery students. This video is to be shared regionally and nationally through the Chief Midwifery Officers.

3.4.1 Birth to Midwife Ratio (table 1)

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

The current national recommendation is a ratio of 1:28 midwives.
Between July 2023 – December 2023 there was an average birth rate per month of 146 births. This is a slight increase from the previous reporting period of 142 births per month.
This has resulted in a Midwife to Birth ratio as displayed in Table 2. The birth to midwife ratio falls within the national recommendation.

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

Regional discussions are ongoing about the value of birth to midwife ratio as the use of acuity tools to monitor optimum staffing levels are deemed to be more reliable and useful.

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

Time period	Midwife: Birth Ratio
Jul 23	1:20
Aug 23	1:18
Sept 23	1:19
Oct 23	1:22
Nov 23	1:20
Dec 23	1:18

3.4.2 Nationally Mandated Workforce Models across Maternity Pathway

In addition to the above, there have been several national trajectories that have been set by NHSE in relation to the provision of maternity care. This resulted in the need to redesign our midwifery service, to meet the requirement that most women receive continuity of carer (MCoC) from a small team of midwives with a ratio of 1.36.

The Birthrate Plus® review undertaken in November 2020 took this into account and, therefore, identified the increase in midwifery establishment to meet this need. Work is ongoing to increase the midwifery workforce within the community teams including allocating preceptee midwives to community teams within the service.

The consultation that was undertaken to align the hospital and community shift patterns, has completed. A new system which aligned these shifts and terminated the on-call model of care was implemented in November 2023, this has addressed much of the staff feedback that had been collated over the last 2 years. Work is now being undertaken by the PMAs and Retention Midwives to evaluate the new system and its impact on staff.

The three-year delivery plan specifies the need for a maternity specific workforce strategy to be in place. The Director of Midwifery is progressing this in conjunction with the care group people partner.

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

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

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

Time period	%
Jul 23	100%
Aug 23	100%

Sept 23	100%
Oct 23	100%
Nov 23	100%
Dec 23	100%

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

5.0 Obstetric Workforce

The capacity of the obstetric workforce has been significantly challenged during this reporting period; this has been further exacerbated by is the requirement to ensure a standard operating procedure (SOP) for the implementation of compensatory rest by consultants after an on-call period (this relates to the purpose of self-certification for the Maternity Incentive Scheme - CNST). This issue has been raised by the Clinical Director for O&G, who is also one of the maternity safety champions and an options appraisal briefing paper was drafted and discussed with senior medical staff and executives within the trust regarding additional O&G Consultant staffing. A full-service review around capacity and workforce within the speciality concluded in October 2023. The recommendation was that an uplift of 4.0 WTE consultants was required and, as a result, the Trust Executive have approved progression of the business case. At the present time 1.0wte consultant post has been advertised.

The required uplift was also noted as part of the November 2023 CQC maternity inspection and the requirement to ensure sufficient medical staffing is a CQC ‘Must Do ‘action.

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

6.0 Red flags

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

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

Table 3

Red flag	Descript	Incidence						
		Jul	Aug	Sep	Oct	Nov	Dec	Tot
RF1	Delayed or cancelled time critical activity	0	0	0	0	0	0	**0**
RF2	Missed or delayed care	1	0	0	3	0	1	**5**
RF3	Missed medication	0	0	0	0	0	0	**0**
RF4	Delay in providing pain relief	0	0	0	0	0	0	**0**
RF5	Delay between presentation and assessment	0	0	0	0	0	0	**0**
RF6	Full clinical examination not carried out when presentation in labour	0	0	0	0	0	0	**0**
RF7	Delay of ≥2 hours between admission for induction of labour and beginning of process	0	0	2	0	0	0	**2**
RF8	Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	**0**
RF9	121 care in labour	0	0	0	0	0	0	**0**
RF10*	Unable to facilitate out of hospital birth	3	4	4	2	1	0	**14**
RF11	Coordinator unable to maintain supernumerary status- providing 1:1 care in Labour	0	0	0	0	0	0	**0**
RF12	Coordinator unable to maintain supernumerary status - Not providing 1:1 care	3	4	2	5	3	0	**17**
	Totals	**7**	**8**	**11**	**10**	**4**	**2**	**42**

From our analysis of the system, red flags generally occur at times of high acuity. The Maternity Matron reviews any red flag events and discusses these with the Delivery Suite Co-ordinator, where relevant, using the same process as the supernumerary status. The red flags are also discussed at the daily safety huddle and mitigations to address them are enacted. There has been an increase in the number of red flags reported in this period from **26** to **42** in the last bi- annual report.

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

The second most common reason relates to our inability to provide an out-of-hospital birth. This is often due to the requirement to have two staff members attend a home birth/out of hospital birth experience. These two leading themes are the same as those outlined in the last bi-annual report.

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

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

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

The ongoing ambition is to achieve 100% supernumerary status for the Delivery Suite Coordinators. Table 3 (above) demonstrates our compliance with this ambition for the period July to December 2023.

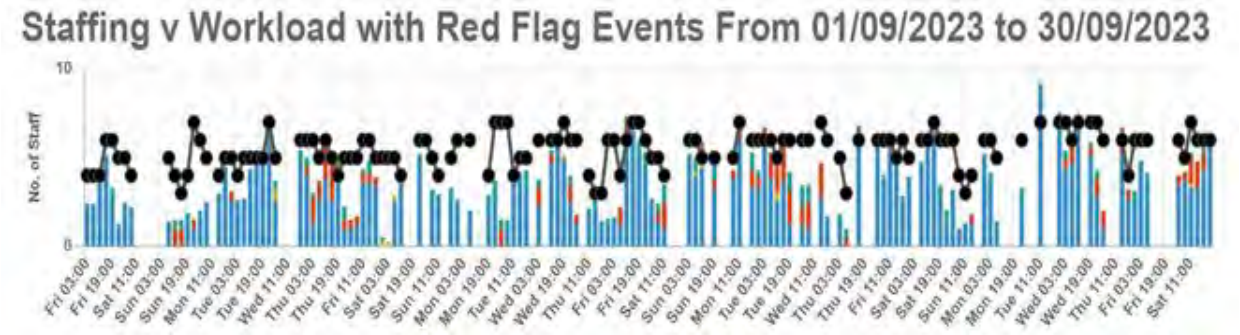
From March 2023 there was an additional red flag added (as displayed in table 4) to report the compliance with supernumerary status if caring for women who do not require constant observation (e.g., when relieving for breaks etc) This must not be on a regular or recurrent basis. During the 6-month period there were 17 reported incidents, this equates to an average of less than once a week and is, therefore, not a regular occurrence.

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

7.0 Acuity Data

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

Chart 1: Staffing v Workload Example



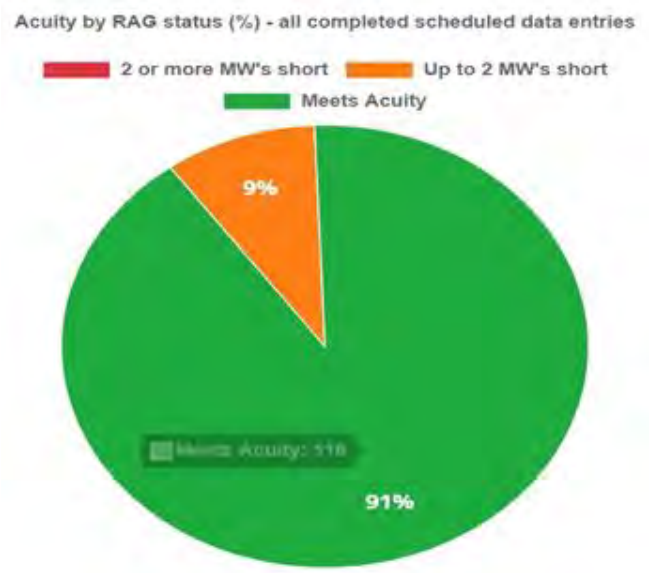
On the above bar chart, the individual bars represent the total number of women on the Delivery Suite. Each woman is categorised into a colour, blue in labour and requiring 1 to 1 care in labour or antenatal high risk, yellow relates to low risk postnatal women, red to high-risk postnatal women, green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

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

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

The data for this period indicates that staffing levels were more than 2 midwives short (Red) 0% of the time during the month and that 9% of the time staffing levels were up to 2 midwives short. (Amber) Therefore staffing levels met the acuity levels 91% of the time.

Chart 2: Staffing levels met acuity



In summary, acuity was met for > 91% of the time, with August and October 2023 being the exceptions at 87% and 89% respectively.

A review of the dashboard data for August and October does not highlight any deviations in birth rate or activity. Despite ongoing vacancies, we have managed to maintain this metric by use of bank staff and staff working additional hours.

Table 4: Acuity percentages

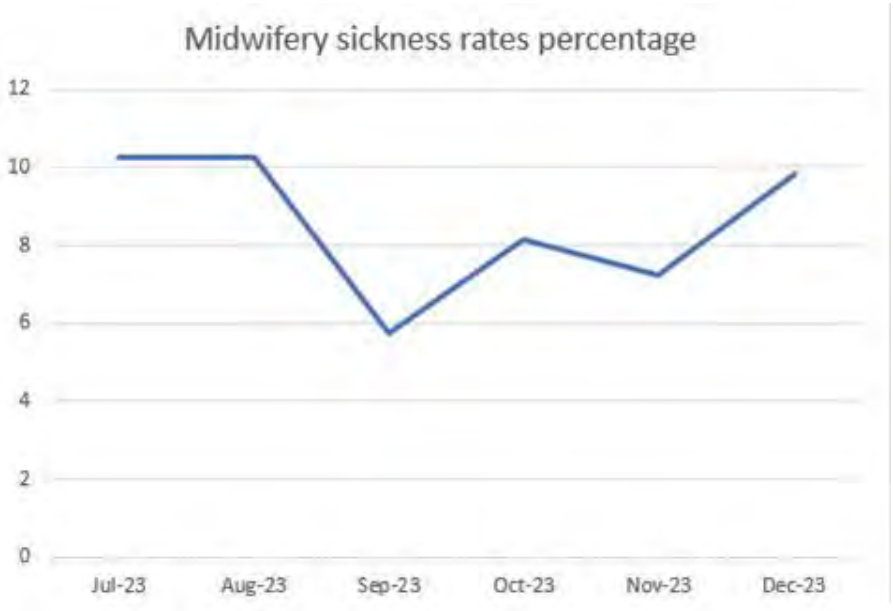
Time period	%
Jul 23	91%
Aug 23	87%
Sept 23	91%
Oct 23	89%
Nov 23	92%
Dec 23	93%

8.0 Sickness

Whilst there was a fall in sickness rates in September 2023, the remaining months in this reporting period show raised levels of sickness absence within the maternity service.

Targeted support is being provided to staff following long term absence, including flexibility and adaptations to working patterns to support staff with ongoing health needs and tailored phased return plans. Further support has also been provided to staff by the Retention Midwives and Professional Midwifery Advocates (PMAs).

Chart 4: Midwifery Sickness Percentage



9.0 Escalation and Interventions to Assure Safety

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

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

10.0 Conclusion

Following the service-wide consultation regarding the on-call model of care, a new shift system has been introduced and is becoming well-embedded. Work is being undertaken by the PMAs and Retention Midwives to evaluate the new system and its impact on staff.

The Obstetrics and Gynaecology medical service review has evidenced a gap in service provision and work is now being undertaken to address this by active advertising and potential recruitment to new Consultant posts.

The senior professional leadership team will continue to work with workforce and the finance team to ensure we strengthen, and triangulate service-held maternity establishment data to ensure accuracy of funded establishment. The staffing against acuity data remains stable and demonstrates the service's ability to meet acuity, even with continued vacancies. A deeper analysis of the reasons behind this will be considered now that the consultation on shift alignment has been completed. This may mean result in the need for a further workplace establishment review to ensure accuracy of updated requirements for the service.

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

11.0 Recommendations

The Trust Board of Directors is asked to:

- Note the positive influence of the retention midwifery role.
- Note the mitigations to ensure safety and quality.
- Note the conclusion of the service review of the Obstetrics and Gynaecology team and actions being taken to address this.
- Note the conclusion of the midwifery organisational change staff consultation and new shift pattern alignment that has been introduced.

- Note the impact that externally funded posts can have on the headcount within the establishment.

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Report to the Trust Board of Directors		
Report title: Safe Staffing 6-month Review (July 23 – December 2023)		Meeting date:27th March 2024
Report appendix:	Appendix 1: Nursing and Midwifery Workforce Strategic Framework Appendix 2: E Rostering KPI's Appendix 3: Care Hours per Patient Day Appendix 4: Safer Staffing – Planned versus Actual	
Report sponsor:	Chief Nurse	
Report author:	Head of Nursing Workforce	
Report provenance:	Quality Assurance Committee March 2024	
Description/Purpose of the report and key issues for consideration/decision:	The purpose of this paper is to provide assurance to the Trust Board of Directors that processes are in place to ensure nursing and midwifery workforce safe staffing levels, across the clinical inpatient settings to ensure high quality care and excellent outcomes for patients. The publication of the NHS Long Term Workforce Plan 2023 is an opportunity to improve staffing and patient care. It sets out the strategic direction for the long term, as well as action to be taken locally, regionally, and nationally to address current workforce challenges. Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. This report covers the six-monthly reporting period of July 2023 to December 2023 and contains a range of data that provides assurance of safe staffing levels at Torbay and South Devon NHS Trust clinical Inpatient wards. • 6-monthly report on nurse staffing levels • Safe Staffing Policy and Framework • Community Staffing workforce planning • Safer Staffing Establishment (Nursing) • Care Hours Per Patient Day (CHPPD) • Safer Staffing – Planned versus Actual • Vacancies • Temporary Staffing and Controls (Nursing) • Nursing recruitment pipeline • E-Rostering, Acuity and Dependency and Red Flag The assurance of the safer staffing workforce metrics and Rostering data is monitored monthly at the Nursing, Midwifery and AHP workforce council, which is chaired by the Chief Nurse.	

	Although it has remained a challenge to maintain optimum staffing levels, actions taken have provided appropriate mitigation to maintain clinical safety and workforce is appropriately assessed and monitored to ensure safe staffing levels.		
Action required:	**For information ☐**	**To receive and note ☒**	**To approve ☐**
Recommendation:	The Trust Board of Directors is asked to: • Receive and note the content of this report. • Be assured that safe staffing levels have been maintained during the last 6 months. • Note the mitigations and action plans in place.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	Improving the quality of care for patients and people is the driving force behind everything we do. Providing high quality care to everyone who uses health and care services that are sustainable and well led. This report demonstrates how the organisation set out the framework in which decisions about staffing puts patients first.		
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 Objective 9 - Integrated Care System Objective 11 – Equality, Diversity and Inclusion		
Risk: Risk ID: *As appropriate*	Board Assurance Framework Risk score 16 Risk Register Risk score 16		
External standards affected by this report and associated risks	Care Quality Commission NHS Improvement National policy/guidance		

Torbay and South Devon NHS Foundation Trust

Report title: Safe Staffing 6-month Review (July 23 – December 2023)		**Meeting date:** 25th March 2024
Report sponsor	Chief Nurse	
Report author	Head of Nursing Workforce	

1.0 Introduction

The purpose of this paper is to provide assurance to the Trust Board of Directors that processes are in place to ensure nursing and midwifery workforce safe staffing levels, across the clinical inpatient settings and the quality of care delivered.

In 2021 NHSI published the Nursing Workforce Standards, which builds on the NQB guidance and includes recommendations on workforce standards to strengthen the commitment to safe, high-quality care. Evidence show that having the right numbers of nursing staff, with the right skills, in the right place, at the right time improves health outcomes. *The nursing workforce is the most important factor in the provision of safe, effective, high quality compassionate care. NMC Nursing Workforce Standards (2021)*

Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. NHS England issued joint guidance to Trusts on publishing staffing data.

- Report and publish a monthly return to NHSE/I indicate a planned and actual nurse staffing level by ward.
- Publish information with the planned and actual registered and unregistered nurse staffing for each shift.
- Provide a 6-monthly report on nurse staffing to the Trust Board

The Board acknowledged the Safe Staffing 6-month Review paper (January 23 - June 23) in September 23, and this provided assurance that safe staffing levels had been maintained. This report covers the six-monthly reporting period of July 23 - December 23 and contains a range of data that provides assurance of safe staffing levels at Torbay and South Devon NHS Foundation Trust clinical Inpatient wards.

2.0 Context

The current sustained operational pressures across the system continue to have an impact on safer staff demand and capacity in Torbay and South Devon NHS Foundation Trust. When there are not sufficient nurse staffing levels, staff are deployed to ensure patients receive safe and effective care.

In 2023 the Trust received the temporary staffing controls and interventions directive to reduce temporary staffing spend. Tighter control and grip interventions have been implemented to support decisions around safer staffing and the nursing workforce. The Care Groups have been monitoring temporary staffing spend within their services.

The vacancy position for nurses, midwives and health care support workers remains at a consistent level. The delivery of a robust workforce strategy will provide a framework for building upon the provision of a safe skilled workforce.

2.1 National context

The number of people aged over 85 is estimated to grow by 2037, as part of a continuing trend of population growth, it is forecast to leave us with a shortfall of staff by 2036/37. The lack of a sufficient workforce, in number and mix of skills, is already impacting patient experience and productivity (*NHS Long Term Workforce Plan, 2023*). The publication of the NHS Long Term Workforce Plan is an opportunity to improve staffing and patient care. It sets out the strategic direction for the long term, as well as action to be taken locally, regionally, and nationally to address current workforce challenges.

The NHS Long Term Workforce Plan sets out a 15-year plan to change and improve new ways of working. Growing the workforce for the future, leading new ways of working and developing people and managing talent. The plan focusses on the three areas where we will act to ensure that the NHS has the workforce it needs for the future (*NHS Long Term Workforce Plan, 2023*).

2.2 Priority areas:

- **Train**: significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more doctors and dentists, more nurses and midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.
- **Retain:** ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.

- **Reform**: improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

3.0 Safe Staffing

Safe staffing levels in the clinical nursing inpatient's wards in both the acute and community setting are monitored and any risks mitigated during the twice daily nursing staffing meetings. The staffing meetings are chaired by a nominated matron and the Head of Nursing Workforce is present for any staffing escalation. The nursing daily staffing exception report, which is completed following the meeting, gives a status overview of staffing levels for each care group area.

The functions of the Allocate and SafeCare systems are used to support informed decision making, to ensure the effective management and redeployment of clinical staff to achieve safe levels, mitigate and articulate any risks as they arise. All clinical staff should feel supported and able to raise any concerns with staffing levels at these meetings and all actions taken before the meeting closes.

The assurance of the Trust safer staffing workforce metrics and rostering data is monitored monthly at the Nursing Midwifery and AHP Workforce Council, which is chaired by the Chief Nurse.

3.1 Governance and controls

To ensure robust governance and visibility of safe staffing levels

- Daily nursing staffing meeting and staffing exception reporting
- Monthly E-Rostering Key Performance Indicators (KPI's) reports
- Monthly Nursing, Midwifery and AHP workforce Council
- System wide workforce controls (ICB)

The following staffing RAG matrix will determine the level of clinical safety within the clinical areas daily and will form part of the overall status.

Level	Descriptor	Description
Low Risk	Business As Usual	Normal Staffing Rations RN: Patient 1:1 – 1:8 No Red flags Acuity and Dependency expected within area
Heightened Risk	Patient Safety & Quality Compromised/Impact on service delivery	RN:Patient : 1:9 - 1:12 SCBU1-2 HDU, 1-6 LC 1-3 HDU 1-5/6 Red flags identified in all areas Acuity and Dependency elevated above expected within area Staffing Escalation plan reviewed and actioned
Significant Risk	Clinically Unsafe/Unable to deliver a service	RN:Patient : 1:13 - 1:15 SCBU1-4 HDU 1-4 LC 1-4 HDU 1-7 Red flags identified in all areas Acuity and Dependency elevated above expected within area Staffing Escalation plan in effect
High Risk	significant clinical risk and inability to deliver all services	RN:Patient : 1:16 - 1:19 SCBU1-5 HDU 1-3 L/C 1-5 HDU1-8 Red flags identified in all areas Acuity and Dependency elevated above expected within area Staffing Escalation plan in effect
Highest Risk	significant clinical risk and inability to deliver all essential services	RN:Patient : > 1:20 SCBU >1-8 LC >1:20 Red flags identified in all areas Acuity and Dependency elevated above expected within area Staffing Escalation plan in effect

3.2 Policy, Procedure, Framework

The policies and guidance are intended to provide a structure and framework to address the daily pressures managed within existing resource and workforce needs. These workforce needs are driven by a range of factors, including acuity of daily care needs, skill mix and safer staffing rostering practices to meet service needs and to provide assurance around safe staffing.

- *Winter Safer Staffing Risk Mitigation and Escalation Framework* Nursing Framework to ensure safe, sustainable and productive workforce planning
- *Flexible Workforce Strategy* Framework sets out four levels of responsibility and accountability for temporarily redeployed staff
- *(TSDFT) Nurse Staffing Meeting, Standard Operating Procedure (SOP)*
- *Service Managers Unsafe Staffing Escalation* Utilised during Industrial action
- *Incident Control Centre Tactical Control Managers Guidance – Unsafe Staffing Escalation* Utilised during Industrial action
- *Torbay and South Devon NHS Foundation Trust (TSDFT) Roster Management Policy (V1)*

3.3 Clinical Nursing Inpatient Staffing Establishment review (2023)

A robust review of clinical nursing inpatient ward staffing establishments has been undertaken in line with national guidance and incorporating professional judgement to agree safe staffing levels. Working with the Care Group ADNPP's, Finance and Chief Nurse the Clinical Inpatient Staffing Establishment review began in November 2023.

4.0 Community Staffing

The Community Nursing Safer Staffing Tool (CNSST) has been implemented in the Torbay and South Devon Foundation NHS Trust Community Services.

The CNSST Tool is an evidence-based workforce planning tool that supports the establishment review process in adult community nursing teams. The tool captures patient care needs to ensure that the number of staff within the team is sufficient to provide optimal care. To use the tool each member of staff will need to score each contact during the seven-day census (data collection) period.

4.1 CNSST Training

Staffing Lead and Education Team developed the CNSST Tool Training on the E-Learning platform HIVE for Go Live date 1st February 2023. The CNSST training provides the guidance on the use of the tool and an assessment for completion. On completion of the CNSST training staff will be able to navigate the tool and use within their services.

4.2 CNSST Seven Day census (data collection)

Every member of staff working in the team uses either the rapid or detailed decision matrix to assign a dependency/acuity category (ranging from 1 4) to each patient contact every day for seven days (the census period).

It is recommended for a second Seven-day census (data collection) period and data analysis for the Torbay and South Devon Foundation Trust Community Teams in 2024. NHSE/I recommend at least 2 data sets.

5.0 Care Hours Per Patient Day (CHPPD) Trust Position

The CHPPD calculation measures the combined number of hours of care provided to a patient over a 24-hour period by both nurses and healthcare support workers. This measure has been used to provide assurance externally of staffing levels and is published monthly. Appendix one CHPPD data for December 2023.

5.1 CHPPD

CHPPD data for registered nurses (actual RN) for the Trust is showing a December 2023 position reported as 4.21 but remains below the carter recommendation of 4.7.

The actual HCA current position of CHPPD data was 3.86 in December which remains above the carter recommendation of 2.91. This is due to the increased need for HCSW to provide 1:1 supportive observation care.

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.

5.2 Safer Staffing – Planned versus Actual

The Registered Nurse fill rate for days during December was 96.1% which is a decrease on 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%. Appendix two Safer Staffing – Planned versus Actual (December 2023)

The fill rate for Health care support workers for days during December is 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 Health Care support workers at night is to mitigate any risks associated with the registered nurse fill rate.

6.0 Acuity and Dependency

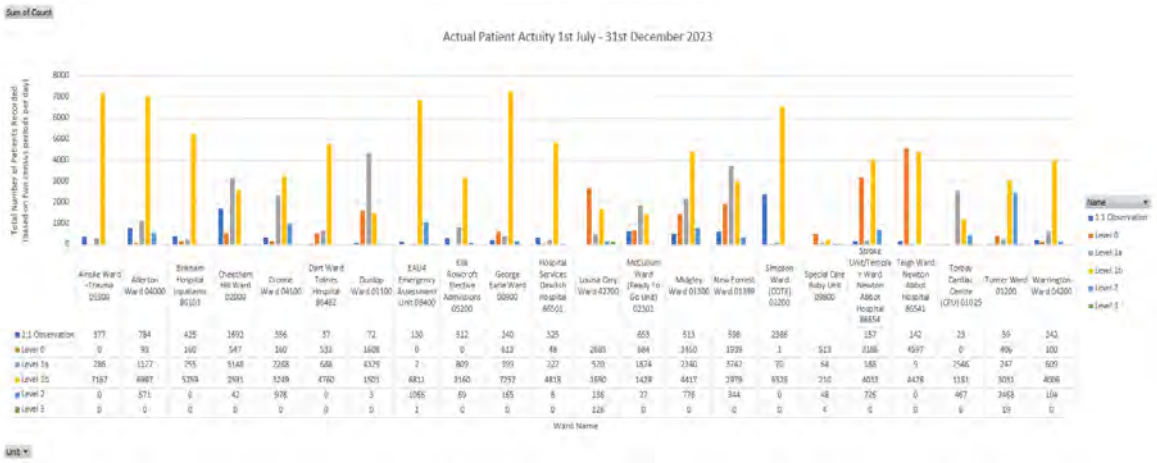
All patient's acuity and dependency care needs are assessed using the Safer Nursing Care tool twice a day. This is captured on the electronic Allocate Safe Care module and this information is used to inform staffing decisions at the twice daily Matron led staffing meetings.

Table three shows the level of patient acuity over the last 6 months for each ward. Ainslie, Allerton, EAU4, Simpson and George Earle Ward recorded the highest 1b levels in the 6-month period with Simpson identifying the highest 1:1 Observation care needs required.

The levels of acuity are described below;

- 1:1 patient requiring supportive observation
- Level 0 – Patient needs met by provision of normal ward carers.
- Level 1a – Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate.
- Level 1b – Patients who are stable but are dependent upon nursing care to meet most of their daily needs.
- Level 2- May be managed within clearly identified, designated beds, resources with the required expertise and staffing levels OR may require transfer to a Level 2 unit.
- Level 3 – Patients needing advanced respiratory support and / or therapeutic support.

Table 3 Trust Acuity and Dependency 01/07/2023 – 31/12/2023

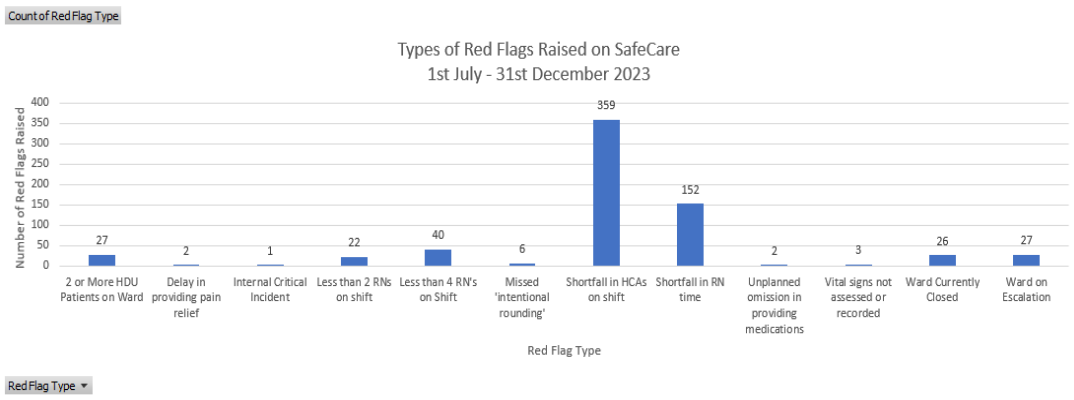


7.0 Red Flag events

The National Institute for Health and Care Excellence (NICE) released guidelines for the safe staffing of nursing in acute hospitals. They recommend recording, monitoring, and reporting problems that might occur on a ward that could affect patient safety. Those incidents are recorded as red flags. Red flags could be a risk to the safety of patients, staff, or both if immediate actions are not taken.

Table four below shows the number of red flags that have been raised by nursing staff in relation to any patient safety issues. The highest proportion of red flags raised are in relation to a shortfall of HCSW or RN's.

Table Four Types of Red Flags raised on SafeCare July 2023 – December 2023



8.0 E- rostering

The E-Rostering Key Performance Indicators (KPI's) are shared with the Matrons and ADNPP'S and are presented monthly at the Nursing, Midwifery and AHP Workforce Council meeting, chaired by the Chief Nurse.

The KPI's demonstrate that the Trust has a monitoring system in place, to provide assurance of the safe staffing levels, within the Health Roster and SafeCare system.

See Appendix One for further information.

9.0 Temporary Staffing

The demand for Registered Nurses (RN) has steadily increased since July 2023 with a peak in October 2023. The majority of RN shifts are filled by Agency staff, table eight whilst the majority of shifts for Health Care Support Workers (HCSW) are filled by Bank staff, table nine. The key drivers for Bank and Agency use in the inpatient wards include supportive observations, vacancies, and sickness. See section 10.1 Temporary Staffing Controls (Nursing) for actions taken.

The key drivers include the provision of HCSW's for enhanced supportive observation and 1-1 care provision for patients. Some patients require more than a standard level of observation and intervention, with the primary aim of reducing risk and protecting the patient.

Actions taken to reduce reliance on Bank for supportive observation shifts.

- Recruitment of Clinical Nurse Specialist (Supportive Observations).
- Review the Bank and Agency booking request reasons.
- Daily staffing meetings, supportive observations risk assessments discussed before escalation to Bank.

Actions taken to reduce reliance on Bank and Agency for vacancies.

- Monthly centralised recruitment events in place for all clinical HCSW Band 2 and Band 3 posts for the Trust, since May 2023.
- Submitted a successful bid for additional nurses for the NHS England International nurse recruitment: 2023/24 winter preparation funding. This offer is to enable the Trust to recruit additional nurses ahead of the coming winter and to support in-year reductions in agency nurse expenditure and Trust's longer-term ambitions to reduce reliance on agency spend.

The Trust no longer use Off Framework agencies for RN's and has seen a steady increase in the use of Tier 1 and Tier 2 Agencies and a decrease of Tier 3 requests.

A new **Tier 3 Agency Request protocol** has been introduced in August 2023.

If a working shift requires escalation for staff cover and is critical to maintain patient safety, the Agency request checklist details the necessary steps involved, to ensure the effective management of clinical staff to achieve safe levels of care.

9.1 Temporary Staffing Controls (Nursing)

Interventions that can be used to reduce temporary staffing spend sit on a sliding scale - from supportive through to strong. The controls chosen to reduce temporary staffing spend will depend on the organisation's current controls, feasibility of new controls and an organisation's scale of ambition to reduce temporary staffing cost.

Actions taken.

1. Implemented Workforce Check in Meetings (Governance oversight), during November to December 2023, to review all Care Group (ICO'S) data, E-Rostering KPIs, vacancies, overtime, additional hours, bank and agency spend and unutilised hours. New monthly report produced by E-rostering team.
2. Implemented the Tier 3 Agency Protocol, to ensure workforce is appropriately assessed and monitored, to ensure safe staffing levels across the Trust. If a working shift requires escalation for staff cover and is critical to maintain patient safety, the Agency request checklist details the steps involved.
3. Implemented a workforce escalation ladder (Nursing and Midwifery).If a working shift requires escalation for staff cover and is critical to maintain patient safety, the workforce escalation ladder details the steps involved and the approval level, to ensure the effective management of clinical staff to achieve safe levels of care. A risk assessment is required as necessary.
4. Implemented fast track for Bank applications from November 2023**.** Fast tracking of all substantive staff Bank applications.
5. Nursing Midwifery and AHP Workforce Council, assurance of the safer staffing workforce metrics and rostering data is monitored monthly chaired by the Chief Nurse.
6. Daily Staffing Meetings, safe staffing levels in the clinical inpatient's wards are monitored and any risks mitigated during the twice daily nursing staffing meetings. The meetings are chaired by a matron and the Head of Nursing is present for any staffing escalation. The daily staffing exception report gives a status overview of staffing levels for each ICO care group area.
7. The SafeCare system is used to support shared informed decision making, to ensure the management and redeployment of clinical staff to achieve safe levels, mitigate and articulate any risks as they arise.

10.0 Conclusion

The Trust Board of Directors is asked to note this paper and to take assurance that processes are in place to ensure nursing and midwifery workforce safe staffing levels and the quality of care delivered.

Safe staffing levels in the clinical inpatient's wards are monitored and any risks mitigated during the twice daily nursing staffing meetings and adherence to staffing policies and frameworks. The functions of the Allocate and SafeCare systems are used to support shared informed decision making, to ensure the effective management and redeployment of clinical staff to achieve safe levels, mitigate and articulate any risks as they arise.

Although it has remained a challenge to maintain optimum staffing levels at times, actions taken have provided appropriate mitigation to maintain safety and workforce is assessed and monitored to ensure safe staffing levels.

The Nursing and Midwifery Workforce Strategy developed in collaboration provides a real focus on the future improvement plan for 2024 and the interventions to be used for governance and control. To support our clinical teams, there are several targeted improvement programmes, which will improve the delivery of workforce and safer staffing.

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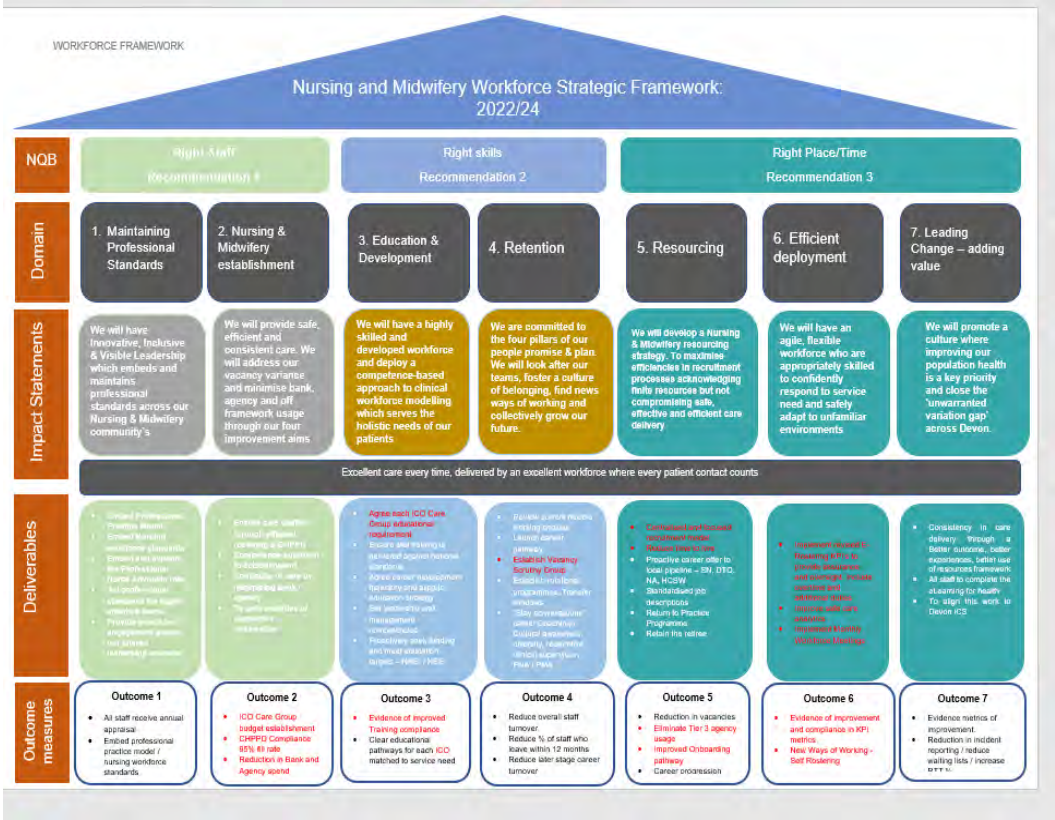
Appendix One

Nursing and Midwifery Workforce Strategic Framework



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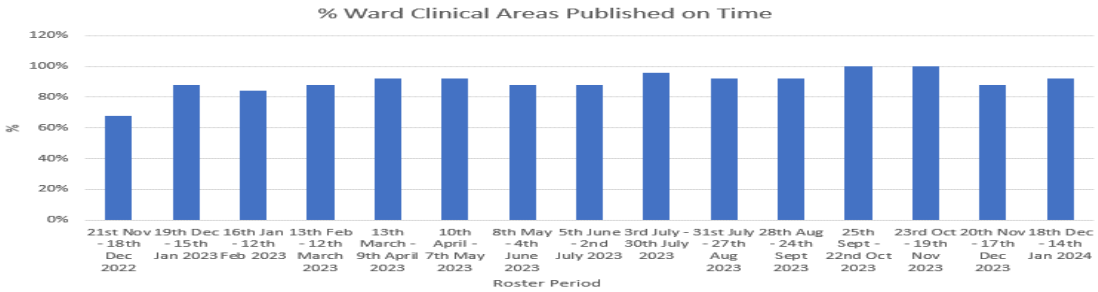
Appendix Two

E-Rostering KPI's

Planned Roster KPI's	Rosters worked KPI's
7 Key Performance Indicators (KPI's) for E-Rostering (Healthroster & Safe Care System), ICO Care Group: KPI 1: No of Cost Centres on an Electronic Rostering System KPI 2: Rosters Published 6 Weeks in Advance KPI 3: Annual Leave & Study Leave % KPI 4: Unfilled Shifts Following Publication KPI 5: Unutilised Hrs following Publication KPI 6: Areas Finalising on Time & % Finalised on Time By ICO KPI 7: % of Roster Requested, Auto-Rostered, Manually Produced	**6 Key Performance Indicators (KPI's) for E-Rostering (Healthroster & Safe Care System), ICO Care Group:** Following Roster Approval KPI 1: Overtime Hrs KPI 2: Additional Duties KPI 3: RN Bank & Agency Usage KPI 4: HCA Bank & Agency Usage KPI 5: Bank & Agency Usage Overview KPI 6: % Changes Following Roster Approval

KPI 2: Rosters Published 6 Weeks in Advance

The KPI 2 data demonstrates a steady increasing figure % with compliance for producing rosters in advanced for the Inpatient Wards, compared to the previous months. The data demonstrates that 23 in-patient areas have completed, finally approved, and published their off-duty 18th December 2023 – 14th January 2024 except for 2 ward areas. This shows a figure of 92% with compliance, which is an increase in comparison to last month figure of 88%.



KPI 3: Annual Leave & Study Leave %

The Care Groups have demonstrated a continued improvement in KPI 3, with the allocation of the Annual Leave threshold of 14.5% planned minimal in the roster period. To allow flexibility the weekly amount of annual leave granted each week should be between 11% and 18%.

KPI 4: Unfilled Shifts Following Publication

The KPI 4: data shows that HCA bank requests remain the highest proportion of shift requests per month. The data consistently shows that the ED Department have a high number of unfilled shifts for RN and HCA shifts for both Day and Night shifts. The Bank and Agency usage report reflects this.

KPI 6: Areas Finalising on Time

The ICO Care Groups have seen a steady rise in compliance with KPI 6, and with improvements in place to ensure that all worked shifts are 100% finalised within the timeframes.

Actions

- New weekly Headroom % report – see example table eight
- SafeCare Link Nurses
- SafeCare refresher session dates are now bookable via the Hive
- Face to Face drop in sessions

The Head of Nursing Workforce is continuing to work working closely with the ward managers, Matrons and ADNPP's to facilitate the achievement of compliance with the E-Rostering KPI's.

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Appendix Three CHPPD data (December 2023)

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)
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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

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							

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Appendix Four Safer Staffing – Planned versus Actual (December 2023)

Ward	RN / RM		Nursing Associates		Care Staff		RN / RM		Nursing Associates		Care Staff		Total Patients	Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - nursing associates (%)	Average fill rate - care staff (%)
	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours	Total Monthly Planned hours	Total Monthly Actual hours							
Ainslie	1783	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%


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Report to the Trust Board of Directors			
Report title: Torbay Carers' Interagency Strategy			Meeting date: 27 March 2024
Report appendix:	Appendix 1: Who is a Carer Appendix 2: Summary of Carers UK State of Caring Survey Appendix 3: Draft Inter-agency Carers' Strategy		
Report sponsor:	Interim Chief Nurse		
Report author:	Carers' Lead		
Report provenance:	The Strategy was developed with extensive engagement of and consultation with Carers. It has been circulated to members of the Feedback and Engagement Meeting of 12th March, and no concerns were raised. It also has a parallel approval route through Torbay Council, having been approved at Overview and Scrutiny Board of 13th March, and at Cabinet on 19th March. If approved, the final Strategy with completed action plan will be tabled for the Health and Wellbeing Board in June.		
Description/Purpose of the report and key issues for consideration/decision:	The purpose of this report is to highlight the issues faced by unpaid Carers, to seek approval for Torbay's draft Interagency Carers' Strategy, and to seek support for the actions required of the Trust to achieve this Strategy. The key issues are to consider how the Trust can help achieve Carers' I statements, at both individual and strategic levels: 1. As soon as I start my caring role, I want to be identified, recognised and valued as a Carer. 2. I want to be able to easily find information, advice and support to meet my needs as a Carer. 3. I want to know that every Carer involved in a person's care can have a Carer's assessment when they need one. 4. I want to be confident that Carers guide all things that affect them. 5. I want the care and support to the person that I care for to also meet my needs as their Carer. NB Due to Local Authority (LA) responsibilities, Carers' Strategies are based upon LA boundaries, hence this Strategy is for Torbay. However, Torbay Carers works closely with partners to improve Carer Support across the Devon footprint and provides work-based support to Trust staff who are Carers regardless of where they live.		
Action required:	**For information** ☐	**To receive and note** ☐	**To approve** ☒
Recommendations:	1. To approve the Draft Strategy *2.* To note and support the outline actions required of the Trust to help achieve this Strategy.		

Summary of key elements	
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	Supporting unpaid Carers, not only improves their ability to live well, but also significantly improves the outcomes of the people that they care for, thus enabling them to live well.
How does the report support the Triple Aim:	1) health and wellbeing – Carers' Services aim to improve Carers' health and wellbeing. The early identification of Carers is essential to mitigate the negative impact of caring on Carers' physical and mental health, their emotional and financial wellbeing. 2) quality of services provided – the Strategy will enable the Trust to meet the required standards of support to Carers. 3) sustainable and efficient use of resources – This Strategy and associated action plan will be addressed within existing budgets. As it is predicated on interagency working, this maximises the sustainability and efficiency of working together to make a difference to Carers.
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience – Evidence is that involving Carers significantly improves people's experience. Supporting Carers well enables the Trust to achieve NICE Quality Standards. Objective 2 – People – One in three of Trust staff are juggling working with caring for someone. Supporting them well reduces the chances of experienced staff leaving the Trust. Objective 5 - Operations and Performance Standards – The performance standards are included in the Outline Action Plan at the end of the draft Carers' Strategy at Appendix 3 Objective 8 - Transformation and Partnerships – The Strategy involves significant partnership working with the partners highlighted at Section 7 of the Strategy, as well as voluntary sector partners. Objective 9 - Integrated Care System – This strategy involves significant pan-Devon work to address the needs of Carers, for example work with PCNs to meet GP Quality Markers for Carers. Objective 11 – Equality, Diversity and Inclusion. Caring is a social determinant of health. There is work within the Strategy to improve equality of access and support to Carers.
Risk: Risk ID: *As appropriate*	
External standards affected by this report and associated risks	Care Act 2014, Children and Families Act 2014, Health and Care Act 2022 Carers Leave Act 2023 NICE NG150 Quality Standards for Carers of Adults Devon-wide Commitment to Carers

Report title: Torbay Carers' Interagency Strategy	Meeting date: 27 March 2024
Report sponsor	**Interim Chief Nurse**
Report author	**Carers' Lead**

1 Introduction

1.1 Carers are people who support family, friends and neighbours who cannot manage alone due to their health and care needs. (Detail in Appendix 1)

1.2 Carers can be any age, so this Strategy has relevance for both Adults and Children's Services in both health and social care. There is a detailed Interagency Carers Under 25 Strategy[1] which sits beneath it. Both strategies run for three years and are monitored quarterly by Strategy Steering Groups which include Carers and various statutory and voluntary sector partners.

1.3 This Strategy brings together the work that Health and Care organisations in Torbay plan to undertake with Carers during 2024-2027. This ensures that organisations meet their legal obligations to Carers, work towards best practice / quality standards and that their work is joined up. It ensures that Carers are at the heart of their work, that Carers are aware of services and that these services meet Carers' needs.

1.4 The Strategy Outline Action Plan at the end of Appendix 3 includes service standards and legal obligations. Over the coming months, a detailed action plan will be developed with Carers and partners. The Strategy with detailed action plan will be presented to the Health and Wellbeing Board in June.

2 Reason for Proposal and its benefits

2.1 Carers provide significant benefit not only to the person that they care for, but also to health and care services. In 2021 Carers UK estimated that the value of the unpaid care that Carers provide is £162 billion - greater than the budget for NHS health service spending[2]. This equates to £365 million in Torbay (not adjusted for age or deprivation).

2.2 Although it is generally accepted that the 2021 Census under-identified Carers, Torbay clearly has a much higher than average number of Carers providing over 20 hours of care. Torbay is 6th highest in England for Carers undertaking 50+ hours of care - at 3.9% Torbay is 50% higher than the England average of 2.6%.

Provision of unpaid care, Torbay 2021	Number	%	England 2021
Provides no unpaid care	118,359	88.8%	91.2%
Provides 19 hours or less unpaid care a week	6,514	4.9%	4.3%
Provides 20 to 49 hours unpaid care a week	3,207	2.4%	1.8%
Provides 50 or more hours unpaid care a week	5,185	3.9%	2.6%
Total: All usual residents aged 5 and over	133,265		

[1] Torbay Young Carers Under 25 Strategy 2022-2025

[2] Unpaid carers are providing care worth a staggering £162 billion a year- the budget for NHS health service spending in England in the 2020/21 financial year was £156 billion. Carers UK. Valuing Carers 2021.

2.3 This comes at a cost to the Carer. The National Carers' Survey shows that Carers' quality of life is deteriorating year on year, and this is mirrored in Torbay[3].

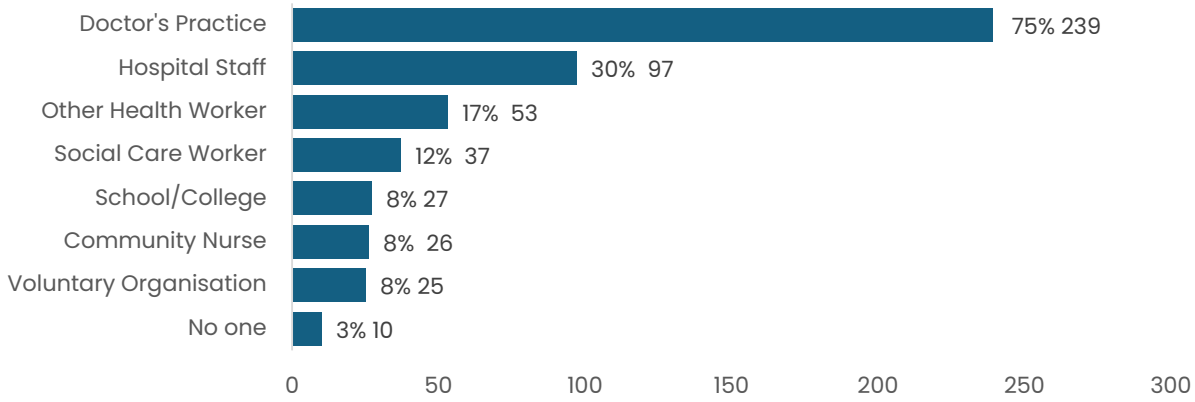
2.4 Caring is a social determinant of health[4] with impact on Carers' health and wellbeing.

2.5 Carers UK State of Caring Report 2023[5] highlighted Carers' concerns which make stark reading. A summary is at Appendix 2, but with a few highlighted here.

- More than three quarters of all Carers (79%) feel stressed or anxious, half (49%) feel depressed, and half (50%) feel lonely.
- 72% of those on Carers' Allowance worry about the impact of caring responsibilities (e.g. petrol for hospital visits, heating, specific dietary requirements) on their finances and 46% are cutting back on essentials, including food and heating.
- 27% of unpaid Carers have bad or very bad mental health, Despite feeling they are at breaking point, nearly three quarters (73%) of Carers with bad or very bad mental health are continuing to provide care.
- 40% had given up work due to caring responsibilities.

2.6 The Carers' Strategy promotes the importance of early identification and support of Carers in order to mitigate the negative impacts of caring. From early analysis of Torbay's Carers Strategy Survey (not yet published), it is clear that early identification is still a significant issue, particularly across health services.

Fig 3: Responses to where a Carer could have been identified sooner



2.7 With young Carers especially, early identification and support is essential. Otherwise the impact of caring can affect school attendance, attainment and future prospects.

2.8 It is therefore essential that all staff are Carer Aware, in order that they can identify Carers who use their services or work for their services. Paperwork, processes and IT systems must be enablers to this being as simple as possible.

[3] Personal Social Services Survey of Adult Carers in England - NHS Digital
[4] Caring as a social determinant of health (publishing.service.gov.uk)
[5] State of Caring survey | Carers UK

2.9 Carers must be valued as expert partners in someone's care. The Trust's commitment to the Triangle of Care and IRIS (identifying, recording, involving and supporting Carers) should be consistently in evidence across the Trust.

2.10 For inpatients, the inpatient protocol and the practical steps that includes, such as the Carers' orange lanyard and Carers' symbol on paperwork and systems, should also be consistently applied.

2.11 It is essential that support for Carers is easy to access, and preventative in nature. Supporting Carers not only benefits the Carer, but also the person / people for whom they care, thus improving both parties' health and wellbeing whilst reducing inequalities.

2.12 From Torbay Carers Strategy Survey, early indications are that there are issues about support for both adults and children with mental health issues and their Carers. This is an area requiring further investigation and attention.

2.13 For Adult Social Care particularly, the main issue for Carers is about the availability of appropriate and timely replacement care ('respite') for the person that they care for. As this cannot be booked at long or short notice, this has a significant impact on a Carer's ability to take a break from caring, thus leading to Carer breakdown, and its associated impact on health and social care.

2.14 Given the evident impact of caring on health, wellbeing, finances and employment, support in this Strategy will be developed / directed at improving this wherever possible, and the Trust is a critical partner in achieving this.

Appendix 1: Who is a Carer?

A Carer is anyone, including a child, who provides care to another person, apart from those who do it as paid work, voluntary work or ordinary parenting.
It includes caring for a partner, relative, friend or neighbour, who due to physical, sensory or learning disability, mental health or drug/alcohol issues, frailty, illness, long-term health condition and/or vulnerability cannot manage alone in the community.
Sometimes people are mutual Carers where they both provide support to each other, and everything works well until one person's health deteriorates or their situation changes. This is especially common in older couples.
Two out of three of us (65%) will be a Carer at some time in our life, but many people do not realise that they are considered to be a Carer, or that there is a wide range of support available to them. Torbay Carers' Strategy helps us to address this issue.

In Torbay, in response to a request from Carer representatives, we capitalise the 'C' of Carers to demonstrate their worth and to distinguish them from care workers who are often referred to as 'carers'.

Appendix 2: Summary of Carers UK State of Caring Survey

State of Caring survey 2023 Summary

The impact of caring on: employment

Our report on carers and employment found that caring responsibilities are having a significant impact on people's capacity to work and earn a full-time wage.

40% of carers surveyed – many of them caring for more than 50 hours a week - said that they had given up work to provide unpaid care, and 22% had reduced their working hours because of their caring role.

- Over half (57%) of people who had stopped working or reduced their hours at work to care said they had done this because of the stress of juggling work and care.
- Nearly half (49%) of carers who had given up work or reduced their working hours had seen their income reduce by over £1,000 per month.

The Carer's Leave Act, coming into force in April 2024 at the earliest, will give carers the right to take up to five days of unpaid carer's leave. However, over two thirds of carers (67%) were unsure if their employer had started to prepare for new rights under the Carer's Leave Act, and over a quarter (28%) said they didn't know anything about unpaid carer's leave. Carers UK is sharing recommendations for employers to:

- Recognise the range of skills that carers gain through their caring role, to retain existing employees and support carers returning to work.
- Consider becoming early adopters of unpaid carer's leave before providing five days becomes law – or go one step further and provide paid carer's leave, making it even more accessible to their employees with caring responsibilities.
- Adopt Carers UK's Carer Confident benchmark, run by Employers for Carers, to move towards becoming a carer friendly employer.

The impact of caring on: health

Our report on caring and health finds that a widespread lack of support and recognition from health and care services is severely damaging unpaid carers' mental health. It highlights how people caring round the clock for older, disabled or seriously ill relatives do not have adequate support from statutory services that are in place to help them – leaving many steeped in thoughts of hopelessness, fear, and dread, and urgently in need of support.

- More than a quarter (27%) of unpaid carers have bad or very bad mental health, rising to 31% of those caring for more than 50 hours a week, or for over 10 years.
- 84% of carers whose mental health is bad or very bad have continuous low mood, 82% have feelings of hopelessness and 71% regularly feel tearful.
- 68% of carers with bad or very bad mental health are living with a sense of fear or dread.
- More than three quarters of all carers (79%) feel stressed or anxious, half (49%) feel depressed, and half (50%) feel lonely.
- 65% of carers agreed that the increase in the cost of living was having a negative impact on their physical and/or mental health.
- Despite feeling they are at breaking point, nearly three quarters (73%) of carers with bad or very bad mental health are continuing to provide care.

Not being able to access the support they need is taking its toll on unpaid carers, many of whom are worn out and exhausted. Far too many carers are having to wait long periods for health treatment - or putting it off because of the demands of their caring role; are unable to rely on fragmented social care services to support with caring, and are struggling financially because they cannot earn a higher income.

It's clear that unpaid carers desperately need to be recognised and supported with their caring roles. Working with local authorities, the Government and NHS England must urgently drive a programme of quicker and more targeted interventions to prevent poor mental health amongst carers. That's why Carers UK is urging the Government to provide the necessary investment in the NHS and social care so that unpaid carers can take care of their physical and mental health. We are also calling on the Equality and Human Rights Commission to undertake an inquiry into unpaid carers' ability to access health services in England.

The impact of caring on: finances

Our first report was about the impact of caring on finances.

This year's survey found that carers are struggling even more with their finances. A higher proportion of carers said they are struggling to make ends meet, and carers who are already struggling with the high cost of living, are being further impoverished by having their ability to earn restricted by Carer's Allowance.

Concerningly, 75% of unpaid carers receiving Carer's allowance are struggling with cost-of-living pressures, while almost half (46%) are cutting back on essentials, including food and heating. As worryingly, 45% were even more likely to say they were struggling to make ends meet, compared with 39% last year.

This year's survey found that, of carers receiving Carer's Allowance:

- 34% were even more likely to be struggling to afford the cost of food compared with 21% of all carers. This was an increase from 29% in 2022
- 71% were even more likely to say they were worried about living costs and whether they can manage in the future, compared with 61% of all carers
- 72% are worried about the impact of caring responsibilities (e.g. petrol for hospital visits, heating, specific dietary requirements) on their finances
- 54% had cut back on seeing family and friends, compared with 43% in 2022 and 38% in 2021

Unsurprising, given the rise in the cost of living, a significant proportion of all carers who responded to the survey are worried about their ability to manage in the future:

- There has been an increase in the proportion of carers who are struggling to make ends meet compared to last year (30% compared with 27%)
- A fifth (21%) of carers are struggling to afford the cost of food. Over a third (34%) of carers said they had cut back on essentials such as food or heating compared to 25% in 2022 and 13% in 2021
- 60% of carers agreed they were worried about the impact of caring responsibilities on their finances and 62% agreed that they've been finding it more difficult to manage financially due to the increase in the cost of living

Government and policy makers need to have a clear understanding of the risks of financial hardship for unpaid carers. There must be a robust poverty prevention strategy across government which targets and prevents poverty. In the report, we make several recommendations, from reforming the benefits system to providing targeted financial support and supporting carers to remain in paid employment.

Appendix 3.

DRAFT

Torbay Carers' Strategy 2024 - 2027

An Inter-agency Commitment to meet the needs of Torbay's Carers, including Young Carers.

Content **Page**

1. Introduction

Who is a Carer?
A Carer is anyone, including a child, who provides care to another person. This excludes people who do it as paid work, voluntary work, or ordinary parenting.
It includes caring for a partner, relative, friend or neighbour, if they have a physical, sensory, or learning disability, mental health or drug/alcohol issues, frailty, illness, long-term health condition and/or vulnerability which means that they cannot manage alone in the community.
Sometimes people are 'mutual carers' - they support each other. Often everything works well until one person's health deteriorates or their situation changes.
Two out of three of us (65%) will be a Carer at some time in our life. Many people do not realise that they are considered to be a Carer, or that there is a wide range of support available to them. Torbay Carers' Strategy helps us to address this issue.

Why have a Carers' Strategy?
Torbay has had an inter-agency strategy (plan) for Carers since 2000 and it is updated every three years. Torbay's Carers are consulted to find out what their priorities are, and these are worked into the Carers' Strategy alongside national and regional priorities. The main agencies who come into contact with Carers then work together to create an action plan to achieve these priorities.

Having an inter-agency Strategy and Action Plan helps partners work together in a joined-up way, to achieve what Carers really need. Representatives of Carers and of the various agencies meet quarterly to ensure that the Strategy Action Plan remains on track. The updates are published on-line.[1]

2. National Context

In the 24 years since our first Strategy was published, awareness about Carers, especially Young Carers has increased significantly. In 2014, the Care Act and Children and Families Act made the health and wellbeing of Carers a priority by law.

In 2019, the NHS published a Long-Term Plan with the following priorities for Carers.

1. GP Quality Markers for Carers
2. Identify and Support for Carers from Vulnerable Communities
3. Adoption of Carers' Passports
4. Information sharing
5. Contingency Planning
6. Supporting Young Carers

NICE (National Institute for Health and Care Excellence) published guidelines for support to Carers of Adults in 2020 and launched Quality Standards in March 2021[2].These will be built into the Strategy action plan.

[1] https://www.torbayandsouthdevon.nhs.uk/services/carers-service/strategy-policy-and-quality/ .
[2] Overview | Supporting adult carers | Quality standards | NICE

The Health and Care Act 2022 introduced an obligation for Carers to be involved in hospital discharge planning and for the NHS to consult with Carers.
Carers UK undertakes annual surveys of Carers. Their 2023 survey shows that Carers' health and wellbeing is deteriorating, their employment is significantly affected by caring, and the cost of living is also having an adverse effect. *'It highlights how people caring round the clock for older, disabled or seriously ill relatives do not have adequate support from statutory services that are in place to help them – leaving many steeped in thoughts of hopelessness, fear, and dread, and urgently in need of support'* [3] .

3. Local Context

In the 2021 Census, approximately 15,000 people in Torbay identified themselves as Carers. However, we know that many people do not see themselves as Carers, or do not identify their children as having a caring role in the family. Actual numbers are likely to be much higher and this is backed up by the 2023 GP survey[4]. Torbay has a very high level of Carers providing more than 50 hrs care per week – 6th highest Local Authority out of 317 in England according to the 2021 census.

In 2018, Carers' Leads and Carers developed a Devon-wide Commitment to Carers. It was based on NHSE's 2014 Commitment to Carers and the Triangle of Care (treating Carers as expert partners in care). The seven principles are:

1: Identifying Carers and supporting them
2: Effective Support for Carers
3: Enabling Carers to make informed choices about their caring role
4: Staff awareness
5: Information-sharing
6: Respecting Carers as expert partners in care
7: Supporting Carers whose roles are changing or who are more vulnerable

Devon's main health and care organisations signed up to these principles in October 2019. Many have subsequently undertaken self-assessments and action plans to help them to achieve these priorities.[5] Every year, their top three priority actions are added to the Action Plan for the Carers' Strategy and reported quarterly.

Carers is a cross-cutting Area in Torbay's Joint Health and Wellbeing Strategy 2022-2026.[6]

In 2023-24, other strategies were launched that impact upon Torbay's Carers:

- Torbay Adult Social Care Strategy,[7]

[3] State of Caring survey | Carers UK
[4] National GP patient survey 2023
[5] Carers - One Devon
[6] Joint Health and Wellbeing Strategy 2022-2026 - Torbay Council
[7] Adult social care - Torbay Council

- Torbay's Learning Disability Big Plan[8]
- Torbay SEND Strategy[9]
- Devon Partnership Trust's Carers' Strategy. *(not yet published)

The Carers' Strategy Action Plan will include actions relating to all the above.

4. Review of Torbay Carers Strategy 2021-2024[10]

Despite Covid impacting Carer Support in 2021-22, almost all the **169** targets within the 2021-24 strategy were achieved. That huge success is testament to the dedication and hard work of all parties but particularly Torbay Carers Services in keeping actions on track. The main summary is below, and final progress will be published on-line in May 2024[11].

Identification of Carers – 29 targets (28 met)

- All Torbay's main health and care organisations other than SW Ambulance Service signed a Commitment to Carers (C2C), and most report quarterly on their priorities. Citizens Advice Torbay also signed a C2C whilst Samaritans and Fire Service signed a Memorandum of Understanding.
- All Torbay's GP practices completed their Carers' Quality Markers, and achieved their Carer identification target, some reaching the stretch target of 7% of patient list. However, Carers still report that doctor's surgeries are the main place where they could have been identified sooner.
- Torbay Hospital is re-promoting the Triangle of Care, improving identification and involvement of Carers. This started in the Emergency Department and is being rolled out across the Hospital.
- Work has been undertaken to improve identification of Carers from minority ethnic backgrounds, and a community link worker is being piloted to further improve this.
- Awareness campaigns have been undertaken with a wide range of organisations.
- Torbay Carers Services now runs an annual event for Carers Rights Day with Paignton Library's Christmas Fayre in order to raise public awareness. It provides information, advice, and support for Carers with a huge range of partners.

Information, Advice and Support (59 targets, 50 met, 2 delayed but may happen before end March* (Carers information Booklet, Passport) 6 partially achieved, 1 not achieved – Performance in Top Quartile – Carers find information easily)

- We have maintained most existing Carers' Information and Support Services, and those that have been used have been generally well-rated by Carers. Signposts information Service and Signposts Newsletter were the most positively reviewed.* *(NB * means 'Information such as link or data to be added when updated')*
- The Community Mental Health Team reduced their Carer Support Worker hours.

[8] Big Plan - Torbay Council
[9] Torbay SEND strategy 2023 - Torbay Council
[10] https://www.torbayandsouthdevon.nhs.uk/uploads/torbay-carers-strategy-2021-2024.pdf
[11] https://www.torbayandsouthdevon.nhs.uk/services/carers-service/strategy-policy-and-quality/.

Whilst their Assessments are on track, 81% of Mental Health Carers felt not at all or not very supported.*

- Torbay Carers Service suffered significant IT issues. Changes in the Council IT server necessitated a 17-month Carers' Register rebuild, significantly delaying planned developments and the launch of the Carers' Passport. The 'Torbay Carers Together' website changed hosting platforms and is not live at present.
- Despite the Register issues, the 10% increase target was achieved year on year and as of January 24 there are 5350 registered Carers*. Processes are seen nationally as good practice in terms of asking consent to share with partner organisations, and of having Carer Contingency Plans and discounts as standard.
- Hospital support was fully reinstated after Covid. Funding was obtained to appoint a worker to improve Hospital communication with Carers and evaluation shows that this was very successful*. Developments also included supporting Carers with Virtual Wards and technology to support Carers with discharge.
- Torbay Young Carers Service moved to the Youth Trust in 2021 and back to the Council in 2023. Young Carers were not adversely affected by the changes as the service worked hard to maintain direct support. There has been a significant increase in identification of primary school age Young Carers during this time.
- The interagency Young Carers Under 25 Strategy 2022-25 was launched and its work demonstrates good partnership working to achieve early identification of and support to Young Carers under 25.
- On-line support to Parent Carers has improved with several on-line workshops, awareness, training sessions provided throughout the year, particularly at school transition times.
- With regard to staff Carers, Torbay and S Devon NHS Foundation Trust achieved Employers for Carers, Carer Confident Level 2 'Accomplished' Award – only the second NHS Trust to achieve this. It also launched an award for managers who support staff Carers which is now being adopted by Torbay Council.
- Partnership work including the voluntary sector continues. A network of Carers allies meets regularly and there are close links with Paignton's Community Hub.
- Targeted work has been undertaken to support veterans and Carers of veterans, with much positive feedback from these Carers.
- Carers Aid Torbay has group activities targeting men as they are not well-represented at many Carers groups or activities. Their Bay Benefits Service for Carers now includes Carers' Choices cost-of-living support.
- Work has continued to improve support Carers from ethnic minority, refugee, and asylum seeker backgrounds, although Carers Services has not yet achieved the target of parity between population and Register. A Community-link worker role is being piloted to continue this work and also target Carers in areas of deprivation or who are vulnerable.

Carers' assessment including whole family approach (39 targets, 34 achieved)

- GP Carer Support Workers exceeded their annual target of 500 Health and Wellbeing Checks (HWBCs) in two out of the three years.*
- Carers' Aid Torbay continued to provide independent enabling and advocacy, and they met all annual targets.
- This contributed to Adult Social Care meeting their Assessment target of 36% each year and are on track for their stretch target of 40%.*

- Children's Services met their target for Parent Carers Needs Assessments in 21-22, increased the target for 22-23 which was not achieved, but are on track to achieve it for 23-24*.
- Referrals to Young Carers Service from Adult Social Care, Mental Health and Substance Misuse are consistently low and not achieving target.

Involvement of Carers in service delivery, evaluation and commissioning (23 targets, all achieved to some extent

- Carers Services used Healthwatch's 2021-24 Strategy Report and National Carers' feedback to shape the Strategy and action plan.
- Staff Carer support has been shaped with staff Carers, and this will continue.
- Carers are represented in all levels and functions of Torbay Carers Service and the Young Adult Carers Operational Group demonstrates good levels of involvement with Young Adult Carers (16-25).
- SEND Family Voice Torbay has been set up during this time which enables engagement with Parent Carers of children.
- There has also been a much-improved level of engagement and co-production with Carers within the Strategies mentioned in Section 3.
- Peer support improved with some new groups, eg Carers of Adults with Autism and 'Your Time' Carers' group. The Carers' Volunteer Phoneline suffered a hiatus with the retirement of some key members but re-launched in January 2024.
- The Autism Partnership Board which was set up during this strategy period has two Carer Ambassadors representing Carers' Voice, in the same way as the Learning Disability Partnership.
- Many service evaluations have been undertaken by Carer Evaluators and the feedback built into developing services. Use of Carers' Direct Payments, Carers Technology Enabled Care Pilot, Carers of Adults with Learning Disability Service, Hospital Carer Liaison Pilot, Volunteer phoneline and Carers Assessments. Evaluations are published on-line. [12]

Enhancement of Support to the person being cared for (19 targets, 3 not fully achieved yet, 16 achieved)

- Replacement Care is still the biggest area of concern for Carers of Adults, and it is on the Adult Social Care Improvement Plan. Torbay's share of 2024-26 Accelerated Reform Funding will be targeting this enabling us to improve Shared Lives provision and accelerate achievement of two of the targets not yet fully achieved - the volunteer-run sitting service and increasing Carers' access to the Arranging Support Team.
- Although availability and provision of Short Breaks for adults needs to be improved, the processes within the Short Break Vouchers Scheme for adults with a learning disability are being significantly improved based on feedback from Carers who use it.

[12] Strategy, policy and quality - Torbay Carers Service (torbayandsouthdevon.nhs.uk)

- Children's Services reviewed their Short Breaks offer and have an ongoing recruitment campaign to recruit additional foster Carers offering specialist support and breaks to Carers.
- Torbay Carers Service has continued to work with local hospitality providers to provide discounted stays for Carers and signed up to Carefree Breaks which offers occasional free breaks to Carers. Both have a significant impact on Carers' health and wellbeing.
- Torbay Carers Service Technology Enabled Care pilot was very successful and therefore ongoing funding has now been allocated within baseline budget.
- Planning ahead is of critical importance to prevent Carer breakdown. It has been built into the contract for Carers of Adults with Learning Disability to work with Adult Social Care to achieve this more rigorously. Carers Services have improved their website information about planning ahead, and the recent Carers' Rights event had a room dedicated to planning ahead which included solicitors, Rowcroft, Age UK Torbay and other partners.

5. Formulation of Priorities for 2024-2027

The development of potential priorities for 2024-27 was based on Carer Consultation while taking account of national and local priorities, and evidence of what works well.

Engaging Community South West carried out a Carers' engagement exercise in late 2023, with 377 Carers responding. Despite sending paper surveys to all, this was a lower return rate than previously, but still significantly higher than most Carers Surveys. We think this was due to 'consultation fatigue' as Carers had engaged in the three strategies mentioned in Section 3, plus Healthwatch's own Survey into Carer Breakdown* and the biennial Personal Social Services National Carers Survey. The full report can be seen at* (include links when published.)

The detailed feedback from Carers will be used to shape the action plans linked with this Strategy and the Young Carers under 25 Strategy 2025-28. The higher level actions for Young Carers under 25 will be outlined within this Strategy and monitored in both Strategy Steering Groups.

6. Carers' Priorities for 2024-27

Carers have agreed that the priorities from the previous strategy will remain the same. They have developed 'I statements' showing what they want.

1. **'**As soon as I start my caring role, I want to be identified, recognised and valued as a Carer.'
2. 'I want to be able to easily find information, advice and support to meet my needs as a Carer.'
3. 'I want to know that every Carer involved in a person's care can have a Carer's assessment when they need one.'
4. 'I want to be confident that Carers guide all things that affect them.'
5. 'I want the care and support to the person that I care for to also meet my needs as their Carer.'

Within these priorities, there are other issues to be addressed:

a. Information to Carers to include support to the person they care for
b. Carers and employment
c. Carers' own mental health and support to people with Mental Health issues and their Carers
d. Partnership working / information sharing across organisations
e. Carers finance / cost-of living challenges
f. Improving support at transitions
g. Improving use of technology and digital support

7. Commitment to Carers – Partners in Torbay

Torbay Council (Council)
Torbay and South Devon NHS Foundation Trust (Trust)
Devon Partnership Trust (DPT)
One Devon – Integrated Care Board (ICB)
Rowcroft Hospice
Citizens Advice Torbay
Compass House Medical Centres
Plus all Torbay GP practices (under GP Carers' Quality Markers)

Where 'partners' are referred to in the action plan, this will include all partners above, 'Health and Care partners' excludes Citizen's Advice Torbay.

Torbay Carers' Strategy 2024 – 2027. Action Plan Outline

1. 'As soon as I start my caring role, I want to be identified, recognised and valued as a Carer.'	
Service Standards for Identifying, recording and valuing Carers: Commitment to Carers Principles 1 & 7, NICE Quality Standard 1, Torbay SEND Strategy Priority 2; DPT Carers' Strategy – Priority 1; GP Quality Marker - Identification and registration.	
1.1	Partners to work towards identifying Carers at every opportunity when the public link with their services.
1.2	Torbay Council, Trust and DPT to prioritise early identification of Carers within Education, Health and Social Care using the whole family approach. This means identifying any Carer eg Education actively identifying Young Carers and Parent Carers, but also supporting identification parents who may have caring responsibilities for adults.
1.3	SEND services to proactively identify parent Carers and sibling Carers at the earliest opportunity.
1.4	Adult Social Care and Children's Social Care to ensure early identification is prioritised at people's first contact including through family or community hubs.
1.5	To promote Carer self-identification, all partners' communications team to produce or disseminate communications to support public awareness of Carers such as during Carers Week / Carers Rights Day / Young Carers Action Day. (Carers Services will support this). Also to promote self-identification of staff who are Carers.
1.6	All partners to develop systems to identify staff Carers at appointment and at annual reviews.
Enablers – sharing information – Service standards: Commitment to Carers Principle 5; DPT Carers' Strategy Priority 3	
1.7	All organisations, whenever a Carer is identified, to have systems in place to record this (GPs to SnoMed code correctly), to record consent to share this information with appropriate partners, such as Torbay Carers, and then do so.
1.8	Within services supporting Carers, to encourage Carers to allow sharing of their information so that support is sensitive, tailored, joined-up and effective.
1.9	Health and Social Care organisations to have appropriate policies and protocols about confidentiality and information sharing. Practice should encourage people with care and support needs to share information about their needs with their Carer(s) to enable their full participation in care and support planning.
Enablers – Awareness / training – Service standards: Commitment to Carers Principle 4; DPT Carers' Strategy Priority 2; GP Quality Marker - Awareness and Culture;	
1.10	Partners to work towards staff having Carer Awareness training at a level appropriate to their role. This should be undertaken at induction and as part of workforce development plans. This should include Managers' awareness of staff Carers and how to support them. For education (SEND), health and social care staff this should include valuing Carers as equal partners in someone's education, care and support.

2. 'I want to be able to easily find information, advice and support to meet my needs as a Carer.'

Service standards for Information provision – Care Act 2014, Children and Families Act 2014, NICE Guidance for Carers of Adults (NG150); DPT Carers' Strategy Priority 5; GP Quality Marker - Information, involvement, and communication.	
2.1	Health and Care partners to meet the legal requirements and guidance above. Information should be developed with Carers, be easy to find, easy to understand and accessible. Information must enable Carers to find support for themselves and the person that they care for.
2.2	Council and Trust to maintain funding for Carer Information Services to enable access to Carer information above. This includes Signposts Carers Information Service including electronic and paper resources as required.
Service standards for Effective Support for Carers – Care Act 2014, Children and Families Act 2014, Commitment to Carers Principles 2+3 DPT Carers' Strategy Priorities 4 + 6; GP Quality Markers - holistic support; in practice support; appointments and access.	
2.3	All partners to meet the legal requirements and guidance above. Support to Carers must mitigate the negative impacts of caring – mental / physical / educational / financial / employment
2.4	Health and Care partners must enable Carers to make informed choices about their lives, including choosing not to provide care or to limit their caring role. Services must plan ahead with the Carer and the person that they care for in order to meet both person's needs to include: a. contingency, short term and long-term plans including for end-of-life care and life after caring b. transitions between schools / to adulthood / to adult services c. transitions between services d. transitions to increased independence
2.5	Torbay Council to maintain funding of Torbay Young Carers Service to support Carers younger than age 18. Service to include school-based support, activity-based support and 1-1 support of those young Carers most in need. Service to mitigate the impact of caring on Young Carers' educational attendance and attainment, their future employment and life choices.
2.6	Council / Trust to maintain funding of Torbay Carers' Service for: • Torbay Carers' Register and associated support • Carer Education Courses • Carers Emotional Support Scheme for eligible Carers of people aged 16 or over • Carers Direct Payments for eligible Carers of Adults • Carer Support Workers in GP practices • 'Floating' Carer Support available across Bay • Carers Centres in each town, linked with voluntary sector partners

	• Carers' Assessment, Support and Enabling Service (Carers' Aid Torbay) • Bay Benefits and Carers Choices Cost of living Support (provided by Carers' Aid Torbay) • Hospital-based Carer Support including Advice Point, Carer Support Workers and Family / Carer Supporters • Older People's Mental Health Support Worker • Young Adult Carer Service (16-25) • Support to Carers of Adults with a learning Disability (provided by Devon Link-Up) • Support to Carers of Adults with autism (provided by Dimensions for Autism) • Access to Carers UK digital and Employers for Carers Support
2.7	Carer Support will include: • Work related support – to enable Carers to continue to work or return to work • Digital inclusion – to ensure Carers who wish to are enabled to increase their skills and confidence on-line • Targeted support to Carers who are under-represented or find it hard to access services such as those from black and minority ethnic backgrounds, LGTBQ+ Carers, Carers with a learning Disability or who are Sign Language users. • Development of a 'checking in' type of support to Carers who are most in need.
2.8	Torbay Council Children's Services to maintain funding for parent Carer support.
2.9	Given Carer feedback particular focus needs to be given to supporting Carers of people with mental health issues.
Service standard for Support to Staff Carers - NICE Quality Standard 5.	
2.10	All partners to offer supportive working arrangements to staff who are also Carers.

3. 'I want to know that every Carer involved in a person's care can have a Carer's assessment when they need one.'

Service standards for Carers' Assessments – Care Act 2014, Children and Families Act 2014, NICE Quality Standards 3 + 4.	
3.1	Council, Trust and DPT to meet the legal obligations and Quality Standards above. Assessments must be person-centred, strengths-based, and focusing on what matters to the Carer. NB Targets will be set and evaluations carried out. • Young Carer's Assessments • Parent Carer Needs Assessments • Carer's Assessments (separate or combined)

3.2	Health and Care partners to ensure that the Whole Family Approach is fully embedded in all services so that every Carer involved in a person's care is identified, whatever their age and regardless of the number of Carers involved. They should each be offered their own Carer's Assessment.
3.3	Health and Care partners to ensure that Carers' assessments identify Carers at highest risk of breakdown. Once 'high risk' Carers identified, agree support required and contingency plans. Develop over-arching plans to target those most at risk.
3.4	Health and Care partners to ensure that Carers are regularly given the opportunity to discuss the value of having a break from caring and the options available to them. This links with Section 5 about support to the person being cared for, where 'replacement care' (often known as 'respite' care) is essential to enable Carers to have a break.

4. 'I want to be confident that Carers guide all things that affect them.'

Service standards for respecting Carers as expert partners in care – Commitment to Carers Principle 6, NICE Quality Standard 2, Health and Care Act 2022.	
At an individual level	
4.1	Health and Care partners will respect Carers as expert partners in care and involve them holistically in care planning, decision making and reviews both for them and the person that they care for.
4.2	Health and Care partners' staff will support and empower Carers to fulfil the above role.
4.3	Health partners will involve Carers in an inpatient's care and discharge planning at the earliest opportunity.
At a more strategic level such as planning or commissioning services which affect them.	
4.4	Council, Trust and DPT will involve Carers in guiding, monitoring and reviewing services that affect them and the person that they care for so that they can demonstrate successes and where improvements are required. This should include engagement with service development, service delivery, evaluation, and commissioning.
4.5	Council, Trust and DPT to ensure that Carers are involved at all levels in shaping Carers' services, aiming for true co-production. This includes service development, service delivery, evaluation and commissioning for Torbay Carers Service, Torbay Young Carers Service and services to parent Carers.
4.6	The Integrated Care Board will consult with Carers on changes to health services, either new services or ways of delivering health services.
4.7	Health and Care partners to identify unmet Carers' needs and where appropriate build into future commissioning plans.
4.8	Whenever Carers are involved or consulted, all partners will be clear about timescales for action and feedback. This is so that Carers are aware of their impact in shaping services which affect them, but also clear when this is not possible, and the reasons why not.

5. 'I want the care and support to the person that I care for to also meet my needs as their Carer.'	
Service Standard for Services meeting needs of both the Carers/s and the person that they care for Care Act 2014, Children and Families Act 2014; Health and Care Act 2022; Commitment to Carers Principle 2; GP Quality Marker - Information, involvement and communication.	
5.1	Health and Care partners' staff to ensure that a Carer's needs are taken into consideration when planning care and support for the person being cared for. This includes their need to have regular breaks from caring. Carers are to be treated as valued partners in the care and support of the person that they care for.
5.2	Given Carer Feedback, the above needs to be a particular target for Mental Health Services, including within the Community Mental Health Framework.
5.3	Council and Trust commissioners to improve access to and the range of replacement care to enable Carers to take regular or sporadic breaks from caring. This must include breaks at both long and short notice. The care delivered must be appropriate to the care needs of the person being cared for and offered either at home or in another establishment. Work will involve data collection about unmet need which will help with the development of both short-term and longer-term commissioned solutions.
5.4	The Council, Trust and DPT should ensure that planning ahead happens in a timely fashion with transition, emergency, contingency and long-term plans being developed with the Carer and the person that they care for. This is especially important where the person being cared for is likely to need time to adapt to change such as a person with learning disability, autism, mental health issue or dementia.
5.5	Council and Trust to give consideration to the eligibility criteria for provision of equipment / technology to the person being cared for, if it also gives a Carer peace of mind, supporting their caring role. Continuation of Carers Services funding for short-term technology enabled care.
5.7	All Health and Care partners to involve Carers in service development, evaluation and commissioning of services to the person being cared for that also affect /benefit them. Where there are unmet Carers' needs, these should be noted and where appropriate built into future commissioning plans.

Background Documents

Torbay Young Carers Under 25 Strategy 2022-2025

Personal Social Services Survey of Adult Carers in England - NHS Digital

Caring as a social determinant of health (publishing.service.gov.uk)

State of Caring survey 2023 | Carers UK

Supporting Information

1. Introduction

1.1 The 2024-27 Strategy builds on evidence and learning from Torbay's 2021-24 Carers' Strategy and national good practice. Services work very closely with partners across Devon Integrated Care System.

2. Options under consideration

2.1 There are no other options under consideration. This Strategy is a means of coordinating and prioritising partnership working to the benefit of Carers.

3. Financial Opportunities and Implications

3.1 There is no additional financial implication within this Strategy. The actions to achieve the priorities within this Strategy will be within current budgets.

4. Legal Implications

4.1 This Strategy meets the legal obligations of Health and Social Care organisations under:

- Care Act 2014
- Children and Families Act 2014
- Health and Care Act 2022

5. Engagement and Consultation

5.1 There has been extensive consultation with the Carers of Torbay. This has been managed by Engaging Communities South West in order to maintain independence.

5.2 Carers have also been involved in shaping the strategy and producing 'I statements' about their priorities. We continue to work with them in the design, delivery and evaluation of Carers' Services.

5.3 Carers' Representatives sit on the Strategy Steering Group and all working parties.

6. Purchasing or Hiring of Goods and/or Services

6.1 Any services procured or provided by the public sector organisations under this Strategy will meet Social Value Act (2012) requirements.

6.2 The Carers' Enabling, Assessment and Advocacy contract and Carers of Adults with a Learning Disability contract have both been procured under this framework.

7. Tackling Climate Change

7.1 This Strategy does not alter ways of working that will impact on Climate Change. However on-line meetings, courses and support, with the associated benefit for Climate Change will continue to be developed.

7.2 There are Carers' Centres in each town which will reduce unnecessary travel. These are all accessible by nearby public transport.

8. Associated Risks

8.1 If the Strategy were not approved, this would have significant negative impact on Torbay's Carers, their health, wellbeing and feeling of value. This would impact on the health and wellbeing of people they care for, and by increasing the risk of Carer breakdown, increase admissions to hospital / residential care and strain on Torbay's Health and Social Care.

9. Equality Impacts - Identify the potential positive and negative impacts on specific groups'

	Positive Impact	Negative Impact & Mitigating Actions	Neutral Impact
Older or younger people	Young Carers and older mutual Carers		
People with caring Responsibilities	Yes		
People with a disability	Yes - indirectly		
Women or men	(Targeting male Carers as underrepresented)		No differential
People who are black or from a minority ethnic background (BME) (Please note Gypsies / Roma are within this community)	Yes – explicitly targeting these groups to have positive impact		
Religion or belief (including lack of belief)			No differential
People who are lesbian, gay or bisexual	(promoting support to LGBTQ+ Carers)		No differential
People who are transgendered	(as above)		No differential
People who are in a marriage or civil partnership			No differential
Women who are pregnant / on maternity leave			No differential

Socio-economic impacts (Including impact on child poverty issues and deprivation)	Addressing support with Carers' finances and in areas of deprivation		
Public Health impacts (How will your proposal impact on the general health of the population of Torbay)	Positive impact on Carers' Health and Wellbeing and those who they care for.		

10. Cumulative Council Impact

10.1 None

11. Cumulative Community Impacts

11.1 None

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors		
Report title: Board member EDI Objectives		Meeting date: 27th March 2024
Report appendix:	Nil	
Report sponsor:	Chief People Officer	
Report author:	Chief People Officer	
Report provenance:	Discussion with CEO	
Description/Purpose of the report and key issues for consideration/decision:	The Board has already pledged it's commitment to creating a culture at work where everyone feels safe, healthy and supported, which is being rigorously tackled via the People Promise, PSIRF and Embedding an Inclusive Culture. The latter forms a central part of the action plan to address the CQC Well Led Must Do regarding EDI. The action plan also incorporates the actions directed within the NHSE EDI Improvement Plan, which places three actions on Trust Boards. • Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process (by March 2024). • Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025). • NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024) (Confirmed, BAF Objective 11). Board members are currently in the process of reviewing their annal objectives. It is recommended that within this review, each Board member commits to including an EDI related objective. Proposed generic EDI Objective for TSD Board Members. "To create an environment through my values and leadership practice that eliminates the conditions in which bullying, discrimination and harassment occur. I commit to invest in my development as a compassionate leader and to include with care, listen with curiosity, and act with courage to call out inappropriate behaviours. Through clear leadership I will hold myself, colleagues and those I lead to account so that collectively we deliver an improved culture at work where everyone feels safe, healthy and supported. Within this reporting year, complete Compassionate Leadership Development, and #ItStartsWithMe EDI training."	

	This draft objective meets the SMART criteria – it is specific, measurable (via completion of training and intangibly through staff survey feedback for whole Trust) achievable, relevant and timebound. Individuals may wish to consider personalising their own objective. For example, individual objectives may include Exec/NED sponsorship of one of the Staff Networks. However, as the reinvigoration of each of these networks sits within the CQC Must Do action plan, it is proposed that Board members consider including to 'confirm alignment to x staff network within the 24/25 operating year' rather than confirm specific allegiance at time of objective setting.		
Action required:	**For information ☐**	**To receive and note ☐**	**To approve ☒**
Recommendation:	The Board is invited to approve the inclusion of an individual EDI objective within personal objectives for operating year 24/25.		
Summary of key elements			
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	Creating a culture at work where our staff feel safe, healthy and supported is essential for good patient care and experience, and for attraction and retention of staff.		
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	3547 Upwards Trend in Equality, Diversity and Inclusion (EDI) Related Investigations (Workforce Risk) BAF 11		
External standards affected by this report and associated risks	Equality Act Care Quality Commission NHSE National policy, guidance		

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Report to the Board of Directors			
Report title: Fundraising strategy			Meeting date: 27th March 2024
Report appendix:			
Report sponsor:	Deputy Chief Executive/Chief Strategy and Transformation Officer		
Report author:	Associate Director of Communications and Partnerships; Fundraising and Partnerships Manager		
Report provenance:			
Description/Purpose of the report and key issues for consideration/decision:	To share with the Board our Fundraising Strategy which was approved by the Charitable Funds Committee on 06.03.2024.		
Action required:	**For information** ☐	**To receive and note** ☒	**To approve** ☐
Recommendation:	The Board of Directors are asked to receive and note the fundraising strategy.		
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 with the approved fundraising strategy which, when enacted, will directly contribute to our organisational 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 8 - Transformation and Partnerships		
Risk: Risk ID: *As appropriate*			
External standards affected by this report and associated risks	National policy, guidance		

Report title: Fundraising strategy		**Meeting date:** 27th March 2024
Report sponsor	Deputy Chief Executive/Chief Strategy and Transformation Officer	
Report author	Associate Director of Communications and Partnerships; Fundraising and Partnerships Manager	

1. Background

In recognising its role in supporting our people and communities, our new fundraising strategy looks to explore the greater role our Torbay and South Devon NHS Charity can play in supporting our wider organisational objectives, aligning our strategic intent with organisational priorities, and investing in the resources required to enable our charity to reach its full potential.

Drawing on insights from a range of stakeholders we have developed what we believe is an ambitious but focused five-year fundraising strategy that recognises the constraints in which we are working and the baseline from which we need to build.

We are acutely aware of the challenges that face our communities and mindful of the potential disruption on local giving that developing our charity could have.

We are privileged to have eight hospital League of Friends who support specific services and locations in our localities as well as the Torbay Medical Research Fund. These are our partner charities.

We also have several associate charities, outlined in our fundraising protocol, who have been selected because their aims are aligned with ours and because they raise funds or provide services for the benefit of health and care services or people working in health and care services in Torbay and South Devon.

We are seeking to build an abundance model in which we bring additional funds into our local communities to deliver on our vision of better health and care for all.

2 Recommendation

Committee members are asked to **receive and note** the fundraising strategy.

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Fundraising strategy 2024-2029

Torbay+ South Devon NHS Charity
Helping to make things better

1 Background

Our charity has been fairly undeveloped since it was registered on 24 January 1996 with the Charity Commission, yet collectively NHS charities support their respective NHS trusts by raising over £1million a day to deliver and support projects that are beyond the scope of statutory funding and enhances the services offered by the NHS. In 2022/23 our charity received £143K in donations (a positive increase on £123K received in donations in 2021/22).

Over the course of the pandemic, our charity has received access to grant funding that has enabled it to support our organisation in ways that it couldn't before while also building the infrastructure needed to develop both the charity and our approach to fundraising. The NHS as a whole has benefited from the kindness and generosity of our communities with people making both financial donations and gifts-in-kind.

NHS Charities Together, historically known as the Association of NHS Charities and a peer-support member organisation, took on a new role as a grant giver following the monies raised by Sir Captain Tom Moore for the NHS Charities Together: COVID-19 Appeal and now all NHS charities nationally are members of NHS Charities Together. Our charity has to date received £303,000 in grants from NHS Charities Together, including a grant of £30,000 to develop our charity's infrastructure.

With the appointment of an experienced Fundraising and Partnerships Manager in 2021/22 and the grant from NHS Charities Together, we have the opportunity to focus on raising our charity's profile among staff, volunteers, local businesses, our people and our communities to maximise charitable income to support the strategic and operational objectives of the organisation, to better prepare for the future and to deliver our vision of better health and care for all. Our fundraising strategy will help us focus our efforts and measure our success.

This is particularly timely as the latest research on UK charitable giving[1] identified a trend of fewer people giving to charity with donation levels below the pre-pandemic figures and that one in eight donors are considering cutting back on or reducing donations to charities in response to the cost of living crisis. We know that many people have less to give and so are prioritising causes that are personal to them.

2 Our communities

Our population reflects that of many coastal and remote rural communities, with a significant level of health inequality and high levels of deprivation. Torbay itself is the most highly deprived community in the south west.

We have a low wage and low skill local economy with a heavy reliance on tourism. Poverty and deprivation are key determinants of health and as a result we see significantly more alcohol and self-harm related admissions and poorer mental health and physical health outcomes. Many of our children start their lives at a disadvantage. We have high numbers of looked after children and children with protection arrangements in place.

We have a larger proportion of older people than the national average and, due to our area's attractiveness as a retirement location, we expect to see this increase further.

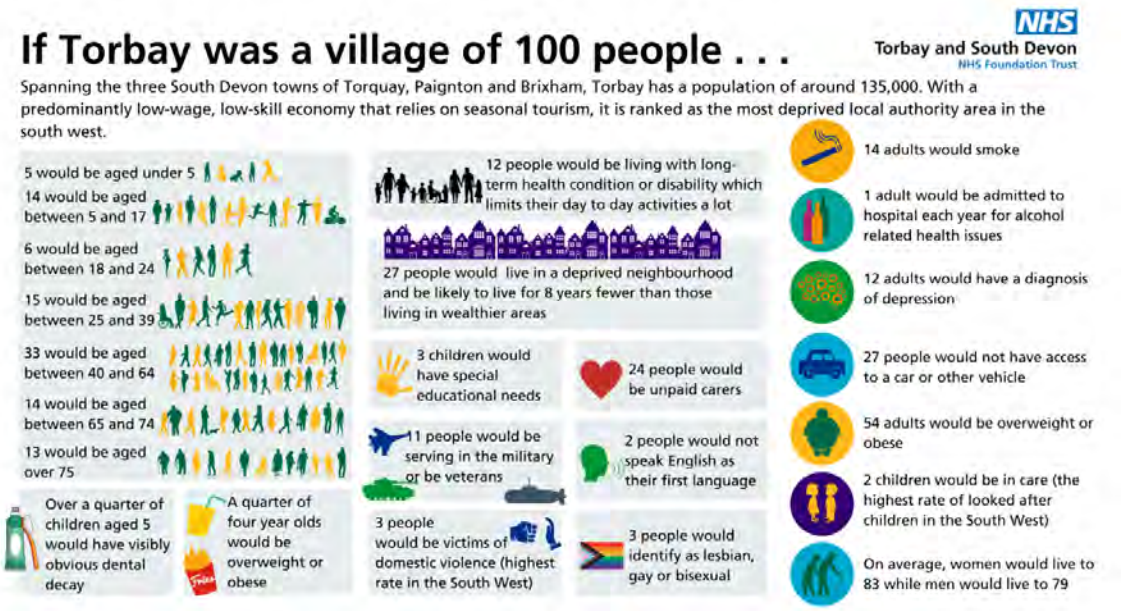
[1] UK Giving 2022 | Largest charity giving study in the UK | CAF (cafonline.org)

Many of our older people are living with one or more long-term conditions which results in a greater demand for older people's health and care services, with less young people in our labour market to provide care.

We have some of the highest rates of self-harm and suicide in the country as a result of the high levels of deprivation in our communities. 1 in 6 adults experience a mental health problem and poor mental health is the second leading cause of ill-health.

The suicide rates in our communities are significantly higher than the national average, alongside high rates of self-harm and high levels of domestic abuse. 44% of our self-harm admissions relate to children or young people and we also have high rates of teenage pregnancy and admissions for alcohol related issues in young people.

The infographic below is based on data from the Torbay Joint Strategic Needs Assessment. Our coastal and remote rural communities in South Devon face similar challenges.



3 Our operating context

We are proud and grateful to benefit from the support of a number of partner and associated charities including our eight hospital League of Friends.

Our eight Leagues of Friends are steadfast and generous supporters of those services which are based in our hospitals (or our former hospitals which are now health and wellbeing centres – such as Paignton, Ashburton and Teignmouth). In the majority of cases, it is their custom and practice to focus on donating equipment to services based at their relevant site and they have supported bids both large and small and for both medical and non-medical equipment.

We will continue to work closely with our Leagues of Friends to ensure that we support them to focus on those areas which matter to them while keeping them informed of our plans and developments, ensuring that we build an abundance model locally which maximises opportunities for our services and patients to benefit from charitable giving.

We will also look to work more closely with the charities of our NHS partner organisations in Devon where this brings added benefit. For example, Children and Family Health Devon is run by ourselves and Devon Partnership NHS Trust – our charities will look to work together to benefit this service, the people the service supports and the staff of both organisations who work for the service.

Our charity currently has 160 restricted funds with some funds having significant amount of monies while others are very low. Our unrestricted funds are low which inhibits our ability to support those of our services who do not have access to a restricted fund. There is a lack of equity and equality of opportunity in terms of access to charitable funds which is concerning, particularly among our adult social care and community services, which this fundraising strategy actively seeks to address.

3 Our emerging thinking – fundraising strategy

Our fundraising vision – helping to make things better

Our fundraising vision must be aligned to and support our organisational vision – better health and care for all. To this end, we have chosen ‘helping to make things better’ as our fundraising vision and strapline for our branding.

Our vision is to provide better care for you, your family and neighbours, from birth to the end of life and everything in-between. By supporting us, you are helping to make things better for people in Torbay and South Devon.

Our fundraising mission is to work with Torbay and South Devon NHS Foundation Trust to make a positive impact on the health and wellbeing of people who use our services and our dedicated, talented and amazing people. By investing in innovative healthcare initiatives and promoting the wellbeing of our people, we strive to create an inclusive culture that benefits all those who come into contact with our charity. Our intent is to ensure equity of opportunity for all our health and social care services to benefit from our charity.

Our NHS values drive us to support excellent care every day, ensuring that the needs of our people and our communities are cared for both now and in the future.

Our aim for our charity

It will be well governed, well managed and resourced as it grows, aiming to raise over £1million in income annually by 2028 to deliver for our people and communities providing positive benefit and impact for our people and our communities.

It will be visible across all our services and be a key driver in our organisational people priority to create a culture at work where people are safe, healthy and supported. Our charity will engage our people, volunteers and communities in fundraising initiatives and demonstrate a clear benefit to our organisation.

It will be the charity of choice for our staff and volunteers who will champion it and use their friends and family networks to encourage further support of our charity and promote it to patients, carers and the public.

Using innovative fundraising campaigns and compelling story telling to raise its profile, our charity will be well recognised and respected by our communities who will trust us to

use their donations in line with their wishes and to thank our staff for the care they provide to themselves and their loved ones. During the lifetime of the strategy we will grow a database of supporters who we will keep informed and engaged aiming to build a community of lifelong supporters.

We will retain our supporters by making them feel really valued with handwritten thank you notes, creating opportunities to meet the teams they support, letting them know the difference their donation has made and keeping in regular touch with updates and information.

Our fundraising aims
Within the life of this strategy our fundraising will:

- grow an annual charitable income of over £1 million
- increase the percentage of unrestricted donations and gift aid as a percentage of our income from 1.4% to 25%
- increase the percentage of donations on which we receive gift aid from 2.8% to 15%
- actively engage our people and volunteers in fundraising and as charity ambassadors
- establish a stewardship programme that encourages donors to become lifelong supporters
- establish a robust scheme for unrestricted income based on our fundraising principles
- launch a staff lottery that will fund grants for staff wellbeing projects aiming to achieve 5% of staff playing (350) with an average of 1.5 entries (525) contributing £25,200 pa by the end of this strategy
- develop a wealth of case studies and examples of charity funded projects to demonstrate its impact.

We recommend that alongside our fundraising programme the charity undertakes a programme of work to condense our 160 restricted funds to fewer than 10 under broad themes that both reduce bureaucracy and increase equality of opportunity.

For example, five years ago Wirral University Teaching Hospitals NHS Foundation Trust streamlined over 120 restricted funds to eight restricted funds (Heart care, Stroke, Respiratory, Cancer care, Breast care, Critical care, Childrens and Patient Wish).

Should the Charitable Funds Committee wish to take this forward, a programme of robust engagement with current fund managers as well as other key stakeholders will be needed but the potential benefits are, we believe, significant.

Our fundraising principles
To effectively deliver our fundraising strategy we are proposing to establish fundraising principles that will help shape and guide everything we do across our services and communities and which are aligned to our organisational strategic objectives. By clearly setting these out, it will help us shape and support our funding decisions, drive and direct our fundraising activities and ensure that our work aligns with our organisational strategy.

Reducing health inequalities – supporting our services to provide equal healthcare opportunities for all

We are committed to raising funds to support initiatives and programmes that promote inclusion, access and equality in healthcare. This may include funding for services that help to reduce health inequalities, such as outreach programmes to under-served communities or initiatives that improve access to healthcare for marginalised groups.

This may also include funding for travel and accommodation for family members, for example, to visit loved ones who are undergoing specialist treatment outside their local area who would not otherwise be able to support them or spend time with them.

We will aim to fund initiatives and programmes that promote diversity and inclusion within our workforce. This may include funding for programmes and training that help people from under-represented groups to pursue careers in healthcare as well as initiatives that promote a more diverse and inclusive workplace culture.

We will also, where funding allows, support initiatives that promote cultural competence and sensitivity among our people. We may fund programmes that provide our people with training and resources to better understand the healthcare needs of our diverse populations.

Supporting our people – through activities and initiatives that bring people together

Through the income from our staff lottery, we will fund a range of activities, initiatives and projects that bring our people together in an inclusive and supportive way. Colleagues will be invited to bid for funds to support activities that promote team building or, for example, physical activity, time in nature or creative thinking.

We know that when our people feel supported, valued and cared for, they are better able to provide high quality care and support to people who use our services and are less likely to experience ill health or leave our employ.

Supporting health education – supporting health education and awareness

Where funding allows, we will fund initiatives that promote health education and training for our people, community-based programmes and outreach initiatives that provide health education and support. We will use emerging evidence to identify the most appropriate way of providing this.

We will look to collaborate with local partners on outreach initiatives to those in our communities who may find it difficult or challenging to access traditional healthcare.

By supporting health education and awareness, we will be contributing to our organisational purpose to support the people of Torbay and South Devon to live well, improving health outcomes in our local communities while lowering healthcare costs and reducing future demand on healthcare services.

Improving people's experience and their environment

We believe that healthcare goes beyond treating physical or mental ill health. What matters to us is ensuring that our people feel comfortable, cared for and supported. By improving the environment in which we deliver care we can alleviate stress and anxiety and improve everyone's wellbeing.

We will seek to raise funds to support a range of projects and initiatives that seek to improve our environment and people's experiences when visiting and working in our buildings.

We may fund or seek grants to fund art work, lightboxes and digital screens where they can improve the physical environment for our people. We may also fund improvements to waiting areas and public areas in our buildings as well as rest rooms for our people. We may also fund or seek grants to fund improvements to our external environment which may include walking trails, tree plantings, landscaping, sculpture etc.

Agreeing our fundraising campaigns

As we grow our unrestricted funds we are proposing the following allocation:

- 50% to fund our microgrants scheme (the grants will be given to improve and enhance patient care and/or benefit staff wellbeing. Priority will be given to teams without a charitable fund and/or who are unable to apply for external charitable funding, for example from our League of Friends)
- 50% to fund two or three agreed annual projects or programmes that align with our fundraising principles

We are proposing that each year we run a small number of targeted fundraising campaigns where there is a specific call to action to donate funds for a purpose that is simple to explain, clearly marketable and aligns to our fundraising principles.

We are recommending the establishment of a fundraising operational group which sits under and reports to the Charitable Fund Committee and includes representatives from clinical, operational and corporate services. Suggested membership includes:

- Fundraising and partnerships manager
- Either a care group director, associate medical director, associate director of operations or associate director of nursing and professional practice from **each** of the four care groups
- Director of capital developments
- Director of workplace
- Associate director of people
- Deputy chief nurse
- Deputy medical director
- Associate director of transformation
- Deputy director of finance
- Representatives from our staff networks
- Staff side representatives

This group would actively canvass project bids from across the organisation for the annual projects or programmes and score these against an agreed matrix, making recommendations to the Charitable Funds Committee for approval.

Representatives from the group would also sit on the microgrants panel.

Terms of Reference for the group would be developed and submitted to the Charitable Funds Committee for approval should this recommendation be approved.

Consideration will also be given to how the views of people who use our services and our local communities are heard by this group and influence decision making.

How we will deliver our fundraising strategy

We will deliver our fundraising strategy through six workstreams:

- building our infrastructure
    - completion of the work funded through NHS Charities Together development fund
    - fully implement CRM
    - all income and donor details on the CRM
    - regular reporting
    - gift aid declarations and data consent preferences for all supporters
    - key fundraising policy documents

- growing our income
    - focus on unrestricted income channels
    - develop a marketing mix of fundraising income streams including a legacy giving programme and regular giving programme (direct debit or standing order is now the most common way to give to charity in the UK)
    - increase gift aid
    - stewardship to enable us to develop long-term donor relationships
    - providing both online and offline ways to give including contactless donation boxes and terminals

- engaging our people
    - actively engage our staff and volunteers in fundraising and as charity champions and ambassadors
    - launch charity website (launched February 2024)
    - develop social media channels (Facebook and Instagram launched)
    - annual fundraising award (presented at our people celebration event May 2024)
    - launch staff lottery (launching 2024/25)
    - consider charity presence on estate and fleet
    - microgrants scheme (launching early 2024)

- developing and engaging our fund managers
    - establishing regular lunch and learn sessions
    - developing a forward-looking, planned approach for using funds
    - ensuring protocols and guidance is in place to maximise impact, steward donors and capture feedback and stories

- creating and widening opportunities
    - establishing and growing our events calendar and annual campaigns while simplifying donating and fundraising
    - develop online community
    - annual events calendar
    - campaigns
    - patrons and high profile supporters
    - major donors
    - legacies
    - donor recognition
    - stewardship events

- communicating impact
    - developing a wealth of case studies and examples of charity funded projects to demonstrate impact
    - supporting newsletter (launching 2024)
    - annual report magazine
    - NHS Charities Together member connect
    - grant reporting
    - evaluation tool

Trends in charitable giving and our opportunities to increase fundraising income
There is so much we could do to increase our fundraising income and ensure that we are able to fund the best projects that will have the biggest positive impact for our people and our communities. However, we need to be mindful of ensuring sustainable growth, building a solid foundation from which our charity can grow and focus our limited resources effectively – rather than trying to do everything at once.

We will determine our priorities based on our analysis of trends in charitable giving, our local insights and intelligence and our desire to build an abundance model in Torbay and South Devon which does not negatively disrupt local giving.

Online giving
Online giving grew significantly during the COVID-19 pandemic (representing more than 1/8 of all charitable giving in 2020).

Our charity is registered with JustGiving which allows donors and supporters to set up personalised fundraising pages and donate directly online. We have recently registered with Stripe for donations which will replace JustGiving on our website as it has lower fees and more functionality (giving donors the ability to specify the area they wish to donate to and supporting integration with our new CRM).

We are also registered with ‘Easyfundraising’ which has over 7,000 brands signed up to give a percentage donation of sales to our charity when our supporters buy through their website. We currently have 19 people registered as supporters of our charity through this website and we aim to grow this through promotion and marketing to our people and our communities.

YouTube and Instagram are also seeing a growth among charity account followers with YouTube seeing a 52% grow and Instagram an 82% growth. In contrast, growth among charity supporters on X (formerly Twitter) was minimal at just 3%. For these reasons we are targeting Facebook and Instagram as our initial social media platforms for our charity and will set KPIs for followers for these channels.

Email marketing is vitally important for running successful appeals. Using our new CRM we will build our database and data consents to make this work for us.

Gift aid
We are registered with HMRC in order to be able to claim Gift Aid (a tax rebated of 25p in every £1 donated). We currently receive gift aid on 2.8% of donations. We aim to increase that to 15% by 2028. Ensuring that we have robust systems in place for asking about and recording Gift Aid consent is key to achieving this target.

Mobile giving
According to the Blackbaud Institute, in 2020 28% of online donations were made using mobile devices and we expect this figure to continue to grow. We are, therefore, developing a mobile friendly website for our charity with one-click donations and seamless email functions to form a streamlined donation experience.

We will also look to install tap donate points across our sites as our brand identity and awareness grows through the life of this strategy.

Offline donations
Despite the growth in online and mobile giving, cash and cheques are still well used by many people in our local communities. We need to ensure that we develop and sustain good processes for managing offline donations.

Legacies
Legacies or gifts in Wills raise £3.4bn every year for charities. As baby boomers head towards retirement, there is an opportunity to create a legacy strategy for our charity that could provide a stable income stream.

It is estimated that 2/3 adults between the ages of 35-54 have not made a Will. This area is one of our biggest opportunities and consideration should be given to setting it as a priority growth area. We would need a clear ask for legacy marketing to be developed and we would need to be very mindful not to damage our relationships with our Leagues of Friends if we chose to focus on this area.

In-memory
Creating a dedicated in-memory programme would allow us to proactively offer our supporters a meaningful way to remember a loved one. This requires a personal touch, empathy and sincerity at the heart of how we honour their loved one’s memory.

We currently use a few platforms for funeral and in memory donations including ‘MuchLoved’. It would be beneficial to work in partnership with funeral directors if we choose to develop this programme.

Staff lottery
Many NHS charities run a lottery – some of which are open to the public while others are restricted to staff.

We will be introducing a staff lottery in the first year of the strategy. Through the staff lottery we seek to create a sustainable income stream to fund wellbeing projects for our people while also offering our staff the opportunity to support our charity and potentially win regular sums of money. We are mindful that our staff lottery needs to be marketed and managed responsibly. We will be put a cap on the maximum number of entries people can make and include advisory wording from the gambling commission.

Major donors
We are lucky to have benefited from a major donor who approached us proactively in 2023. Typically, relationships with prospective major donors take 18-24 months to come to fruition. At present we do not have capacity to build a prospect pool or to increase this potential income stream, however, as our strategy progresses, we will seek to address this.

Events
We have seen an increasingly positive response to our new calendar of events through skydives, runs and inflatable challenges since it launched last year. We aim to grow our calendar of events and will look to create our own bespoke events to bring our local communities together while supporting physical activity.

Grants
We have benefited significantly from grants through NHS Charities Together in recent years which have helped us to improve our physical environment as well as supporting our people's wellbeing and creative arts projects. However, these grant rounds are likely to reduce and potentially stop over the next year or so.

Therefore, one of our priorities is to build our grant identification capacity and capability, creating a compelling case for support documents and targeting applications where we feel we can bring the biggest benefit to our people and communities (and have the greatest chance of success).

The high levels of social deprivation in our communities are particularly relevant for trust and grant applications.

Corporate sponsorship and partnerships
We will build partnerships with local companies and commercial companies who deliver projects for our trust.

We will develop a range of ways for businesses to donate their money, time, energy and expertise to spread our messages and raise funds for our people and communities.

Our initial focus will be on securing corporate sponsorship for our trust's annual celebration event for award winners and long service. Over the lifetime of the strategy we will expand this focus on local partnerships, events, charity of the year, payroll, events and further sponsorship opportunities.

Merchandise
Our initial focus is on developing appropriately branded materials for our fundraisers and supporters for their events.

We do not consider that during the lifetime of this strategy, the benefit of developing a line of merchandise would be sufficient to prioritise this area. This is an area to be considered at a future time in the development of our charity.

Resourcing our fundraising strategy
Through this strategy we will deliver a range of fundraising 'products' with an initial focus on low-risk, low resource income streams while our charity remains relatively small e.g. identified campaigns and events, staff fundraising, shared initiatives. As resource and expertise is recruited into the fundraising team over the lifetime of this strategy we can develop more resource intensive higher yielding endeavours e.g. corporate fundraising, major donor stewardship.

The fundraising team will need to grow to be able to resource the fundraising activities and support the relationships that we wish to develop. Income growth will need to be supported by increased investment into fundraising, primarily through additional staffing within the fundraising team.

We propose the recruitment of a community fundraiser and events officer in 2025/26 and a trust fundraiser and communications officer in 2027/28 with the intent that by 2028/29 there will be a team of three in the fundraising team who will be delivering our ambition of £1million a year.

Workplan

Our charity has identified key areas within each workstream to focus on in each year of this strategy. In summary these are:

Work plan year	Priorities
Current year in progress	Implement CRM Twice yearly fundraising campaigns identified (for example, NHS Big Tea and Christmas Cake Off) Launch our people award charity/fundraising category Support NHS Charities Together grand applications and reporting Launch charity website
Year 1 – scope and build 2024/25	Approved fundraising strategic direction Full utilisation of the new Donify CRM for recording and monitoring income and facilitating communications with supporters Launch Instagram account Launch staff lottery to fund wellbeing projects for our people Launch of microgrants scheme for 50% of unrestricted funds aligned to fundraising principles Launch supporter newsletter Establish lunch and learns with fund managers Review terms of reference, standing financial instructions, policies and procedures Grow events activity Develop supporter lifecycle
Year 2 – learn and grow 2025/26	Recruitment of a community fundraiser and events officer Grow events activity Focus on growing database of supporters Develop trading opportunities for commercial and/or merchandising Develop legacy strategy Grant identification programme expanded Identify and recruit patrons/high profile supporters
Year 3 – develop and promote 2026/27	Work with charity champions and ambassadors to demonstrate impact through case studies Donor stewardship events Review supporter lifecycle and retention
Year 4 – promote and mature 2027/28	Recruitment of a trust fundraiser and communications officer

	Review corporate partnerships and sponsors Develop major donors strategy
Year 5 – evaluate and review 2028/29	Write new five-year fundraising strategy Evaluate appeals and campaigns Stakeholder engagement/review of fundraising activities Review branding and market position

Measuring success and evaluating outcomes
We want to ensure that every aspect of who we are, what we do and the way we work is aligned to what we are trying to achieve.

We are proposing to set clear key performance indictors and report to Trust Management Group on a monthly basis with KPIs on an infographic. We are proposing that a quarterly performance report will be delivered to the Charitable Funds Committee.

Our first measure of success will be quantitative and focused on the level of income generation we achieve against our targets and the consequent expenditure on charitable projects. But equally important will be our qualitative measures that focus on the impact that those projects are having on the lives of our people and communities.

Potential KPIs

By 2028 we will have an annual income of over £1million
- we will monitor income against annual financial targets
- we will monitor expenditure against annual financial targets

Active engagement of our people and volunteers in fundraising and as charity ambassadors
- we will monitor participation in our staff lottery
- we will monitor our people's engagement in fundraising events
- we will aim to recruit 50 charity ambassadors or champions across our services by 2028

Grow a database of consenting supporters
- we will invest in a CRM to manage donor and supporter care
- we will monitor the number of consented donors against an annual target

Develop a wealth of case studies and examples of charity funded projects to demonstrate impact
- we will create a portfolio of images and videos to celebrate what we fund
- we will develop an evaluation tool to assess our charity's impact.

NHS
Torbay and South Devon
NHS Foundation Trust

Report to the Trust Board of Directors			
Report title: Sustainability Position and Green Plan Implementation			Meeting date: 27th March 2024
Report appendix:	Appendix One – Baseline Ecological Survey		
Report sponsor:	Interim Chief Finance Officer		
Report author:	Workplace Director		
Report provenance:	Workplace Performance and Compliance Group		
Description/Purpose of the report and key issues for consideration/decision:	This paper sets out the Trust's current sustainability position, achievements to date and future objectives to comply with national NHSEI sustainability targets.		
Action required:	**For information** ☒	**To receive and note** ☐	**To approve** ☐
Recommendation:	That the Trust Board note the content of the report.		

Summary of key elements	
How does this report further our purpose to "support the people of Torbay and South Devon to live well"?	As a taxpayer funded anchor organisation with a large property portfolio, the Trust has an obligation to maximise the environmental efficiency of its estate for the benefit of the health and wellbeing of employees, patients, and the local community. Reducing carbon emissions improves health.
How does the report support the Triple Aim:	1) population health and wellbeing 2) quality of services provided 3) sustainable and efficient use of resources
Relevant BAF Objective(s):	Objective 1 - Quality and Patient Experience Objective 2 - People Objective 3 - Financial Sustainability Objective 4 - Estates Objective 5 - Operations and Performance Standards Objective 10- Green Plan/Environmental, Social and Governance Objective 11 – Equality, Diversity and Inclusion
Risk: Fit for Purpose Estate Risk ID: 2179	Risk is already included in DATIX and outlined on the corporate risk register
External standards affected by this report and associated risks	Laws or regulations Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance

Report title: Sustainability Position and Green Plan Implementation		**Meeting date:** 27th March 2024
Report sponsor	Interim Chief Finance Officer	
Report author	Workplace Director	

1.0 Introduction

As a healthcare provider the Trust is morally obligated to ensure: the delivery of sustainable healthcare; safeguarding of human health; and statutory requirements in the context of sustainability. The Trust has begun making meaningful contributions towards the reduction of carbon emissions as both a provider of healthcare services and as a major local employer.

This report sets out the achievements and work being undertaken by the Trust to improve the environmental efficiency and sustainability of its portfolio and to contribute, in a meaningful way, to the reduction of carbon emissions, the protection and preservation of wildlife and its habitat, and the contribution towards achieving the NHS net zero objectives as outlined below:

- Net Zero for the emissions the NHS directly controls (the NHS Carbon Footprint) with an 80% reduction by 2028-2032
- Net Zero by 2045 for the broader emissions we can influence (the NHS Carbon Footprint Plus) with an 80% reduction by 2036-2039

2.0 Progress Against Previous Commitments

In the 2023 sustainability update to Trust board a set of 'Must Do' actions which outlined the work being undertaken to support the Trust's environmental and sustainability ambitions, these were accompanied by individual updates. The latest iteration of these actions and associated progress notes are outlined below:

Action	Status	Progress Update
Continue to develop the opportunity to collaborate with a partner organisation to develop a strategy for the provision of solar generated power to the Torbay Hospital site.	**In Progress**	Opportunity was competitively tendered by the Trust in late 2023, a preferred bidder has been appointed and commercial negotiations have commenced.
Implement an automated Monitoring & Targeting software system to	**Closed**	Agreed that the costs of implementation would be prohibitive and that, data

improve tracking and trending of utilities consumption.		would continue to be reviewed manually.
Nominate a Senior Responsible Officer (SRO) to act as a Net Zero Carbon (NZC) Lead.	**Complete**	The Trust's Interim Chief Financial Officer is the current SRO for NZC.
The development of a three-year Green Plan which aligns to *Greener NHS* guidance.	**Complete**	Published and available in the public domain.
Approve the formation of a Sustainability & Wellbeing Group	**Complete**	Group has been formed and meets on a quarterly basis.
The development of resource plan to enable the organisation to appropriately resource our Green Plan and its delivery	**Complete**	Flexible resource plan developed which gives due consideration to existing capacity and financial challenges.
Complete the current phased rollout of LED lighting and identify additional opportunities for deployment of this technology in our older retained building stock.	**Complete**	This was concluded in the final quarter of the 2021/2022 financial year.

A more detailed overview the status of incomplete actions is outlined below.

2.1 Solar Farm Opportunity

In early summer 2023, the Trust placed a public notice via the Find a Tender Service platform, inviting organisations to bid for a contract with it for the provision of a private wire power purchase agreement, for the supply of solar-generated electric to Torbay Hospital.

Several organisations expressed an interest and submitted proposals, and in February 2024 a preferred bidder was nominated. The Trust is now in the early stages of negotiating the commercial aspects of the bidder's proposal, with a view to reaching final award stage by the end of June 2024. Approval will be sought from the Trust's Finance and Performance Committee to move to final award, and a more detailed update will be provided to Trust board following this.

2.2 Automated Targeting and Monitoring Software

Significant financial investment would be required to support the implementation of such technology. Given the challenged financial position of the Trust and the fact that such data is already available, albeit manually, it was decided that this action would be closed and re-considered in less austere times and, as part of the Trust's Building a Brighter Future programme.

It is worth noting that, a series of improvements have been made to the Trust's Building Management System (BMS), which has enhanced its ability to identify inefficient plant and, undertake targeted interventions in order to reduce its environmental impact.

In addition to this, for any new Trust buildings constructed (e.g. new endoscopy unit, TIF theatres etc) additional sub-meters are now installed, allowing for very specific monitoring of energy consumption and environmental performance of the building in question. This also allows the Trust to monitor whether the newly constructed units are performing within the design parameters for energy consumption.

3.0 Sustainability Initiatives

In addition to the activities outlined in section 2.0 and those highlighted in the 2023 update to board, several high impact initiatives have been implemented across the Trust to enhance its environmental efficiency, take ownership of its responsibility to the environment and wildlife and its habitat on and around the estate, and better engage staff and patients in the green agenda which are outlined below.

3.1 Keep Cup Initiative

in late 2023, the Trust ceased to use wax-finished carboard cups in hot beverage outlets on the acute site, instead issuing all staff members with a re-usable takeaway cup (which also provides a discount on purchases made) and encouraging non-staff members to either rent or buy a reusable takeaway cup, or 'drink in' using crockery cups and mugs.

The initiative was a huge success and landed well with staff as a clear demonstration of the Trust's commitment to reducing its carbon footprint and acting in a more environmentally conscious way.

This simple change has reduced the number of cardboard cups disposed of by the Trust by 35,000 each year and, has resulted in a financial saving of £8k per annum.

3.2 Electric Bike Loan Scheme

In April 2024, the Trust will launch its electric bike loan scheme. This allows our staff to loan an electric bike for a period to allow them to cycle to and from work, negating the need to drive and therefore, reducing carbon emissions.

3.3 Healthy Travel Event

In August 2023, the Trust launched its inaugural Healthy Travel Event, promoting its: cycle to work scheme; discounted bus travel scheme; walk to work information; personalised travel plan service; staff travel survey; and the electric

bike loan scheme. These events will continue to take place routinely at key points throughout the year, with the next taking place in April 2024.

3.4 The Gloves Are Off Campaign

The Trust launched its 'The Gloves Are Off' campaign in September 2023, raising awareness about the correct and appropriate use of non-sterile gloves. The aim of this ongoing campaign is to improve patient safety and deliver high quality care which is sustainable and cost-effective.

3.5 Biodiversity

Enhancing the natural environment on Trust sites and utilising our significant green footprint to improve conditions for wildlife, and make outdoor space more enjoyable for staff, patients, and the local community remains a priority for the Trust.

Both the acute and community sites continue to benefit from biodiversity initiatives including bee and bug hotels; meadows; pollinator patches; bird and bat boxes and sensory walks.

In July 2023, Devon Wildlife Trust undertook a baseline ecological survey of the acute site to establish the work the Trust is required to undertake in order to achieve the prestigious Biodiversity Benchmark, which is a standard that certifies and celebrates the management of landholdings for nature and wildlife. If successful, Torbay and South Devon would be the first NHS Trust in England to attain this standard.

The report recognises and commends the biodiversity initiatives already implemented by the Trust, and has made a series of recommendations for implementation, which would qualify the Trust for the Biodiversity Benchmark in the 24/25 financial year. These recommendations are currently being implemented and will be completed in the second quarter of the 24/25 financial year. The survey is annexed to this report.

3.6 BREEAM Compliant Construction

BREEAM is the Building Research Establishment Environmental Assessment methodology and is followed by the Trust in the construction of any new buildings. BREEAM encourages the construction of buildings in an environmentally efficient way which has resulted in innovations such as the installation of solar panels newly constructed buildings and units within the Trust (e.g. Dartmouth HWBC, New Theatres, Endoscopy etc).

4.0 Priorities for 2024/2025

Environmental and Sustainability priorities for the Trust for the 2024/2025 financial year are as follows:

- Attainment of the Biodiversity Benchmark
- The implementation of sensory gardens across the community estate
- Final award and mobilisation of power purchase agreement for renewables
- Continued delivery of campaign events (e.g. The Gloves Are Off, Healthy Travel Week, Greener AHP Week etc)
- Refreshing the Trust's Green Plan (expires 2025)

These priorities will be led by the Workplace Team, accountable to the Trust's Sustainability and Wellbeing Group and will form the basis of the sustainability update to board in 2025.

5.0 Summary

The Trust has made significant progress in embedding a sustainability focussed mindset as part of its culture and has focussed on the delivery of initiatives which are both educational and engaging for staff, patients, and the local community.

Almost all of the 'Must Do' actions previously identified have been implemented and these, along with the numerous sustainability initiatives implemented across the past year have supported the Trust to make material progress in reducing its carbon footprint and better supporting the protection and improvement of wildlife and its habitat.

The Trust must continue with the current energy and focus on the sustainability agenda into future years and work hard to deliver on its five sustainability priorities for 2024/2025.

6.0 Recommendation

The Trust board is asked to note the content of this report.

DEVON WILDLIFE CONSULTANTS

Torbay Hospital, Devon

Baseline Ecological Survey for Biodiversity Benchmark

Report No: 23/4226.01
Date: July 2023
Client: Torbay and South Devon NHS Foundation Trust

Wildlife Trust Consultancies

Unit 2, Aldens Business Court, Chudleigh Road, Exeter EX2 8TS
01392 455930
dwc@devonwildlifetrust.org
www.devonwildlifeconsultants.co.uk

Revision	Prepared by	Authorised by	Dated
Initial Issue	**James Woodin BSc. (Hons) ACIEEM** **Megan Irwin BSc. (Hons)**	**Li-Li Williams MEnvSci. (Hons) MCIEEM**	08/08/2023

This report has been prepared for Torbay and South Devon NHS Foundation Trust in accordance with the terms and conditions of appointment supplied with Tender Number T/4226.01 dated 28th April 2023. Devon Wildlife Consultants cannot accept any responsibility for any use of or reliance on the contents of this report by any third party.

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DEVON WILDLIFE CONSULTANTS

Contents

1 Introduction

1.1 Purpose of Assessment

DWC was commissioned by Torbay and South Devon NHS Foundation Trust to undertake a Baseline Ecological Survey for a site known as Torbay Hospital, Devon. It is understood that it is proposed to enter the site for the Biodiversity Benchmark Scheme.

The site was surveyed for signs of legally protected or notable habitats or species, and to evaluate the habitat and wildlife value/potential of the site. The aim of the baseline survey is to provide a record of habitats that are present within the survey area using a recognised habitat classification (UK Habitat Classification) and to undertake an assessment for protected and other noteworthy species and assess the importance of the habitat features recorded.

1.2 Location

The site is located in the north-eastern extent of Torbay, Devon, centred at National Grid Reference SX 898 658.

1.3 Current Site Management

It is understood that it is proposed to enter the site for the Biodiversity Benchmark Scheme.

The first stage of the Biodiversity Benchmark assessment is to:

- Undertake a baseline survey to record the habitats and species present;
- complete a review of these habitats and the condition of the site as it currently stands;
- undertake a review of all biodiversity data available for the immediate area around the site; and,
- derive a series of options for management for optimal enhancement for biodiversity.

2 Survey Methodology

2.1 Preliminary Ecological Appraisal

The Baseline Ecological Survey comprised a walkover survey using The UK Habitat Classification Survey methodology as set out in the UK Habitat Classification User Manual version 1.1 (Butcher *et al*. 2020). This is a standard technique for classifying and mapping habitats within the United Kingdom. Areas within the site were surveyed and assessed for indicators of ecological value, including the presence or signs of any protected or rare species. A condition assessment of all habitats was undertaken and a desk-based assessment to identify protected species and habitats present within a 1km radius of the site was also undertaken.

2.1.1 Desk Survey

Searches undertaken for the desk study are summarised in Table 2.1:

Source	Information sought
Devon Biodiversity Records Centre (DBRC)	A standard search area consisting of a 1km radius of the site from a central grid reference was requested from DBRC. Details of statutory and non-statutory sites designated for nature conservation or interest, together with records pertaining to protected species and/or species of conservation concern were obtained.
Devon Bat Group (DBG)	Information pertaining to bat species was requested from DBG for an extended search area radius of 2km from the site. This extended area is to account for the mobile nature of bat species, with particular emphasis on the identification of known roosts for greater horseshoe bats *Rhinolophus ferrumequinum*.
Magic (www.magic.gov.uk)	Information regarding the presence of statutory designated sites within a 2km radius of the site. The search was extended to 10km for Natura 2000 sites (Special Areas of Conservation (SAC) and Special Protection Areas (SPA)).
Devon County Council Environment Viewer (www.maptest.devon.gov.uk)	The Environment Viewer was consulted to determine whether the site is located within the Devon Nature Recovery Network.
Open source 1:25,000 Ordnance Survey mapping	Any mapped water bodies within a 500m of the site.

Table 2.1 Summary of Desk Study Search Methodology

2.1.2 Badger Sett Assessment

The site was surveyed for the presence of badger *Meles meles* setts. Any setts identified were classified into the following sett types:

- Main sett – large number of holes, with signs of recent activity including fresh spoil and well-worn tracks to and from the sett.

- Annexe sett – several holes which are close to a main sett and are connected by well-worn paths.
- Subsidiary sett – small number of holes not connected to another sett by paths.
- Outlier sett – one or two holes with signs of sporadic use.

2.2 Biodiversity Net Gain Assessment

Specific areas within the site were surveyed and assessed for their ecological value and condition. Where appropriate, habitat condition assessments were undertaken in line with the methodology outlined in the Biodiversity Metric 4.0 Technical Supplement (2023).

2.3 Limitations

It is possible that some species may have been overlooked in the field or were not recorded because they were not evident at the time of survey. No account can be taken for the presence or absence of a species on any particular day.

It should be noted that the scope of the survey did not include an assessment of bat roosting potential of the buildings or trees.

2.4 Personnel

The site was surveyed on 23rd June 2023 by Li-Li Williams MEnvSci. (Hons) MCIEEM and James Woodin BSc. (Hons) ACIEEM. DWC staff are professional ecologists and follow the code of conduct of the Chartered Institute of Ecology and Environmental Management (CIEEM). This survey work has been undertaken following the CIEEM Guidelines for Preliminary Ecological Appraisal (CIEEM, 2017).

3 Survey Results

Desk study data provided by DBRC pertaining to designated sites is presented in Appendix 1. Full desk study data from DBRC and DBG can be provided on request. All relevant legislation and planning guidance is provided in Appendix 2. Raw survey data is included in Appendix 3. A UKHab Baseline Map (DWC Drawing Number 23/4226.01-01) is presented in Appendix 4, including Target Notes (TN) highlighting features of interest. Site photographs are provided in Appendix 5.

3.1 Designated Sites

There are eight non-statutory designated sites within a 1km radius of the survey area. However, these sites are considered unlikely to be affected by the works. The closest of these sites is Shiphay Hospital (OSWI) located in the western extent of the survey area.

The site falls within a Great Crested Newt (GCN) Consultation Zone,

3.2 Habitats

The habitat parcels within the survey area at Torbay Hospital largely comprise amenity landscaping around car parks, roads and buildings, with areas of woodland also present adjacent to the site boundaries. Much of the amenity landscaping immediately surrounding the buildings comprises modified/amenity grassland which is regularly mown, with areas of shrub planting also present. However, habitats around the periphery of the site are less intensively managed and there are areas of other woodland; mixed and other woodland; mixed mainly broadleaved on the eastern and south-western site boundaries.

In other areas, existing habitats have already been enhanced for wildlife/biodiversity and parcels of other-neutral grassland were identified during the site survey, particularly in the south-western extent of the site. Numerous bat, bird and insect boxes are located throughout the site, and standing and fallen deadwood piles have been created in the woodlands.

A number of hedgerows were identified within the survey area, comprising both native and ornamental/non-native hedgerows. Several semi-mature trees were also recorded throughout the survey area. The habitats present on site are described fully in Table 3.1 – 3.4. These habitats have been classified using the UKHab classification system (Butcher *et al*. 2020).

A UKHab Baseline Map (DWC Drawing Number 22/4226.01-01) is presented in Appendix 4 and details the location of each habitat parcel.

3.2.1 Area Habitats - Grasslands

Habitat Parcel No.	Grassland Areas	UKHAB Code
17	Habitat Parcel No. 17 comprises other-neutral grassland. The majority of the grassland attains a sward height above 7cm.	g3c

Other-neutral grassland	Frequent species present in the grassland include false-oat grass, oxeye daisy *Leucanthemum vulgare*, cock's-foot *Dactylis glomerata*, field bindweed *Convolvulus arvensis*, common nettle *Urtica dioica*, spear thistle *Cirsium vulgare*, bramble *Rubus fruticosus* agg. and common hogweed *Heracleum sphondylium*.	
25 & 26 Other-neutral grassland	Habitat Parcel No. 25 and 26 comprise other-neutral grassland. The majority of the grassland attains a sward height above 20cm. The grasslands are dominated by herbaceous species and abundant species present in the sward include common knapweed *Centaurea nigra*, common nettle, oxeye daisy, field bindweed, common hogweed, yarrow *achillea millefolium*, white campion *Silene latifolia* and creeping buttercup *Ranunculus repens*.	g3c
29 Other-neutral grassland	Habitat Parcel No. 29 comprises other-neutral grassland. The majority of the grassland attains a sward height below 7cm. Frequent species present in the grassland include Yorkshire fog *Holcus lanatus*, sweet vernal grass *Anthoxanthum odoratum*, common bent *Agrostis stolonifera*, brome sp. *Bromus* sp., common daisy *Bellis perennis* and common catsear *Hypochaeris radicata*. Occasional species present include common knapweed, creeping buttercup *Ranunculus repens*, oxeye daisy, broad-leaved dock *Rumex obtusifolius*, field bindweed, red clover *Trifolium pratense* and ribwort plantain *Plantago lanceolata*. Scattered trees have been planted within the grassland and comprise Scot's pine *Pinus sylvestris*, ash *Fraxinus excelsior*, beech *Fagus sylvatica*, birch *Betula pendula*, lime *Tilia x europaea*, holly *Ilex aquifolium* and wild cherry *Prunus avium*.	g3c
50 Other-neutral grassland	Habitat Parcel No. 50 comprises other-neutral grassland. The majority of the grassland attains an average sward height of above 20cm, though there are significant patches of bare ground. Dominant species present in the grassland include false-oat grass, annual meadow grass *Poa annua* and common bent. Other species present include perennial rye *lolium perenne*, cock's-foot, ox-eye daisy, common bird's-foot-trefoil, *Lotus corniculatus*, ribwort plantain, common daisy, common catsear and red valerian *Cantranthus ruber*.	g3c
18 Modified Grassland	Habitat Ref No. 18 comprises modified grassland. The majority of the grassland attains a sward height below 7cm. Species present within the sward include perennial rye grass, common daisy and yarrow.	g4
1 & 2 Modified grassland	Habitat Parcels No. 1 and 2 comprise modified grassland. The majority of the grassland attains a sward height below 7cm. Frequent species present in the grassland include Yorkshire fog, creeping buttercup and common daisy. Scattered tulip sp.	g4

	Tulipa sp. has also been planted within the grassland as well as planters containing ornamental species.	
4 & 43 Modified grassland	Habitat Parcels No. 4 and 43 comprise modified grassland. The majority of the grassland attains a sward height below 7cm. The grassland is dominated by perennial rye grass. Additional grass species within the sward include, Timothy P*helum pratense*, cock's-foot, crested dog's-tail *Cynosurus cristatus* and Yorkshire fog. Forbs present within this grassland include white clover, creeping buttercup, greater plantain *Plantago major*, dandelion *Taraxacum officinale* and broad-leaved dock. Scattered trees are also present in these areas.	g4
6 & 12 Modified grassland	Habitat Parcels No. 6 and 12 comprise modified grassland. The majority of the grassland attains a sward height below 7cm. This grassland contains various grass species such as perennial rye, annual meadow grass and common bent. Herbaceous species present include common knapweed, common mouse ear *Cerastium fontanum*, ribwort plantain, common daisy, common catsear, selfheal and meadowsweet *Filipendula ulmaria*. Scattered oak trees *Quercus robur* are present in Habitat Parcel No.12 with hawthorn *Crataegus monogyna*, beech, blackthorn *Prunus spinosa* and alder *Alnus glutinosa* trees present in Habita Parcel No. 6.	g4
7 Modified grassland	Habitat Parcel No. 7 comprises modified grassland. The majority of the grassland attains a sward height below 7cm. Frequent species present in the grassland include perennial rye grass, annual meadow grass, common daisy and dandelion. Occasional species present include white clover, lesser trefoil, common catsear, yarrow and ribwort plantain. A number of scattered trees are located within the habitat parcel including oak, cherry, ash and Norway maple *Acer platanoides*.	g4
8 Modified grassland	Habitat Parcel No. 8 comprises modified grassland. The majority of the grassland attains a sward height below 7cm. The grassland contains species such as perennial rye grass, annual meadow grass, common daisy, white clover, common sorrel *Rumex acetosa*, dandelion, common catsear and creeping buttercup. A mixture of non-native shrubs are present on the boundaries of the habitat parcel. Species present include laurel *Laurus nobilis*, winter jasmine *Jasminum nudiflorum* and snowberry *Symphoricarpos albus*.	g4
14 & 15 Modified grassland	Habitat Parcels No. 14 and 15 comprise modified grassland. The majority of the grassland attains a sward height below 7cm. Frequent species present in the grassland include common daisy, dandelion, perennial rye grass, annual meadow grass and white clover. Scattered trees are present including crab apple *Malus sylvestris* and birch. A number of shrubs are also present including sycamore *Acer pseudoplatanus*, ivy *Hedera helix*, hazel *Corylus avellana* and fuchsia sp. *Fuchsia* sp.	g4

16 Modified Grassland	Habitat Parcel No. 16 comprises modified grassland. The majority of the grassland attains a sward height below 7cm and mostly contains overturned ground that has been recently reseeded. However, there is an area of grassland within the parcel. Species present include oxeye daisy, red clover, white clover, common catsear, ribwort plantain, yarrow, field bindweed, cock's-foot, perennial rye grass and false oat grass.	g4
19 Modified grassland	Habitat Parcel No. 19 comprises modified grassland. The majority of the grassland attains a sward height below 7cm. Frequent species present in the grassland include Yorkshire fog, false-oat grass, sweet vernal-grass, cock's-foot, common knapweed, creeping buttercup, field bindweed, common sorrel, ribwort plantain, common daisy and common catsear. Scattered cherry trees are present within the parcel.	g4
19a Modified grassland	Habitat Parcel No. 19a comprises modified grassland. The majority of the grassland attains a sward height above 7cm. Dominant species present in the grassland include nettle and hogweed. Other frequent species include false-oat grass and field bindweed.	g4
30, 35 Modified grassland	Habitat Parcels No. 30 and 35 comprise modified grassland. The majority of the grassland attains a sward height below 7cm. Frequent species present in the grassland include daisy, yarrow, white clover, common catsear, dandelion, ribwort plantain and greater plantain. A number of scattered trees are present in this area and comprise cherry, elder *Sambucus nigra* and beech *Fagus sylvatica*.	g4
47 Modified grassland	Habitat Parcel No. 47 comprises modified grassland. The majority of the grassland attains a sward height below 7cm. Dominant species present in the grassland include Yorkshire fog, creeping buttercup and common daisy. Other species present include red fescue *Festuca rubra* and white clover. Scattered trees have also been planted within the grassland.	g4
9, 13, 49 Modified grassland/ Parkland	The habitat found within these habitat parcels comprises modified grassland within a parkland setting. The grassland beneath the scattered trees is regularly mown and approximately 90% of the sward is below 5cm in height. The sward is dominated by perennial rye grass and annual meadow grass, with common daisy and dandelion also present. The trees present within the parkland include beech, horse chestnut *Aesculus hippocastanum* and turkey oak *Quercus cerris*.	g4 - 20
21 & 22 Modified grassland/ Parkland	Habitat Parcel No. 21 and 22 comprise modified grassland within a parkland setting. The grassland present attains a sward height below 7cm, and the sward is dominated by red clover, red campion, wild mustard *Sinapis arvensis*, poppy *Papaver somniferum* and daisy.	g4 - 20

37, 38, 39 Modified grassland/ Parkland	The habitat found within these habitat parcels comprises modified grassland within a parkland setting. The grassland present attains a sward height below 7cm and the sward is dominated by perennial rye grass and annual meadow grass, with common daisy and dandelion also present. The trees present within the parkland include cherry, ash, hornbeam *Carpinus betulus* and apple.	g4 - 20
23, 28, 32, 33, 34, 40, 40a, 47 Modified grassland	The habitat present within these habitat parcels comprises modified grassland verges. The majority of the verges attain a sward height below 7cm and are regularly mown. Frequent species present within the swards include perennial rye grass, common daisy, yarrow, dandelion, ribwort plantain and annual meadow grass.	g4 - 64

Table 3.1 UKHAB habitat descriptions with codes

3.2.2 Area Habitats - Woodlands

Habitat Parcel	Woodland Areas	UKHAB Code
3 Other woodland; mixed; mainly broadleaved	Habitat Parcel No.3 comprises other woodland; mixed; mainly broadleaved. Many of the trees within the canopy are of similar ages and there are two age classes present throughout the woodland. Tree species present within the canopy include beech, holly, sycamore, ash, Scot's pine horse chestnut, silver birch, oak, wild cherry and rowan *Sorbus aucuparia*. The understorey predominantly comprises species such as hazel and rowan. The ground flora within the woodland is relatively developed with some ancient woodland indicators present such as bluebell *Hyacinthoides non-scripta*, wild garlic *Allium ursinum*. Other species present within the ground flora include soft shield fern *Polystichum setiferum*, hart's tongue fern *Asplenium scolopendrium*, herb Robert *Geranium robertianum* and pendulous sedge *Carex pendula*. The Schedule 9 species three-cornered-leek *Allium triquetrum* was also identified within the woodland.	w1h5
20 other woodland; Mixed; mainly conifer	Habitat Parcel No.20 comprises other woodland; mixed; mainly conifer. Nearly all the trees within the canopy are the same age and there is one age classes present throughout the woodland. The canopy predominately comprises conifer species including Scot's Pine and Douglas fir *Pseudotsuga menziesii*. Deciduous species present within the canopy include beech, ash and sycamore. The understorey within the woodland is limited to isolated stands of hazel and the ground flora is dominated by common nettle, bramble and small areas of modified grassland.	w1h6

36 Other woodland; mixed	Habitat Parcel No. 36 comprises other woodland; mixed. Species present within the canopy includes ash, Scots pine, oak, beech and Douglas fir and many of the trees have a dense cover of ivy on their trunk. The understorey and ground flora is limited and does not represent a typical NVC community found in native woodlands.	w1h

Table 3.2 UKHAB habitat descriptions with codes

3.2.3 Area Habitats – Other Habitats

Habitat/ Habitat Parcel	UKHAB Habitat Descriptions	UKHAB Code (including Secondary Codes)
Buildings	Much of the developed land within the survey area comprises buildings associated with the hospital. These buildings are permanent features and essential to the functionality of the hospital.	u1b5
Other developed land	The remaining developed land within the survey area is essential infrastructure associated with the hospital including roads, car parks and footpaths.	u1b6
Introduced shrub	There are small areas of shrub planting scattered throughout the survey area. These are typically found in close proximity to buildings or roads.	u - 1160
48 Vegetated garden	Habitat Parcel No. 48 comprises a garden. The majority of the grassland attains a sward height below 7cm with some areas of bare ground. Scattered native and non-native tree and shrub species are present throughout the parcel.	u1 - 231
51 Vegetated garden	Habitat parcel No. 51 comprises a vegetated garden dominated by rose species *Rosa* sp. Also present within the parcel includes small areas of mown modified/amenity grassland and wild cherry trees. Raised beds are present adjacent to the eastern, southern and western boundary of the parcel but are largely devoid of vegetation.	u1 - 231

Table 3.3 UKHAB habitat descriptions with codes

3.2.4 Linear Habitats - Hedgerows/banks & Lines of Trees

Habitat parcel	UKHAB Habitat Descriptions	UKHAB Code (including Secondary Codes)
H1 Native hedgerow	Hedgerow 1 (H1 on the UKHab Baseline Map) comprises a recently laid hazel hedgerow with gaps. Vegetation present beneath the hedgebank comprises ivy, nettle, cleavers *Galium aparine* and lords and ladies *Arum maculatum.*	h2a6
H2 Ornamental hedgerow	Hedgerow 2 (H2) comprises an ornamental hedgerow dominated by privet *Ligustrum Ovalifolium.*	h2b
H3 Line of trees	Hedgerow 3 (H3) comprises a line of beech trees.	w1-1174
H4 Line of trees	Hedgerow 4 (H4) comprises a line of trees including sweet chestnut.	w1-1174
H5 & H15 Line of trees	Hedgerows 5 & 15 (H5 & 15) comprise lines of trees consisting of beech, horse chestnut and turkey oak.	w1-1174
H6 Native hedgerow	Hedgerow (H6) comprises a native hedgerow consisting of hawthorn, elder, hazel, beech, holly and maple.	h2a6
H7 Line of trees	Hedgerow 7 (H7) comprises a line of trees consisting of birch and Norway maple.	w1-1174
H8 Ornamental hedgerow	Hedgerow 8 (H8) comprises an ornamental hedgerow consisting of privet.	h2b
H9 Ornamental hedgerow	Hedgerow 9 (H9) comprises an ornamental hedgerow made up of non-native shrub species.	h2b
H10	Hedgerow 10 (H10) comprises a newly planted line of trees.	w1-1174

Line of trees		
H11 Line of trees	Hedgerow 11 (H11) comprises a line of trees consisting of conifer species, rowan and maple species.	w1-1174
H12 Line of trees	Hedgerow 12 (H12) comprises a line of young birch trees.	w1-1174
H13 & H14 Line of trees	Hedgerow 13 and 14 (H13 & H14) comprises a line of beech trees.	w1-1174

Table 3.4 UKHAB habitat descriptions with codes

3.2.5 Linear Habitats – Watercourse

A watercourse is located adjacent to the western boundary of the survey area which flows on a south to north orientation through the site. The watercourse is small, with a maximum bankfull width of 2.5 – 3.0m. The average water depth along the length of the watercourse was approximately 0.3m at the time of the survey, with a number of pools approximately 0.4 – 0.5m deep. The sinuosity of the watercourse along the majority of the watercourse within the survey area is low and there are large sections where the channel is very straight. However, there are some more sinuous sections with small meanders and bends present. Given the urban nature of the river and its proximity to residential housing, it is likely that the watercourse is over-deep for its river type.

The bank faces of the watercourse are largely vegetated with some bare sections of exposed sediment. Vegetation present on the bank faces include a variety of fern species, hemlock water-dropwort *Oenanthe crocata*, pendulous sedge, bramble, hazel, common ivy, beech, sycamore and willow *Salix* sp. In places, hemlock water-dropwort is extremely vigorous and is shading out entire sections of the watercourse. There are a variety of habitats on the bank tops within 10m of the river channel including other woodland; mixed, tall herbs predominantly comprising nettle and modified grassland.

There are a variety of sediment size classes present within the channel and on the channel bed. The channel bed is a mix of silt, cobble, gravel, sand and occasional small boulders. This variety of material leads to differences in flow types within the wetted area of the channel. Observed flow types include smooth flow and rippled flow with small areas of marginal backwater. Debris in the form of fallen deadwood is present in the channel, leading to an impeding of flow in some areas, resulting in pools upstream of the debris. The turbidity of the water within the channel is low, with the channel bed clearly visible in many areas.

3.3 Species

3.3.1 Badgers

Badger are known to be present on site and a range of activity was identified within the survey area. This includes the identification of an active main sett with 9+ entrances (TN1 on UKHab Baseline Map).

3.3.2 Bats

DBG identified records of at least fourteen bat species within a 2km radius of the site, including greater horseshoe bat *Rhinolophus ferrumequinum,* brown long-eared bat *Plecotus auritus,* common pipistrelle *Pipistrellus pipistrellus*, soprano pipistrelle *Pipistrellus pygmaeus*, Daubenton's bat *Myotis daubentonii*, Leisler's bat *Nyctalus leisleri*, Nathusius' pipistrelle *Pipistrellus nathusii*, Natterer's *Myotis nattereri*, whiskered bat *Myotis mystacinus*, serotine *Eptesicus serotinus,* barbastelle *Barbastella barbastellus* and an unidentified Myotis species *Myotis sp*.

DBRC have identified records of at least four bat species within a 1km radius of the site. These records include unidentified bat species, noctule *Nyctalus noctule,* lesser horseshoe bat *Rhinolophus hipposideros* and unidentified long-eared bat species *Plecotus* sp.

3.3.2.1 Roosting Bats

DBG hold a number of records of bat roosts within a 2km radius of the site including a large soprano pipistrelle breeding roost within 1.9km of the site. A common pipistrelle house roost is located within 0.57km of the site and a lesser horseshoe day roost is located within 1.63km of site. MAGIC (www.magic.defra.gov.uk) indicates that there are no records of Natural England licences regarding bat species within a 2km radius of the site.

3.3.2.2 Bat Activity

The site provides a range of habitat features which may be utilised by bats. The woodland areas, grassland and river provide suitable foraging habitat. In addition, the hedgerows, watercourse and woodland edge provide flightlines which bats utilise for commuting to and from roosts or foraging areas.

3.3.3 Birds

The hedgerows and woodland within the site are considered likely to support a range of nesting birds, likely to comprise commonly encountered species.

DBRC returned records of several bird species including herring gull *Larus argentatus,* linnet *Linaria cannabina*, dunnock *Prunella modularis*, common bullfinch *Pyrrhula pyrrhula*, whitethroat *Sylvia communis* and song thrush *Turdus philomelos* within 1km of the survey area.

3.3.4 Dormice

The woodland and hedgerows on site represent habitats with potential to support dormice *Muscardinus avellanarius*, However, the site is bound to all aspects by residential housing and is therefore isolated from connected suitable habitats and is also likely to be subject to high levels of light spill and disturbance. This combined with the lack of records of this species from within the vicinity of the site, suggest that it is unlikely that a viable population of dormice could be supported by the habitat available within the site. Dormice will therefore not be considered further within this assessment.

3.3.5 Great Crested Newts

The site is located within a Devon Great Crested Newt Consultation Zone; this is a 5km buffer around historical records of great crested newt *Triturus cristatus*. If a site is located within this zone, the potential presence of great crested newts must be considered.

Great crested newts typically travel up to 500m from a breeding pond and spend the majority of their lifecycle in terrestrial habitats; therefore, if a site has suitable terrestrial habitat even if it does not support ponds or ditches it may be used by great crested newts.

DBRC did not return any records of great crested newt within a 1km radius of the site. Furthermore, DWC undertook an eDNA Survey for a pond adjacent to the survey area in 2020 (DWC, 2020) which returned a negative result.

There are no ponds located within the survey area. Ordnance Survey mapping indicates that there is one pond within a 500m radius of the site. However, the railway and A3022 Road are located between the site and the pond, which are considered to form a barrier to commuting newts.

3.3.6 Otters

DBRC hold no records of otter *Lutra lutra* within a 1km radius of the survey area.

Otters use a variety of riparian habitats to commute through the landscape and it is likely that they will on occasion utilise the watercourse present within the site, however no potential otter holts or resting locations were identified during the survey.

3.3.7 Reptiles

The areas of other-neutral grassland on site represent potential foraging and basking habitat for reptile species such as slowworm, *Anguis fragilis* and the hedgebanks/woodland areas may provide shelter and dispersal corridors, with tree roots providing suitable hibernation sites.
DBRC hold records of slowworm within a 1km radius of the survey area.

Previous reptile surveys within the survey area identified a population of slowworm and common lizard *Zootoca vivipara* on the site. Reptiles were identified utilising habitats adjacent to Cadewell Lane Car Park and Football Field Car Park in the northern, southern and western extent of the site (Jacobs, 2015).

3.3.8 Other Species

The hedgerows, scrub and woodlands on site in addition to the adjacent residential gardens are considered to provide suitable foraging and refuge habitat for hedgehog *Erinaceus europaeus*, a Section 41 species. DBRC hold no records of hedgehog within 1km of the site, however this may indicate an absence of records rather than an absence of this species.

3.3.9 Invasive Plant Species

Three cornered leek was identified within the woodland in Habitat Parcel No. 3.

4 Recommendations

The following recommendations are based on current UK wildlife legislation and national and local planning policy. The recommendations must be followed to ensure this legislation is not contravened by proposed development or any site investigation or vegetation clearance works.

4.1 Further Survey

Potential for protected and/or noteworthy species has been identified as part of the survey. The following further species surveys are recommended in order to establish target species, take legally protected species into account, and to provide a baseline to monitor enhancement of habitat and species populations.

Survey	Area	Timing/Details
Bat activity – general	Whole site	Three surveys in April/May, July/August and September/October. Two automated detectors deployed for a minimum of 5 nights per survey. Bat activity surveys will assess the level of bat activity across the site and may help identify target species for future monitoring.
Breeding birds	Whole site	Presence/absence: Two surveys spread across March to June. Bird surveys will help identify the presence of any notable species and inform target species for future monitoring.
Reptile	Grassland	Seven visits April – September (inclusive). Reptile surveys were last carried out on the site in 2015 and subsequent habitat enhancement works have been carried out. Updated reptile surveys are desirable to ascertain whether populations have increased/expanded as a result of enhancement works. Survey results will also inform site management works.
Butterfly	Grassland	Transect Survey – Fortnightly visits 1st April – 29th September. Butterflies are good indicators of pollinator abundance and grassland quality. Future butterfly surveys may identify target species which will inform habitat enhancement measures.

Table 4.1 Further Survey Recommendations

4.2 Monitoring

Habitat Condition
It is recommended that the condition of habitats is monitored in the future. This will determine the effectiveness of future enhancements and monitor the change in habitats over time. Monitoring habitats will also help to identify whether habitat management practices need to be altered to achieve the desired outcome, particularly with regard to any target species identified.

Species
The further survey options recommended above will help to identify target species which can be monitored to inform habitat enhancement measures.

UK Pollinator Monitoring Scheme (PoMS)
The PoMS is a citizen science pollinator monitoring scheme which measures the abundance of pollinators across the UK. Records can be submitted by individuals or organisations and it is recommended that information on pollinators within the survey area are submitted to the PoMS on an annual basis. This will record the abundance of pollinators within the survey area and indicate the effectiveness of habitat enhancement measures within the site.

5 Habitat Condition Assessment

The condition of habitats within the survey area was assessed in line with the methodology outlined in the Biodiversity Metric 4.0 Technical Supplement (2023). Habitats are assigned a condition of either poor, moderate or good. Specific focus was given to the habitats that have the highest potential for biodiversity uplift in the future. Therefore, not all habitat parcels within the survey area were assessed against the condition assessment criteria, as outlined in the Biodiversity Metric 4.0 Technical Supplement.

5.1 Grassland Communities

Other neutral grassland

Habitat Parcel No. 17
Habitat Parcel No. 17 comprises other-neutral grassland in poor condition. The grassland fails all but one of the condition assessment criteria outlined by the Biodiversity Metric 4.0 Technical Supplement (2023). The grassland only passes Criteria D, which relates to percentage of bracken *Pteridium aquilinum* and bramble cover.

Habitat Parcel No. 25
Habitat Parcel No. 25 comprises other-neutral grassland in poor condition. The grassland fails all but two of the condition assessment criteria outlined by the Biodiversity Metric 4.0 Technical Supplement (2023). The grassland only passes Criteria C and D which relate to percentage cover of bare ground and bramble/bracken.

Habitat Parcel No. 26
Habitat Parcel No. 26 comprises other-neutral grassland in poor condition. The grassland fails all but one of the condition assessment criteria outlined by the Biodiversity Metric 4.0 Technical Supplement (2023). The grassland only passes the Criteria D, which relates to percentage of bracken and bramble cover.

Habitat Parcel No. 29
Habitat Parcel No. 29 comprises other-neutral grassland in good condition. The grassland passes all but one of the condition assessment criteria outlined by the Biodiversity Metric 4.0 Technical Supplement (2023). The criteria the grassland failed Criteria B relates to varied sward height, as the grassland is regularly mown and there is no variation in sward height.

Habitat Parcel No. 50
Habitat Parcel No. 50 comprises other-neutral grassland in poor condition. The grassland fails all but two of the condition assessment criteria outlined by the Biodiversity Metric 4.0 Technical Supplement (2023). The grassland fails Criteria C, D, F and A which relate to sward height, species per m^2, bare ground cover and the habitat being a good representation of the habitat type.

Modified Grassland

Habitat Parcel No. 40
Habitat Parcel No. 40 comprises modified grassland in Moderate condition. The grassland passes all but two of the condition assessment criteria outlined by the Biodiversity Metric 4.0 Technical Supplement (2023). The grassland fails Criteria B and D which relate to sward height and physical damage.

Habitat Parcel No. 47
Habitat Parcel No. 47 comprises modified grassland in poor condition. The grassland passes all but two of the condition assessment criteria outlined by the Biodiversity Metric 4.0 Technical Supplement (2023). The grassland fails Criteria B and D which relate to sward height and physical damage.

Habitat Parcel No. 6, 8 & 12
Habitat Parcel No. 6, 8 & 12 comprise modified grassland in moderate condition. The grassland fails two of the condition assessment criteria outlined by the Biodiversity Metric 4.0 Technical Supplement (2023). The grassland fails Criteria B and E which relate to sward height and bare ground percentage.

Habitat Parcel No. 19
Habitat Parcel No. 19 comprises modified grassland in moderate condition. The grassland passes all but two of the condition assessment criteria outlined by the Biodiversity Metric 4.0 Technical Supplement (2023). The grassland fails Criteria B and E which relate to sward height and bare ground percentage.

Habitat Parcel No. 19a
Habitat Parcel No. 19a comprises modified grassland in poor condition. The grassland fails three of the condition assessment criteria outlined by the Biodiversity Metric 4.0 Technical Supplement (2023). The grassland fails Criteria A, B and E which relate to species per m^2, sward height and bare ground percentage.

5.2 Parkland

Habitat Ref No. 9
Habitat Parcel No. 9 modified grassland within a parkland setting. The condition of the parcel is poor as it fails five of the seven criteria outlined by the Biodiversity Metric 4.0 Technical Supplement (2023). The parcel fails criteria A, B, D, F and G.

5.3 Woodland Habitats

Habitat Parcel No. 3
Habitat Parcel No. 3 comprises other woodland; mixed; mainly broadleaved in moderate condition. The woodland scored 30/39 within the scoring index outlined by the Biodiversity Metric 4.0 Technical Supplement (2023), indicating that there are areas suitable for enhancement to improve the condition score. The woodland scored poorly in fields such as invasive species cover, native tree cover, veteran tree presence and amounts of deadwood

abundance. The woodland scored well in fields such as, browsing pressure, woodland regeneration and tree mortality.

Habitat Parcel No. 20
Habitat Parcel No. 20 comprises other woodland; mixed; mainly conifer in poor condition. The woodland scored 23/39 within the scoring index outlined by the Biodiversity Metric 4.0 Technical Supplement (2023), indicating that there are areas suitable for enhancement to improve the condition score. The woodland scored poorly in fields such as age classes, native tree cover, tree mortality, deadwood abundance and veteran tree presence. The woodland scored well in fields such as, browsing pressure, invasive species cover and native tree cover.

Habitat Parcel No. 36
Habitat Parcel No. 36 comprises other woodland; mixed in moderate condition. The woodland scored 27/39 within the scoring index outlined by the Biodiversity Metric 4.0 Technical Supplement (2023), indicating that there are areas suitable for enhancement to improve the condition score. The woodland scored poorly in fields such as age classes, NVC communities, veteran tree presence and deadwood abundance. The woodland scored well in fields such as, browsing pressure, invasive species cover and native tree cover.

5.4 Watercourse

The watercourse within the eastern extent of the site varies in condition along its length. Some sections of the watercourse are dominated by hemlock water dropwort, which shades out the banks and the river channel. However, in other areas, a variety of native species are present on the bank face and bank top and the wetted area of the channel is accessible. Numerous insects were observed utilising the watercourse during the site walkover including butterflies, banded demoiselle *Calopteryx splendens* and other species of dragonfly. The water quality within the watercourse is unknown but given the urban nature of the watercourse, there is likely to be some degree of pollution/contamination.

5.5 Other habitats

These habitats have not been assessed against the condition assessment criteria, as outlined in the Biodiversity Metric 4.0 Technical Supplement, as they were deemed to have lower potential for uplift in the future.

Non-Native Shrubs
This habitat has relatively little value in terms of provision for wildlife. Whilst the denser areas of shrub will provide nesting/foraging habitat for birds and small mammals, the vast majority of this habitat provides a formal landscaped function with little value in terms of biodiversity, although flowering species have value for pollinators.

Vegetated Garden
This habitat does provide value in terms of provision for wildlife. The garden located in habitat parcel 51 has a number of both native and non-native flowering species, which are of value to pollinators and the wild cherry trees provides foraging habitat for birds. A second garden located in habitat parcel 48 comprises a mixture of native and non-native tree species and

shrubs. Whilst the trees and shrub will provide nesting habitat for breeding birds, the vast majority of this habitat provides a landscaped function with minimal value in terms of biodiversity.

Hedgerows/Banks & Lines of Trees
Many of the hedgerows within the survey area predominantly comprise non-native ornamental species, which provide limited value to biodiversity. However, the dense structure of the hedgerows does provide nesting and sheltering habitat for birds and small mammals. The native hedgerows present within the survey area are likely to be of higher value to biodiversity.

There are a total of 10 lines of trees within the survey area and the majority of the trees within these features are native species, although some non-native species are present. The features are likely to provide roosting/nesting opportunities for bats and birds.

Buildings
The structures on site are likely to support features suitable for nesting birds and roosting bats. The overall suitability of the site for roosting bats is lowered due to the presence of extensive artificial night lighting which is known to be lighting the site for part of every night. However, no specific assessment of the buildings to support nesting birds and roosting bats was undertaken.

5.1 Legal Compliance

It should be noted that these recommendations must be followed to ensure the legislation is not contravened, including during any habitat maintenance works. Detailed construction compliance recommendations cannot be provided until the further survey information is obtained for the legally protected species listed in Section 4.1 including:

- Roosting bats
- Foraging and commuting bats

However, more generic recommendations can be made for the species/species groups outlined below.

5.1.1 Badger

An ecologist should be consulted regarding maintenance works or vehicle access within proximity of the known badger setts; these locations are clearly marked out. Any vegetation management in proximity to the badger setts should be undertaken under a method statement to ensure disturbance is minimised and the setts are not affected by e.g. felled vegetation blocking sett entrances.

5.1.2 Birds

The removal or management of any vegetation suitable for nesting birds should ideally be undertaken outside of the main bird nesting season of March to August (inclusive). This would minimise the risk of potential delays to site clearance works. It should be noted that nesting may extend outside this period; this is often dependent on weather conditions and species. When

programming the works, it may be advisory to undertake vegetation clearance in advance of any other works, in order to avoid the nesting bird season. This would minimise the risk of potential delays to the works programme.

If such works cannot be undertaken outside of the nesting season, a nesting bird check should be undertaken by an ecologist immediately prior to the vegetation removal works. The construction schedule should allow for potential delays in this case as any active nests must remain undisturbed until all the young have fledged naturally, which may take several months.

5.1.3 Otters

As a precautionary measure, an ecologist should be consulted prior to any major works within 30m of the watercourse.

5.1.4 Reptiles

It is understood that all habitat suitable for reptiles will be retained and enhanced within the site. However, if any area of habitat is to be removed or cut back in the future, an ecologist must undertake a hand search for reptiles prior to any works being carried out within habitats suitable for reptiles. Vegetation will then be carefully strimmed to ground level under the supervision of the ecologist to enable any reptiles present to be moved into an area of safety. These works must be undertaken during periods of warm, sunny weather from April to September (inclusive).

5.1.5 Hedgehog

Hedgehogs make day nests in summer and winter hibernation nests in habitats such as scrub, stacked wood piles, at the base of hedgerows, in piles of brash, compost and leaves. Nests consist of accumulated leaves, grass, and other foliage and tend to have an open structure in summer. If removal of any of the above habitats is required, this will be undertaken during late September and October when hedgehogs are active, avoiding sensitive breeding and hibernation seasons.

5.1.6 Invasive Plant Species

Three-cornered leek has been identified on site and therefore the client must ensure that the species is not caused to spread either within or beyond the site. As an invasive non-native species it would be preferable to eradicate three-cornered leek from the site

6 Biodiversity Enhancement Options

6.1 Introduction

This section summarises the baseline surveys and data available to form a wildlife usage baseline for each of the habitat parcels. This information is then taken forward to inform a number of enhancement options/mechanisms, the purpose of which is to improve habitats and biodiversity within the survey area. Specific consideration will be given to the identified target species which are outlined in Table 4.1. Devon Wildlife Consultants will enter into consultation with Torbay Hospital about the options and to discuss how to take forward the proposals made in this section and develop a management plan for the site.

A summary of the recommended enhancements is presented in the Summary Map of Potential Enhancements (DWC Drawing No. 23/4226.01-02) in Appendix 6.

6.2 Modified/Amenity Grassland

Habitat Parcel No. 1, 2, 4, 7, 18, 19, 33, 34, 40, 43, 47 & 49

6.2.1 Current Value

A significant proportion of the habitat parcels within the survey areas comprise regularly mown modified/amenity grassland communities. Whilst these grasslands do support flowering species such as common daisy and yarrow, and targeted areas of diverse wildflower seeding, the uniform short sward provides very little value to insect and invertebrate populations. The botanical diversity within the grasslands is also poor, due to the intensive mowing regime.

6.2.2 Enhancement Potential

It is recognised that some of the amenity/modified grassland areas within the survey area will need to be retained in their current form, as they are used by patients and staff at the hospital for amenity purposes. However, there are several areas of amenity/modified grassland that are not regularly utilised for amenity purposes that could be enhanced into more species rich neutral grassland, namely habitat parcel numbers 1, 2, 4, 7, 18, 19, 33, 34, 40, 43, 47 and 49.

Given the relatively species poor plant communities present within these parcels, enhancement should focus on increasing the floristic diversity of the grasslands and relaxing the mowing/management regime. This will require the scarification of the existing grasslands and over-sowing of an appropriate seed mixture to increase diversity. This is considered to be an appropriate way to expedite the development of native, valuable grassland communities within the survey area. Where possible, locally sourced seed mixes from appropriate assemblages should be used to maintain local identify in the grasslands.

An increase in both the floristic and structural diversity within the sward will provide larval and nectar food plants for butterfly species. Continued management of these habitat parcels as neutral grassland will increase the food sources for a large number of other invertebrate species including: spiders, harvestmen (along the woodland edge habitat), craneflies, bugs, moths, shield bugs, grasshoppers, earwigs and beetles which will increase the diversity and wildlife

value of this habitat. Invertebrate species provide a food source for a range of additional species including bats, birds and reptiles.

Habitat Parcel No. 19a

6.2.3 Current Value

Habitat parcel no 19a comprises a modified grassland dominated by tall herb species such as common nettle and common hogweed. The species assemblage of the grassland indicates that the fertility of the soil is likely to be high and there is a distinct lack of grass species within the sward. Whilst the flowering species of hogweed, red campion and meadowsweet provide opportunities for pollinators, the abundance of undesirable species such as docks and common nettle is a major contributor to the poor condition score of this grassland.

6.2.4 Enhancement Potential

Enhancement of the grassland should focus on reducing the abundance of undesirable species within the sward and increasing the abundance of grass species. This will require the grassland to be cut, subsequently scarified and then seeded with an appropriate seed mixture to increase diversity. It will be necessary to remove the arisings following the cut to reduce the risk of nettle seeds dropping back into the soil. It is recommended that the EM10 seed mix from Emorsgate (or similar) is used, as this will create tussocky grassland.

Tussocky grassland supports a variety of grass species such as cock's-foot and tall fescue *Festuca arundinacea,* which form tussocks and may assist with naturally supressing the abundance of nettle within the sward. However, it may still be necessary to control nettle manually until the sward has established. Tussocky grassland also provides excellent habitat for reptile species such as slowworm and grass snake *Natrix natrix* and increasing its prevalence within the survey area will also benefit many invertebrate and insect species, which in turn are prey for a variety of bat/bird species.

6.3 Other-Neutral Grassland

Habitat Parcel No. 17

6.3.1 Current Value

Habitat parcel no. 17 comprises a small area of other-neutral grassland in poor condition. The sward is dominated by grass species and herbaceous species within the sward are limited. Approximately 95% of the sward is greater than 20cm in height. The grassland is likely to have some value to invertebrates and provides a small area of potential reptile habitat and reptiles have been recorded within the vicinity.

6.3.2 Enhancement Potential

Enhancements should focus on increasing the floristic diversity of the grassland. This will require the scarification of the existing grasslands and over-sowing of an appropriate seed mixture to increase diversity. An increase in both the floristic and structural diversity within the sward will provide larval and nectar food plants for butterfly species as well as species outlined in Section 6.2.2.

Habitat Parcel No. 25 & 26

6.3.3 Current Value

Habitat parcel no. 25 and 26 comprises other-neutral grassland in poor condition. The sward in each parcel is dominated by herbaceous species including common knapweed, oxeye daisy and field bindweed. The high percentage of herbaceous species present within the sward is likely to be of value to a variety of invertebrate and insect species including bees and butterflies. However, despite the prevalence of herbaceous species, the botanical diversity within the sward is low and there is a lack of grass species.

6.3.4 Enhancement Potential

Enhancements in these areas should focus on increasing the botanical diversity of the sward by increasing the abundance of grass species and reducing the dominance of some herbaceous species, particularly field bindweed. This can be achieved by over-sowing the grassland with an appropriate seed mix and implementing an effective management regime.

An increase in both the floristic and structural diversity within the sward will provide larval and nectar food plants for butterfly species. Continued management of these habitat parcels as neutral grassland will increase the food sources for a large number of other invertebrate species including: spiders, harvestmen (along the woodland edge habitat), craneflies, bugs, moths, shield bugs, grasshoppers, earwigs and beetles which will increase the diversity and wildlife value of this habitat; and, are all prey for a range of bat and bird species.

Habitat Parcel No. 29

6.3.5 Current Value

Habitat parcel no. 29 comprises other-neutral grassland in good condition. The sward is relatively diverse with a variety of grass and herbaceous species and there are 10 species per m^2. However, the grassland is regularly mown and 90% of the sward is less than 7cm height. Whilst the grassland supports flowering species, the uniform short sward provides very little value to insect and invertebrate populations.

6.3.6 Enhancement Potential

Enhancements of the grassland in the parcel should focus on improving the structural and botanical diversity of the sward. This is likely to be achievable by implementing an effective management regime, which will involve leaving the grassland uncut from March through to mid-late summer. This will allow flowering species to set seed and over time the botanical and structural diversity of the sward will improve.

An increase in both the floristic and structural diversity within the sward will provide larval and nectar food plants for butterfly species. Continued management of these habitat parcels as neutral grassland will increase the food sources for a large number of other invertebrate species. Additionally, the improved sward structure will provide habitat for reptiles.

Habitat Parcel No. 50

6.3.7 Current Value

Habitat parcel no. 50 comprises other-neutral grassland in poor condition. There is a mixture of both grass and herbaceous species within the sward, but the botanical diversity is relatively poor. Nevertheless, the herbaceous species present do provide habitat for invertebrates and insects, but the sward is not dense enough to provide suitable sheltering and foraging habitat for reptile species. Additionally, around 30% of the grassland consists of bare ground. The grassland parcel is surrounded by developed land and is relatively isolated from other semi-natural habitats.

6.3.8 Enhancement Potential

Enhancements should focus on increasing the floristic diversity of the grassland. This will require the scarification of the existing grassland and the over-sowing of an appropriate seed mixture to increase diversity. A seed mixture with a similar composition to the EM2 seed mix from Emorsgate may be suitable, as there are a variety of herbaceous species and fine grasses within the mix.

Seeding the grassland will increase both the floristic and structural diversity within the sward as well as reducing the amount of bare ground within the parcel. The improvement in floristic diversity will provide larval and nectar food plants for butterfly species and continued management will increase the food sources for a large number of other invertebrate species. A summary of the enhancement benefits is presented in Table 6.1.

Habitat Parcel(s)	Enhancement Mechanism	Positive outcomes
1, 2, 4, 7, 18, 19, 33, 34, 40, 43, 47 & 49	Scarification and over-seeding to increase floristic diversity	Enhanced floristic diversity
		Provide larval food and nectar sources for native **butterfly** species
		Provide breeding habitat and food sources for a wide variety of invertebrate species
		Provide a source of invertebrate prey for locally and nationally important **bat** species
		Provide foraging habitat for **reptile** and amphibian species
19a	Scarification and over-seeding to increase floristic diversity and reduce nettle abundance	Reduce abundance of nettle within the sward to optimise the species diversity of the grassland in a short period to improve the appearance and wildlife value of these areas. This will improve the value of the parcel for a variety of **invertebrate** species.
	Scarification and over-seeding to increase floristic diversity and implementation	Enhanced floristic diversity
		Provide larval food sources and nectar sources for native **butterfly** species
		Provide breeding habitat and food sources for a wide variety of invertebrate species

17, 25, 26, 29, 50	of management regime.	Provide a source of invertebrate prey for locally and nationally important **bat** species
		Provide foraging habitat for **reptile** and amphibian species.

Table 6.1 Summary of Enhancement Benefits to Modified and Neutral Grassland
(highlighted in bold are species groups that could provide potential future monitoring species)

6.4 Woodland

Habitat Parcel No. 3

6.4.1 Current Value

Habitat parcel no. 3 comprises **other woodland; mixed; mainly broadleaved** in moderate condition. The woodland canopy, understorey and ground flora largely comprises native species including some ancient woodland indicators such as bluebell and wild garlic, though there are some non-native and invasive species present. The woodland is likely to have significant potential to support protected species including badger, bats and a variety of nesting bird species.

6.4.1 Enhancement Potential

Enhancements should focus on removing the non-native and invasive species within the woodland. Many of these are concentrated within the understorey and ground flora. Species such as cherry laurel should be removed and replaced with native species such as hazel and guelder rose. Felled trees could be used to create habitat piles and increase the abundance of deadwood within the woodland. Three-cornered-leek was identified within the woodland which is listed as a non-native/invasive species under Schedule 9 of Wildlife and Countryside Act 1981. The species should be removed from the woodland to prevent it spreading further into the woodland.

Habitat Parcel No. 20

6.4.1 Current Value

Habitat parcel no. 20 comprises **other woodland; mixed; mainly conifer** in poor condition. The woodland canopy predominantly comprises Scot's pine, which is not considered native to southern England. The trees within the canopy are all of very similar age and do not possess veteran features. However, the woodland is provides value for badger, bats and nesting birds.

6.4.2 Enhancement Potential

Enhancements should focus on increasing the diversity of species within the canopy. This could be achieved by planting native shrub species within the understorey such as hazel and hawthorn. This will also increase the number of age classes within the woodland parcel and provide additional foraging/nesting opportunities for birds. The development of a more natural and diverse ground flora community is also recommended. At present, much of the ground flora within the woodland parcel comprises frequently mown amenity grassland and large stands of nettle and occasional bramble.

One methodology of increasing the diversity of the woodland ground flora within a short period of time would be to acquire and plant plugs of native woodland species and/or to obtain an appropriate seed mix. This will expedite the diversification process of the woodland communities present on site and would add instant value for local wildlife. Species suitable for plug planting include wild garlic, dog's mercury *Mercurialis perennis*, wood anemone *Anemone nemorosa* and common dog violet *Viola riviniana*.

Providing a well-structured woodland community in this parcel will enhance the quality of the woodland and provide habitat for a large range of invertebrate, bird and mammal species. Creation of wood piles within the woodland structure will provide ground floor dead wood; dead wood when dropped onto the woodland floor should not be removed but should be left where it falls. This will provide habitat for bryophyte, fungi and invertebrate species which are all important in developing a diverse habitat and woodland structure. Where possible (and where safe to do so) a small number of the non-native trees could be ring-barked and left in situ to provide standing dead wood. This will also allow more light to penetrate the canopy, which will aid the development of ground flora. A number of additional bat and bird boxes could be installed onto these trees to provide additional roosting/nesting opportunities in the short term. Given the extensive woodpecker damage to boxes previously installed, it would be recommended to utilise bird boxes with metal plates to protect against damage.

Habitat Parcel No. 36

6.4.3 Current Value

Habitat parcel no. 36 comprises **other woodland; mixed; mainly conifer** in moderate condition. This area of woodland is relatively small and is isolated within an urban environment. The trees present within the woodland are similar in age but there is some broadleaved regeneration within the understorey. The ground flora does not represent a recognisable NVC community typically found in native woodlands. However, the woodland is still likely to support a limited array of protected species including badger and nesting birds.

6.4.4 Enhancement Potential

Enhancements should focus on increasing the diversity of the shrub layer and ground flora within the woodland parcel to provide better quality habitat for a large range of invertebrate, bird and mammal species.

Some planting may be required to establish a shrub layer. Species such as hawthorn, hazel bramble, honeysuckle *Lonicera periclymenum* and dog rose *Rosa canina* could be planted to provide an immediate enhancement to the shrub layer within the woodland parcel. Alongside this, plug planting could be used to increase the diversity of ground flora within the woodland parcel. Species suitable for plug planting include bluebell, wild garlic, dog's mercury, male fern *Dryopteris filix-mas* and primrose *Primula vulgaris*. Providing a well-structured woodland community in this parcel will enhance the quality of the woodland and provide habitat for a large range of invertebrate, bird and mammal species.

Creation of wood piles within the woodland structure will provide ground floor dead wood; dead wood when dropped onto the woodland floor should not be removed but should be left

where it falls. This will provide habitat for bryophyte, fungi and invertebrate species which are all important in developing a diverse habitat and woodland structure. It is also recommended that additional bird/bat boxes are installed on trees to provide additional roosting/nesting opportunities for both species groups. A summary of the enhancement benefits is presented in Table 6.2.

Enhancement Mechanism	Positive outcomes
Canopy management and ringbarking	Permit light to penetrate through the canopy and increase potential for the development of a more natural woodland structure.
	Provide a source of dead wood and log-pile habitats.
Planting of shrub and ground flora species	Enhanced floristic diversity within the woodland as well as a more natural woodland structure.
	Increase the potential to support a greater range of invertebrate and **bird** species, and provide a source of invertebrate prey for locally and nationally important **bat** species.
Dead wood piles and creation of standing dead wood	Diversify the structure and species range of the woodland to provide habitat for a range of invertebrate, fungi, fern, moss and liverwort species.
	Provide a food source for locally and nationally important bat and bird species.
Seeding and planting	To optimise the species diversity of the woodland in a short period to improve the wildlife value of these areas. This will improve the value of the site for a variety of invertebrate species.

Table 6.3 Summary of Enhancement Benefits
(Highlighted in bold are species groups that could provide potential future monitoring species)

6.5 Watercourse

6.5.1 Current Value

The watercourse within the western extent of the site varies in condition along its length. Some sections of the watercourse are dominated by hemlock water dropwort, which shades out the banks and the river channel. However, in other areas, a variety of native species are present on the bank face and bank top and the wetted area of the channel is accessible. The watercourse has value to a variety of insect and invertebrate species including butterflies, damselflies and dragonflies.

6.5.2 Enhancement Potential

Enhancements should focus on increasing the botanical diversity on the bank tops and riverbank. In some sections of the watercourse, this will involve reducing the dominance of hemlock water dropwort and field bindweed in areas where it is shading out the watercourse. This can be achieved through repeated cutting prior to the plant flowering and over time this will weaken the plant. Where large patches of hemlock water dropwort are cleared, the riverbanks should be seeded with a wetland/pond edge seed mixture to increase the botanical diversity on the riverbanks.

In other areas of the watercourse, the bank tops are dominated by nettle. The dominance of nettle in these areas could be reduced through cutting and subsequent removal of the cuttings. It is best to cut the nettle stands prior to the plant flowering. Following this, the areas could be seeded with a wetland seed mix to increase the botanical diversity.

Towards the northern extent of the watercourse, tree canopy cover is extremely dense and very little light is penetrating the canopy. It is recommended that a crown thinning programme is undertaken on the trees surrounding the watercourse to improve light levels and encourage a greater botanical diversity on the riverbanks.

Given the watercourse is located in an urban area, it is probable that the water is polluted to some degree. In order to improve water quality, a series of leaky dams could be constructed along the length of the watercourse. Leaky dams provide a range of benefits for wildlife. They provide important habitat for a range of aquatic species such as damselflies and hawker dragonflies *Aeshna juncea,* which lay their eggs into rotten pieces of wood. In times of high flow, the dams improve water quality by encouraging sediment and pollutants to settle out, thus reducing nutrient enrichment in adjacent watercourses.

The leaky dams should be constructed using locally sourced, untreated logs, wood and brash. These logs should be large enough the span the width of the ditch and should be built at right angles to the channel banks to reduce scour. The dams should also be built to allow low flows to pass unimpeded at all times. This can be achieved by leaving small gaps between the logs, allowing water to leak through. The dams should be built in a series with a minimum of three created at various points along the watercourse. Ideally, the spacing between the dams should be approximately 5-7 times the width of the channel. Once constructed, there is very little management required. After periods of high flow, any debris that has built up against the dams should be removed and the dam should be checked for any structural damage.

It should be noted that the installation of leaky dams may alter the flow of the river and this could have implications on flood risk. Given the urban nature of the watercourse, flood risk will need to be fully considered and the Environment Agency may need to be consulted if the river flow will be altered by enhancement works. A summary of the enhancement benefits is presented in Table 6.3.

Enhancement Mechanism	**Positive outcomes**
Crown thinning of trees	Permit light to penetrate through the canopy and increase the botanical diversity on the riverbanks.
Reducing dominance of hemlock water dropwort/nettle on riverbank and bank top	Increases the accessibility of open water habitat, which will benefit aquatic species that lay their eggs in water.
Seeding of riverbank and bank top	Increase in botanical diversity on riverbank/bank top which will provide improved habitat for insects and invertebrates.
	Improvement in water quality.

Leaky dam installation	Provides important habitat for a range of aquatic species such as damselflies and dragonflies.

Table 6.3 Summary of Enhancement Benefits
(Highlighted in bold are species groups that could provide potential future monitoring species)

6.6 Other Habitats

6.6.1 Parkland – Habitat Parcel No. 9

Habitat Parcel No. 9 comprises modified grassland within a parkland setting and is in poor condition. The parkland is principally used for amenity purposes and quiet recreation. It is understood that at least some of the area will need to be retained for amenity purposes. However, in some areas the management regime could be relaxed and the modified grassland could be enhanced into other-neutral grassland (wildflower grassland). This would require areas of the grassland to be scarified and seeded with an appropriate seed mix to increase botanical diversity. The management of the grassland would then involve leaving the grassland uncut between April-August, to allow flowering species within the sward to flower and set seed.

Enhancing the grassland will improve botanical diversity within the sward, which will provide nectar sources for a variety of insect and invertebrate species including butterflies. The improved structural diversity within the sward will provide sheltering/foraging habitat for reptile and amphibian species. Enhanced areas of the grassland should have ecological connectivity to one another and provide a corridor through the habitat parcel. This will allow insect, invertebrate, reptile and amphibian species to commute through the area more easily and provide sheltering habitat for a variety of small mammals.

6.6.2 Hedgerows

There are a number of native and ornamental non-native hedgerows within the survey area. Enhancements should focus on managing the native hedgerows to maintain a tall bushy structure to provide foraging and nesting habitat for birds.

The ornamental hedgerows within the site are of limited value to wildlife, aside from providing nesting habitat for birds. Where possible, the non-native species within the ornamental hedgerows should be gradually replaced with native species. This could be achieved by planting native species within gaps in the ornamental hedgerows. If no gaps exist, small gaps could be created within the hedgerow to provide space for planting. Species such as hawthorn, guelder rose, hazel, field maple *Acer campestre* and holly should be planted. These species will provide improved nesting habitat and a winter food source for native bird species and many of the proposed species also provide nectar sources for pollinators during the winter and early spring. Management of native hedgerows should consist of cutting no more than 1/3 of the hedgerow per annum and the cut should be undertaken in late February, to allow wintering birds to forage on berries over the winter.

6.6.3 Rose Garden – Habitat Parcel No. 51

Habitat parcel no. 51 comprises a vegetated garden dominated by rose species. Also present within the parcel are small areas of mown modified/amenity grassland and wild cherry trees.

Raised beds are present adjacent to the eastern, southern and western boundary of the parcel, but are largely devoid of vegetation.

Enhancements should focus on utilising the raised beds to provide nectar sources for pollinators. This could be achieved by scarifying the beds to create patches of bare ground and then subsequently seeding them with a perennial wildflower seed mix. Using a perennial mix will require less management than utilising an annual seed mix and management will consist of leaving the flowers uncut between April-August. This will allow flowering species to flower and set seed. Following this, the flowers can be cut and the arisings should be removed following the cut. It is likely that the beds will require regular watering during extended dry periods, due to the shallow nature of the soil. Alternatively, the raised beds could be planted with shrubs such as, lavender *Lavandula* sp., and rosemary *Salvia rosmarinus.* These species are more tolerant of dry soils and will require less maintenance than a perennial wildflower mix. These species will also provide nectar for a range of pollinators.

6.6.4 Buildings

There are a significant number of buildings within the survey area. Whilst no assessment was made of their potential to support nesting birds/roosting bats during the site walkover, it is possible that the buildings support both nesting birds and roosting bats. Where possible, it is recommended that bat and bird boxes are installed onto the exterior of suitable buildings. Bat boxes should be installed on a southerly aspect and bird boxes on a northernly aspect. This will provide additional nesting/roosting for both species groups. In addition, bee/bug hotels could also be installed on the exterior of suitable buildings.

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Appendices

Appendix 1: Desk Study

Appendix 2: Legislation

Appendix 3: Raw Survey Data

Appendix 4: UKHab Baseline Map

Appendix 5: Site Photographs

Appendix 6: Summary Map of Potential Enhancements

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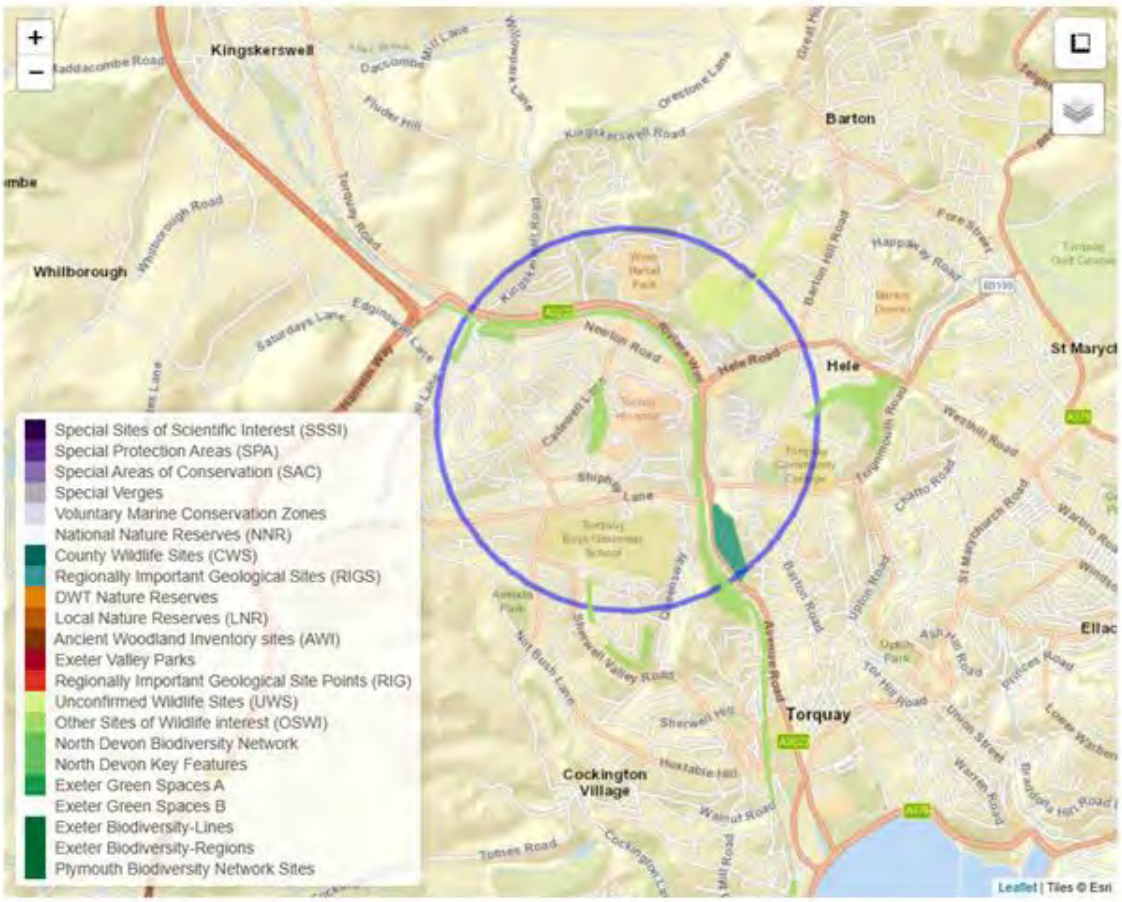
Appendix 1 – Desk Study



Desk Study Data (DBRC, 2023)

Appendix 2 – Legislation

Hedgerows
'Important' hedgerows which meet specific wildlife and landscape criteria of the Hedgerow Regulations 1997 (as amended) are protected under this legislation. A Hedgerow Removal Notice must be submitted to the Local Planning Authority in order to obtain permission to damage or remove important hedgerows. It should be noted that planning approval also qualifies as permission.

Badgers
Badgers are protected by the Protection of Badgers Act 1992 and the Wildlife and Countryside Act 1981 (as amended), Schedule 6. Under the Wildlife and Countryside Act it is illegal to intentionally kill, capture, injure or ill-treat any badger. Under the Protection of Badgers Act it is an offence to obstruct, destroy or damage a badger sett or disturb badgers within a sett, with any works which will contravene this legislation requiring prior licensing from Natural England.

Bat Roosts
All British bats and their roosts are afforded strict protection under the Wildlife and Countryside Act 1981 (as amended), as well as the Conservation of Habitats and Species Amendment (EU Exit) Regulations 2019. In combination, these pieces of legislation give substantial protection to bats and their roost sites, and make it an offence for any person to carry out the following acts:

- Intentionally or recklessly kill, injure or take a bat.
- Damage, destroy or obstruct access to any place that a bat uses for shelter or protection. This is taken to mean all bat roosts whether bats are present or not.
- Intentionally or recklessly disturb a bat while it is occupying a structure or place that it uses for shelter or protection.

Proposed developments which affect bats or their roosts are likely to require a European Protected Species Licence (EPSL) from Natural England.

Bat Flight Lines & Foraging Habitat
As a signatory to the Bonn Convention (Agreement on the Conservation of Bats in Europe) the UK is committed to protecting bat habitats, which necessitates the identification and protection from damage or disturbance of important feeding areas and commuting routes. In order to comply with the Natural Environment and Rural Communities Act 2006, it is necessary to demonstrate that foraging bat species have been adequately considered through the planning process.

The lesser/greater horseshoe bat is listed under several international directives including Appendix II of The Bonn Convention, Appendix II of the Bern Convention. Protection of lesser/greater horseshoe bats is also covered under the Conservation of Habitats and Species Regulations 2017 which maintains protection of European sites through the Conservation of Habitats and Species Amendment (EU Exit) Regulations 2019

Under the EC Habitats Directive 1992, core areas of habitat for Annex II species must be protected and the sites managed in accordance with the ecological requirements of the species.

Birds
All birds, their nests and eggs are protected under the Wildlife and Countryside Act 1981 (as amended). Nesting is determined as being from when birds first initiate nest building up until the point when fledglings stop returning to the nest. It is an offence to:

- Intentionally kill, injure or take any wild bird.
- Intentionally take, damage or destroy the nest of any wild bird.
- Intentionally take or destroy the egg of any wild bird.

Dormice
Dormice are afforded strict protection under the Wildlife and Countryside Act 1981 (as amended) and the Conservation of Habitats and Species Amendment (EU Exit) Regulations 2019. This makes it illegal to intentionally kill, injure, take, possess, sell or disturb dormice. The legislation also makes it illegal to intentionally or recklessly damage, destroy or obstruct their place of shelter or protection. Proposed developments which affect dormice or their place of shelter are likely to require a European Protected Species Licence (EPSL) from Natural England.

Reptiles
Reptiles are protected against intentional killing and injury, sale and transport for sale under the Wildlife and Countryside Act 1981 (as amended). Natural England states that activities such as site investigations, site clearance and movements of machinery may breach this legislation by causing death or injury to reptiles (English Nature, 2004).

Great Crested Newts
Great crested newts are afforded strict protection under the Wildlife and Countryside Act 1981 (as amended) and the Conservation of Habitats and Species Amendment (EU Exit) Regulations 2019. This makes it illegal to intentionally kill, injure, take, possess, sell or disturb great crested newts. The legislation also makes it illegal to intentionally or recklessly damage, destroy or obstruct their place of shelter or protection. Proposed developments which affect great crested newts or their place of shelter are likely to require a European Protected Species Licence (EPSL) from Natural England.

Otters
Otters are afforded strict protection under the Wildlife and Countryside Act 1981 (as amended) and the Conservation of Habitats and Species Amendment (EU Exit) Regulations 2019. This makes it illegal to intentionally kill, injure, take, possess, sell or disturb otters. The legislation also makes it illegal to intentionally or recklessly damage, destroy or obstruct their place of shelter or protection. Proposed developments which affect otters or their place of shelter are likely to require a European Protected Species Licence (EPSL) from Natural England.

Section 41 Species

Species listed within Section 41 of the Natural Environment and Rural Communities (NERC) Act 2006 are defined as species of principle importance for the conservation of biodiversity in England. The NERC Act extends the biodiversity duty set out in the Countryside and Rights of Way (CROW) Act 2000 to public bodies and statutory undertakers to ensure due regard to the conservation of biodiversity.

Appendix 3 – Raw Survey Data

Parameter	Condition
Temperature (ºC)	22
Cloud cover (%)	50
Wind	F2
Precipitation	None

Table A3.1 Weather Conditions Recorded During the Survey

English name	Scientific name
Acanthus	*Acanthus mollis*
Alder	*Alnus glutinosa*
Annual meadow grass	*Poa annua*
Ash	*Fraxinus excelsior*
Aspen	*Populus tremuloides*
Beech	*Fagus sylvatica*
Birch	*Betula pendula*
Blackthorn	*Prunus spinosa*
Bluebell	*Hyacinthoides non-scripta*
Bramble	*Rubus fruticosus*
Broad-leaved dock	*Rumex obtusifolius*
Brome sp.	*Bromus* sp
Cherry	*Prunus avium*
Cock's-foot	*Dactylis glomerata*
Common bent	*Agrostis stolonifera*
Common bird's-foot-trefoil	*Lotus corniculatus*
Common catsear	*Hypochaeris radicata*
Common daisy	*Bellis perennis*
Common knapweed	*Centaurea nigra*
Common mouse ear	*Cerastium fontanum*
Cotoneaster	*Cotoneaster horizontalis*
Crab apple	*Malus sylvestris*
Creeping buttercup	*Ranunculus repens*
Crested dog's-tail	*Cynosurus cristatus*
Cupressus	*Cupressus sempervirens*
Cypress	*Cupressus sempervirens L.*
Dandelion	*Taraxacum officinale*

English name	Scientific name
Douglas fir	*Pseudotsuga menziesii*
Elder	*Sambucus nigra*
False-oat grass	*Arrhenatherum elatius*
Field bindweed	*Convolvulus arvensis*
Fuchsia	*Fuchsia* spp.
Ginkgo	*Ginkgo biloba*
Goosegrass	*Galium aparine*
Greater plantain	*Plantago major*
Hart's tongue fern	*Asplenium scolopendrium*
Hawthorn	*Crataegus monogyna*
Hazel	*Corylus avellana*
Hebe	*Veronica speciosa*
Herb Robert	*Geranium robertianum*
Hogweed	*Heracleum sphondylium*
Holly	*Ilex aquifolium*
Hornbeam	*Carpinus betulus*
Horse chestnut	*Aesculus hippocastanum*
Iris sp.	*Iris* sp.
Ivy	*Hedera helix L.*
Laurel	*Laurus nobilis*
Lesser trefoil	*trifolium dubium*
Lime	*Tilia x europaea*
Lords and ladies	*Arum maculatum*
Maple	*Acer campestre*
Meadowsweet	*Filipendula ulmaria*
Nettle	*Urtica dioica*
Norway maple	*Acer platanoides*
Oak	*Quercus robur*
Ox-eye daisy	*Leucanthemum vulgare*
Pendulous sedge	*Carex pendula*
Perennial rye	*lolium perenne*
Poppy	*Papaver somniferum*
Portuguese laurel	*Prunus lusitanica*
Privet	*Ligustrum ovalifolium*
Red campion	*Silene dioica*
Red clover	*Trifolium pratense*
Red fescue	*Festuca rubra*

English name	Scientific name
Red valerian	*Cantranthus ruber*
Ribwort plantain	*Plantago lanceolata*
Rose sp.	*Rosa* sp.
Rowan	*Sorbus aucuparia*
Scots pine	*Pinus sylvestris*
Selfheal	*Prunella vulgaris*
Snowberry	*Symphoricarpos albus*
Soft shield fern	*Polystichum setiferum*
Sorrel	*Rumex acetosa*
Spear thistle	*Cirsium vulgare*
Sweet vernal grass	*Anthoxanthum odoratum*
Sycamore	*Acer pseudoplatanus*
Three-cornered leek	*Allium triquetrum*
Timothy	*Phelum pratense*
Tulip	*Tupia* spp.
Turkey oak	*Quercus cerris*
Tutsan	*Hypericum androsaemum*
White clover	*trifolium repens*
Wild carrot	*Daucus carota*
Wild garlic	*Allium ursinum*
Wild mustard	*Sinapis arvensis*
Wilson's honeysuckle	*Lonicera nitida*
Winter jasmine	*Jasminum nudiforum*
Woundwort	*Stachys palustris*
Yarrow	*Archillea millefolium*
Yorkshire fog	*Holcus lanatus*

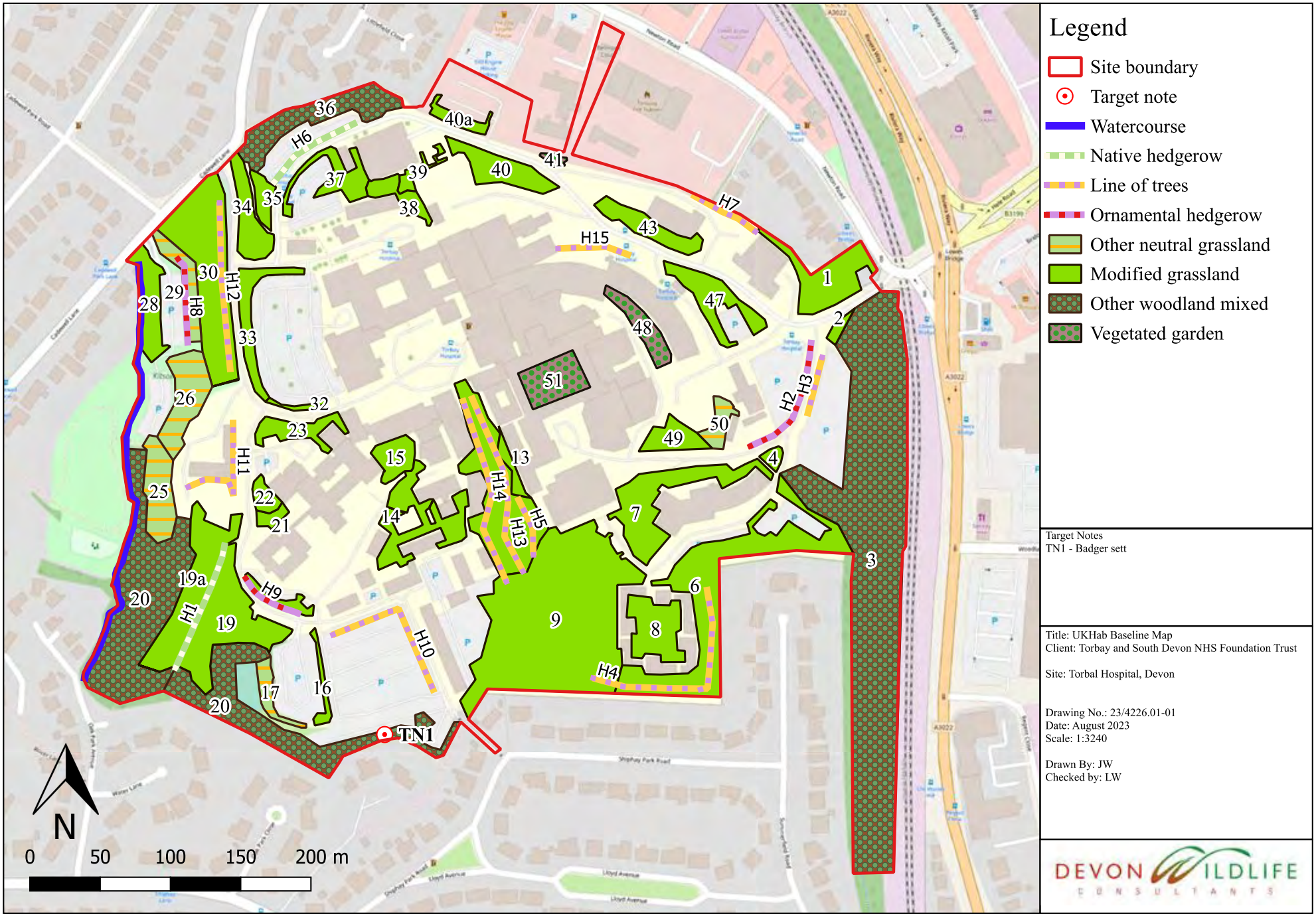
Table A3.2 Botanical Species Recorded During the Preliminary Ecological Appraisal

English name	Scientific name
Blackbird	*Turdus merula*
Blackcap	*Sylvia atricapilla*
Blue tit	*Cyanistes caeruleus*
Carrion crow	*Corvus corone corone*
Chiffchaff	*Phylloscopus collybita*
Coal tit	*Pepriparus ater*

English name	Scientific name
Dingy skipper	*Erynnis tages*
Dunnock	*Prunella modularis*
Goldfinch	*Carduelis carduelis*
Great tit	*Parus major*
Great spotted woodpecker	*Dendrocopos major*
Herring gull	*Larus argentatus*
Jackdaw	*Corvus monedula*
Meadow brown	*Maniola jurtina*
Meadow pipit	*Anthus pratensis*
Robin	*Erithacus rubecula*
Speckled wood	*Pararge aegeria*
Wood pigeon	*Columba palumbus*
Wren	*Troglodytes troglodytes*

Table A3.3 Fauna Recorded During the Baseline Survey

Appendix 4 – UKHab Baseline Map


Legend
Site boundary
Target note
Watercourse
Native hedgerow
Line of trees
Ornamental hedgerow
Other neutral grassland
Modified grassland
Other woodland mixed
Vegetated garden
Target Notes
TN1 - Badger sett
Title: UKHab Baseline Map
Client: Torbay and South Devon NHS Foundation Trust
Site: Torbal Hospital, Devon
Drawing No.: 23/4226.01-01
Date: August 2023
Scale: 1:3240
Drawn By: JW
Checked by: LW
DEVON WILDLIFE CONSULTANTS
N
0 50 100 150 200 m
TN1

Appendix 5 – Site Photographs

Area Habitats – Grasslands/Vegetated Gardens	
	Habitat Ref No. 29 Other- neutral grassland
	Habitat Ref No. 50 Other- neutral grassland

 	Habitat Ref No. 1 & 2 Modified grassland

 	Habitat Ref No. 4 & 43 Modified grassland

 	Habitat Ref No. 6 & 12 Modified grassland

	Habitat Ref No. 7 Modified grassland
	Habitat Ref No. 8 Modified grassland

 	Habitat Ref No. 14 & 15 Modified grassland

	Habitat Ref No. 16 Modified Grassland
	Habitat Ref No. 19 Modified grassland

	Habitat Ref No. 19a Modified grassland

 	Habitat Ref No. 25, 26, 30, 35 Modified grassland

	Habitat Ref No. 47 Modified grassland

 	Habitat Ref No. 9, 13, 49 Modified grassland/ Parkland

	
	Habitat Ref No. 21 & 22 Modified grassland/ Parkland

	Habitat Ref No. 37 Modified grassland/ Parkland
	Habitat Ref No. 48 Vegetated garden

	Habitat Ref No. 51 Rose Garden/Vegetated garden

 	Habitat Ref No. 23 & 32 Modified grassland/ Mown

Table A5.1 Site Photographs of Grasslands and Vegetated Gardens

Area Habitats – Woodlands	
	Habitat Ref No. 3 Other woodland; mixed; mainly broadleaved

 	Habitat Ref No. 20 Other woodland; mixed; mainly conifer

	Habitat Ref No. 36 Other woodland; mixed

Table A5.2 Site Photographs of Woodlands

Linear Habitats – Hedgerows/Banks & Lines of Trees	
	Habitat Ref No. H1 Native hedgerow

	Habitat Ref No. H2 & H3 Ornamental hedgerow
	Habitat Ref No. H4 Line of trees

	Habitat Ref No. H5 Line of trees
	Habitat Ref No. H6 Native hedgerow

	Habitat Ref No. H7 Line of trees
	Habitat Ref No. H8 Ornamental hedgerow

	Habitat Ref No. H9 Ornamental hedgerow
	Habitat Ref No. H10 Line of trees

	Habitat Ref No. H13 & H14 Line of trees
	Habitat Ref No. H15 Line of trees

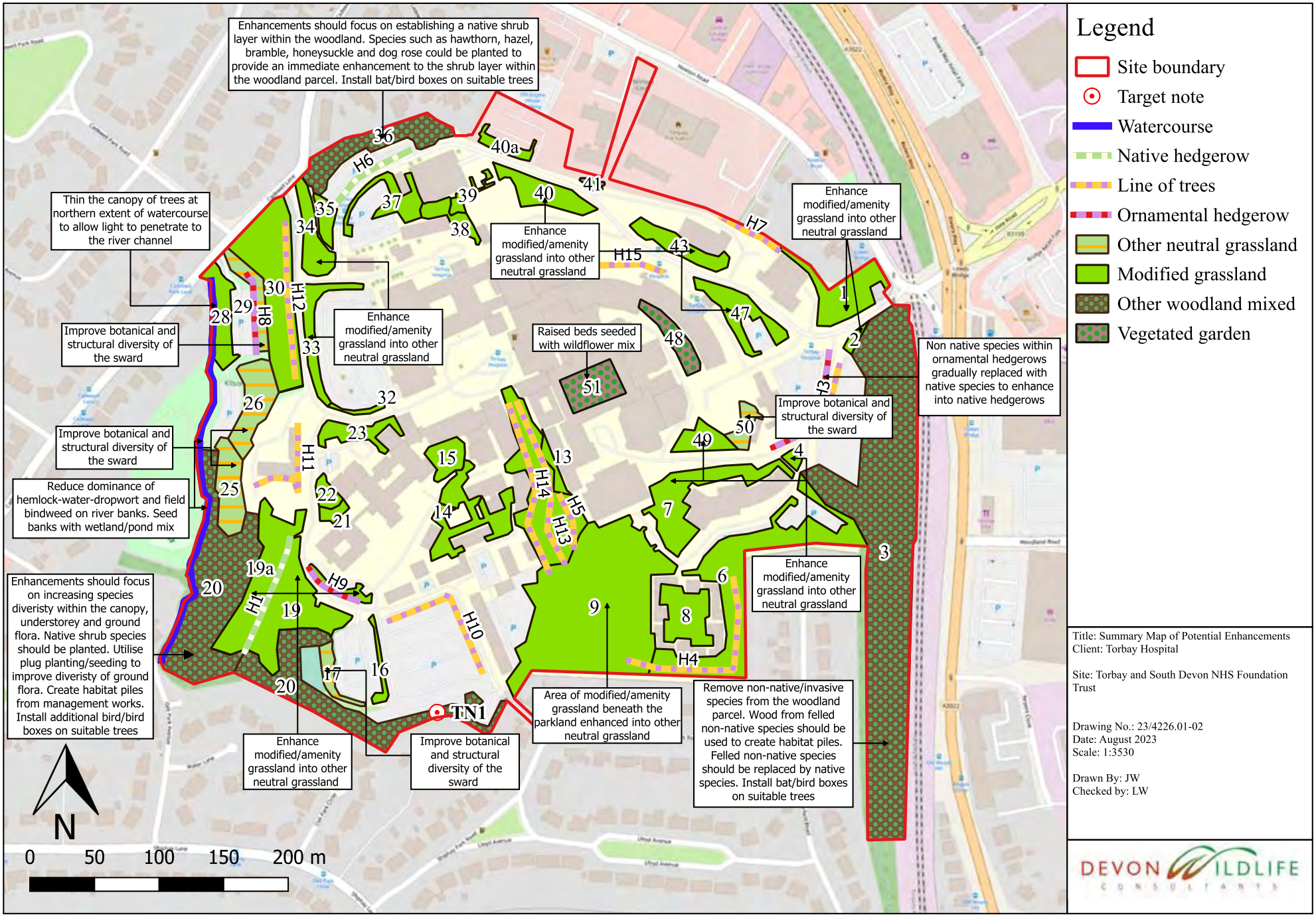
Table A5.3 Site Photographs of Hedgerows/banks and Line of trees

Watercourse

	Open section of watercourse
	Section of watercourse shaded out by vegetation

Table A5.4 Site Photographs of Watercourse

Appendix 6 – Summary Map of Potential Enhancements


Enhancements should focus on establishing a native shrub layer within the woodland. Species such as hawthorn, hazel, bramble, honeysuckle and dog rose could be planted to provide an immediate enhancement to the shrub layer within the woodland parcel. Install bat/bird boxes on suitable trees
Thin the canopy of trees at northern extent of watercourse to allow light to penetrate to the river channel
Improve botanical and structural diversity of the sward
Improve botanical and structural diversity of the sward
Reduce dominance of hemlock-water-dropwort and field bindweed on river banks. Seed banks with wetland/pond mix
Enhancements should focus on increasing species diveristy within the canopy, understorey and ground flora. Native shrub species should be planted. Utilise plug planting/seeding to improve diveristy of ground flora. Create habitat piles from management works. Install additional bird/bird boxes on suitable trees
Enhance modified/amenity grassland into other neutral grassland
Enhance modified/amenity grassland into other neutral grassland
Enhance modified/amenity grassland into other neutral grassland
Raised beds seeded with wildflower mix
Improve botanical and structural diversity of the sward
Area of modified/amenity grassland beneath the parkland enhanced into other neutral grassland
Enhance modified/amenity grassland into other neutral grassland
Enhance modified/amenity grassland into other neutral grassland
Non native species within ornamental hedgerows gradually replaced with native species to enhance into native hedgerows
Improve botanical and structural diversity of the sward
Remove non-native/invasive species from the woodland parcel. Wood from felled non-native species should be used to create habitat piles. Felled non-native species should be replaced by native species. Install bat/bird boxes on suitable trees
TN1
N
0 50 100 150 200 m
Legend
Site boundary
Target note
Watercourse
Native hedgerow
Line of trees
Ornamental hedgerow
Other neutral grassland
Modified grassland
Other woodland mixed
Vegetated garden
Title: Summary Map of Potential Enhancements
Client: Torbay Hospital
Site: Torbay and South Devon NHS Foundation Trust
Drawing No.: 23/4226.01-02
Date: August 2023
Scale: 1:3530
Drawn By: JW
Checked by: LW
DEVON WILDLIFE CONSULTANTS

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: 27 March 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 and Performance 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 March 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 3 and 6.		
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
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NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2023/24

BUILDING A Brighter Future
improving health & care in Torbay & South Devon

Our People AT THEIR BEST

BOARD ASSURANCE FRAMEWORK SUMMARY

Ref	Objective	Executive Lead	Current Risk Score	Target Risk Score	Executive Comment
1.	Quality and Patient Experience	CNO	16	12	
2.	People	CPO	20	16	
3	Financial Sustainability	CFO	25	15	Control total adjusted to reflect further non-recurrent allocation of £13.1m Revised control total for 23/24 now £27m deficit.
4	Estates	CFO	25	10	
5	Operations and Performance Standards	COO	16	12	
6	Digital and Cyber Resilience	DTP	25	25	Updated the rationale for score to include legacy systems interim support as a factor
7	Building Brighter Future (BBF)	DTP	20	15	
8	Transformation and Partnerships	DTP	16	9	
9	Integrated Care System	DTP	16	8	
10	Green Plan/Environmental, Social and Governance	CFO	12	6	
11	Equality, Diversity and Inclusion	CPO	16	12	

Strategic context:

The Board Assurance Framework ("BAF") is the key source of evidence that links the delivery of the Trust's strategic objectives to risk, control and assurance; and is the primary internal control that the Board uses for strategic oversight and assurance.

The current Trust Strategy was approved in February 2022 and can be found on our website here: https://www.torbayandsouthdevon.nhs.uk/about-us/our-vision-and-strategy/

An Executive Lead is nominated for each BAF Objective, to maintain, review and manage the narrative around each Objective, as well as overseeing the associated risk and controls impacting on delivery. Each Objective is then delegated to a Board Sub-Committee who scrutinise their individual BAF Objectives and undertake a detailed review at each meeting.

The Risk Group also review the BAF and Corporate Risk Register ('CRR').

The Board then undertake a review of the whole BAF, assuring themselves that the narrative and controls contained therein provide sufficient oversight and mitigation of risk as well as noting progress against the Trust strategy; noting the risk position and any exception reporting at their meetings.

Methodology:

In reviewing this document Executives will have regard to the Trust's risk management policies, procedures and methodology, as amended from time to time. Noting the importance of tiered mitigation for controls through the "3 lines of defence" as a matter of good governance:

- First Line Assurance - (assessments undertaken and owned by functions that own and manage the risk) – An example of this could be a local monthly compliance check that is undertaken within a specific function.
- Second Line Assurance - (oversight of functions that oversee or who specialise in compliance or the management of risk) – An example of this could be a system, process or piece of assurance that has been reviewed and assessed by the Risk or Governance Team, independently from the first line. Produced distinct from those who are responsible for delivery
- Third Line Assurance - (objective and independent assurance) An example of this could be an assessment of a system and processes by the Trust's Internal Auditors, External Auditors, or regulatory bodies.

The current policies in place are: Risk Management Policy, approved September 2022 & Risk Management Strategy, approved September 2022. It should be noted that these are to be merged during 2023/24 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	7, 20, 2
3 - Possible	3	6	9	12	5, 15
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**	**Mar 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	4	
Risk Score	16	16	16	16	12	16	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
1.1 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: February** 24

BAF Risk Scoring

Current Position					**Target:**	**Year on Year**	**Rationale for Risk Level**
	Jul 23	**Sept 23**	**Nov 23**	**Jan 24**	**Aug 24**	**Mar 23**	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 People Promise 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.
Likelihood	5	5	5	5	4	4	
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 (including skills needed- in particular digital skills and confidence), 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. Digital literacy working group now includes Strategic Workforce Planner and People Digital lead.	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	Our People Promise includes three priorities: 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 Priority 2: the development of a sustainable workforce for the future, aligned to the national long-term plan and New Hospitals Programme is under development by our Strategic Workforce planner. Priority 3: embedding a culture of inclusion is aligned to the CQC action plan, and includes mandatory Inclusion training for all	CPO	Board approval May-July 2023 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 and Performance Committee | **Last Updated: January 24**

BAF Risk Scoring

Current Position	Jul 23	Sept 23	Nov 23	Jan 24	Target April 24	Year on Year Mar 23
Likelihood	5	5	5	5	4	5
Consequence	5	5	5	5	4	5
Risk Score	25	25	25	25	16	25

Rationale for Risk Level

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).

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. Control total now adjusted to reflect further non-	3.7B	Deterioration in financial performance and failure to deliver NOF 4 exit requirements

			recurrent allocation of £13.1m Revised control total for 23/24 now £27m deficit.		
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	Jul 23	Nov 23	Sep 23	Jan 24	Target: 2030	Year on Year Mar 23	Rationale for Risk Level
Likelihood	5	5	5	5	2	5	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.
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	Jul 23	Sep 23	Nov 23	Jan 24	Target April 24	Year on Year Mar 23	Rationale for Risk Level
Likelihood	4	5	5	5	3	5	Consequence: Performance Risk - Failure to meet professional standards or statutory requirements. Likelihood: If the activity continues without controls in place, there is a strong possibility the event will occur as there is a history of frequent occurrences.
Consequence	4	3	3	3	4	4	
Risk Score	16	15	15	15	12	20	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		Mitigating Factors (internal controls):		Impact of risk occurring:	
5.1.A	Imbalance between time of emergency admissions and discharges	5.1.B	Daily Control meetings to align daily discharges with daily admissions. Work programme of transformation improvement team in respect of urgent care recovery plan. UEC Group improvement programmes overseen by Trust Recovery Board UEC funding agreed with ICS. Weekly Tier 1 meetings with ICS and NHSE	5.1.C	Delays in progressing patient decisions resulting in delays in treating patients both internally and externally
5.2.A	Insufficient capacity in Care Home and Domiciliary care market	5.2.B	Work programme of transformation improvement team in respect of urgent care recovery plan. Community Transformation Group being established overseen by Trust Recovery Board Agreement on funding arrangement to incentivise market development. Newton Europe Report concluded, and actions being implemented	5.2.C	Increased number of patients with no criteria to reside and reduced bed capacity for emergency and elective patients leading to an inability to treat patients in a timely way resulting in harm.
5.3.A	Continued infection outbreaks resulting in reduced bed capacity and ability to move patients to the right bed	5.3.B	Daily Control meetings include IPC representatives who work with operational staff to maximise bed capacity while ensuring safe care. Reviews of IPC controls to ensure alignment with national guidance.	5.3.C	Misalignment of bedded capacity resulting in increased LOS and bed occupancy resulting in delays to treatment and harm
5.4.A	Insufficient internal and externally sourced capacity to manage elective demand.	5.4.B	Work programme of transformation improvement team in respect of planned care recovery plan. Planned Care Group improvement programmes overseen by Trust Recovery Board. 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: March 2024**

BAF Risk Scoring

Current Position	Jul 23	Sept 23	Nov 23	Jan 24	Target: April 24	Year on Year Mar 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, and the wider risk of legacy IT systems interim support during the EPR implementation phase. Secondly, general cyber security vulnerabilities are significant threats to IT systems globally. The recent 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	1.4.24	Secured for 2022/23 with additional external capital. Secured support for 23/24 business critical investment in high priority IM&T projects, aligned with the risk based approach to investment in most critical systems 15.2.24 - Development of the capital plan in place aligned to the IM&T prioritisation matrix
6.3A	Successfully secure EPR funding from the national team	DTP	1.8.2024	Secured OBC approvals and completed procurement phase. FBC now in development and will align with the Devon Digital Transformation Strategy. Monthly oversight on delivery of business case reported into the BBF committee.
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. Agreement of the Target Operating Model proposal for Digital has been reached in principle A meeting to agree the partnership governance architecture across Devon and the Peninsula will take place at end of February 2024 to develop proposals for system-wide work
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	1.12.24	A twin track procurement and implementation has been in progress to ensure that this significant risk is mitigated. The preparation for the implementation of Cirdan through the Peninsula Patgology Network is underway, there are however outstanding commercial concerns that the CFO is reviewing. Additionally, an options appraisal for Beaker implementation will conclude 16.2.2024

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: February 2024**

BAF Risk Scoring

Current Position					**Target**	**Year on Year**	**Rationale for Risk Level**
	Jul 23	**Sep 23**	**Nov 23**	**Feb 24**	**May 24**	**Mar 23**	
Likelihood	3	3	3	4	2	3	Risk level increased 15.2.24 - The availability of a national funding for cohort 4 and the pace of the national programme. The significant reliance on the NHP to resolve business critical estate failures that are escalating, including concrete failure of the Tower block, sewerage issues and multiple failures of key clinical estate.
Consequence	5	5	5	5	5	5	
Risk Score	15	15	15	20	10	15	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
7.1A	Availability of central funding and political support to the original programme	7.1B	BBF programme office and capital development team are working through a range of different scenarios should capital funding not be made available at a national level.	7.1C	Should funding not be made available the Trust still requires significant capital investment on its estate infrastructure and as such, would then pursue one of the scenarios previously highlighted.
7.2A	Availability of the specialist support within the BBF programme team to deliver a project of this magnitude and complexity.	7.2B	The Programme office has a well-developed recruitment and retention strategy that highlights requirement for external specialist support in areas such as design, cost advise and legal services. The team will be able to draw on this expertise as required.	7.2C	The costs associated with the external support would be detailed in any 'seed' funding allocation and would be agreed with the national team in advance of the requirement for the specialist support
7.3A	Timeline for programme completion	7.3B	The programme office has developed a range of scenarios associated with the delivery of the programme and these have been shared with the BBF Committee	7.3.C	The inflationary pressures of the programme will continue to increase without the required clarity from the national team on timetable and funding allocation. These costs would be funded centrally.
7.4A	National team resourcing the 'seed' allocation not in line with our timetable	7.4B	The 'seed' funding for 2023/24 has now been confirmed at a further £1.06m, which is in line with the funding provided for the last 2 years. In addition, the Trust has been able to secure a further £422,000 which will be required to complete the Site Enabling FBC.	7.4.C	The Trust now has the required funding to complete the site enabling FBC, which will enable the business case to be presented to the Trust Board in May 2024.
7.5A	Planning the clinical and operational support within the Trust to support the delivery of the programme plan from 1/4/23	7.5B	This matter is under review with the SRO and Health and Care Strategy Director and will form part of the 'seed' funding requirements for 23/24.	7.5C	The ability of the Trust team to deliver the BBF programme will be reviewed by the NHP national team, so to avoid 'step in' it is essential that the programme is able to benefit from the required clinical and operational support.

7.6A	Inflationary cost pressures in preferred option	7.6B	The national team will ensure that the inflationary pressures associated are funded through the 'target cost modelling' review that will be undertaken as part of the approvals process.	7.6C	The impact would be significant as the Trust would be required to reduce the scope of the construction project to absorb the inflationary pressure on the project.
7.7A	Alignment of strategic direction with the acute services review in Devon and any associated consultation process.	7.7B	The Programme office is sighted on the requirement for the Outline and Full Business Case(s) to be consistent with the recommendations made within the Provider Acute Sustainability Programme.	7.7C	The business case(s) would not be supported by the One Devon ICB and as a result would not be able to secure approval from the regional office. The programme would be delayed as a result.
7.8A	Support from the One Devon ICB for the business cases required to secure approval	7.8B	The Programme office will be developed an engagement strategy for ensuring that the business cases are fully supported by the ICB in a timely manner.	7.8C	The business case(s) would not be supported by the One Devon ICB and as a result would not be able to secure approval from the regional office. The programme would be delayed as a result.
7.9A	Ability to deliver the site enabling and support services elements for the project within the timetable to enable main construction commencing in 2025	7.9B	The Trust are not able to progress the scheme without the required support from the national new hospital team. The national team have confirmed that a funding announcement will confirm both allocation and timetable.	7.9C	The programme office had confirmed that the risk associated with the programme not being able to complete by 2030 are now seen as high.
7.10A	Availability of contractors and materials to complete programmes of work and potential lengthy lead in times.	7.10B	Capacity does need to be developed in order for the scale of the investment to be delivered, and this is being progressed at a national level.	7.10C	The development of the hospital 2.0 concept will mean that this risk is held at a national level. Therefore, the cost and time implications of this issue are being managed centrally
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: o Detailed design for site enabling o Integrated assurance strategy for programme o 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	DTP	31.3.2024 review	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	DTP	Feb 2024	The OBC for the site enabling measures has been approved by Board and has now been presented to the NHP for their review. Significant risk around approval process and development of mitigating action plan underway and will be presented to BBF committee in February 2024.
7.4A	Inflationary implications of construction costs on overarching programme delivery	DTP	Mar 2025	This is addressed through the business case processes

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: February** 2024

BAF Risk Scoring

Current Position					**Target**	**Year on Year**	**Rationale for Risk Level**
	Jul 23	**Sep 23**	**Nov 23**	**Jan 24**	**March 24**	**Mar 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	4	
Consequence	4	4	4	4	3	4	
Risk Score	16	16	16	16	9	16	

Risk Scoring Analysis

Aggravating Factors increasing risk profile:		**Mitigating Factors (internal controls):**		**Impact of risk occurring:**	
1.1A	Inadequate improvement and innovation capacity within the Trust	1.1B	Oversight of recruitment through new Transformation Group.	1.1C	Harm to patients arising from services not delivering most effective care
1.2A	Lack of ICS wide improvement capability to create an engine room for system change	1.2B	Peninsula Acute Provider Collaborative Board mandated the development of an investment proposal.	1.2C	Trust does not deliver required improvements at pace to meet NOF4 exit criteria
1.3A	Lack of operational and clinical leadership capacity	1.3B	Oversight of delivery of the outcomes from coaching programme, delivered through Transformation Group and planned to be reported to BBF Committee from July 2023	1.3C	Regulatory action for safety, quality and performance standards
1.4A	IT infrastructure is inadequate for significant transformation	1.4B	EPR Digital business case in approval pipeline with National team, oversight through Exec Advisory Group & BBF committee	1.4C	Low morale and increasing fragility in the workforce as a result of moral injury
1.5A	Estate infrastructure is inadequate for significant transformation	1.5B	FPDC oversight of TIF capital developments and opening of new AMU. BBF committee oversight of NHP programme delivery	1.5C	
1.6A	Too many competing priorities across the ICS and Trust	1.6B	Regain and Renew plan provides a framework for focus on most critical Trust / ICS priorities – monitored by TMG		
1.7A	Operational and Clinical ownership and delivery of all transformation portfolios	1.7B	Executive oversight of delivery of Transformation Programmes within their governance oversight frameworks (e.g Safety and Quality to Executive Quality Group) oversight of overall programme of change proposed will sit with new BBF Committee TOR – implementation in July 2023.		
1.8A	Culture of Continuous Improvement not embedded into organisation to enable improvement capability across workforce.	1.8B	Oversight of programme to embed continuous improvement methodology, including self-assessment against national NHS Impact standards delivered through Transformation Group and reported to BBF Committee. (October 2023)		

1.9A	Benefits specified in the EPR full business case are not fully realised	1.9B	Ownership of benefits specified in partnership with operational/clinical leads who will be responsible for their delivery	1.9C	Trust does not deliver the efficiencies and working practices to ensure sustainable services now and into the future

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	Complete	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 has concluded. Further assessment of capacity requirements will be developed through business planning.
1.7A, 1.7B, 1.9B	All transformation portfolios led by Executive leads and delivering against agreed milestone actions with robust monitoring	DTP	Complete	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	31.3.2024	Business case has been approved by PAPC and TSD are the lead organisation. Recruitment to this additional capacity will take place following completion of the recruitment approvals.

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 Mar 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 Mar 23
Likelihood	4	4	4	4	3	4
Consequence	3	3	3	3	2	3
Risk Score	12	12	12	12	6	12

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: February 2024**

BAF Risk Scoring

Current Position					Target	Year on Year	Rationale for Risk Level
	Jul 23	Sep 23	Nov 23	Jan 24	Sept 25	Mar 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	**Complete**. 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	**Complete** The inclusion module has been created and launched. The 12 month 'It Starts with me' campaign has begun, integrated with our People Promise comms and engagement.

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Torbay and South Devon NHS
NHS Foundation Trust

DATIX RISK MODULE REPORT

(Exceptions highlighted in Yellow.)

ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	Specialty	Risk Location	Title	Description Cause: Effect:	Consequence (Inherent / Initial)	Likelihood (Inherent / Initial)	Rating (Inherent / Initial)	Controls in place	Gaps in Control	Review due date	Consequence (Current)	Likelihood (Current)	Rating (Current)	Risk Progress Notes Last 3 entries minimum.	Consequence (Residual)	Likelihood (Residual)	Rating (Residual)	Action Point/Plans relating to Risk Synopsis of Open Action Point/Plan	Action Point Owner	Review due date (Action Plan)	Completed by	Completed on	Action Plan Progress Notes Last 3 entries minimum.
1083	01/01/2016	Corporate Level Risk	Estates	Jake O'Donovan	Jake O'Donovan	Chief Finance Officer (Mark Brice)	Financial Risk		Site Non-Specific	Failure To Provide A Fit-For-Purpose Estate That Supports The Delivery Of Safe/Quality Care.	Cause: Lack of adequate long-term capital funding to ensure backlog maintenance is adequately addressed. Effects: A. Failure of aged plant and deteriorating building fabric, resulting in unplanned cancellation of clinical services. B. Potential impact on ability to meet RTT and other contractual clinical standards. C. Increased risk of harm to staff, patients or members of the public from failing infrastructure. D. Increased estate maintenance costs (revenue and capital) and risk of financial penalties due to clinical breaches. Linked to Risks: DRM ID No 2353 - Cellular Pathology Portacabin No Longer Fit for Purpose. DRM ID No 2542 - Potential Failure of Theatres DSU 3 & Ophthalmology Ventilation Units. DRM ID No 2718 - Inability To Expand Clinical Services Due To Lack Of Space. DRM ID 2429 Ward Kitchens Environment in Acute and Community Settings in Need of Updating - 26 locations identified. DRM ID 3621 External Wall Tiles on Tower Block becoming loose with potential to detach from their fixings and fall from height DRM ID 2878 Increased fire risk in the Torbay Hospital tower	Catastrophic	Almost Certain	25	1. Risk assessment, prioritisations and approval process in place to manage highest risks. Highest risk elements prioritised in the capital programme, as funding will allow. 2. Increased financial contingency built into capital programme to respond to unplanned critical estates failures. 3. Increased maintenance for key areas. 4. Business continuity plans in place to respond to potential loss of infrastructure. 5. Robust planned preventative maintenance regime in place. 6. Estates Planned Prevenative Maintenance performance and compliance status and critical failures reported and monitored monthly via Capital Infrastructure and Environment Group; Finance, Performance and Investment Committee; Infection Prevention and Control Committee; exceptions to Trust Board meeting. 7. Statutory Estates Roles and Responsibilities appointed and tracked monthly. 8. Annual review of mandatory and statutory systems compliance by externally appointed Authorising Engineer(s). 9. Board has approved annual capital programme based on actively considered risks versus maintaining a cash balance. 10. Trust has submitted Business Case for new acute hospital facilities.	1. Insufficient funds available to address all high priority risks over a 5-year period. 2. Equipment and plant continues to fail and due to age, cannot always be repaired. 3. Due to the scale of potential failures, business continuity plans are unlikely to be able to respond to all eventualities. 4. Access to undertake essential maintenance is more difficult to plan without causing disruption to clinical services, which are at capacity.	29/03/2024	Catastrophic	Almost Certain	25	[01/11/2023 11:35:35 Paul Hayman] No Change - review in March 2024 [31/07/2023 12:09:44 Paul Hayman] No change - review in October 2023. [05/04/2023 12:57:05 Paul Hayman] Works for new CT_RT scanner commenced and Northcott Hall and Embankment demolished as part of early site clearance works for BBF.	Catastrophic	Possible	15						
1159	18/09/2012	Corporate Level Risk	All Departments (Risk Only)	Gary Holline	Adél Jones	Director of Transformation and Partnership (Adél Jones)	Information and Communications Technology Risk		Site Non-Specific	Current IT Systems And Infrastructure Will Not Meet Future Demands.	Cause: Lack of available capital funding to spend on IT infrastructure and IT Systems. Effects: A. Failure of key IT infrastructure and IT systems resulting in impact on service delivery. B. Lack of cyber security investment may expose the Trust to risk of fines equal to 4% of Turnover or £ capped at £17M following a successful cyber-attack similar to the May 2017 "Wannacry" attack. NHS Digital (for NHS England) are highlighting the number of CareCERTs they have mandated that Trusts have mitigated. C. Inability to meet future statutory or regulatory requirements around reporting. D. Possible impact on clinical systems impacting patients /service users. E. Failure to meet future CQC registration requirements unless the Trust can achieve "minimum digital functionality" as detailed in the Accelerating Digital Healthcare white paper of October 2020. F. Inability to achieve the Government's requirement (2023) of 100% having or implementing EPRs by 2026. Note: Our plans are predicated on an on-going capital investment plan to ensure optimum performance of service. Linked to Risks: 1168 - National Programme for IT HSCIC. 1174 - Increasingly Software Companies Are Changing Their Licensing. 2696 - WinPath V5 Incompatibility Risk. 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 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).	01/05/2024	Catastrophic	Almost Certain	25	[23/01/2024 09:44:24 Gary Holline] Reviewed in light of potential new risk relating to Swift+ being over-configured, affecting its performance. [29/11/2023 11:14:46 Gary Holline] 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.	Catastrophic	Rare	5	Support the activities described in the Trust's Digital Strategy regarding the priority action to procure an EPR	Gary Holline	21/07/2024			[14/06/2023 09:04:44 Gary Holline] OBC with national team for approval
2996	01/02/2021	Corporate Level Risk	Finance	Tian Ze Hao	Tian Ze Hao	Chief Finance Officer (Mark Brice)	Financial Risk		HQ, Regents House	Financial Sustainability Risk Rating for 23/24 and 24/25	Cause: Lack of Improvement in underlying financial position of the Trust and medium term financial sustainability. Effect: 1. Possible Failure to deliver 2023/24 deficit financial plan 2. Failure to address underlying financial performance of the Trust over £70m recurrent deficit, and failure to deliver the agreed financial plan for 2024/25 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 2402 Increasing Costs Of High Value Drugs & Devices 3274 Failure to Identify and Deliver CIP in Full	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. Via internal control process and governance group such as Vacancy review panel, Non-pay control panel and weekly recovery group, regular updates are 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, albeit moving to the right direction. 3. Governance and delegation compliance rate following spending protocols requires monitoring and addressing	14/06/2024	Catastrophic	Almost Certain	25	[07/03/2024 14:23:52 Tian Ze Hao] Since October 2023, the Trust had been working closely with system partners and ICB in finding ways to mitigate the list of certain risks that the Trust had been carrying throughout the year. As result, a new deficit control total was agreed in November 2023 with additional NHSE/ICB funding in year (e.g. supporting industrial actions). In addition, the Trust had also set up a number of internal control and governance groups such as vacancy review panel, Non-pay control panel and weekly recovery group. The impact of which meant that the Trust is likely to be on track to deliver the 23/24 deficit control total in year and we are currently in discussion with NHSE /ICB regarding operational and financial planning for 24/25 and the deliverability of CIP. The Risk rating has been reduced to reflect the in year deficit agreed and the controls are now in place. [23/08/2023 14:08:07 Tian Ze Hao] Risk still remain the same driven by unidentified / under-delivery of CIP schemes and the increasing cost pressure in Adult Social Care. This is not just for 23/24, for the medium term we are developing a joint understanding with ICB on interventions required. [26/05/2023 09:29:27 Dave Stacey] Updated DS May 2023 [30/01/2023 13:34:45 Tian Ze Hao] Risk updated for the current and coming financial year (23/24). We are in the process of submitting a joint acceptable operational plan with the ICB in Feb 2023.	Catastrophic	Likely	20						

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Torbay and South Devon NHS
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.
3684	12/12/2023	Corporate Level Risk	Estates	Jake O'Donovan	Jake O'Donovan	Chief Finance Officer (Mark Bilson)	Operational Risk	Estates Operations	HOS. Torbay Hospital Tower Block	Tower Block Building Fabric Weakened - (cracked pillars and core samples contain ASRs)	Cause. 1. Following a recent survey cracking was noted in the structural elements of the concrete frame of the Tower block. Case structural engineers were appointed and in turn had laboratory tests carried out by Birmingham City Laboratories. The results showed disturbingly high levels of Chloride & Carbonation which weakens the integrity of the steel reinforcing and concrete. Effects. 1 The presence of high levels of Chloride & Carbonation in the concrete show's weakness in the strength of the steel reinforcements within the concrete and the concrete itself. High levels mean the structure could become unstable and even collapse. 2 The short-term effect is that it is not yet possible to quantify what the remaining useful life of building might be. 3 The long-term effect is to place a limited life span on the building. 4 The Podium Block was also constructed at the same time, and cracks have already been detected in some areas including the Fracture Clinic area. Linked to: 1083 Failure To Provide A Fit-For-Purpose Estate That Supports The Delivery Of Safe/Quality Care.	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.	01/04/2024	Catastrophic	Almost Certain	25	[05/02/2024 13:44:52 Paul Hayman] Minor update to Cause and Effect details. [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					
1070	29/05/2014	Corporate Level Risk	Emergency Department (ED)	Joann Hall	Lisa Houlihan	Chief Operating Officer (Arun Chandran)	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.	Catastrophic	Almost Certain	25	1. Good data analysis available - ED dashboard linked with control room - good and accurate weekly data sheets produced to monitor performance. 2. New medical "O" drive - to allow other specialities (Medicine) to be monitored in same way as ED - pressures easier to identify earlier. 3. Escalation policy in place. 4. 3 x daily control meetings with real-time information and appropriate management responses. 5. Ward discharge coordinators have daily meetings to review ward discharges. 6. AMU re-provided on Level 2 from 21/03/16 to divert medically expected patients from ED. 7. "See & Treat" trial in 2017 was successful and is now used during periods of escalation. 8. JET Team now fully operational to provide support for early discharge. 9. Acute Care Model in Bay 5 to accept direct HCP referrals from 10th April 19. Prioritise use of EAU3 as assessment space, additional push from Jan 2020. 10. There are 3 improvement work streams in place with project plans for each; Emergency floor programme, ward processes, and Home First. We also have support from ECIST who are actively supporting a range of improvements. Governance structure in place to support these and currently looking to source additional project support. 11. Increased robustness of internal ED escalation.	1. Linkage of the overcrowding risk score not formally linked to the escalation policy. Need for better OPEL linked escalation. 2. Patient flow out of the ED and other assessment spaces (MRU/SRU)	30/10/2023	Catastrophic	Likely	20	[29/03/2023 11:27:49 Amanda Anders (Risk Officer)] Title changed by COO [22/11/2022 17:30:40 Melody Andrews] Risk reviewed and no change at present [10/06/2022 10:36:11 James Merrell] Risk reviewed and no changes at present.	Catastrophic	Unlikely	10	To support improvements an urgent care board has been established to monitor the workstreams affecting flow and process issues across ED, medicine , frailty , bed management and discharge processes. Each workstream holds a specific action plan for improvement measures which is monitored weekly with oversight weekly at the urgent care board .	Joann Hall	29/03/2024			[16/07/2023 13:37:34 Joann Hall] Minutes and action log available in shared teams drive
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: Inability to deliver a sustainable health and care service required to meet the needs of the local population. Defined as: - Clinical sustainability - Workforce sustainability - Financial sustainability Linked risks: 3484: Failure of acute provider collaborative to deliver on acute sustainability plan programme 3485: Failure of ICS operating framework to support collaboration in line with health and social care policy requirements	Catastrophic	Likely	20	1. Chair, CEO and Executive engagement with ICS Committees and decision making groups 2. Chair, CEO and CMO core members of the Peninsula Acute Provider Collaborative. 3. Peninsula Acute Provider Collaborative and established governance including a decision making framework approved by all Boards. 4.Development of ICS governance arrangements to include ICB, ICP Local Care Partnerships and Provider Collaboratives 5. Internal appointments Delivery Director and PMO 6. Provider Collaboratives- Acute, MHLDN and plans for Primary Care and Community 7.Regular TSDFT executive engagement and attendance at ICS Board and Place Based/ICP planning meetings. 8.TSDFT CEO leads the Acute Provider Collaborative and Chair, DCEO and CMO also members 9.Director level participation at Strategic/Clinical networks: ICS Executive, Finance Working Group and HRD Executive Forum 10.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. Engagement with Healthwatch and Health Overview and Scrutiny. 11. System Recovery Board. 12. Trust internal governance.	Internal 1.Lack of robust planning arrangements 2.Operational capacity and strength of new care group governance External 3.System Acute clinical strategy 4.Agreement on pace of change from Partners 5.ICS governance structures are emerging and decision making at organisation, place and ICS level is ambiguous at times. 6.Implications of revised governance arrangements on FT governance and decision making	09/05/2024	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	01/05/2024			[08/02/2024 11:14:17 Sophie Byrne] Delivery against plan including risks and issues set out in Integrated Performance Report (IPR).
																									System Operating Plan	Liz Davenport	01/05/2024			
																									Trust Governance Process - Recovery Board	Liz Davenport	01/05/2024			
																									Leadership Capacity and Capability	Michelle Westwood	04/12/2023			
																									Regain and Renew (SOF4 Exit plan)	Adel Jones	04/12/2024			
1266	01/10/2015	Corporate Level Risk	All Departments (Risk Only)	Derren Westacott	Kerry Naughton	Chief Operating Officer (Arun Chandran)	Performance Risk		HOS. Torbay Hospital	Failure to Achieve Constitutional Target Regarding RTT Resulting in Poor Patient Experience And Quality Of Care.	Cause: Supply and demand imbalance across most specialities to meet constitutional waiting times, leading to an inability to deliver quality patient experience in relation to waiting times. Effect: Poor patient experience and quality of care, reputational impact for the Trust Linked to Risks: DRM ID No 2307 - Oncology Outpatient Clinic Issues. DRM ID No 2036 - Endocrine Outpatients - Increase on Demand with Limited Consultant Time.	Major	Almost Certain	20	1. Performance reporting and action plans with support of the Performance team, via Risk and Assurance weekly meeting 2. Waiting list management process, weekly PTL meetings 3. Operational teams identifying capacity and maximising all available sessions, also utilising insourcing companies and outsourcing where able. ICB supporting and involved with oversight 4. Support from other specialties creating sense of team working, ie UGI team supporting colleagues within Colorectal to reduce cancer backlog. Greater system working across the region with Urology 5. regular monitoring of demand in services, use of Tableau now integral part of planning	1. Saturday 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						

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1697	07/11/2016	Corporate Level Risk	Human Resources	Michelle Westwood		Michelle Westwood	Chief Peoples Officer	Financial Risk		Site Non-Specific	Difficulty In Recruiting Service Critical Staff And The Scheduling Of Staff (Workforce Risk).	Cause: Lack of strategic workforce planning means we are unable to proactively develop our workforce pipelines to satisfy our current and future workforce need. This is compounded by National shortages mainly due to the deficit between the numbers of trained staff required and the number coming through training providers. Effect: Difficulties in delivering on corporate objectives and national targets. Increase in temporary workforce usage including agency leading to budget overspends. Linked to Risks: DRM ID No 1830 - Cancer Services Vacancy for Breast and Colo-rectal Clinical Oncology. DRM ID No 2066 - Vulnerability of Medical Take Due to Increases in Last 10 Years. DRM 2928 Inadequate Medical Physics Resources Impacting on Service Provision DRM 2576 Lack Of Anaesthetic Cover To Cover 85% Of Scheduled Lists. 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 between requirement to train additional staff and sufficient capacity to deliver placements for students and other trainees. Ctrl 5. E-Rostering system not in place for all staffing groups.	19/04/2024	Major	Almost Certain	20	[12/02/2024 08:41:34 Sarah Blacoe] Progress being made between finance and ESR team to cleanse data. Progress expected to hit first milestone on 31/3/24. CFO and CPO being updated bi-weekly. [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	Major	Possible	12						
3231	18/09/2023	Corporate Level Risk	Radiotherapy	Jose Eduardo Villarreal Barajas		Ria McCoy	Chief Operating Officer (Acorn Chandrian)	Operational Risk		HOS Torbay Hospital Medical Physics	Critical Staff Shortages in Radiotherapy Physics (Workforce Risk)	Cause: 1. Removal of establishment through run rate calculation 2. Increase in clinical workload 3.Commitment to continued support to R & D clinical trials 4. New work e.g. lung SABR program(no extra resources) 5.Radiotherapy physicist supporting nuclear medicine services 6. Funding from R&D B7 physicist for 12months, awaiting AfC no. 7. From the beginning of February 2024 our Medical Physics Expert coverage has been reduced to only 2.66 WTE. Effects: 1. No resilience within team 2. Limited and no further ability to support and develop new services 3.Delays to patient pathway leading to breaches 4. Low moral within teams affecting health and wellbeing 5. Succession planning required 6.- Medical Physics Expert WTE's low establishment is reducing our ability to cover basic routine services within our Radiotherapy operations. Linked to 1697 Difficulty In Recruiting Service Critical Staff And The Scheduling Of Staff (Workforce Risk).	Catastrophic	Likely	20	1. Staff already working additional hours 2. Prioritisation of some projects to allow for day-to-day patient activity. 3.- Asking the RTP Exeter for MPE coverage whenever required.	1. Radiotherapy physics staffing 2.Complencies across the team 3. RD&E unable to provide additional support at this time	09/05/2024	Catastrophic	Likely	20	[12/03/2024 13:33:37 Amanda Anders (Risk Officer)] Discussed at March Risk Group- agreed to add the risk to the Corporate Risk Register, as predicted mitigations have failed the current score has been raised back up to 20. [28/02/2024 14:20:18 Jose Eduardo Villarreal Barajas] Revised the risk updated the risk description, and added an action [17/10/2023 11:26:45 Ria McCoy] Workforce plan in development for Medical Physics - budgets currently being aligned between diagnostic and RT. Workforce strategy paper expected Nov 23	Catastrophic	Unlikely	10	Business case to increase staffing via business planning process	Ria McCoy	31/03/2024			
3547	05/04/2023	Corporate Level Risk	Human Resources	Sarah Lehmann		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 Lehmann	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.
3536	14/03/2023	Corporate Level Risk	Human Resources	Michelle Westwood		Michelle Westwood	Chief Peoples 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	01/08/2024	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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ID	First Recorded	Type	Department	Risk Owner	Risk Owners Senior Mgr	Risk Owners Director	Risk Category	Specialty	Risk Location	Title	Description Cause: Effect:	Consequence (Inherent / Initial)	Likelihood (Inherent / Initial)	Rating (Inherent / Initial)	Controls in place	Gaps in Control	Review due date	Consequence (Current)	Likelihood (Current)	Rating (Current)	Risk Progress Notes Last 3 entries minimum.	Consequence (Residual)	Likelihood (Residual)	Rating (Residual)	Synopsis of Open Action Point/Plan	Action Point Owner	Review due date (Action Plan)	Completed by	Completed on	Action Plan Progress Notes Last 3 entries minimum.
3546	16/03/2023	Corporate Level Risk	CFHD Safeguarding	Val Watkins	Cheryl Vidall	Interim Chief Nurse (Nicola McKeown)	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	29/04/2024	Major	Almost Certain	20	[16/01/2024 11:15:44 Cheryl Vidall] Discussion with COO Arun Chandran regarding corporate risk and mitigations to be taken. Agreed to remain at risk score of 20 until additional resources can be found. Recognised that daily enquiries are being timed out due to capacity and demand. Used national and local data to identify significant growth in moderate and high risk cases being brought to MASH that need Health input, which often changes the rating of the enquiry. Revision of ICB Business case to request x3 WTE safeguarding practitioners and 0.5 WTE administrator to manage rising demand for service and provide an element of future-proofing for the service. [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.	Major	Unlikely	8	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.
																									Business Case developed for additional resourcing to meet increased demand - ICB to respond.	Cheryl Vidall	19/07/2024			[16/01/2024 11:08:29 Cheryl Vidall] Business case to be resubmitted to the ICB in January 2024.
3738	27/02/2024	Corporate Level Risk	All Departments (Risk Only)	Emma O'Connell	Beverley Mack	Chief Operating Officer (Arun Chandran)	Performance Risk	All Specialty (Risk Only)	CFHD, Capital Court	Funding Gap Between the Original CFHD Commissioned Specifications and Actual Demand	Cause: There is an acknowledged funding gap between the original CFHD commissioned specifications and the actual and increasing demand and complexity amongst the children and young people population of Devon including Torbay. Gaps in the specification have been noted, costed and raised to the ICB and Alliance partnership board. Capacity and Demand on CFHD is also compounded by significant delays in the recruitment of replacement and newly configured posts. This delay from predominantly TSDFT is due to the financial position of NOF4. Recruitment challenges are further compounded by the national lack of skilled workforce in professional groups (OT, SALT, Psychology). Effect: The effect of the above is that service provision is either not available (i.e. Out of Hours End of Life Care), capacity is not sufficient to meet the sustained and or increasing demand (i.e. referrals for autism assessments and MASH enquiries) and CFHD is unable to meet strategic requirements (i.e. SEND requirements for Devon and Torbay). Care is delivered at the highest possible level with CFHD, however these gaps and challenges mean that we are not able to consistently provide a timely or appropriate service to all who request provision, and this disproportionally impacts children with safeguarding concerns, children with special educations needs and children at the end of life.	Major	Almost Certain	20	1. The ICB commenced a review of service specifications with CFHD in May 2023, in an attempt to address commissioning gaps; this piece of work has not been signed off by the ICB so lack of clarity remains. 2. CFHD have (utilising the review of specification) undertaken a extensive piece a work to map evidence based and evidence informed clinical provision in each pathway. 3. Harm reviews undertaken by the ICB and CFHD in key areas (Early Childhood Development, End of Life Care, Autism Assessments , Mental Health, Speech and Language and Occupational Therapy and Physiotherapy.) to help inform commissioning decisions and potential additional funding streams for 2024/25. 4. Each individual pathway risk has been identified to CFHD Integrated Board and the ICB. 5. CFHD complied with the TSDFT "call to action" financial planning. 6. Demand, activity and capacity project for each pathway to understand capacity gaps - commencing March 24. 7. Workforce planning underway.	1. Lack of progression with jointly updated CFHD service specifications. 2. Two Harms still to finalise by CFH , but 4 have been sent to ICB	08/04/2024	Major	Almost Certain	20	[12/03/2024 13:27:21 Amanda Anders (Risk Officer)] Risk discussed at March Risk Group and approved onto the CRR	Major	Unlikely	8	1. Actions plans relating to individual risks can accessed via their allocated risk page. 2. Continue to raise and escalate reviewed specification at ICB/CFHD contract meetings.	Emma O'Connell	08/04/2024			
1815	05/08/2014	Corporate Level Risk	Cancer Waits Team	Alex Atkins	Ria McCoy	Chief Operating Officer (Arun Chandran)	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 and CT colon. Unable to deliver timed cancer pathways through diagnostics to enable achievement of the 62 day pathway consistently. B. Urology capacity for outpatients reduced. c. Consultant vacancies in Dermatology and Urology. Reliant on Locum cover. D. Insufficient capacity in diagnostics - CT, CTC, MRI and hysteroscopies 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 and 62 day referral to treatment targets. 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 3 cancer sites - Gynae, LGI and Urology F. Additional work ongoing to escalate, complete breach analysis and recovery plans. G. Poor Trust reputation and increased scrutiny from regulators.	Major	Almost Certain	20	1. Fortnightly Cancer Task and Recovery meetings with Senior Management and Devon ICB 2. Site specific escalation lists on Infoflex for operational managers to access 3. Cancer Clinical Leads meetings to share risks and concerns across the ICO 4. Regular reporting to Planned Care Board to escalate risks and concerns 5. Cancer patients are always prioritised when capacity reduced 6. Weekly PTL meetings set up with at risk cancer sites to escalate potential breaches and discuss concerns 7. 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	28/03/2024	Major	Almost Certain	20	[28/02/2024 09:30:44 Jacqui Robinson] The Trust have achieved 28d standard consistently for a 12 month period and achieved 31d standard in January. However we continue to fail 62 with main concerns in Gynae, Urology and LGI. [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.	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	30/04/2024			[29/02/2024 11:19:29 Jacqui Robinson] The Trust continues to maintain their position outside of Tier 1 and have now successfully achieved the 28d standard for a period of 12 months. 1 of only 22 Trusts in the Country to do so. Our main areas of concern continue to be Urology, Gynae and Colorectal with all of these failing the 28d target and both pathway analysis work is underway between clinical leads and cancer managers to improve performance. Cancer Managers are continuing to work closely with clinical teams to improve performance again 31 and 62 day targets. Strikes and staffing continue to have an impact.
																									The Urology service are an outlier across the Peninsula for template prostate biopsy service. Should be delivering as an outpatient procedure under LA, which will reduce delay to diagnosis and increase DSU capacity. An appropriate outpatient suite required to deliver a safe service at Torbay Hospital	Kevin Pirie	08/07/2024			[24/07/2023 08:02:23 Emma Brooks] 24/7/23 - TP biopsy waiting times now within target and works currently underway at Paignton Hospital to create a procedure room, due for completion August 23 [09/05/2022 12:23:38 Ali El-Eleimi] No change in status following the relocation of urology services to Paignton, still waiting an EXE decision on suitable space within OPD at the main site. [05/05/2022 09:43:09 Jake Gibbons] Reassigned to Ali El-Eleimi from Neal Foster
																									There a 10s of actions related to the achievement of this risk, these are need to be recorded in a central Trust's Cancer Action Plan and overseen through the Cancer Cabinet structure.	Alex Atkins	31/03/2024			[02/08/2022 08:20:39 Alex Atkins] Action plans in place for key sites - ongoing monitoring needed [10/03/2022 14:43:51 Alex Atkins] Completed for Breast, Derm, Urology and LGI. [25/02/2022 08:41:14 Alex Atkins] 25/02/2022 - Action plan template created and started to be populated [14/12/2021 11:00:18 Alex Atkins] 14/12/2021 - Draft action plan in place
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						

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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 (If/Inherent / Initial)	Likelihood (If/Inherent / Initial)	Rating (If/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.
2957	19/11/2020	Corporate Level Risk	All Departments (Risk Only)	Kate de Burgh	Ria McCoy	Interim Chief Nurse (Nicola McMinn)	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)	Catastrophic	Likely	20	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
2966	3/01/2020	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	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	28/02/2024	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 sites(e.g. RCHT) under pressure. Both Histo and	Major	Unlikely	8						
2948	13/11/2020	Corporate Level Risk	Emergency Department (ED)	Lisa Houlihan	Nicola McMinn	Interim Chief Nurse (Nicola McMinn)	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.	02/09/2024	Major	Likely	16	[27/02/2024 14:26:56 Melody Andrews] risk remains. no change. MH patients often having long delays in ED awaiting bed [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.	Major	Possible	12						
3195	19/09/2021	Corporate Level Risk	PMU Finance	Leon Rudd	Emma Rooth	Managing Director Torbay Pharmaceuticals (Emma Rooth)	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	30/04/2024	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	Medical Director (Kate Lasser)	Clinical Safety Risk		HOS Torbay Hospital George Earle Ward	Stroke Services (overarching risk)	Cause: 1) Vulnerability of nursing workforce; high number of new nurses including overseas nurses filling what were previously high number of vacancies. 2) Challenge to ensure all clinical staff gain & maintain stroke competencies; high turnover & large number of new staff plus pressures in system on capacity to give & to receive training. 3) Significant pressure within the system including poor flow; challenges to get patients to the right ward within 4 hour target window Effects: 1) & 2) a) Risk of increased clinical incidents; staff not able to get specialist skills in a timely manner. b) Impact on staff/ health & wellbeing; experienced staff having to support less experienced staff & trying to train staff in an already pressured system c) Difficulty covering specialist nurse & thrombolysis rotas 3) a) Performance on SSNAP - particularly Domain 2 time to & time spent on a stroke unit - poor & continuing to deteriorate b) Reputational risk; Domain 2 is part of CQC performance metrics This service sits within the category of small and vulnerable services which will only be fully addressed through networking on clinical services across the wider Devon footprint. Linked risks: 1069 Stroke Service Performance Measured in SSNAP - Bed Occupancy and Direct Admission.	Major	Likely	16	1) Training programmes in place 2) & 3)& 4) ADNPP leading Health & wellbeing work across ISU to support all staff 5) a) stroke improvement plan in place detailing actions & supporting the monitoring of progress b) Regular breach analysis & SSNAP meetings to monitor progress c) Assurance that stroke outliers are seen by Stroke team	Control 3) Ongoing challenge to maintain skills Control 5) b) Breaches continue; as few as 2% of patients reaching the stroke unit in 4-hours with consequential impact on ability to get specialist assessment within time, swallow screening etc. NB: Stroke Risk 1069 remains scored at 16 due to inability to get sustained improvement on Domain 2	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/compelencies across all professions. Improvement plan monitored via Management meetings or when these are cancelled due to operational pressures via direct links to action holders	James Hobbs	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
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.
3316	12/11/2021	Corporate Level Risk	Building a Brighter Future / New Hospitals Programme	CK\	CK\	Director of Transformation and Partnership (Adel Jones)	Financial Risk		Site Non-Specific	Failure to Complete the Outline Business Case for the main NHP Programme (Overarching Risk)	Cause: The BBF team are not able to complete the Outline Business Case for the NHP programme in a timely manner Effect: Risk in securing funding for the programme Linked to the following risks: 3270 BFF Commissioning - Workforce Risk (closed) 3269 BFF- Business Case Authorship - OBC and FBC (closed) 3268 BFF- OBC and FBC Business Case Authorship -(CIP) (closed) 3267 BFF: OBC Support Services- Lack of Efficiencies (closed) 3266 BFF: OBC - Support Services Not Aligned (closed)	Major	Likely	16	1) The BBF Programme office are working through all the requirements of the OBC to ensure that they have the required resource in place to deliver the Programme. 2) There is regular dialogue with the National Team and Trust Executives to ensure that the matter is being escalated. 3) Data gathering work has commenced with the National team.	1) The national team are not currently able to confirm definitive timescales associated with the completion of the OBC, but the BBF team are in regular dialogue to ensure that the matter is being escalated.	24/01/2024	Major	Likely	16	[24/10/2023 09:57:14 Emily Widdicombe] Risk reviewed on 24/10/23 with CK. Title - added 'main' as risk relates to the main Programme OBC. Controls in place - added point 3. Risk Handler/Owner to be reviewed in 3 months (24/01/23) [01/08/2023 10:37:38 Emily Widdicombe] Risk reviewed by CK, no updates required - rescheduled review date for 01/11/23. [27/03/2023 14:07:20 Sandi Clemo] Risk reviewed, no updates required - rescheduled review date for 01/06/2023 [07/12/2021 10:52:13 Amanda Anders (Risk Officer)] Agreed to add to CRR	Major	Likely	16							
3437	09/09/2022	Corporate Level Risk	PMU Operations	AR[	Emma Rooth	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.	30/04/2024	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)	30/04/2024			
3309	03/11/2021	Corporate Level Risk	IT Operations	Gary Hotine	Adel Jones	Director of Transformation and Partnership (Adel Jones)	Information and Communications Technology Risk		Other not listed	Patient Admin System Becomes Unsupported	Cause: The PAS is obsolete and support will cease. Effect: The Trust cannot function and deliver its prescribed services and functions without a PAS Linked to CLR: 1159: Current IT Systems And Infrastructure Will Not Meet Future Demands.	Catastrophic	Almost Certain	25	1. Early identification of the issue so that re-procurement and implementation can be accomplished (18 months) 2. Confirmation from supplier that at least 24 month's notice will be provided	1. EPR full business case approval.	05/06/2024	Catastrophic	Possible	15	[29/01/2024 15:40:58 Gary Hotine] Reviewed and rescored in light of Preferred Bidder being identified and timeline for FBC approval understood. [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 reassessed [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.	Catastrophic	Rare	5	The business case for additional HIS resources provides the minimum resources to enable the HIS to maintain BAU services, and increase the project capacity required to implement a PAS which is a major undertaking.	Adel Jones	01/08/2024			[26/09/2022 18:31:33 Gary Hotine] Taken to Execs and FPDC twice but no funding solution available
2920	12/10/2020	Corporate Level Risk	Finance	Neil David Elliott	Adel Jones	Director of Transformation and Partnership (Adel Jones)	Performance Risk	Buenes Intelligence Finance	HQ, Regents House	Activity Dataset Non-Compliance For Community Setting	Cause: Non compliance in recording activity within the community setting. Effect: Not able to report Activity on SUS, National Cost collection returns, Non compliant with Mandatory NHSE&I requirements. Unable to understand the activity and productivity within the community setting	Catastrophic	Possible	15	1. A Community Data Development Steering Group has been formed that is Chaired by the CFO and will report to CASCIT. 2. The Head of Data Engineering is aiming to get 2 band 6 members of staff recruited to help with resource issues in the team, hopefully some of this resource can be directed to mitigating this risk. 3. In the meantime funding has been agreed for 60 days of agency staff to come in and start work on formulating the dataset. The plan is for this resource to start on Monday 4th October 2021.	No plan to implement the requirements during the role out of the trust wide community system.	28/04/2024	Catastrophic	Possible	15	[30/01/2024 08:57:33 Neil David Elliott] Progress is being made with data recorded on PARIS. The development team have have introduced a new process and templates for recording Physio Community data, this started in Jan-24. Data should be available in Mar-24 to add to the current submission. If this is successful the PARIS team will then roll out this process and method of recording to other services that are part of CSDS. [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.	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.
2965	30/11/2020	Corporate Level Risk	Maternity Services	Jonathan Hindley	Joanna Bassett	Interim Chief Nurse (Nicola McMinn)	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 secon 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. 8) Matron for in patient services and Matron for Theatres meeting monthly to review Cat 1and 2 and communication.	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).	30/04/2024	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						

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3293	14/10/2021	Corporate Level Risk	PMU Finance	David Houghton	Emma Rooth	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.	30/04/2024	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 position and, if these cases are found against them,	Catastrophic	Possible	15						