



Torbay and South Devon
NHS Foundation Trust

Public Board of Directors

Date: Wednesday 24 September 2025

Time: 12 noon – 2.30 pm

**The Boardroom, Hengrave House,
Torbay Hospital**

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TSDFT Public Board of Directors

The Board Room - Hengrave House



Torbay and South Devon
NHS Foundation Trust

24/09/2025 12:00 - 14:30

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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

Workplan - Public Board of Directors 2025/26

	May	July	September	November	January	March
Preliminary matters	Welcome, Apologies and Quoracy Declarations Workplan	Welcome, Apologies and Quoracy Declarations Workplan	Welcome, Apologies and Quoracy Declarations Workplan	Welcome, Apologies and Quoracy Declarations Workplan	Welcome, Apologies and Quoracy Declarations Workplan	Welcome, Apologies and Quoracy Declarations Workplan
Standing Items	Minutes and matters arising BAF/ Risk Map	Minutes and matters arising BAF/ Risk Map	Minutes and matters arising BAF/ Risk Map (full DRR)	Minutes and matters arising BAF/ Risk Map	Minutes and matters arising BAF/ Risk Map	Minutes and matters arising BAF/ Risk Map (full DRR)
Approval Items	Review of Directors' Interests Operational Plan	Committee Annual Reports	Annual Adult Care Strategic Agreement Winter Plan		Maternity CNST	SFls/SoD/Sos (2026) Review of Board Workplan Risk Management Strategy/Policy Trust Strategy
Cyclical items	Patient Story Chairman's Report Chief Executive's Report/NOF 4 Progress report Reports from Board Committees IPQR Mortality Safety Scorecard Maternity: - Perinatal Governance Report ~~CQC Registration Annual Report~~ ~~Safer Staffing~~ Quarterly Guardian of Safe Working Hours Annual Staff Survey Report Board Self-Assessment	Patient Story Chairman's Report Chief Executive's Report/NOF 4 Progress report Reports from Board Committees IPQR Mortality Safety Scorecard Maternity: - Perinatal Governance Report ~~Patient Experience Annual Report~~ ~~Infection Control Annual Report~~ Annual Revalidation Report People and Education Annual Report Our Plan for Better Care	Patient Story Chairman's Report Chief Executive's Report/NOF 4 Progress report Reports from Board Committees IPQR Operational Plan (review of performance) EPR Status Report Maternity: - Perinatal Governance Report - Maternity Bi-Annual Staffing Safeguarding Children Annual Report Safeguarding Adults Annual Report Adult Social Care Local Account Mortuary Report Guardian of Safe Working Hours (amalgamated report) Our Plan for Better Care	Patient Story Chairman's Report Chief Executive's Report/NOF 4 Progress report Reports from Board Committees IPQR EPR Status Report Trust Strategy Update Mortality Safety Scorecard Maternity: - Perinatal Governance Report - Clinical Incidents Annual Report - CQC National Inpatient Survey Quarterly Guardian of Safe Working Hours Freedom to Speak Up Bi-annual Report F2SU/Whistleblowing annual report Our Plan for Better Care	Patient Story Chairman's Report Chief Executive's Report/NOF 4 Progress report Reports from Board Committees IPQR EPR Status Report Mortality Safety Scorecard Maternity: - Perinatal Governance Report - Maternity Bi-Annual Staffing - Maternity CNST EPRR – NHSE Assessment Our Plan for Better Care	Patient Story Chairman's Report Chief Executive's Report/NOF 4 Progress report Reports from Board Committees IPQR Summary of Planning Guidance and Trust Approach EPR Status Report Digital Strategy Update Maternity: - Perinatal Governance Report - Maternity CQC Patient Survey - Maternity Bi-Annual Staffing 7 Day Week Assurance End of Life Annual Report Quarterly Guardian of Safe Working Hours Freedom to Speak Up Bi-annual Report Gender Pay Gap Report Green Plan Our Plan for Better Care
Information Items						
Closing matters	Review of meeting Matters for escalation/AOB Date of next meeting	Review of meeting Matters for escalation/AOB Date of next meeting	Review of meeting Matters for escalation/AOB Date of next meeting	Review of meeting Matters for escalation/AOB Date of next meeting	Review of meeting Matters for escalation/AOB Date of next meeting	Review of meeting Matters for escalation/AOB Date of next meeting
Deferred from previous meeting		Mortality Safety Scorecard (May) Inpatient Nursing Safer Staffing Review (May) GOSW (May)	CQC Registration Annual Report (May) ~~Patient Experience Annual Report~~ Annual Plan 2024/25 (May) Delivery of the Workforce Plan Fuller Enquiry CQC report for Children & Young People for Torbay Hospital	Safeguarding Adults Annual Report Patient Experience Annual Report		
Requested Reports	NHS WRES/WDES Report					
Future Items			Green Plan Trust Strategy			

Tba – bi-annual research and development report

Key:

- Strategy
- Quality and Safety
- Performance
- Workplace and Culture
- Governance/Regulatory
- Finance



Torbay and South Devon
NHS Foundation Trust

**MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARDROOM AND MS TEAMS
AT 12 NOON ON WEDNESDAY 30 JULY 2025**

Present:	Prof. C Balch	Chairman
	Dr M Beaman	Non-Executive Director
	Mr J Teape	Chief Executive
	Ms A Jones	Deputy Chief Executive/Chief Operating Officer
	Mr M Brice	Chief Finance Officer
	Mrs L Edwards-Smith	Non-Executive Director
	Mr A Ghadiali	Associate Non-Executive Director
	Mr M Greaves	Non-Executive Director
	Dr C Lissett	Chief Medical Officer
	Mr P Richards	Non-Executive Director
	Mr C Saxby	Non-Executive Director
	Mr S Tapley	Interim Chief Strategy and Planning Officer
	Mr R Williams	Non-Executive Director
In Attendance:	Mrs J Bassett	Director of Midwifery and Gynaecology
	Mrs V Browning	Governor
	Mrs S Byrne	PA to the Chairman and NED's (Board Secretary)
	Mrs A Hall	Member of the Public
	Mrs L Houlihan	Associate Director of Nursing and Professional Practice – Emergency Care and Medicine in Planned Care
	Ms K McMoran	Matron
	Mrs J Piper	Acting Chief People Officer
	Cllr D Thomas	Governor (part)
	Mrs A Williams	System Improvement Director
	Mr S Wadham-Sharpe	Director of Operational Recovery

	WELCOME AND INTRODUCTIONS
76/07/25	The Chairman welcomed all those in attendance.
	PRELIMINARY MATTERS
77/07/25	Apologies for Absence and Quoracy No apologies for absence were received. The Chair confirmed the meeting as quorate.
78/07/25	Declaration of Interests No declarations of interests were received.

79/07/25	Corporate Objectives The Trust's Corporate Objectives were noted.
80/07/25	Board workplan The Board workplan was noted.
81/07/25	Unconfirmed Minutes of the Meetings held on 28 May 2025 The Board received the minutes of the meeting held on 28 May 2025, circulated with the agenda pack. The action log was reviewed, and updates were received on outstanding actions. The Board APPROVED the Unconfirmed Minutes from the Public Board meeting held on 28 May 2025 as a true and correct record
82/07/25	Patient Story Mr Marty McCauley together with his Wife, Mrs Sam McCauley presented their story to the Board. The following was discussed: • Mr McCauley was admitted via Ambulance due to an inability to move his legs. He was discharged with a package of care and was then readmitted for a period of 12 weeks. • The care received from the staff, particularly the Social Care Reablement Team, Physiotherapists and Occupational Therapists was for the most part phenomenal; noting in particular the day to day care from the nurses and health care assistants. • However, he did have some difficult experiences whilst he was in hospital, namely: - o Non-inclusive and unkind language about him, either said directly to or in front of him; leading him to feel judged due to his weight; - o A lack of appropriate equipment or individuals with appropriate training for bariatric care across the whole Trust; for example, the Trust did not have the correct size bowls for the bariatric commode; - o His wife came in regularly to personally care for him (including toileting) and this became the expectation; and - o Limited visiting hours. Furthermore, he challenged the Board to conduct their visits during handover, nighttime or quiet periods where the wards may not be so prepared for their visits to get a true reflection of patient stays. The Board thanked Mr McCauley for his candour, courage and articulate representation of the good and bad, noting that there was much to reflect on from his experience – both operationally and culturally. It was agreed a deep dive into the concerns raised would be undertaken at Quality Assurance Committee and the findings would be received by the Executive Committee. ACTION: NM It was agreed the Interim Chief People Officer, Chief Nurse and the Patient Experience Lead would meet to consider how patient experience data and staff experience data across the Trust could be improved. ACTION: NM/JP The Board received and noted the patient story.

	Chair's Welcome The Chair briefed the Board as follows: Siân Walker-McAllister would relinquish her role as NED for the Trust from 31 August 2025 at the end of her first 3 year term. She was thanked for the contribution she had made to the Board, in particular her knowledge of adult social care; and her commitment to the role of Maternity Safety Champion. Cardiology Test of Change • The Chief Executive and Chair had written to the Devon Integrated Care Board (ICB), raising a set of questions; and it had been agreed the Test of Change would be withdrawn until the ICB had undertaken a full review and the appropriate evidence had been sought. The review was likely to take around 12 months. • The Chairman had attended one public meeting of the Heart Campaign where he sought to set out the Trust's position. System and Peninsula Level Consultations • The merger of Devon and Cornwall ICB was likely to be completed by April 2026. • The Devon ICB Clinical Strategy was in the process of being populated. Right Care Week • The Chair had visited various wards to support them with the whole hospital approach to driving improvements in performance and handovers; and looking at obstacles and opportunities to discharge patients. • The Director of Operational Recovery would prepare a report based on the feedback received which would be presented to the Urgent and Emergency Care Group. Visits • The Chair had undertaken visits to: - o International Recruitment - o St Edmund's – to present the Chairs Award to The Personalised Care Team - o Grounds and Waste Management Team - o Mortuary - o Cardiology • Attended the Totnes League of Friends Celebration Event for Allison Bayliss, the current Chair, who had been a member of the league for 30 years. • Was a member of the Torquay Place Based Leadership Board, which supported how £320m worth of public funding was used to support community based initiatives and improvement in deprived parts of Torbay. Cardiology Virtual Wards • The Heart Failure Virtual Ward had been stood down due to a lack of continuation of funding however the Medicine Team were working with the Cardiology Team to bring together a sustainable model of care for those

	patients aligned to frailty, community and cardiology virtual wards which would shortly be launched. The Board received and noted the report of the Chairman.
83/07/25	Chief Executive's Report The Board received the report of the Chief Executive, circulated with the agenda pack. The following was discussed: Cardiology - Devon ICB would be leading on a piece of work around Cardiology Disease and undertaking a full review of services that would take around 12 months. The Trust would be fully engaged with the process. Chief People Officer - Mrs Jess Piper had been appointed, Acting Chief People Officer until 31 October 2025. Well Led Review - Ernst and Young had been commissioned to undertake a Well Led Review of the Trust. The work had now been completed and would be presented to private Board in August 2025 for further discussion. NHS Oversight Framework Segment Rating - The new segmentation had been issued. The scores had been recast and all providers would be notified of their scores by 31 August 2025. Industrial Action - Industrial Action finished at 8am on 30 July 2025 and another round of Industrial Action was anticipated. 82% of the Trust's Junior Doctors participated in the Industrial Action. 395 patient appointments were cancelled, due to the advice from the Secretary of State to continue booking patient appointments. - Patient safety was maintained, together with a greater number of empty beds and changes to behaviours in reports due to senior decision makers being at the front door. - Nurses, Allied Health Professionals and Doctors were all thanked for their contribution. It was acknowledged some had cancelled annual leave and others had worked multiple nights in a row to keep the Trust's services safe. - The impact of the strike on activity would be seen when the quarterly review figures were prepared however, a draft report would be presented to Finance and Performance Committee. - Going forward the Trust would take a more robust approach to derogations. The Board RECEIVED and NOTED the report of the Chief Executive.
84/07/25	Board Assurance Framework (BAF) The Board received the BAF, circulated with the agenda pack. The following was discussed:

	- It was the focus of Audit and Risk Committee and Board Development this month; and it was scheduled to be reviewed further at the next Board Development Session. - There were a high number of high level corporate risks and the Chair of the Risk Group was undertaking a deep dive of every risk on the Corporate Risk Register. The Board RECEIVED and NOTED the Board Assurance Framework, Organisational Risk Map and Datix Summary Report and AGREED the recommended assurance recommendations.
	FOR REVIEW
	Performance
85/07/25	Reports from Board Committees The Board received the Reports from Board Committees report, circulated with the agenda pack. Committee Chairs provided a briefing on the content of the reports, and a verbal briefing was provided on the recent Finance and Performance Committee, which was not included in the agenda papers: - The Patient Transport Service – Fleet Replacement Business Case was to be re-presented at Finance and Performance Committee who had delegated authority to approve the Business Case. - There was to be a Deep Dive into the Workforce Plans. - The Trust's £12m non-recurrent CIP was noted as high risk. - The Trust was currently meeting its financial target but, there needed to be a strong focus on CIP. The Board NOTED the Reports from Board Committees report and AGREED the recommended assurance recommendations.
86/07/25	Integrated Performance and Quality Report The Board received the Integrated Performance and Quality Report (IQPR), circulated with the agenda pack. The following was discussed: - The IPQR was being developed to be aligned to national best practice. It was hoped it would be in place by quarter 3. - It would ensure the following data was triangulated: People, Finance, Nursing and Medical against the four National Oversight Framework (NOF) metrics, community services and speciality level details. Diagnostics - A full delivery improvement plan was in the process of being finalised to improve performance. Factors affecting performance included: - Technical machinery failures; - Loss of significant capacity due to re-prioritisation; - Issues in key modalities out of kilter with performance. - To mitigate the Trust was outsourcing diagnostics, requesting mutual aid and was currently in contracting discussions with the Community Diagnostic Centre (CDC) to change x-ray capacity that was not required to ultrasound and echo scanning. The mismatch in capacity was due to the CDC being a

	national initiative and the Trust needed to consider how to inform commissioning of the local need. • Part of the Winter Plan included enabling patients to be discharged and offering them the opportunity for their scans to take place at CDC. • There was still likely a shortfall in MRI capacity, this was Devon wide. Jack Sears • Currently there was an over provision of community hospital beds that were easier to access than the completing the application to admit a patient to Jack Sears, this was a cultural issue which the Trust was aware of and was looking to resolve. Cardiology • A patient presented with signs of heart failure and was offered an outpatient appointment 16 days after the original presentation. By the time of the appointment he was too unwell to receive a valve replacement and sadly died. A review of the patient's history would be undertaken and learning opportunities sought. Stroke national reporting • The Trust had moved from category D to E due to the targets increasing. • The Trust was working with David Harbour to deliver care differently on the Stoke Ward. Thrombolysis Rate • The Trust had met the national thrombolysis rate. Infection Prevention and Control • A reduction in hospital acquired infections had been seen; and • The availability of team at weekends had improved outcomes. Post-Natal Smoking Cessation • The post-natal no smoking rate at time of delivery was 3.8%. Regulatory inspections • The Patient Transport Service CQC Inspection Report had not yet been received. • Due to the amount of external regulatory inspections, the Trust was currently having all inspections brought together in one report. Performance Trauma and Orthopaedics • Based on modelling the 78ww and 65ww were likely to be cleared by October 2025. • Job planning and booking processes had been reviewed. • The 65 week wait and 52 week wait position reduction was continuing to meet the trajectory set in operating plan. • Industrial action would impact the trajectories but there was a buffer, however, there was further risk due to Winter and the implementation of Epic.

	• The Trust was currently missing the 28-day Fast Diagnosis stretch trajectory • The 28-day faster diagnosis stretch trajectory was currently not being met. A quarter 1 review would be undertaken. Assurance was provided that bookings continued to be prioritised in the correct way. Cancer review • Diagnostic performance was having an impact on cancer targets. • There were capacity issues within Dermatology. • In Urology Nurse Led TP biopsy training, recruitment of Consultants the use of the robot would support the capacity issues. Urgent and emergency care. • Emergency Department (ED) performance was 71.5% and 76% week commencing 21 July 2025; • Ambulance handover times were just under 24 minutes; • The Trust was in the best position for No Criteria to Reside patients. • The Emergency Care Intensive Support Team had stated the Trust the had made the largest change that they had seen within two visits. The challenge was now to maintain the level of pace and collaboration focusing on specific pieces of work in ED and pathways to drive improvement. • Working closely with nursing colleagues, the Flow Programme had been implemented, golden discharge and the use of the discharge lounge was being encouraged. Winter Plan • Learning would be taken from last year; • There was a need to create levels of escalation space. Currently, together with nursing colleagues all spaces were being reviewed. • The Epic roll out and ED development not being completed were significant risks to the winter plan. • The Community Frailty Unit was seen as a core way to release capacity on the acute site. The Board AGREED the recommended assurance rating and took LIMITED/ SATISFACTORY assurance as to those matters reviewed. The Board ACCEPTED the overarching assurance recommendations: • Safety and Quality – approved the recommendation that there was satisfactory assurance that safety and quality issues at care group level were understood and managed; • Performance UEC - approved the recommendation that the Trust had not met UEC performance trajectories and there was limited assurance and that strengthened plans and assurance was needed to demonstrate that the Trust would meet the key UEC performance metrics as per the 2025/26 Operational Plan; • Performance Elective - approved the recommendation of Limited Assurance. The Trust did not meet performance targets to clear 78 weeks for RTT and Cancer 62 days. Requirement for more detailed

	recovery actions and trajectory to improve assurance of delivery in 2025/26; • Finance – approved the recommendation that there was limited assurance on financial delivery for month 3. Due to CIP forecast that showed a potential £12m shortfall. Recovery action plans had been requested by Care Groups to be reviewed with the Executive team week commencing 28th July; and • Workforce – noted the update on workforce performance metrics and assurance ratings by care group.
87/07/25	Our Plan for Better Care The Board received the Our Plan for Better Care report, circulated with the agenda pack. The following was discussed: • The Workforce programme was in a good position. • A review of the expressions of interest to support ‘Our Plan for Better Care’ needed to be considered. • The Trust were working with the Recovery Support Programme Team and Allison Williams regarding specialist resource. The Board: • Noted the progress made during the reporting period; • Acknowledged the ongoing transition into the delivery phase from August 2025; and • Took assurance that the improvement programme initiation remained on track.
	Quality and Safety
88/07/25	Guardian of Safe Working Hours Report The Board received the Guardian of Safe Working Hours report, circulated with the agenda pack. The following was discussed: • A decrease in exception reporting from the previous quarter had been noted. • A staffing risk was emerging on New Forrest Ward, as the Trust was currently using the ward to support patients with mental health problems who required additional medical support. The staffing managers and Flow Team were currently reviewing staffing levels and the ward’s exception reporting would continue to be monitored, as opposed to the recommendation in the report to increase staffing levels with immediate effect. • If it was noted particular clinicians had a higher reporting rate, the Trust made contact and offered support. However, this process would change with the new Exception Reporting – National Framework, further information would be received in September 2025. • The Trust had welcomed fifty extra Foundation 1 doctors, the vast majority of which were female. It was clarified they would have a very structured support programme of pastoral, educational and clinical support.

	The Board AGREED the recommended assurance rating and took LIMITED/SATISFACTORY/SIGNIFICANT assurance regarding those matters reviewed.
89/07/25	Mortality Score Card The Board received the Mortality Score Card report, circulated with the agenda pack. The following was discussed: • The full 26 page report was scrutinised by the Quality Assurance Committee at its recent meeting. • Hospital Standardised Mortality Rate was within the expected range as present the Trust could not code for frailty, therefore it showed a low number of frail patients. Coding would improve with the implementation of Epic. • The Summary Hospital Level Mortality Indicator data showed no difference in weekday and weekend mortality. • There was challenge around the Learning from Lives and Deaths (LEDER) referrals and whether the Trust was doing enough to equip staff to care for those with mental illness coming through ED given the level of the deprivation in the area. The Board NOTED the Mortality Safety Scorecard report and AGREED the recommended assurance recommendations.
90/07/25	Inpatient Nursing Safer Staffing Review Report The Board received the Inpatient Nursing Safer Staffing Review report, circulated with the agenda pack, noting the Trust was meeting all of the required benchmarks. The Board was asked to consider and note: • A third census was required in September 2025 to eliminate any potential discrepancies; • Agreement of budget centralisation of the maternity leave uplift of 2% to reduce overspend in areas with greater than 2% parental leave; • Undertake a review of 23% headroom allocation to ensure it was aligned to establishments; • Undertake review of current ETOC spend, designing a more universal role which will improve patient care and outcomes and reduce financial cost; and • An EQIA would be completed to assess the impact of ward managers working two clinical shifts per week.
91/07/25	Perinatal Governance and Safety Bimonthly Report The Board received the Perinatal Governance and Safety Bimonthly report, circulated with the agenda pack. The following was discussed: • At the recommendation of the national maternity review the Trust was reviewing how it heard the voices of women and families and the way it acted upon staff feedback. • The Maternity Safety Support Programme was supporting the perinatal improvement plan and through an expressions of interest the Trust was working with the National Improvement Advisor.

	• A gap in provision has been identified in the perinatal mental health services offered across Devon, providers were working collaboratively to address the gap due to commissioning but, this remained a risk for the Trust. • The Trust's current Clinical Negligence Scheme position had moved and safety action two was now green. • There had been recent social media activity regarding University Hospital Plymouth and the Trust's maternity services from former staff members. The Trust was working closely with the Nursing and Midwifery Council and CQC and supporting all staff concerned. The Board AGREED the recommended assurance rating and took satisfactory assurance for Maternity Incentive Scheme and limited assurance for Perinatal Mental Health Provision. The Board also: • Noted the key quality and safety issues identified in the report and the measures in place to address any areas of concern; • Noted the mechanisms that were in place to hear the voices of women and families within the service. This included the refresh of and increase in capacity of the Devon MNVP resource; • Noted the high compliance level of the service for the Saving Babies Lives Care Bundle.; • Acknowledged the findings of the deep dive into the services offered for women with perinatal mental health needs within the service; • Noted the current self-assessed position against the MIS safety actions with the intention for full compliance at the end of year 7; and • Noted the scope of the national maternity review as well as considered the suggestions within the subsequent letter from Sir J Mackay and to ensure that the governance and oversight recommendations were in place within the organisation to support this assurance requirement.
	Annual Reports
92/07/25	Appraisal and Revalidation Annual Report The Board received the Appraisal and Revalidation Annual report, circulated with the agenda pack. The following was discussed: • Of the 426 doctors completed 295 appraisal were completed. The Board was reminded there were a number of Consultants who only work for the Trust for short periods of time, therefore 100% compliance would never be achieved. The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board supported appraisals by requiring a solution to the issue regarding the process for providing Datix information for appraisals, and noted the issue related to funding of PAs for appraisal roles.

93/07/25	Infection Prevention and Control Annual Report The Board received the Infection Prevention and Control Annual report, circulated with the agenda pack. The following was discussed: • There was a risk due to the workforce gap with microbiologists. • The Board was mindful that its estate was aged and environmental issues would contribute to the spread of infection. It was agreed the Chair and Chief Executive would write a letter of thanks to the newly formed Infection Prevention and Control Team. ACTION: JT/CB The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board took SATISFACTORY assurance that the report demonstrated compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2022), based on assurance given, noting the risks identified and the work being undertaken to mitigate these.
94/07/25	Board Sub-Committee Annual Reports The Board received the Board Sub-Committee Annual Reports report, circulated with the agenda pack. The Committee are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.
	CLOSING MATTERS
95/07/25	Any Other Business No further business was discussed.
96/07/25	Date and Time of Next Meeting: The next Board meeting in public was scheduled to take place at 12.30 pm on Wednesday 24 September 2025. <i>Trust Board papers will be published on the website and interested members of the public are invited to submit questions in line with the Trust's normal processes.</i>

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 ACTION LOG**PUBLIC**

No	Issue	Lead	Progress since last meeting	Status
50/03/25	Freedom to Speak Up Bi -Annual Report – ascertain publication date of the Trust’s Sexual Misconduct Policy	ICPO	May Update: Policy in the process of being finalised. It would be presented to Agenda for Change Partnership Forum in May and Joint Local Negotiating Committee (JLNC) in June, before publication. June Update: The Sexual Safety Policy is due to go to Partnership Forum in July now pending a further review following staff side feedback. Following this, it will be presented to JLNC.	Open
82/07/25	Patient Story – deep dive on the issues raised to be undertaken at the Quality Assurance Committee,	NM		Open
82/07/25	Patient Story – consider how patient experience data and staff experience data across the Trust could be improved	NM/JP		Open
93/07/25	Infection Prevention and Control Annual Report – letter of thanks to be written to the Infection Prevention and Control Team.	JT/CB		Open

Board of Directors

Chief Executive's report

Date of meeting	Date report produced
24.09.2025	16.09.2025

Author(s)		Report approved by	
Name and title:	Jane Harris, Associate Director of Communications and Partnerships	Name and title:	Joe Teape, Chief Executive
Phone:		Date:	19.09.2025
Email:	jane.harris18@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
n/a

Executive summary
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.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
N/A

Key recommendations and actions requested
The report seeks to highlight key issues not covered in other reports and which need to be brought to the attention of the Board. These are structured into four sections: • Leadership, engagement and service visits • Priority areas – planning, strategy and people • National, regional and local issues and topics of interest

- Local media update

The Board is asked to receive and note the Chief Executive's report.

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

Aim	Impact
Population Health and Wellbeing	1
Quality of services provided	2

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	
People	
Financial Sustainability and Productivity	
Estates	
Operations and Performance Standards	
Digital and Cyber Resilience	
Building a Brighter Future	
Strategy and Transformation	
Sustainability: Green Plan/ Environmental	
Equality, Diversity and Inclusion	
Provision of Community and Care Services Delivered in Partnership	

Risk: Risk ID (as appropriate)

Risk	Risk ID
N/A	

External Standards affected by this report and associated risks

Care Quality Commission

Terms of authorisation, NHS England licence and regulations

National policy, guidance

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Chief Executive's report

Leadership, engagement and service visits

Engagement with our staff and partners

1. I have continued to visit as many areas of the wider organisation as I can, and it has been extremely valuable for me to listen to all of our teams and their views of our services and what it is like to work here. The feedback from my visits is being used to inform our planning going forward and the detail of actions we will take will be included in our plan for better care.
2. My twice-monthly Meet Joe sessions continue to provide a valuable opportunity to hear directly from colleagues alongside a quarterly online session for colleagues who work from home or would struggle to attend a face-to-face session.
3. I was proud to join our second of our two long service award winner celebration events last month (the previous one being held in July). Our long service awards are for colleagues with more than 25 years' service, recognising their commitment and dedication. I was also delighted to join a Unity Supper and to join an Open Mic night – both fantastic grass roots initiatives by colleagues that give us an opportunity to come together outside of work.
4. My routine meetings with the Integrated Care Board, NHS England, the Peninsula Acute Provider Collaborative, Torbay Council and our Council of Governors continue and I also had a good meeting with the Chief Executive of Rowcroft Hospice as well as meeting with representatives of the local Heart Campaign in Torquay. Listening to the concerns and ideas of local people and communities is very important to me.
5. I am very much looking forward to the unveiling of our long-planned organ donation memorial at Torbay Hospital at the end of this month. We have a very special event planned for our donor families and colleagues who directly support organ donation. Giving the gift of life and supporting the wishes of loved ones in this regard is truly humbling.

Business planning 2025/26

6. While we are making progress in the implementation of our plan for better care (our plan for 2025/26) we know that we need further pace if we are to succeed in the delivery of our annual plan and specifically our financial plan.
7. We remain in line with our financial plan for month five, but we must reduce our current spend if we are to deliver our annual plan.
8. We have increased our spending controls further as this is the only straightforward short-term measure available to us whilst we implement more sustainable changes. These include extending the current vacancy freeze to the whole workforce (with agreed exceptions) which will include all contract change requests as well as recruitment to new or vacant posts, stopping overtime for all non-patient facing roles, strengthening our approvals for the

use of temporary staff and overtime for patient facing roles (including enhanced approvals) and weekly oversight meetings.

9. For assurance all our decisions will be supported by quality assessments to make sure we maintain safe care and the executive panel overseeing this process includes the Chief Medical Officer and Chief Nursing Officer.
10. These actions are not how we would choose to run our organisation but are necessary in the short term to try and reduce our spending and deliver on the commitments we have made.
11. The Board will be aware that staff morale is already low, and this is likely to have further impact and long term we must have a clearer framework on which we make spending decisions. I hope the relaunch of service line reporting within our organisation and a strengthened contracting process will enable us to make better decisions on resource allocation as we move forward.
12. It is likely 2026/27 will remain a very challenging year for us from a financial perspective within both the Trust and across the wider health system in Devon.
13. I have shared with our staff a mid-year financial message which sets out the likely scale of the financial challenge we will face and our approach and some of the more challenging decisions and opportunities we face as we look forward, these will include: -
 - a) Reducing our workforce further
 - b) Sharing our services with partners where we can do so at reduced costs whilst maintaining quality.
 - c) Reviewing again fragile services and seeking alternative models where we cannot run services sustainably.
 - d) Ensuring we realise the benefits of our new Electronic Patient Record EPIC in how we work.
 - e) Increasing our productivity further.
 - f) Going further in reducing our agency spend linked to fragile services.
 - g) We also need viable options for the future of Adult Social Care and Continuing Healthcare.
 - h) Continuing with our programme of estates work in line with our strategy to rationalise and close parts of our old estate, as we continue to lobby and bid for the investment needed to build new.

Medium term financial plan

14. As part of the business planning and contracting round for 2026/27 we have started work on developing our Medium-Term Financial Plan (MTFP).
15. The MTFP is based on key assumptions for allocation, income and expenditure volume and price growth. It is built on a formulaic baseline and forward look but nuanced to include our strategic intentions
16. The plan is built at organisation level and will incorporate a base case that enables the development of sophisticated scenarios to include base case, upside and downside through numerous variables, and efficiency requirements and will have been extended and developed to include population demand modelling, workforce, activity, point of delivery as well as subjective income, pay, non-pay and beds .
17. Work has already started to confirm the forecast outturn and the movement to the underlying recurrent financial position and exit ULP. Contract rebasing work is underway to rebuild PBR contracts and clarify for activity variability and fixed elements i.e. deconstructing existing block contracts.
18. The timeline is in accordance with national phasing to include a first output of scenarios along with the strategy in September 2025 and then a second phase to complete the planning round by the end of December. Regular updates will be brought to the Board each month.

Our future – our strategy

19. Over the past month, we've undertaken extensive engagement with both colleagues and the public to inform the development of our future strategy. This included two complementary surveys—one public-facing and one for staff—which together received over 700 responses. We also held a range of interactive sessions with colleagues including workshops, focus groups and at our monthly all staff briefing. Public engagement was supported through by our community partners and the Torbay Learning Disability Ambassadors. These insights are now being analysed to shape the next phase of our strategic framework and ensure it reflects what matters most to our people and communities.
20. At the heart of this work will be our proposed “signature moves”—the major shifts we believe are necessary to deliver the future we seek. These moves will be designed to be bold, clear, and actionable, and will help us communicate our ambitions in a way that resonates across our organisation, with our partners and with our communities.
21. While the strategy remains in draft, we are now focusing on refining both the content and the structure to ensure it is accessible and compelling. The Strategy Task-and-Finish Group, which includes representation from non-executive directors, clinical and professional groups, and the strategy team is overseeing the drafting of the strategy and will ensure that the strategy is shaped by a wide range of voices.
22. Further updates will be shared as the work progresses, including opportunities for wider staff and stakeholder input.

23. We are continuing our work to refresh our organisational strategy, evolving our integrated care model and aligning with the new 10-year health plan for England. This involves incorporating insights from previous engagements and feedback from local people and communities about what matters to them, what they want improved, and what they wish to retain in relation to local NHS services.

Successes – our people and teams

Digital first MSK physiotherapy team shortlisted for the Allied Health Professional (AHP) Digital Practice CAHPO Award 2025

24. We have been shortlisted for developing a digital first virtual MSK physiotherapy service that significantly reduced routine wait times for MSK physiotherapy and sustained dedication to continue to reduce waits and provide excellent patient care.
25. The service has already been recognised as part of the national Getting it Right First Time (GIRFT) work and have provided support to Royal Devon University Healthcare NHSFT in reducing their MSK waiting lists.

Our 0-19 service is helping to give children the best start in life

26. Our health visiting team has recently had its work celebrated by the government's Cabinet Office's mission delivery unit, which reports direct into 10 Downing Street.
27. The team received a visit from the MDU who wanted to find out more about a particular area of good practice - the 2.5-year health and development review. This is a real testament to the dedication of our health visiting team and their commitment to working together with partners, putting the child at the centre of their care.

Unique local nursing education offer shortlisted for national award

28. Our Clinical Education team has been shortlisted for the Nursing Times Workforce Team of the Year 2025. This recognition celebrates their pioneering work in widening participation and developing a unique nursing education offer in partnership with the Open University.
29. The team's innovative approach has created a more inclusive pathway into nursing, offering all placements within Torbay and South Devon services and offering accessible entry requirements tailored to the needs of the local population. This model has opened doors for aspiring nurses from diverse backgrounds, helping to address workforce challenges and build a future-ready nursing community within Torbay and South Devon.

Pathology – UKAS findings

30. We have received formal confirmation that our laboratories have resolved all UKAS findings.
31. Clearing UKAS findings and maintaining UKAS accreditation to UKAS is a rigorous process that ensures our laboratories meet the highest national standards for quality and competence. It involves detailed evidence gathering, process reviews, corrective actions, and close engagement with assessors.

32. Achieving full compliance is not only a regulatory requirement but also a marker of the Pathology team's commitment to patient safety, continuous improvement, and service excellence. It reflects months of sustained effort and incredibly hard work behind the scenes by staff at all levels. The team have continued to show dedication, professionalism and teamwork despite facing many challenges throughout the year including a new Laboratory Information Management System (LIMS) and an 18.25% increase in workload with ongoing challenges to estates and staffing issues.

Adult Inpatient Survey Results – September 2025

33. The Care Quality Commission (CQC) has published its latest adult inpatient survey, reflecting feedback from 527 patients across 131 NHS trusts. Our results are broadly in line with national averages.
34. Patients continue to rate our care highly, particularly in areas of kindness, compassion, dignity, and privacy. Confidence in our clinical teams remains strong, and pain management is well supported.
35. Significant improvements have been noted in nutrition and hydration, thanks to collaborative efforts led by our dietitians and nutritionists across acute and community services. Initiatives such as ward dressing competitions and themed events have helped embed this culture.
36. Cleanliness also received consistently high ratings, recognising the dedication of our cleaning teams.
37. One area requiring attention is room temperature, which showed a decline. Work is underway to understand and address this.

National Cancer Patient Experience Survey 2024

38. For the third consecutive year, our cancer services have been rated among the best in the country.
39. In the 2024 National Cancer Patient Experience Survey, 299 patients treated between April and June rated our services above the national average in all categories. We achieved an overall care score of 9.1/10, compared to the national average of 8.9, ranking us 21st out of 131 organisations.
40. Highlights include:
- 95% received information about diagnostic tests in advance.
 - 89% said diagnostic staff had access to their information, avoiding the need to repeat their story.
 - 91% knew who was coordinating their care, and 96% found their contact helpful.
41. Importantly, no areas scored below the expected benchmark.

Cancer vaccine trial for head and neck cancer patients in Torbay and South Devon

42. Torbay Hospital is among 15 NHS sites participating in a new trial for an investigational mRNA cancer vaccine targeting advanced head and neck cancers linked to HPV-16. Over 100 patients in England, including those in Torbay and South Devon, are being fastracked into the trial via the NHS Cancer Vaccine Launch Pad.
43. The vaccine trains the immune system to recognise and destroy cancer cells containing HPV proteins. With head and neck cancers having a two-year survival rate below 50%, this trial offers a promising new treatment approach and potential improvement in patient outcomes.

Wider roll out of blood pressure monitor loans in local libraries

44. As part of the “Check Your Blood Pressure” campaign, a successful pilot scheme offering blood pressure monitor loans from libraries in Brixham, Churston, Paignton and Torquay has now been expanded to over 50 libraries across Devon. Led by Devon County Council Public Health, Libraries Unlimited, and NHS Devon ICB, the initiative aims to make it easier for people to monitor their blood pressure at home, identify potential health issues early, and reduce demand on GP appointments. Each kit includes a monitor, simple instructions, a blood pressure diary, and guidance on what to do if readings are high.
45. This community-based approach supports our wider prevention agenda and aligns with national priorities to reduce cardiovascular risk. The scheme has received positive feedback and is being actively promoted through local events and social media. There is also a targeted effort to engage university students during Freshers Week, recognising the importance of early intervention in younger populations.

Two more of our nurses awarded prestigious Queen’s Nurse title

46. Emily Selley, Clinical Team Manager in our Community Children’s Nursing team, who has been awarded the prestigious title of Queen’s Nurse.
47. Emily is now the fifth Queen’s Nurse in Children and Family Health Devon’s (CFHD) community nursing team, which is a testament to the team’s exceptional standards of care, and one of 12 across CFHD.
48. Our Lead for Tissue Viability Services, Nicky Richardson, has also been awarded the prestigious title of Queen’s Nurse.
49. The Queen’s Nurse title is awarded to nurses, health visitors, and midwives who have demonstrated an outstanding commitment to patient care and nursing practice in the community. Applicants must have at least five years’ experience in community, primary, or social care.

MyRecovery app launched

50. We’ve launched a new patient app and monitoring system to help people who are having a total hip or knee replacement to prepare for and recover from their surgery.
51. The patient-facing myrecovery app contains interactive exercise videos, articles, informative videos, and checklists to help people before and after their surgery, while questionnaires and insights will help the clinical team

involved with their care to monitor and track their progress through a real-time dashboard. All information is personalised to each patient, and they can also use the app to report any concerns or to ask questions to their care team.

52. Patients will also be encouraged to complete daily pain scores and exercises which both they and their clinician can use to track their progress and ensure they're getting the support they need.

53. Early patient feedback has been overwhelmingly positive, with people highlighting how reassuring it is to have clear, accessible information at every stage of their journey and more than 110 people have already signed up for the app locally since it was launched on 28 July.

Leadership updates

54. At the end of August, we said farewell to Siân Walker-McAllister who served us diligently as a Non-Executive Director for three years. On behalf of the Board I would like to formally acknowledge and thank Siân for her dedicated service. Throughout her tenure, Siân brought invaluable expertise and thoughtful challenge, particularly in the areas of adult social care and maternity care. Her contributions have helped shape our strategic direction and strengthened our commitment to integrated, person-centred care.

55. Our Chief Financial Officer Mark Brice retired in mid-September 2025. Mark has worked for the organisation for just over two years and through one of the organisation's most challenging periods having joined in July 2023.

56. Although I have only worked with Mark for a relatively short period, he has always remained professional and positive despite the immense challenges the organisation has and continues to face, at the same time demonstrating our true organisational values of what we stand for. I am sure the Board will want to join me in wishing Mark all the very best in the future.

57. As the Board members will be aware, and despite recruitment processes, we have not been able to successfully recruit to permanent roles for the Chief People Officer (CPO) and Chief Finance Officer (CFO).

58. Following the non-executive director remuneration committee meeting held on 02 September 2025 we have made the following key appointments: -

- Chief Planning and Strategy Officer: following an interview process we have appointed Simon Tapley to this role permanently. Simon has been covering this role for an interim period, and I am pleased to be able to confirm this will now become permanent. Simon is a very valuable and supportive member of the Executive Team and has led several complex projects for us over the last six months including the development of our strategy and review/management of our section 75 agreement with Torbay Council in relation to adult social care. He has extensive NHS experience across the Devon system, and this will be invaluable to us all as we navigate some of the changes ahead.
- Deputy Chief Operating Officer: following an interview process, involving the recovery support programme, we have appointed Sam Wadham-Sharpe to this role. Sam has been with us for a short period on

secondment from the Devon Integrated Care Board and he will now join us permanently. Sam has extensive operational experience across a wide range of NHS sectors and has managed in his career services across mental health, planned care, cancer, urgent and emergency care, and clinical support services. I am extremely grateful Sam has chosen to stay with us full time and he will be a fantastic addition to our leadership team.

- Chief People Officer: The non-executive remuneration committee have agreed to extend Jess Piper in this role initially until the end of March 2026. It has been a pleasure for us all to work closely with Jess over these last few months. She is a highly motivated and committed colleague and the stability this brings in this important role for us is very welcome.

59. These appointments bring continued strength and continuity to our senior leadership at a time when there is huge change ahead for us all. It is important for me that they all work with the values, compassion, and commitment that we expect across all our services in our organisation.

Performance improvement results in moving out of tiering

60. On 11 August we received confirmation from NHS England that following a review of elective, cancer and diagnostic performance, and in agreement with the national team, we will move out of Tiering for Quarter 2 of 2025/26.
61. This is because of the significant improvement in our performance. Due to this and our removal from Tier 2, any further improvement support will be included as part of the Recovery Support Programme.
62. Performance progress will continue to be formally reviewed and agreed on a quarterly basis between National and Regional NHS England teams. However, in exceptional circumstances, changes to Tiering status can be made within quarters. Tiering status changes will be ratified through the new NHS England Transformation Executive.
63. Our average ambulance handover delays have more than halved in the last year. Between April to July 2024 our average was 1 hour 28 minutes and 49 seconds. Between April to July 2025 our average was 41 minutes and 44 seconds. While we still have more to do to reduce this further, this is a significant achievement that has taken the dedication of teams across the organisation and a strong partnership with South Western Ambulance NHSFT. It is our aim to eliminate all ambulance handover delays that are more than 45 minutes.
64. We have used a delivery plan which focuses on five key areas and a range of KPIs which are actively monitored. For example, the ambulance handover position is supported by a range of efforts which include time to assessment in the Emergency Department, time from decision to admit to bed being available and moving from the Emergency Department, rapid assessment processes and timings. There are a range of measures in our assessment areas such as medically referred patients moving from the Emergency Department to our assessment areas and maintaining our acute physicians in the assessment area. There are further measures in our wards such as our focus on pre noon discharge, effective use of the discharge lounge, your next patient and supporting early flow. Our out of hospital teams contribute through

maintaining our complex discharge numbers, use of reablement capacity etc. It has been a whole organisation effort to achieve this.

65. Across all our planned care specialties, at the end of July 2025, 68.5% of people were waiting 18 weeks or less. This ranks us in the top 40 of trusts in England in performance in this area. We need to reach a target of 66.6% this year so this is positive news which reflects the work and commitment of our clinical, operational and corporate teams making improvements.
66. We now have 615 people who have been waiting more than 52 weeks to begin treatment which is ahead of our trajectory. While we this is still far too long for people to be waiting, I want to recognise the progress that our teams are making in eliminating the number of waits over 52 weeks.
67. In terms of our cancer performance, seasonal demand has led to waits of more than 28 days for urgent suspected cancer referral to first outpatient attendance within skin.

Publication of segmentation dashboard

68. As part of the Government's commitment to greater transparency and improvement in NHS performance, NHS England has launched a new interactive dashboard under the NHS Oversight Framework 2025/26. This dashboard allows both NHS leaders and members of the public to explore how providers are performing across key services — including urgent and emergency care, elective services, mental health and more — and to compare performance across England.
69. For the first time, providers have been placed into one of five segments based on their overall performance and financial position. Segment 1 includes organisations with the narrowest range of challenges, while segment 4 includes those with the broadest. A new segment 5 has been introduced for providers facing the most significant performance or governance challenges, who may receive intensive support through the Recovery Support Programme (RSP).
70. We've now been formally notified that we have been placed in segment 3. We are ranked 71 out of 134 NHS trusts in England.
71. While we continue to face financial pressures, this rating reflects good performance in key areas such as effectiveness and experience and, as we are only too well aware, more to do in access, safety and people (workforce).
72. Segment 3 is the highest rating possible for a provider in financial deficit and it shows that we are holding our own. It is absolutely the best we could have hoped for given our challenges and it is testament to the improvement work that is happening across our organisation. Every one of our dedicated colleagues plays a part in this and we are deeply grateful for their commitment to care, change and collaboration.
73. We know that rankings are not a definitive judgement of one trust being "better" than another — they are a guide to where we sit among our peers. Rankings may change each quarter as performance across the NHS evolves.

74. We'll continue to receive support through the national recovery programme and focus on delivering improvements through *Our Plan for Better Care*, which sets out priorities across leadership, strategy, performance, money and people.

Board self-assessment

75. As set out in the recently published [NHS Oversight Framework](#) (NOF), NHS England will consider not only an organisation's delivery, as evidenced by its NOF segment, but also its capability. The rating of provider capability will help inform the response to NOF segmentation and may also inform any decisions about entry into the National Provider Improvement Program (NPIP), as well as trusts being considered for new FT status.

76. The aim is to ensure that NHS England has a holistic view of providers, not just focussed on delivery of national programmes but also capturing wider information relevant to grip and governance. It is also intended to be a development tool, helping Boards to reflect on their competencies, develop robust approaches to internal assurance, and encourage continuous improvement.

77. The capability rating will be based on:

- an annual self-assessment by provider Boards and submission to NHS England, with supporting evidence. The assessment will be based on themes from last year's publication of '*The Insightful Board*' (<https://www.england.nhs.uk/publication/the-insightful-provider-board/>)
- a review of the self-assessment, triangulated with the provider's track record to date and any third-party information (including CQC), to provide an overall view on the Board's capability. Whilst ICBs remain jointly responsible and involved in provider oversight we would also seek their views on the provider capability self-assessments for the providers in their systems.
- across the year, NHS England will use the capability rating and self-assessment to inform the relationship with the provider, revising the capability rating should events merit it e.g. if an issue emerges that was not foreseen in the self-assessment.

78. Please note that it is currently intended that the capability rating will be published alongside the NOF segmentation.

79. NHS England have issued the self-assessment template, along with guidance. They will give provider Boards two months to carry out and return their assessments. It is anticipated that the questions underpinning the self-assessments will be familiar to provider Boards. While the assessment will incorporate information from more recent CQC well-led reports, it is intended that the provider capability assessment will help NHS England maintain a nationally consistent, and real-time view of how Boards are managing the challenges of running their trusts.

Priority areas

Maximising use of our cardiac cath labs

80. The Devon ICB have indicated their intention to review cardiovascular services including cardiology and cardiac surgery across Devon. A case for change is being drafted which we understand will be finalised in late September / early October 2025. It will be important we have full engagement in this review process, and we have provided lead names from our teams to participate in the review process across senior medical staff, nursing, radiography, operational management and physiology.
81. Alongside this we have developed a business case on several options for expanding our cath lab capacity from the funded 13 sessions we run currently. This has been submitted to the Devon Integrated Care Board for approval.

10 point plan to improve the working lives of resident doctors

82. In response to longstanding concerns raised by resident doctors, NHS England has launched a 10-point plan aimed at improving the working lives of the 75,000 resident doctors across the service. The plan, issued nationally on 29 August 2025 by Sir James Mackey and Professor Meghana Pandit, sets out urgent actions for all NHS trusts to implement within a 12-week timeframe.
83. These include ensuring timely rota and payroll accuracy, access to rest facilities and hot meals, fair leave allocation, and reducing the burden of repeated mandatory training during rotations. Trusts are expected to appoint both a senior leader and a resident doctor representative to oversee implementation and report progress to their boards. The plan is now embedded within the NHS Oversight Framework and will be reflected in annual reporting requirements.
84. Locally, we have begun our response, with our Chief Medical Officer, Dr Kate Lissett, leading the coordination of a self-assessment against the plan, in collaboration with the Resident Doctors Representative Committee. A progress update will be brought to the People Committee and the Executive Committee for assurance.
85. We already have strong foundations in place, including the Flexible Working Champion Resident Doctors role, our Doctors in Residence Support Booklet 2025/26 and our Resident Doctors and Locally Employed Doctors Locum which collectively support wellbeing, flexible training, and equitable employment practices. These resources will be reviewed and aligned with the national plan to ensure a comprehensive and meaningful local response.

Well Led Review

86. We have received a final report from Ernst & Young following our well led review. We are currently working to focus in on the key messages for Board and the specific actions we need to take.

Adult Social Care CQC inspection

87. The adult social care arrangements with Torbay Council are currently undergoing a Care Quality Commission (CQC) inspection and the onsite visit commenced on 08 September 2025. It will provide us with an opportunity to

share the unique integrated care organisation arrangements that we have here and celebrate some of the positive outcomes and good practice we have developed over the years.

88. We have been briefed that the CQC plan to complete visits to all Local Authorities in and neighbouring Devon ICB to inspect their adult social care services by the end of December 2025, with all reports being published by the end of March 2026.
89. As outlined, Torbay's inspection visit will commence on 08 September. Cornwall and Plymouth were visited in June, Devon's date is to be confirmed but they are interviewing Devon Carers and Healthwatch shortly after similar interviews in Torbay so expect it to follow Torbay's closely.

Community equipment service – contract change

90. NRS Healthcare, the provider of community equipment and Technology Enabled Care Services (TECS) in Torbay, ceased operations as part of a wider national closure affecting around 40 councils across England and Northern Ireland. NRS had delivered essential equipment such as beds, mattresses, mobility aids, alarms and monitors to support individuals with both short and long-term clinical needs at home.
91. Millbrook Healthcare are now the provider of the community equipment service in Torbay.

Annual Members Meeting

92. This year's event takes place on Thursday 25 September from 4pm to 6pm in the TREC centre, Torbay Hospital, Torquay.
93. Following the recent publication of the 10 Year Health Plan, which places a strong emphasis on preventing ill-health and using technology to support people to manage their health and wellbeing, the focus of this year's meeting will be the launch of our new electronic patient record in Torbay and South Devon next spring.
94. Chief Operating Officer and Deputy Chief Executive Adel Jones and her team will present an overview of Epic, how it will work and what it means for people in Torbay and South Devon.
95. The annual members meeting is free to attend, but please reserve your place by contacting the [Foundation Trust Office](#) or calling 01803 655406. A web link will be available nearer the time for people to watch live online.

National flu vaccination programme

96. In line with NHS England's national campaign to improve flu vaccination uptake among frontline healthcare staff, we are implementing a targeted programme to support winter resilience. The programme responds to declining national uptake rates and aims to improve local uptake by at least five percentage points this year.
97. We have appointed named executive leads for winter preparedness and staff vaccination. From 01 October, flu vaccines will be made available across all sites with a focus on accessibility and convenience. We are also working with

clinical teams to ensure eligible inpatients are offered vaccination as part of routine care. Uptake will be actively monitored and the programme adjusted as needed throughout the winter.

Working together in pathology services

98. The Peninsula Pathology Network is looking into innovative solutions that support the sustainability of pathology services, and through this can have a positive impact on other clinical services.
99. The demand for pathology is increasing. The vision is to create a sustainable model of pathology across Devon, Cornwall and the Isles of Scilly that helps patient pathways to be as effective and efficient as possible.
100. With colleagues from each of the four acute trusts in the Peninsula, they have been working to identify different options to transform pathology services across Devon, Cornwall and the Isles of Scilly.
101. Staff in pathology services have been briefed on the programme and will receive further updates soon. The network is setting up webinars and site visits to go through the options being considered in more detail and seek their input.
102. 'This is a unique opportunity to explore new ways of working across the peninsula that will benefit patients, provide investment in pathology services and improve clinical safety. By looking at what we can achieve in partnership, our aim is to increase capacity and make pathology services more sustainable and better for patients.' Wayne Thomas, Peninsula Pathology Network Clinical Director

Delivering best value from our community estate: Teignmouth Hospital and the relocation of the Chronic Pain Team to Ashburton Health and Wellbeing Centre

103. Over the past decade, considerable time and investment have been dedicated to exploring an integrated model of community-based care for Teignmouth and its surrounding areas. This model aimed to bring together primary care, health and social care, and community wellbeing services in a cohesive and accessible way. However, escalating costs ultimately rendered the development of a proposed health and wellbeing centre in Teignmouth unachievable. Despite extensive negotiations with Devon ICB and NHS England, a viable solution to meet the increased capital costs could not be found.
104. As we said at the time that the decision not to proceed with the health and wellbeing centre was taken, we are reviewing alternative options. This could include relocating those services identified in the 2020 consultation for relocation to Dawlish Community Hospital while we explore local solutions for those services which are heavily used by local people in Teignmouth.
105. We have carefully considered the potential renovation of Teignmouth Community Hospital. This potential renovation has been thoroughly assessed and unfortunately, the substantial projected costs required to restore the building to an acceptable standard made this option equally unfeasible.

106. In 2024, a comprehensive assessment of Teignmouth Community Hospital identified significant fire safety risks, particularly affecting the first and second floors. In order to mitigate these risks we were required to stop using the first and second floor. The first floor was primarily used by the Chronic Pain Team who had temporarily relocated to Teignmouth during the COVID-19 pandemic as the site offered more space to see people in line with the social distancing requirements of the time. Prior to this the Chronic Pain Team were based at Torbay Hospital.
107. As the Chronic Pain Team provide a service to the whole of Torbay and South Devon, therefore, it was important to ensure that we consider both equity of access as well as suitability (and availability) of space within our community estate for their relocation. Their new base at Ashburton Health and Wellbeing Centre offers improved accessibility for many people, particularly those travelling from the South Hams area, where journey times are now shorter and more convenient. Importantly, the relocation also maintains reasonable travel times and continued access for patients from Teignmouth and Dawlish (as well as Torbay), ensuring that service coverage is equitable across the region. The Team successfully relocated in July.
108. We are continuing to review potential options. However, the substantial backlog of maintenance work at Teignmouth poses an ongoing risk which requires careful management to ensure the safety of those using the building. The current buildings are not fit for purpose and decisions will need to be made about its future. No decisions have yet been made.
109. We have, however, given notice on the leases to Sure Start (who use the former nurses home on site) and the GP surgery who utilise space in a building that is located on the site. The notice periods are 12 months and we have taken this action so that any future options are not restricted by current tenancies.
110. We remain committed to ensuring that the health and wellbeing needs of the Teignmouth community are met through alternative, sustainable service models and facilities. We will engage with key stakeholders and the local community as and when there are any proposals to relocate local services from Teignmouth Community Hospital.

National, regional and local issues and topics of interest

Baton of Hope comes to Torbay

111. On 30 September 2025, Torbay will host the Baton of Hope, the UK's largest suicide prevention campaign. The baton will travel through Torquay, Paignton and Brixham, carried by those affected by suicide, with events promoting mental health awareness and support.
112. Highlights include a relay across the Bay, community activities, and the BIG Show of Hope gala at the Riviera International Centre. Local fundraising efforts, such as Tommy's World Walk of the Bay, have supported both the national charity and a local grant pot.

Changes to sexual health services for Torbay (provided by Royal Devon University Healthcare NHS Foundation Trust)

- 113. From 01 October 2025, Devon Sexual Health Torbay (based at Castle Circus Health Centre, will not provide appointments for routine smear test in accordance with their commissioning arrangements.
- 114. After this date, people looking to self-refer for a routine smear test appointment will be directed back to their GP.
- 115. People who are due a smear test and are attending the service for a different need, and those who do not have access to GP services, will continue to be offered testing.

ICB Cluster chair announcement for NHS Cornwall and Isles of Scilly and NHS Devon

- 116. The Chair of the new NHS Cornwall and Isles of Scilly Integrated Care Board (ICB) and NHS Devon ICB Cluster has been announced as John Govett, following approval by the Secretary of State for Health and Social Care.
- 117. John will take up his new role from 01 September, ahead of the first cluster Board meeting, when he also hopes to be able to announce the new aligned group of ICBs' and Cluster Non-Executive Directors, along with the new ICB Cluster governance and committee arrangements.

Graduate Guarantee announced by Government

- 118. In August, the Government announced a *Graduate Guarantee* with the aim of ensuring that thousands of new posts are easier to access by removing barriers for Trusts, creating a wealth of opportunities for graduates and ensuring a seamless transition from training to employment.
- 119. These new measures aim to tackle graduates' concerns about job availability, after record numbers of people chose to study nursing during the pandemic, while fewer nurses and midwives leave the profession.
- 120. While this demonstrates real progress in health professionals choosing to stay and thrive in their NHS careers, it has created barriers in the workforce— with up to three times as many graduates as there are vacancies in some areas.
- 121. To address this, the government has committed to a comprehensive package of reform and support, which will see more healthcare professionals deployed across a wide variety of sectors, improving access for patients as part of its Plan for Change.
- 122. This package comes as a result of collegiate and good faith working between government, the Royal College of Midwives, and the Royal College of Nursing, demonstrating that by working together, the NHS, patients, and staff all benefit.
- 123. NHS providers will begin recruiting newly qualified nurses and midwives before vacancies formally arise, with trusts supported to employ staff based on projected need rather than headcount, ensuring the NHS has

the right number of staff to provide the best possible care to patients everywhere.

124. Additionally, every newly qualified nurse and midwife will receive the backing they need to succeed in their first role, which includes an online hub with important information and advice for those applying for roles.
125. Vacant maternity support worker posts will be temporarily converted to Band 5 midwifery roles, backed by £8 million to create new opportunities specifically for newly qualified midwives and further ease the recruitment strain.

Mums-to-be to skip the GP to get faster first NHS midwife appointments

126. Last month NHS England announced that hundreds of thousands of newly pregnant women across England can now self-refer online to get their “all-important” first midwife appointments quicker, ensuring the best and most personalised care for their baby.
127. By completing a simple online form on NHS.uk, mums-to-be can now refer themselves directly to their local maternity services without seeing a GP first.
128. The new NHS England service enables families to choose which NHS trust to refer themselves to, helping them to meet their midwife and begin NHS pregnancy care as early as possible.
129. First appointments are vital to help expectant mums talk through anything that might be worrying them about their pregnancy and arrange important early screening tests including to identify those with potentially high-risk pregnancies.

Local media update

130. Since the July report, activity to promote the work of our people, services and partners has included:

Key media releases and responses

[Diamond River brings light to Ashburton](#)

[Remembering those who gave the gift of life in Torbay and South Devon](#)

[Find out more about our new electronic patient record at our annual members' meeting](#)

[Torbay and South Devon's cancer services rated highly by patients](#)

[Local people invited to help shape our future](#)

[New app supports people to prepare and recover from hip and knee surgery](#)

[NHS issues urgent appeal for care home volunteers](#)

[Torbay Hospital hosts new exhibition celebrating the English Riviera's UNESCO-recognised marine heritage](#)

[Clinical Education team shortlisted for prestigious national award](#)

[Our adult inpatient services are rated highly by people we've cared for](#)

Coverage

We are grateful to BBC Spotlight, Channel 4 news, Torbay Weekly, We are South Devon, Dartmouth Chronicle, Mid Devon Advertiser, Daily Express, Torbay Today and Dawlish Today, for covering our work in August and September.



Torbay and South Devon
NHS Foundation Trust

Trust Board

Responding to the invited developmental Well-led Review

Date of meeting	Date report produced
24 th September 2025	12 th September 2025

Author(s)		Report approved by	
Name and title:	Emily Long, Director of Corporate Governance Allison Williams, Improvement Director	Name and title:	Joe Teape, Chief Executive

Phone:

Date:

Email:

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

This paper reports on the outcome of the externally commissioned developmental well-led review, makes recommendations to strengthen Board governance and identifies opportunities for further Board development. For openness and transparency it has been agreed to take this paper in public.

Executive summary

A decision was taken by the Board in the first quarter of 2025/26 to commission an external developmental well-led review to objectively inform future development and improvements in Board and organisational capacity and capability.

The review was conducted in the context of:

- the organisation being in the highest level of escalation in the national oversight framework (NOF4) since 2022 and a recent self-assessment that further improvements were needed prior to de-escalation
- a significant financial deficit resulting in the need for deficit support in 2025/26
- the need to develop a revised MTFP by December 2025 that does not rely on future deficit support
- an independent report into delivery of the 2024/25 annual plan which raised concerns about levels and veracity of assurance taken with regard to CIP reporting

- work already underway to refresh the organisational strategy and the development of an integrated improvement plan **“Our Plan for Better Care”**

The findings were presented to the Board in a Development session in August 2025. A number of key recommendations were made with wider observations for further improvement and development.

The Board remitted the Chief Executive and Director of Corporate Governance to put forward a proposal for delivering on the key recommendations in the first instance with a view to incorporating the wider learning as part of further development later in the year.

This report summarises the work done to date to align the output of the review with the integrated improvement plan and immediate proposed next steps.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
All	Satisfactory	N/A

Committees that have previously discussed/agreed the report, and outcomes of that discussion

The feedback from the Well-led Review has been previously reviewed and discussed in a Board Development session (August 2025) when this paper was commissioned to be directly received by the Board.

Key recommendations and actions requested

The Board is asked to:

- Formally **receive** the output of the well-led review
- **Accept** the recommendations made to strengthen Board and organisational governance arrangements
- **Discuss and approve** the proposed alignment with the integrated improvement plan ‘Our Plan for Better Care’
- **Agree** that progress against the ‘Well led-review’ key recommendations will be reported through the revised ‘Our Plan for Better Care’ governance arrangements
- **Approve** the outline October Board Development Programme priorities
- **Agree** that a further report will be brought to the Board in 6 months (March 2026) to consider what further action may be required in respect of the wider findings of the review

Appendices

Annex 1 – Well-Led Review Report

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

Strengthening Board governance, capacity and capability will improve overall organisational effectiveness.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	tbc
Quality of services provided	tbc
Sustainable and efficient use of resources	tbc

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	To be assessed
People	To be assessed
Financial Sustainability and Productivity	To be assessed
Estates	To be assessed
Operations and Performance Standards	To be assessed
Digital and Cyber Resilience	To be assessed
Building a Brighter Future	To be assessed
Strategy and Transformation	To be assessed
Sustainability: Green Plan/ Environmental	To be assessed
Equality, Diversity and Inclusion	To be assessed

Risk: Risk ID (as appropriate)

Risk	Risk ID
The plan highlights the areas of focus arising from various reviews and risks that have been identified	

External Standards affected by this report and associated risks

Recovery Support Team
 Care Quality Commission
 National policy, guidance (ability to submit a compliant annual plan)

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

1. **Background**

A decision was taken by the Board in the first quarter of 2025/26 to commission an external developmental well-led review to objectively inform future development and improvements in Board and organisational capacity and capability to deliver on its objectives and statutory duties.

A number of recent new appointments at Executive and Non-Executive level meant that this was a timely opportunity to take stock of what works well within the organisation and what needs to change to best meet the internal and external expectations of the leadership team.

The review was conducted in the context of:

- the organisation being in the highest level of escalation in the national oversight framework (NOF4) since 2022 and a recent self-assessment that further improvements were needed prior to de-escalation
- a significant financial deficit resulting in the need for deficit support in 2025/26
- the need to develop a revised MTFP by December 2025 that does not rely on future deficit support
- an independent report into delivery of the 2024/25 annual plan which raised concerns about ‘false assurance’

It was also recognised that at the time of commissioning the review, a number of key pieces of work had only just commenced which would most likely not be sufficiently advanced to be reflected in the feedback. These include the establishment of an integrated improvement plan “*Our Plan for Better Care*” and the development of a revised clinical strategy for the Trust.

The scope of the review was agreed with the Chair and Chief Executive and shared with the Board at the outset. Key lines of enquiry were focused around four domains as summarised in **Figure 1**.

Figure 1: Key Lines of Enquiry (KLOEs)

Shared direction and culture • Vision and values • Strategy and plan • Objectives • Stakeholder involvement • Addressing challenges • Local and national context • Alignment • Monitoring and review of delivery • Understanding challenges • Addressing behaviours	Capable, compassionate and inclusive leaders • Experience, capability, capacity and integrity • Skill mix and experience • Culture of health wellbeing, safety and compassion • Proactive listening • Proactive risk management • Building equity • Modelling positive behaviours • Leadership development
Governance, management and sustainability • Understanding and effectively meeting personal accountability • Governance, assurance, risk and accountability structures • Effective decision-making • Partnership arrangements • Continuous improvement • Robust data and systems • Clinical and internal audit • Emergency preparedness	Partnership and communities • Meaningful collaboration to improve services and address challenges • Building relationships • Shared planning and decision-making • Stakeholder engagement and feedback • Governance and management of partnerships

These represent 4 of the 8 KLOEs contained within the CQC guidance and were considered to be the most relevant to the current organisational improvement priorities.

Information to inform the findings and recommendations was gathered through:

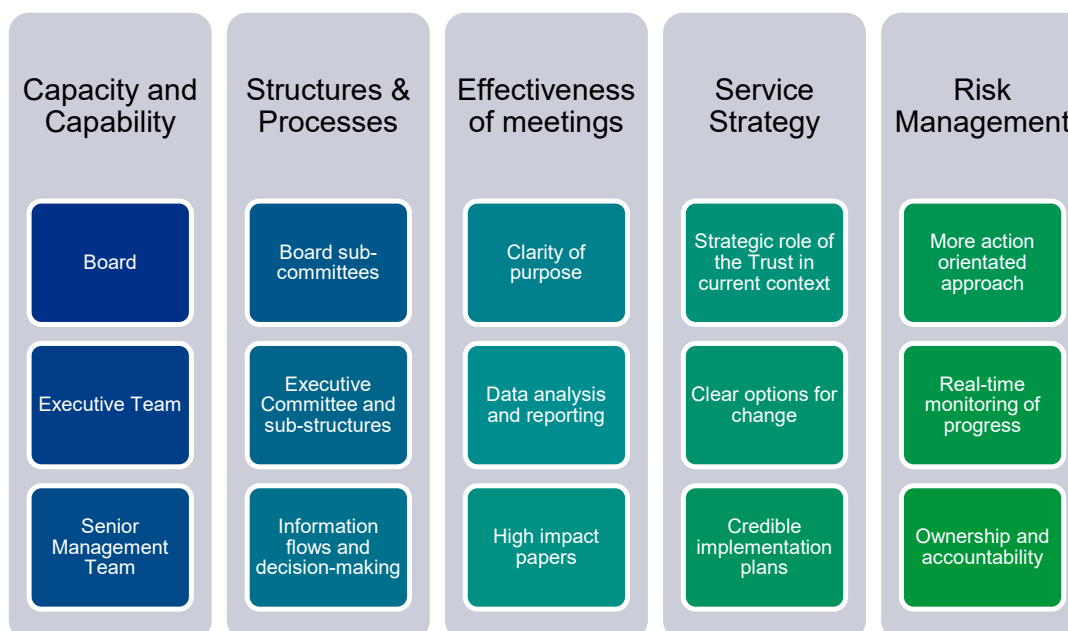
- Document review
- Interviews with staff
- Interviews with Board members and governors
- Observations at Board and sub-committee meetings

Findings were aligned to each of the KLOEs and triangulated where possible.

The external review team presented their key findings to the Board in a development session on 27th August 2025 and the full report was circulated to all Board members (**Annex 1**).

In discussion with the Chair, Chief Executive and NHSE Improvement Director, it was agreed that the recommendations would be structured around 5 core themes outlined in **Figure 2**.

Figure 2: Thematic approach to defining outputs from well-led review



Following receipt of the feedback from the Review team, it was acknowledged that progress is already underway in a number of these areas but that there is more work to be done to deliver on the review recommendations and improvement expectations of the Board.

A number of actions were identified as part of the Board development session and delegated to the Chief Executive and Director of Corporate Governance as follows:

- Map the key recommendations to the existing integrated improvement plan ('Our Plan for Better Care') and update the deliverables as appropriate
- Identify any key recommendations not currently included in the integrated improvement plan and consider the most appropriate governance route for delivery
- Develop a paper for the September Board to outline how the key recommendations will be taken forward and reported back to the Board

This paper responds to those delegated actions and puts forward a number of proposals for discussion and consideration by the Board.

2. Current position

The Executive Team has been working hard over recent months to streamline the approach to organisational improvement. This includes reducing the numbers of action plans in response to external inspections and internal priorities through the development of a single integrated improvement plan '***Our Plan for Better Care***'.

This approach enables the governance and oversight of delivery to be discharged through a simplified accountability process which aims to optimise cross-cutting actions and avoid duplication. Reporting is standardised and the PMO function fully aligned to the programme. Therefore, if the recommendations from the 'Well-led review' are to be mainstreamed within the organisation, it is important that they are embedded in the integrated improvement plan.

'Our Plan for Better Care' is structured around 5 core programmes of work, underpinned by 26 workstreams. Accountability for each programme is ascribed to an Executive Director and each workstream has a lead senior manager responsible for delivery. The key deliverables for each of the workstreams have been mapped to the well-led themes as outlined in **Table 1**.

Table 1 – 'Our Plan for Better Care' workstreams

Programme	Workstream	SRO	Well-led Theme
Leadership	Governance and Assurance	Joe Teape	- Structures & processes - Effectiveness of meetings - Risk Management - Capacity and Capability
	Well-led		
	Board and Executive Development		
Strategy	3-5 year strategy	Simon Tapley	- Service Strategy - Risk Management - Capacity and Capability
	EPIC		
	Peninsula Acute Sustainability Programme		
	Adult Social Care		
	Continuing Healthcare		
	Child and Family Health Devon		
Performance	Elective Care	Adel Jones	- Risk Management - Capacity and Capability
	Diagnostics		
	Outpatients Transformation		
	Cancer Services		
	UEC Flow		
	Community services redesign (Frailty)		
	Community Services Redesign (Elective Centre of Excellence)		
	Maternity and Neonatal Safety Improvement Programme		
	Managing our estate		
Finance	Sustainable Financial Improvement - Process	James Corrigan	- Risk Management - Capacity and Capability
	Sustainable Financial Improvement - Delivery		
	Financial capacity and capability		
	Managed services & Wholly-owned Subsidiary		
People	One Devon Shared Services	Jess Piper	- Risk Management - Capacity and Capability
	Workforce Plan and Transformation		
	People & Education capacity and capability		
	Culture, Organisational Development & learning		

The initial review of the well-led key recommendations identifies that the majority map directly to the integrated improvement plan workstreams with the exception of the requirement to improve data analysis and reporting. The initial analysis is summarised in **Table 2**.

Table 2: Well-led key recommendations mapped to integrated improvement plan workstreams

Programme	Workstream	Well-led recommendation
Leadership	Board & Executive Development	• Refine the existing Board development plan by identifying the collective development needs of the Board, the needs of the NEDs, and the needs of Executives • Generate a 12-month plan for each group and share it for input and refinement • The plan should be structured around annual objectives and quarterly reviews and should consider succession planning • Board members should consider how they can trust that parts of the governance structure they do not attend are effectively discharging their duties
	Governance & Assurance	• Implement a streamlined governance model to redesign the Trust's governance structure, reduce the number of committees, and eliminate duplication of activities • Conduct a comprehensive review and refresh of all committee Terms of Reference (ToRs) to ensure they are current, aligned with the streamlined governance model, and provide clarity on reporting lines and responsibilities • Develop and embed a robust governance transformation programme with clear milestones, leadership, and mechanisms to hold stakeholders accountable for implementing changes • Conduct a Trust-wide exercise to clearly define and communicate roles, responsibilities, and accountabilities at all levels, including formalizing delegated authorities • Develop and embed a standardized, mandatory process for consistently incorporating risk into the Trust's operational plans • Optimise Board and Committee meeting efficiency by introducing and embedding practices to ensure meetings are focused, concise, and paper-light • Formalise a "lessons learned" risk culture by ensuring the effective integration of post-incident reviews, near-miss analysis, and risk mitigation effectiveness studies • Define and clearly communicate ownership and accountability for risks at all levels of the organisation and establish clear, standardised escalation paths • Ensure alignment between recorded risks and the Trust's strategic objectives and operational plans.
Strategy	3-5 year strategy	• Create a new, overarching Trust strategy that clearly outlines service delivery options and serves as an evidence-based input for key stakeholders • Alongside the future strategy, develop a detailed integrated delivery plan for years 1-3 that articulates resource allocation, KPIs, and accountability • Develop and embed a governance framework to oversee the implementation and regular review of the new Trust strategy • Align and consolidate existing delivery unit-level strategies (e.g., for UEC and nursing) with the newly developed overarching Trust strategy
People	People and Education capacity and capability	• Expedite the recruitment and onboarding of a permanent Chief People Officer and Chief Financial Officer. The criteria for these appointments should include technical knowledge and experience of operating at a Board level • Establish a cross-functional executive panel to oversee long-standing, high-risk, or complex performance cases to ensure consistency and drive action.

		Resource the Employee Relations and Talent teams to reduce the backlog of approximately 200 outstanding performance and grievance cases
	Culture, Organisational Development and learning	Mandate accountability training for all people managers on embedding Trust values, early intervention on conduct and capability issues, and applying consistent standards across teams

A small number of key recommendations from the 'Well-led review' do not map directly to the current integrated improvement plan workstreams. Rather than establish a separate governance arrangement, it is proposed that the 'Well-led' workstream under the Leadership Programme led by the Chief Executive is redefined to incorporate the outstanding recommendations as outlined in **Table 3**.

Table 3 : Proposed addition to the 'Well-led' workstream

Programme	Workstream	Well-led recommendation
Leadership	'Well-led'	<u>DATA ANALYSIS AND REPORTING</u> - Formulate a strategy to enhance data quality and accessibility through assessments, training, a governance framework, and continuous monitoring - The Trust needs to review its approach to business analysis, as responsibility for generating and reporting management information is split across three different teams - The Trust should define KPIs (approximately 20) that allow it to gain an overview of Trust performance, covering Quality, People, Finance, and Operations - These KPIs should be reported to the Board in a dashboard format - Dashboard outputs should be effectively integrated with outputs of key committees, such as Quality, for holistic and integrated oversight of Trust performance

This may require changes in the leadership and/or support to the workstream leads to be determined by the SRO.

3. Immediate next-steps

Each of the SROs have been asked to work with the individual workstream leads to update the key deliverables to reflect the thematic recommendations from the well-led review. This will be completed during September and updated for the October meetings cycle.

Approval of the updated plans will be via the Executive Committee. It will be scrutinised by the Finance and Performance Committee on behalf of the Board and then reported to the Board at their October meeting.

This will enable reporting of progress against the key recommendations from the 'Well-led Review' to be picked up via the regular "Our Plan for Better Care" reports to the Executive Committee, Finance and Performance Committee and Trust Board, negating the need for a separate action plan, report and governance arrangements.

Notwithstanding this proposed approach, there are a number of priority actions for October that need to be urgently progressed as these will also form part of the evidence base for the Board self-assessment as part of the revised Natinoal Oversight Framework requirements. These will be presented to the October Board Development session and include:

- An outline proposal to stream-line the key committee structures and suggested timeline for implementation
- A revised template for Board and Committee reports
- A timeline and process for revising the data analysis and reporting to underpin the revised governance arrangements
- Confirming the outline development programmes for the Board (October 2025 to April 2026 in the first instance). This will include:
 - an outline of the content and approach for each development session
 - coaching offer for Executive and Non-Executive Directors

It is also proposed that there will be a facilitated session on the respective roles of the Board, sub-committees and the Executive Committee in scrutiny, assurance and decision-making as part of the October Board Development session.

The proposals set out in this paper pick up the key recommendations from the 'Well-led review'. There were further observations made that also need to be considered in due course. It was recognised in the feedback session that these are secondary to the key recommendations and are likely to be picked up as part of the wider integrated improvement plan. However, it is important that these are not lost and it is therefore proposed that a stock-take is undertaken in February 2026 of progress against the wider recommendations with any further improvement requirements reported to the Board for discussion in March.

4. Recommendations

The Board is asked to:

- Formally **receive** the output of the well-led review
- **Accept** the recommendations made to strengthen Board and organisational governance arrangements
- **Discuss and approve** the proposed alignment with the integrated improvement plan 'Our Plan for Better Care'
- **Agree** that progress against the 'Well led-review' key recommendations will be reported through the revised 'Our Plan for Better Care' governance arrangements
- **Approve** the outline October Board Development Programme priorities
- **Agree** that a further report will be brought to the Board in 6 months (March 2026) to consider what further action may be required in respect of the wider findings of the review

2 September 2025

TSDFT Public Board of Directors-24/09/25



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Private and Confidential

Directors of Torbay and South Devon NHS Foundation trust
Lowes Bridge, Torbay Hospital.
TQ2 7AA

2 September 2025

Subject: Developmental Well-Led Review – Report

Dear Board Members

Thank you for the opportunity to support Torbay and South Devon NHS Foundation Trust through a developmental Well-Led Review during July 2025, in line with our Statement of Work dated 24 June 2025. This document summarises the review findings.

The review took place during a period of significant change at the Trust. New Non-Executive Directors had joined the Board and further changes were anticipated in the senior leadership team, with key appointments to CFO and CPO roles ongoing. As a relatively small Trust, with a proud tradition as an Integrated Care Organisation, South Devon & Torbay faced pressure in its finances, workforce resilience and performance, and was also beginning to consider its future strategic options, with key decisions coming up (e.g. on the future of the integrated adult social care offer in Torbay).

Purpose

The review was commissioned to focus on four key aspects of the CQC well-led review framework, namely the Trust's: shared direction and culture; governance, management and sustainability; capable, compassionate and inclusive leaders; and partnerships and community. The review was designed to support the Trust to take stock of its current position by understanding the views of board members and senior leaders and reflecting on how the Trust operated its systems and processes of decision making and governance and supported its people through its board and leadership approach. It did this by offering an "outside-in" perspective, and providing the Board with constructive, evidence-based insights to strengthen leadership, governance, and strategic delivery—recognising the good practice already in place, while focusing on where improvements could offer the most value.

Methodology

The review involved:

- A series of structured interviews and meetings with senior leaders, Non-Executive Directors, clinical and operational staff, sample of Governors, and system partners;
- Analysis of key governance documents and supporting materials;
- A focused assessment against four core areas of the NHS Well-Led Framework.

While many strengths were observed, inevitably the review focused on identifying priority areas that could best support the Board and Trust to move forward positively at this important juncture. In particular, the review identified three key priorities:

1. **Refining governance arrangements** and developing a clearer accountabilities framework to enable clearer decision making, improved oversight, and stronger links between strategic priorities and operational delivery
2. **Using data to set out the Trust's future configuration and service delivery options**, providing a clearer plan for the Board to work to and freeing up capacity across the team to focus on what needs to be done in a targeted way; and
3. **Sourcing the capacity required to resolve longstanding and in-year workforce challenges**, as these are critical to the Trust's in-year operational and financial plan and are an enabler to freeing up senior staff to focus on the Trust's wider People and Culture plans.

Together, these areas of focus were highlighted to help the Trust's leadership team enhance clarity, better utilise internal capacity, and focus on what matters most for the Trust and Board.

Yours sincerely

Chris Neill and Ross Tudor

Ernst & Young LLP

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Executive Summary

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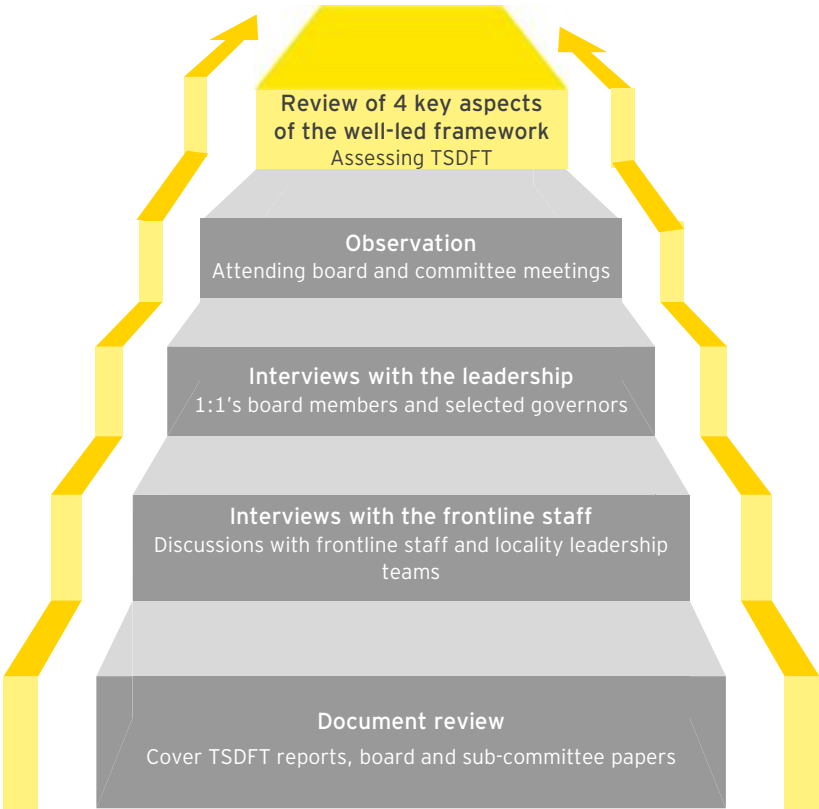


Context for the Review and Findings

Background and context for the project	
1	This Review was invited by the Board to assist in shaping the leadership priorities recognised as needing development and improvement.
2	There have been a number of recent changes in Executive and Non-Executive leadership which are both unsettling and also an opportunity for the organisation.
3	The Review is set in the context of a significant financial deficit and an independent report in 2024/25 that highlighted concerns about 'false assurance' in respect of delivery of the annual plan.
4	It represents a point in time and it should be recognised that some developmental work is already underway within the organisation which may not yet be reflected in the feedback.
5	The Trust is in the process of establishing its integrated improvement plan and revised clinical strategy and is about to start developing its medium-term financial plan. These are set in the wider context of a developing system strategy and associated set of strategic commissioning intentions that are, as yet, unknown.



The review approach & methodology



Review approach:

This report details the findings from a well led review of Torbay and South Devon Foundation Trust against four of the eight Key Lines of Enquiry (KLOE) per CQC guidance.

With the implementation of the 8 new CQC KLOE domains in April 2024, EY undertook a mapping exercise to validate the alignment of these 8 KLOEs against the previous 8 KLOE domains of the Well-Led Framework (initially developed in 2017), and the supporting themes and questions. Where there are new lines of questioning that are not addressed by these, EY developed additional question areas to validate the effectiveness of the Trust's governance arrangements against the 8 KLOE domains.

Based on the outputs of our fieldwork, we have identified a number of findings, both in terms of areas of good practice and for further development.

Detailed recommendations for each Key Line of Enquiry (KLOE) have been provided for the Trust's consideration. The key findings are structured as follows:

- ▶ An assessment against the KLOE criteria from the information and observations reviewed during the review period
- ▶ A detailed summary of findings by KLOE and KLOE theme
- ▶ Recommendations within the key findings for each KLOE and KLOE theme
- ▶ Key next steps to be taken following the review's conclusion

The CQC Well-led framework contains areas of duplication across KLOE's due to key behaviours affecting multiple areas of effective governance. Efforts have been made to minimise duplication including in the summarising of the top 3 strategic priorities for the Trust and Board identified in the opening letter of this report.



The Key Lines of Enquiry focussed on within the review

Assessed as part of this review

Shared direction and culture • Vision and values • Strategy and plan • Objectives • Stakeholder involvement • Addressing challenges • Local and national context • Alignment • Monitoring and review of delivery • Understanding challenges • Addressing behaviours	Capable, compassionate and inclusive leaders • Experience, capability, capacity and integrity • Skill mix and experience • Culture of health wellbeing, safety and compassion • Proactive listening • Proactive risk management • Building equity • Modelling positive behaviours • Leadership development
Governance, management and sustainability • Understanding and effectively meeting personal accountability • Governance, assurance, risk and accountability structures • Effective decision-making • Partnership arrangements • Continuous improvement • Robust data and systems • Clinical and internal audit • Emergency preparedness	Partnership and communities • Meaningful collaboration to improve services and address challenges • Building relationships • Shared planning and decision-making • Stakeholder engagement and feedback • Governance and management of partnerships

Not in scope for this review

Freedom to speak up • Culture of speaking up • Communication and feedback • Positive behaviours • Active promotion • Training and support • Policies and procedures	Workforce equality, diversity and inclusion • Equality, diversity and inclusion culture • Equitable treatment and staff empowerment • Processes, structures and use of nationally mandated programmes • Actions taken to address bullying and harassment • Fairness in recruitment and career progression • Engaging staff
Learning, improvement and innovation • Shared purpose and vision • Systematic approach to improvement • Quality improvement methods • Capability and capacity • Research, innovation and improvement approach and governance • Investment in people and culture • Quality assurance and management	Environmental sustainability • Commitment to environmental sustainability • Appropriate governance and leadership to support • Processes and measurement of actions to improve care, reduce carbon emissions and environmental harm • Stakeholder and partner involvement

Executive Summary (Key Observations and Key Recommendations) (1/4)

Board Capacity and Capability 	The new NEDs are seen as good appointments, with those board members with finance and clinical experience in particular cited as adding expertise and value to board discussions. The Executive Team needs to make two key appointments of Chief People Officer (CPO) and Chief Financial Officer (CFO) with interviewees believing it is important that the successful candidates bring technical knowledge, as well as knowledge of operating at Board level. While the new NEDs are viewed as positive appointments, they collectively need further development regarding knowledge of the NHS and/or how to operate at Board level and they require the support of the Trust management team in this. Similarly, Executives need further support in how to work together effectively as a High Performing Team and how to perform a Unitary Board member role - especially since many Executives are board members for the first time. The Trust has initiated a series of development sessions (both for Executives and for the collective Board) and these need to continue as part of a structured development plan over the next 12 months.	• Refine the existing Board development plan by identifying the collective development needs of the Board, the needs of the NEDs, and the needs of Executives • Generate a 12-month plan for each group and share it for input and refinement • The plan should be structured around annual objectives and quarterly reviews and should consider succession planning • Board members should consider how they can trust that parts of the governance structure they do not attend are effectively discharging their duties
Capacity and Capability within Senior Management 	Additional capacity and capability has been brought into the Trust below Executive level, particularly with the addition of deputy CFO and deputy Chief Operations Officer (COO) roles. The acting CPO is also gaining valuable experience. However, there are concerns regarding the capacity of the Executive team to deliver the level of change required, as the organisation is under pressure, and capacity and capability within Care Group leadership teams. The Trust has acknowledged this and some plans are in development, for example, using Band 8D nurses instead of Band 8C nurses as part of this. However, Operational Leaders require ongoing development, support to navigate the strategic choices the Trust plans to make, and the accountabilities of the Care Group Medical Leaders need to be more clearly defined. Finally, the business partnering support from Finance and People can be further improved, with senior Finance and People professionals becoming more embedded and visible within the Care Group leadership teams, and with greater clarity, ownership and access to integrated Business Intelligence across the Trust.	• Expedite the recruitment and onboarding of a permanent Chief People Officer and Chief Financial Officer. The criteria for these appointments should include technical knowledge and experience of operating at a Board level • Resource the Employee Relations and Talent teams to reduce the backlog of approximately 200 outstanding performance and grievance cases • Mandate accountability training for all people managers on embedding Trust values, early intervention on conduct and capability issues, and applying consistent standards across teams • Establish a cross-functional executive panel to oversee long-standing, high-risk, or complex performance cases to ensure consistency and drive action.



Executive Summary (Key Observations and Key Recommendations) (2/4)

Develop Strategic Options and credible implementation plans 	Interviewees do not believe the Trust's current strategy has an accompanying implementation plan and is, therefore, of limited value. The Trust's strategy was last reviewed in 2022 and may therefore not be aligned to the Trust's current operational status and needs of staff, patients and the wider community. All interviewees agreed on the need for further strategic clarity at the Trust. There was a view that without a clear plan it was proving challenging for the Trust to focus its limited capacity on the right issues and the right governance to deliver the changes required. An opportunity exists for the Trust to develop strategic options that will provide its population with high quality, affordable care whilst ensuring operational sustainability is fully incorporated into plans. It can then proactively discuss and agree these options with stakeholders within the local system. Once strategic options are better understood and agreed, a set of objectives should be mapped to the strategy to provide a set of tangible strategic and operational goals for the Trust. These should be supported by an implementation plan to provide sufficient steer and accountability for delivery against these goals.	• Create a new, overarching Trust strategy that clearly outlines service delivery options and serves as an evidence-based input for key stakeholders • Alongside the future strategy, develop a detailed integrated delivery plan for years 1-3 that articulates resource allocation, KPIs, and accountability • Develop and embed a governance framework to oversee the implementation and regular review of the new Trust strategy • Align and consolidate existing delivery unit-level strategies (e.g., for UEC and nursing) with the newly developed overarching Trust strategy
Improve data analysis and reporting 	The need to improve data quality (including within clinical coding) and data analysis has been frequently raised. A data improvement plan should be produced, with immediate focus on producing a data strategy (which takes in to account the pending EPIC implementation) and defining data governance (including defining Data Owners for all key data sets). As part of the data improvement plan, the Trust needs to review its approach to business analysis. There appears to be a lack of clarity regarding the roles of three different teams (Data Engineering, the Performance Team, Business Intelligence). In the medium term, the implementation of EPIC could compound this. .	• Formulate a strategy to enhance data quality and accessibility through assessments, training, a governance framework, and continuous monitoring • The Trust needs to review its approach to business analysis, as responsibility for generating and reporting management information is split across three different teams

Executive Summary (Key Observations and Recommendations) (3/4)

Review Committee Structure and Operation 	The Board has more Committees than are typically seen at comparable NHS providers - and Executives are spending considerable time servicing these. The Trust should review its Committee Structure, considering which aspects of its obligations it needs to delegate to Committees. In particular, the role of the Building a Brighter Future Committee needs to be reviewed. At some providers, we also see People issues being discussed at either a Finance and Performance Committee or at a Quality Committee. Similarly, Executive Committees should be reviewed. The Trust has already started this, reviewing the role of the Executive Operations Group (EOG). At both Board and Executive level, It is important that the role of each Committee is clear and that work and discussions are not duplicated. As part of the Board Development sessions, Board members should consider how they can trust that parts of the Governance structure they do not attend are effectively discharging their duties.	• Implement a streamlined governance model to redesign the Trust's governance structure, reduce the number of committees, and eliminate duplication of activities • Conduct a comprehensive review and refresh of all committee Terms of Reference (ToRs) to ensure they are current, aligned with the streamlined governance model, and provide clarity on reporting lines and responsibilities • Develop and embed a robust governance transformation programme with clear milestones, leadership, and mechanisms to hold stakeholders accountable for implementing changes
Decision making 	Decision-making formally sits with the Board, supported by sub-committees that provide scrutiny and assurance rather than direct authority, while the Executive Team is responsible for operational delivery. In practice, unclear delegations and risk aversion often drive escalation to Board level, creating duplication, blurred roles between assurance and operations, and slower progress, with focus weighted towards compliance over strategic transformation	• Conduct a Trust-wide exercise to clearly define and communicate roles, responsibilities, and accountabilities at all levels, including formalizing delegated authorities • Develop and embed a standardized, mandatory process for consistently incorporating risk into the Trust's operational plans

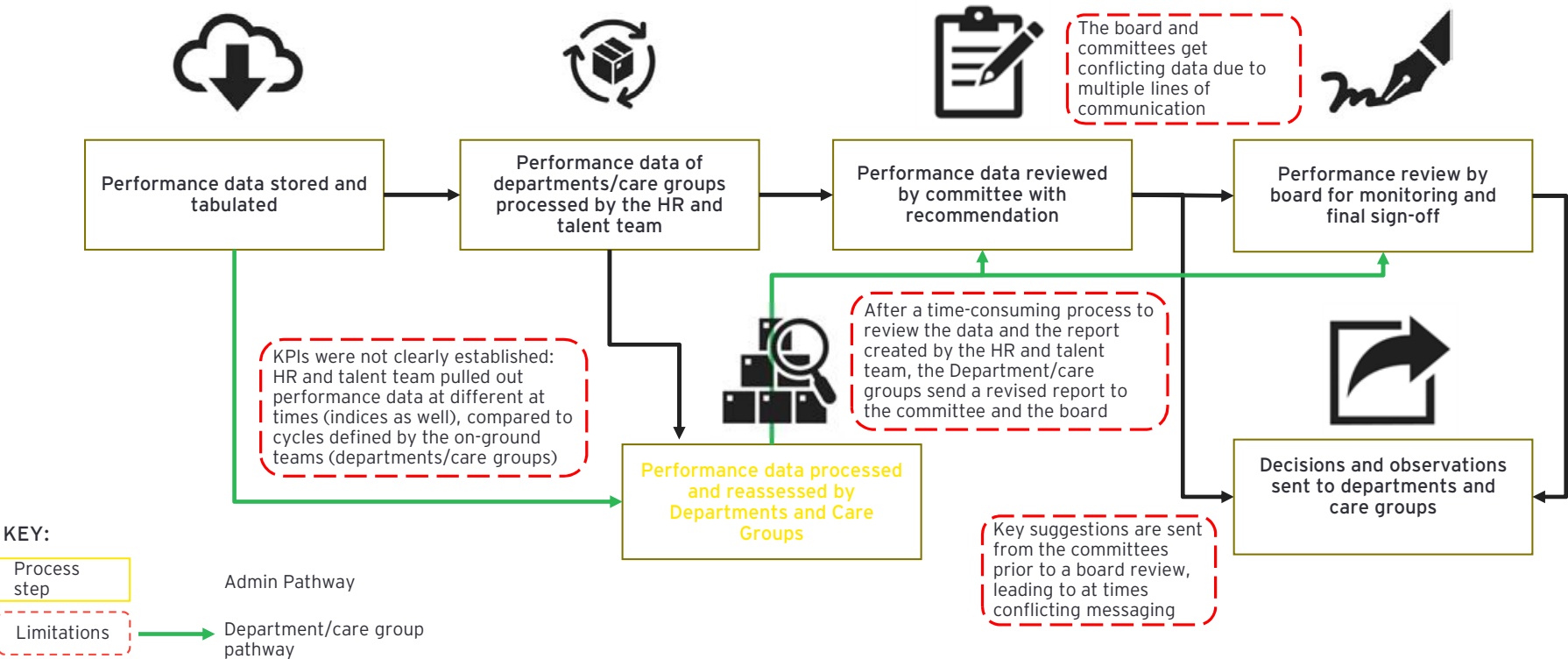


Executive Summary (Key Observations and Recommendations) (4/4)

Improve effectiveness of Board meeting through high impact papers 	Board members feel that Board papers are often of poor quality and voluminous. They contain too much information, lacking succinct analysis and lacking clarity on the options and proposals. Executives have commented they are not clear on occasion why they are asked to take papers to Committees, they are not always clear about the decision-making processes they need to work within, and NEDs have commented that they believe there are too many items on agendas. Once the role of each Board and Executive Committee is clarified, a standing agenda should be prepared for each that allows them to discharge their respective obligations. The Chair of the committee should define the key analysis each paper should contain. The Trust needs to review and improve the Integrated Performance Report. We see this work well at other providers where a succinct dashboard is used at the start of Board agendas to monitor performance (through a small number of KPIs) at Trust level against their objectives for Quality, People, Operational Performance and Finance. Performance against other KPIs are reported by exception. These Trust level KPIs are also able to be report, where applicable, at Care Group Level down to Ward level.	• The Trust should define KPIs (approximately 20) that allow it to gain an overview of Trust performance, covering Quality, People, Finance, and Operations • These KPIs should be reported to the Board in a dashboard format • Dashboard outputs should be effectively integrated with outputs of key committees, such as Quality, for holistic and integrated oversight of Trust performance • Optimise Board and Committee meeting efficiency by introducing and embedding practices to ensure meetings are focused, concise, and paper-light
Risk Management 	The approach to Risk management within the Trust is not action-oriented, with no ongoing or real-time monitoring of progress of actions to reduce risk to target levels and / or within tolerance. As a result, mitigating actions are not taken in a proactive or timely fashion. While progress has been made with the recent development of updated Board Assurance Framework reporting, and reviews of Risk registers, there is still no consolidated view of risks and related actions; the Trust needs to develop arrangements to address this, with the focus of reporting being actions taken and progress in achieving them. This would also help address issues identified by stakeholders regarding a lack of coordination of risk management, resulting in increased risk of duplication of effort, siloed approaches, and lack of accountability and ownership.	• Develop a robust system, including dashboard reporting, for tracking and monitoring the prompt implementation and effectiveness of risk mitigation actions • Formalize a "lessons learned" risk culture by ensuring the effective integration of post-incident reviews, near-miss analysis, and risk mitigation effectiveness studies • Define and clearly communicate ownership and accountability for risks at all levels of the organization and establish clear, standardized escalation paths • Ensure alignment between recorded risks and the Trust's strategic objectives and operational plans.

Key observation - Decision-making process issues

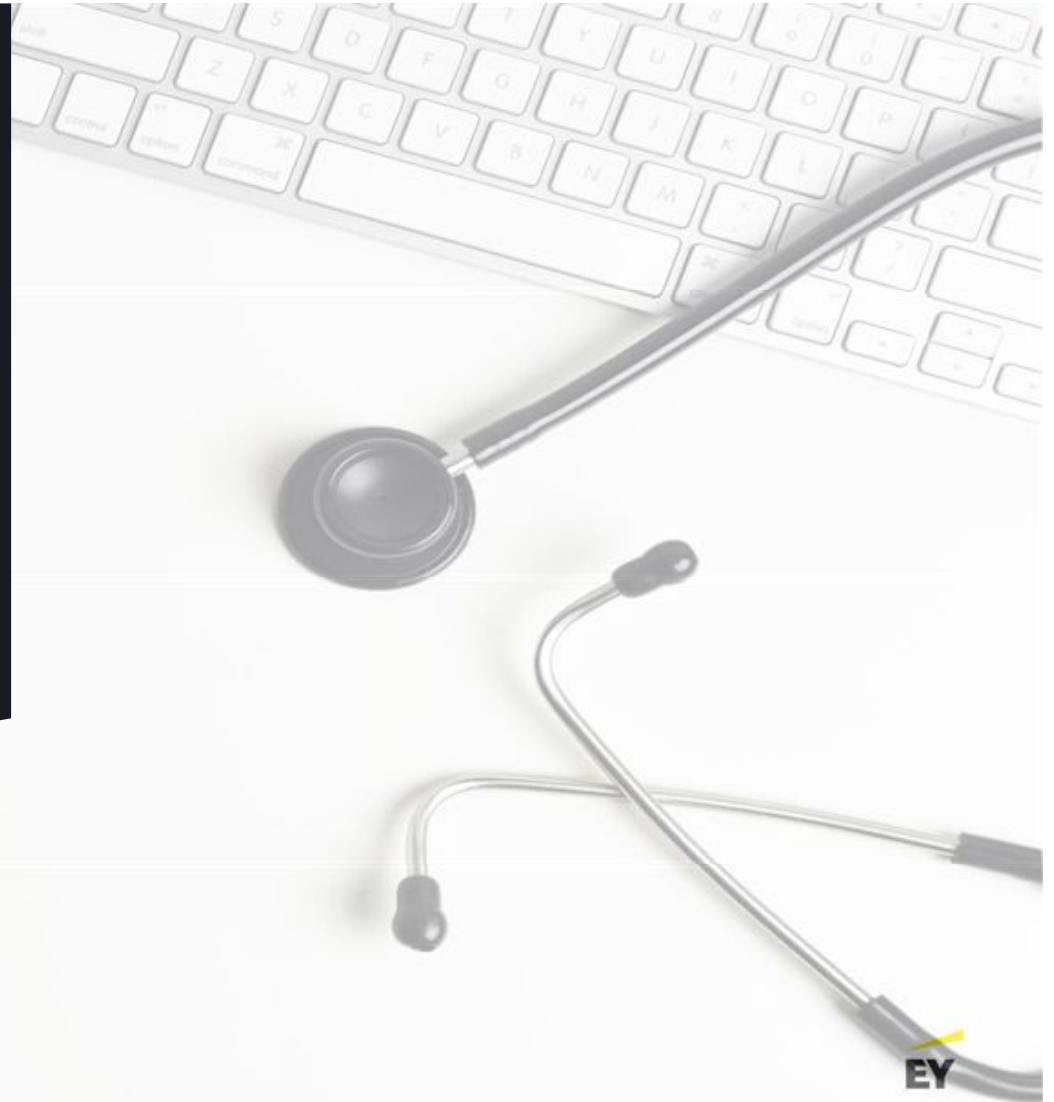
The current decision making process flow illustrates how care-group/department performance data is sent through to the committees (e.g. Quality/People) and to the Board at a high-level. The process flow and highlighted limitations demonstrate the need to have an efficient and well-defined governance process with clearly defined KPIs. An efficient process will reduce time constraints and provide a better and more timely understanding of Trust’s performance



* The example presented above is indicative based on our conversations/interviews with the three care groups and departments like Nursing and Maternity

Immediate Next Steps

Outlines the key next steps that could be undertaken to initiate the improvement process



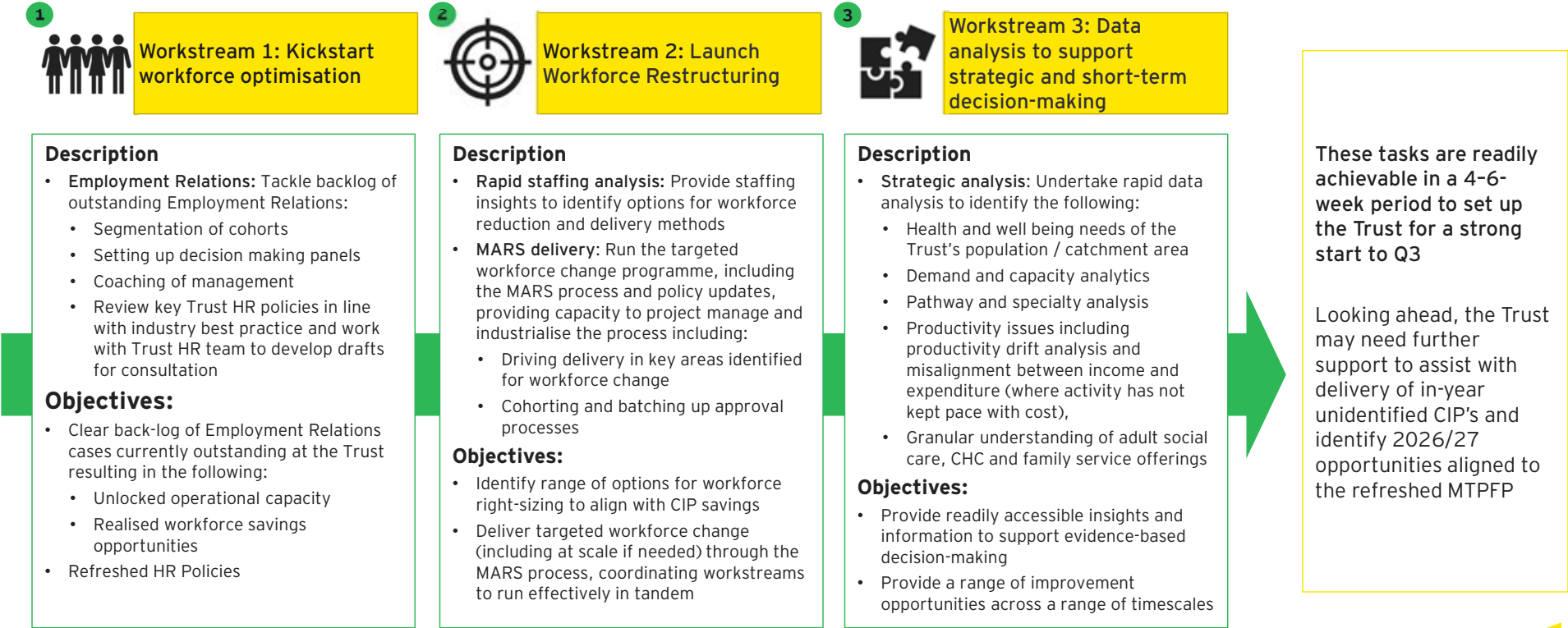
Immediate Next steps

A short term improvement focus over 6-8 weeks in key action areas would set the Trust up for smoother delivery in the second half of this financial year



Immediate Next steps - How we can help

In addition, in line with our discussions and based on our observations, we believe we can help provide practical support in the following ways. The below are examples of how and where external support could make a step change at TSD



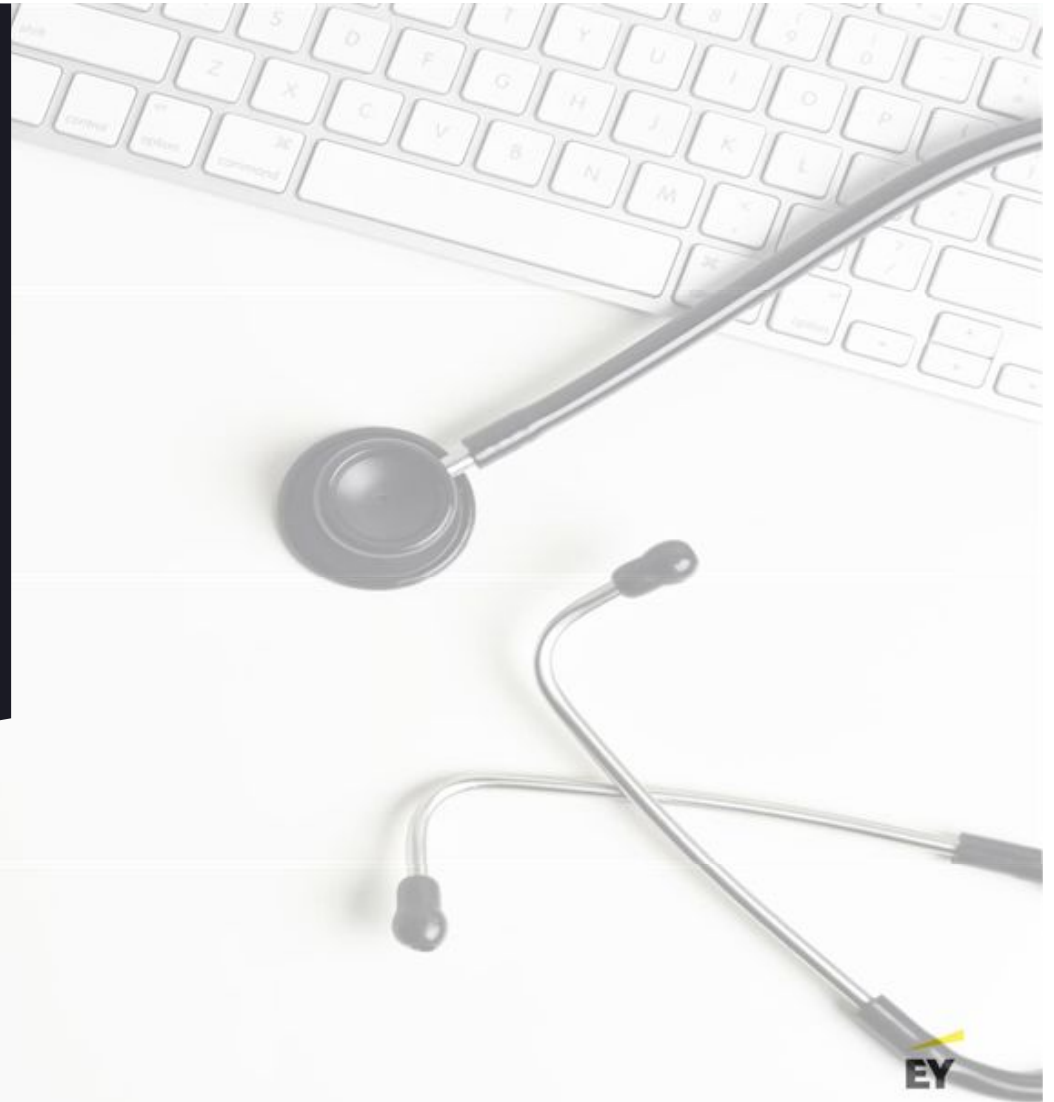
Immediate next steps and how we can help

Immediate Next Step	Objective
 Phase 1: Foundational Governance & Data Clarity	To immediately clarify governance structures, enhance data accuracy for robust decision-making, and create a workplace culture that is more accountable and supportive of employees' mental well-being
 Phase 2: Framework Development & Capacity Building	To build sustainable organisational capabilities through formalised frameworks for collaboration, proactive risk management, and a skilled, supported workforce
 Phase 3: Strategic Integration/Alignment & Continuous Improvement	To ensure the trust's strategy aligns with national and local contexts, ensure robust system-wide integration, and create a culture of continuous improvement focussing on quality and efficiency.

How we can help	Objective
 Workstream 1: Kickstart workforce optimisation	- Clear back-log of Employment Relations cases currently outstanding at the Trust resulting in the following: - Unlocked operational capacity - Realised workforce savings opportunities - Refreshed HR Policies
 Workstream 2: Launch Workforce Restructuring	- Identify range of options for workforce right-sizing to align with CIP savings - Deliver targeted workforce change (including at scale if needed) through the MARS process, coordinating workstreams to run effectively in tandem
 Workstream 3: Data analysis to support strategic and short-term decision-making	- Provide readily accessible insights and information to support evidence-based decision-making - Provide a range of improvement opportunities across a range of timescales

Headlines by Key Line of Enquiry (KLOE)

Summarises areas where the Trust demonstrates good governance, as well as key areas of development



Headlines by KLOE (1/2)



KLOE 1: Shared Culture and Direction

- **Strategic Alignment Opportunity:** The Trust's existing strategy offers a foundation, but it does not yet fully reflect the Trust's stated ambition to embed financial and wider sustainability at the heart of its vision and values
- **Enhancing Reporting Integration:** While multiple reporting mechanisms were in place, there is an opportunity to strengthen integration and alignment across departments to improve the timeliness, accuracy, and consistency of performance reporting—particularly in relation to clinical coding quality and depth
- **Clarifying Accountability:** The strategy refresh offers a timely opportunity to strengthen and embed clearer accountability frameworks for addressing underperformance and behaviours not aligned with Trust values, building on recent progress to ensure consistent expectations and actions at all levels
- **Strategic Alignment Opportunity:** There is an opportunity to strengthen the alignment between current one-year improvement plans and the Trust's broader multi-year strategic objectives. Clarifying ownership at the senior leadership level would help ensure that identified challenges are consistently addressed through formal strategic planning and delivery
- **HR Backlog Issues:** There were a large number of outstanding performance issues and grievance claims (understood to be approximately 200), with concerns regarding the Talent team's capacity to address the issues in a timely fashion



KLOE 2: Capable, compassionate and inclusive leaders

- **Leadership capacity and development:** Recent leadership appointments had brought valuable insights, but capacity constraints remained in key roles such as the Chief People Officer and Chief Financial Officer. There was also an opportunity to strengthen development pathways for middle-grade clinical leaders and to embed more consistent succession planning across the organisation
- **Career pathways and capability:** Efforts were underway to reform leadership structures, including the introduction of 8D nursing roles. However, stakeholders highlighted underdeveloped career pathways for some clinical groups. Improving appraisal completion rates would further support leadership development and talent progression
- **Organisational culture and psychological safety:** The Trust was recognised for its compassionate and patient-focused culture, with staff demonstrating a strong commitment to organisation buy in and high-quality care. Further work was needed to ensure all staff feel psychologically safe and supported to raise concerns, particularly in relation to clarity about Trust priorities and objectives, and protected characteristics
- **Feedback and engagement mechanisms:** The Trust had implemented a range of feedback mechanisms such as patient engagement and senior leadership visits. There was an opportunity to enhance how staff and community feedback is systematically captured and integrated into governance and strategic decision-making processes
- **Risk management and equity considerations:** The Trust was working to strengthen risk oversight, though operational risks were not always escalated or aligned with wider strategic themes. Clarifying risk ownership and reinforcing equity and inclusion efforts, including addressing pay disparities and ensuring fairness in recruitment and progression, would support a more inclusive and accountable approach

Headlines by KLOE (2/2)



KLOE 3: Governance, management and sustainability

- **Governance Effectiveness:** There are opportunities to streamline governance processes by reducing duplication across committees, clarifying roles and delegated authorities, and managing senior-level workload more effectively
- **Risk Ownership and Accountability:** Inconsistencies were present in how risks were identified, owned, and escalated across care groups. As part of cultural and structural change, clearer definitions of accountability and consistent processes for addressing performance and behaviours were needed
- **Data Integration and Insight:** The current approach to performance monitoring was hindered by fragmented systems, inconsistent data quality, and limited integration. Strengthening data governance and accelerating readiness for Epic implementation would be key to improve the visibility and decision-making
- **Quality Improvement Infrastructure:** While examples of innovation existed at local levels, there was no unified quality improvement framework across the Trust. National benchmarking for participation and complaint handling processes also varied, limiting opportunities for systematic learning and improvement
- **Formalising Strategic Partnerships:** The Trust was re-engaging with local system partners, but many relationships were still informal and the role of key groups including the PASP programme had been unclear for some time. Formalising these partnerships through documented agreements and clearer governance mechanisms will eventually result in more consistent and coordinated service delivery
- **Emergency Preparedness and Resilience:** The Trust did not have a fully integrated, organisation-wide EPRR governance or testing framework. Strengthening emergency planning in collaboration with system partners and addressing workforce resilience would improve preparedness and responsiveness.

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KLOE 4: Partnership and communities

- **Progress in Rebuilding Relationships:** Under new leadership, the Trust had effectively rebuilt connections and enhanced engagement with external stakeholders and system partners. Key staff and partners felt and commented on this.
- **Need for Formalised Engagement:** Building on these improvements, there is an opportunity to formalise and document engagement pathways, establish a unified partnership model across organisations and departments, and develop formal collaborative planning protocols with external partners to further align efforts and strengthen local community relations
- **Fragmented Patient, Public, and Staff Involvement:** Patient and public involvement primarily operated at the service level, with opportunities identified to implement unified organisation-wide mechanisms for consistent feedback capture and action, including for protected groups. Staff feedback channels were present but could be refined to enhance accessibility and inclusivity across the Trust
- **Data Integration and Accountability Gaps:** Data submission to external bodies was routinely completed, but this was largely manual, ad hoc and did not always benefit from QA and checking. These processes could benefit from further standardisation. The planned Epic system implementation was recognised as a significant opportunity to expand data integration, alongside clarifying accountability for data management and sharing beyond the Trust; however, based on experience, this is likely to be a 2 year journey.
- **Benchmarking and Audit Underutilisation:** Participation in national benchmarking and audit schemes was in place, with the potential to embed this insight across all services to maximise the value derived from these activities.

EY

Detailed Findings and Recommendations

Detailed report of the findings and
specific actionable
recommendations

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KLOE 1: Shared Direction and Culture (1/5)

KLOE Theme	Key Question	Key Findings
Vision and Values	Is there a clear vision and a set of values, with quality and sustainability as the top priorities?	- The Trust's strategy outlined a vision and set of values. Quality and patient care were at the centre of these as core guiding principles. The Strategy was last revised in January 2022. - Sustainability was not explicitly called out within the vision and values, however, financial efficiency (if not sustainability) was a core principle of the Trust's stated purpose. - The Trust is due to revise its strategy in 2025 and should ensure that quality and sustainability (both financial and environmental) are reflected as explicit drivers of the strategy.
Strategy and Plan	Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?	- As noted above, the Trust had a strategy in place, which was last revised in January 2022. - The Trust needs to develop its strategic options in the context of the wider system and then discuss them with internal and external stakeholders. The Trust is likely to need to explore and lay out its own views, rather than waiting for the system to develop these for it. - Once agreed, the Strategy would need to be supported by a plan for the delivery of its objectives. - Stakeholders were positive about opportunities whilst highlighting that the Trust may need additional capacity to implement change. We understand that the Board will consider a refreshed strategy in September. The Board should consider whether it will have had opportunity to produce the necessary data and analysis for September and whether it will have had an opportunity to sufficiently engage stakeholders - Although there is a need to update the Trust wide strategy, it should be noted that there are a number of delivery unit-level strategies in place, such as those for UEC and nursing (the latter newly-implemented). However, these will require a review once the updated Trust strategy is agreed. Furthermore, delivery units without strategies (or where strategies are out-dated) should prepare these and align them to the overall strategy.

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Our Recommendation

- **Develop a Comprehensive, Future Strategy in quarter 2 25/26:** Create a new, overarching Trust strategy that clearly outlines service delivery options within the wider system context. This strategy should be evidence based and serve as the basis for input from key stakeholders, addressing the capacity for change required and explicitly referencing how the Trust will achieve sustainability
- **Formulate an Integrated Delivery Plan ready for implementation from quarter 3 of 25/26:** Alongside the future strategy, develop a detailed integrated delivery plan for years 1-3. This plan should clearly articulate resource allocation, key performance indicators, and accountability for delivering good quality, sustainable care
- **Establish Robust Governance for Strategy Implementation & Review at quarterly intervals:** Develop and embed a governance framework dedicated to overseeing the implementation and regular review of the new Trust strategy. This includes defining clear roles, responsibilities, reporting mechanisms, and processes for adapting to changing priorities and monitoring progress on quality and sustainability
- **Align and Consolidate Delivery Unit-Level Strategies by quarter 4 of 25/26:** Review and align existing delivery unit-level strategies (e.g., UEC, nursing) with the newly developed overarching Trust strategy. Where appropriate, consolidate or integrate these to ensure consistency, eliminate duplication, and support unified strategic delivery

KLOE 1: Shared Direction and Culture (2/5)

KLOE Theme	Key Question	Key Findings
Objectives	Does the Trust have a clearly defined set of objectives mapped to its strategy?	The board strategy did not set out a specific defined set of objectives; however, the Trust had agreed an in-year plan and related KPI's which would articulate what is required for effective provision of care across UEC, Elective and other delivery units. There are opportunities to align and add to these in-year performance targets a set of broader multi-year strategic objectives alongside the development of the new Strategy
Stakeholder Involvement	Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?	As noted above, once the Trust has defined its options for the future strategy, these should be discussed with internal and external stakeholders, particularly system partners. The resulting strategy needs to consider the needs of staff and local patients and service users, and, where applicable, patients across Devon. The review team discussed initiating this process through a rapid demand and capacity analysis of the Trust's population
Understanding Challenges	Has the Trust assessed its internal and external challenges and reflected them in its strategy?	The Trust was aware of the external and internal challenges faced. It now needs to generate options for addressing these and providing sustainable, high quality services to its population, in collaboration with others. The impetus for delivering on this is likely to need to come first and foremost from the Trust itself as the issues are most key to the Trust.
Addressing Challenges		



Our Recommendation

- **Align Performance Targets to Multi-Year Strategic Objectives (Q4 2025):** Develop and implement a formal process to align current one-year improvement plans and KPIs with broader multi-year strategic objectives. This will ensure all efforts contribute to a unified, long-term direction, empowering leadership and delivery at all levels.
- **Translate Strategic Objectives into Empowering Leadership Action (Q1 2026):** Clearly communicate and cascade the agreed-upon set of strategic objectives to all leadership levels. Provide training and tools to empower leaders to translate these objectives into actionable plans within their respective areas, fostering a sense of ownership.
- **Formalize Stakeholder Insights (Q2 2026):** Proactively prepare strategic options, leveraging health intelligence where possible. Consult key stakeholders (staff, services and external partners) to gather their feedback and preferences. Develop a structured and ongoing mechanism to formally integrate insights gathered from these stakeholders into strategic planning and implementation processes. This ensures strategies remain responsive and reflective of diverse perspectives, whilst still proactive in terms of driving timely implementation.
- **Embed Identified Challenges Fully into Strategic Documents (Q3 2026):** Ensure that all identified internal and external challenges are not only discussed but are fully and explicitly reflected within formal strategic documents. This includes outlining how the strategy will address these challenges.
- **Clarify Senior Leadership Ownership of Strategic Portfolios (Q4 2026):** Define and clearly communicate which senior leadership roles and portfolios will hold ownership and accountability for addressing specific identified challenges and delivering related strategic initiatives, reducing ambiguity and driving action

KLOE 1: Shared Direction and Culture (3/5)

KLOE Theme	Key Question	Key Findings
Local and National Context	Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?	- The Trust demonstrated in interviews and documentation appropriate awareness of the national context, as reflected in the newly articulated nursing and maternity strategy, where reporting processes and strategies are aligned to wider national frameworks. - As part of the Trust's review of its strategy, it will need to ensure they fulfil all regulatory requirements, including fulfilling the requirements that flow from changes in its national oversight rating. These requirements are likely to include: - Achieving financial recovery / balance by delivering on significant cost improvement plans, significantly improving operational performance such as reducing waiting times for elective care and in urgent and emergency departments, enhancing the overall quality of patient care and addressing any Care Quality Commission concerns, and stabilising the workforce through improved recruitment, retention, and fostering a positive organisational culture - Furthermore, the Trust will need to continue to exhibit strong and accountable leadership, embedded continuous improvement practices, and effective collaboration with the wider Devon Integrated Care System to ensure sustainable system-wide health outcomes.
Alignment	Does the Trust strategy align with priorities of external stakeholders and regulatory requirements?	



Our Recommendation

- Boost & Formalize Participation in National Benchmarking:** Conduct a gap analysis to identify opportunities for services to participate in relevant national benchmarking schemes to allow for leveraging of nationally identified good practice to drive continuous improvement. A good example of this in practice is Maternity reporting process and strategy. A key opportunity for SDT is to rapidly assimilate learnings and experience from other Integrated Care Organisations (ICOs) globally, to inform the strategy setting for the organisation
- Please refer to KLOE 1 (Monitoring Review and Delivery) recommendation related to monitoring of progress against NSOF Exit criteria**
- Please refer to KLOE 1 (Stakeholder Engagement, Understanding challenges and Addressing Challenges) and the recommendation related to utilising health and care intelligence as part of developing strategic options**

KLOE 1: Shared Direction and Culture (4/5)

KLOE Theme	Key Question	Key Findings
Monitoring and Review of Delivery	Does the Trust have arrangements in place to monitor and report on delivery of services, including appropriate analysis of performance data?	- There were a number of reporting mechanisms currently in place within the Trust. Stakeholders interviewed had identified a number of areas of improvement: - Reporting arrangements were not unified and did not provide sufficiently integrated performance reporting, based on timely, accurate, and consistent data sets. - Service line reporting was in development - Reporting was disaggregated between different delivery units and governance committees; similarly, responsibility for generating and reporting MI is split across three different teams. - Stakeholders had identified that depth of clinical coding is weak compared to that experienced at other providers. - The Trust had understood the challenges outlined above and their impact on stakeholders; as such were in the process of reviewing and refining these arrangements, including implementing service line reporting, and developing integrated performance reporting, with one objective being weighted performance scorecards.



Our Recommendation

- Develop a KPI framework and Reporting arrangements (Q4 2025):** The Trust should define those KPIs that allow it gain an overview of Trust performance. These should be linked to Trust objectives, with other providers finding it useful to have approximately 20 KPIs that cover Quality, People, Finance and Operations, as well as others (e.g. NSOF4 exit criteria). These KPIs should be reported to the Board in a Dashboard format. Where applicable, these KPIs should be capable of being monitored at a disaggregated level - Care Group down to ward. Additional KPIs would be monitored by management, but reported to the Board by exception. In time, a real time dashboard should be produced that allows the user to drill down in to areas of performance. Dashboard outputs should be effectively integrated with outputs of key committees such as Quality for holistic and integrated oversight of Trust performance.
- Develop a Comprehensive Data Improvement Strategy (Q1 2026):** Formulate a strategy to enhance data quality and accessibility through assessments, training, a governance framework, and continuous monitoring. This will empower staff, ensure compliance, and improve data management and data quality, ultimately supporting better decision-making and patient outcomes.
- Develop a Unified Stakeholder Engagement Framework (Q1 2026):** Create and implement a comprehensive, Trust-wide framework for consistent engagement with all external stakeholders (e.g., NHS England, system partners, local communities), clearly outlining pathways, protocols, and responsibilities, and ensuring integration with local planning activities and regional bodies (combines findings from 'Relationships & Engagement' and 'Local and National Context')

KLOE 1: Shared Direction and Culture (5/5)

KLOE Theme	Key Question	Key Findings
Addressing behaviours	Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority?	- As part of the review of vision and values as part of the refresh of the strategy, there are opportunities to ensure that accountability structures are clearly defined and allow for effective action to be taken in the event of underperformance or behaviour misaligned with Trust values. - Stakeholders noted that historically there had been some acceptance of unclear accountability structures, leading to ineffective action taken when issues had been identified. However, it was felt this was beginning to change under the Trust's renewed leadership arrangements - There were concerns with regards to the ability to take evidence-based decisions and address issues in a timely fashion. There were outstanding performance issues and grievance claims (understood to be approximately 200), which the Talent team did not have capacity to address, due to resourcing constraints and turnover in the People function. Stakeholders expressed concerns about the perceived length of time it can take to complete investigations.



Our Recommendation

- Embed Clear Accountability for Performance (Q4 2025):** As part of the ongoing strategy refresh and vision/values review, clearly define and embed accountability structures and processes to ensure effective, timely action is taken in response to underperformance or other issues (e.g. sickness)
- Strengthen People Function Capacity (Q1 2025):** Resource the Employee Relations and Talent teams to reduce the backlog of ~200 outstanding performance and grievance cases. Prioritise recruitment and retention within the People function to ensure investigations and case management are completed promptly and consistently. Consider short term capacity to resolve the historic issues more rapidly.
- Establish Senior Oversight for Conduct Cases (Q4 2024):** Introduce a cross-functional executive panel (e.g. HRD, Medical Director, COO) to oversee long-standing, high-risk, or complex performance cases. This will ensure consistency, escalation where needed, and signal visible commitment to accountability at all levels
- Mandate Accountability Training (Q1 2025):** Deliver compulsory training for all people managers on embedding Trust values, early intervention on conduct and capability issues, and applying consistent standards across teams. Reinforce expectations through regular case audits and leadership communications

KLOE 2: Capable, Compassionate, Inclusive Leaders (1/4)

KLOE Theme	Key Question	Key Findings
Experience, capability, capacity and integrity	Is there the leadership capacity and capability to delivery high quality and sustainable care?	- Although there had been a number of changes in senior leadership, stakeholders noted the positive impact of individuals in key roles, for example the CEO's interactions with both internal and external stakeholders and the positive improvements seen since the Deputy CEO undertook the role of COO - Due to the large number of new appointments to key leadership roles, there is an opportunity to further build both institutional knowledge and effective team structures. For example, some NEDs need further experience of the NHS and the role of NHS NEDs, while some Executives need further experience around operating in a unitary board. It was recognised by interviewees that new Board members will be able to provide fresh insights and challenge to help steer change at the Trust
Leadership development	Are there sufficient efforts undertaken to effectively develop leadership capabilities, including effective succession planning.	- Efforts were already underway to help new Board members (and the Board collectively) through a series of development sessions. Stakeholders welcomed the sessions, with an opportunity to have a forward plan of sessions that align to the Board's areas of greatest collective need. - There was acknowledgment that capacity and capability at senior positions had been increased - for example, the appointment of a deputy CFO and Deputy COO and plans to increase the seniority of nurses supporting Care Group sin Leadership positions. Some of these positions need to be confirmed (e.g. the Deputy COO). However, more capacity and capability was needed, most notably the need to appoint a permanent Chief People Officer and Chief Financial Officer. These resourcing needs also extend to the need to strengthen Operational Leadership within Care Groups and provide Care Groups with enhanced People and Finance business partnering. - Succession planning arrangements needed be further embedded into Trust practices, such as controls to monitor and identify and/or trigger succession activities that need to take place.

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Our Recommendation

- **Refine the Board and Executive Development Plan (Q1 2026):** Refine the existing Board development plan by identifying the collective development needs of the Board, the development needs of the NEDs and the development needs of Executives. Generate an 18-month plans for each group and share it with each group for input and refinement. Structure around annual objectives and quarterly reviews. Consider Succession Planning as part of this programme.
- **Prioritise Strategic Leadership Appointments (Q2 2026):** Expedite the recruitment and onboarding of a permanent Chief People Officer and Chief Financial Officer. Seek help from NHS England where required. Criteria for these appointments should include technical knowledge and experience of operating at board level. The Trust may need to ask for system support in identifying the right candidates.



KLOE 2: Capable, Compassionate, Inclusive Leaders (2/4)

KLOE Theme	Key Question	Key Findings
Skill mix and experience	Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?	- The Trust was taking steps to reform leadership and career development structures within clinical environments, an example being the review of nursing leadership structures. - However, stakeholders have commented that career development in some areas, such as those for some middle-grade clinical roles is underdeveloped. At present there were no initiatives to ensure leadership development of individuals with protected characteristics to improve representation. - Appraisal rates sat below the compliance rate of 90%, with the shortfall in completion rate being attributed to leadership capacity issues. The Trust was aware of these issues and is proactively discussing them in People Committee
Culture of health wellbeing, safety and compassion	Is the culture within the Trust one that is focussed on delivering safe, effective and compassionate care to patients	- Stakeholders consistently commented that there was a strong culture across all levels of staff towards high quality of care and good patient outcomes. Executives were similarly perceived as committed towards achieving these aims. - There was positive feeling amongst stakeholders that Trust staff would be able to further deliver in line with this culture with greater resource capacity in both clinical and operational contexts.



Our Recommendation

- Deliver an Integrated Clinical Workforce Development and Skill Mix Optimisation Strategy (Q1-Q3 2026):** Design and implement a Trust-wide clinical career development framework that provides clear, standardised progression routes, particularly for middle-grade clinical staff. This should include structured training, mentorship, and accessible development pathways. Alongside this, equip line managers with targeted training and tools to deliver high-quality appraisal and career development conversations, helping identify individual aspirations and organisational needs. Conduct a Trust-wide skill mix review to assess current capacity, identify gaps or overlaps, and inform a data-driven optimisation strategy that aligns workforce capability with safe, effective, and sustainable service delivery
- Reinforce and Leverage a Patient-Oriented Culture (Ongoing):** Develop a communications strategy to consistently reinforce and celebrate the Trust's strong patient-oriented culture, high quality of care, and good patient outcomes. Use this cultural strength as a foundation for further embedding safe, effective, and compassionate care

KLOE 2: Capable, Compassionate, Inclusive Leaders (3/4)

KLOE Theme	Key Question	Key Findings
Building equity	How does the Trust work with its staff to enable them to feel like their contributions and involvement are respected and valued?	- The Trust had a number of recognition mechanisms in place, including periodic People Choice awards, as well as Greatix performance awards that are being trialled in a number of medical departments. The Greatix performance awards are notable in that in addition to being peer nominated, the Trust was trialling patient-to-staff nominations, which was the first such trial in the country. Stakeholders also indicated that leadership, particularly the acting CPO and CEO have been supportive of awards and recognition. - The most recent People Survey reflected an increase in positive sentiment regarding staff recognition (the only one of the 7 categories to have an improvement). Following review of People Committee documentation, it was not possible to obtain evidence of an action plan to address these categories; however the results of this Survey have not yet been fully discussed by the committee. - The Trust also had a number of feedback mechanisms, particularly with regards to patient engagement, and senior leadership were looking to engage more regularly with staff, such as with Board member on-site visits. Staff inputs were acknowledged as part of this process - There were opportunities to further develop the frameworks to ensure that staff and community feedback was effectively inputted into governance and planning discussions and fed into strategic and operational decision making
Proactive listening	Do the Trust effectively and proactively listen to stakeholders, and take appropriate action based on feedback received?	
Proactive risk management	Does the Trust have in place arrangements to identify, quantify and monitor risks to the organisation on an ongoing basis?	Please see KLOE 3 'Governance, assurance, risk and accountability structures' for further details



Our Recommendation

- Establish and Embed an Integrated Feedback Framework (Q2 2026):**
As part of agreeing KPIs to be monitored at Board level, the Quality Committee should agree a suite of KPIs under a structured framework (e.g. detailed RACI) that it will review at each meeting. These should explicitly cover among other things, patient, staff and community feedback along with a clearly defined process for playback and actions as a result

KLOE 2: Capable, Compassionate, Inclusive Leaders (4/4)

KLOE Theme	Key Question	Key Findings
Modelling positive behaviours	Is there a strong emphasis on safety and well-being of staff?	An Associate NED had been appointed to the Board who has substantial experience of championing Equality, Diversity and Inclusion. There were opportunities to further increase the diversity of Trust leadership.
	Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?	- There were concerns as raised in staff surveys (including the People Survey) and feedback and key equality data on a number of points: - Staff had reported that they did not feel psychologically safe and that their well-being was not supported; furthermore, they felt that although there are frameworks in place to raise concerns, that actions would not be taken to address issues raised. - There were concerns regarding equitable treatment for individuals with protected characteristics as raised in DES and RES reporting, for example with regards to ethnicity pay gaps in nursing. Whilst there was a good understanding of Equality and Diversity within the Trust, various issues were approached on a siloed basis rather than promoting a cohesive approach across all protected characteristics.
	Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?	Stakeholders had commented that positive team cultures were not consistently in place. Whilst there are several teams where stakeholders are confident of good practice and positive team culture, these were perceived to be reliant on good individual leadership rather than practices that could be readily replicated.
	Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?	- However, the Trust leadership, particularly the CEO was both perceived as and had demonstrably taken efforts to drive positive change in this area, with staff reporting increased optimism about those issues as a result. The CEO had continued support for the People Promise programme, which was designed to specifically target the issues identified above, with a sponsor for this programme sitting on the board. - Frameworks had been put in place at a leadership level to promote collaborative ways of working such as the triumvirate leadership model, which encouraged clinical leads across a range of delivery units to jointly work together. There were opportunities to develop these further to facilitate cohesive and consistent outcome.



Our Recommendation

- Develop a Transparent Trust-Wide Concern-to-Action Framework that Embeds Well-Being and Accountability:** Design and implement a standardised, transparent framework for capturing, escalating, and addressing concerns raised by staff and service users. Ensure clear timelines, defined ownership, and robust feedback loops so individuals know how concerns are handled and what actions have been taken. Embed this within a broader well-being and psychological safety approach by providing training for leaders and staff on active listening, supportive communication, and fair accountability. This will reinforce Trust, demonstrate that staff voices are valued, and promote a learning-focused, responsive culture
- Adopt a Cohesive Approach to Equality and Diversity:** Create a unified strategy for addressing equality and diversity issues that encompasses all protected characteristics. This strategy should include specific actions to address identified disparities, such as ethnicity pay gaps, and promote equitable treatment across the Trust. Regularly review and report on progress to ensure transparency and accountability.
- Foster Consistent Positive Team Cultures:** Develop and disseminate best practice guidelines for building positive team cultures that can be replicated across the Trust. Encourage collaborative working through structured team-building activities and cross-departmental initiatives. Leverage the existing People Promise programme to support these efforts and ensure that successful practices are shared and celebrated throughout the organisation.

KLOE 3: Governance, Management & Sustainability (1/7)

KLOE Theme	Key Question	Key Findings
Understanding and effectively meeting personal accountability	Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?	- Encouragingly, Stakeholders noted that the new executive team was promoting a more open culture, with early signs of more candid and constructive discussions at Board and committee levels. However, this process was not yet consistent across the organisation. Stakeholders reported that cultural change remained uneven, with frontline staff and some middle leaders still expressing hesitation in escalating concerns. - Stakeholders noted that they do not believe stakeholders always feel confident that concerns raised will lead to meaningful action; this is further highlighted by the low uptake of the NHS Staff survey, and of the 39% participation, the Trust ranked lower than average in most categories. Nonetheless, there is evidence of listening and collaboration, in efforts like the revised nursing strategy - Discussions with care groups leads (for example UEC) have identified the use of improvement frameworks; however, this process is not universal across the Trust - Board papers and committee documents do showcase an approach to management feedback and concerns raised. The Trust is on trajectory to ensure a feedback loop structure is fleshed out in detail; however, there is scope to ensure the mechanisms behind the structure are consistent and operate with clearly defined protocols



Our Recommendation

- **Embed Psychological Safety & Candid Dialogue Trust-Wide (Q1 2026):** Develop and implement a comprehensive program, including leadership training and clear guidelines, to foster psychological safety and encourage open communication without fear of retribution
- **Scale Up Care-Group Improvement Frameworks Trust-Wide (Q4 2026):** Evaluate successful care-group improvement frameworks and adapt them for Trust-wide implementation, ensuring a consistent approach to converting concerns into organisational learning and improvements
- **Formalise Board & Committee Oversight of Feedback & Concerns (Q1 2027):** Define and embed within board and committee documents a consistent mechanism for oversight and management of feedback and concerns, including standardised reporting of actions and impact
- **Please refer to KLOE 2 (Modelling positive behaviour) for further recommendations**

KLOE 3: Governance, Management & Sustainability (2/7)

KLOE Theme	Key Question	Key Findings
Governance, assurance, risk and accountability structures	Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?	- At present there were opportunities to revise and streamline governance processes, with efficiency being a key area for improvement for a number of reasons: - In terms of governance activity there were more committees at Board and Executive levels than typically observed at comparable providers, with a resultant impact on senior stakeholder workloads. In addition, this increased the risk of duplication of activities. This was compounded by a lack of development of accountability and ownership of key tasks and governance activities, with functional siloes remaining a challenge. - Discussion within governance activities also remained an opportunity for greater efficiency. At present committee meetings were paper-heavy, both in terms of volume and length of papers, hindering the ability to have sufficiently robust discussions about the subject matter. Steps were being taken to address this, such as the implementation of KPI based performance monitoring of care groups (including score cards), however integrated, consistent and cohesive performance discussions needed to be further embedded within governance practice. - As part of the revision of governance processes to accommodate this streamlining, Terms of Reference need to be refreshed as several are out of date, contributing to uncertainty around committee remits and reporting lines. - There was a shared appetite amongst leadership for simplification of governance arrangements, with interviews with senior stakeholders showing an openness to change. However, there was not a robust programme in place to drive systematic transformation and ensure that key stakeholders are held accountable for implementing these changes.



Our Recommendation

- Implement a Streamlined Governance Model (Q1 2026):** Redesign the Trust's governance structure to reduce the number of committees at Board and Executive levels, eliminate duplication of activities, and clarify accountability and ownership of key tasks. This will optimise senior leadership workloads and improve efficiency
- Revise and Update Terms of Reference (Q2 2026):** Conduct a comprehensive review and refresh of all committee Terms of Reference (ToRs) to ensure they are current, aligned with the streamlined governance model, and provide clarity on reporting lines and responsibilities, eliminating uncertainty
- Optimise Board and Committee Meeting Efficiency (Q3 2026):** Introduce and embed practices to ensure committee meetings are focused, concise, and paper-light. This includes strict agenda management, pre-reading requirements, time limits per item, and a focus on strategic discussions rather than routine updates, to enhance decision-making
- Develop and Embed a Robust Governance Transformation Programme (Q4 2026):** Create and implement a structured programme to drive the systemic transformation of governance arrangements. This programme must include clear milestones, designated leadership, and mechanisms to hold key stakeholders accountable for implementing and sustaining these changes
- Please refer to KLOE 1 (Monitoring Review and Delivery) for further recommendations**

KLOE 3: Governance, Management & Sustainability (3/7)

KLOE Theme	Key Question	Key Findings
Governance, assurance, risk and accountability structures	Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?	- There were opportunities and appetite to review the Trust's approach to risk management following discussions about issues: - Stakeholders and documentation reviews identified that risks had historically been fragmented and addressed on a siloed basis, resulting in lack of understanding of ownership, duplication of effort, and inconsistency of approach. - It was also identified that actions relating to risks were not proactively and promptly taken, leaving risks unaddressed. - Stakeholders and documentation reviews highlighted that risk culture was compliance-focussed, with limited emphasis on continuous improvement. - Our interviews and reviews of documentation indicated that the Trust was taking a number of positive steps to address these issues: - An enhanced Board Assurance Framework had been created and provided details on key risk areas, with risk scoring and relevant actions documented. However, we were not able to evidence live tracking of progress against those actions and emerging events impacting those risks, such as through a dashboard. Furthermore, emerging risks and exception reporting were not incorporated into these discussions. - The Executive Oversight Group had been tasked with tracking risk registers and following up on pending risks; however, we were not able to evidence coordination with discussion of the BAF, which may result in the risk of duplication of activities. - Stakeholders had reported that the culture is shifting towards a more proactive approach to risk management.



Our Recommendation

- Strengthen Risk Mitigation Action & Monitoring (Q2 2026):** Develop a robust system, including dashboard reporting for tracking and monitoring the prompt implementation and effectiveness of risk mitigation actions as relates to the Board Assurance Framework and risk registers. This includes regular, evidence-based reviews by relevant individuals and committees to ensure risks are being addressed in a timely and effective fashion.
- Formalise Lessons Learned Risk Culture (Q2 2026):** There is opportunity to further develop a structured and consistent, 'lessons learned' approach to risk management by ensuring the effective integration of post-incident reviews, near-miss analysis, and risk mitigation effectiveness studies into a continuous improvement cycle
- Clarify Risk Ownership, Accountability, and Escalation (Q4 2026):** Define and clearly communicate ownership and accountability for risks at all levels of the organisation. Establish clear, standardised escalation paths to ensure operational risks are promptly escalated to relevant individuals and committees and linked to Trust-wide themes
- Integrate Risk Registers with Strategic and Operational Planning (Q4 2026):** Ensure alignment between recorded risks in the new risk registers and the Trust's strategic objectives and operational plans. This involves formalising how identified risks inform resource allocation, policy development, and service changes

KLOE 3: Governance, Management & Sustainability (4/7)

KLOE Theme	Key Question	Key Findings
Governance, assurance, risk and accountability structures	When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?	Evidence suggested good practice of quality impact assessment was in place at regular intervals. However, there was opportunity to further enhance the impact of these activities by linking the findings of these assessments into the quality assurance reports
Effective decision-making	Do all levels of governance and management function effectively and interact with each other appropriately?	- Documentation suggested that current governance arrangements were reasonably clear. Deputy care group leads feed into the care group leads who report to the Board through the Deputy CEO. Based on conversations with the care group leaders and their deputies, there was a need to streamline the process of decision making and escalation to enable effective interactions between operations, the committees and the board. They felt they had similar conversations at Board as they do at Committee meetings and decision making processes (e.g. for changes or investment) were not always clear. - Documented organisation charts did outline roles and responsibilities; however, recent leadership changes and vacancies meant that there are ambiguities in current roles and accountabilities - The quality assurance document did highlight that potential risks were considered when planning for disruptions and fluctuations. The stakeholders also noted the incorporation of learnings from last year's winter plan into the Trust's operational plans. - Department leads suggested the need to improve performance reporting. Due to the limitations of the systems and unclear protocols, data is fragmented and inconsistent, often requiring a manual time-consuming exercise to ensure consistency.
	Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?	
	Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?	
	Is there transparency and openness with all stakeholders about performance?	



Our Recommendation

- **Clarify Roles, Accountabilities, and Delegated Authorities (Q1 2026):** Conduct a Trust-wide exercise to clearly define and communicate roles, responsibilities, and accountabilities at all levels, including formalising delegated authorities.
- **Formalise Risk Integration in Operational Planning (Q2 2026):** Develop and embed a standardised, mandatory process for consistently incorporating "risk into Trust's operational plans." This includes clear methodologies for identifying, assessing, mitigating, and monitoring potential risks (e.g., demand fluctuations, staffing disruptions) across all service planning.
- **Enhance Performance Reporting through Integrated Systems (Q3 2026):** Prioritise investment in and implementation of integrated data systems (e.g., Epic fully utilised for performance data) to overcome current data limitations that lead to fragmented and inconsistent performance transparency. Establish a consistent reporting framework for all stakeholders.

KLOE 3: Governance, Management & Sustainability (5/7)

KLOE Theme	Key Question	Key Findings
Continuous improvement	Are there processes to manage current and future performance? Are these regularly reviewed and improved?	Please see KLOE 1 for findings regarding performance management and monitoring arrangements.
	Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?	Documentation (Quality assurance and Board papers) showcased the leadership's understanding of performance. The Trust Board papers referred to an Integrated Performance Report. However, there was no single report that showed integrated performance at Trust level across Quality, People, Finance and Operational domains.
	In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?	Based on the Quality Assurance papers localised examples of innovation were plentiful (e.g., ESDEC, management of Sepsis), however, stakeholders had suggested greater outreach and efficient improvement would be better served by formal knowledge-sharing mechanisms
	Is there the leadership capacity and capability to delivery high quality and sustainable care?	Our interviews suggested some instances of research and accreditation existed, but at a small-scale level
	Are there standardised improvement tools and methods, and do staff have the skills to use them?	Interviews with the nursing leads suggested the presence of learning pathways and rewards/recognition as part of their new strategy, however, evidence for a Trust-wide view was not seen
	How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?	Quality report and minutes suggested structurally process' are in place to handle complaints, conduct mortality reviews, and examine incident reports
	Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?	



• Our Recommendation

- **Implement a Unified Quality Improvement (QI) Infrastructure (Q4 2025):** Establish a Trust-wide, standardised QI infrastructure and capability-building program to ensure consistent application of quality improvement methodologies across all departments, moving beyond localised efforts and supporting CQC compliance and NSOF 4 exit criteria
- **Formalise Knowledge-Sharing and Innovation (Q1 2026):** Develop and implement formal mechanisms (e.g., dedicated platforms, regular forums, structured processes) to capture, disseminate, and scale localised examples of innovation and best practice (like ESDC) across the entire Trust, maximising their outreach and impact
- **Embed Learning Pathways and Recognition Trust-Wide (Q2 2026):** Integrate embedded learning pathways, rewards, and recognition systems for continuous improvement and innovation into the overarching Trust strategy revamp, drawing lessons from successful departmental initiatives like those in nursing
- **Standardise Complaint and Incident Management (Q3 2026):** There is opportunity to review the existing complaint handling, and incident management processes to help refine and standardise. Furthermore, incorporating the use of digital platforms (EPR) will assist in mitigating the large staff workload and data quality issues

KLOE 3: Governance, Management & Sustainability (6/7)

KLOE Theme	Key Question	Key Findings
Robust data and systems	Are there clear and robust service performance measures, which are reported and monitored?	Please see 'Monitoring and Review of Delivery' for findings and recommendations concerning issues regarding effectiveness of performance arrangements.
	Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?	Stakeholders further indicated that although large volumes of data were available, there were limitations to the extent that this was robustly analysed and consolidated to facilitate effective monitoring of performance. Furthermore, data sets are not sufficiently centrally collated across different teams and delivery units, further hindering ability of management to have a consolidated and consistent view of this data and take timely and effective action. Although the implementation of Epic (EPR) will consolidate patient data, there are still further opportunities to create more unified data.
	Are information technology systems used effectively to monitor and improve the quality of care?	Stakeholders noted in interviews that they felt confident regarding Trust data security; furthermore Information Governance, Cyber and IT Security are all included as topics on the Internal Audit plan annually through to 2027-28.
	Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?	
Partnership arrangements	Does the Trust take steps to ensure that partnerships are supported by agreed documented arrangements?	Evidence to showcase documented working arrangements was not found. Interviews suggested partnership engagement was largely informal. Although, under the new leadership documented norms have begun to be established



Our Recommendation

- **Standardise Performance Reporting and Monitoring (Q4 2025):** Implement a unified, Trust-wide framework for performance metric monitoring and reporting, ensuring consistency in data presentation and analysis across care groups, teams, and HR. This will enhance committee trust in reported information
- **Accelerate Epic Implementation for Data Quality & Efficiency (Q1 2026):** Prioritise and expedite the full implementation of Epic (EPR) to resolve clinical inconsistencies in data accuracy and monitoring, thereby reducing time-consuming manual verification processes and enhancing the ability to assess quality impacts of efficiency changes. Prepare for the interim period when the EPIC implementation will create disruption
- **Develop Formalised Data Breach Management Protocols (Q2 2026):** Synchronise existing departmental data breach mechanisms into a formal, Trust-level protocol. This includes clear escalation paths, responsibilities, and communication strategies for responding to, investigating, and learning from data security incidents, drawing lessons from events like the NHS data leak
- **Integrate Technology Investment into Strategic Planning (Q3 2026):** Embed a dedicated process within the strategic review to systematically evaluate and allocate resources for technology investments that directly support improved quality of care, efficiency, and sustainability, ensuring technology acts as an enabler rather than an after thought
- **Formalise Partnership Governance and Documentation (Q4 2026):** Translate improved partnership engagement into agreed and documented working arrangements and consistent governance documentation. This includes establishing formal MOUs or partnership agreements, defining joint decision-making processes, and ensuring clear communication protocols with regional bodies and others

KLOE 3: Governance, Management & Sustainability (7/7)

KLOE Theme	Key Question	Key Findings
Clinical and internal audit	Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved? Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?	- Overarching structure for monitoring as evidenced through stakeholder interviews was clear and simple; where the deputy CEO monitored the performance of the Care Groups/departments and within the Care Groups/departments, leads and deputy leads monitored their different teams and team specific KPIs - There was evidence of multiple national clinical audits being completed for the Trust. Furthermore, there was evidence to suggest the Trust had taken the areas of improvement and translated them into KPIs to measure against specific departments, which ultimately were reviewed and tracked by the quality committee - There was a robustly developed internal audit function delivered by an outsourced supplier. A comprehensive internal audit plan and strategy had been developed through to 2028, and Internal Audit activities were discussed in both Audit and Risk Committee and the main Board. Progress against internal audit recommendations was tracked, although tracking of this could be enhanced through a reporting dashboard.
Emergency preparedness	What arrangements are in place for continuity of provision of care and recovery in the event of an emergency, disaster or other disruption?	- A winter resilience plan was in place, aligned with the One Plan – but not underpinned by a broader emergency preparedness strategy - Stakeholders and quality papers mentioned workforce fragility as a significant risk, with limited staffing resilience and surge capacity across departments - Departmental escalation protocols exist but would benefit from being formalised at a Trust level - The Internal Audit plans for 2024-5 and 2025-6 both included an Emergency Preparedness, Resilience and Response (EPRR) audit; it is important that the Trust learn from the outputs of these audit activities and implement actions on a timely basis - While the clinical and operational leadership had an agile approach, and interviewees referenced a “crisis response culture,” there an opportunity to formalise it into strategy as a standard emergency response governance framework



Our Recommendation

- Establish a Robust, Integrated EPRR Governance Framework (Q4 2025):** Implement a formal, Trust-wide emergency response governance structure and testing framework, integrating existing agile approaches into a standardised, documented strategy
- Develop and Formalise Trust-Level Escalation Protocols (Q1 2026):** Consolidate existing departmental escalation protocols into a unified, Trust-level document, ensuring clear, consistent, and well-understood procedures for all incidents
- Enhance Workforce Resilience and Surge Capacity (Q2 2026):** Implement a comprehensive strategy to address workforce fragility, focusing on cross-training, flexible staffing models, and surge capacity planning across all departments
- Implement Joint Emergency Plans with System Partners (Q3 2026):** Develop and clearly document joint emergency plans with system partners, ensuring seamless coordination and shared understanding for multi-agency responses
- Leverage Epic for Enhanced Data Continuity & Clinical Performance Monitoring (Q1 2026):** Fully utilise the Epic implementation to improve data quality and consistency, ensure information continuity during crises, and enhance clinical performance monitoring

KLOE 4: Partnership and communities (1/3)

KLOE Theme	Key Question	Key Findings
Meaningful collaboration to improve services and address challenges	Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?	There was evidence to suggest patient views were considered. Patient stories were also a standing agenda item at board meetings. This indicates that there are opportunities to reflect on the perspectives of patients during the development and selection of strategic options
	Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture, does this include those with a protected equality characteristic	There was some evidence of engagement with protected groups through the nursing strategy and local council, however there is benefit from creating a detailed engagement guide for protected groups in planning or service design
	Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?	At departmental level there was evidence (nursing strategy) of co-production with people who use and provide the service. The Trust could benefit from a more uniform approach and strategy embedded in its new governance framework
	Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?	- Staff feedback mechanisms were in place. Their implementation and processes could be refined to ensure the pathway was not fragmented and accessible to all groups, including those with protected characteristics - The Trust under the new leadership had taken measures to re-engage with external system partners. That said building collaborative planning protocols will further decrease inconsistencies and create formal approaches to collaboration through governance structures (e.g. through joint or committees in common).



Our Recommendation

- **Service Delivery Review:** Generate options for future service delivery models based on local demand and capacity analysis and performance imperatives that need to be addressed with partners (e.g. Maternity and Social Care)
- **Develop and Embed a Unified, Inclusive Engagement and Communication Framework**
Design and implement a Trust-wide framework that brings together structured engagement with patients, staff, underrepresented groups, and system partners. Embed inclusive protocols to ensure individuals with protected characteristics are actively involved in all service planning, design, and evaluation. Standardise tools and feedback loops so insights inform board-level decisions and service improvements. Formalise partnership arrangements through Memoranda of Understanding and service-level agreements, clarifying shared responsibilities and joint accountability. Establish a clear communication plan to demonstrate leadership's commitment to transparency and collaboration, supported by executive leadership, a cross-functional steering group, and targeted training for consistent and high-quality delivery across the organisation.
- **Formalise External Partnership Governance:** Design and implement formal protocols and governance structures for all key external system partnerships, defining shared objectives and decision-making processes
- **Please refer to KLOE 4 (Building relationships) for further recommendations**

KLOE 4: Partnership and communities (2/3)

KLOE Theme	Key Question	Key Findings
Building relationships	How does the Trust engage with the wider community and key external stakeholders to develop effective working relationships?	- As per discussions with committee leaders, relationships with community and other external stakeholders were developing and in some cases had been strained recently (e.g. in the implementation of new cardiology service pathways); however, the new CEO, assisted by the members of the Board, was seeking to reset relationships and drive the Trust's requirements for greater clarity through them - Engagement with external stakeholders such as NHS England and system partners was improving. However, there was an opportunity to clearly define approaches to more formal engagement, options development and evidence-based decision making
Shared planning and decision-making	Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?	- No evidence found for the Trust not submitting returns. Nonetheless as discovered through documentation and discussions, there are underlying data quality issues that need to be addressed - No single function is accountable for data generation of data leaving the Trust - There was evidence suggesting participation in certain benchmarking schemes (e.g. Maternity Care), however, such schemes were not fully embedded across all the services and the processes behind them were different, with ownership lying with the department/care group



Our Recommendation

- Please refer to KLOE 4 (Meaningful collaboration to improve services and address challenges) for further recommendations regarding building relationships
- **Standardise Data Submission:** Integrate standardised data submission protocols and reporting requirements into the Trust's operational strategy by Q1 2026, including clear guidelines, timelines, and designated ownership for all external data submissions. The role of the board members should be defined as a part of this process
- Please refer to KLOE 3 (Robust Data) for recommendation regarding data integration
- Please refer to KLOE 1 (Local and National Context / Alignment) for recommendation regarding benchmarking

KLOE 4: Partnership and communities (3/3)

KLOE Theme	Key Question	Key Findings
Stakeholder engagement and feedback	Is the culture centred on the needs and experience of people who use services?	- The One strategy, quality papers, and interviews with care-group/departmental leads suggested that on paper the Trust was focused on managing people's needs and has various processes in place to do it (QR code feedback.) There seems to be considerable departmental autonomy to run initiatives to cater for patients, for example the process Maternity care took to ensure views of staff, patients, potential patients were documented, discussed while developing the new maternity care strategy. However, a documented Trust-wide approach was not evidenced. - Based on interviews with care-group leads and nursing leads, engagement with individuals from diverse backgrounds, including those with protected characteristics, did take place at a departmental level ensuring an inclusive environment. - NHS staff survey and service user input (QR code) is evidenced and discussed during quality and board meetings. However, the extent to which this is reflective of staff sentiment was impacted by the fact that there was a low uptake rate (39%) of the survey. - Stakeholders had indicated that their viewpoints are not consistently considered at the senior Trust level (an issue that was reported in the 2024 National Staff Survey). This had been reported as an issue in recent People Committee activities. This has therefore created an opportunity for improved communication and representation, promoting a more collaborative leadership approach.
Governance and management of partnerships	Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?	Collaborative efforts existed, but they often relied on individual relationships rather than standardised protocols or agreements, indicating an opportunity to develop these protocols, strengthening partnerships and enhancing service integration. Furthermore, a large turnover at a board level means there is an opportunity to reset relationships with system partners including the council



Our Recommendation

- **Please refer to KLOE 4 (Building Relationship) for further recommendations**
- **Standardise collaboration protocols:** Although processes are in place, but further focus on joint working protocols and shared care pathways will reduce reliance on informal relationships and embed consistency a cross-partner interfaces
- **Make inclusive culture a leadership priority:** Set clear expectations and KPIs for inclusive engagement and responsiveness to be discussed in quality committees and board, holding leaders accountable for driving improvements in reach, Trust, and impact of engagement

Appendix:

Examples of best practice

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Example 1: Effective Reporting to Committees & Board

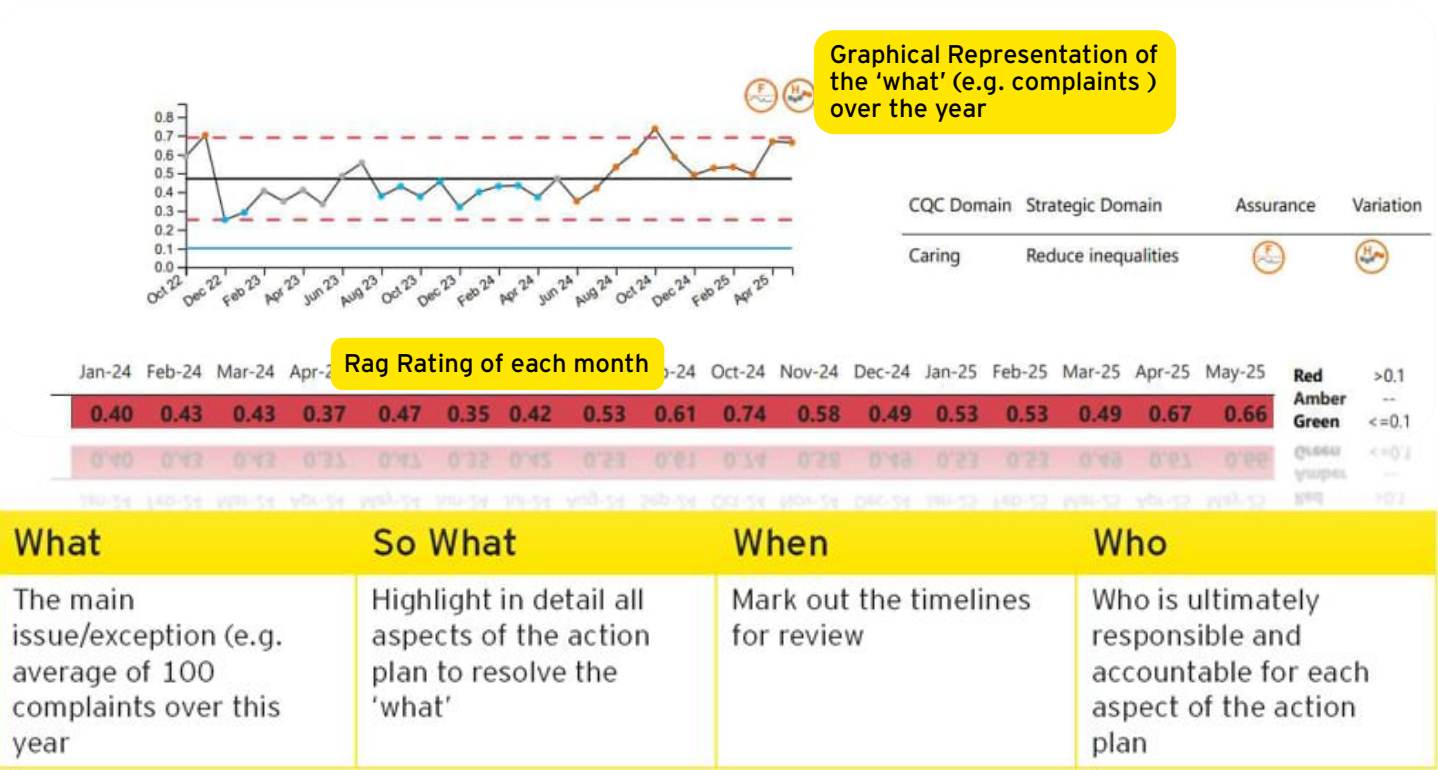
Purpose: To provide clear, concise, and action-oriented insights that enable robust oversight, strategic decision-making, and assurance on Trust performance

Strategic Alignment and Clarity	Action-Oriented Categorisation (Alert, Advise, Assure Framework):	Data-Driven Insights with Context	Concise Assurance Summaries	Implications and Recommendations
• Reports explicitly link performance metrics to the Trust's overarching strategic objectives and core quality domains (e.g., Safe, Caring, Effective, Responsive, Well-Led). • The purpose of each report is clearly stated at the outset (e.g., For Information, For Assurance, For Discussion, To Approve), guiding the audience on the expected engagement.	• Used for metrics showing concerning variation, such as consistently falling below or rising above targets, or exhibiting erratic trends. These require Investigation and Urgent Action. • Advise: Applied to metrics that are currently failing the standard but showing improvement, or those passing but beginning to deteriorate, or not consistently hitting the target. These require Investigation and Action. • Assure: Designates metrics that are performing well, consistently passing, or showing sustained improvement. These instances warrant Celebration and Learning to understand and replicate success.	• Reports utilise visual tools, such as Statistical Process Control (SPC) charts, to illustrate performance trends over time, identify unusual patterns (special cause variation), and show performance against established control limits, not just static targets. • An "Executive Summary" is included to provide a high-level overview, highlighting key successes, ongoing challenges, and any significant exceptions requiring attention. • For any exceptions or areas of concern, a structured "What, So What, When, Who" breakdown is provided, detailing the issue, its implications, the timeline for resolution, and the individuals or teams responsible for action.	• Committee Chair's Assurance Reports are structured using a "TO ESCALATE," "TO ADVISE," and "TO ASSURE" format, offering clear, brief bullet points to direct the Board's attention to critical issues, areas needing awareness, and areas providing confidence, respectively. • Any new risks, significant developments in existing risks, or items requiring referral to other committees are clearly identified for appropriate onward action.	• Reports explicitly outline the potential implications of the findings across various critical domains, including Patient Safety, Financial impact, Risk exposure, Legal/Regulatory compliance, Reputational standing, and Equality considerations. • Clear decisions or specific recommendations are provided for the Board's consideration (e.g., "To note," "To approve," "To discuss"), ensuring a direct path from insight to action.

Clear Ownership & Presentation: Ensure each key point or recommendation within the report clearly identifies the responsible owner and, where applicable, the presenter, ensuring accountability and direct communication.



Example 2: Exception Reporting



- Highlighting exception issues when reporting in the format described, will showcase clearly the issues, the resolution and the thought process behind it
- This reporting format allows for tagging of staff who is responsible and accountable for each aspect of the resolution
- Monitoring cadence can be cleared marked clearly for review cycles

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Board of Directors

Committee Chairs' Report

Date of meeting	Date report produced
24 September 2025	19 September 2025

Author(s)		Report approved by	
Name and title:	Sophie Byrne PA to Chairman	Name and title:	Emily Long Director of Corporate Governance and Trust Secretary
Phone:		Date:	
Email:			

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
n/a

Executive summary
The attached report provides the Board with a summary of the discussions held at Board sub-committees in the reporting period. The reports received and assurance position is also noted and has been collated to provide an overarching assurance recommendation (being Limited, Satisfactory or Significant) for the Board to receive. Minutes of the meetings can be found within the Diligent online library: Diligent Boards: South Devon Health Information Services: Resource Center

Appendices
Committee Chairs' Report

Committees that have previously discussed/agreed the report, and outcomes of that discussion

N/a

Key recommendations and actions requested

The Board is asked to note the Committee Chairs' report and AGREE the recommended assurance recommendations.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

In providing the Board with a high-level report of the activities of the Committees that have met in the reporting period, it gives the Board with opportunity to consider if any action needs to be taken to support any areas of concern that might impact on its population.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Yes
Quality of services provided	Yes
Sustainable and efficient use of resources	Yes

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	All
People	
Financial Sustainability and Productivity	
Estates	
Operations and Performance Standards	
Digital and Cyber Resilience	
Building a Brighter Future	
Strategy and Transformation	
Sustainability: Green Plan/ Environmental	
Equality, Diversity and Inclusion	

Provision of Community and Care
Services Delivered in Partnership

Risk: Risk ID (as appropriate)	
Risk	Risk ID
N/a	

External Standards affected by this report and associated risks
Terms of authorisation, NHS England licence and regulations National policy, guidance

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Committee Chairs' Report

Audit and Risk Committee – 23 July 2025

REPORTS RECEIVED BY COMMITTEE & ASSURANCE RATING:

The Board are asked to note that the following reports were received by the Committee, in addition the standing items (including BAF/RISK)

- Board Assurance Framework - satisfactory
- Treasury Report Social Care Aged Debt and Write Off Position Q1 - satisfactory
- IA Recommendations (Core Financial Systems) Update - satisfactory
- Losses and Special Payments Register - satisfactory
- Waiver of Competition Report - limited

- Cyber Assurance Update – satisfactory/significant
- Head and Neck Portacabin Road Traffic Collision Update - satisfactory
- Protocol of the Use of DoLs in ED - satisfactory
- Committee Annual Report - satisfactory
- ASW Assurance Interim Report - na
- Counter Fraud Interim Report - na
- Counter Fraud Annual Report – na

ASSURANCE RECOMENDATION:

The Board are asked to AGREE the recommended assurance rating and TAKE SATISFACTORY ASSURANCE as to those matters reviewed by the Committee; NOTING the following risks, mitigations, actions and successes:

ALERT: Alert to matters that need the Board's attention or action (Such as safety/finance risks, areas of non-compliance, gaps in control, or matters referred to other Committees)

General theme as to limited resource/capacity is delaying matters or preventing issues being address promptly (esp Procurement, Governance (IG, BAF, etc) and {more future focused} IT/Cyber).

BAF development continues with general agreement as to revised/updated approach but considerable work remains.

Internal Audit plan for 25/26 subject to change and significant additional requests from exec which will require further work and prioritisation.

Particular concern about the number of overdue outstanding internal audit recommendations.

ADVISE: Advise the Board of where assurance is absent or limited and this is being reviewed

Limited assurance on recoverability of ASC debts, although new resource will be focused in this area, and urgently addressing the number of competition waivers (see below)

ASSURE: Inform the Board where positive assurance has been received

Good progress on EPRR and action plan arising from Portacabin vehicle incident.

Good update from Josh on Cyber with satisfactory/significant assurance in most places apart from Cyber workforce training and back up/recovery (with some cross over re IG training/lack of resource). Issue re senior IT resources both in TSD and region.

RISK: Advise the Board which risks were discussed and any new risks identified

Risks are still higher in contract management and procurement highlighted by number of waivers of competition reports, particularly in respect of high cost care packages, with limited assurance being given here.. It is unsure how the procurement centralisation due shortly will improve on this (esp. noting contract management is not part of this arrangement). This conflicts with the need to reduce overspending.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding

Reports for the pack were of much improved quality in being focused and shorter, esp the DoLS protocol
Better coordination between the committee to minimise duplication.
Good compliance with Counter Fraud regulation, including incoming organisational focused legislation.

Committee Chairs' Report

Finance and Performance Committee – 28 July 2025

REPORTS RECEIVED BY COMMITTEE & ASSURANCE RATING:

The Board are asked to note that the following reports were received by the Committee, in addition the standing items (including BAF):

- Patient Transport Service Business Case - Limited
- Month 3 Financial Report - Satisfactory
- CIP Progress Report – Limited

- Conformance to response to spend controls feedback - Limited
- PIR's Review Programme - Satisfactory
- IPQR – Limited/Satisfactory
- Care Group Delivery – Families and Community And Home - Satisfactory

ASSURANCE RECOMENDATION:

The Board are asked to AGREE the recommended assurance rating and TAKE [LIMITED- SATISFACTORY – SIGNIFICANT] ASSURANCE as to those matters reviewed by the Finance and Performance Committee; NOTING the following risks, mitigations, actions and successes:

ALERT: Alert to matters that need the Board's attention or action (Such as safety/finance risks, areas of non-compliance, gaps in control, or matters referred to other Committees)

Patient Transport Service – Fleet Replacement – recommendation to proceed to tender (5-year lease) – seeking innovative solutions. FPC to have the opportunity to review the results of the tender. Ensuring expert advice from the One Devon Procurement Team (Claire Buy). Important that we align with the wider System in future tendering of the PTS and to explore further efficiency opportunities. Virtual wards – we need some clarity on our strategy for virtual wards as we are getting conflicting messages. We would like to see this set out as a full programme in line with our approach to Neighbourhood Care as per the 10 year plan.

ADVISE: Advise the Board of where assurance is absent or limited and this is being reviewed

Workforce Plan Assurance is Absent– Further granular detail in relation to the Workforce Plan is required that contains the clear action plans and phasing of the CIP being released/officers responsible – Deep dive into the Workforce Plan to be undertaken at the August FPC led by the interim CPO.

ASSURE: Inform the Board where positive assurance has been received

The post implementation review of the Day Case Theatres investment.

RISK: Advise the Board which risks were discussed and any new risks identified - risks that impact on other Board Sub-Committees to be identified

Securing 2025/26 deficit support – this is a payment made at System level that is informed by the in-year delivery (YTD) and confidence of delivery for the remaining quarters – this is reliant on the performance of all Devon Providers – not just TSD.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding

Committee Chairs' Report

Finance and Performance Committee – 20 August 2025

REPORTS RECEIVED BY COMMITTEE & ASSURANCE RATING:

The Board are asked to note that the following reports were received by the Committee, in addition the standing items (including BAF):

- Board Assurance Framework – Satisfactory
- Month 4 Finance Report - Satisfactory
- Annual Planning 2026/27 - Satisfactory
- Service Line Reporting Progress Update - Satisfactory
- PIR – Endoscopy Expansion Business Case – Satisfactory
- IPQR – Limited/Satisfactory

- Our Plan for Better Care – Workforce Plan Deep Dive - Satisfactory
- CIP Progress Report - Limited
- Care Group Delivery – Surgical - Satisfactory
- Money Transmission MoU - Satisfactory

ASSURANCE RECOMMENDATION:

The Board are asked to AGREE the recommended assurance rating and TAKE [LIMITED- SATISFACTORY – SIGNIFICANT] ASSURANCE as to those matters reviewed by the Finance and Performance Committee; NOTING the following risks, mitigations, actions and successes:

ALERT: Alert to matters that need the Board's attention or action (Such as safety/finance risks, areas of non-compliance, gaps in control, or matters referred to other Committees)

Identified risk to delivery of cost improvement plans needs addressed following the re-forecast in month 5 including an assessment of risks and mitigations to ensure overall delivery of the financial plan for 2025/26
Concerns raised that papers were getting the appropriate oversight at Executive Oversight Group and concise reports were being received by the Committee

ADVISE: Advise the Board of where assurance is absent or limited and this is being reviewed

Limited assurance across CIP, Financial Risks and Workforce and a review of the forecast as month 4 is being undertaken during month 5 to provide assurance on the forecast, identification of risks and mitigations to ensure delivery of the financial plan.

ASSURE: Inform the Board where positive assurance has been received

Our Plan for Better Care – Workforce Plan Deep Dive received providing assurance on actions being taken to reduce workforce costs in year whilst maintaining safety of services.
Deep Dive undertaken on Surgery noting performance on referral to treatment times, 65 week waits and work being undertaken on diagnostics and cancer standards
Post Implementation review received on the Endoscopy Expansion business case
Risk to deficit support funding and reliance on system delivery (rather than the Trust)

RISK: Advise the Board which risks were discussed and any new risks identified - risks that impact on other Board Sub-Committees to be identified

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding

Improvement in quality of Finance and Workforce data was noted whilst recognising that there was more to be done.

Committee Chairs' Report

Quality Assurance Committee – 15 September 2025

REPORTS RECEIVED BY COMMITTEE & ASSURANCE RATING:

The Board are asked to note that the following reports were received by the Committee, in addition the standing items (including BAF):

The Board are asked to note that the following reports were received by the QAC, in addition the standing items (including BAF/RISK)

- Quality Report for Healthcare – Limited/Satisfactory
- Adult Social Care Report – Limited/Satisfactory
- CQC Action Plan Update – Limited/Satisfactory
- Perinatal Governance and Safety Report (1 June 2025 – 31 August 2025) - Satisfactory
- Maternity and Neonatal Staffing Report (1 January 2025 – 30 June 2025) - Satisfactory
- Update on Martha's Rule implementation – Limited/Satisfactory

- Report on EQIA process and outcomes to date - Satisfactory
- Mortuary Annual Report 2025 – Limited/Satisfactory/Significant
- Safeguarding Children Annual Report – Limited/Satisfactory
- CQC Registration - Satisfactory

ASSURANCE RECOMMENDATION:

The Board are asked to AGREE the recommended assurance rating and TAKE [LIMITED- SATISFACTORY – SIGNIFICANT] ASSURANCE as to those matters reviewed by the Finance and Performance Committee; NOTING the following risks, mitigations, actions and successes:

ALERT: Alert to matters that need the Board's attention or action (Such as safety/finance risks, areas of non-compliance, gaps in control, or matters referred to other Committees)

Martha's rule is working effectively on our inpatient wards. It was not implemented within the ED, however it became known to QAC that some patients who were significantly unwell were being held in the resuscitation section of ED as there was no HDU environment to transfer them to. This could be relevant to our 12 hour ED wait performance. They are either stabilised and then transferred to ward or transferred to ICU if deteriorating. It would seem appropriate firstly, for the Board to consider requesting a BC for a 4 bedded HDU facility and secondly consider extending Martha's rule to the resuscitation section of ED with posters etc.

ADVISE: Advise the Board of where assurance is absent or limited and this is being reviewed

QAC received it's first Annual Mortuary report which was of good quality but did raise some areas where assurance was limited. We have legal obligations under the 2004 Human Tissue act to ensure safe and effective storage of deceased patients. In addition following the Fuller Inquiry reports additional standards have been set. One red area of concern is the absence of a swipe to exit card system to determine how long and individual has spent in the mortuary. Another red area is ensuring in safeguarding mandatory training that the security and dignity of deceased people is included and that this should sit in the portfolio of the CNO.

ASSURE: Inform the Board where positive assurance has been received

The implementation of Martha's rule in TSDFT went live in December 2024. up to end of August 23 calls received and none resulted in missed critical illness requiring transfer to ICU. There is satisfactory assurance this new service is working as planned but importantly our current processes for escalating sick and deteriorating patients seems to be working effectively.

RISK: Advise the Board which risks were discussed and any new risks identified - risks that impact on other Board Sub-Committees to be identified

Concern was raised around the impact of reducing non-clinical staff who may have an impact on clinical efficiency. The example given was administrative staff supporting consultants.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding

All serious incident reports are now complete from a significant backlog a year ago.

Committee Chairs' Report

People Committee – 18 August 2025

REPORTS RECEIVED BY COMMITTEE & ASSURANCE RATING:

The Board are asked to note that the following reports were received by the Committee, in addition the standing items (including BAF/RISK)

- Board assurance framework - satisfactory
- Our plan for better care – people programme culture plan - satisfactory
- WRES/WDES action plans 2025/26 - satisfactory
- Our plan for better care people programme – delivering the workforce plan report – Limited/Satisfactory

- Report of the guardian of safe working hours – limited/satisfactory
- Guardian of safe working hours annual report – limited/satisfactory
- People Performance Report - satisfactory
- Committee self-assessment - satisfactory
- Internal audit reports consultant and SAS additional payments- limited

ASSURANCE RECOMENDATION:

The Board are asked to AGREE the recommended assurance rating and TAKE LIMITED/SATISFACTORY/SIGNIFICANT ASSURANCE as to those matters reviewed by the People Committee; NOTING the following risks, mitigations, actions and successes:

ALERT: Alert to matters that need the Board's attention or action (Such as safety/finance risks, areas of non-compliance, gaps in control, or matters referred to other Committees)

There is still work to be undertaken to achieve alignment of staff data between People Services and Finance. This work is planned but not yet complete

ADVISE: Advise the Board of where assurance is absent or limited and this is being reviewed

. Four reports as highlighted above had limited assurance though Committee felt that there has been significant progress, though at this stage, full satisfactory assurance could not be given, despite satisfactory progress in some areas

ASSURE: Inform the Board where positive assurance has been received

People Committee now receives a 'Staff Story' Of significance at this committee was an example of delivering an app within Orthopaedics to improve patient preparation for surgery, experience and recovery. The 2 staff members evidenced significant and positive actions which they had undertaken to be inclusive and involving of all their colleagues to deliver this Digital app

RISK: Advise the Board which risks were discussed and any new risks identified

Concerns were expressed that whilst necessary recruitment limitations were being implemented, there was sometimes a resultant overspend because of using overtime to cover gaps in service

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding

The Committee celebrated the actions of the two individuals who presented their 'staff story' and how as 'People Promise' Ambassadors, they had delivered significant improvements in patient quality service and evidenced support and inclusion of colleagues. The Interim CPO has led significant change to achieve current progress.

Committee Chairs' Report

Building a Brighter Future Committee – 21 August 2025

REPORTS RECEIVED BY COMMITTEE & ASSURANCE RATING:

The Board are asked to note that the following reports were received, in addition the standing items (including BAF/RISK)

- Board assurance framework - satisfactory
- Digital update – significant
- EPR progress report – significant
- Acceleration of digital innovation – satisfactory
- Surgical admissions relocation short form business case satisfactory
- Ophthalmology lanes short form business case – satisfactory
- Maxillo-facial service expansion and remodelling business case satisfactory

- Day surgery theatre and eye replacement of air handling – satisfactory
- NHP close report – satisfactory
- Estates capital highlight report – satisfactory
- Estates Infrastructure update – satisfactory
- Green plan refresh – satisfactory
- Committee self assessment feedback template – satisfactory
- Cyber security vulnerability (patch) management and change management IA report – limited
- IG requests and status report - satisfactory

ASSURANCE RECOMENDATION:

The Board are asked to AGREE the recommended assurance rating and TAKE LIMITED/SATISFACTORY ASSURANCE as to those matters reviewed by [COMMITTEE]; NOTING the following risks, mitigations, actions and successes:

ALERT: Alert to matters that need the Board's attention or action (Such as safety/finance risks, areas of non-compliance, gaps in control, or matters referred to other Committees)

- Remedial & improvement works continue to mitigate health & safety risks with the Tower including meeting fire regulations. Fire Services are being engaged for advice ahead of the next formal fire service inspection. Non compliance with fire regulations and associated risks continue despite works. Despite increased scrutiny & plan of works, this continues to be a high profile significant risk in the event of an incident
- Limited IT leadership across the Trust with no substantial progress in appointment of One Devon CIO, interim leadership at TSD with retirement of long-standing Head of IT & lack of clarity on future cyber security management – collectively & along with planned strategic system changes point to a growing risk with IT leadership

ADVISE: Advise the Board of where assurance is absent or limited and this is being reviewed

- Short form business cases reviewed (in advance of seeking full Board approval) for building works – Surgical Admissions Relocation, Ophthalmology Lanes, MaxFax Service Expansion, Day Surgery & Eye replacement of air handling – funded through Return to Constitutional Standards funding. Challenge & questions raised on the business cases in terms of overall strategic alignment 'fit' & depth/strength of financial analysis (benefits) as each case is built more around availability of source of funding.

ASSURE: Inform the Board where positive assurance has been received

- Notwithstanding the fragility of estates & ongoing maintenance works, greater clarity received on actions to manage current major risks/issues
- Informative & comprehensive update to the Green Plan received with constructive discussion on using this to support the unique features of TSD & rolling the action plan out throughout the organisation

RISK: Advise the Board which risks were discussed and any new risks identified

- Early sight of EPR business readiness approach & early benefits realisation provides update on structure & approach, although lacking in insight & understanding of delivery; will continue to monitor as programme progresses
- ED rebuild 14 weeks behind schedule & now due for completion in winter; assurance taken that potential operational impact with associated winter pressures has been explored with operational/clinical leaders
- Verbal update on progress with plans to relocate Medical Records & mitigate H&S risks

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding

- Informative & positive update on Digital Innovation programme to accelerate building innovation skills & roll-out of digital capabilities including partnerships with universities & wider visibility (inc Downing Street)

Committee Chairs' Report

Charity Committee – 10 September 2025

REPORTS RECEIVED BY COMMITTEE & ASSURANCE RATING:

The Corporate Trustee is asked to note that the following reports were received by the Committee, in addition the standing items (including BAF/RISK):

- Draft Charity Impact Report - Satisfactory
- Fundraising Report - Satisfactory
- Fundraising Operational Group Update - Satisfactory

- Financial Report – to include legacies and fund balances - Satisfactory
- Annual Report and Accounts Update - Satisfactory
- Committee Self-Assessment - Satisfactory
- Draft Charity Risk Register - Satisfactory

ASSURANCE RECOMENDATION:

The Corporate Trustee is asked to AGREE the recommended assurance rating and TAKE SATISFACTORY ASSURANCE as to those matters reviewed by the Charity Committee; NOTING the following risks, mitigations, actions and successes:

ALERT: Alert to matters that need the Corporate Trustee's attention or action (Such as safety/finance risks, areas of non-compliance, gaps in control, or matters referred to other Committees)

The Corporate Trustee is asked to note the following 2 items:

- Successful recruitment of a part-time experienced Finance Manager (start date September).
- In light of the decision to cease using charitable funding for staff Christmas parties and socials from January 2026 (in line with the charity's objects), the committee has asked the Trust's Governance office to clarify how monies given to staff teams specifically for parties/socials should be treated and accounted for.

ADVISE: Advise the Corporate Trustee of where assurance is absent or limited and this is being reviewed

ASSURE: Inform the Corporate Trustee where positive assurance has been received

The committee was assured that:

- appropriate financial controls are in place and that the financial position of the Charity is low risk.
- the charity is supporting a wide range of charitable endeavours that reflect the Trust's footprint.
- the 5-year fundraising strategy is on track with year 2 funds (raised at month 4) ahead of previous year.

RISK: Advise the Corporate Trustee which risks were discussed and any new risks identified

Funds restructuring: the Charity will shortly commence work on a draft plan to re-structure and reduce the number of funds it manages. There is recognition that alongside the necessary legal and financial requirements, it is imperative that fund managers are actively engaged and involved in this change.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Committee considers to be outstanding

The Corporate Trustee is asked to note the following items:

- Impact stories: 1. Funded by the Charity - Ashburton Health and Wellbeing Centre art installation at the entrance to provide a welcoming space and support a local artist's first commission - [Ashburton Art - Amy Whittingham Interview on Vimeo](#). 2. Grant secured by the Charity from Torbay Council – promotion of the Trust's Early Pregnancy Smoke Free Service through marketing materials and a social media campaign <https://youtu.be/2pkx7lsqik8>

Trust Board

25/26 Winter Plan

Date of meeting	Date report produced
24 th September 2025	10 th September 2026

Author(s)		Report approved by	
Name and title:	Sam Wadham-Sharpe, Director of Operations	Name and title:	
Phone:	07951 454058	Date:	
Email:	s.wadham-sharpe@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary

This paper outlines the approach to the development and operationalisation of the 2025/2026 winter plan for the Torbay and South Devon NHS Foundation Trust.

This year, NHS England published the Urgent and Emergency Care Recovery Plan in June, underpinned by an extensive programme of work to deliver improvements across urgent and emergency care ahead of winter. The plan outlines the 7 priorities by which systems and Trusts will be measured and that will have the largest impact on UEC improvement over this winter.

To support the creation of the Torbay and South Devon NHS Foundation Trust Winter Plan for 25/26, a winter planning group has been convened consisting of medical, nursing and operational leads from each of the care groups, in addition to leads from key corporate and non-clinical areas of the Trust. This group has been chaired by the Director of Operational Recovery and has ensured a clear locally held plan is created to respond to each of the key criteria, created by the staff who will enact the plan. The group has also enabled effective check and challenge of plans, identified potential areas of conflict or risk between plans, and enabled effective idea generation from across the Trust.

The requirement to obtain Board sign off for the winter plan by the end of August has required the working group to work at pace to understand the challenges that need addressing and to develop the plans for executive and board members to consider. The requirement to meet the August deadline has meant that the detailed data on flu and respiratory illness monitoring has not been available at the

beginning of this process. As such, the working group made the decision to review internal and Integrated Care Board (ICB) held data relating to last winter to inform decision making, with an understanding that the plans will focus on the correct challenges with a need to be flexible on scaling and timeframes once the modelling data was available. The table below describes the timeline worked towards from commencement of process to board sign off and adoption.

One of the main requirements of a winter plan is to ensure a clear plan is made to manage the expected increases in non-elective demand, particularly due to flu and respiratory related conditions. This winter plan has focussed on these key areas but is also designed to provide key management actions and assurance on other key issues expected through winter such as staff wellbeing, trauma management, staff and patient vaccination programmes, safety of the estate. This winter plan is therefore designed to be a full trust response to a wide range of winter challenges.

At the beginning of the winter plan process the key objectives for the Trust to safely manage winter were identified and defined by the winter planning team and agreed with executives.

Objective 1 - Deliver the requirements of the NHSE Urgent Emergency Care (UEC) Plan

Objective 2 - Identify local challenges and risks for winter and develop mitigation plans

Objective 3 - Develop strategies to manage expected winter demand, ensuring patient waiting times, outcomes and experience are maintained

Objective 4 - Maintain delivery of our 25/26 operating plan, including elective services, financial and productivity delivery

Objective 5 - Keep our staff well and motivated, including a robust staff vaccination and communication schemes

Objective 6 - Ensure all of our estate remains safe and accessible at all times including community estate

Objective 7 - Develop plans to deal effectively with any demand surge or other issues through effective site management, on call arrangements and contingency plans

This plan has been developed to ensure a clear response to each of these objectives ahead of winter and to understand the requirements to input interventions to ensure winter is managed safely and to limit the impact on delivery of the Trust operating plan. It is recognised that at present, a bed gap remains despite the plans and mitigation identified within this plan. It is expected that the ICB plan will support a further mitigation of this gap and this plan will be amended ahead of the September Board to demonstrate this. It is also recognised that further work is required on the demonstration of maintaining elective capacity and managing our financial position through winter, and this too will be updated ahead of the September finalisation of the plan.

Following previous review the paper has been updated with additional detail on winter funding, alignment with EPIC and the ICB demand management plan.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Deliver the requirements of the NHSE UEC Plan	Satisfactory	
Identify local challenges and risks for winter and develop mitigation plans	Satisfactory	
Develop strategies to manage expected winter demand, ensuring patient waiting times, outcomes and experience are maintained	Limited	
Maintain delivery of our 25/26 operating plan, including elective services, financial and productivity delivery	Limited	
Keep our staff well and motivated, including a robust staff vaccination and communication schemes	Satisfactory	
Ensure all of our estate remains safe and accessible at all times including community estate	Satisfactory	
Develop plans to deal effectively with any demand surge or other issues through effective site management, on call arrangements and contingency plans	Limited	

Appendices

None

Committees that have previously discussed/agreed the report, and outcomes of that discussion

This paper was reviewed at the Executive Committee held on 21 August 2025. It was agreed further work is required before final sign off in September around clinical support services including a more robust plan around staff wellbeing, specifically linked to physiotherapy, EPIC implementation and a wider review around financial implications.

It has subsequently been presented to Executive and Finance and Performance Committees on 18 September 2025.

Key recommendations and actions requested

The Trust Board are asked to AGREE the recommended assurance rating and take LIMITED/SATISFACTORY/ assurance as to those matters reviewed.

It is recommended the Board take satisfactory assurance that significant progress has been made in the creation of a Trust wide winter plan and note that further work will be undertaken ahead of September sign off.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

This plan is developed to support the safety and wellbeing of the population, including staff and patients through winter and ensure the maintenance of safe and effective services.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	This plan is developed to support the safety and wellbeing of the population, including staff and patients through winter and ensure the maintenance of safe and effective services.
Quality of services provided	This plan is developed to support the safety and wellbeing of the population, including staff and patients through winter and ensure the maintenance of safe and effective services.
Sustainable and efficient use of resources	This plan has been designed using repurposing of existing resource where required

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	Maintenance of safe and effective services through winter
People	Support staff wellbeing through winter
Financial Sustainability and Productivity	This plan has been designed using repurposing of existing resource where required

Estates	Maintenance of safe estate through winter
Operations and Performance Standards	Support meeting key performance standards despite expected winter demand pressures
Digital and Cyber Resilience	
Building a Brighter Future	
Strategy and Transformation	
Sustainability: Green Plan/ Environmental	
Equality, Diversity and Inclusion	
Provision of Community and Care Services Delivered in Partnership	

Risk: Risk ID (as appropriate)	
Risk	Risk ID

External Standards affected by this report and associated risks

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Our plan for keeping people in Torbay and South Devon safe this winter



**Torbay and South Devon NHS Foundation Trust's
winter plan, 2025/26**

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Winter Plan 25-26

Context

This paper outlines the approach to the development and operationalisation of the 2025/2026 winter plan for the Torbay and South Devon NHS Foundation Trust.

This year, NHS England published the Urgent and Emergency Care Recovery Plan in June, underpinned by an extensive programme of work to deliver improvements across urgent and emergency care ahead of winter. The plan outlines the 7 priorities by which systems and Trusts will be measured and that will have the largest impact on UEC improvement over this winter. As a minimum these are:

- patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – receive an ambulance within 30 minutes
- eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes
- a minimum of 78% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours
- reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time
- reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month
- tackling the delays in patients waiting once they are ready to be discharged – starting with reducing the 30,000 patients staying 21 days over their discharge ready-date
- seeing more children within 4 hours, resulting in thousands of children receiving more timely care than in 2024/2

Trusts and Systems will be required to develop and test collective winters plans, which must be signed off by every board and chief executive within the summer of 2025. Plans will be further refined and stress tested with regional teams through September 25 with additional support provider to the most challenged organisations in advance of winter. As a minimum, each system plan will need to demonstrate a response to

- improve vaccination rates
- increase the number of patients receiving care in primary, community and mental health settings

- meet the maximum 45-minute ambulance handover time standard
- improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care
- set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings

Further guidance on the content of Trust winter plans has been defined within the NHSE urgent and emergency care plan in the format of a range of roles and responsibilities. These are detailed below, and the Torbay and South Devon NHS Foundation Trust Winter Plan will ensure these, along with the 7 priorities and the system plan requirements will be considered and responded to accordingly. It is notable that there is significant correlation and cross over between the priorities and roles and responsibilities within the differing guidance. The roles and responsibilities detailed for acute trusts are below

- Demonstrate plans to improve vaccination rates in health and care workers.
- Have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments.
- Acute trusts to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target.
- To achieve the target of more children being seen within 4 hours, deliver effective utilisation of Urgent Treatment Centres (UTCs), children and young people's specific services and standards.
- Acute trusts to set stretching local performance targets for daily pathway 0 discharges and profile them through the week.
- Acute trusts and local authorities to set local performance targets for pathway 1, 2 and 3 patients.
- Demonstrate effective use of capacity across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside Infection Prevention Control (IPC) cohorting where it is effective and appropriate to do so

To support the creation of the Torbay and South Devon NHS Foundation Trust Winter Plan for 25/26, a winter planning group has been convened consisting of medical, nursing and operational leads from each of the care groups, in addition to leads from key corporate and non-clinical areas of the Trust. This group has been chaired by the Director of Operational Recovery and has ensured a clear locally held plan is created to respond to each of the key criteria, created by the staff who will enact the plan. The group has also enabled effective check and challenge of plans, identified potential areas of conflict or risk between plans, and enabled effective idea generation from across the Trust. The Winter Planning Group reported directly to the Executive Committee, ensuring executive oversight of all elements of the plan. The membership of the Winter Planning Group can be seen below

Area Covered	Responsible Individual
Winter Lead (Chair)	Sam Wadham-Sharpe
Medicine/UEC Ops Lead	Lizzi Vooght
Planned Care Ops Lead	Ria McCoy
W&C Ops Lead	Sarah Hughes
Community Lead	Sarah Bradley and Natalie Keens
Medicine/UEC Clinical Lead	Catherine Blakemore and Rachel Winfield
Planned Care Clinical Lead	Stuart Andrews and Lesley Archer
Medicine Nursing Lead	Lisa Houlihan
Planned Care Nursing Lead	Sharon Boyne
Vaccination Lead	Natalie Herring
Site Flow and Ops Lead	Craig Owen
Workforce Lead	Jess Piper
Estates and Facilities Lead	Tony Hopkins
EPRR Lead	Sam Biden
EPIC Lead	Kevin Pirie
Communications Lead	Jane Harris
ICB Locality Lead	Christine Kelly

The 25/26 winter planning process was launched on the 19th June 2025 with a meeting of the winter planning group, supported by other senior individuals such as the Chief Medical Officer, Chief Nursing Officer, Chief Operating Officer and Care Group Directors. This meeting set out the key areas of work to be undertaken to enable the Board to sign off the plan on the 27th August, disseminated that tasks across the working group, agreed the objectives of the 25/26 winter plan and agreed the timelines and touch points for the group to reconvene and review progress. Following the first meeting of the winter planning group, the following objective for the Trust 25/26 Winter Plan were agreed.

Objective 1 - Deliver the requirements of the NHSE Urgent Emergency Care (UEC) Plan

Objective 2 - Identify local challenges and risks for winter and develop mitigation plans

Objective 3 - Develop strategies to manage expected winter demand, ensuring patient waiting times, outcomes and experience are maintained

Objective 4 - Maintain delivery of our 25/26 operating plan, including elective services, financial and productivity delivery

Objective 5 - Keep our staff well and motivated, including a robust staff vaccination and communication schemes

Objective 6 - Ensure all of our estate remains safe and accessible at all times including community estate

Objective 7 - Develop plans to deal effectively with any demand surge or other issues through effective site management, on call arrangements and contingency plans

The delivery of these objectives is how the success of the 25/26 winter plan will be measured, alongside the continued delivery of the 25/26 operating plan and the Trusts regular monitoring of patient safety and outcomes.

The requirement to obtain Board sign off for the winter plan by the end of August has required the working group to work at pace to understand the challenges that need addressing and to develop the plans for executive and board members to consider. The requirement to meet the August deadline has meant that the detailed data on flu and respiratory illness monitoring has not been available at the beginning of this process. As such, the working group made the decision to review internal and Integrated Care Board (ICB) held data relating to last winter to inform decision making, with an understanding that the plans will focus on the correct challenges with a need to be flexible on scaling and timeframes once the modelling data was available. The table below describes the timeline worked towards from commencement of process to board sign off and adoption.

	16th June	23rd June	30th June	7th July	14th July	21st July	28th July	4th August	11th August	18th August	25th August
Launch Event											
Initial Work Up											
Check In Events											
Winter Group Session - Check and Challenge											
Executive Committee - Initial Brief											
Further Work Up - including cost/benefit analysis											
Winter Group Session - Agreement on Plans											
Extraordinary Exec Committee - Trade offs and Decisions											
Final Work Up and Winter Group Sign Off											
Executive Committee - Endoresment											
Trust Board - Sign Off											

Ownership and Governance

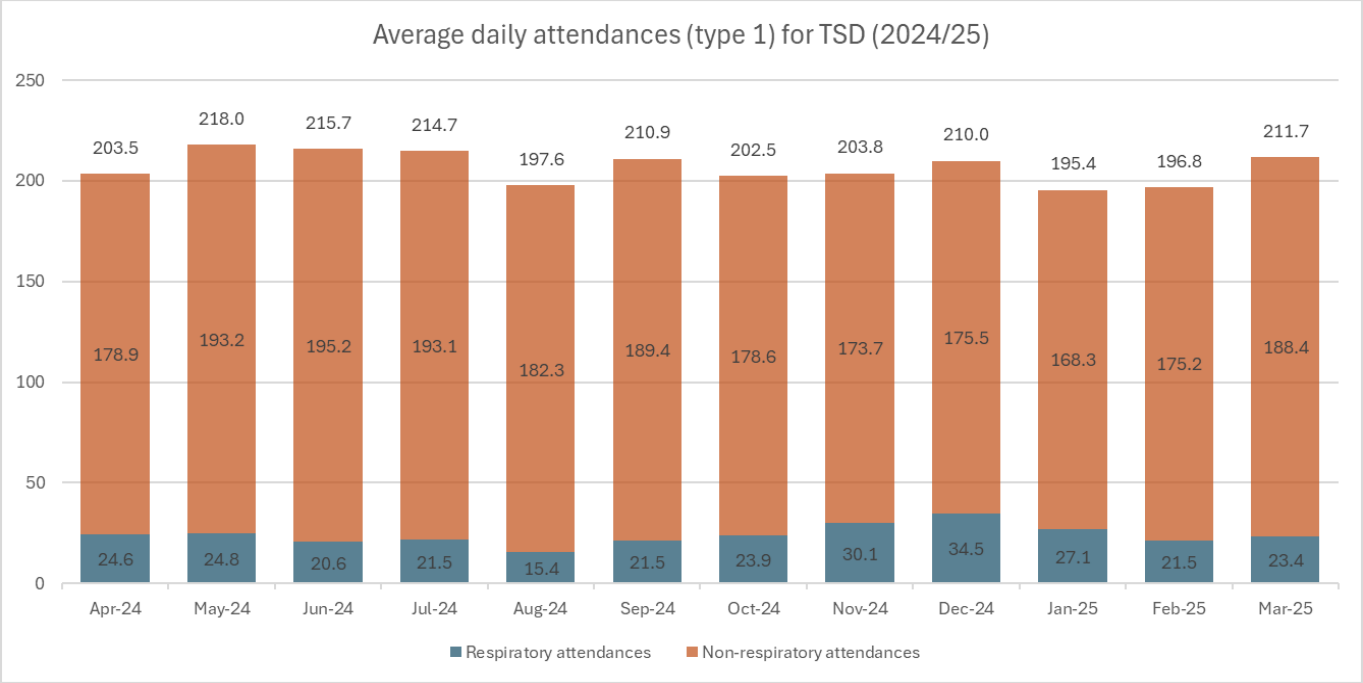
Executive Director Lead – Adel Jones, Chief Operating Officer and Deputy Chief Executive Officer

Operational Delivery Lead – Sam Wadham-Sharpe, Director of Operations

- The Trust Executive Committee has overall responsibility and oversight of the plan, which it carries out through the Trust Executive Board
- Version control and governance of the Winter Plan will remain the responsibility of the Director of Operations
- Following approval by the Trust's Board of Directors, this plan will be distributed to the Trust's Executive Team, to individuals on the Director, Manager and Senior Nurse on-call rotas and the Site Management Office. The approved plan will also be made available on the Trusts' Intranet.
- In addition, this plan will also be distributed to partner organisations in the local healthcare community including NHS Devon ICB
- Care Groups have the responsibility for communicating and adhering to their specific delivery plans

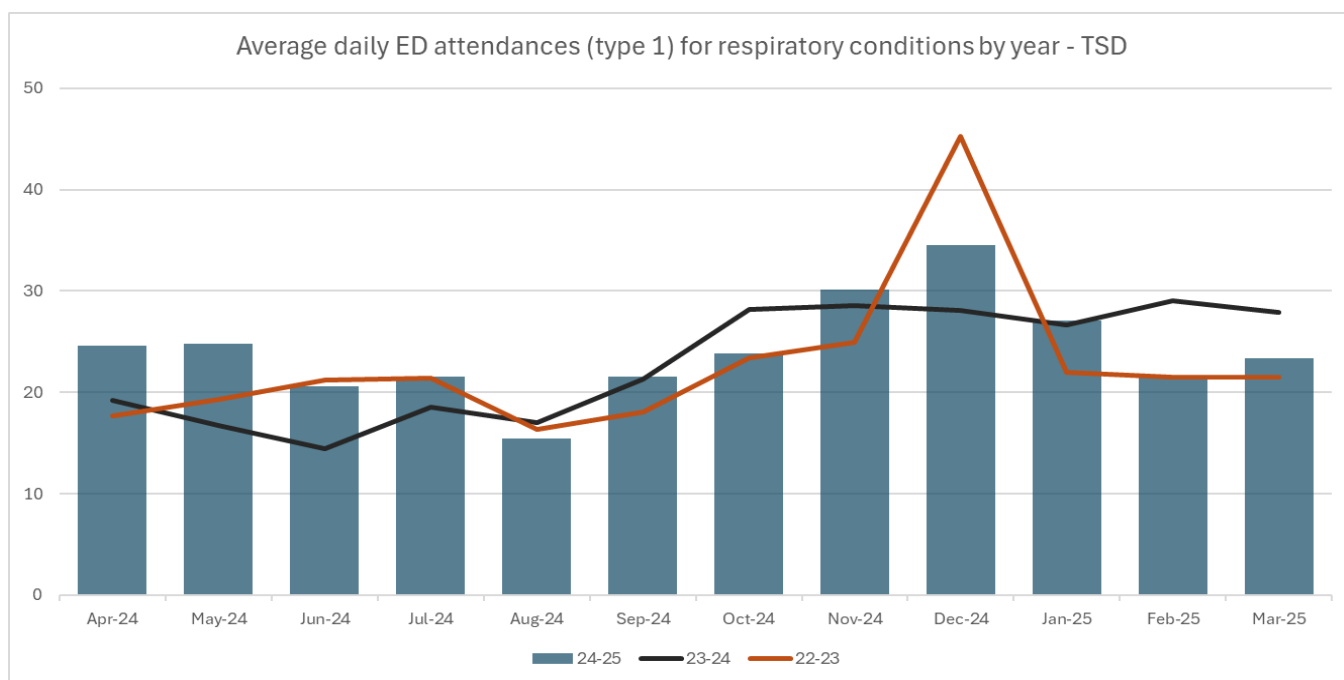
Learning from Winter 24/25

The chart below shows how the average daily number of type 1 Emergency Department (ED) attendances varied throughout 2024/25 for the Trust. There was an average of around 205 attendances per day over the year. There is some variability in the daily attendance rate with a low point in August, January and February. The peak attendance rate was reported in May, but several other months (June, July, December and March) were also relatively high. At this high level there isn't any clear winter surge visible.



However, the above chart also breaks down attendances into those that are for respiratory conditions as a proportion of the total. The seasonal pattern in attendances is much more visible, with a peak in attendances for respiratory conditions in December at 35 per day. The low point in attendances for respiratory conditions was reached in August at 15.4 which is less than half the peak demand. It is the increase in demand for respiratory conditions that is the primary driver of the winter surge.

The chart below shows the average daily number of ED attendances (type 1) for respiratory conditions across within the Trust. This is then compared to the previous two years to see how the size of the winter surge has varied.



It is clear that each of the last 3 years have been quite different in terms of the seasonality in demand: -

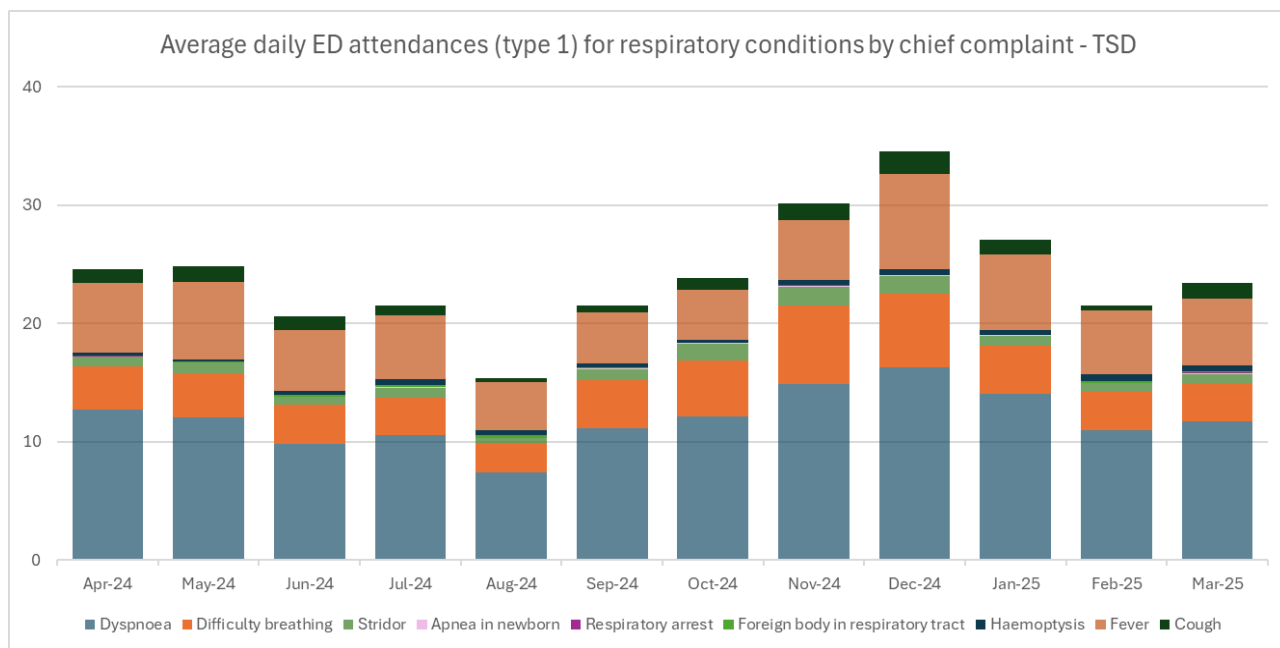
2022/23 – Showed a very significant winter peak in ED attendances in December 2022. This was the highest peak in demand seen at any point over the last 3 years. However, outside of this peak the overall levels of respiratory attendances were relatively low. As this year was closer to the pandemic it is possible that there was still some residual social distancing / reduced presentations across the population that created lower levels of activity

2023/24 – This year recorded the overall lowest levels of respiratory activity and peak demand was also very low. Rather than peak activity in a single month we saw a much flatter peak in ED attendances with relatively stable activity from November through to March. We also see this attendance rate push into the subsequent financial year so April / May 2024 reported similar levels to the winter peak. The use of the Acute Respiratory Infection (ARI) hubs in Q4 2023/24 might have impacted on reported activity however this does not explain why ED attendances were higher during this late winter period compared to other years.

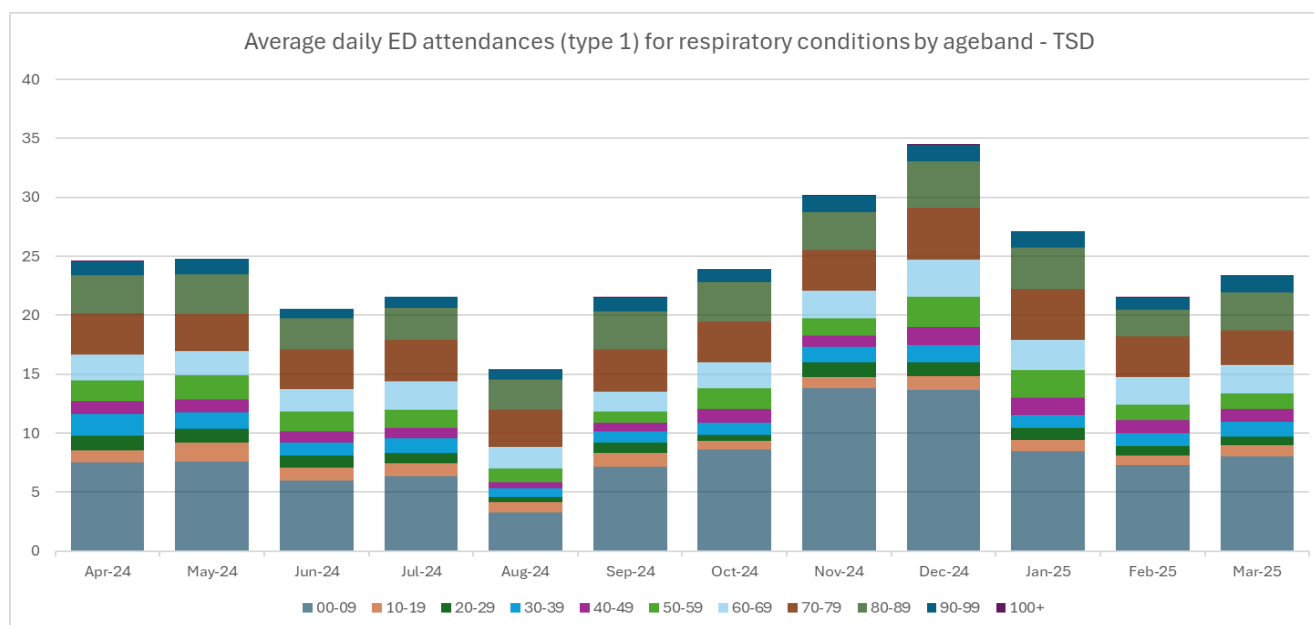
2024/25 – Whilst the peak in December 2024 was below the level reported in the same month in 2022 the overall level of demand over the winter period was higher than seen in any of the last 3 years. This coupled with higher activity in April / May meant that in 2024/25 attendances was around 4647 higher than in 2023/24 and 3192 above that seen in 2022/23.

We can also view the surge in ED attendances for respiratory conditions by the chief complaint.

It should be noted that we don't always see a full diagnosis given in ED, so the most common chief complaints were dyspnoea (shortness of breath), difficulty breathing or fever. These three presenting chief complaints make up around 83% of the total respiratory attendances.



The chart below shows the discharge destination for patients attending ED in 2024/25 for respiratory conditions split by age band. There are around a third of patients where the discharge destination isn't recorded. However, where it is recorded, we see that the conversion rate (admitted to a ward) is around 25% for young children under 10 but is about 80% for those aged 80+. Thus, as older people are more likely to be admitted and once admitted also have a longer length of stay (LoS) we see an increase in bed pressures that is more closely aligned to the increase in ED attendances for older people. This creates a peak bed pressure on the system in late December into January even though peak ED attendances is about a month earlier than this.



By breaking down demand into the two main cohorts that contribute to the winter surge ie young children and older people we can better understand the pattern of pressure on the system. The surge in demand for young children (linked to Respiratory Syncytial Virus [RSV] etc) often starts to build when the schools start back after the summer holidays. This wave peaks in November/ early December. The surge in demand for older people (more closely linked to flu etc) peaks slightly later usually late December into January.

The overlap between these two cohorts creates the peak in ED attendances we saw in December but the bed pressure on the system doesn't peak until January as it is primarily driven by the higher bed utilisation rates for older people.

When measuring the increased respiratory and associated admissions on length of stay and occupancy data, it identified that last year the Trust admitted 464 patients more in winter with an average length of stay of 5.5 days. When converted to an impact on beds, this equates to a 82.6 bed deficit based on a bed occupancy of 92%. Eliminating this bed deficit through admission avoidance schemes, reducing length of stay, increasing capacity and other initiatives will form a fundamental part of the 25/26 winter plan.

Spell Dominant Diagnosis (ICD)	Summer minima	Winter maxima	Total (ytd)	Increase	Average LoS	Bed impact
J101 : Influenza with other respiratory manifestations, seasonal influenza virus identified	0	64	175	64	3.0	6.1
J219 : Acute bronchiolitis, unspecified	3	42	148	39	1.4	1.8
J22X : Unspecified acute lower respiratory infection	19	69	418	50	5.8	9.4
J210 : Acute bronchiolitis due to respiratory syncytial virus	0	14	27	14	3.0	1.4
B349 : Viral infection, unspecified	16	47	330	31	2.6	2.6
J069 : Acute upper respiratory infection, unspecified	8	24	157	16	1.5	0.8
J440 : Chronic obstructive pulmonary disease with acute lower respiratory infection	25	49	398	24	6.7	5.2
J189 : Pneumonia, unspecified	20	41	307	21	7.9	5.4
J100 : Influenza with pneumonia, seasonal influenza virus identified	0	35	62	35	4.5	5.1
J459 : Asthma, unspecified	5	35	175	30	2.9	2.8
J181 : Lobar pneumonia, unspecified	76	140	1061	64	11.7	24.1
J09X : Influenza due to identified zoonotic or pandemic influenza virus						
T814 : Infection following a procedure, not elsewhere classified	11	34	236	23	2.9	2.2
J050 : Acute obstructive laryngitis [croup]	1	10	46	9	0.6	0.2
J441 : Chronic obstructive pulmonary disease with acute exacerbation, unspecified	11	26	175	15	5.0	2.4
I635 : Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries	8	16	131	8	14.8	3.8
S720 : Fracture of neck of femur	17	24	233	7	13.6	3.1
I639 : Cerebral infarction, unspecified	15	29	217	14	14.2	6.4
Estimated winter surge	235	699	4296	464	5.5	82.6

Due to the system pressures and length of delays to ambulance handovers, particularly at Torbay & South Devon (SD) and University Hospital Plymouth (UHP), the Integrated Care Board (ICB) and providers were required to attend and chair several calls through the day to ensure oversight of system pressure and recovery.

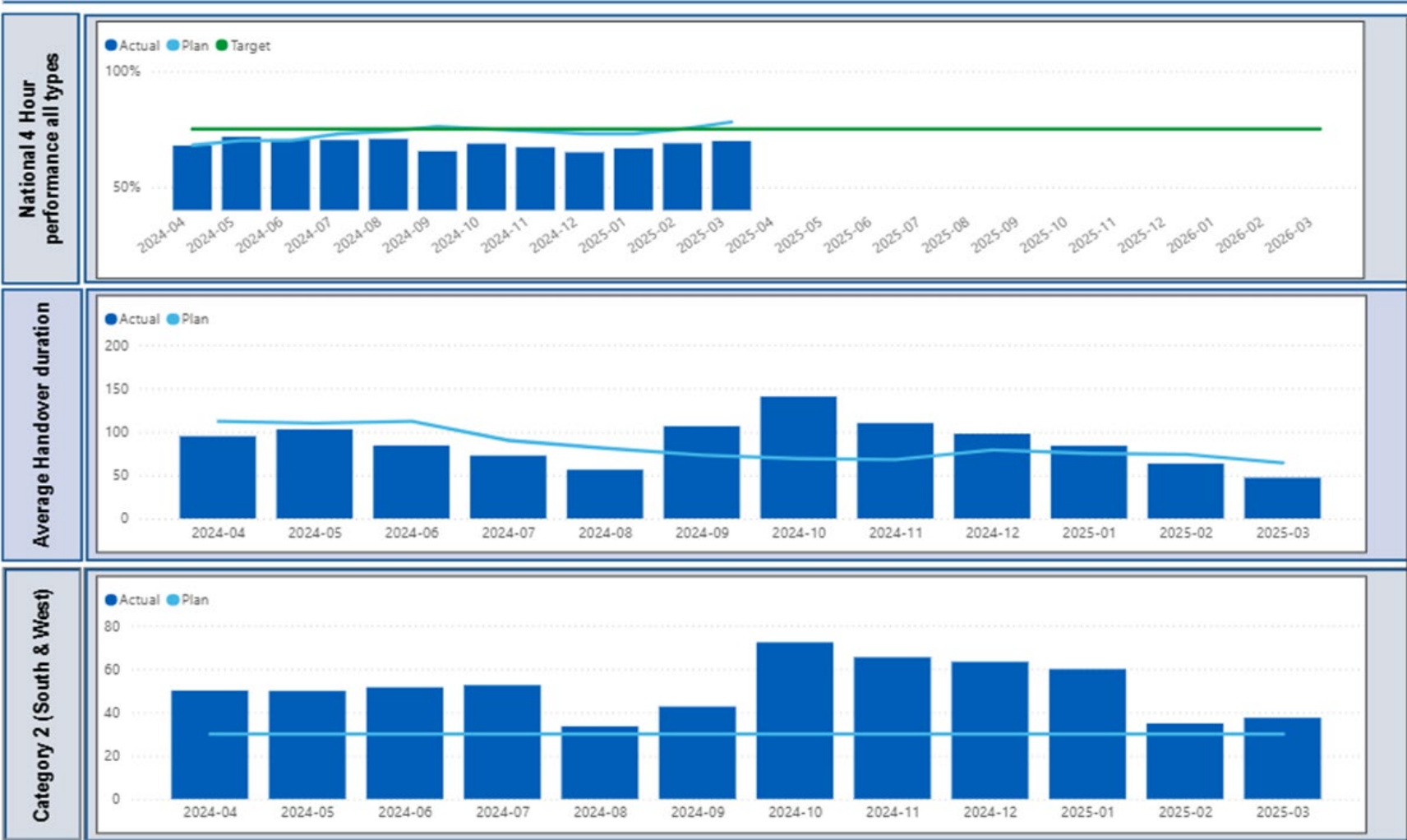
At present these calls are

- 8am on call handover
- 11am system tactical
- 1pm region incident management
- 2pm system gold
- 4:30pm system tactical
- 5pm regional gold
- 7:30pm system evening tactical

Alongside the regular cadence of meetings, NHSE South West implemented an ambulance delay in extremis Standard Operating Procedure (SOP) which required a system GOLD meeting to be convened following any 24-hour period in which an 8 hour ambulance handover delay was recorded. This timeframe was reduced to 6 hours during the winter. As a result of this SOP and other pressures seen across the region there were a total of 13 regional Incident Management Team (IMT) calls and 30 system GOLD calls. This equated to a minimum of 43 additional hours spent on escalation calls with large attendance lists including clinical and non-clinical executives. In addition to this the regional SOP required any system that had recorded a breach in line with the SOP in previous 24 hours to attend a regional escalation call at 17:00 each day (this was changed to twice a week in January) alongside any other Integrated Care System (ICS) who had recorded the same.

These meetings were on top of the 43 hours of additional meetings undertaken within the system and on many occasions were poorly attended by Devon teams in comparison to other systems, which was recognised by regional executives. It should be noted that the SOP mandated that these meetings should be attended by Chief Executives, and as part of this years winter plan, a clear list of senior representatives will be required to support this regional and national requirements.

Last winter the Trust experienced significant issues in delivering the expected UEC performance standards and trajectories. While significant improvements were made from February and continued into March, ambulance handover performance worsened in September and then October, and did not recover to trajectory until February. 4-hour performance mirrored that of ambulance handover performance with a significant worsening in September and not improving until February. It should be noted that 4-hour performance did not recover to trajectory until April. The charts below demonstrate the performance position through FY24/25 and the worsening of performance entering into the winter period and the recovery seen in February.



As part of the worsening of performance and the long ambulance handover delays experienced within Q3, the Trust has received feedback on the perceived lack of planning and the lack of robust response to surge. Feedback also noted that this position improved significantly after Christmas following the development of clear escalation and oversight protocols that enabled the organisation to increase bed capacity and better manage demand. As part of the 25/26 plan, a full review of the surge and escalation protocols will need to be completed and tested ahead of September. The escalation space traditionally available within the organisation consists of the discharge lounge, Acute Medical Unit (AMU) level 2 and Surgical Receiving Unit (SRU), which are all important areas for creating flow in mornings, and as such, alternative options for escalation will need to be considered for this winter.

Responses to the challenges – closing the bed gap internal

Emergency and Acute Medicine

To support the service to meet the expected demand increases in winter an adjustment has been made to the consultant and resident doctor rotas. From August 2025 changeover the minimum core staffing levels for Resident Doctors will increase from 2 per shift to a minimum of 3. This applies to all day shifts, late shifts and weekend shifts and approximately 90% of night shifts.

Consultant e-rostering has been approved and PO raised. When live this will increase from 2 to 3 Consultants per shift as a minimum (Monday to Friday) balancing out for a more sustained Consultant cover to support timely decision making and demand. There will also be approximately an additional 5 direct clinical care programmed activities (DCCPAs) of clinical activity per week re-purposed because of the change in rostering process (approximate change is anticipated end of October 25).

As part of the UEC recovery plan, a review is in progress to understand any changes of conversion rates to medicine from the emergency department. This work alongside a continued focus on redirection or streaming direct from triage will support the Trust to manage expected demand increases. From September 2025, all referrals from ED to acute medicine will be made via the phone to support the effective management of admissions.

The emergency department is currently undergoing a large-scale redevelopment which will improve service delivery when complete. These works will unfortunately not be finished ahead of winter and discussions are ongoing regarding maximising utilisation and ambulatory pathways within the department whilst building works are anticipated to be on-going until the end of March 2026. It has been confirmed that no additional space will be lost as part of the re-build and currently only 1 – 2 minor's spaces will remain out of action.

Medical Admissions Avoidance Team (MAAT) is a team of nurses who provide care to people in their own home which would have normally required a hospital stay. This team works alongside the medicine care group and interfaces with the virtual ward. This team provides treatments such as intravenous fluids or antibiotics, anti-coagulant drugs before surgery, or giving certain injections. Treatments like this require frequent monitoring and specialist nursing skills to deliver; previously, patients requiring them would have been admitted to hospital for days or even weeks. The MAAT team are able to give these treatments in the community, either in a person's own home, in a care home, or in a community clinic. This enables people to return home sooner after an inpatient stay, or to avoid having to go into hospital altogether. The MAAT team work closely with hospital and community teams, helping to identify people who they can care for at home. They work with Torbay Hospital's microbiologists to identify where patients can receive different kinds of antibiotics, which can be delivered away from hospital.

Outpatient Parenteral Antimicrobial Therapy (OPAT) virtual ward (VW) bed capacity is currently at 8 beds and will increase to 10 to support escalation with a projected date of December 2025 and support Respiratory Virtual Ward as and when required.

There is an opportunity to expand the OPAT Virtual Ward by including a wider range of patients requiring intravenous (IV) therapy, such as those with osteomyelitis or heart failure, to facilitate early discharges. A planning process has been arranged with Microbiology to explore opportunities for expanding patient cohort.

UEC Transformation

In support of the winter plan, the Trust has been undertaking improvement work on UEC pathways and performance to support improvement in the priority areas of 4-hour, 12-hour, ambulance handover and discharge. The Improvement and Innovation team alongside external support from the national Emergency Care Intensive Support Team have supported the Trust in delivering meaningful improvements to urgent care pathways and performance.

The team have been working in close partnership with clinical and operational colleagues to drive improvement across key areas including surgical and paediatric pathways, emergency department productivity, admission and attendance avoidance, and overall patient flow. For 25/26, the team will continue to focus on implementing high-impact, evidence-based changes to support the Trust in achieving its urgent care objectives and strengthening resilience during the most challenging winter months.

UEC Flow Improvement portfolio KPIs

- 78% of patients attending ED are seen, admitted or discharged within 4-hours - 95% 4-hour A&E for children
- Maximum 10% 12 hours in ED - No +24hour waits for mental Health Patients in ED.
- Ambulance handovers at 40 mins - No Ambulance handovers over 45 minutes
- ED Time to see Clinician - 100% within 1 hour
- Wards - Improvement in overall patient LOS (0.5 days)
- Wards - Improved performance in pre-noon discharges by 10% - Improvement in % pre-5pm discharges (target 75%) - Improved ratio of weekday/weekend discharges (72%/28%)
- Wards Improvement in the average % of patients with NCTR (<5%)

Programme	Aim	Headline Deliverables	Overarching Timeframes
ED Demand and Capacity management	To ensure that the workforce plan and internal ED processes meet the demands of the department to ensure that patients are seen in the right place at the right time within the department.	• 1 SPOC model across UEC • Revised Nurse triage criteria for diversion out of acute trust • Revision of Fit2Sit criteria to increase usage - recording of validation breaches and ED usage of the area. • Workplan / rotas that align to demand and capacity and to workforce skill / mix, including GP Rota / financial issue • Standardisation of implementation roles across the department • Visibility and internal monitoring of ED key metrics , measurement of current position / escalation • Standardisation of RAA process	May – September 2025
Flow and Ward Management	To ensure that processes across the wards enable effective oversight and management of the processes relating to flow and bed management	• Rigour and assessment around internal processes • Standardisation and visibility of ward processes such as TTA, CPS, EDD • Criteria Led discharge. • Revision of Patient flow meetings • Clear and impactful Surge and Escalation Processes • Weekend capacity / forward planning • Standardised Ward meetings / board rounds with standardised outcomes	May – September 2025
Internal Urgent Care Streaming	To ensure that patients are streamed from ED to the right place in their urgent care pathway at the right time.	• Patients streamed to SRU, AMU and Paeds within 4 hours of arrival at ED (admitted and non admitted) • Acute Medics out of the Emergency Department to cover EAU4 • Provision during weekends and extension of hours • Revised admission process to assessment units • Direct streaming from SWAST • Clear Internal Professional Standards that support the culture around decision making and referrals processes	May – November 2025
Timely Handover Process	To ensure that all ambulance handovers are completed within 45, with the average handover time being 15 minutes	• Creation of THP escalation plan with a whole Trust approach • Standardization of roles and responsibilities of those supporting ambulance handovers • Review of Stroke and PCI pathway • Review of portering across the pathway	July -October 2025
Long Length of Stay patients in ED	For there to be no patients waiting over 12 hours in ED.	To Be Confirmed – this programme of work to be initiated on completion of the above programmes • Understanding the blockages and areas causing delays to onward referral or discharge • Consistent application of YNP and selection of patients • Admission rights to speciality areas to be consistently applied • Criteria to admit tool • Patients that are "Not Ward Ready" but not ITU suitable" • Pathways for Mental Health patients • Strong links to Patient flow meeting to stream patients effectively	October – March 2026

Medical Staffing

To better manage various pressures, trial rotas were developed for August to December in collaboration with finance and operational teams. The aim was to optimise use of substantive funding, reduce unnecessary locum spend, and create a fairer distribution of out-of-hours (OOH) shifts for Residents. Assuming these rotas continue beyond December, the expected benefits to combatting winter pressures include:

General Medicine: Enhanced evening and night support during weekdays, with variable coverage. Additional OOH coverage provided above core staffing averages at 2 resident doctors per shift. This will support early clerking of patients and requesting of required diagnostics, resulting in an expected 5 additional discharges before midday. Additional weekend cover averages 3 resident doctors per day across all shifts providing 10 additional discharges across the weekend. Christmas and New Year Bank holiday rostering will be aligned with actual service demand, drawing on substantive staff rather than requirements for sourcing last-minute locum bookings. 5 additional doctors will be rostered across the 24hr period, maintaining the weekday discharge improvements and limiting the requirement for opening escalation spaces in these times.

Improved overall staffing resilience, reducing the impact of sickness-related absences and decreasing reliance on locum cover. Short notice sickness will reduce by 3% from last year's performance related to general improvements in equity across the roster, providing a consistent team. This will benefit processes resulting in the potential for an additional 2 discharges per day.

Acute Medicine: Escalation shifts which were previously filled by locums are now substantiated within established numbers, better utilisation of substantive staff and cutting locum expenditure significantly. The roster will provide an average increase of 2 doctors per day resulting in improvements in pre-noon discharges of 2 per day and total of 5 additional daily discharges from assessment areas.

There is the possibility of providing additional medical cover to the discharge lounge for the winter period, but this will require additional funding or to repurpose slippage in spend that is available through changes in the discharge lounge opening times. A proposal to merge discharge lounge and McCallum 2nd resident doctor to provide this cover would secure the service provision and ensure effective use of resource. It would also resolve the medical ownership of the colleague allocated to the discharge lounge. A decision would need to be made before August Rota starts to secure this solution and is being investigated by the medicine leadership team.

Cardiology and Chest Pain Services

To support resilience within the service to meet the expected increases in chest pain demand ahead of winter, the service has developed a mitigation plan which will be enacted between December and February.

A 7 day a week chest pain nurse service will be in place to support the emergency department and enable access to timely assessment and decision making, aiming at reducing waiting times in the department and admissions. This initiative will be supplemented with 1PA of consultant time Monday to Friday supporting the emergency department and assessment areas to enable earlier commencement of treatment and support both reductions in admission from emergency department and reduced length of stay in admission units.

The service will be aiming to ensure timely access to echo inpatient diagnostics through effective prioritisation of resources which is linked to the services echo recovery plan. In addition to this the service will increase inpatient cath lab activity in weekends through the existing on call and Waiting List Initiative (WLI) standard operating procedure.

Respiratory Services

The main priority for Respiratory Winter Planning is to maximise the level of consultant input to the wards and the Front Door whilst maintaining core outpatient services and without impacting on cancer and Referral to Treatment (RTT) performance.

The respiratory service has created the following initiatives to support admission avoidance and limit the expected growth in length of stay this winter

- 1) Unplanned Admissions – support patient flow and improve bed capacity by:
 - Mobilise additional consultants on to Midgley and Cromie to achieve rapid assessment, treatment and early discharge of inpatients during December and first two weeks of January. Achieved through reduction of Outpatient (OP) activity.
 - Early consultant annual leave planning for Christmas/New Year period
 - Strengthening SAFER meetings using criteria-lead discharge planning over weekends
 - Maintaining safe levels of nurses and resident doctors on the ward
- 2) Respiratory Support Unit (RSU) – commencement of the Unit will enable step-down of patients from Intensive Care Unit (ICU), releasing ICU bed days and accelerating movement of patients from ED to RSU, expediting care plans, releasing beds/space and improving patient flow. It is currently planned for this unit to open in October '25.
- 3) Increase Respiratory Virtual Ward bed capacity from 25 to 30 beds. To enable this the service will require the extension of the current locum consultant contract to January 2026

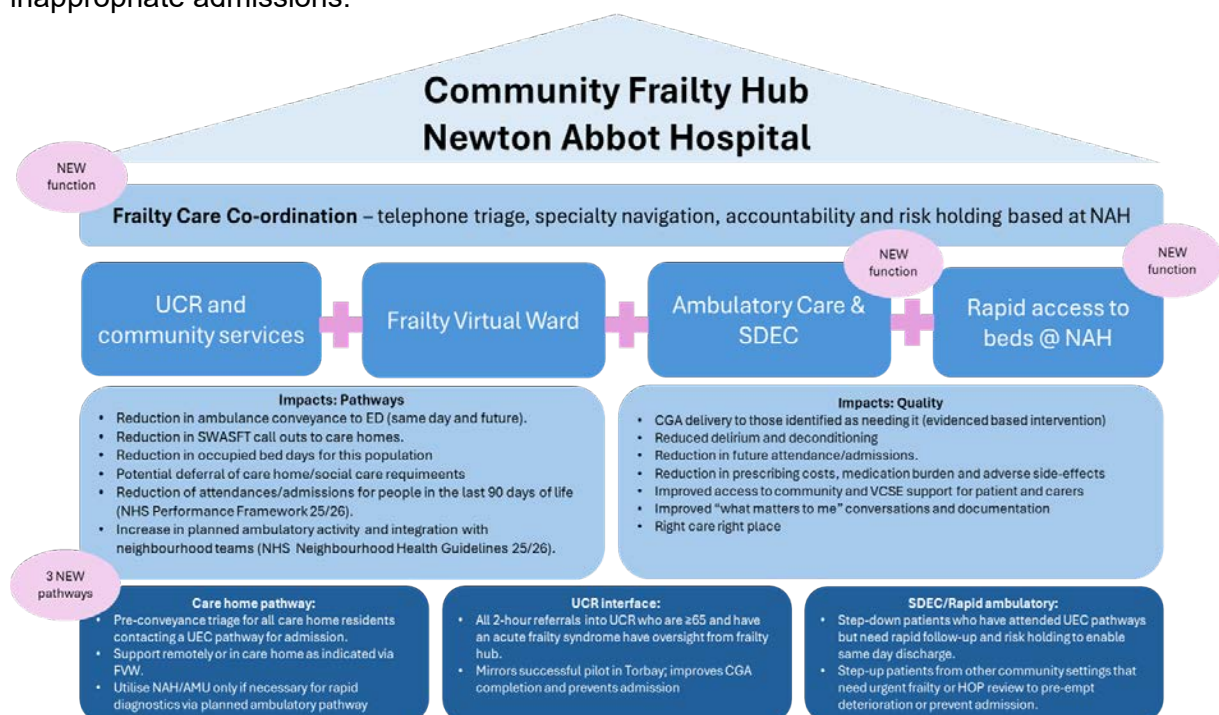
To enable the delivery of the winter responses with the current budget the service will focus reduced consultant capacity on certain pathways such as TB, COPD, virtual nodule reviews and asthma, which are the main causes of unplanned admissions. The service will effectively prioritise by clinical need and length of RTT wait.

Frailty Transformation Programme

The trust is undertaking a significant transformation of its frailty services in response to an ageing population, increasing system pressure, and mounting evidence that the current hospital-centric model leads to poor outcomes for frail older people. Between 2025 and 2030, the Trust's population aged 70+ is forecast to grow by 9.9%, compared to just 1.4% for those under 70.

Frail older adults account for a disproportionate share of ED attendances, hospital admissions, and bed occupancy— often leading to harms such as deconditioning and loss of independence.

To address this, TSDFT is advancing a community-first model of care where hospital admission for frailty alone is treated as a "never event". This redesigned model prioritises anticipatory, preventative care and aims to manage frailty in the community through a combination of services, including a Newton Abbot-based frailty hub, virtual wards, care coordination, Same Day Emergency Care (SDEC), and early supported discharge. A care coordination hub, co-locating staff from Urgent Community Response (UCR), AMU referral handling, and other navigation functions, will be central to optimising urgent care pathways and reducing inappropriate admissions.



Evidence from internal audits and national data indicates that nearly 50% of frail older people currently seen in ED and discharged within 24 hours could potentially be managed more effectively outside of the acute setting, particularly if we improve our anticipatory care offer as part of Integrated Neighbourhood Teams. Case audit work of older adults wards and AMU done earlier this year indicate that over 30% of current inpatients might have been suitable for community-based care if alternative services were available.

The Trust is also developing digital innovations - such as wearable monitoring, extended reality for cognitive support, and AI-powered pattern recognition - to support personalised, proactive care.

To ensure successful implementation, TSDFT is investing in leadership, staffing, cultural change support, and communication strategies. A stakeholder co-design event held in July 2025 revealed strong backing for the vision. Further development work, including a second engagement event and detailed modelling, is scheduled ahead of a phased launch from late in Q3, aligning with the peak winter period.

The programme's benefits and value realisation work link these initiatives to measurable improvements in patient outcomes, staff satisfaction, resource efficiency, and system resilience. It outlines a commitment to regular monitoring and iterative improvement, ensuring that community-based frailty care is not only clinically effective but also financially and operationally sustainable across the winter and beyond.

Paediatrics

As described in the demand data charts, the expected winter surge for paediatrics will occur between November until the end of the school term in December. To support the management of the paediatric demand through this period the team has set themselves the following objectives

- Anticipate and manage seasonal pressures in paediatrics
- Maintain safe, timely, high-quality care for children and families
- Ensure children and young people are seen and treated in the right place, by the right person at the right time.
- Strengthen operational resilience across the Trust

Based on modelling from Australia, the team have created the below understanding of demand challenges for this winter which widely align to last years presentations.

Virus	Australia Peak Activity	Paediatric Impact	2025 Observations	Anticipated UK Impact
RSV	May–July	High infant admissions; oxygen therapy frequently needed	Off-season spikes noted; severity highest in <6 months	Likely UK peak in Sept–Nov ; early surge in <1s; prep for high acuity
Influenza	June–July	Increased hospitalisation among CYP; low vaccine uptake	~57K confirmed cases in July; ICU utilisation ↑	UK peak expected Dec–Jan ; risk of low paediatric vaccine uptake
COVID-19	May–July	Lower paediatric admission; ongoing testing challenges	Reduced transmission vs 2024, but mortality remains notable	Baseline paediatric impact; co-circulation risk with flu/RSV in winter

To support the creation of the plan, the paediatrics team have ensured that the winter dashboard is fit for purpose by confirming the accuracy and the accessibility of real time data to enable effective decision making. They have engaged in preparedness and planning meetings at speciality and Trust level, collaborating with the emergency department and planned care teams to align capacity plans. The team have also agreed governance accountability across the wider care group, defining shared responsibilities where services intersect, particularly where children and young people may move between services and pathways.

Following the planning process, the paediatric team have created the following plan for winter

Initiative	What We're Doing	Expected Output	RSV Mitigation Impact
Green Pathway (Live Trial)	Streaming eligible patients from Paeds ED to Louisa Cary Unit (9:00–17:00)	Reduced ED congestion; faster access to assessment and treatment	Frees ED space for high-acuity RSV cases; supports early flow
Nurse-Led Discharge (SSPAU)	Launching Aug: Transfer of patients eligible under protocol (gastro & respiratory criteria) from ED to SSPAU without routine medical review	Streamlined discharge for common presentations; optimised SSPAU capacity	Reduces ED and inpatient strain ahead of RSV peak; enables rapid turnover for non-escalating respiratory cases
Surge Protocols	Ward flexes from 19 to 26 beds using predefined triggers; cohorting by diagnosis; daily oversight via paed's huddle; staffing flexed via acuity tools	Immediate capacity uplift; effective use of bay spaces; responsive staffing support	Expands inpatient space for RSV admissions; mitigates cubicle constraints; enhances real-time response to pressure
ICS Escalation Framework	Devon-wide CYP escalation protocol in place	Consistent system-level response; coordinated diversion and admission planning	Supports regional redistribution of RSV cases when local capacity exceeded
Cross-Specialty Collaboration	Agreement in progress to review surgical CYP on SSPAU	Reduced inpatient delays; improved flow for non-medical paed's patients	Frees inpatient beds for RSV admissions; reduces ED boarding
Workforce Flexibility	Nursing workforce flexed across Neonates, Paeds, and ED based on acuity	Responsive staffing model; improved coverage during peak periods	Ensures safe staffing during RSV surge; supports high-flow and escalation needs
Enhanced SPOC Cover	Additional SPOC cover embedded into winter weekday rota; linked to flow and surge triggers	Strengthened operational oversight; improved responsiveness to escalation, discharge delays, and ED boarding	Supports proactive management of paediatric surge pressures; ensures continuity in flow coordination and system engagement

While the paediatric plan will not contribute to the overall bed mitigations required for the Trust, the plan will ensure effective capacity to enable a flow of paediatric patients from the emergency department when required, enabling patients to access the right care and treatment, as well as supporting to manage capacity in the emergency department.

Community Plan

The Trusts community plan for winter is designed to support the management of increased winter demand through supporting our population to remain well and at home, reducing attendances and admissions to hospital, and to ensure there are adequate pathways and capacity to enable patients to return to their place of residence as swiftly as possible. There are several linked services already well established within our community services and clear plans to enhance admission/attendance avoidance with a robust frailty management plan commencing phase 1 in November with phase 2 early in the new year utilising Newton Abbot to provide a health aging frailty unit. Also linking with primary care and the anticipatory care work. The Trust's community care model will provide a strong focus on Home first, further reducing reliance on community hospital beds and increasing use of home-based care and intermediate care rehabilitation beds, rebalancing our resources to achieve this. There is a community cover rota with community service managers to ensure consistency in approach to the community plan which includes:

Urgent Community Response is delivered through a multi-disciplinary team and is a key factor in preventing admission. To support improving the number of patients seen within 2 hours to 94%, over the last 6 months there has been joint working with the frailty virtual ward, this balanced risk-taking approach and increase acuity has improved performance and delivery this will be further developed across the whole footprint. This will also provide access to Jack Sears reablement beds as part of delivering improved occupancy in reablement but also allow for enhanced medical cover through the virtual ward programme. Plans for frailty increased referrals directly from South Western Ambulance Service (SWAST) and from primary care have been mapped. The trusts well established enhanced intermediate care can support at home or through access to reablement facilities across the footprint. In addition to the well-established community nursing teams there is a trust wide out of hours team providing unscheduled night care. The localities have direct access to community pharmacists

Locality pharmacists are members of locality health and wellbeing teams. As well as doing medicine reviews for people who are house-bound and unable to get to see their GP or community pharmacist, they also work particularly closely with intermediate care teams and care homes, to support people who have multiple long-term conditions and who are therefore taking a number of different medicines. They also ensure that any unnecessary medicines are discontinued. Locality pharmacists also educate people about their medicines, helping them to understand what their medicine is for and why it is important to take them correctly. The locality pharmacists are also integral with supporting safeguarding concerns, especially in whole service safeguarding enquiries.

Community nursing teams support housebound patients who have a nursing need. These team members visit patients in their own home and in residential homes. They manage and treat patients with wound care, long term conditions management, supporting diabetes management, bowel and bladder care, end of life care. The Community nursing teams are supported by specialist nurses.

The specialist nurses manage Chronic Obstructive Pulmonary Disease (COPD), epilepsy, diabetes, heart failure and Parkinson's Disease when appropriate and the patients needs are complex to help manage their symptoms and help prevent hospital admissions.

Community nurses work closely with Primary Care to support the housebound community.

Discharge hub, complex work and NCTR improvement Capacity and market issues in the community can impede timely discharge, accessing more complex care for those with significant behavioural issues with the increasing levels of dementia and complex behaviour on pathway 3. Improvements in domiciliary care provision has reduced the challenge for P1 patients.

Reablement and rapid response service is provided by therapists and support workers who visit during the day from 7am to 10pm. There is access to night sits for people who need a period of low-level support. The emphasis for all the teams is home first and ensuring accessible discharge to assess (D2A) is available across the localities. The Occupational Therapist (OT) in reach role plays a significant part in ensuring correct pathways and supports both education but also seamless flow. These teams also support avoiding hospital admissions and facilitating early discharges.

Jack Sears and Mapleton Optimising occupancy in the reablement facilities is being managed across different approaches including as already described the linking with the frailty as well as the In Reach OT working across all ward areas to promote and a step from community push with teams.

Adult Social Care works alongside health in providing support for health and social care. As an integrated organisation this allows the patients to be managed in a seamless manner as they flow between the teams in a timely manner. This also minimises hand offs between the teams. There is a clear link with voluntary sector partners as part of supporting local care. There are strong links and daily touchpoints with complex reviews across Torbay and South Devon (Devon County Council) to manage flow and delays.

LOS and Community hospitals There is an improvement programme focused on reducing length of stay in the community hospitals, a recent addition of 2 locally employed doctors in Newton Abbot supports the frailty development. There is an active approach across all 4 community hospitals to promote step up from the community into the beds to reduce admission to Torbay. There is a weekly LOS review meeting and involvement of the trusted assessor to bridge communication between ward and provider to support timely transfer.

Adult Social Care works alongside health in providing support for health and social care. As an integrated organisation this allows the patients to be managed in a seamless manner as they flow between the teams in a timely manner. This also minimises hand offs between the teams. The Better Care Funds are used to support Intermediate Care, UCR and hospital discharge.

To support robust delivery of winter plans in community, the Trust's community care model will provide a further focus on Home first, further reducing reliance on community hospital beds and increasing use of home-based care and intermediate care rehabilitation beds, rebalancing our resources to achieve this. The community Associate Directors of Operations will jointly work with community service managers to ensure consistency in approach to the community plan which includes

Planned Intervention	Expected Impact
Virtual Frailty Ward to access Jack Sears Intermediate Care for 72-hour short stay Virtual ward utilisation for patients awaiting pathway 1 – pathway 3 packages of care Discharge Hub clinicians support with D2A's and environmental visits to reduce length of stay D2A capacity in localities- community teams to ensure D2A slots are available daily to facilitate discharge. Hub to support in escalation or when limited capacity OT In-reach role to right size discharge pathways and support. Fully utilise IC block beds and monitor LOS community MDT to support Trusted placement Advisor to support with back to care home discussions and new placements/challenges on discharge.	Reach and maintain 5% NCTR Increase Block Book Beds to 80% Occupancy
Daily reprioritisation of team workload to increase UCR capacity Virtual ward access to UCR teams to enable admission avoidance Community nursing resource re-prioritised toward UCR 3rd Party Delegation to carers and care homes to support complex patients in the community	Increase UCR 2 hour response to 94%

Band 7 review of all discharge to assess opportunities to facilitate early discharge Community input into weekly LoS meetings in acute and community hospitals to identify patients suitable for earlier discharge Implement additional daily complex discharge meeting Daily system partner call to understand unsourced care and bedded care market to optimise capacity Fully utilise all Torbay and South Devon P2 block booked bed capacity Review all community hospital referrals to assess suitability for intermediate care placement	Reduce LoS by 0.5 days

Responses to the challenges – closing the bed gap ICB and external

The ICB have committed to supporting UEC demand management through the implementation of specific schemes or programmes focussing on high impact cohorts of patients.

The current ICB programme consists of

<u>Programme of Work</u>	<u>Expected Impact</u>
Acute respiratory infection response – spirometry and Feno project, CYP information and navigation, Preventing exacerbation for COPD and Pulmonary Rehab	Reduction in ED attendances of 189 between November and March
Primary Care Network Acute Care Service – dedicated primary urgent care focussed on Torquay PCN	No impact modelling
111 Enhanced Validation of Emergency Outcomes – validation of 111 patients directed to emergency departments	Reduction of 976 ED attendances between November and March
Care Coordination Hub – effective navigation of 999 calls to alternative services	Reduction of 427 ED attendances between November and March
High Intensity User Services – targeting frequent users of emergency departments to find alternative services to ED and to support self-management	Reduction of 105 ED attendances between November and March

At present, work is still ongoing to understand the detail behind each of these schemes to ascertain the referral routes, patient criteria and how the Trust can engage with each of these programmes. The Trust is a standing member of the ICB Emergency Department Demand Management Group which will be overseeing the implementation and delivery of these programmes.

Maintaining Elective Services

Trauma planning

During the high-demand periods of December/January and July/August, trauma service capacity will be increased by implementing the Planned Second Trauma lists on Mondays, Tuesdays, Thursdays, and Fridays, specifically targeting the peak winter months. In addition, consultant cover for hip trauma will be prioritised, with dedicated hip trauma consultants scheduled every Monday and Friday to ensure optimal flow. This strategic allocation of resources is designed to address seasonal surges in trauma cases and streamline the management of complex injuries. See below output from demand profile.

		Monday		Tuesday		Wednesday		Thursday		Friday	
	Week	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Jan	1	T	T	T	T	E	E	T	T	T	T
	2	T	T	T	T	E	E	T	T	T	T
	3	T	T	T	T	E	E	T	T	T	T
	4	T	T	T	T	E	E	T	T	T	T
Feb	5	T	T	E	E	T	T	E	E	T	T
	6	T	T	E	E	T	T	E	E	T	T
	7	T	T	E	E	T	T	E	E	T	T
	8	T	T	E	E	T	T	E	E	T	T
Mar - Jun	9	T	T	E	E	E	E	E	E	T	T
	10	T	T	E	E	E	E	E	E	T	T
	11	T	T	E	E	E	E	E	E	T	T
	12	T	T	E	E	E	E	E	E	T	T
	13	T	T	E	E	E	E	E	E	T	T
	14	T	T	E	E	E	E	E	E	T	T
	15	T	T	E	E	E	E	E	E	T	T
	16	T	T	E	E	E	E	E	E	T	T
	17	T	T	E	E	E	E	E	E	T	T
	18	T	T	E	E	E	E	E	E	T	T
	19	T	T	E	E	E	E	E	E	T	T
	20	T	T	E	E	E	E	E	E	T	T
	21	T	T	E	E	E	E	E	E	T	T
	22	T	T	E	E	E	E	E	E	T	T
	23	T	T	E	E	E	E	E	E	T	T
	24	T	T	E	E	E	E	E	E	T	T
Jul - Aug	25	T	T	T	T	E	E	T	T	T	T
	26	T	T	T	T	E	E	T	T	T	T
	27	T	T	T	T	E	E	T	T	T	T
	28	T	T	T	T	E	E	T	T	T	T
	29	T	T	T	T	E	E	T	T	T	T
	30	T	T	T	T	E	E	T	T	T	T
	31	T	T	T	T	E	E	T	T	T	T
	32	T	T	T	T	E	E	T	T	T	T
Sep	33	T	T	E	E	T	T	E	E	T	T
	34	T	T	E	E	T	T	E	E	T	T
	35	T	T	E	E	T	T	E	E	T	T
	36	T	T	E	E	T	T	E	E	T	T
Oct - Nov	37	T	T	E	E	E	E	E	E	T	T
	38	T	T	E	E	E	E	E	E	T	T
	39	T	T	E	E	E	E	E	E	T	T
	40	T	T	E	E	E	E	E	E	T	T
	41	T	T	E	E	E	E	E	E	T	T
	42	T	T	E	E	E	E	E	E	T	T
	43	T	T	E	E	E	E	E	E	T	T
	44	T	T	E	E	E	E	E	E	T	T
	45	T	T	E	E	E	E	E	E	T	T
	46	T	T	E	E	E	E	E	E	T	T
	47	T	T	E	E	E	E	E	E	T	T
Dec	48	T	T	T	T	E	E	T	T	T	T
	49	T	T	T	T	E	E	T	T	T	T
	50	T	T	T	T	E	E	T	T	T	T
	51	T	T	T	T	E	E	T	T	T	T
	52	T	T	T	T	E	E	T	T	T	T

Daily Trauma Status Review:

- Review to be completed each day to monitor the current situation and ensure timely delivery of trauma.
- Track the number of patients awaiting surgery at home.
- Record the number of inpatients awaiting trauma operations.

Standard Operating Procedure (SOP) for Surge Management:

A clear SOP will be established for managing surges in trauma demand. Based on the Plymouth SOP, a defined threshold for trauma hours will be set. If this threshold is exceeded, elective procedures will be stood down to facilitate recovery of the trauma service position. This approach ensures responsiveness during periods of high demand, preserving patient safety and optimising resource allocation during winter. A specific plan will be developed and implemented for ensuring appropriate access to hip trauma surgery to ensure the Trust works to meet the national timeframes for these procedures.

Escalation plans

To manage routine elective inpatients, a cap of 10 inpatients per day will be enforced unless specific approval is granted by the Care Group Director in conjunction with the Director of Operations or the Chief Operating Officer. Consideration will be given to redistributing activity more evenly across the week, particularly re-profiling cases from the typically higher volume elective and non-elective demand day of Mondays and Tuesdays to later in the week, in order to optimise capacity and reduce bottlenecks.

The emphasis will also remain on increasing the throughput of day case procedures and outpatients throughout the period, this will put less strain on the inpatient bed base during the critical 6-week period at the height of winter. Efforts will focus on reducing outpatient waits to 40 weeks and achieving a reduction of 805 outpatients waits over a 40-week period by 31 December. This strategic target aims to give as much performance cushion ahead of winter. Methods will include continuing with outpatient transformational work, reprofiling of elective recovery funds, job plan reconciliation processes, limitations on annual leave in Q4 due to EPIC and a stricter 6-4-2 process to allow for redistribution of theatre activity if no anaesthetics is available. This will need to be tempered with financial recovery efforts.

Escalation measures will continue to be supported by utilising the 14 Ella Escalation beds and maintaining overnight escalation in the SRU as needed, ensuring flexibility and resilience in the face of fluctuating demand. Having earlier shifts posted will provide better chance of pick-up, rather than leaving to on the day planning.

Supporting surgical flow

A significant barrier to maintaining surgical flow is the limited capacity of side rooms, which hampers movement from ED onto the wards, specifically T&O. To address this, a cost benefit analysis will be developed to justify and help mitigate the impact of converting four beds on the Anslie ward, specifically enabling infectious patients who are often held up in the ED to be transferred more rapidly. Side rooms remain a critical issue for facilitating prompt flow out of ED for surgical cases.

Reducing elective inpatient waits remains a primary objective, with a target to bring waits down for 52 weeks to a target of 145 patients by 31 December 2025.

Between January and mid-February, admission criteria will prioritise cancer cases, urgent referrals, and the longest waiters within Trauma & Orthopaedics. Progress is currently on track but must be balanced with ongoing financial recovery actions. There will be a reprofiling of Elective Recovery Fund (ERF) spending, moving allocations from Q4 into Q2 and Q3 to accelerate the pace of recovery initiatives and maximise available resources earlier in the year.

Additionally, the surgical admission capital plan and timeline will be further refined and updated in collaboration with Estates in the latter part of August. This will review whether the additional Same Day Emergency Care (SDEC) capacity for surgical returners can be implemented ahead of winter. Timelines are not known at time of writing but must be delivered before the end of the financial year. This will give additional spaces opposite SRU to help with capacity constraints.

There will be changes to Ear, Nose & Throat (ENT) infection control policies. Final departmental ratification will be required. The aim is to prevent patients with ENT infections from remaining unnecessarily long periods in ED, thereby supporting more timely admissions to SRU.

Surgical Point of Contact

Recognising the ongoing need to strengthen team performance and resilience, a renewed emphasis will be placed on capacity and capability training for newer and some existing members of the team. Structured induction programmes, targeted workshops, and mentorship opportunities will be developed to ensure that all staff are equipped to navigate the complexities of surgical flow and escalation procedures.

Clinical Support Services

Clinical Support Services

Radiology continues to play a vital role in the discharge pathway, with a Standard Operating Procedure (SOP) for discharge with imaging follow-up currently under development. The SOP completed in July 2025 and will be in use for winter. This SOP aims to support clinical teams' confidence in post-discharge imaging arrangements. Further review into machine resilience and the Community Diagnostic Centre (CDC) infrastructure being fully utilised will be assessed.

In the Patient Access Centre (PAC), the absence of an electronic solution for the 6-4-2 process in outpatients necessitates a manual approach to ensure full utilisation of available clinical space. While effective, this reliance on manual oversight presents challenges, especially as patient volumes increase, and underscores the need for ongoing review of system efficiency and capacity management.

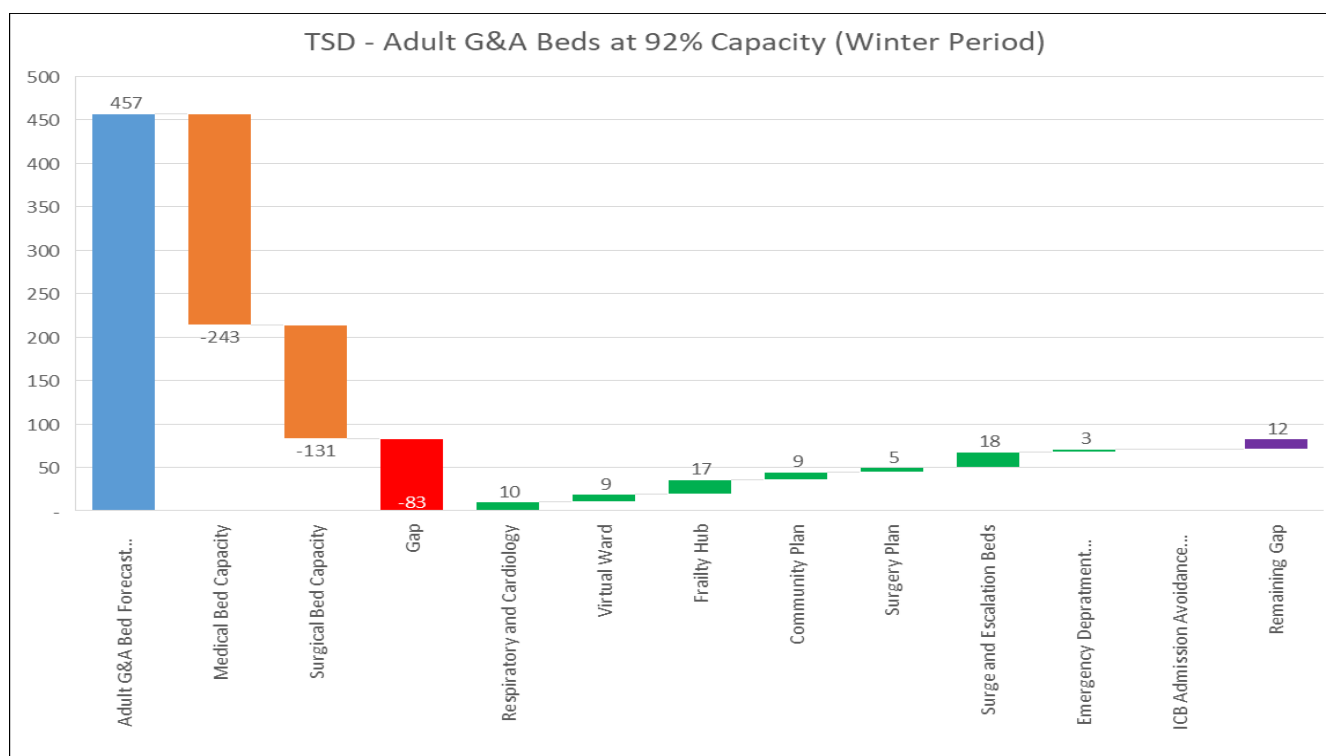
Point-of-Care Testing (POCT) in Microbiology is under financial review, with a forecast requirement of 305 boxes of Quad Kits and 70 boxes of Green Swabs. Last winter, POCT spending exceeded the budget by £148,981.20, and at present, there is no dedicated funding to cover a repeat overspend this year. Confirmation from Finance is awaited regarding funding sources utilised previously and potential solutions for covering anticipated costs; if unresolved, this represents a significant cost pressure moving into the winter period.

Mortuary flow, previously impacted by absences in the Medical Examiners Office over the Christmas period, has been addressed with a new plan now in place to ensure robust coverage and support effective transfer and flow during peak demand periods.

Pathology services have seen an 18.25% increase in activity at Month 3 compared to last year, with the potential for a further 5% increase during winter based on historical trends. The current capacity is unable to fully meet elective demand, and the anticipated increase in acute work over winter could exacerbate this shortfall. Without additional staffing, specifically the release and onboarding of two Biomedical Scientists (BMS) requested through the Elective Recovery Fund (ERF), the ability to maintain elective throughput will be compromised. Prompt release and training of these BMS posts is essential to mitigate the impact on elective and acute pressures; otherwise, elective work may need to be restricted further to prioritise acute demand.

Bed Gap Mitigation

Each of the key elements of the plan outlined in the section above has been modelled from either admission prevention, length of stay reduction, increased discharge. This modelling has then been applied as a bed equivalent to support an understanding of the scheme contribution toward closing the 82.6 bed gap that was identified at the beginning of the planning process. The outputs of this work have been compiled into a waterfall chart below to show the initial bed gap, the proposed mitigation plans and the remaining gap. This is based on the peak of winter demand which is expected in January.



It is important to note that this model is based on the national working assumption of bed occupancy at 92%. The regular bed occupancy for the Trust last winter was ~98%, however it is understood for the Trust to maintain the required levels of flow and to maintain running elective services effectively, a bed occupancy level of 92% must be the aim.

The current ICB programmes have provided impact analysis based on reduction in attendances rather than admissions avoidance. As such, it is difficult to apply a bed mitigation to support the closure of the anticipated bed gap. Therefore, for the purpose of the chart above, the remaining gap has been left as 12 beds at the point of highest demand. It should be expected that despite the modelling being based on attendance, there will be a reduction in admissions which will support a mitigation of the 12 bed gap.

Escalations and cadence

Site Operations

Site Operations and responsibility for safety and flow of the Trust is the responsibility of the Director of Operations. Out of hours the accountability for this sits with the Director on Call, supported by the Head of Operations and Clinical Site Managers.

To strengthen leadership and operational oversight during weekends, the Trustwide Site Operations Team will move to providing seven-day cover. The role will be undertaken by the Head of Site Operations and Head of Operations, ensuring experienced operational leaders are present to provide visible, on-site leadership between 08:00 and 17:00 daily. Outside of these hours, the on-call Manager will continue to provide leadership support, maintaining full 24-hour cover

This change is intended to deliver several key benefits:

- **Consistency of leadership** – by making senior decision-makers more accessible and responsive to the day-to-day operational needs of the organisation.
- **Improved operational efficiency** – enabling faster problem-solving and more effective coordination across the Integrated Care Organisation (ICO).
- **Visible senior presence and staff support** – providing a single point of contact for patient safety, flow, and operational issues.

The Safety and Flow Meetings are in place to monitor and manage safety, capacity, and demand across the organisation. The meetings are held in person at the Site Operations Centre/Incident Command Centre (Level 4 – Yellow Zone – Torbay Hospital) at 08:45, 12:00, 15:30, 20:00, and 22:00, with additional ad hoc meetings as required.

The purpose of these meetings is to ensure the organisation remains well-positioned to anticipate and respond to site safety concerns, pressures on patient flow, and surges in demand. This includes resilience across all patient pathways, from urgent and emergency care to elective and community services. The 08:45 meeting focuses on reviewing the previous day's performance, confirming the day's predictor data, and declaring the Operational Pressure Escalation Levels (OPEL) status. It also provides a clear overview of pressures across divisions and sites within the Integrated Care Organisation (ICO), with updates on key challenges, safety concerns, actions in place, and support needs. The meetings ensure that actions are agreed upon and documented to support effective patient flow and safety, and these are reviewed at subsequent meetings to track progress.

Time	Meeting	Required to Attend
08:00	Safer Staffing Meeting – use Safer Staffing Link	Senior Nurses, CSM
08:45	Site Operations Meeting	Site Team, SPOCS for Care Groups, Infection Control, Facilities
11:00	Devon System Call	Head of Site Operations
12:00	Site Operations Meeting	Site Team, SPOCS for Care Groups, Infection Control, Facilities
14:00	System OPEL 4 Devon Call - Will be confirmed at 1100 Devon Call if required.	CEO or Executive Director
15:00	Safer Staffing Meeting – use Safer Staffing Link	Senior Nurses, CSM
15:30	Site Operations Meeting	Site Team, SPOCS for Care Groups, Infection Control, Facilities
16:30	Devon System Call	Head of Site Operations
19:30	System OPEL 4 Devon Call - Will be confirmed at 1630 Devon Call if required.	OCM
20:00	Site Operations Meeting	OCD, OCM, Site Team, ED, AMU, SRU, Senior Nurses
22:00	Site Operations Meeting	OCM, Site Team

In periods of Opel 4 or any form of business continuity incident or major incident, the leadership of these processes will escalate to the Director of Operations with delegated authority from the Chief Operating Officer. In the period between November 2025 and February 2026, a 17:00 Site Operations meeting will become part of the routine cadence to reduce the time between the 15:30 and 20:00 meetings. This additional meeting has also been deemed necessary to provide oversight due to the changing between day teams and on call teams, and the well understood changes to discharge profiles and site position that can occur after 15:30 each day

On Call Manager

As part of a rotational rota, designated managers act as the on-call Manager for the Trust during 1700-0800, providing senior oversight and decision-making to ensure the safe and effective operation of the organisation. During their duty period, the on-call manager maintains awareness of current access and capacity pressures and remains contactable at all times. They are responsible for responding promptly and appropriately to issues raised by the Site Management Team or Switchboard, determining whether matters can be resolved remotely or require on-site attendance. The role involves making timely decisions to support the Trust in maintaining safe services and meeting key performance indicators (KPIs). When necessary, the on-call Manager will liaise with system or regional NHS colleagues to resolve operational issues and escalate to the on-call Director for matters requiring higher-level authority. All key decisions must be recorded by the staff member to ensure a clear audit trail is maintained. To support on call teams ahead of winter there will be two briefing sessions on key operational elements of the Trust and system winter plans to ensure all on call managers are fully aware of expectations, requirements and the plans to enact when required. These sessions will be recorded and cascaded for any on call manager unable to attend a face-to-face briefing session.

Surge Plan

The Trust currently manages surges in demand or issues with balancing inpatient demand capacity through the full hospital protocol. This is a protocol that has been designed between operational and clinical senior staff and is endorsed by executives. The protocol outlines areas that can be escalated in hours to provide short term access to flow in order to decompress the emergency department and also beds that can be opened for use overnight to provide additional capacity where inpatient demand will exceed the required discharges to enable a safe site overnight.

It should be noted that many of the areas identified in the protocol for use overnight are the areas that are required early each morning to enable early flow and a decompression of the emergency department. As such, a further review of alternative escalation spaces is being undertaken between the Head of Site Operations and senior nursing colleagues ahead of winter and this plan will be amended accordingly.

At present the escalation plan is as follows

In Core Hours (8am – 8pm)

As part of the Trust's response to the Timely Handover Process for ambulance offloads, the Trust Your Next Patient SOP was redeveloped to describe how patients will move to wards in advance of discharges at particular times of the day to provide early flow and create space ahead of ambulance arrivals in line with expected demand profiles. This protocol is developed in line with the expected discharge numbers for each ward on a 'typical' day. These spaces are for use in hours only and cannot be used overnight due to staffing and safety.

To provide additional space in the emergency department for ambulance offloads, where core capacity cannot be created within the 45 minute requirement, cubicle 8a and cubicle T9 can be used to create two additional ambulance offload spaces. These should be used as short-term escalation only, with a clear plan in place to create the flow to decompress these spaces within an hour.

Within assessment areas, a cubicle space has been identified on both AMU L3 and in EAU4 that can be 'doubled up' and receive an additional patient. This escalation space can also only be used with a clear plan to deescalate within a timeframe agreed with the matron ahead of use.

The other option to provide rapid escalation space within hours is to use the ringfenced pathway beds for areas such as stroke, fractured neck of femur or cardiology. These beds will be used in collaboration with the nursing staff responsible for these wards and initially, suitable patients in the emergency department or assessment areas will be identified to move to these spaces. Each of these areas will have its own criteria for use and de-escalation which are described within the table below.

Excess demand for trust services can be dealt with through; admission avoidance, increased discharges, flexing or changing the bed capacity, use of theatres, change to staffing, or a combination of these. To manage demand the below areas have been identified to support flow across the ICO. (Please note this is a guide only and the COO/Care Group directors/on-call Director can adapt this plan to maintain patient safety and experience at any time)				
To generate flow across the acute hospital, we will:	Operating Hours	Capacity	Comments	
Utilise Discharge Lounge (0800-2000)	0800-200 Monday to Friday	8 Beds and 15 Chairs (early access to acute beds)	All patients in the acute hospital for discharge or transfer to be reviewed for using the lounge.	
Commence Your Next Patient (YNP) protocol	Day time action	Flexible	See SOP	
Pre-emptive transfer into Community Hospital beds	Day time action	Flexible	See SOP	
Move MRSA negative screen patients from Ainslie to Ella Rowcroft	24/7	Flexible	See SOP - Infection Prevention and Control Protocol for Ella Rowcroft Ward (Elective Orthopaedics), Ella HCU and Ainslie Ward (Trauma)(G1681)	
Full Hospital Protocol Trigger to enact Surge Capacity/Full Hospital Protocol: 1. Ambulance holds over 30 minutes with no offload plan 2. More than 10 DTA in ED, ED Majors, escalation and Fit2Sit is full with no onward moves in the planned next 30 minutes. 3. Assessment units (AMU/SRU) are full (excluding waiting room capacity) with no onward moves in the planned next 60 minutes. 4. Specialty need for demand – (e.g. Cardiac, Surgery)				
To generate flow across the acute hospital, we will:	Operating Hours	Capacity	Staffing need	Comments
Use Escalation spaces in ED	24/7	Use T9 for patients with a onward move pending transfer. Major 8a to support offloading of CAT 1, high acuity SWAST offload and Resus	Within ED establishment	Linked to THP handover process.
Escalate our Assessment areas AMU Level 3 EAU 4 by 1 additional patient.		1 x AMU + 1 x EAU4	No requirement for additional staff.	Linked to THP handover process.
George Earle Ward - Stroke beds Use of the ring-fenced beds for non-stroke patients	24/7	2 ring fenced beds	No requirement for additional staff.	Working with the specialty team, ensuring there is a discharge identified for later to bring back pathway within next 4 Hours. Or a medical patients ID to transfer off in the event of an acute Stroke.
Dunlop Ward Flexing from Cardiac to medical beds	24/7	Flexible	No requirement for additional nursing staff. Requires Medical cover to review patients.	Complete Surge Checklist below - Flexing from Cardiac to medical beds. Working with the specialty team – No Medical Dr Cover . Patients would be classed as an outlier.
Ainslie Ward Short term use of NOF Beds for T&O Patients only	24/7	2 ring fenced beds	No requirement for additional staff.	Working with the specialty team, ensuring there is a discharge identified within the next 2 hours to bring back pathway.
Short term use of Primary CCU bed. Use CCU Primary bed and utilise Recovery bed if required short term	24/7	1 ring fenced bed	No requirement for additional staff.	Ensure there is a discharge identified, that can be completed in the next 2 hours.
IP theatre Recovery (Max of 2 High care or ward-able patients)	24/7	Maximum 2 ward-able patients. Not able to support if have High Care/Step down ITU patients – Post Op only	No requirement for additional staff.	Theatre patients having had surgery to be held in recovery rather than utilising ward beds. Appropriate to free up acute surgical beds overnight - See SOP
Capacity opportunity - Use surgical beds for medical patients.	24/7	Excluding Ella Rowcroft	No requirement for additional staff.	Complete Surge Checklist below (Patients would be classed as an outlier.)
Optimise all beds across the Acute site. Use capacity for patient normally excluded from speciality areas.	24/7	Flexible	No requirement for additional staff.	Use capacity for patient normally excluded from speciality areas. Working with the specialty team

Outside of Core Hours

To support an increase in Trust overnight occupancy, there are additional bed spaces which have been identified to provide overnight escalation and increase the Trust bed base. Many of these spaces will impact on flow for the following day and all of them will require additional staffing which will negatively impact the financial position of the organisation. To enable the most effective decisions to be made to balance the safety and flow of the Trust alongside the need to meet the operational plan, decisions on additional escalation space will ideally be made at the 15:30 safety and flow meeting which would be chaired by the Director of Operations. Making decisions at this time of the day would ensure adequate time to obtain the additional staffing required to open these spaces, identify the patients suitable for outlying into the spaces, and to ensure mitigation plans are in place to de-escalate as swiftly as possible the following day. Each of these areas will have its own criteria for use and de-escalation which are described within the table below.

Excess demand for trust services can be dealt with through; admission avoidance, increased discharges, flexing or changing the bed capacity, use of theatres, change to staffing, or a combination of these. To manage demand the below areas have been identified to support flow across the ICO. (Please note this is a guide only and the COO/Care Group directors/on-call Director can adapt this plan to maintain patient safety and experience at any time)				
To generate flow across the acute hospital, we will:	Operating Hours	Capacity	Comments	
Full Hospital Protocol <i>Trigger to enact Surge Capacity/Full Hospital Protocol:</i> 1. Ambulance holds over 30 minutes with no offload plan 2. More than 10 DTA in ED, ED Majors, escalation and Fit2Sit is full with no onward moves in the planned next 30 minutes. 3. Assessment units (AMU/SRU) are full (excluding waiting room capacity) with no onward moves in the planned next 60 minutes. 4. Specialty need for demand – (e.g. Cardiac, Surgery)				
To generate flow across the acute hospital, we will:	Operating Hours	Capacity	Staffing need	Comments
Escalation Capacity (unfunded capacity)				
AMU Level 2 overnight	Overnight	6 trolleys spaces > increase to 12 with approval by on call director	Additional RN required for night shift	Only the On-call Director out of hours, or the COO in hours will have the authority to authorise this area to bed patients due to Health and safety risk. See SOP
SRU	Overnight	Increase capacity from 10 > 12	Additional RN required for night shift	
Cath Lab Recovery	Overnight	5	RN and HCA required	Unfunded area – requires On Call Director approval Complete - Opening Cath lab Checklist Please see Cath lab Escalation Admissions criteria SOP
DCL overnight	Overnight	8 Beds > increase to 12 with approval by on call director by taking out ambulatory bay	8 beds - 2 RN required. Increase to 12 beds additional HCA required.	Unfunded area – requires On Call Director approval Complete - Opening Discharge Lounge OOHs Checklist Identify patients across Acute beds who are for discharge the next day or have an allocated Community bed. Discharge Lounge can support 8 Bedded patients overnight. Across two bays. Increase to 12 with approval by on call director by taking out ambulatory bay
Broadsands Unit (Decant)	24/7	6 Beds (Same Sex) + 1 SR	1 RN + 1 HCA required. Medical cover.	Complete - Unfunded Escalation area - Opening Escalation Checklist below See SOP for opening of escalation beds.
Unfunded Community Beds	24/7	2 x Totnes 2 x Dawlish	1 HCA required for each site escalated	Unfunded beds – requires Executive/On Call Director approval. Complete - Opening Unfunded Community Hospital beds Checklist
Louisa Cary	24/7	Increase from 19 core beds. Unit has 27 physical spaces linked to patient profile - Cot vs Bed spaces.	Workforce need as detailed in SOP as depended on patient profile and need.	See SOP
Ella Rowcroft	24/7	Increase of beds from 14 > 19	Depended on the patient profile on the ward, assessed by senior nurses.	Supports an increase in Trauma demand.
IP theatre Recovery	Overnight	Increase from 2 High care/wardable patients up to 4 patients	Additional ODP or RN - depended on patient profile	

The table above identifies 35 additional bed spaces that could be used to increase adult general and acute (G&A) occupancy. The Lousia Cary beds identified in the chart are paediatric beds and have therefore not been included as a possible adult G&A bed mitigation. To ensure the winter plan is as realistic as possible, the bed mitigation provided from the escalation plan above has been 'capped' at 18 based on the organisational memory of the amount of escalation space that can be staffed and opened at any one time, particularly accounting for the expected increased sickness rates and staff availability over winter.

Any use of additional escalation capacity needs to be made on the basis of safety but understanding the potential impact on the financial position of the Trust. Currently within budget for November to March is £73k of winter funding to support expected demand pressures. This is specifically to enable the discharge lounge to open 4 nights per week (x3 weekdays and x1 at the weekend). It is not anticipated that any additional winter monies will be made available at present, however if there were additional monies then additional use of escalation would need to be a key consideration for any submission. The trust has other options already in progress for submission should any additional funding become available. These include

- Additional medical staffing at weekends
- Additional virtual ward capacity
- X-Ray car based on the UHP model
- Additional P1 and P2 capacity to support discharge

Emergency Preparedness and Business Continuity

The arrangements for responding to any major incident are contained in the Trustwide Incident Response Plan. The Trust also has a Business Continuity Management Policy as well as a Strategic Business Continuity and Recovery Plan for Eastern Services and a Business Continuity Plan for Northern Services which is currently being merged into a Trustwide document. This document is being taken to the next Emergency Preparedness, Resilience and Response (EPRR) Group in June for approval. The plans are available on the Trust's intranet site.

Adverse Weather Conditions

The Trust receives warnings of adverse weather from the Met Office and health warnings from the UKHSA. The Trust also receives additional information from a Met Office Advisor via the Local Resilience Forum if forecast weather has the potential to cause disruption. The Trust has an Adverse Weather Plan which can be found on the Emergency Preparedness page of the Trust intranet and covers all types of weather including heatwave and snow/ice.

The plan is reviewed each year against national guidance which corresponds to Met Office Cold Weather Alert and Heat Health Watch periods. Weather warnings are also shared with key staff, so operational planning can be in line with weather risks.

Vaccination

The NHSE urgent and emergency care plan states that all trusts must have an accessible occupational health offer for staff which is available throughout the entire flu campaign. This must include onsite bookable appointments and walk in appointments. All trusts must have a fully developed plan for improving flu vaccine uptake for NHS staff by the end of Q1, including a stretch target for increasing the percentage of staff vaccinated in 24/25. The plan should include:

- improved communications and engagement with staff to increase their vaccination rates and to support the promotion of vaccination to eligible patients, better highlighting the link with winter pressures Urgent and Emergency care plan 2025/26 10
- work with sector partners to proactively promote available vaccination offers to those who provide and draw on care
- a requirement for NHS hospitals to offer vaccination on discharge to any patients going into a care home

The tables below demonstrates the Trust's 24/25 vaccination position for both covid and flu vaccines in relation to other providers in the system, as well as against regional and national aggregated position. The tables also demonstrate the Trust vaccination position at care group and staff group level, with a breakdown of sickness at care group level.

TRUST	Covid end of winter 23/24	Covid end of Winter 24/25	Flu end of winter 23/24	Flu end of winter 24/25
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	35.20%	30%	44.50%	47%
DEVON PARTNERSHIP NHS TRUST	37.10%	35%	49.20%	49.2%
ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST	41.40%	35%	51.30%	48.8%
SOUTH-WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST	45.30%	28%	53.30%	46.5%
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	45.10%	40%	52%	53%
Regional Average	47.80%	24.10%	50.20%	48.7%
National Average	30.20%	21%	42.80%	40.95%

Trust vaccination rates in comparison to rest of system and regional/national averages can be seen above with vaccination rates by care group and staff type seen in the two tables below.

	Children and Family Health Devon	Families & Communities	Medicine and Urgent Care	Planned Care and Surgery	Shared Corporate Services
COVID %	16.67%	26.38%	29.29%	40.02%	35.34%
FLU %	19.25%	35.07%	44.36%	52.30%	42.71%

Substantive Staff	Both Vaccines	Covid Only	Flu Only	No Vaccine	Grand Total	Both Vaccines	Covid Only	Flu Only	Total
Medical and Dental	359	3	48	295	705	50.92%	0.43%	6.81%	58.16%
Registered Nursing, Midwifery and Health Visiting Staff	527	18	249	954	1748	30.15%	1.03%	14.24%	45.42%
Registered Scientific, therapeutic and technical staff	402	9	106	599	1116	36.02%	0.81%	9.50%	46.33%
Support to Clinical Staff	373	16	224	1010	1623	22.98%	0.99%	13.80%	37.77%
Total NHS Infrastructure support	682	14	215	1277	2188	31.17%	0.64%	9.83%	41.64%
Grand Total	2343	60	842	4135	7380	31.75%	0.81%	11.41%	43.97%

Substantive Staff	Both Vaccines	Covid only	Flu Only	No Vaccine	Grand Total	Both	Covid only	Flu Only	Total
Front Line	1661	46	627	2858	5192	31.99%	0.89%	12.08%	44.95%
Back Office	682	14	215	1277	2188	31.17%	0.64%	9.83%	41.64%

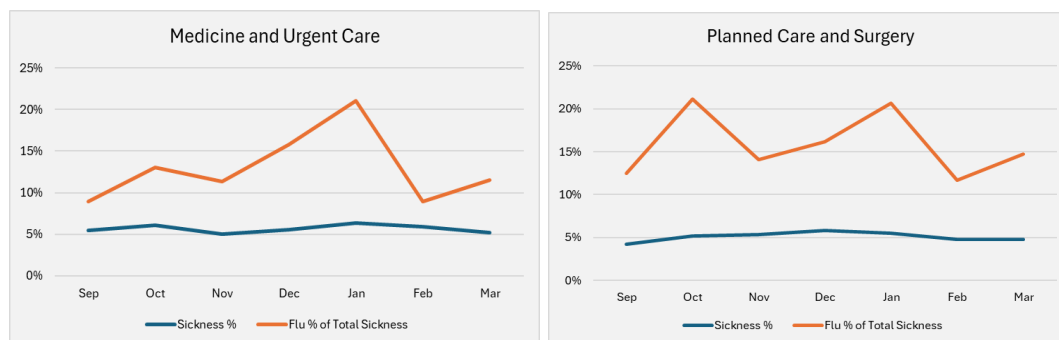
In last years vaccination campaign, the Trust recorded the best position for vaccination in the Devon system, including SWASFT, and also exceeded the regional and national average positions for both vaccines. Despite this, the Trust only vaccinated just over half of the workforce against flu and within winter 24/25 experienced a significant increase in sickness from the year before as demonstrated below.

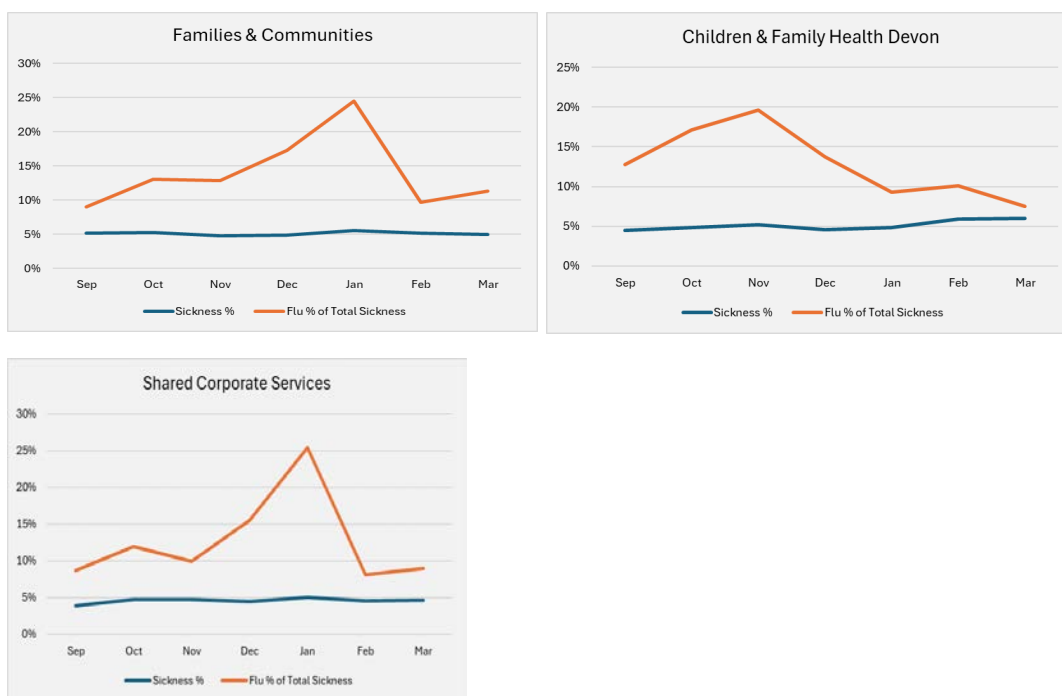
Winter Planning - Sickness Absence

	2024 Oct	2024 Nov	2024 Dec	2025 Jan	2025 Feb	2025 Mar
Sickness Absence	8,510	9,905	6,230	6,796	5,038	5,158
Sickness %	5.24%	5.41%	5.22%	5.22%	4.51%	4.69%
Flu Absence	1,685	1,616	1,709	2,265	1,321	1,017
Flu %	19.80%	16.31%	27.43%	33.33%	26.22%	19.71%

	2023 Oct	2023 Nov	2023 Dec	2024 Jan	2024 Feb	2024 Mar
Sickness Absence	5,938	5,146	5,834	6,700	5,667	4,534
Sickness %	5.45%	6.68%	5.33%	4.78%	5.20%	4.54%
Flu Absence	1,160	1,125	1,622	1,880	1,358	1,146
Flu %	19.54%	21.86%	27.80%	28.06%	23.97%	25.26%

A further breakdown of care group flu sickness as a proportion of total sickness can be seen below.





The national flu immunisation programme letter stated that flu vaccinations for 2025/2026 will be undertaken as follows

- Pregnant women and all eligible children will start from **1st September 2025**.
- All other adult flu cohorts will start from **1 October 2025** and will run until the **31 March 2026**.
- Although, we anticipate that the majority of vaccinations should be completed by the **end of November 2025** to provide the best possible protection going into winter.
- The COVID-19 programme will run from **1 October 2025 to 31 January 2026**. However, the majority of COVID-19 vaccinations should be completed by **19 December 2025**.

The below cohorts are the identified groups that are eligible for Covid-19 vaccinations.

NHS England has acknowledged the differences in cohorts for Covid-19 and Flu however, would encourage co-administration where possible for the following cohorts:

- Adults aged 75 years and over
- Residents in a care home for older adults
- Individuals aged 6 months and over who are immunosuppressed

The Trust winter vaccination programme has been led by the Deputy Chief Nurse with support from the tissue viability specialist nurse matron to ensure trust wide oversight. To enable the delivery of the internal vaccination programme, a working group was convened in July and met twice weekly to develop the plan. A request was made for each care group to identify staff members who will enable effective vaccination roll out within their care group by end of July 25.

To support the design of the vaccination plan for this winter, a literary review was undertaken alongside an analysis of vaccination uptake data from 24/25 to understand which areas of the organisation may require a differing approach to improve vaccination uptake. For example, Children & Family Health Devon (CFHD) had low uptake previously, therefore a targeted approach would be taken during this programme. Also, there will be a focus on sickness data to plan a targeted approach for areas with above average sickness levels in relation to flu.

Following learning from winter 24/25, a new model of delivery for staff and patients has been designed for this winter consisting of;

- Patients – Eligible patients will receive vaccinations from the Infection Prevention & Control (IPC) team (daily walk rounds) on the acute sites, Community Hospital Matrons
- Staff:
 - I. IPC team to offer staff vaccinations on a daily basis when visiting clinical areas with trust wide support to ensure delivery of vaccines across acute site
 - II. Booked clinics in Bay View led by a small group of vaccinators
 - III. Senior Nurses to support with peer vaccinators in the community supported by roving vaccinators

The Trust vaccination programme will be conducted between Wednesday 1st October and Friday 19th December 2025. It will be administered predominantly from the Bayview Balcony between 8am and 8pm on these days, initially 7 days per week and then reducing to 5 days per week. An alternative plan to increase vaccination uptake within our community settings will also be created to prevent the need for these staff groups to travel to the main hospital site to receive their vaccination.

Our primary goal is to increase staff flu vaccination and COVID uptake across the Trust, with particular focus on clinical staff to help protect patients and the immunosuppressed to help reduce the sickness spike we experience around Christmas and New Year period.

"Protecting our patients starts with protecting ourselves" campaign should emphasise clinical leadership, peer influence, and accessibility whilst addressing vaccination hesitancy through myth-busting and positive messaging and asking medical staff to remember why they joined the NHS in the first place; to help patients and protect others.

Key tools and areas to focus on include:

- Staff videos to help launch our winter campaign along with screensavers, intranet pages (including landing screen and website), ICONews, Managers briefing and Trust Talk.
- Create a team of Peer Champions – staff who are not part of the project team who can help support the roll out and change the opinions on vaccinations. This will link with the learning taken from the Right Care Week which recently gained strong results from their “Go See” / Back to the floor campaign; A script to be created to help roving vaccinators, peer champions and senior leaders to help with ward-level discussions.
- Myth busting; discussing vaccination hesitancy openly and sharing with staff the cough cold and flu sickness spike data to help with open and honest discussions.

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To ensure a robust and ongoing evaluation of the Trust’s vaccination programme, the following internal governance structure has been created. This will enable the Trust to identify any issues with previously identified challenges such as suitable levels of vaccine supply, recording of data, robust coverage of vaccinators to enable provision to staff working unsociable shift patterns. The governance structure designed includes

- Flu & Covid Vaccination Working Group Meeting (Will move to weekly when programme launched)
- Weekly review at IPC update and review meeting
- Monthly reports submitted to Safety Quality Assurance Group (SQAG) and IPC governance team
- Monitoring of incidents and complaints with appropriate action taken by IPC Associate Director of Nursing and Professional Practice (ADNPP)

Infection Prevention and Control

The IPC team currently work across acute and community settings with all workstreams to be reviewed in 2025-26 following the appointment of an ADNPP. The trust's clinical microbiologists support the team in all aspects of IPC and take over IPC on-call cover out of regular working hours. This support also includes outbreak management, surveillance, for and management of healthcare associated infections (HCAI's), and provision to primary and secondary care.

The IPC team meet twice daily for the discussion of new clinical cases / situations in order to prioritise the workload. There is a weekly IPC meeting where care groups attend to discuss their compliance with IPC, and they are able raise any issues. This will be reviewed as part for the workplan for 2025/26. Through this governance framework, issues are identified and worked upon both proactively and reactively, coordinating actions between multiple parties to reduce infections and improve standards. The reporting framework ensures oversight and insights into variations in practice, with a focus on hotspots requiring targeted action.

In The trust's high level of cleanliness has continued into 2024-2025 where protocols have been adapted to meet the needs and demands of the clinical teams and getting back to business as usual after the COVID-19 pandemic. Compliance with the national cleaning standards introduced in 2021 has been established and maintained. Coupled with weekly reactive cleans on floors, walls and beds in all areas, the hotel service staff have continued to keep all wards and departments to a high standard of cleanliness. Any areas that have not met standard through auditing or visual inspection, have gone through the rectification timeframe and re-audited to meet standards expected. It has also been the second full year with the new cleaning standards and going from a percentage score to a score rating from 1 – 5 with 5 being very good. Functional areas achieving 4 score-rating or below will generate remedial actions to improve. In these instances, the activity generated through rectification will serve as a training opportunity going forward and to enhance the focus in all areas to provide assurance.

Deep Cleans

The number of deep cleans undertaken in 2024/25 was 14695 an increase of 3347 from 2023/24. This may in part be due to the increase in alert organisms and, given the finite amount of side rooms, and the complexity of patients requiring this resource, the number of deep cleans for these have increased significantly. Work will be undertaken in 2025/26 to develop a joint review process with IPC and facilities and an education programme around this. The trust provides two type of Deep Cleaning services: Hydrogen Peroxide Vapour treatment (HPV's), which is the recognised Standard of deep cleaning, with the addition of Ultraviolet Cleaning (UVC) in May 2024, which was added to improve the speed of the deep cleans and provided the same standard of cleaning for difficult areas to access. During the summer months particularly August/September there was a higher failure rate with HPV's due to the humidity recognising that HPV machines needed an operating temperature to be below 26 °C to work.

With the agreement of IPC and the Director of Infection, Prevention & Control (DIPC), a double deep clean was the fall-back alternative when this occurred. The average number of HPVs was 31 per month in 2023/24, compared to a decrease monthly average of 22 in 2024/25. The decrease is mainly due to the introduction of the UVC cleaning and hotter room temperatures in the summer resulting in HPV failures.

April 2024 - March 2025	2023-24 Quarter Four			2024-25 Quarter One			2024-25 Quarter Two			2024-25 Quarter Three			2024-25 Quarter Four			Trend	Totals to date	Average to date
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25			
	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			
Torbay Only - HPV Cleans per month	31	25	29	20	17	19	25	23	17	18	20	20	11	22	39		336	22
Torbay Only - UVC Cleans per month					11	20	4	13	3	3	27	4	0	6	2		93	8
Torbay Only - Deep Cleans per month	1096	991	823	797	883	926	1245	967	926	941	857	1260	1240	830	913		14695	980

There is open and clear communication with patients, their carers, family and the wider public, with work being undertaken to embed members of the IPC team within Care Groups and provide a visible, accessible service at the point of patient contact. There are a variety of patient information leaflets available for the wards to print off on the IPC ICON page, which will be reviewed and updated by October 25. IPC continue to communicate and display information about Infection Control Standards, with weekly updates in standard meetings (IPC is referenced in the managers' weekly briefing) posters, screen savers etc as well as website information and the use of social media via the trust Communications team. We have also had stands on level 4 promoting good hand hygiene and when gloves are required and not required. This enabled the IPCT to reach out to a significant number of staff and relatives trust wide, spreading the importance of glove usage in the prevention of infection and becoming a greener, more sustainable organisation. The roadshow also continued to embed the hand hygiene standards on a trust wide basis.

Identification and Prevention of Transmission

With the increasing pressure on the trusts urgent and emergency pathways, there has been a review across the whole organisation on responding to Operational Pressure Escalation Levels (OPEL) status and bed pressures. There are acknowledged risks which recognise the harm that can be sustained from a patient perspective both whilst waiting for an ambulance and waiting in an ambulance due to capacity /flow issues. To ensure appropriate monitoring, and use of side rooms, a side room tool has been implemented in Sept 24 by the Operational Site Team and IPC. This is a live document which is completed by the IPC team throughout the day across the 7-day week. In response to these risks and pressures, the IPCT has looked at ways to maintain patient safety and assist the flow of patients. Areas which are being reviewed are:

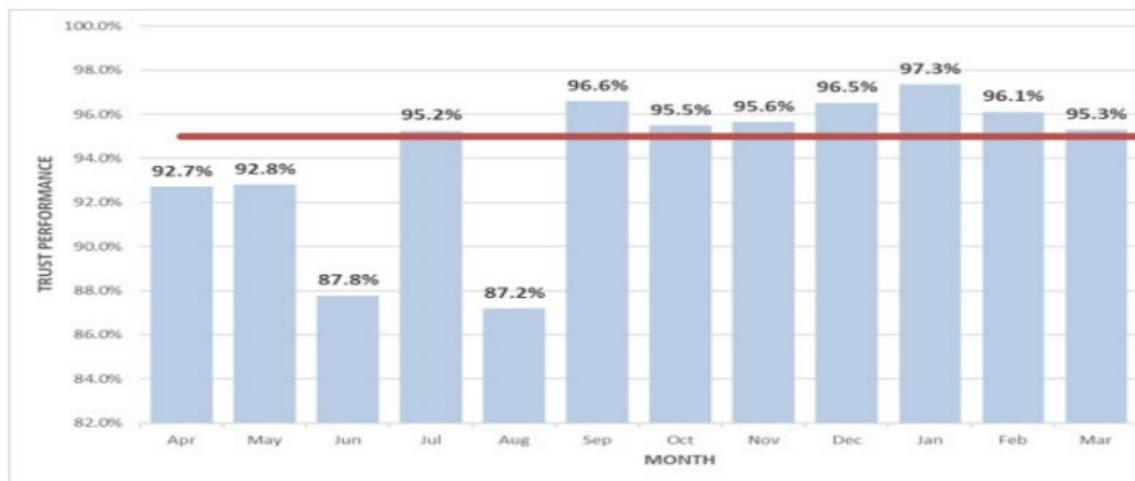
- Placement of medical patients in surgical wards. With appropriate risk assessments done by nursing staff patients can be cared for in different clinical environments which supports flow of patients out of ED if all beds are being utilised
- Use of side rooms through supporting ward nurses to review if the patient with an infection still needs to be isolated e.g. if after 48 hours of appropriate antibiotics and with appropriate risk assessment a patient can come out of a side room.
- Review of the Isolation Policy in conjunction with the trust wide site team to ensure all eventualities are considered with appropriate patient placement identified.
- Daily risk assessments are being reviewed to support staff in making decisions on appropriate bed use. The IPCT works closely with wards, operational site teams, and housekeeping teams, to ensure patients with infection are rapidly identified and isolated correctly with additional cleaning in place as required. This close working enables efficient responses to outbreaks to limit spread through standard work and precaution usage.

Mandatory training at trust induction continue to include infection prevention & control as core requirements. Please see Mandatory training compliance figures as displayed in table. This indicates that trust wide training has remained above the required level of 90% for seven consecutive months. This shows sustainable improvement even over the winter months

	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Infection Control LT*	92.07%	93.23%	91.35%	90.63%	89.83%	89.86%	89.55%	93.30%	92.83%	93.26%	93.26%	93.51%	93.45%	93.70%

Hand Hygiene

All mandatory and clinical induction training is in line with National Educational Framework. Hand hygiene compliance needed a targeted approach as audits undertaken between April-August 24 (except for June) fell below the required 95% standard. It is important to get our fundamentals of care right and audit results have been consistently above 95% since September 24, following the implementation of the hand hygiene road show and review of how audits were being undertaken to ensure consistency in completion.



Robust data supports quality improvement work and aids the IPC team to focus and respond targeted work to improve hand hygiene. There are areas where hand hygiene is particularly low, and these have been targeted to support improvement. The IPCT has provided targeted interventions as required to wards which has included:

- Turbo training- an informative 10-minute theory burst to support staff in making hand hygiene a habit.
- Glow box training- a physical demonstration of how easy it is to spread an unseen hazard around a clinical environment alongside the effectiveness of good hand washing to remove this.
- Implementation of a An IPC Champion programme, to reinvigorated roles and responsibilities in clinical practice, will be developed over 2025/26 and will be aligned with the Tissue Viability Champions programme

Side Rooms

Isolation for infection prevention reasons means caring for a patient in a single room, preferably with ensuite toilet and washing facilities. Only 30% of the inpatient beds on the Torbay Hospital site are single rooms with only 30% of these rooms being used for IPC related isolation. Most beds across the acute hospital site are in bays for 4-6 people. The side room capacity is higher in the community hospitals; Newton Abbot, Dawlish, and Totnes and Brixham. To ensure appropriate monitoring, and use of side rooms, a side room tool has been led and developed by the Deputy Chief Nursing Officer, supported by Operational Site Team and IPC team, to provide daily oversight of all side rooms across acute inpatient areas.

EPIC Implementation and Winter

The Trust is currently in the process of implementing a new patient record with a scheduled 'go live' of 3rd April 2026. This will require a significant amount of resource to be focussed on the implementation between the February and March 2026 which will coincide with a large period of the expected winter pressures.

The winter team will continue to work alongside the EPIC team as the winter plan is implemented to ensure that plans are consistent and complement each other where possible. Three areas where work is ongoing and EPIC requirements will impact on winter are annual leave for staff, training requirements for staff and the requirement to reduce clinical activity in the lead up to 'go live'.

A set of guidance for annual leave scheduling has been issued as below
We'll be launching our new One Devon EPR, Epic, on 03 April 2026. To ensure a successful delivery and implementation, we need to plan for the right levels of staff before, during and after go-live, as well as earlier on in the year to ensure all staff leave is taken.

Our EPR readiness owners (the care group triumvirates and their equivalents in corporate roles) have overall responsibility for ensuring that we are fully prepared for a successful go-live, while maintaining safe, high-quality care.

Our annual leave policy requires that colleagues take their leave evenly throughout the year so that we can plan and deliver care effectively. This year, it's particularly important that we have managers' support to ensure people are not building up leave to take at the end of the leave year (i.e. 31 March 2026). This will help your teams to be able to fully engage with the EPR training programme that will be running in February and March 2026 and the go-live in April 2026.

Some additional guidance, to run alongside our usual policy, has been prepared for managers.

- *Managers must remain aware of annual leave outstanding for each team member and should balance leave requests so that safe levels of cover can be put in place before, during and after go-live.*
- *By 31 December 2025 colleagues should have used a minimum of 75% of their leave. By extension, by 31 January 2026, 10 months' annual leave allowance (around 85%) should have been taken.*
- *Staffing capacity and availability could be increased by considering the following at the manager's discretion:*
 - *Confine the taking of annual leave during February - April 2026 to 60% of the allocation and carry over the leave to 2026-27 (up to a maximum of five days, in line with our usual annual leave policy).*

- o *Any annual leave carried over must be used in the first nine months of the 2026-27 financial year.*
- o *Exceptions during the period from February to April 2026 to the above will be considered by service management on a case-by-case basis.*

The guidance to increase the annual leave taken by the end of Q3 has the potential to impact on capacity and resource in the first half of the winter period. This will need careful planning from operational leaders. While there should be fewer staff members taking annual leave between January and March, this will be the time when training requirements for EPIC will be at the highest level. The operational teams will continue to work with EPIC teams to limit the impact on activity.

In terms of the levels of clinical activity to be reduced between January and March, a planning workshop is planned for the 15th September to begin to scope these requirements. Clinical leaders will be engaged in this work to understand and mitigate the clinical risks to reducing this activity, as well as understand how this could impact positively or negatively on winter delivery.

Staff wellbeing

A key impact on staff well-being is the level of safe staffing levels and this is an area that has been and will continue to be challenging as a result of many factors including Industrial Action (IA) by various staff groups. With the number of strikes already having taken place the Trust is well versed and prepared with a good structure in place for planning and constant review through its Gold Command structure. It does not, however, remove the fact that backlogs of work build as a result.

Despite the challenges of IA, the Trust's vacancy level has positively exceeded its target of 7% currently standing at 4.94% demonstrating good progress in filling key roles particularly in our nursing workforce group. The successful recruitment of nurses from overseas has allowed a reduced reliance of bank and agency workers although some skill mix balances still need some temporary workforce support.

The Trust has managed its unregistered nurse vacancy down to a good level and introduced a robust retention plan to maintain turnover levels. Key successes in the recruitment of some long standing hard to fill medical roles is also helping vacancy levels. The overall Trust turnover has seen a drop to 10.7%.

Staff sickness has fluctuated in recent months but currently stands in a better position than has been seen in the previous few years at 4.61%. COVID-19 sickness continues to be present and again a fluctuation in the number of staff off sick with COVID-19 symptoms has been seen in recent months.

Anxiety/stress/depression/other psychiatric illnesses contribute to over a quarter (27.4%) of all sickness absence, with this being more prevalent in staff working in UEC areas. When the Trust is in an escalated position for any length of time it impacts on staff, as they are asked to move within the hospital to maintain overall safe staffing numbers. Staff moves impact on staff morale and ultimately absence.

The high level of escalation beds constantly having to open with no funding to staff them impacts the overall staffing position. This is coupled with also having to care for patients with complex mental health needs over and above what would have been their required length of stay as care settings are unable to accept them back into their placement. A higher level of acuity of patients and changes to the ward base for some specialties has also led to an increased establishment requirement.

The Trust has a number of controls in place to ensure that overall safe staffing levels are maintained. This includes daily staffing meetings led by our Directors of Patient Care, monthly workforce group meetings for the core staffing groups (Nursing, Midwifery, AHPs and doctors) and collaborative system meetings focused on the usage and management of temporary workforce.

Wellbeing

There remains a significant level of violence and aggression, particularly within areas of UEC, and this is contributing to staff fatigue.

To mitigate this, the Devon system is continuing with a campaign to reduce the incidence of violence and aggression towards healthcare staff within the health arena, in addition to a robust wellbeing focus at senior leadership events within the Trust. It is acknowledged that an element of the workforce strategy is to offer overtime, and staff are already tired. A winter health and wellbeing plan is in train and will be added when complete, but some support structures include;

- o Staff support and counselling including single session therapy
- o Wellbeing ward rounds
- o Team reflection sessions
- o Fitness for work advice
- o Sleep physiologist support
- o Expert nutritional advice
- o Financial management, support and advice
- o Trauma support
- o Stress & burnout workshops and support
- o Commitment to ongoing investment in rest and wellbeing facilities
- o Comprehensive Employee Assistance Programme which includes external counselling provision

The Occupational Health and Wellbeing team remain vigilant endeavouring to provide timely accurate advice in response to queries and ensure that all published information available via the intranet is up to date. Managers could support with this by ensuring that staff are aware of relevant policies and protocols relating to illness and any subsequent required absence from work in order that it can be managed effectively and safely. There is a provision of a dedicated duty adviser to assist with this if queries remain unresolved.

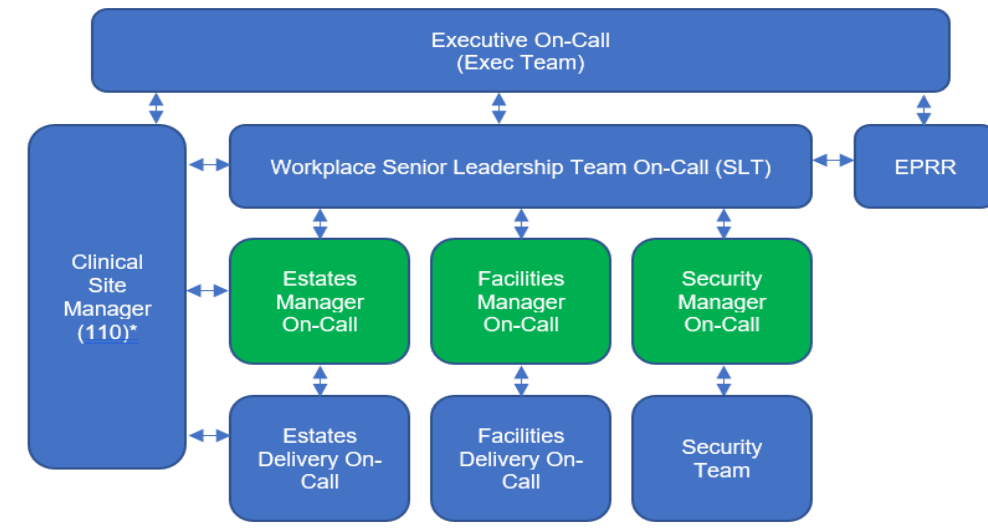
Flexible Working

In order to support work-life balance, the Trust continues to support flexible working. Staff are able to work flexibly, in agreement with their manager, with many staff working a hybrid model of some days on site and some at home each week. Appropriate IT equipment has been made available and a set of Home Working principles developed and communicated.

Estates and facilities – including community

Estates and facilities plans and escalation processes are contained within the Workplace on call and Incident Handbook. This document was last updated in April 2025.

Workplace On-Call Structure



Workplace Senior Leadership (SLT) on-call team: this team will manage the communications to the above teams and will provide any support required by the Estates Manager on-call or Facilities Manager on-call teams. They are also part of the Incident Response Team **(Tactical)** and will act when called upon.

Estates Manager on-call team: the primary role of this team is to provide operational management support to the on-call teams, both 'in-house' and 'outsourced' service providers. They also provide support to the Facilities on-call manager as and when required. They will respond to, assist, and escalate any information/actions or impact as required by other on-call managers within the Trust. They are also part of the Incident Response Team **(Operational)** and will act when called upon.

Facilities Manager on-call team: the primary role of this team is to provide operational management support to the Facilities Supervisors and Delivery teams, both 'in-house' and 'outsourced' service providers. They also provide support to the Estates on-call manager as and when required. They will respond to, assist, and escalate any information/actions or impact as required by other on-call managers within the Trust. They are also part of the Incident Response Team **(Operational)** and will act when called upon.

Estates Operational Delivery on-call team: consists of an Electrical and a Mechanical Technician. They have the required knowledge to address and make safe any part of the Estates infrastructure. They are informed of when a task is required to be escalated and the procedures in place to follow. They have the authority to call specialist contractors for advice or assistance.

This team is the 'first response' to the Acute site and are currently called directly from either the Clinical Site Manager, Switchboard or Workplace SLT/ Estates on-call Managers.

Community Maintenance on-call Provider: the on-call service for the Community Properties is provided by our contracted maintenance provider, on behalf of the Estates Delivery department team, and operate their own 'out of hours' Service desk.

This team is the 'first response' to the Community sites and are currently called directly from either the affected Site, Clinical Site Manager, Switchboard, Workplace SLT or Estates On-call Managers.

There may be occasions that the either the Acute teams or Community on-call teams may be required to attend and assist any property managed by the Trust.

The PFI Hospital (Newton Abbot) operates it own on-call service, with the exception of Medical Gas services. The competent Estates Delivery on-call person may be required to attend this sites and replace the oxygen cylinders.

Security Manager on-call: provides management support to the Security teams, both 'in-house' and 'outsourced' service providers in support of Trust-wide Security Aims and Objectives. They will respond to, assist, and escalate any information/actions or impact as required by other on-call managers within the Trust. They are also part of the Incident Response Team (**Operational**) and will act when called upon.

Specialist Deep Cleaning Services

To support with management of IPC issues through winter, a review of specialist cleaning services has been undertaken to ensure requirements for cleaning do not impact on the flow of the organisation.

The Specialist Deep Cleaning Team operate 24/7 and have specialist deep cleaning team, working through the day and night to meet our Infection Control requirements. The Specialist Deep Cleaning team, can be contacted via the Helpdesk on 01803 655331 or via Switchboard between 20:00 to 08:00

The Specialist Deep Cleaning Team, undertake deep cleaning for infections, such as:

- Covid 19
- Clostridium Difficile
- Norovirus
- D & V and other infectious diseases that require deep cleaning or HPV Cleaning. Please note that HPVs are arranged through the Facilities Helpdesk as normal.

Maintaining Safe Estate

Any out of hours issues related to the grounds of the acute site issues can be dealt with firstly through the on-call Facilities Manager to make safe out of hours.

In winter, the Grounds & Gardens (G&G) team will be made aware of any weather issues from the Met Office and grit paths. The council will grit main roads during icy conditions. This will happen normally between 1st December until 31st March and the G&G team can be contacted on: 07785 720098 Monday – Friday 08:00-16:00. The G&G team also have an on-call rota during the winter months which is shared by the whole team. Although on-call team members do not have a work phone, they can be contacted on their personal number.

The spreadsheet for the on-call rota and the personal numbers can be found on the shared drives (HOT_SER, ON CALL, G&G On call).

As part of the Adverse Weather Business Continuity Plan, an assessment will be made on any issues related to the safety of trees on the estate. Any tree issues will be escalated to Teign Trees on:
normal hours Monday – Friday: [01626 773499](tel:01626773499)
Out of hours - 24hr assistance: **07815 837424**

Communications plan

Our plan has been developed using learning from previous winters and will adopt an evidence-based campaign approach which will package messages together under three clear themes, in-line with our organisation's winter objectives.

Our winter plan will be implemented from October 2025 to March 2026, with the main activity taking place in December and January when there is the greatest level of demand.

We will take a tactical approach to deliver our messages, selecting tested channels for each theme to reach their intended audience and achieve the greatest impact. This approach will ensure we minimise confusion and message fatigue during the winter period.

Our campaign materials will be created using our data to identify and target key groups and communities (including by post code as well as social networks) to help achieve our objectives (for example, the early targeting of parents and carers to minimise the impact of RSV in our acute hospital in October and November by promoting self-care and primary care service; or promoting treatment at minor injury units for weekend sports-related injuries, which will be targeted at clubs, leisure centres and channels used by this demographic).

We will co-design a new and impactful staff vaccination campaign with a select group of our people to address low vaccination rates linked to issues of trust or fatigue, while addressing difficulty in accessing the vaccination by promoting the ways to get vaccinated.

The campaign will aim to remind all colleagues, both clinical and non, of the reasons why they joined the NHS: to help people and how vaccinations are a key part in delivering safe care.

It will be informed by data that shows the impact non-vaccination has on our ability to run safe and effective services and the need to protect each other.

Time has been scheduled into our plan in August and September to test messaging and materials with colleagues, including vaccination champions to ensure it has the greatest impact, and a range of tactics will be used to create a sense of excitement and friendly competition as part of the delivery plans.

We will use a variety of channels including TV, radio and print, social media, digital screens in our hospitals, internal communication channels, while also using community champions and leaders, partner communication channels and established networks to maximise our messaging.

We will use our people and service users in our content to tell our stories for authenticity and to create a community of ownership. We know from previous campaigns that people respond to faces and voices they recognise from their own community, rather than stock images.

Our tagline of Protecting our NHS will run throughout all of our communication products and messaging (we will test this with a focus group before launching).

Collaboration

Effective communications protocols are in place between key partners in Devon's NHS and local authorities to ensure a consistent approach to our winter messaging and responding to incidents and pressures, including critical incidents.

We will continue to adopt a One Devon approach to develop and deliver our winter campaigns, working in partnership with colleagues at NHS Devon, NHS trusts, NHS England, local authorities and Healthwatch. This will include agreeing key messages and campaign materials for standardised messaging which will be tailored to meet our organisation's needs (such as staff vaccinations, the promotion of key services and responding to incidents such as a critical incident to avoid confusion in messaging).

A representative from the communications team will continue to attend the daily organisational operational call and weekly system communications hub to monitor and react to system pressures, refining our messaging and tactics when needed.

Our aim and objectives

Our plan outlines our commitment to ensuring people receive the right care in the right setting, with a focus on doing more to support people to avoid being admitted to hospital by receiving care in their community and remaining independent at home; and, if they are admitted to our hospitals, supported to get back home as quickly as possible, with personalised wraparound care that meets their needs. This ensures people receive the right care in the right place, while aiming to reduce inappropriate attendances and pressure.

We will place a strong emphasis on preventing ill-health and encouraging winter wellness through the uptake of seasonal vaccinations amongst our staff to not only protect our patients and colleagues, but also the viability of our services.

Our plan is focused around supporting the delivery of three organisation's strategic objectives:

- **Protecting our patients starts with protecting ourselves** (staff vaccinations): To listen to and understand the views and experiences of our people about seasonal vaccinations to co-design and embed a campaign which helps improve vaccination rates among our staff and vulnerable at-risk groups to 55% or more, overcoming issues of trust or fatigue
- **Help us to help you** (choosing the right service): To create impactful, engaging and evidence-based communication products which supports flow through our services and reduces pressure (particularly in our emergency department) by educating people how to access the most appropriate service for their condition.

- **Help us get your loved ones home** (discharge and flow): Encourage prompt collection and discharge of patients who are ready to leave hospital and supporting people to get the care they need in their home and community through a range of services, including our new community frailty hub, SDEC and TEC-enabled care.

Deliverables:

Protecting our patients starts with protecting ourselves (staff vaccinations)

1. Opportunities to listen to and work with our people to co-design our campaign which acknowledges and addresses vaccine fatigue and hesitancy.
2. Produce content which features our people for authenticity and connection.
3. Create a community by sharing our people's stories about why vaccination is important to them and appealing to colleagues to protect others, particularly the vulnerable.
4. Through stories, highlight the impact flu and COVID can have on our teams and services if people become unwell and take time off work.
5. Investigate funding to create a branded selfie frame to capture staff stories at vaccination points. Content will be shared in ICONews, SharePoint, TV screens and screen savers. We will also share stories on our Facebook and Instagram to show our communities how we're keeping them safe this winter.
6. Investigate funding to create a rewards scheme for teams and areas with the highest vaccination rates and colleagues who vaccinate the most people.
7. Use screen savers and TV screens to share updates about department vaccination rates, team of the week and testimonials from that week's vaccination drive.
8. Rotate positive vaccination messages on TV screens and screen savers.
9. Share myth-busting information across our channels and via vaccination champions.
10. Promote the ease and accessibility of vaccination sessions across all our sites, not just Torbay Hospital.
11. Create opportunities to listen to our people, particularly in areas where vaccination rates are low, and use their feedback to refine our communication messaging and approach.

Help us to help you (choosing the right service)

1. Create a suite of communication products which are informed by our data and evidence to identify common conditions being treated in our emergency department which can be treated in other settings. Identify groups by demographic and post code to help target messaging.
2. Communication products will feature our people and those identified in our data (such as parents of young children; sportspeople etc) sharing their positive experiences of being treated in the right setting.
3. Provide a comms toolkit for partners to share on their channels to amplify our messaging.
4. Amplify child and young people-specific messaging by childminders, nurseries, schools, colleges, and sports clubs and leisure centres for sporting-related injuries.

5. Identify engagement opportunities at public events where our teams and community champions can share our messaging and share feedback we hear with our teams.
6. Use channels including Healthy Futures, Facebook and Instagram, public TV screens (including GP waiting rooms and exploring funding opportunities to advertise on externally owned public TV screens in towns and leisure centres).
7. Share content with community Facebook groups like Spotted to amplify messages
8. Share content on our internal communication channels: ICO News, SharePoint, TV screens and screen savers, team briefs and Trust Talk. Refine based upon the findings of our communications review, taking place during the summer.
9. Create opportunities for the public to share their experiences of using our services to both share positive accounts on our channels as part of a Protecting our NHS ownership campaign and sharing feedback with services as part of our continual improvement and refining our messaging and approach.

Help us get your loved ones home (discharge and flow)

1. Encourage prompt collection and discharge of patients who are ready to leave hospital and supporting people to get the care they need in their home and community through a range of services, including our new community frailty hub, SDEC and TEC-enabled care.
2. Encourage teams to get patients home for lunch / back to their own bed by providing clear information about the services available to them to support discharges, including the new community frailty hub (launching October), the enhanced care team, McCallum ready to go ward, virtual wards and adult social care / TEC-enabled care packages.
3. Celebrate teams and individuals who champion the home first approach on our channels, including ICO News, screen savers and TV screens, Trust Talk, and Our People Award nominations.
4. Identify champions to feature in our campaign materials as part of our Protecting Our NHS branding.
5. Where appropriate, identify media opportunities to illustrate how our people are helping to get people back home.
6. Create regular opportunities to increase visibility of senior leaders (including care group directors) in our acute and community settings to listen to our people about the challenges they experience getting people home. Use feedback to improve services and our communication messaging and approach
7. Remind our people about the harm patients are coming to by staying in a hospital bed longer than needed (particularly the frail and elderly).
8. Use channels including Healthy Futures, Facebook and Instagram, public TV screens (including GP waiting rooms) and media opportunities asking the public to support us by collecting their loved ones promptly. Create a sense of community by asking people to check on neighbours and friends who have recently left hospital to avoid re-admission.

9. Create media and team-generated content to explain why your own bed is the best bed and why we're focused on providing care away from the acute to the community to help overcome misconceptions that hospital care is always appropriate. Campaign materials will be fronted by the people we care for (with their consent).

Communications planner (this will be developed as vaccination and community hub frailty plans are finalised, and other communication opportunities to support our objectives are identified)

Risk Log

The following risks have been identified which, if materialised, could impact on delivery of both the plan and also upon patient care and service delivery:

- Failure to successfully deliver all elements of the plan, including difficulty in recruiting fixed term staff
- Risk that additional intervention schemes will not receive funding from UEC slippage and further risk of additional exposure to financial expenditure risk as a result
- Increase in Emergency Department demand above forecast levels and subsequent impact on performance and delayed ambulance handover times
- Risk to financial position if additional escalation required over and above that in the financial plan
- Increase in non-elective admissions above predicted numbers, putting pressure on paediatric, intensive care and medical beds particularly
- Risk to elective activity due to UEC demand and cancellation of elective admissions, including oncology and haematology treatments, due to the number of emergency admissions and/or delays in patients waiting for onward care, therefore reducing ability to meet cancer and referral to treatment waiting times
- IPC Outbreaks
 - o Increased demand impacting on bed availability
 - o Exceeding ITU and respiratory support capacity
 - o Loss of workforce due to unplanned absence
 - o Loss of domiciliary care hours and care home beds
 - o Exceeding mortuary capacity
- Further impacts of Industrial Action, resulting in minimal staffing numbers, cancellations of planned activity and increased pressures within UEC
- Adverse weather conditions, such as snow and ice, flood and high winds
- Partner agencies, such as GPs, social care, acute providers, unable to cope with increased demand resulting in patients diverting to the Trust
- High numbers of patients who are waiting for onward care with no criteria to reside
- Patient transport resilience is compromised
- Increased costs, for instance through providing additional staff, accommodation, transport
- Reassigning staff to work in unfamiliar areas at times of staffing shortage

The Urgent and Emergency Care Risk Assessment is currently being updated and sits on the corporate risk register.

Acronym Buster

Acronym	Meaning
ADNPP	Associate Director of Nursing and Professional Practice
AMU	Acute Medical Unit
ARI	Acute respiratory infection
CFHD	Children & Family Health Devon
COPD	Chronic obstructive pulmonary disease
D2A	Discharge to assess
DCC	Devon County Council
DCCPAs	Direct clinical care programmed activities
DIPC	Director of Infection, Prevention & Control
ED	Emergency Department
ENT	Ear, Nose & Throat
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
ERF	Elective recovery fund
G&A	General & acute
G&G	Grounds & gardens
HCAI's	Healthcare associated infections
IA	Industrial Action
ICB	Integrated Care Board
ICS	Integrated Care System
ICU	Intensive care unit
IMT	Incident Management Team
IPC	Infection Prevention Control
IV	Intravenous
LoS	Length of stay
MAAT	Medical admissions avoidance team
OOH	Out of hours
OP	Outpatient
OPAT	Outpatient parenteral antimicrobial therapy
OPEL	Operational pressure escalation levels
OT	Occupational therapist
PAC	Patient Access Centre
POCT	Point of care testing
RSU	Respiratory support unit
RSV	Respiratory syncytial virus
RTT	Referral to treatment
SDEC	Same day emergency care
SOP	Standard operating procedure
SQAG	Safety Quality Assurance Group
SRU	Surgical Receiving Unit
SWAST	South Western Ambulance Service
TSDFT	Torbay & South Devon NHS Foundation Trust
UCR	Urgent community response
UEC	Urgent & Emergency Care
UHP	University Hospital Plymouth
UTC	Urgent Treatment Centre

VW	Virtual ward
WLI	Waiting list initiative

Classification: Official

Publication reference: Public Board paper (BM/25/27(Pu))



Annex – Board Assurance Statements

Agenda item: 6 (Public session)

Report by: Sarah-Jane Marsh, National Director for Urgent and Emergency Care and Operations

Paper type: For approval

17 July 2025

Section B: 25/26 Winter Plan checklist

Annex B – Board Assurance Statement for NHS Trusts

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Board signed off initial plan at August Board and will receive final plan at September board on 24 th September.
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	No	This will be undertaken in October
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	A full winter planning group was commenced and included representation from social care and the ICB
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Partial	Both regional winter sessions have been attended by Trust operational and clinical representatives. The plans of system partners were discussed as part of this process and additional learning was taken and incorporated into plan update. The ICB is planning a testing exercise in October.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	The Deputy COO will be the winter executive for winter with delegated authority from the COO.
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	All areas covered within the plan document.
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	This is fully covered within the plan document and will be dynamically assessed and evolved as required through winter.
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	The Trust continues to commit to meeting its performance trajectories submitted as part of planning.

Provider CEO name	Date	Provider Chair name	Date
Joe Teape		Chris Balch	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	A robust vaccination plan is included which includes a minimum of 5% uplift on last years uptake.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	This has been fully modelled including a bed gap forecast with each of the key areas of the plan contributing a bed mitigation
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Plans in place to increase medical staffing over key weeks either side of Christmas period
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	The Trust has a full understanding of the 7 day discharge requirements and these are covered in daily safety and flow meetings with representation from LA on these meetings.
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	The current elective position remains ahead of plan from a RTT perspective. Cancer recovery plan is cognisant of winter pressures with plans to ringfence elective beds and maintain elective activity through winter.
Infection Prevention and Control (IPC)		

1. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	A robust IPC plan is included. This process has now commenced and the plan will be built upon heading into winter.
2. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Partial	Mask fit testing is underway as the masks currently in use will be out of circulation from December 25 so this is being revisited by areas and raised at IPCG. Current approach is central training provided along with train the trainers training with the expectation they go back to their areas and train their staff. requested last week that areas ensure they are compliant and that records are shared with the training team. Comms regarding PPE regarding checking areas have supplies and know how to order them, this was also raised at IPCG with procurement to ensure supplies are available on Unit4. IPC started winter readiness adding to their daily walkarounds a checklist that includes checking areas have FFP3 masks, aprons, gloves, water resistant masks etc in stock and have a train the trainer on their ward and checking staff compliance re masks.
3. A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Full escalation plan included.
Leadership		
1. On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	On call plan is in place. Winter briefing events will be held with on call teams ahead of winter to ensure clear understanding of plans.
2. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	This is undertaken in real time by all areas and collated centrally by the site team.
Specific actions for Mental Health Trusts		
3. A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		
4. Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.		

Trust Board

Green Plan Refresh

Date of meeting	Date report produced
24 September 2025	23 July 2025 (version update 21 August 2025)

Author(s)		Report approved by	
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Phone:	07717806618	Date:	19th September 2025
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If this paper needs to be presented at a private meeting, please state why and mark as **CONFIDENTIAL**:

Executive summary

In 2020, the NHS became the world’s first health system to commit to reaching net zero emissions. The Delivering a Net Zero National Health Service report set out the scale of ambition. The Health and Care Act 2022 reinforced this commitment, placing new duties on integrated care boards (ICBs), NHS trusts and foundation trusts to consider statutory emissions and environmental targets in their decisions. Trusts and ICBs are expected to meet these duties through the delivery of board-approved green plans.

The Torbay and South Devon NHS Foundation Trust Board approved the Trust’s initial Green Plan in February 2022. NHS England subsequently published updated statutory green plan guidance in February 2025 requiring Trusts to further refresh green plans in line with the update guidance by 30th September 2025.

Trust Board are asked to take assurance that the refreshed Green Plan positions the Trust to make good progress in the delivery of its duties to meet net zero emissions within the limited resources that we have available to progress Sustainability.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Refreshed Green Plan positions the Trust to make good progress in the delivery of its duties to meet net zero emissions within the limited resources that we have available to progress Sustainability	Satisfactory	Not Applicable
Management resources in place to mobilise action plans and delivery of Green Plan commitments	Limited	Not Applicable

Committees that have previously discussed/agreed the report, and outcomes of that discussion

Executive Operations Group –Commitment to include Green Refresh as part of the Trust strategy. Change the name of the group to something that will engage wider workforce.

Executive Committee – 14th August 2025

Building a Brighter Future Committee 21st August 2025 - Recommendation to request CEO sponsorship (subsequently agreed that the sponsor is the COO).

Key recommendations and actions requested

Trust Board are asked to approve the Green Plan Refresh.

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

Aim	Impact
Population Health and Wellbeing	NHS carbon emissions contribute to global warming, which drives: Heat-related illnesses (heatstroke, dehydration, worsened chronic conditions) Extreme weather events (flooding, storms) that damage housing, disrupt care, and increase injury risk

Shifts in disease patterns (e.g., more heat-related deaths, wider spread of vector-borne diseases)

Quality of services provided	Quality of Service is impacted by air pollution from our hospital operations On-site energy use (heating, running backup diesel generators) and transport (ambulances, staff commuting, supply chain deliveries) release nitrogen oxides (NO_x), particulate matter (PM_{2.5}), and other pollutants. These pollutants are linked to respiratory disease, cardiovascular disease, and premature death. Vulnerable groups are more sensitive to these pollutants.
Sustainable and efficient use of resources	Climate change driven events increase demand for healthcare, stretching resources. Higher operational costs from energy use and climate damage repairs divert budgets away from patient care

Impact on BAF Objectives	
BAF Objective	Impact
Quality and Patient Experience: Personalised Care	
People	
Financial Sustainability and Productivity	
Estates	
Operations and Performance Standards	
Digital and Cyber Resilience	
Building a Brighter Future	
Strategy and Transformation	
Sustainability: Green Plan/ Environmental	Delivery of a workplan that will mitigate risk set out in the BAF and drive improvement towards the trust's sustainability objectives
Equality, Diversity and Inclusion	

Provision of Community and Care
Services Delivered in Partnership

Risk: Risk ID (as appropriate)	
Risk	Risk ID
Trust's Failure to Achieve Objectives Set Out in the Trust's 2040 Green Plan	3566

External Standards affected by this report and associated risks
Health and Care Act 2022 NHS England Statutory Guidance Feb 2022 NHS Standard Term Contract HTM 07-07 Sustainable Health and Social Care Buildings HTM 07-01 Safe and Sustainable Management of Healthcare Waste

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Green Plan Refresh

Introduction and background

In October 2020, the NHS became the first national health system to commit to net zero emissions, with the publication of “Delivering a Net Zero National Health Service”, which has been issued as statutory guidance.

The NHS has committed to a 2040 net zero target for the NHS’s carbon footprint and a 2045 net zero target for the NHS carbon footprint ‘plus’ (for the broader emissions that the NHS can influence). These targets include interim targets of an 80% reduction by 2028-2032 and 2036-2039, respectively.

The Health and Care Act 2022 reinforced this commitment, placing new duties on ICBs and NHS Trusts to consider statutory emissions and environmental targets in their decisions. The TSDFT Trust Board approved the Trust’s initial Green Plan in February 2022 which has since been updated to align with the new updated guidance published in February 2025.

The updated statutory green plan guidance requires Trusts to ensure that their Green Plans align with the latest guidance. It is expected that refreshed green plans should be approved by the organisation’s Board, published in an accessible location on the organisation’s website and shared with NHS England by 30 September 2025.

In addition, the Devon ICB requires the Devon NHS Trusts to submit their draft Green Plans to the ICB to inform the system Green Plan, which is also due for submission to NHS England by 30 September 2025.

This report aims to summarise the key changes made to an updated version of the Trust’s Green Plan, which is attached as an Appendix, to ensure it aligns with the latest guidance.

Assessment

A gap analysis was undertaken which identified areas of the current Green Plan that required updating to align with the latest green plan guidance. Additionally, in some areas, the Trust is currently going beyond the requirements of green plan guidance, such as the adoption of biodiversity, digital innovation and the control of volatile gases.

The following table provides a summary of the key updates required and actions included in the refreshed Green Plan.

Update required	Action included/to undertake
The plan will require senior leadership and oversight of delivery from a range of functions, which may include: - Chief Medical, Chief Nursing, Chief AHP Officers and Chief Pharmacists - Directors of EFM	Non-Executive Director to Chair Sustainability and Well Being Group. Refreshed Terms of Reference for the Sustainability and Well Being Group which will include membership from senior Trust leads, ensuring accountability for

• Directors of Procurement • Chief Information Officers • Directors of Finance	workstreams within the sustainability programme. The group will be responsible for agreeing objectives, setting targets, approving relevant work plans, and monitoring progress. The forum will also be used to share ideas, create solutions, and plans with our system partners within the Devon Integrated Care System and the broader NHS.
Identify a clinical lead with oversight of net zero clinical transformation, with formal links into board-level leadership and governance.	The Trust needs to identify a board level clinical lead to drive progress towards net zero.
Organisations should support their staff and leaders to learn, innovate and embed sustainability into everyday actions. There are several actions that are required to be implemented regarding training, workforce capacity and skill requirements for delivering the green plan.	To ensure these actions are included in the green plan, the 'Workforce & System Leadership' section has been updated with a commitment to: Assess the workforce capacity and skill requirements for delivering the Green Plan, considering good practice examples such as hybrid roles, apprenticeships, fellowships and NHS estates sustainability career pathways Promote and set uptake targets for core training offers set out on the Greener NHS Training Hub Promote specialist training for staff groups who underpin the delivery of Green Plans, such as board members, procurement, finance, estates and facilities staff and clinicians, particularly through carbon literacy training.
Set out actions to prepare for severe weather events and improve climate resilience of local sites and services, including digital services.	A set of actions has been included to clearly identify how the Trust is preparing for the impacts of Climate Change, which includes producing a CCRA (Climate Change Risk Assessment) which will identify the potential risks associated with climate change and how Trust operations may be affected

The other amendments to the Green Plan to note include:

- The Chief Operating Officer/Deputy Chief Executive Officer named as the Senior Responsible Owner for Sustainability replacing the Chief Finance Officer.
- Updated annual carbon emissions have been reported to demonstrate progress made in recent years.
- A summary of key actions and progress made since 2022.

- More detailed actions for continuation of standards to enhance the environment working towards the biodiversity benchmark.

Assurance and Recommendations

It is recommended that the updated Green Plan is approved by Trust Board.

It is determined that the Green Plan updates will have minimal impact on the Trust as they will not provide additional risks to those that already exist (e.g. cost pressures) through the existing commitments of the current Green Plan.

By updating the Green Plan, it will also ensure that the Trust meets the sustainability and net zero carbon statutory requirements of the NHS Standard Term Contract.

It is recommended that the membership of the Sustainability and Well Being Group is supported, including the updated Terms of Reference. It is also intended that a detailed sustainability programme plan will be produced with actions included for each workstream with accountable departments responsible for providing timely responses at each Sustainability and Well Being Group.

One of the key risks is that the Trust has insufficient resource to drive forward the work of the Sustainability and Well Being Group and deliver the action plans and commitments set out in the refreshed Green Plan. All options need to be looked at in respect of how to fulfil this requirement including approaching Devon EFM colleagues with respect to sharing resources to try to mitigate additional cost. It should be noted that additional management resource to drive sustainability is likely to be offset by significant savings potential linked to sustainability actions.

The Board are asked to support consideration of a nomination of a Non-Executive Director who will champion Sustainability working alongside the COO/Deputy CEO who has designated Board level accountability. The Board are also asked to endorse a senior/board level Clinical Leader to embed sustainability changes into clinical practice.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Refreshed Green Plan positions the Trust to make good progress in the delivery of its duties to meet net zero emissions within the limited resources that we have available to progress Sustainability	Satisfactory	Not Applicable
Management resources in place to mobilise action plans and delivery of Green Plan commitments	Limited	Not Applicable

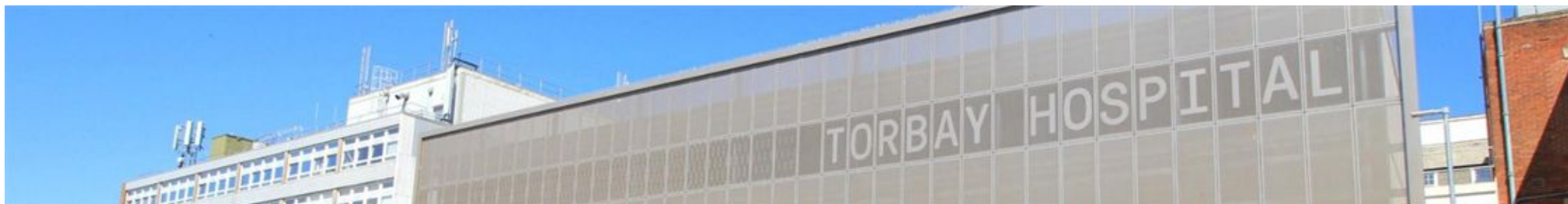
GREEN PLAN 2025 – 2028

TORBAY & SOUTH DEVON NHS FOUNDATION TRUST

Version: 3

Issue Description: *Final – For Public Use*

Date of Issue: 19/09/25



1. WELCOME

I am pleased to introduce our refreshed Green Plan, covering the period from 01 October 2025 to 30 September 2028. This document builds on the foundations laid in 2022 and reflects our continued commitment to reducing our environmental impact while delivering high-quality care.

The 10-Year Health Plan for England makes clear that the NHS must embrace transformational change to remain sustainable. It calls for a reimagined model of care—one that is predictive, preventative, and resilient. Environmental sustainability is central to this vision, and our Green Plan is a key part of how we will deliver it.

Over the next three years, we will:

- review our progress and engage with clinical and staff groups to refresh priorities.
- align our actions with national targets, including the NHS's interim 80% emissions reduction goals for both carbon footprint and carbon footprint plus.
- define clear actions and key performance indicators (KPIs) for each area of focus.
- strengthen governance and reporting processes to ensure transparency and accountability.
- uphold our legal duties, including reducing inequalities and considering the wider effects of our decisions.

We recognise the urgent need to act. Climate change, waste accumulation, air pollution, and biodiversity loss are not distant threats they are realities affecting the communities we serve. As part of the wider Devon health and care system, our environmental footprint is significant.

We must empower our people, teams and volunteers to help us meet the NHS net zero target and become a truly sustainable organisation.

But we're not starting from scratch. Across our organisation, passionate individuals and teams have already made meaningful contributions. We've installed high-efficiency LED lighting, reduced emissions from anaesthetic gases, cut single-use plastics, sourced more food locally, enabled remote working, planted trees, and partnered with our local authority to develop a large-scale solar PV farm adjacent to Torbay Hospital.

But we must go further. Our Green Plan is a live strategy—one that will evolve alongside our Building a Brighter Future (BBF) programme and broader organisational strategy. It will be reviewed internally twice a year and updated annually to reflect new insights and priorities.

We face a formidable challenge, but I am confident that through the dedication of our people and our unwavering commitment to collaboration with system partners, local authorities, and our communities, we will play our part in delivering a net zero NHS.

Let's move forward together—with purpose, with urgency, and with hope.

Adel Jones - Deputy CEO and Chief Operating Officer

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ABOUT US

2.1 WHO WE ARE

We are one of England’s few integrated health and social care organisations. Since 2015, we’ve delivered joined-up care across our communities—from acute services at Torbay Hospital to health and social care in homes and community settings from Dawlish to Dartmouth.

We work closely with partners to provide accessible support as close to home as possible, making best use of our community estate and digital technology and innovation. Our specialist services, such as day surgery, are nationally recognised for best practice.

In line with the 10-Year Health Plan for England, we’re committed to going even further to transform care by shifting services closer to home, embracing digital innovation, and prioritising prevention. Sustainability is central to this mission.

2.2 WHO WE SERVE

We serve a resident population of over 290,000 people across Torbay and South Devon, including communities from Dawlish to Dartmouth and around 100,000 visitors during the summer holiday season. Our geography covers 350 square miles, including rural communities, urban centres and 75 miles of coastline

Our integrated health and social care services are designed to support people at every stage of life—whether they need urgent hospital care, help managing long-term conditions, or support to live independently at home.

We work in partnership with local authorities, voluntary organisations, and community groups to ensure care is accessible, inclusive, and tailored to local needs. Our aim is to help people live well, stay connected, and access the right support, in the right place, at the right time.

2.3 OUR ORGANISATION IN NUMBERS

Number of staff	7387	Population	293,400
Foundation Trust Public members	7315	Visitors during holiday season	+100,000
Number of volunteers	567	GP practices	28

Per Annum	
Number of outpatients appointments	450,000
Number of elective day case procedures	3,822
Number of elective inpatient procedures	37,802
Number of Accident and Emergency attendances (including Minor Injury Units)	127,953
Number of emergency admissions	38,321

3. OUR VISION

We are refreshing our organisational vision and strategy in response to the ambitions set out in the 10-Year Health Plan for England. This national plan calls for a shift towards more preventative, digitally enabled, and community-based care—principles that align closely with our care model and our own ambitions for our services.

Our purpose has remained clear, to support the people of Torbay and South Devon to live well.

To shape a sustainable future together, we are actively engaging with our staff, partners, and local communities to understand what matters most to them. Their insights will help us co-create a refreshed vision that reflects local priorities, tackles health inequalities, and builds on our strengths in innovation, partnership working, and environmental responsibility.

We are proud to be a part of the government's £20 billion New Hospital Programme, which gives us a once-in-a-generation opportunity to transform our acute estate and services. Our plans include rebuilding inpatient wards, expanding emergency care, and creating a modern, digitally enabled hospital on the Torbay site—designed to be faster to build, more sustainable, and better suited to future care needs

Together, we are building a brighter, more resilient future for health and care in Torbay and South Devon.



4. ABOUT THIS DOCUMENT

4.1 BACKGROUND

In October 2020, the *Greener NHS* National Programme released a landmark report *Delivering a Net Zero National Health Service*. The connection between climate change and healthcare was made clear and with the NHS, one of the largest employers in the UK, contributing to 4% of England's carbon footprint, it is evident that the NHS has a significant role to play. Our Green Plan provides context for our place in the wider NHS green journey now and in the future. The report also drew attention to the necessity to build adaptive capacity and resilience into the way care is delivered. While we acknowledge the importance of the NHS net zero target, adapting to the changing physical climate, such as increases in extreme weather, is just as important to ensure sustainable healthcare.

To help achieve a net zero NHS, both NHS trusts and integrated care systems are required to develop green plans, as set out by the NHS standard contract in 2021/22. Our Green Plan aims not only to focus our efforts in delivering ever-more sustainable healthcare but also to improve people's experience of health and care services while supporting our vision for better health and care for all.

4.2 PURPOSE

Our Green Plan defines our commitment to environmental sustainability with a primary focus on how we will drive towards the NHS net zero targets. The key outcomes include:

- ensuring we are aligned to the NHS-wide ambition, and that of the Devon Integrated Care System to become the world's first healthcare system to reach net zero carbon emission.
- defining our strategic approach in such a way that we make the right sustainability decisions first time.

- prioritising interventions that support world-leading patient care and population health, and reduce inequalities, while tackling climate change and broader sustainability issues
- supporting high-quality, preventative and low-carbon care, in line with the NHS’s goal to boost out-of-hospital and digitally enabled care, improve prevention of ill health and reduce health inequalities
- reducing air pollution by decarbonising the NHS fleet, which is set to save the NHS over £59 million every year and deliver a range of health benefits valued at over £270 million.
- modernising and decarbonising the NHS estate, which is expected to reduce energy costs while creating a better environment for patient care
- minimising waste through circularity – where reusable, remanufactured or recycled solutions are used – which is often cost-saving and helps protect against external supply disruptions

Our plan covers 2025-2028 however we will ensure it is updated and expanded regularly, as, and when there is a better understanding of our environmental impacts and how to reduce them. Our Green Plan will also be aligned with actions and timescales that *Delivering a Net Zero National Health Service* set out, including the targets for the next 20+ years.

4.3 WHO IS OUR GREEN PLAN FOR?

- Our Green Plan summarises both where we currently are on our sustainability journey and where we aim to get to. As such, it is intended for all our key stakeholders, including;
- our staff
 - our Board of Directors and senior leadership teams
 - our Sustainability and Wellbeing Group
 - our governors and members
 - our patients and the communities we serve

- our partners in Torbay and South Devon including local authorities, voluntary, community and social enterprise organisations, housing and education

4.4 KEY DRIVERS FOR CHANGE

4.4.1 LEGISLATIVE

Table 1: Legislative and healthcare sustainability drivers

Climate Change Act 2008 (2050 Target Amendment) Order 2019	This sets legally binding UK targets for the reduction of carbon emissions. As a public body the NHS must meet these targets. The targets include a 34% reduction by 2020, which has already been achieved, and a 50% reduction by 2025. The act was amended in 2019 to add a goal of net zero carbon by 2050.
Civil Contingencies Act 2004	Requires all NHS organisations to prepare for adverse events and demonstrate they have undertaken risk assessments and that carbon reduction plans are in place.
Public Services (Social Value) Act 2012	All commissioners of public services to consider social and environmental value, when buying goods and services. Social value is defined as the collective gain to the community from commissioning/procurement.
The Second National Adaptation Programme 2018-2023	Sets out actions that organisations need to take to respond to the risks identified in the Climate Change Risk Assessment. This report forms part of the five-yearly cycle of requirements laid down in the Climate Change Act 2008.

NHS Standard Forms Contract	Mandated by NHS England which contains a requirement for NHS providers to maintain a Green Plan demonstrating how progress will be made.
Health & Care Act	On 1 July 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Care Act 2022. This places duties on NHS England, and all trusts, foundation trusts, and integrated care boards to contribute towards statutory emissions and environmental targets.

4.4.2 FINANCIAL

Energy costs have continued to rise year on year. Government projections indicate that gas and transport fuel costs will continue to rise for the foreseeable future; electricity prices, however, are expected to peak around the middle of the current decade, before beginning to fall again. Figure 1 and Figure 2 suggest that grid electricity will become a more financially attractive resource over the next two decades, however as it is currently considerably more expensive per unit than gas, we can expect our overall energy costs to rise if we do not reduce our consumption.

Given turbulent market conditions are expected to prevail in the near term, it is critical now, more than ever, that we focus on minimising energy consumption across our estate. It also highlights the importance of considering additional opportunities to source a greater proportion of our energy demands from on-site, low carbon generation such as solar, Photovoltaics (PV).

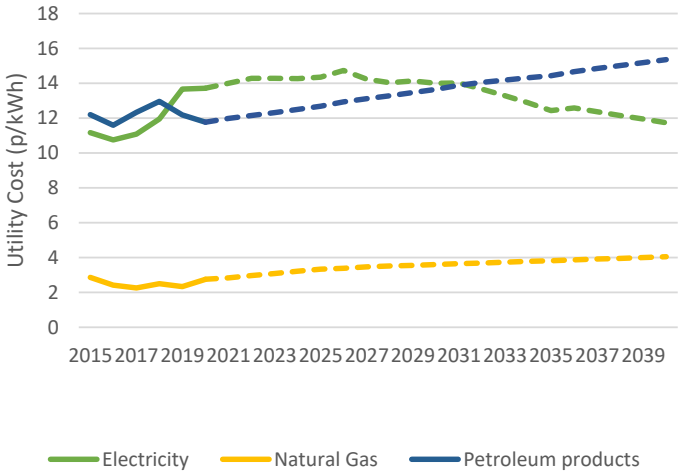


Figure 1: Forecast utility costs per kWh (BEIS, 2019)

4.4.3 CAPACITY

The UK faces a significant challenge in the near future to supply sufficient energy to meet the country’s ever-growing demand. By 2030 a large proportion of the UK’s operating nuclear reactors are due to be retired. At the same time, the Government has stated that it aims to close all remaining coal power plants by 2025 to align with its decarbonisation targets. Forecasts from the Department of Business, Energy and Industrial Strategy show that while renewable generation will continue to grow, nuclear is expected to make up an increased proportion of future energy mix. There is a risk that if new nuclear projects suffer delays or cancellation, that fossil fuels will continue to be relied upon to make up the shortfall. It is therefore critical that we prioritise reductions in energy demand wherever possible, along with improving resilience of supply and reducing reliance on grid systems.

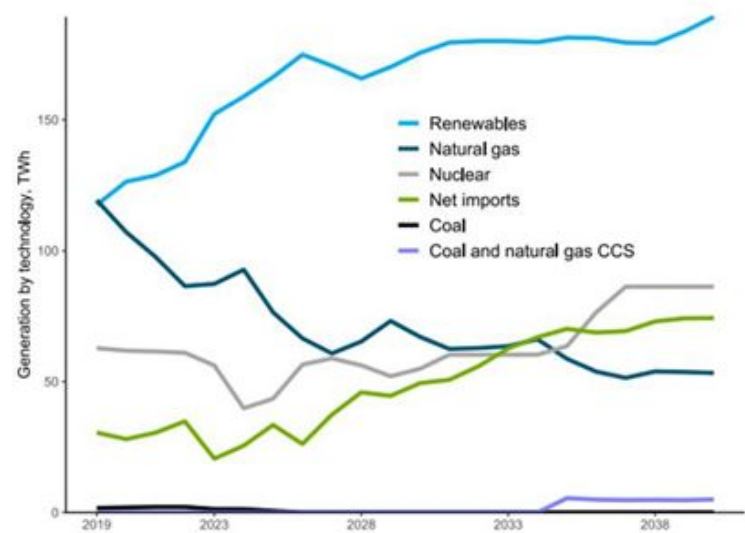


Figure 2: UK Energy Mix forecasts (BEIS, 2019)

4.4.4 GREENER NHS

In January 2020, the then Chief Executive of the NHS, Sir Simon Stevens, launched the campaign “For a Greener NHS” which outlines a practical, evidence-based, and quantified path to a net zero NHS. Later that year, within the landmark report *Delivering a Net Zero National Health Service* the organisation has defined clear targets for the NHS to reach net zero carbon;

- Net Zero by 2040 for the NHS Carbon Footprint, with an ambition for an 80% reduction by 2028 to 2032
- Net Zero by 2045 for the NHS Carbon Footprint Plus, with an ambition for an 80% reduction by 2036 to 2039

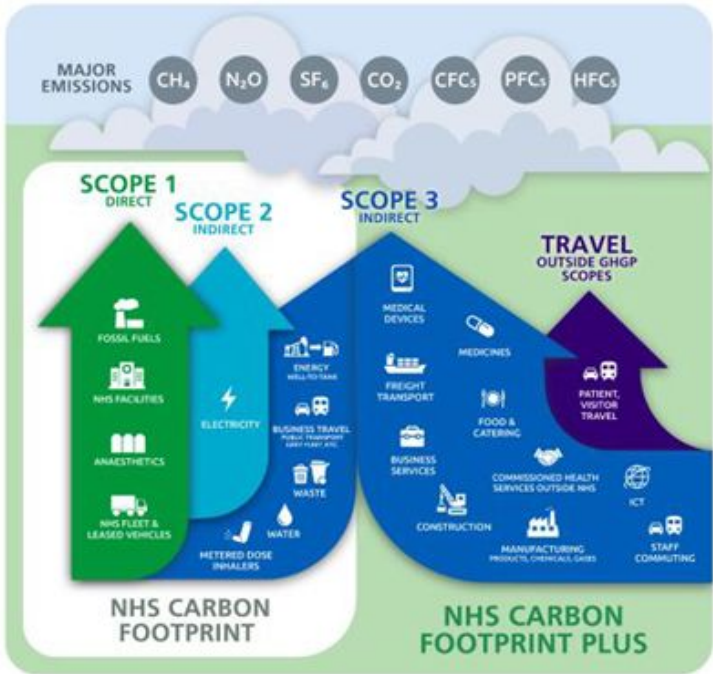


Figure 3: GHG Protocol scopes set out in Delivering a 'Net Zero' National Health Service (Greener NHS, 2020)

5 NHS CARBON FOOTPRINT

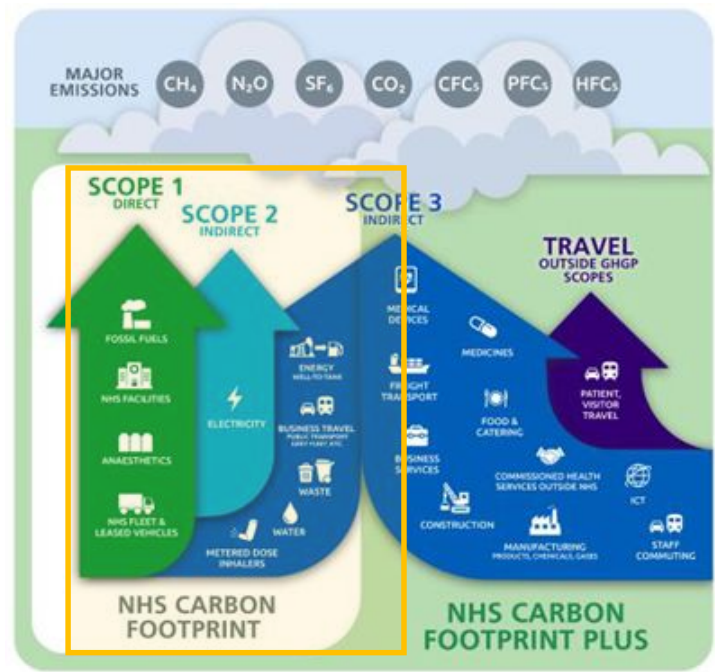


Figure 4: GHG emissions scope - NHS Carbon Footprint

This section addresses areas of focus which will primarily impact our NHS Carbon Footprint (as shown in [Figure 4](#)). These are the carbon emissions for which we have direct control.

Figure 5 presents a breakdown of our NHS carbon Footprint. The chart shows that emissions that result from heating and powering our buildings make up over 85% of our total footprint. Reducing emissions from energy use, in particular eliminating natural gas, presents the greatest challenge for us to reach net zero for our NHS Carbon Footprint.

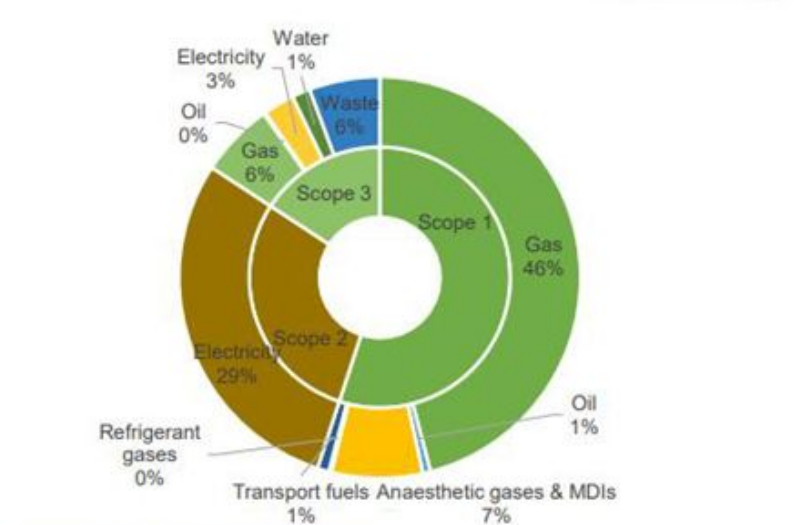


Figure 5: Our Carbon Footprint breakdown

5.1 CARBON TARGETS

Figure 6 displays the NHS targets for reducing the NHS Carbon Footprint. We are aligned to reaching these goals, recognising as we do, that it will require a significant, concerted effort both from ourselves and through collaboration with the wider Devon Integrated Care System and central NHS functions.

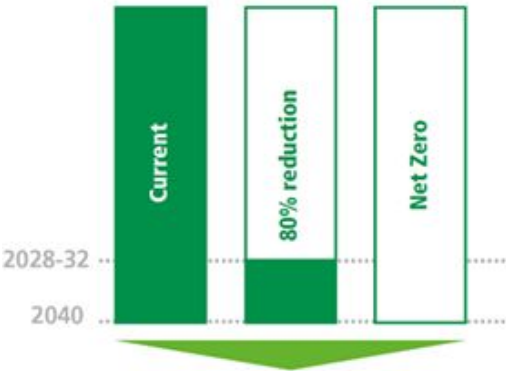


Figure 6: NHS Carbon Footprint reduction targets

With a baseline year of 2016/17, our carbon footprint targets are:

- 80% reduction by 2032
- 100% reduction by 2040

2016/17 has been selected as our baseline year as it is the earliest year for which we believe we have good quality data upon which to calculate our emissions

In Figure 7, we can see the scale of the challenge ahead of us for meeting our interim 80% reduction target by 2032. The chart shows our progress between the baseline year and the last financial year. It also shows the further emissions reduction we would expect to see if we continued to operate in the same way, without any changes in service demand. This reduction would occur as a result of the electricity grid continuing to reduce in carbon intensity.

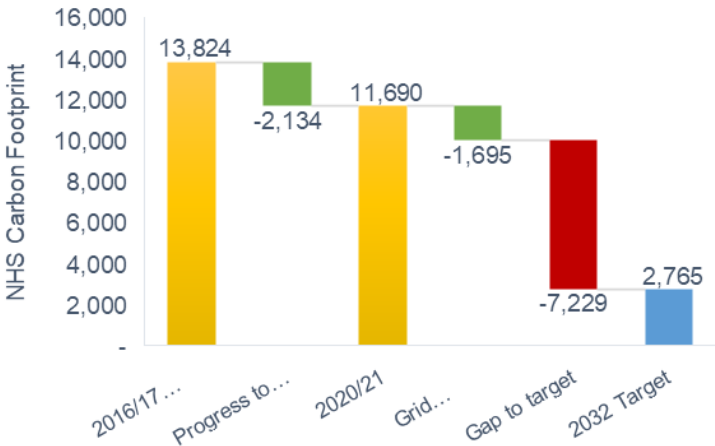


Figure 7: Our 'Business as Usual' carbon footprint forecast

5.2 ESTATES AND FACILITIES

5.2.1 ENERGY

Emissions from energy use in our buildings make up 85% of our NHS Carbon Footprint. It is therefore critical that we make reductions in this area to achieve our target of 80% reduction by 2032.

WHERE WE ARE

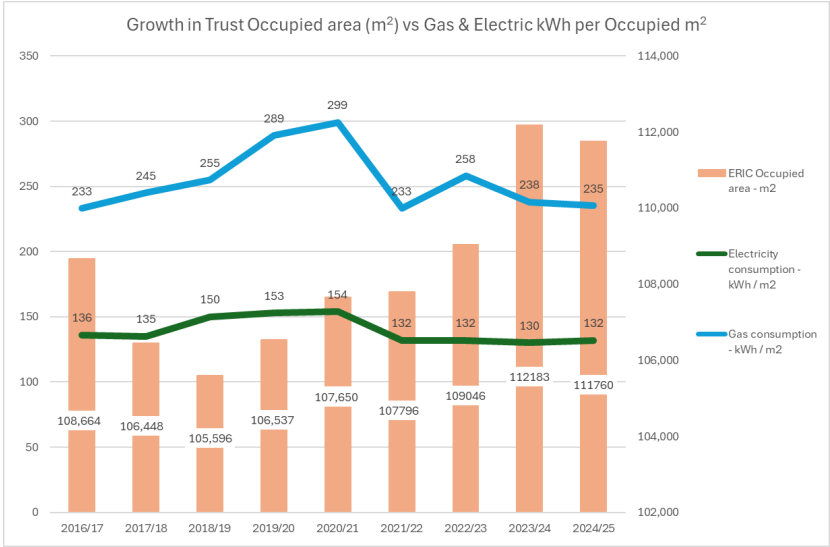


Figure 8: Our annual energy demand by resource

Figure 8 shows that our total energy consumption since our baseline year 2016/17 had risen, driven by an increased demand for natural gas however, for year 2024/25 energy consumption has now plateaued. This shows an overall improvement in our Trust energy usage even with an increase in our occupied floor space, in part, due to the introduction of air

sourced heat pumps for new developments within our Acute Medical Unit.

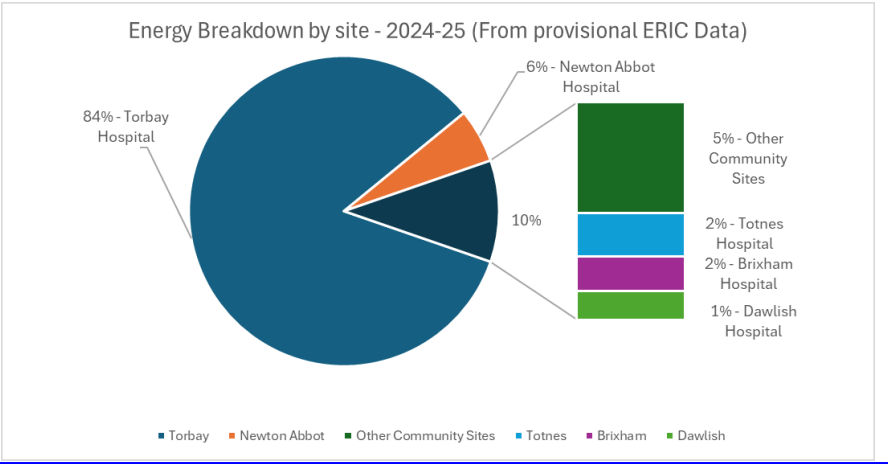


Figure 9: Our 2024/25 energy breakdown by site

Figure 9 reveals the relative energy demand of different sites across our estate. Our acute site consumes 84% of our energy and therefore must remain the priority for delivering energy saving but we recognise that the energy demands of our community estate are by no means insignificant at 16%. In 2021, we commenced a programme to upgrade lighting to high efficiency LEDs both at Torbay Hospital and across several community sites. The project will reduce our utility bills by £140k and save around 290 tCO₂e p.a.

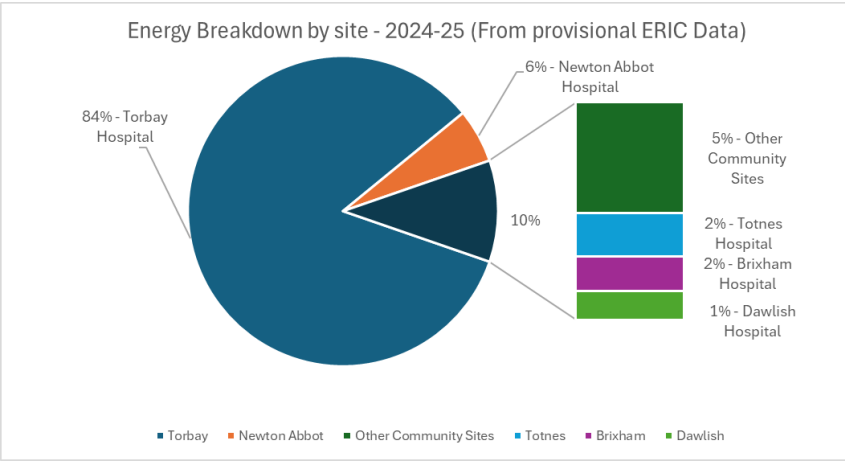


Figure 9: Our 2024/25 energy breakdown by site

WHERE DO WE WANT TO BE

We must find innovative ways to reduce the total energy we consume, in line with increased service demand and deteriorating condition of our estate due to the age of our buildings. We also need to understand opportunities to decarbonise heat, through the elimination of gas-fired heating systems where suitable.

WHAT WE HAVE ACHIEVED 2022 -2025

- 1. **Automated Meter Reading (AMR).** Introduced accurate meter recording providing half hourly readings, accurate up to date information to reduce wastage, eliminate estimated readings.
- 2. **Building management system, sub metering.** Introduced in our new developments providing accurate readings and enable profiling to review electricity efficiency from events.
- 3. **Building management systems.** Providing improvements in maintenance and enabling replacement programmes.

- 4. **Air sourced heat pumps.** These have been installed in our new developments within our Acute Medical Unit, new Theatres and Endoscopy unit.
- 5. **Thorlux Building Management System.** Provides a smart reporting system which scans energy usage and effectiveness with further innovation opportunities for energy reduction.
- 6. **Lighting presence detection.** Automatic turn off periods after specific time period.
- 7. **LED Lighting replacement programme.** Within specifications for any new works and replacements.
- 8. **PV Farm Tender process.** Completed in 2023, progress ongoing.
- 9. **Decarbonisation Plan.** Produced Trust plan in 2022, progress ongoing.

HOW WE PLAN TO IMPROVE

- 1. **Site Redevelopments.** Embed net zero design into our Building a Brighter Future programme.
- 2. **Decarbonisation Plan.** Continue to implement actions within our decarbonisation plan.
- 3. **Heat decarbonisation.** Complete heat decarbonisation plans funded via Low Carbon Skills Fund such as phasing and replacing fossil fuel heating systems with lower carbon alternatives, such as heat pumps or connecting to a heat network system
- 4. **Utilities.** Procure certified green electricity backed by REGOs for all our supplies.
- 5. **Solar Farm.** Continue to collaborate with local authority to develop opportunity for large-scale solar Photovoltaics (PV) farm to be built adjacent to Torbay Hospital for the creation of renewable energy.
- 6. **Energy Efficiency.** By installing measures such as insulation and double-glazed windows.
- 7. **Local Area Energy Plans.** Consider opportunities from heat networks and other low-carbon solutions.
- 8. **Identifying installations** in scope of the UK Emissions Trading Scheme and outline plans to reduce emissions in line with allocated targets

9. Business cases. To deliver the measures outlined in the HDP, as energy efficiency and renewable energy interventions, with a view to submitting a funding application through the public sector decarbonisation scheme (PSDS) if projects cannot be financed through internal budgets.

5.2.2 WASTE

Waste disposal is a key support service without which hospitals cannot operate. In 2019 Simon Corben, newly appointed Senior Responsible Officer for clinical waste across the NHS, wrote to all NHS trusts to encourage a renewed focus on the area. A clear, directional strategy was developed for the next 10 years including building a national infrastructure and supplier resilience plan which aimed to:

- remove plastics from high temperature incineration.
- move toward UK approved reusable containers or non-plastic sharps and pharmaceutical packaging.

In 2023 a new NHS clinical waste strategy was produced by NHSe to support NHS providers in making the necessary step change in waste management practices;

- reduce waste and improve compliance to lower waste volumes
- encourages the use of innovation to increase NHS waste management resilience
- improve data use to help guide decision making
- improve staff engagement and training to improve compliance and seek out carbon reduction opportunities

Figure 10 shows the waste hierarchy for clinical waste. There are 7 levels to the hierarchy, signifying the most to the least desirable clinical waste management techniques from an environmental perspective. At the top of the hierarchy and least harmful is level 1: prevention. Level 2 is 'correctly segregate'; level 3 'recirculate/back into use', level 4 'recycle', level 5 'generate for energy sources' level 6 'dispose' and level 7 'in the ground landfill'

landfill'. At level 6, 'dispose', there is an additional arrow to 'Flock' which, depending on whether it contains metal or plastic can re-enter the hierarchy at level 4 (yes) or level 5 (no).

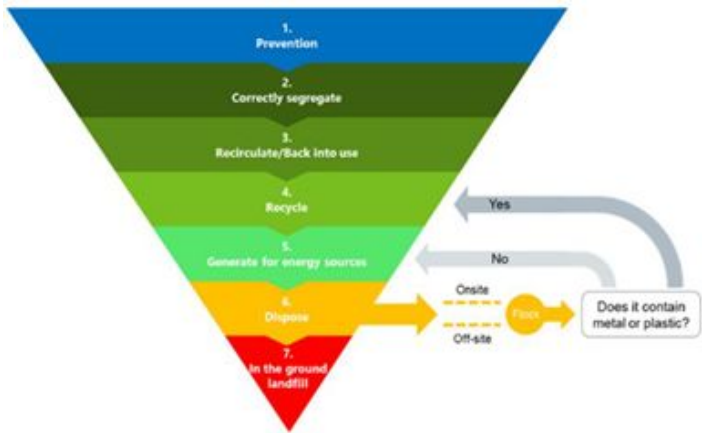


Figure 10: The Waste Hierarchy (adapted for clinical waste)

WHERE WE ARE

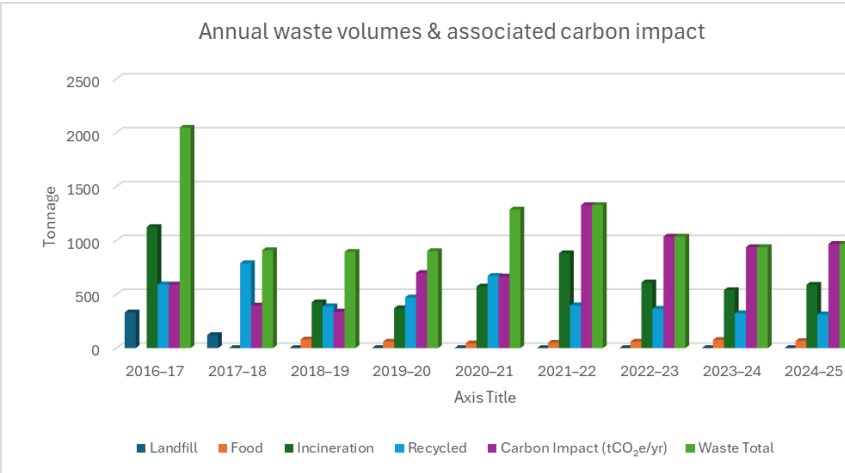


Figure 11: Annual waste volumes & associated carbon impact

Figure 11 shows our annual waste volumes since our baseline year of different waste streams and carbon impact. The chart shows the pattern of waste streams with a removal of landfill disposal from 2018/19. In the years from 2021/2022 the trust has shown a reduction in its annual waste disposal. The highest impact of carbon emissions is our food waste at 1.9.CO₂e per kg which has a very high impact due to methane and embodied emissions with our lowest impact being recycling at 0.05 CO₂e per kg.

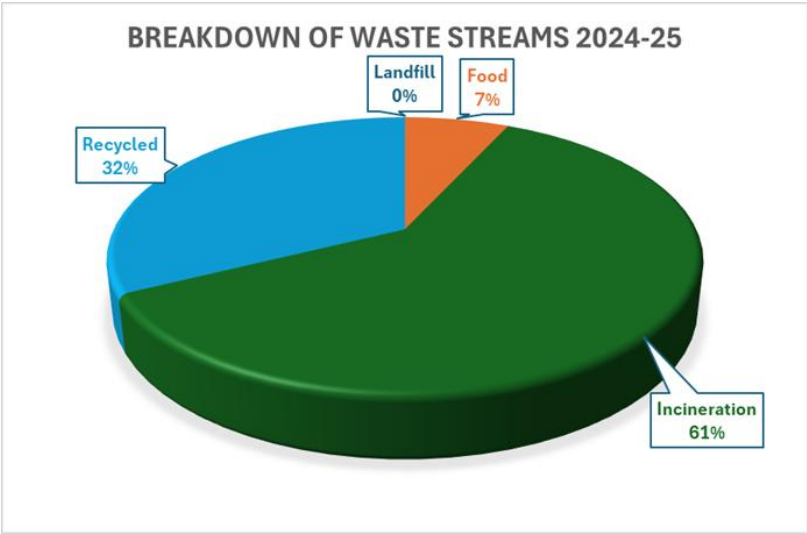


Figure 12: Breakdown of waste streams 2024/25.

Figure 12 shows that, including food sent for anaerobic digestion, we currently recycle 32% of our waste, with 61% being sent for incineration and 0% to landfill.

We recognise that there is scope for us to improve in this area, but we have already driven significant improvements in our management of waste. In 2019 we commenced a trial to implement Biosystems an alternative to sharps and pharmaceutical bins which reduces disposal of existing single-use containers and improves waste segregation with movable bins on trolleys rather than being fixed. Biosystems is a safe, sustainable, and cost-effective way to dispose of sharps, pharmaceuticals and instruments into a container that can be used up to six hundred times. Since the trial commenced, we have achieved a 70% phased introductionIn the financial year April 24 to March 25, we have seen;

- an estimated avoidance of 99.05 tonnes of CO2 emissions

- 8,325 sharps contained diverted from incineration
- An avoided of 16.06 tonnes of plastic from manufacturing.

In addition to this, we have an exemplary recycling segregation system which means we separate streams on site for cardboard, metal, food, electronics, glass, and wood. On site segregation minimises the need for downstream treatment and enables high quality output from recycled materials.

WHERE DO WE WANT TO BE

We recognise that we must find innovative ways to reduce waste and to improve our use of resources and reduce carbon impact. To proactively work to reduce harmful emissions, improving local air quality and achieve the 2045 net zero carbon target. Key activities to achieve a 50% reduction in the carbon emissions produced from waste management by **2026** and an 80% reduction by **2028-32**.

WHAT WE HAVE ACHIEVED 2022 -2025

1. **Waste reduction.** Implemented 70% of biosystems (reusable sharps bins) at the Trust.
2. **Tiger waste stream.** Offensive (tiger) waste stream is now providing waste to energy.
3. **Segregation.** Improved waste segregation in line with NHSe clinical waste strategy targets.
4. **Recycling.** Approximately 6 tonnes of cardboard waste is recycled monthly undertaken by in house waste team by baling and then put back into circular economy.
5. **Recycling.** We continue to recycle metal, food, electronics, glass and wood and seen increased activity.
6. **Recycling.** Introduced recycled coffee granules from our on-site coffee shops as compost for our trust gardens.
7. **Waste reduction.** Introduced glove off campaign to reduce single use plastics.

8. **Metal recycling.** Introduced metal bins for the recycling of clinical instruments used within our dermatology department. These products are disinfected and recycled, reducing waste generation, lower disposal costs and reducing carbon impact.

HOW WE PLAN TO IMPROVE

1. **Biosystems.** To continue to rollout Biosystems reusable sharps bins and pharmaceuticals more extensively.
2. **Circular Systems.** Continue to minimise waste through circularity - where reusable, remanufactured or recycled solutions.
3. **Education.** Continue to educate clinical teams through regular departmental, ward audits to encourage the correct segregation of waste.
4. **Innovation.** Continue to support innovative initiatives Trustwide to reduce the use of single use plastics entering waste streams.
5. **Clinical Waste Strategy.** In line with the 2023 NHS clinical waste strategy in waste management practices, strive and continue to, reduce waste and improve compliance to lower waste volumes, encourage the use of innovation to increase NHS waste management resilience, improve data use to help guide decision making, improve staff engagement and training to improve compliance and seek out carbon reduction opportunities

5.2.3 WATER

Water is a basic necessity and in many parts of the world is very scarce. While its availability is currently not a major concern in the UK, with an increasing population and a fast-warming climate, the problem is likely to develop.

Water is a critical resource, and its consumption drives a considerable proportion our overall utilities bill. Compared with other utilities, water does not have a significant impact on our carbon footprint, but its cost and potential future scarcity mean we must make sure that it is monitored, controlled, and used sensibly.

WHERE WE ARE

Figure 13 shows our water consumption since 2016 and the respective carbon impact. From 2016/17 to 2017/18, our water consumption declined by 6%, but then saw a dramatic increase in 2018/19 by 31% to approximately 175,000 m3/yr. The anomalously high consumption in this year was primarily driven by issues at a number of community sites. From 2020 to 2025 we have seen a gradual marked increase in water consumption on the acute site.

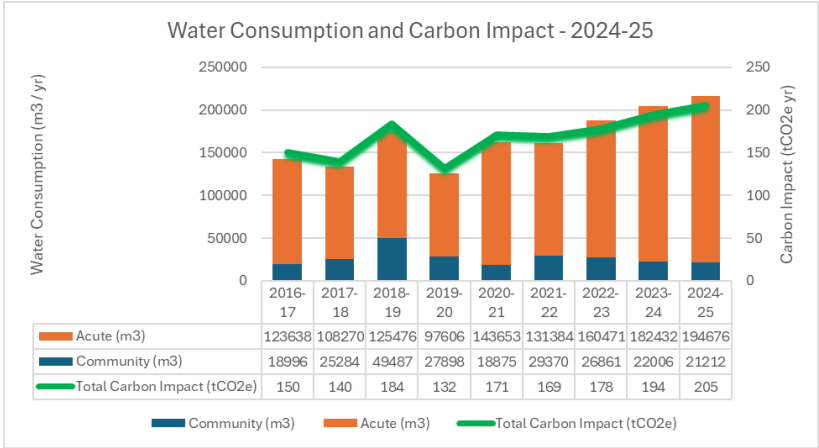


Figure 13: Our annual water consumption

Our water consumption is primarily driven by an identified leaks at the main hospital due to the aged estate with a marked increase up to 2024/25. Developing the capability to quickly identify and resolve abnormally high consumption across our estate will be critical to drive down our water demand on an ongoing basis, in addition our water safety procedures are more robust in its process with flushing regimes.

WHERE DO WE WANT TO BE

Our aim is to ensure that we use this valuable resource effectively and efficiently by minimising waste.

We have engaged with water management company Advanced Demand Side Management (ADSM) with a 5-year term to utilise their AquafundTM programme.

Through AquafundTM we are looking at ways to improve water management and reduce consumption on a permanent and sustainable basis.

Preventing us from achieving our aim is our aged infrastructure, and our restricted ability to locate leaks promptly. Improving our coverage of AMR's will reduce the time in locating water leaks.

Automatic Meter Reading (AMR) devices are a technology that we could implement and install onto our water meters to provide accurate and consistent readings. Although this technology would assist in identifying leaks quickly, reducing water waste, and thus, costs, it is expensive to install. Using the AquafundTM National Grant the Trust would benefit from (ADSM) installing these meters, funded through the grant and repaid though the savings achieved. In addition to the use of (AMR) devices, we should review opportunities to deploy submeters across the acute site, these are relatively low cost and can be effective for identifying abnormal consumption in specific areas, aiding our ability, (ADSM) will also assist in managing this. Educating our staff and the patients can also help reduce the overall water consumption; through provision the correct training and awareness programmes, costs and our overall carbon impact can be kept to a minimum.

WHAT WE HAVE ACHIEVED 2022 -2025

- 1. Engaged water management company (ADSM) 5-year term to utilise their AquafundTM programme.

- 2. Introduction of Automatic Meter Readings (AMR).
- 3. Leak prevention strategies.
- 4. Improved infrastructure. Pipe replacement programme scheme.

HOW WE PLAN TO IMPROVE

- 1. **AMR.** Continue to review opportunities to deploy AMR technology and decide whether they are a cost-effective option to drive down water consumption.
- 2. **Training and Education.** Undertake staff training and increase patient awareness of sustainable water management.
- 3. **Leak Detection.** Improve and progress with prevention strategies.
- 4. **Management systems.** Improve system collaborations.

5.3 TRAVEL AND TRANSPORT

We have had a green travel plan since 2007. This section provides an update on the current initiatives and planned action with defined travel measures to support sustainable travel choices for patients, staff, and visitors. It also describes the transition of our transport fleet to ultra-low and zero-emission vehicles.

WHERE WE ARE

We support our staff to work differently and closer to home in a way that enhances wellbeing and reduces carbon emissions from their journeys to and from work, while also reducing pressure on our limited car parking provision. We will be focusing on active travel, public transport, and zero-emission vehicles, and have a clear understanding of staff commuting. We review and update our green travel plan and sustainable travel measures regularly in line with the NHS net zero travel and transport strategy.

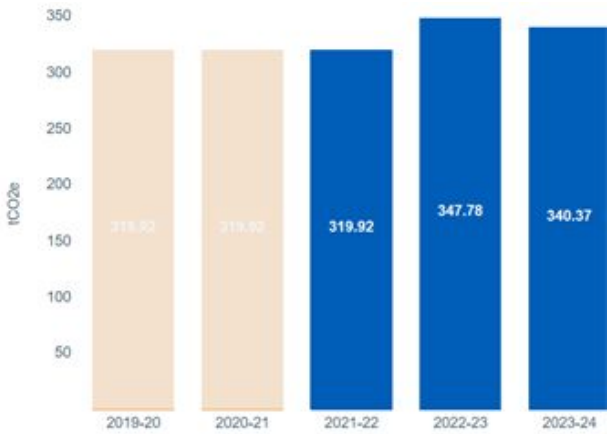


Figure 14: Total fleet emissions.

Sustainable and active travel has been encouraged by deployment of a few EV chargers at our acute site, installation of cycle shelters and a cycle path entrance separate from the main road.

We have recently introduced digital technology to enable the assessment and benchmarking of staff commuting patterns and emissions. This will include a scoping analysis to achieve ACEL (Average Commuter Emissions Level). Through this data analysis, we will identify further travel options that will include optimised car sharing for staff via a digital platform and information to support improved public transport options to our various locations of care (and work).

We collaborate closely with our local authority partners on all green travel initiatives to ensure we maximise opportunities reduce carbon emissions through improved public transport links and healthy choice options.

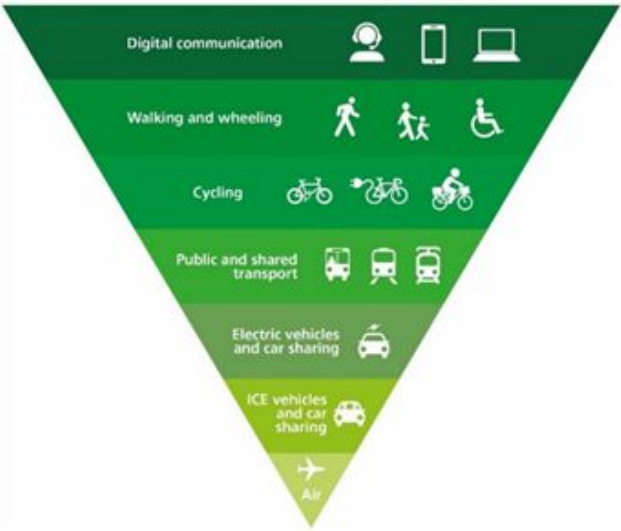


Figure 15: Sustainable travel hierarchy.

WHERE DO WE WANT TO BE

We recognise that to fully meet the expectations of our patients, staff, and visitors we need to improve sustainable travel options to our site encouraging the use of public transport and other options such as cycling.

We also respect that we serve a rurally dispersed community where personal vehicular access is sometimes the only way to access our services.

The NHS Long Term Plan sets out a commitment for 90% of the NHS fleet to use low, ultra-low and zero-emission vehicles by 2028, reaching net zero emissions by 2040. We must align to this ambition.

The NHS Net zero travel and transport strategy outlines a roadmap to decarbonise NHS travel and transport, while also providing cost-saving and health benefits.

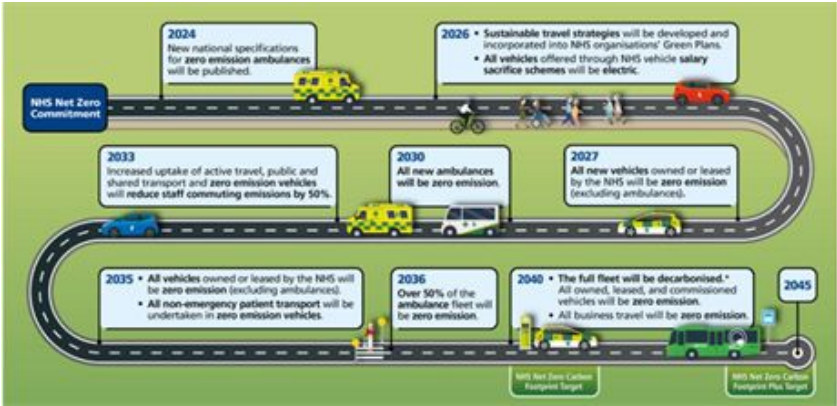


Figure 16: Travel & Transport strategy roadmap.

WHAT WE HAVE ACHIEVED 2022 -2025

1. **Fleet EV.** IT team purchased three electric vehicles for fleet.
2. **Fleet EV.** Transport team purchased two electric vehicles for couriers.
3. **EV Charging points.** Installed three dual use electric charging points.
4. **PTPs.** Introduced personal travel plans available for all staff.
5. **Events.** Introduced regular sustainable travel events.
6. **E. Bike Scheme.** Implemented a free e. bike loan scheme for staff.
7. **Data Mapping.** Introduced annual data mapping of staff locations to support sustainable travel options, influencing public transport providers to provide additional transport routes to hospital sites.
8. **Staff Travel Surveys.** Introduced annual staff travel surveys providing an understanding of staff travel modes to work and support additional sustainable travel modes.

9. **Introduced ACEL Rating.** On an annual basis we record the average commuter emissions of our staff. This rating is the only standardised methodology for benchmarking and comparing commuter emissions. This rating system empowers the Trust to understand, benchmark and improve their commuting emissions.
10. **Bike Shelters.** Additional bike shelters have been installed on the Torbay hospital site.

HOW WE PLAN TO IMPROVE

1. **Fleet Vehicles.** To transition courier vans, to zero emission vehicles: target date 2027 for new vehicles and all vehicles owned or leased by 2035.
2. **Pool Vehicles.** To transition fleet to zero emission vehicles: target date 2027 for new vehicles and all vehicles owned or leased by 2035.
3. **Patient Transport Fleet.** To investigate solutions in line with technology. Review in line with the current lease agreement arrangements with any new ambulances to be zero emissions by 2035.
4. **Pharmacy Home Delivery Fleet.** To transfer to zero emission vehicles: target date 2027 for new vehicles and all vehicles owned or leased by 2035.
5. **Salary Sacrifice Scheme.** Offer only zero-emission vehicles through vehicle salary sacrifice schemes from December 2025 onwards (for new lease agreements)
6. **Metrics.** To introduce metrics to track progress of, total fleet and grey emissions, % of owned and leased fleet that is ultra-low emission vehicle (ULEV), or zero-emission vehicle (ZEV) and salary sacrifice travel schemes.
7. **Drive/Car Share.** To accelerate staff car sharing to introduce a dedicated car share platform to encourage and reduce single mode occupancy car journeys to work.
8. **Electrical Infrastructure.** To increase electrical capacity to sites to support transition to electric vehicle fleet.

9. **Dedicated shower facilities.** To introduce dedicated shower facilities to encourage and support sustainable and active travel for staff.
10. **Existing green travel plan.** To incorporate this plan as an annex document within this green plan.
11. **Public transport.** To collaborate with public transport providers to influence additional bus routes support sustainable travel for patient, visitors, and staff.
12. **Patient and visitor travel surveys.** To undertake these surveys to understand travel patterns to support sustainable travel.

5.4 MEDICINES - ANAESTHETIC GASES AND METERED-DOSE INHALERS

Medicines account for around 25% of NHS emissions. A few medicines account for a substantial portion of these emissions, for example, anaesthetic gases (2% of NHS emissions) and inhalers (3%).

Inhaled anaesthetic agents, including volatiles - used for anaesthesia in theatres - and Nitrous Oxide (N₂O) & Entonox (50% O₂/50% N₂O) - used for pain relief in a range of clinical settings, are critical to our delivery of care. However, these are also potent greenhouse gases and thus even with low volumes used across our services, shows that they make-up 7% of our NHS Carbon Footprint.

5.4.1 VOLATILE ANAESTHETIC GASES

WHERE WE ARE

We are fortunate to have an exceptionally talented clinical team in this area, many of whom are passionate about sustainability. Team members have setup a Green Theatres Group which is dedicated to encouraging wider theatre users to help address the environmental impact of this aspect of care. The group is driving sustainability improvements in a range

of areas and has been particularly effective at reducing the carbon impact from volatiles use in theatres.

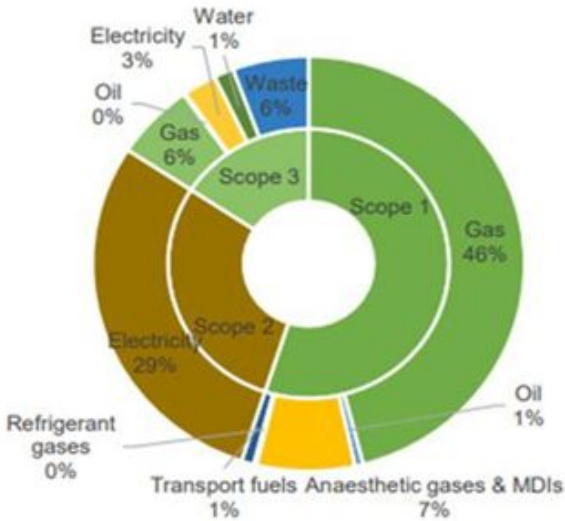


Figure 17 Our Carbon Footprint breakdown

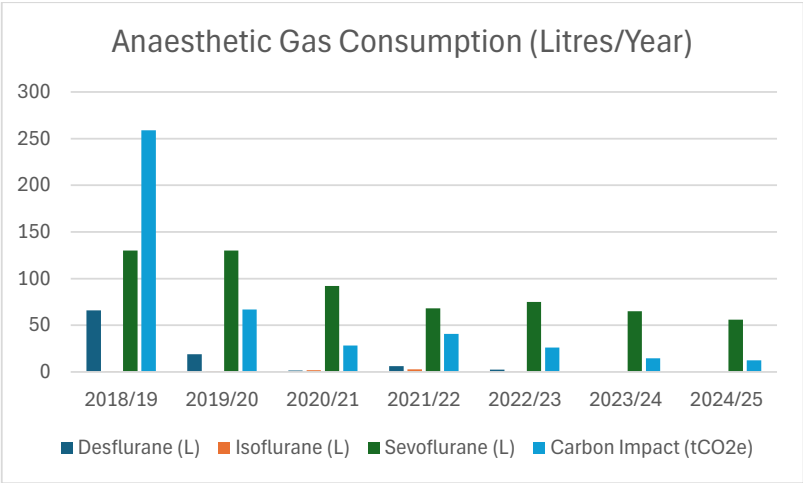


Figure 18: Volatiles use and associated carbon impact.

Figure 18 shows how volatiles use has reduced over a six-year period, with a desflurane (the most detrimental gas used in theatres) having been eradicated. The result of this has been a significant reduction in carbon emissions which has been driven by concerted actions by our clinical teams;

- desflurane bottles have been removed from anaesthetic machines and are stored separately, only available on specific request.
- low flow techniques have been adopted to reduce sevoflurane use.

WHERE DO WE WANT TO BE

We aim to maintain and where possible, further reduce our carbon impact from volatiles, we will continue to keep desflurane off the anaesthetic machines and use only when clinically critical. We will also continue to encourage low flow techniques, even in the anaesthetic room. Furthermore, we will look to drive down the use of sevoflurane by considering how to deploy regional/neuraxial anaesthesia in greater

proportion of scenarios, reviewing options for increased use of intravenous anaesthetics and assessing options for capturing exhaled volatiles.

WHAT WE HAVE ACHIEVED 2022 -2025

- 1. **Medical Gases.** Desflurane eradicated.

HOW WE PLAN TO IMPROVE

Our plans to further mitigate volatiles impact include;

- 1. **Anaesthesia.** Encourage use of regional/neuraxial anaesthesia in an increased % of cases, plan to look at new patient pathways using neuraxial techniques in place of general anaesthesia and to measure the carbon footprint of each pathway.
- 2. **Alternative Anaesthetics.** Review potential to use intravenous anaesthetic alternatives e.g. remifentanyl.
- 3. **Gas Capture.** Evaluate cost and carbon reduction benefits of exhaled gas capture/treatment technologies.
- 4. **Drug Waste and Processes.** As high users of intravenous anaesthetic alternatives e.g. Propofol/remifentanyl we will need to audit our drug waste and then institute measures to reduce this.
- 5. **Funding Streams.** Continue to look at grants for funding volatile gas capture in our 'high volatile use' theatres, this will mean a high return on investment.

5.4.2 NITROUS OXIDE AND ENTONOX

WHERE WE ARE

Given that the impact of volatiles has been dramatically reduced, our most significant carbon impact is driven by N₂O. Figure 19 shows the breakdown of volume (litres) of nitrous oxide, and we can see a downward trend since mid-year 2022/23 in manifold usage indicating a reduction in waste of the carbon emissions of inhaled agents used. This reduction has been actualised due to our decommissioning action plans to cap off

pipework leg supplies. On, this basis, reduction of N₂O use must be the priority for us going forward. Our priority for reducing the impact of N₂O/Entonox use must be to identify where wastage is occurring within our system and reduce the reduce nitrous oxide waste from medical gas pipeline systems. This will involve collaborative working between clinical leads, estates teams and the medical gases committee we are currently at a stage where the completion of. While cutting our gas wastage will have the most significant impact in this area, we must also encourage and challenge clinical colleagues to consider where clinical use of N₂O/Entonox can be limited or eliminated.

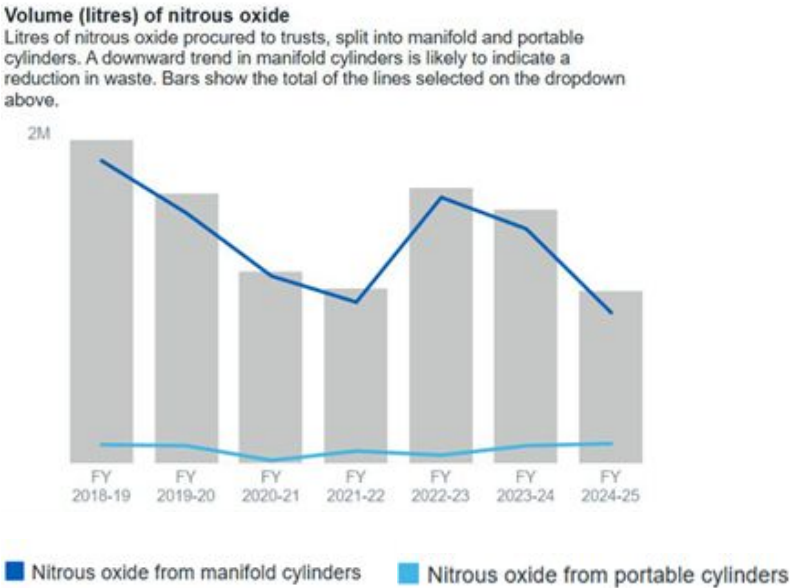


Figure19: Breakdown of volume (litres) of nitrous oxide

WHAT WE HAVE ACHIEVED 2022 -2025

- 1. Programme of works implemented with end of July 2025 date for manifold supply to be capped off.
- 2. Decommissioning of all nitrous oxide outlets in all the anaesthetic rooms and theatres (and any other places where anaesthesia is delivered in the hospital) current plan in progress; timeline, pipework legs will be capped off by the end of May 2025. AVSU valves to be shut off by end June 2025. Manifold supply capped off by end of July 2025. Work confirmed as completed.

HOW WE PLAN TO IMPROVE

- 1. Review options for portable delivery systems for entonox.
- 2. Conduct Entonox waste review by evaluating consumption in maternity against benchmarks and producing plans for reduction.

5.4.3 METERED DOSE INHALERS (MDIS)

Pressurised metered dose inhalers (pMDIs) prescribed within the National Health Service (NHS) contribute approximately 3% of all greenhouse gas emissions generated by the healthcare system. These inhalers contain hydrofluorocarbon (HFC) gases that are used as propellants to deliver medicine to a patients’ lungs; the propellants that are used are potent greenhouse gases with a global warming effect.

pMDI use in England is responsible for nearly one million tonnes of CO2 equivalent per year.

Salbutamol MDI, a short acting reliever inhaler, has been identified as the largest single source of carbon emissions from NHS medicines prescribing. In December 2023, a total of 50,795 salbutamol MDI inhalers prescribed across Devon, and an additional 66,164 non-salbutamol MDI inhalers were prescribed across Devon.

Inhalers are medications breathed through the mouth into the lungs to help open the airway thereby allowing increased ease of breathing. They are predominantly prescribed to patients with asthma.

Table 2: Description of inhaler types

Inhaler type	Description	Carbon impact
Pressurised Metered Dose Inhaler (pMDI)	Most common type. Pressurised propellant in aerosol chamber expels medicine into lungs.	Contain hydrofluorocarbon (HFC) propellants that have very high GWPs.
Breath-Actuated Inhaler (BAI)	Inhalation combined with propellants enable medicine to reach lungs.	Typically contain the same HFC propellants as pMDIs so similar carbon impact.
Dry Powder Inhaler (DPI)	Medicine is in powder form and is inhaled without propellants.	Do not use propellants and active ingredients have relatively low GWP.
Soft Mist Inhaler (SMI)	Medicine is in liquid form delivered as a mist without propellants.	Do not use propellants so lower impact than MDI & BAIs.

WHERE WE ARE

Torbay and South Devon NHS Foundation Trust as local prescribers work in collaboration with other Trusts in Devon to form The Devon Formulary which promotes safe, effective, and economic prescribing across primary and secondary care in Devon. It provides clinical guidance on the management of a wide variety of common conditions, including locally recommended drug choices and extensive information regarding the carbon impact.

WHERE DO WE WANT TO BE

We are committed to moving away from pMDIs to dry powder and soft mist alternatives as part of its plan to reduce the carbon impact of medicines. Our Chief Pharmacist will continue to collaborate with clinicians as part of our transition strategy which will report proposed target milestones and

delivered progress to our Sustainability and Well Being Group. Progress will be reported within future editions of our Green Plan.

To support high-quality, lower-carbon respiratory care in secondary care, including supporting patients to choose the most appropriate inhaler(s) in alignment with clinical guidelines.

Procurement, prescribing, dispensing and collection of medicines all have an environmental impact. If these medicines are subsequently not used – the environmental impact could be avoided.

WHAT WE HAVE ACHIEVED 2022 -2025

1. **Guidance.** Each available inhaler is listed quoting the annual carbon impact to support prescribers and members of the respiratory team.
2. **Transition Strategy.** Working in conjunction with the Devon formulary continue make decisions which take carbon impact into consideration.
3. **Safe Disposal.** Used pMDI canisters still contain propellants; all used pMDI canisters returned to pharmacy to dispose of in an environmentally safe way.
4. **Prescription waste.** We have put in place processes within the Trust to help ensure that we do not supply medicines that are not required by the patient.

HOW WE PLAN TO IMPROVE

1. Continue to develop transition strategies to increase the use of lower carbon alternatives to pMDIs.
2. To continue to choose the most appropriate inhaler(s) in alignment with clinical guidelines considering the environmental impact of inhalers
3. Continue to undertake technique checks with patients and promote the appropriate disposal of inhalers
4. To continue build on progress reducing point of use emissions while improving patient care and reducing waste.

5. Environmental Impact of prescription waste. To continue to deliver schemes which focus on only supplying medicines that patients are going to take.

5.5 WORKFORCE AND SYSTEM LEADERSHIP

WHERE WE ARE

We have appointed the Deputy Chief Executive/Chief Operating Officer to take the role of senior responsible officer to oversee net zero carbon reduction and its operational support, workforce capacity and skill requirements for the delivery of the green plan.

We will promote, and consider setting uptake targets for, core training offers set out on the Greener NHS Training Hub and promote specialist training for staff groups who underpin the delivery of green plans, such as board members, procurement, finance, estates and facilities staff and clinicians.

We have also approved the creation of a Sustainability and Wellbeing Group who will maintain central leadership on all sustainability, wellbeing, and green plan matters. The group will be responsible for agreeing objectives, setting targets, approving relevant work plans, and monitoring progress. We will also use the forum to share ideas, create solutions, and plans with our system partners within the Devon Integrated Care System and the broader NHS.

As already identified, our Green Plan is a key enabling plan to support us to deliver our vision for 'better health and care for all' and our organisational strategy.

WHERE DO WE WANT TO BE

We recognise and fully embrace the climate emergency and the imperative to meet nationally set targets. We must therefore ensure net

zero carbon is fully considered in all our business going forward. To achieve this level of consideration, all our governance will include acknowledgement of whether or not carbon reduction/mitigation is relevant to a decision process, and where it is, we will report how carbon reduction mitigation will be achieved or not.

Since the pandemic, our workforce has admirably adjusted to working differently, often working from home continuously or intermittently. We have learnt much about how to better support our staff to work from home.

There has been a clear benefit to both the environment and our staff from travelling less. With this in mind, and through staff engagement, we will be optimising hybrid working across our community estate. This will enable staff to make shorter journeys reducing carbon emissions and, in some cases, offer walking or cycling opportunities, while working in an office setting with other staff colleagues.

As a Trust we need to assess our workforce capacity and skill requirements for delivering the green plan, considering good practice examples such as hybrid roles, apprenticeships, fellowships, and NHS estates sustainability career pathways. We need to support our staff and leaders to learn, innovate and embed sustainability into everyday actions.

WHAT WE HAVE ACHIEVED TO DATE

1. **Established Groups.** Creation of our Sustainability and Wellbeing Group (SWG) and department sustainability subgroups.
2. **Carbon Literacy Training.** Delivery of training to Estates and Facilities core staff and other core staff groups.

HOW WE PLAN TO IMPROVE

1. **Communications Plan.** Communicate our Green Plan all our teams and encourage feedback and engagement.
2. **Integrate.** To support Trust staff and leaders to learn, innovate and embed sustainability into everyday actions.

3. **Training.** To continue to promote training opportunities via the Greener NHS Training Hub for varying staff groups who underpin the delivery of green plans, such as board members, procurement, finance, estates and facilities staff and clinicians.
4. **Training.** To continue to embed internal sustainability training for staff from induction to essential to role and to mandatory
5. **Promotion.** To promote and consider setting targets for core training offers set out on the Greener NHS Training Hub.

5.6 DIGITAL TRANSFORMATION

WHERE WE ARE

Digital transformation of health and care, and the success of our new hospital redevelopment programme are vital to delivering our health and care plan and our overall vision and strategy and with it the associated carbon reduction benefits. This success requires both investment and commitment to a major transformational change programme. We continue to work toward the delivery of (EPR) Electronic Patient Records a new One Devon electronic patient record in 2026.

WHERE DO WE WANT TO BE

Our key objectives are to maximise the benefits of digital transformation to reduce emissions and improve patient care, by reducing the use of paper and providing virtual pathways where clinically appropriate. To deliver digital assets and services which are carbon-efficient and support the net zero carbon agenda whilst ensuring digital inclusion for all our communities. We intend for our future digital systems to meet national standards in relation to the environment and net zero carbon. Our transformation programme will demonstrate how digital innovation can be a primary enabler of sustainability goals, including:

- reducing requirement to travel through expanded virtual care pathways, driving measurable emissions reductions in patient and staff travel

- eliminating paper-based processes through full EPR implementation
- optimising resource utilisation through AI and digital twin technologies
- embedding circular economy principles in all digital procurement and asset management
- ensuring digital inclusion strategies leave no patient or staff member behind in our digital transformation

WHAT WE HAVE ACHIEVED TO DATE

1. **Virtual printing** follow on printing, eliminates automatic printing, higher specification and capacity printers reduces number of printers required
2. **Recycled copier paper** the introduction of highly recycled paper use.
3. **IT Fleet** the whole fleet transitioned to Electric vehicles. Electric Charging stations introduced.
4. **IT Equipment Refresh** undertaken every 4 years to ensure not running energy inefficient equipment
5. **WEEE Waste Strategy** sustainable disposal of IT equipment, reconditioned for re-use, deployed via third party, extending life of equipment
6. **Digital Supplier Data Centre** tender completed for the consolidation of data or new data centres to minimise electricity demand

HOW WE PLAN TO IMPROVE

We are looking to drive improvements through the following activities;

1. Continue to encourage the use of video conferencing options for meetings between teams at different sites, with remote contractors and with patients, where appropriate, establishing targets for virtual delivery of routine follow-up appointments across suitable specialties.
2. Continue with circular approach to IT hardware management, with re-use as a priority and WEEE recycling as a fall back.
3. Continue with equipment refresh which include longer device lifetimes and energy efficient equipment.
4. Consider pc power down software options.
5. To continue to promote staff agile/homeworking and hot desks to reduce journeys to and from work reducing carbon emissions and energy usage.
6. To continue with tender to progress with the consolidation and relocation of data and data systems providing high efficiency equipment and resilient storage facilities. New data centre designed for maximum efficiency using renewable energy and smart systems minimising electricity demand. To benchmark energy savings realised with change to new data centre.
7. To continue to progress to improve virtual pathways, clinics, attend anywhere.
8. To continue to work toward the delivery of (EPR) Electronic Patient Records a new One Devon electronic patient record in 2026. The One Devon EPR will enable us to improve the way we use and share patient information. The requesting of paper notes will reduce significantly as the patient record will be accessed digitally as the programme is fully embedded and more records are digitised contributing to a more efficient and sustainable way of working.
9. To undertake digital maturity assessment to consider opportunities and to continue to embed sustainability in digital services.
10. Where possible, embed NHS Net Zero Supplier Roadmap requirements in all digital procurement exercises, including mandatory carbon reduction plans and sustainability weighting in tender evaluations for all major digital purchases.
11. Establish community digital champions network and partner with local organisations to provide digital skills training, ensuring 90% of patients can confidently access basic digital health services by 2027, with alternative pathways for digitally excluded groups.
12. Use the Digital Futures Hub to develop AI-powered energy optimisation systems, smart building IoT sensors for environmental monitoring, and digital twin technology for space utilisation and carbon footprint reduction.
13. Integrate digital solutions into clinical pathways specifically targeting carbon reduction, including remote monitoring programmes to reduce

hospital visits, AI-assisted diagnostics to minimise repeat appointments, and digital therapeutics for chronic disease management.

6. NHS CARBON FOOTPRINT PLUS

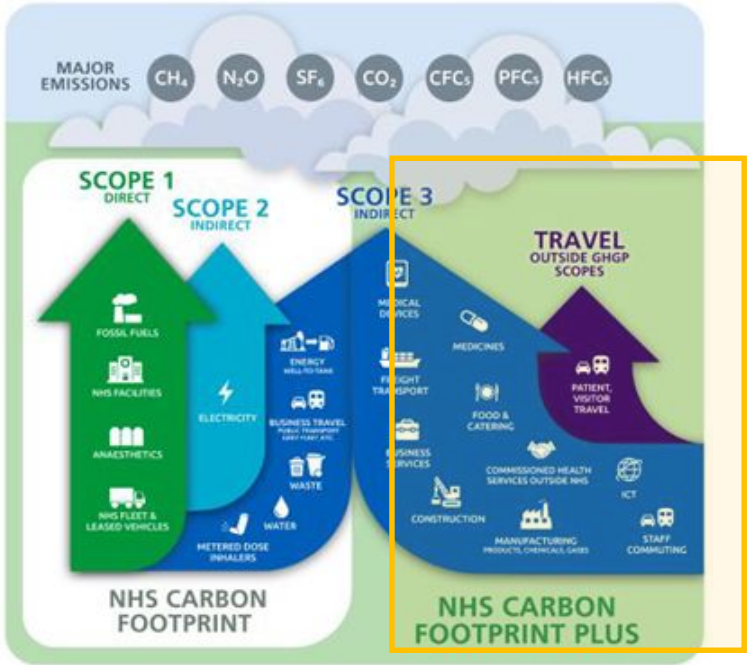


Figure 20: GHG emissions scope - NHS Carbon Footprint Plus

This section addresses areas of focus which will primarily impact our NHS Carbon Footprint Plus. These are the carbon emissions for which we generally do not have direct control but are able to influence.

Figure presents an overview of the NHS Carbon Footprint Plus. We have not yet completed a baselining exercise to evaluate our specific breakdown but as an integrated care trust, it is expected to be like the average. On this basis, we can see that 76% of the total emissions result from sources extraneous to our core business operations. We recognise the significance of our challenge in this area.

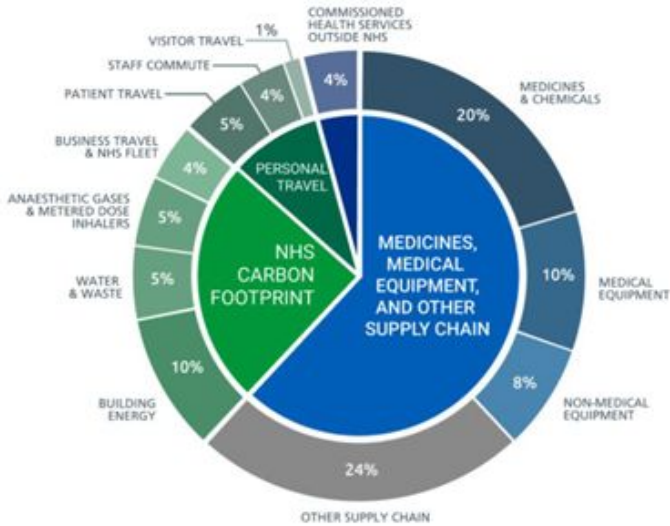


Figure 21: NHS average emissions breakdown by source.

6.1 CARBON TARGETS

In line with much of the NHS, our approach to carbon reduction to date has focussed on reducing operational emissions – those associated with building utilities and transport. Going forward, it is clear that a broader approach must be adopted to tackle not only the emissions which we control but also our wider emissions, which we are able to influence. Our initial focus will be to understand the breakdown of our own Footprint Plus to enable us to prioritise improvement.

Figure 22 displays NHS targets for Carbon Footprint Plus. We are aligned to reaching these goals, recognising as we do, that it will require a significant, concerted effort both from within our organisation and through collaboration with the wider Devon Integrated Care System and central NHS functions. With a provisional baseline year of 2016/17, our Carbon Footprint plus targets are:

- **80% reduction by 2039**
- **100% reduction by 2045**

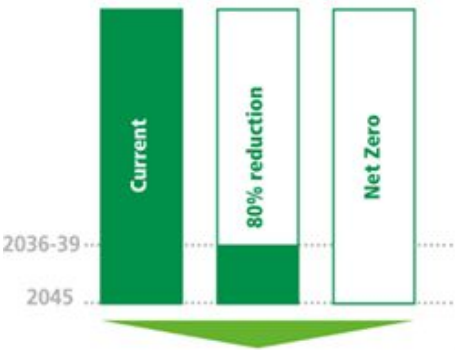


Figure 22: NHS Carbon Footprint Plus reduction targets.

6.2 SUPPLY CHAIN AND PROCUREMENT

WHERE WE ARE

According to the *Delivering a Net Zero National Health Service* report from October 2020, the NHS supply chain is responsible for 62% of the NHS Carbon Footprint Plus. Torbay & South Devon is an integrated care Trust and therefore it is likely that our supply chain will contribute a similar proportion of our footprint.

WHERE DO WE WANT TO BE

We recognise that before we can define clear plans to mitigate the carbon impact of our supply chain, we must understand our baseline position. We will commit to completing an initial baselining assessment of our NHS Carbon Footprint Plus prior to the annual review of this Green Plan. Our baseline will enable us to understand where ‘hotspots’ exist in our supply chain and thus allow us to prioritise plans for reduction.

While defining our baseline will be our primary focus, we know that there are actions that we can undertake now to proactively reduce the carbon impact our purchased goods and services. Our procurement team are currently reviewing how to effectively incorporate sustainability metrics as a core element of future tender evaluation processes.

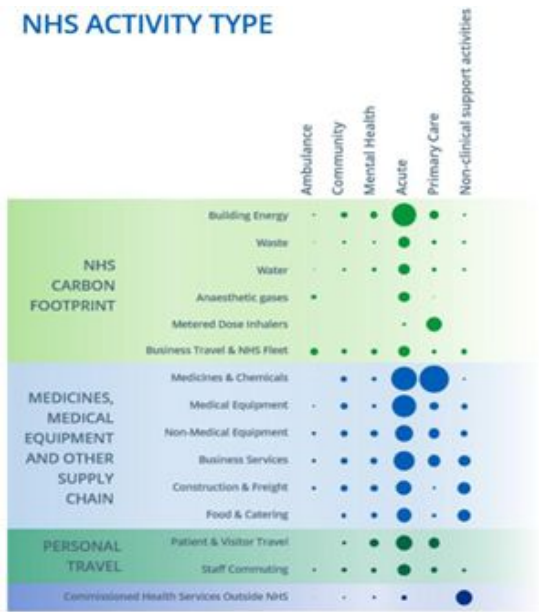


Figure 23: Emissions sources by activity type and care setting (Greener NHS, 2020)

WHAT WE HAVE ACHIEVED TO DATE

1. **All tendered contracts.** To now include a minimum 10% social value criteria from the Social Value Model and includes sustainability and carbon reduction criteria where appropriate.
2. **All tendered contracts.** Above relevant threshold contracts are required to meet the Carbon Reduction Plan provisions and proportionate Net Zero Commitment as detailed in the [NHS net zero supplier roadmap](#) .
3. **Single Use Plastics.** The Trust have introduced schemes such as, Reusable sharps bin's, Gloves off campaign, keep me cups enabling single use plastic reductions from our supply chain.

4. **Contract Renewal.** Elis our laundry contract provider has made the 2045 net zero commitment and joined the NHS Net Zero International Leadership Group.
5. **Training.** In Support of the Net Zero targets the procurement senior leadership team have all undergone Carbon Literacy training through The Carbon Literacy Project.
6. **Devon wide Finance and Procurement.** The Trust has committed to a Devon wide Finance and Procurement solution supported by NHS SBS (Shared Business Services) from April 2026. NHS SBS has made the commitment to be net zero from 2040 with a plan to achieve a 90% emission reduction and 10% offset. The Trusts in Devon will work together on a shared procurement policy and strategy in line with the NHS Net Zero ambitions.
7. **New Contract.** A new Devon wide sandwiches contract with local supplier Tamar Fresh, a supplier currently ahead of its committed path to net zero by 2050. The new contract includes a commitment to investment in a 'One Devon' sustainable, easily accessible, sandwich packaging, produced and supplied in a certified carbon neutral production facility based in Plymouth, including biodegradable sandwich window that is fully recyclable.
8. **New Contract.** Contracts signed to move Trust's data centres to the Crown Hosted Ark Centres that prioritize environmental sustainability and efficiency utilizing green sourced electricity and achieving prominent levels of water savings compared to UK averages, emphasizing energy-efficient cooling technologies and compliance with relevant environmental standards.

HOW WE PLAN TO IMPROVE

1. To collate financial and material data required to complete NHS Carbon Footprint Plus baseline.
2. Implement process to ensure sustainability KPIs are included in tender evaluation criteria for tenders above a defined value.

- 3. NHS Net Zero Supplier Roadmap. To undertake steps to ensure suppliers follow and align with the NHS net zero ambition between now and 2030.
- 4. From April 2026 the Net Zero Commitment requirement will be extended to all relevant contracts.
- 5. To encourage suppliers to go beyond minimum requirements and engage with the Evergreen Sustainable Supplier Assessment to support a single conversation between the NHS and its suppliers on sustainability priorities.
- 6. To continue to reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects.
- 7. To reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects



Figure 24: Net zero supplier roadmap

6.3 CAPITAL PROJECTS

WHERE WE ARE

The NHS aims to become the world’s first net zero national health service. TSDFT is committed to aligning with this ambition by addressing both embodied and operational carbon across its estate.

To date, the Trust has made progress in embedding sustainability into the design of new developments, such as the appointment of a global healthcare architectural practice to lead the Building a Brighter Future programme. This team is actively assessing the embodied carbon impact of concept designs for future hospital buildings. Early efforts also include raising awareness within the capital team and referencing the NHS Net Zero Building standards in project planning.

However, achieving Net Zero requires a much broader view that extends beyond construction materials. The current estate relies heavily on legacy systems, including fossil fuel-based heating infrastructure, ageing electrical networks, and inadequate energy distribution systems. The existing electrical load capacity (3.9 MVA) is already under strain and building energy systems remain fragmented and carbon intensive. The infrastructure does not yet support the long-term electrification required for a Net Zero healthcare model.

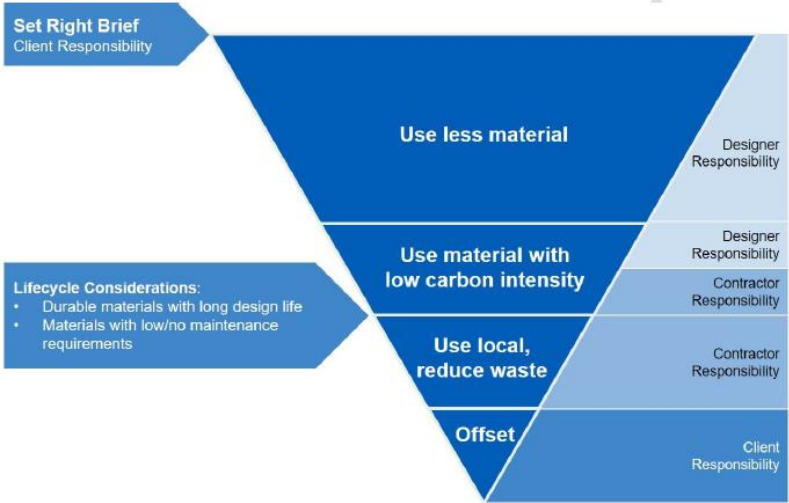


Figure 25: Embodied carbon of buildings - mitigation hierarchy.

WHERE DO WE WANT TO BE

To support the NHS Carbon Footprint targets—net zero by 2040 (direct) and 2045 (indirect)—the Trust must transition to a fully electric, low-carbon estate supported by smart, resilient infrastructure and improved building performance.

By 2035, TSDFT aims to:

- Fully electrify the site's heating, hot water, and operational energy systems.
- Replace existing gas-fired and steam-based systems with decentralised heat pumps and electric generation.
- Upgrade building fabric performance (insulation, high-performance glazing) to reduce energy demand and support heat retention.
- Expand electrical network capacity to a predicted 7.2 MVA load to support electrification and growing digital integration.

- Integrate resilient, low-carbon utilities infrastructure across both clinical and support services to ensure compliance with NHS Net Zero objectives and mitigate climate-related risks.

WHAT WE HAVE ACHIEVED TO DATE

1. **High Volatility (HV) strategy** developed, and a 5-year programme of work has commenced to fulfil the forecast net zero capacity requirements.
2. **New buildings** being delivered embracing modern methods of construction with all electric solutions using renewable energy solutions.
3. **Building management systems** being delivered on all new infrastructure replacements to improve efficiencies.

HOW WE PLAN TO IMPROVE

To achieve these goals, the Trust will adopt a phased, system-wide infrastructure transformation programme that aligns with clinical, operational, and sustainability priorities. Key actions include:

Energy Infrastructure Upgrades

- Substation upgrades to increase current load capacity and support increased electrification.
- Installation of new substations and reinforcement of the high-voltage (HV) network across both North and South sites.
- Replacement of centralised boilers with decentralised ground-source heat pumps and electrical steam generation units.

Building Performance Enhancements

- Improve energy efficiency of retained estate through targeted fabric improvements, including insulation and high-efficiency windows and cladding.
- Ensure all refurbishment and new build projects comply with the latest NHS Net Zero Building Standards.

Operational Integration and Governance

- Embed Net Zero and infrastructure resilience as core criteria in capital investment business cases.
- Continue engaging external sustainability and technical advisors to inform system design and delivery.
- Monitor electrical and environmental performance across the estate, using data to inform phased investment planning.

By addressing both embodied and operational carbon, and modernising energy infrastructure in parallel with estate redevelopment, TSDFT will move confidently toward its Net Zero goals, while improving system resilience, operational efficiency, and patient safety.

6.4 FOOD AND NUTRITION

We are committed to reducing the carbon impact of our food offer to patients, staff and visitors and continue to implement the national standards for healthcare food and drink delivering high quality, healthy and sustainable food and minimise waste.

WHERE WE ARE

Patient food is provided throughout all our sites using 'cook freeze' products purchased from an NHS national framework supplier. As the food is frozen, the shelf life is longer and helps to reduce food waste. Food is packaged in recyclable containers and available in multi portion units which again contributes to reducing food waste.

Patients order meals twice per day via an electronic meal ordering system; fast turnover wards such as maternity and the emergency admissions wards offer an individual plated meal system which is ordered at the point of service, giving patients more choice while providing an efficient, flexible solution to help further reduce cost and waste.

Food is managed and regenerated at ward level by catering assistants who solely focus on patient feeding, liaising closely with the main kitchen ensuring the patients receive the correct food, thus minimising food waste.

Our Bayview restaurant provides retail food for staff and visitors and is freshly cooked daily. Seasonal menus are offered and locally grown produce from nominated suppliers used wherever possible. Out of the twelve fresh meat products purchased, only five are processed. The aim is to reduce the amount of processed food used while incorporating more fresh, sustainable products into the menus and including more plant-based dishes where possible.

The Trust reported sixty-six tonnes of food waste last financial year 2024/25, this is a significant improvement from seventy-six tonnes in the previous reporting period 2023/24.

WHERE DO WE WANT TO BE

The catering team will develop initiatives and plans to deliver further food waste reduction year on year with an ambition to reduce food waste to only unavoidable residual waste within the next three years. We must continue with good practices we have already adopted such as;

- sourcing fruit and vegetables from a large variety of over sixty growers throughout the South West of England
- purchasing dairy products from a local family-owned business delivering the finest locally sourced food and produce in South Devon
- using fresh fish sourced from suppliers certified with the Marine Stewardship Council (MSC)
- making menus healthier and lower carbon, providing seasonal menus high in fruit and vegetables and low in heavily processed foods

WHAT WE HAVE ACHIEVED TO DATE

- Removed single use cups from Bayview Restaurant:** On 01st November 2023, re-usable cups were established in the restaurant preventing 35,000 single use cups going to landfill each year.
- Single use plates, cups and cutlery removed from wards:** Apart from a few critical areas, disposable items have been replaced with reusables. This has further reduced waste, reduced the environmental impact, reduced spending, and lowered our carbon footprint.
- Reduced our supply base to only use reputable vendors:** Using reputable vendors helps to meet our social and environmental responsibility. For example, reputable vendors will share their green plans outlining human rights protection through supply, environmental sustainability, reduced waste, and resource efficiency.
- Reduced deliveries on site by consolidating suppliers and capping deliveries:** A further benefit of reputable vendors is the use of modern multi-temperature vehicle fleet. This enables all produce (chilled, frozen, and ambient) to be delivered on one drop. This coupled with a strict delivery schedule reduces on-site congestion and air quality.
- Collaborated with key supplier to ensure that our fresh fruit and veg is sourced from local suppliers where possible:** Our fresh fruit and veg, along with our patient sandwiches are supplied by Tamar Fresh. They provide pro produce from local growers and producers.
- Patient sandwiches will be in fully sustainable packaging:** Tamar Fresh also provide our patient sandwiches and have committed to introducing 100% sustainable packaging for these products. This includes the clear film on the cardboard sandwich pack. This demonstrates a further benefit of collaborating with reputable suppliers.
- Introducing a new catering system including plated meals:** The introduction of the 'CarteChoix' plated meal throughout the bedded wards will result in a significant reduction of food waste. These meals are nutritionally balanced and created using sustainable ingredients. The move from a multi portion service to a single plated meal will minimise unnecessary over ordering by caterers.

- Introduced a system of weighing food to reduce waste:** All food waste is now collected and weighed prior to disposal. This enables us to monitor flow and put in measurable mechanisms to further waste from both the wards and the restaurant.
- Developed menus that include greater quantities of plant-based elements:** Following engagement with suppliers and staff engagement with industry professionals we have been able to modernise our menus to incorporate a greater level of plant-based produce. This has the benefit of increased health appeal, cost savings, and sustainable raw produce.
- Reduction of equipment/freezers in kitchen:** Over the last two years we have gone through a programme of reducing excess refrigeration equipment within the main kitchen. This has resulted in a drop of around 30% with further reductions expected as new processes are introduced. This has resulted in improved energy efficiency within the department.



HOW WE PLAN TO IMPROVE

Further to our ongoing sustainability drive in this area we will look to;

- To use products with added sustainable palm oil only
- To further reduce the amount of processed meat offered (currently five types) and replace with fresh meat where possible.
- To implement further processes and controls to ensure food waste is reduced.
- To ensure that all takeaway food to be served in recyclable packaging
- To reduce food waste by the implementation of plated meals – 10% reduction 2026

6. To introduce food waste collections across all wards & set a food waste reduction target.
7. To introduce a 'Boomerang' mechanism for packaging: 'Project Boomerang' is an initiative by Apetito, our patient food supplier. This is a closed loop mechanism where food and specialist diet meal trays are returned to the supplier free of charge, recycled, and put back into circulation. This represents an estimated 1696kg CO₂e per year.

7. OTHER ENVIRONMENTAL IMPACTS

7.1 NON-CARBON TARGETS

This section addresses aspects of sustainability that do not have a direct link with net zero carbon but are still important to our holistic aim of reducing our environmental impact as an organisation.

7.2 LOCAL AIR POLLUTION

If not carefully measured, polluted air is a serious health hazard which can lead to respiratory diseases, with young children and older adults being the most vulnerable. Improving the air quality around the trust and the NHS lies alongside one of the UK's main priorities, with cleaner air benefiting both the quality of life and the economy. Pollutants of specific concern include oxides of nitrogen (NO_x and particulate matter (PM) as these have been shown to drive respiratory issues.

WHERE WE ARE

The primary sources of local air pollution in and around the communities we serve will be vehicular traffic and, to a lesser extent, combustion of gas in our heating systems. According to the government website, UK Air, the air quality in the surrounding area of Torbay Hospital is currently level 2, "Low".

WHERE DO WE WANT TO BE

While the local air quality is not especially bad in our area, we recognise that we must ensure minimise our impact. We are also aware that while the general air quality in the area is not poor, there may be specific 'hotspots' in and around our sites which could be negatively impacting on the health and wellbeing of our staff, patients, and visitors. Developing a clearer picture of risk areas would be a key step in developing a targeted action plan.

HOW WE PLAN TO IMPROVE

1. review potential benefits of an air sampling campaign to identify high risk areas for NO_x and particulates.
2. engage with local council to understand opportunity to align on awareness-raising communications such as a 'no engine idling' campaign.
3. review viability of adopting key actions from the Clean Air Hospital Framework developed at Great Ormond Street Hospital.

7.3 GREEN SPACE AND BIODIVERSITY

WHERE WE ARE

Enhancing the natural environment on Trust sites and using 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.

We are constantly looking to expand the number of green spaces within our estate and through this promote biodiversity. We recognise the benefits green space has on our staff, and especially to the patients around our sites. Built environments which incorporate significant green space and associated biodiversity has been proven to improve patients' health outcomes and decrease the duration of hospital stays.



Figure 26: The topography and openness of our acute campus allows for many areas of green space.



Figure 27: Tree planting activity on the Torbay Hospital site

In 2019, Torbay Hospital joined the NHS Forest scheme where 160 trees were planted and circular habitats around the hospital were produced, where staff and patients can walk along various paths through the nature and enjoy the wildlife. We continue on an annual basis our tree planting programme to form hedgerows and increase overall biodiversity.

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 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 support the Trust’s project for the



Biodiversity Benchmark. These recommendations are currently being implemented and will be reviewed at the end of 2025 for potential completion.

WHERE DO WE WANT TO BE

Green spaces are of huge value for hospitals, and our goal is to increase the quantity, and the quality of biodiversity throughout. Through our Building a Brighter Future programme, we have a fantastic opportunity to incorporate green spaces into redeveloped areas of the site. This is a core priority of our programme’s sustainability agenda. We also have an opportunity to collaborate with the local authority and community nature organisations, to discuss how best to promote biodiversity throughout our local communities.

WHAT WE HAVE ACHIEVED TO DATE

- 1. **Staff Plant shop.** The introduction of a plant shop for staff issuing c1500 plants for offices, staff rooms, waiting, reception area enhancing the hospital environment.
- 2. **Biodiversity Benchmark.** The continuation of standards to enhance environment working towards biodiversity benchmark.
- 3. **Green Space Enhancements.** New gardens created including sensory planting schemes and rehabilitation wheelchair planters in our acute and within our community settings.
- 4. **Woodland Trail.** Additional enhancements to improve woodland trail environment including tree, sensory trails, interpretation boards, hibernaculum’s, bug, bat and bird boxes and wildflower meadows.
- 5. **Planting schemes.** Annual tree planting and pollinator patch schemes



HOW WE PLAN TO IMPROVE

- 1. Communicate plans to develop green space and biodiversity as part of our Building a Brighter Future programme to staff and garner feedback.
- 2. Incorporate green space and biodiversity promotion into our Sustainability and Wellbeing Group’s areas of focus and engage with local authority to discuss collaborative approach.
- 3. To continue to work toward the biodiversity benchmark for the Torbay Hospital site

7.4 ADAPTATION

WHERE WE ARE

This section addresses plans to ensure that we are able to suitably adapt to meet the challenges that will arise from the changing climate. While the NHS as a whole is driving towards our net zero targets to minimise its contribution to climate change, we are already seeing weather conditions becoming more extreme each year. Last year we saw forest fires, flooding, and heat waves all over the globe with many people losing their homes and their livelihoods. As an NHS trust, we are in danger of our services being overrun and/or disrupted due to such events, therefore, we are continually looking to improve our efforts to minimise our contribution to climate change.

WHERE DO WE WANT TO BE

While some risks which are likely to be exacerbated by the changing climate are already being managed through our Emergency Planning procedures, we do not currently have a Climate Change Risk Assessment (CCRA) document in place. The CCRA is used to specify the risks associated with climate change, how our operations might be affected, and what needs to be done to minimise and/or avoid the risks involved. By producing a CCRA for the next five years, we will understand where we are vulnerable and where our priorities lie, thus, allowing each site to adapt to minimise the effect of the risks.

WHAT WE HAVE ACHIEVED TO DATE

- 1. **Weather Alerts.** Cascade weather health alerts, severe weather warnings, digital messaging across the organisation, in line with the government’s Adverse Weather and Health Plan
- 2. **System wide exercises.** participation in system wide exercises relating to severe adverse weather linked to climate change.
- 3. **Local resilience forum.** Participation in local resilience forum and local health resilience partnership meetings

HOW WE PLAN TO IMPROVE

- 1. To produce a CCRA, detailing the risks to our operations associated with climate change, and how they are able to adapt.
- 2. Climate change adaption planning to be considered as a longer-term impact on an organisation as part of a business continuity policy and plans.
- 3. To factor in the effects of climate change when making infrastructure decisions and designing new facilities, including enhancements like improved green spaces, drainage systems and passive cooling solutions.



Figure 27: Climate change risks and their variation by area (Under the Weather V2 – improving health, wellbeing and resilience in a changing climate, March 2015)

8. SUSTAINABILITY GOVERNANCE

8.1 GOVERNANCE & REPORTING

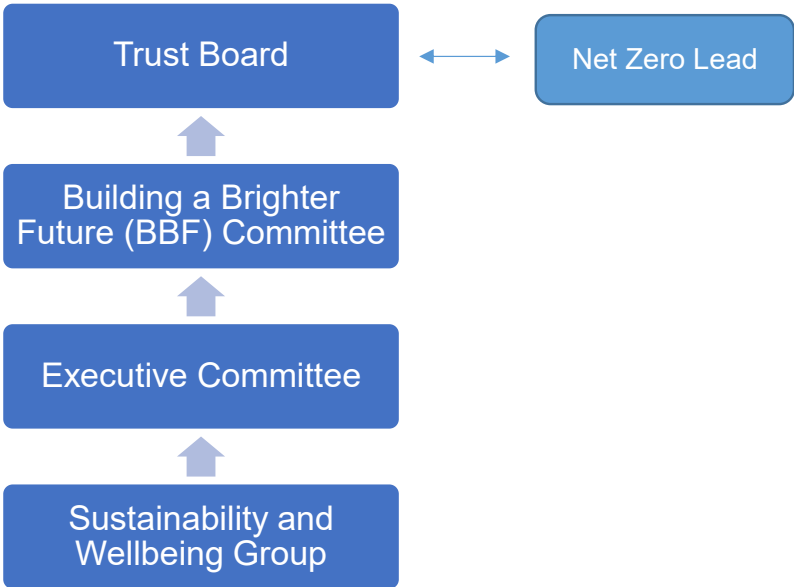
Our Green Plan will be updated and approved by the Trust Board on an annual basis. At the end of quarter two each year, a progress report will be submitted to the Board to review Key Performance Indicators and the progress of improvement actions.

Our drive for sustainable development and our net zero agenda will be championed at Board level by our designated net zero lead: Adel Jones, Deputy CEO and Chief Operating Officer.

The administration and upkeep of the plan will be the responsibility of the Workplace Director and team with its implementation and development being driven primarily via our Sustainability and Wellbeing Group.

The plan will also require senior leadership and oversight of delivery from a range of functions, which may include:

- chief medical, chief nursing, chief allied health professional officers and chief pharmacists
- directors of estates and facilities
- directors of procurement
- chief information officers
- directors of finance



Key elements of our sustainability reporting and the respective timescales are outlined below.

- Annual

- ERIC (Estates Information Return Collection)
 - Mandatory data collection for all NHS Trusts
 - Green Plan Review
 - Update sustainability KPIs
 - Update actions
- Half-year

- Green Plan Progress update
 - Summary of KPIs which can be tracked monthly and action progress for H1
- Month

- Data collection
 - Tracking of sustainability KPIs

8.2 TRACKING PROGRESS

Our Green Plan updates will allow us to provide a narrative to our staff, patients, and community about the actions we are taking to improve our sustainability. We will also use it to report our progress against our targets, using a number of key environmental indicators. These are outlined in [Table 3](#).

Table 3: Our Sustainability KPIs

KPI	Unit	Description
Electricity consumption	kWh/ m²	Total electricity demand per m² of occupied floorspace.
Gas consumption	kWh/ m²	Total gas demand per m² of occupied floorspace.
Carbon from energy	kgCO₂e/ m²	Total carbon output per m² of occupied floorspace.
Waste production	kg / m²	Total waste produced by Trust per m² of occupied floorspace.

Waste recycled	%	Proportion of total waste fraction which is segregated into recycled waste streams.
Water impact	m³/m²	Total water consumption per m² of floorspace.
NHS Carbon Footprint	tCO₂e	Total emissions from Trust-controlled activities
NHS Carbon Footprint Plus	tCO₂e	Total emissions from wider Trust-influenced emissions

8.3 SUSTAINABILITY RISK MANAGEMENT

Risks and opportunities relating to sustainable development will be tracked and managed through our Sustainability and Wellbeing Group and overseen by the Director of Environment.

Identifying and mitigating potential risks which may inhibit our sustainability agenda, in particular our drive towards net zero carbon will be critical to enable us to achieve our ambitions.

Within this first iteration of our Green Plan, we have identified generic sustainability risks which are likely to be faced by trusts throughout the NHS. In future versions, we will aim to develop our sustainability risk register to be specific to our operations and challenges.

Failing to meet carbon reduction targets

When considering factors such as the planned changes to our estate, the evolving requirements of high-quality healthcare and changing carbon intensity of grid utilities it is by no means guaranteed that we will continue our current trend of reducing overall core carbon emissions.

To minimise the impact that factors outside of our influence can have on our sustainability reporting, we have chosen to benchmark our KPIs using normalising factors (e.g. m² floorspace or patient numbers)

Finance

Finance will be required to deliver on the commitments of our strategy. Efficiency savings and embedded sustainability practices may be masked by rising utility costs and changing requirements of healthcare.

We can mitigate this risk through senior support and clear, consistent reporting.

Failing to comply with environmental legislation

Given our size, disaggregated estate, and complexity of operations it is conceivable that we could inadvertently fail to comply with one or more elements of environmental legislation.

This risk is managed on an ongoing basis through the retention of expert support and diligent oversight.

Climate change

Climate change risks are currently incorporated within our Emergency Planning Risk Register; however, it is important that we produce a specific Climate Change Risk Assessment (CCRA).

Identified risks will be managed through the accompanying Climate Change Adaptation Plan (CCAP) as specified by SDU guidance.

Local community influence

As part of our purpose to support local people live well, we recognise that a coordinated approach which incorporates environmental and social sustainability is paramount. As a core part of the community and an anchor institution, we must lead by example on sustainable development to ensure the concept is embedded in the wider community.

This will be managed through a robust commitment to our sustainability strategy and reporting.

9 APPENDICES

9.1 APPENDIX A: KPI TRACKING

KPI	Unit	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Trend
Electricity consumption	kWh/ m ²	136	135	150	153	154	132	132	130	↓
Gas consumption	kWh/ m ²	233	245	255	289	299	233	258	238	↓
Carbon from energy	kgCO ₂ e/ m ²	109	102	100	103	101	tbc	tbc	tbc	↓
Waste production	kg / m ²	18.7	18.4	13.8	20.4	18.6	22.4	16.7	15.5	↓
Waste recycled	%	28%	40%	50%	41%	39%	32%	20%	19%	↓
Water impact	Litres/m ²	1,313	1,255	1,651	1,294	1,672	1,427	1,718	1,822	↑
NHS Carbon Footprint	tCO ₂ e	13,824	12,623	12,322	12,481	10,051	9689	10023	10027	↓
NHS Carbon Footprint Plus	tCO ₂ e	No data	No data	No data	No data	Pending	tbc	tbc	tbc	N/A
Number of Oil-led heating systems	No	No data	No data	No data	No data	No data	No data	1	1	↔
% of GIA covered by LED lighting	No	No data	No data	No data	No data	No data	No data	31.85%	35.90%	↓
ERIC Occupied area	m ²	108,664	106,448	105,596	106,537	107,650	107796	109046	112183	↑

Table 4: Annual sustainability Key Performance Indicator Summary

1.2 APPENDIX B: KEY PERFORMANCE INDICATORS (KPIs) – AREAS OF FOCUS - SUMMARY ACTION PLAN

Area of focus	Ref.	Action
Energy	1.1	Embed net zero design into our Building a Brighter Future programme and site redevelopments
	1.2	Continue to implement actions within our decarbonisation plan
	1.3	Procure certified green electricity backed by REGOs for all our supplies.
	1.4	Continue to collaborate with local authority to develop opportunity for large-scale solar PV farm to be built adjacent to Torbay Hospital for the creation of renewable energy
	1.5	Complete heat decarbonisation plans funded via Low Carbon Skills Fund such as phasing and replacing fossil fuel heating systems with lower carbon alternatives, such as heat pumps or connecting to a heat network system
	1.6	Identify installations in scope of the UK Emissions Trading Scheme and outline plans to reduce emissions in line with allocated targets
Waste	2.1	Rollout Biosystems reusable sharps and pharmaceutical more extensively
	2.2	Investigate options to implement reusable facemasks and PPE
Water	3.1	Continue to review opportunities to deploy AMR technology and decide whether they are a cost-effective option to drive down water consumption
	3.2	Organise staff training and increase patient awareness of sustainable water management.
	3.3	Improve and progress leak detection prevention strategies with prevention strategies
	3.4	Improve management system collaborations
Transport & Travel	4.1	Continue to work toward transition of Trust fleet to ultra-low and zero emission vehicles in line with the NHS Net zero travel and transport strategy roadmap. .
	4.2	To only offer only zero-emission vehicles through vehicle salary sacrifice scheme from December 2025 onwards (for new lease agreements)

	4.3	To review and source funding streams for sustainable travel options for staff including a dedicated car sharing application, travel hub including cycle facilities, shelters and shower facilities
	4.4	To collaborate with public transport providers to influence additional or amended bus routes to support sustainable travel to the hospital for patient, visitors, and staff
	4.5	To undertake travel surveys for our patients and visitors to support sustainable travel.
	4.6	To review, update the Trusts Green healthy travel plan and travel measures
Volatile anaesthetic gases	5.1	Encourage use of regional/neuraxial anaesthesia in an increased % of cases, plan to look at new patient pathways using neuraxial techniques in place of general anaesthesia and to measure the carbon footprint of each pathway
	5.2	To put in processes to audit our drug waste and then institute measures to reduce this
	5.3	Undertake a review for the use intravenous anaesthetic alternatives e.g. remifentanyl
	5.4	Source funding streams such as grants to use exhaled gas capture/treatment technologies volatile gas capture in our 'high volatile use' theatres
N ₂ O & Entonox	6.1	Conduct Entonox waste review by evaluating consumption in maternity against benchmarks and producing plans for reduction
	6.2	Review options for portable delivery systems for Entonox
MDIs	7.1	Develop transition strategy to increase the use of lower carbon alternatives to pMDIs and to choose the most appropriate inhaler(s) in alignment with clinical guidelines considering the environmental impact of inhalers
	7.2	To educate by undertaking technique checks with patients to ensure the correct usage and promote the appropriate disposal of inhalers reducing environmental waste
Workforce & System Leadership	8.1	To integrate and support Trust staff and leaders to learn, innovate and embed sustainability into everyday actions.
	8.2	To continue to promote training opportunities via the Greener NHS Training Hub for varying staff groups who underpin the delivery of green plans, such as board members, procurement, finance, estates and facilities staff and clinicians
	8.3	To continue to embed sustainability training for staff from induction to essential to role and to mandatory

	8.3	Communicate our Green Plan objectives to all our teams and encourage feedback and engagement.
Digital Transformation	9.1	Consolidation of data systems and selection of high efficiency equipment for new data centres to minimise electricity demand.
	9.2	Continue to encourage the use of video conferencing options for meetings between teams at different sites, with remote contractors and with patients, where appropriate.
	9.3	Continue with circular approach to IT hardware management, with re-use as a priority and WEEE recycling as a fall-back including equipment refresh which include longer device lifetimes and energy efficient equipment
	9.4	Progress with the tender for consolidation and relocation of data and data systems providing high efficiency equipment and resilient storage facilities. New data centre designed for maximum efficiency using renewable energy and smart systems minimising electricity demand. To benchmark energy savings realised with change to new data centre.
	9.5	To continue to work toward the delivery of (EPR) Electronic Patient Records a new One Devon electronic patient record in 2026. The One Devon EPR will enable us to improve the way we use and share patient information. The requesting of paper notes will reduce significantly as the patient record will be accessed digitally as the programme is fully embedded and more records are digitised contributing to a more efficient and sustainable way of working.
	9.6	To undertake digital maturity assessment to consider opportunities and to continue to embed sustainability in digital services.
	9.7	Embed NHS Net Zero Supplier Roadmap requirements in all digital procurement exercises, including mandatory carbon reduction plans and sustainability weighting in tender evaluations for all major digital purchases.
	9.8	Establish community digital champions network and partner with local organisations to provide digital skills training, ensuring 90% of patients can confidently access basic digital health services by 2027, with alternative pathways for digitally excluded groups.
	9.9	Use the Digital Futures Hub to develop AI-powered energy optimisation systems, smart building IoT sensors for environmental monitoring, and digital twin technology for space utilisation and carbon footprint reduction.
Supply Chain & Procurement	10.1	Collate financial and material data required to complete NHS Carbon Footprint Plus baseline.
	10.2	Implement process to ensure sustainability KPIs are included in tender evaluation criteria for tenders above a defined value.
	10.3	To undertake steps in line with the NHS net Zero Supplier roadmap to ensure suppliers follow and align with the NHS net zero ambition between now and 2030

	10.4	To encourage suppliers to go beyond minimum requirements and engage with the Evergreen Sustainable Supplier Assessment to support a single conversation between the NHS and its suppliers on sustainability priorities.
	10.5	From April 2026 the Net Zero Commitment requirement will be extended to all relevant contracts
	10.6	To continue to reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects
Capital Projects	11.1	Ensure all current and new capital team members have reviewed the latest NHS guidance on net zero building standards.
	11.2	Continue engaging external sustainability and technical advisors to inform system design and delivery, to ensure redevelopment works conducted as part of our Building a Brighter Future programme and other meet the highest sustainability standards
	11.3	To undertake Energy Infrastructure Upgrades, substations to increase current load capacity and support increased electrification
	11.4	To undertake a replacement programme of centralised boilers with decentralised ground-source heat pumps and electrical steam generation units
	11.5	Improve energy efficiency of retained estate through targeted fabric improvements, including insulation and high-efficiency windows and cladding and ensure all refurbishment and new build projects comply with the latest NHS Net Zero Building Standards
	11.6	Embed net zero and infrastructure resilience as core criteria in capital investment business cases
	11.7	Monitor electrical and environmental performance across the estate, using data to inform phased investment planning
Food & Nutrition	12.1	Use products with added sustainable palm oil only
	12.2	Further reduce the amount of processed meat offered (currently five types) and replace with fresh meat where possible
	12.3	Ensure plant-based substitutes are available on staff and patient menus
	12.4	Implement further processes and controls to ensure food waste is reduced

	12.5	To implement further processes and controls to ensure food waste is reduced including all takeaway food to be served in recyclable packaging and introduce food waste collections across all wards and set a food waste reduction target
	12.6	To reduce food waste by the implementation of plated meals – 10% reduction 2026
	12.7	To introduce a 'Boomerang' mechanism for packaging a closed loop mechanism where food and specialist diet meal trays are returned to the supplier free of charge, recycled, and put back into circulation.
Local Air Pollution	13.1	Review potential benefits of an air sampling campaign to identify high risk areas for NO _x and particulates
	13.2	Engage with local council to understand opportunity to align on awareness-raising communications such as a 'no engine idling' campaign
	13.3	Review viability of adopting key actions from the Clean Air Hospital Framework developed at Great Ormond Street Hospital
Green space & biodiversity	14.1	Communicate plans to develop green space and biodiversity as part of our Building a Brighter Future programme
	14.2	Incorporate green space and biodiversity promotion into our Sustainability and Wellbeing Group's areas of focus and engage with local authority to discuss collaborative approach
	14.3	To continue to work toward the biodiversity benchmark for the Torbay Hospital site
Adaptation	15.1	Produce a CCRA, detailing the risks to our operations associated with climate change, and how they are able to adapt
	15.2	Review and consider climate change adaption planning as a longer-term impact on the organisation as part of a business continuity policy and plans i.e., when making infrastructure decisions and designing new facilities, including enhancements like improved green spaces, drainage systems and passive cooling solutions

Public Board

Our Plan for Better Care People Programme 5.3 Culture Plan

Date of meeting	Date report produced
24 th September 2025	Updated 13 th August 2025 (People Committee) Updated 18 th September 2025 (Public Board Committee)

Author(s)	Report approved by
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 People Committee Chair and members (via the development session)

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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

N/A

Executive summary

The culture plan, standards we set and behaviours, will be key to enable delivery of our Trust strategy, 'our plan for better care' and financial and performance priorities as well as support our BAF objective 'to develop and embed a culture where our people feel valued and supported and that embeds the principles of the people promise', with the intention to deliver this via a single plan.

Incidents, our survey data and staff engagement demonstrate the need for our culture plan to be clear, visible and central to our delivery of Trust Strategy and

ensure the culture of our organisation is one that aligns to our shared values and beliefs.

The purpose of this report is to:

- To present the culture plan which will be led, overseen and delivered through programme 5.3 of 'our plan for better care'.
- To summarise and present clear direction for:
 - 1.) the standards and behaviours we expect – based on our Culture Charter and Compassionate Leadership
 - 2.) the outcomes we want to see and how these will be measured – based on a clear set of cultural insights and an integrated infrastructure to oversee and manage
 - 3.) the key actions and interventions needed for success – driven by our cultural insights

The people directorate have re-formed the cultural insights group and culture network to co-design and deliver the culture plan with clinical and patient safety colleagues. This has also been supported by:

- A Board development Session
- A People Committee development session with the CPO, COO, CNO and People Committee Chair and non-executives to support the co-design.

An important part of the culture plan will be to refocus on the Culture Charter already committed to and through staff engagement continue to build a vision for our culture that is aligned to our overall Trust strategy.

Progress with delivery of the actions against the KPI's will be reported via the 'our plan for better care' governance via the People Programmes Leads and SRO and assurance provided to the People Committee. Please see appendix 1 for the latest flash report.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
All	Satisfactory	N/A

Committees that have previously discussed/agreed the report, and outcomes of that discussion

N/A

Key recommendations and actions requested

The Board are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

The Board are asked to AGREE the culture plan approach and priority actions as outlined, whilst noting that further refinement, engagement and socialisation is required.

Progress with delivery of the actions against the KPIs will be reported via the 'our plan for better care' governance via the People Programmes Leads and SRO.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

Improving patient and staff engagement and experience.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Yes
Quality of services provided	Yes
Sustainable and efficient use of resources	Yes

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	Yes
People	Yes
Financial Sustainability and Productivity	Yes
Estates	No
Operations and Performance Standards	No
Digital and Cyber Resilience	No
Building a Brighter Future	No
Strategy and Transformation	Yes
Sustainability: Green Plan/ Environmental	No

Equality, Diversity, and Inclusion	Yes
Provision of Community and Care Services Delivered in Partnership	No

Risk: Risk ID (as appropriate)	
Risk	Risk ID
N/A	

External Standards affected by this report and associated risks
CQC NHSE (including well led) People Promise and Plan Just and Learning Culture 10 year Plan

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Our Plan for better Care People Programme 5.3 Culture Plan

1. Introduction

Our overarching culture objective in our Trust BAF is 'to develop and embed a culture plan that ensures our people feel valued and supported and that embeds the principles of the people promise'.

Our culture plan is a key enabler to:

- Create, maintain and nurture a Board led culture which is aligned to our values and our strategy, where everyone acts with integrity and leads by example.
- Build a culture at work where our people feel safe, healthy and supported, by embedding the principles of an inclusive and a restorative just and learning approach.
- Delivering our patient safety, quality and patient and people experience objectives.

To deliver this, the Trust will focus on a single improvement plan which will be developed across 3 key themes:

- Patients, people receiving our care and support and carer engagement and experience
- Staff engagement and experience
- Leadership and management

As a result of implementing and embedding our culture plan, the outcomes will be:

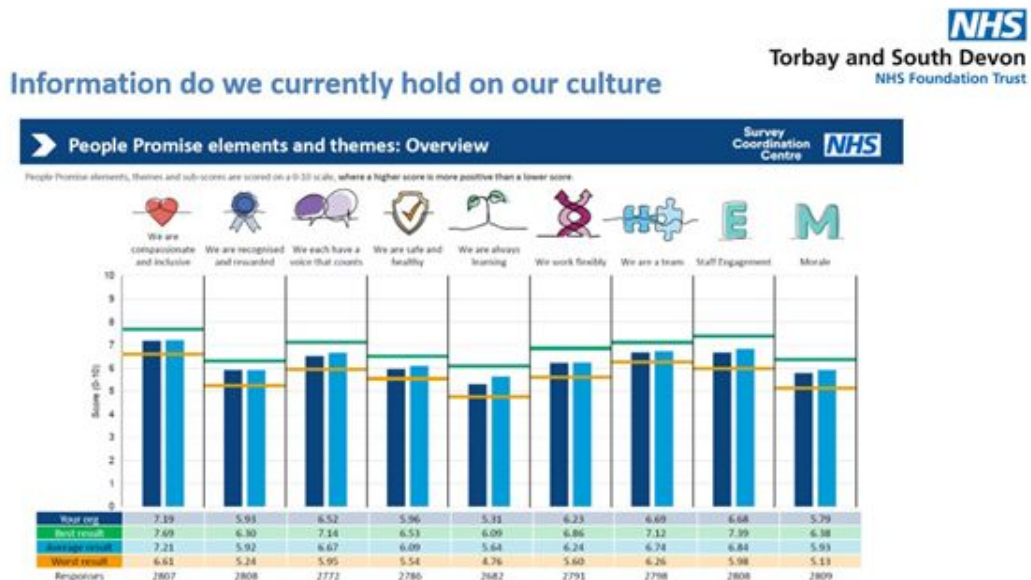
- Improved experience demonstrable through measures such as the Friends and Family Test (FFT) and Staff Survey.
- Improved staff voice through embedding staff engagement mechanisms such as staff networks.
- Embedded Restorative Just and Learning principles enabled by our policies and processes and delivered through our leadership behaviours.
- Improved employee relations, sickness absence, staff retention and wellbeing measured through our people KPI's.
- Direct improvement in our response rate and performance in staff survey and WRES and WDES.
- Embedded behaviours such as our compassionate leadership that people live and breathe every day demonstrable through a culture of obtaining regular feedback for learning and improvement.
- Staff feel supported and well in their roles with opportunities to develop and this is demonstrable in our staff survey performance.
- A positive patient safety culture which is crucial for preventing adverse events and improving patient outcomes. This culture shift can lead to reduced

mortality rates, fewer infections, and increased patient satisfaction according to a BMJ Open study

2. Assessment of prior culture work

Over the past year, we have taken important steps to progress several commitments aligned to our organisational culture. Under the leadership of the Culture Committee and with engagement from colleagues across the organisation, we have laid a few foundations. These include the continued delivery of our Compassionate Leadership Framework, the onboarding of key roles such as the People Promise Manager, our Head of Inclusion, Diversity and Equity, and our Associate Director of People.

Whilst these initiatives have brought localised improvements and allowed us to deliver some of our statutory and mandatory reporting, they have not addressed the wider strategic need within the organisation. The limited impact of these initiatives at scale has had consequences for our workforce, including a measurable drop in morale and engagement, reflected in both our staff survey data and departmental feedback. This raises the critical question of whether our current frameworks, such as the Culture Charter and Compassionate Leadership model remain fully fit for purpose.



The summary table above shows the Trust falls just below the national average on all staff survey indicators.

Over 5000 staff have completed the mandatory 'It Starts with Me' EDI module, we have not seen a corresponding shift in reported lived experience from staff with protected characteristics. Similarly, we have had a significant uptake across the organisation of our Compassionate Leadership Programme (1,400 people), but we continue to see behaviour that does not align to the framework.

The cultural deep dive developed by the People Promise Manager highlighted that we often see a pattern of initial progress followed by a loss of momentum, in the case of applying and embedding a Just and Learning Culture, whilst this has been viewed as a priority for the organisation, the reality is that the work is in its infancy without training or policy alignment yet in place.

The NHS Staff Survey and Pulse Survey remain some of our most data rich sources, yet in places we continue to see poor uptake, gaps in reporting and corresponding action plans with established governance in place.

We have found several themes as part of the deep dive which need to be addressed including:

- Disconnect between Compassionate leadership and Patient safety incident response frameworks and lived experience:

Despite the launch of frameworks like the Culture Charter and Compassionate Leadership, many staff report experiencing inconsistent behaviours, lack of inclusion, and limited psychological safety.

- Delays to implementation of Just and Learning Culture and policy review:

Our people have reported our culture to be punitive, arising from a variety of organisational challenges and changes that TSD has experienced, and expressed that learning is not taking place systematically. This is contributing to our people feeling unsafe and unable to speak out. The lack of informal resolution in place adds to this feeling.

- Low follow-through on learning and listening:

Staff survey responses and local feedback highlight clear areas for improvement, yet the absence of a robust follow up process means we risk undermining trust.

- Minimal application of JLC which is a core competent of embedding PSIRF:

Without consistent practice and leadership accountability, these frameworks remain theoretical, limiting transformative potential. We need to frame and build our Culture Plan around both frameworks to full support and implement change, by enabling a governance forum that adopts lessons learnt.

- Incomplete adherence to NHS Sexual Safety Charter action plan:

Although we are signed up and committed to the Charter, 6 commitments are still incomplete/in progress, 2 are in part complete (1 and 7), 2 completed (4 and 10). This work started in February 2024 and is still incomplete.

- Ineffective outcomes from the Compassionate Leadership Framework:

The about programme was rolled out in September 2023 with 1400 attendees however our Staff Survey results do not reflect the change in leadership behaviour, nor confidence from our staff that leadership behaviour has changed.

The expectations and ambitions of the framework need to be more explicit from the organisation, such as improved patient care outcomes due to better staff engagement, reduction ER cases, or staff attendance. The study day itself highlights scores of 4.56/5. In the current climate the desired behavioural culture change would become clear if accountability is measured through Achievement Reviews, Leadership or EOG governance meetings.

The Trust has experienced some challenging times not helped by NOF4, that may have contributed to not implementing the above initiatives. However, moving forward to effect successful outcomes we encourage leaders to consider the need for appropriately resourced teams. In challenging times, changes in leadership at various levels and the conflicting priorities has also resulted in lack of cohesion between different part of the organisation who have a responsibility in changing our culture.

3. Overarching feedback & recommendations

The number of changes and incomplete plans outlined in this paper as well as feedback from our initial scoping highlights the importance of cohesion across the organisation to achieve the intended cultural shift. The culture plan outlined should be considered as a priority for our Trust in supporting the well-led priorities for the long term through delivery via Our Plan for Better Care programmes. These recommendations are:

1. A focus on four fundamental shifts

- A shift to openness and transparency
- A shift to valuing people and ensuring equity and inclusion
- A shift to ensuring culture directly connects to effective patient care
- A shift to ensuring a physically and psychologically safe working environment.

Shifting the Trust culture will take consistent, visible efforts, to improve the experience for staff. The underlying cultural issues will not change overnight and will require Executive support of the culture plan to alter the trajectory into a direction that makes staff feel safe and proud to work at the Trust.

These consistent efforts will require responsibility from senior leaders to listen, understand the workforce needs, and to take positive action. This will also need all staff to continue speaking up by providing an accessible platform to provide the confidence staff need to come forward. These shifts will enable the Trust to move forward and begin building a sustainable, inclusive, and compassionate culture; fit for the future.

2. Improvement in staff experience and voice. Our staff will have their voice heard and feeling included in decision making.

We will review the trust exit data and consider existing platforms where we already engage with our staff. We will redesign our platforms to enable staff responses that

contribute towards one for our Staff Survey, and our Pulse Survey results. The outcomes will be incorporated into existing plans at Trust level as well as Care Group levels which are reported and measures through the right governance structures.

3. Staff Well-being and mental health

We will prioritise colleague wellbeing to ensure our workforce remained flexible and resilience in the face of change.

Our current wellbeing offers are primarily provided externally; this support does not appear to deliver the expected outcomes. For example, high levels of long-term sickness, therefore a review of our current commitments is needed.

4. Effective patient care reducing health inequalities.

We will do this through delivering the Patient Safety Incident Reporting Group Framework which focuses on learning and improvement. This work is already in train, requires extension of its current remit to include JLC approach of its governance to listen, action from reported lessons learnt, considering risks from events and cases that are presented in a measured approach.

5. Revision to our employee relations approach to just and learning culture

This will support a cultural shift to deliver the principals of a just and learning culture the proposed action plan in Appendix 1 will enable embedding Just and Learning Culture via updating our policies to reflect change in behaviour and accountability. This work will be resourced to enable improvement to our culture to be well-led.

Revision of key HR Policies and procedures, to include an Early Resolution process in line with JLC approaches in Grievance, Disciplinary, Improving performance and New Dignity at Work policies. These changes will define and communicate the actions expected by all staff and create a zero-tolerance approach to inappropriate behaviour. We have seen this work well in RDUH with the "It's not ok campaign."

6. Freedom to Speak Up and Guidance reframing.

Revision to policy and guidance to foster improved working relationships. between staff and managers. Intention to improve employee engagement. That show confidence in leadership listening and shaping improvements. Employees sign-posted to resolution focussed outcomes with leadership.

7. Safety, Legal and Compliance

Revision to Human Factors (Process) at Service Manager, Ward level to understand insights. To shape governance approaches that consider Just and learning practice built into Human Factors process across the trust, that aligns with PSIRF.

8. Investigations

Revision to our HR and Clinical investigation approach and practice to incorporate the just learning method linked to point 1, 2 and 5.
Renewed guidance on best practice on cases and events to shape the Positive outcomes and improvements in behaviour and leadership.

9. Training and Development

We will offer innovative training and development opportunities across our ~~our~~ staffing groups that contributes to Our Plans for Better Care with a skilled and well-led supported workforce. This would be supported by implementing an organisational development programme for Just and Restorative Learning Culture, in partnership with staff, that places cultural understanding and awareness, and learning and compassion at its core and links with point 2, 4 and 8. This programme should be underpinned by an effective communication method, which includes policy updates and focuses on learning.

Our current development and training offer needs to be reviewed for effectiveness to prove a curiosity and inquisitive mindset; to consider if there is a return on investment if the existing training needs analysis provides insights.

Our staff feedback suggests we do not believe our existing development aligns with the intended organisational priorities. The board should take a leadership role in ensuring the training needs analysis showing these behaviours:

- ensure all leaders show and evidence how staff feedback is being promoted, managed, and acted upon in their business area
- to check where and why particular groups of staff cannot show the use of feedback, and take targeted action for example via our staff and pulse surveys and corresponding action plan

4. Standards and behaviours that support our Culture

The Trust is already signed up to and committed to the NHS Trust values, Culture Charter and Compassionate Leadership framework to drive the standards and behaviours we expect.



Culture Charter – Our Boards Pledge to our People

Our Board's pledge to our people -

- We do not tolerate any form of discrimination, harassment, bullying or violence
- We each have a responsibility and role to play in making the NHS a place where we all feel we belong
- We will promote a culture that fosters openness and transparency and does not tolerate unwanted, harmful and/or inappropriate behaviours

What our people can expect from us –

- We lead our people and manage our processes in line with our compassionate leadership approach: we include with care, we listen with genuine curiosity, we act with courage
- We listen with respect to the voices and lived experience of colleagues, patients, and all individuals and groups who experience discrimination or lack of fair representation.
- We work together with our people to identify, reduce and remove inequalities within our organisation
- We use our influence and our voice to assist others within our local communities to address discrimination, inequality and unfairness
- We acknowledge that past action has failed to bring about the change we need to see and we recognise and are accountable for our own role in creating a fairer and more inclusive environment in and at work

What we expect from our people -

- We all recognise that people are different and value people for their difference
- We all treat people fairly, with respect and without bias We all take personal responsibility for our own words, behaviour and actions and understand our role in creating a fairer and more inclusive workplace
- We all challenge bullying and harassment when we see or hear it, and report concerns We all listen and learn from the experiences of others.
- We listen with care and with curiosity and are respectful of people's lived experience What we will do together
- Through our actions, words and behaviour, we create a workplace where everyone feels safe and confident to speak up
- We work together to reduce and remove unfairness and discrimination within our communities, within the NHS and our partner organisations and within society as a whole

Our Compassionate Leadership framework



How: Our Approach

We listen... With genuine curiosity

We are open to listening to all that people have to share

We take the risk of hearing things that are challenging or difficult to resolve

We listen to and use your feedback on the actions we've taken

We include... With care

We encourage diversity of thinking such that all ideas and opinions are welcomed

We value and celebrate different perspectives in order to bring positive change

We have open, transparent (adult to adult) two-way communication and feedback



We act... With courage

We are brave in the way we tackle difficult situations

We make an effort to work with you to resolve challenges or concerns and feed back what we've done

We trust and support each other and 'have your back' if things go wrong

Following review at the People Committee development session it was agreed that the Trust should remain committed to these frameworks and that only minor amendments are required at this stage with improved communications and engagement being key to re-introduce the expected and committed standards and behaviours as outlined.

It is recognised that previous culture plans and development initiatives have been overcomplicated and ineffective in driving the desired change and outcomes and this is evident from our recent staff survey, WRES and WDES results. Therefore, the action plan, KPI's and infrastructure to oversee and manage improvement will be key (as outlined in this plan).

The culture and our leadership standards and behaviours will be key to enable delivery of 'our plan for better care' and financial and performance priorities.

5. The culture plan: Delivery Year 1

3 key themes identified to deliver the culture plan:

- Patients, people receiving our care and support and carer engagement and experience
- Staff engagement and experience
- Leadership and management

Delivery Year 1 (September 2025 – September 2026) - what we will do:

Theme 1: Patients, people receiving our care and support and carer engagement and experience

- Review and re-launch our approach to Friends and Family Test
- Introduce the 15 steps model as part of our regular cycle of feedback.

- Incorporate carer engagement in the regular nursing audit
- Develop a framework and integrate our NED feedback into our KPI oversight to inform our priority actions and response.
- Consider the use of other feedback mechanisms for patients including Patient Opinion
- Continue to embed the Patient Safety Incident Framework (PSIRF), ensuring that learning is collating and embedded across the organisation
- See feedback from staff and patients who have participated in safety reviews and investigations to understand their experience of the process and if this was in line with a just learning culture approach
- Actions relating to ASC and community to be developed and aligned

Theme 2: Staff engagement and experience

- Implement an app for the staff pulse survey focussed on 3 x key questions. Initially this will be measured through our Pulse Survey and Staff Survey, with a focus on strengthening our engagement and uptake.
- Implement staff network recruitment with executive sponsorship, and strengthen existing governance processes to ensure networks thrive and are able to escalate concerns and implement actions
- Support care group to develop specific action plans in response to care group staff survey results reported through IPR
- Identify and explore hot spots for ER/sickness, Freedom to Speak up Guardian (FTSUG) or Trade union cases and work with the relevant leadership teams to develop improvement plans that are monitored
- Update the Trust policies to reflect a just and learn approach using best practice examples – including early resolution approaches and integrated approaches to grievances, bullying and harassment etc.
- Implement the RCN cultural ambassador's programme
- Reform our wellbeing support and develop an options appraisal for the future service and offer.
- Revise and update our FTSUG guidance and approach and embed this within our structures – option appraisal to be developed for the future approach to be developed (including better use of our wellbeing buddies/network).
- Review our occupational health provision and future options for the service.
- Review of welcome and Induction (including local induction) and learning from preceptorship models

Theme 3: Leadership and management

- Develop a continuous programme of visible leadership including the 15 steps approach.
- Implement the accountability framework
- Move towards an 'in-place' work approach (rather than directed by Ms Teams) whilst supporting flexible working, model to be scoped and tested
- Align compassionate leadership to appraisal
- Implement a regular 360 feedback cycle for all leaders/managers aligned to our standards and behaviours in the management and leadership competency framework

- Implement a series of workshops and events for managers to improve knowledge and competence in key skills
- Options appraisal for future investigation model, including training opportunities, for ER cases and ER training for managers to support management and decision making.
- Review and implement the national standards for managers and leaders

Cross cutting actions

- Organisational design and development review and plan that responds to supporting people through change programmes – required to support 5.1 workforce transformation
- Assess ourselves against previous culture plans and commitments to identify outstanding gaps and impact
- Implement Restorative Just and learning Culture approach and policy development and review – using good practice and evidence from other NHS partner organisations
- Develop and deliver a communication and engagement plan to seek out feedback on what culture people want (linked to values)
- Develop and deliver a communications and engagement plan focussed on our standards and behaviours
- Create integrated reporting on our cultural measures and KPI performance and Introduce culture insight reporting and performance through the care groups
- Implement clear governance for reporting (recommended that this is mapped to the 'our plan for better care' programme 5.2)
- Identify the risks and gaps in our plan
- Establish our cultural insights group
- Make the minor amendments required to our Culture Charter
- Implement Board level accountability and oversight
- Set expectations, roles and responsibilities through how we engage and work with our leaders
- Drive up capability and capacity through re-focussed training and development
- Introduce culture insight reporting and performance through the care groups

6. How we will measure delivery of the culture plan

Cultural insights

The measures we use are key to enable us to have real time insights into our culture and this can be drawn from a range of quantitative and qualitative sources. The organisation does not currently align these insights to provide an integrated picture on measuring performance. For example, the Trust will report separately on staff survey results and WRES and WDES reports, and each have separate action plans to address the results.



Our newly formed and re-focussed cultural insights group and network is developing and starting to draw on the different sources of data and information to triangulate themes. This is important to ensure actions and interventions are having the impact required and that these are focussed on the right priorities, challenges and areas in our organisation. The intention will be to provide regular performance reporting at a Trust wide and care group level.

Key performance indicators

KPI's need to be simple and provide as 'live' picture as possible utilising the digital technology available and learning from best practice such as maternity. The KPI's need to focus on 'what' we do rather than what we say we will do.

Bold indicates KPI's already featured in our 5.3 programme.

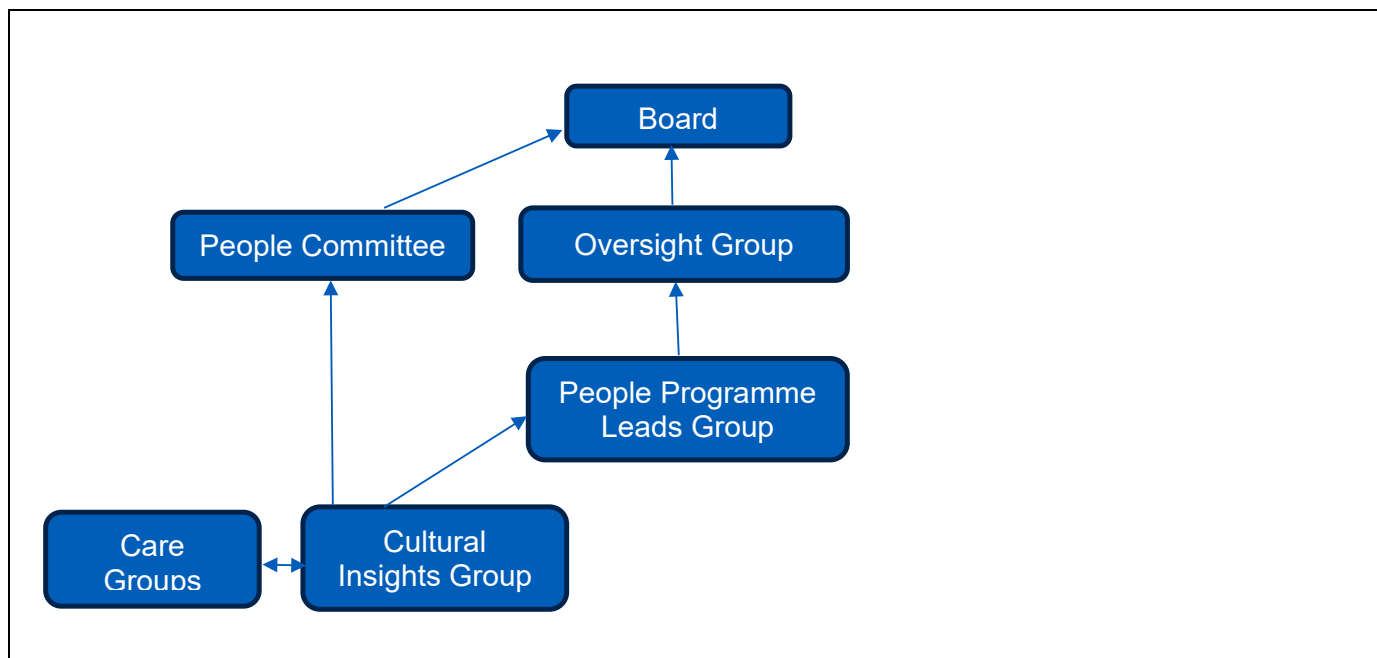
Priority theme	Measure
Patient, people, carer engagement and experience	Friends and family test (FFT) Datix / incident data Complaints data Compliments data 15 steps NHSE toolkit Carer involvement
Staff engagement and experience	Staff survey response rate and results In addition - would you recommend this as a place to work (if not why not and if yes why) Would you recommend this as a place to receive care (if not why not and if yes why) Pulse survey response rate and results (digital app) Civility toolkit WRES and WDES report Staff networks (with exec sponsors) Sickness and ER case specific KPI's FTSU and trade union case specific KPI's Appraisal rates CPD/development data Retention data Occupational health data and trends
Leadership and management	Staff survey results Pulse survey results 360-degree appraisal ER and sickness data Feedback collated from a programme of visible leadership (including feedback from role modelling 'in-place' work practices) NED feedback from visits

The KPI's will be overseen by the cultural insights group and triangulated to report themes. It is recommended that trajectories are set against the KPI's as well as overall targets to measure improvement over a more incremental time period for performance reporting. This will not only provide us with valuable insights in how we are performing but also how we can build a continuous cycle of learning and improvement. The transition and journey to PSIRF has embraced a just and learning culture approach, however there is more work to be done. It must be noted that through applying a just and learn approach we may see an increase in reporting of incidents and complaints it is important to shift focus from the number of such incidents to understanding themes to drive continued improvement will be key. We

will also undertake a benchmarking exercise reviewing national and regional performance and work with partners to continue learning from best practice.

Leads and advocates/sponsors will be identified to support delivery as well as ongoing cultural development work with all of our people and stakeholders.

Governance and reporting



7. Recommendations

The Board are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

The Board are asked to AGREE the culture plan approach and actions as outlined for year 1, whilst noting that further refinement, engagement and socialisation is required.

Progress with delivery of the actions against the KPI's will be reported via the 'our plan for better care' governance via the People Programmes Lead and SRO.



Torbay and South Devon
NHS Foundation Trust

Public Board

Annual Mortuary Report 2025

Date of meeting	Date report produced
24th September 2025	2 nd September 2025

Author(s)		Report approved by	
Name and title:	Simon Hughes, Mortuary Manager	Name and title:	Ria McCoy ADO – Cancer and Clinical Support Services, Catherine Lissett, CMO
Phone:	01803 655251	Date:	02/09/2025
Email:	Simon.hughes1@nhs.net		Catherine.lissett@nhs.net

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary

Mortuary services are subject to statutory regulation and should be treated with equivalent importance to other regulated activities in governance arrangements.

This report provides an overview of Mortuary activity, reports areas of good practice, achievements and highlights areas of concern.

It fulfils **Recommendation 15 of the Fuller Inquiry Phase 2**

<https://www.gov.uk/government/publications/david-fuller-inquiry-phase-2-report>): “ All NHS trusts should establish a routine reporting system for mortuary and body store matters. This should include a formal report, by the accountable executive director, to the Trust Board on a routine basis.”

Assurance is provided that deceased patients are cared for to a high standard, in line with Human Tissue Authority (HTA) legislation and codes of practice.

The Mortuary continues to deliver a high-quality service, evidenced by positive inspection outcomes and recognition through awards.

Some operational and infrastructure challenges remain, notably the ageing Air Handling Unit (AHU) in the Post Mortem room and limitations in mortuary facilities.

Most recommendations from the Fuller Inquiry have been met or are in progress, with a formal gap analysis included.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Compliance with Human Tissue Act	Satisfactory	N/A – First report
Post Mortem room Air handling unit	Limited	N/A – First report
Fuller Inquiry: Phase 2 report actions	Satisfactory	N/A – First report
Activity Summary	Significant	N/A – First report
Storage – Winter Plans	Satisfactory	N/A – First report

Key recommendations and actions requested

The Board are asked to AGREE the recommended assurance rating and overall SATISFACTORY assurance as to those matters reviewed.

Air Handling Unit (AHU): Support is requested for replacing the AHU in the Post Mortem room, which is graded as 'Poor' and poses a risk to service continuity.

Mortuary Facilities: Consider options for improving mortuary facilities, including layout reconfiguration and additional workstations, to be detailed in an upcoming business case.

Fuller Inquiry Recommendations: Continue to address outstanding actions from the Fuller Inquiry Phase 2, including:

Finalising security reviews and implementing systemic barriers (e.g., mobile device restrictions).

Developing shared Standard Operating Procedures (SOPs) with third-party partners.

Ensuring that safeguarding training and policies explicitly cover the security and dignity of deceased patients.

Implementing 'swipe to exit' systems for enhanced audit capability.

Review the remit of the Chief Nurse to include address recommendation 20: "The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores".

HTA Inspection: Complete minor outstanding works to resolve the final shortfall identified in the May 2025 HTA inspection.

Winter Storage Plans: Maintain and review escalation plans for increased storage needs during winter pressures.

Staffing and Resources: Continue to train and assess competencies for Anatomical Pathology Technical staff and ensure adequate resources for the Mortuary Manager role.

Appendices

N/A

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

This report seeks to provide assurance that deceased patients within Torbay Hospital Mortuary are being cared for to a high standard, in line with Human Tissue Authority Legislation and Codes of Practice.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Adequately store deceased patients and care for deceased patients in a dignified, respectful and secure manner.
Quality of services provided	Provide a high-quality service for the Hospital, Coroner, Bereaved Relatives, Funeral Directors and all service users, that fulfils all of the standards set out in the Human Tissues Act 2004.
Sustainable and efficient use of resources	To utilise existing resources to deliver a high-quality service and raise carefully considered, risk-assessed business cases where required.

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	Personalised care and quality will be upheld wherever possible
People	There is some difficulty in having appropriate workstations for all staff due to the departmental layout and footprint
Financial Sustainability and Productivity	We are still waiting for sign-off on the Coroners Service Level Agreement, but this will help with delivering a cost-effective service.
Estates	Some areas are showing wear and tear such as the AHU and Post Mortem room

Operations and Performance Standards	One outstanding shortfall from our HTA inspection to close; otherwise, our performance is within expected levels.
Digital and Cyber Resilience	The Eden operating system is running well, and the department has started using the 'Beaker' section of Epic. No risks identified.
Building a Brighter Future	Some longer-term issues have been identified that may be dealt with under the BBF project.
Strategy and Transformation	With the Mortuary Manager now responsible for the Bereavement team, we are investigating how we can better utilise this service.
Sustainability: Green Plan/ Environmental	Options are always investigated to repair/reuse equipment rather than purchase new.
Equality, Diversity and Inclusion	We will always try to accommodate requests received if feasible.
Provision of Community and Care Services Delivered in Partnership	We work with other partners in the region to develop the service.

Risk: Risk ID (as appropriate)	
Risk	Risk ID
AHU in PM room is in poor condition, though still legally compliant	ID 4296

External Standards affected by this report and associated risks
Human Tissue Act 2004 – One outstanding shortfall from the inspection in May 2025.
Fuller Inquiry: Phase 2 report (15 th July 2025) – See GAP analysis in Appendix 1.

Overall Assurance Opinion Definition: The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Annual Mortuary Report 2025

Introduction and background

This report details how the Mortuary is performing against its legal obligations under the Human Tissue Act 2004 and what steps have been taken to provide a safe and effective service for the storage of deceased patients and provide a post-mortem service for the Devon Coroner.

Assurance and Recommendations

Section	Assurance (Limited/Satisfactory/Significant)	Trend
Compliance with all legal obligations under the HTA 2004	An HTA inspection was carried out in May this year, which highlighted 4 minor shortfalls and 1 major shortfall. On average, around 15 shortfalls are identified during inspections, so this was a very positive inspection. HTA inspections are also now unannounced to gain a truer picture of how a department runs. The major shortfall and 3 of the minor shortfalls have now been resolved and signed off by the HTA. The final shortfall should be rectified by 05/09/2025. We are awaiting an external contractor through Estates to complete some minor work to secure the external condensers of the fridge units to close this. Satisfactory - Pending work completion	N/A
Air Handling Unit (AHU)	The AHU for the Post Mortem (PM) room has been graded as 'Poor' following inspections by external contractors. Though still legally compliant, the age of the unit causes it to be a risk factor for breakage. If the AHU were to break, we would be unable to carry out Post Mortem examinations, which would come with media attention, loss of income, risks to our HTA Licence, and increased pressure on other hospitals in the region to cope with the increased workload. The AHU is on the Estates risk register, and we have been told it will likely be in the next round of units to be replaced. Limited	N/A
Fuller Inquiry: Phase 2 report.	The report from phase 2 of the Fuller Inquiry (An Inquiry following the crimes of David Fuller in Kent, who accessed the Mortuary department and sexually assaulted deceased patients) has been published with several	N/A

	recommendations to provide assurance that deceased patients are being cared for appropriately and securely. Whilst we fulfil the legal requirements set out by the Human Tissue Authority under the Human Tissue Act 2004, The Fuller Inquiry seeks to further enhance controls to provide a higher standard of security and care. Whilst the recommendations are not Law, they have been considered as best practice by a multi-disciplinary panel. We currently fulfil most of the recommendations already, through our own process and the work that was carried out following phase 1 of the Fuller Inquiry. Please see Appendix 1 for a Gap analysis of where we are against the Inquiry recommendations. Satisfactory – Some areas require more work (See Gap Analysis in Appendix 1)	
Activity summary	In the past 12 months, the Mortuary department has looked after 1857 deceased patients, of which 481 had a Post Mortem examination. The total number of deceased patients is around 100 lower for the year than it has been in the previous 3 years, and the number of Post Mortems is around 25 lower. The way that we care for deceased patients has changed in the last 3 years, and though more complex and involved for each individual case, we are now providing a better quality of care. We passed our HTA inspection with minimal areas of improvement identified and have been removed from the scope of UKAS accreditation. This was felt not to be relevant as we hold an HTA licence, and at the time we were removed from the UKAS scope, we fulfilled the requirements to meet accreditation. Throughout the last 12 months the Mortuary team have been recognised for the care we provide via the Our People awards and the Primrose award. Whilst the introduction of the Statutory Medical Examiners system in last September proved challenging over the winter period last year, it has progressed as a service and is running more smoothly. Significant – The Mortuary continues to provide a high-quality service.	

Storage – Winter plans	Winter pressures always provide storage challenges for the Mortuary department as we see an increased mortality rate arising from flu/seasonal illnesses and significant disruption over the Christmas and New Year period with bank holidays and limited collections. We have a multi-stage escalation plan in place for storage over this period that increases our standard capacity of 85 to a maximum of 109, utilising 2 temporary units. This is supported via trigger points to alert Hospital command teams and the local Council to increasing capacity demands. There are Service Level Agreements in place with 2 Funeral Directors for storage; these sites have been inspected for suitability and signed off by the Mortuary Manager In addition, we have a plan of action with the Medical Examiners' Office to release once scrutiny has taken place, but prior to the Medical Cause of Death Certificate (MCCD) being completed by doctors, when we face significant pressures. Though waiting for the MCCD is a slightly more robust process, the ability to expedite releases once a Medical Examiner has deemed the case acceptable to have an MCCD completed is an important part of the escalation plan. Satisfactory – Existing plans should suffice; there is always a risk of an unforeseen rise in mortality rates though.	
Mortuary facilities	It is appreciated that there has been investment in the Mortuary department in the last few years, and the increased capacity, along with the refurbished viewing facility, has improved the way that the department is able to function, as well as provide a better service to those that we care for and their relatives. There are still challenges within the department, though, with the Post Mortem room being dated and not up to the standard of more modern facilities, with only 2 Post Mortem tables and no downdraft bench for the Pathologist's dissection. The current bench is a stainless steel countertop with a sink. Ideally, a Mortuary carrying out the number of post-mortem examinations that we do would have 3 or 4 PM tables to allow smooth operation of the department.	

	Additionally, we have increased headcount in the department, which has helped to provide a better service, but also allowed Senior staff and the departmental manager to spend more time focusing on strategic issues and more complex operational issues. With the recent expansion of capacity within the Mortuary, we had to make a decision on how to utilise our existing footprint, and in doing so, lost important admin space and workstations. With the Bereavement team now under Mortuary management, ideally, they would be located within the Mortuary, but with a lack of appropriate work stations for Mortuary staff, this has not been possible. We have some mitigating procedures in place with our Post Mortem Observation gallery being repurposed into a Manager's Office, and a PC being placed into one of the changing rooms to allow another workstation for staff, but these are not ideal circumstances. There is a current issue whereby the same entrance to the Mortuary is used for Porters delivering deceased patients from the wards, as Bereaved relatives coming to see their loved ones in our viewing room. Due to the increased capacity and the space we had available, one of the rooms where deceased patients are stored is off the same corridor that relatives use to access the viewing room. This can cause some issues if Funeral Directors arrive to collect a patient from this area and a family is in the viewing room. We mitigate this with communication and managing workflow, but if an opportunity arose to reconfigure the layout, moving the viewing room to have a separate entrance for bereaved relatives would be preferable. In summary, we are able to function as a department, but with several mitigating factors. The investment that has taken place in the department is really appreciated, and with the current financial status of the Trust, I appreciate that any finances spent must be assessed for risk on a case-by-case basis. We will be putting forward a business case with phased options for the development of the department, and hope that these are considered. Limited – Age of parts of the department are starting to restrict workflow/ability to function correctly	

Committees that have previously discussed/agreed the report, and outcomes of that discussion

The report has been reviewed by the CMO, who is also the Designated Individual under the Human Tissue Act Licence that is held by the Trust to store deceased patients and carry out post-mortem examinations.

The report has also been signed off by the Associate Director of Operations for Cancer & Clinical Support Services.

Issues raised within this report have been raised at local meetings, Pathology Quality meetings, and Governance meetings for Cancer & Clinical Support Services.

This report was presented at the Quality Assurance Committee in September 2025

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Compliance with Human Tissue Act	Satisfactory	N/A – First report
Post Mortem room Air handling unit	Limited	N/A – First report
Fuller Inquiry: Phase 2 report actions	Satisfactory	N/A – First report
Activity Summary	Significant	N/A – First report
Storage – Winter Plans	Satisfactory	N/A – First report
Mortuary Facilities	Limited	N/A – First report

Consideration is required to support replacing the Post Mortem room Air Handling Unit, and to consider the options provided to improve the Mortuary facilities in an upcoming Business case.

Overall, the Assurance provided in delivering a safe, respectful Mortuary service is Satisfactory



Torbay and South Devon

NHS Foundation Trust

Appendix 1 – Fuller Inquiry: Phase 2 report gap

analysis.

	Fuller Phase 2 Action Plan					
	Recommendation	Progress	Action	Owner	Deadline	RAG
Recommendation 1	All Trusts with Mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of 1. The systems in place to identify any unauthorised access to the facility 2. The strength and effectiveness of barriers to prevent unauthorised access to the facilities 3. The systems in place to identify any access to deceased people for unauthorised purposes 4. How CCTV is used, including its monitoring and any audits undertaken	Partially met. A full local review of security of the Mortuary was undertaken in response to Fuller 1 Inquiry. This was undertaken with the Mortuary Manager, Director of Operations and Security team. Access to the Mortuary is via individual swipe cards and CCTV and swipe card audits are carried out each week. All access requests must be signed off by the Mortuary Manager, Director of Operations and DI.	A report will be sent to the Trust Board in September with the detail of the security measures in place for a decision on an external security review	Mortuary Manager ADO DI	01/10/2025	

Recommendation 2	All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the postmortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges	Completed in response to Fuller 1 Inquiry – CCTV in place in all areas referenced	Complete – no action	N/A	N/A	
Recommendation 3	All NHS trusts should routinely audit the access data of all facilities used to store deceased people	Completed in response to Fuller 1 Inquiry. Mortuary security audit carried out every Monday	Complete – no action	N/A	N/A	
Recommendation 4	The practice of using shared electronic swipe cards for specific staff groups should cease immediately	Completed in response to Fuller 1 Inquiry. All shared access cards revoked and individual access cards in use	Complete – no action	N/A	N/A	

Recommendation 5	All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons	No rule in place currently that prevents electronic devices within the Mortuary. Trust mobile phone policy in use, along with Policy for use of mobile communication devices within hospital buildings.	Signs prohibiting use of mobile phones to be installed in the Mortuary department A Process assessment is required to indicate what systemic barriers would be appropriate/enforceable	Mortuary Manager ADO	01/11/2025	
Recommendation 6	All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.	Security breaches reviewed by Mortuary Manager, with input from Security team where required.	Action plan to be developed for each incident and to be incorporated into governance reports and reported via Trust incident framework	Mortuary Manager ADO Security	31/10/2025	

Recommendation 7	The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority	N/A. No Body stores in use by the Trust. Only fully licenced Mortuary at Torbay Hospital	N/A	N/A	N/A	
Recommendation 8	All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.	No swipe to exit system currently in use.	To be costed	Mortuary Manager ADO Security Estates	31/10/2025	
Recommendation 9	All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.	Complete. This is carried out by the Mortuary Manager each Monday via an automated Swipe permissions list and access log being sent, that is reviewed. Results of these audits are held on Q-Pulse.	Contingency plan to be developed for when Mortuary Manager absent	Mortuary Manager ADO	01/09/2025	
Recommendation 10	NHS trusts should ensure that Designated Individuals have enough time and resource to fulfil their responsibilities, including time for learning and development.	Complete. CMO stated that she had enough time to complete her functions as DI	N/A	N/A	N/A	

Recommendation 11	NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.	Complete. Senior Managers and the Chief Executive were involved in HTA inspection feedback, and understand the importance of the HTA and DI role.	N/A	N/A	N/A	
Recommendation 12	NHS trusts should ensure that Designated Individuals attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.	Complete. DI attends the correct governance forums	N/A	N/A	N/A	
Recommendation 13	A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager	Complete. Mortuary Manager has background in Mortuary services and holds Certificate and Diploma in Anatomical Pathology Technology. This is essential criteria within the job description	N/A	N/A	N/A	
Recommendation 14	NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.	Partially met. There are processes in place in the department to assist the Mortuary Manager to complete all relevant tasks and staffing levels increased in 23/24 –	Continue to train and competency assess Anatomical Pathology Technical staff	Mortuary Manager	01/02/2026	

		duties and processes still in development as well as competencies				
Recommendation 15	All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include: 1. Staffing Matters 2. Security Incidents 3. All Serious Incidents 4. HTA Reports (where applicable) 5. All Security Audits, including audits of access and any access breaches	Partially met. A formal board report has been agreed and due to go to Trust Board in September -headings and info will be included in the report. Director of Operations updates on Mortuary matters via Divisional and Care Group governance	Board report to be presented at September Board	Mortuary Manager ADO	29/08/2025	
Recommendation 16	Trust boards should assure themselves that the recommendations in this Report have been implemented.	Partially met. Board report was developed and signed off in response to Fuller 1 Inquiry - A further formal board report has been agreed and due to go to Trust Board in September -headings and	Board report to be presented at September Board	Mortuary Manager ADO	30/09/2025	

		info will be included in the report.				
Recommendation 17	Trust boards should ensure that these recommendations and governance arrangements are applied to any temporary facilities used by trusts for the storage and care of deceased people	Partially met. Temporary storage facilities have been assessed by the Mortuary manager, including site visits to Funeral Directors that the Trust holds SLA's with. This information will be contained in the board report.	Board report to be presented at September Board	Mortuary Manager ADO	30/09/2025	
Recommendation 18	Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements	Complete – represented by DI as Board member	n/a	n/a	n/a	
Recommendation 19	NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.	Incomplete - Assessment needed to see if the current safeguarding training and policies cover deceased patients. Where this is not the case, plan to be	Raised to Chief Nursing Officer and plan to be developed, will also be identified in	ADO CNO	01/02/2026	

		developed and implemented.	September Board Report			
Recommendation 20	The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores	In progress, the chief nurse had previously been involved in assurance of the dignity & Security of deceased patients when an emergency temporary storage facility was actioned.	Raised to Chief Nursing Officer and plan to be developed.	ADO CNO	01/02/2026	
Recommendation 69	Where organisations work together to care for people after death, the arrangements should be formalised through contracts or service level agreements. This should include joint Standard Operating Procedures. The parties to the contracts or service level agreements should ensure that the contracts or agreements are managed effectively, and that they seek assurance that the arrangements protect the security and dignity of people after death.	Partially met. SLA's are in place that state the steps that have to be taken for third parties to manage the safety and security of deceased patients in their care on behalf of the Trust, though there are currently no shared SOP's in place.	Develop shared SOPs in line with SLA's	Mortuary Manager ADO	01/02/2026	



Torbay and South Devon
NHS Foundation Trust

Trust Board

Month 5 Finance Report

Date of meeting	Date report produced
24 th September 2025	15 th September 2025

Author(s)		Report approved by	
Name and title:	Nichola Rees Finance Partner	Name and title:	James Corrigan Director of Operational Finance
Phone:		Date:	15 th September 2025
Email:	nichola.rees@nhs.net		james.corrigan4@nhs.net

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary

The purpose of this report is to inform the Trust Board of the financial position as at end month (31st August 2025) and forecast out turn (FOT) for the year ended 31st March 2026.

The deficit target for 25/26 is £8m, after receipt of £30.8m of deficit support funding. This includes a CIP delivery target of £41.5m (slide 4).

As at month 5 the Trust is reporting a net YTD deficit of £9.8m against a planned deficit of £9.8m. The forecast for the year end is as planned at £8m deficit (slide 3).

At the planning stage risks of £22.m were identified of which £11.0m were mitigated, resulting in a net risk to the year-end position of £11.0m.

Following a review of the month 4 forecast the gross risk has been assessed as £19.8m to delivering the £8m planned deficit. Actions are in place to reduce run rates and in total these actions give the ability for the Trust to deliver the forecast plan for 2025/26. As yet, there is only confidence in the ability to deliver £11.2m of the further savings; with a further £4.8m of high-risk actions identified, leaving a gap of £3.8m. The current net risk to delivering the forecast outturn is therefore £8.6m.

The Trust is reporting £12.4m YTD CIP achievement, £1.7m ahead of plan (slide 4) although recurrent is lower than plan (£6.3m v £6.9m). The annual forecast is to

achieve the £41.5m plan, (split recurring £30.6m and non-recurring £11.0m) as we assess the recurrent savings will increase significantly over future months.

The planned exit underlying position for 25/26 (before national/system support) remains £81.8m deficit. The Trust is working to finalise the recurrent impact of movements in the forecast outturn following the month 4 review to agree the exit underlying financial position. This will be iterative as we move through the planning period and will be used to inform the development of the medium term financial plan (MTFP) which needs to be finalised by the end of December.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Financial Performance	Satisfactory	No change
CIP	Limited	No change
Financial Risks	Limited	No change
Workforce	Limited	No change

Committees that have previously discussed/agreed the report, and outcomes of that discussion

Executive Committee - Review
Finance and Performance Committee - Assurance

Key recommendations and actions requested

The Board is requested to agree the overall assurance level relating to the financial position of TSDFT as SATISFACTORY assurance on financial performance and LIMITED assurance on CIP, financial risks and workforce.

The Board is also asked to NOTE the following:

- The Trust financial performance to 31st August 2025

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

This report demonstrates the Trust's commitment to financial responsibility. By achieving cost efficiencies and making strategic investments.

How does the report support the Triple Aim

Aim	Impact
Sustainable and efficient use of resources	Robust financial information and forecasting is key to ensure the financial sustainability and ensuring efficient use of the Trust resources

Impact on BAF Objectives	
BAF Objective	Impact
Financial Sustainability and Productivity	Robust financial information and forecasting is key to ensure the financial sustainability and ensuring efficient use of the Trust resources

Risk: Risk ID (as appropriate)	
Risk	Risk ID
N/A	

External Standards affected by this report and associated risks
N/A

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Assurance and Recommendations

1. The core financial systems that support productions of these reports are subject to annual review though both internal and external audit, the reported financial information is taken directly from and reconciled to the Trust general ledger.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Financial Performance	Satisfactory	No change
CIP	Limited	No change
Financial Risks	Limited	No change
Workforce	Limited	No change

The Trust Board is requested to agree the overall assurance level relating to the financial position of TSDFT as SATISFACTORY assurance on financial performance and LIMITED assurance on CIP, financial risks and workforce.

The Board are also asked to NOTE the following:

- The Trust financial performance to 31st August 2025



Monthly Financial Performance Report

Month 5

Executive Summary



The Trust Finance Report seeks to provide assurance to the Trust Board on the financial position year to date (YTD) as at August 2025 and forecast out turn (FOT) for the year ended 31st March 2026. Additionally, the impact of any financial changes in the underlying deficit is explained.

The deficit target for 25/26 is **£8.0m**, including **£30.8m** of deficit support funding and **£18.9m** of regional support. This is after a CIP target of **£41.5m** (slide 4). As at month 5 the Trust is reporting a net YTD deficit of **£9.8m** against a planned deficit of **£9.8m** The net forecast for the year end is as planned at **£8.0m** (slide 3).

At the planning stage risks of £22.0m were identified of which £11.0m were mitigated, resulting in a net risk to the year-end position of £11.0m. Following a review of the month 4 forecast the gross risk has been assessed as £19.8m to delivering the £8m planned deficit. Actions are in place to reduce run rates and in total these actions give the ability for the Trust to deliver the forecast plan for 2025/26. As yet, there is only confidence in the ability to deliver £11.2m of the further savings; with a further £4.8m of high-risk actions identified, leaving a gap of £3.8m. The current net risk to delivering the forecast outturn is therefore £8.6m. (see separate paper on agenda)

The Trust is reporting £12.4m YTD CIP achievement, £1.7m ahead of plan (slide 4) although recurrent is lower than plan (£6.3m v £6.9m). The annual forecast is to achieve the £41.5m plan, (split recurring £30.6m and non-recurring £11.0m) as we assess the recurrent savings will increase significantly over future months

The planned exit underlying position for 25/26 (before national/system support) remains £81.8m deficit. The Trust is working to finalise the recurrent impact of movements in the forecast outturn following the month 4 review to agree the exit underlying financial position. This will be iterative as we move through the planning period and will be used to inform the development of the medium term financial plan (MTFP) which needs to be finalised by the end of December.

Total Exit Underlying (£m)	23/4	24/5	25/6	26/7	27/8	28/9
TSD	-85.0	-87.7	-81.8	-45.5	-26.8	-

The Finance Committee is requested to agree the overall assurance level relating to the financial position of the Trust as **SATISFACTORY** assurance on financial performance and **LIMITED** assurance on CIP, financial risks and workforce

Financial Position – Month 5

	M5				YTD M5				Financial Year			
	PY 24/25	CY 25/26			PY 24/25	CY 25/26			PY 24/25	CY 25/26		
	Actual £m	Plan £m	Actual £m	Var +/- £m	Actual £m	Plan £m	Actual £m	Var +/- £m	Actual £m	Plan £m	Forecast Outturn £m	Var +/- £m
Operating Income	54.6	61.9	62.9	1.0	267.5	309.0	313.0	4.0	729.3	742.3	754.4	12.1
Operating Expenditure - Pay	(29.3)	(31.9)	(31.7)	0.1	(147.0)	(160.1)	(160.0)	0.1	(389.0)	(375.7)	(378.2)	(2.5)
Operating Expenditure Non-Pay and Financing Cost	(30.2)	(31.6)	(32.8)	(1.1)	(150.4)	(158.7)	(162.8)	(4.1)	(373.5)	(374.6)	(384.2)	(9.6)
Surplus / (Deficit) Sub Total	(4.9)	(1.6)	(1.6)	(0.0)	(29.9)	(9.8)	(9.8)	(0.0)	(33.2)	(8.0)	(8.0)	0.0
<i>Excluding Non Recurrent Deficit Funding</i>	0.0	(2.6)	(2.6)	0.0	0.0	(12.9)	(12.9)	0.0	0.0	(30.8)	(30.8)	0.0
Surplus / (Deficit) Total	(4.9)	(4.2)	(4.2)	(0.0)	(29.9)	(22.7)	(22.7)	(0.0)	(33.2)	(38.8)	(38.8)	0.0

Financial Position

The Trust's financial position at the end of August shows a year-to-date deficit of **£9.8m**, against a planned deficit of **£9.8m**. This position excluding the deficit support funding of **£12.9m** would be a year-to-date deficit of **£22.7m**

Year to date - Income **£4.0m** higher than plan (Pass Through Drugs & Devices £1.2m, CFHD £2.9m, other income £1.2m, offset lower than plan CIP delivery £1.2m), Pay costs marginally lower than plan **£0.1m**, Non pay costs **£4.1m** higher than plan (slide 12).

The Trust is reporting a year end forecast **£8.0m** deficit including support funding of **£30.8m**, work has now been concluded on revising the forecast outturn including risks and mitigations and is set out in a separate paper. The position excluding support funding is **£38.8m deficit**.

Forecast - Income **£12.1m** higher than plan (Pass Through Drugs & Devices £2.9m, CFHD £7.0m, R&D & Education £4.6m, offset lower than plan CIP delivery £3.1m), Pay costs higher than plan **£2.5m** mainly temporary staffing costs, Non pay costs **£9.6m** higher than plan (slide 12)

The Committee can take **satisfactory assurance** that the plan to date is delivering.

Underlying Financial Position

The underlying position has been updated and shows the true financial position of the organisation excluding one-off or non-recurring items. Based the last review during planning, the Trust is forecasting an underlying recurrent deficit for 25/26 of £81.8m (slide 2), which is a £5.9m improvement on 24/25 exit position. Material contributors to the recurrent underlying deficit are currently Adult Social Care and Continuing Healthcare driving approximately £39m of the underlying deficit

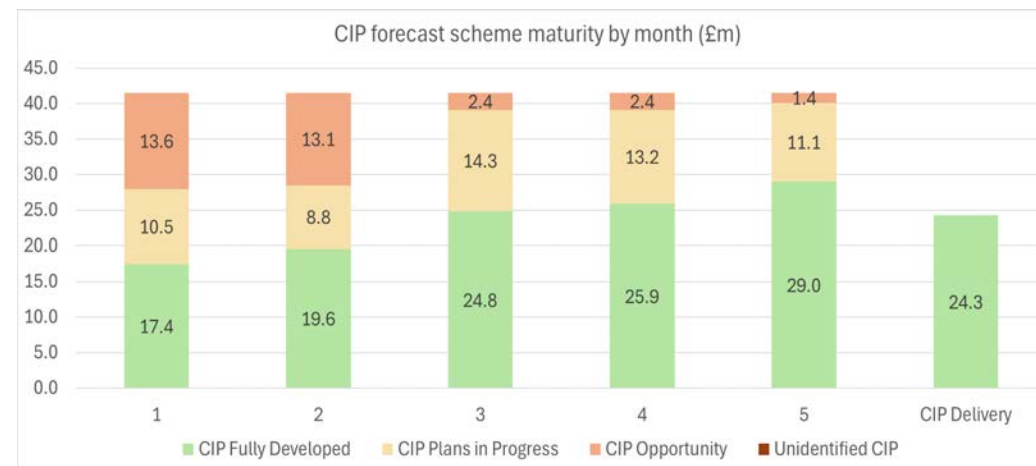
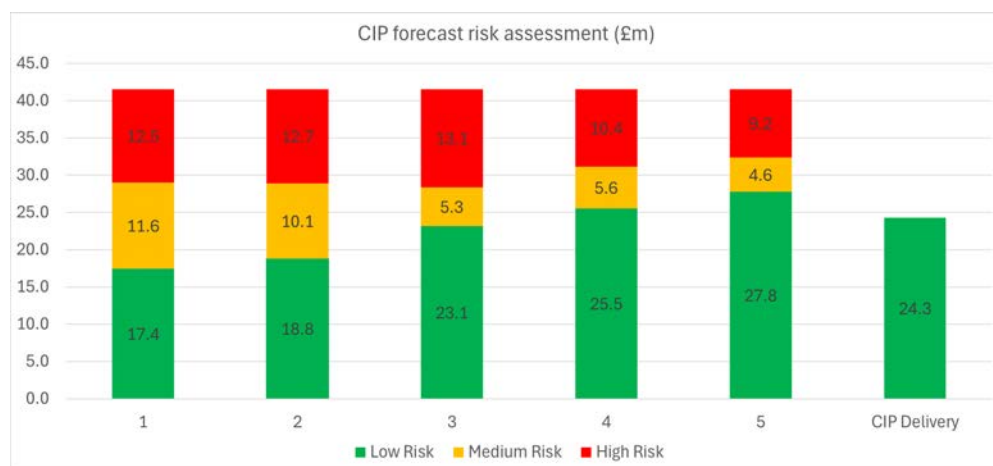
Efficiencies/CIP – maturity & risk

Profile of plan across quarters

Q1 – 14%
Q2 – 19%
Q3 – 31%
Q4 – 37%

	Year to Date			Forecast Outturn		
	Plan CIP delivery £m	Actual CIP Delivery £m	Var +/- £m	Plan for the year £m	Forecast £m	Var +/- £m
Recurrent efficiencies	6.9	6.3	(0.6)	32.8	30.6	(2.2)
Non-recurrent efficiencies	3.8	6.1	2.3	8.7	11.0	2.2
Total	10.7	12.4	1.7	41.5	41.5	0.0
Recurrent %	65%	51%		79%	74%	
Non-recurrent %	35%	49%		21%	26%	

Care Group	High Risk Forecast CIP Delivery £
Medicine and Urgent Care	0.2
Planned Care and Surgery	0.4
Shared Corporate Services	8.4
Shared Corporate Services - Workplace	0.2
Grand Total	9.2



The Trust is reporting £12.4m YTD CIP achievement, £1.7m ahead of plan. The annual forecast is to still achieve the £41.5m plan although at M5 forecast split recurring £30.6m (£2.2m less than plan) and non-recurring £11m (£2.2m ahead of plan). The recurrent savings will continue to be assessed and expected to increase in future months.

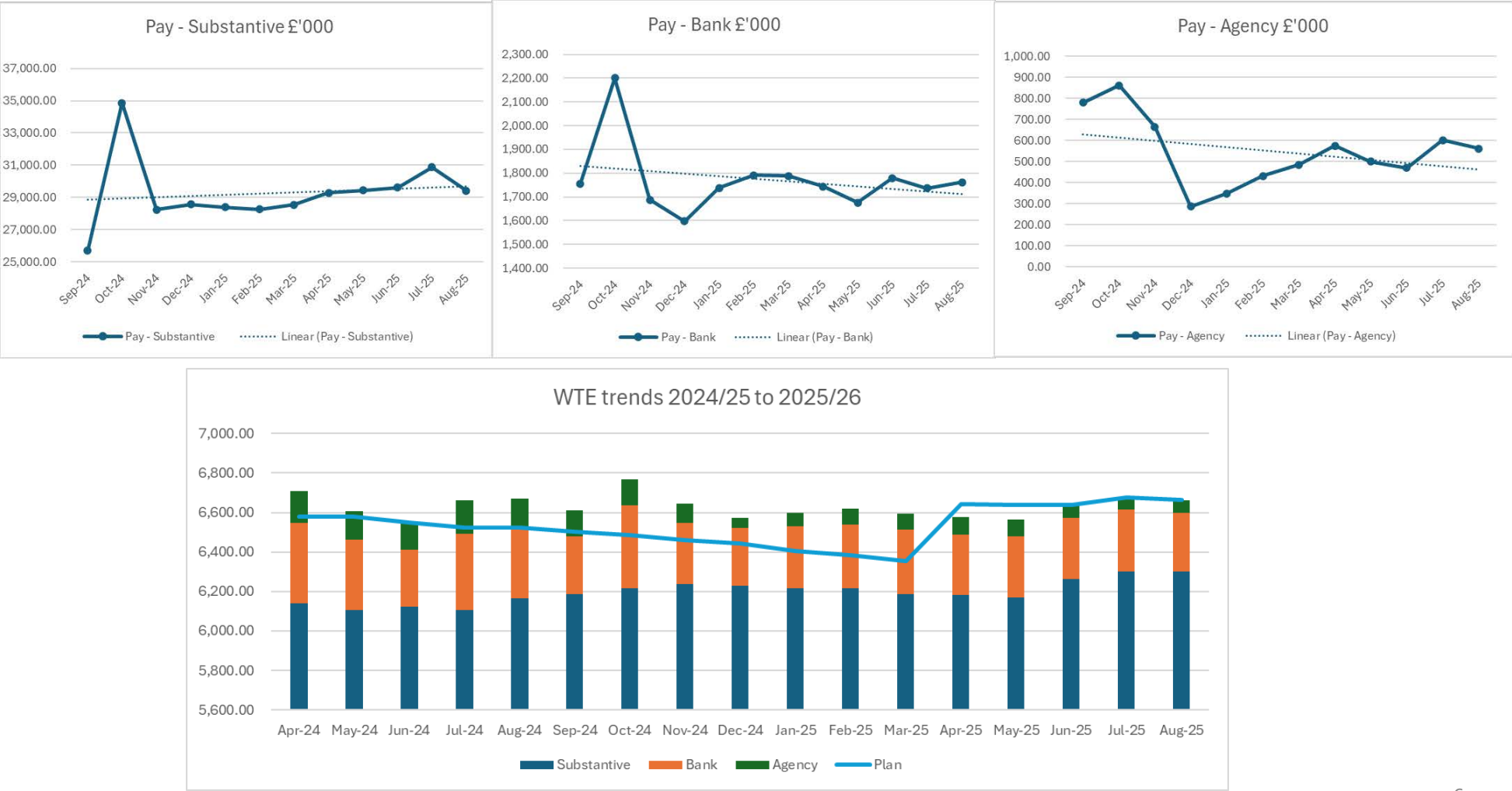
There is **limited assurance** around delivering the full efficiency requirement particularly in relation to levels of recurrent delivery and the percentage high risk CIP to be delivered for the remainder of the year

Workforce

	Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
Class	Plan £m	Actual £m	Var +/- £m	Full Year Plan £m	Forecast £m	Var +/- £m	WTE Plan	WTE Worked	Var +/-
Pay - substantive	(149.1)	(148.6)	0.5	(349.7)	(352.8)	(3.1)	6,300	6,225	75
Pay - bank	(8.0)	(8.7)	(0.7)	(18.9)	(19.3)	(0.3)	300	323	(23)
Pay - agency	(3.0)	(2.7)	0.3	(7.1)	(6.1)	1.0	63	93	(31)
Grand Total	(160.1)	(160.0)	0.1	(375.7)	(378.2)	(2.5)	6,663	6,642	21

- Current month (as at 31st August finance ledger) there are 21WTE lower than plan which are mainly due to vacancies.
- The financial position YTD is marginally lower than plan for overall pay costs, with substantive posts lower than plan £0.5m although there are vacant posts 75WTE. This is due to pay costs include the additional premium overtime payments, payments to staff for regular overtime absence and senior doctor additional sessions that do not attract additional WTE, and also agency premium costs

Month 5 – Rolling Worked WTE and Pay Run Rate Trends



Cash Position – Month 5

	YTD Plan £m	YTD Actual £m	YTD Variance £m	Forecast Outturn £m
Opening cash balance	3.3	26.7	23.4	26.7
Operating surplus/(deficit) - excluding finance costs	(7.0)	(7.2)	(0.2)	(1.7)
Capital Non-Cash movements (depr&amort)	8.9	8.9	(0.0)	23.6
Working Capital Movement	14.9	(3.1)	(18.0)	(18.4)
Net cash generated from / (used in) operations	20.1	25.4	5.2	30.2
Net Capital Expenditure (Purchase/Disposals)	(16.9)	(5.4)	11.5	(60.7)
Interest Received	0.5	0.7	0.2	1.5
Net cash generated from/(used in) investing activities	(16.4)	(4.7)	11.7	(59.1)
PDC paid/received	2.9	0.0	(2.9)	41.1
Loans paid/received	(0.7)	(0.7)	(0.0)	(2.0)
Capital on finance leases and PFI	(2.1)	(1.8)	0.3	(5.1)
Interest element on loans, finance lease and PFI	(0.9)	(0.9)	0.0	(2.5)
Net cash generated from/(used in) financing activities	(0.9)	(3.4)	(2.6)	31.6
Closing cash balance	2.8	17.2	14.3	2.6

The closing cash balance for M5 is £14.3m higher than plan, explained by:

- Opening cash balance at the start of the year was **£23.4m** has been utilised to make supplier payments in M1-2.
- Net cash generated from operation has **£5.2m** variance to plan, which is largely attributable to the rephasing of ICB income to match revenue and CIP risk.
- Investing activities show a **£11.7m** variance, reflecting re-phasing of the capital plan.
- Financing activities are broadly in line with plan. The **£2.9m** variance is due to planned PDC capital not drawn down due to timing of capital expenditure.

Cash Risk: PDC revenue support of £8m not being funded within the system. There is also a risk of non-delivery of CIP impacting on cash. Potential industrial action and MARS pay pressures will impact on a cash balance later on in the year.

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	(7.2)
Finance income	0.7
Finance expense	(1.8)
PDC dividend expense	(2.4)
Other gains/(losses) including disposal of assets	0.0
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	(10.6)
Capital donations/grants/peppercorn lease I&E impact	0.3
PFI revenue costs on an IFRS 16 basis	1.9
PFI revenue costs on a UK GAAP basis	(1.4)
TOTAL Provider Surplus/(Deficit) - System performance	(9.8)

Cashflow Forecast – Month 5

Start Date 01.09.2025	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	£000	£000	£000	£000	£000	£000	£000
Cash Balance B/F	17,094	9,716	17,099	15,881	15,751	7,097	9,593
TOTAL RECEIPTS	60,694	79,351	62,534	67,616	63,907	68,649	64,539
TOTAL PAYMENTS	(68,072)	(71,968)	(63,753)	(67,746)	(72,561)	(66,152)	(71,520)
Net Movement	(7,378)	7,383	(1,218)	(130)	(8,654)	2,496	(6,981)
Cash Balance C/F	9,716	17,099	15,881	15,751	7,097	9,593	2,613

The Month 5 cashflow forecast has been prepared based on the following assumptions:

- Income remains materially unchanged from the plan and is in line with the M05 forecast.
- The £8m deficit being funded by PDC revenue support per the plan will still be funded centrally following recently issued guidance
- The capital plan and associated funding sources remain unchanged including £4m of system capital PDC.
- There may be a requirement for non-cash balance sheet adjustments, which support the position later in the year, which would impact cash - to be monitored and mitigations actioned where required.

Balance Sheet – Month 5

Statement of Financial Position (SOFP)

	Plan £m	Actual £m	Variance £m
Fixed Assets	290.1	263.5	(26.6)
Other Non-Current Assets (Receivables)	4.0	4.1	0.1
Cash & Cash Equivalents	2.8	17.2	14.3
Working Capital (excl cash)	(39.2)	(53.8)	(14.5)
Non-Current Liabilities (Loans/Leases/Other)	(55.7)	(52.7)	3.1
Total Assets Employed (Assets + Liabilities)	202.0	178.4	(23.6)
Public Dividend Capital	281.2	278.3	(2.9)
Revaluation	61.0	60.7	(0.3)
Surplus / (Deficit) Sub Total	(10.6)	(10.6)	(0.0)
I&E reserves	(129.6)	(150.0)	(20.4)
Reserves Total	202.0	178.4	(23.6)

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	(7.2)
Finance income	0.7
Finance expense	(1.8)
PDC dividend expense	(2.4)
Other gains/(losses) including disposal of assets	0.0
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	(10.6)
Capital donations/grants/peppercorn lease I&E impact	0.3
PFI revenue costs on an IFRS 16 basis	1.9
PFI revenue costs on a UK GAAP basis	(1.4)
TOTAL Provider Surplus/(Deficit) - System performance	(9.8)

- Fixed Assets are lower than plan **£26.6m**. Capital spend has been re-phased to support cashflow, however, it is expected that the year-end position is still expected to align close with the agreed full-year plan. There were also some movements in the opening balances in relation to impairments and revaluations at the time of the planning process.
- Cash is **£14.3m** higher than plan, explained in detail in cashflow report.
- Loans and Leases liabilities are **£3.1m** lower than plan, due to capital (lease) spend phasing.
- PDC capital drawdown has not been made yet in the year.
- YTD capital expenditure stands at **£7.85m**, reduced to **£6.30m** due to property disposals (£1.55m), originally planned in month 6. Planned capital expenditure for month 5 was **£3.1m**.

One Devon– ICS position

As at month 5 the Devon ICS is reporting a year to date £11.4m deficit, in line with plan. The forecast for the year end is to breakeven at system level.

Description	Month 5			Forecast Outturn		
	Plan £m	Actual £m	Var +/- £m	Plan £m	Forecast £m	Var +/- £m
Devon ICB	3.3	10.7	7.3	8.0	8.0	0.0
Devon Partnership NHS Trust	0.2	0.2	0.0	0.0	0.0	0.0
Royal Devon University NHS FT	(2.4)	(9.8)	(7.3)	0.0	0.0	0.0
Torbay and South Devon NHS FT	(9.8)	(9.8)	0.0	(8.0)	(8.0)	0.0
University Hospitals Plymouth NHS FT	(2.7)	(2.7)	0.0	0.0	0.0	0.0
Total	(11.4)	(11.4)	0.0	0.0	0.0	0.0

Based on the discussions held with ICS organisations and review of finances and workforce it was recommended to the ICS Finance & Performance Committee that the overall level of assurance that the ICS will achieve the planned forecast outturn for 2025/26 as at month 4 (month 5 yet to be assessed formally) is as follows:

Section	Assurance	Trend from previous month
Overall assurance	Limited	No change
Financial performance	Satisfactory	No change
Savings and efficiencies	Limited	No change
Financial risks	Limited	No change
Workforce	Limited	No change

Devon Financial Escalation Framework – to support consistency of reporting, Devon ICS partner organisations have agreed several KLOE against which financial risk is assessed. As at month 4 the Trust is reporting red risks in the areas of Efficiency Schemes Assessed as High Risk, Forecast Recurrent Efficiency Delivery Against Plan, Forecast Net Unmitigated Risk as a % of Plan Operating Expenditure, and YTD Capital Spend as a % of Allocated System Capital – more detail is available on slide 18

Board of Directors

Integrated Quality and Performance Report

Date of meeting	Date report produced
24 September 2025	10 September 2025

Author(s)		Report approved by	
Name and title:	Paul Procter Head of Performance	Name and title:	Sam Wadham-Sharpe Director of Operational Recovery
Phone:	01803 654158	Date:	11/09/2025
Email:	paul.procter@nhs.net	Email:	s.wadham-sharpe@nhs.net

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

N/A

Executive summary

The Trust's Integrated Quality and Performance Focus Report (IQPR) is scrutinised by the Executive Operations Groups (EOG) which has been constituted to strengthen the governance assurance process for the operational management of the Trust. This is the key governance group where the Executive triumvirate (COO, CMO and CNO) hold the Care Group Directors to account for all aspects of delivery on safety and quality, performance, finance, and workforce.

The Executive Operations Group identifies issues for the attention and escalation to the Finance and Performance Committee and Trust Board and assurance assessments are included below.

Copies of the minutes, care group reports, and IPR data packs are available for further scrutiny should a member of the Executive or Board require these.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Safety and Quality	Satisfactory	No Change
Performance UEC	Limited	No Change

Performance Planned Care	Limited	No Change
Workforce	Satisfactory	No Change
Finance	Limited	No Change

Appendices

M5 2025/26 Integrated Performance Focus Report
M5 2025/26 Integrated Performance Dashboard of Key Metrics

Committees that have previously discussed/agreed the report, and outcomes of that discussion

Care Group Executive Operations Group – 9 September 2025
 Finance and Performance Committee – 18 September 2025

Key recommendations and actions requested

The Board are asked to AGREE the recommended assurance rating and take LIMITED / SATISFACTORY assurance as to those matters reviewed. The Board are asked to ACCEPT the overarching assurance recommendations:

- Safety and Quality – **approve the recommendation that there is satisfactory assurance** that safety and quality issues at care group level are understood and managed.
- Performance UEC - **approve the recommendation that the Trust has not met UEC performance trajectories and there is limited assurance.** Strengthened plans and assurance is needed to demonstrate that the Trust will meet the key UEC performance metrics as per the 2025/26 Operational Plan.
- Performance Elective - **approve the recommendation of Limited Assurance.** The Trust did not meet performance targets to clear 78 weeks for RTT, Cancer 62 days and Faster Diagnosis standard. Requirement for more detailed recovery actions and trajectory to improve assurance of delivery in 2025/26.
- Finance – **approve the recommendation that there is limited assurance on financial delivery for month 5.** Financial recovery plans need to be **developed to address areas of overspend.**
- Workforce – **Approve the recommendation that there is Satisfactory assurance** on workforce performance metrics and assurance ratings by care group.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

Good governance drives operational performance and accountability, ensuring we deliver a safe and quality service.

How does the report support the Triple Aim	
Aim	Impact
Population Health and Wellbeing	
Quality of services provided	Good governance drives delivery & quality
Sustainable and efficient use of resources	
Impact on BAF Objectives	
BAF Objective	Impact
Quality and Patient Experience: Personalised Care	
People	
Financial Sustainability and Productivity	
Estates	
Operations and Performance Standards	
Equality, Diversity and Inclusion	
Provision of Community and Care Services Delivered in Partnership	
Risk: Risk ID (as appropriate)	
Risk	Risk ID
N/A	Overarching legal and regulatory risk theme.
External Standards affected by this report and associated risks	
<i>Laws or regulations</i> <i>Care Quality Commission</i> <i>Terms of authorisation, NHS England licence and regulations</i> <i>National policy, guidance</i>	

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Integrated Quality and Performance Report (IQPR)

Introduction and background

The Executive Oversight Group (EOG) received a formal report from each Care Group Director on the operational performance of their care group across quality and safety, performance, finance, and workforce alongside detailed performance information contained within the Integrated Performance Focus Report and Key Performance Indicator Dashboard, attached at appendix 1 and 2. This IQPR provides an assurance assessment and escalation of risk and provides assurance that actions to mitigate these risks are captured in an action plan that is regularly reviewed.

To support delivery against all the key domains of the operation plan and to enable targeted reviews and action planning against any area of the plan that is not delivering, Balanced Scorecards were shared with each Care Group. The scorecards continue to develop and will provide the oversight of metrics to triangulate impacts of decision making between performance, quality, finance and workforce.

Copies of the meeting minutes, Terms of Reference and Care Group performance packs are available for Board members on request from the Corporate Office.

This report outlines the key issues of assurance and matters for escalation to the Board.

Assurance and Recommendations

1. Safety and quality

Care Group	EOG assurance assessment
Family and community Child, Women’s, Public Health, and Communities	Satisfactory
Planned Care	Satisfactory
Medicine and UEC	Satisfactory

The Board is asked to note that there was sufficient evidence in the meeting and triangulation between reports through the Patient Safety and Quality reviews that there is **satisfactory assurance** that patient safety and quality issues are understood and being managed across care groups through patient safety and quality governance.

The following issues were raised:

- 1.1 Mixed Sex Accommodation – breaches have improved this month (124 in August from 200 in July). Efforts to mitigate mixed sex breaches by prioritising beds for vulnerable patients and utilising consulting rooms, noting that space constraints and reduced bed numbers post-pandemic remain

significant challenges. Mixed sex accommodation breaches is an area of focus with regional attention from Devon ICB.

- 1.2 Access to second obstetric theatre remains on the corporate risk register. Recruitment processes are in hand to meet the staffing requirements of a second obstetric theatre. The risk score has not been amended at this time and will be reviewed once start dates have been confirmed.
- 1.3 Mental health delays in the Emergency Department (ED) account for a high proportion (43%) of ED long stays, requiring continued escalation work with Devon Partnership Trust (DPT). Quarterly Care Group/DPT meetings will review cases and identify solutions, but the issue remains a DPT capacity challenge, affecting emergency floor capacity, security, and staffing. The group agreed to write to the Chief Medical Officer at Devon ICB to seek higher-level intervention to support these patients.

2. Performance and activity

	EOG assurance assessment
Family and community Child, Women's, Public Health, and Communities	Satisfactory Focus required on community waits, gynaecology activity plans and the Jack Sears contract review.
Planned Care	Limited - Cancer – Faster Diagnostic Standard (FDS) and 62-day standard not met - Diagnostics – not met. - RTT – not met
Medicine and UEC	Limited Context of good improvement and system performance across UEC performance metrics against a backdrop of high attendance. Assurance rating however reflects that we remain behind our operational plan trajectories for 4 hours and handovers and concerns regarding cancer performance.

The Board is asked to note the improvements made this month across many of the key performance metrics in Particular in planned care and overall RTT performance and the continued improvements against Urgent and Emergency care 4 hour standard and ambulance handover times. Where the Trust is not meeting the required performance, trajectories have been requested against detailed action plans. Overall, the assurance is assessed as **Limited**.

2.1 Cancer

Cancer Referrals

Between January and August, the Trust received 17,120 Urgent Suspected Cancer referrals, representing a 9.6% increase compared to the same period last year.

Cancer FDS

The Trust did not meet the Faster Diagnosis Standard with August performance at 60.8% against a target of 75%.

Lower GI (53%) and Urology (37%) remain the biggest areas of concern, with both high patient volumes and low compliance. Specialty level recovery plans are in place and early indications for September are that the trajectory will be met.

Cancer 62-day standard

The 62-day target in August was 69.1% against a monthly trajectory of 75.2%. We expect performance to remain below the 70% interim target at 65.2%, with the poorest results in Colorectal (29%), Urology (26%) and Head & Neck (38%). Delays are focused on the diagnostic end of the pathway, and the actions targeting FDS performance will also see an improvement in the 62-day standard.

The 62-day backlog has remained high (257 patients from 220 in July and 90 in August 2024), which is an indication that performance into September will remain relatively static.

2.2 Diagnostics (DM01)

The DM01 standard was not met with August performance at 37% against a target of 5%. Recovery plans are in place and include extra insourcing, mutual aid with other providers, and renegotiation of contract with the Community Diagnostic Centre to increase capacity, with mobilisation expected in October and ongoing monitoring of progress.

In July, recovery plans with associated trajectories were set across all diagnostic modalities. The current revised recovery trajectory achieves 10% in March 2026 against the national target of having less than 5% of diagnostics requests waiting over 6 weeks.

2.3 Referral to Treatment (RTT)

The improved RTT wait less than 18 weeks was noted with an August position of 68.8% against an August trajectory of 63.8% and 73.3% for a patient wait for first appointment less than 18 weeks against a trajectory of 67.2%.

The Planned Care Group Director is confident that this position can be held noting the risk of Winter pressures and the current EPR implementation will mitigate further improvement.

Further assurance has been requested from the Care Group Directors on the EPR programme and in particular lost capacity to support go live training and how this will impact on activity, performance trajectories, and associated recovery plans.

Weekly monitoring of patients waiting longer than 65-weeks and 78 weeks is on-going with expectations that there will be no patients waiting longer than 65 weeks by the end of December 2025.

2.4 Community waiting times

Community waits were discussed with ongoing work to improve data accuracy.

2.5 Urgent Care

- The four-hour performance remained above 70% for the sixth consecutive month, with August reaching 74.1%, the highest percentage recorded since June 2022.
- Average Ambulance Handover Time was 38 minutes – maintaining sub 40 minutes consistency from July.
- Average ambulance time lost over 15 minutes is better than trajectory.
- No Criteria to reside is the lowest it has been for 12 months (target of <5%)

All these UEC metrics were delivered during the Trust's third busiest attendance month ever.

3. Finance

	EOG assurance assessment
Family and community	Limited
Planned Care	Limited
UEC	Limited

The Board is asked to note that good progress has been made following the care group reviews in August. Despite this improvement and greater detail of CIP and recovery plans the Assurance however remains **limited** due to the forecast deficit positions by all Care Groups.

More detailed analysis into the financial position at M5 is given in the Finance report to the Board.

At the end of month 5 the Trust is on plan year to date with a deficit of £9.8m. The Trust has delivered £1.7m more CIP than planned, however there are emerging pressures as follows:

- demand and cost growth on packages of care in Adult Social Care,
- demand led pay and non-pay pressure across UEC,
- increased consumable and lab costs within planned care linked to delivery of elective targets,
- additional costs related to industrial action at the end of July,
- shortfall on funding for pay awards,

The Trust remains committed to delivering its forecast outturn in line with plan for 2025/26. Written recovery plans have been requested with the relevant EQIAs completed from all Care Groups.

A further round of Cost Improvement Programme (CIP) deep-dive meetings will be scheduled with Care Groups in the coming weeks.

4. Workforce

	EOG assurance assessment
Family and community Child, Women's, Public Health, and Communities	Satisfactory
Planned Care	Satisfactory
Medicine and UEC	Satisfactory

The Board is asked to note that there was sufficient evidence in the meeting and triangulation between reports through the People Committee that there is **satisfactory assurance** that workforce issues are understood and being managed across care groups through People governance.

Workforce issues raised included:

- 4.1 The need to complete consultant job planning to inform capacity planning for 2026/27 Operational Planning.
- 4.2 Training requirements for the EPR implementation and the impact on activity and patient safety.
- 4.3 The need to triangulate high sickness rates with cost pressures, especially in Emergency Department nursing, to ensure targeted interventions and effective use of resources.
- 4.4 The negative impact of holding vacancies and increased workloads.

5. Overarching assurance

The Board are asked to agree the recommended assurance rating and take limited/satisfactory assurance as to those matters reviewed.

Integrated Performance Focus Report (IPR)



Torbay and South Devon
NHS Foundation Trust

September 2025: Reporting period August 2025 (Month 5)

		Page
1.	National Oversight Framework (NOF) Introduction	2
	NOF 4 Performance Summary - Urgent and Emergency Care	3
	Exception reports -Urgent and Emergency Care	5
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Working with you, for you

Oversight Framework - Introduction

In December 2022, NHS England rated Torbay and South Devon NHS Foundation Trust at NOF segment 4 for financial and operational performance along with the wider Devon System. The levels are rated as segment 1 to 4 with NOF segment 4 being the highest level of regulatory oversight. The Trust, alongside other Devon providers, did not meet the timeline to exit segment 4 by Q1 2025/26.

Operational Plan: As part of the 2025/26 NHS National Planning process the Trust submitted (April 2025) an Operational Plan for 2025/26 contributing to a Devon System Operational plan to deliver the expectations of the NHSE Planning Guidance.

National Oversight Framework: To ensure delivery of the 2025/26 Operational Plan NHS England has published an updated Oversight Framework 2025/26 (April 2025) to determine how organisation performance will be assessed and the levels of support that will be needed. The publication of the year 1 assessment and updated segmentation of regulatory oversight for providers is expected early in Q2 2025/26.

The Oversight Framework 2025/26 metrics have been reviewed alongside Operational Plan commitments. These metrics now inform an updated performance section of the Integrated Performance Focus Report. Where the standards / operational plan trajectory are not being met these are reviewed through the monthly Care Group Review meetings and Executive Oversight group meetings. Exception reports against key performance indicators have been created in this report. These reports are part of the monthly assurance process with care groups and the Executive Committee.

System performance governance and reporting

Monthly meetings remain in place to review system progress and Trust level reports against Oversight Framework and additional performance assurance metrics.

- The Locality, Delivery, and Planning Meeting – South, chaired by the ICB and attended by TSDFT Executive team, reviews current position and progress against agreed plans.
- System Improvement Assurance Group (SIAG) meeting with Region, Devon ICB and provider CEOs.

Tier 1 National performance oversight:

The Trust remains in the Tier 1 (the highest level of oversight) performance regime from NHS England for Urgent and Emergency Care performance and Tier 2 for Elective Care. The Trust attends weekly executive led meetings with the Southwest region performance leads to review progress and gain assurance on agreed action plans to achieve UEC elective recovery.

National Oversight Framework– Urgent and Emergency Care Performance Summary

Torbay and South Devon NHS Foundation Trust																
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Operational Plan trajectory Aug 2025
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)			1576	3330	4343	3275	3108	2532	1625	1268	839	1530	1159	725	943	960
Average handover time (mins)	45 mins		56	106	139	109	95	84	62	47	36	52	45	32	38	34
Total average time in ED (hours/minutes)			05:25	06:20	06:44	06:18	06:17	06:20	05:53	05:26	04:58	05:40	05:11	04:50	04:50	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		525	779	979	854	793	818	677	615	415	688	494	457	426	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		7.9%	11.8%	14.8%	12.6%	12.8%	13.8%	9.6%	9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	5.6%
UEC 4-hour target (RAG against local trajectory to national target)	78%		70.7%	65.5%	68.7%	67.3%	65.0%	66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	76.0%
% patient discharges pre-noon	33%		18.9%	20.8%	21.5%	22.3%	20.4%	19.9%	21.2%	22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%		6.0%	6.9%	5.9%	9.5%	6.6%	8.3%	9.1%	7.4%	8.1%	7.7%	7.5%	8.0%	6.3%	5%

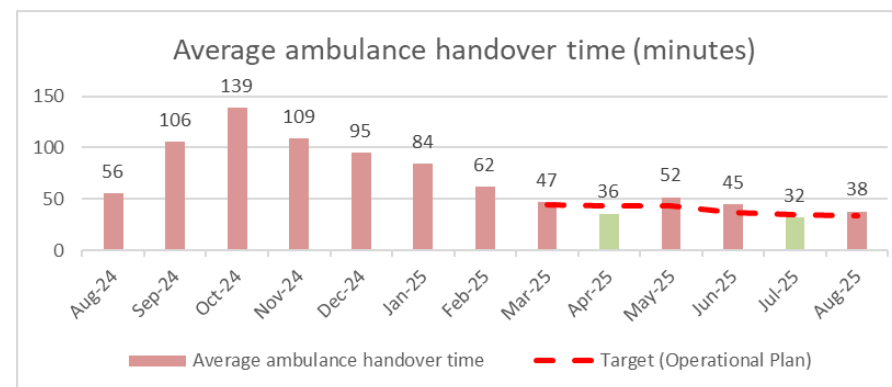
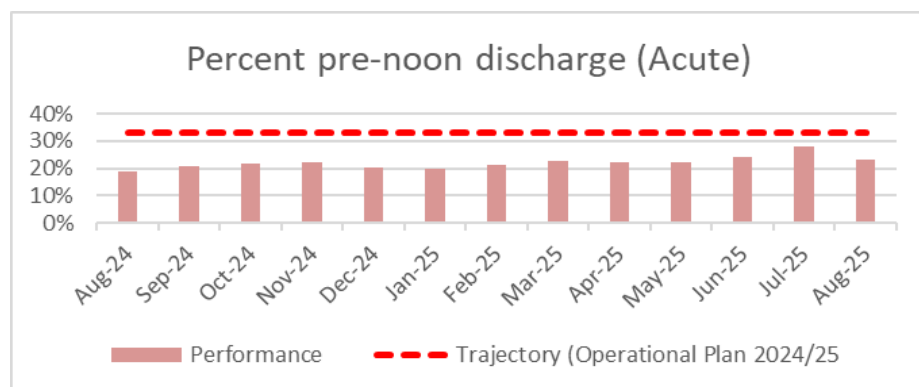
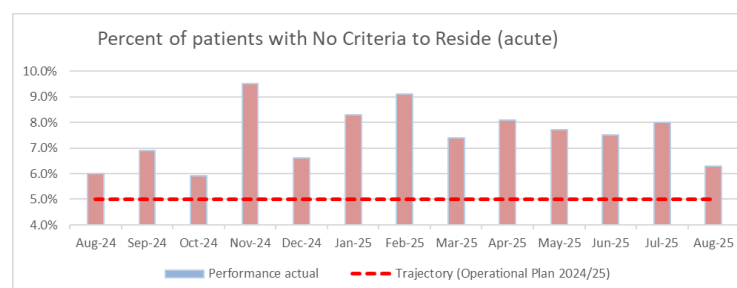
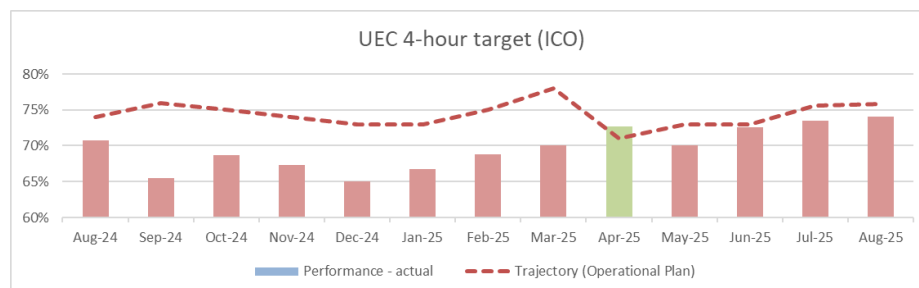
Trajectories have been agreed as part of the 2025/26 Operational Plan submission. The latest month trajectory, where applicable, is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories.

RAG indicator

Meeting monthly trajectory

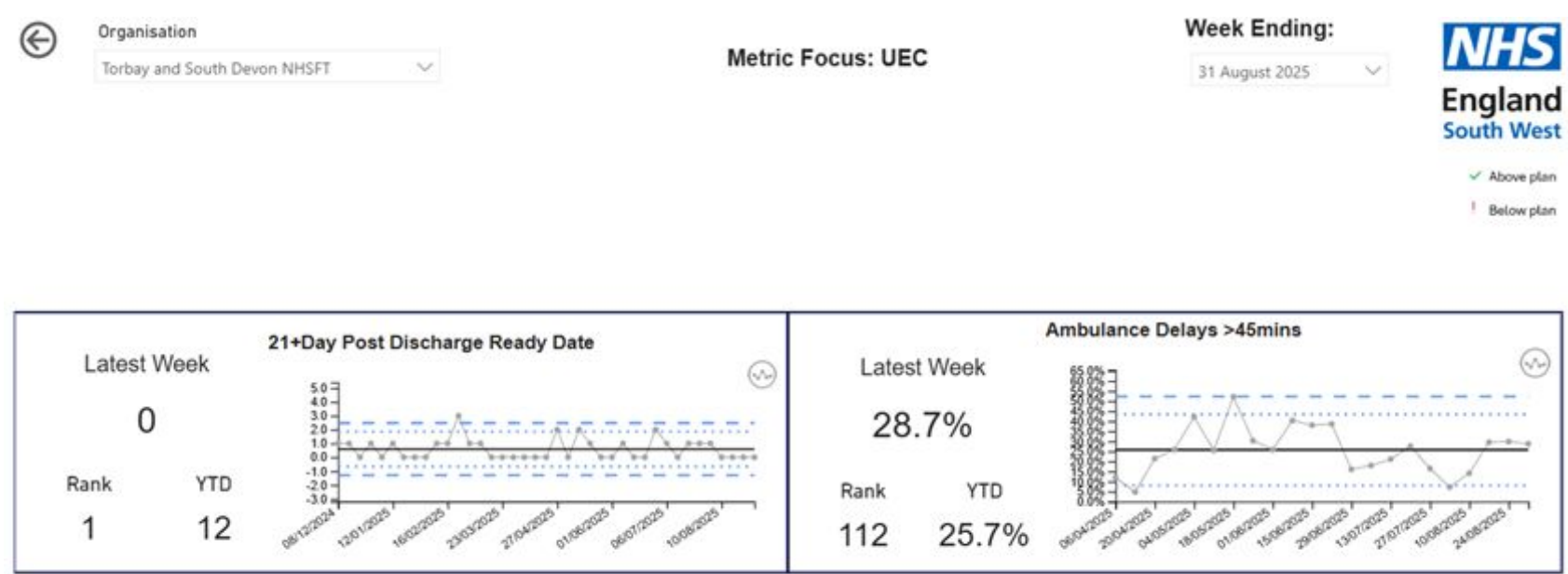
Not meeting monthly trajectory

Meeting national target but not monthly Operational Plan trajectory



Urgent and Emergency Care Performance Summary - NHS England monitoring report

The reports below have been taken from the national NHSE Southwest weekly performance dashboard which monitors performance against key UEC metrics. These metrics form the basis of the weekly performance reviews with NHS England.



Exception report: Average Ambulance Handovers time: Urgent and Emergency Care

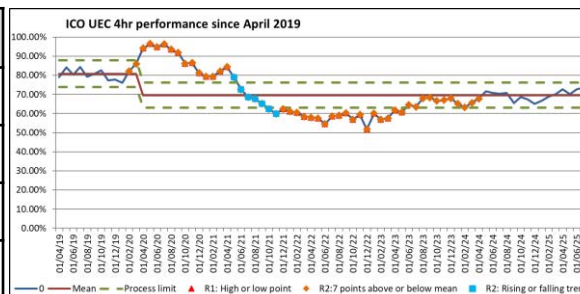
Performance	Operational update																																																																																		
The total number of ambulance conveyances to the ED in August was 2216 at the T1 ED with a slight reduction on July (2250). The average handover time increased to 37:34 minutes from 31:53 in July (see peer comparison below) Average handover time – rolling 30 day (as at 1 September 2025) Rolling 30-day position as at 01 September 2025 click on a bar to highlight site on the trend chart <table><tr><th>Ambulance Trust</th><th>Site Name</th><th>Time</th></tr><tr><td>South East Coast</td><td>Chelsea & Westminster Hospital</td><td>1:13:10</td></tr><tr><td>South Western</td><td>Royal United Hospital</td><td>1:03:01</td></tr><tr><td>South Western</td><td>Deriford Hospital</td><td>1:02:32</td></tr><tr><td>South Western</td><td>Royal Cornwall Hospital (triliske)</td><td>0:51:09</td></tr><tr><td>South East Coast</td><td>A & Conquest</td><td>0:50:28</td></tr><tr><td>South Western</td><td>The Great Western Hospital</td><td>0:47:50</td></tr><tr><td>South Western</td><td>Torbay Hospital</td><td>0:41:00</td></tr><tr><td>South East Coast</td><td>Queens Hospital</td><td>0:32:50</td></tr><tr><td>South Western</td><td>Royal Devon & Exeter Hospital (w.</td><td>0:31:56</td></tr><tr><td>South East Coast</td><td>University College Hospital</td><td>0:30:44</td></tr><tr><td>South East Coast</td><td>National Hosp For Neurology/neur.</td><td>0:30:28</td></tr><tr><td>South Western</td><td>Yeovil District Hospital</td><td>0:30:21</td></tr><tr><td>South East Coast</td><td>St Thomas' Hospital (camhs Ment.</td><td>0:29:41</td></tr><tr><td>South Central</td><td>Royal Bournemouth Hospital</td><td>0:28:51</td></tr><tr><td>South East Coast</td><td>St Thomas' Hospital</td><td>0:28:11</td></tr><tr><td>South Western</td><td>Royal Bournemouth Hospital</td><td>0:27:07</td></tr><tr><td>South Western</td><td>Bristol Royal Infirmary</td><td>0:26:18</td></tr></table>	Ambulance Trust	Site Name	Time	South East Coast	Chelsea & Westminster Hospital	1:13:10	South Western	Royal United Hospital	1:03:01	South Western	Deriford Hospital	1:02:32	South Western	Royal Cornwall Hospital (triliske)	0:51:09	South East Coast	A & Conquest	0:50:28	South Western	The Great Western Hospital	0:47:50	South Western	Torbay Hospital	0:41:00	South East Coast	Queens Hospital	0:32:50	South Western	Royal Devon & Exeter Hospital (w.	0:31:56	South East Coast	University College Hospital	0:30:44	South East Coast	National Hosp For Neurology/neur.	0:30:28	South Western	Yeovil District Hospital	0:30:21	South East Coast	St Thomas' Hospital (camhs Ment.	0:29:41	South Central	Royal Bournemouth Hospital	0:28:51	South East Coast	St Thomas' Hospital	0:28:11	South Western	Royal Bournemouth Hospital	0:27:07	South Western	Bristol Royal Infirmary	0:26:18	Ambulance handovers remain a key focus for the Trust. August saw the third busiest attendances of ambulances conveyed to the Type 1 ED, alongside the second highest attendances overall to the ED since June 2022. The team have managed to continue the improvement journey, whilst managing the THP@45 expectations from 08:00-20:00 Mon-Fri and 08:00-14:00 Sat-Sun. The percentage of ambulance handovers over 3 hrs has increased in August to 1.96% from 1.11% in July (6.7% August 2024), which is directly linked with the reduction in discharge performance across the organisation. . Average ambulance handover time Thursday 1 August 2024 - Sunday 31 August 2025 - Monthly data Month starting 01 Aug - Average Handover Time - 0:37:34  <table><tr><th>Date</th><th>Average Handover Time</th></tr><tr><td>Thu 1/8</td><td>0h 56m 18s</td></tr><tr><td>Sun 1/9</td><td>1h 46m 14s</td></tr><tr><td>Tue 1/10</td><td>2h 19m 23s</td></tr><tr><td>Fri 1/11</td><td>1h 49m 24s</td></tr><tr><td>Sun 1/12</td><td>1h 35m 50s</td></tr><tr><td>Wed 1/1</td><td>1h 23m 53s</td></tr><tr><td>Sat 1/2</td><td>1h 2m 37s</td></tr><tr><td>Sat 1/3</td><td>0h 47m 7s</td></tr><tr><td>Tue 1/4</td><td>0h 36m 22s</td></tr><tr><td>Thu 1/5</td><td>0h 52m 36s</td></tr><tr><td>Sun 1/6</td><td>0h 45m 30s</td></tr><tr><td>Tue 1/7</td><td>0h 31m 53s</td></tr><tr><td>Fri 1/8</td><td>0h 37m 34s</td></tr></table>	Date	Average Handover Time	Thu 1/8	0h 56m 18s	Sun 1/9	1h 46m 14s	Tue 1/10	2h 19m 23s	Fri 1/11	1h 49m 24s	Sun 1/12	1h 35m 50s	Wed 1/1	1h 23m 53s	Sat 1/2	1h 2m 37s	Sat 1/3	0h 47m 7s	Tue 1/4	0h 36m 22s	Thu 1/5	0h 52m 36s	Sun 1/6	0h 45m 30s	Tue 1/7	0h 31m 53s	Fri 1/8	0h 37m 34s
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Actions to complete next month • Post ECIST and Improvement and Innovation support, the main workstreams have now been developed into operationally led programmes of work: ○ ED Demand and Capacity Recovery and Improvement. ○ Internal urgent Care Streaming ○ Ward Flow & Improvement ○ Timely Handover process (THP) @45 • Close monitoring via weekly F2F meetings with action-based focus are in place re all above programmes of work. • Winter Planning is underway, which also supports operational escalation throughout the year.	Risks/issues • Financial balance of locums v substantive staffing, and short notice escalation cover. • Insufficient bed capacity during escalation with the SDEC environment being used for overnight support and bedding. • Fragility in the Consultant Acute Internal Medicine (AIM) workforce, a recruitment plan is in place to give as positive outcome as possible from the strategy. • Sustained increase in demand above historical trend.																																																																																		

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

Performance

	Aug 2024	Aug 2025
MIU/UTC attendances	3,820	3,765
MIU/UTC performance	99.6%	99.5%
ED (type 1) attendances	6,829	7,390
ED (type 1) performance	54.8%	61.1%
ICO attendances	10,649	11,155
ICO performance	70.4%	74.1%



Opel score

August 2025							August 2024						
Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
				1 L2	2 L3	3 L3				1 L3	2 L3	3 L3	4 L3
4 L3	5 L3	6 L3	7 L3	8 L3	9 L3	10 L3	5 L3	6 L3	7 L2	8 L2	9 L1	10 L2	11 L2
11 L3	12 L3	13 L3	14 L3	15 L3	16 L3	17 L3	12 L3	13 L3	14 L3	15 L3	16 L3	17 L2	18 L2
18 L3	19 L3	20 L4	21 L3	22 L4	23 L2	24 L3	19 L3	20 L4	21 L3	22 L2	23 L2	24 L1	25 L2
25 L3	26 L3	27 L3	28 L3	29 L3	30 L3	31 L4	26 L1	27 L1	28 L3	29 L3	30 L2	31 L2	

Operational update

4hr Performance for the month stands at 74.1%, which is 1.9% below trajectory. This performance represents the best performance since May 2022 against a backdrop of the second highest attendances overall to the ED.

In Aug 2025, the Trust recorded its 2nd highest number of attendances in the past five years. The ICO had 11,155 attendances and marked the third month this year with over 11,000 attendances. The Emergency Department recorded 7,390 attendances, second biggest attendance level since the previous peak set in July 2025.

Actions to complete next month

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

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

This is supported and monitored via the 4 key programmes of work that have led on from the Right Care Week and ECIST support.

- Post ECIST and I&I support, the main workstreams have now been developed into CGD led programmes of work:
 - ED Recovery and Improvement.
 - Internal Streaming
 - Ward Flow & Improvement
 - Timely Handover Process (THP) - 45mins
- Close monitoring via weekly F2F meetings with action-based focus are in place re all above programmes of work.
- Winter Planning is underway, which also supports operational escalation throughout the year.

Risks/issues

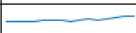
- Financial position of the Care Group and organisation and the impact on temporary versus substantive staffing, plus escalation.
- Any further increase or duration in the use of escalation bed spaces further hampers UEC Flow.
- Any Infection, prevention, and control escalations cause a negative impact.
- The delay in the new ED Wraparound build of up to 16 weeks will have a continued impact on flow and staff/patient experience.
- Sustained increase in demand above historical trend.

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

Performance	Operational update																																																																																																																																																
Performance Analysis: August vs September 2025 Acute wards saw a decline in both pre-noon and pre-5PM discharges. Community wards showed an improvements pre-noon. ICO performance overall remains stable and close to targets. Pre Noon and Pre 5PM Discharges - Adult only <table><caption>Estimated data for Pre Noon and Pre 5PM Discharges - Adult only</caption><tr><th>Month</th><th>Acute Pre Noon</th><th>Community Pre Noon</th><th>ICO Pre Noon</th><th>Pre Noon Target</th><th>Acute Pre 5PM</th><th>Community Pre 5PM</th><th>Pre 5PM Target</th></tr><tr><td>April 2024</td><td>75%</td><td>50%</td><td>25%</td><td>75%</td><td>95%</td><td>70%</td><td>33%</td></tr><tr><td>May 2024</td><td>74%</td><td>55%</td><td>26%</td><td>75%</td><td>94%</td><td>71%</td><td>33%</td></tr><tr><td>June 2024</td><td>73%</td><td>52%</td><td>25%</td><td>75%</td><td>93%</td><td>70%</td><td>33%</td></tr><tr><td>July 2024</td><td>72%</td><td>58%</td><td>24%</td><td>75%</td><td>92%</td><td>71%</td><td>33%</td></tr><tr><td>August 2024</td><td>71%</td><td>55%</td><td>23%</td><td>75%</td><td>91%</td><td>70%</td><td>33%</td></tr><tr><td>September 2024</td><td>70%</td><td>54%</td><td>22%</td><td>75%</td><td>90%</td><td>71%</td><td>33%</td></tr><tr><td>October 2024</td><td>71%</td><td>56%</td><td>23%</td><td>75%</td><td>91%</td><td>72%</td><td>33%</td></tr><tr><td>November 2024</td><td>72%</td><td>55%</td><td>24%</td><td>75%</td><td>92%</td><td>73%</td><td>33%</td></tr><tr><td>December 2024</td><td>73%</td><td>54%</td><td>25%</td><td>75%</td><td>93%</td><td>74%</td><td>33%</td></tr><tr><td>January 2025</td><td>74%</td><td>55%</td><td>26%</td><td>75%</td><td>94%</td><td>75%</td><td>33%</td></tr><tr><td>February 2025</td><td>75%</td><td>56%</td><td>27%</td><td>75%</td><td>95%</td><td>76%</td><td>33%</td></tr><tr><td>March 2025</td><td>76%</td><td>57%</td><td>28%</td><td>75%</td><td>96%</td><td>77%</td><td>33%</td></tr><tr><td>April 2025</td><td>77%</td><td>58%</td><td>29%</td><td>75%</td><td>97%</td><td>78%</td><td>33%</td></tr><tr><td>May 2025</td><td>78%</td><td>59%</td><td>30%</td><td>75%</td><td>98%</td><td>79%</td><td>33%</td></tr><tr><td>June 2025</td><td>79%</td><td>60%</td><td>31%</td><td>75%</td><td>99%</td><td>80%</td><td>33%</td></tr><tr><td>July 2025</td><td>80%</td><td>61%</td><td>32%</td><td>75%</td><td>100%</td><td>81%</td><td>33%</td></tr><tr><td>August 2025</td><td>70%</td><td>55%</td><td>28%</td><td>75%</td><td>92%</td><td>75%</td><td>33%</td></tr></table>	Month	Acute Pre Noon	Community Pre Noon	ICO Pre Noon	Pre Noon Target	Acute Pre 5PM	Community Pre 5PM	Pre 5PM Target	April 2024	75%	50%	25%	75%	95%	70%	33%	May 2024	74%	55%	26%	75%	94%	71%	33%	June 2024	73%	52%	25%	75%	93%	70%	33%	July 2024	72%	58%	24%	75%	92%	71%	33%	August 2024	71%	55%	23%	75%	91%	70%	33%	September 2024	70%	54%	22%	75%	90%	71%	33%	October 2024	71%	56%	23%	75%	91%	72%	33%	November 2024	72%	55%	24%	75%	92%	73%	33%	December 2024	73%	54%	25%	75%	93%	74%	33%	January 2025	74%	55%	26%	75%	94%	75%	33%	February 2025	75%	56%	27%	75%	95%	76%	33%	March 2025	76%	57%	28%	75%	96%	77%	33%	April 2025	77%	58%	29%	75%	97%	78%	33%	May 2025	78%	59%	30%	75%	98%	79%	33%	June 2025	79%	60%	31%	75%	99%	80%	33%	July 2025	80%	61%	32%	75%	100%	81%	33%	August 2025	70%	55%	28%	75%	92%	75%	33%	We continue to avoid routine use of the Discharge Lounge for overnight escalation and our trial of closing the lounge as weekends is ongoing. Daily allocation of a resident doctor in the Discharge Lounge supports earlier patient flow. We continue to see a reduction in Length Of Stay (LOS) delays in the Emergency Department (ED) and shorten 48-hour waits within the assessment units. Extended stays in ED over 24 hours have also dropped by almost 50% in month and reduced from 78 in May to 15 in August, but zero tolerance is still required due to potential harm. August recorded zero breaches over 48 hours. Despite these positive developments, challenges remain with bed pressures and demand for elective vs emergency care. Our Length of Stay (LOS) review programme continues twice weekly. These reviews are focused on setting clear, proactive discharge plans to support safe, timely, and well-coordinated patient discharges. Outcomes of these meetings are shared with governance meeting.
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Actions to complete next month • Monitor impact of trial closure of Discharge Lounge at weekends in prep to update EQIA and decision post 8-week trial.	Risks/issues • Medical senior oversight and governance of Resident Locum Doctor in the discharge lounge – this risk remains unresolved. • We continue to not meet the 33% pre-noon target for acute wards.																																																																																																																																																

7

National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

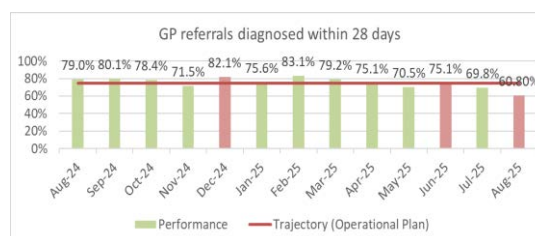
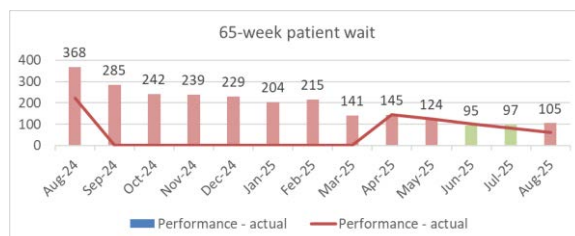
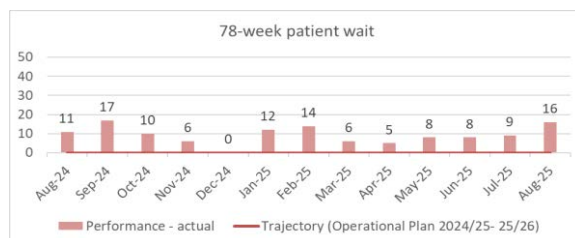
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Operational Plan trajectory Aug 2025
Oversight Framework																
Elective recovery																
RTT 78 week wait incomplete pathway	0		11	17	10	6	0	12	14	7	4	8	8	9	16	0
RTT 65 week wait incomplete pathway	0		368	285	242	239	229	204	215	141	145	126	95	97	105	63
RTT 52 week wait incomplete pathway	268		1761	1651	1451	1276	1265	1238	1209	931	914	805	740	615	618	728
RTT % Incomplete pathways <18 wks	66.8%		60.0%	61.3%	62.2%	61.6%	61.6%	61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	63.8%
RTT Wait for first appointment <18 weeks	70.3%		62.5%	62.9%	65.6%	65.3%	64.6%	63.8%	69.3%	70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	67.2%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		79.0%	80.1%	78.4%	71.5%	82.1%	75.6%	83.1%	79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	75.0%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		74.3%	73.1%	77.3%	81.3%	77.3%	74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	75.2%
Cancer: No of patients waiting >62 days to start treatment	138		90	85	78	77	110	95	94	111	133	185	223	181	228	138
Cancer: % of patients > 62 days to start treatment	tbv		5.5%	5.1%	4.4%	5.0%	7.0%	6.0%	5.7%	6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	tbv

Trajectories have been agreed as part of the 2025/26 Operational Plan submission. The latest month trajectory is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories; 3 of the 7 trajectories in Month 5 have been met.

RAG indicator

Meeting monthly trajectory

Not meeting monthly trajectory



Actions on-going this month

- Detailed 78-week focus on clearing all remaining patients. Recruitment of T&O consultants.
- Increasing capacity in Dermatology for Faster Diagnosis Standard (FDS). Review change of basal cell carcinoma inclusion in FDS aligned to UHP.
- Focus on all undated new outpatients greater than 52-weeks wait.
- Business planning investments will seek to exit insourcing to transition to core capacity. Recruitment tracker monitored through Elective Delivery Board.
- Continue RTT pathway validation sprint.

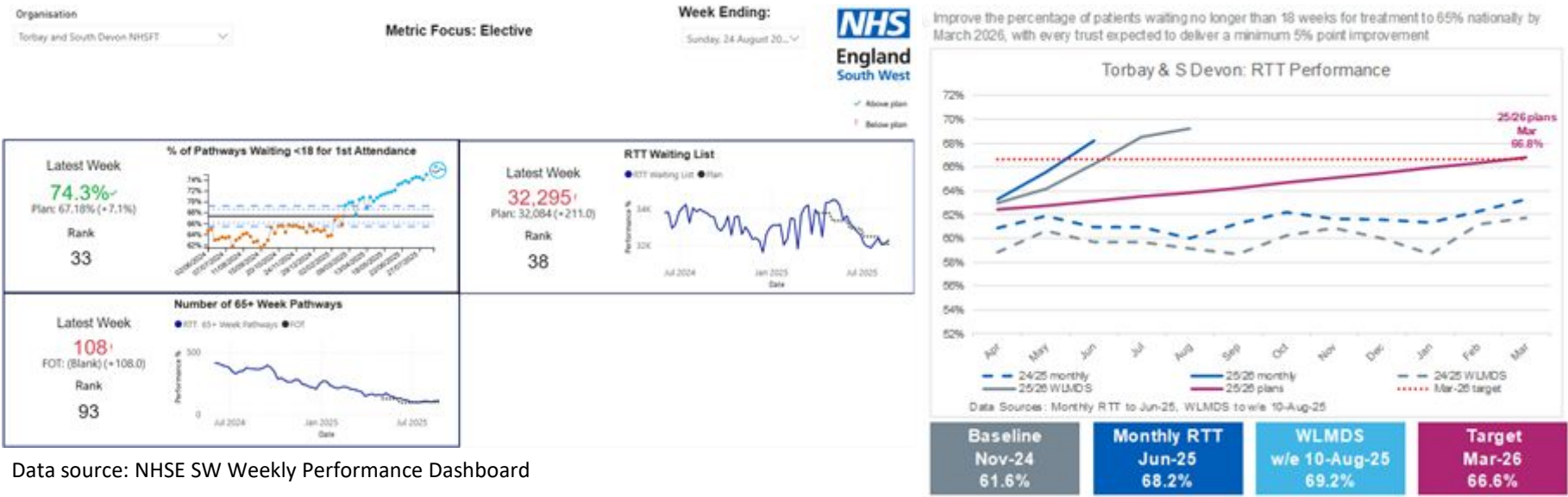
Risks and Barriers

- Workforce – enough surgeons and anaesthetists to meet demand. Admin (secretary / booking) to cope with additional demand.
- Balance of recovery of cancer/urgent/long waits continues to pose pressure on long-waiters. Growth in Dermatology referrals (14% growth year-to-date).
- Trauma and Anaesthetics capacity – impact on T&O lists.

Elective Care Performance Summary - NHS England monitoring report

The reports below have been taken from the national NHSE Southwest weekly performance dashboard which monitors performance against key elective care metrics.

- Excellent progress on delivering RTT against operational plan year-to-date.
- Main area of concern is recovery of 78-week and 65-week long waits. Outside of T&O all other specialties are forecasting to deliver against trajectory.
- T&O recovery plan predominantly includes successful recruitment of consultants as per the business plan. This includes anaesthetic consultants.

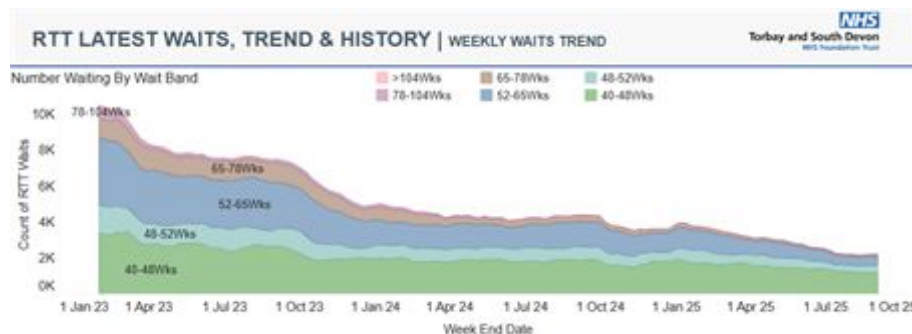


Exception report: 78-Week and 65-Week Clearance: NOF 4 Exit Criteria – Elective Recovery

Performance

Good progress has been made over the last 12 months to reduce the number of RTT long wait patients.

	August 2024	August 2025
78 weeks	11	16
65 weeks	374	105
52 weeks	1753	618



Operational update

78 week: At the end of August (provisional figures) are 14 orthopaedic patients and 1 UGI patients who have been waiting over 78-weeks against the target of zero. The primary issues are specialty capacity for complex cases and patient choice.

65 week: In August (provisional figures) are 98 breaches ENT (112), Gynae (7), Ophthalmology (2), Oral and Maxillo Facial (1), Orthodontics (1), T&O (70), UGI (2), Pain Management (2), Urology (1).

Operational plans for 2025/26 are under review with significant focus on productivity building on the two key workstreams on elective improvement and outpatient improvement and will incorporate optimising advice and guidance, patient-initiated follow-up and reducing DNA's and maximising clinic templates. The team are driving up core capacity within stretched specialties. Less reliance on insourcing. Review of what can move off the acute site for outpatients to release clinic capacity.

Actions to complete next month

- Continued insourcing in key areas.
- To recruit locum to manage the transition to approved substantive posts in T&O.
- Theatre recovery programme.
- Start recruiting agreed posts to exit insourcing reliance as part of business planning.
- Implement outpatient improvement programme with detailed plan milestones agreed by service area.

Risks/issues

- Trauma and cancer impacting long-wait elective capacity.
- Admin pressures impacting additional insourcing.
- Lost operational capacity due to estate failure e.g. theatre breakdown.
- Risk of delays to recruitment against agreed posts to deliver additional capacity and transition away from insourcing.
- 65w recovery at risk in T&O due to delayed sign-off of new consultant posts leading to a dip in capacity due to retire and return posts.

Exception report: Stages of treatment – Elective Recovery



FILTER

Module
(All)

Local Treat. Functn
(All)

Clinic or List
(All)

WLMDS Pathway
Yes

NAVIGATE

Cover Page

New OP & Pending

All New Waits

Follow Up Pending

IFOC

OP Trends

OP Totals

STAGE OF TREATMENT WAITING LISTS | NEW OP & PENDING

Torbay and South Devon
NHS Foundation Trust

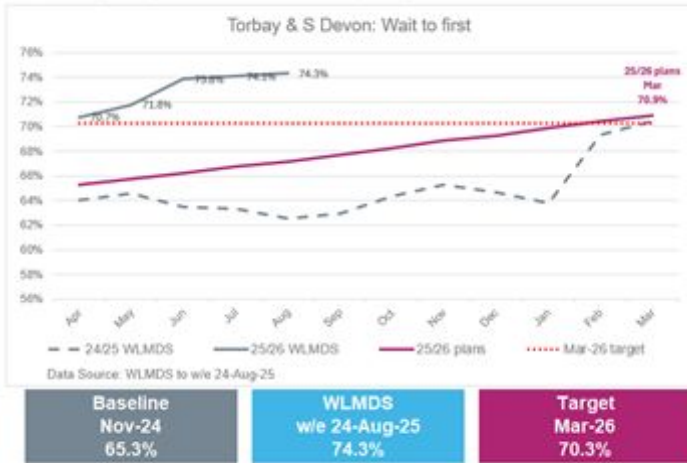
New Outpatient & Pending List as at 31/08/2025 (based on current wait)

Treatment Function	F	00-18 weeks	>18-26 weeks	>26-52 weeks	>52-85 weeks	>85-78 weeks	Grand Total
120 - ENT		1,271	373	474	4		2,122
130 - OPHTHALMOLOGY		1,420	319	224	6	2	1,971
140 - ORAL SURGERY		776	289	573	1		1,639
330 - DERMATOLOGY		1,321	160	43			1,524
110 - TRAUMA & ORTHOPAEDICS		734	159	217	7		1,117
101 - UROLOGY		790	105	42			937
400 - NEUROLOGY		540	132	207	2		881
502 - GYNAECOLOGY		594	69	23			686
104 - COLORECTAL SURGERY		455	62	41			558
320 - CARDIOLOGY		483	38	3	1		525
410 - RHEUMATOLOGY		410	38	42			490
340 - RESPIRATORY MEDICINE		426	37	6			469
420 - PAEDIATRICS		328	79	33			440
302 - ENDOCRINOLOGY		257	32	104	18		411
301 - GASTROENTEROLOGY		318	12	9			339
191 - PAIN MANAGEMENT		186	39	93	1		319
655 - ORTHOPTICS		258	37	8			303
106 - UPPER GASTROINTESTINAL SURGERY		257	6	11			274
430 - GERIATRIC MEDICINE		142	42	72			256
103 - BREAST SURGERY		174					174
143 - ORTHODONTICS		46	19	54	6		125
107 - VASCULAR SURGERY		106					106
401 - CLINICAL NEUROPHYSIOLOGY		83	1				84
650 - PHYSIOTHERAPY		72		3			75

The Stage of Treatment table indicates the specialties with the longest wait for routine outpatient appointment. There is a significant number of patients waiting over 26 weeks for first outpatient attendance. Access policy standards for chronological booking based on clinical urgency criteria are being maintained, however, in several specialties waits for routine appointments remain too long and risk giving poor patient experience. The operational plan for the coming year is to target these long waits and move towards having no patient waiting longer than 26 weeks by March 2026. This will support delivery of the national Referral To Treatment (RTT) target to reduce overall waiting times and achieve the target set for TSDFT being 66.6% of patients waiting under 18 weeks from referral to treatment. The end of August position is 68.8% against an August trajectory of 63.8%.

Over the coming months all teams will have plans tested to confirm that outpatient productivity increases will drive these reductions however in some areas additional capacity may be require support through Elective Recovery funding. The Outpatient Improvement Group will maintain productivity oversight and drive forward these improvements.

Improve the percentage of patients waiting no longer than 18 weeks for first activity to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement



Torbay & S Devon: Wait to first by specialty

Specialty	0-18 weeks	First activity	Wait to first	Baseline	Target	% point change
Oral Surgery	778	1,630	47.7%	-17.5%	-22.5%	
Elderly Medicine	166	283	58.7%	-6.6%	-11.6%	
Neurology	548	909	60.3%	-5.0%	-10.0%	
ENT	1,324	2,185	60.6%	-4.7%	-9.7%	
Other - Other Services	37	56	66.1%	0.8%	-4.2%	
Trauma & Orthopaedics	807	1,191	67.8%	2.5%	-2.5%	
Other - Medical Services	1,084	1,533	70.7%	5.4%	0.4%	
Ophthalmology	2,003	2,604	76.9%	11.6%	6.6%	
General Medicine	18	23	78.3%	13.0%	8.0%	
Other - Surgical Services	1,033	1,284	80.5%	15.2%	10.2%	
Gastroenterology	813	966	84.2%	18.9%	13.9%	
Gynaecology	700	826	84.7%	19.5%	14.5%	
Urology	913	1,073	85.1%	19.8%	14.8%	
Cardiology	1,318	1,546	85.3%	20.0%	15.0%	
Rheumatology	556	650	85.5%	20.3%	15.3%	
Plastic Surgery	24	28	85.7%	20.4%	15.4%	
Dermatology	1,568	1,792	87.5%	22.2%	17.2%	
Thoracic Medicine	634	706	89.8%	24.5%	19.5%	
Cardiothoracic Surgery	1	1	100.0%	34.7%	29.7%	
Other	22	22	100.0%	34.7%	29.7%	
	-	-	-	-	-	
	-	-	-	-	-	
	-	-	-	-	-	
	-	-	-	-	-	
	-	-	-	-	-	
Total pathways	14,347	19,308	74.3%	9.0%	4.0%	

Data Source: WLMDS for w/e 24-Aug-25

Baseline is the WLMDS for 01-Dec-24

Below baseline Above target

The Trust has demonstrated that it is achieving good stages of treatment management by already achieving the end of year target for waits to New (First) outpatient appointment - set by NHS England by the end of Quarter 1.

Exception report: Cancer Waiting Time Standards

Performance					Actions to complete next month
	May 2025	Jun 2025	Jul 2025	Aug 2025	Dermatology - Additional insourcing from an external provider and conversion of routine activity to support the Urgent Suspected Cancer (USC) remain the core actions. - Performance for September is forecasting to improve to 72%. - Implementation of a Basal Cell Carcinoma pathway in Q4 2025 to reduce USC demand by 10-15%. Colorectal - Theatre capacity issues, with a shortage of anaesthetists have been a regular occurrence in August. New starters in anaesthetics in September should mitigate this issue. Urology - Waits for MRI and prostate biopsy are primary factor. - Increased number of MRI scans are being completed at the Community Diagnostic Centre, which will improve the waiting time position. - New (2nd) Trans-Perineal (TP) nurse becoming independent in September will see a reduction in waits.. Breast - Waiting times for first appointments have reduced to 15 days, improved from 19 days.
28-day FDS	70.5%	75.8%	70.1%	62.2%	
31-day treatment	93.5%	94.0%	93.0%	88.9%	
62-day cancer RTT	71.0%	64.5%	58.3%	68.1%	
62-day backlog	225 (8.9%)	223 (7.9%)	220 (7.8%)	257 (9.2%)	
28-day Faster Diagnosis Standard (FDS) Performance For August, the Trust's position is 62%. Continued long waiting times for Dermatology appointments are having the greatest impact on the overall position, with 58%. 31-day treatment standard (96% target) Majority of the breaches are in radiotherapy, excluding this treatment modality, performance is 94%. 62-Day Performance (70% target increasing to 75% by March '26) Poorest performance seen in Urology (23%) and Colorectal (31%)					
Risks/issues					
- Seasonal demand has led to waits of greater than 28 days from Urgent Suspected Cancer (USC) referral to first outpatient attendance within skin. - Radiotherapy staffing remains a key constraint on the 31-day performance. On-going agency usage and staff overtime are essential to continue current level performance whilst posts are being recruited.					

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Quality and Safety Indicators – dashboard of key metrics

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)		
Pressure Ulcers –new and deteriorated		
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) – 4 months in arrears		↓
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	Month 4	↑
Stroke patients spending 90% of time on a stroke ward (>80%) - one month in arrears	Month 4	↑
Mixed sex accommodation breaches (0)		↑
Follow-ups 6 weeks past to be seen		↓

Quality and Patient Safety Summary

AREAS OF DETERIORATION AND RISK

Patient safety incidents

There were a total of 8 incidents reported as 'death' or 'severe' in August. This is higher than most previous months. One 'death' reflects a relative's concerns. All are being investigated and trends monitored. No never events reported in August.

Stroke care

There has been a marked reduction in % of patients admitted to the stroke unit with 4 hours from 47% to 28%. There is also a reduction in patients scanned within 20 minutes. The stroke team met with the National Clinical Director for Stroke and will draft an improvement plan in the next 2 weeks. This will be presented at SQAG

VTE (Venous Thromboembolism) Assessment

The overall VTE assessment compliance for all applicable patients is reduced to 93.3%, below target. This may be associated with new resident doctors and reflects similar performance in Aug 2024. We anticipate EPIC will support improvement

Follow-ups past 6 weeks to be seen date

There is an increase for the 4th consecutive month of patients awaiting follow up past 6 weeks

Fractured neck of femur

Time to theatre is broadly stable on the data (with a 2-month lag). Trust data is showing a deterioration and a T&O action plan is being developed.

AREAS OF STABLE OR IMPROVING PERFORMANCE

Maternity

In August there were two stillbirths but the rate of still birth within the Trust remains below the national trend. Other maternity metrics were fairly stable.

Safer Staffing

July data is within the NHSE suggested tolerance of 80-120% and the TSDFT tolerance of 90-110% fill rates. RN numbers are at the lower end of this range, as are care staff fill rates on day shifts. Fill rates for care staff at night at the higher end of range but this is reducing.

Complaints

There has been a decrease in complaints in August but further validation is required.

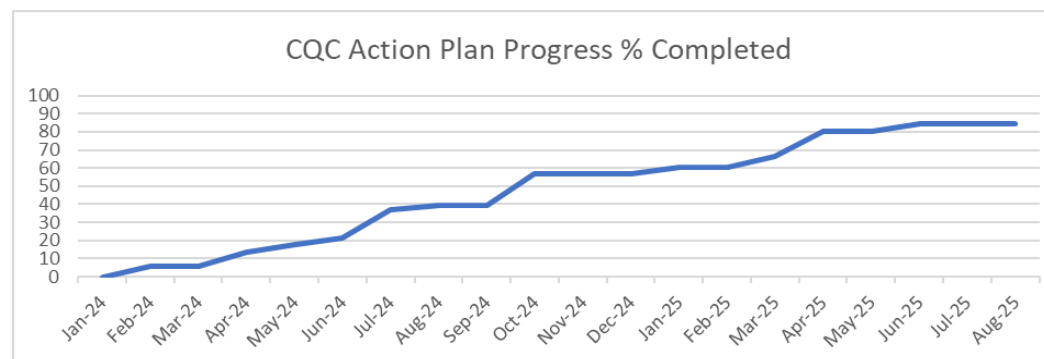
CQC Update

CQC 2023 Well Led Inspection May – Sept 2023

The current position for the Well Led Must Do and Should Do action completion is 84.31% (84.31% reported since June 2025), of which 80% of the Must Do actions have been completed. The outstanding Must Do actions related to the NOF 4 financial position, EDI agenda and outpatient waiting list times. In relation to the EDI agenda, the Trust has signed up to the Royal College of Nursing Cultural Ambassador Programme which does not just impact nursing colleagues but will support culture change. There is also the Culture Plan which is one of the Better Care Plan programmes.

Currently 86.1% of Should Do actions have been completed. The remaining 5 Should Do actions relate to Freedom to Speak Up resource and long term work force planning, and Outpatient Transformation actions.

CQC Compliance Actions Status					12 August 2025	
CQC Core Service	No. of Actions		Completed		Must Do status	
	Must Do	Should Do	Must Do	Should Do	MD Actions	MD Closed
Trustwide	2	7		6	2	0
Urgent and Emergency	2	6	2	6	2	2
Medical Care	3	6	3	6	3	3
OPD	1	10		6	1	0
Diagnostics Imaging	7	7	7	7	7	7
TOTAL	15	36	12	31	15	12
Total MDSD Actions	51				% Closed 80.00%	
Total MDSD Actions Closed	43					
Percentage MDSD Actions Closed	84.31%	12/08/2025				



Paediatric Inspection August 2024

The Paediatric action plan (Louisa Cary) is currently reporting as 84.2% completed. This was previously reported at 66.7% in June 2025. There were 39 sub actions presented to the CQC Assurance Group in March 2025, of which 32 have been completed, one is a duplicate and has been merged, and the remaining 6 are in progress with revised target completion dates. The majority of these actions are due to be completed by the end of December 2025. One is due to be completed by April 2026 as it aligns with the implementation of the Electronic Patient Record EPIC.

Patient Transport Service (PTS) Inspection

The Patient Transport Service draft CQC report has been received and the factual accuracy process completed. The Trust is awaiting the final report and publication date.

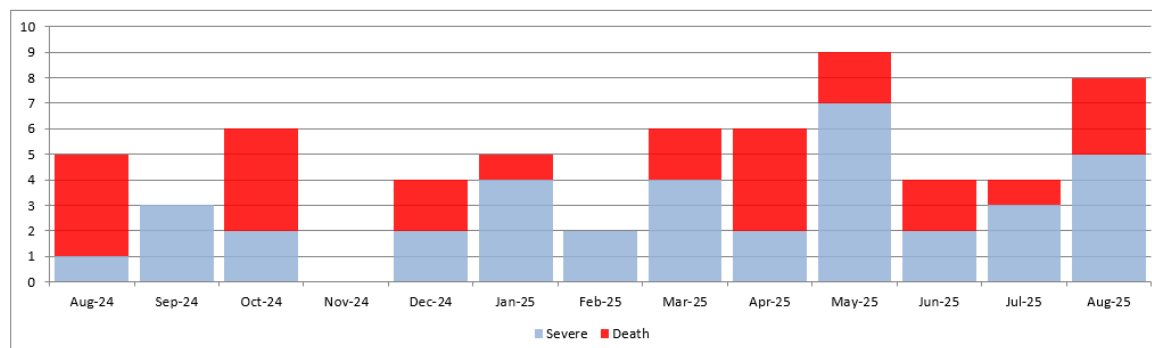
CQC Engagement Meeting

The next onsite CQC engagement meeting is 16th September 2025. It has been requested that Medicine and Urgent and Emergency Care presentations are held this visit. Invitations have been sent to Care Group representatives.

Quality and Safety exception reports – Reported incidents

Reported Incidents - Severe and Death

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Severe	1	3	2	0	2	4	2	4	2	7	2	3	5
Death	4	0	4	0	2	1	0	2	4	2	2	1	3



Incidents reported as severe harm or death

In August 2025 there were 3 incidents of death and 5 of severe harm incidents were reported:

[DEATH] - Intrauterine death at 26/40 weeks.

[DEATH] - Intrauterine death >24 weeks.

[DEATH] - Family concerns about a patient death.

[SEVERE] - Obstetric related issue.

[SEVERE] - Radiology reporting discrepancy.

[SEVERE] - Patient fall with fracture neck of femur.

[SEVERE] - Patient fall with fracture neck of femur.

[SEVERE] - Patient fall with fracture neck of femur.

Patient Safety Incident Response Framework (PSIRF) and remaining serious incidents

There are 9 **patient safety incident investigations (PSIIs)** underway:

6 National Priority

- 3 x Child death – one report in the final stages of factual accuracy
- 1 x Never Event – misplaced NG tube
- 2 x Patient death meeting national criteria
- 1 x reported as referred to MNSI

3 Local Priority

- 2x delays across our urgent and emergency care pathway – one report nearing completion
- 1 x delayed access to elective/planned care

4 PSIIs have been completed in August:

- Delayed diagnostic
- Thematic review of 6 never events
- Thematic review of harm associated with extended time in ED
- Clinical assessment reviewed as a Patient Safety Review (PSR)

Serious Incident Framework (TSDFT transitioned from this on 1st February 2024)

There is one **serious incident** investigations remaining this is in relation to a maternal death and is being reviewed in conjunction with DPT & ICB as recommended by the Ockenden review.

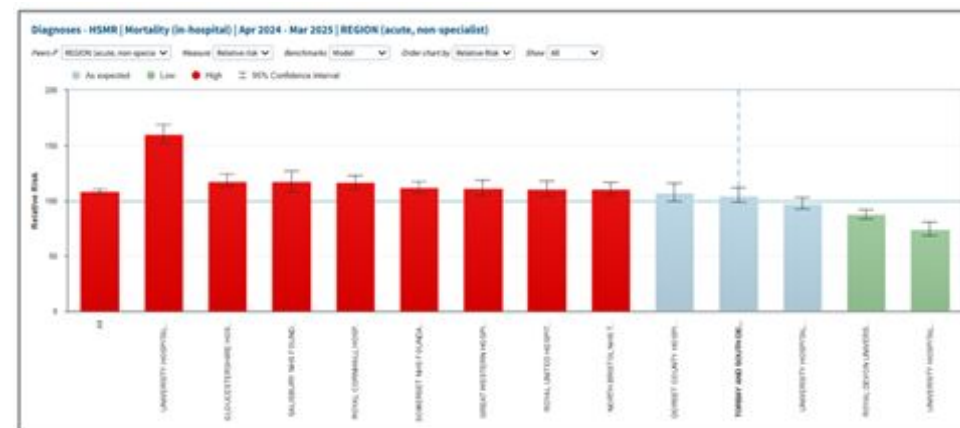
The previous outstanding Trust report was reviewed and signed off on 10 July 2025 and submitted to the ICB therefore there are no outstanding Trust serious incidents.

Quality and Safety exception reports – Hospital Standardised Mortality Ratio HSMR

No update in August 2025.

A Telstra Health report was presented to Mortality Surveillance Group on 10th July 2025. Based on the M13 HES data extract (discharges to Mar 25). All; months shows a low volume of R69 (uncoded) data. The report has, therefore, been produced with data for the full financial year April 24 to Mar 25.

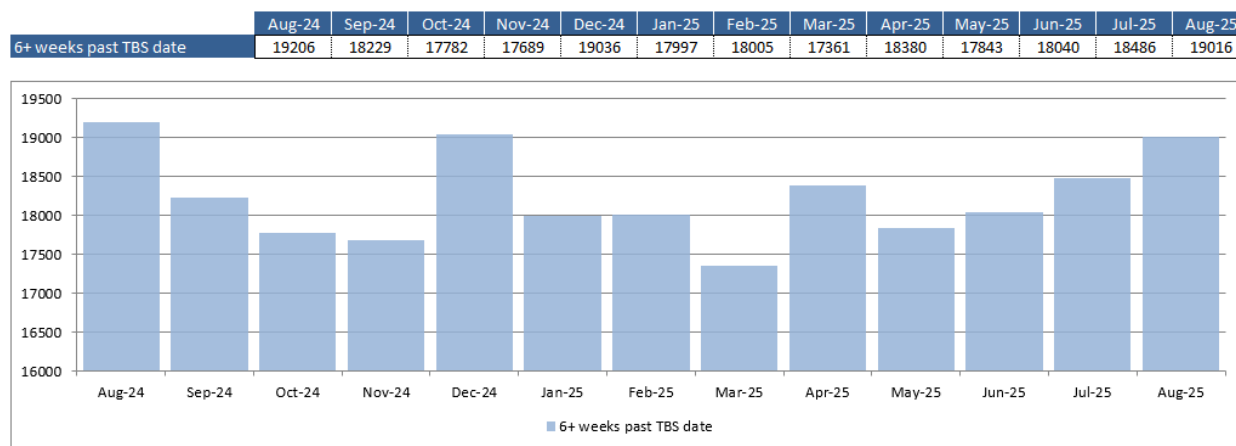
- Regional Peers (Acute non-specialist) - The Trust is 1 of 4 trusts that are within the expected range (out of 14).



- The latest HSMR for April 24 to March 25 is **104.7** (98.3 – 114.4), this is statistically within the expected range.
- The HSMR+ for non-elective admissions for the current 12-month period is **104.4** and within the expected range. The crude mortality rate for the current 12-month period is 5.6% (National = 5.7%, Region = 5.6%). Overall the non-elective rolling 12-month trend for HSMR+ The non-elective rolling 12-month trend for HSMR+ has been declining but sees a level picture in latter periods.
- The HSMR for elective admissions is **113.0** and remains within the expected range. The rolling 12-month trend shows a general upward trajectory over the last six periods, but all are within the expected range.
- Compared to the dashboard in the previous report there are five new CUSUM alerts, these trends will be monitored by the mortality steering group (MSG).
 - Cancer of breast
 - Congestive heart failure
 - Diseases of white blood cells
 - Genitourinary symptoms
 - Respiratory failure
- SHMI-The new published SHMI value for Feb 24 to Jan 25 is 0.96 (rounded) and statistically 'as expected' (^).
- There are no monitored SHMI groups that are statistically higher than expected.

Quality and Safety exception reports – follow-ups past to be seen by date/fractured neck of femur

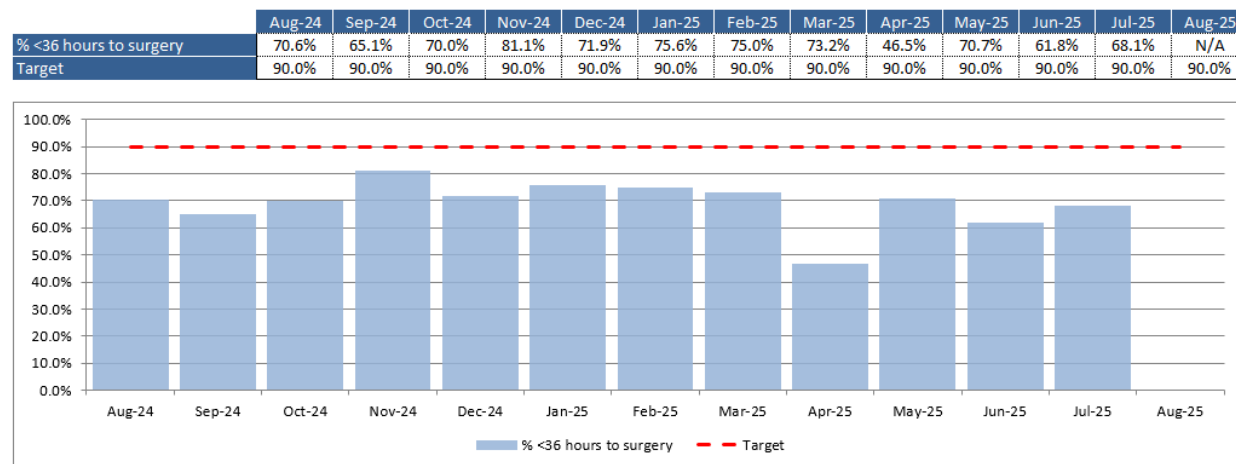
Follow ups 6 weeks past to be seen by date



Follow-ups past 6 weeks to be seen date

A review of the longest overdue patient waits is being carried out in line with best practice to see if these patients require further review, can be discharged, returned to their GP, or self-care utilising Patient-Initiated Follow Up (PIFU).

Fractured neck of femur - <36 hours to surgery



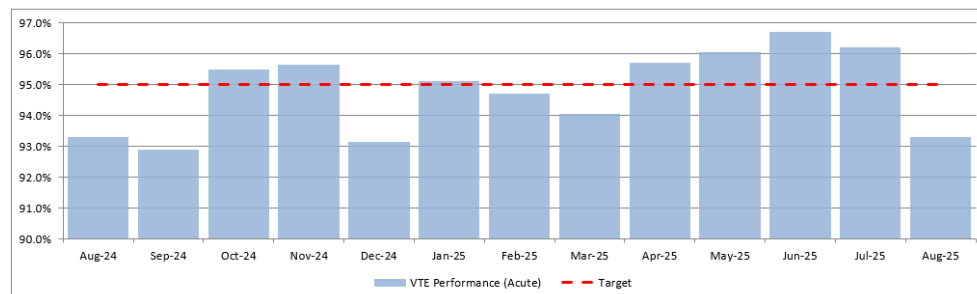
Fractured Neck of Femur (one month in arrears – Month 4 data not yet available on National Hip Fracture Database).

August saw 59 admitted femoral fractures with a drop in average time to theatre to 42 hours. 8 of these fractures were periprosthetic fractures. 13 of these patient waited in excess of 60 hours for surgery despite the cancellation of 16 elective procedures due to increase in trauma demand

Quality and Safety exception report – VTE/ Mixed Sex Accommodation

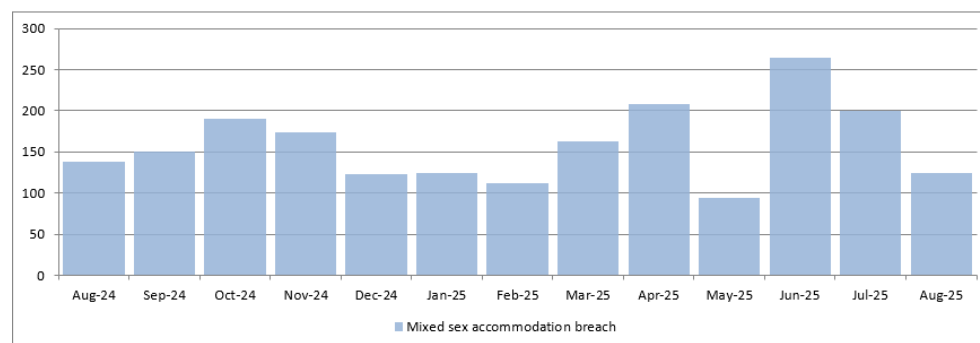
Acute VTE risk assessment on admission

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
VTE Numerator	5861	5981	6358	6365	5767	6453	5792	5752	6406	6613	6427	6910	6139
VTE Denominator	6282	6438	6659	6655	6192	6785	6116	6116	6692	6885	6646	7183	6580
VTE Performance (Acute)	93.3%	92.9%	95.5%	95.6%	93.1%	95.1%	94.7%	94.0%	95.7%	96.0%	96.7%	96.2%	93.3%
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%



Mixed sex accommodation breach

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Breaches - actual	138	150	190	174	123	125	112	163	208	94	265	200	124
Target	0	0	0	0	0	0	0	0	0	0	0	0	0



VTE assessment

The overall VTE assessment compliance for all applicable patients is 93.3 % in August, this is a drop on the last four months and the first time in the last five months the figure has dipped below the 95% target. That said it is exactly the same percentage for the same month last year and may reflect the fact August sees the start of a new cohort of resident doctors. The Deputy Medical Director of Planned Care and the Head of Compliance and Assurance are seeking to develop VTE reporting structures. It is also expected that implementation of the EPR is likely to significantly support the process and application of VTE assessment in the Trust.

Mixed Sex Accommodation

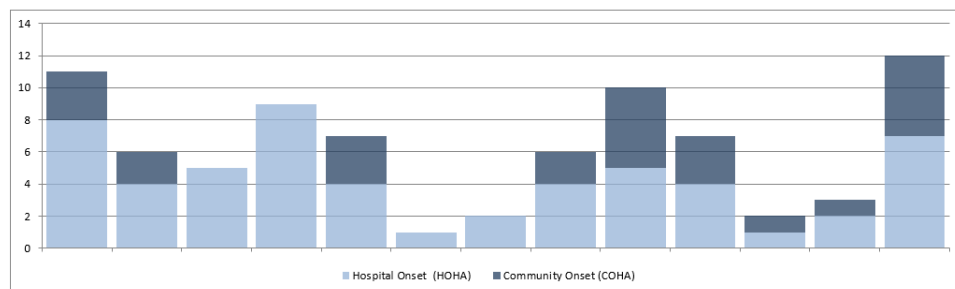
All reported breaches related to mixed-sex accommodation when patients remain on the Surgical Receiving Unit (SRU) without transfer to an inpatient ward within four hours of a decision to admit, or when patients are transferred to the SRU from the Emergency Department following a clear decision to admit but without an onward ward bed arrangement. These issues are influenced by the Trust's escalation status and the need to balance risk across the Torbay and South Devon systems.

In August we recorded 124 breaches a reduction of 76 from July.

Quality and Safety exception report - Infection control

Number of Clostridium Difficile cases

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Hospital Onset (HOHA)	8	4	5	9	4	1	2	4	5	4	1	2	7
Community Onset (COHA)	3	2	0	0	3	0	0	2	5	3	1	1	5



HOHA – Hospital Onset Hospital Associated

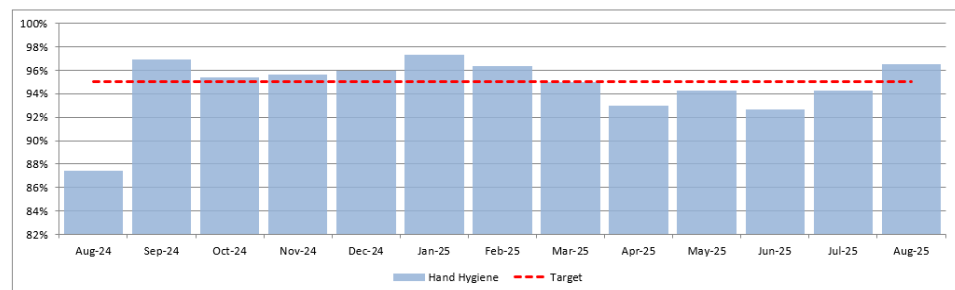
During August there were 7 CDiff HOHA's reported across 6 different in-patient areas relating to patients being within the hospital setting for greater than 48hrs. Two samples have been sent for typing from New Forrest ward to determine origins. The IPC team will review all data with relevant wards to identify any learning opportunities

COHA – Community Onset Hospital Associated

During August there were 5 CDiff COHA's reported across 3 in-patient areas with two samples sent from both Cheetham Hill and Allerton ward to determine typing/origin. The IPC team will review all data with relevant wards to identify any learning opportunities.

Hand Hygiene

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Hand Hygiene	87%	97%	95%	96%	96%	97%	96%	95%	93%	94%	93%	94%	97%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

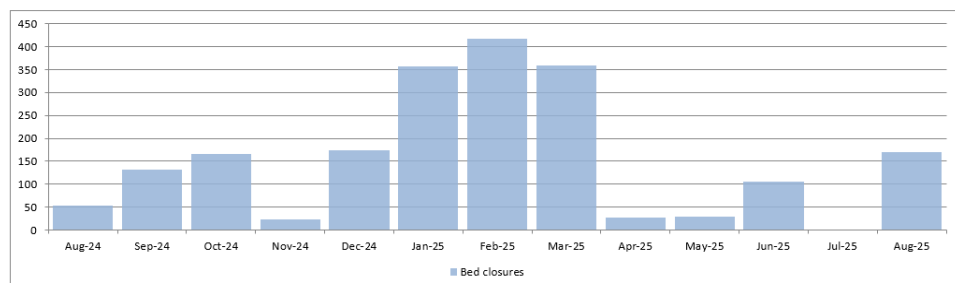


Hand hygiene result for August 25 was 96.2% This is a significant improvement from August 24 which was 87.2%.

In-patient ward audits are now being completed by IPC ward champions to support real time feedback and learning in practice. IPC are reviewing One Devon approach to benchmark against other local trusts who monitor compliance against a 90% target rate.

Infection control - Bed days lost (Acute)

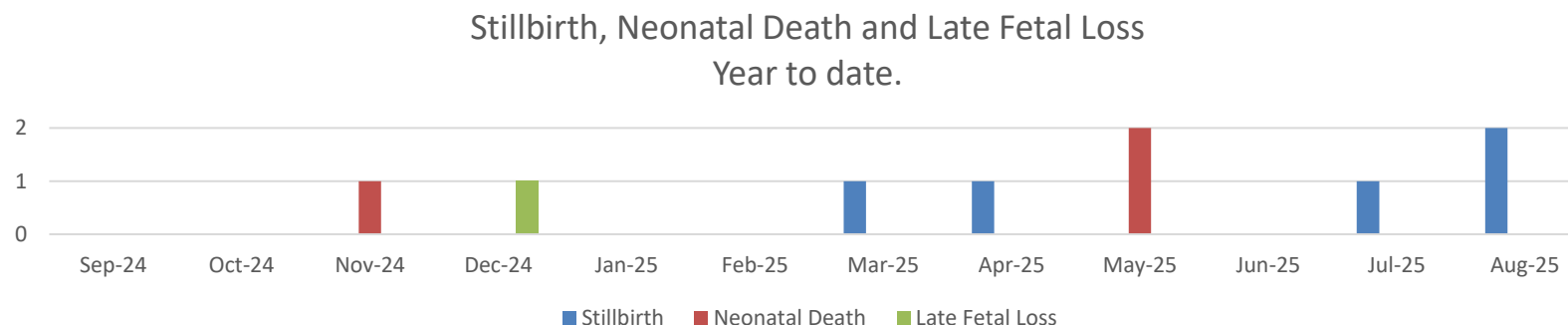
	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Bed closures	53	132	166	24	174	358	418	360	28	29	105	0	170



There were 27 bed days lost in August 25 due to infections. Cheetham Hill was closed due to a Covid outbreak resulting in 14 bed days lost. Side room usage continues to be reviewed daily across all in-patient areas working with the site team, and wards, to ensure appropriate usage. IPC are working closely with SRU to look at the isolation policy to support flow within the trust. This is to be explored further across the trust which will be through a refreshed task and finish group.

Quality and Safety- Perinatal Clinical Quality Surveillance September (August data) 2025 Maternity

Following the publication of the Ockenden Report (Dec 2020), national guidance sets out the requirement to strengthen and optimise Board oversight for maternity and neonatal safety. Review of maternity and neonatal safety and quality is required monthly by the Trust Board.



Mortality:

- **Nov 2024** – 1 x Neonatal Death – baby born at 22+3 showing signs of life.
- **Dec 2024** – 1 x Late Fetal loss at 20 weeks gestation
- **Mar 2025** – 1 Stillbirth at 35+3
- **Apr 2025** – 1 x Stillbirth at 40+5
- **May 2025** – 2 x Neonatal Death – Baby born at 32+5, failed resuscitation. 1 Baby born at term with severe Hypoxic Ischaemic Encephalopathy (HIE), transferred to Level 3 Neonatal Unit for therapeutic cooling, care withdrawn on day 5 of life and baby passed away.
- **July 2025** – 1 x Stillbirth at 36+1 weeks gestation
- **August 2025** – 2 x Stillbirths - 1 x stillborn baby at 39+3 weeks gestation to White British woman. 1 x stillborn baby at 26 weeks gestation to a woman who was White Other.

Incidents moderate and above = 3

2 Deaths – Stillbirth at 39+3 weeks and Stillbirth at 26 weeks

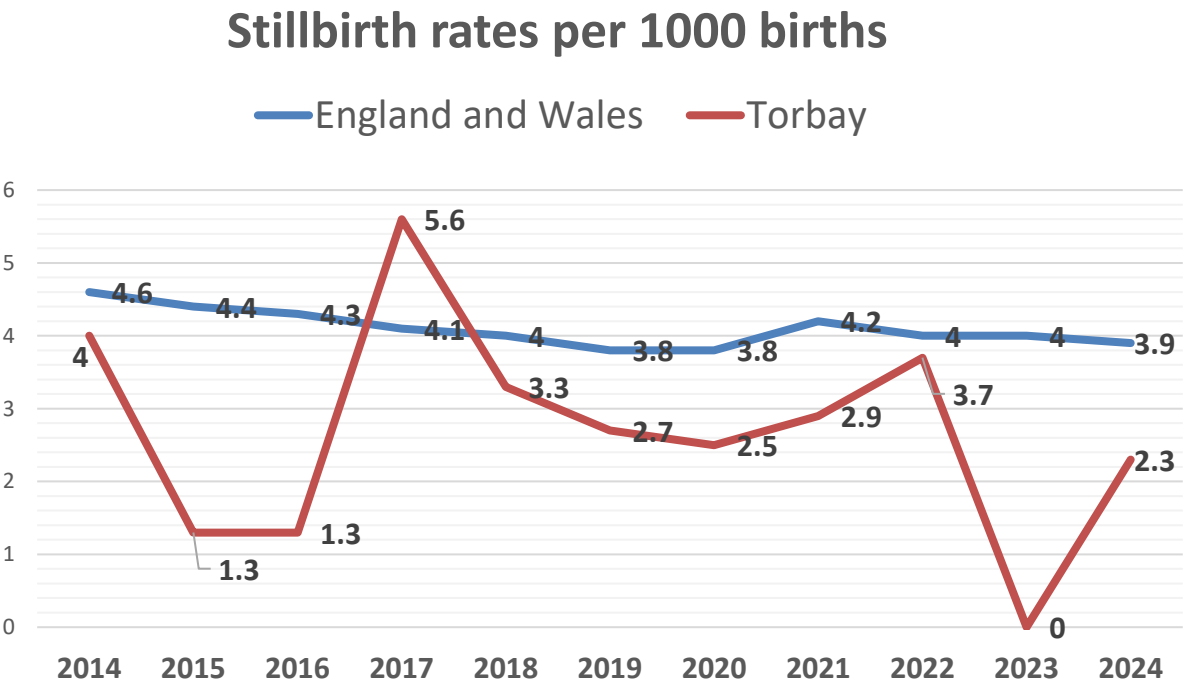
1 Severe – Undiagnosed partial anal sphincter injury sustained during a delivery in Jan 2023, recently referred to pelvic health team.

MNSI – No new referrals

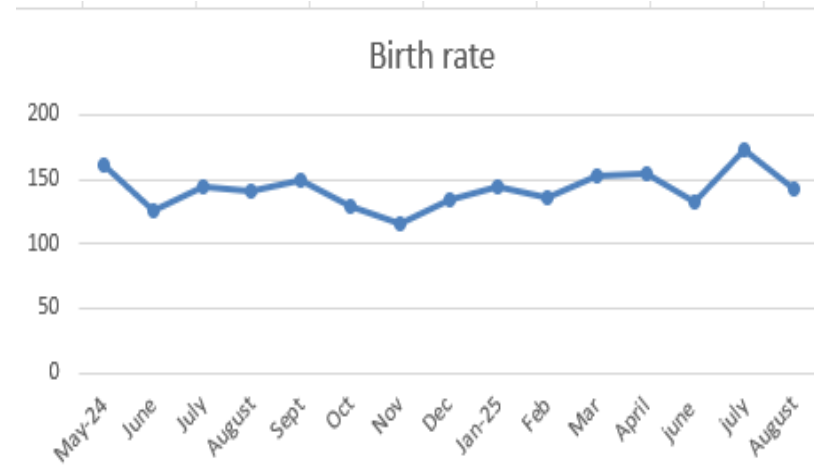
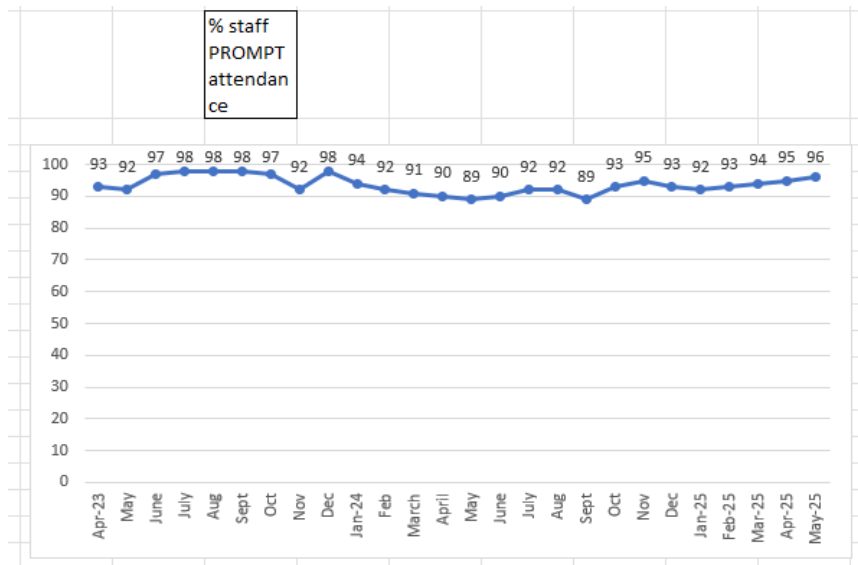
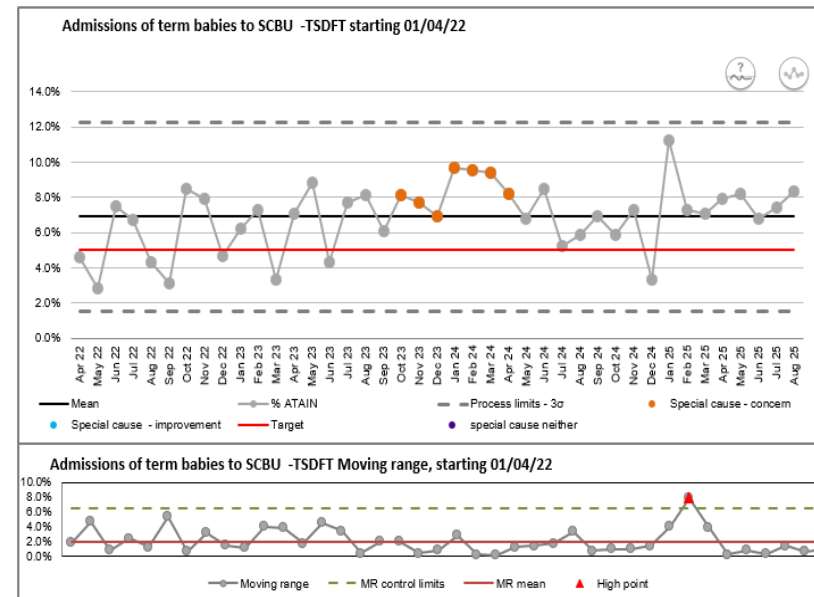
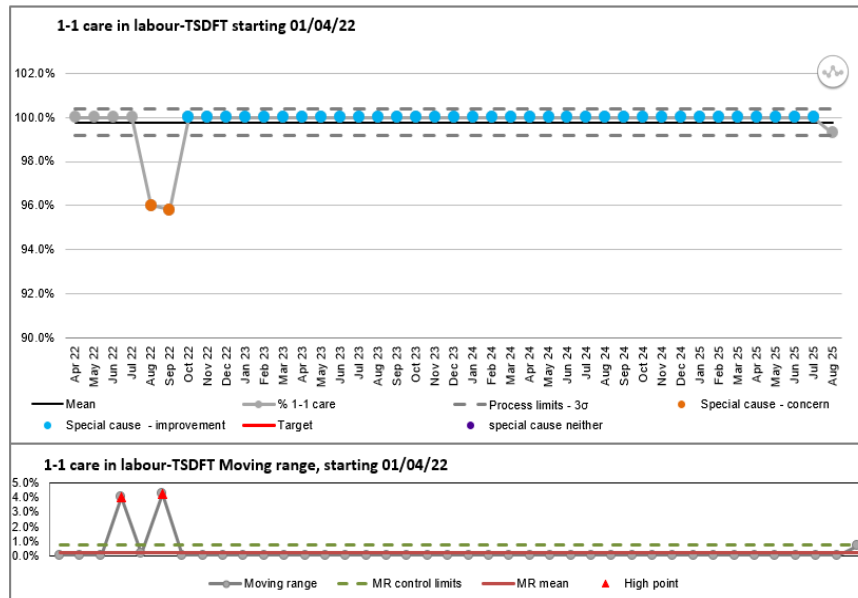
CQC – None

Coroner referral – No new referrals

Quality and Safety- Stillbirth rates per 1000 births (August data) 2025 Maternity

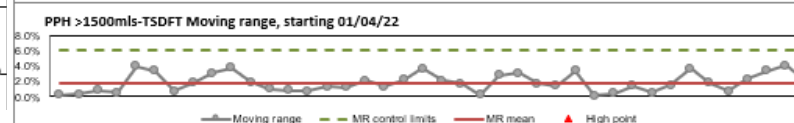
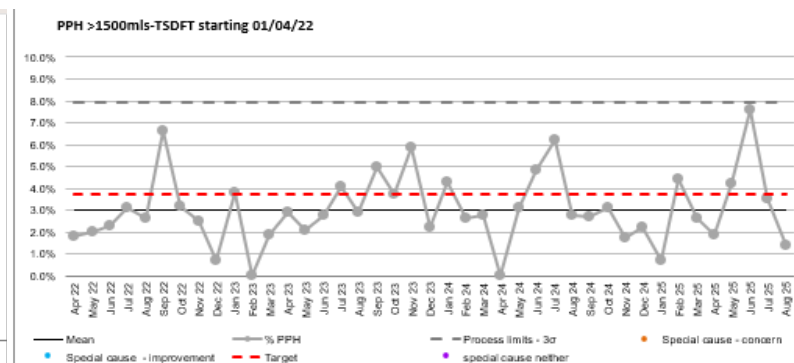
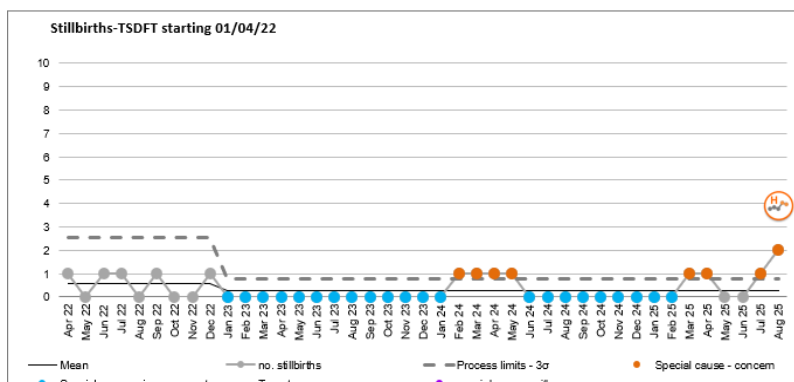
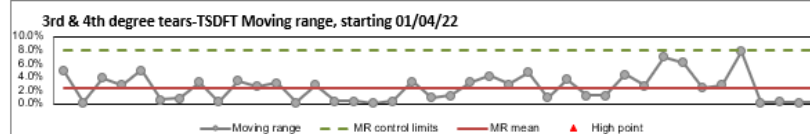
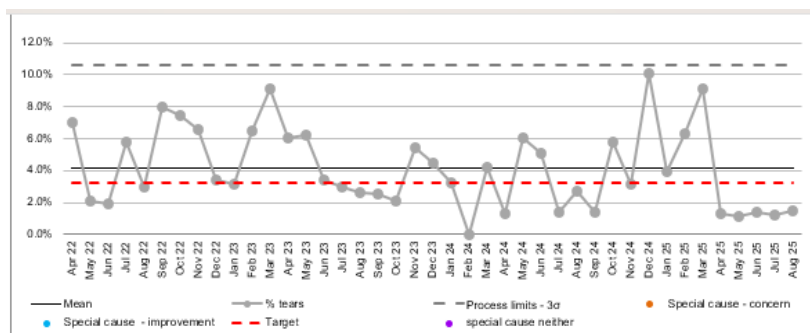
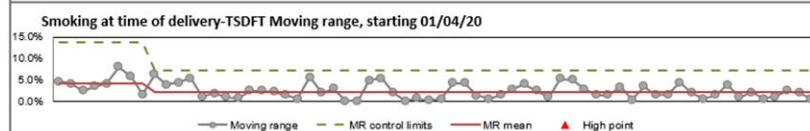
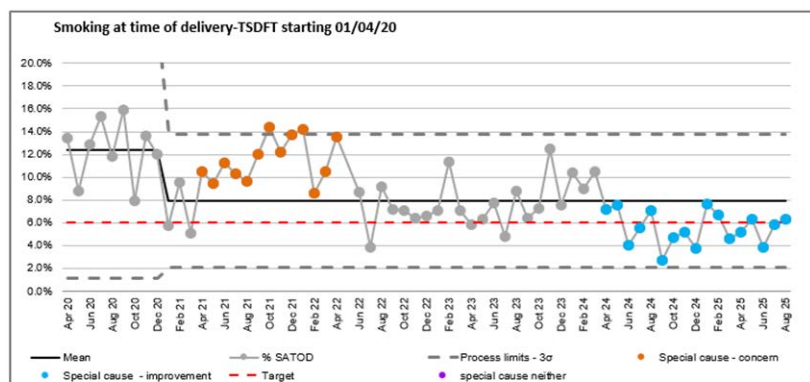


Quality and Safety- Metrics relating to the provision of quality maternity care



Quality and Safety- Metrics relating to the provision of quality maternity care- August 2025

- Births in August – small reduction to 143
- Marginal increase in smoking at delivery 6.3 % just tipping the national average
- Two stillbirths in the month of August- rate below national rate per 1000 births
- Sustained reduction in the number of 3rd/4th degree tears from 9.1 % in March to 1.5 % in August .National Maternity and Perinatal audit average is 3.2%
- PPH>1500mls halved this month at 1.5%
- An increase in term baby admissions to SCBU to 8.3%. QI work in place to reduce rate.



Quality and Safety exception report – Stroke care

Data for June below; data for previous month only available from 15th of current month.

Time critical Stroke Standards	Natl. average Jan-Mar 2025												
		Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number of patients (N)		63	54	42	50	46	50	46	56	55	62	54	50
% Scanned within 20 minutes updated target	27.60%			11.9%	10.0%	15.20%	24.0%	14.9%	23.20%	16.40%	29.00%	43.10%	24.50%
% Admitted to Stroke Unit within 4 hours	46.60%	36.80%	30.00%	31.70%	36.70%	25.00%	34.00%	24.40%	50%	37%	37%	47.30%	28%
Median time to reach the stroke unit (hours:mins)	04:10	4.5	6.87	10:37	07:32	10:08	07:53	09:23	03:45	06:00	05:31	04:16	06:17
% of patients spending 90% of their time on the Stroke Unit	80% (Team)	81%	67%	69.40%	71%	59%	71.40%	70.20%	83.60%	69.10%	77.40%	75.90%	78.90%
% (No.) Patients that received Thrombolysis	11.80%	22.8% (12)	16% (8)	11.9% (5)	20% (10)	26.1% (12)	10% (5)	8.5% (4)	5.4% (3)	14.5% (8)	11.3% (7)	20.7% (11)	13.2% (7)
Median time between clock start and thrombolysis (hours:minutes) New target	00:55mins			01:23	01:12	01:17	01:17	01:08	01:06	01:36	01:17	01:08	01:07

- In July there was a deterioration from the very positive results seen in June:
- A reduction in the proportion of patients scanned within 20 minutes; just below the national average.
- A reduction in the proportion of patients admitted to the stroke within 4 hours; the lowest since February 2025 and significantly below the national average.
- The median time to get to the stroke unit was 2 hours outside the national average.
- Thrombolysis rates for July reduced but remained above the national average.
- Median time to receipt of thrombolysis improved by 1 minute; 12 minutes outside the national average.

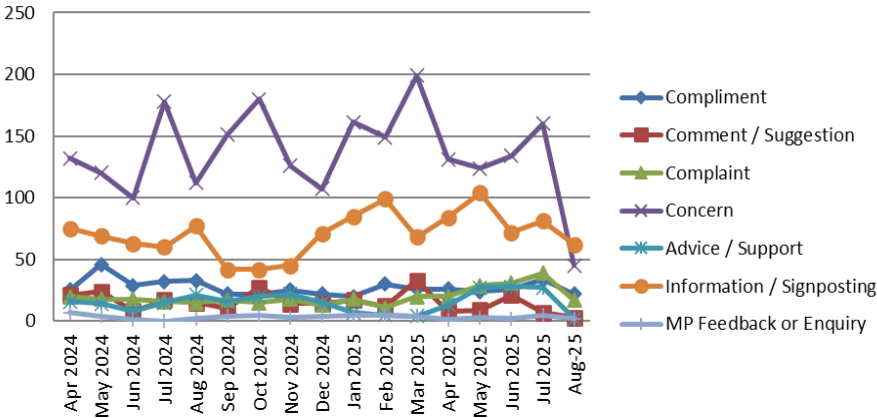
A further meeting was held with Dr David Hargroves. He confirmed his expectations, and these are now being put into a plan. They include many of the standards we report on above but also include ensuring that we reduce variation so that we ensure all patients follow the direct to CT pathway – not just those who might be eligible for reperfusion therapy, and a focus on improving our performance on a formal swallow assessment within 24 hours.

He also reiterated his belief that out of hours consultant support for reperfusion decision making was essential via a rota at regional level. A recent SW regional thrombectomy meeting led to discussions that might see the possibility of Torbay and Truro joining a West of England rota, which Cheltenham & Gloucester are part of.

The new stroke action plan should be drafted within the next 2 weeks.

Quality and Safety exception report – Feedback and engagement

First received – by type of feedback

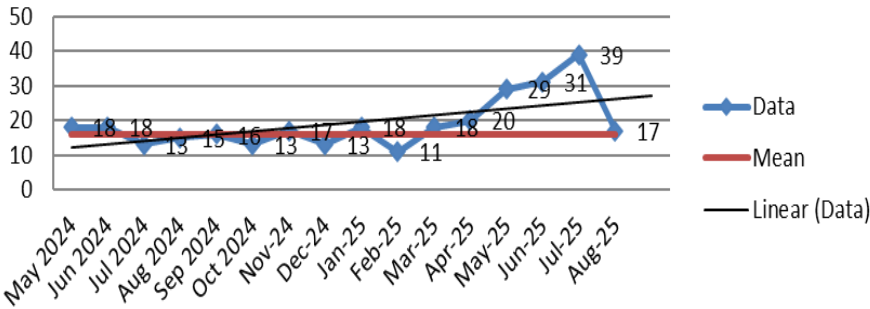


The Trust’s Patient Experience Team processed 153* contacts received during August 2025. To date these comprise:

- 45 concerns
- 22 compliments
- 17 complaints
- 62 related to advice, signposting, comments

These figures may increase in the coming months due to the lag between receiving and processing contacts due to a reduction in capacity.

Complaints received by month



Top 3 complaint themes
Clinical treatment
Care
Appointments

August 2025 Compliance:

- 10 complaints (59%) were not acknowledged within 3-working days of receipt. This is likely to increase. (July n=23 59%; June n=22 71%) Patient Experience vacancy and resulting capacity issues is the primary factor contributing to acknowledgement breaches (and general processing lag)
- One complaint response (4%) breached the 6-month August deadline for completion
- 4 complaints remain open beyond their 6-month deadlines (June and July 2025)

Escalation: Risk number 4286

Team

- The Patient Experience team continues to be significantly impacted by multiple vacancies (x5)
- Staffing levels continue to impact capacity, and the team are unable to adequately manage the continuous workflow. Pressure on the team is intense
- Additional resource was identified but will not be available after September, which may impact on recovery

Data

- The team are behind with case management. The data reported is only what has been processed to date. There are calls/emails which have not been processed for the month of August 2025. It will take some months to resolve the backlog of calls and emails, as more arrive each day. The situation will deteriorate as notice periods are worked, and temporary support staff leave the team, but improvements will be made once new staff join the team
- New approaches to the allocation and distribution of cases are being trialled within the team and constantly reviewed

**Data collected 10.09.2025 – all data subject to change due to recategorisation & delayed processing

Quality and Safety – Safer Staffing – Dashboard July 2025

Beds		Staffing Fill Rates				Actual Staffing Split				Care Hours Per Patient Day (CHPPD)										HR Metrics			Temporary Staffing			
		Days		Nights		Days		Nights		RN / Midwives		Days		Overall Day		Nights		Overall Night		Sickness Rate (Jun-25)	Turnover Rate	Vacancy Rate	Prop. Bank Hours	Prop. Agency Hours		
		RN / Midwives	Care Staff	RN / Midwives	Care Staff	% RN / Midwives Hours	% Care Staff Hours	% RN / Midwives Hours	% Care Staff Hours	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual							
518	94.9%	93.0%	94.9%	94.6%	108.6%	54.8%	45.2%	53.2%	46.8%	2.5	2.3 (-7.5)	2.0	1.9 (-2.9)	4.4	4.2 (-10.4)	1.9	1.8 (-6.2)	1.4	1.6 (+2.1)	3.3	3.4 (-4.1)	5.2%	9.8%	4.7%	12.2%	3.8%

PATIENT SENSITIVE INDICATORS										
Safety								Feedback		
Red Flags Raised		Mod. Harm Incs and Above	Hosp. Acq. PUs G2+	Falls		Medicine Errors	% Obs Taken on Time	Patient Complaints	FFT	
ETOC Red Flags ²	All Red Flags			No Harm	Harm				% Positive Resp.	Number of Resp.
3	25	21	31	41	33	31	91.0%	2	98.9%	265

CHPPD- Satisfactory

The Trust overall actual CHPPD for Days is 4.2. This is slightly under the overall planned of 4.4. The last 3 months has seen a stabilisation of the targets being achieved. However, where the CHPPD is red it can be noted that these are within clinical areas that require registrants with an extended or specialised skill set. These areas are also carrying high vacancies of which recruitment are supporting with focused campaigns.

The overall CHPPD actual for nights is 3.4. This is above the recommended planned CHPPD of 3.3. The actual CHPPD being over the planned is reflective of the Enhanced Therapeutic Observations of Care that is required at night. The CHPPD has decreased significantly overnight over the last 2 months, this reflects the processes and governance that has now been embedded within the ETOC service to ensure service efficiency whilst improving patient safety.

Quality and Safety – Safer Staffing – Dashboard July 2025

Bed occupancy- Limited - Our bed occupancy indicates that we are running at an average of 94.9%. This puts many of our inpatient areas at a rating of red. Having an increased bed occupancy reduces our ability to aid flow within the hospital.

Staffing Fill Rates- Satisfactory - RN Fill rate for days has an average of 93%. RN fill rate for nights averages at 94.9%. This is a sustained increase with a RN fill rate of above 90% for the last 3 months. The average HCSW fill rate for days is 94.6% and average HCSW fill rate for nights is 108.6%. This has remained above 90% for the last 4 months. The increase in HCSW fill rate overnight is to support the level 4 ETOC overnight.

HR Metrics- Sickness Rate- Limited - Average sickness rate is 5.2%. Even though this metric is flagging as red there is a 0.4% improvement for sickness across the Trust.

- **Average turnover rate- Satisfactory** - Average Turnover rate is 9.8%. This metric has remained within target for the last 3 months and has seen a 1.3% reduction.

- **Vacancy Rate- satisfactory** - Vacancy Rate resides at 4.7%. This is 8.1% reduction in vacancies since April 2025.

Temporary Staffing

- **Proportion of Bank hours- Limited** - The proportion of shifts escalated to bank is 12.2% this is an increase of 3.5% since June 2025.

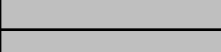
- **Proportion of shifts escalated to agency- Limited** - The proportion of shifts escalated to agency is 3.8% this is an increase of 1% since June 2025.

Areas where there are higher levels of request to bank and agency relate to areas who are carrying higher vacancy and sickness rates. The on boarding process for recruitment is now at an average of 82.7 days influencing the use of temporary workforces as vacancies are being backfilled to maintain SNCT.

Red Flags - These are being used to demonstrate where there are shortfalls in staffing. Use of red flags for ETOC are minimal indicating that are most complex patients are being cared for appropriately by those working within the ETOC service.

Community and Social Care Indicators - Summary of key metrics

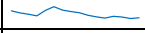
Key									
↑ = Performance improved from previous month ↓ = Performance deteriorated from previous month ↔ = No change									
	Not achieved		Under-achieved		Achieved		No target set		Data not available

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)		
Community Hospital patient discharges pre-noon		
Urgent Community Response 2 hours		
Domiciliary Care hours per week – total demand		
Domiciliary Care hours per week – % outstanding		
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%)		

The above metrics are reviewed by the Family and Community Care Group governance process and detailed in the performance dashboard.

Operational Performance Indicators - dashboard of key metrics

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							↓	Ambulance handover delays > 30 minutes					↓	
Cancer – 28-day faster diagnosis standard							↓	Ambulance handover delays > 60 minutes					↓	
Cancer - 31-day wait from decision to treat to treatment - national reporting							↓	UEC - patients seen within 4 hours					↑	
Cancer - 62-day wait for treatment - national reporting							↑	ED patients with >12-hour visit time pathway					↑	
Cancer - Patient waiting longer than 104 days from 2 week wait							↓	Time to Initial Assessment within 15 mins – Emergency Department					↑	
Referral to treatment - % Incomplete pathways less than 18 weeks							↑	Clinically Ready to Proceed delay over 1 hour - Emergency Department					↓	
RTT 65-week wait incomplete pathway							↓	Non-admitted minutes mean time in Emergency Department					↓	
RTT 78-week wait incomplete pathway							↓	Admitted minutes mean time in Emergency Department					↑	
RTT 104-week wait incomplete pathway							↔	Diagnostic tests longer than the 6-week standard					↔	
On the day cancellations for elective operations							↑	Dementia Find						
Cancelled patients not treated within 28 days of cancellation							↑	Care Planning Summaries % completed within 24 hours of discharge – Weekday					↓	
Theatre utilisation							↑	Care Planning Summaries % completed within 24 hours of discharge – Weekend					↓	
Virtual Outpatient (Non-face-to-face) appointments							↑	Clinic letters timeliness - % specialties within 4 working days					↑	
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)							↓							

Torbay and South Devon  NHS Foundation Trust																
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Operational Plan trajectory Aug 2025
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)			1576	3330	4343	3275	3108	2532	1625	1268	839	1530	1159	725	943	960
Average handover time (mins)	45 mins		56	106	139	109	95	84	62	47	36	52	45	32	38	34
Total average time in ED (hours/minutes)			05:25	06:20	06:44	06:18	06:17	06:20	05:53	05:26	04:58	05:40	05:11	04:50	04:50	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		525	779	979	854	793	818	677	615	415	688	494	457	426	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		7.9%	11.8%	14.8%	12.6%	12.8%	13.8%	9.6%	9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	5.6%
UEC 4-hour target (RAG against local trajectory to national target)	78%		70.7%	65.5%	68.7%	67.3%	65.0%	66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	76.0%
% patient discharges pre-noon	33%		18.9%	20.8%	21.5%	22.3%	20.4%	19.9%	21.2%	22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%		6.0%	6.9%	5.9%	9.5%	6.6%	8.3%	9.1%	7.4%	8.1%	7.7%	7.5%	8.0%	6.3%	5%
Elective recovery																
RTT 78 week wait incomplete pathway	0		11	17	10	6	0	12	14	7	4	8	8	9	16	0
RTT 65 week wait incomplete pathway	0		368	285	242	239	229	204	215	141	145	126	95	97	105	63
RTT 52 week wait incomplete pathway	268		1761	1651	1451	1276	1265	1238	1209	931	914	805	740	615	618	728
RTT % Incomplete pathways <18 wks	66.8%		60.0%	61.3%	62.2%	61.6%	61.6%	61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	63.8%
RTT Wait for first appointment <18 weeks	70.3%		62.5%	62.9%	65.6%	65.3%	64.6%	63.8%	69.3%	70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	67.2%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		79.0%	80.1%	78.4%	71.5%	82.1%	75.6%	83.1%	79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	75.0%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		74.3%	73.1%	77.3%	81.3%	77.3%	74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	75.2%
Cancer: No of patients waiting >62 days to start treatment	138		90	85	78	77	110	95	94	111	133	225	223	220	257	138
Cancer: % of patients > 62 days to start treatment	tdc		5.5%	5.1%	4.4%	5.0%	7.0%	6.0%	5.7%	6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	tdc

RAG indicator

Meeting monthly trajectory

Not meeting monthly trajectory

Torbay and South Devon NHS Foundation Trust			INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS															Performance Report - August 2025	
RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Year to date		
QUALITY LOCAL FRAMEWORK																			
Reported Incidents - Severe	Trustwide	<6		1	3	2	0	2	4	2	4	2	7	2	3	5	19		
Reported Incidents - Death	Trustwide	<1		4	0	4	0	2	1	0	2	4	2	2	1	3	12		
Medication errors resulting in moderate harm	Trustwide	<1		2	1	1	0	0	0	0	0	2	1	0	1	1	5		
Medication errors - Total reported incidents	Trustwide	N/A		51	44	71	50	47	57	44	55	42	42	60	62	53	259		
Grade 3 and 4 pressure ulcers acquired in our care (new and deteriorated)	Trustwide				31	42	32	29	26	26	25	24	35	26	31	27			
Never Events	Trustwide	<1		1	1	0	0	0	1	0	0	1	0	0	0	0	1		
Strategic Executive Information System (STEIS) (Reported to CCG and CQC)	Trustwide	<1		4	0	1	0	0	1	0	2	4	2	0	0	1	10		
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		1	1	0	0	0	0	0	1	1	0	1	0	0	3		
Formal complaints - Number received	Trustwide	20		15	18	15	18	13	18	11	19	20	29	31	37	16	133		
VTE - Risk Assessment on Admission (acute)	Trustwide	>95%		93.3%	92.9%	95.5%	95.6%	93.1%	95.1%	94.7%	94.0%	95.7%	96.0%	95.6%	96.2%	93.3%	95.6%		
VTE - Risk Assessment on Admission (Community)	Trustwide	>95%		95.2%	87.2%	90.2%	84.8%	82.7%	97.5%	98.6%	87.3%	87.5%	100.0%	90.0%	95.5%	90.5%	90.8%		
Hospital standardised mortality rate (HSMR) (4 months in arrears)	Trustwide	<100		106.1	106.3	106.8	106.1	105.7	106.2	106.5	104.7	104.6							
Safer staffing - ICO - Day time	Trustwide	90% - 110%		90.6%	90.9%	90.5%	90.4%	89.3%	88.2%	87.8%	89.6%	93.6%	91.5%	92.4%	93.0%	90.9%			
Safer staffing - ICO - Night time	Trustwide	90% - 110%		94.0%	92.9%	93.1%	93.0%	91.5%	91.5%	93.1%	94.1%	93.2%	91.8%	94.0%	94.6%	94.4%			
Bed capacity impacted by Infection Control (Acute beds closed in month)	Trustwide	<100		53	132	166	24	174	358	418	360	28	29	105	0	170	332		
Hand Hygiene	Trustwide	>95%		87.4%	96.9%	95.4%	95.6%	96.0%	97.3%	96.4%	95.0%	93.0%	94.3%	92.7%	94.3%	96.5%			
Number of Clostridium Difficile cases (COHA+HOHA)	Trustwide	<3		11	6	5	9	7	1	2	6	10	7	2	3	12	42		
CDiff - Hospital Onset Healthcare Associated (HOHA)	Trustwide			8	4	5	9	4	1	2	4	5	4	1	2	7	26		
CDiff - Community Onset Healthcare Associated (COHA)	Trustwide			3	2	0	0	3	0	0	2	5	3	1	1	5	16		
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		70.6%	65.1%	70.0%	81.1%	71.9%	75.6%	75.0%	73.2%	46.5%	70.7%	61.8%	68.1%	n/a			
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		81.0%	67.0%	69.4%	71.0%	59.0%	71.4%	69.0%	83.6%	69.1%	77.4%	75.9%					
Mixed Sex Accommodation breaches	Trustwide	0		138	150	190	174	123	125	112	163	208	94	265	200	124	891		
Follow ups 6 weeks past to be seen date	Trustwide	6400		19206	18229	17782	17689	19036	17997	18005	17361	18380	17843	18040	18486	19016			
WORKFORCE MANAGEMENT FRAMEWORK																			
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.0%	4.9%	4.9%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	n/a	n/a			
Appraisal Completeness	Trustwide	>90%		77.9%	76.0%	80.0%	78.6%	78.8%	78.8%	78.5%	79.6%	78.9%	79.8%	79.5%	80.2%	n/a			
Mandatory Training Compliance	Trustwide	>85%		88.3%	87.7%	88.8%	88.8%	88.8%	88.6%	88.7%	89.0%	89.0%	84.7%	85.3%	85.0%	n/a			
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.9%	10.8%	10.8%	10.8%	11.0%	10.9%	11.2%	11.1%	11.3%	11.0%	11.0%	10.9%	n/a			
COMMUNITY & SOCIAL CARE FRAMEWORK																			
Carers Assessments Completed year to date	Trustwide	40% (Year end)		18.7%	18.5%	18.7%	18.2%	17.9%	17.9%	18.1%	18.2%	17.8%	18.2%	18.5%	18.8%	18.5%	18.5%		
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%			6.4%			6.4%						5.7%					
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET							517	529	560	642	658	631	612	568			

Torbay and South Devon NHS Foundation Trust		INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS															Performance Report - August 2025
RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Year to date
Intermediate Care - No. urgent referrals	Trustwide	NONE SET		328	334	351	266	266	329	270	273	239	240	223	234	199	1135
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		215	190	206	186	201	194	193	221	206	202	208	214	171	1001
Community Hospital Length of Stay (days) - (non-stroke)	Community Hospital	NONE SET		13.8	13.1	13.8	14.9	13.4	14.8	14.0	13.2	13.9	14.2	13.4	14.3	15.5	14.2
Community Hospital % patient discharges pre-noon	Community Hospital	33%		55.0%	53.0%	52.0%	57.0%	56.0%	52.0%	55.0%	50.0%	50.0%	47.0%	47.0%	49.0%	50.0%	
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	80% ICB target		96.2%	89.7%	90.7%	88.0%	88.6%	91.5%	89.5%	87.4%	87.7%	88.8%	87.8%	89.0%		88.3%
Urgent Community Reponse (2 hour) - Number of referrals	Trustwide	157		104	117	226	249	202	236	181	215	219	197	172	227		815
Domiciliary hours per week - total demand (Health and Social Care) (one month in arrears)	Community	NONE SET		15098	15586	15278	15198	14801	14794	15261	16860	15626	15195	14965	14137	13532	
Domiciliary hours per week - % outstanding (Health and Social Care) (one month in arrears)	Community	NONE SET		0.7%	0.6%	0.6%	0.4%	0.4%	0.1%	0.9%	0.3%	0.1%	0.2%	0.5%	0.0%	0.4%	
ADULT SOCIAL CARE TORBAY KPIs																	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		35.2	36.5	33.9	31.3	30.0	28.7	28.7	30.0	26.1	23.5	20.9	31.1	24.6	24.6
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		832.2	821.6	866.8	870.4	862.5	820.3	830.8	907.3	772.8	778.1	783.4	750.6	721.9	721.9
Proportion of clients receiving direct payments	Trustwide	25%		18.7%	18.5%	18.7%	18.2%	17.9%	17.9%	18.1%	18.2%	17.8%	18.2%	18.5%	18.8%	18.5%	18.5%
% reablement episodes not followed by long term SC support	Trustwide	83%		89.3%	89.3%	89.2%	86.9%	86.8%	87.0%	86.6%	86.2%	86.1%	86.9%	88.3%	89.1%	88.8%	88.8%
PERFORMANCE FRAMEWORK																	
Cancer - Two week wait from referral to date 1st seen - regional reporting	Trustwide	>93%		42.2%	42.7%	43.6%	42.7%	38.5%	59.4%	65.4%	62.6%	38.5%	33.5%	31.7%	31.7%	24.9%	
Cancer - 31-day wait from decision to treat to treatment - national reporting	Trustwide	>96%		97.0%	96.5%	94.7%	96.7%	94.2%	92.3%	91.1%	91.7%	89.9%	93.3%	90.7%	91.4%	88.9%	
Cancer - 62-day wait for treatment - national reporting (2024/25 target 70%) (2025/26 target 75%)	Trustwide	75%		74.3%	73.1%	77.3%	81.3%	77.3%	74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	
Cancer - Patient waiting longer than 104 days from 2ww - regional reporting	Trustwide	20		7	8	9	7	11	18	17	19	26	22	52	24	28	
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		60.0%	61.3%	62.2%	61.6%	61.6%	61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	
On the day cancellations for elective operations	Trustwide	<0.8%		1.5%	1.0%	1.6%	0.8%	0.6%	0.9%	1.4%	0.8%	0.9%	0.8%	1.3%	1.3%	1.1%	
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		20	6	6	10	3	1	0	3	3	5	11	21	11	
Theatre Utilisation	Trustwide	85%		65.7%	68.6%	68.7%	69.2%	81.9%	80.7%	84.6%	83.1%	82.7%	83.2%	81.1%	76.7%	82.3%	
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		16.6%	16.4%	16.4%	16.9%	17.3%	17.5%	16.5%	16.3%	17.0%	15.7%	16.2%	15.9%	16.7%	
Bed Occupancy	Acute	90.0%		92.4%	95.4%	96.9%	97.4%	95.0%	96.7%	96.0%	95.8%	95.2%	95.9%	96.1%	96.0%	95.3%	
% patient discharges pre-5pm	Acute	75%		67.9%	68.8%	70.9%	73.8%	66.5%	69.9%	70.4%	73.0%	71.8%	71.0%	72.6%	75.3%	71.4%	
Number of patients >7 days LoS (daily average)	Acute	153		157.5	160.0	168.9	169.9	150.0	160.6	161.4	139.2	151.5	144.2	148.0	149.2	149.2	
Number of extended stay patients >21 days (daily average)	Acute	35		38.8	40.6	42.6	43.2	31.3	38.2	34.0	32.3	35.7	32.5	31.5	28.4	38.8	
Ambulance handover delays > 30 minutes	Acute			994	1400	1488	1235	1387	1243	1098	966	720	1122	951	716	804	4313
Ambulance handover delays > 60 minutes	Acute	0		587	1077	1164	934	1001	850	679	521	307	601	531	302	390	2131
UEC - patients seen within 4 hours (23/24 plan target 76%)	Trustwide	76%		70.7%	65.5%	68.7%	67.3%	65.0%	66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	72.6%
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute			67.7%	59.8%	59.8%	63.3%	62.6%	66.7%	67.6%	60.0%	63.3%	58.0%	58.7%	60.9%	63.7%	
Clinically Ready to Proceed delay over 1 hour - Emergency Department	Acute			22.4%	26.6%	27.0%	25.0%	22.9%	27.6%	26.2%	24.2%	25.7%	28.3%	23.6%	22.0%	19.7%	
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute			04:03	04:32	04:22	04:22	04:27	04:19	04:01	04:00	03:52	04:10	03:54	03:48	03:50	

Torbay and South Devon NHS Foundation Trust			INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS															Performance Report - August 2025	
RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Year to date		
Admitted minutes mean time in Emergency Department (hh:mm)	Acute			08:23	10:18	11:51	10:22	10:13	10:12	09:51	08:25	07:12	08:59	08:04	07:08	07:05			
Diagnostic tests longer than the 6 week standard	Trustwide	5%		23.2%	28.0%	27.7%	32.3%	37.3%	40.0%	31.7%	31.8%	32.4%	37.8%	34.0%	37.0%	37.0%			
Dementia - Find - monthly report	Trustwide	>90%		91.9%	90.8%	n/a	n/a	86.6%	95.7%	97.2%			96.5%	96.8%	93.6%		95.8%		
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		77.0%	80.3%	79.5%	81.5%	76.3%	83.0%	76.5%	77.5%	83.6%	81.9%	75.7%	80.0%	77.8%	79.8%		
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		53.9%	60.5%	60.1%	59.7%	65.9%	69.6%	64.0%	65.2%	67.5%	61.0%	64.6%	62.5%	60.8%	63.1%		
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		78.1%	70.2%	72.5%	70.7%	63.6%	75.4%	76.5%	65.6%	71.9%	68.1%	74.9%	76.0%	79.3%			
37% against a target of 5%																			
Day cases										102%	116%	114%	116%	111%	116%	111%	114%		
Elective inpatient admissions										84%	90%	102%	85%	80%	78%	95%	88%		
Admitted Patient Care Total										107%	112%	112%	112%	108%	112%	109%	111%		
Outpatient - first appointment										102%	118%	104%	98%	98%	95%	96%	98%		
Outpatient - first appointment with procedure										156%	148%	153%	161%	146%	154%	165%	155%		
Outpatient - follow-up with procedure										106%	138%	177%	151%	129%	136%	113%	140%		
Outpatient Appointment Total										110%	125%	131%	121%	114%	116%	110%	118%		
ERF Income Grand Total (% above 2019/20)		114%								100%	115%	124%	120%	114%	113%	112%	116%		
Non-ERF activity 2024/25 amd 2025/26 vs Plan																			
Non-elective admissions													116%	121%	128%	0%	121%		
UEC attendances (Type 1 and 3)													110%	106%	0%	0%	104%		
NHS I - FINANCE AND USE OF RESOURCES																			

EBITDA - Variance from Plan - cumulative (£'000's)	Trustwide			-476.0													
Agency - Variance Full Year Budget/spend cap (%)	Trustwide			185%	180%	185%	184%	175%									
CIP - Variance from plan - cumulative (£'000's)	Trustwide			6	15	54	51	-1728									
Capital spend - Variance from Plan - cumulative (£'000's)	Trustwide			796	2132	4197	9063	10012									
Distance from NHSI Control total (£'000's)	Trustwide			-476	0	0	-3537	-6829									

Board of Directors

Our Plan for Better Care

Date of meeting	Date report produced
24 th September 2025	17 th September 2025

Author(s)		Report approved by	
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

N/A

Executive Summary

This report provides an update to the Board of Directors at TSDFT on delivery progress of the Integrated Improvement Plan (IIP), Our Plan for Better Care which includes 5 core domains - Leadership, Strategy, Performance, Finance and People (recognising Quality runs as a golden thread through all).

Highlight reports from each workstream have been reviewed by the Our Plan for Better Care Oversight Group, chaired by the CEO and form the basis for this report which includes activities planned for the next reporting period, key risks to delivery and highlights current mitigations in place if available. Work continues to develop a detailed IIP Risk Register to ensure sufficient mitigation is in place. This will further provide the Board of Directors with oversight of our highest risks which could impact delivery. Through the oversight process, an overarching Executive assurance rating has been allocated to each workstream. Our Plan for Better Care have agreed to align the Executive Assurance RAG to the Board Assurance RAGs to ensure consistent application and understanding of the status of each workstream. This will be available to the Board of Directors from Month 7.

The overarching objective of the programme is to create the conditions for sustainable improvement and not just deliver financial savings. However, in 2025/26, there is a requirement for the combined outcomes from a number of the workstreams to deliver £36.4m of the £41.5m savings required to deliver the annual plan.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Whole report	Limited	Limited

Appendices

Annex 1: Our Plan for Better Care Oversight Assurance Report as at September 2025

Committees that have previously discussed/agreed the report, and outcomes of that discussion

Our Plan for Better Care Oversight Group.

Key recommendations and actions requested

The Board are asked to AGREE the recommended assurance rating and take LIMITED assurance as to those matters reviewed. The Board are also asked to:

- **Note** the first IIP delivery report and progress made during the reporting period with the Board of Directors invited to **Discuss**.
- **Acknowledge** the risks and ongoing work required to improve delivery in the core domains.
- **Take assurance** that the improvement programme is being actively driven by the Executive Team and is beginning to impact on delivery of the organisation's key priorities.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

Our Plan for Better Care includes a well-defined, time-bound, measurable, and achievable set of actions that will bring clarity of purpose and direction for Torbay and South Devon NHS Foundation Trust (TSDFT) and its wider stakeholders. It aims to drive sustainable improvements across performance, quality, and finance. The plan will deliver high-quality, sustainable improvements and lasting change for the population it serves and support the Trust's transition to Segment 3 of the current NHS Oversight Framework (NOF).

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Improved outcomes through sustainable, needs-based service delivery.
Quality of services provided	The golden thread of quality and safety needs to be explicit and will be led by the Chief Medical Officer and Chief Nursing & Midwifery Officer across all programmes of improvement providing a triumvirate approach to leadership.
Sustainable and efficient use of resources	Finance programme of improvement directly aligned to efficiency and productivity.

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	Ensuring quality and safety through the improvement plan will be a golden thread.
People	People programme of improvement will address specifically our workforce and consistent and transparent communication, and engagement will be established.
Financial Sustainability and Productivity	Finance programme of improvement will address this objective but also working collaboratively across all programmes in a triumvirate approach.
Estates	Finance programme of improvement will address this objective.
Operations and Performance Standards	Performance programme of improvement will address this objective.
Digital and Cyber Resilience	Digital innovation will be considered throughout all programmes of improvement.
Building a Brighter Future	Our Plan for Better Care will be aligned to the organisations branding.
Strategy and Transformation	Strategy programme of improvement will address this objective.
Sustainability: Green Plan/ Environmental	No new issues identified so far however, will be managed through a risk and mitigation framework.
Equality, Diversity and Inclusion	Consideration of EDI will be taken into account throughout designing and delivery of workstreams.
Provision of Community and Care Services Delivered in Partnership	Performance and Strategy programmes of improvement will address this objective.

Risk: Risk ID (as appropriate)	
Risk	Risk ID

The improvement plan addresses a range of organisational risks, which will be monitored and updated through the appropriate risk management processes which will be effective as on Month 7. Specific risk IDs will be assigned and mitigation explored and reviewed.

External Standards affected by this report and associated risks

National Oversight Framework Segment 4 mandated intensive support.

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Torbay and South Devon NHS Foundation Trust – Our Plan for Better Care

1. Background

- 1.1 The improvement plan branded locally as '*Our Plan for Better Care*' aims to establish the foundations for sustainable improvement and organisational recovery. With clearly aligned delivery management and oversight across performance domains, it also supports the Trust's progression to Segment 3 of the NHS Oversight Framework.
- 1.2 Following commencement of the Trusts new Chief Executive, a diagnostic exercise was undertaken to establish a deeper understanding of the size of the challenge for TSDFT and the priority remedial actions. Engagement was undertaken with key internal stakeholders to agree a single improvement plan '*Our Plan for Better Care*' that is underpinned by the organisation's values and objectives for 2025/26 and beyond.
- 1.3 In May 2025, the Board of Directors reviewed and supported the strategic intent of the plan, which includes five improvement domains (programmes of improvement). Each domain consists of dedicated workstreams, led by an Executive Senior Responsible Officer (SRO). In June and July 2025, progress towards initiating and planning for the IIP was shared with the Board of Directors.
- 1.4 From August 2025, Workstream Leads have been reporting delivery progress to the Our Plan for Better Care Oversight Group through monthly highlight reports. Supported by the RSP team, these have been reviewed by SROs and the wider Executive team to test any assumptions made, review progress and offer support where necessary.
- 1.5 This report summarises the position in September 2025.

2. Delivery Update

- 2.1 September continues to see Workstream Leads produce highlight reports against a set of pre-determined key deliverables. These have been signed off by SROs reinforcing accountability for delivery before being presented to the Executive Team for oversight and scrutiny of performance.
- 2.2 The Managing Our Estate and One Devon Shared Services (Finance and Procurement) workstreams require an extensive review in October to ensure the plan to progress is fully in place with key deliverables, KPIs and risks documented. The PMO team will work closely with key stakeholders to step this up.
- 2.3 The Oversight Group continues to promote a culture of constructive challenge between peers, to ensure that the process actively challenges assumptions, stretches ambition and maximises opportunities to accelerate pace.

- 2.4 An overarching Executive assurance sponsor rating per workstream as been applied. The rating takes into account the delivery of key performance indicators, if the workstream is on schedule to achieve the deliverables and any associated risks. From the October cycle of reporting Our Plan for Better Care have agreed to align the Executive Assurance RAG to the Board Assurance RAGs to ensure consistent application and understanding of the status of each workstream. The below table summarises the September position relative to that reported previously in August;

Table 1:

Workstream	Executive Sponsor Rating August	Executive Sponsor Rating September
Leadership		
Governance & Assurance		
Well-Led		
Board & Executive Development		
Strategy		
3-5 Year Strategy		
EPIC		
Peninsula Acute Sustainability Programme		
Adult Social Care		
Continuing Health Care		
Child & Family Health Devon		
Performance		
Elective Care		
Diagnostics		
Outpatients Transformation		
Cancer Services		
UEC Flow		
Community Services Redesign (Frailty)		
Community Services Redesign (Elective Centre of Excellence)		
Maternity and Neonatal Safety Improvement Programme		
Managing Our Estate		
Finance		
Sustainable Financial Improvement Programme Process		
Sustainable Financial Improvement Programme Delivery		
Financial Capability & Capacity		
Managed Services & Subsidiary Company Arrangements		
One Devon Shared Services - Finance		
One Devon Shared Services - Procurement	New workstream in M6	
People		
Workforce Plan & Transformation		
People & Education Capability & Capacity		
Culture, Organisational Development & Learning		

- 2.5 As an integrated improvement plan, the domains within 'Our Plan for Better Care' collectively contribute to setting the foundations for future sustainability. This means that whilst a number of the workstreams will generate longer-term non-financial benefits, others are expected to make direct financial savings in-year to support delivery of the 2025/26 annual plan.
- 2.6 Where the IIP workstream is expected to make cost savings, delivery oversight of the financial targets are incorporated within the highlight reports and subsequent oversight and scrutiny process for the programme.

- 2.7 The Trust has a challenging £41.5m CIP target to achieve in 2025/26, of which *Our Plan for Better Care* contributes £36.4m (Original Plan). Year-to-date (M1–M5) delivery stands at £10.5m.
- 2.8 The table below summarises the CIP position by workstream identifying delivery year to date (M1-M5) and the full year effect, together with the forecast. The forecast is RAG rated to denote the level of delivery risk, highlighting a remaining variance of £8.3m. There remains a further £5.1m CIP directly delegated to budget-holders, the delivery of which is being monitored through separate governance arrangements outside of the IIP remit.

Table 2:

CIP Workstream Summary Dashboard								
Workstream name	Original Plan	Year to Date Delivery (M1-M5)	Full Year Delivery	Forecast – Potential and Delivered	Forecast - High delivery risk	Forecast - Medium delivery risk	Forecast - Low delivery risk	Variance between original and forecast
2.4a Adult Social Care/Continuing Health Care	£ 7,982,000	£ 2,487,873	£ 6,398,268	£ 7,795,704	£ -	£ 1,397,436	£ 6,398,268	£ -
2.4b Continuing Health Care	£ 2,127,000	£ 790,739	£ 2,036,165	£ 3,087,191	£ -	£ 461,028	£ 2,626,165	£ 960,191
3.1a Planned Care – Elective Care	£ 2,000,000	£ 450,000	£ 1,500,000	£ 1,500,000	£ -	£ -	£ 1,500,000	£ 500,000
3.1b Planned Care – Diagnostics DMD1	£ 580,000	£ 210,000	£ 504,000	£ 504,000	£ -	£ -	£ 504,000	£ 78,000
3.1c Planned Care – Outpatients Transformation	£ 500,000	£ -	£ -	£ -	£ -	£ -	£ -	£ 500,000
3.2 UEC Flow	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
3.3a Community Services Redesign (Frailty)	£ 750,000	£ -	£ -	£ -	£ -	£ -	£ -	£ 750,000
3.5 Managing Our Estate	£ 1,622,000	£ 523,307	£ 908,521	£ 1,374,021	£ 200,000	£ 27,500	£ 1,146,521	£ 247,979
4.3 Managed Services & Subsidiary Company Arrangements	£ 1,500,000	£ -	£ -	£ -	£ -	£ -	£ -	£ 1,500,000
5.1 Workforce Plan & Transformation*	£ 19,387,192	£ 6,089,088	£ 9,034,870	£ 13,825,308	£ 300,000	£ 1,684,278	£ 11,841,030	£ 5,561,884
Total	£ 36,448,192	£ 10,531,007	£ 20,971,824	£ 28,086,224	£ 500,000	£ 3,570,240	£ 24,015,984	£ 8,361,968

* Excluding schemes already covered in the workstreams above to avoid double counting. The original value for 5.1 is £20.4m.

- 2.9 Within month, the process for developing and stepping up an IIP risk register has been agreed and will be effective from October. This is intended to be an interim framework, pending the arrival of two Risk Consultants this month who will undertake a full review of risk information, technology infrastructure and risk management training capability. By integrating risk management into the Oversight Group, we can optimise efforts and improve the overall success of the IIP by systematically identifying, assessing and responding to potential risks.
- 2.10 Considerable work has been achieved to enable *Our Plan for Better Care* to be a robust mechanism of monitoring the organisations key priorities. Work continues to be progress to ensure it is a fully embedded programme of excellence with coaching, upskilling and resourcing in key areas. This progress continues to be made reflecting the organisation's shared commitment to addressing its challenges effectively.
- 2.11 A detailed IIP overarching report is attached as Annex 1.

3. Recommendations

- 3.1 The Board of Directors are invited to:
- **Note** the IIP delivery report and progress made during the reporting period with the Board of Directors invited to **Discuss**.
 - **Acknowledge** the risks and ongoing work required to improve in the core domains.
 - **Take assurance** that the improvement programme is executively owned and is evidencing impact to the organisation's key priorities.

4. Assurance

- 4.1 Due to the risks identified in the report the Board are asked to AGREE the recommended assurance rating and take LIMITED assurance as to those matters reviewed.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Whole report	Limited	Limited

- 4.2 Considerable work continues to be undertaken to develop and embed Our Plan for Better Care as a programme of excellence.



Our Plan for Better Care

Torbay and South Devon NHS Foundation Trust
September 2025





Executive Summary



This report provides an update the Board of Directors at TSDFT on delivery progress of the Integrated Improvement Plan (IIP), Our Plan for Better Care which includes 5 core domains - Leadership, Strategy, Performance, Finance and People (recognising Quality runs as a golden thread through all). It offers assurance of delivery based on highlight reporting from each workstream presented to the Our Plan for Better Care Oversight Group. The report also acknowledges activities planned for the next reporting period, key risks to delivery and highlights current mitigations in place if available.



Delivery of the IIP is overseen by the Our Plan for Better Care Oversight Group which is chaired by the Chief Executive. Programmes and workstreams are striving to ensuring the level of evidence for improvement meets the TSDFT and other stakeholder requirements i.e. system partners, region and national. The evidence gathered has been through a rigorous scrutiny process to determine how this is influencing core metrics and CIP delivery (if applicable) to enable inclusion of an overarching Executive assurance sponsor rating per workstream.



The Board of Directors will receive a monthly update on delivery of the IIP focusing on success, challenges and actions to mitigate any key risks to delivery. Work continues to develop a detailed IIP Risk Register to ensure sufficient mitigation is in place. This will further provide the Board of Directors with oversight of our highest risks which could impact delivery. Our Plan for Better Care have agreed to align the Executive Assurance RAG to the Board Assurance RAGs to ensure consistent application and understanding of the status of each workstream. This will be available to the Board of Directors from Month 7.



RAG definitions are;

Fully Assured - on schedule to achieve the deliverables / metrics are trending positively or meeting or exceeding expectations

Partially Assured – some delay in schedule / off track to achieve deliverables / metrics that are continuously trending negatively

Not Assured – a significant delay in schedule with majority of deliverables off track / metrics are falling below acceptable threshold





The Improvement Programmes Impact to CIP



Torbay and South Devon
NHS Foundation Trust

The Trust has a challenging **£41.5m** CIP target to achieve in 2025/26, of which *Our Plan for Better Care* contributes **£36.4m** (original plan). Year-to-date (M1–M5) delivery stands at **£10.5m**, with full year delivery of **£20.9m** and a forecast of **£28.1m**. The dashboard below summarises the CIP position by programme and further by workstream highlighting a remaining variance of **£8.3m**. There remains a further **£5.1m** CIP outside the IIP being monitored through other governance.

Our Plan for Better Care - Dashboard								
Programme	Orginal Plan	Year to Date Delivery (M1-M5)	Full Year Delivery	Forecast – Potential and Delivered	Forecast - High delivery risk	Forecast - Medium delivery risk	Forecast - Low delivery risk	Variance between original and forecast
Strategy programme	£ 10,109,000	£ 3,278,612	£ 9,024,433	£ 10,882,895	£ -	£ 1,858,462	£ 9,024,433	£ 773,895
Performance programme	£ 5,452,000	£ 1,183,307	£ 2,912,521	£ 3,378,021	£ 200,000	£ 27,500	£ 3,150,521	£ 2,073,979
Finance programme	£ 1,500,000	£ -	£ -	£ -	£ -	£ -	£ -	£ 1,500,000
People programme	£ 19,387,192	£ 6,069,088	£ 9,034,870	£ 13,825,308	£ 300,000	£ 1,684,278	£ 11,841,030	£ 5,561,884
Total	£ 36,448,192	£ 10,531,007	£ 20,971,824	£ 28,086,224	£ 500,000	£ 3,570,240	£ 24,015,984	£ 8,361,968

CIP Workstream Summary Dashboard								
Workstream name	Orginal Plan	Year to Date Delivery (M1-M5)	Full Year Delivery	Forecast – Potential and Delivered	Forecast - High delivery risk	Forecast - Medium delivery risk	Forecast - Low delivery risk	Variance between original and forecast
2.4a Adult Social Care/Continuing Health Care	£ 7,982,000	£ 2,487,873	£ 6,398,268	£ 7,795,704	£ -	£ 1,397,436	£ 6,398,268	£ 186,296
2.4b Continuing Health Care	£ 2,127,000	£ 790,739	£ 2,626,165	£ 3,087,191	£ -	£ 461,026	£ 2,626,165	£ 960,191
3.1a Planned Care – Elective Care	£ 2,000,000	£ 450,000	£ 1,500,000	£ 1,500,000	£ -	£ -	£ 1,500,000	£ 500,000
3.1b Planned Care – Diagnostics DM01	£ 580,000	£ 210,000	£ 504,000	£ 504,000	£ -	£ -	£ 504,000	£ 76,000
3.1c Planned Care – Outpatients Transformation	£ 500,000	£ -	£ -	£ -	£ -	£ -	£ -	£ 500,000
3.2 UEC Flow	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
3.3a Community Services Redesign (Frailty)	£ 750,000	£ -	£ -	£ -	£ -	£ -	£ -	£ 750,000
3.5 Managing Our Estate	£ 1,622,000	£ 523,307	£ 908,521	£ 1,374,021	£ 200,000	£ 27,500	£ 1,146,521	£ 247,979
4.3 Managed Services & Subsidiary Company Arrangements	£ 1,500,000	£ -	£ -	£ -	£ -	£ -	£ -	£ 1,500,000
5.1 Workforce Plan & Transformation*	£ 19,387,192	£ 6,069,088	£ 9,034,870	£ 13,825,308	£ 300,000	£ 1,684,278	£ 11,841,030	£ 5,561,884
Total	£ 36,448,192	£ 10,531,007	£ 20,971,824	£ 28,086,224	£ 500,000	£ 3,570,240	£ 24,015,984	£ 8,361,968

* Excluding schemes already covered in the workstreams above to avoid double counting. The original value for 5.1 is £20.4m.

There remains significant risk to the delivery of the overall 2025/26 savings target, including the reliance on non-recurrent CIP schemes particularly for workforce reductions. Urgent action to identify and develop mitigating plans and to convert non-recurrent schemes to recurrent, is being progressed through the continuation of the Care Group CIP Deep Dive meetings, chaired by the Chief Executive. The meetings scheduled at the end of September are extending their scope to incorporate a full financial review.



The Improvement Programmes Impact to WTE



Torbay and South Devon
NHS Foundation Trust

As part of the 2025/26 CIP programme, the Trust has a challenging target to reduce the workforce by 452 WTE. This is being co-ordinated through *Workstream 5.1 Workforce plan & Transformation*. At month 5 a reduction of 159.7 WTE was delivered totalling £6.3m compared to a plan of 194.1 WTE and £5.0m. However, only 35.6 WTE has been delivered recurrently. The end of year forecast recognised by PMO indicates a gap of 294.3 WTE and £6.2m largely attributed to the closure of the compulsory redundancy scheme. The finance forecast includes 205WTE and £6.3m achieved through the planned development of additional pay controls but these are yet to be progressed through the PMO CIP assurance process to formulate robust plans.

WTE Reduction (including forecasts);

	Month											
	1	2	3	4	5	6	7	8	9	10	11	12
Total WTE Reductions												
Planned WTE reduction	-188.8	-188.8	-189.6	-178.2	-194.1	-198.7	-427.0	-427.0	-427.0	-452.5	-452.5	-452.5
Delivered WTE reduction	-8.0	-182.7	-173.0	-216.1	-159.7	-45.6	-45.6	-45.6	-45.6	-44.6	-44.6	-44.6
Forecast WTE reduction						-107.6	-99.0	-97.9	-97.9	-113.6	-113.6	-113.6
Total WTE reduction (Delivered + Forecast)	-8.0	-182.7	-173.0	-216.1	-159.7	-153.2	-144.5	-143.5	-143.5	-158.2	-158.2	-158.2
Variance	180.8	6.0	16.6	-37.9	34.5	45.5	282.5	283.5	283.5	294.3	294.3	294.3
Total WTE Reductions	-8.0	-182.7	-173.0	-216.1	-159.7	-153.2	-144.6	-143.5	-143.5	-158.2	-158.2	-158.2
Non-recurrent	-5.0	-166.9	-148.4	-186.7	-124.1	-110.8	-102.2	-100.5	-100.5	-96.7	-96.7	-96.7
Recurrent	-3.0	-15.8	-24.5	-29.4	-35.6	-42.4	-42.4	-43.0	-43.0	-61.5	-61.5	-61.5

WTE Reduction as £m (including forecasts)

	Month											
	1	2	3	4	5	6	7	8	9	10	11	12
Total WTE Reductions as £'000												
Planned WTE reduction	-1.0	-2.0	-3.0	-3.9	-5.0	-6.0	-8.4	-10.7	-13.1	-15.5	-17.9	-20.4
Delivered WTE reduction	-0.2	-2.0	-3.5	-5.0	-6.3	-6.7	-7.2	-7.6	-8.1	-8.5	-9.0	-9.4
Forecast WTE reduction						-0.8	-1.4	-2.0	-2.7	-3.4	-4.1	-4.8
Total WTE reduction (Delivered + Forecast)	-0.2	-2.0	-3.5	-5.0	-6.3	-7.5	-8.6	-9.7	-10.7	-11.9	-13.0	-14.2
Variance	0.8	-0.1	-0.5	-1.1	-1.3	-1.5	-0.2	1.1	2.3	3.6	4.9	6.2
Total WTE Reductions £'000	-0.2	-2.0	-3.5	-5.0	-6.3	-7.5	-8.6	-9.7	-10.7	-11.9	-13.0	-14.2
Non-recurrent	0.0	-1.5	-2.6	-3.7	-4.6	-5.3	-6.0	-6.6	-7.2	-7.8	-8.4	-9.0
Recurrent	-0.1	-0.5	-0.9	-1.3	-1.7	-2.2	-2.6	-3.1	-3.6	-4.1	-4.7	-5.2

Leadership Programme

Senior Responsible Owner – Joe Teape, CEO

Stable and successful Board with continuous effective leadership development. Robust governance framework at all levels to ensure statutory duties and regulatory compliance is adhered to and the Board are sighted on risk, data and robust plans to make informed decisions.



Governance & Assurance



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ A key dependency of this workstream, was obtaining receipt and reviewing the Ernst Young Well-Led Report. This was shared at a Board Development session in August 2025, enabling key deliverables to now initiate as planned and ensure the planned organisational governance review and alignment can commence using the recommendations of the Well-Led Review. ✓ The final iteration of the updated BAF was submitted to the Board Development Session in August 2025 for ratification which now enables revised BAF objectives to be implemented in September 2025. ✓ TSDFT's Balanced Scorecard has made significant progress in the development and testing phase through Executive Operational Groups, including supporting a draft set of metrics for the IQPR which awaits sign off from domain leads. Further efficiency is now being sought from the Business Intelligence Team to automate the scorecard. ✓ Approval of additional Risk resource has enabled agreement for key personnel to commence mid-September 2025. This will support refreshing the organisations risk management training and build capability and skills across teams, ensuring training compliance is captured and recorded.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Governance review action plan implementation	Agreed actions scoped for implementation	>90% of governance improvement actions completed within 6 months	Action plan being derived from Well Led review and Board development (27/08)	↔
Updated BAF and aligned to risk register with cyclic process defined and implemented	New BAF objectives agreed at Board level with plan to implement.	Complete and process in place	On track	↔
Deadlines are met for executive and sub-committee meeting papers	Deadlines are clear and communicated	>90% over 6 months review period	Improvement in position but some delays still noted	↔
Improved quality of papers providing effective data	Papers are produced on the standardised pro-forma on time	The papers facilitate and encourage effective debate and decision making	Improvement noted but remains variable: specific actions agreed at Board development (27/08)	↔
% Risk Management Training undertaken	0	>90% Q3 26/27	Training data not available yet meeting Education team 06/08 to progress	↔
Refreshed IPQR, aligned to best practice with robust governance applied	Existing	Refreshed version ratified	On track	↔

Next Steps
➤ The Governance & Assurance workstream will take forward a series of actions to strengthen organisational oversight and accountability. This will include a review of the recommendations arising from the Well-Led Review to ensure alignment with the planned organisational governance review, and the initiation of the Board self-assessment process. A comprehensive roadmap for governance improvement, incorporating the development of additional KPIs, will be prepared for consideration at the September Board. In addition, a governance framework document will be developed to provide clarity and consistency of approach, supported by the induction of additional risk personnel to enhance capacity and ensure delivery of key governance priorities.

Risk	Mitigation
1. Volume of work is challenging given current capacity	Mitigation through the request for interim A&C support which will focus on governance and risk deliverables. Risk resource due to commence mid-September.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
No CIP aligned to workstream					

Assurance	Rating
Executive Sponsor Rating	Partially Assured



Well-Led



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ The Well-Led workstream is progressing in line with planned deliverables. The final Well-Led Review report has been received from Ernst Young, TSDFT’s strategic partner, and a Board Development session was held on 27 August 2025 to review the findings with Board members. ✓ The full set of recommendations from the report is currently being mapped into themes, with key priority actions identified for presentation to the Private Board on 24 September 2025. Subject to Board approval, the delivery and monitoring of these actions will be overseen through Workstream 1.1: Governance & Assurance, enabling this workstream to be formally closed.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Consistent compliance with best practice CQC Well-Led Single Assessment Framework Quality Statements	37	100%	Well Led review was commissioned to review a specific sub-set of the statements not the full set of 37 therefore this KPI cannot be tracked.	
Review undertaken, findings and report shared with Board with actionable recommendations	N/A	Completed and evidenced through Board reporting	Completed	↑
Evidence of immediate actions completed by end of September 25 with timeline in place aligned to monitoring arrangements for longer-term actions	N/A	100%	TBC post September 25	

Next Steps
➤ An action plan, setting out the proposed approach and timescales for delivery, will be presented to the Executive Committee and subsequently to the Board in September for consideration and approval. ➤ Monitoring of the action plan will be aligned to workstream 1.1 Governance & Assurance enabling this workstream to be formally closed down.

Risk	Mitigation
1. Organisations capacity and capability to deliver final recommendations	Resource mapping and alignment to other workstreams to avoid duplication. Assessment of gaps in resource and consideration of RSP / Regional support being aligned.
2. Failure to agree on review recommendations and next steps both internally or with regulators	Ensuring strong stakeholder engagement with clear action plan and rationale.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
No CIP aligned to workstream					

Assurance	Rating
Executive Sponsor Rating	Fully Assured



Board & Executive Development



Delivered
✓ The workstream is progressing as planned. One deliverable is running one month behind the original plan relating to defining and implementing Board development sessions for 25/26. However, this is interdependent to the themes determined from the Well-Led report to enable understanding of where board development needs to take place. Delay in this deliverable is not anticipating having impact on overall workstream delivery. ✓ The recruitment process for the Chief Planning & Strategy Officer, initiated on 1 September 2025, has now concluded with the appointment now complete. Interim arrangements remain in place for the Chief Financial Officer and Acting Chief People Officer positions, with recruitment processes for substantive appointments scheduled to commence in October. The final review of the Executive portfolio organogram has been completed, approved, and published on the Trust intranet to support wider organisational awareness. ✓ In addition to the ongoing Executive development sessions, the rhythm for Executive huddles has been established, with a forward deep-dive planner developed and fully populated. ✓ The communications plan for Our Plan for Better Care has been finalised and is now being actively implemented as part of the broader organisational communications approach. In response to feedback from the Oversight Group, the KPI for Board engagement has been updated to reflect a rolling 12-month position. ✓ The Workstream Lead responsibility has transferred to Director of Corporate Governance.

Next Steps
➤ Forthcoming priorities for the workstream include delivery of the Executive Development Away Day and the Board Development Session, both in September. In addition, the Leadership Behaviours Framework will be finalised and communicated across the organisation to support alignment and consistency in leadership expectations.

Key Performance Indicator	Baseline	Target	Current Position	Trend
Substantive executive leadership posts filled by 30 th March 2025	75%	100% of posts substantively filled	75%	↔
Delivery of Executive development sessions as scheduled	4	100%	All scheduled with 25% completed	↔
Delivery of board development sessions as scheduled	12	100%	All scheduled with 25% complete	↔
Board engagement & participation (12 month rolling)	89% - March 2025	>85% attendance at Board	88%	↑
Agreed QI methodology in place and with evidence of embedding across the organisation	N/A	QI in place & evidenced use	TBC in following months as deliverable is progressed	↔
Board & leadership effectiveness rating (survey & 360° feedback)	N/A	85%+ positive feedback	TBC work yet to commence	↔
Exec portfolios defined and shared widely	75%	Complete	Complete	↑
Objective setting and appraisal completion for all board members by 24/06/2025	47%	100%	100%	★

Risk	Mitigation
1. Completing priorities / capacity to invest in people and resistance to new ways of working.	Resource mapping and alignment to other workstreams to avoid duplication. Assessment of gaps in resource and consideration of RSP/Regional support and clear change management processes and communication with staff and stakeholders.
2. Selection process for CFO and CPO resulted in no substantive offers.	Interim agreements in place and proposal for renewed recruitment process to recommence in October 2025 approved at NED Nominations Committee on 18th July 2025.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
No CIP aligned to workstream					

Assurance	Rating
Executive Sponsor Rating	Partially Assured

Strategy Programme

Senior Responsible Owner – Simon Tapley, CPSO

Development and delivery of a strategic strategy aligned with the ICS Peninsula Acute Provider Collaborative, ensuring the continued provision of safe, high-quality and equitable services for our population. Strengthening collaboration, improving clinical sustainability and supporting long-term system resilience across the region.



3-5 Year Strategy



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ The strategy development process remains on track and continues under the oversight of the Board-commissioned task-and-finish group. This group, chaired by a Non-Executive Director and comprising clinical and operational leaders from all care groups, meeting fortnightly to provide direction and pace. A further series of workshops completed w/c 11th August 2025. These built on the outputs of the earlier sessions, focusing on more detailed questions with both clinical and support service teams to inform our strategic priorities. ✓ Work has now commenced on drafting the strategy document. This follows testing of alternative formats with key stakeholders, with the emphasis placed on setting the TSDFT’s direction within its wider context and providing a clear, compelling narrative rather than adopting a purely traditional and technical approach. ✓ Close Board involvement through the task-and-finish group provides strong oversight, with members asked to sense-check direction, promote engagement and ensure alignment between recovery plans and the emerging strategy.

Next Steps
➤ The workstream is progressing towards completion of the draft strategy document, drawing on the wider context, outputs from workshops and engagement to date, and insights from existing work already underway. ➤ Further engagement activities planned and close collaboration with the communications team to include varied mechanisms to share and seek feedback on the emerging strategy. ➤ By the time of the forthcoming Board development workshop; proposed positions on issues or a clear process and timeline will be presented for resolution ensuring that decisions are taken in the right sequence and with the appropriate stakeholder involvement.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Ratification of final strategy by Board	N/A	Oct 2025	Final living strategy to be shared with Board in Oct	↔
Commence strategy communications with organisation and relevant information available online and through other relevant channels	N/A	Nov 2025	Workshops & informal conversations have been underway through July & August. Staff and external surveys published in Aug with focus groups planned for Sept.	↑

Risk	Mitigation
1. Potential conflicts between our strategic direction and that of the wider community.	Regular ongoing discussion with partners (particularly through Executive Team) and more formal engagement planned as content is drafted and key elements take shape.
2. Increasing challenges with meeting demand within limited resources – strategy will need revisiting.	Strategy to be tested with “real world” constraints and “tough choices” discussed at Board development session in August.
3. Cultural resistance and capability barriers to strategic planning in wider workforce.	Broad organisational approach required to address issues and shift culture over time under direction of Trust Board.
4. Limited time for planning and wide engagement in strategy may hinder quality/wider acceptability.	Pace and ambition of strategy development means we may have to accept imperfect engagement/involvement early on and make up for some of this later.
5. The strategy will provide clarity around direction and priorities but will not resolve all challenges faced by the trust. Expectations need to be managed, and other work commenced following its completion.	Rigorous testing of our strategy and vision against the realities of our current situation (with key partners) will be required alongside coordination with our recovery plans.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
No CIP aligned to workstream					

Assurance	Rating
Executive Sponsor Rating	Fully Assured



EPIC



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ The EPIC Programme continues to maintain a ‘Good’ status overall, with progress in critical areas and actions in place to address risks and issues across Beacon (<i>serious</i>), third-party contracting (<i>serious</i>), technical readiness (<i>at watch</i>) and the capital gap of £1.1M (£4M for One Devon Program) for EUD which has been reduced to £250K at TSDFT with further work expected to fully close the gap. ✓ TSDFT successfully transitioned from Phase 1 to Phase 2 (User and System Readiness) during the past month and will run through to 23rd January 2026. The Super User Programme remains on track and the process for identifying TSDFT Super Users has now been established, leveraging the Manager Validation workflow. This approach provides strong tracking and reporting capabilities and is aligned to wider management initiatives with the first pilot session, fully subscribed, for Manager Validation occurring end-August. Manager Validation is scheduled for mid to late September. ✓ Third-Party contracting (3PC) now resolved as former risk to following priority 1. However to note; systems remain outstanding for test system readiness having missed their mitigation timelines and will delay the start of integrated testing and mapped record testing for Haemonetics SafeTrace (TSD), Haemonetics SafeTrace (UHP), and Philips ISCV CPACS (all). ✓ The technical workstream remains alert to key challenges of delayed device ordering timelines across both Trusts, outstanding tender for Estates and delayed procurement of server hardware.

Next Steps
➤ Continuation of the ‘User and System Readiness’ phase including progressing training and readiness delivery and finalising end-user device (EUD) funding and procurement. ➤ An Epic Implementation “Deep Dive” session is planned for Executives on 5 September 2025, plus a Benefits Deep Dive has been included on the EPR Program Board agenda for September.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Implementation – As defined in the Epic progress and Orion Build & Change Management reports	NA	‘Good’	Current Status is ‘Good’	★
Benefits realisation – aligned to FBC submission and workgroup change plans	As per FBC	Current from FBC £164M – 10 years	Work on developing Benefits profiles continues, along with identification of emergent benefits. Rebaselining activity will be undertaken in coming months to assure an accurate benefits position is maintained. Benefits has improved to “Good”	↑
Quality & Safety indicators	TBC	TBC prior to rollout	Quality and safety is embedded in Epic as a product, and within our Programme by CxIO overview.	↔
Patient & staff experience	TBC	TBC prior to rollout	There is a continual engagement and communications approach, including roadshows, regular bulletins, and a pulse survey (included on page 2)	↔
Operational Performance	TBC	TBC prior to rollout	TBC	↔
Training for Trainers	TBC	30 November 2025	The training resource plan will be finalised by 15 th Sept and the schedule of train the trainer activities will follow.	↑

Risk	Mitigation
Affordability (R01), Organisational Change (adoption, data quality/reporting) (R04/R05), Planning and Dependency Management (resource allocation, misalignment on plan, other programmes) (R17/R18), Benefits Management (financial) (R19) (All scoring 16).	EPIC full Risk Report details mitigations in place.
Beacon analysts’ outstanding completion of build wave 4 tasks and lack of protocol validation progress.	Additional support from EPIC and further analyst intervention has improved the build position; additional Protocol Validation Standard Operating Procedure and Checklist was tabled and confirmed; Chief Pharmacists have committed to a resource plan that delivers the protocol validation rate; a back up (locum) plan is in place.
3rd Party contracting.	Being resolved through EPIC governance.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG	Assurance	Rating
No CIP aligned to workstream						Executive Sponsor Rating	Partially Assured



Peninsula Acute Sustainability Programme


Torbay and South Devon
NHS Foundation Trust

Summary Position
✓ The Oversight group were updated on the overall PASP programme which focuses on reshaping hospital services across Devon & Cornwall. An escalation was made regarding the slowing of pace for some PASP projects, together with continued challenging relationships between some organisations and difficulty making collaborative decisions at the PAPC Committee in Common (e.g. in relation to cardiology) leading to reducing confidence in the programme. ✓ Progress on developing an organisation-specific highlight report has not been advanced. A fundamental escalation was the recommendation for a Board-level discussion, previously presented in the Partnership Update in June BBF Committee, to agree clear expectations for PASP. This would facilitate agreement of necessary intervention (if appropriate) and be informed by discussions underway with the strategy-in-development. In the meantime, the organisation continues to engage with the programme through the following routes: Top-level direction of the Acute Provider Collaborative (Chair, CEO & CMO), Executive clinical engagement with both workstreams and direct leadership of specific projects across the Peninsula, Strategic leadership and engagement with both workstreams, including direct leadership of specific projects across the Peninsula, Clinical and operational engagement with all projects and Finance, Performance and Workforce support to all projects.

Next Steps
➤ Strategy/Workstream Impact Paper to be developed to facilitate discussion at TSDFT Board-level to ensure discussion is undertaken to agree clear expectations for PASP from the organisation. ➤ Consider the forth coming Strategy Paper to Board to provide a mandate for the team involved to work with system partners to sense-check, align and progress accordingly.

KPIs	Baseline	Target	Current Position
TSDFT has not set expectations for PASP in terms of KPIs for our organisation, and PASP does not currently report KPIs to the wider Peninsula or partner trusts (beyond delivery progress). The KPI headings listed above set broad categories that we might seek to agree targets within with Board support for exploration with the PASP team.			

Risk	Mitigation
1. PASP’s scope is wide and ambitious but impact on system and partners is unclear. Delivery resource, infrastructure and organisational alignment does not match aspiration.	Encourage PAPC and system partners to prioritise developments, clarify aims and ensure resources align with ambitions.
2. Potential conflict between wider system aims and those of TSDFT community.	Escalated to Our Plan for Better Care to facilitate Board to clarify TSDFT aims/ expectations for PASP.
3. Many services are under extreme pressure, which ability of our teams to effectively engage with projects.	Ongoing prioritisation and engagement with system partners to support collaborative work.
4. Risk of conflict between projects under-way and new direction from national or regional developments.	Ongoing liaison with PMO and strategic partners to align aims.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
No CIP aligned to workstream					

Assurance	Rating
Executive Sponsor Rating	Not Assured



Adult Social Care



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ Following a review of this workstream the deliverables have been substantially revised to more closely reflect the work that is required to deliver the workstream objectives. These were subsequently approved by the Oversight Group.
- ✓ A CQC inspection during August and September has required significant management focus on the forthcoming assessment, reducing capacity for the IIP ASC Workstream. Nonetheless, substantial progress has been achieved in preparation activities. These include confirming leadership roles, benchmarking staffing structures, and initiating engagement sessions with operational teams. Work has also commenced on reviewing costs and funding using SLR and other financial data, and a draft performance specification covering quality and KPI measures has been completed. In addition, actions are underway to address longest waits, case reviews, and safeguarding.

KPIs	Baseline	Target	Current Position	Trend
To manage year on year growth to be less than or equal to 2%	TBC	2%	TBC	TBC
To manage year on year cost increase to be less than 3%	TBC	3%	TBC	TBC
Market capacity for Supported Living / Extra Care Housing	TBC	TBC	TBC	TBC

Next Steps

- Resolution of outstanding KPI data issues.
- Progress will be advanced on the data migration required for the implementation of the new case management and provider payment system, together with the continuation of SLR benchmarking and delivery of the improvement plan.
- Detailed planning will be undertaken for choosing and embedding a practice model to support the strengths-based approach in Torbay's social care practice, including occupational therapy.
- Strengthen processes to ensure more effective management of front door demand.

Risk

1. Unknown baseline for KPIs impacts on understanding where services should aim in the future.
2. Workforce capacity to drive review of service as indicated in the objective and drive delivery

Mitigation

Agree KPI specification to build a KPI report to aid reporting and review. A draft KPI specification has been shared with key stakeholders for return by mid September following which the information team will build the report for ongoing monitoring and reporting.

Recognising the CQC inspection has required resource to be temporarily moved from the delivery of this workstream onto the inspection. PMO support for the substantive project lines remains outstanding. Escalation will be via the S75 meeting.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG		Assurance	Rating
Client Review & Transformation (2 schemes)	7,981	6,398	7,796	-31 (Client Reviews)	Transformation	Client Reviews	Executive Sponsor Rating	Partially Assured



Continuing Health Care



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ At M5 the CHC team have overdelivered their full year CIP target and are forecast to continue to deliver additional CIP to support the organisations overall CIP position.
- ✓ Client numbers continue to be in line with NHSE tolerance levels for conversation rates.
- ✓ The service consistently achieves the NHSE KPI's on decisions concluded within 28-day, increasing by +2 percentage points (86%) and long waits over 12 weeks remain as previous month (0).
- ✓ It is recognised that overdue FNC reviews is off track and have increased in month. A resource-based recovery plan has been developed, and the recruitment process has commenced.
- ✓ The service continues to await the publication of the Model ICB, for which a number of the deliverables within this workstream are dependent. This includes a review of CHC governance and reporting to ensure the Executives and Board are sighted on the CHC service and understand the regulations associated. This deliverable is currently off-track due to delays in the publication but which is expected imminently. In the meantime, the organisation continues to engage with conversations across Devon & Cornwall to start alignment.

Next Steps

- Consult on Model ICB with key stakeholder once available (expected early September 25).
- Review current governance structures for the service and evaluate to strengthen considering the NHSE mandated requirements and publication of Model ICB.
- Progress implementation to recruit 2x B6 WTE additional staff to enable additional CIP.

Key Performance Indicators	Baseline	Target	Current Position	Trend
To manage year on year cost growth to be < or equal to 3%	TBC	3%	TBC but above 3%	↓
Client numbers and spend activity using NHSE benchmarking and cluster data to ensure that TSD is in line with peer cluster groups and rest of Devon			Unable to currently report on this KPI. To be reviewed & updated for October Oversight	↑
No long waiters (over 12 weeks) and 80% of decisions concluded within 28 days	69	Only those due in month	86%	↑
Reduction in overdue FNC reviews	196	60	221	↓
CIP target reached 25/26	N/A	£2.2m	£3.08 (TBC by Trust finance)	★

Risk	Mitigation
1. Procurement of multiple IT Systems (Torbay Council have procured CMS, ICB have procured CHC end to end system, Community Health services are planning to use EPIC) presents a risk of Case Managers in Torbay not having access to up to date case notes which will ultimately impact on the patient's overall care.	Escalated to TSD Informatics. Work has commenced to process map the information flow in order to identify and mitigating actions and cost.
2. The workstream is heavily reliant on the outcome of the Model ICB report to drive several deliverables forward.	This is expected to be shared with CEO's and CNO's imminently.
3. Growth – there is an increase in cost growth this month due to 2 specific care packages, although client numbers do continue to fall. This reflects the unpredictability of the service given the complexity of the patient users and we could see this pattern month on month	Working with Finance to pull through cost growth into the internal performance dashboard enabling efficient analysis. This will enable the team to report on growth KPI next month in terms of clear figures.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG	Assurance	Rating
Continuing Healthcare Reviews	2,127	2,626	3,087	960 over plan		Executive Sponsor Rating	Partially Assured



Child & Family Health Devon



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ Options appraisal report for single provider to be presented to DPT Board on 16th September and TSDFT Board on 24th September. Subject to approval this will be submitted to the ICB at the end of September. In the meantime, fortnightly collaborative single provider planning group continues with a dedicated action plan which is on track.
- ✓ Engagement with CFHD staff continues as planned with a whole staff communication session on 28th August and a further planned for 23rd September. Staff side are engaged in the CFHD engagement events in preparation for decisions being made and next steps.
- ✓ Fortnightly IM&T transfer workstream continues with a target for transfer w/c 22 September 2025 and devise deployment w/c 15 September 2025.
- ✓ In parallel to the options appraisal, due diligence continues to be prepared. CFHD are funding (from underspend) additional People service resource. This is currently being sourced by the HR business partner. HR support has been confirmed within TSDFT.
- ✓ Close working between TSDFT and CFHD regarding 2 posts that have been identified as potentially not transferring and will need agreement.

Next Steps

- Provider option to be agreed by TSDFT and DPT Boards and submitted to Devon ICB at the end of September.
- Financial risks and implications are to be completed.
- Several people-based activities will continue or start including staff-side and stakeholder engagement once key decisions have been made.
- Dedicated leads from each Trust to be identified from DPT and TSDFT.
- Source additional HR/employee relations support.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Develop a Communication plan	No plan	Commence August 25	Commenced and ongoing	↔
Agree final single provider option		30 September 25	On track with presentation to boards planned	↑
Identify financial risks		September 25	Under development	↔
Reduce / remove interoperability challenges within CFHD		3 months post-transfer completion	On track	↔
Agree TUPE transfer of staff to new provider		March 26	On track	↔

Risk	Mitigation
1. Areas other than contractual that need to be addressed e.g. access to systems, maintenance contracts, training, supervised practice. Inability to resolve which could result in failure to deliver service.	Mapping for each area to be undertaken.
2. Decision not been made within the timescale set by the ICB for the emergency awarding of the contract to be utilised	
3. Information governance delays regarding information sharing for both IM&T transfer and single provider due diligence	Escalated 27 th August

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
No CIP aligned to workstream					

Assurance	Rating
Executive Sponsor Rating	Fully Assured

Performance Programme

Senior Responsible Owner – Adel Jones, COO

Improved and sustained delivery of the agreed improvement trajectories across urgent and emergency care whole system pathways. Focus on recovery and elimination of long waiters across cancer and elective care including efficient waiting list management and transformed embedded pathways. Emphasis on reduction of clinical harm to provide better patient outcomes.



Elective Care



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ An Elective Delivery Group has been established to improve oversight and rigor of elective care. Work is now progressing to ensure this is a robust forum and outcome driven. This includes confirming the relevant KPIs for monitoring and format / frequency of highlight reporting. Success has already been noticeable within the KPIs. Finalising overview project plan.
- ✓ There has been an external visit by the ICB at RTT meetings and theatre planning meeting. Feedback has been received and will be reviewed for learning/ changes going forward.
- ✓ The ICB have confirmed funding for the Netcall service will be transferred for a period of 12 months. Discussions with Netcall commenced around transition to TSDT.
- ✓ Interviews for the Orthopaedic posts took place in August and are predicted to commence in month 10. One Dental nurse has commenced, which has enabled OMFS to cover additional clinics and cease outsourcing from the end of July.
- ✓ An external transport review has been conducted to inform the best location for the diagnostics lanes to be based. Currently awaiting report.
- ✓ OMFS has concluded the preferred location of the new unit and is currently finalising planning around this. Funding still to be confirmed.

Next Steps

- Analyse feedback and identify required structural/process changes for PTL and theatre planning
- Obtain Trust board sign-off decision of location of diagnostic lanes
- Recruit to any existing validator posts
- Identify capital plan to determine the preferred solutions for Maxillo-facial expansion scheme and solution to achieve the theatre upgrade; Options for design have been approved by Exec.
- Recruit WTE for OMFS (at interview stage)
- Recruit ENT SAS doctor (at interview stage)
- Consider alignment of KPI's to model hospital including capped theatre utilisation %, and average length of stay for elective admissions

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
Additional Income [...] to achieve 114%	2,000	1,242,431	2,000	0	

Key Performance Indicators	Baseline	Target	Current Position	Trend
RTT 18 week wait by March 2026	58.56%	66.6%	68.1%	★
RTT 52 week wait by March 2026	3.74%	<1% of waiting list	2.0%	↑
Theatre utilisation rates	80%	85%	82.34% (August)	↑
Theatre fallow sessions	81%	85%	78% (August)	↓
Reduce all long waiters over 78 week and 65 weeks	9	0 (End of Oct 2025)	14 over 78W (Aug) 83 over 65W (Aug)	↓
Wait to 1st activity by March 2026	63%	70.3%	69.2%	↓
Validation in the last 12 weeks	38%	90%	76%	↑
Reduce LCAD in Ophthalmology for Medical Retina and Glaucoma	18%	>5%	19% Glaucoma 40% MR	↔
Achieve activity volumes as per Targeted Investment Fund (TIF) business case	18 / 40	25 / 60	ESU2 45/60 DSU4 14/30	↑
Activity against plan 19/20 baseline	Activity v 19/20 levels by POD Planned Care	114% of 19/20 baseline	118% at month 5 activity 117% income	★

Risk	Mitigation
Netcall unconfirmed position	SRO has previously met with ICB and EPIC to commence discussions to repatriate Netcall system to TSD. Funding from ICB to be transferred for 12 months.
Drive and support developing an elective care dashboard – it is recognised there are capacity issues for the internal BI team with an ever-increasing list of requests to automate & improve reporting.	Progression of producing the elective dashboard has been escalated to the interim COO who is unpicking priorities for the team, awaiting outcome.
Glaucoma - No feedback received.	Feedback from execs on decision of location of diagnostic lanes following meeting 14 th August.

Assurance	Rating
Executive Sponsor Rating	PARTIALLY ASSURED



Diagnostics DM01



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ MRI Performance shortfalls are mitigated by CDC Radiographers training to image small bowels, currently within InHealth governance; agreement to send non-USC prostates and liver scans to CDC with training commencing in September and October respectively.
- ✓ CT performance continues to be driven by Cardiac CT. Actions to support performance include additional CT cardiac list, training plan requested for Radiographer-led CT imaging, review of Consultant rota for short term weekend capacity; workforce planning review and request for finance support regarding vacancies.
- ✓ Monthly 17% rejection rate from CDC indicating high proportion are patients declining to attend the CDC and choosing to wait for an appointment at TSD. High rate of assurance that all appropriate CT request are referred to CDC. MIG has been set too high which has been consistently escalated however, September re-profiling should assist.
- ✓ CDC re-profiling exercise completed. This will seek a reduced requirement of bloods and x-rays in place of required activity such as NOUS and ECHO. Now with InHealth to mobilise contract.
- ✓ NOUS on track for 0% waiting over 6 weeks by March 2026.
- ✓ Physiological services Dexamethasone insourcing and mutual aid commenced in August. ECHO recovery plan in place and linked to CDC reprofiling.

Next Steps

- Imaging Action Plans to be submitted to September EOG
- Review and update KPI's to reflect modalities and consider inclusion of equipment utilisation
- Mobilise new CDC reprofiled activity
- Recruit into Endoscopy posts.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
Endoscopy Workforce Transformation	80k	0	0	-80k	Amber
Mobile scanning unit	500k	504k	504k	0k	Green

Key Performance Indicators	Baseline	Target	Current Position	Trend
Achieve <5% for 6 weeks diagnostics	35%	5%	37.1%	↑
CT Urgent 2ww - Reporting turnaround time - in days	17	3	24	↓
CT Urgent – Reporting turnaround time - in days	22	5	25	↓
CT Routine – Reporting turnaround time - in days	22	10	26	↔
MRI Urgent 2ww - Reporting turnaround time - in days	11	3	9	↑
MRI Urgent- Reporting turnaround time - in days	20	5	22	↔
MRI Routine - Reporting turnaround time - in days	22	10	24	↔
X-ray Urgent 2ww- Reporting turnaround time - in days	2	3	3	↑
X-ray Urgent - Reporting turnaround time - in days	2	5	13	↔
X-ray Routine- Reporting turnaround time - in days	3	10	13	↔

Risk	Mitigation
1. Non-elective care impact on elective recovery, e.g. MRI.	Ensure full usage of CDC, review of referral practices to MRI.
2. Ability to recruit into all desired posts to increase core capacity in areas Imaging/ endoscopy.	Ongoing recruitment plans in place.
3. Machine breakdown due to equipment past life expectancy.	Good maintenance contracts in place.
4. Endoscopy behind plan with regards to operator and nursing recruitment. This will put pressure on the £80k benefit this financial year however, will continue with scheme given the full-year recurring effect will be c.£250k.	The mitigation this year has been to offset other ERF planned spend to reduce risk of CIP not achieving. Review has taken place in August to reprofile and save c.£400k in ERF planned spend.

Assurance	Rating
Executive Sponsor Rating	Partially Assured



Outpatients Transformation



Delivered
✓ Information received from all specialties in August regarding what services must be delivered on the acute site (clinical criteria). This will inform the objective around which services need to remain onsite and be able to maximise all the community footprint. Analysis throughout September and recommendations to be produced in October report. ✓ BookWise procurement issues have now been resolved, and the programme has progressed to the mobilisation phase (12 weeks). Preparatory milestones remain on track, with implementation and post-go-live monitoring aligned to ensure sustainability. A SOP has been produced for 6-4-2 utilisation in preparation for go live. ✓ Updated appointment text alerts: IT coding changes underway to ensure all clinic codes are accurate. New text wording generated to clearly state appointment location, service area, date/time, and cancellation options. ✓ All clinics have been standardised in line with GIRFT clinic recommendations. The next step is to clarify capacity released by this with the specialties and include it in the next reporting cycle ✓ No OPUG meeting in August due to lack of attendees and EPIC commitments so specialty reports to be received in September

Next Steps
➤ Space review for the acute site- agreed and approved for implementation in October 2025 ➤ Job planning review ➤ 5 – 10 year transformation plan ➤ Nursing review ➤ Operational & Clinical risks ➤ Strategic direction/plan for outpatients across the acute and community sites

Key Performance Indicators	Baseline	Target	Current Position	Trend
RTT 18 week wait	58.56	66.6%	68.8%	★
RTT 52 week wait	3.74%	<1% of waiting list	1.9%	↓
PIFU	8%	9%	8.2%	↓
DNA	4.5%	4%	4.7%	↑
Cataract market share	62%	75%	67%	↑

Risk	Mitigation
1. Wider transformation effort is limited by the absence of a single structured and integrated outpatient delivery model	Outpatient services are not solely managed by one team, and various workstreams and services feed into a fragmented system without central oversight. Multiple workstreams and services contribute to outpatient activity. This is a significant risk for clinic utilisation, where variation in booking practices, staffing, and space availability can result in inefficiencies and underuse. Additionally, the use of multiple outpatient locations, some of which may be impacted by community consolidation (e.g. Paignton), places further pressure on physical capacity and service delivery. Escalation to support a defined governance model and coordinated delivery approach as progress remains vulnerable. There is a need for executive oversight to support structure, clarity, and integrated planning across outpatient pathways as well as job planning.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
Outpatient transformation	500k	0	0	-500k	Closed – not progressing

Assurance	Rating
Executive Sponsor Rating	Partially Assured



Cancer Services



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ During August, for the 28-day FDS, the current position is at 62.7% and not achieving the 75% target; Lower GI (53%) and Urology (37%) remain the biggest areas of concern, with both high patient volumes and low compliance. Despite these challenges early indications for September are that the 65% trajectory will be met. ✓ In response to the position a number of actions have been implemented including the establishment of weekly oversight meetings to provide assurance against the RAP. Timed pathway reviews, benchmarking services against national best practice are underway which has generated new actions and targeted interventions in urology already. Radiology management met to review MRI recovery plan, setting goals against best practice urology pathway, noting MRI Prostate is a principal delay in the pathway. Draft change plans have been produced by dermatology for creating a dedicated BCC pathway for low-grade skin lesions and using teledermatology with dermoscopic images to support lesion triage. ✓ 62-day Cancer Standard performance rate stands at 66%, pending in-month validation. Following validation, we anticipate this figure will decrease to between 62% and 64%. The lowest performing areas include Lung (47%), Colorectal (46%), and Urology (27%). With the recovery of Dermatology waiting times, we have overachieved the initial estimate of 60% performance. ✓ Note: Overall this workstream has been rated as RED as all KPIs are below acceptable standard.

Next Steps
➤ Draft change plans have been produced by dermatology for creating a dedicated BCC pathway for low-grade skin lesions and using teledermatology with dermoscopic images to support lesion triage. Next steps are to identify funding requirements and potential sources of income/efficiency. ➤ Timed pathway analysis started, detailed plans underway with urology and further meetings in the dairy.

Key Performance Indicators	Baseline (June 2025 – submitted figures)	Target	Current Position (August 2025)	Trend
28-day Faster Diagnosis Standard	75.6%	80% (by March 2026)	62.7%	↓
62-day Cancer standard	64.6%	75% (by March 2026)	66.1%	↑
31-day Treatment Standard	93.6%	96%	88.4%	↓

Risk	Mitigation
1. The 62-day backlog (remains high, which is an indication that performance into September will remain relatively static.	The targeted interventions described aim to reduce this but are likely to increase breaches in the coming month as the backlog is cleared.
2. Higher growth in referrals than planned for, i.e. increase in cancer referrals in dermatology and H&N. Risk increased (12 → 16) regarding the impact of increasing cancer referrals.	Dermatology, specific demand management action regarding BCCs. Other sites to monitor demand, increasing capacity where needed. The Deputy COO is holding weekly improvement meetings, supporting services to develop robust recovery actions and support the delivery of these.
3. Workforce (many sites have single points of failure/small teams and/or hard to recruit to specialism).	Workforce plans to be produced in high-risk areas, to advise on site-specific actions needed.
4. Operational capacity (stress during time of high pressure/change).	Workload and wellbeing of staff to be prioritised.
5. Financial risk (Insourcing and WLI – including admin and clerical staff).	WLI/Insourcing cases to continue to be presented to Care Group Directors for sign-off. To use external funding where possible, balance the risk of performance delivery vs. financial constraints.
6. Competing demands in 18-week RTT, ED and Cancer.	Prioritisation of cancer work over 18-week, where clinically appropriate.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG	Assurance	Rating
No CIP associated with scheme						Executive Sponsor Rating	Not Assured



UEC Flow



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ Process improvements for Triage and RAA are complete in readiness for embedding in BAU alongside SRU Bleeps to Phone project completion. ✓ A SWAST and SRU improvement for patients with catheter issues has been identified and is being developed. ✓ Process improvement relating to flow and bed management includes the completion of SPOC standardisation and continuation of improvement in ‘safety crosses’ checklist. Feedback was collated and shared after Go-Sees proposal was approved by the Recovery Group in August. Criteria-led discharges, weekend capacity and clear & impactful escalation process require agreement on improvement plans. ✓ ECIST review in August (of July activity) was positive. ECIST satisfied with progress made. Improved performance has continued into August.

Next Steps
➤ Focus on daily breaches & near misses with associated actions highlighted at daily handovers, focusing on flow from waiting room and resolving capacity issues that are impacting on Fit2Sit. ➤ Maximising Fit2Sit; night-time breaches; re-focus on embedding the ward improvement benefits achieved during Right Care week – namely Golden Patients and consistent YNP. Additionally, in September, AMU will be implementing a single point of access phone test of change to triage and manage calls from health care professionals, GPs and SWAST. ➤ Complete the ED workplan and finalise night-time rotas. ➤ Embed process improvement as BAU for RAA and Triage ➤ THP45 Phase 2: Extend out of hours to midnight (Mon-Fri) and weekends to 8pm ➤ Work on escalation policy for ambulance handover delays including identification of additional escalation spaces, effective use of bed spaces, processes for transfers and decision-making.

Key Performance Indicators	Baseline	Target	Current Position (August)	Trend (month-month)
4 hour performance (% below 4 hour wait)	70.09	78%	74.1%	⬆️
Average Ambulance handover time (Minutes)	47 mins	45 mins	38 minutes	⬇️
45 min Max handover per ambulance (No. Breaches)	659	0	543	⬇️
No Mental Health patients over 24hrs in ED	8	0	10	⬆️
Paeds 4hr Performance (% children spending less than 4 hrs in ED)	86%	95%	86.1%	⬇️
Max 12 hrs in the ED (% patients spending >12 hrs)	5.8% ICO / 8.71% ED	10%	5.8%	⬆️

Risk	Mitigation
1. Deliverables 1 and 2 in the plan have not been fully delivered by August 2025 due to delays caused by staff capacity.	It is expected that they can be delivered now by the 30 th September 2025.
2. Deliverable 3 (Ambulance Handovers) has not been delivered by the end of August 2025.	Agreed a phased approach in partnership with SWAST ref implementation of THP45 and will continue to expand the initiative throughout the year. A more achievable timescale for this deliverable is 31 st March 2026 as this will allow time to explore and trial all possible opportunities to improve handover times and will enable with the completion of the ED re-build/configuration.
3. 4 out 5 months this year have shown over 11,000 attendances as an ICO and 7,000 attendances to ED, new demand highs with July and August being the two of the busiest months ever experienced.	Mitigations in place and delivery continues to improve against those challenges.
The impact of the ED build on patient and staff experience linked to environmental issues	ED Operations Manager working with building contracts to minimise disruption

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG	Assurance	Rating
No CIP associated with scheme						Executive Sponsor Rating	Partially Assured



Community Services Redesign (Frailty)


Torbay and South Devon
NHS Foundation Trust

Delivered
✓ The Frailty Business Case has been submitted through EOG, Executive Committee, FPC, and Board. Further development is required ahead of submission to the September Board. A staged approach will be necessary, with the November launch model reflecting current constraints, as recruitment at risk is not possible to enable deployment of an SDEC model at this stage. ✓ Scoping with IM&T and review of support request initiated, alongside development of POD and EQIA, for Stage 1, leading to submission for approvals. ✓ Initial conversations have begun with the Head of Site Operations and the Associate Director of Nursing Professional Practice for the community regarding the rapid access bed on Teign Ward at Newton Abbot which is a pivotal pathway in Stage 1. ✓ The second process mapping sessions, with key stakeholders including SWAST, pharmacy and QAIT, was held to identify the patient pathway proposed to enable a gap analysis of outstanding requirements and processes that are required. ✓ Proposed new deliverables have been developed and are reliant on approval through the frailty reports being presented to ExCo, FPC & Board in August and September. Proposed KPIs were included in the business case submitted to EOG in August.

Next Steps
• Develop Mobilisation Plan to develop trajectory from November 25 start to Phase 1 being fully mobilised (dependent upon corporate sign off and successful recruitment) • Deliver impact assumptions for the 25/26 Winter Plan • Submission of EQIA to the panel on the 11th September. • Introduction meeting scheduled with the change management team in EPIC for the 28th August to ensure the development of these pathways can be integrated into our EPR system for launch next year. • Meeting with Digital Innovations Lab to understand how AI could support the Community Healthy Ageing Hub model and the care provided to these cohort of patients • Attendance to weekly Frailty Programme Huddles to maintain momentum and strong communication with key project lead and to the Frailty Programme Board meeting to provide updates, escalate concerns and any changes to risk status/scores.

KPIs	Baseline	Target	Current Position	Trend
Reduced ED attendances	KPIs have been reviewed, and subsequently supported by Oversight Committee, with the Business Intelligence team to provide assurance on monitoring once the model is launched and to ensure the outstanding KPI can be captured in a more robust and accurate manner.			
% of CGAs completed				
Occupied bed days				

Risk	Mitigation
Insufficient funding available to deliver the workforce model, particularly future phases which see extended operating hours (Very High Risk = 20	Workforce modelling is underway for delivery of phase 1 of the new model of care. Modelling for future phases will then be required with a gap analysis undertaken to understand staffing requirement.
IM&T system amendments required e.g. new ward set up area on swift plus, a new take list on Clinical Portal 2 to enable clinicians to complete notes for onward community care plan summaries. This poses clinical risk should this not be resolved due to accuracy of patient status and information sharing.	Project Management support from IM&T required.
Contract management of Care Coordination given current failure rate of patients attending ED via ambulance	Risk added in Oversight Committee, confirmation of mitigation with SRO

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
No CIP associated with scheme					

Assurance	Rating
Executive Sponsor Rating	Partially Assured

Community Services Redesign (Elective Centre of Excellence)

Torbay and South Devon
NHS Foundation Trust

Delivered
✓ The performance deliverables for Ophthalmology and OMFS continue to progress through the Elective Care Workstream. ✓ Work is required to review and redefine the deliverables so that they align to the capital estate work that is being completed to deliver the service reconfiguration. This requires the appointment of a workstream lead. This has not been progressed in month due to competing capacity challenges but will be appointed in the next reporting period to enable the development of a detailed delivery plan

Key Performance Indicators	Baseline	Target	Current Position	Trend

To be developed post development of delivery plan

Next Steps
✓ Develop detailed delivery plan, including KPI's .

Risk	Mitigation
To be populated post development of delivery plan	

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
There is currently no justification for developing or transacting any CIP linked to this workstream until its future scope and delivery approach are confirmed through routine governance processes. Should the workstream be reactivated, any potential CIP opportunities will be assessed and developed in line with Trust procedures.					

Assurance	Rating
Executive Sponsor Rating	Not Assured



Maternity and Neonatal Safety Improvement Programme



Delivered

- ✓ Workstream leads were assigned and brought together as part of an introductory meeting after completed collation of the Maternity & Neonatal Improvement Plan (MNIP) and continuation of ensuring the plans are robust and have assigned project leads.
- ✓ MNIP draft governance process has been outlined,
- ✓ Continued work on the MNIP governance with support from Maternity Improvement Adviser to align with best practice and will ensure robust rhythm and rigor for all workstreams is implemented within its own structure. This will further enable reporting through internal quality forums and externally to the Local Maternity and Neonatal system (ICB) and national maternity teams. The programme oversight will also report as part of the One Plan for Better Care to give assurance and oversight to all execs.
- ✓ Birthrate Plus (BR+) Establishment review – Meeting is now confirmed for end of September when draft report is expected. This will then need to be reviewed and amended before the final report is ready.
- ✓ Safety standards for Maternity Incentive Scheme (CNST) shows an improvement from 6 to 7 due to improved engagement from the Maternity and Neonatal Voices Partnership with the Board level safety champions and the QUAD team and are anticipated to remain on track to meet 10/10 by March 2026.

Next Steps

- Workstream leads, with project leads, to review action plans ensuring no duplicated actions, robust aims and measures are in place and hold first workstream group meetings. Workstream leads meeting also planned.
- Continue to align governance processes with the NHSE Maternity governance tool kit
- The first Peri-natal Improvement Board is scheduled for October, and invites will be sent
- Terms of Reference will be drafted for Peri-natal improvement Board and Workstream Groups
- Confirmation of report on improved triage model, which has been delayed with procurement, but will enable initiation of contractor appointment.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Safety standards for Maternity Incentive Scheme (CNST)	8/10 for 24/25	10/10 by March 2026	7/10 - Sept 25	↑
Birthrate Plus (BR+) Establishment review	100% compliant for most recent report published April 2021	100% compliant by December 2025	Awaiting report – not due until Dec 25 (see update below)	
MSSP Exit Criteria	<20% complete	60% complete by March 2026	<20% complete	↔
A medical workforce to meet service acuity and activity requirements	See Risks for note	fully established by end of 25/26	Still to be reviewed as part of MNIP	↔
Improved triage model	60% compliant with national standards	100% compliance with national standards by Q3 25/26	60% compliant – at bas	↔

Risk	Mitigation
1. Potential inability to increase the headcount that may be identified as part of the BR + review	Workforce workstream stood up. Awaiting report detail in order to identify effective mitigations – expected end September. Current biannual staffing report being presented to QAC/Board in September which highlights positive metrics in relation to optimum staffing levels and acuity.
2. KPI for medical workforce – Demand and capacity planning shows that Gynae services has sufficient capacity to meet current demand.	Demand and Capacity planning did not include Obstetrics, and gaps remain around remuneration and protected time to complete obstetric leadership roles. Women's Health will not be seeking funding for additional workforce within the remainder of 25/26 financial year. However, as part of the 26/27 business planning round as well as production of a perinatal workforce strategy, we will review the longer- term workforce needs to ensure we have resilience and succession planning over the next 2-5 years
Improved Triage Model – slight delay with procurement to progress with Estates work	Report not expected until 12.09 which will then allow a contractor to be appointed.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
No CIP associated with scheme					

Assurance	Rating
Executive Sponsor Rating	Partially Assured

BUILDING A
Brighter
Future

Managing Our Estate

NHS

Torbay and South Devon
NHS Foundation Trust

Delivered
✓ The Board Sub-committee (BBF) received report that highlighted areas of key actions regarding critical estate risks and the approach jointly taken by Capital Development and Estates and Facilities Team to eliminate and reduce risks. A mini summit is being set up led jointly by Capital Development Director and EFM Director (Workplace) to enable a holistic review of key estate infrastructure risk of the Tower Block. ✓ Planned divisional assessment activity is underway for a dedicated Executive Committee meeting to consider report from the Workplace Director providing assessment of the key headline risks for the division with recommendations. Meeting to be set up before end of September 2025. This will set out key workstreams that will build on this plan (IIP) and will cover a review of capacity and capability, fire and health and safety management systems, compliance and estates delivery. The output of the assessment report will enable a review and updating of the deliverables and KPI's within this workstream. ✓ Financial escalations have been put to the Oversight group regarding the emergence of cost pressures in year due to additional buildings being acquired by the trust or extended clinical activities that requires hard and soft FM services but for which no revenue budget has been assigned. With immediate effect the oversight group instigated a complete stop on all Care Group requests that increase the cost burden on Workplace team unless there is a funding source.

Next Steps
✓ Development of assessment following first 3 months in post setting out recommendations for focus around key risk themes. ✓ Targeted action around critical risk of Tower by convening a mini risk summit involving board members and technical teams led jointly with Caroline Couzens, Capital Development Director. ✓ Extended deep dives around financial plan for EFM given slippage on strategic areas of change that are outside scope this financial year. Site disposals, WOS. ✓ Review opportunity to numerate the current KPI position

Key Performance Indicators	Baseline	Target	Current Position	Trend
Assessment of compliance and technical capabilities	Consider recommendations following completion of independent review	>50% of recommendations that are agreed to be taken forward within 6 months	Next steps to agree focus for work.	↔
Review governance structures and processes within the division including implementation of improvement programme to strengthen estates operations functions	Improvement programme for estates ops team has been developed and agreed with team.	>80% of improvement programme actions completed within 12 months	Underway with staff consultation commenced	↔
Commission full 6 facet condition survey (prioritising acute site in the first instance)	Condition reports are 5 years old	100% completion of process to commission 6 facet survey within 3 months	Approval to commission at Executive Committee 14 th August	↔
Business case completed and funding secured for CAFM	Obsolete BackTRAC system in place	Commission new CAFM system and commence asset management	Not Started – preliminary work underway	↔

Risk	Mitigation
Inadequate Capital Investment to deliver estate strategy	Commission 6 facet condition survey to support management of estate risks.
Critical Infrastructure failure causes significant harm	Implement estates improvement programme to increase reactive and proactive maintenance capacity.
Constrained financial position may restrict access to capital and revenue to invest in condition survey and CAFM system	Set up programme of work to instigate steps to replace CAFM system
Implementation delays impacting full year impact of savings resulting in £500k gap to CIP delivery.	Finance specifically reviewing CIP scheme 26-043 to mitigate any double counting prior to transaction

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG		Assurance	Rating
Schemes x 12 totalling	1,462	1.0	458	-1,004	10 Schemes	2 Schemes	Executive Sponsor Rating	Not Assured

Finance Programme

Senior Responsible Owner – Mark Brice, CFO

Delivery of a sustainable financial improvement plan that strengthens stability and control, achieves a robust cost improvement programme and supports the development of a credible, high-performing finance function to enable the organisation to make informed decisions, optimise resource, restore financial stability whilst ensuring we live within our means.



Sustainable Financial Improvement Programme Process


Torbay and South Devon
NHS Foundation Trust

Delivered
✓ Actions associated with the NHSE CIP review report are progressing well with 24 of the 34 actions completed and the remainder are on track for completion on schedule. Actions completed in reporting cycle include; the development of an earlier business planning process; clear definitions for scheme risk ratings developed and applied; forecasting process embedded and becoming BAU have been delivered. Developing process and working arrangements between PMO and Finance continues to improve as both teams work to newly agreed processes. ✓ Future improved governance for CIP being progressed at pace by the Director of Corporate Governance with engagement with key stakeholders. Current status being mitigated through the continuation of the Executive CIP Deep dives which will continue until the new governance process is in place. ✓ Less progress has been made on productivity which now needs focus and effort to progress with a paper due to FPC in September 2025. This links to the SLR work but there are specific requirements that need to be met so this will be addressed as part of the planning process.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Introduction of SLR	Reporting unavailable	Reporting available & embedded	Figures have been issues to Care Groups. Detailed packs have been shared for largest loss-making services. Workshops with Care Groups have been scheduled for week beginning 8/9/25. Links to planning process have been described.	

Next Steps
✓ CIP action plan improvements to be completed including embedding of new improved CIP processes and close partnership with the Finance Team. ✓ SLR implementation plan progressing with workshops to be undertaken. ✓ CIP governance to be confirmed following the deep dive process. ✓ Comms strategy: developing guidance to help managers facilitate CIP conversations with front line teams and translate ideas into cash releasing benefits; trialling CIP Drop-In session with the PMO team to help develop ideas into schemes; creating an infrastructure within the Care Group to receive and review grass route ideas. ✓ A focus on productivity and links to SLR and planning with FPC Paper in September. ✓ Review KPI's to include % of service that are viable, was due to be completed in August and is dependent on development and introduction of SLR in each Care Group

Risk	Mitigation
1. Pace of change to leadership, culture and accountability	Ensuring engagement continuously takes place when new leaders on board.
2. Delay in data standardisation and PMO tracker rollout.	Risk is reducing as the work is progressing.
3. Capacity and capability across the Trust to deliver and investing in PMO and Finance Teams to support.	Further investment needed but this is in progress with recruitment planned.
4. Poor quality of reporting hindering effective oversight	Improvements are being progressed as per workstream plan.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG	Assurance	Rating
No CIP associated with scheme						Executive Sponsor Rating	Fully Assured



Sustainable Financial Improvement Programme Delivery


Torbay and South Devon
NHS Foundation Trust

Delivered
✓ The CIP programme totalling £41.5m represents a significant delivery challenge for the Trust and risk has been previously reported. CIP achieved and transacted in months 1 to 5 is being reported above plan by £1.687M as recorded by the Finance Team in the ledger. Planning process for 2026/27 will now be examining the ongoing financial pressures in the context of developing ULP and MTFP. ✓ A more robust process for transacting and forecasting CIP is bedding in. The latest forecast of red rated CIP schemes (high risk of non-delivery) is £9.1m. Urgent Deep Dive sessions to address the risk have been held with Care Groups although this has largely focused on addressing existing Care Group targets rather than the “gap”. The oversight group heard that as part of the revised forecasting process, a long list of schemes have been identified to mitigate the gap which will now be folded into the CIP programme to track progress. ✓ There were 14 unapproved CIP schemes outstanding reported to EOG on 9th September 2025 and it is planned that these will be submitted to EOG on 25th Sept. There will be further schemes added following the deep dive reviews and the PMO are working with Care Group Directors to continue to develop PODs as soon as new schemes are identified

Next Steps
• Identify mitigations for c.£10m to £12m of risk in the CIP plan • Ongoing CIP governance agreed • Approval of outstanding PODs, development of new schemes, converting non recurrent to recurrent all needs urgent attention • Clarify savings estimates from MARS, management review, admin review to quantify impact and manage risks • Agree reporting strategy to ICB and region of the risk position • Review and confirm potential change to workstream lead with SRO • Consider additional deliverable relating to grip and control of non pay and procurement

Key Performance Indicators	Baseline	Target	Current Position	Trend
Total CIP target (£) vs. delivered (£)	£41.5 m	£41.5 m	£2,4259,111 transacted at month 5	↑
% of recurrent vs. non-recurrent savings	79% of plan recurrent	79% delivered recurrent	Recurrent = 70% of transacted at month 5	↓
Efficiency and productivity improvements demonstrated in NHSE monitoring, NCC data	As per NHSE planning guidance targets 2025/26	As per operating plan submission 2025/26	TBC	
Variance from forecast at M3, M6, M9	N/A	£0	Month 5 = £1.7M favourable variance	↑

Risk	Mitigation
1.Pace of change to leadership, culture and accountability	Implement recommendations from Well Led
2. Developing robust mitigations for red rated CIP schemes and other reduced delivery	Deep dive sessions and follow ups
3. Capacity and capability across the Trust to deliver and investing in PMO and Finance Teams to support	Resource plans being implemented
4. Delivery slippage and over-optimistic phasing	More robust forecast process at scheme level now in effect
5. Overreliance on non-recurrent or one-off savings	Challenge through deep dives to convert non recurrent to recurrent

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
Multiple Schemes totalling	41,538	24,259	41,538	0	

Assurance	Rating
Executive Sponsor Rating	Not Assured



Financial Capability & Capacity

Delivered

- ✓ A Planning paper was tabled at and supported by FPC to extend the financial training programme offer to SLT, non budget holder and the enhanced use of finance systems.
- ✓ Development of a monthly financial briefing pack for all staff has still to be started but Finance are still confident that the deliverable can be recovered and completed by end of September 2025 as it will be developed from FPC papers.
- ✓ Finance team structure and workforce plan is progressing with the 30-day staff consultation exercise planned to start after the last post is job matched in early September 2025. The consultation and management response to feedback is expected to be completed by the end of October. Following which recruitment and training of staff into finance structure will progress in November.
- ✓ Work to build a sense of 'valued Finance Team' continues with a training log established to track finance staff attending listed HFMA courses. The TSD finance Team are signed up to the HFMA system for external mentoring and an internal mentoring system will be developed. Level 1 Finance accreditation progresses well.
- ✓ Regents House first floor office refurbishment continues with stage 3 of 5 stages in early September.

Next Steps

- Develop financial briefing pack for all staff and finance training pack for budget holders.
- Commencement of Finance Team restructuring consultation and appointment to Director of Operational Finance & Head of Financial Service roles.
- Progress L1 HFMA Finance accreditation.
- Continue refurbishment of Regents house.
- SLR meetings with operational teams commence.
- Monthly progress of forecasting and analysis of underlying financial position being developed and rolled out.

Key Performance Indicators	Baseline	Target	Current Position	Trend
% of finance staff with completed PDRs	41% (April 25)	100%	53.9% (July) Timing issue with ESR	↓
% of finance roles appointed to future-state senior structure	64%	100%	Consultation on restructure commencing September. Appointments expected to start in November.	↔
Percentage of non-finance staff trained in finance essentials	Not recorded	100%	A working group has been established to develop a financial training programme targeted for clinical and operational leads. An initial assessment about what is offered has been completed which has identified further work that is being discussed.	↔
Improved forecast and UL assessment	6 monthly	Monthly	This is under development and a progress update will be provided for month 6	↔

Risk	Mitigation
1. Awaiting information from Corporate Services on the assessment process required to assess the competencies of the financial team.	Principles outlined in the operational management review paper due for presentation to ExCo in September.
2. Availability of financial resources to implement team changes.	Business case for additional resource to address gaps in capacity to be approved.
3. Workload issues (particularly in teams carrying long-standing vacant posts) reduces capacity to instigate change.	Business case for additional resource to address gaps in capacity to be approved.
4. Availability of financial resources to implement team changes.	Business case for additional resource to address gaps in capacity to be approved.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
No CIP associated with scheme					

Assurance	Rating
Executive Sponsor Rating	Partially Assured



Managed Services & Subsidiary Company Arrangements


Torbay and South Devon
NHS Foundation Trust

Summary Position
✓ A formal Highlight Report has not been submitted for Our Plan for Better Care Oversight Group this month. Highlights were presented verbally for consideration. ✓ This reflected that a number of opportunities have been identified for wholly owned subsidiaries including PENRAD, Linen services, managed theatres and EFM. ✓ The volume of work to fully scope these opportunities means it will be unlikely that the opportunities will be developed in year. Effort will continue to bring these opportunities together under a single workstream, for which a workstream lead must be identified. ✓ Once a clear model has been identified, the tax advice commissioned for PENRAD will be utilised or recommissioned if necessary.

KPIs	Baseline	Target	Current Position	Trend

Next Steps
➤ Appointment of Workstream Lead to take forward POP and deliverables

Risk	Mitigation

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG	Assurance	Rating
Special Purpose Vehicle for Estates, Facilities & Capital	1,000	0	0	-1,000		Executive Sponsor Rating	Not Assured



One Devon Shared Services (Finance)


Torbay and South Devon
NHS Foundation Trust

Delivered
✓ A workstream lead has been appointed in month. ✓ Commenced establishing the workstreams plan on a page, including KPI's. This will be submitted to Oversight group for approval via the SRO.

KPIs	Baseline	Target	Current Position	Trend

Next Steps
✓ Workstream Lead to finalise the plan on a page for One Devon Shared Services (Finance workstream) and to develop a detailed delivery plan underneath for monitoring and tracking delivery.

Risk	Mitigation

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG	Assurance	Rating
No CIP associated with scheme						Executive Sponsor Rating	Not Assured



One Devon Shared Services (Procurement)


Torbay and South Devon
NHS Foundation Trust

Delivered
✓ A workstream lead has been appointed in month. ✓ Commenced establishing the workstreams plan on a page, including KPI's. This will be submitted to Oversight group for approval via the SRO and Procurement Shared Services Leadership.

KPIs	Baseline	Target	Current Position	Trend

Next Steps
✓ Workstream Lead to finalise the plan on a page for One Devon Shared Services (Procurement workstream) and to develop a detailed delivery plan underneath for monitoring and tracking delivery.

Risk	Mitigation

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG	Assurance	Rating
No CIP associated with scheme						Executive Sponsor Rating	Not Assured

People Programme

Senior Responsible Owner – Jess Piper

Delivery of a Workforce Plan to ensure the right size workforce is in place to support improved patient outcomes. Delivering a People programme that fosters a positive, inclusive culture with high levels of staff engagement. Developing a people strategy aligned to the Trust's long-term vision, priorities and values.



Workforce Plan & Transformation

Delivered
✓ Overtime Controls: Costings have been calculated on options for overtime targets to reduce the overall spend, with proposals focused on reductions in all patient facing areas and all admin/support across the Trust, except Workplace recognising the support they directly provide to patients. Requires sign off from CFO. ✓ Pay control – vacancies: Work with the recruitment and finance team continues to develop a process to track the financial impact of the 'break glass process' to enable us to quantify the scheme. Oversight group heard that finance have completed costings as part of the revised forecast ✓ The Mutually Agreed Resignation Scheme has now closed, with 49 applications received of which 44 were approved totalling 36.44WTE. Communication of panel decision to applicants was sent out in early September detailing process for approved applicants to leave TSDFT. The Oversight group were supportive in principle to run a second round of MARS to be launched in February 2026, pending NHSE approval but requested it was tabled at ExCo in October. ✓ Strengthen collaboration between Finance and Workforce: Viridian has completed their work which examined both internal and external workforce and financial reporting outputs, with a focus on identifying root causes of data quality issues. Stakeholder session between Finance and Workforce is now complete. Highlighted key issues and opportunities for improvement have been provided by Viridian which needs further collaboration between the both teams to reach agreement on next steps. ✓ The delayed start to workforce transformation workstreams (e.g. A&C and leadership restructures) was escalated to the oversight group give the impact on in-year financial benefits. The oversight meeting heard that the scoping paper for the Operational Management Review for the Care Groups is nearing finalisation and is to be presented to ExCo in September. ✓ Further actions escalated and approved by oversight group were; an extension to the planned completion date for ICB Workforce Controls (Deliverable 4) to 31.10.25. All pay controls are complete but some 'softer' controls are still outstanding. An extension to the planned completion date for conducting a strategic review of Employee Relations (incorporating on-call) to 31st December 25.

Next Steps
➤ Work with PMO, finance and recruitment to understand the financial impact of the vacancy control and break glass process. ➤ Agree a plan to fix data quality issues as highlighted by Viridian and next phase to develop a comprehensive workforce and finance dashboard. ➤ Implement weekly oversight meetings for corporate/non-patient facing areas to review overtime/bank spend. ➤ Confirm resource for Medical E-rostering. ➤ Review feedback from Board paper with regards to changes to KPIs. ➤ Complete MARS Process and plan for next MARS round. Ongoing KPI work with Finance as noted in the KPI table.

Key Performance Indicators	Baseline	Target M12	Current Position (M5)	Trend
Achieve Month 12 Workforce Plan of Total Workforce (WTE)	6815	6363	Ongoing work with finance (see action in escalations)	Ongoing work with finance - to be populated upon completion of work with Finance
Total Recurrent Workforce (WTE)	6244	5992	At M5, 35.59 WTE recurrent vacancies were removed from the baseline establishment.	
Pay cost reduction	£365.9m	£20.4m (reduction)	£14.2m – Forecast (£9.4m – Delivered)	
MARS Scheme (50WTE reduction)	0	50 WTE	To be confirmed in October report following receipt of signed settlement agreements	
Reduction in Agency spend by 30%	£10.1m	£7.1m (reduction 3m)	Year-to-Date spend - £2.7m	
Reduction in Bank spend by 10%	£21.1m	£19m (reduction £2m)	Year-to-Date spend £8.7m	

Risk	Mitigation
1. Clarity for reporting governance for this workstream as reports to different committees	Resolution of reporting governance by Chief Executive prior to oversight meeting.
2. Delayed start to workforce transformation workstreams (e.g. A&C and leadership restructures) limits in-year financial benefits.	The oversight meeting heard that the scoping paper for the Operational Management Review for the Care Groups is nearing finalisation and is to be presented to ExCo in September.
3. On-call review will have increase ongoing costs and potential arrears payment costs in 25/26.	Extend the planned completion date for conducting a strategic review of Employee Relations (incorporating on-call), deliverable 2 to 31.12.25, action approved by Oversight Group.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG	Assurance	Rating
WTE Reduction	£20.4m	£9.4M	£14.2m	-£6.2M		Executive Sponsor Rating	Partially Assured



People & Education Capability & Capacity



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ To enable shaping future People and Education team to support the organisation robustly in the future, a needs assessment method has been agreed and a manager survey rolled out. Work has started on collating responses on current work priorities, skills, training and development needs, talent, succession and career pathway opportunities, structure and appropriate relevant KPIs for monitoring. This comprehensive analysis and insights gained will support agreement of refreshed workstreams by end of November. Regular workstream communications update for the directorate commenced ongoing.
- ✓ Interviews have started with stakeholders on workforce performance dashboard to help shape design.
- ✓ Significant sickness and capacity issues have impacted progress on policy review, update and sign off work. Actions to address this are underway as detailed in the associated risk.
- ✓ Assurance review is underway to benchmark existing leadership structure and reporting against 'best in class' peers using Model Hospital. Due for completion end September and must align to direction set by Governance and Assurance workstream following recommendations from the Well-Led review.
- ✓ PELT already in place and will formalise from September onwards as the People and Education Directorate Leadership Team oversight and assurance Group.
- ✓ Decision made to develop a dashboard using Tableau.

Next Steps

- Collation and analysis of directorate needs analysis work to base line 'as is' position for work, skills and structure and planning for future state through workshops October 25.
- Increase number of policies reviewed within correct time to 80% by November Partnership Forum date (20/11/25).
- Agree and KPIs for workforce performance reporting.
- Work with external expert to review directorate structure. Develop draft organisational change paper for end October, aligning to planned operational restructure.
- Further reduction in open ER cases. Work with staff side colleagues to ensure that ER and sickness case data aligned. Agree priority policies with staff side colleagues.

Key Performance Indicators	Baseline	Target	Current Position	Trend
% of People and Education policies reviewed within review period.	44%	70%	44%	↔
Number of high-risk vacancies impacting delivery of workforce improvement plan.	10	0	5	↑
% progress of skills and capabilities based on People and Education gap analysis	TBC once skills audit is undertaken	100%	TBC once skills audit is undertaken	TBC
Effectiveness and timeliness of decision making and assurance through revised governance structure, using stakeholder feedback	20%	100%	20%	↔
Number of open ER cases	56 (May 2025)	Awaiting confirmation	22	↑
Reduction in the number of sickness absences	189 (May 2025)	Awaiting confirmation	176 (August 2025)	↑
Governance structure in place	50%	100%	50%	↔
Effectiveness rating of governance structure (internal to directorate)	Awaiting confirmation	Awaiting confirmation		TBC
Customer services satisfaction rating	Reporting will commence in November 2025			TBC

Risk	Mitigation
1. Annual leave and sickness (within ER team) resulting in delays to policy review and sign off work.	Policy review work started, process and review group set up to start September 25. funded ER support via RSP to expedite policy work and reviewing and agreeing priority policies with staff side colleagues
2. Lack of admin and project management support leading to delays in collation and analysis of survey data and workshop planning.	Volunteer support secured 7.5 hours per week from w/c 8/9. Application for project admin support one day per week still pending sign off.
3. Skill development and capacity within Workforce Information Team (WIT) to monitor and maintain workforce performance dashboard post implementation	Provide training to WIT using specialist support secured from the ICB. Follow up meeting planned end September
4. Increased risk in employee relationships (ER)	Short-term mitigation and short-term plan required. We also need short-term resource to develop and agree actions.
5. High level of sickness absence	Working with Care Group colleagues through planned sickness deep dives to reduce levels of short- and long-term sickness absence

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG		Assurance	Rating
Schemes x 7	£403,000	£262,756	£262,851	-£140,149	6	1	Executive Sponsor Rating	Partially Assured

BUILDING A
Brighter
Future

Culture, Organisational Development & Learning

NHS

Torbay and South Devon

NHS Foundation Trust

Delivered

✓

Senior leaders have been equipped with messaging regarding staff networks with an ongoing communications campaign. There has been positive interest across most networks, with the notable exception of the Global Majority Staff Network. Specific comms and outreach plans are being developed to drive up interest. The staff network chair recruitment has officially launched.

✓

Work is underway to introduce weekly campaigns focusing on People Promise area to gather staff feedback. Meeting dates for the various meetings are now in the diary with governance plans in progress to support reporting.

✓

Current wellbeing offers have been identified and recognise there is an Occupational Health Tender due in November. Work is underway to form staff focus groups to look at their needs in relation to wellbeing, reasonable adjustments and occupational health.

✓

There is an agreed plan to bring together Just and Restorative Learning Culture and the Patient Incident Framework. Meeting dates are being planned.

✓

A group is being set up to support the creation of a plan to drive up understanding and uptake of the Pulse Survey and Staff Survey following the positive upward trend of the last People Pulse. The data from the latest People Pulse survey is being analysed, and the results will be overlayed with the NETs Survey result and other data and insight to form recommendations .

✓

The Culture Paper was shared with People Committee for assurance and feedback. The roll out of Inclusive Leadership train the trainer programme.

✓

It was identified that our current Datix groupings do not allow staff to report incidents as aligned to discrimination, we're working on expanding the categories and introducing new ones to ensure we can report on these as part of our BAU.

Next Steps

➤

Progressing change processes.

➤

External training packages focused on culture and inclusion.

➤

Development of staff voice in relation to wellbeing offers.

➤

Details on staff engagement aligned to the People Promise.

➤

Updates on Datix reporting expansion of categories to include EDI related concerns.

➤

Formal reporting for our People Pulse through existing governance processes.

➤

Confirmation of staff network gaps and exec sponsorship.

➤

First test of cultural insights group to respond to latest pulse survey feedback.

Key Performance Indicators

Baseline

Target

Current Position

Trend

Staff feedback: National Staff Survey

39%

45%

39%

Staff Feedback: Pulse Survey response rate

1.96% (Q1)

45%

5.54% (Q2)

Recommend as a place to work Staff Survey People Pulse

62%
34% (Q1)

66%
66%

Data will be provided on a quarterly basis

Recommend the Trust for care Staff Survey People Pulse

66%
46% (Q1)

70%
70%

Data will be provided on a quarterly basis

ER number of cases open Long Term Sickness cases

56 (May 25)
189 (May 25)

65%
Reduce to 100 by Mar 2026

Data will be provided on a quarterly basis

Compliments received

332 (2024/25)
76 (Q4 2024/25)

20% increase

Data will be provided on a quarterly basis

Datix closure from last annual period

801 (2024/25)

20% decrease

40% of incidents from 2024/25 now closed 474 now open from last financial year

Workforce and Retention data Workforce and Stability data

88.90%
79.41%

90%
81%

Data will be provided on a quarterly basis

Risk

Mitigation

1. The number of deliverables in the culture plan and the teams capacity to deliver the workplan against the expected timescales and pace of change

Strengthening support for the team, extending the current RDUH arrangement and increasing some hours through existing roles.

2. There are gaps in both Associate Director(AD) level roles that support culture leadership roles

Recruitment for one AD post and a longer-term restructure planned as part of the 5.2 programme.

3. KPI's require review following feedback which has not been undertaken

Will remedy and present back in the next Highlight Report.

4. Culture plan needs further review before Board to take into consideration EPR change management and expanding the wellbeing plan

Review of Culture Plan with considerations described in risk

CIP Scheme Name

25/26 Original Plan £000's

Transacted £000's (FYE)

Forecast £000's

Variance from plan to forecast £000's

Delivery RAG

Assurance

Rating

No CIP associated with scheme

Executive Sponsor Rating

Partially Assured

Trust Board

Electronic Patient Record (EPR)

Progress Report-

Date of meeting	Date report produced
24 th September 2025	15 th September 2025

Author(s)		Report approved by	
Name and title:	Kevin Pirie EPR Lead	Name and title:	Simon Tapley
Phone:	07901696807	Date:	19th September 2025
Email:	Kevin.pirie2@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary

This report summarises the progress of the 1 Devon EPR program using the Epic Progress Report dated 12th September 2025 as the primary information source.

At the 12th September the overall program status is reported by Epic as “Good”, measured as 8 /10.

Progress of the electronic patient record (EPR) implementation:

Progress against Phase 2 (User and System Readiness) of the EPR is assessed as “Good” maintaining a significant level of assurance.

Of 45 application areas, one (Beacon) is reported as serious. 17 are on watch status with agreed measures in place to fully mitigate project risk, the remaining applications are reported as satisfactory, providing a significant level of assurance

Our overall score of 8/10 compares favourably with the average score of 6.8/10 for other Epic implementations at the same User and System Readiness stage.

Programme risks

There are 3 areas that have been escalated for Executive oversight. A detailed summary of the issues driving Executive escalation can be found in the Epic Progress report alongside the actions required to mitigate program risks.

- Beacon protocol build and validation
Capacity to build and validate 783 regimens for go live is currently insufficient.
- TSD Estates – Electrical infrastructure
Procurement delays for electrical infrastructure and fire safety evaluations
- Materials Management system integration
The transition to the new finance systems requires an Epic integration plan.

Key Readiness Messages

Application testing started on time following excellent progress across Build Wave 5, this puts the Program in a strong position to begin integrated testing in September.

Manager Validation of our >4.5K workforce (involving >150 of our Operational and Clinical Managers) started on time and will continue up to 26th September. This is a critical process which ensures all staff are aligned to the correct Epic access profile and training track. This process will also be used to identify the c900 Super Users required to support implementation.

Training resource plans will be finalised following the completion of the Manager Validation process. Our trainers are progressing curriculum development, with lesson plans, exercise books, and course builds delivered on schedule.

Staff from Torbay and S Devon continue to attend Go Live Readiness Assessments at East Suffolk and North Essex Foundation Trust to experience how readiness activities are being delivered at other Epic locations. Some of our experienced Information Officers will be attending the go live in Ipswich and Colchester in October to support local teams with implementation.

Staff and patient engagement is increasing in line with our Communications plans. >500 members of staff are being directly engaged with every month and in July >8.5K visits to the EPR Intranet were recorded.

Key Decisions –

Guidance on the importance of managing annual leave during the training and go live period has been shared at Trust talk and a guidance document went to Managers Briefing on Monday 11th August and all staff on 8th September.

End User Devices (EUD) budgets have been signed off without any reduction in Medical Devices functionality as described in the Full Business Case. This is an important step allowing the procurement of c.4K of additional EUD to begin.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
EPR Program update	Satisfactory	Satisfactory

Appendices

One Devon Monthly Progress report

Committees that have previously discussed/agreed the report, and outcomes of that discussion

Key recommendations and actions requested

The Trust Board are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

It is recommended the Trust Board take significant assurance that progress is good and that strong foundations have been created. Two independent NHSE (FLD) assessments have described the program as “exemplar” This level of assurance is also based on the risks identified and the work being undertaken to mitigate these.

How does this report further our purpose to ‘support the people of Torbay and South Devon to live well’?

The EPR is the key enabler of clinical transformation in Torbay and South Devon. Using a single instance of the Epic EPR, transformation will take place across the entire Devon footprint, strengthening our clinical and operational capacity and ability to deliver high quality care in line with “Our Plan for Better Care”. Epic will also allow the people of Devon to take more control of their healthcare pathways by providing digital access to their clinical information.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	The EPR will support self-managed care and care closer to home.
Quality of services provided	The networked EPR enables standardisation of pathways based on best practice.
Sustainable and efficient use of resources	Providing efficient and best value services

Impact on BAF Objectives		
BAF Objective		Impact
Quality and Patient Experience: Personalised Care		The networked EPR enables standardisation of pathways across Devon based on best practice.
People		Modern, contemporary and fully integrated electronic systems such as the One Devon EPR provide our people with the best experience in the digital realm, increasing user satisfaction.
Financial Sustainability and Productivity		Critical enabler for the development of best practice standardised pathways and reductions in variation.
Estates		Reduced footprint of multiple paper based systems will enable better use of space
Operations and Performance Standards		The many operational benefits of a single EPR will support better performance across all constitutional standards
Digital and Cyber Resilience		Appropriate digital systems and supporting infrastructure ensures clinical and service delivery provided to the community by the Trust are not compromised Significantly reduces digital and cyber related risks associated with aging technology
Strategy and Transformation		Signature development in Devons Strategy and transformation plans
Sustainability: Green Plan/ Environmental		Use of hosted datacentres to the highest standards reduces the carbon footprint by between 3 and 5 times that of the legacy on-premise facilities)
Equality, Diversity and Inclusion		
Provision of Community and Care Services Delivered in Partnership		The networked EPR enables standardisation of pathways based on best practice and promotes and supports partnership working
Risk: Risk ID (as appropriate)		
Risk		Ris k ID
Current IT systems and infrastructure will not meet future demands		1159, on Datix, no escalation
Computer hardware risks		
Computer infrastructure risks - Datacentres		2830, on Datix, no escalation 2831, on Datix, no escalation
Failure to meet cybersecurity and information governance standards		2838, on Datix, no escalation

External Standards affected by this report and associated risks

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.



One Devon Monthly Progress Report

11 August 2025 – 12 September 2025



OVERALL PROJECT STATUS



OVERALL SCORE: **8.0/10.0**

AVERAGE EPIC CUSTOMER SCORE FOR
PHASE 1: **6.8/10.0**

GO-LIVE DATES:
3 April 2026 (TSD) & 23 July
2026 (UHP)

RECIPIENTS

To: Adel Jones, Arunangsu Chatterjee, Adrian Harris, Chris Tidman, Joe Teape, James Brent, Mark Hackett, Sam Higginson, Sarah Brampton, Paul Richards

From: Tara Kneller, Implementation Director

cc: Kath Potts, Kevin Pirie, Gervaise Khan-Davis, Guy Boosey, Helen Vigne, Richard Collins

OVERVIEW

The programme overall remains at a status of good, as we continued to progress across all major workstreams.- specifically with important developments like the agreement of a plan for Haemonetics and ISCV. Additionally, both trusts signed off the EUD budgets, ensuring device ordering and deployment can proceed, and information officers were able to engage the majority of all specialties for specialty review, decreasing the risk in that area.

Configuration teams continued with core configuration, making significant progress across build wave 5 and starting application testing on time. Integration teams progressed key testing efforts, having completed functional testing for several key systems and starting small scale data migration validation in September. These efforts put the programme in a strong position to begin integrated testing later this month.

The Super User programme remains on track, with TSD continuing candidate identification. The end-user training model is being reshaped to supplement classroom learning with mandatory practice time and refresher sessions after go-live. Trainers are progressing curriculum development, with lesson plans, exercise books, and course builds delivered on schedule. Manager packs launched at TSD, starting with staffing validation to confirm users' security and training assignments. Managers will play a critical role in coordinating staff learning and ensuring readiness is embedded.

Next month, XX will focus on executing mitigation plans for Beacon protocol build and contracting for required estates work (see *Issues Needing Executive Intervention* for additional details). TSD operational managers will complete staff validation and super user identification, configuration teams will complete application testing and starting integrated testing, and change teams will continue working on change action planning.

To remain at a status of *good*, One Devon must complete the items outlined in the INEO section below and accomplish the following three key items:

1. The project team will complete all remaining Build waves 1-5 tasks by 26 September.
2. The project team will successfully pass 90% of Integrated testing round 1 scripts by 3 October.
3. The training team will complete curriculum development required for MST build by 10 October ahead of pre-MST build tasks.

ISSUES NEEDING EXECUTIVE INTERVENTION

No issues require executive intervention at this point in time.



One Devon Monthly Progress Report

11 August 2025 – 12 September 2025



ISSUES NEEDING EXECUTIVE OVERSIGHT

Beacon protocol build and validation are off track due to insufficient resourcing. The Beacon team built 144 of 211 expected regimens, and pharmacy provided initial review (validation step 1 of 3) for 56 of 100 expected regimens. Due to build complexity, multiple source documents and clinical queries per regimen, the build team can build an estimated 15 regimens per week, which is insufficient for the full scope of 783 regimens for go-live on 3 April 2026. Additionally, pharmacists have validated an average of 14 regimens per week, while 28 must be reviewed per week to validate full go-live scope. To mitigate these risks and catch up to expected volumes for build and validation, Richard Collins, Jason Scott, and Amandeep Kaur will onboard an additional pharmacy locum to dedicate 37.5 hours/week to protocol validation from October - January and two additional build locums by October to complete 40 protocols a week to close validation and build resourcing gaps. These external builders and validators must be onboarded and starting by 1 October. Once in role, Amandeep Kaur will closely monitor and report on progress to confirm we remain on track and avoid the need for scope reductions or further resourcing.

Estates work at TSD is off track due an 8-week procurement delay, with added risks around electric capacity and fire safety. This threatens the completion of estates work in December ahead of Technical Dress Rehearsal (TDR). Dominic Geldard and Sal Williams will continue to work with Dawn Butler to finalise supplementary contracting roles by 19 September. Tower block electrical evaluations run from 15 September to 10 October, and fire safety evaluations will continue now until 19 September. Any delays to these timelines will be escalated to Richard Collins and Adrian Harris. Depending on the evaluation outcomes, we may need additional leadership support and mitigation planning. This could include expediting estates work or formally replanning the agreed scope and device locations.

RDUH and TSD do not have a plan to integrate with a materials management system at go-live. The transition to new finance systems requires the replacement of materials management systems at TSD and RDUH. No approved business case or implementation plan is in place, which puts integration with Epic before go-live is at risk. Without integration, additional staff will be required to support manual processes of duplicating and maintaining supply information across Epic and external systems. Adrian Harris and Angela Hibbard are working with Colin Dart to determine next steps for system procurement and identify an executive lead for the materials management programme by 19 September.



One Devon Monthly Progress Report

11 August 2025 – 12 September 2025



PROJECT STATUS				
APPLICATION STATUS				
↓▲ ASAP	● Grand Central	● Clin Doc & Stork	● Orders	▲ Willow
↓▲ Ambulatory	◆ Beacon	● Phoenix	● Research	● MyChart
● Compass Rose & Dorothy	▲ Beaker	▲ OpTime & Anaesthesia	↓▲ HIM	▲ Patient Access & Springboard
▲ Beans	↑▲ Cupid			
CROSS-APPLICATION AREAS				
▲ Staffing, Training, and Certifications	↑● Third-party Contracts	↓▲ Operational Readiness	● User Provisioning	
▲ Interfaces	● Patient Confidentiality	↓▲ Data Migrations	● Charge & Coding Generation	
● Budget	● Super User Programme	● Patient Safety Surveillance	● Good Install	
↓▲ Materials Management	● Training	↓▲ Testing	↑● Business Intelligence	
▲ Technical	● Environment Management	● Decision Support	▲ Device Integration	
● Day Cases	● Facility Structure	● Surgical & Procedure Orders	↑▲ Specialty Review	
● Benefits Realisation	● Business Continuity Planning	● Interoperability	● Cutover	

STATUS KEY							
Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
●	●	▲	◆	◆	N/A	↑	↓



One Devon Monthly Progress Report

11 August 2025 – 12 September 2025



PROJECT ASSESSMENT – AREAS OFF TRACK

CROSS APPLICATION AREAS

Materials Management		See issues needing executive oversight for more.
Interfaces		Interfaces remains at <i>watch</i> as 15 of an expected 29 systems are ready for integrated testing and 28 of an expected 63 systems are ready for MRT. We completed 122 of 216 (57%) of an expected 98% ITR scripts and 201 of 443 (45%) of an expected 84% MRTR scripts. The interface team will prioritise starting interface testing for Data Innovations (UHP) and Haemonetics (TSD) by 26 September and completing testing for Clinisys ICE (UHP), CRIS (UHP), Elekta Mosaic (TSD), GE MUSE (RDUH + TSD), Philips ISCV, and Varian Aria (RDUH) by 3 October so integrated testing round 2 can include these systems.
Staffing, Training & Certification		Staffing and certification are at <i>watch</i> as 17 of 24 net new application analysts achieved certification. Three of these analysts have certifications in other applications and can build, however analysts who are not certified are unable to build for their assigned areas. This could delay configuration and subsequent downstream activities. Tara Kneller and Jason Scott are actively coordinating and executing contingency plans for uncertified roles.
Technical		Technical status remains at <i>watch</i> as contracting for estates is off track, device ordering for TSD is behind schedule, and server hardware procurement is delayed. Orders for end user and server hardware must be placed this month to avoid delays to starting Technical Dress Rehearsal (TDR). See issues needing executive oversight above for more detail on estates risk.
Device Integration		Device Integration (DI) remains at <i>watch</i> , as the workgroup has not confirmed scope of the patient device list. To improve to <i>good</i> , Aaron James will work with clinical engineering to finalise the beds and wards in scope for Go-Live by 19 September. Harrison Kirwin, Amy Johnson, Yetunde Adewumi, and Claire-Marie Hunt will build patient monitor and anaesthetic carts by 26 September.
Data Migrations		Data Migrations (DM) remains at <i>watch</i> . Although preparation for full-scale validation has been strong and full-scale round 1 is on track, only 67 of 90 (75%) data types were developed on time for the start of testing. The remaining data types can be completed in parallel with validation activities, but they will continue to divert team resources from full-scale testing. This keeps the team at full capacity with no room for additional scope. The DM team will complete full-scale round 1, including at least 17 of the 23 (74%) data types that currently remain in development.
Specialty Review		Specialty Review increases to <i>watch</i> as involvement from Mike Green, Mia Jones, Simeon Brundell, Gemma Taylor and the wider IO team led to increased responses from most specialties. There are 4 UHP and 3 TSD specialties without sufficient clinical data collection returned. Admin specialty review build began on 3 September and clinical build began 9 September. To increase to <i>good</i> , all data collection clarification questions must be promptly resolved and analysts must complete core build by 3 October. The table below outlines the statuses for each specialty.

APPLICATION AREAS

Beacon Protocol Build & Validation		See issues needing executive oversight for more.
Beaker Dependent Projects: Data Innovations & ICE		Beaker remains at <i>watch</i> as Data Innovations (DI) and ICE dependent projects are currently off track, impacting the programme-wide 22 September MRT start date for both systems and clinical content validation (CCV) did not begin as expected on 2 September. To improve to <i>good</i> , Mark Ogier will ensure key DI tasks are completed for analyser testing to start on 22 September, Trevor Hadfield will ensure configuration in place to start testing with AMS by 26 September. The team will confirm ICE environment strategy by 19 September and begin ICE configuration by 29 September.
Patient Letters		Patient Access/Springboard remains at <i>watch</i> , as outstanding contracting with Synertec and Netcall for Letters/SMS workflows and communications content collection and SME identification is incomplete

STATUS KEY

Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		



One Devon Monthly Progress Report

11 August 2025 – 12 September 2025



		from both trusts. To increase to <i>good</i> , the 3PC team will work with TSD and UHP to finalise outstanding Synertec and Netcall contracts for appointment communications and the TSD and UHP Admin IO teams will identify the appropriate trust/vendor contracts for content review and consolidation by 29 September
Application Build		The following applications are at <i>watch</i> this month as they are more than 15% behind with Build Wave 5 building blocks and tasks: Ambulatory, Beacon, Beaker, Cupid, Kaleidoscope, Orders, Research, and Springboard. All application teams are following plans to get back on track which are outlined in the project assessment section.
Application Testing		The following applications are <i>watch</i> this month as they are more than 15% behind with Application testing as of 12 September: ASAP, Ambulatory, Springboard, HIM, XXX. All application teams are following plans to get back on track which are outlined in the project assessment section.

STATUS KEY							
Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		



Torbay and South Devon
NHS Foundation Trust

Public Board of Directors

Title: Perinatal Governance & Safety Report (1 June 2025 – 31 August 2025).

Date of meeting	Date report produced
24.09.2025	12.09.2025

Author(s)		Report approved by	
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary

The report outlines the safety improvement initiatives led by the Maternity Governance Group aimed at achieving the national target of reducing brain injuries during or shortly after birth, as well as stillbirths, neonatal and maternal deaths by 50% by 2025. These efforts align with the safety workstream of the Devon Local Maternity & Neonatal System (LMNS) and comply to the mandatory reporting requirements under the Perinatal Quality Surveillance Model & the NHS England Three-Year Delivery Plan. This work is an integral component of the maternity reporting framework for NHS England.

This report is a required component of the maternity reporting framework for NHS England (NHSE) and aims to assure the Board on critical elements of the maternity safety agenda by;

- Outlining the Trust position on perinatal mortality and morbidity
- Reporting progress and compliance with priority areas of focus.
- Provide system level assurance on maternity quality and safety.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
4.9 Maternity incentive scheme – current position	Satisfactory	Improvement from compliance in 6 to 7 safety actions in this reporting period.
2. 1- Maternity and Neonatal Voices Partnership Capacity	Satisfactory	Escalation by LMNS to regional oversight team as well as Trust action plan required.

Boards that have previously discussed/agreed the report, and outcomes of that discussion

Metrics contained within this report have been presented at the monthly maternity Governance and Service meeting as well as at the monthly maternity and gynaecology Quality Meeting. The data is also shared as a slide set for the monthly Families and Communities Care Group governance meeting. Escalation of concerns will be via this quality group and/ or via the executive quality group. The CQC action plan is presented monthly at the Trust CQCAG

Key recommendations and actions requested

The Board are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed. The Board are also asked to:

- Note the progress and compliance position regarding the priority areas.
- Note the key quality and safety issues identified in the report and the measures in place to address any areas of concern.
- Note the mechanisms that are in place to hear the voices of women and families within the service. This includes the refresh of and increase in capacity of the Devon MNVP resource noting that the Devon resource will still not enable full compliance with all the recommendations for hearing the service user voice. It will remain as a risk on the service risk register and will require an action plan.
- Note the current position of compliance against the Maternity Incentive Scheme with full compliance anticipated in March 2026
- Note the collaboration with Somerset Foundation NHS Trust to second two Labour ward Coordinators increasing resilience within our workforce.

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

Aim	Impact
Population Health and Wellbeing	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
Quality of services provided	

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	
People	
Strategy and Transformation	

Risk: Risk ID (as appropriate)

Risk	Risk ID

NA

External Standards affected by this report and associated risks

NHS England licence and regulations
National policy, guidance

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.



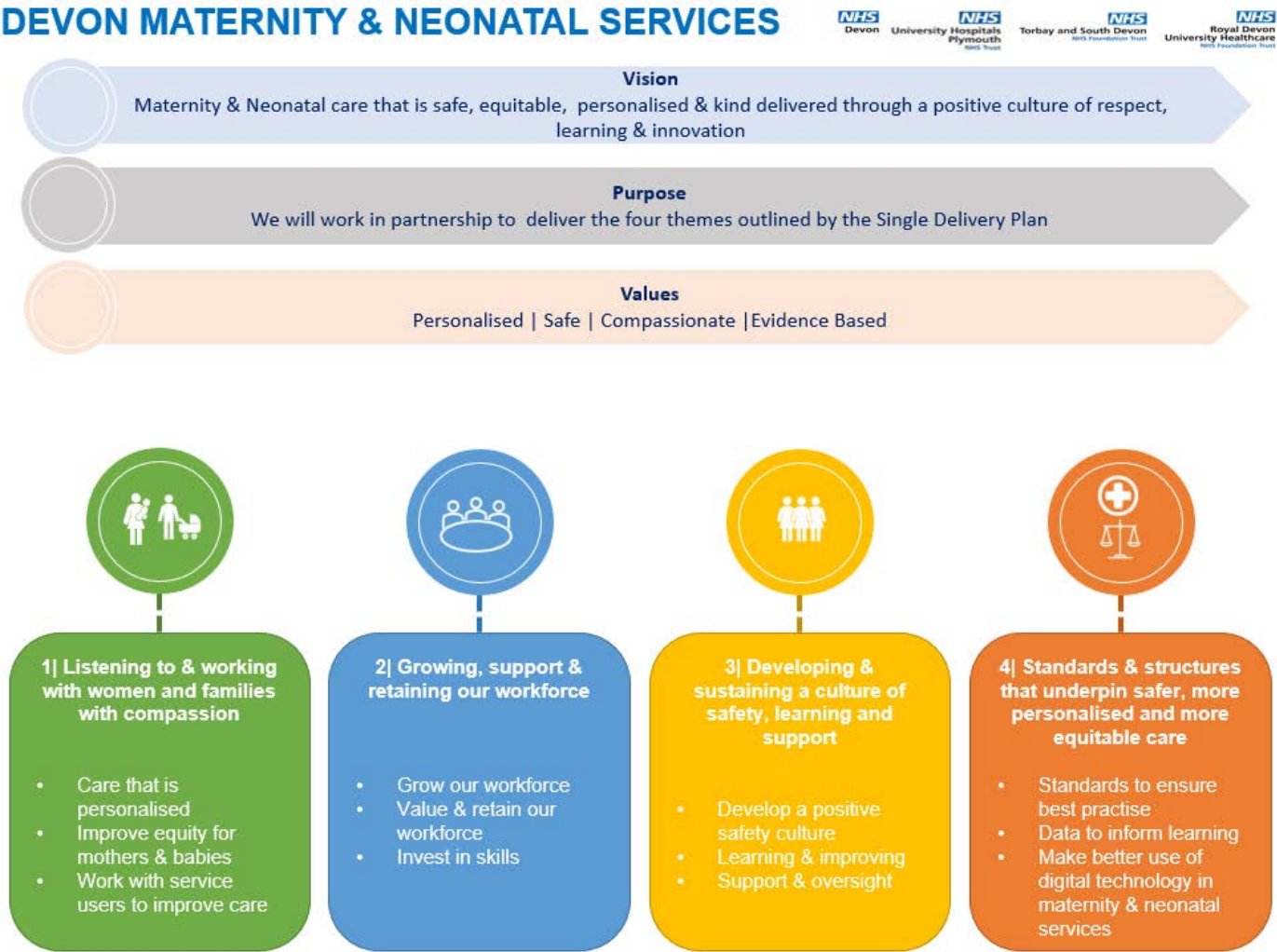
Torbay and South Devon NHS FT MATERNITY BOARD REPORT

JUNE - AUGUST 2025



Control

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



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Introduction

Purpose

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

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

Information is colour coded for expected frequency of reporting.

Monthly- Green (where reporting is quarterly, report as quarterly)

Quarterly- Yellow

Annual- Amber

RAG ratings as follows:

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

Glossary

Maternity and Newborn Safety Investigations Programme (MNSI)

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

Clinical Negligence Scheme for Trusts (CNST)

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

Avoiding Term Admissions into Neonatal Units (ATAIN)

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

Perinatal Mortality Review Tool

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

Essential Reporting: Trust Board & LMNS Oversight

Item	Source	Frequency (Min.)
Minimum Data Set 1. CQC rating (as updated) 2. MSSP status 3. Findings of PMRT & HSIB reviews 4. Incident reports moderate & above 5. Training compliance 6. Minimum safe staffing 7. Service user feedback. 8. Staff feedback 9. HSIB/NSHR/CQC concerns or requests for action. 10. Coroner Reg 28 11. CNST progress 12. Staff survey (Midwives & Obstetricians)	Implementing a Revised Perinatal Quality Surveillance Model	Monthly
All Maternity SI Reports	Ockenden Interim (IEA1)	Quarterly
Maternity Dashboards	Ockenden Interim (IEA1)	Quarterly
Multidisciplinary training	Ockenden Interim (IEA3)	Quarterly
Minimum staffing levels (if not nationally agreed levels)- to be locally agreed with LMNS	Ockenden Final (IEA1)	As required

Sustained inability to meet staffing levels	Ockenden Final (IEA2)	As required
Learning from reviews of maternal deaths	Ockenden Final (IEA6)	As Required
Content of Human Factor Training	Ockenden Final (IEA7)	Annually
Neonatal care outside agreed pathways- including births <27 weeks at units <Level 3 NICU Care outside agreed pathways must be monitored & reviewed by Trusts, the LMNS & the ODN	Ockenden Final (IEA14)	Quarterly
Trusts to ensure that there is proper representation of maternity care on their boards	Reading the Signals	Ongoing
SDP Outcomes: 1) Staff Survey	Single Delivery Plan	
SDP Progress	Single Delivery Plan	As required
SDP Evidence	Single Delivery Plan	As required
SDP Regulation & Incentivisation: 1) CQC 2) CNST	Single Delivery Plan	

1.0 Introduction and background

1.1 This report will provide oversight of the safety and quality of perinatal services and will inform the Board of present and/or emerging safety concerns within maternity and neonatal services. It will reflect the required reporting as set out by NHS England via The Perinatal Quality Oversight Model (PQOM) (2025) and the three-year delivery plan. The PQOM is designed to proactively identify NHS trusts that require support before serious issues arise. It ensures consistent, methodical oversight of maternity and neonatal services, enabling early intervention and continuous improvement. This model integrates perinatal clinical quality into Integrated Care System (ICS) structures, with clear lines of responsibility and accountability at trust, ICS, regional, and national levels.

1.2 At present a summary of perinatal quality and safety is presented at the quality assurance Board (QAC) meeting as well as at the

Trust Board meeting. Perinatal safety dashboard metrics are also included in the monthly integrated performance reports as well as through both Families and Communities Care Group governance and the Safety and Quality assurance group to continue to meet the requirements of MIS as well as ensure good oversight of perinatal safety and quality.

2.0 Listening to Women & Families with Compassion

2.1 User Feedback-

FEEDBACK	Comments	Impact	Ongoing Actions	Timescales
Service User Feedback: 1) Compliments	Significant numbers of MNVP compliments, 2 x official via PALS, Greatix and Daisy nominations received. One People Award received for a midwife	Celebrate the positive work that is done daily.	Continually share feedback with staff, work with staff to increase the rates of returns	Ongoing
2) Themes of complaints	There was one formal complaint in the period and 3 concerns raised. Complaint was regarding antenatal communication		Labour Ward Coordinators to provide solution to ensure that women are kept informed if there are delays to surgical pathways.	

	around homebirth. Concern around staff reticence in communication when surgical delays occur as issues arising when staff avoid that conversation. LWC team tasked with providing an answer to this. Others around documentation and complications following perineal tear.			
3) Devon Maternity & Neonatal Voice projects/ additional comments	DMNVP have benchmarked themselves against the national standard and identified they cannot meet all the requirements for MIS without additional resources	In the event of the DMNVP being unable to meet all the requirements of MIS the trust can declare compliance if the risk is escalated via PQSM and the ICB board and an action plan devised.	Additional funding has been received by the DLMNS and procurement of additional MNVP resources are in progress. Current DMNVP are continually to attend all trust meetings as required and to review and update the current feedback mechanisms for	To be completed by the end of the MIS reporting period of Nov 2025

4) CQC Maternity survey 2024	Progress continues the CQC maternity survey action plan	Challenging estates is hindering progress with partners staying on the ward postnatally	Implement partners staying on the ward postnatally. Improve discharge process on Postnatal ward. Update to plan presented at the August QUAD/Board level safety champions meeting.	Improvement plan to be completed by 30 th November 2025

There is a risk identified in relation to the achievement of CNST Safety Action 7 which requires a fully funded MNVP for Devon. Devon ICB have had a significant increase in MNVP funding ensuring Devon moves from the least funded MNVP to a system where the MNVP can be actively involved in maternity service improvements. The current MNVP structure was not in place until May 2025 and although they are now able to provide an increase in service user feedback engagement, they are not able to meet all the requirements of MNVP national guidance. National funding to further increase the Devon MNVP capacity has been received by the LMNS and they are in the process of procurement and recruitment, but this will not have been completed with the current MIS assurance timeframe. The MIS allows for full compliance with safety action 7 if this risk is escalated to the trust board and an action plan is in place to achieve compliance.

2.2 Additional Service User Feedback

Debriefs / Birth Afterthoughts	Themes from Birth Afterthoughts services are collated and presented at the monthly perinatal triangulation meeting. Annual audit of service to be presented at clinical effectiveness meeting in December 2025. Pathways to access debriefs and birth afterthoughts service currently under review to ensure appropriate referrals and improved access for service users
Friends and Family test	Capacity challenges within the organisation to enable robust data collection and circulation of feedback so not assured of validity of returns received. This is being addressed through Trust feedback and engagement lead. Other feedback mechanisms utilised as alternative mechanisms of gaining service user feedback such as MNVP monthly feedback cards.

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

3.1 Staff Feedback-

FEEDBACK	Comments	Impact	Ongoing Actions	
Staff Feedback. 1) Safety Champion Walkaround after staff listening event in May 2025 -(see table 1 for details)	Discussion regarding impact of actions following staff listening exercise.	Maternity staff feeling vulnerable and disillusioned	Out of hours informal on call arrangements produced. Escalation guideline updated to include actions from MATOPEL scoring from leadership. Acuity information published on a weekly basis.	Ongoing
2) Listening events with Maternity Improvement advisor	Inconsistent working practices of consultant workforce when on call.	Maternity staff feeling frustrated around processes that impede effective working practices	SOP to be devised around on call consultant expectations/role.	

	Some challenges around feeling valued for some staff groups. Inadequate stock and equipment for staff to access when required.		Feedback to staff involved. Improved communication around logistical issues	
3)Score culture Survey	The remaining actions associated with the SCORE survey will be included within the perinatal improvement plan	This will provide assurance and oversight of the actions and will enable continuing progress around cultural safety.	The communication strategy and continuing work with civility toolkit will also support the work to continuously improve culture	

Safety Champions meetings - Table 1

Table 1

Date	Attendees	Feedback
June 2025	Board Safety champion-NED Maternity Safety Champion	Visited labour ward and discussed staff concerns following band 6 Midwife acting up as LWC. Discussed senior team response and positive feedback was received. Actions described above
July 2025	Maternity Safety Champion Neonatal Safety Champion	Temperature in theatre at time of birth
August 2025	Board Safety champion-NED Board Safety Champion - CNO Maternity Matron	Issues with inappropriate use of Maternity triage service due to inaccessibility of GP services in the community. Also, some internal staffing communications work needed to ensure they are signposting Triage in the correct way.

3.2 Minimum Safe Staffing Exception Reporting

Minimum safe staffing events	Occurrence	Actions taken
Midwifery (CNST Safety Action 5 Red Flags)		
Redeployment of staff to other services/sites/wards based on acuity.		Our workforce is multiskilled and able to flex across the system to account for times of high acuity within a specific area. This is the way the service operates and not a red flag.
Delayed or cancelled time critical activity.	0	
Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing).	0	
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).	0	
Delay of more than 30 minutes in providing pain relief.	0	

Delay of 30 minutes or more between presentation and triage.	-	
Full clinical examination not conducted when presenting in labour	0	
Delay of two hours or more between admission for induction and beginning of process.	1	There was 1 x delay of more than 2 hours between admission for induction and beginning of the process – this occurred to ensure safety of proceeding with IOL due to unit acuity.
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).	0	
Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.	0	
Labour Ward Coordinator (LWC) is not supernumerary	3 – not providing 1:1 care 1 – providing 1:1 care	These occasions were all out of hours. In line with new CNST standards there was always a supernumerary LWC at the start of each shift time. In august 2025 two LWC started a secondment from Somerset Foundation Trust following the temporary closure of Yeovil Maternity Unit. This will boost resilience in the team.

Retention Issues	0	No concerns. Majority of year 3 student midwives that trained at Torbay were successful at securing a preceptee band 5 post. Retention Midwife left post in August for personal reasons and to pursue opportunities outside of NHS.
Obstetric cover on Labour Ward		All gaps were filled within the existing Obstetric workforce. Long term locum cover required.
Gaps in obstetric rota		Further absence has resulted in consultants being required to cover at short notice increasing the required number of on calls and intensity of work. This impacts on the capacity to complete non-clinical work and administrative tasks that the consultants are required to do.
Neonatal unit staffing Nursing -	There is a requirement for a minimum of 1 Qualified in Speciality (QIS) Nurse per shift to support stabilisation of pre- term / term unplanned admissions. QIS as % of registered workforce is 62% (BAPM min 70%) Imminent retirement from Sept – Dec 25 to be taken into consideration.	2 Band 5 RN to commence QIS course in December 2025. Further 2 candidates in pipeline for courses in 2026. Unit Manager has now completed QIS course - confirmation of qualification not expected until Sept 25. 1.84 Band 6 QIS recruited in August, to which 0.92 is internal promotion. Further 1 WTE B6 awaiting vacancy panel. 1 WTE Band 5 recruited. Ongoing workforce establishment review for consideration of structure redevelopment to

Medical staffing	Despite some challenges with short notice absence, we have managed to ensure minimum safe staffing numbers and QIS. Lack of suitable resource (QIS/neonatal experience) via NHSP. Meets BAPM standards for level 1 special care unit	ensure it meets the service needs now and in the future Use of Practice Educator in clinical numbers and staff picking up additional hours and bank shifts. Request for 3-month capped rate agency placement has been approved to provided short term resilience for impending retirement and onboarding of new staff. NHSP have not been successful to date with filling this.

3.2.1 Safe Maternity Staffing- Fill rates – planned verses actual

Area	Day		Night	
	Midwives	MSW's	Midwives	MSW's
June 2025	88.3%	72.5%	96.7%	80.6%
July 2025	86.1%	87%	102.4%	111.9%
August 2025	83.7%	87.3%	91.9%	92.8%

Fill rates alternate for several reasons, these include gaps caused by sickness absence, ongoing vacancies or staff who are working in a supernumery capacity. The benefit of having an integrated model of midwifery care in place means we can mitigate less than 100% fill rates by redeployment of our staff across our flexible midwifery service. Integrated midwives can work cover community work, intrapartum care as well as inpatient antenatal and postnatal care.

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Temporary staffing solutions – bank staff or staff working additional hours
- Request midwifery staff undertaking specialist roles to work clinically.
- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Request additional support from the maternity matrons/managers.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

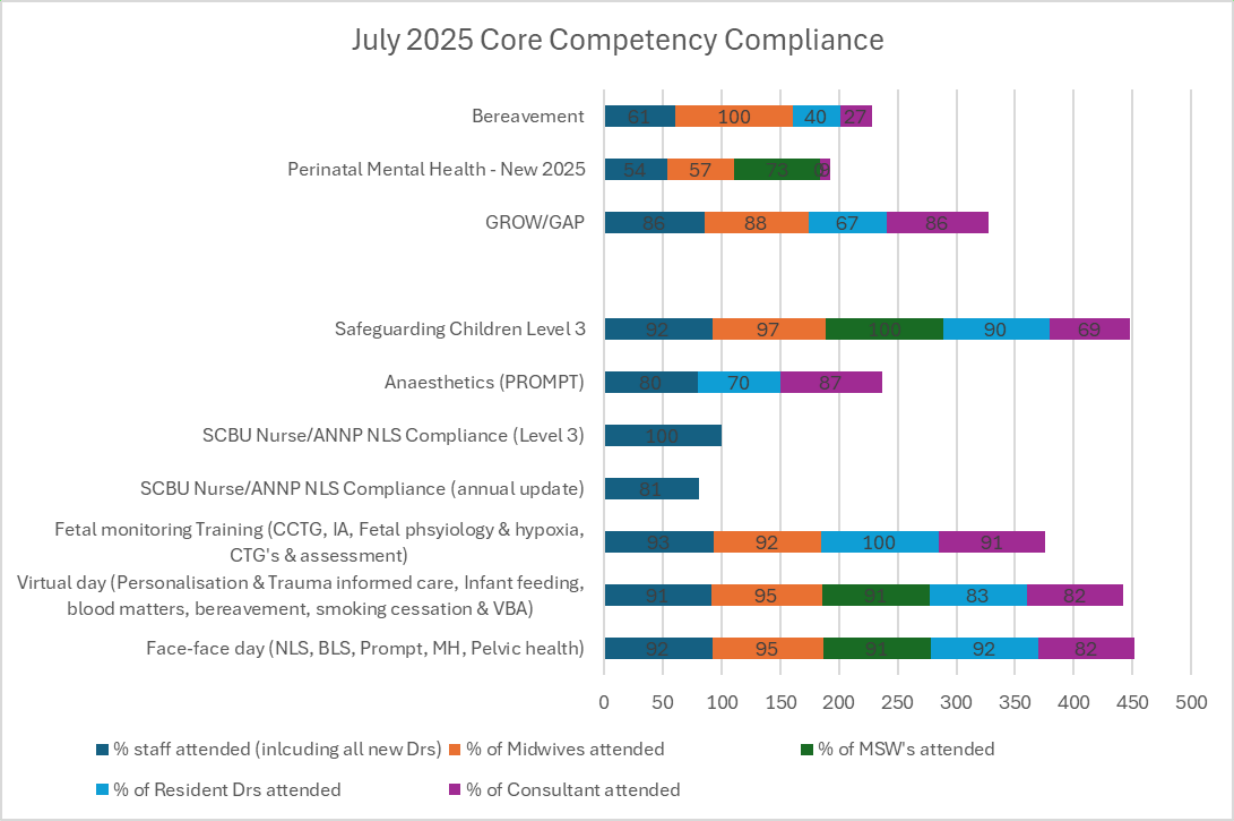
3.3 Multidisciplinary Training Compliance-

TRAINING COMPLIANCE	PROMPT	Fetal Monitoring	Safeguarding
Midwives	92%	94%	98%
Maternity Support Workers	94%	NA	95%
Obstetric Consultants/Registrars	92%	96%	75%
Anaesthetists	60%	NA	NA
<i>Actions required</i>	To continue to book all staff on training in advance and closely monitor compliance. Liaise closely with the medical team and anaesthetic consultant lead for Obstetrics to ensure staff attend within a 12-month timeframe. Additional PROMPT MDT mop-up sessions have been arranged to improve anaesthetic compliance Monthly meeting with the medical administrator ensures that any medical staff who have been taken off training	This training is delivered in line with MIS standards and is now a full face to face day's training, with assessments. We currently use K2 assessments and staff are required to achieve over 85% to be deemed competent in this training. All staff are booked onto the training in advance, and attendance closely monitored to ensure compliance levels. Monthly meeting with the medical administrator ensures that any medical staff who have been taken off training	Staff are notified when their training is due – ensuring attendance within a 3-year period, wherever possible Regular meetings between the operations manager and Education Lead Midwife continue to take place to look at ways of mitigating the risk regarding the lower compliance numbers within obstetrics. All new starters receive a 1:1 session with the Safeguarding Lead Midwife and an agreement has been made that no further CPD will be authorised for the Drs, until they can evidence completion

	due to clinical demands are re-booked within 2 weeks. The medical service manager is given a full report of medical compliance every month and follows up on those who have not completed their training, copying the education lead into email trails. The Education lead midwife and medical administrator meet monthly to re-book any medical staff who were unable to attend mandatory training on their allocated month.	due to clinical demands are re-booked within 2 weeks. The medical service manager is given a full report of medical compliance every month and follows up on those who have not completed their training, copying the education lead into email trails. The Education lead midwife and medical administrator meet monthly to re-book any medical staff who were unable to attend mandatory training on their allocated month.	of or booking of mandatory training – including The medical service manager is given a full report of medical compliance every month and follows up on those who have not completed their training, copying the education lead into email trails. The Education lead midwife and medical administrator meet monthly to re-book any medical staff who were unable to attend mandatory training on their allocated month.

Current training compliance for all staff groups in maternity related to the core competency framework and wider job essential training (Table 2)

Table 2



4.0 Standards That Underpin Safer, More Personalised & More Equitable Care

4.1 CQC Rating

Overall	Safe	Effective	Caring	Well-Led	Responsive	MSSP

Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Formally entered the programme June 2024 - see below

4.2 Neonatal care outside agreed pathways

In this reporting period there were no babies born in Torbay and South Devon at less than 27 weeks' gestation. These babies must be delivered in a level 3 Neonatal intensive care unit. We did have 4 babies born at less than 32 weeks at Torbay which falls outside of our commissioned service. The team review all these cases to review the reasons behind these births and provide feedback to the SW Neonatal network.

4.3 Safety Improvement Plan -Maternity Safety Support Programme (MSSP) - Appendix 1

Torbay and South Devon Maternity Services have commenced on the MSSP due to the Trust's NOF4 position. All Devon Trusts are included in the MSSP.

Suzanne Cunningham has provided monthly progress reports since June 2025. The August report is yet to be completed. This details the progress made and any areas for escalation. The 12 exit criteria have been finalised and are included within the June monthly report. (**Appendix 1**) Progress is underway in developing the Perinatal Improvement Plan (PIP). Progress was reviewed at the first performance workstream of the Trust's 'Our Plan for Better Care in July 2025. The five workstreams identified within the PIP are:

- Listening to Women
- Workforce Planning
- Culture and Leadership
- Clinical Pathways and Infrastructure
- Safety and Quality

4.4 Three Year Delivery Plan Measuring Success: Regulation (CQC)

Summary of progress with CQC MUST DO actions.

Although progress has been made against the CQC action plan, there is still estates works required to facilitate service improvement. This work is reliant on external contractors, building regulations and capital funding. These factors may impede timely progress.

CQC MUST DO actions	Achievements	Action for Improvement
Maternity Triage	• Dedicated phone line in place. Netcall now installed and working well. • Consistent documentation process embedded in the electronic record includes a standardised risk assessment mechanism. • Allocated midwife to answer the phone line, day and night. • Reconfiguration of staffing establishment to increase Triage team complete, staff in place and service now running 8-8 in the Day Assessment Unit. • Monitoring via audit process	• Progress needed to implement full Triage risk assessment model (BSOTS) - gap analysis completed. • Estates work required, Project lead identified, tendering process completed waiting costings. Potential start date end of Sept. • All staffing appointed to and opening hours increased.
Obstetric theatre	• Dedicated emergency theatre • Improved process for out of hours theatre provision • Formal regular review meetings between leads • Ongoing audit of theatre cases and decision to delivery intervals. • Progress with recruitment of ODP (Operating Department)	• Improving progress with recruitment to theatres. Trajectory that staffing will be in place by October 2025. • The Trust wide transformation team and local team working on a Quality Improvement project to review both elective and emergency pathways. • Regular monthly update meetings held with maternity and theatres.

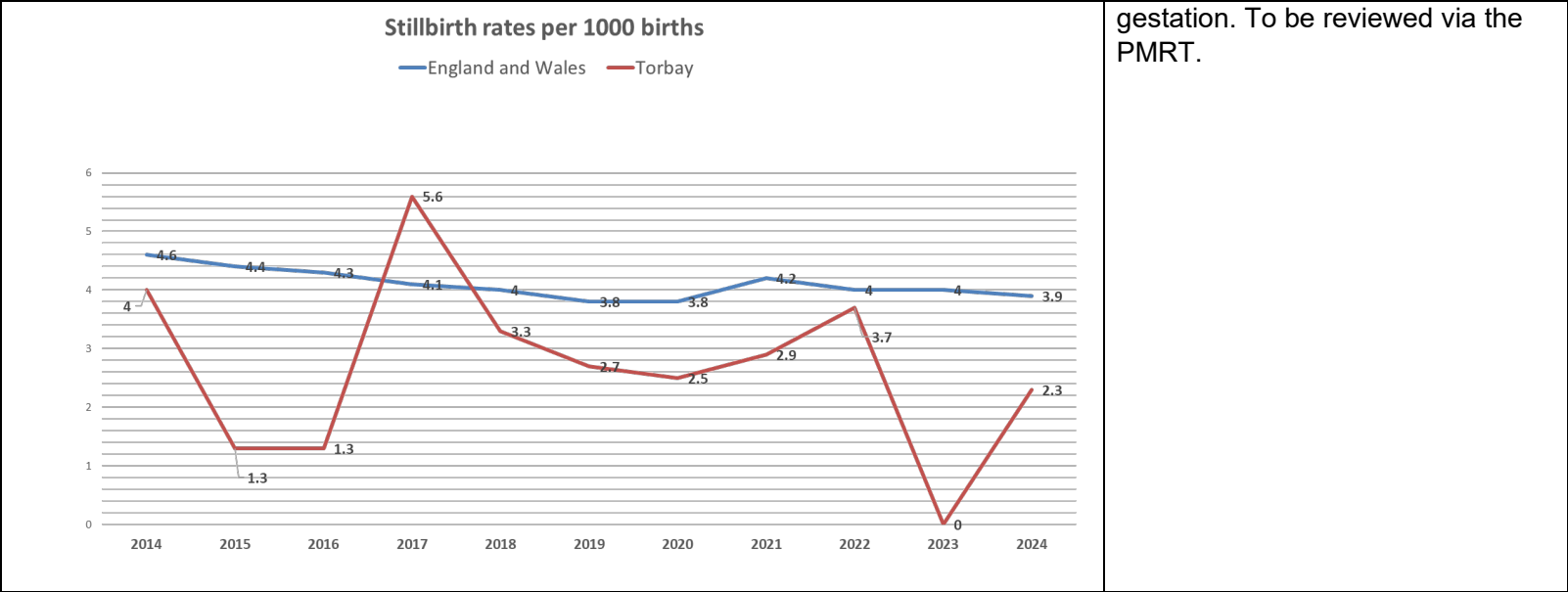
	Practitioners) / theatres staff. New overseas recruits projected to be at required standard by October 2025	- Quarterly progress meeting with both care groups to provide oversight of actions. - Ongoing discussion re scoring of risk around this action on the Maternity risk register.
Fetal Monitoring oversight	- Audit of “fresh eyes” – now quarterly. - Full day fetal monitoring training for all midwives and doctors commenced in 2024 and is ongoing. This includes an assessment – which is currently being completed on K2 - Action Closed on action tracker	
Use of Electronic MEOWS system	- Increased surveillance and support of system to improve the completion. - New digital midwife now in place to ensure work can continue in this area. - QI project complete, no on regular audit cycle - Action Closed on action tracker	
Medical staffing	- Business case to increase the number of FTE consultants progressed via Trust and ICB processes. Recruitment of 2 FTE completed and now working within the trust. - Action closed on action tracker	

Provision of Emergency Equipment	• Replacement CTG's and resuscitaires in place; staff trained to use.	• Department recognises that there is no suitable dedicated area to store resuscitation equipment on postnatal ward. This is under consultation with estates to create a bespoke space.
Medical staffing – safeguarding children training compliance	• Improvement in compliance figures. Practice educator collaborating with clinical director to support attendance. • Safeguarding support in place within unit as part of day to day working. • Bespoke, local safeguarding input as part of induction	• Safeguarding Children level 3. An additional e learning module for doctors is being considered to improve safeguarding compliance.
Governance oversight and assurance	• New governance structure embedded following internal audit recommendations.	• Terms of reference being completed for all meetings delivering on governance. • Governance deep dive undertaken by MSSP, recommendations received, will form part of the MNIP. • Recommendations from deep dive to include more oversight of policies and guidelines and the audit programme. • Implement NHSE governance tool kit.

4.5 Patient Safety

4.5.1 Perinatal Morbidity and Mortality Summary for the period

Stillbirth, Neonatal Death and Late Fetal Loss Year to date. <table><tr><th>Month</th><th>Stillbirth</th><th>Neonatal Death</th><th>Late Fetal Loss</th></tr><tr><td>Sep-24</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Oct-24</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Nov-24</td><td>0</td><td>1</td><td>0</td></tr><tr><td>Dec-24</td><td>0</td><td>0</td><td>1</td></tr><tr><td>Jan-25</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Feb-25</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Mar-25</td><td>1</td><td>0</td><td>0</td></tr><tr><td>Apr-25</td><td>1</td><td>0</td><td>0</td></tr><tr><td>May-25</td><td>0</td><td>2</td><td>0</td></tr><tr><td>Jun-25</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Jul-25</td><td>1</td><td>0</td><td>0</td></tr><tr><td>Aug-25</td><td>2</td><td>0</td><td>0</td></tr></table>	Month	Stillbirth	Neonatal Death	Late Fetal Loss	Sep-24	0	0	0	Oct-24	0	0	0	Nov-24	0	1	0	Dec-24	0	0	1	Jan-25	0	0	0	Feb-25	0	0	0	Mar-25	1	0	0	Apr-25	1	0	0	May-25	0	2	0	Jun-25	0	0	0	Jul-25	1	0	0	Aug-25	2	0	0	1st June 2025 – 31st August 2025 June 2025 No perinatal losses in June July 2025 Stillbirth – Datix No: 26398 - A Woman who was White British had a stillborn baby at 36+1 weeks gestation. To be reviewed via the PMRT. August 2025 Stillbirth - Datix No: 26900 - A Woman who was White British, had a stillborn baby at 39 weeks' gestation. To be reviewed via the PMRT. Stillbirth – Datix No: 27496 - A Woman who was White Other had a stillborn baby at 26 weeks'
Month	Stillbirth	Neonatal Death	Late Fetal Loss																																																		
Sep-24	0	0	0																																																		
Oct-24	0	0	0																																																		
Nov-24	0	1	0																																																		
Dec-24	0	0	1																																																		
Jan-25	0	0	0																																																		
Feb-25	0	0	0																																																		
Mar-25	1	0	0																																																		
Apr-25	1	0	0																																																		
May-25	0	2	0																																																		
Jun-25	0	0	0																																																		
Jul-25	1	0	0																																																		
Aug-25	2	0	0																																																		



gestation. To be reviewed via the PMRT.

The graph above demonstrates how the Trust is performing against the national safety ambition.

4.5.2 Patient Safety Incidents

PATIENT SAFETY Incidents (PSI)	Number	Key themes/ trends/ escalations
Serious Incidents	4 in total	1st June 2025 – 31st August 2025 June 2025 – No Serious incidents were reported. July 2025 – 1 Serious Incidents reported 1 Death – Datix No: 26398 - Stillbirth at 36+1 weeks gestation. August 2025 – 3 Serious Incidents reported 2 Deaths – Datix No: 27496 - Stillbirth at 26 weeks and Datix No: 26900 - Stillbirth at 39 weeks (see above). 1 Severe – Datix No: 27170 Undiagnosed partial anal sphincter injury sustained during a delivery in Jan 2023, recently referred to pelvic health team. Action plan being led by pelvic health midwife. *Due to the number and severity of incidents in the preceding 6-month period we held a Multi-disciplinary Perinatal Review meeting at end of June 2025 including CNO, Improvement advisors and the trust patient safety team. This looked to determine any actions or themes that require immediate safety intervention. The outcomes of this review will be shared with the Board once finalised.

Moderate Incidents	1 in total	June 2025 – 1 Moderate Incident reported 1 Moderate – Datix No: 24266 - A baby who experienced a shoulder dystocia at birth was found to have a broken humerus following the birth. July 2025 – No Moderate Incidents reported August 2025 – No Moderate Incidents reported

PATIENT SAFETY	Number	Key themes/ trends/ escalations
New referrals to MNSI	0	No referrals were made to MNSI in this period.
Findings of final MNSI reports returned (themes only)	1	MNSI case no: 039424 – Datix No: 19051 - One report was received from MNSI during this period following an incident from Jan 2025 where a baby had been transferred to a higher-level neonatal unit for cooling therapy. The actions for the trust were focused on fetal monitoring, and an action plan is being produced to reflect this. (see table 2) Family was informed, duty of candour completed and ENS referral made – ENS No: M24CT173/008

Findings of cases reviewed under PMRT. (themes only)	2	2 PMRT cases were reviewed in this period. Case 1 – Datix No: 21439 - CNST SA1 (a) met, (b) met (c) met, Requirement for external panel members, met - PMRT MDT meeting was held on 10th July 2025, Report completed on 16th July 2025. The MDT determined that cause of death was placental insufficiency with no issues in care found. Case 2 – Datix No: 22060 - CNST SA1 (a) met, (b) met (c) met, Requirement for external panel members, met - PMRT MDT meeting was held on 7th August 2025, Report completed on 16th July 2025. The MDT determined that cause of death was due to a true knot in the cord. One care issue was discussed at the meeting in relation to symphysis fundal height measurements following a scan, but it was determined that this made no difference to the outcome for the baby as the baby was not growth restricted at birth. (see table 1) 4 PMRT reviews are pending. Dates due for completion: Case 3 – Datix No: 22736 - CNST SA1 (a) met, (b) met (c) partially met – 100% Factual Questions complete, PMRT MDT meeting to be held 25th September 2025, Report due by 1st November 2025. Standards will be met once PMRT MDT meeting held. Case 4 – Datix No: 26398 - CNST SA1 (a) met, (b) met (c) partially met – 100% Factual Questions complete, PMRT MDT meeting to be held date tbc, Report due by 30th January 2026. Will be met once PMRT MDT meeting held. Case 5 – Datix No: 26900 - CNST SA1 (a) met, (b) met (c) partially met – 100% Factual Questions complete, PMRT MDT meeting to be held date tbc, Report due by 13th February 2026. Will be met once PMRT MDT meeting held.

		Case 6 – Datix No: 27496 - CNST SA1 (a) met, (b) met (c) partially met – 100% Factual Questions complete, PMRT MDT meeting to be held date tbc, Report due by 28 th February 2026. Will be met once PMRT MDT meeting held.

SI's, MNSI Referral and PMRT's - Ethnicity and Deprivation* Table 3

Table 3

Datix Number	Ethnicity	Deprivation Score
19051	White British	3
21439	White British	5
22060	White British	8
22736	White British	8
26398	White British	6
26900	White British	5
27496	White Other (Finland)	3
27170	White British	3
24266	White British	3

*An IMD score refers to the Index of Multiple Deprivation score, which is an official government measure used in England to identify and rank small geographic areas (Lower-layer Super Output Areas or LSOAs) by their relative levels of deprivation. A higher IMD score indicates a greater degree of deprivation, with rank 1 being the most deprived and the highest rank being the least deprived. The IMD is calculated by combining and weighting data from seven different [domains of deprivation](#), such as income, employment, health, and the living environment.

Learning from completed PMRT reviews (Table 4)

Table 4

Theme	Issue	Actions	Responsible role	By when
Fetal Growth monitoring	Timeframe for measuring subsequent symphysis fundal heights following a scan.	GAP institute contacted for response to issue, discussion of whether to include follow up scan as additional intervention. Not to be progressed as not a national mandate from NICE.	Antenatal Clinic Lead Midwife	Completed

Learning from MNSI reviews (Table 5)

Table 5

Theme	Issue	Actions	Responsible role	By when
Fetal monitoring	A variety of issues predominantly around interpretation of the fetal heart rate.	Action plan being developed	CGC/Fetal Monitoring Leads	31.10.2025

Outstanding reports due from Coroner Table 6**Table 6**

Identifier	Date Listed	Summary
Maternal Death	02.06.2025	Woman found deceased at home at 9 days postnatal. Multiagency report being finalised by ICB.
TOP for medical reasons	21.01.2025	A woman undergoing a termination of pregnancy (TOP) due to the baby having a congenital abnormality. Baby born at 22+5 weeks gestation showing signs of life. Died shortly afterwards.

Review of NHS Resolution Scorecard Table 7**Table 7**

Themes Identified	Actions	Responsible role	By when
Litigation around perineal trauma	Pelvic health midwife completing Obstetric Anal Sphincter Injury (OASI) training and, improvements noted and rates decreasing. Rate of OASI dropped from 9.1% in March 2025 to 1.5% in August 2025	Pelvic Health Midwife	Ongoing

4.6 Saving Babies Lives Care Bundle. - RAG Rating

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

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

Narrative by exception

Element	Areas of non-compliance	Actions Required
2	Change to requirement for data on the % of babies identified as growth restricted on scan	Data not available from S1 to investigate how to extract data from viewpoint
4	Changes required to fetal monitoring guideline to ensure compliance	Fetal monitoring leads to review and update guidelines
5	Changes required to Multiple birth and neonatal respiratory support policies Slight rise in preterm birth rate. Change to requirement to use regional born in the right place data Thermoregulation for preterm babies	Obstetric and Neonatal consultants to review and update guidelines Continue with the PERIPrem quality improvement project.
6	Change to requirements from, continuous glucose monitoring to. closed loop monitoring	Obstetric and Diabetes teams to review and update guidelines Audit to ensure changes to policy have been implemented

The 2025-26 Q1 (March 25-May25) data has been reassessed by the DLMNS against the updated SBL audit Tool. On going the burden of audit has been removed for several elements and replaced with assurance through polices and exception reporting. During this transition period, whilst our policies are updated to reflect the new requirements, there has been a drop in compliance to 87%.

The DLMNS are satisfied that Torbay & South Devon Foundation Trusts is continuing to make sufficient progress against the improvement trajectory and action plans are in place where trajectories have not been met.

4.7 Quadrumvirate (QUAD) – Culture and Leadership

QUAD working is deemed to be the best way to improve collaboration and develop psychologically safe cultures within the perinatal teams. The QUAD consists of the director of midwifery, obstetric lead consultant, operational lead, and neonatal lead. The QUAD, as a team, meets monthly with an invite extended to the maternity improvement advisors and the clinical lead. Bimonthly meetings also occur with the QUAD and the safety champions including the Board level champions. The QUAD/ safety champion meeting for this reporting period was held in August.

Topics addressed include:

- MNVP capacity, funding and engagement opportunities.
- Disruptive social media and ways to counteract with positive feedback stories and encouragement for service users to feedback on their experiences.
- Transformation midwife provided update on the 2024 national maternity survey and progress on actions.
- Safety champion update – Sian Macallister Walker (NED) is stepping down at end of August. Appreciation for the support she has provided in her tenure. Martin Beaman (NED) taking over as Board Safety Champion in September 2025.
- Update on MIS progress given.

4.8 Maternity Outcomes Signal System (MOSS)

MOSS is a national safety surveillance tool developed by NHS England. MOSS presents trend data on term stillbirths and neonatal deaths in maternity units in a new way. It uses AI and data analytics to detect safety signals in maternity services based on reported incidents, outcomes, and expected benchmarks for unit size and complexity. Signals of potential safety issues are flagged in units when there has been a recent doubling in the rate of these events compared to what would normally be expected, given the total numbers of births at a given site. Using term events means that MOSS is targeted for use on key elements of safe intrapartum care, as these have an association with intrapartum standards of care not being met. **It is important to understand that a signal does not necessarily**

mean that a service is unsafe – which should be confirmed through follow-up safety checks. MOSS will be accompanied by Standard Operating Procedures which will be published imminently. These procedures will advise on the necessary actions that maternity services should take when a signal occurs. While the Standard Operating Procedures for the safety check following a signal are finalised, the national team will meet with the regional and perinatal leadership team to support a discussion about MOSS and an appropriate response during this pilot phase.

On the 19th of August 2025, the Trust received a signal notification from MOSS regarding three cases of perinatal mortality from April, May and August 2025. All cases had been reported and reviewed as per national requirements. The Trust is actively engaging with NHS England (MOSS Team) and regional partners to ensure appropriate review and response to these signals

4.9 Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (MIS)

Year 7 commenced on 2nd April 2025. A national webinar was held at the end of April 2025 to highlight the changes and new areas of focus. Trusts are required to submit their declarations for year 7 by 3rd March 2026.

The discretionary award that is to be received as part of the non-compliance for year 6 was received by the Trust in July 2025. This money must be spent on activity that will support the areas of non-compliance last year. The DOM and Associate Director of Operations are progressing the recruitment of a Perinatal Compliance post to support this work. Additional funds will be used to temporarily increase the governance leads contracted hours as well as to provide audit support from a midwife.

Additional information included in section 2.1 around compliance with safety action 7 (MNVP resource)

The table below demonstrates current self-assessment rating against the MIS standards with full compliance anticipated for year 7.

Safety Action	Maternity Incentive Scheme Y7 - Safety Action Detail	Current position	Anticipated position	Narrative
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?			Review of PMRT report for June 2025
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			
3	Can you demonstrate that you have transitional care (TC) services in place to minimise separation of parents and their babies?			
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?			Processes updated since CNST Yr6 with more robust monitoring of Locums being compliant with RCOG guidelines. Audit required to meet compliance
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?			
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?			
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.			The new MNVP contract only started in May 2025, DMNVP have benchmarked themselves against the national standard and identified they cannot meet all the requirements for MIS without additional resources. Devon wide meeting with providers and ICB/LMNS has agreed that the system will not meet the full requirements for CNST. This is being escalated by the LMNS and the Trust risk register has been updated. Due to the escalation process the Trust will not need to declare compliance with all areas of SA7 to meet this standard as long as there is an action plan shared with the LMNS.
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?			Improvement from last month with Anaesthetics (PROMPT) now at 80% from 60%.
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?			
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?			

5.0 Risks and concerns

5.0 Conclusion.

The maternity and neonatal teams continue to ensure that systems are in place to provide assurance in relation to safe midwifery care. They continually review and can evidence progress against several trajectories to improve the quality of care delivered. The perinatal team will embed the strategic aims of the Devon LMNS to ensure that care is personalised and responsive to the needs of women, families, and staff. The requirements for assurance continue to increase and place additional demands on the team.

5.1 Assurance and Recommendations

Overall, there is a satisfactory level of assurance around perinatal surveillance for quality and safety.

Recommendation:

- Note the progress and compliance position regarding the priority areas.
- Note the key quality and safety issues identified in the report and the measures in place to address any areas of concern.
- Note the mechanisms that are in place to hear the voices of women and families within the service. This includes the refresh of and increase in capacity of the Devon MNVP resource noting that the Devon resource will still not enable full compliance with all the recommendations for hearing the service user voice. It will remain as a risk on the service risk register and will require an action plan.
- Note the current position of compliance against the Maternity Incentive Scheme with full compliance anticipated in be March 2026
- Note the collaboration with Somerset Foundation NHS Trust to second two Labour ward Coordinators increasing resilience within our workforce.

The Board are asked to agree the recommended assurance rating noting the mitigations around assurance for point **4.9** and point **2.1**.

Appendix 1 – Monthly Maternity Safety Support Programme Reports

Maternity Safety Support Programme Monthly Update Report

Trust Name:	Torbay & South Devon NHS Hospital Trust	Report Date:	June 2025
MIA(s):	Suzanne Cunningham (MW) Erum Khan (Obs)	MSSP Phase:	Improvement

Progress and successes New midwifery MIA allocated in May following a 4 month gap. Obstetric MIA allocated June. Exit Criteria created from Diagnostic report recommendations. Currently being agreed with Trust & ICB. Project support sourced for creation of Maternity & Neonatal Improvement Plan. The plan is currently being drafted. MSSP Exit Criteria included in wider Trusts improvement programme for RSP.	Key issues or areas of concerns Trust have had some disruptive social media attention. DON, DOM, FTSU Guardian involved in several listening events with staff that have been well attended and actions agreed with wider Team. CQC enquiries made related to care for women not resident within maternity, escalation SOP and staffing. Two NN deaths and a baby transferred for cooling in May. Trust conducting a rapid learning review including MSSP. MNSI & PMRT reviews commenced. 4 maternal deaths in last 16 months. Not direct deaths but Maternity services involved in the review being led by ICB involving local authorities and mental health services. 2 of the deaths involved drug use.
Escalations No escalations at present All requests from MSSP have been attended to promptly	Next steps MIA support for 'Reading the signals' MDT review of recent perinatal incidents Agree Exit Criteria and support to draft Maternity & Neonatal Improvement plan Mia to support further listening events with labour ward co-ordinators and wider midwifery team Agree governance arrangements for MNIP and Improvement Board Investigate and confirm MNVP resources and ICB expectations

Maternity Safety Support Programme Monthly Update Report

Compliance with exit criteria				
Action / Recommendation	Evidence required	Trust lead	Agreed completion date	Progress
The perinatal leadership team is appropriately resourced with Midwifery, Obstetric Neonatal & Operational Leads, administrative and project management support.	Review of Team resources,	ADO/DM	January 2026	Project Lead agreed for MNIP
The Birthrate Plus Workforce Study should be completed and a workforce plan created that addresses the services acuity and activity requirements	Completed BR+ Report, Workforce plan agreed, Business case if required	HOM	December 2025	Data with BR+but further work needed from IT as errors highlighted. Resource needed to support.
The service should have an agreed obstetric consultant workforce plan to enable safe delivery of all aspects of the service acuity and activity, including supporting professional activities. The plan should include workforce numbers alongside workforce retention and appointment trajectories (if required)	Workforce & retention plan, appointment trajectories if required	ADO/CD	January 2026	Review 18 months ago implemented with 2 appointments funded. One replacement role being advertised.
Review the obstetric leadership roles required to contribute to a safe service are reviewed, agreed, funded and appointed to. Each role should have a job descriptor which is used as a basis of support individuals to fulfil their role and develop as high-quality compassionate leaders.	Review of Job planning, agreed job descriptors,	ADO/CD	January 2026	Job Planning not commenced
Review the current model of care that is delivered to ensure that those women who are hard to reach have the support required. This should include linking with wider support services.	Review pathway for vulnerable women, process map support available, review mw model in the community, implementation of agreed plan.	DM	April 2026	MIA to support
The service should have an agreed strategy which describes how it will continue building a culture that facilitates psychological safety in particular the work that has already started should include the Obstetric workforce. This should be planned, measured and monitored	Culture strategy agreed, SCORE Survey actions in MNIP implemented, civility workshops, minutes of Improvement Board progress	Quad	April 2026	Staff listening events completed. Maternity Meeting implemented. Civility Workshops delivered.

Maternity Safety Support Programme Monthly Update Report

Compliance with exit criteria				
Action / Recommendation	Evidence required	Trust lead	Agreed completion date	Progress
Development of a triage service that reflects the standards of the RCOG good practice guidance.	Building alterations completed, Audit data agreed – 80% women seen within 15 mins	DM	September 2026	Guidelines drafted, Building alterations out to tender. On Risk Register (8)
Provision of availability and access 24/7 to a second theatre team and location for obstetric emergencies	Options appraisal complete, mitigations in place if required agreed through governance	ADO/DM		Working group meeting, staffing models being reviewed. On Risk Register (20)
Ensure that safeguarding provision within the Maternity Services is adequately resourced with staff appropriately prepared to provide safe responsive care with system partners.	Review current service, process map with wider services, Agree and implement option agreed	Head of Midwifery	September 2026	Job matching submitted, consultation drafted
The Trust will have a MNIP in place with progress against expected measures. This will be developed as a Devon wide approach with Trust and ICB oversight and support.	MNIP and governance arrangements implemented	Quad	January 2026	MNIP being drafted resources to support available. Governance processes out for discussion. Exit Criteria with Hospital Transformation plan
The Trust will have a Governance Framework that reflects the MSSP governance Framework and PSIRF is established	Review current system against MSSP Governance Toolkit & PSIRF, implement agreed changes,	DM	March 2026	Resources to support the Team required before this can take place- MIA to support
The Trust will work with the MNVP to ensure that feedback from families is timely and responsive. It should be an integral part of the culture of co production and listening to women.	Improvement Board minutes, evidence of co production and feedback/complaints	DM	April 2026	3 new across Devon MNVP's appointed and starting work with the 3 hospitals.

Maternity Safety Support Programme Monthly Update Report

Trust Name:	Torbay & South Devon NHS Hospitals Trust	Report Date:	July 2025
MIA(s):	Suzanne Cunningham (MW) Erum Khan (Obstetrics)	MSSP Phase:	Improvement

Progress and successes	Key issues or areas of concerns
New Obstetric MIA allocated. Focus will be on culture, leadership, governance and PMRT Perinatal Improvement Plan drafted and shared with Leadership Team. Leads and deputy for each workstream have been identified. First Board meeting agreed date in October. Engagement events with stakeholders planned. Chief Nurse to chair the Perinatal Improvement Board. MSSP Exit Criteria also forms part of Trust improvement plans alongside the RSP. Monthly assurance agreed Devon MNVP has now been launched. 3 women leading across Devon with affiliations to specific Trusts. MNSI Quarterly meeting held with good engagement and feedback. ~~Communication strategy drafted. Maternity Service Meetings on going.~~	Disruptive social media attention continues. CQC enquiries continue into leadership Team, staff being supported by Trust, RCM & MIA. A number of clinical guidelines are out of date. Currently engagement with clinicians is challenging. Leadership Team supporting solutions related to capacity & leadership. Screening QA visit has taken place. 1 urgent action asked for regarding training which has been actioned. Actions related to recommendations will be absorbed into PIP. Reorganisation of Midwifery leadership and safeguarding roles is progressing slowly. Currently no fulltime HOM to support the service. Timeframes to be established.
Escalations	Next steps
No escalations	PIP to be finalised and projects established with leads Assurance regarding out of date guidelines to be established to ensure guidance is correct and timeframes for completion. Awaiting Birthrate + report Support governance refresh of systems and processes



Torbay and South Devon
NHS Foundation Trust

Public Board of Directors

Title: Maternity & Neonatal staffing Report (1 January 2025 – 30 June 2025).

Date of meeting	Date report produced
24 September 2025	4 September 2025

Author(s)		Report approved by	
Name and title:	Deputy Director of Midwifery & Gynaecology – Maria Mortimore Inpatient and Community Matron – Mair Davies	Name and title:	Director of Midwifery & Gynaecology – Joanna Bassett Nicola McMinn – Chief Nurse
Phone:		Date:	15 September 2025
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary

This report provides assurance on the measures in place to maintain safe and effective midwifery, obstetric, and neonatal staffing. It covers compliance with national standards (e.g. midwife-to-birth ratio, Birth Rate Plus® acuity tool, supernumerary labour ward coordinators, and one-to-one care in labour), monitoring of red flag incidents, specialist roles, staffing fill rates, escalation processes, and recruitment activity.

It reflects NICE guidance around safe staffing levels as well as Ockenden recommendations. This is monitored by the Maternity Governance and Service Group.

The purpose of the report is to provide an update to the Trust Board 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 should note the 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.
- The Obstetrics & Gynaecology medical workforce continues to experience capacity issues, although support has been provided by the Trust,
- Women and birthing people continue to be provided with 1:1 care in labour 100% of the time.
- The current fall and further projected fall in the vacancy rate for midwifery staffing
- The continuing reduction in sickness levels for midwifery staff

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
O&G medical workforce capacity	Satisfactory	Some positive change, but continuing oversight and planning still required.
Challenges in relation to QIS (Qualified in Speciality) nurses within SCBU	Satisfactory	Some improvement

Boards that have previously discussed/agreed the report, and outcomes of that discussion

Metrics contained within this report have been presented at the monthly Maternity Governance and Service Meeting as well as at the monthly Maternity and Gynaecology Quality Meeting. The data is also shared as a slide set for the monthly Families and Communities Care Group Governance Meeting. Escalation of concerns will be via this quality group and/ or via the Executive Operations Group. This report has also been presented to the Quality Assurance Committee

Key recommendations and actions requested

The Board are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed. The Board are also asked to:

- Note the mitigations taken within the maternity service to ensure safety and quality.
- Note the ongoing service requirements of the Obstetrics and Gynaecology team.
- Note the continuing falling levels in sickness rates within maternity staff
- Note the significant fall in vacancy rate for midwifery staff and further projected fall, which is likely to be evident by October 2025

- Note the action plan that has been developed to address the challenges in relation to QIS nurses in SCBU.
- Note that workforce recommendations form part of the recommendations of the MSSP report.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

This report describes how staffing and acuity levels are managed within the maternity and neonatal service to ensure that care is provided that is both safe and of a high quality for the pregnant population and their families in Torbay and South Devon. It also describes the mechanisms that are in place that monitor these levels and actions taken to ensure these are maintained.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	This report supports the aims described by demonstrating best practice guidance in the maintenance of safe staffing levels to ensure the health and wellbeing of pregnant people and babies
Quality of services provided	

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	
People	
Strategy and Transformation	

Risk: Risk ID (as appropriate)

Risk	Risk ID

Lack of consultant obstetrician and consultant workforce

Risk score = 12

3478

Action taken: 2 Recruited, start dates early 2025

External Standards affected by this report and associated risks

NHS England licence and regulations
National policy, guidance

1.0 Introduction

This report covers the period from 1 January 2025 to 30 June 2025 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 the workforce as one of its four key pillars (2023)

‘Growing, retaining and supporting our workforce.’

The Clinical Negligence Scheme for Trusts (CNST) maternity incentive, Year 7, sets out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows:

- a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.
- b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
- c) The Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.
- d) All women in active labour receive one-to-one midwifery care.
- e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the MIS year seven reporting period.

3.0 Midwifery Staffing Establishment

3.1 Birthrate Plus®

Considering the Ockenden Review (Dec 2020), Trusts have been required to articulate how 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 in 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 to address this gap. The funded establishment for midwifery staffing has remained at this level since the last BR+ review in 2021.

Year 7 of the Maternity Incentive Scheme (CNST) sets out the expectation that an establishment review must be carried out every three years. For this reason, a further BR+ establishment review has been approved and is currently being conducted in the Maternity Services at TSDFT. It is anticipated that the draft report will be received in September 2025.

3.2 Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the midwifery staff within maternity for this reporting period.

Month	Day Registered %	Night Registered %	Day Unregistered	Night Unregistered
January 2025	82.7%	93.5%	88%	102.5%
February 2025	84.06%	92.86%	87%	89.4%
March 2025	91.8%	93.8%	79.3%	74.2%
April 2025	94.59%	86.24%	91.5%	88.46%
May 2025	82.9%	99.44%	93%	89.64%
June 2025	88.3%	96.7%	72.5%	80.6%

Fill rates alternate for several reasons, these include gaps caused by sickness absence, ongoing vacancies or staff who are working in a supernummary capacity. The benefit of having an integrated model of midwifery care in place means we can mitigate less than 100% fill rates by redeployment of our staff across our flexible midwifery service. Integrated midwives can work cover community work, intrapartum care as well as inpatient antenatal and postnatal care.

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Temporary staffing solutions – bank staff or staff working additional hours
- Request midwifery staff undertaking specialist roles to work clinically.
- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Request additional support from the maternity matrons/managers.

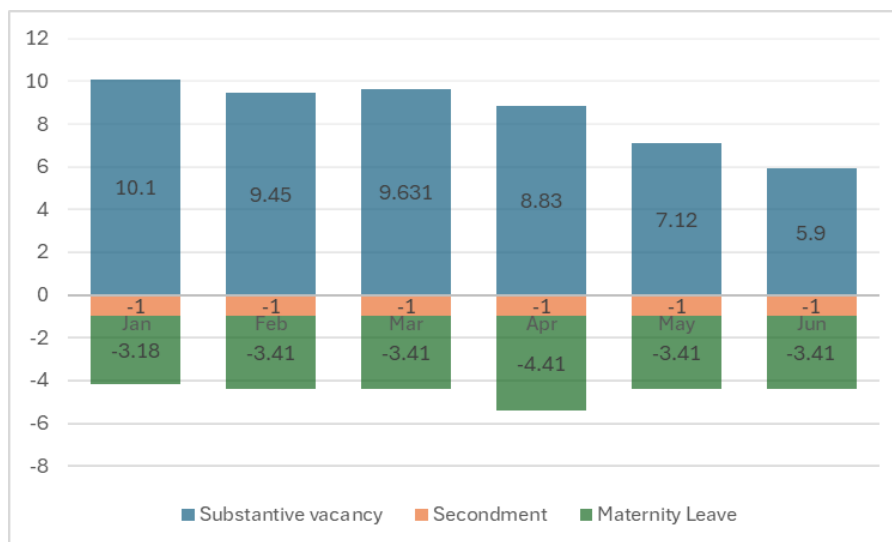
All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

3.3 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 who are working non-clinical duties are also monitored, to ensure efficient staffing cover in all areas of the service.

3.3 Recruitment

Chart 1: Midwifery pipeline



During the 6-month period covered within this report, we have seen a significant fall in the monthly vacancy rate, from 10.1wte in January 2025 to 5.9wte in June 2025 (Chart 1). This is predominantly in the Band 6 Midwife group, which is the largest staff group within the maternity service.

The Maternity service continues to receive additional funding for fixed term specialist midwifery posts. This impacts the substantive workforce, as these posts are filled by internal staff, thereby creating temporary vacancies within the clinical workforce. Despite the best efforts of the service, there has been some challenge in backfilling

these roles, due to their temporary nature, and cover has had to be provided using bank staff and staff working additional hours. It is anticipated that there will be an agreement from the ICB that most of these temporary posts will be funded via service development funding (SDF) on a permanent basis, this decision is expected in the latter half of this calendar year. If permanent funding is obtained this will allow the service to recruit to the backfilled posts, thereby improving the vacancy rate further.

The maternity service currently has 5.48wte band 5 preceptee midwife. These are 12-month fixed term posts which support in growing the future workforce and readying newly qualified midwives for band 6 midwifery positions. The preceptee midwives are provided with support from the Retention and Education Midwives and receive additional support through inclusion in the Trust-wide preceptee programme.

There is a very low rate of attrition in the maternity workforce at TSDFT, and active succession planning is in place, with the vast majority of preceptees successfully applying for substantive band 6 midwifery posts within the Trust at the completion of their programme.

3.4 Retention

Funding continues to be received to continue to fund the Retention Lead Midwife post and this role is now undertaken by one post holder working 0.8wte.

The retention work for this reporting period has continued to focus on Culture and Civility. This has included the embedding of the Maternity and SCBU Civility Toolkit. The toolkit was developed in response to the SCORE survey results and in collaboration with the Organisational Development Team, as it aligns with the Compassionate Leadership programme.

In addition, the Retention Midwife has:

- Continued to lead the Birth Afterthoughts service, including admin and facilitating clinics - weekly.
- Provided individual and group Restorative Clinical Supervision to MWs, Drs, MSWs and admin staff.
- Developed 'Civility Advocate' training with the strategic people partners from the organisational development team, training days attended in March 2025.
- Taught monthly session on 'Personalisation and Trauma Informed Care' on the virtual maternity mandatory day.
- Ambassador for Peoples Promise.

The Retention Lead is also the PMA (Professional Midwifery Advocate) Lead, this role includes:

- Developed bespoke 'Trauma Informed Training' for PMAs with external psychology organisation to develop and improve our trauma informed service. Training being undertaken in Feb 2025, training developed and led by Torbay PMAs but opened to PMAs across the SW region, 6 external PMAs booked to attend.

- Developed and launched 'R U OK?' A programme to support staff following incidents, run by the PMA team. Following a potentially distressing incident staff receive a support phone call within 72hrs, to check they are ok and offer an RCS.

In May 2025 the maternity service received notice that the Retention Lead Midwife would be stepping down from her role in August 2025. Discussions will be held regarding how the external funding for this role will be utilised moving forward.

3.5 Specialist Midwives

Birth Rate Plus recommends that 10-12% of the total establishment are not included in the clinical numbers, This includes management positions and specialist midwives. The current percentage for TSDFT maternity services is calculated to be 8.75%. This gap has been acknowledged within the diagnostic element of the Maternity Safety Support Programme (MSSP) and will form part of the recommendations to be considered in the ongoing improvement plan for perinatal services.

3.6 Birth to Midwife Ratio (Table 2)

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 January 2025 – June 2025 there was an average birth rate per month of 143 births. This is a slight increase from the previous reporting period of 138 births per month. This has resulted in a Midwife to Birth ratio as displayed in Table 1. The birth to midwife ratio falls within the national recommendation.

The complexity and acuity of women, both medically and socially, continues to increase. This is 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, in addition to increasing safeguarding requirements and support for vulnerable women and families.

Discussions continue regionally regarding 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. TSDFT maternity services currently utilise the Birthrate Plus (BR+) acuity tool on Labour Ward and have introduced the antenatal and postnatal BR+ acuity tool on John Macpherson Ward, in order to provide a more accurate reflection of the acuity within the service.

Table 2: Midwife to Birth ratio (exc. DOM, Deputy DOM, Matrons and Specialist roles)

Time period	Midwife: Birth Ratio
Jan 25	1:18
Feb 25	1:17
Mar 25	1:18
Apr 25	1:19
May 25	1:17
Jun 25	1:16

3.4.2 Nationally Mandated Workforce Models across Maternity Pathway

TSDFT continues to provide a fully integrated maternity service. Compliance with Midwifery Continuity of Carer (MCoC) is recorded monthly, but there are currently no national trajectories for this. The service is undertaking a Birthrate Plus review of staffing with the draft report due in September 2025.

Focussed work has been undertaken to increase the midwifery workforce within the community teams, this has included allocating preceptee midwives to community teams within the service. With the aim that these preceptee midwives will be successful in gaining band 6 community midwifery posts upon completion of their preceptee year.

We are now part of Maternity Safety Support Programme (MSSP) through NHS England, as are all the Maternity Services within Devon. The diagnostic report that has been published includes findings and recommendations around the requirements for the perinatal workforce.

4.0 Women receiving one-to-one care in labour

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

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

Time period	%
Jan 25	100%
Feb 25	100%
Mar 25	100%
Apr 25	100%
May 25	100%
Jun 25	100%

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

5.0 Obstetric, Neonatal Medical & Neonatal Nursing Workforce

5.1 Obstetric workforce:

Challenges have continued regarding the capacity of the obstetric workforce during this reporting period. A required uplift was noted as part of the November 2023 CQC maternity inspection and the requirement to ensure sufficient medical staffing is a CQC 'Must Do' action. A full-service review around capacity and workforce within the speciality was concluded in October 2023, resulting in a recommendation for an uplift of 4.0wte consultants, a business case was written, and the Trust Executive approved an uplift of 2.0wte. These posts have now been recruited to; one consultant started in February 2025 and the other in March 2025. Ongoing workforce requirements remain in remuneration and protected time to complete obstetric leadership roles. This will be addressed via business planning for 26/27 as well as through a perinatal workforce strategy.

5.2 Neonatal medical workforce:

The neonatal medical workforce does meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing. Examples of rotas have been provided which confirm this and will be used as part of the evidence that will be submitted for CNST.

5.3 Neonatal nursing workforce:

There are defined service specifications for neonatal nursing requirements as outlined by the British Association of Perinatal Medicine (BAPM) and NHSE Service Specification for Neonatal Critical Care (2024)

A nurse staffing report for 24/25 has been compiled by the Southwest Neonatal Network correlating data from the quarterly workforce returns and cot occupancy for this period. This indicates that no additional funding is required to meet the registered nursing workforce need, and no additional non-registered staff are required. Based on 24/25 Intensive and High Dependency care activity, the report identified 84.9% of the required nursing workforce should be registered nurses, this currently sits at 74% indicating a workforce imbalance.

Quarterly neonatal network workforce returns continue to be completed and submitted to the network for review and form part of a network response to NHSE regarding regional workforce and establishment.

5.3.1 Workforce analysis:

Although there have continued to be challenges within this reporting period regarding the continued vulnerability in ensuring optimum staffing levels and the delivery of both the neonatal and maternity pathway, there has been an improvement in the neonatal nursing workforce trajectory as detailed in 5.4.2; to note there has been some successful recruitment of band 5 nurses which is providing a pipeline of candidates to complete QIS training. Whilst there is an established regional educational pathway to support this training, the timeline for completion and consolidation is around two to two and a half years meaning there will still be some workforce resilience challenges in the short term. The contributory factors to the workforce gaps are a combination of retirement, long-term sickness, maternity leave, vacancies and short notice absence.

Currently the workforce structure is under review, taking into consideration the findings of the recent network staffing report for TSDFT. A case for change is being drafted at present, outlining rationale - increasing acuity and complexity the service experiences and the need for resilience and responsiveness; and a proposal to address this.

Without a Qualified in Speciality (QIS) nurse on shift, the neonatal unit would have to declare a temporary inability to accept babies, and maternity services would not be able to provide facilities for woman in labour/birth activity during that period. Women in labour or those who may labour would need to be diverted to an alternative unit. The Maternity Services Escalation policy has been updated within this reporting period to describe the necessary actions that would be taken in this instance.

The issues highlighted in relation to the neonatal workforce are also reflective of the challenges being experienced both at regional network and national level.

5.3.2 Neonatal Nursing Action Plan:

- The action plan will be presented to the Trust Board as part of the Maternity Incentive Scheme (CNST) requirements and shared with the ODN and ICB.
- This action plan will be monitored through the monthly SCBU quality & safety meeting, and progress will be reported through paediatric governance for oversight.

Action No:	Action	Current Status	Responsible	Completion by:	Completed
1	Ongoing recruitment of registered staff	• Recurrent advertisement of vacant posts • Short term capped rate agency QIS placement to provide bridging cover.	Unit Manager / Matron	Jan 2026	Ongoing: Recent successful recruitment to Band 6 QIS & Band 5. Impending retirement will create further vacancy in QIS. 1 WTE B6 with vacancy panel and 3 month capped rate agency placement with NHSP to fill.
2	To consider 'growing own' registered workforce	• Band 3 Trainee Associate Practitioner roles to be	Unit Manager / Matron	September 2025	Completed Following review of workforce requirements to meet service

		explored with the expectation of progressing to registered nurse.			needs now and in the future, consensus decision to restructure with focus on registered workforce for future service resilience.
3	Supporting all registered staff access QIS training	- Unit Manager has completed course and awaiting results. 2 candidates starting course in Dec 25 with 2 further identified to join Sept 26 cohort	Unit Manager / Matron	Ongoing	Ongoing: Successful Band 5 recruitment to ensure a consistent pipeline to access QIS training
4	Risk register: articulating risk to neonatal and maternity pathway if no QIS available. Identifying mitigation and gaps in controls.	Risk has been added again to risk register as imminent retirement and recruitment gaps leave staffing vulnerable to short notice absence.	Matron	Completed Aug 25	Completed: Risk 4287
5	Practice Educator and Unit Manager to work clinically where gaps in roster are identified.	Ongoing P Ed picking up more shifts to cover short notice absence	Unit Manager / Matron	Ongoing	Ongoing
6	Review of current establishment structure with support from the Neonatal Network	Further review of workforce structure to address registered workforce imbalance and reflect the needs of service	Unit Manager / Matron/ADNPP	Dec 25	In progress: Case for change paper drafted and shared with operational, midwifery and medical leads for comments

6.0 Maternity Red flags

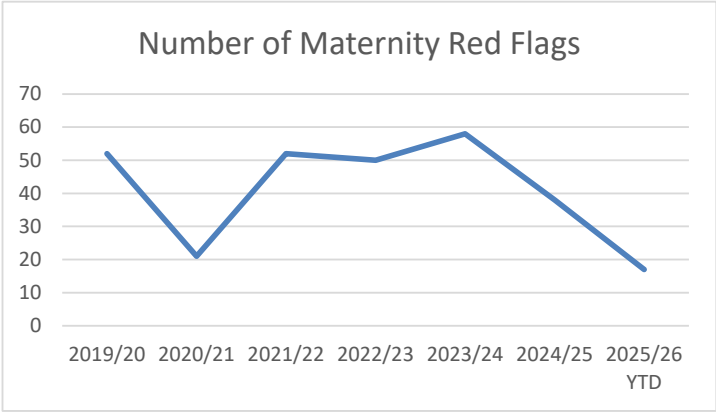
NICE guidance identifies several events that can be viewed as red flags. These indicate that there may not be enough midwives available to meet the acuity demand. 9 red flag events were identified by NICE, whilst locally we have added a further flag (denoted with an *):

Red flag events and actions taken in response to these are captured using the Birthrate Plus ® Acuity Tool. The midwifery red flags for the reporting period are detailed in Table 3 below

Table 3

Red flag	Description	Incidence						Tot
		Jan	Feb	Mar	Apr	May	Jun	
RF1	Delayed or cancelled time critical activity	0	0	0	0	0	0	0
RF2	Missed or delayed care	0	1	0	0	0	0	1
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	1	0	1	0	2
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	1	1	1	0	0	3
RF8	Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	0
RF9	1:2:1 care in labour	0	0	1	0	0	0	1
RF10*	Unable to facilitate out of hospital birth	1	2	1	1	3	0	8
RF11	Coordinator unable to maintain supernumerary status- providing 1:1 care in Labour	1	0	0	0	0	0	1
RF12	Coordinator unable to maintain supernumerary status - Not providing 1:1 care	0	0	3	6	0	0	9
Totals		2	4	7	8	4	0	25

Maternity Red Flags	No
2019/20	52
2020/21	21
2021/22	52
2022/23	50
2023/24	58
2024/25	38
2025/26 Year to Date	17



From our analysis of the system, red flags continue to occur predominantly during periods of high acuity. Each red flag event is reviewed by the Maternity Matron and, where appropriate, discussed with the Labour Ward Coordinator using the same governance process applied to supernumerary status. This ensures that any deviation from expected care standards is scrutinised and addressed in real time.

All red flag instances within this reporting period were triggered intentionally as part of a proactive safety strategy. This approach reflects a conscious decision to prioritise safety across the maternity service, even when operational pressures are high.

The most frequently reported red flag between January and June 2025 was **RF12 – Coordinator unable to maintain supernumerary status (not providing 1:1 care)**, with **9 recorded instances**. This flag was added to the acuity app in March 2023 and reflects the ongoing challenge of maintaining oversight and leadership on the labour ward during times of increased demand overnight. It remains the most common reason for red flag escalation and highlights the tension between maintaining supernumerary status and ensuring safe staffing ratios.

The second most reported red flag was **RF10 – Unable to facilitate out-of-hospital birth**, with **8 instances**. This continues to be a significant theme, often linked to staffing constraints and the requirement for two staff members to attend for extended periods—longer than would typically be required on an acute site. This mirrors the findings of the previous bi-annual report and underscores the need for strategic workforce planning to support community birth options. This is a quality issue which needs to be addressed.

RF7 – Delay of ≥2 hours between admission for induction of labour and beginning of process was reported 3 times, indicating ongoing pressures in managing induction pathways during peak activity. Similarly, **RF5 – Delay between presentation and assessment** occurred twice, suggesting occasional delays in initial triage and evaluation.

Other flags, including **RF2 – Missed or delayed care**, **RF9 – 1:2:1 care in labour**, and **RF11 – Coordinator unable to maintain supernumerary status while providing 1:1 care**, were each triggered once. These isolated events still warrant attention to ensure that care remains responsive and personalised. An update to the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, which focuses on safety,

changed the requirement for Trusts from never having this as a red flag as a safety measure, to ensuring that there is a supernumerary labour ward coordinator at the start of every shift. The most likely rationale for this change was that managing this as an absolute, when the maternity workload is so variable, became untenable for many Trusts.

Notably, several red flags—including **RF1, RF3, RF4, RF6, and RF8**—had zero reported incidents, which is reassuring and suggests that critical safety standards in these domains are being consistently upheld.

In total, **25 red flag events** were recorded during this six-month period, with the highest monthly incidence occurring in **April (8 events)**. This trend aligns with known seasonal fluctuations in service demand and reinforces the importance of dynamic staffing models and acuity monitoring.

In summary, while the overall number of red flag events remains relatively low, the dominant themes of **supernumerary status challenges** and **limited capacity for out-of-hospital births** persist. These insights will inform ongoing service improvement efforts and workforce planning to ensure safe, equitable care across all maternity settings.

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 hours a day. This specialist role ensures that a clinical expert is available to oversee safety within the department, provide support, advice, and clinical interventions as needed.

Our maternity staffing and escalation framework sets out that the Labour Ward Co-ordinator must remain in a supernumerary role. All instances where the Co-ordinator has not been working in a supernumerary capacity are recorded via the Birthrate Plus® acuity tool.

The ongoing ambition remains to achieve 100% supernumerary status for Labour Ward Co-ordinators. Table 3 (above) demonstrates our compliance with this ambition for the period January to June 2025.

From March 2023, an additional red flag was introduced (RF12) to monitor compliance with supernumerary status when the Co-ordinator is caring for women who do not require constant observation (e.g., when relieving for breaks). This should not occur on a regular or recurrent basis. During the current six-month reporting period, **9 instances** of this red flag were recorded, equating to an average of 1.5 per month. While this is slightly higher than the previous period, it remains within expected parameters given the size and complexity of the service. The increase may reflect improved reporting practices or temporary pressures in staffing. The unpredictability of workload in an acute maternity setting means complete elimination of these occurrences is unlikely.

Additionally, **RF11 – Coordinator unable to maintain supernumerary status while providing 1:1 care** was triggered once during this period. This reflects rare but necessary decisions made during high acuity to ensure safe care delivery.

The service continues to operate a robust escalation plan with clearly defined actions for the Co-ordinator to take during periods of high acuity or unexpected staff absence. The Co-ordinator providing direct care on Labour Ward remains one of the final steps in this escalation process, due to the safety-critical nature of maintaining a helicopter view of the maternity service. The Co-ordinator will return to supernumerary status at the earliest opportunity. During times of increased demand, specialist midwives and midwifery managers will work clinically to support the service and uphold safety standards.

The service has also launched a development competency framework for aspiring labour ward coordinators which enables experienced and competent band 6 midwives to take charge if required in the unexpected absence of the coordinator.

7.0 Acuity Data

Acuity of the patients on Labour Ward is captured via acuity monitoring, available from the Birthrate Plus ® Acuity Tool. The acuity tool has now been introduced on John MacPherson, the mixed ante and post-natal ward, this is utilised to assist in the safe allocation of staff across the maternity service.

Chart 2: Staffing v Workload Example

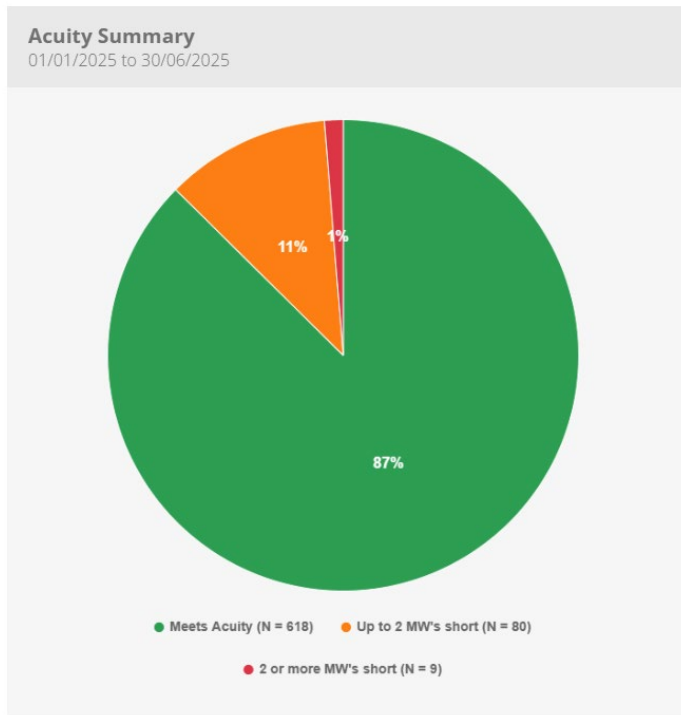
The chart below indicates the number of occasions in this reporting period where staffing met the acuity level, this is indicated in green. Red and amber indicate that staffing levels were not met.

The data for this period indicates that on labour ward staffing levels were classified as red <1% of the time during the reporting period (a red classification indicates that staffing was more than 2 midwives short) and that 11% of the time staffing levels were up to 2 midwives short (Amber). Therefore, staffing levels met the acuity levels 88% of the time.

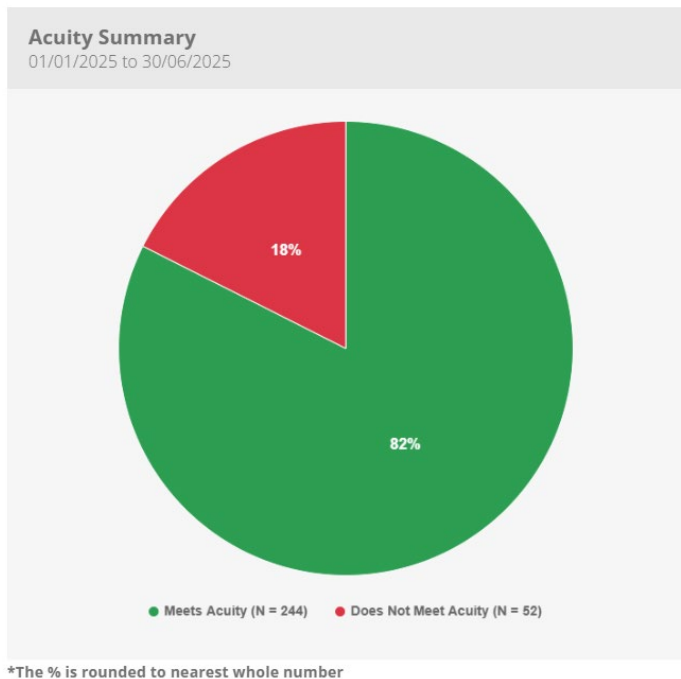
On John Macpherson Ward staffing levels were red 18% of the time and staffing levels met the acuity levels 82% of the time.

Staffing levels met acuity (Chart 2)

Labour Ward January – June 2025



John MacPherson, January – June 2025



Staffing levels across the service met with acuity levels on most occasions (over 80% of the time on both wards). When staffing falls short of acuity the service considers operational safety and deploys available staff to the most appropriate location to maintain safety. Almost all staff are multi-skilled and able to work across locations in maternity.

For this period, we have included data from our newly launched acuity tool for John MacPherson our mixed ante and post-natal ward. This was added to the Trust's reporting at no additional cost. Integrating the ante- and postnatal acuity tools into the existing Birthrate Plus labour ward acuity framework, significantly enhances the overall understanding of maternity service safety. While the labour ward tool captures real-time staffing needs during intrapartum care, adding acuity assessments for the antenatal and postnatal ward provides a more comprehensive view of workload across the entire maternity pathway. This broader lens allows for proactive staffing adjustments, based on fluctuating patient needs before and after birth, not just during labour. It also helps identify pressure points that may otherwise go unnoticed, ensuring that safe staffing levels are maintained throughout the continuum of care. Ultimately, this holistic approach strengthens workforce planning, supports better clinical decision-making, and promotes safer, more responsive care for mothers and babies across all stages of their journey.

Whilst labour ward acuity data reflects short, high-intensity intrapartum care episodes, mixed antenatal/postnatal ward data captures a broader spectrum of care needs over longer stays. Acuity on these wards is driven by the combined dependency of mother and baby, antenatal monitoring requirements, and postnatal recovery — often with overlapping needs. This results in different patterns of workload, skill mix requirements, and bed utilisation, meaning direct comparison with labour ward data is not appropriate without adjustment for case mix and care model : -

1. **Acuity scores are not directly comparable**
A “high acuity” shift on a mixed ward may reflect *sustained moderate needs across many patients* rather than a small number of intense intrapartum cases.
2. **Staffing ratios differ**
Labour ward ratios are based on one-to-one care in labour; mixed ward ratios must account for *aggregate care hours* across AN and PN categories, plus neonatal needs.
3. **Bed occupancy and turnover patterns**
Mixed wards may appear “less acute” in headline scores but can be *operationally busier* due to constant admissions/discharges, multiple care pathways, and dual mother–baby dependency.
4. **Skill mix planning**
Data should inform not just *numbers* of staff but the *type* — e.g. postnatal breastfeeding support, antenatal monitoring expertise, neonatal care skills

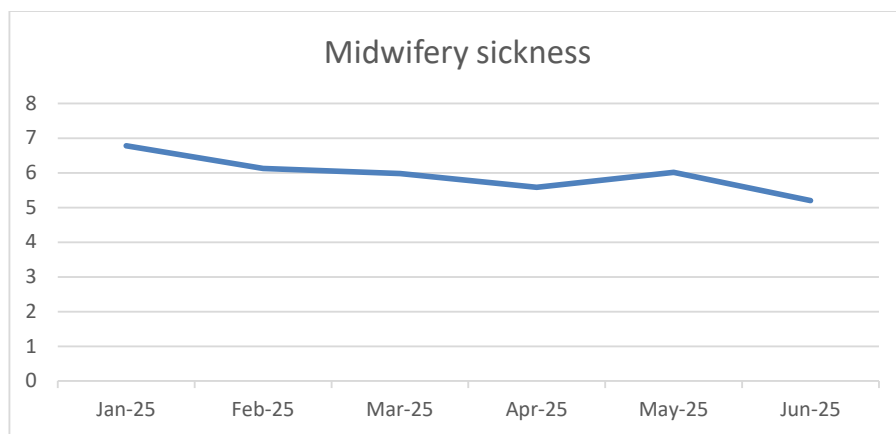
Within the reporting period staffing met acuity levels most of the time. Regularly (monthly) there are short periods where staffing cannot meet the acuity needs.

8.0 Sickness

There continues to be a general downward trajectory in sickness rates within maternity in this reporting period. This is a further reduction on the sickness rates in the last reporting period and the third consecutive 6-month reporting period which has demonstrated a reduction. This may be reflective of the current focus on Culture and Civility within the service and the staff engagement work that has been undertaken.

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 is also provided to staff by the Professional Midwifery Advocates (PMAs).

Chart 4: Midwifery Sickness Percentage



9.0 Escalation and Interventions to Assure Safety

There are ongoing challenges in relation to determining an appropriate model for midwifery escalation. This is a common issue in maternity services across the country and, at present, 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 interim, the senior leadership team continue to 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

There is still a challenge in the ability of the consultant workforce to perform all the required leadership activities required. This will be addressed via the development of a workforce strategy as well as through business planning in 2026/2027.

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 results of the workplace establishment review are due in September 2025. This will ensure the accuracy of updated requirements for the service.

Workforce recommendations form part of the MSSP diagnostics report that was published in early 2025. These recommendations will be shared as part of a full overview report of the diagnostic process and will form part of the exit criteria needed to be achieved to exit the support programme.

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 Assurance and Recommendations

Overall, there is a satisfactory level of assurance around the maternity and neonatal workforce metrics. This assurance level relates to the challenges highlighted within the obstetrics and gynaecology consultant workforce due to the continuing capacity demands and challenges. There is also satisfactory assurance in relation to the reduced ratio of QIS (Qualified in Speciality) nurses within SCBU due to the impact such ratios can have on the ability to staff the unit at optimal levels as well as impacting on the maternity service.

- Note the mitigations taken within the maternity service to ensure safety and quality.
- Note the ongoing service requirements of the Obstetrics and Gynaecology team.
- Note the continuing falling levels in sickness rates within maternity staff.
- Note the significant fall in vacancy rate for midwifery staff and further projected fall, which is likely to be evident by October 2025
- Note the action plan that has been developed to address the challenges in relation to QIS nurses in SCBU.
- Note that workforce recommendations form part of the recommendations of the MSSP report.

The Board is asked to receive and note this paper.

The Board are asked to agree the recommended assurance rating and take **SATISFACTORY** assurance for point 5.1 and 5.3.

Public Board of Directors

CQC Registration

Date of meeting	Date report produced
24 th September 2025	1 st September 2025

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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

N/A

Executive summary

This report is being presented to the Board to provide assurance that an annual CQC registration review of all registered locations and regulated activity has been undertaken.

The statement of purpose document has been revised and the following amendments have been made:

- Removal of Covid related temporary changes made in 2022 which includes Brixham Hospital as Covid community hospital and Ricky Grant Chemotherapy Unit area relocation to the Horizon Centre including the unit conversion to a 10 bedded ward named Joan Williams ward.
- Revised statement from Children and Family Health Devon (CFHD) to echo Devon Partnership NHS Trust's statement.
- Removal of Sexual Health Services at Castle Circus as now run by Royal Devon University Healthcare NHS Foundation Trust (RDUH) since 1st July 2025. The Torbay Pregnancy Advisory Service (ToPAS) remains.
- Removal of Walnut Lodge as a registered location and the addition of Shrubland House to reflect the Torbay Recovery Initiative service physical location move.

Please see appendix 1 for full list of registered locations and regulated activity.

The assurance ratings in this report related to the undertaking of the annual registration review.

Action Ref	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
N/A	Satisfactory	Not known

Boards that have previously discussed/agreed the report, and outcomes of that discussion

This report has been produced for the Quality Assurance Board. Due to the meeting timings, this report has not been taken to the CQC Assurance Group, however core members are part of the consultation to ensure the content is accurate.

Key recommendations and actions requested

The Board are asked to CONSIDER the SATISFACTORY assurance that the annual CQC registration has been undertaken.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

This report provides assurance that the organisation is meeting the legal requirements set out in the Care Quality Commission (Registration) Regulations 2009 and Health and Social Care Act 2008. In doing so, the organisation is able to provide regulated health activity to the people of Torbay and South Devon.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Not meeting the regulatory requirements would mean the organisation would not be able to provide regulatory activity/care or operate with restriction.
Quality of services provided	
Sustainable and efficient use of resources	

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	Not having accurate Care Quality Commission (CQC) registration carries significant risks, including prosecution, fines, reputational damage and the potential for conditions on a new or existing registration. It is a criminal offense to provide regulated activities without being registered, and inaccurate declarations on an application can lead to penalties.
People	
Financial Sustainability and Productivity	
Estates	
Operations and Performance Standards	

- Digital and Cyber Resilience
- Building a Brighter Future
- Strategy and Transformation
- Sustainability: Green Plan/
Environmental
- Equality, Diversity and Inclusion
- Provision of Community and Care
Services Delivered in Partnership

Risk: Risk ID (as appropriate)	
Risk	Risk ID
Trust Wide Legal and Regulatory Compliance (Overarching Risk)	3955

External Standards affected by this report and associated risks
Care Quality Commission (Registration) Regulations 2009 Health and Social Care Act 2008

CQC Registration

Introduction and background

All providers of healthcare (individual, partnership or organisation) who provides regulated activity as defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 must be registered with the CQC.

Whilst it is not a set requirement to undertake an annual review is it a requirement to ensure that the organisation maintains it's legal duty.

Assurance and Recommendations

1. The assurance level below is based on the completion of the annual CQC registration review.

Action Ref	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
N/A	Satisfactory	Not known

Summary of Regulated Activities by Registered Locations

Summary of Regulated Activities by Registered Locations										
Regulated Activity Registered Location	Diagnostic and screening procedures	Family Planning	Management of supply of blood and blood derived product	Maternity and Midwifery services	Surgical procedures	Transport services, triage and medical advice provided remotely	Treatment of disease, disorder or injury	Termination of pregnancy	Personal Care	Assessment or medical treatment for people detained under the Mental Health Act 1983
Ashburton Hospital	✓						✓			
Brixham Hospital	✓						✓			
Brunel Dental Centre	✓				✓		✓			
Castle Circus Health Centre	✓	✓			✓		✓	✓		
Dartmouth Wellbeing Centre	✓						✓			
Dawlish Hospital	✓						✓			
Kingsbridge Hospital (Dental)	✓				✓		✓			
Newton Abbot Hospital	✓			✓			✓		✓	
Paignton Hospital	✓				✓		✓			
St Edmunds									✓	

Tavistock Hospital (Dental)	✓				✓		✓			
Teignmouth Hospital	✓				✓		✓			
Torbay Hospital	✓	✓	✓	✓	✓	✓	✓	✓		✓
Totnes Hospital	✓						✓			
Walnut Lodge – To be replaced with Shrubland House	✓						✓			



Torbay and South Devon
NHS Foundation Trust

Public Board of Directors

Safeguarding Children Annual Report

Date of meeting	Date report produced
24th September 2025	2 nd September 2025

Author(s)		Report approved by	
Name and title:	Phillipa Hiles Named Nurse Safeguarding Children	Name and title:	Nicola McMinn – Chief Nurse Natalie Herring – Deputy Chief Nurse
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

N/A

Executive summary

This report provides the Trust Board with high-level assurance regarding the oversight, effectiveness, and governance of safeguarding children across Torbay and South Devon NHS Foundation Trust. The content has been summarised for the Board, while the full, detailed report has been reviewed and endorsed by the Quality Assurance Committee, ensuring comprehensive scrutiny of data, audits, and improvement actions.

The Trust continues to meet statutory obligations under Working Together to Safeguard Children (2023) and Section 11 of the Children Act (2004), with robust engagement in multiagency partnerships, Child Safeguarding Practice Reviews (CSPRs), Child Death Reviews, and National Child Mortality Database (NCMD) audits. Actions identified through these processes are implemented and monitored via the Safeguarding Children Operational Group (SCOG) and relevant governance forums, ensuring learning is embedded into practice and emerging risks to children's safety and wellbeing are managed effectively.

Safeguarding activity levels remain high, reflecting increasing complexity and demand across child protection, child protection medicals, court report requirements, and supervision needs. Workforce capacity is recognised as a Trust risk, with mitigating actions in place to maintain statutory compliance and safe

practice. Key improvements include updating safeguarding policies in line with current legislation, implementing quality assurance audits, embedding professional curiosity in supervision and training, and maintaining 100% health service provision within Torbay MASH.

Training compliance has improved, with Level 1 and 2 statutory training consistently above target, and Level 3 progressing toward the 80% target by November 2025. Targeted support, supervision, and induction programmes are in place for higher-risk staff groups, providing assurance that statutory training requirements are being met.

The Trust remains actively engaged with national and regional developments, including the Families First Partnership Programme and future Integrated Care Board commissioning arrangements, to ensure safeguarding responsibilities continue to be fulfilled. Inspection outcomes, including the November 2023 Joint Targeted Area Inspection (JTAI) and CQC monitoring of Louisa Cary Ward, demonstrate effective multiagency working and positive outcomes for children and families.

Overall, this report provides assurance to the Board that safeguarding arrangements are robust, risks are monitored, learning is embedded, and the Trust is compliant with statutory and regulatory requirements.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
1. Key Risks	Satisfactory	Delayed risk ICB pressures
2. Update on CSPR	Satisfactory	On track
3. Update on Child Death Review	Satisfactory	On track
4. Key workload challenges	Satisfactory	On track
5. Key Improvements	Satisfactory	On track
6. Safeguarding Children Training Compliance	Satisfactory	On track
7. National changes	Limited	Emerging risk
8. Inspection outcomes	Satisfactory	On track

Appendices

Appendix 1
Appendix 2

Committees that have previously discussed/agreed the report, and outcomes of that discussion

The content and data presented in the full annual report have been reviewed and overseen by the Safeguarding Children Operational Group (SCOG) and the Integrated Safeguarding and Inclusion Group (ISIG).

Trust dashboard performance information is routinely shared with the Integrated Care Board (ICB), and onward to NHS England, as well as with the local Safeguarding Children Partnerships, in line with national strategic requirements. The full report has also been considered and endorsed by the Quality Assurance Committee, providing additional assurance regarding the accuracy, governance, and strategic oversight of safeguarding arrangements.

Key recommendations and actions requested

The Board are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

It is recommended the Board take satisfactory assurance that the safeguarding practice of Torbay and South Devon Foundation Trust staff, overseen by the Safeguarding Childrens Team is in accordance with national and local legislation. This is based on quality assurance through audit and data reporting against national standards noting the risks identified and the work being undertaken to mitigate these. Further assurance should be taken from monthly monitoring and reporting to Safeguarding Children's Operational Group (SCOG) and Integrated Safeguarding Inclusion Group (ISIG) chaired by the Chief Nurse.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

To provide assurance that all staff practice effectively to ensure that children are safeguarded against harm whilst accessing trust services and that the organisation has appropriate monitoring processes to evidence this to professional regulatory bodies.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Improve family life and safety of children
Quality of services provided	Enable multiagency collaboration to support outcomes for families
Sustainable and efficient use of resources	Align process and working practice with local partner agencies and neighbouring local authorities.

Impact on BAF Objectives	
BAF Objective	Impact
Quality and Patient Experience: Personalised Care	Individual restorative family support that enables parents/ carers to sustain safety for their children
People	Supporting staff and families to provide care in a multiagency framework that promotes improved outcomes for children
Financial Sustainability and Productivity	Potential significant change to services
Estates	Co-location of multiagency support services
Operations and Performance Standards	Shared multiagency governance and accountability
Digital and Cyber Resilience	
Building a Brighter Future	Supporting staff and families to provide care in a multiagency framework that promotes improved outcomes for children
Strategy and Transformation	Potential significant change to services
Sustainability: Green Plan/ Environmental	N/A
Equality, Diversity and Inclusion	Individual restorative family support that enables parents/ carers to sustain safety for their children
Provision of Community and Care Services Delivered in Partnership	Supporting staff and families to provide care in a multiagency framework that promotes improved outcomes for children
Risk: Risk ID (as appropriate)	
Risk	Risk ID
Included on Datix. Initial Health Assessments not meeting national targets.	1599
Included on Datix: Lack of capacity in Safeguarding Children Team preventing ability to meet identified quality assurance responsibilities	4159

External Standards affected by this report and associated risks

Working Together to Safeguarding Children – A guide to multiagency working to help, protect and promote the welfare of children, December 2023, HM Government.

Families First Partnership programme guide – Delivery expectations for safeguarding partners in England, March 2025, Dept of Education
Childrens Act 2004 – compliance with Section 11 regulatory guidance and standards.

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Safeguarding Children Annual Report

Introduction and background

This Annual Report outlines progress against the Trust’s safeguarding children’s priorities for July 2024–June 2025 and provides assurance that statutory duties under Working Together to Safeguard Children (HM Government, 2023) and Section 11 of the Children Act (2004) are being met.

The report evidence how the Trust is discharging its responsibilities for the safety and wellbeing of children and young people across all services, including Child and Family Health Devon. Assurance is drawn from data and operational oversight provided by the Safeguarding Children Operational Group, chaired by the Deputy Chief Nurse, with representation from key safeguarding professionals and service leads.

The Trust continues to engage actively with both Devon and Torbay Safeguarding Children Partnerships, ensuring executive-level health representation and input into operational sub-groups covering quality assurance, neglect, child exploitation, safeguarding practice review, and related priorities.

1. Key Risks

Key Safeguarding Children Risks – Summary

The Trust continues to monitor a number of key safeguarding risks through the Safeguarding Children Operational Group (SCOG). Current areas of focus include:

- Timeliness of Initial Health Assessments for children entering foster care, with ongoing work to meet national targets.
- Capacity constraints within the Safeguarding Children Team, which may impact the Trust’s quality assurance responsibilities.
- Information accessibility across multiple Trust IT systems, affecting the ability to maintain professional oversight and support safeguarding practice.
- Implementation of the Families First Partnership programme, with potential operational impacts pending national guidance.
- Provision of paediatric radiology services for skeletal surveys, critical to child protection medical examinations, with solutions under review.

These risks are actively monitored, with mitigating actions in place and escalated where appropriate. Full risk details and scores are included in the appendix for Board consideration.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
1. Key risks	Satisfactory	Delayed progress on Trust risk due to ICB pressures following national restructure directive.

2. Update on Child Safeguarding Practice Reviews (CSPR)

The Torbay and Devon Safeguarding Children Partnerships retain accountability for undertaking and publishing Child Safeguarding Practice Reviews (CSPRs), rapid reviews, and after-action reviews. During the reporting period, several reviews have been completed, covering issues such as child deaths, neglect, child mental health, and child criminal exploitation.

Where actions have been identified for the Trust, these have focused on strengthening professional curiosity, improving safeguarding supervision, enhancing communication between services, and ensuring timely therapeutic support. All actions are being monitored through the Safeguarding Children Operational Group (SCOG), with progress overseen by the Deputy Chief Nurse.

The Trust continues to contribute actively to the multiagency CSPR subgroups through the Named Nurse for Safeguarding Children, ensuring that learning is identified, disseminated to service leads, and embedded into practice. This provides assurance to the Board that safeguarding learning is effectively acted upon and that governance processes are in place to evidence compliance.

Appendix 2 provides further detail on individual reviews, associated action plans, and progress updates for information

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
2. Update on CSPR	Satisfactory	On track

3. Update on Child Death review statutory process

3.1 Data – Child Death review process – activity from July 2024 to June 2025

Reported Deaths 1 July 2024-30 June 2025		Under 1s	1-17
Unexpected	5	2	3
Expected	6	4	2

Early response meetings	Child Death review meetings
1	5

3.2 Governance process.

Child Death Review Process

The Child Death Review process is a statutory requirement under Working Together to Safeguard Children (2023). The Trust has appropriate governance in place, with a designated Child Death Review Coordinator and Named Doctor, ensuring compliance with statutory and professional standards.

All reviews are anonymised and reported through the Child Death Overview Panel (CDOP), with serious incidents escalated to the One Devon ICB and local Safeguarding Children Partnerships. Learning is shared internally via the Safeguarding Children Operational Group (SCOG) and Child Health governance meetings.

From 2025, enhanced governance arrangements ensure that the child death review process provides regular oversight and assurance to the Trust Board.

Appendix A provides further detail on individual reviews, associated action plans, and progress updates for information

3.4 National Child Mortality Database (NCMD) Reports and Audits**

The NCMD provides thematic learning from child death reviews to provider agencies. During the reporting period, the Trust completed audits on children with learning disabilities and autism, national child death data, and deaths from asthma or anaphylaxis.

All audits were submitted within required timescales, and identified actions have been completed or are actively monitored through the Safeguarding Children Operational Group (SCOG) and relevant governance forums, providing assurance to the Board that learning is embedded into practice.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
3.Update on Child Death review	Satisfactory	On track

4. Key workload challenges:

Safeguarding Children – Operational Overview

Performance data for July 2024–June 2025 demonstrates that safeguarding arrangements continue to meet statutory requirements, with consistent oversight of multiagency Child Protection activity, including neglect and emotional abuse. Activity levels remain high, reflecting increasing complexity for children, young people, and families, including rising demand for child protection medicals, court reports, and safeguarding supervision.

While operational pressures on the Safeguarding Children Team have been noted, these are actively managed through governance structures, including the Safeguarding Children Operational Group (SCOG), and monitored against statutory obligations. Workforce capacity has been recognised as a Trust risk, with mitigating actions in place to ensure the delivery of safe and effective safeguarding practice.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
4.Key workload challenges	Satisfactory	On track

5. Key Improvements:

The Trust has made significant progress in strengthening safeguarding children practice and governance. All Trust safeguarding policies are being updated to align with Working Together to Safeguard Children (2023), following recommendations from the Section 11 self-assessment.

Audits and quality assurance activities have been completed or are underway across key areas, including paediatric presentations, child protection medicals, restraint episodes, and information sharing between services. Learning from the Joint Targeted Area Inspection (November 2023) has been implemented, including the launch of professional curiosity resources to support supervision, training, and practice improvements across Trust services.

Safeguarding supervision is embedded for Level 3 trained staff, with service improvements enhancing accessibility, flexibility, and support for frontline teams. The Trust continues to provide 100% health service provision within the Torbay MASH, ensuring robust multiagency safeguarding oversight and timely intervention. These developments demonstrate the Trust's commitment to continuous improvement and provide assurance to the Board that safeguarding arrangements are effective and responsive to emerging needs.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
5.Key improvements	Satisfactory	On track

6. Safeguarding Children's Training compliance

Safeguarding children training compliance across the Trust has shown sustained improvement over the reporting period, despite challenges such as staffing pressures and seasonal workload. Level 1 and 2 statutory training remain consistently above target, while Level 3 compliance has improved from 71% to 78%, with a trajectory in place to achieve 80% by November 2025.

The following staff groups with higher risk exposure, are monitored closely through the Safeguarding Children Operational Group (SCOG). Where compliance gaps exist, targeted support is provided, including additional "turbo-training," supervision, and facilitated access to training for new and international staff. The Safeguarding Children Team maintains 100% compliance and leads induction and ongoing training, providing assurance that staff are supported to meet statutory safeguarding obligations.

- Torbay 0–19 Public Health Nurses,
- Emergency Department,
- Louisa Cary Ward,
- Special Care Baby Unit,
- Maternity services
- Paediatricians

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
6.Safeguarding Children Training Compliance	Satisfactory	On track

7. National Changes

Working Together to Safeguard Children (2023) remains the core statutory guidance for interagency safeguarding practice, incorporating recommendations from the 2022 Independent Review of Children's Social Care. Implementation is closely linked to the Families First Partnership Programme, which sets out expected practice changes to improve support for children and families.

The Trust is actively engaged in the Torbay workstreams, with representation at strategic and operational levels, though the impact on Trust services is not yet fully clear.

In November 2023, the Torbay Safeguarding Children Partnership underwent a Joint Targeted Area Inspection (JTAI), a multiagency inspection process evaluating local safeguarding effectiveness.

Future system changes, including ICB strategic commissioning and efficiency requirements, may affect safeguarding processes, and the Trust continues to engage nationally and regionally to ensure statutory responsibilities and service provision are maintained.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
7.National changes	Limited	Emerging risk

8. Inspection outcomes – including JTAI, CQC and Section 11

The Joint Targeted Area Inspection (JTAI) in November 2023 focused on the multiagency response at the Front Door (MASH). The Trust received recommendations as part of the Torbay Safeguarding Children Partnership action plan, which are monitored through the Safeguarding Children Operational Group (SCOG) and the Quality Assurance partnership subgroup. A task and finish group has been established to review completed actions and evidence improved outcomes.

Key themes addressed include

- Professional Curiosity,
- Quality Assurance
- Data Reporting.

Professional Curiosity resources have been developed and implemented, quality assurance work is underway, and data-sharing processes have been strengthened across multiagency partners. Outstanding actions from the Section 11 self-assessment are progressing, including updates to safeguarding policies, integration into the appraisal system, and alignment with EPIC electronic records, all monitored via SCOG.

A CQC monitoring visit to Louisa Cary Ward in August 2024 reviewed care for young people with disordered eating and mental health needs, providing positive feedback. Safeguarding oversight continues with daily reviews and monthly supervision, supporting staff and ensuring safe care for children and young people.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
8.Inspection outcomes	Satisfactory	On track

9. Assurance and Recommendations

9.1

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
1. Key Risks	Satisfactory	Delayed progress on Trust risk due to ICB pressures following national restructure directive. Escalated to Chief Nurse.
2. Update on CSPR	Satisfactory	On track. Work in progress on current identified actions – no new activity for TSCP.
3. Update on Child Death review	Satisfactory	On track
4. Key workload challenges	Satisfactory	On track. Sustained increased workload challenges – deadlines not met but work continues to be progressed.
5. Key Improvements	Satisfactory	On Track. Positive progress on Peninsula partnership actions – Data workstream for JTAI actions completed and now in practice.
6. Safeguarding Children Training Compliance	Satisfactory	On Track. Progress in place and supported via Service Leads.
7. National changes	Limited	Emerging risk. Additional paper produced for consideration of impact on Trust services from National Childrens Social Care reforms and initiating Family First Partnership Programme (due April 2026)
8. Inspection outcomes	Satisfactory	On track. Work complete and assurance process in progress.

The Board is asked to note the report and ongoing work of the Safeguarding Children Operational Group (SCOG), which provides assurance to the Integrated Safeguarding and Inclusion Group (ISIG) that the Trust maintains robust systems and processes and works effectively with partner agencies to safeguard children and young people in the local community.

Appendices

Appendix 1

Risk 1599 score: 9 with controls in place: 9

Initial health assessments for children entering foster care not meeting national timescales target. Collaboration between Named Doctor for Children in Care, Associate Director of Nursing and Professional Practice (ADNPP) for Families and Communities and Local Authority managers to identify causative factors and work to improve responses within national target timeframes. (identified 01/06/2023)

Risk 4159 score: 16 with controls on place: 12

Lack of capacity in Safeguarding Children Team preventing ability to meet Trust quality assurance responsibilities. Business case submitted, supported by ICB Designated Safeguarding Nurse. Risk score reviewed by ADNPP / Named Nurse. (April 2025). Further delay in outcome has been escalated to Chief Nurse's for TSDFT and ICB. (identified 18/02/2025)

Under review at SCOG as emerging risks

Impact of multiple Trust IT systems on information accessibility to support professional curiosity and safeguarding of children and young people – raised by Named Doctor at SCOG. Mitigating factors in place of Trust Safeguarding Children Team accessibility to all systems and ability for staff to contact for advice, guidance and supervision. Monitoring situation. (identified March 2025)

Impact of implementation on Trust operational services of the Families First Partnership programme in accordance with the Department of Education Children's social care reforms. The programme provides updated delivery expectations for safeguarding partners in England following the national review of the deaths of Star Hobson and Arthur Labinjo-Hughes. Impact currently unknown – awaiting further detail at workstreams – operational and strategic representation for Trust at these events. (identified July 2025)

Potential risk to Trust services due to challenges to the provision of paediatric radiology service for skeletal surveys, supporting the child protection medical examination process. Meeting planned between Safeguarding Lead and Radiology Service Lead to explore solutions currently in progress and clarify risk. (identified July 2025)

Appendix 2

C110/111/112 – Child Safeguarding Practice review (Child death)

C105/106/107 – After Action review (Neglect)

C104 – After Action review (Children mental health)

C101 – Rapid review

C100 – Rapid review

C95 – After Action review (Child criminal exploitation)

Trust actions for reviews:

C110/111/112 – Safe sleep advice, CPR training for parents, professional curiosity. Action plan is awaiting sign off by TSCP CSPR panel – actions in progress, monitored by SCOG.

C105/106/107 – learning re professional curiosity, use of the Graded Care profile tool to evidence neglect and using the TSCP professional differences policy.

C104 – CFHD report re reducing waiting times for therapeutic support, CFHD to provide partners with information of interventions available to support partnership understanding of resources.

C101 – bruising and injuries for non-mobile children practice, improvements to handover between midwifery and Torbay 0 to 19 services, review safeguarding supervision model for Torbay 0 to 19 service, IT system review re safeguarding alerts, improve professional curiosity of Adult Substance misuse service workers,

C100 – no actions identified for Trust.

C95 – no actions identified for Trust.

DSCP has undertaken 3 rapid reviews which identified the need for a CSPR focussing on the common theme of neglect: this report is currently in progress. Learning briefings have been published and shared with Trust staff via the staff bulletin and the Safeguarding Supervisor network to operational teams. The briefings published in the timeframe for this report are Ricki – adolescent's safety and care and Neglect – thematic review Sept 2024. No current identified actions for the Trust.

Trust Board -Public

Adult Social Care Local Account Summary

Date of meeting	Date report produced
24 th September 2025	25 th June 2025

Author(s)		Report approved by	
Name and title:	Sharon O'Reilly Deputy Director Adult Social Services	Name and title:	Anna Coles Director of Adult Social Services Nicola McMinn Chief Nurse
Phone:	07739393203	Date:	10 th July 2025
Email:			

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary

This report presents Torbay's Adult Social Care (ASC) Local Account Summary, providing an accessible and transparent overview of performance over the past year. It reflects our commitment to accountability, continuous improvement, and high-quality, person-centred care, setting out how ASC has supported residents, responded to challenges, and delivered positive outcomes.

The Local Account demonstrates how ASC has helped over 2,700 residents with complex needs and supported nearly 6,000 carers, while continuing to drive innovation and transformation despite financial and workforce pressures. Key achievements include increased satisfaction levels, improved safeguarding outcomes, and a successful reablement pilot, alongside acknowledgement of areas requiring continued focus and development.

The Local Account Summary is intended as an accessible and transparent overview of performance. It is not a technical report, but a clear and accountable account of service delivery, demonstrating the impact of our work, areas for improvement, and our commitment to high-quality, person-centred care.

Drawing on data, case studies, and the voices of people who draw on care and support, the report illustrates the real-life impact of ASC services. It also sets out priorities for 2025/26, including expanding reablement, strengthening support for carers, and preparing for future regulatory inspection.

Produced collaboratively with stakeholders, partners, people who use services, and the ASC workforce, the Local Account represents an open and honest assessment of current performance, progress made, and future direction. The Trust Board is asked to note the Local Account Summary as a key mechanism for public accountability and ongoing service improvement.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Full report	Satisfactory	No change

Appendices

The Local Account Summary – Appendix 1

Committees that have previously discussed/agreed the report, and outcomes of that discussion

Quality Assurance Committee
Torbay Cabinet

Key recommendations and actions requested

The Board is asked to take assurance that the Adult Social Care Local Account Summary has been developed through the appropriate governance and quality assurance processes and has been approved with no changes by the Local Authority.

The Board are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

The Adult Social Care Local Account Summary provides clear and accessible information about the delivery of adult social care services, highlighting what has been achieved, how services have been delivered, and the outcomes for individuals and communities. By openly reflecting on both successes and areas for improvement, the Summary fosters trust with the public and demonstrates a strong commitment to transparency and continuous improvement—fundamental to supporting people to live well.

Importantly, the document adopts a clear focus on outcomes, shifting the narrative from processes to person-centred impact. It illustrates how services promote independence, dignity, wellbeing, and quality of life—outcomes that directly align with Torbay and South Devon NHS Foundation Trust's (TSDFT) vision of helping people live healthier and more fulfilled lives.

The Summary also provides tangible examples of how health and social care work collaboratively, reflecting TSDFT's integrated care model. This joined-up approach supports individuals more effectively by making care pathways more seamless, responsive, and tailored to individual needs—an essential factor in enabling people to live well.

Furthermore, the document provides evidence how people have been empowered to shape their own support, with an emphasis on choice, control, and independence in their lives.

In conclusion, the Adult Social Care Local Account Summary demonstrates how services are currently supporting people in Torbay and South Devon to live well. It also provides a foundation for ongoing improvement, reinforcing the organisation's commitment to delivering high-quality, person-centred care through transparency, collaboration, and a focus on outcomes.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Improving people's health and wellbeing
Quality of services provided	Improving the individual's experience of Adult Social Care
Sustainable and efficient use of resources	Improving best value outcomes

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	We will ensure our organisation delivers great care through careful use of our financial resources, great environments, and a resilient organisation.
Operations and Performance Standards	To support our staff to deliver high quality compassionate interventions that enable people to maintain independence and promote well-being

Risk: Risk ID (as appropriate)

Risk	Risk ID

N/A

External Standards affected by this report and associated risks

Laws or regulations
Care Quality Commission
National policy, guidance

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Local Account Summary

Introduction and background

Adult Social Care (ASC) plays a vital role in supporting individuals to live independently, maintain their wellbeing, and lead fulfilling lives. Each year, local authorities are encouraged to publish a Local Account, a public-facing summary that outlines how Adult Social Care services have performed, the difference they have made to people's lives, and the priorities moving forward.

This summary reflects on the past year's activity, highlighting achievements, ongoing challenges, and how the service has responded to the changing needs of the population. It draws on a range of evidence, including performance data, feedback from people who draw on care and support, and case studies, to provide a balanced and transparent account of service delivery.

The Local Account also supports meaningful dialogue with people who draw on care and support, carers, and partner organisations, reinforcing our commitment to continuous improvement and co-production in shaping care and support across our community.

It also offers an insight into our wider role of promoting and enabling good health and wellbeing for all adults through the voice of people who are drawing on care and support.

It is an important part of Torbay Council and the Integrated Care Organisation's commitment to transparency, showing adult social care performance over the last 12 months and demonstrating how services are meeting the needs of residents.

This document provides an overview of Adult Social Care, outlining the scope of our services, our target populations, and the support we provide. It includes a detailed breakdown of expenditure and the number of people supported. Importantly, the report incorporates feedback from service users and their carers regarding their experiences of care and support. In addition, the summary highlights the Adult Social Care Transformation Programme, detailing the changes implemented and the evolution of service delivery over the past year.

Summary highlights

- Adult Social Care (ASC) in Torbay supported over 2,700 residents with increasingly complex needs. Carer register grew to 5,764 (+6.9%).
- Continued financial and workforce pressures are being addressed through innovation, transformation, and stronger partnerships.
- Safeguarding concerns are down by 12.4%, indicating possible improvements in early intervention.
- Reablement pilot: 79% achieved full independence post-intervention, reducing demand for long-term care.
- Direct payments project launched to streamline processes and boost uptake.
- Improvements at the "front door" have diverted referrals to community-based solutions.
- 28 Technology-Enabled Care Champions have been identified.
- 88% of people were satisfied with services; 98% (Easy Read survey) found support adequate or better.

Looking Ahead (2025/26 Priorities)

- Expand reablement and direct payments.
- Strengthen support for unpaid carers.
- Develop extra care housing and supported living, especially for mental health needs.
- Prepare for CQC inspection and embed learnings from the Local Government Association review.

Assurance and Recommendations

The Committee are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Local Account Summary	Satisfactory	No change



TORBAY COUNCIL



Torbay and South Devon
NHS Foundation Trust

Adult Social Care Local Account Summary 2024/25

Local Account Summary 24/25 – Draft Version

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Cllr Hayley Tranter, Torbay Council's Cabinet Member for Adult and Community Services, Public Health and Inequalities



I'm pleased to once again present our local account summary, which provides a snapshot of how adult social care is performing across Torbay.

We continue to enhance the quality of our services, promote independence, and improve the overall wellbeing of those we serve.

We have implemented innovative programmes, strengthened partnerships – so important in Torbay – and adapted to the evolving needs of our community.

Teams across the Bay work tirelessly to ensure that every individual receives the compassionate and effective care they deserve.

You can read figures and statistics in this summary but just as important are the voices of those delivering this care. You'll also hear the experiences of those who have been cared for. This year's summary has more video content than ever before, and I hope this truly brings to life their stories.

The continued high cost of living, recruitment challenges and rising demand for services presents us with many challenges but we remain committed to continuous improvement and building on our successes.

Anna Coles – Director of Adults and Community Services, Torbay Council Torbay Council



As a newcomer to Torbay, this is my first introduction to this annual summary.

In the first few months in my new role, I've been learning lots about adult social care in Torbay.

We support more than 2,700 people with a range of needs, many of them more complex than ever before. This means we need to be more innovative and creative in how we best

support individuals to meet their outcomes than ever before.

We continue to encourage people to be healthy and stay healthy so that they can retain their independence for as long as possible.

We also need to be ready to adapt to new technologies, moving away from the conventional. I'm pleased that we now have 28 technology-enabled care champions to be ambassadors for using more innovative ways of support.

One thing that has struck me, and I hope it's obvious in this local account summary, is how much – and how well – we at the council and the ICO work with our voluntary sector.

Their support is vital and we continue to build these strong relationships to deliver excellent care.

I'm pleased that our Adult Social Care Survey 2024 showed most people were satisfied with the care and support services they receive. We engage and collaborate with people regularly so we can understand their experiences and improve services.

This report features their stories, in words and in videos, and we focus on the voices of specific groups. These include those with autism, people receiving support for poor mental health and young people transitioning into adulthood.

This year has also seen us engage more with our workforce as we undergo our transformation programme to become a service fit for the future.

Adult social care would not be what it is without our staff. Their compassion for the people they care for really does come across in this report.

We know improvements can always be made and we do not shy away from them. By strengthening our relationships with service users, partners and our workers, we will be in a good position to meet those challenges head on.

Thank you to our fantastic social care teams, care providers and partners for the work that you do to support residents in Torbay to thrive and prosper.

Anna

Joe Teape Chief Executive and Chris Balch –Chairman, Torbay and South Devon NHS Foundation Trust



We are pleased to present our annual local account summary, our first as Chairman and Chief Executive at Torbay and South Devon NHS Foundation Trust.

We are proud of our partnership and, importantly, our people who work tirelessly every day to support people in our community to access high quality adult social care when they need it. This summary provides an opportunity for us to

celebrate our achievements and the challenges of the past year at a time when demand continues to grow, while managing our financial pressures.

While people's attention is often focused on our urgent and emergency care system, the work of our adult social care teams is central to our belief that care as close to home as possible benefits everyone.



There is much to be proud of, particularly in our work to support people to remain independent at home, to receive the care and support they need in their community and supporting them to get home from hospital when they no longer need acute care. Technology-enabled care and our virtual wards are critical in helping us to deliver 21st century care, in line with the government's shift of moving from analogue to digital, and you can read more about these exciting innovations in this report.

Thank you to our teams for all you do.

Chris and Joe

Introduction: Torbay Adult Social Care Local Account 2024/25

Welcome to the Torbay Adult Social Care Local Account Summary for 2024/25. This document provides an overview of how adult social care services are supporting people in Torbay to live independent, fulfilling lives, with dignity and choice.

Adult social care in Torbay plays a vital role in supporting residents who are older, disabled, or facing challenges that impact their day-to-day living. Each year, we work alongside our partners in the NHS, voluntary sector, and local communities to meet growing and changing needs while continuing to focus on what matters most to people: being safe, staying connected, and having control over the care they receive.

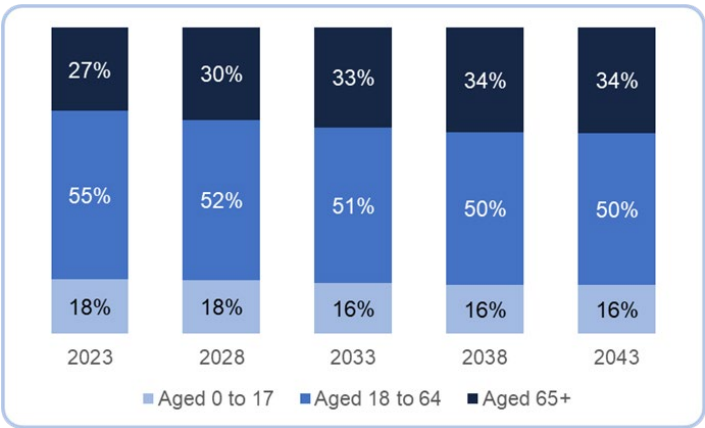
In this summary, we highlight the key achievements, challenges, and areas for improvement in 2024/25. It reflects the voices of those who use our services, carers, and professionals, offering transparency and accountability to residents. As we continue to operate in a context of financial pressures and increasing demand, our commitment remains firmly rooted in improving outcomes, promoting wellbeing, and ensuring that care and support are person-centred.

Thank you for taking the time to read this account. Your feedback helps us learn and improve, and we welcome your thoughts on how we can better serve you.

Our Community

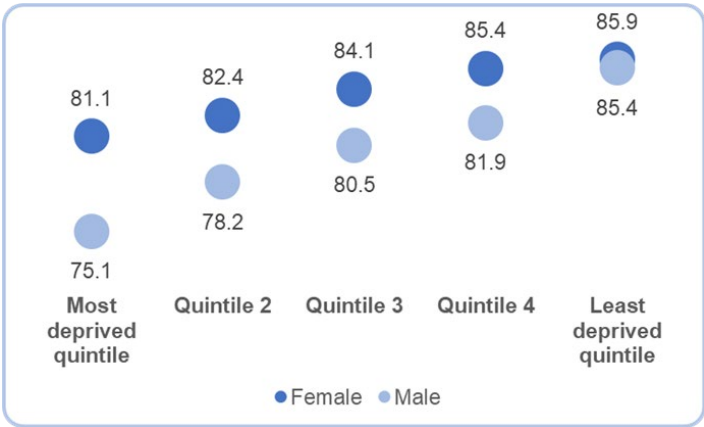
The Office for National Statistics estimates that Torbay has 139,485 people living in our area in approximately 63,000 households. The overall population in Torbay has grown by 4.9% in 2023 since 2013, this compares to 7% growth across England. 27% of our population is over 65 years of age which is set to increase to 34% during the next 20 years. This is only a slight increase since 10 years ago, when this group represented 25%.

Torbay’s population is projected to rise from 139,485 in 2023 to 153,088 by 2043. The proportion of the population aged 0 to 17 is projected to fall from 18% to 16% by 2043. Those aged from 18 to 64 are projected to fall from 55% to 50% by



2043, the proportion of those aged 65 and over is expected to rise from 27% in 2023 to 34% by 2043. The projected rate of fall amongst those aged younger than 65 is steeper than the projections for England as a whole.

Life expectancy for males is 78.3 years and females 83.1 years. This is slightly below the national average for the latest three-year period for males but in-line for females. The average England life expectancy in males is 79.1 years and females 83.1 years. When compared to the South West, Torbay’s life expectancy is approximately two years lower during the past three years for men and one year for women. The average for males in the Southwest is 80.1 years and females 84.0 years.

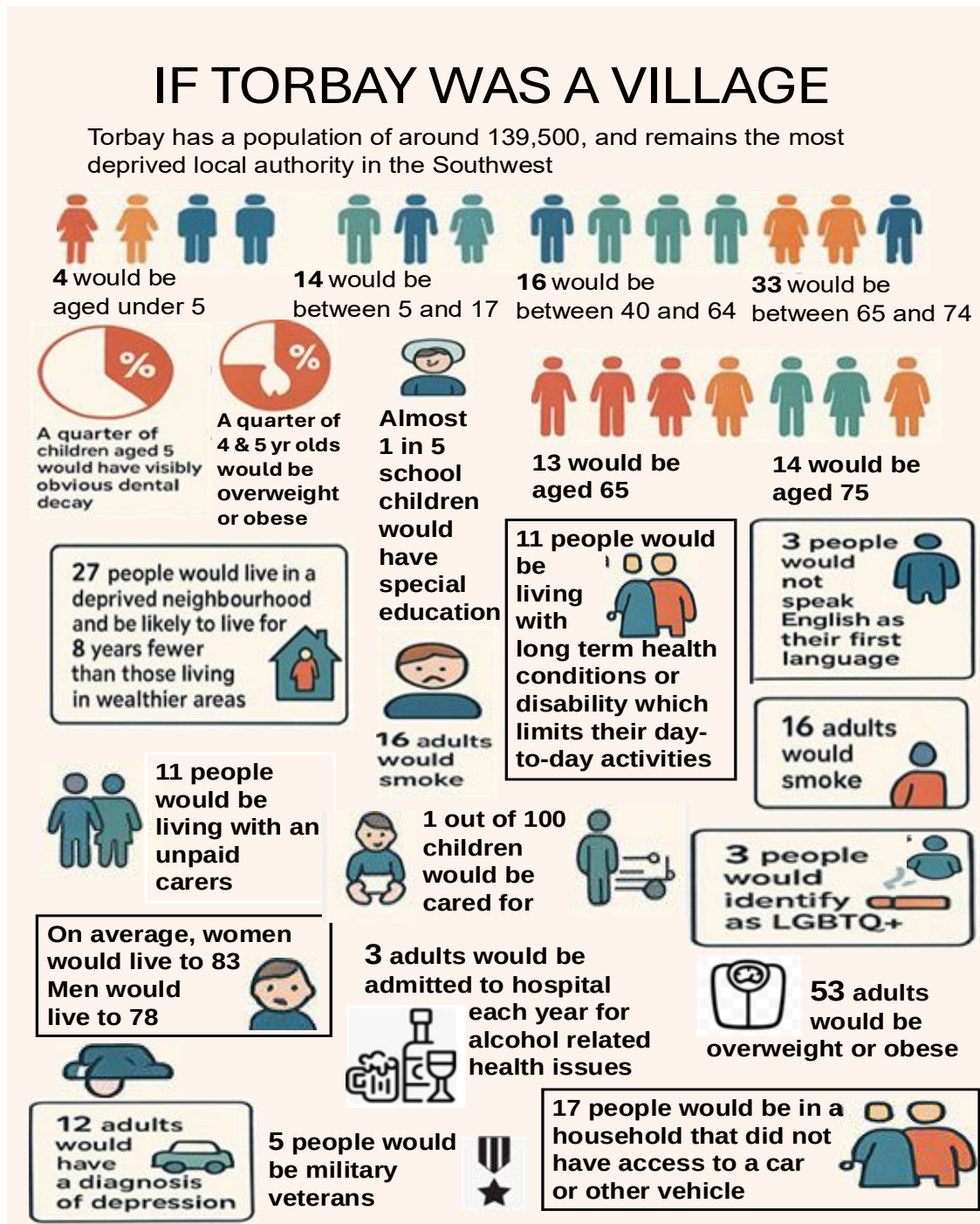


It is known nationally that there is a gap in life expectancy between the richer and poorer. From 2019 – 2023, men living in areas of Torbay that are amongst the 20% most deprived areas in England have a life expectancy of 10.3 years less

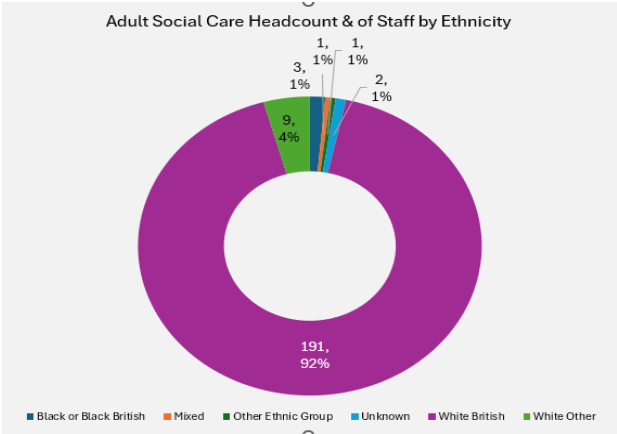
than those men living in our 20% least deprived areas. For women, the gap is 4.8 years.

Data on early mortality in Torbay from 2021 - 2023, those younger than 75 , indicates that for causes of death relating to cardiovascular diseases, cancer, respiratory

diseases and liver diseases, in females are broadly in line with the England national average along with respiratory diseases and liver diseases for males. When looking at cardiovascular diseases and cancer, in males are significantly higher than the England national average. Torbay is reported as having similar rates to the England average rates for both males and females in the preventable causes category over recent years.

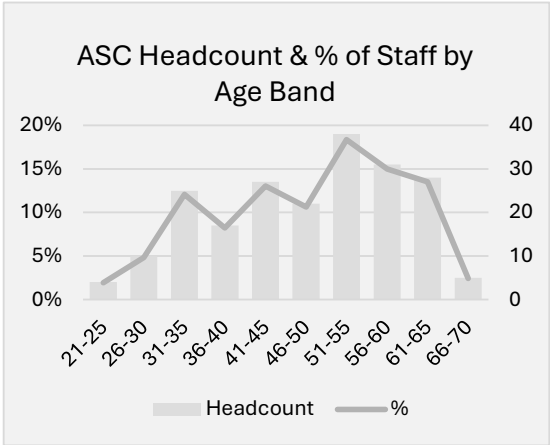


Our adult social care: people and teams



Adult Social Care (ASC) in Torbay has made significant strides in modernising service delivery and strengthening workforce engagement. A major milestone was the reorganisation of teams to a Bay-wide model, enhancing consistency, efficiency, and flexibility in operations.

To support this transition, senior leaders introduced a range of engagement initiatives, including listening events, whole-service updates, and lunch and learn sessions. Long-standing monthly social care leads meetings continue to provide a platform for collaboration and are being reviewed to better align with ongoing transformation work.



The 2023 NHS Staff Survey and Local Government Association (LGA) Employer Standards Health Check highlighted key strengths such as flexible working, strong management support, and a safe working environment. Challenges, however, remain, including low survey participation, concerns around discrimination and inclusion, and reports of harassment from the public. These findings have informed a detailed action plan to drive improvement (IR04F).

ASC governance is supported by the Section 75 Executive Board and thematic steering groups, enabling co-produced improvements, such as refining panel

procedures. Senior leadership team meetings ensure strategic oversight, while targeted training supports professional development.

Financial position and use of resources (Torbay and South Devon NHS Foundation Trust)

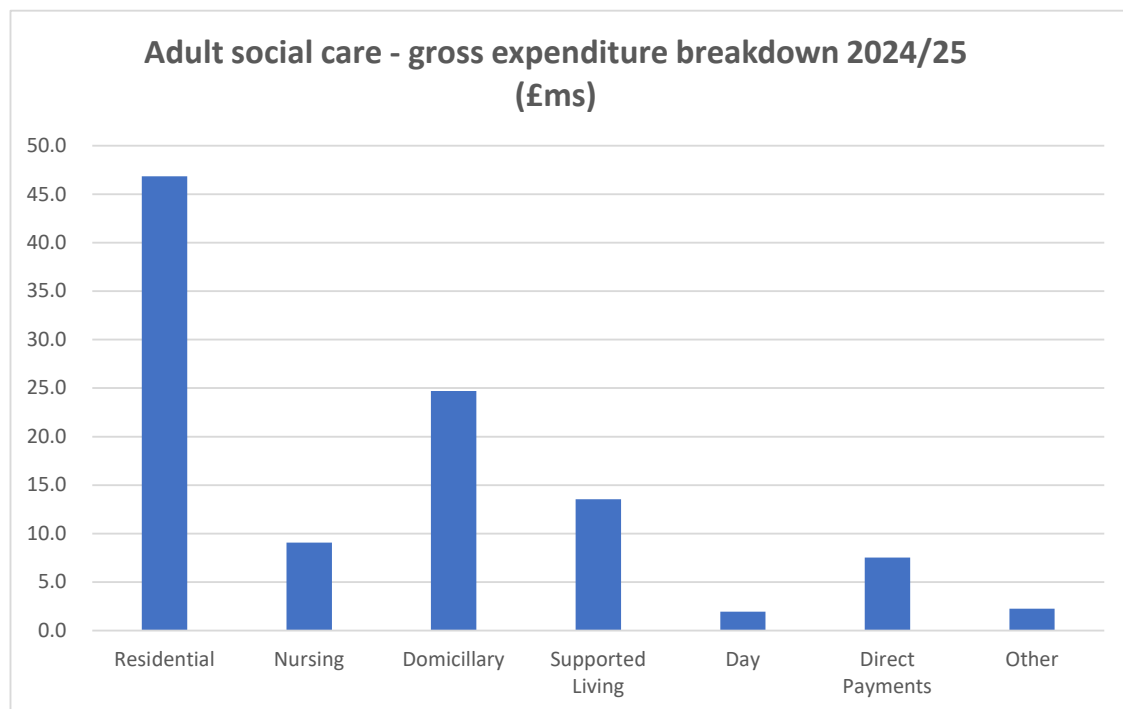
Our aim with this section of the review is to describe the financial resources available and how they have been used in the care sector. On 01 October 2015, an Integrated Care Organisation (ICO) was formed, and this organisation’s remit was to provide Adult Social Care (ASC) on behalf of the population of Torbay. From a financial perspective Torbay Council’s role as a commissioning body is to provide a funding contribution to the overall running costs of the ICO. In 2024/25 the council income contribution, including grants amounted to £65.6million. This was made up as follows.

	£million
Core contract	£56.500
Market sustainability	£3.625
Social care grant	£3.425
Delay discharges grant	£2.065
Council income contribution 2024/25	£65.615

The ICO provides a diverse range of service, of which ASC is a part. The ASC aspect specifically comprises of care management and social care support across Torbay as well as the cost of social workers, community care workers, occupational therapists, physiotherapists, finance and benefit assessors and support service staff. The council contribution towards ICO running costs aims to cover the cost of these staff, in addition to the actual cost of client care (outlined in more detail below).

The vast majority of ASC spend is used to purchase client care (including residential, nursing, supported living and domiciliary care) from independent providers. The majority of these providers are based in Torbay; however, the ICO also funds some specialist residential care provided out of area.

Net expenditure on the cost of care totalled £82.3million in 2024/25. This is the net figure after taking into account all client contributions towards the cost of care.



Under national legislation people assessed as having a social care need are also given an individual financial assessment. This assessment can result in a client being asked to contribute towards the cost of any care that the council then puts in place. The income collected from these client contributions in 2024/25 amounted to £23.6million. The total (gross) expenditure on services was £105.9million and the allocation of this gross expenditure across different types of services is illustrated in the following chart.

At any point in time throughout 2024/25 we are supporting more than 2,700 people and these services are provided to people aged 18 – 100 (and older), who have a range of needs such as learning disabilities, mental health issues, dementia, as well as those with sensory or physical disabilities, vulnerable people, and the frail and elderly.

Continuing from last financial year, in 2024/25 Torbay and South Devon NHS Foundation Trust has faced a number of ASC challenges linked with sustained pressure from the health system in general and a marked increase in the volume of people needing support, as mentioned above.

There has also been a continued increase in complexity which has seen the average cost of packages of care rising throughout the year (over and above any inflationary uplift). Underpinning this is the dynamic between care work and hospitality work and the latter have increased remuneration to attract workers into their sector. In the last couple of years to acknowledge this, the council, through national funding (ASC Market Sustainability) has been able to increase some rates to residential, nursing and domiciliary providers. This rise in cost has continued despite the volume of clients tailing back, highlighting the impact of the net movement of new clients coming into the system at higher rates.

Financial outlook for 2025/26 and beyond

The 2025/26 fee setting process is now complete and a new structure has been shared with providers.

Partners are working closely together on a joint adult social care transformation programme (using identified council reserves), to identify improvements and efficiencies to the current operating model in Torbay to address the variance in budgets set and costs accrued, focussing on areas such as robust commissioning arrangements, improved contractual management, streamlined processes and procedures, enhanced reablement offers, greater choice and control for individuals, improved learning disability support and additional extra care provision.

Financial pressures, together with the ageing profile of our population, mean that we must optimise all the adult social care funding we have available.

The ICO and its partner organisations are committed to ensuring resources are managed to ensure the best level of care, for the highest number of people, can be provided. Both Torbay Council and NHS Devon Integrated Care Board acknowledge the pressures facing health and social care and continue to believe that the ICO is still best placed to manage these services.

The ICO will aim to achieve this through the managing of resources across health and social care to deliver a more efficient and effective profile of expenditure. This is needed not only to maintain a financially stable and sustainable model of care, but one that can improve people's experiences. Any development will be done in partnership with the Local Authority. Any service developments will be co-produced

with individuals in receipt of care and support, and we will consult with staff and care providers when appropriate.

Adult social care demand and performance 2023/2024

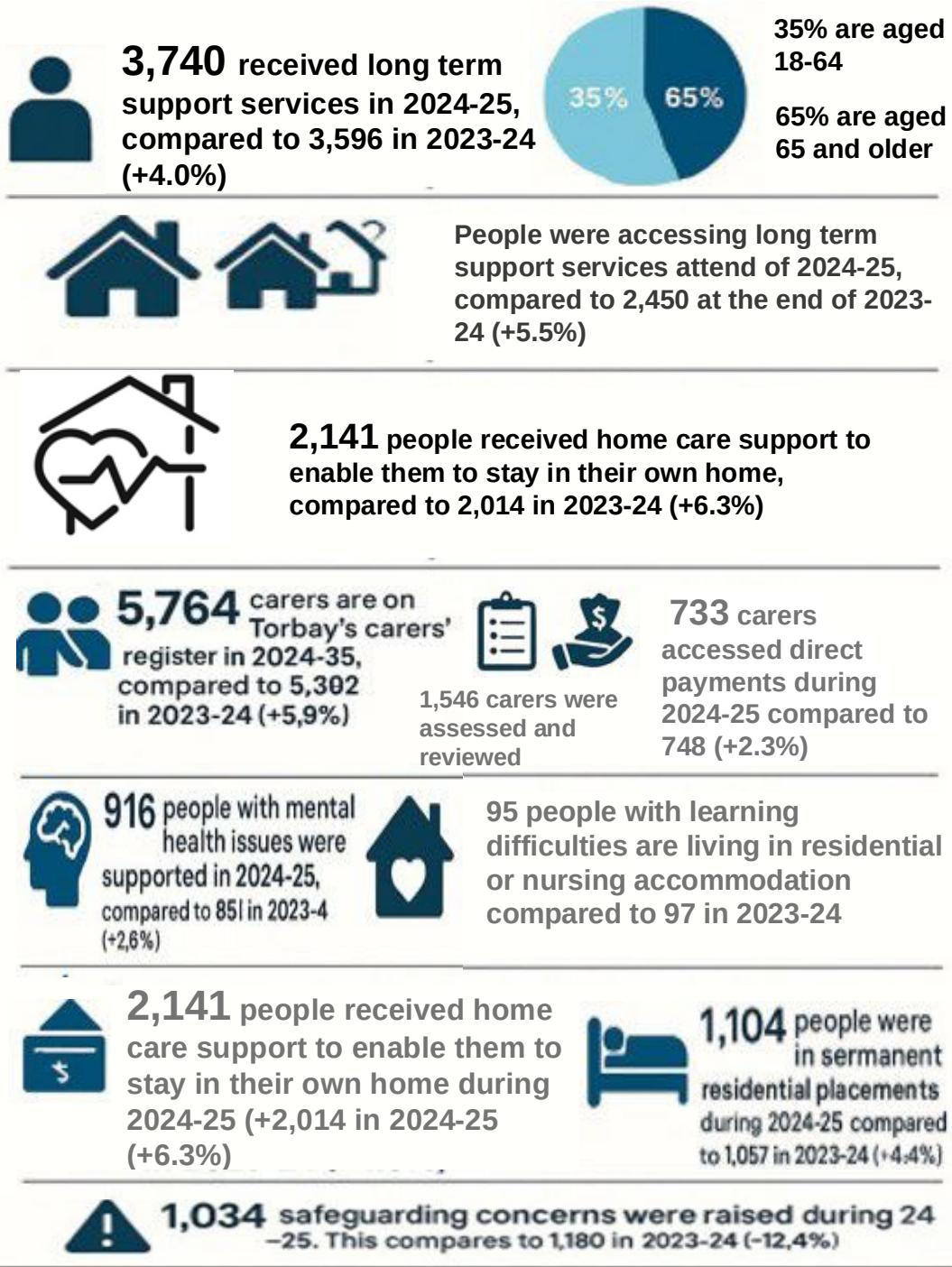
Continued improvements and developments were made to the operational performance reporting during 2024-25. With reporting now well established within the appropriate governance routes and core areas of service performance routinely reported to the Council and Trust Board. Attention has been focussed on incorporating more key areas of service delivery into performance reporting. Work across 2024-25 has included:

- the roll out of referral data into the performance report, giving service leads more insight into cases flowing into ASC and supplementing existing front end waiting list reports
- the inclusion of occupational therapy waiting lists, showing rolling 12-month totals by priority, as well as length of wait data
- the inclusion of mental health service waiting list data for both Adult Mental Health Social Care (working aged adults) and OPMH (65+) teams
- the inclusion of FAB (Financial Assessments and Benefits) team waiting list data
- further development of review reporting, showing the rate of reviews being completed by duration since the last assessment, which provides service leads with greater insight into the rate at which reviews are getting completed
- client attrition reporting, giving improved insight into the rate at which new clients enter, and current clients leave the ASC system, which supplements existing data on the bottom-line number of clients supported at any one time
- the inclusion of a top-level balanced scorecard, providing a quick view picture of month-on-month changes in performance across all reported service areas

ASC operational performance reporting is being continuously improved to provide ever greater insight for service leads and executives into how services across ASC are performing and 2025-26 will see further developments being implemented to ensure improvement trajectories are set against national benchmarking data.

Performance at a glance:

Performance
2024-25



The number of requests for support (new people drawing on care and support) increased in 2024-25, from 2,450 to 2,584 (+5.5%) however, fewer requests resulted in long term social care support, with this dropping slightly from 572 in 2023-24 to 561 (-1.9%). Instead, there was a marked increase in new requests leading to other support (+9.2%), such as short-term care, reablement, health funded support and referrals for Technology Enhanced Care and equipment. This is likely due to growing awareness of alternative and more suitable support away from conventional ASC services. There was also an increase in the number of new requests leading to no support (+2.4%).

The number of people with identified mental health needs who were supported by services again saw a notable increase in 2024-25 on the previous year (+7.6%). This followed a similar increase in 2023-24 of +6.9%.

The number of carers on the carers' register continues to increase, with 2024-25 seeing a +6.9% increase on 2023-24.

The number of safeguarding concerns raised saw a significant decrease in 2024-25 of -12.4%. The 2024-25 total dropped from 1,180 the previous year to 1,034.

ASC in Torbay supports thousands of residents to live independently, stay safe, and enjoy the best possible quality of life. During the past year the service has not only supported more people but also continued to improve how it monitors and manages care, making sure services are working well and meeting local needs.

What's new? – better information for better services

In 2024/25, we made real progress in how we understand and improve our services:

- We now track more types of support, like occupational therapy and mental health services, helping us better manage waiting lists and respond faster.
- We've added new reporting tools that show how many people are entering and leaving the care system. This helps us plan better and keep support sustainable.
- A new scorecard gives a quick monthly snapshot of how we're doing across all service areas.

These changes mean local care leaders can act more quickly to improve services and plan for the future more effectively.

Who did we support in 2024/25?

- 3,740 adults received long-term care (an increase of 4.0% on the previous year) 65% were aged 65 or older
- 2,736 people were still receiving ongoing long-term care at the end of the year (up 4.5%)

We also helped in many other ways:

- 2,584 new requests for support were made (up 5.5%)
 - o 22% led to long-term care
 - o 62% led to short-term or alternative support (like equipment or health-funded care)
 - o 16% required no further help, for example, some people arranged their own care or were supported to find an alternative.

This shift shows that more people are being supported through quicker, more flexible services that may avoid the need for ongoing care.

Supporting carers and mental health

Carers continue to play a vital role:

- 5,764 carers are now on the local register – a 6.9% rise from last year
- 1,546 carers were assessed or reviewed (-2.7%)
- 733 carers received direct payments to manage support themselves (-2.0%)

Mental health needs are also increasing:

- 916 people with mental health issues received support (+7.6%)
- This follows a similar rise last year, showing a continuing trend in need

Other key services

- 2,141 people received help at home – a 6.3% increase, helping more people stay independent
- 1,104 people were in residential care – up 4.4%
- 500 people used direct payments for their own care – slightly down from last year

What does it all mean? In 2024/25, more people asked for help – and more received flexible, tailored support that met their needs without always requiring long-term care. That's a sign that early support options like reablement, equipment, and tech-based care are working well.

We also saw growing demand for mental health services and continued growth in the number of carers. These areas will remain a key focus as we move forward.

Looking ahead

We're committed to continuing this progress in 2025/26. Our goals include:

- Improving support for unpaid carers
- Making it easier for people to manage their own care through direct payments
- Keeping a close eye on safeguarding trends to ensure people are protected
- Using better data to make quicker, more informed decisions

Key service areas:

- Mental health: 916 people supported (+7.6%) reflects growing demand, echoing wider public mental health trends. Sustained year-on-year growth signals a need for strategic workforce and commissioning planning.
- Home care: 2,141 supported (+6.3%) reflects an effective community-based support model.
- Residential care: Slight increases in both learning disabilities and older adults' placements. Alternatives to residential care are being progressed alongside council commissioning colleagues
- Direct payments: The decrease from 517 to 500 (-3.3%) is disappointing. Efforts are underway to embed direct payments more effectively into practice, making them more accessible and user-friendly for both individuals who draw on care and support and the staff who assist them, in order to encourage greater uptake.

5. Quality analysis and Strategic implications

The overall performance trajectory in 2024/25 reflects a maturing, data-driven approach to quality assurance and continuous improvement:

- Proactive diversification: The shift from long-term care to earlier, alternative interventions is aligned with national strategic direction and person-centred outcomes.

- Performance intelligence: Enhancements in reporting enable earlier identification of emerging pressures and ensure more agile, informed leadership responses.
- Sustainability and demand management: Despite a year-on-year increase in demand, the system has responded with proportionate increases in service provision, suggesting resilience, but also a need to monitor capacity closely.

2024/25 has been a year of purposeful enhancement in ASC performance management, grounded in better data, broader scope, and clearer insights. These improvements provide a robust platform to further elevate service quality, improve user outcomes, and support strategic planning into 2025/26 and beyond.

The **Adult Social Care Survey 2024** demonstrated several positive outcomes, reflecting the dedication of staff and the overall quality of care services provided across Torbay and South Devon.

Key highlights include a consistently high level of satisfaction among people who draw on care and support:

- 88% of people who completed the standard questionnaire were satisfied with the care and support services they receive. This compares to 88% in 2023.
- 98% of people who completed the Easy Read version thought that the way staff help them is ok or better (96% in 2023).
- 72% of people feel as safe as they want (68% in 2023) and 22% feel adequately safe, but not as safe they would like (26%). 5% feel less than adequately safe (5%) and 2% do not feel safe at all (1%).
- 85% of those of who completed the standard survey rated their quality of life as alright or better (84% in 2023).

The findings also reflect the success of early engagement strategies, with 75% of responses received following the initial round of letters, indicating an effective approach to outreach and communication. These achievements re-affirm the positive impact of ongoing efforts to support independence, dignity, and satisfaction among those who rely on social care services.

The **Healthwatch report on unpaid carers** reveals several accomplishments that highlight the commitment to supporting unpaid carers across Devon, Plymouth, and Torbay.

From the Healthwatch report, collaboration with carers led to important insights. Carers' feedback helped develop co-designed surveys and guided conversations, reflecting a shared dedication to understanding their needs. Around half (53%) of Torbay respondents said they do know where to go for support, with the most common responses being carers services, social services and the GP, highlighting effective awareness-building efforts. Additionally, many carers reported using beneficial coping strategies, such as time outdoors and support from friends, showing the effectiveness of resilience-building initiatives.

These achievements underline a consistent focus on maintaining user satisfaction, improving accessibility, and ensuring carers and service users are supported through thoughtful policies and practices.

1. Training and awareness resources

The main priority mentioned in the report was around dementia. A particular success in Torbay has been the co-design of a dementia carers' training programme in partnership with a carer / carers' group / carers' services and Torbay and South Devon NHS Foundation Trust's education team. This was launched in February and has had extremely good feedback.

Amplifying people's voices

We recently progressed the Amplifying People's Voices engagement project led by Torbay and South Devon NHS Foundation Trust, which was designed to help us better understand the experiences of people who live in care homes, their families, and representatives. We contacted more than 500 people. A third of people responded. As a result, work is underway to develop a co design approach to the development of a care home toolkit that people said they wanted; two workshops have been held with families and the contract team to co design the new specification for our care homes.

Improving feedback and embedding learning

During the past 12 months, ASC received 45 complaints and concerns. These comprised 60% concerns, 29% formal complaints, 10% MP enquiries, and 1% no further action. Key themes identified included finance and billing (41%), communication (22%), and service delivery (16%).

In response, we have taken targeted action:

- **Finance and billing:** Updated public charging policy leaflets and made them accessible online; increased staff awareness through meetings, emails, and case note reminders.
- **Communication:** Complaint findings are shared with team leads, and learning is embedded through supervision and reflective practice.

All feedback is tracked using a digital tool, with learning outcomes and actions monitored by the Quality Assurance (QA) Lead. This ensures that staff training and service improvements are directly informed by lived experiences.

Carer feedback and service gaps

Recent carer surveys highlighted concerns around communication, lack of respite care, and barriers to accessing support. In response, we are:

- Incorporating carer recognition into all service contact points
- Launching self-assessment tools for carers
- Improving training for professionals on carer identification
- Partnering with local organisations to enhance engagement
- Developing a robust Replacement Care (Respite) offer
- Created a Service Improvement Board to provide a forum to oversee continuous Improvement

Looking ahead

We are committed to a continuous cycle of feedback, learning, and improvement. By reducing crisis interventions, increasing carer support, and embedding reflective practice across teams, we aim to provide responsive, transparent, and person-centred care for all.

Transformation

Adult social care plays a vital role improving people's lives by helping them to remain independent at home and in their community. As we continue to support people to live well within their communities, we recognise we need to do more to ensure we can effectively meet the rising demand for adult social care support and provide sustainable, high-quality support across Torbay.

During the past year, we have undertaken a significant amount of work to improve the service to enhance the support we provide to people. We have continued to remain focused on promoting independence, managing demand effectively, and ensuring we meet our legal duties under the Care Act through preventative and person-centred approaches.

The two key areas of improvement this year have been our reablement pilot and the improvement work happening to improve how people access information and guidance before needing to approach adult social care for support; both of these initiatives have delivered positive outcomes for people and our wider health and care system.

Reablement pilot: Promoting independence

Recognising the importance of supporting people to regain and maintain their independence our delivery partners, Channel 3, helped to launch a reablement pilot in 2024. The aim was to improve people's independence via a community pathway or on a waiting list to enable them to regain skills and confidence with everyday activities.

Key achievements of the reablement pilot include:

- Increased independence levels for people, with 79% of people achieving full independence following their reablement intervention and not requiring a package of care.
- A proportion of people ended up with a reduced package of care because they had developed the skills for daily activities.
- A reduction in commissioned statutory support packages, as people are better equipped to manage their own health and wellbeing at home.

- Positive feedback from people who use our services and families, who report improved quality of life and greater confidence in self-care.
- Cost efficiencies within the care system, as more people successfully move to lower levels of support.

Building on this success, we will be integrating reablement principles further across our services to ensure more people benefit from strengths-based approaches that promote self-sufficiency. We will use the learning from this pilot to inform future commissioning.

Accessing adult social care services: managing demand and promoting diversion

To enhance how people access adult social care support, we have undertaken a front door service improvement activity aimed at improving demand management by promoting diversion to more appropriate services. This work aligns with our Care Act duties, focusing on early intervention, diversion, and appropriate signposting to community-based support.

Key improvements include:

- Strengthened partnerships with community organisations and voluntary sector services, providing alternative support options that prevent escalation of need.
- Enhanced workforce training to embed strengths-based conversations, focusing on what people can do rather than what they cannot.
- Implementation of an enhanced telephony system.

As a result of these improvements, we have seen:

- A reduction in formal care assessments, with more people accessing community-based solutions.
- Greater awareness among residents of preventative support options, helping to build resilience and reduce long-term dependency on statutory services.
- Improved oversight of call quality and demand data which has supported improved decision making, operational planning and management.

Panels

To improve decision-making, one initiative considered practice and process around panels to improve their effectiveness. Key improvements include:

- Streamlined processes which have led to enhanced oversight and accountability.
- More effective decision making because of changes to meeting preparation including a standardised format and chair.
- Technology-Enabled Care (TEC) and intermediate care are now consistently represented in all meetings.
- Commissioning representatives attending the complex care panel.
- Arranging Support Team (AST) validates care package costs and processes care home placements.
- All of which is contributing to improved grip on cost control.

Brokerage

Our aim was to standardise practices for sourcing care via the AST team to improve market management, process for practitioners and grip on spend. Key improvements include:

- A refreshed process and referral form implemented across teams.
- Fee rates negotiated consistently with agreed market rates.
- Reduced errors with contract set up saving operational teams' time.
- Improved data capture.

Hospital discharge

People who no longer need acute care recover better at home, in their own bed, surrounded by their loved ones. We have been working hard to improve how we support people to return home from hospital, with a care package if needed, for lunchtime or by 5pm.

We spent time with teams to understand the reasons why some people were delayed being discharged from hospital, the impacts on outcomes, demand and costs of people discharged through pathway 2. Pathway 2 is a model designed to integrate health and social care services for people with complex needs. By offering

a coordinated, person-centered approach, Pathway 2 has significantly improved health outcomes and quality of life for many residents. This has been evidenced where individuals previously at risk of hospital admission were able to receive tailored care in their homes, leading to a reduction in unplanned hospital stays and increased satisfaction people and their carers. A multi-disciplinary team (MDT) approach was used to review individuals and understand through a social work lens if people could have achieved a better outcome. Recommendations are being reviewed but immediate actions were taken to:

- Improve Technology Enabled Care practice by organising training for the team.
- Reinforce Home First principles.
- Address improvements linked to mental capacity assessments

Commissioning report

Our vision: Thriving communities where people can prosper

During 2024/25, our strategic commissioning team has continued to deliver against the wide-ranging programme of work set out in the [Torbay Adult Social Care Market Transformation Blueprint](#) to support commissioning projects across health, housing and adult social care. Our Market Position Statement (MPS) 20025 (draft), reinforces our commitment to meet our moral and statutory duties. The Care Act 2014 places a duty on Torbay Council to “facilitate a diverse, sustainable, high-quality market for their whole local population and to promote efficient and effective operation of the adult care and support market as a whole. They must also ensure continuity of care in the event of provider failure”. This duty will be met within the context of four overarching strategic priorities:

Our priorities remain:

- Enabling more people to be healthy and stay healthy
- Enhancing self-care and community resilience
- Integrate and improve community services and care in people's homes
- Deliver modern, safe and sustainable services

In line with the strength-based approach underpinning the Care Act 2014

We are working to increase the use of enabling housing-based models of care and support so that people have greater choice and control over how, where, and with whom they live and how their care is provided.

These options include

- Ambitious capital projects such as multigenerational extra care housing, smaller schemes for groups with specific needs, and new models of home care to support people's remaining living with family carers at home.
- Increase the number of people maintaining their own independence by offering better information at an early stage to enable people to recognise their own strengths and assets, combining them with voluntary or community support and access to equipment and technology to meet their needs in the first instance.
- Reduce the systemic use of residential care to meet low-level social care needs. This means not placing working-age adults into care homes wherever possible and delaying the point at which older people enter residential care. The council and our NHS partners will only commission homes capable of meeting very complex and nursing needs, working with our care home sector to constantly improve quality and capability within Torbay.
- To support and help people stay as well and independent as possible and able to manage their own well-being in their homes, wherever possible. Where care is needed, we want people to have a choice about how their needs are met and only have to tell their story once. The people receiving services must be at the heart of what we and providers deliver together.
- We want people to remain in control of their lives, to remain independent and to have the opportunity to make their own choices about their care and support arrangements.
- We will achieve this by our direct payment system being as clear as possible and allowing people true autonomy to meet their eligible care and support needs.

- To further our work, Torbay have initiated the direct payments project, which aims to review and implement recommendations for improvement. This meeting will bring together key partners from the council and the ICO for collaborative work to improve our approach to direct payments in ASC.
- We have supported a wide-ranging transformation programme which has included developing a policy framework for direct payments, redevelopment of our front door into social care and test some small-scale test of concept ideas around reablement.

This has led to setting up some priority pieces of work to be completed in 2025/26.

We are proud of the work that continues around our LD ambassadors this has included further development of the [Big Plan learning disability strategy](#), and an event held called the Big Event to galvanise support for the strategy. This strategy is now leading to the development of an action plan which we are committed to starting during 2025/26.

We have also supported the trust and the council in its preparation for a pending CQC inspection process. In June 2024 we took part in a LGA peer review for ASC which allowed us an opportunity to review our system with the support of an external team.

This year the team led on or supported an increasingly demanding stream of grant funding programmes from central government, including the market sustainability and improvement fund, the accelerated reform fund, and the better care fund. The team has provided a strategic market view that supports quality assurance workstreams such as adult safeguarding, provider quality assurance and individual packages of care that require support with services outside of adult social care.

Finally, the team has continued to directly procure and support key infrastructure services, including the community helpline and hub, Healthwatch Devon, and an extension to the Citizens' Advice contract.

Voluntary sector partnerships

We have continued to build positive partnerships across our third sector organisations. The community and voluntary sector are buoyant and well developed in Torbay. We receive actively engaged from the sector to work on shared endeavours with a common goal of maximising independence and support to people within our communities. This wider network supports people in ways that are outside of scope for statutory services but neither the less offer the glue that often keeps people safe, well and connected. We remain committed to furthering our relationship so we can really hear and understand the voices from our community and find ways to strengthen and build resilience for local people closer to home.

Front door and in-person hub support

We have re-procured our community helpline and community hub (which is in Paignton Library)

These services support us to divert statutory referrals to the community and voluntary sector, where we believe outcomes can be improved by addressing low level needs early, which may prevent or delay people needing statutory/commissioned care.

We continue to actively engage with the voluntary sector network as we start to look at national schemes that build on the principles of place and neighbourhoods. Taking a joined-up view on how services (across the whole health and social care network including voluntary sector) work in a joined-up way to impact on the whole population living within a defined geographic area.

The hub at Paignton Library offers a relaxed and accessible environment where people can get advice, information, and support. The helpline is a telephone service which is accessible to members of the public or health and social care professionals to seek advice, guidance or make a referral for support.

Supported living and extra care housing

- Our vision is to ensure that people can be as independent as possible in a place they can call home, with the right support. For some people this may mean increasing care and support provision over time to delay a need for

more intensive support like a residential placement, for other people this may be about building new skills and decreasing support until they can move onto their very own accommodation one day without support. In some circumstances this means the housing care and support offer needs to be more specialised in the form of a supported living scheme or extra care housing.

- We continue to support people who draw on social care services to make choices about where, how and with whom they live across a range of housing options. By having an experienced supported housing commissioner within the Strategic Commissioning Team, we have greatly improved our ability to meet increasingly complex needs within mainstream social housing. This has enabled people to step down from long-term out-of-area hospital beds directly to a home of their own with the security of an assured tenancy and all the necessary adaptations to maximise their independence.
- We also continue to slowly increase the availability of housing with support, now that we have an effective Strategic Housing Delivery Team working with us and using the Government's social housing funding programme to deliver the adult social care housing requirements set out in the Torbay Housing Strategy. The Council is now seeking planning consent for a new 92-apartment extra-care housing scheme in Paignton, with building due to start in March 2026 and be completed in late Spring 2028. This will be followed by a further scheme of similar size in Torquay, scheduled for completion in 2030.
- Work is ongoing to improve our commissioning partnerships with Registered Providers of social housing, independent social developers, specialist support providers, health and social care professionals and the supported living sector as a whole. During 2025-26 this will ensure the delivery of 8 new 1-bed and 2-bed adapted apartments for people with complex learning disabilities; 12 new 1-bed apartments for people recovering from mental illness and other bespoke housing opportunities for people needing specific environments or locations.
- Looking ahead, our focus will be on continuing to prepare the supported housing sector for the implementation of the Supported Housing (Regulatory Oversight) Act 2023, and to deliver more Social Housing Grant-funded social housing for people drawing on health and social care services. We will

continue to improve our engagement with both housing providers and commissioned support providers, driving up quality and choice across Torbay.

Direct payments

Enabling people to have choice and control over their care is an important feature of adult social care. In June 2024, a review was undertaken on direct payments with a series of recommendations which include:

- Improved policy and procedures.
- Streamline processes and resources to support operational team's practice.
- In-depth analysis of the Personal Assistant (PA) market and improve visibility and quality of PAs.
- Exploring the creation of a direct payment officer role to drive practice improvements.

Looking ahead

The work undertaken in 2024/25 has demonstrated the impact of proactive, person-centred approaches in adult social care. We will continue to refine our reablement offer, expand the improvements which will enable people to access community support before seeking ASC interventions, and strengthen our partnerships with health, housing, and community services to create a more sustainable, integrated system of care.

We remain committed to ensuring that people receive the right support at the right time, promoting independence, and enhancing quality of life across our communities.

Principal Social Work Annual Report

The British Association of Social Workers (BASW) describes the social worker role as aiming to improve people's lives by helping with interpersonal difficulties, promoting human rights and wellbeing. From helping keep a family under pressure together to supporting someone with mental health problems, to safeguarding adults with care and support needs from abuse, social work is a varied, demanding, often emotional and very rewarding career.

Social workers must be registered with Social Work England (SWE) and apply a set of professional standards which describe what they must know, understand and be able to do.

The principal social worker role is enshrined in the Care Act to ensure there is professional practice oversight in place to lead, oversee, support and develop excellent social work practice and in turn lead the development of excellent social workers and social care practitioners.

Local Government Association's Peer Challenge Review statement.

[LGA Corporate Peer Challenge \(Torbay\) Report](#)

In June 2024 Torbay's adult social care service took part in the Local Government Association's (LGA) Peer Challenge Review. The review was an opportunity for the LGA to provide feedback as a critical friend to support improvement across the service. It was not an inspection and nor did it award a rating or score.

People working across our services in the council and NHS, carers and other partners took part in the review, including giving interviews to inform the LGA's feedback report.

The feedback identified our strong culture of "grow your own" in the local workforce, with good evidence from staff about opportunities for development and promotion, and low sickness, vacancies, and turnover rates.

Staff who met with the team were very positive about the support they received from their colleagues and described good support from visible professional leadership and line management, including through supervision and appraisal, and more informally.

Learning processes are in place to support improvements in practice, and more widely to assure it: this includes through safeguarding adult reviews, the mandatory Oliver McGowan training, working with people who draw on care and support, and working with the voluntary sector. Training was described as good, and there was positive engagement with social work practice weeks, where a focus on sharing good practice has engaged staff and senior managers.

My story: Abbie, a newly qualified social worker

“I absolutely loved my first year of practice within an Assessed and Supported Year in Employment (ASYE) programme and feel so lucky to have had the opportunity to transition from completing the degree into an ASYE role.



“It goes without saying that the level in which I enjoyed my ASYE and first year of practice, is because of the fantastic team I worked within, alongside very supportive managers and the well-mapped ASYE programme. I always felt heard, understood, and part of a team where we all root for one another.

“I benefited from the ASYE a lot, as it enabled me to integrate what I learnt through the degree and placements into practice, while also being protected with a reduced caseload to continue to learn, reflect, and find my feet putting everything into real practice while developing my social work identity. I enjoyed the timescales of the ASYE programme as the level of demand was significantly less than completing the degree, and I also had a good level of study time which could be used flexibly in a way that best suited my learning style. This study time was very important for my ASYE journey, as the day-to-day role in social work is so busy, it would be challenging to factor in real time for reflection and research.

“I am grateful to my manager, practice educator and the complex care team for all the support and consistency they gave me. Honestly, I could not have asked for a better start to my social work career.”

My story: Naomi, an ASYE assessor

“I have worked for Torbay and South Devon NHS Foundation Trust since 2008, joining as a health and social care coordinator. Throughout my employment I have progressed to become a social worker, practice educator and now, in the past 12 months, as an ASYE assessor.



“It is both a privilege and pleasure to be in this role and be part of the journey as the social worker embarks on their new career path. The role supports the social worker to implement learning from their social work training and

apply this into a practice setting, providing provision for support to ensure rich learning and development, with a real focus on the AYSE critical reflective skills.

“As an assessor, I feel the organisation provides good levels of support to both the AYSE, the assessor and supervisor. The organisation also provides access to the Research in Practice for Adults ([RIPFA](#)) website. This provides me with excellent practice teaching tools and the AYSE an evidence-based resource to enable the continuation and embedding of learning into practice.

“I feel my role as AYSE assessor has developed directly because of the ongoing support of the principal social worker and senior leadership team as they are demonstrably keen to support continuing professional development.

“I thoroughly enjoy my role of AYSE Assessor and look forward to working with many more social workers undertaking their AYSE in the future.”

Pete – Student social worker

“Since I started working for the trust in 2006, I had recognised an evolving passion for working with those accessing our services, becoming increasingly aware of the struggles people face in life, whether it be inequality, social injustice, mental health challenges, the impacts of poverty or simply the weight of feeling unheard. With this developing desire to empower individuals, families, or communities I was encouraged and supported by my line manager, and the trust’s Principal Social Worker, to apply to study social work via the Open University. This represented a significant opportunity, but one that came with huge feelings of trepidation and anticipation, would I be good enough, could I return to academic study after twenty years? All these thoughts were tempered with the desire to effect positive change and a knowledge that I had a lot to give to the profession. Since starting the course, I have been afforded so many positive opportunities, initially in the transitions team and subsequently with the adult mental health social care team. During my time within these teams, I have developed a keen awareness of the skills and capabilities of the organisation’s social workers, as well as being afforded the opportunity to apply my developing knowledge of social work legislation and theories into practice. For example, exploring how theories such as the social model of disability or the ecological perspective can help empower people, promoting the wellbeing principle and person-centred ethos of the Care Act 2014. I am so pleased that I chose to

study to be a social worker. For although the material is challenging, taking a significant amount of time and a considerable amount of self-reflection, it is so rewarding and laced with the opportunity for creating positive change.”

My Story: Alex, a practice educator

“I have been a qualified practice educator for more than three years. Despite now being in a more senior role within the organisation, I still very much enjoy providing the practice educator role; not only is it thoroughly rewarding being part of a student social worker’s journey into their new career, it also offers timely reminders to ensure fundamental aspects of the profession are applied as a practitioner myself. This could include, for example, time to reflect on values or to look at new pieces of research. The practice educator role is crucial in ring-fencing time to ensure the theory and concepts that underpin our work are understood and applied by students; on that basis, its positive impact on our student social workers and workforce in general cannot be understated.”



Professional practice

During 2024/25, we reviewed our practice quality standards which provide the fundamental practice benchmarks for all staff to embrace and use in their day-to-day practice. They are designed to help people who draw on care and support to understand our practices. They also help staff measure their work and use these standards for quality assurance and supervision in adult social care.” The standards describe everything from our approach to strengths-based practice to equity, diversity and inclusion.

We have also provided workforce training opportunities ranging from a leadership training programme, trauma-informed practice to cultural humility and anti-racist practice.

We are looking forward to embedding our Practice Quality Standard framework as well as focusing on a number of workstreams in our transformation programme.

Findings from audits

We continue to undertake a monthly audit system focusing on the quality of adult social care intervention. We continue to undertake a monthly audit system focusing on the quality of adult social care intervention. The findings from these audits are analysed and thematically reported to the Service Improvement Board, where they inform decision-making, identify areas for development, and shape improvement plans. This process ensures a clear line of sight to the Council by providing a structured mechanism for governance, accountability, and assurance on the quality and impact of adult social care practice.

Last year we recruited a quality assurance social work lead, who now runs the monthly audits, capturing any themes that require improvements and working closely with colleagues and their line managers to improve standards. One of the main audit outcomes has been the need to better identify and support carers. The quality assurance lead has been meeting with teams and undertaking one to one training sessions with staff to demonstrate where we can improve performance.

The audits have evidenced that our standards of social care assessments, case recordings and multi-disciplinary working are of a good standard overall. Positive feedback is also shared with colleagues, which has been received well with one stating, 'it is nice to have my hard work recognised, as we only usually receive feedback when something has gone wrong'.

The monthly audits support the findings of the LGA Peer Challenge Review which summarised: 'The case file audit undertaken as part of the challenge review found good practice, including around legal decision making, and least restrictive practice' (LGA Peer Challenge Review 2024).

Torbay Learning Disability Partnership Board ambassadors' report 2025



The ambassadors have completed another busy year with more than 20 people visiting them to talk about a variety of subjects. They were really pleased to welcome Torbay Council's Chief Executive, Anne- Marie Bond, and asked her a lot of TEC questions about her role. Tracie, who is one of the Learning Disability Ambassadors, created three pieces of artwork for Anne- Marie which are proudly displayed in her office.



The ambassadors spent time working with Macmillan to look at the information that is available about cancer and how it could be improved for people with learning disabilities. The team created a poster and leaflet for people to take to GP appointments to explain any symptoms or things they are worried about.



Torbay Hospital made the ambassadors very welcome when they took part in the Treat Me Well day in April 2024. The ambassadors worked with hospital staff to look at the reasonable adjustments that are made for people who use the hospital. It was a good day, and everyone felt they learnt a lot.



Dr Clenton Farquharson a consultant, auditor, trainer, and coach on inclusion, equality and disability, visited the team of ambassadors as part of the Local Government Association's Peer Challenge Review, and he was impressed with the work the ambassadors have achieved. He particularly liked the training delivered and how the council listened to the need for Easy Read information and Reasonable Adjustments.



The work on the Big Plan continues and the team meet up with Nigel Williams, Torbay Council's Strategic Commissioning Manager, to see what is needed next. The team has created a survey about day services and helped with information about housing. It is good that the plan is becoming a real focus and there is still a lot to do.

At the partnership board, Neil Harvey stood down as co-chair with Mike Fuller taking over the role.



Three members of the ambassador team are delivering the Oliver McGowan training. This is training to provide health and social care staff with the knowledge and skills to better support people with learning disabilities and autism. Three ambassadors are directly employed by the partnership board.

Hollocombe Community Resource Centre

[Take a tour of Hollocombe](#)

Autism Partnership Board annual report

Focus on Autism

Learn more about how we provide safe, quality care and the best experience for autistic people.

Autism Partnership Board

The Autism Partnership Board launched in November 2022 and members meet four times a year. The board is driven by the voices of autistic people, their carers and professionals who work together to improve outcomes for Torbay's autistic community. The board is supported by eight ambassadors and two carers' representatives who raise issues important to the autistic community.

In September 2024, the ambassadors held their second autism awareness event, the Autistic Education and Employment Conference and Fair, at the Redcliffe Hotel Paignton. More than 100 autistic people, their carers, professionals and local organisations attended the successful event. The ambassadors gave speeches about their experiences on a variety of topics relating to education (studying and teaching), employment, self-employment, and volunteering. Afterwards, stalls run by local organisations opened for attendees to visit, and the ambassadors ran a drop-in Q&A session for attendees to have one-to-one informal chats.

The ambassadors were very grateful for the overwhelmingly positive feedback they received and will be using it to plan their 2025 event. When asked what the most useful part of the event was, comments included:

- ✅ "I was interested to listen to the experiences of the ambassadors. Also, the networking was very useful."
- ✅ "Listening to lived experiences - this was the most impactful part. Also, being able to network, meet other professionals, organisations and parents."
- ✅ "Getting to hear from the ambassadors was very informative and uplifting. They really are ambassadors."

The board's main focus last year was the production of the Torbay Autism Strategy, Torbay Council's application of [The national strategy for autistic children, young](#)

[people and adults: 2021 to 2026](#), the government's policy for improving the lives of autistic people and their families and carers. This has been done in full co-production with both the autism ambassadors and the carers representatives, tailoring the strategy to focus on the needs of Torbay's autistic community. A six-week public survey was launched in October 2024, and more than 270 responses were received. The Torbay Autism Strategy will be available in the Autumn of 2025.

In the past year, the Autism Partnership Board has consulted on Torbay Council's Reasonable Adjustments Policy, the Torbay multi-agency Suicide Prevention Plan 2024-2027 and the Local Government Peer Review. The autism ambassadors have consulted on Torbay Council's web review, the NHS 10 Year Plan, and the carers' representatives have consulted with representatives from Devon and Cornwall Police's diverse communities' team to develop a communication strategy for information on exploitation and grooming, with a focus on hidden crime.

The Autism Partnership Board and the autism ambassadors have worked together to develop a health passport. Autistic people can use health passports to record personal, medical and other essential information such as communication styles, sensory differences, anxiety and distress responses and how medical professionals can best assist that person. The health passport can then be taken to medical appointments to share with health professionals to better inform their care. This health passport is available to download from [Torbay Council's website](#).

The Autism Partnership Board, the autism ambassadors and the carers' representatives continue to pursue and support the interests of Torbay's autistic community, increasing public awareness, understanding and acceptance, improving recognition of autism by statutory organisations, improving social inclusion and pushing for reasonable adjustments for autism in all fields.

Torbay Advice Network

Torbay Advice Network (TAN) is commissioned to support autistic people and their carers and provides free impartial advice on a range of benefit issues. This includes helping people to understand what benefits they are entitled to and assist in challenging benefit decisions, including improving access to support with appeals.

TAN's employment-related support also includes guidance and templates for reasonable adjustment requests in the workplace and details on how the Access to Work scheme can help people to stay in or access employment.

In addition to Access to Work scheme guidance, they give free advice on welfare and benefits including:

- Accompaniment to benefit related medical assessment
- Attendance allowance
- Benefit appeals
- Benefit application assistance
- Carers' Allowance
- Disability Living Allowance
- Housing Benefit
- Income Support
- Jobseeker's Allowance
- Personal Independence Payment (PIP)
- Reasonable adjustments guidance
- Universal Credit

You can access TAN's services at www.advisingtorbay.org

Dimensions For Autism

Dimensions for Autism (DFA) provide peer support groups for autistic adults. The Torbay group usually meets on the last Monday afternoon of each month in Paignton. There are also online support groups that meet at least twice a month, such as the LGBTQ+ ASC group and younger adults' group, to support people who do not feel able to attend real-life events. Members can attend any online or in-person group regardless of where they live, such as the women's group based in Exeter. The groups provide a vital platform for members to share interests and hobbies and speak about day-to-day matters that may be affecting them.

Here are some of the things members have said about the help they have received from Dimensions for Autism:

"I was diagnosed with autism when I was 15, but I knew that I was autistic from a very young age. The world I grew up in was very different to the one we live in today

– stigma was rife, even among my own family members, and while there were a fair few people in my life trying their best to support me, the understanding they had of autism was very limited. Sadly, that meant that a lot of that stigma ended up bleeding into the way I viewed myself. I felt a great deal of shame for being autistic, felt guilty about the way I was judged by others, and was hesitant to even be diagnosed, fearing carrying the label with me, but a diagnosis was required for me to access support in my GCSEs.

“Due to my low self-esteem, I never made an effort to learn about autism, or the way it affected me. All I had was the stigma, the occasional media representation (many of which were equally stigmatic), and deeply complicated labels like high functioning that made me even more critical of my own intelligence, successes and capabilities. After leaving school, now feeling like a failure in addition to all the other ways I hated myself, I isolated myself from the world for the better part of 10 years, feeling that it was better that I felt lonely than to find the ways I’d been judged in the past, and the ways I continued to judge myself, be validated in other people.

“I missed a lot in that time, but one thing I did miss was the way that public awareness and understanding of autism improved, and Dimensions for Autism played a big part in that. I now know that many people felt just as lonely as I did, and in finding, and eventually coming to Dimensions for Autism’s groups, I, like they did before me, found so much healing in coming together to share experiences. DFA’s dual focus of having the chance to talk about your experiences with people you can trust who have gone through similar things, and discussing psycho-educational topics and topics that impact our community as a group of peers, means I’m learning so much more about myself, and learning how many things about myself I felt I was alone with that I share with the rest of my community.

“Dimensions for Autism is a vital part in the wider picture of autism awareness and acceptance in Torbay. We live in a better world today than the one I grew up thanks to the efforts of Trish and everyone that makes DFA the safe and healing space that it is, one that is rapidly becoming free of stigma, of misinformation and of judgement, and I’m so grateful to them to know that not only do I not need to feel ashamed or guilty for simply being myself, but that nobody ever should.”

Autistic After Hours

Autistic After Hours is a Community Interest Company (CIC) set up as a result of conversations at the Autism Partnership Board. Members of the board identified that there was a distinct lack of services for autistic adults in the evenings and weekends which left people socially isolated, so two board members decided to apply for funding to provide that support. Autistic After Hours has now been running for more than a year and has 87 members on its mailing list. The group meet once a month on a Saturday afternoon in Paignton, where members come and socialise in a safe environment with other autistic people. Additional evening and weekend events are planned by the group on a month-to-month basis and include a regular games night in Torquay and a coffee morning in Paignton.

The group has gone from strength to strength and offers additional activities such as a day at the Autism Woodland Project and a trip to a National Trust house and garden. There are many positives to spending time with other people who understand you and members of the group have expressed how valuable they find the time together. We hope to expand our offerings to people in the future and are considering offering peer support in the future.

Here is feedback from one of AAH's members about the impact being part of AAH has had on their lives:

“Before becoming a member of Autistic After Hours, I was in a significantly worse place. I always felt like my autism was something I needed to compensate for, and that I would never be enough as I was. My self-esteem and confidence were incredibly low, I was socially isolated outside of my job, which I felt was the only thing that gave me tangible value, and when I was unable to continue working, it felt like my life was over, and knowing the place I was in, it truly may have been if not for being told about AAH.

“At my first meeting I remember my anxiety was through the roof, I barely spoke, I avoided eye contact, I kept the exit in my peripheral vision, all things I'd been taught how to mask when I'd interacted with people before, and all things I simply didn't have the energy to hide anymore. To my surprise, it wasn't a problem like it'd been made out to be in my past, in fact many people were feeling just as anxious, and

those who weren't feeling as anxious right then had absolutely felt like that previously. Everyone understood, and, even more importantly, I was accepted as I was.

"Since that first meeting, the impact AAH has had on my life has been immeasurable. Having the space to be my authentic self, even having the space to discover who that authentic self is after decades of having to hide it in the interest of being accepted, has done wonders. My confidence and self-esteem got higher with each month, and being accepted and even welcomed by AAH meant beginning to accept myself, and in doing so, the foundations were laid for me to make the most meaningful friendships I've ever had.

"The best part about the impact AAH has had on my life, as paradoxical as it will sound, is that I still have days where my anxiety is high, where I struggle to say anything, where things still feel harder than the many challenges the confidence and self-worth that my time with AAH has instilled me with have allowed me to overcome. I know now that that's okay. Even when I'm not in a good place, Autistic After Hours is a group where I will feel just as accepted and just as welcomed on my worst day as on my best day."

A.I.M.S

The Autism / ADHD Information, Mentoring and Support service (A.I.M.S) is a service run by Therapy Services South West CIC. Launched in September 2024, it provides monthly 45-minute one-to-one sessions, either by phone, face to face or online, focusing on post-diagnostic and social skills support and covering issues people may experience.

The service works with people to help them understand their autism and / or ADHD better, helping people to identify the ways their lives are impacted and to develop coping strategies. They also act as a sounding board for people that may not have family or friends they feel able to confide in, promote independence, signpost people to advocacy and other appropriate autism-friendly community-based support and provide guidance to mainstream services on how they can better provide support.

Here are some of the things clients of A.I.M.S and professionals referring to them have said about the importance of their support:

“Services like A.I.M.S are vital to neurodiverse members of the community. Many forms of therapy are a one size fits all structure which is not conducive to effective treatment of those with additional needs. A.I.M.S has given me preventative measures to manage my ADHD/autism on a day-to-day basis as opposed to the usual reactive measures given when my condition has reached a boiling point. This allows me to work through my needs at a steady pace. I believe this will save the trust a huge amount of money on expensive mental health care. Support for neurodiversity should be regular and not given as a last resort when the condition becomes unmanageable.”

“Being a late diagnosed autistic adult has brought up lots of confusion, questions and uncertainty. It has made me look back on my life with new eyes and forced me to re-evaluate my sense of identity. Finding the A.I.M.S service has been invaluable. To be able to talk through things with someone who understands has been really strengthening at a time when I have felt very fragile. This service is vital to help provide ongoing support for the autistic community. Having autism can often make it difficult to connect with others and one can end up feeling alone and isolated. Having a service like A.I.M.S has helped me feel listened to and that I matter. Thank you for being there at a time when no one else was. I have really appreciated your time and care.”

“As an occupational therapist working in primary care, I have made several referrals for mentoring support under the A.I.M.S programme with Therapy Services Southwest CIC. With a rise in people seeking diagnosis for both ADHD and autism, A.I.M.S meets an unmet need for our neurodiverse population. People referred have been positive about the specialist neuro-affirming guidance, mentoring and support that they have received and are gaining important insights, coping strategies and community connections. Having a monthly space to help manage life events, reflect on their strengths, needs and manage anxieties is invaluable and not anything provided by other services. I hope that Therapy Services Southwest CIC can continue to offer this support free of charge for this to be fully accessible for a group of people who are often disadvantaged economically.”

The AIMS service is making a significant positive impact on autistic and ADHD adults by offering low intensity coaching that is person centred, empathic and strength

based. It creates a safe space for neurodivergent people to thrive both as clients and as coaches. The service focuses on personalised practical support that not only helps people better manage their lives but also creates an inclusive and empowering workplace for neurodivergent professionals promoting an environment where everyone's unique strengths are valued and celebrated.

The service's coaching helps people gain the tools they need to live more independently reducing reliance on external support systems and boosting their self-sufficiency.

AIMS offers an excellent workplace for neurodivergent people by offering opportunities for reflection, supervision and self-care practices where neurodivergent coaches can lean on each other for support and strategies and learn from one another's experiences. This reduces the isolation often felt by neurodivergent people in traditional work settings. AIMS encourages an atmosphere of mutual respect, understanding and shared learning. Neurodivergent coaches bring a valuable perspective that resonates with clients. Their lived experience enables them to connect with people on a deeper level offering insights and strategies that are both practical and empathetic.

Focus on mental health

As we work towards developing our vision to create thriving communities where people can prosper, we need to offer accessible quality mental health care and support.

Older person mental health service

Torbay Older Person Mental Health (OPMH) service ensures we provide our statutory social care functions, alongside our partners Devon Partnership NHS Trust which provides community mental health services.

We work with older people and their families and carers who are experiencing complex mental health difficulties including dementia. The service prides itself on actively challenging perceptions of older age, oppression, and discrimination. Social workers have expertise in areas of assessment, safeguarding, individual and family therapeutic intervention.

Our work is underpinned by legislative frameworks (the Care Act 2014, the Mental Health Act 1983/2007, the Mental Capacity Act 2005, the Human Rights Act 1998, the Equality Act 2010 etc.), which ensure evidence-based and proportionate interventions in the lives of the people we support.

We work with our partners to provide a multi-disciplinary approach to integrated care, improved communication, and timely joint visits to people who need our services. We work with those who have dementia as well as those with life-long mental illnesses such as depression and anxiety.

We work hard to involve families in assessments and decision making from the start. We have a dedicated carer support worker who can come alongside loved ones with knowledge and compassion at critical times. Our team of social workers and community care workers understand the legal aspect of caring for their loved ones when they can no longer make decisions for themselves and help families through this.

We are creative in care planning recognising that everyone is an individual and one size doesn't fit all. We believe people have the right to take risks even in older age and we champion people's rights to live independently for as long as possible in their own homes and will help find specialist carers to achieve this.

We are skilled in safeguarding older people from those who may not have their best interests at heart.

We are skilled practitioners who have a wealth of expertise and experience in older age mental disorders. We support and work collaboratively with our social care colleagues through the link work scheme where specialist mental health support and joint working is offered to social work colleagues who are working with people who might be experiencing mental health difficulties. This also provides an opportunity to identify people who are in need of social care and would benefit from the care of the specialist mental health service.

We are proud to host student social workers, several of whom have stayed with as qualified workers. We have also supported social workers to complete specialist training as approved mental health professionals, which enhances our legal literacy and speedy access to enhanced expertise. We embrace a grow your own approach

having supported several excellent community care workers through the Open University training programme to become qualified social workers. For the first time this year we are supporting one of our community care workers to undertake the social work apprenticeship programme.

Care Home Education and Support Services (CHESS) – part of Older People Mental Health

CHESS provides support, advice, and guidance to care homes in Torbay. Its role is to support care homes to develop ways to improve the mental health and wellbeing of residents who have a diagnosis of dementia, and who present with the associated behavioural and psychological challenges (BPSD) of the condition.

CHESS is a multi-disciplinary team and develops collaborative partnerships across health and social care to enhance the quality of service and lived experiences of people living in care homes and experiencing the symptoms of BPSD.

In April 2022 a 12-month development project began to implement CHESS as a standalone service with dedicated staff members from Devon Partnership Trust and Torbay and South Devon NHS Foundation Trust. The trial was a success and has been established as the model of care for Torbay-based care home patients with dementia. The service has continued to evolve since then and is now an integral part of the Enhanced Health in Care Homes (EHCH) support framework for care homes.

During the past six months, following investment from NHS England, we have been able to focus on the provision of specialist dementia education to the care homes across south Devon in non-pharmacological approaches. This is in addition to our established reactive support and has given us the opportunity to explore proactive educational work to improve the quality of life for those with dementia residing in residential and nursing care environments. This has been very well received by the care homes and wider health and social care support network.

Mental health adult social care team

During the past year the Torbay mental health adult social care team started using the Torbay electronic system which aligns with our colleagues in other adult social care teams in the Bay to continue delivering a high-quality service.

The team has close links with the Bay's social care teams, and community mental health team. It's in a unique position to provide creative and collaborative services for people across the Bay, working on close links with housing providers, voluntary sector partners and community resources. Our aim is one of a strength-based approach, working with people to find solutions from a wide range of sources.

We have embarked on a journey to review and reimagine our mental health services with a view to developing stronger partnerships not only with our colleagues in secondary mental health services, but also with our social work colleagues in all the teams across Torbay to provide the best quality care for people who need our help.

The team includes mental health social workers and community support workers who assess eligible social care needs and plan support with people and their families and carers. We work with people to identify strengths in their networks and to access services and activities in their community that promote their independence, recovery, and social inclusion.

Where appropriate we work with our partners in the arranging support team to build packages of support to meet people's unmet needs and regularly review the commissioned care, under statutory responsibilities.

We ensure section 117 aftercare rights of a person are reviewed and meet NHS policies, and any commissioned social care support is identified to support hospital discharge and reviewed in the community to ensure it continues to meet people's aftercare needs.

Next year we will review and reimagine our mental health services, with the aim of developing stronger partnerships not only with our colleagues in secondary mental health services, but also with our social work colleagues in all the teams across Torbay,

Our aim is to provide the best quality service for people who may need our help and their families and carers, and to ensure that people with lived experience of mental health have a voice and play a key role in transforming the service.

My story: Ele, a mental health social worker in mental health adult social care team

I have been working with SW who is a vulnerable woman with a diagnosis of Autism and Dissociative Identity Disorder. SW experiences dissociative episodes which impacts on her daily living skills alongside her neurodiversity, and she requires support to live independently in the community.

“There are also safety issues linked to dissociative episodes, and I have needed to support the community team to manage the risks involved in these events which have included periods of being missing and alleged abuse during these times.

“I have worked with SW continually during the past two years and taken time to build the rapport and continuity with SW to develop her trusting relationship in me. This has enabled SW to feel safe and confident in my approach towards her and allow her to share the complexities of her life with her social worker to build a through and robust plan of care around her. Having had social workers in the past, it was difficult when she first met me to be able to put her trust in such a professional relationship, however taking the time to listen to her and validate her experiences has allowed us to work well together and it has been a pleasure to not only work alongside SW, but for me to learn as a practitioner first-hand what it involves to experience this condition.”

My story: SW shares her experience of working with Ele:

“Ele’s work with me started with a social care needs assessment. Since then she has responded to many changes in my circumstances with curiosity, compassion and (when needed) humour. When things have been stable and good, she’s left me to it. When things have changed and not been good, her response has always been proportionate. I enjoy working with her- it does feel like collaboration. I have nothing but praise (which is unusual for me) for the way that she has persevered to gain trust and help me live as independently and safely as possible. She understands my needs really well, but also my strengths. I’m a 3D person.”

Approved mental health professionals

Mental health services play a crucial role for supporting our community. The prevalence of mental health issues has surged since Covid-19 and world hostilities.

To deliver our vision to create **thriving communities where people can prosper**, we need to offer accessible quality mental health care and support. The Torbay

approved mental health professional (AMHP) service is a vital part of this delivery of care

Our AMHPs are approved by Torbay Council to carry out certain duties under the Mental Health Act. A key function of the AMHP is considering and coordinating Mental Health Act Assessments (MHAAs). When satisfied that it is appropriate to do so, we are responsible for making applications for detention in hospital for assessment/treatment of mental disorder, alongside various other statutory responsibilities and duties, whilst adhering to the Guiding Principles set out in the MHA Code of Practice (DoH 2015). Torbay has a 24/7 access to an AMHP.

The convening of a Mental Health Act Assessment is complex and wholly dependent upon multi-agency working.

Emergency duty service

We are very proud of our emergency duty service (EDS) and the often-challenging work they undertake in a calm and effective manner.

A social worker is available 24 hours a day, seven days a week. Outside of normal working hours (Monday to Friday, 9am to 5pm), this role is undertaken by the emergency duty service. This is a small team consisting of six qualified social workers and five health and social care coordinators. There is always at least one social worker on duty.

In practice this can mean that we can find ourselves moving from dealing with someone's concerns about a young baby, to arranging a support package for an older person who is near the end of their life, to undertaking a Mental Health Act assessment to determine whether someone needs admission to hospital. The role is therefore wide and varied, and being an emergency duty team means that we never know what situation will arise that needs us to offer support next. Our aims as a team are:

- To ensure that children, young people, and adults within Torbay remain safeguarded from harm.
- To ensure that the statutory social care responsibilities are met in a consistent and timely manner.

- To ensure that people in priority need of housing are placed in accommodation until the next working day when they can have a fuller assessment of need.

Sensory team

We understand the life-changing impact that sight and hearing difficulties, including loss, can have on someone's life.

Our team of specialists and community care workers, including a British Sign Language communication and rehabilitation support worker, play a vital role in supporting people to understand the impact of sensory loss and work with them to reduce isolation, confusion and challenges with communication and mobility difficulties.

We support people living alone to maintain their independence, especially when their confidence has been reduced because of their sight and/or hearing loss. An example of this in practice could be providing equipment to support people to hear the safety alarms and other alerts such as the doorbell or phone to accept visits from family, friends, carers and health professionals.

We advise on support, provide rehabilitation, low vision assessments, and support to people and their carers with hearing and/or sight difficulties to lead independent lives. We work closely with the Guide Dogs Trust to support our young people when they move from children to adults' services.

We visit people in their home to assess need and can provide information and advice, which can include the loaning of equipment such as amplified phones, lighting, alerting equipment and magnifiers.

We team encourage people to attend Jasmyn House, sight and hearing hub in Paignton which is a drop-in centre for people with sensory loss. During drop-in sessions, help and advice is provided, and regular groups are held such as:

- Regular tinnitus meetings.
- Coffee mornings
- Craft club
- Book clubs

My story: Bob (pseudonym)

Bob lives in Torbay with his wife who has a terminal illness. Bob has macular degeneration and double vision, and his sight is continuing to deteriorate, which is something he is struggling to accept.

Feedback from Bob following assessment and support from a rehabilitation office for visual impairment (ROVI) highlighted the following: “I met the ROVI for the first time and was very reticent with her due to not accepting my sight situation. She was very understanding in her approach and made several helpful suggestions, explaining the benefits of white sticks and tactile markers. I was also provided with useful equipment to promote my independence at home including a liquid level indicator, high contrast matt and bright coloured tape to highlight edging.”

Feedback:



We created a feedback form for home visits and groups and for the past 12 months we've had extremely high returns with 100% excellent feedback and also some useful requests for guest speakers at some of the groups.

Group feedback:

"Very good content and the practical was very helpful and useful."

"Bevis exemplifies the ethics of 'praising his pupils'. He has never ending patience with us all and we never feel that we are not keeping up. He is also very humorous which is refreshing and lightens up the sessions".

Transitions – Pathway to Adulthood

Torbay ASC is committed to providing young people with the support they need as they transition from children's services into adult social care. This crucial period of transition is designed to empower young people, ensure continuity of care, and help them live as independently as possible in adulthood. Our approach is person-centred, collaborative, and focused on equipping young people with the skills, knowledge, and resources to thrive in their adult lives. This summary provides an overview of the activities, progress, and plans related to young people in transition in Torbay.

1. Transition process overview:

The transition from childhood to adulthood can be a challenging time, particularly for young people with special educational needs and disabilities (SEND). In Torbay, we follow a coordinated approach to transition that brings together children's services, adult social care, education providers, healthcare professionals, and other relevant agencies.

The transition process begins at least 12 months before the young person turns 18, with a focus on:

- **Assessment of needs:** A thorough assessment is carried out to understand the young person's health, social care, and education needs.
- **Person-centered planning:** We work closely with the young person, their family, and any professionals involved in their care to develop a transition plan that reflects their aspirations, needs, and preferences.

- **Skills development:** Throughout the transition period, the emphasis is placed on developing skills for independent living, including budgeting, cooking, managing personal care, and accessing services.
- **Preparation for adulthood:** Our transition plans incorporate elements of employment, housing, social inclusion, and health, preparing young people for the challenges and opportunities of adulthood.

2. Key achievements and activities:

Person-centred transition plans:

We have seen significant progress in developing tailored, person-centred transition plans for young people. These plans cover a broad range of areas including education, employment, health, housing, and community involvement. Key achievements include:

- **Collaboration with families:** Families have been fully engaged in the planning process, with regular reviews to ensure the plans remain relevant and reflect the changing needs of the young person.
- **Transition support workers:** Dedicated transition workers have been assigned to young people to provide consistent guidance and support throughout the process. They ensure that plans are implemented and that young people are supported in accessing the appropriate services.
- **Education and employment pathways:** We have worked closely with education providers and local employers to support young people in accessing further education, training, or employment opportunities. Several young people have successfully secured apprenticeships or placements within local businesses.

Personal independence and wellbeing:

We have focused on equipping young people with the skills needed for independent living. Several key initiatives have been implemented to enhance personal independence:

Promoting independence – Sarah's journey

Sarah is a young adult with a learning disability and global developmental delay. She expressed a strong desire to become more independent, although her parents initially felt uncertain about this transition. In response, the social care team worked

closely with Sarah and her family to identify a suitable personal assistant who could support her in developing key life skills.

For 18 months, Sarah was supported to build confidence in using public transport, particularly travelling to and from college and to various social activities. Regular reviews were held throughout this time to ensure the support provided was appropriate, effective, and responsive to Sarah's evolving needs.

As a result of this support, Sarah is now confidently travelling independently by bus to college and planned social events. During this journey, Sarah expressed a new aspiration — to find employment. The team helped her access volunteering opportunities, which eventually led to part-time paid work. Sarah is now successfully employed and has chosen to end her involvement with adult social care, as she no longer feels she needs formal support.

3. Challenges and areas for improvement:

While significant progress has been made, there are still areas that require ongoing attention:

- **Timeliness of transition planning:** Some young people's transition plans have been delayed, impacting their ability to move smoothly from children to adult services. We are working to address this by ensuring that assessments and planning begin earlier, with a focus on meeting key deadlines.
- **Access to ASC services:** Moving to ASC can be complex, particularly for those with complex needs. We have identified the need for clearer pathways and more support in navigating adult services.
- **Mental health and wellbeing support:** Many young people in transition experience mental health challenges, and access to appropriate services can sometimes be inconsistent. We are working to strengthen mental health support within the transition process, ensuring that young people's emotional wellbeing is adequately addressed.
- **Employment and training opportunities:** While some young people have successfully secured employment or education placements, others face barriers to accessing suitable opportunities. We are exploring partnerships with local employers and training providers to improve these opportunities.

4. Plans and actions:

Torbay's ASC service is committed to continuing to improve the transition process for young people. Our plans include:

- **Streamlining the transition process:** We will work towards earlier identification of young people who will require transition support, with a focus on ensuring that assessments and planning start well in advance of the young person turning 18.
- **Developing new partnerships:** We aim to expand our partnerships with local businesses, educational institutions, and housing providers to create more opportunities for young people in transition, particularly in terms of apprenticeships, internships, and supported living options.
- **Improving access to mental health support:** Recognising the importance of mental health in the transition process, we plan to further integrate mental health services into the transition planning process, ensuring that young people receive the support they need to manage emotional well-being as they move into adulthood.
- **Expanding independent living programs:** We are planning to enhance independent living programs to include more tailored support for those with complex needs, ensuring that young people have the skills and confidence to live as independently as possible.
- **Feedback and review mechanism:** We are committed to improving our feedback mechanisms, ensuring that young people and their families have a voice in shaping the transition process. We will be introducing regular surveys and consultations to gather insights and identify areas for improvement.

Focus on the arranging support team

The Arranging Support Team (AST) is a group of nine professionals who work with health and social care teams, people, families, and providers to match individuals with the right support. They focus on specific areas of care, building strong relationships with providers to negotiate fees and provide expert guidance. The team arranges various types of care, including residential placements, home care, live-in care, respite, day care, supported living, and specialist services for complex needs.

They also help prevent hospital admissions and assist with hospital discharge to maintain patient flow. In 2024, the team created a list of voluntary and community

organisations in Torbay, helping people access community support instead of relying on paid services.

The team collects data on care services, which is shared with commissioners to help shape the market and understand service availability and demand. Additionally, they ensure contracts are raised and payments to providers are processed promptly, supporting efficient financial tracking for adult social care spending.

My story: Mr G

Mr G is an elderly gentleman who has various health conditions including dementia. He had several cycles of going from home to hospital into a care home for rehabilitation and then home again, which he found very distressing. Following another hospital admission the arranging support team looked at different options to support Mr G rather than him go into a care home. The broker was able to source wraparound care at a reduced fee to support Mr G at home where he could be in a familiar environment and carry out his usual routines which helps to minimise his distress.

His family said he was settled and doing well, his daughter reports “they are really good at keeping him busy, they always seem to be doing something, which is nice for dad.”

My story: Mr B

Mr B lived on his own with no family or next of kin. He received care from an agency four times a day to support him with his daily needs and had involvement from Rowcroft.

On arriving for their morning visit, the care agency called an ambulance crew who assessed Mr B as being near the end of life and too unwell to move. A broker sourced support for Mr B to ensure his care needs were met and he had someone with him until his passing later that day.

My story: Mrs K

Mrs K is a 59-year-old woman who has a diagnosis of Emotionally Unstable Personality Disorder (EUPD) and has experienced complex trauma. Her physical health conditions include COPD, angina and acute coronary syndrome.

In January 2024 Mrs K was detained under the Mental Health Act. On discharge from hospital, she was provided with a package to support her in the community. This was unsuccessful and a referral was made to AST to find a placement for her. Mrs K had previously received support from a variety of agencies in Torbay including a residential placement, home care and enabling support which were all unsuccessful due to the care arrangements not being able to meet her complex needs.

The broker was able to source a placement for her in a home which specialises in supporting people who have a diagnosis of EUPD. Mrs K moved into the placement in January 2025 and is settling in well.

My story: Mrs J

An urgent referral was made into AST by an occupational therapist (OT) at 1.45pm on a Friday. They had been to visit Mrs J at home following a referral from the district nurse team. Mrs J had recently discharged herself from Jack Sears House, a reablement care home. On visiting Mrs J, the OT found her in bed uncared for and there were signs of domestic abuse. They were concerned for her health and wellbeing and concluded she needed to go into a placement as soon as possible.

Within an hour of receiving the referral the broker sourced a placement for her to move into that afternoon. The OT had exhausted all options to arrange transport; pulling on the resources of our adult social care teams, our in-house day service provider was able to provide a minibus and driver to support with moving her. A HSCC liaised with her GP to organise essential medication.

Altogether, seven members of staff across five different teams worked together swiftly to make sure Mrs J was in a place of safety where her needs could be met.

Signposts for Carers - information

Signposts for Carers is Torbay carers' information and advice service. It's the first stop for anyone with a caring role in Torbay. The service is available 9am-4.30pm, Monday to Friday (except bank holidays) by phone, email or in person at Torbay Hospital's advice point on level 4 main reception.

Carers can also drop into the Carers Centre at Paignton Library or make appointments at Brixham or Torquay Carers Centres.

Colin is the Signposts Information Officer.

What is the best part of your job?



“Providing people with information that supports them with their caring role. Referring carers onto carer support workers and other agencies to boost their confidence and enable them to thrive. Carers should know that they are not alone in their caring role. They should not struggle in silence or solitude. Support, advice and advocacy are all available in various forms from many different agencies. It only takes a phone call or email to Signposts for Carers.”

This year the service has answered 786 phone calls, made 482 visits and responded to 1189 email queries. The service has posted 1393 register packs.

Carer support workers

The mainstay of the carers services is the carer support workers which is based in GP surgeries. They undertake carers’ health and wellbeing checks / assessments. This helps carers to look at the impact of their caring role and give them the support that they provide.



This year our GP-based carer support workers have undertaken 629 assessments (against a target of 500).

There are other carer support workers based in mental health services, older people’s mental health and working with young adult carers aged 16-25 or carers from the armed forces community.

Carers Aid Torbay provides assessment, support and advocacy.

This year Carers Aid workers have completed 148 assessments against a target of 100. Its Bay Benefits service also brought in £731,291 in additional benefits to carers in Torbay in 2024.

Various support workers also run groups which offer carers' peer support, with positive feedback, including:

"Great friendly environment to come to and chat with other carers. It's a good place to get out of the house and to get help and advice if needed."

"I have found Wednesdays every month to be very informative. Everyone is friendly and you soon learn from other people, and to have someone listen is the best thing."

"Discussing circumstances is very helpful and I have learnt a lot. Would be nice to do a few more activities/ quiz so I can get to know people better."

"Convenient location and free parking is good. I received a friendly welcome and it felt easy to make conversation with other carers. I asked a question of the organisation and was pointed in the right direction."

"This was my first visit and have found it relaxing and pleasant to be able to talk to others that understand where I'm coming from."

"A friendly group of people, the carers' support is very helpful with anything that you need."

"I really look forward to coming to this group. I can speak freely, get useful advice and meet understanding people. We have a laugh and chat about all sorts apart from our caring roles."

My story: Sally Smith, a hospital carer support worker

"My role is to speak up for carers when the person they care for is in hospital. I offer help around complex discharge planning and support carers to have the right conversations to get what they need in hospital and when they leave hospital. I also signpost carers to community and volunteer support. Part of my role is to identify carer stress and put things in place to avoid situations reaching crisis point."

What is the best part of your job?

“Helping carers to navigate the help and support that is available when the person they care for is in the hospital. I find preventing people from feeling isolated in their caring role and ensuring their voice is heard very rewarding.”

Involving carers

Carers have been involved in many aspects of carer services work.

[They've written five 'I statements' saying what Carers' priorities are for the Carers' Strategy.](#)

Carer ambassadors involved in the Learning Disability Partnership Board, the Autism Partnership Board and the Carers' Strategy Steering Group. They've also helped re-write and re-design some of our carers' leaflets.



Focus on safeguarding adults

Our aim in the broadest sense is for the public, volunteers, and professionals to work together to uphold human rights and ensure everyone is treated with dignity and respect, and that people have choice, control, and compassionate care in their lives. Everyone has the right to live their lives free from violence, fear and abuse and all adults have the right to be protected from harm or exploitation, but not everyone can protect themselves.

Safeguarding is a term used to mean both specialist services and other activity designed to promote the wellbeing and safeguard the rights of adults with care and support needs where neglect or abuse has or is suspected to have occurred.

Our responses to concerns are driven by Care Act 2014 statutory guidance and the national Making Safeguarding Personal (MSP) agenda. This includes working with people or their representatives to establish their preferred outcomes to concerns and work with people to meet those outcomes. Where adults with care and support needs do not have the mental capacity to make specific decisions, we will ensure there is an appropriate legal advocate to act on the individual's behalf.

Qualitative feedback on safeguarding responses

We actively seek feedback from people who experience safeguarding responses. We commission independent quality checkers who undertake discovery interviews with those who consent to giving feedback. We then receive summary reports from the quality checkers and feed this information back to frontline practitioners via our Safeguarding Adult Improvement Group. An example of feedback given in 2024 is:

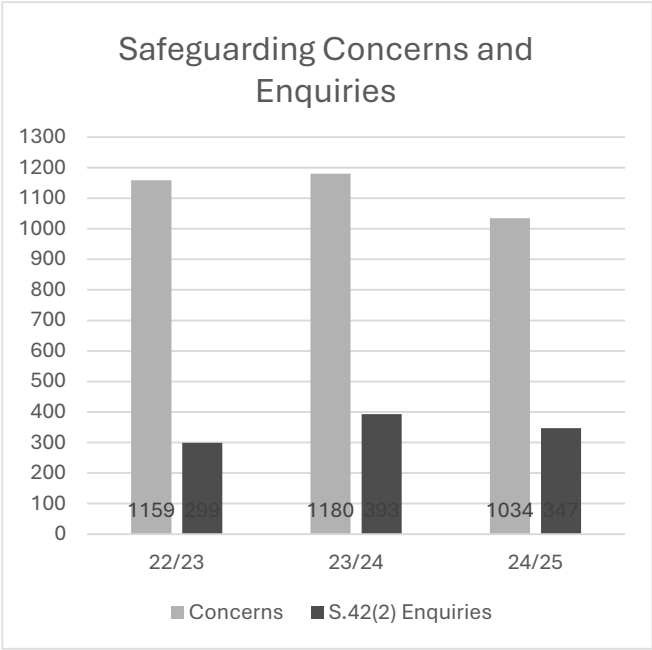
I feel the safeguarding process was detailed and robust in ensuring that relevant policies, procedures, and practice were reviewed and updated to ensure appropriate safeguards were implemented and embedded where required. The evidence indicates that best interests' decisions considered the principles of least restriction in relation to any protective measures that were required" (Independent Mental Capacity Act Advocate)

'All questions were answered positively with all objectives fully met, when asked about safety, the response was "Absolutely". (Quality Checker summary of discovery interview)

She felt that all outcomes were fully achieved, she felt listened to and "much safer". (Quality Checker summary of discovery interview)

Safeguarding adult enquiries summary

Section 42 of the Care Act 2014 requires that local authorities must make enquiries or cause others to do so if it believes an adult with needs for care and support are experiencing or at risk of abuse or neglect.



From April 2024 to March 2025 there were 1034 safeguarding adult concerns were received which is a 12.4% **decrease** on the previous year. The number of concerns which proceeded to Care Act s.42(2) enquiry **decreased** by 11.7% **to 347**. The conversion rate from concerns to s.42 enquiries increased by 0.3% to 33.6%. The table below provides a comparator during the past three years.

Our work in this area primarily divides between the adult social care community operational teams who respond to safeguarding concerns and our market management team which works with care homes and domiciliary care providers to promote high quality care and proactively monitor quality standards.

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

Last year, the most common types of alleged abuse were neglect, self-neglect, financial and physical.

During 2024/25 we completed one large-scale safeguarding enquiry in response to system-wide safeguarding adult concerns.

Torbay and Devon Safeguarding Adult Partnership (TDSAP)

TDSAP oversees local safeguarding arrangements and has a structure to support its objective to protect adults with care and support needs.

The structure includes learning and improvement and performance and quality assurance sub-groups. The partnership also has a specific Safeguarding Adult Core Group responsible for commissioning and overseeing Safeguarding Adult Learning

Reviews. The partnership has an independent chair who oversees local arrangements.

The TDSAP Strategic Business Plan for 2025 – 2028 sets three priorities:

- Seek assurance from partners in relation to practice improvements in key risk areas.
- Seek assurance from partners that learning from Safeguarding Adult Reviews (SARs) is embedded into practice.
- Improve awareness, engagement and inclusion.

More information on the partnership can be found at

www.devonsafeguardingadultspartnership.org.uk

We continue to support the partnership to meet its strategic objectives.

Learning from safeguarding adult reviews

The TDSAP must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult. Boards must also arrange a SAR if an adult in its area has not died, but the Safeguarding Adult Board (SAB) knows or suspects that the adult has experienced serious abuse or neglect. Boards may also arrange for a SAR in any other situations involving an adult in its area with needs for care and support if it deems it appropriate. The focus of SARs is to identify learning not to apportion blame.

In this reporting period there have been three SAR referrals to TDSAP connected to our local area. Two referrals related to people in circumstances of self-neglect have been identified as meeting section 44 Care Act safeguarding adult review criteria by the TDSAP, which is a system wide referral. The Partnership published seven SARs which are available on the TDSAP website [here](#). The learning and improvement subgroup ensures that recommendations from learning reviews are completed and is supported by a number of organisations, including ourselves.

Advocacy for people unable to make decisions for themselves.

We continue to use advocacy services across the three legal frameworks: mental health/IMHA, mental capacity/IMCA and Care Act.

This is via a contract with the Devon Advocacy consortium. We regularly refer people and have contract monitoring systems in place to monitor uptake of services.

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) procedure is designed to protect people's rights if the care or treatment they receive in a hospital or care home means they are, or may become, deprived of their liberty, and they lack mental capacity to consent to those arrangements. For example, where due to the serious onset of dementia someone's capacity to act safely is significantly affected.

We proactively work with colleagues across the South West to ensure our systems and processes remain contemporary and as streamlined as possible.

Safeguarding adults: a summary

We constantly strive to understand emerging issues for safeguarding adults in Torbay and our joint board arrangement with Devon County Council assists in driving collaborative responses to the safeguarding adult agenda.

We promote a zero tolerance of adult abuse, and that safeguarding adult is everyone's business. When adult abuse concerns are raised, we work in a multi-disciplinary and multi-agency context to understand risk and ensure responses are person centred, include the right people, and include the right partner agencies.

Our main focuses next year is to support TDSAP in meeting its strategic priorities as well as ensuring qualitative feedback is sought and listened to from those who experience a safeguarding adult response.

Technology enabled care service (TEC)

It's been an extremely busy year for the service, with more staff being trained and an increase in people using the service. TEC's position and recognition of an alternative to in-person care, helping people to stay independent and confident in their own situation, has grown, and Torbay has seen the benefit of this. This has led to a greater involvement in social care package input through multi-disciplinary working across all teams.

Our teams are committed to embedding TEC across Torbay's ASC service to empower people to fulfil their potential, retain their independence and remain at home. Focus was given to improve practice across teams to drive the opportunities for people to receive TEC as part of packages of care.

Key improvements include:

- Since April 2024, 29% of new people who draw on care and support are now receiving TEC.
- An additional 28 TEC champions have been created across teams since July 2024
- A staff practice survey identified increased confidence using TEC and further initiatives are being identified to help them improve.
- A TEC decision-making tool launched with teams to assist with linking people's outcomes and TEC equipment.

Work is also underway to develop a new TEC model to commission.

Training has been a focus of the year, with many of the staff receiving specialised approvers and awareness sessions so that knowledge can be cascaded into the teams. We have generated more guidance than ever before to allow staff more access to equipment functionality. TECS has also supported Jack Sears House by providing a box of demonstration equipment for residents to see and for staff to explain how it could be of assistance as they are discharged home.

The TECS team has been involved in various projects throughout the year alongside a delivery partner, including: input into review and insights team activity; a pilot involving the remote sensor system, Canary Care; assisting a project with the health and social care coordinators when reviewing people's support packages.

The service is due to be recommissioned as the term has matured, and in-depth requirements work on a service that will best serve our community have been another major focus of the year. Staff and members of the public should expect to see a new service begin in 2025/26/

The team is fully linked into local, regional, and national subject groups and regularly attends sessions both online and in-person to learn best practices and bring new and

innovative input to the service in Torbay; this will continue as we seek to be a forward-thinking and market leading TECS provider in the UK.

Experiences

My story: Mr T

Mr T, a 29-year-old with learning difficulties, lives with his mother. His goal is to find suitable accommodation to live independently in the community and to feel safe using public transport. However, due to a previous bad experience, Mr T does not feel comfortable traveling outside his current town and experiences anxiety when using public transport.

The social care and TEC teams met with Mr T to explore TEC solutions that could support his needs. With his consent, they provided him with an Oysta Pearl II, a device that includes:

- An emergency button
- A falls detector
- A loudspeaker phone for two-way communication
- A location tracker

The Nottingham Rehab Service Ltd (NRS) technician demonstrated how to use the Oysta Pearl II, to make sure Mr T felt confident using the device. .

Since receiving the Oysta Pearl II, Mr. T's confidence has increased significantly. He is now looking forward to using public transport independently, which will allow him to expand his accommodation search and meet new friends. Knowing he can call for help if he feels threatened or anxious, he feels safer and more in control of his journey toward independent living.

My story: Mrs B

Mrs B, an 80-year-old woman, often forgets to take her morning medication. Her daughter, who works full-time, is unable to provide daily support. Concerned about the risk of hospital admission, Mrs B's daughter contacted the social care team to explore possible solutions that could help her mother manage her medication independently.

The team recommended Memrabel 3 as a suitable solution to support Mrs B's needs. With her consent, the device was ordered and installed, and both Mrs B and her daughter were shown how to operate it. The Memrabel 3 provides timely reminders, enabling Mrs B to manage her medication without requiring carer support.

Since using the Memrabel 3, Mrs B has reported a significant reduction in anxiety and feels more in control of her medication and overall wellbeing. Her daughter has also expressed relief and reassurance, knowing that her mother can remain independent while effectively managing her medication.

Jack Sears Rehabilitation Unit



Jack Sears is a 29-bed rehabilitation unit in Paignton which opened in June 2024. It aims to support people to recover and regain independence to be able to return home.

People can be admitted from hospital or if they are struggling at home. Common reasons for admissions are falls, fractures, infections and reduced mobility due to illness. Staffing in the unit consists of a team of carers and a therapy team

(physiotherapist, occupational therapist, assistant practitioner and support worker).

We also have visits from nursing, pharmacy, GPs and dieticians. Assessments are carried out by the therapy staff on the day of admission and rehabilitation goals are jointly agreed.

Since Jack Sears opened, we have admitted 209 patients. 87% were admitted from hospital and 13% from the community. The average length of stay for a patient is 22 days and 75% of patients were able to return to their own homes. 2% of patients were transferred to a long-term care home placement.



Jack Sears – Patient Stories



My story: Mr C

Mr C

My admission

I was admitted to hospital following a fall and unfortunately fractured my hip and required surgery. Following my surgery, I was only able to stand up with the help of two staff and I was not able to walk. The hospital recommended I go to Jack Sears rehab unit to have intensive therapy to help me walk again. On the day I arrived, I was feeling very low in mood and tearful. My wife had recently been admitted to a care home due to her dementia and I missed her. I had not been able to visit her since before my fall. The staff in Jack Sears immediately arranged for me to speak with my wife by a video call. They also arranged to take me to visit her at the care home a couple of days later, even arranging flowers and a card to celebrate our anniversary. I felt that the staff understood what mattered to me and this helped me to feel more positive about my future.



My rehab

I was assessed by the therapy team, and they discussed what my goals were with me. I wanted to be able to walk with a frame and to be able manage the stairs to return home. The therapy team and the carers helped me to achieve this within a few weeks. They also took me home for a visit and to decide what equipment may help me at home. The team also discussed with me what help I may need at home initially and we agreed I would benefit from four carer visits a day initially and hopefully this would reduce as I settled, and my confidence increased.



My discharge

I returned home with my care package to support me and was also visited regularly by the community therapy team. I told them I wanted to be able to walk outside and be able to take a taxi to visit my wife. They gave me an outdoor walker to use and practised this with me. I was able to visit my wife within a week of returning home. My confidence increased and I was able to manage my personal care independently and no longer needed the care package. I now only have twice a week visits for cleaning and domestic help which I arranged myself. I am so happy with how I have improved. Everything in Jack Sears was amazing.



Jack Sears – Patient Stories



My story: Mr B



Mr B

My admission

I was admitted to hospital with a chest infection. I was very poorly and needed to stay in bed for several days. As I have Parkinson's disease my ability to walk declined very quickly and I was pleased to be able to come to Jack Sears to help me walk again.



My rehab

The physiotherapist came to see me and checked my chest as well as my mobility. I was given exercises to do which the carers helped me with. They also helped me to practise walking. I needed two people to help me stand up initially and I could only take a few steps. A dietician also came to see me as I had lost a lot of weight. My wife and I had a meeting with the team to plan for me returning home and what support I may need.



My discharge

I returned home after 10 days.. I was able to walk with a frame by myself and I could manage the stairs. The community team visited me to help with showering and I was soon able to manage this with just support from my wife. I am so grateful for my time at Jack Sears. I will always remember how caring the team were, particularly on my first night when I was anxious and a carer sat and talked with me to help me feel calm; I never felt alone. This was so important to me at that time.

Preparing for Care Quality Commission inspection of Adult Social Care

The CQC assessment of local authorities was reintroduced as part of the Health and Care Act 2022, after a break of 10 years. CQC has the responsibility to assess how well local authorities are meeting their duties under part one of the Care Act.

The CQC assessment is broken down into four themes with nine sub sections.

Theme 1: Working with people	Theme 2: Providing support	Theme 3: Ensuring safety	Theme 4: Leadership
• Assessing needs • Supporting people to live healthier lives • Equity in experiences and outcomes	• Care provision, integration and continuity • Partnerships and communities	• Safe systems, pathways and transitions • Safeguarding	• Governance, management and sustainability • Learning, improvement and innovation

As part of our preparations for an upcoming CQC assessment, there have been several activities undertaken:

- Completion of a self-assessment describing areas of good practice and areas which need improving
- Identification of 50 cases, of which CQC will randomly select eight to 10 to talk to about their experience of care and support provided.
- Evidence gathering for the information return, requested by CQC.
- Staff engagement sessions, sharing key information around the CQC assessment process, overview of key policies, reflection of good practice and open discussions in relation to what could be improved.
- Mock inspections of teams, giving staff an idea of what to expect, also highlighting team strengths and areas of improvement.

Along with our internal preparations, in June 2024 we took part in the [LGA peer review challenge](#)

Areas of Strength	Areas for Improvement
• Our new Section 75 agreement and our long-embedded integration of health and social care services. • The Partnership Boards also received praise and were described as very good. • Quality individualised care through the Multi-Disciplinary Team and people are kept safe and urgent issues responded to well. • Ambassadors were seen as a good example of giving local people a voice. • Case file audit – good practice around legal decision making, least restrictive practice and good person-centred practice.	• More work to do in relation to carers - communication and expectation management and explaining how different services interact with each other. • Improve staff awareness of priorities plans and strategies. • Direct payments are below the England average, processes not well understood or embedded in teams. • It was recommended that we should develop our Equality, Diversity and Inclusion work, and ensure its more visible across Council and Integrated Care Organisation (ICO).

With the areas of improvement and the recommendations given in the report an action plan was put into place, and work has commenced. The Peer Review Action Plan is reported on quarterly to the Adult Social Care and Health Overview and Scrutiny Sub-Board and its current progress can be viewed [here](#).



Healthwatch Devon, Plymouth and Torbay – Response to the TSDF Local Account Summary 2024/25

Healthwatch in Devon, Plymouth, and Torbay welcomes the publication of the Local Account Summary 2024/25 and appreciate the commitment of Torbay Council and the Integrated Care Organisation (ICO) to transparency, co-production, and service improvement.

Healthwatch is pleased to see that feedback from people using services, carers, and community partners has informed service developments over the past year. The increased focus on prevention, independence, and person-centred care is welcome, especially in light of rising demand and financial pressures.

We particularly commend the report's emphasis on "Amplifying people's voices" and "Improving feedback and embedding learning." The increased integration of service user and carer experiences, including video content, is a positive step towards truly person-centred care. The success of initiatives like the co-designed dementia carers' training programme and the "Amplifying People's Voices" engagement project with care home residents are excellent examples of co-production in action.

Our own Healthwatch report on unpaid carers further underscores the importance of collaboration, with carers' feedback actively shaping survey development and guiding conversations. This Carer feedback, collected through our joint engagement activities, has rightly shaped new initiatives such as co-designed dementia training and improved recognition of carers in service contacts. However, our engagement still shows that many carers face significant challenges, including inconsistent communication, limited access to respite, and lack of visibility of available support. We support the Council's commitment to improving these areas and call for measurable outcomes to ensure carers' experiences improve in practice.

We welcome the development of the Autism Partnership Board, and the way it is driven by voices of autistic people, their carers, professionals and local organisations. People with lived experience have been at the centre of strategy, events, and practical tools like the health passport. Similarly, the mental health service developments – particularly efforts to improve transitions, recovery-focused planning, and integration with community support – reflect what some people have shared with us about their needs and aspirations.

We also note the council's efforts to improve learning from complaints, and to embed service user feedback into quality assurance. We believe it's vital this learning is routinely shared with the public, to build trust and show how listening leads to change. This is echoed in a recent report into the NHS Complaint's process from our national partner Healthwatch England, which among other areas recommended the development of a culture of listening to and learning from complaints.

The progress in data-driven performance reporting, the reablement pilot's success in increasing independence, and the streamlining of access to adult social care services are commendable. We look forward to seeing the continued positive impact of these initiatives.

Finally, we applaud the emphasis on working with the voluntary sector and community partners to provide earlier support, especially through initiatives like the community hub and helpline. These routes often make a difference in preventing crisis, and we encourage further investment in this area.

Healthwatch remains committed to working collaboratively with Torbay Council and its partners to ensure that adult social care services continue to evolve, respond to community needs, and provide high-quality, person-centred care for all residents in Devon, Plymouth, and Torbay.

We look forward to continuing our work with the council, the ICO, and wider system partners to amplify people's voices and ensure services across Torbay remain responsive, accessible, and accountable.

Trust Board

Board Assurance Framework

Date of meeting	Date report produced
24 September 2025	16 September 2025

Author(s)		Report approved by	
Name and title:	Sarah Fox Corporate Governance Manager	Name and title:	Emily Long Director of Corporate Governance and Trust Secretary
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

n/a

Executive summary

Please find enclosed the Board Assurance Framework (BAF), BAF Highlight Report, Organisational Risk Map (ORM), and Datix Risk Register for the Board's review.

The Board Assurance Framework (BAF) is the key source of evidence to the Board that the Trust's 'mission critical' strategic objectives are being delivered, as well as analysing the risks, controls and assurances affecting each objective.

The Board has delegated detailed review of a number of risks to Board Sub-Committees.

During the course of July (Audit and Risk Committee) and August (Board development) the Board Assurance Framework and the corporate objectives were revised, introducing SMART supporting objectives. These objectives have been finalised during the month of September implemented for the Board meeting today (enclosed). It has not however been possible to take these through the Committee structure, as such, assurance ratings for the corporate and supporting objectives have been proposed by the Executive Committee for the Board's review and approval. In future, the supporting objectives will be recommended by the relevant Board sub-committee, with a recommendation made to Board as to the overarching corporate objective assurance rating.

In accordance with the Trust's Risk Management Policy and Strategy, the Board are also presented:

- the Organisational Risk Map (ORM) (providing oversight of the overarching risk position of the Trust, adjusted for inherent and residual risk); and
- a summary of the Datix Risk Register (Datix being the Trust's operational risk management system)

This facilitates the Board to review the Trust's overarching risk portfolio, and all risks scored high and very high each month. Six monthly the Board also receives the full Datix data set to ensure granular analysis of risk is undertaken by the Board.

The ORM and Datix Risk Register are 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. Together these tools evidence, to the Board, that the internal controls of the organisation are being maintained as well as reporting against strategic delivery.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
BAF Highlight Report	Satisfactory	n/a
BAF	Satisfactory	No change
Organisational Risk Map	Satisfactory	No change
Datix Summary Report	Satisfactory	No change

Appendices

Board Assurance Highlight Report
Board Assurance Framework
Organisational Risk Map
Datix Summary Report

Committees that have previously discussed/agreed the report, and outcomes of that discussion

Executive Committee

Key recommendations and actions requested

To receive and note the Board Assurance Framework, Organisational Risk Map and Datix Summary Report and AGREE the recommended assurance recommendations.

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	
Aim	Impact
Population Health and Wellbeing	Yes
Quality of services provided	Yes
Sustainable and efficient use of resources	Yes

Impact on BAF Objectives	
BAF Objective	Impact
Quality, Safety and Patient Experience	Yes
Leadership and Governance	
Performance	
People and Culture	
Strategy and Business Intelligence	
Finance	

Risk: Risk ID (as appropriate)	
Risk	Risk ID
N/a	

External Standards affected by this report and associated risks
Care Quality Commission NHS England licence and regulations National policy, guidance

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

BOARD ASSURANCE FRAMEWORK: HIGHLIGHT REPORT

Ref	Objective	Executive Lead	Overseeing Committee	Assurance rating*
Quality, Safety and Patient Experience				
1.	Corporate Objective: To deliver safe, effective, compassionate and affordable care that meets regulatory standards and provides high quality outcomes and experiences for people and their families.	CEO	Board	
1.1	Supporting Objective: By Q4 2025/26, demonstrate a 10% reduction in avoidable harm incidents (falls, pressure ulcers, medication errors) through improved use of safety huddles, early warning systems, and learning from incidents and mortality reviews across all clinical areas.	CNO	QAC	Satisfactory
1.2	Supporting Objective: Restore and sustain delivery of key operational performance standards through improved patient flow, real-time risk escalation, and full implementation of clinical harm stratification for long waits by October 2025, ensuring timely access to care and minimising harm.	CNO	QAC	Satisfactory
1.3	Supporting Objective: By December 2025, deliver targeted prevention and early intervention programmes achieving a 10% improvement in access to screening, health promotion, or support for long-term conditions.	CNO	QAC	Limited
1.4	Supporting Objective: By December 2025, ensure that 100% of service areas have implemented and are routinely using real-time patient feedback mechanisms, with action plans in place for services scoring below 85% in FFT or local experience measures.	CNO	QAC	Limited
1.5	Supporting Objective: By March 2026, maintain ≥95% compliance with all core patient safety and quality standards while delivering services within the agreed annual financial budget, through monthly performance monitoring, targeted improvement actions, and quarterly Board assurance reporting.	CNO	QAC	Satisfactory
1.6	Supporting Objective: By March 2026, deliver a trust-wide IPC improvement programme that embeds evidence-based practices in 100% of clinical areas, achieves ≥95% compliance in monthly IPC audits, provides targeted training to 100% of frontline staff, and ensures all identified infection risks are escalated and acted upon within 24 hours, with monthly assurance reports to the Board through the IPQR.	CNO	QAC	Limited
1.7	Supporting Objective: By March 2026, ensure that 95% or more of women and birthing people receive personalised care plans; achieve and maintain 100% compliance with all statutory and regulatory maternity safety requirements; reduce the rate of avoidable maternity harm events (as measured by the NHS Maternity Incentive Scheme) by at least 10% from the 2024 baseline; and demonstrate improvement in maternity experience scores in the national Maternity Survey.	CNO	QAC	Satisfactory

Leadership and Governance					
2.		Corporate Objective: To create, maintain and nurture an inclusive, Board led, culture which is aligned to our values and our strategy - where everyone acts with integrity and leads by example.	CEO	Board	
	2.1	Supporting Objective: Development programmes for the Board and Executive team in place and ongoing- aligned with IIP(integrated improvement plan) delivery milestones.	CPO	People	Satisfactory
	2.2	Supporting Objective: Develop a strong executive team with clear accountabilities and objectives- aligned with IIP delivery milestones.	CEO	Nomination & Remuneration	Satisfactory
	2.3	Supporting Objective: Robust governance processes and assurance embedded across the organisation - aligned with IIP delivery milestones.	DCG	Audit	Satisfactory
	2.4	Supporting Objective: Engage the workforce to manage the significant change agenda ensuring people management approaches and policies that are underpinned by the compassionate leadership approach - aligned with IIP delivery milestones.	CPO	People	Satisfactory
Performance					
3		Corporate Objective: Deliver the 2025/26 plan, including finance, quality, operational performance and workforce objectives	CEO	Board	
	3.1	Supporting Objective: To deliver levels of performance that meet the trajectories outlined in the Trust operating plan for 25/26 in line with the exit criteria for National Oversight Framework Level 4.	COO	FPC	Limited
	3.2	Supporting Objective: To manage the fire risk within the estate (for example 'the tower') through a programme of capital and estates works, in addition to robust training and exercising for specific staff groups.	COO	BBF	Limited
	3.3	Supporting Objective: To mitigate critical estate risks through the deployment of the Trust estate strategy and capital programmes, to meet the needs of local people.	COO	BBF	Satisfactory
	3.4	Supporting Objective: Develop a full understanding of the current contract and cost of delivery of adult social care; including health, to ensure the services can be provided within the funding received. When this understanding is obtained, identify core demand and capacity available to reach trajectories for TSD against the nationally recognised KPIs.	CSPO	FPC	Limited
	3.5	Supporting Objective: CFHD service delivered by a single employer safely in a more cost-effective way ensuring safety of children and families and quality of service delivered is maintained throughout transfer of staff and financial detriment to TSD is mitigated and minimised where possible.	CSPO	FPC	Satisfactory

	3.6	Supporting Objective: To deliver on our plans and commitments to environmental sustainability and decarbonisation, as set out in the Trust Green Plan.	COO	FPC	Limited
People and Culture					
4		Corporate Objective: To Develop a people strategy aligned to the Trust's long-term vision, priorities and values, which delivers a workforce plan that ensures the right workforce is in place and that fosters a positive, inclusive culture with high levels of staff engagement to support improved patient outcomes.	CEO	Board	
	4.1	Supporting Objective: Develop and deliver a sustainable, workforce strategy and plan that delivers an efficient, agile, skilled and high performing workforce aligned to system and organisational priorities.	CPO	People	Satisfactory
	4.2	Supporting Objective: To develop and implement a culture plan that ensures our people feel valued and supported and that embeds the principles of the people promise.	CPO	People	Satisfactory
	4.3	Supporting Objective: To build a high-performing, forward-thinking and values driven People and Education Directorate, with the right capacity, skills, systems, and leadership to enable the organisation to deliver its strategic people priorities, meet regulatory expectations, and drive long-term workforce sustainability.	CPO	People	Satisfactory
	4.4	Supporting Objective: To implement the 10 Point Plan to improve resident doctors' working lives, as required by NHSE. The plan sets out clear expectations for NHS England and providers, with a 12-week delivery window for initial actions and further milestones extending into 2026	CMO/CPO	People	Satisfactory
Strategy and Business Intelligence					
5		Corporate Objective: Develop and deliver a clear strategic vision for the Trust	CEO	Board	
	5.1	Supporting Objective: Full definition and resourcing of Our Plan for Better Care is in place; alongside the phases of delivery contained therein.	CSPO	BBF	Satisfactory
	5.2	Supporting Objective: To engage with key stakeholders, internally and externally in the development of our strategy – ensuring clinical and non-clinical workforce engagement.	CSPO	People	Satisfactory
	5.3	Supporting Objective: Strategic alignment for medium-to-long-term transformation designed, with the 10 year plan principles being used as the basis for the strategy.	CSPO	BBF	Satisfactory
	5.3	Supporting Objective: To work with stakeholders to deliver services in our community where it is both sustainable for our Trust and we are best placed to do so, supporting the population we serve to live well; one of the pillars of the strategy will be integrated neighbourhood teams which will provide proactive, joined up care in the communities in which people live.	CSPO	QAC	Satisfactory

	5.4	Supporting Objective: To support initiatives and work collaboratively with stakeholders and our NHS provider colleagues to deliver services that meet the needs of those living in the Peninsula now and in the future; for example: the OneDevon initiatives and PASP workstreams	CSPO	QAC	Satisfactory
	5.5	Supporting Objective: Campaigning for, and bringing in resources for, the Trust, especially capital funding post New Hospital Programme decisions consistent and opportunistic briefing and bidding being undertaken.	CSPO	BBF	Satisfactory
	5.6	Supporting Objective: To provide a resilient digital infrastructure, that underpins the delivery of clinical and corporate services. To implement the electronic patient record (EPR), improving operational, clinical and resourcing productivity and quality.	CSPO	BBF	Limited
	5.7	Supporting Objective Create and cultivate a culture of innovation through research and development and digital futures, establishing centres of excellence for research and innovation; increasing the quality of our services, our productivity and attracting high quality people	CSPO	QAC	Satisfactory
Finance					
6		Corporate objective: Providing a fit for purpose environment, where our people have the conditions to succeed and deliver excellent patient care.	CEO	Board	
	6.1	Supporting Objective: By March 2026 to have developed and agreed a medium term financial plan that gets the Trust to a breakeven position within the planning period through productivity and efficiency improvements and service transformation.	CFO	FPC	Satisfactory
	6.2	Supporting Objective: By March 2026 to have delivered the planned forecast outturn deficit (£8m) and to have improved the exit underlying financial position through delivery of recurrent cost improvement	CFO	FPC	Limited
	6.3	Supporting Objective: To assess and cultivate opportunities to deliver services across the Devon ICS as "One Devon" and Peninsula; exploring innovative operating models where appropriate.	COO	FPC	Limited

* Assurance rating from Board papers to be used

BOARD ASSURANCE FRAMEWORK 2025/26

BUILDING A
**Brighter
future**
improving health & care
in Torbay & South Devon

Our People
AT THEIR BEST



Strategic context:

The Board Assurance Framework (“BAF”) is an important assurance mechanism which assesses the delivery of the Trust’s strategic objectives. The BAF is complementary to and should be read in conjunction with the Trust’s risk reporting.

The Datix Risk Register risk register assesses and categorises operational risks logged in the Trust’s risk management system (Datix), whereas the Organisational Risk Map (ORM) analyses the output from the DRR, the inherent risk held by the Trust and describes the residual risk held by the organisation; having applied appropriate mitigation measures and noting variation from the desired risk position described within the Trust’s Risk Management Strategy & Policy.

Together these documents are the primary source of information and assurance to the Board of Directors as to the Trust’s strategic delivery and the risk portfolio held month on month.

Methodology:

The BAF is structured around Corporate Objectives (which are high level and aspirational) and Supporting Objectives (which outline specific actions to be taken). These objectives are aligned to the Trust’s strategy, its operational plan for the year and the Chief Executive Officer’s objectives – ensuring focussed strategic delivery.

Monitoring of Supporting Objective delivery is allocated to Board Sub-Committees, whilst the Board hold responsibility for monitoring of the delivery of the Corporate Objectives. An assessment of assurance of delivery is made against each Corporate and Supporting Objective, monthly. The assessment rating follows that used for Board papers (NO- LIMITED- SATISFACTORY- SIGNIFICANT), detail can be found in **Appendix 1**.

Supporting Objectives: Allocated to an Executive lead and Board Sub-Committee. The Executive lead is responsible for day to day oversight and completion of the BAF assessment documentation for Board Sub-Committee review. The Committee will note, review and challenge the assessment made by the relevant Executive as to whether the objective is being delivered on trajectory and the level of assurance they can take in that regard.

In completing the assessment and making a recommendation to the Board Sub-Committee, the Executive lead shall provide supporting narrative, detail aggravating and mitigating risk factors, as well as overseeing delivery of associated actions where gaps arise; within the timescale articulated. In doing so, they must also have regard to the Trust’s Risk Management Policy & Strategy, 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.

Corporate Objectives: Allocated to the Chief Executive (who will oversee these with the Executive Committee) and the Board. The Board will receive the completed BAF highlight report in their Board pack (template included as **Appendix 2**) and all completed Supporting Objective assessments; made available to them in a separate information pack. The Chief Executive, supported by the Executive Committee, will recommend an assurance rating for each Corporate Objective, for the Board to review and approve. This assessment will be based upon the assurance assessment confirmed by the relevant Board Sub-Committee as well as all other information available; such as the risk reporting and performance reporting.

SUPPORTING OBJECTIVE: By Q4 2025/26, demonstrate a 10% reduction in avoidable harm incidents (falls, pressure ulcers, medication errors) through improved use of safety huddles, early warning systems, and learning from incidents and mortality reviews across all clinical areas.		
OVERARCHING CORPORATE OBJECTIVE: To deliver safe, effective, compassionate and affordable care that meets regulatory standards and provides high quality outcomes and experiences for people and their families.		
Executive lead: Chief Nursing Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: Satisfactory (August 2025)
Overarching Comment & Rational for Assessment (Summary):		
Progress is being made towards reducing avoidable harm, with safety huddles, early warning systems, and strengthened incident and mortality review processes increasingly embedded across clinical areas. Evidence shows early improvement in falls and pressure ulcer prevention, but variation in practice and slower progress in medication safety limit full assurance at this stage. Continued leadership focus, consistent application of learning, and strengthened feedback loops are required to achieve the 10% reduction target by Q4 2025/26		
Risk to delivery:		
Aggravating factors: (Described below) • Workforce vacancies • High patient acuity and increased frailty seeing a rise in demand and baseline of risks	Mitigating factors: (Described below) • Daily safety huddles • Established early warning scores and risk assessments • Incident date reported and monitored by clinical governance teams • Leadership and safety walk arounds	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) • Inconsistent adoption of safety huddles across some areas • Medication safety programme not fully embedded and limited digital prescribing • Limited triangulation of data across harm events
Three lines of defence:		
First Line of Defence - Operational and Management Controls 1. Safety Huddles 2. Clinical leadership and Matron Audits 3. Education, training and competency assessments in falls, pressure ulcer prevention and medication safety 4. Incident reporting	Second Line of Defence - Oversight Functions and Internal Assurance 1. Patient Safety and Quality teams monitoring incident trends and learning form review and leading QI programmes 2. Divisional and Corporate Governance structure (SQAG/QAC/Risk Group) 3. Mortality review group providing structured learning and escalation of themes 4. Nursing and Medical leadership oversight through quality dashboard/IPR 5. Internal reporting to QAC and FPC via IPR	Third Line of Defence - External Assurance: 1. Internl/external audit review of patient safety themes 2. External regulatory assessment (CQC, NHSE, peer reviews) 3. Benchmarking against national data (Model Hospital) 4. Board level scrutiny via Audit Committee and Trust Board

SUPPORTING OBJECTIVE: Restore and sustain delivery of key operational performance standards through improved patient flow, real-time risk escalation, and full implementation of clinical harm stratification for long waits by October 2025, ensuring timely access to care and minimising harm.		
OVERARCHING CORPORATE OBJECTIVE: To deliver safe, effective, compassionate and affordable care that meets regulatory standards and provides high quality outcomes and experiences for people and their families.		
Executive lead: Chief Nursing Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: Limited (August 2025)
Overarching comment & rationale for assessment: The organisation is actively restoring and sustaining operational performance standards through strengthened patient flow processes, real-time risk escalation, and implementation of clinical harm stratification for long waits. Early evidence indicates improved identification and prioritisation of patients at risk of harm, but pressures on capacity and variability across divisions limit full assurance of timely access in all areas. Continued focus on escalation, monitoring, and multidisciplinary coordination is essential to achieve the October 2025 target and minimise harm associated with delayed care.		
Risk to delivery:		
Aggravating factors: <i>(Described below)</i> • Workforce shortages and reliance on temporary staff • High patient demand and seasonal surges • Backlog in elective and urgent care increasing risk of harm from delays	Mitigating factors: <i>(Described below)</i> • Daily operational huddles and escalation protocols • Executive oversight through Site Management and Executive Operations Group (EOG) • Quality Governance monitoring including focus on harm from long waits • Targeted initiatives to improve discharge planning and flow (right care week)	Gaps in control & associated actions: <i>(Described below- actions must be allocated a timescale for delivery)</i> • Limited assurance on the impact of operational improvements on long wait harm outcomes • Need for stronger cross care group coordination to manage peaks in demand • Data reporting and validation processes require enhancement to provide real time assurance
Three lines of defence:		
First Line of Defence - Operational and Management Controls 1. Frontline operational teams managing patient flow to meet performance standards 2. Clinical teams implementing harm stratification for long waiting patients and escalating risks 3. Local ward leadership monitoring performance and addressing bottlenecks 4. Daily ward huddles and twice daily board rounds	Second Line of Defence - Oversight Functions and Internal Assurance 1. 3 times a day Safety and Flow meetings 2. Risk escalation committees ensuring long wait patients with potential harm are prioritised 3. Regular reporting to the Executive Committee and QAC 4. CMO and CNO leadership	Third Line of Defence - External Assurance: 1. Internal audit reviewing operational processes 2. External regulatory (CQC/NHS) assessing access standards and safety of long waits 3. Independent harm reviews associated with delayed care 4. Benchmarking against national standards for waiting times and elective and urgent care 5. Board level scrutiny via Audit committee

SUPPORTING OBJECTIVE: By December 2025, deliver targeted prevention and early intervention programmes achieving a 10% improvement in access to screening, health promotion, or support for long-term conditions.		
OVERARCHING CORPORATE OBJECTIVE: To deliver safe, effective, compassionate and affordable care that meets regulatory standards and provides high quality outcomes and experiences for people and their families.		
Executive lead: Chief Nursing Officer	Board oversight Committee: Quality Assurance Committee	
Current assessment: Limited (September 2025)	Previous assessment: Limited (August 2025)	
Overarching comment & rationale for assessment:		
Targeted prevention and early intervention programmes are improving access to screening, health promotion, and long-term condition support, with early evidence of positive uptake. However, variation across communities and capacity constraints limit full assurance of achieving the 10% improvement by December 2025. Continued oversight, targeted outreach, and robust monitoring are essential to maximise impact and reduce inequalities.		
Risk to delivery:		
Aggravating factors: (Described below) - Socioeconomic and geographic inequalities impacting access and engagement. - Workforce shortages in public health, and health promotion teams. - Competing operational pressures reducing capacity to deliver targeted programmes. - Limited awareness among patients and communities about available prevention and early intervention services. - Variation in digital access or literacy affecting uptake of online or remote services.	Mitigating factors: (Described below) - Targeted community outreach and engagement strategies to improve access. - Established programmes for screening, vaccination, and long-term condition support. - Monitoring and reporting of uptake metrics to identify gaps and areas for improvement. - Partnership working with primary care, local authorities, and community voluntary organisations. - Health promotion campaigns tailored to high-risk populations. - Executive CMO/CNO oversight through Public Health and Population Health Governance structures.	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) - Inconsistent data collection and validation across all programmes and communities. - Limited assurance on the effectiveness of interventions in reducing health inequalities. - Variation in programme delivery and intensity between geographic areas. - Lack of robust benchmarking against national or regional performance targets. - Need for stronger mechanisms to track long-term outcomes from early intervention.
Three lines of defence:		
First Line of Defence - Operational and Management Controls - Frontline public health and community teams delivering screening, health promotion, and early intervention services. - Local leadership monitoring programme uptake and outreach activities. - Patient engagement, education, and proactive risk identification in primary and community care.	Second Line of Defence - Oversight Functions and Internal Assurance - Population Health / Public Health teams providing oversight, reporting, and quality assurance. - Regional leadership reviewing programme performance and equitable access. - Executive oversight via quality and performance dashboards to the Board.	Third Line of Defence - External Assurance: - Internal Audit of prevention and early intervention programme delivery and effectiveness. - External review from regulators or national bodies assessing public health programme outcomes. - Benchmarking against national screening and long-term condition management standards.

		4. Board-level scrutiny through Audit or Quality Committees.

SUPPORTING OBJECTIVE: By December 2025, ensure that 100% of service areas have implemented and are routinely using real-time patient feedback mechanisms, with action plans in place for services scoring below 85% in FFT or local experience measures.		
OVERARCHING CORPORATE OBJECTIVE: To deliver safe, effective, compassionate and affordable care that meets regulatory standards and provides high quality outcomes and experiences for people and their families.		
Executive lead: Chief Nursing Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Limited (September 2025)		Previous assessment: Limited (August 2025)
Overarching comment & rationale for assessment: Real-time patient feedback mechanisms are increasingly embedded across services, with most areas now collecting and reporting results. However, variation in consistent use and action planning for low-scoring services limits assurance that patient experience improvements are fully realised. Focus on closing gaps in implementation, strengthening action plans, and improving visibility of “you said, we did” outcomes is critical to achieving the December 2025 target		
Risk to delivery:		
Aggravating factors: <i>(Described below)</i> - Variation in staff engagement with feedback systems across service areas. - Digital and infrastructure limitations in some clinical environments. - Workforce pressures reducing capacity to prioritise feedback collection and follow-up. - Risk of patient and carer survey fatigue leading to lower response rates. - Inconsistent visibility of “you said, we did” actions limiting patient trust in feedback processes. - Vacancies in the Patient Experience team and no dedicated Patient Engagement Lead - Service-level dashboards tracking performance against the 85% threshold not routinely recorded	Mitigating factors: <i>(Described below)</i> - Real-time patient feedback mechanisms deployed in most service areas. - Friends and Family Test (FFT) and local measures mostly monitored. - Patient Experience Team providing central support, training, and oversight where able - Escalation to Deputy CNO where patient experience scores fall below threshold. - Governance oversight through Quality & Safety Committee and Patient Experience Groups	Gaps in control & associated actions: <i>(Described below- actions must be allocated a timescale for delivery)</i> - Not all services are consistently applying real-time feedback mechanisms. - Variable quality and timeliness of action planning for services below 85%. - Insufficient evidence of feedback driving measurable service improvement in all areas. - Data triangulation with complaints, compliments, and incidents not fully embedded. - Limited external benchmarking of patient experience performance.
Three lines of defence:		
First Line of Defence - Operational and Management Controls - Service teams collecting and responding to real-time patient feedback. - Local leadership monitoring FFT and patient experience scores. - Ward and clinic managers accountable for action plans in low-scoring areas.	Second Line of Defence - Oversight Functions and Internal Assurance - Patient Experience Team providing oversight, training, and assurance on implementation. - Divisional governance and performance reviews monitoring patient experience outcomes. - Quality dashboards and reporting to Quality & Safety Committee.	Third Line of Defence - External Assurance: - Internal Audit review of patient experience systems and processes. - External regulators (CQC, Healthwatch) assessing patient experience and feedback responsiveness. - Independent patient surveys and peer benchmarking of FFT/local experience scores. - Board scrutiny via Audit Committee and full Board reporting.

SUPPORTING OBJECTIVE: By March 2026, maintain ≥95% compliance with all core patient safety and quality standards while delivering services within the agreed annual financial budget, through monthly performance monitoring, targeted improvement actions, and quarterly Board assurance reporting.		
OVERARCHING CORPORATE OBJECTIVE: To deliver safe, effective, compassionate and affordable care that meets regulatory standards and provides high quality outcomes and experiences for people and their families.		
Executive lead: Chief Nursing Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: Satisfactory (August 2025)
Overarching comment & rationale for assessment: The organisation is sustaining high levels of compliance with core patient safety and quality standards while delivering within the agreed deficit budget. Operational pressures and resource constraints present risks, but monthly monitoring, targeted improvement actions, and robust Board oversight provide assurance that ≥95% compliance can be maintained by March 2026. Continued integration of quality, safety, and financial performance monitoring is essential to mitigate emerging risks.		
Risk to delivery:		
Aggravating factors: • Workforce pressures impacting ability to sustain safe staffing and quality standards. • High demand and complexity of patient care increasing risk of breaches in safety and quality metrics. • Persistent financial pressures • Operational disruption or service redesigns impacting compliance or efficiency. • Variability in implementation of quality standards across some service areas.	Mitigating factors: • Targeted improvement actions and escalation for areas below standard. • Monthly performance monitoring and reporting of core safety, quality, and financial metrics • Board assurance through quarterly reporting on performance and quality compliance. • Financial controls, budget monitoring, and forecasting to ensure delivery within agreed annual budget. • Executive oversight and corporate governance structures to identify and manage emerging risks. • Use of audit and regulatory review to provide independent assurance.	Gaps in control & associated actions: <i>(Described below- actions must be allocated a timescale for delivery)</i> • Partial assurance in some service areas where compliance monitoring is less consistent. • Reliance on timely data submission and reporting; delays may limit real-time corrective action. • Limited triangulation of quality, safety, and financial data to identify cross-cutting risks. • External benchmarking against peer organisations or national standards could be strengthened. • Contingency plans for emerging operational or financial pressures not fully tested.
Three lines of defence:		
First Line of Defence - Operational and Management Controls • Service teams ensuring day-to-day compliance with patient safety and quality standards. • Local leadership monitoring performance and initiating corrective actions. • Operational budget managers ensuring adherence to financial limits.	Second Line of Defence - Oversight Functions and Internal Assurance • Corporate Performance and Quality Teams providing monitoring, analysis, and escalation support. • Executive leadership reviewing monthly performance and financial reports. • Quality Governance Committees and Finance & Performance Committee providing oversight.	Third Line of Defence - External Assurance: • Internal Audit reviewing compliance with safety, quality, and financial standards. • External regulators (CQC, NHS England/Improvement) assessing performance and compliance. • Benchmarking against peer organisations for quality and financial performance. • Board-level scrutiny through Audit Committee and quarterly reporting.

SUPPORTING OBJECTIVE: By March 2026, deliver a trust-wide IPC improvement programme that embeds evidence-based practices in 100% of clinical areas, achieves ≥95% compliance in monthly IPC audits, provides targeted training to 100% of frontline staff, and ensures all identified infection risks are escalated and acted upon within 24 hours, with monthly assurance reports to the Board through the IPQR.		
OVERARCHING CORPORATE OBJECTIVE: To deliver safe, effective, compassionate and affordable care that meets regulatory standards and provides high quality outcomes and experiences for people and their families.		
Executive lead: Chief Nursing Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Limited (September 2025)		Previous assessment: Limited (August 2025)
Overarching comment & rationale for assessment: The trust-wide IPC improvement programme is embedding evidence-based practices, achieving high audit compliance, and delivering targeted frontline staff training. While progress is strong, some variability across clinical areas and operational pressures present residual risk. Continued monitoring, timely escalation, and monthly Board assurance through IPQR are essential to maintain ≥95% compliance and ensure all infection risks are effectively managed by March 2026.		
Risk to delivery:		
Aggravating factors: - High patient acuity and operational pressures increasing infection risk. - Workforce pressures, including temporary staffing, may affect adherence to IPC protocols. - Variation in audit compliance across clinical areas. - Potential gaps in rapid escalation and response in complex or high-pressure areas. - Emerging infectious threats or seasonal pressures increasing IPC demands.	Mitigating factors: <i>(Described below)</i> - Trust-wide IPC improvement programme with clear objectives and monitoring. - Monthly IPC audits with ≥95% compliance targets. - Mandatory targeted training for all frontline staff, supported by IPC team. - Robust escalation process for identified infection risks with 24-hour action requirement. - Governance and oversight through the newly developed IPC Committee and monthly IPQR reporting to the Board. - Alignment with national IPC guidance and regulatory requirements (CQC, NHS England).	Gaps in control & associated actions: - Variability in compliance across some clinical areas and staff groups. - Partial assurance on the sustainability of improvements in high-pressure areas. - Limited triangulation with incident, outbreak, or infection data to provide full assurance. - Need to ensure 100% staff training completion and knowledge retention. - External benchmarking and peer comparison of IPC performance could be strengthened.
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- Clinical teams implementing IPC practices daily and completing audits. - Ward/department managers monitoring compliance and escalating issues. - Frontline staff completing targeted IPC training and following protocols.	- IPC team monitoring audit results, providing support, and tracking training completion. - Divisional and corporate oversight ensuring compliance and escalation processes. - Monthly IPQR reports providing structured assurance to Executive Team and Board	- Internal Audit reviewing IPC programme delivery, audits, and risk escalation. - External regulatory inspections (CQC, NHS England) assessing IPC compliance. - Benchmarking against national IPC standards and peer organisations. - Board-level scrutiny through IPQR and Audit Committee review.

SUPPORTING OBJECTIVE: By March 2026, ensure that 95% or more of women and birthing people receive personalised care plans; achieve and maintain 100% compliance with all statutory and regulatory maternity safety requirements; reduce the rate of avoidable maternity harm events (as measured by the NHS Maternity Incentive Scheme) by at least 10% from the 2024 baseline; and demonstrate improvement in maternity experience scores in the national Maternity Survey.		
OVERARCHING CORPORATE OBJECTIVE: To deliver safe, effective, compassionate and affordable care that meets regulatory standards and provides high quality outcomes and experiences for people and their families.		
Executive lead: Chief Nursing Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: Satisfactory (August 2025)
Overarching comment & rationale for assessment: Maternity services are improving personalised care, safety compliance, and patient experience, with early evidence of reduced harm and positive trends in survey feedback. . Continued monitoring, standardisation of care plans, and targeted improvement actions are essential to achieve ≥95% personalised care, full safety compliance, and a ≥10% reduction in avoidable harm by March 2026.		
Risk to delivery:		
Aggravating factors: • Workforce shortages, particularly obstetric staff, impacting continuity of care • High acuity and complex maternity cases increasing risk of harm events. • Competing operational priorities potentially impacting timely action on safety alerts and improvement initiatives. • Limited data triangulation between harm events, audits, and patient experience feedback.	Mitigating factors: • Governance and oversight via Maternity Safety Champions, Maternity Governance Group, and Board reporting. • Implementation and monitoring of personalised care plans across all maternity services. • Statutory and regulatory compliance tracked monthly with clear escalation pathways. • NHS Maternity Incentive Scheme reporting and action planning to reduce avoidable harm. • Staff training, competency assessments, and continuous professional development programmes. • Patient experience feedback via national survey and local feedback mechanisms to inform improvement. • Maternity Improvement Advisor on site to support	Gaps in control & associated actions: • Inconsistent delivery of personalised care plans • Variation in compliance monitoring and timely response to safety alerts. • Partial assurance on sustained reduction in avoidable harm events across all units. • Limited triangulation between harm reduction, compliance, and patient experience metrics. • Benchmarking against peer organisations could be strengthened to provide external assurance.
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
• Maternity clinical teams delivering personalised care plans and adhering to safety protocols. • Ward/department managers monitoring daily compliance and initiating improvement actions.	• Maternity Governance Group and Safety Champions monitoring compliance, harm events, and experience metrics. • Care Group leadership reviewing performance dashboards and overseeing corrective actions.	• Internal Audit reviewing maternity compliance, harm reduction initiatives, and patient experience processes. • External regulatory review (CQC, NHS England) assessing safety, compliance, and patient experience.

• Staff completing mandatory training and participating in continuous professional development.	• Executive oversight through Quality & Safety Committee and Board reporting.	• NHS Maternity Incentive Scheme reporting and benchmarking against national standards. • Board-level scrutiny via Audit and Quality Committees.

SUPPORTING OBJECTIVE: Development programmes for the Board and Executive team in place and ongoing- aligned with IIP (integrated improvement plan) delivery milestones.		
OVERARCHING CORPORATE OBJECTIVE: To create, maintain and nurture an inclusive, Board led, culture which is aligned to our values and our strategy - where everyone acts with integrity and leads by example.		
Executive lead: Chief People Officer		Board oversight Committee: People Committee
Current assessment: SATISFACTORY September 2025		Previous assessment: N/A August 2025
Overarching comment & rationale for assessment: The workstream is deemed in month (September 2025) as green status – ‘assured’ as all KPIs are on track and, whilst one deliverable is 1 month behind the original plan, this is being recovered and does not materially impact on workstream delivery. The final review of the Executive portfolio organagram has been approved and published on the Trust intranet to support wider organisational awareness. In addition to the Executive development sessions, the rhythm for the Executive huddles is now complete with a deep dive planner established and populated The CSPO was successfully appointed to in September 2025. Interim CFO and Acting CPO are in post-up to March 2026 pending recruitment processes commencing for substantive recruitment. The Communication plan for Our Plan for Better Care has been developed and is being implemented as part of the wider organisational communication approach. The target for the Board engagement KPI has been updated upon request on the oversight group, to reflect a rolling 12-month position. The workstream lead has been confirmed as Emily Long.		
Risk to delivery:		
Aggravating factors: (Described below) • Delay in programme of development • Completing priorities / capacity to invest in people • Resistance to new ways of working • Recruitment to substantive executive positions • Tension between organisational focus and system priorities • Potential for organisational changes / changes to group model • RSP resource and support is withdrawn • Conflict and division between board members	Mitigating factors: (Described below) • Resource mapping and alignment to other workstreams to avoid duplication. Assessment of gaps in resource and consideration of RSP support • Clear change management processes and communication with staff and stakeholders • Revisit substantive recruitment in October 25 • Oversight and priorities reviews at Executive Committee • Alignment of workstreams to mitigate any unintentional consequence and oversight at Exec Committee • Reprioritising work plan by Executive Committee • Individual and group communication and engagement	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) • Board and leadership effectiveness rating – survey and 360 feedback in plans
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:

Monthly flash report and progress made against KPI's	Oversight Group Board	NHSE RSP CQC

SUPPORTING OBJECTIVE: Develop a strong executive team with clear accountabilities and objectives- aligned with IIP delivery milestones.		
OVERARCHING CORPORATE OBJECTIVE: To create, maintain and nurture an inclusive, Board led, culture which is aligned to our values and our strategy - where everyone acts with integrity and leads by example.		
Executive lead: Chief Executive		Board oversight Committee: Nomination and Remuneration Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: N/A (August 2025)
Overarching comment & rationale for assessment: A strong, cohesive executive team with clearly defined accountabilities is essential to the effective delivery of organisational objectives and the management of strategic risk. This objective ensures that executive responsibilities are unambiguous, measurable, and aligned to agreed corporate priorities and the 'Our Plan' IIP delivery milestones. Clear accountability supports robust performance monitoring, strengthens governance arrangements, and provides assurance to the Board that leadership capacity and capability are in place to deliver the organisation's strategic plan. Through this objective, the Board can take assurance that executive leadership arrangements are fit for purpose, risks to delivery are being actively managed, and the organisation remains on track to achieve both regulatory requirements and improvement priorities		
Risk to delivery:		
Aggravating factors: (Described below) A number of changes in the Executive team in recent years impacts on cohesive and stable leadership or perception thereof.	Mitigating factors: (Described below) - Executive Development days – Team development using established and recognised methodologies- Meeting dates arranged for this financial year - Executive huddles allowing team deep dives into planned and emerging strategic and operational topics. Meetings planned for the next quarter - Alignment and mapping of individual personal objectives to the CEO objectives completed. - Planning underway for 6 month achievement reviews and initiation of 360 reviews for the Executive team - Interim CFO and Acting CPO in post until March 2026 to allow organisational and departmental stability - Recruitment to substantive posts planned to commence Oct / Nov 2025	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) Current gaps in substantive posts

Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
Chief Executive oversight	- Integrated improvement plan and oversight of delivery with regular check and challenge in place - Insightful Board self-assessment (due October 2025)	- RSP oversight - Internal audit oversight - Well led review (2025)

SUPPORTING OBJECTIVE: Robust governance processes and assurance embedded across the organisation - aligned with IIP delivery milestones.		
OVERARCHING CORPORATE OBJECTIVE: To create, maintain and nurture an inclusive, Board led, culture which is aligned to our values and our strategy - where everyone acts with integrity and leads by example		
Executive lead: Director of Corporate Governance		Board oversight Committee: Audit and Risk Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: N/A (August 2025)
Overarching comment & rationale for assessment: Whilst it is recognised that there is still much to do in this area, there is a clear plan and delivery is on track. Following the output of the Well Led review, the Trust is now focussing on delivery of the recommendations (as aligned to the Integrated Improvement Plan). Within the Board papers for today's meeting, the proposed steps to action this and how the Board will be collaboratively involved in the shaping and implementing the action of these recommendations is outlined in the paper.		
Risk to delivery:		
Aggravating factors: <i>(Described below)</i> - Significant and competing priorities for delivery could delay the improvement workstream. - It is recognised additional resource will be required to drive improvements in risk management across the organisation including review of all risks and refreshing risk training for the wider organisation. This has been actioned with interim resource starting work week commencing 15 September 2025.	Mitigating factors: <i>(Described below)</i> - Regular reporting to Board and Audit Committee, liaising with HOIA and RSP colleagues to ensure all stakeholders are sighted. - A Governance Delivery Group has been convened with key stakeholders from the governance team and wider personnel to progress the workstream deliverables and improve oversight of governance delivery and improvement moving forward. - The deep dives on risk and NED perceptions of risk are laying the groundwork for revised governance infrastructure (changes to policy and meetings), noting the aforementioned. - The BAF has been reshaped to increase granularity of reporting with SMART objectives. This was socialised as a mechanism for internal control with the Audit Chair and then presented and agreed at the Audit Committee in July and subsequently reviewed at Board development in August 2025. - The first IQPR Improvement Task & Finish Group was held in July to socialise the need for change with key stakeholders, with weekly meetings now planned to give pace to needed improvements. Balanced scorecards have been well developed with testing took place at Executive Operational Groups on 12th August.	Gaps in control & associated actions: <i>(Described below- actions must be allocated a timescale for delivery)</i> Whilst there are no significant notable gaps in control at this time, the detail of the improvements required are articulated through the IIP and Well Led report.

Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
Governance delivery group	- Integrated improvement plan and oversight of delivery with regular check and challenge in place - Insightful Board self-assessment (due October 2025)	- RSP oversight - Internal audit oversight - External audit oversight - Well led review (2025) - Independent review (2024)

SUPPORTING OBJECTIVE: Engage the workforce to manage the significant change agenda ensuring people management approaches and policies that are underpinned by the compassionate leadership approach - aligned with IIP delivery milestones.		
OVERARCHING CORPORATE OBJECTIVE: To create, maintain and nurture an inclusive, Board led, culture which is aligned to our values and our strategy - where everyone acts with integrity and leads by example		
Executive lead: Chief People Officer		Board oversight Committee: People Committee
Current assessment: SATISFACTORY September 2025		Previous assessment: n/a August 2025
Overarching comment & rationale for assessment: Aligned supporting objective - 'To develop and implement a culture plan that ensures our people feel valued and supported and that embeds the principles of the people promise.' Our ambition is that we will embed a supportive and inclusive culture that is truly felt by our people and that will enable our people to deliver high quality care to our patients and community. Incidents, our survey data and staff engagement demonstrate the need for our culture plan to be clear, visible and central to our delivery of Trust Strategy and ensure the culture of our organisation is one that aligns to our shared values and beliefs. - The information we currently hold on our culture, such as from our staff survey and WRES and WDES results, tells us that improvement is required across multiple themes including staff engagement, bullying and harassment, inclusion and racism. - Our people dashboard continues to report non-compliance with KPI's such as appraisal, and we continue to perform below our target workforce plan, significantly impacting our financial performance and ability to exit NOF4. - The CQC action relating to equality, diversity and inclusion remains open and there continues to be no clear strategy for equality, diversity and inclusion. - A greater understanding is required of our cultural insights and how we use this to drive the required action needed for improvement, and we need to align our patient safety and quality, freedom to speak up and employee relations insights to inform our priorities. - Previous initiatives such as compassionate leadership and the launch of the culture charter have not demonstrated the desired improvement in our performance. Our people continue to work. - Financial and workforce data do not align and require integration into our performance dashboard for more accurate and consistent reporting to inform workforce plans. - Ongoing complex ER caseload and long-term sickness challenges.		
Risk to delivery:		
Aggravating factors: (Described below) Lack of improvement in our culture and staff experience or clear objectives and measures to address the issues raised in our metrics.	Mitigating factors: (Described below) - Our plan for better care' people programme 5.3: develop and embed a culture where our people feel valued and supported and that embeds the principles of the people promise. - To be achieved through - - Triangulating the information, we receive on our cultural insights and set up a mechanism to proactively analyse, respond and action (staff survey, WRES, WDES, ER, etc.) - Establish a staff engagement plan which is focussed on Inclusion, staff experience, feedback Inc. networks and FTSUG	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) - Response rates for surveys and lack of clear staff engagement plan and our ability to respond at the time feedback is received – to be picked up by the cultural insights group. - Leadership and resource to deliver the priority programmes of work – COMPLETE - No current governance and reporting structure within the people/HR services (education has

	• Refresh our wellbeing support, focussing on proactive/preventative interventions and support • Ensure our trust learning and development programme meets the needs of the trust priorities (Inc. review of compassionate leadership) • Implement policies and processes that will support a just and learn approach to our everyday practices • Enhance our commitment to the Trust Culture Charter and the behaviours we expect everyone to uphold NED and Executive co-design workshop for culture plan. Executive Director visibility and engagement plan to be developed with comms.	maintained its governance group and existing reporting temporarily for NHSE assurance) COMPLETE • Ongoing challenges with the data, our ability to analyse, triangulate with finance – including gaps in our ability to report adequate data for the medical workforce pending approval of business case etc. - Business case approved – plan with finance and Viridian system to support approved • No clear response to the CQC action in relation to EDI – group set up to oversee across people/clinical and agree actions aligned to culture plan – 5.3 programme work to be shared as evidence to CQC. • No oversight and reporting of ER caseload aligned to staff side insights and lack of organisational capability to investigate and manage cases – governance and reporting to be in place - COMPLETE – plan for managers and investigation options appraisal to be developed to be actioned and complete – extended to October 2025
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
• SRO (CPO) weekly review with workstream lead • People Dashboard, IPR, staff survey, WRES and WDES, student surveys, NETs, GMC NTS, exception reporting, ER caseload data, workforce information and NHSP reports, directorate risk register. • Individual team and service reviews as part of management and team meetings. • NHSE and HEI reporting.	• Monthly flash report submitted to the Oversight Group • Monthly review by the People & Education Leadership Team (PELT). • Monthly review of Care Group and Trust wide workforce performance at Executive Operational Group (EOG) • Corporate Risk register • Regular review at the ICB Workforce Delivery Management Group (Tactical and Strategic Cells) • Bi-monthly reviews at People Committee • Internal audit	• ICB/NHSE • NHSE Senior Leader Visit (annual). • NHSE and CQC visits and or reports.

SUPPORTING OBJECTIVE: To deliver levels of performance that meet the trajectories outlined in the Trust operating plan for 25/26 in line with the exit criteria for National Oversight Framework Level 4.		
OVERARCHING CORPORATE OBJECTIVE: Deliver the 2025/26 plan, including finance, quality, operational performance and workforce objectives		
Executive lead: Chief Operating Officer		Board oversight Committee: Finance and Performance Committee
Current assessment: Limited (September 2025)		Previous assessment: na (August 2025)
Overarching comment & rationale for assessment: Achieving some but not all of the current performance trajectories. Improvement seen across a range of the required performance metrics in UEC and elective services but not meeting trajectory or national standards for - 4 hour performance - Ambulance handover in excess of 45 minutes - RTT long waiters - Cancer - Diagnostics		
Risk to delivery:		
Aggravating factors: (Described below) • Demand growth in excess of expected levels. This has been experienced in UEC and also cancer within H1. • Reliance on insourcing/outsourcing to deliver elective activity • Gaps in required workforce to deliver activity levels, for example anaesthetics • Estate failures leading to closure of theatres/cath labs and reduction in outpatient capacity • Industrial action leading to cancellation of elective activity to maintain safety within non-elective services • Requirement for capital investment in additional diagnostic capacity	Mitigating factors: (Described below) • Action – Attendance at System Demand Management Group and key data provided routinely - ongoing • Action – ECIST improvement programme further right care week to be undertaken in October25 • Action – UEC Recovery Plan Re-design for Q2 focus – Now in place. Further focus on ward improvement programme • Action – Winter Plan finalised and signed off by Board – September 25. System and regional plan testing October 25 • Action – Improvement coaching programme directed at operational teams next cohort Q3 2025 • Targeted recruitment to increase elective activity – September – December 25 • Re-work of the CDC contract – October 25	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) • SOP for any further industrial action to be developed – October 25 • Workforce v demand reviews to be undertaken in ED and medical wards and presented to executives – November 25 • Operational Planning to account for required increases in activity and productivity – Jan 26
Three lines of defence:		
First Line of Defence - Operational and Management Controls - UEC recovery plan and meeting - Cancer Recovery plan and meeting - Diagnostics Recovery Plan and Meeting	Second Line of Defence - Oversight Functions and Internal Assurance - Care Group Delivery Reviews (EOG) - Executive Committee - Our Plan for better care	Third Line of Defence - External Assurance: - Weekly regional performance - ICB contract reviews - Regional elective recovery meeting

- Outpatient Transformation Plan - Elective Delivery Plan and Meeting	- Committees - Board	- Cancer Alliance

SUPPORTING OBJECTIVE: To manage the fire risk within the estate (for example 'the tower') through a programme of capital and estates works, in addition to robust training and exercising for specific staff groups.		
OVERARCHING CORPORATE OBJECTIVE: Deliver the 2025/26 plan, including finance, quality, operational performance and workforce objectives		
Executive lead: Chief Operating Officer		Board oversight Committee: Building a Brighter Future Committee
Current assessment: Limited (September 2025)		Previous assessment: Not applicable (August 2025)
Overarching comment & rationale for assessment: As a healthcare organisation covering an acute campus, 22 community sites 17 leasehold properties and residential accommodation facilities, the trust is responsible for effective fire safety which combines physical fire precautions and a robust and effective system of fire management. The trust should ensure that the incidence of fire is minimised, that physical systems are maintained, that there is an effective response in the event of a fire incident and that the impact is minimised. The Regulatory Reform (Fire Safety) Order 2005 sets out statutory responsibilities and the Firecode Health Technical Memoranda provides guidance to support functional provisions in healthcare premises (i.e. fire detection and alarm systems, escape lifts, arson prevention, fire engineering in healthcare premises). The age and the condition of our estate increases fire risk due to areas of the built environment not being constructed to the latest guidance set out in HTM 05-02 and HTM 05-03. The trust is also responsible for a Higher Risk Building (The Tower) which due to its height (18m or 7+ storeys) and its use as a hospital is subject to more stringent building safety regulations overseen by the Building Safety Regulator. This means that fire improvements to the building (e.g. compartmentation, fire dampers, fire alarm upgrades, fire door set replacements) are subject to an application to the BSR via a gateway approval process which was introduced in 2023 and is currently taking up to and sometimes in excess of 20 weeks from the point of application with a substantial amount of pre-application work to complete beforehand. It is possible that fire improvement work to the Tower will not be completed until March 2027. Limited assurance is offered to the Board in regard to this objective taking account of the condition and age of the estate, limited capital funding to enact remediation or replacement to deliver fire improvement to premises, limited technical resources in the estates team to optimise fire maintenance and limited fire safety management resource to optimise fire management systems.		
Risk to delivery:		
Aggravating factors: (Described below) Buildings: Substantial area of trust estate (70% condition D documented in last 6 facet survey 2020) is in poor condition and life expired. Large areas of built environment not constructed to latest guidance HTM 05-03. Insufficient capital to undertake required remediation and replacement of infrastructure to meet Firecode HTM. Fire safety condition of some trust buildings will not meet condition B assessment for the following areas: 1. Compartmentation 2. Fire Doors 3. Means of Escape	Mitigating factors: (Described below) Fire safety Management system in place following guidance of HTM 05-01. Processes to reduce incidence of fire to As Low As Reasonably Practicable (ALARP): Fire Safety Policy (The Organisation has a Management of Fire Safety and Evacuation Policy, Issue 4, Feb 2025) Fire Safety Management Structure (Management duties, roles and responsibilities are set out in the policy and the Fire Audit (August 2025) has issued a satisfactory outcome for management accountabilities.	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) • Meeting with DSFRS (Fire service) underway Wednesday 24th September 2025. This will specifically review Tower Risk. • BSR application for capital fire improvement works to the Tower due 30th January 2026. • Fire Strategy for Tower to be finalised December 2025. • Fire Strategies for all existing buildings (6 strategies overall) have been scoped and are subject to securing revenue/capital finance. • 6 facet survey to provide up-to-date estate condition report underway (14 week process for completion)

4. Alarms and Detection Systems 5. Textiles and Furniture 6. Storage of Flammable substances Capacity and technical competency: 1. Inadequate level of technical resource to optimise fire maintenance schedules. 2. Inadequate level of dedicated fire management resource to proactively optimise fire safety management systems given the complexity and breadth of the estate. 3. Insufficient resources and processes dedicated to Fire risk assessment completion. Up to date fire risk assessments should be in place for all areas under the organisation's ownership, occupation or control. A lot of risk assessments are out of date (overall the trust has 160 fire risk assessments which should be updated every 2 years for non-clinical environments and every year for clinical environments). Environment: Storage of equipment and combustible items in corridors and lobbies impeding evacuation routes due to space restrictions in clinical areas. EPR/EPIC Implementation of EPR system increases user devices by 4000 including devices that have lithium batteries and need to be charged in clinical areas as well as increased number of computers on wheels and other medical devices that have no dedicated storage areas or charging areas. Digital Systems and Processes: 1. No digital management of FRA's which means there is no system for allocating or collecting substantial risk information without opening each FRA (160). This limits exposure of the Board to where substantial risks are awaiting remediation. 2. No digital system that enables live time review of completion of daily, weekly and monthly routine fire checks across clinical and non-clinical settings,	Fire Safety Protocols and Fire Safety Information Manuals (Some protocols are in place, but improvements are required) Underway starting October 2025. Specific operational framework/manual being developed for the Tower given level of operating risk. (Underway September 2025) Fire Risk Assessments. Improvements are required to ensure all areas of the trust estate have up to date risk assessments that are in line with new HTM guidance Part K. Fire emergency action plans and fire drills and exercises. Action underway to deliver additional fire exercises for The Tower given level of operating risk. (Planned exercises as part of EPRR workplan underway from Q4 2025/6) Staff Training and records and management audit. (Mandatory training compliance is at 91% completed online every 2 years) 123 fire wardens and 317 evacuation leads trained as at August 2025. Fire Safety Audit (Annual AE Fire Audit completed August 2025) Improvements and action plan being implemented and overseen by fire safety group.	• Review of Fire Safety Management System as part of PAM compliance process underway (October 2025) • Review and recommendation regarding capacity for estate fire Maintenance underway as part of risk assessment in response to Cost Improvement plans. • Review of dedicated fire safety team (separated from health and safety team) incorporated as part of Director assessment underway (September 2025). • Improve robustness and clinical and operational engagement in Fire safety Group (October 2025)

Operating Environment: 1. Workforce sometimes do not comply with protocols and change the use of their operating environment that increase the risk of fire incidents. 2. Visitors to the site and contractors sometimes do not comply with protocols and increase the risk of fire incidents.		
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- Fire Safety Management System - Fire Policy and Protocols - Emergency Evacuation Plans - Fire Drills & Fire Safety Training - Fire Risk Assessments - Fire Safety Reports, risk assessments and action plans - Workplace Performance and Compliance Group (incorporating Firecode Health Technical Memoranda)	- Fire Safety Group - Health and Safety Committee - Capital Fire Improvement Group - Executive Operations Group - Executive Committee - Our Plan for Better Care - BBF Committee - Board	- Trust Annual Fire Audit (Authorising Engineer) - - Devon and Somerset Fire and Rescue Service Annual Audit - Property Assurance Model - National ERIC Return

SUPPORTING OBJECTIVE: To mitigate critical estate risks through the deployment of the Trust estate strategy and capital programmes, to meet the needs of local people.		
OVERARCHING CORPORATE OBJECTIVE: Deliver the 2025/26 plan, including finance, quality, operational performance and workforce objectives		
Executive lead: Chief Operating Officer		Board oversight Committee: Building a Brighter Future Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: na (August 2025)
Overarching comment & rationale for assessment: The Trust estate presents a number of critical risks, including ageing infrastructure, backlog maintenance, compliance challenges, and capacity constraints, which can directly affect the quality of care, patient safety, operational resilience, and staff wellbeing. It also directly contributes to workplace health and safety risks and latent harm experienced by all users of our environment. This supporting objective seeks to mitigate those risks through the systematic deployment of the Trust's Estate Strategy and delivery of prioritised capital programmes. These programmes are designed to address immediate safety and compliance concerns, modernise facilities, and ensure the estate is fit for future models of care. Maintaining our built environment with a high proportion of the estate being classed as condition D (69% last 6 facet survey 2020) increases the importance of compliance with industry standard maintenance schedules and ensuring sufficient resource to respond to reactive critical infrastructure failures. The estates operations resources are not sufficient to manage current assets given the condition of the estate and the level of remediation and replacement of failing infrastructure exceeds the capital that is available for backlog maintenance and life cycle replacement. By aligning capital investment with clinical priorities and population health needs, the Trust can provide safe, efficient, and sustainable facilities that meet regulatory standards and support service transformation. This approach also strengthens resilience against infrastructure failure, reduces the risk of service disruption, and enhances the patient and staff experience. Successful delivery will require effective governance, robust prioritisation of schemes, and strong partnership working with national, regional, and system stakeholders to secure funding and enable timely implementation.		
Risk to delivery:		
Aggravating factors: (Described below) • Aging estate profile with high levels of critical backlog maintenance. • Limited availability of local and national capital funding and significant delays of New Hospital Programme investment. • Construction market inflation (and general inflation) driving cost pressures and reducing affordability. • Capacity constraints within internal estates and project teams to deliver concurrent programmes. • Regulatory pressures (e.g., fire, water safety, Building Safety Act, sustainability requirements) requiring urgent compliance schemes. • Dependency on external stakeholders (regional/NHSE approvals, planning authorities, supply chain). • Disruption risk to clinical services during project delivery works.	Mitigating factors: (Described below) • Approved Trust Estate Strategy aligned to clinical strategy and population health needs. • Prioritisation framework to target high-risk backlog and compliance schemes. • Capital planning group, Capital Investment Delivery Group and Programme Board governance to oversee pipeline and delivery. • Robust project management arrangements (business cases, risk registers, change control). • Partnership working with system partners and national bodies to maximise funding opportunities. • Active monitoring of estate risk profile via ERIC data, PAM, PLACE scores, and statutory compliance audits. • Early engagement with clinical and operational teams to manage service continuity during works.	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) • Insufficient secured funding to address the full scale of critical estate risks. • Capacity gaps in specialist estates roles impacting delivery pace. • Lack of a modern CAFM system limits the ability to proactively manage critical estates risk. • Lack of full recording of estates issues by operational teams impacts our ability to fully identify the productivity benefits of investment – often critical to securing national capital. • Limited forward visibility of national capital allocations creating planning uncertainty. • Incomplete assurance on future sustainability compliance (net zero, energy efficiency).

		Variable maturity of benefits tracking to evidence impact of capital schemes.
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- Trust Estate Strategy approved and aligned with clinical priorities. - Capital planning group, Capital Investment Delivery Group and Programme Boards overseeing prioritisation and delivery. - Estates and Facilities compliance monitoring (fire, water, asbestos, electrical, statutory checks). - Risk registers maintained at project, programme, and corporate levels. - Routine monitoring of backlog maintenance profile and capital scheme progress. - Monthly finance and performance reporting on capital delivery. - Clinical and operational engagement to ensure continuity of services during works. - EFM Compliance and Performance Group manage oversight of maintenance schedules.	- Director of Capital Developments oversight of capital programme, supported by Capital Investment Delivery Group. - Director of Estates and Facilities oversight of reactive and proactive estate operations and technical compliance to maintain existing assets. - Building a Brighter Future Committee oversight of capital programme delivery and operational estates and facilities management. - Audit & Risk Committee scrutiny of estate risk management and capital governance. - Finance Committee review of business cases, capital allocation, and affordability. - Board-level oversight of estate strategy, capital pipeline, and risk profile. - System-level assurance via ICB capital planning processes. - Independent compliance audits (fire safety, HTM, HBN, statutory requirements). - Use of external cost advisors and design assurance panels for key schemes.	- Internal Audit reviews of capital governance, procurement, and risk management. - External Audit assurance on capital accounting and asset management. - NHSE scrutiny and approval of major capital schemes and business cases. - Health & Safety Executive, CQC, and Fire Authority inspections. - PLACE assessments and national ERIC and PAM data benchmarking. - External specialist reports (e.g., sustainability, structural surveys, engineering audits). - Gateway Reviews and independent project assurance for large capital projects.

SUPPORTING OBJECTIVE: Develop a full understanding of the current contract and cost of delivery of adult social care; including health, to ensure the services can be provided within the funding received. When this understanding is obtained, identify core demand and capacity available to reach trajectories for TSD against the nationally recognised KPIs.		
OVERARCHING CORPORATE OBJECTIVE: Deliver the 2025/26 plan, including finance, quality, operational performance and workforce objectives		
Executive lead: Chief Strategy and Planning Officer	Board oversight Committee: Finance and Performance Committee	
Current assessment: Limited (September 2025)	Previous assessment: N / A (August 2025)	
Overarching comment & rationale for assessment: Following a review of this work, deliverables have been substantially revised to more closely reflect the work that is required to deliver the objectives. These were subsequently approved by the Our Plan for Better Care Oversight Group. All deliverables are on track to meet planned completion dates Substantial progress has been made on the preparation activities. This includes; - Ensuring leadership roles in place; benchmarking for staffing structures and initiation sessions with operational teams; - Commencing the review of costs and funding using the SLR data and other financial data - Draft performance specification has been completed that covers quality and performance KPI - Work has started to resolve longest waits, case reviews and safeguarding. There is now project management support in place to support some of the work. Partial assurance reflects the need to baseline and monitor KPI's before full assurance can be provided.		
Risk to delivery:		
Aggravating factors: <i>(Described below)</i> - Unknown baseline for KPIs impacts on understanding where services should aim in the future - Workforce capacity in order to drive review of service as indicated in the objective and drive delivery	Mitigating factors: <i>(Described below)</i> - Agree KPI Specification to build a KPI report to aid reporting and review. - PMO support for the substantive project lines remains outstanding – will be escalated.	Gaps in control & associated actions: <i>(Described below- actions must be allocated a timescale for delivery)</i> - A draft KPI specification has been shared with key stakeholders for return by mid September. Following which the information team will build the report for ongoing monitoring and reporting - Escalation will be via the S75 meeting.
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- ASC Senior Management Team - CPSO oversight	- Section 75 Meetings - Executive Committee - Our Plan for better care - Committees - Board	- ICB review of financial position - Work with NHSE RSP Team

SUPPORTING OBJECTIVE: CFHD service delivered by a single employer safely in a more cost-effective way ensuring safety of children and families and quality of service delivered is maintained throughout transfer of staff and financial detriment to TSD is mitigated and minimised where possible.		
OVERARCHING CORPORATE OBJECTIVE: Deliver the 2025/26 plan, including finance, quality, operational performance and workforce objectives		
Executive lead: Chief Strategy and Planning Officer		Board oversight Committee: Finance and Performance Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: N/A (August 2025)
Overarching comment & rationale for assessment: - Options appraisal report for single provider to be presented to DPT Board on 16th September and TSDFT Board on 24th September. Subject to approval this will be submitted to the ICB at the end of September. In the meantime, fortnightly collaborative single provider planning group continues with a dedicated action plan which is on track. - Engagement with CFHD staff continues as planned with a whole staff communication session on 28th August and a further planned for 23rd September. Staff side are engaged in the CFHD engagement events in preparation for decisions being made and next steps. - Fortnightly IM&T transfer workstream continues with a target for transfer w/c 22 September 2025 and devise deployment w/c 15 September 2025. - In parallel to the options appraisal, due diligence continues to be prepared. - Close working between TSDFT and CFHD regarding 2 posts that have been identified as potentially not transferring and will need agreement.		
Risk to delivery:		
Aggravating factors: <i>(Described below)</i> - No Resource to lead or transact work - Focus of SLT drawn away from TSD priorities - Change and uncertainty resulting in loss of staff impacting on capacity to deliver service - Slippage to tasks due to staff being on leave over summer holiday period - Elements other than contractual that need to be addressed e.g. access to systems, maintenance contracts, training, supervised practice. Inability to resolve which could result in failure to deliver service.	Mitigating factors: <i>(Described below)</i> - Identified individual, backfill to come from CFHD underspend, Mitigate with appointment of above - Ongoing staff engagement and support from each Trust - Realistic and adjusted targets - Mapping for each area to be undertaken	Gaps in control & associated actions: <i>(Described below- actions must be allocated a timescale for delivery)</i> - likely in post until mid Sept 25 - Engagement to continue - Targets adjusted - Mapping to be completed
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- CFHD Senior Management Team - CPSO oversight	- Integrate Governance Board - Executive Committee - Our Plan for better care - Committees - Board	- ICB review of financial position - Work with NHSE RSP Team

SUPPORTING OBJECTIVE: To deliver on our plans and commitments to environmental sustainability and decarbonisation, as set out in the Trust Green Plan.		
OVERARCHING CORPORATE OBJECTIVE: Deliver the 2025/26 plan, including finance, quality, operational performance and workforce objectives		
Executive lead: Chief Operating Officer		Board oversight Committee: Building a Brighter Future Committee
Current assessment: Limited (September 2025)		Previous assessment: Not applicable (August 2025)
Overarching comment & rationale for assessment: The Torbay and South Devon NHS Foundation Trust Board approved the Trust's initial Green Plan in February 2022. NHS England subsequently published updated statutory green plan guidance in February 2025 requiring Trusts to further refresh green plans in line with the updated guidance by 30th September 2025. The Refreshed Green Plan is going to public Board for approval on 24th September 2025. Satisfactory assurance is offered that the refreshed Green Plan positions the Trust to make good progress in the delivery of its duties to meet net zero emissions on the basis that the trust is able to mobilise action and drive implementation of the workstreams set out in the refreshed Green Plan. The workstreams have been informed by the outputs of a full gap analysis which was undertaken against the initial Green Plan (2022) that has subsequently been updated to fall in line with the latest green plan guidance issued by NHS England. In some areas, the Trust is currently going beyond the requirements of green plan guidance, such as the adoption of biodiversity, digital innovation and the control of volatile gases. Overall, the current BAF assessment offers Limited assurance due to the insufficient resource to drive forward the work of the Sustainability and Well Being Group and deliver the action plans and commitments set out in the refreshed Green Plan. In addition, the Trust has no dedicated management resource to lead energy sustainability and decarbonisation. All options need to be looked at in respect of how to fulfil this requirement including looking at Devon Wide System resources. It should be noted that additional management resource to drive sustainability is likely to be offset by the significant savings potential linked to sustainability actions.		
Risk to delivery:		
Aggravating factors: (Described below) - Insufficient capital and revenue funding available to undertake asset replacement to improve estate decarbonisation. - Limited dedicated management resource in-house with specialist knowledge to drive delivery of sustainability workplan and mobilise targeted campaign efforts across workforce - No dedicated specialist expertise to drive improvement of energy agenda and decarbonisation	Mitigating factors: (Described below) Processes in place to enable replacement of environmentally inefficient assets as part of pre-agreed capital projects, so that where a project takes place, environmentally efficient alternatives for assets scheduled for replacement are considered. Capital programmes to improve the environmental efficiency of the estate are supported through the adoption of the BREEAM standard for all newly constructed units.	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) - Green plan is focussed primarily on hard decarbonisation measures, which, whilst important, are only a part of the solution and in many cases the Trust's ability to deliver these is limited owing to financial constraints. The Green Plan is being updated to give a more rounded view of the Trust's approach to environmental efficiency, which has a strong focus on soft measures as well as decarbonisation. (September 2025) - Organisational re-design within the Workplace Team should identify a role for an environment and sustainability lead, which can give full focus and ownership of the Trust's environmental and decarbonisation agenda. This is subject to spending controls which currently limit additional costs in H2. (January 2026).

• Age and condition of the Trust estate means that significant proportion of assets are environmentally inefficient. • Inadequate technology provision to monitor and manage the environmental performance of the estate and initiate relevant interventions. • Challenging organisational context does not position sustainability objectives high on the agenda • Cultural conditions in the trust contribute to 'sustainability fatigue' and lower levels of workforce engagement.	• Some soft sustainability measures are going beyond the requirements of the national green plan guidance. This includes biodiversity performance, waste management optimisation and control of volatile gases. • Improvement to the Trust's building management system is underway which provides a better digital oversight of the environmental performance of the estate. • The Trust Green plan has been refreshed and is due for approval by the Board in September 2025. • The Trust Green Plan Refresh is part of "Our plan for better care – Managing our Estate" and this describes a set of milestones to include a gap analysis of the original Green Plan and progress made since its endorsement in 2020. (Underway) As part of the development of a revised Trust strategy for 2026 onwards we will incorporate commitments across the sustainability agenda as set out in the refreshed Green Plan 2025.	• An Energy and Decarbonisation Manager will be appointed to lead engineering and hard sustainability measures. (November 2025) • Discussions have started with EFM Directors to consider a Devon system sustainability Team. (November 2025) • A Sustainability Group will be set up to energise our workforce and mobilise action around our Trust Green agenda and oversee the implementation of the Green Plan Refresh Workstreams. (Date subject to appointment of sustainability lead)
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- Sustainability Group - Workplace Performance & Compliance Group - Healthcare Technical Memorandums - Workplace SLT	- Executive Committee - Our Plan for better care - BBF Committee - Board	- ICB Sustainability Group - Property Assurance Model - National ERIC Return - External Audits

SUPPORTING OBJECTIVE: Develop and deliver a sustainable, workforce strategy and plan that delivers an efficient, agile, skilled and high performing workforce aligned to system and organisational priorities.	
OVERARCHING CORPORATE OBJECTIVE: To develop a people strategy aligned to the Trust's long-term vision, priorities and values, which delivers a workforce plan that ensures the right workforce is in place and that fosters a positive, inclusive culture with high levels of staff engagement to support improved patient outcomes.	
Executive lead: Chief People Officer	Board oversight Committee: People Committee
Current assessment: Satisfactory (September 2025)	Previous assessment: n/a (August 2025)
Overarching comment & rationale for assessment: The Trust has a £20.4m target for workforce savings and to date there remains a gap to deliver this in full by year end. The Trust doesn't have an up-to-date workforce strategy aligned to the Trust strategy – although a draft was developed in late 2024 this was never approved – this needs to include a refresh of the learning and education plan and align with the development of the refreshed Trust strategy. The programme currently has 12 key deliverables; this progress summary focuses on the deliverables with the most progress in the last month in September - It must be noted that the workforce transformation programmes have yet to be started and fully understood and must align the EPR opportunities and future of people services work in Devon (CCS programme). Overtime Controls: Costings have been calculated on options for overtime targets to reduce the overall spend, the proposal is as follows: 20% reduction on all patient facing areas 80% reduction on all admin/support areas, with the exception of Workplace which has been adjusted to 20% to recognise the vital support they provide directly to patients The calculations have been based on actuals processed in Unit 4 for M1-4 and have assumed these baseline costs are extrapolated into the full year forecast position 25/26 Options calculated to reduce overtime and potential savings to be generated for 6,5,4 and 3 months. This has been calculated between £500k to £1m. Next step- Execs to approve Pay controls- Vacancies: We are working with the recruitment and finance team to develop a process to track the financial impact of the 'break glass process' to enable us to quantify the scheme. MARS- The Mutually Agreed Resignation Scheme: has now closed (22.8.25) Applications received: 49 Applications approved: 46 which totals 37.16 WTE Panel met 4.9.25- communication confirming approved/declined to applicants will go out week commencing 8.9.25. Any approved applications will have a leaving date of 31.10.25. Severance Cost: £1.359m (Including NI) Net in year cost (including saving of salaries from Oct 25): £0.753m Savings 2026/27: £1.887m Strengthen collaboration between Finance and Workforce: Viridian has completed their work which examined both internal and external workforce and financial reporting outputs, with a focus on identifying root causes of data quality issues. Stakeholder session between Finance and Workforce is now complete. A table highlighting the key issues and opportunities for improvement has been provided by Viridian. This needs further collaboration between the two teams in order to reach agreement on next steps. Review of Employee Relations cases- Review of AfC On-call On-call ToR have been drafted Comparative data from our neighbours on-call arrangements has been analysed	

Options appraisal currently being costed with finance		
Aggravating factors: <i>(Described below)</i> - Ongoing non-compliance with delivery of the workforce plan and the organisations' ability to meet the workforce cost savings target. - Lack of workforce strategy and clear learning and education plan.	Mitigating factors: <i>(Described below)</i> Our plan for better care' people programme 5.1: Deliver a sustainable, workforce plan that delivers an efficient, agile and high performing workforce aligned to system and organisational priorities. To be achieved through - - Achieving workforce cost savings through targeted reductions, efficiency, and transformation. - Reducing reliance on temporary staffing while maintaining quality and safety. - Supporting service transformation through focused workforce intervention This programme aligns with 5.2 programme - To build a high-performing, forward-thinking and values driven People and Education Directorate, with the right capacity, skills, systems, and leadership to enable the organisation to deliver its strategic people priorities, meet regulatory expectations, and drive long-term workforce sustainability.	Gaps in control & associated actions: <i>(Described below- actions must be allocated a timescale for delivery)</i> - Leadership and resource to deliver the priority programmes of work – COMPLETE - Ongoing challenges with the data, our ability to analyse, triangulate with finance – including gaps in our ability to report adequate data for the medical workforce pending approval of business case etc. - Business case approved – plan with finance and Viridian system to support approved - No clear response to the CQC action in relation to EDI – group set up to oversee across people/clinical and agree actions aligned to culture plan – 5.3 programme work to be shared as evidence to CQC. - No oversight and reporting of ER caseload aligned to staff side insights and lack of organisational capability to investigate and manage cases – governance and reporting to be in place - COMPLETE – plan for managers and investigation options appraisal to be developed to be actioned and complete – extended to October 2025
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- SRO (CPO) weekly review with workstream lead - People Dashboard, IPR, staff survey, WRES and WDES, student surveys, NETs, GMC NTS, exception reporting, ER caseload data, workforce information and NHSP reports, directorate risk register. - Individual team and service reviews as part of management and team meetings. - NHSE and HEI reporting.	- Monthly flash report submitted to the Oversight Group - Monthly review by the People & Education Leadership Team (PELT). - Monthly review of Care Group and Trust wide workforce performance at Executive Operational Group (EOG) - Corporate Risk register - Regular review at the ICB Workforce Delivery Management Group (Tactical and Strategic Cells) - Bi-monthly reviews at People Committee	- ICB/NHSE - NHSE Senior Leader Visit (annual). - NHSE and CQC visits and or reports. - Internal Audits.

SUPPORTING OBJECTIVE: To develop and implement a culture plan that ensures our people feel valued and supported and that embeds the principles of the people promise.		
OVERARCHING CORPORATE OBJECTIVE: To Develop a people strategy aligned to the Trust's long-term vision, priorities and values, which delivers a workforce plan that ensures the right workforce is in place and that fosters a positive, inclusive culture with high levels of staff engagement to support improved patient outcomes.		
Executive lead: Chief People Officer		Board oversight Committee: People Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: n/a (August 2025)
Overarching comment & rationale for assessment: Our ambition is that we will embed a supportive and inclusive culture that is truly felt by our people and that will enable our people to deliver high quality care to our patients and community. Incidents, our survey data and staff engagement demonstrate the need for our culture plan to be clear, visible and central to our delivery of Trust Strategy and ensure the culture of our organisation is one that aligns to our shared values and beliefs. • The information we currently hold on our culture, such as from our staff survey and WRES and WDES results, tells us that improvement is required across multiple themes including staff engagement, bullying and harassment, inclusion and racism. • Our people dashboard continues to report non-compliance with KPI's such as appraisal, and we continue to perform below our target workforce plan, significantly impacting our financial performance and ability to exit NOF4. • The CQC action relating to equality, diversity and inclusion remains open and there continues to be no clear strategy for equality, diversity and inclusion. • A greater understanding is required of our cultural insights and how we use this to drive the required action needed for improvement, and we need to align our patient safety and quality, freedom to speak up and employee relations insights to inform our priorities. • Previous initiatives such as compassionate leadership and the launch of the culture charter have not demonstrated the desired improvement in our performance. Our people continue to work. • Financial and workforce data do not align and require integration into our performance dashboard for more accurate and consistent reporting to inform workforce plans. • Ongoing complex ER caseload and long-term sickness challenges.		
CQC actions with regards to EDI and staff experience: • There must be an increased focus on equality, diversity and inclusion to address the increase in bullying and harassment across the organisation. The Trust must set a clear strategy, improve the effectiveness of the equality business forum and staff networks, ensure clear policies and procedures, support reasonable adjustments, and consider the resources to support this work. • Consider how to ensure staff feel listened to and their ideas and solutions are well considered, and appropriate actions taken and monitored, or feedback shared with staff. • Consider the current resource for freedom to speak up. Consider implementing a long-term workforce plan across all roles in the organisation to address vacancies and succession planning.		
Risk to delivery:		
Aggravating factors: <i>(Described below)</i> • Lack of improvement in our culture and staff experience or clear objectives and measures to address the issues raised in our metrics.	Mitigating factors: <i>(Described below)</i> • Our plan for better care' people programme 5.3: develop and embed a culture where our people feel valued and supported and that embeds the principles of the people promise. • To be achieved through -	Gaps in control & associated actions: <i>(Described below- actions must be allocated a timescale for delivery)</i> • Response rates for surveys and lack of clear staff engagement plan and our ability to respond at the time feedback is received – to be picked up by the cultural insights group.

	• Triangulating the information, we receive on our cultural insights and set up a mechanism to proactively analyse, respond and action (staff survey, WRES, WDES, ER, etc.) • Establish a staff engagement plan which is focussed on Inclusion, staff experience, feedback Inc. networks and FTSUG • Refresh our wellbeing support, focussing on proactive/preventative interventions and support • Ensure our trust learning and development programme meets the needs of the trust priorities (Inc. review of compassionate leadership) • Implement policies and processes that will support a just and learn approach to our everyday practices • Enhance our commitment to the Trust Culture Charter and the behaviours we expect everyone to uphold	• Leadership and resource to deliver the priority programmes of work – COMPLETE • No current governance and reporting structure within the people/HR services (education has maintained its governance group and existing reporting temporarily for NHSE assurance) COMPLETE • Ongoing challenges with the data, our ability to analyse, triangulate with finance – including gaps in our ability to report adequate data for the medical workforce pending approval of business case etc. - Business case approved – plan with finance and Viridian system to support approved • No clear response to the CQC action in relation to EDI – group set up to oversee across people/clinical and agree actions aligned to culture plan – 5.3 programme work to be shared as evidence to CQC. • No oversight and reporting of ER caseload aligned to staff side insights and lack of organisational capability to investigate and manage cases – governance and reporting to be in place - COMPLETE – plan for managers and investigation options appraisal to be developed to be actioned and complete – extended to October 2025
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
• SRO (CPO) weekly review with workstream lead • People Dashboard, IPR, staff survey, WRES and WDES, student surveys, NETs, GMC NTS, exception reporting, ER caseload data, workforce information and NHSP reports, directorate risk register. • Individual team and service reviews as part of management and team meetings. • NHSE and HEI reporting.	• Monthly flash report submitted to the Oversight Group • Monthly review by the People & Education Leadership Team (PELT). • Monthly review of Care Group and Trust wide workforce performance at Executive Operational Group (EOG) • Corporate Risk register • Regular review at the ICB Workforce Delivery Management Group (Tactical and Strategic Cells) • Bi-monthly reviews at People Committee • Internal audit	• ICB/NHSE • NHSE Senior Leader Visit (annual). • NHSE and CQC visits and or reports.

SUPPORTING OBJECTIVE: To build a high-performing, forward-thinking and values driven People and Education Directorate, with the right capacity, skills, systems, and leadership to enable the organisation to deliver its strategic people priorities, meet regulatory expectations, and drive long-term workforce sustainability.		
OVERARCHING CORPORATE OBJECTIVE: To Develop a people strategy aligned to the Trust's long-term vision, priorities and values, which delivers a workforce plan that ensures the right workforce is in place and that fosters a positive, inclusive culture with high levels of staff engagement to support improved patient outcomes.		
Executive lead: Chief People Officer		Board oversight Committee: People Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: n/a (August 2025)
Overarching comment & rationale for assessment: To enable shaping future People and Education team to support organisation robustly in the future to meet the needs of the organisation a review needs to be undertaken into the capacity and capability in line with the future of people services work at national and system level. A needs assessment method has been agreed and a manager survey rolled out. Work has started on collating responses on current work priorities, skills, training and development needs, talent, succession and career pathway opportunities, structure and appropriate relevant KPIs for monitoring. This comprehensive analysis and insights gained will support agreement of refreshed workstreams by end of November. Interviews have started with stakeholders on workforce performance dashboard to help shape design. Significant sickness and capacity issues have impacted progress on policy review, update and sign off work. Actions to address this are underway as detailed in the associated risk. Assurance review is underway to benchmark existing leadership structure and reporting against 'best in class' peers using Model Hospital. Due for completion end September and must align to direction set by Governance and Assurance workstream following recommendations from the Well-Led review. Regular workstream comms update for the directorate commenced ongoing. PELT already in place and will formalise from September onwards as the People and Education Directorate Leadership Team oversight and assurance Group		
Risk to delivery:		
Aggravating factors: <i>(Described below)</i> Challenged capacity and capability of our people and education directorate to meet the needs of the organisation and its people.	Mitigating factors: <i>(Described below)</i> 'Our plan for better care' people programme 5.2: Build a high-performing, forward-thinking and values driven People and Education Directorate, with the right capacity, skills, systems, and leadership to enable the organisation to deliver its strategic people priorities, meet regulatory expectations, and drive long-term workforce sustainability. - To be achieved through – - Identification and engagement with key stakeholders for this work, both internal and external and development of a comms plan	Gaps in control & associated actions: <i>(Described below- actions must be allocated a timescale for delivery)</i> - Leadership and resource to deliver the priority programmes of work – COMPLETE - No current governance and reporting structure within the people/HR services (education has maintained its governance group and existing reporting temporarily for NHSE assurance) COMPLETE - Ongoing challenges with the data, our ability to analyse, triangulate with finance – including gaps in our ability to report adequate data for the medical workforce pending approval of business case etc. - Business case approved –

	• Directorate work assessment – comprehensive review of existing work activity and how it meets current/future organisational needs • Updated work plan - identification of all new and changing work activity to create collective outputs • People review – comprehensive assessment of colleagues' existing skills, knowledge, behaviour • A people development programme based that prioritises meeting the requirements to deliver • Structure review – setting up agile teams to facilitate effective and efficient completion of work, information and communications flow, including governance, reporting and assurance.	plan with finance and Viridian system to support approved • No clear response to the CQC action in relation to EDI – group set up to oversee across people/clinical and agree actions aligned to culture plan – 5.3 programme work to be shared as evidence to CQC. • No oversight and reporting of ER caseload aligned to staff side insights and lack of organisational capability to investigate and manage cases – governance and reporting to be in place - COMPLETE – plan for managers and investigation options appraisal to be developed to be actioned and complete – extended to October 2025
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SUPPORTING OBJECTIVE: To implement the 10 Point Plan to improve resident doctors' working lives, as required by NHSE. The plan sets out clear expectations for NHS England and providers, with a 12-week delivery window for initial actions and further milestones extending into 2026		
OVERARCHING CORPORATE OBJECTIVE: To Develop a people strategy aligned to the Trust's long-term vision, priorities and values, which delivers a workforce plan that ensures the right workforce is in place and that fosters a positive, inclusive culture with high levels of staff engagement to support improved patient outcomes.		
Executive lead: Chief Medical Officer/ Chief People Officer		Board oversight Committee: People Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: na (August 2025)
Overarching comment & rationale for assessment: NHS England launched its national 10-Point Plan on 29 August 2025, requiring all trusts to deliver urgent improvements to junior doctors' working conditions within 12 weeks. Incorporated into the NHS Oversight Framework, the plan mandates Board-level oversight and corrective action if milestones are missed. In response, the Trust has rapidly initiated delivery across all ten areas, led by Chief Medical Officer Dr Kate Lissett in collaboration with the Resident Doctors' Representative Committee (RDRC). A progress update is scheduled for Executive Committee review on 23 October 2025. Existing resources—such as the Flexible Working Champion and the 2025/26 Doctors in Residence Support Booklet—are being aligned with the national plan to ensure a joined-up local response. With early actions underway and governance structures in place, the current assurance level is rated Satisfactory, indicating reasonable confidence in timely delivery, while recognising that full compliance and measurable outcomes are still in progress.		
Risk to delivery:		
Aggravating factors: Compressed timescale for delivery – a wide range of improvements must be implemented or initiated within 12 weeks, creating pressure on capacity and coordination.	Mitigating factors: <i>(Described below)</i> Clear leadership & accountability: The CMO supported by DME, education leadership madn medical HR are leading the programme and reporting progress to the Board, ensuring governance oversight. Structured implementation: A self-assessment audit is underway, with an action plan co-developed with the Resident Doctors' Committee. Progress will be reviewed at the Executive Committee in October 2025. Existing support: The Trust's Flexible Working Champion, Support Booklet, and wellbeing resources provide a strong foundation and are being aligned with the national plan. Governance & monitoring: The programme is embedded in the Board Assurance Framework and overseen by the People Committee, with regular reporting to escalate and address issues promptly.	Gaps in control & associated actions: - Workplace wellbeing audit & facilities improvement plan –Due November 2025: Conduct a comprehensive audit of priority areas (rest spaces, mess amenities, on-call parking, 24/7 staff catering, remote working options for study) and develop action plans to address any shortfalls. - Board-level leadership -in progress (October 2025): A senior lead for resident doctor wellbeing (Chief Medical Officer) has been confirmed, and a resident doctor representative to the Board will be identified, meeting the requirement for dedicated leadership within 6 weeks - Rota management compliance (8-week/6-week rule) – Ongoing from Sept 2025: Ensure all junior doctors receive work schedules at least 8 weeks before rotation start, and detailed rotas ≥6 weeks in advance. Compliance will be monitored for each rotation cycle going forward, with any breaches investigated and corrected immediately - Payroll accuracy improvement programme – In progress (Q3 2025/26): The Trust has joined the national junior doctor payroll improvement initiative to eliminate rotation-related pay errors. Board-level payroll governance is established, and the goal is a

		≥90% reduction in rotation-induced payroll errors by March 2026, with progress reports submitted nationally • Mandatory training portability – In place (October 2025): The Trust is enforcing the cross-organisation Statutory and Mandatory Training MoU (May 2025) to accept prior training records for incoming resident doctors. This is now standard practice, preventing doctors from having to needlessly repeat mandatory training when they rotate. • Study leave expense reimbursement – Due November 2025: Review and streamline the process for reimbursing course and travel expenses. By Nov 2025, implement a system to reimburse all approved study leave expenses within 4–6 weeks of claim submission (upon receipt of valid proof of purchase, rather than waiting for course completion)
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
Through PGMEC, regular implementation meetings with project leads are held to track progress on each of the 10 actions and resolve operational issues as they arise. - Exception reporting by junior doctors is actively monitored. The Guardian of Safe Working Hours provides quarterly reports on exception reports (additional hours, safety concerns) to management and the Board, ensuring that overwork or safety issues are identified and addressed in a timely manner. - Resident Doctors' Representative Committee (RDRC) feedback is utilised for real-time insight. Issues raised by RDRC reps (e.g. in Guardian oversight meetings) inform immediate operational adjustments to rota staffing or working conditions.	The People Committee to receive a monthly update on this objective, including a review of progress and outstanding risks. The Committee scrutinises delivery against the 10 Point Plan and ensures that any slippage or barriers are challenged and mitigated -Executive oversight is maintained via the Executive Committee and internal performance reviews. A dedicated progress report on resident doctors working lives is scheduled at the Executive Committee in October 2025 for assurance	NHSE Oversight Framework monitoring: Starting Autumn 2025, NHS England will publish trust-level metrics on key aspects (availability of basic facilities, compliance with advance rota notice, incidence of payroll errors, etc. - Regulatory reviews: Periodic NHSE Senior Leadership visits (annual) and CQC well-led inspections include evaluation of workforce wellbeing and organisational culture Educational oversight: External bodies like the General Medical Council (GMC) and Health Education England (Deanery) conduct annual surveys (e.g. GMC National Training Survey) and quality assurance visits that gauge junior doctor satisfaction and training conditions. Feedback from these independent assessments serves as a third-line check, highlighting areas of good practice or concern that the Trust can act upon.

SUPPORTING OBJECTIVE: Full definition and resourcing of Our Plan for Better Care is in place; alongside the phases of delivery contained therein.		
OVERARCHING CORPORATE OBJECTIVE: Develop and deliver a clear strategic vision for the Trust		
Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: Building a Brighter Future Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: n/a (August 2025)
Overarching comment & rationale for assessment: - Development of each workstream plan on a page identified resource requirements which informed the funding request to Recovery Support Programme and a wider 'call to arms' to staff in the wider organisation - The Trust is in receipt of the non-recurring funding from the Recovery Support Programme and NHSE SW Region to provide additional capacity and subject matter expertise to support delivery - Engagement continues with staff who responded to the 'call to arms' to ensure existing internal capacity is utilised. - Given the scale of the work associated with the IIP, it is recognised ongoing reviews of resourcing will be essential to maintain delivery momentum		
Risk to delivery:		
Aggravating factors: <i>(Described below)</i> • Available resource is continually impacted by sickness absence, turnover and competing demands	Mitigating factors: <i>(Described below)</i> • Governance structure to mitigate resource escalations through support for recruitment or potential reallocation of resource	Gaps in control & associated actions: <i>(Described below- actions must be allocated a timescale for delivery)</i> • Short term resource plan to be completed for Employee Relations by 30.09.25.
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
Existing care group governance meetings provide an opportunity to escalate risk requirements	Executive IIP Oversight meetings provide a monthly opportunity for workstream leads to report on delivery of IIP & escalate issues including resource requirements	Regular meeting with RSP regarding the delivery of IIP

SUPPORTING OBJECTIVE: To engage with key stakeholders, internally and externally in the development of our strategy – ensuring clinical and non-clinical workforce engagement.		
OVERARCHING CORPORATE OBJECTIVE: Develop and deliver a clear strategic vision for the Trust		
Executive lead: Chief Planning and Strategy Officer	Board oversight Committee: People Committee	
Current assessment: Satisfactory (September 2025)	Previous assessment: na (August 2025)	
Overarching comment & rationale for assessment: Engaging and involving key stakeholder groups to inform our strategy development has been a key focus since the work commenced. Key engagement activities include: • Board discussion, and establishment of a fortnightly strategy task-and-finish group which includes exec and non-exec directors alongside care group leadership. • Seven intensive workshops with clinical, operational and support teams using three horizons framework supported by external strategic expertise • Wide internal and external (public/partner) surveys complemented by focus group/drop-in sessions coordinated by our communications team • Continuing formal and informal engagement with key system partners including NHS Devon, Local Authorities, Healthwatch, VCSE, primary care and other providers. • Ongoing informal engagement with internal teams and key leads to test and refine elements of the strategy and regular informal briefings with trust leadership. Feedback from engagement activities has been documented, analysed, shared with participants and used to inform strategy development.		
Risk to delivery:		
Aggravating factors: (Described below) • Complexity of the partnership landscape • Challenging financial/performance position and competing pressures for staff and leaders	Mitigating factors: (Described below) • Strong emphasis of process on engagement and listening • Support of communications team	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) • Challenges
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
Ongoing engagement with senior leadership and key internal/external stakeholders	Non-exec and exec oversight, with governance through fortnightly task-and-finish group and BBF committee.	Regular contact with external partners, and alignment of strategic plans as they are developed and published.

SUPPORTING OBJECTIVE: Strategic alignment for medium-to-long-term transformation designed, with the 10 year plan principles being used as the basis for the strategy.		
OVERARCHING CORPORATE OBJECTIVE: Develop and deliver a clear strategic vision for the Trust		
Executive lead: Chief Planning and Strategy Officer	Board oversight Committee: Building a Brighter Future Committee	
Current assessment: Satisfactory (September 2025)	Previous assessment: na (August 2025)	
Overarching comment & rationale for assessment: Our strategy-in-development is robustly informed by national and regional developments as important strategic context, including the three national shifts (analogue to digital, hospital to community and treatment to prevention) and the ten-year plan with associated technological, medical and innovation implications. It is also aligned with more local strategic developments, including the NHS Devon strategy-in-development, Joint Health and Wellbeing Strategies (owned by local authorities) and other provider strategies – both local and further afield. A set of “signature moves” are described in our draft strategy, through which this direction of travel is embodied. These include 1) Building integrated neighbourhood systems 2) Reimagining acute services 3) Tackling failure demand at scale 4) Clinical culture shift from paternalistic and medicalised care to enabling and preventative 5) Digital, technology and clinical innovation backed by R&D 6) Convening the health and care system through partnerships. The strategy also reflects the importance of shorter-term stability and credibility by explicitly linking to delivery of the “plan for better care” in the coming months.		
Risk to delivery:		
Aggravating factors: (Described below) Potential for external intervention to require a different direction-of-travel – for instance focussing on contracting to core acute services rather than community and preventative focus.	Mitigating factors: (Described below) Strong alignment of our strategy with national and local direction of travel.	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) N/A
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
Continued engagement with partners and checking alignment with emerging strategies and plans (e.g. from NHS Devon).	Regular briefings to task-and-finish group, BBF Committee and Trust Board.	External strategy expert is currently supporting development of our strategy, and progress will be shared with commissioners/regulators as appropriate.

SUPPORTING OBJECTIVE: To work with stakeholders to deliver services in our community where it is both sustainable for our Trust and we are best placed to do so, supporting the population we serve to live well; one of the pillars of the strategy will be integrated neighbourhood teams which will provide proactive, joined up care in the communities in which people live.		
OVERARCHING CORPORATE OBJECTIVE: Develop and deliver a clear strategic vision for the Trust		
Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: na (August 2025)
Overarching comment & rationale for assessment: Our strategy-in-development heavily emphasises the role of integrated neighbourhood teams and community hubs as physical spaces to bring complementary services together form across our services, primary care, local authority, mental health and VCSE community support. A key enabler will be the development of a framework for sharing ownership for health and care services with our local community which will describe the roles and relationships of different partners as well as facilitating improved engagement, involvement and collaborative decision-making. Early implementation of our strategy is expected to involve: • Exploring options that are likely to be easier to implement quickly – for instance where GP services are already located adjacent to our community facilities (e.g. Ashburton or Dawlish). • Targeting opportunities where we have identified potential benefits with primary care partners, such as putting in place “interface services” like phlebotomy, assessment and triage. • Working with primary care, VCSE, mental health and Council partners to consider co-location of other complementary services within a framework that we can evaluate and adjust or build on accordingly.		
Risk to delivery:		
Aggravating factors: (Described below) • Potential conflicts with other organisational perspectives – e.g. GP partners and other NHS or VCSE providers	Mitigating factors: (Described below) • The framework for shared ownership (noted above) will be a key mechanism for aligning perspectives and ensuring decisions are made in the best interests of the community.	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) • Significant work will be required in the course of delivering the strategy to put the framework into place and enact it.
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
Continuing engagement with key partners and prioritisation of signature moves.	Regular briefings to task-and-finish group, BBF Committee and Trust Board, transitioning to new framework following completion of the strategv.	Ongoing engagement with key partners in local community.

SUPPORTING OBJECTIVE: To support initiatives and work collaboratively with stakeholders and our NHS provider colleagues to deliver services that meet the needs of those living in the Peninsula now and in the future; for example: the OneDevon initiatives and PASP workstreams		
OVERARCHING CORPORATE OBJECTIVE: Develop and deliver a clear strategic vision for the Trust		
Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: na (August 2025)
Overarching comment & rationale for assessment: Our current “business as usual” involves close work with partners across Devon and Cornwall, focused through two key lenses: - The Peninsula Acute Provider Collaborative (PAPC) and its associated work programme (PASP) where we are working together to design and deliver new collaborative service models (typically centred on clinical networks) for the long-term, while also addressing short-term operationally fragile services with rapid solutions that are compatible with longer-term aims. - Commissioner-led OneDevon initiatives and work programmes, which incorporate Devon-wide urgent care and planned care improvements alongside nationally-linked initiatives such as the “Getting It Right First Time” (GIRFT) programme. Our strategy-in-development will build on existing relationships across Devon and Cornwall for acute and specialist services (may of which will be delivered through network/partnership models in the future) while building much stronger relationships with the local communities that we serve directly. Our understanding of population health needs and preferences will be much improved in the future through improved business information insights generated by our organisation and in partnership with wider Devon’s population health management activities.		
Risk to delivery:		
Aggravating factors: (Described below) • Potential conflict between long-term and short-term priorities for our organisation and partners • Potential conflicts between our population’s interests and those of wider Devon and Cornwall.	Mitigating factors: (Described below) • Shared goals relating to equity across Devon and Cornwall • Focus given to strategic development and delivery	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) • N/A
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
Development of strategy and plans that are compatible with partner ambitions and jointly align with national direction of travel.	Continuing engagement of senior leads between organisations, with PAPC and through existing relationships.	Engagement of commissioners, regulators and PAPC leadership to provide perspective and alignment.

SUPPORTING OBJECTIVE: Campaigning for, and bringing in resources for, the Trust, especially capital funding post New Hospital Programme decisions consistent and opportunistic briefing and bidding being undertaken.		
OVERARCHING CORPORATE OBJECTIVE: Develop and deliver a clear strategic vision for the Trust		
Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: Building a Brighter Future Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: na (August 2025)
Overarching comment & rationale for assessment: The Trust is part of the New Hospitals Programme with investment prioritised to replace all inpatient wards, create a new planned care centre and to provide a new emergency department due to life expired estate dating back to the 1920s, 1960 and 1970s that are not suitable for modern healthcare with poor clinical adjacencies and flow impacting on productivity and quality of care. However due to constrained capital funds and realistic deliverability, work has been national paused on the scheme until 2030 at the earliest with a likely construction commencement date of 2033-2035. This means that new investment will not be operational until the latter part of the next decade. Incidents relating to estate failures including, poor ventilation, electrical failures, sewage overflows, subsidence, concrete failures and inability to manage temperature impact the delivery of clinical services; including a detrimental impact on delivering modern clinical care, significant impact on statutory performance standards, risks to health and safety regulatory compliance, reductions in productivity and additional costs of remedial works. High levels of Critical Infrastructure Risk (CIR) alongside a significant burden of backlog maintenance mean the estate is fragile and the risk of failure of infrastructure is high. Limited capital is dedicated to the Trust to manage and mitigate this risk meaning it will be essential to secure significant external capital to mitigate and manage risk to acceptable levels. Consistent engagement with NHS England, regional teams, local MPs, ICB and system partners is being undertaken to highlight critical estate risks, patient safety issues, and service delivery impacts. The Trust has developed a clear pipeline of prioritised capital schemes, and will continue to develop robust business cases, enabling opportunistic bidding when national funding rounds or system allocations arise. This will be complimented by an updated Estates strategy and Trust wide Development Control Plan (DCP). While the external funding environment remains highly competitive and uncertain, the Trust's structured approach to advocacy, alignment with national priorities (Elective Recovery, UEC, Diagnostics, net zero), and readiness to submit credible bids provides a reasonable level of assurance that all opportunities to secure capital will be maximised. Residual risk remains high due to the scale of the capital deficit and the dependency on national decisions outside of the Trust's direct control.		
Risk to delivery:		
Aggravating factors: (Described below) - The estate is heavily dilapidated with a reported £62,253,523 backlog in the 2024 ERIC return. It should be noted that this is only the cost to remediate to a condition b, not the cost to fully modernise or meet current clinical or compliance standards. Real estimates of true capital needs can be between double and up to 5 times the ERIC return figure, depending on local site conditions and scope of ambition. - Large backlog maintenance and safety-critical estate risks exceed available baseline capital - National capital budgets remain constrained with significant competition across trusts. - Uncertainty following New Hospital Programme (NHP) decisions, with many schemes including the Torbay Hospital scheme deferred by a decade.	Mitigating factors: (Described below) - Clear pipeline of prioritised capital schemes aligned to national priorities (elective recovery, UEC, net zero, diagnostics). - Consistent lobbying and engagement with MPs, ICS leaders, NHSE, and regional teams. - Robust business case development and readiness to submit bids at short notice ("shovel-ready" projects). - Active participation in system capital planning to influence allocations and strengthen bids. - Demonstrated delivery track record on previous capital schemes, enhancing credibility. - Critical Infrastructure Risk funding for 2025/6 application approved providing £7.2m additional capital funding with an invitation to submit a further in year bid.	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) - Lack of certainty on medium/long-term national funding allocations post-NHP delay. - Limited internal capital headroom to address urgent risks without external funding. - No guarantee of success in national competitive bidding rounds despite strong cases. - Revenue affordability constraints may limit ability to accept or progress capital funding even if secured. - Influence on national prioritisation decisions ultimately limited to advocacy, not control.

- External approval processes (NHSE, DHSC, Treasury) are lengthy and subject to political priorities. - Dependence on wider system prioritisation may dilute Trust-specific bids.	New six facet survey has been commissioned and will be completed before the end of the year.	
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- Executive Directors and Capital Development Director leading capital strategy, lobbying, and business case development. - Clear risk-based prioritisation of schemes through Estates Strategy and Capital Planning processes. - Engagement with ICS partners and NHSE regional teams to influence allocations. - Routine monitoring of pipeline schemes, risk registers, and backlog maintenance data.	- Board-level oversight via Executive Committee and Building a Brighter Future Committee. - Regular review of capital risk and assurance within the Board Assurance Framework (BAF). - Independent assurance from ICS capital planning groups on alignment and prioritisation. - Compliance checks against national planning guidance, NHSE business case requirements, and governance frameworks.	- Internal Audit reviews of capital planning, prioritisation, and governance processes. - External Audit opinions on financial statements and capital accounting treatment. - Independent reviews by NHSE/DHSC (e.g. Gateway Reviews, HMT business case scrutiny). - Parliamentary and regulatory oversight (NAO, CQC, Public Accounts Committee inquiries) into capital allocations and NHP delivery

SUPPORTING OBJECTIVE: To provide a resilient digital infrastructure, that underpins the delivery of clinical and corporate services. To implement the electronic patient record (EPR), improving operational, clinical and resourcing productivity and quality.		
OVERARCHING CORPORATE OBJECTIVE: Develop and deliver a clear strategic vision for the Trust		
Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: Building a Brighter Future Committee
Current assessment: Limited (September 2025)		Previous assessment: na (August 2025)
Overarching comment & rationale for assessment: Current IT systems and supporting infrastructure will not meet the current of future business need. The Trust has made significant investment in the upgrades to networks and IT infrastructure to reduce the risk of IT failure. The risk of legacy IT systems fragility will only be mitigated with the successful implementation of Epic, which is scheduled to go-live in April 2026. General cyber security vulnerabilities are significant threats to IT systems globally and recent cyber incidents have had significant and lengthy implications for healthcare providers in the UK. 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). The EPR Programme, working alongside the respective EPRR teams in UHP, RDUH and TSD, will be assessing the risks relating to cyber-attacks on the RDUH-hosted datacentre. The aim is to ensure the appropriate technical mitigations are in place before go-live to enable a speedy recovery, and to ensure the EPRR teams are aware of these timescales and worst-case impact (e.g. all of Devon acute provision unavailable) so appropriate business continuity plans can be designed, implemented and tested.		
Risk to delivery:		
Aggravating factors: (Described below) Failure to meet cyber security or information governance standards. Cyber-attack – local or global e.g. malware / ransomware / zero-day threats.	Mitigating factors: (Described below) - Data Security and Protection Toolkit (DSPT) 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 Care CERT 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). - EPR workstream have developed a cyber assurance framework, based on DSPT, to assess and assure the Epic digital infrastructure.	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) - A sophisticated cyber-attack leading to security measures that do not mitigate the risk - Cyber Security manager providing a series of best practice reviews which will be self assessed and presented to Audit & Risk Committee
Computer hardware risks. Key infrastructure components failing due to age/lack of support.	IT Infrastructure investments being progressed, supported by 2025/26 CDEL and EPR capital funding. IM&T Prioritisation with risk mitigation as a significant criterion in place to ensure that investment is made into the most critical infrastructure areas.	- Longer term capital and revenue investment programmes are required to ensure that digital infrastructure refresh cycles, improvements and maintenance are sustained. - IM&T, along with the Capital Investment Delivery Group (CIDG) has a rolling 5 year plan identifying key investments for capital investment

EPR business case requires significant investment from the Trust capital programme which may lead to de-prioritisation of critical kit requirements	- EPR FBC and national funding approved - Budgetary requirements monitored through the EPR programme board and trust Capital Investment Delivery Group	
Computer infrastructure risks - Datacentres.	2024/25 capital plan. - Data centre provision being transitioned from legacy on-premise to best-in-class managed infrastructure services.	- Risk to EPR programme if delivery does not complete by the end of December 2025. - Plans in place to pause the project with minimal financial impact whilst enabling it to restart post Epic go-live.
Computer patching risks.	Implementation of the M365 'InTune' technologies.	
Historic limited functionality of the PARIS system.	The procurement of a new system driven by Torbay Council for ASC, with the Health component transitioning into the EPR.	
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
Epic and associated IT infrastructure/hosting implementation and a legacy IT systems change freeze.	Data Security Protection Toolkit/Cyber Assessment Framework and ASW validation of evidence of assertions made within the DSPT, and working towards the nationally advised Cyber Essentials/Cyber Essentials+ standards	ASW specific audits focussing on key areas as identified in the annual audit plan

SUPPORTING OBJECTIVE: Create and cultivate a culture of innovation through research and development and digital futures, establishing centres of excellence for research and innovation; increasing the quality of our services, our productivity and attracting high quality people		
OVERARCHING CORPORATE OBJECTIVE: Develop and deliver a clear strategic vision for the Trust		
Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Improving – Satisfactory (September 2025)		Previous assessment: na (August 2025)
Overarching comment & rationale for assessment: The Digital Innovation & Development programme continues to demonstrate satisfactory progress with encouraging upward trends across key performance indicators. The planned launch of the Digital Innovation Steering Group (DISG) governance framework will provide enhanced oversight and structured pathways for innovation projects from concept into implementation stages. We continue to build upon our talent pipeline through both an apprentice model harnessing our relationship with SDC but also for PGR students through a new link to Falmouth University. Key achievements and upcoming developments include: • Acceptance of Digital Futures as a Centre of Excellence (CoE) and testbed for the Health Innovation Network, enhancing our regional leadership role in digital innovation • Preparation for DISG launch with four-gateway governance model ensuring appropriate risk management and resource allocation • Strong performance in strategic alignment with national priorities, including the NHS 10 Year Plan strategic framework • Developing partnerships with external organisations and academic institutions • Secured fourth year support and funding for the InSites CEP (Clinical Entrepreneur Programme) from NHS England, ensuring continued networking with innovation developments • Development of horizon scanning function for systematic scoping of external innovation opportunities • Ongoing formal establishment of innovation governance structures Areas requiring continued focus include cultural transformation and regulatory compliance, both currently rated as "Limited" but showing positive trajectories with targeted improvement initiatives underway, including an innovation comms plan. A particular focus is needed on implementation support capacity and skillsets to ensure successful translation of innovations into practice.		
Risk to delivery:		
Aggravating factors: (Described below) • Implementation Support Capacity - Critical gap in dedicated implementation support resources. • Regulatory Complexity- Evolving regulatory landscape for digital health innovations, particularly around AI and data governance requirements • Skills Gap - Variation in digital literacy across staff groups, potentially impacting adoption rates of new technologies	Mitigating factors: (Described below) • External Partnerships and Support Networks provide access to implementation expertise and resources, though internal team structure and capacity require review • NHS England Regulatory Guidance and DTAC Framework and NP part of NHSE steering committee for ai. Trust AI Policy for ExCo review. • Structured Digital Skills Development Programme has launched level 1 on our LMS	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) • Implementation Support Capacity and Skillsets. Need to establish dedicated implementation support through restructure activity for coverage of full innovation pipeline Timescale: Q4 2025/26 • Benefits Realisation Tracking - Implement standardised benefits realisation framework with regular monitoring and reporting Owner: NP

	with roadmap for further education and training deployment. Ongoing further discussions with government levy providers.	
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
• Digital Futures daily operational oversight of active innovation projects and initial assessment of all proposals • Clinical oversight and safety assessments for healthcare-related innovations with user engagement from our DF Clinical Lead. • Structured project management with regular milestone reviews and risk identification at project level within monthly team activity.	• Digital Innovation Steering Group will provide steering and gateway assessments at innovation key decision points (launching Q4 2025/26) • Quality Assurance Committee delivering board-level oversight of innovation governance and approval of resource commitments • Information Governance ensuring data protection compliance oversight and information security risk management	• Health Innovation Network South West monthly connect points and external device regulation expertise through Ethos providing specialist assurance and regulatory guidance • Academic partnerships providing independent evaluation of innovation outcomes and peer review of methodologies • NHSE InSites program provides regulation, evaluation and governance information sharing and knowledge exchange.

SUPPORTING OBJECTIVE: By March 2026 to have developed and agreed a medium-term financial plan that gets the Trust to a breakeven position within the planning period through productivity and efficiency improvements and service transformation.		
OVERARCHING CORPORATE OBJECTIVE: Providing a fit for purpose environment, where our people have the conditions to succeed and deliver excellent patient care.		
Executive lead: Chief Finance Officer		Board oversight Committee: Finance and Performance Committee
Current assessment: Satisfactory (September 2025)		Previous assessment: Satisfactory (August 2025)
Overarching comment & rationale for assessment: The Trust is required to demonstrate how it will become financially sustainable over the next 5 years. The last assessment of the recurrent underlying financial position (ULP) of the Trust during planning for 2025/26 showed a recurrent underlying deficit of £81.7m and the medium-term financial plan indicated that the Trust would return to financial balance in 2028/29 based on a number of system wide assumptions. The Trust has recently undertaken a reassessment of its forecast outturn for 2025/26, and it is likely that delivery of the financial plan in 2025/26 will be achieved through a higher level of non-recurrent savings than planned, therefore worsening the underlying financial position further. Planning for 2026/27 has now started and a full assessment of the exit underlying position is being undertaken. This will need to be agreed and reflected in the medium terms financial plan before it is then adjusted for income and expenditure growth and inflation, convergence, impacts on known transformational changes i.e. Adult Social Care, Continuing Healthcare, EPR, One Devon Corporate Shared Services etc and this will then inform the required level of productivity and efficiency required year on year throughout the planning period (5 years) to return the organisation to financial sustainability.		
Risk to delivery:		
Aggravating factors: (Described below) The exit underlying position of the Trust for 2026/27 does not improve sufficiently due to higher than planned level of non recurrent CIP delivery in year	Mitigating factors: (Described below) Forecast review undertaken at month 4, additional mitigating actions identified and added to the cost improvement plan	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery) - Further work required to assess in year mitigations as recurrent/non recurrent by the end of September - Care Groups to either identify recurrent pay savings or agree to a recurrent vacancy factor being applied to their budgets by end of September
National planning guidance and allocations when published increase the system requirement to deliver CIP (Convergence, Deficit repayment etc)	- Increased focus on identifying productivity and efficiency opportunities using service line reporting, model hospital and corporate benchmarking - Service developments identified and business cases developed to improve patient pathways to meet demand (i.e. Frailty)	Further work required to analyse productivity and benchmarking information and develop plans for improvement to be included in the 2026/27 planning round by end of October
The Trust does not secure the required level of additional recurrent income from partners to support Adult Social Care and CHC	- Formal notice to be given to ICB relating to CHC to either transfer responsibility of agree risk share by end of December - Review underway to assess the financial and non-financial risks of exiting the s75 arrangements with a view to a Board decision in December 2025.	

Impact of transformational changes either do not materialise or are delayed in implementation	Devon Wide PMO established to track and monitor delivery of transformational change	Further work required to identify all changes with timescales and estimate financial impact by end of October
Three lines of defence:		
First Line of Defence - Operational and Management Controls CFO and CSPO update reports to ExCo, FPC and Board	Second Line of Defence - Oversight Functions and Internal Assurance Our plan for Better Care oversight and Executive Operations Group	Third Line of Defence - External Assurance: Monthly Exec to Exec meetings with ICB and RSP/NHS Region Southwest

SUPPORTING OBJECTIVE: By March 2026 to have delivered the planned forecast outturn deficit (£8m) and to have improved the exit underlying financial position through delivery of recurrent cost improvement		
OVERARCHING CORPORATE OBJECTIVE: Providing a fit for purpose environment, where our people have the conditions to succeed and deliver excellent patient care.		
Executive lead: Chief Finance Officer		Board oversight Committee: Finance and Performance Committee
Current assessment: Limited (September 2025)		Previous assessment: Limited (August 2025)
Overarching comment & rationale for assessment: The Trust Board agreed a financial plan for 2025/26 to deliver a deficit of £8m. As at month 5 the Trust remains on plan year to date and has exceeded delivery of its CIP programme by £1.7m, however following a review of the forecast outturn based on current run rate, there is a gross risk of £19.8m to delivering the £8m planned deficit. Actions are in place to reduce run rates and in total these actions give the ability for the Trust to deliver the forecast plan for 2025/26. As yet, there is only confidence in the ability to deliver £11.2m of the further savings; with a further £4.8m of high-risk actions identified, leaving a gap of £3.8m. The current risk to delivering the forecast outturn is therefore £8.6m. In addition to delivering the required level of savings in year there is a requirement to ensure that the outturn delivers the required level of savings recurrently to ensure the exit underlying run rate improves.		
Risk to delivery:		
Aggravating factors: <i>(Described below)</i> Levels of growth on services exceed planned levels resulting in a requirement to increase resource to maintain performance and safety	Mitigating factors: <i>(Described below)</i> - Increased focus on identifying productivity and efficiency opportunities using service line reporting, model hospital and corporate benchmarking - Service developments identified and business cases developed to improve patient pathways to meet demand (i.e. Frailty)	Gaps in control & associated actions: <i>(Described below- actions must be allocated a timescale for delivery)</i> Further work required to analyse productivity and benchmarking information and develop plans for improvement to be included in the 2026/27 planning round
The planned level of cost improvement is not delivered on a recurrent basis	- Programme Management Office established with clear standard operating procedures to track and report on CIP assurance - Monthly reviews of Financial Position including CIP delivery in place with all Care Groups - Forecast review undertaken at month 4+ to assess risks and identify further mitigations to ensure recurrent delivery of the required level of savings - Increased focus on identifying productivity and efficiency opportunities using service line reporting, model hospital and corporate benchmarking	There is a requirement to embed the new accountability framework across all domains ie Finance, Performance, Workforce, Quality and Safety through Executive Operations Group by end of September
The planned level of deficit support funding is not secured if the system does not deliver its financial plan	- System management of cash led by ICB with Devon wide cash risk management policy in place - Cash Committee meeting monthly	System working to identify sufficient mitigations to maintain cash at a level where all organisations can meet their obligations as they fall due by the end of September

	Daily cash flow monitoring and increased management of Debtors and credit control	
Digital and physical environments are not fit for purpose resulting in a significant backlog maintenance requirement and increased operating costs	- Multi year capital programme and bids for additional cash backed external funding - Regular re prioritising of capital allocations to address highest infrastructure risks.	Business cases submitted for national PDC to support critical infrastructure and constitutional standards awaiting national approval by end of September
Three lines of defence:		
First Line of Defence - Operational and Management Controls - CFO reports to ExCo, FPC and Board - Monthly review and challenge of Care Group financial performance (YTD and Outturn) at EOG, Financial Review meetings	Second Line of Defence - Oversight Functions and Internal Assurance Our plan for Better Care oversight and Executive Operations Group	Third Line of Defence - External Assurance: Monthly Exec to Exec meetings with ICB and RSP/NHS Region Southwest

SUPPORTING OBJECTIVE: To assess and cultivate opportunities to deliver services across the Devon ICS as “One Devon” and Peninsula; exploring innovative operating models where appropriate.		
OVERARCHING CORPORATE OBJECTIVE: Providing a fit for purpose environment, where our people have the conditions to succeed and deliver excellent patient care.		
Executive lead: Chief Operating Officer	Board oversight Committee: Finance and Performance Committee	
Current assessment: Limited (September 2025)	Previous assessment: na (August 2025)	
Overarching comment & rationale for assessment:		
Our current “business as usual” involves close work with partners across Devon and Cornwall, focused through two key lenses: - The Peninsula Acute Provider Collaborative (PAPC) and its associated work programme (PASP) where we are working together to design and deliver new collaborative service models (typically centred on clinical networks) for the long-term, while also addressing short-term operationally fragile services with rapid solutions that are compatible with longer-term aims. - Commissioner-led OneDevon initiatives and work programmes, which incorporate Devon-wide urgent care and planned care improvements alongside nationally-linked initiatives such as the “Getting It Right First Time” (GIRFT) programme. Our strategy-in-development will build on existing relationships across Devon and Cornwall for acute and specialist services (may of which will be delivered through network/partnership models in the future) while building much stronger relationships with the local communities that we serve directly. Our understanding of population health needs and preferences will be much improved in the future through improved business information insights generated by our organisation and in partnership with wider Devon’s population health management activities.		
Risk to delivery:		
Aggravating factors: (Described below)	Mitigating factors: (Described below)	Gaps in control & associated actions: (Described below- actions must be allocated a timescale for delivery)
• Potential conflict between long-term and short-term priorities for our organisation and partners • Potential conflicts between our population’s interests and those of wider Devon and Cornwall	• Shared goals relating to equity across Devon and Cornwall • Focus given to strategic development and delivery	N/A
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance
Development of strategy and plans that are compatible with partner ambitions and jointly align with national direction of travel.	Continuing engagement of senior leads between organisations, with PAPC and through existing relationships.	Engagement of commissioners, regulators and PAPC leadership to provide perspective and alignment

Organisational Risk Map (ORM or Risk Map) – September 2025

	OPERATIONAL RISKS FROM DATIX				STRATEGIC RISK OVERSIGHT			OVERARCHING PROFILE	
Risk type	Overarching Risks in Datix	Relevant risks scoring 13 and above on Datix	Risk score*	Risk appetite	Risk target score	Risk tolerance	Associated BAF objective	Analysis & commentary	Adjusted overarching risk position
Clinical Safety Risk:	3567: Failure to Comply with Regulation 12: Safe Care and Treatment under the Health and Social Care Act 2008.	4001, 1947, 3287, 1085, 2948, 2965, , 4254 4137, , 3502	12	Low	1	Up to 5	Quality and Patient Experience: Personalised care	The median risk score for all risks held on Datix against this risk type is 12 however the median of risks scored above 13 is 16, with 9 risks scoring above 13 currently recorded. The median scores are above the Trust's agreed risk tolerance score. The factors increasing and decreasing risk this month were: Long waits for MH patients in ED, increase in referrals above capacity for diabetes and endocrinology and lack of a dedicated emergency theatre for obstetrics.	Moderate Which is above the Trust's agreed risk appetite.
Performance Risk:	1815: Non-Compliance With the National Cancer Waiting Time Targets. 1070: Trust Patient Flow Pressures Resulting in Ambulance Handover Delays, Poor Levels of Care and Performance for 12hr & 4hr Standard	3249, 2878, 1815, 1070, 4215	9	Low-Moderate	5	Up to 12	Operations and Performance Standards	The median risk score for all risks held on Datix against this risk type is 9 however the median of risks scored above 13 is 15, with 5 risks scoring above 13 currently recorded. The median scores are within the Trust's agreed risk tolerance score. Failure to meet the national access standards for all care domains would hold a high level of risk. It is essential the organisation meets the commitments set in the operating plan for the FY, ensuring a managed financial and quality risk position for the organisation. There has been growth in demand and in particular in high volume specialties not mitigated by ICB demand management schemes, outside of the operational plan commissioned levels. A cancer recovery plan is now in place and will be monitored through a fortnightly review with the Director of Operations. A recovery trajectory has been set to achieve recovery to expected performance standards in November 25; however the forecasted position shows a worsening of performance in August before it begins to improve. UEC performance has improved during Q1 and into Q2 despite growth in non-elective demand. The Trust July performance position demonstrated the best 4-hour performance since June 2022 and the best ambulance handover performance since pre covid. It should be noted that resilience within our recovery is still to be demonstrated and the ability to maintain our performance improvement through winter will be a key demonstrable of the reduction of this risk.	High Which is above the Trust's agreed risk appetite This has been adjusted upwards to reflect the operational performance and progress against NOF4 exit criteria.
Environmental Impact Risk:	3566: Trust's Failure to Achieve Objectives Set Out in the Trust's 2040 Green Plan		12	Moderate	6	Up to 12	Sustainability: Green Plan/ Environmental	The median risk score for all risks held on Datix against this risk type is 12 with 0 risks on datix scoring above 13. The median scores are within the Trust's agreed risk tolerance score.	Moderate

	OPERATIONAL RISKS FROM DATIX				STRATEGIC RISK OVERSIGHT			OVERARCHING PROFILE	
Risk type	Overarching Risks in Datix	Relevant risks scoring 13 and above on Datix	Risk score*	Risk appetite	Risk target score	Risk tolerance	Associated BAF objective	Analysis & commentary	Adjusted overarching risk position
								Strong progress has been made in improving the environmental efficiency of the organisation, particularly through soft sustainability measures. However, the opportunity for improvement sits primarily in the decarbonisation space and this requires significant investment. Some of this is being achieved through the delivery of the capital programme and, some of it will be achieved through the Building a Brighter Future programme. However, without significant investment in environmentally friendly alternatives to the current asset stock, particularly the residual stock which will remain post-BBF, the aspirations of the Trust's Green Plan and Net Zero 2040, will not be realised.	Which is within the Trust's agreed risk appetite
Financial Risk:	2996: Financial Sustainability Risk Rating for 23/24 and 24/25	, , 3274, 2996, 3867, 1083, 3486,	9	Low-Moderate	6	Up to 12	Financial Sustainability & Productivity	The median risk score for all risks held on Datix against this risk type is 9 however the median of risks scored above 13 is 20, with 5 risks scoring above 13 currently recorded. The median scores are within the Trust's agreed risk tolerance score. There is a risk that, despite the significant work undertaken and supported by the NHSE team, that the Trust fails to deliver sufficient improvement to achieve its own, and consequently systems, five-year 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. The impact of this would be significant.	High – Very High Which is above the Trust's agreed risk appetite This has been adjusted upwards to reflect the significant financial deficit the Trust is managing and correlating NOF4 segmentation.
Health and Safety Risk:	2801: Trust Controls Unable to Minimise Staff / Patient / Visitor Health and Safety Related Incidents (Overarching Risk)	2801,2957, 2348, 2639, 2179, 3922, 3733, , 4124, 3664	9	Low	1	Up to 5	Estates	The median risk score for all risks held on Datix against this risk type is 9 however the median of risks scored above 13 is 15, with 8 risks scoring above 13 currently recorded. The median scores are above the Trust's agreed risk tolerance score. The fragility of our estate combined with a limited financial envelope for capital increases risk. This risk is well understood at Board and being managed appropriately with a planned programme of work, whilst it is acknowledged the risk cannot be mitigated in totality.	High- Very high Which is above the Trust's agreed risk appetite.
Infection Control Risk:	3944 Safe Care Requires a Hierarchy of Controls to Prevent and Control/ Manage the Spread of Infectious Diseases. (Overarching Risk)	3944,	8	Low	1	Up to 5	Quality and Patient Experience: Personalised care	The median risk score for all risks held on Datix against this risk type is 8 with 1 risks on datix scoring above 13. The median scores are above the Trust's agreed risk tolerance score.	Moderate Which is above the Trust's agreed risk appetite

	OPERATIONAL RISKS FROM DATIX				STRATEGIC RISK OVERSIGHT			OVERARCHING PROFILE	
Risk type	Overarching Risks in Datix	Relevant risks scoring 13 and above on Datix	Risk score*	Risk appetite	Risk target score	Risk tolerance	Associated BAF objective	Analysis & commentary	Adjusted overarching risk position
								The factors increasing and decreasing risk this month were: increased escalation as IPC numbers increased and a reduced risk score of 9 from 15 as a plan has now been put in place to clean incubators as per national guidance due to lack of space.	
Information & Technology Risk:	1159: Current IT Systems and Infrastructure Will Not Meet Future Demands.	3460, 2838, 2830, 3839, 2831, 1174, 1159, 3869, 2920, 4175	10	Moderate	6	Up to 12	Digital and Cyber Resilience	The median risk score for all risks held on Datix against this risk type is 10 however the median of risks scored above 13 is 15, with 10 risks scoring above 13 currently recorded. The median scores are within the Trust's agreed risk tolerance score. The factors increasing and decreasing risk are: •EPR implementation progress •iOS mobile device hardware replacement. •Addressing collapsed fibre ducts between the two main datacentres (procuring to relocate to hosted datacentres), this project is proceeding as expected. Programme governance is set up and exec escalation in place. •Upgrade of 2008 & 2012 server platforms. •Windows 11 upgrade project. •PC/Laptop hardware replacement to meet Epic warranted environment specifications. •Imprivata single sign-on (SSO). •Horizon virtual desktop infrastructure (VDI) platform deployment. •Replacement of hardware running unsupported operating systems. •Implementation of multi-factor authentication (MFA) as per in-year NHS England Policy change. •SharePoint environment scheduled patching. •Integration of Cynerio with Aruba Clear Pass Policy Manager to improve micro segmentation of network	High Which is above the Trust's agreed risk appetite This has been adjusted upwards to reflect the significant strategic priorities in this area.
Service/ Business Interruption Risk:	1083: Inability to maintain/operate the estate in accordance with customer needs, NHS HTMs & Stat/Mand reqts within allotted funding	3684, 3493, , 3621, 3804, 2542, 2353, 2307, 1069, 3485, 3484, 2429, 3521, 2718, , 3823, , , , 3519, 4222	9	Low	1	Up to 5	Financial Sustainability & Productivity Operations and Performance Standards	The median risk score for all risks held on Datix against this risk type is 9 however the median of risks scored above 13 is 16, with 16 risks scoring above 13 currently recorded. The median scores are above the Trust's agreed risk tolerance score. - Digital and physical environments are not fit for purpose, significant back log maintenance infrastructure challenge (£120m+). - NHP potential investment moved out to mid 2030's. - In line with the above, the fragility of our estate combined with a limited financial envelope for capital increases the risk of business interruption but also infection control, as we predominantly have wards (which do not	Moderate - High Which is above the Trust's agreed risk appetite

	OPERATIONAL RISKS FROM DATIX				STRATEGIC RISK OVERSIGHT			OVERARCHING PROFILE	
Risk type	Overarching Risks in Datix	Relevant risks scoring 13 and above on Datix	Risk score*	Risk appetite	Risk target score	Risk tolerance	Associated BAF objective	Analysis & commentary	Adjusted overarching risk position
								contain infection as well as single rooms); though this is managed as well as possible.	
Workforce Risk	1697: Insufficient permanent workforce capacity to meet patient need (Overarching Risk).	, 3546, 1697,, 3362, 2928,, 2131,, 3789, 3456, 4136, 2037, 4077, 3956, 3396, 4163, 3607, 3183	12	Moderate	6	Up to 12	People	The median risk score for all risks held on Datix against this risk type is 12 however the median of risks scored above 13 is 16, with 15 risks scoring above 13 currently recorded. The median scores are within the Trust's agreed risk tolerance score. Our plan for better care people programme describes a granular approach to deliver a sustainable, workforce plan with an efficient, agile and high performing workforce aligned to system and organisational priorities	Moderate Which is within the Trust's agreed risk appetite
EDI Risk	3547: Upwards Trend in Equality, Diversity and Inclusion (EDI) Related Investigations	3547	12	Low	1	Up to 5	Equality, Diversity and Inclusion	The median risk score for all risks held on Datix against this risk type is 12, there are 0 risks scored above 13 currently recorded. The median scores are above the Trust's agreed risk tolerance score. There has been significant organisational learning from the recent investigations, themes arising from FTSU guardian. This is acknowledged by the Board who have prioritised understanding, learning from escalations to build and nurture a culture in line with our values.	Moderate - High Which is above the Trust's agreed risk appetite
Education Risk	3750: No Access to NHSE Education and Training Contract Income	3750	9	Low-Moderate	5	Up to 12	People	The median risk score for all risks held on Datix against this risk type is 9 however there are no risks above 12 on the system The median scores are within the Trust's agreed risk tolerance score. The factors increasing and decreasing risk this month were: - The NHSE income gap remains £2.1m. - The Trust has received the NHSE income schedule, and the budget forecasting will now be reconciled to reflect this. - The NHSE related expenditure is being approved in the meantime to meet contractual expectations. - Risk to be removed from DRR as no longer relevant	Moderate Which is above the Trust's agreed risk appetite
Strategy & Transformation Risk	3774: Services that are "fragile" or have gone beyond fragility into "crisis" (Overarching Strategic Risk)	3774,	15	Moderate	6	Up to 12	Strategy & Transformation	The median risk score for all risks held on Datix against this risk type is 15 however the median of risks scored above 13 is 15, with only 1 risk scoring above 13 currently recorded. The median scores are above the Trust's agreed risk tolerance score. PAPC fragile services work proceeding. TSD leading work on dermatology and Max Facs. CEO/CMO	High Which is above the Trust's agreed risk appetite

	OPERATIONAL RISKS FROM DATIX				STRATEGIC RISK OVERSIGHT			OVERARCHING PROFILE	
Risk type	Overarching Risks in Datix	Relevant risks scoring 13 and above on Datix	Risk score*	Risk appetite	Risk target score	Risk tolerance	Associated BAF objective	Analysis & commentary	Adjusted overarching risk position
								attending board meetings for updates on non TSD led services	
Collaboration Risk)	3486: Failure to Deliver Strategies that Supports the Delivery of System Priorities on Finance and Workforce	3486,3485, 3484	16	Moderate	6	Up to 12	Strategy & Transformation	The median risk score for all risks held on Datix against this risk type is 16 however the median of risks scored above 13 is also 16, with 3 risks scoring above 13 currently recorded. The median scores are above the Trust's agreed risk tolerance score. Trust strategy is being written for the September Board. Workshops being held and staff engagement launched.	High Which is above the Trust's agreed risk appetite
Communication & reputational Risk:	3557: Potential for Negative Publicity, Public Perception or Uncontrollable Events that may Impact on the Trust's Reputation	3546,	9	Low-Moderate	5	Up to 12	N/A	The median risk score for all risks held on Datix against this risk type is 9 however the median of risks scored above 13 is 16, with 1 risks scoring above 13 currently recorded. The median scores are within the Trust's agreed risk tolerance score. There has been significant political and stakeholder interest in strategic change; specifically the proposed test of change for the system on cardiology- demonstrating positive interest and action from the public but also negative coverage	Moderate - High Which is above the Trust's agreed risk appetite
Legal & Regulatory risk	3955: Trust Wide Legal and Regulatory Compliance (Overarching Risk)	0	8	Low	1	Up to 5	N/A	The median risk score for all risks held on Datix against this risk type is 8 there are 0 of risks scored above 13 currently recorded. The median scores are above the Trust's agreed risk tolerance score. Please note that at this time there are only a small number of risks currently allocated to this new risk type, the median score from Datix is therefore not yet reflective of the overarching risk position. The factors increasing and decreasing risk this month were: Increasing: - Increasing regulatory oversight and intervention (NOF4 segmentation) but also support from the NHSE RSP team - High levels of legal and regulatory activity: NHS 10 year plan conversation, consultations (NOF framework), inquiries (COVID19, Fuller, Thirwall), reviews (Darzi/ Dash/Wimbridge) for the Trust to understand, review, roll out and/or respond to - Greater activity in this area and required preparedness - Continued increase in coronial activity arising from increased Medical Examiner requests Decreasing:	Moderate Which is above the Trust's agreed risk appetite

	OPERATIONAL RISKS FROM DATIX				STRATEGIC RISK OVERSIGHT			OVERARCHING PROFILE	
Risk type	Overarching Risks in Datix	Relevant risks scoring 13 and above on Datix	Risk score*	Risk appetite	Risk target score	Risk tolerance	Associated BAF objective	Analysis & commentary	Adjusted overarching risk position
								- Clear oversight, interaction of legal and regulatory activity - Well managed review and oversight leads to best practice within the organisation and improves the Trust's reputation	

Scoring: *Organisational level risk are scored by Datix through the methodology and matrix included within this policy, to create a blended risk profile.

Risk scoring categorisation: **Very high - 20-25**, **High - 13-19**, **Moderate - 6-12**, **Low- 1-5**

Analysis & commentary: other contextual aggravating and mitigating factors)

Adjusted overarching risk position: Categorised low to very high noting the Datix score, analysis and inherent risk factor

Datix Risk Register (DRR) & Risk Summary Sept 25

The Datix Risk Register is the full register of risks logged on Datix, which are scored and reviewed according to their classification, ranging from very high - low.

Scoring	Review cycle	Reviewer
Very High- 20-25	Ideally monthly but no longer than 3 months.	Board, Sub Committees of the Board
High – 13-19:	No longer than 3 months	Board, Sub Committees of the Board, TMG and Risk Group
Moderate – 6-12	No longer than 4 months	Divisional and Care Group Governance Meetings
Low – 1-5	No longer than 6 months	Speciality/Service Governance Meetings

This paper provides contextual information as to the risk themes contained in the DRR and escalates those scored high or very high for more detailed review.

Risk summary & analysis

Risk scoring profiles in Datix, taken on 18th Sept 2025

The report details new, current and closed risks rated at 15 and above, in month.

A risk rating is undertaken using an NHS standard five by five matrix according to their severity consequence and likelihood, as per the Trust's Risk Management Strategy. There are:

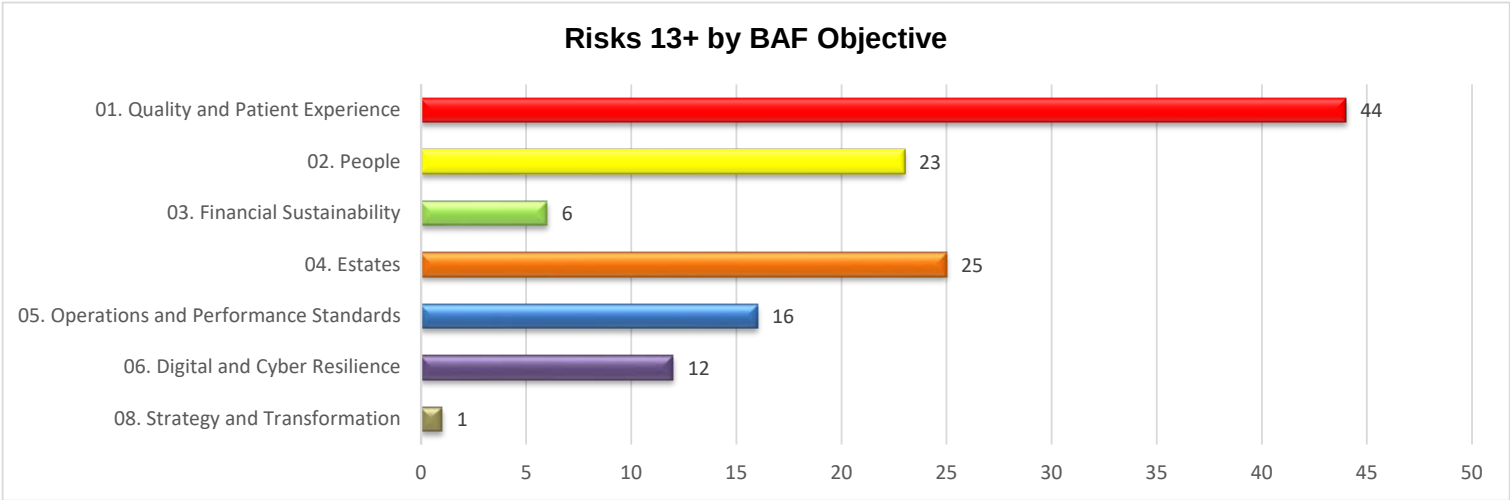
Current risks rated at 15 and above on the risk register	125
Risk(s) increased to 15 and above for review	13
Reduced, closed or suspended risk(s) rated at 15 and above to note	3
Risks requiring validation	50

Risk Heat Map- TSD

Likelihood/ Probability of Risk Occurring	1	2	3	4	5	
	Minimal	Minor	Moderate	Major	Catastrophic	Total
5 Almost Certain	5	4	16	46	9	80
4 Likely	1	16	48	96	16	177
3 Possible	4	23	102	200	16	345
2 Unlikely	2	12	83	47	8	152
1 Rare	4	5	32	18	4	63
Total	16	60	281	407	53	817

Current Risk score by month – rolling year (at the point of report date – taken as preceding month)

Current Risk Score	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Very High (15-25)	25	25	28	30	29	33	31	32	32	34	32
High (13-19)	89	90	96	91	95	88	82	84	88	94	93
Moderate (6-12)	498	520	544	603	586	578	581	580	583	576	582
Low (1-5)	64	64	69	78	83	92	94	94	97	98	99
Total number of risks	676	699	737	794	793	791	788	790	799	802	804



The summary details for all proposed risks requiring validation rated at 15 and above are highlighted in the tables (2 and 3) below. The Risk Leads (Exec and Care Group) for each of the proposed Risks requiring validation may be requested to provide further information as required by Board

2. Risks requiring validation rated 15 and above: to be noted

Department	Ref	Risk Rating	Risk Details. (as described on Datix)	Exec Lead(s)	Date opened
Rheumatology	3433	25	Insufficient Nursing Provision for Drug Monitoring (N & MW Workforce Risk)	Chief Operating Officer	05/08/2022
Emergency Department (ED)	4167	20	Unacknowledged Test Results	Medical Director	27/02/2025
Dermatology	3826	20	Temperature within Theatres at John Parkes and Level 2 Causing Infection Control Risk	Chief Nurse	01/08/2024
Pharmacy	4237	20	Time Critical Medicines - Omitted or Delayed	Medical Director	19/06/2025
Community Neuro Services	4217	20	Significant Number of Vacancies and Maternity Leave (Community Neuro)	Chief Nurse	19/05/2025
CFHD Service Wide	4221	20	CFHD IT Device Replacement Delay	Chief Operating Officer	23/05/2025
Estates	4200	20	HV & LV Capacity & Resilience (CD No8)	Chief Operating Officer	01/06/2025
Estates	4201	20	Cancer Services Building Poor Condition and Capacity (CD No9)	Chief Operating Officer	01/06/2025
Diabetes and Endocrinology	4302	20	Admin Workforce Capacity in Diabetes and Endocrinology	Chief Operating Officer	15/09/2025
Healthcare of the Older Person	4258	20	Urgent Repairs Required to Fire Door	Chief Nurse	05/08/2025
All Departments	4246	20	Ability to Order ICE Under Historical Consultants	Medical Director	01/08/2025
CFHD Service Wide	4255	16	Disruption to Specialist Equipment Provision due to Supplier Receivership	Chief Nurse	31/07/2025
Dermatology	4270	16	Insufficient Admin Resource to Meet Demand into Service inc. Sickness Cover	Interim Chief People Officer	05/08/2025
Audiology	4293	16	Lack of Staffing in the New-born Hearing Screening	Chief Operating Officer	01/09/2025
Patient Transport Services	4233	16	PTS Ambulance Equipment Past Expected Use Life	Chief Operating Officer	10/06/2025
Pathology and Laboratories	1681	16	Incorrect Blood In Labelled Tube.	Chief Operating Officer	18/10/2016
Dermatology	3825	16	Dated Clinical Equipment	Chief Operating Officer	01/08/2024
Nephrology	3901	16	Nephrology Service Provision at TSDFT	Chief Nurse	06/08/2024
Clinical Engineering	4009	16	64-slice CT (MDRRP) (Capital)	Chief Operating Officer	15/11/2024
Clinical Engineering	4020	16	SCBU Transport Trolley (MDRRP) (Capital)	Chief Operating Officer	21/11/2024

Respiratory and Thoracic	4126	16	A waiting list of more than 600 patients waiting to complete the 6 week pulmonary rehabilitation programme	Chief Nurse	01/09/2024
Diabetes and Endocrinology	2336	16	Increase in Diabetes in Pregnancy is Exceeding Capacity	Medical Director	06/11/2018
Estates	4202	16	Heating and Hot water systems infrastructure (CD No 13A)	Chief Operating Officer	01/06/2025
Estates	4203	16	Water drainage and sewerage systems (CD No 13B)	Chief Operating Officer	01/06/2025
Podiatry	4176	16	Failure for Patients with Diabetes and Deteriorating Foot Wound to Access Foot Protection Team Within 24 Hours	Chief Operating Officer	26/03/2025
Estates	4222	16	Potential failure of BacktraqFM CAFM System due to lack of support / obsolescence.	Chief Operating Officer	01/06/2025
Patient Safety and Quality	4294	16	Paper Clinical Records/ Multiple IT Systems Impacting on Patient Safety	Chief Nurse	03/09/2025
Neurology and Neurophysiology	4273	16	Planned Sickness Cover for EP Nurse & COPD Nurse Secretary	Interim Chief People Officer	27/06/2025
Rheumatology	2004	16	Absence of Fracture Liaison Service. (Not Meeting NICE Guidance.)	Chief Operating Officer	12/07/2017
Feedback and Complaints Team (PALS)	4286	15	Patient Experience Team Capacity Concerns	Chief Nurse	20/08/2025
Pathology and Laboratories	4240	15	Formalin Levels in Cellular Pathology	Medical Director	02/07/2025
Respiratory and Thoracic	4284	15	All Electrical Sockets Failure to Side Room 6 Affecting Patient	Chief Operating Officer	18/08/2025
CFHD Service Wide	4291	15	Safety and Suitability of Springfield Court	Chief Nurse	01/09/2025
Patient Access Centre	4292	15	Additional Booking Clerks Required	Chief Operating Officer	01/09/2025
Pharmacy	4236	15	Supply Chain Fragility	Medical Director	19/06/2025
Acute Medicine	4195	15	Temporary Floor Fix Still a Hazard	Chief Nurse	14/04/2025
Estates	4197	15	Histopathology Building Condition (CD No6)	Chief Operating Officer	01/06/2025
Respiratory and Thoracic	4213	15	Faulty Windows Not able to Open and Close Affecting Patients	Chief Operating Officer	13/05/2025
Healthcare of the Older Person	2067	15	Vulnerability Of HOP Consultant Workforce.	Medical Director	09/10/2017
Emergency Department (ED)	1095	15	Overcrowding In Emergency Department.	Chief Nurse	09/01/2012
Diabetes and Endocrinology	2994	15	Diabetes Insulin Pump Service	Medical Director	29/01/2021
Diabetes and Endocrinology	3779	15	Insufficient Staffing for Insulin Pump Therapy (Workforce Risk)	Chief Nurse	05/04/2024
Emergency Department (ED)	3928	15	Clinical Governance Team - Demand Exceeding Capacity-UEC	Chief Nurse	13/09/2024
Emergency Department (ED)	3929	15	High Volume of Medical Patients Remaining in Emergency Department for Extended Periods of Time	Medical Director	13/09/2024
Dermatology	3828	15	Lack of Space Utilisation and Efficiency in Dermatology Unit	Chief Operating Officer	01/06/2024
Respiratory and Thoracic	3830	15	Insufficient Respiratory Consultant Cover (Workforce Risk)	Chief Peoples Officer	16/05/2024

ASD Assessment Children	4162	15	Uncertainty of System-wide Autism Recovery Funding and Project Leadership from 1 April 2025	Chief Strategy and Planning Officer	21/02/2025
Outpatient Services	4228	15	GP - Les Agreements Ended - Effecting Capacity & Demand in Phlebotomy Outpatients	Chief Operating Officer	04/06/2025

Escalation of Very High & High level risks

There are currently 35 risks on the DRR scored 13 or above, being scored very high or high. These risks are summarised below, with additional commentary from this months' updated progress notes.

These risks have been reviewed by Risk Group and identified as:

- a) Overarching risks- that other high scoring risks with the same theme can be linked e.g. estates risks.
- or
- b) Risks that are of significant concern and require visibility to the Board.

ID	Title	Rating (current)		Review Date	Risk Subtype	Notes
BAF Objective 1: Quality and Patient Experience: Personalised care						
4001	Pharmacy Aseptic Services - Risk to Provision of Systemic Anti-Cancer Treatments	20	↔	31/10/2025	Clinical Safety Risk	[01/07/2025] Meetings with Estates ongoing. Estates to arrange an architect visit for guideline price of refurb of current unit, Pharmacy liaising with commercial suppliers of modular units for guideline prices of modular unit options.
2965	Access to an Emergency Theatre for Obstetric Cases	20	↔	31/10/2025	Clinical Safety Risk	[02/09/2025] Met to discuss the risk. The score will remain at 20. To take back to the care group. Labour ward coordinators to collect evidence of theatre availability. To review the progress of the dedicated theatre team. Assured the risk is being cited in reporting mechanisms outside of the maternity services. Raise the importance of completing Datix for near misses with the medical and midwifery team.

3546	Insufficient Staffing Resources to Meet Increased Demand for Safeguarding Services and MASH Enquiries	20	↔	06/10/2025	Workforce Risk	[28/07/2025] Consultation due to commence for band 4 roles. Recruited to 2 band 7 roles but these members of staff are still under their supervision at the moment and are not able to work independently until their onboarding training has been completed. Due to the nature of the role, this training is extensive and can take several months after the position is filled.
1947	Principal Overarching Risk (Medical Device Rolling Replacement Programme) (MDRRP)	16	↔	14/11/2025	Clinical Safety Risk	[04/08/2025] Updated MDRRP list of linked risks (04-08-2025) WIP and attached as a DOC. Consideration is underway regarding a potential transition from the existing DRM to an alternative project management platform. This transition aims to optimize system functionality and enhance the efficiency of risk identification and reporting processes, particularly for risks not assigned CA1 numbers. Such a change may result in a reduction in the number of MDRRP risks recorded within the DRM
2957	Radiation Safety (Staff/Public) : Inadequate Management Controls (Regulatory Compliance)	16	↔	15/06/2025	Health and Safety Risk	
2948	Delay in MH Patients Being Transferred to Appropriate Placement/Assessment Environment	16	↔	01/10/2025	Clinical Safety Risk	
3287	Stroke Services (overarching risk)	16	↔	30/08/2025	Clinical Safety Risk	
3733	Failure to Ensure Effective Processes in Place to Support Safe Working with Ionising Radiation for Both Staff and Patients	15	↔	21/07/2015	Health and Safety Risk	

3944	Safe Care Requires a Hierarchy of Controls to Prevent and Control/ Manage the Spread of Infectious Diseases. (Overarching Risk)	15	↔	15/04/2025	Infection Control and Prevention Risk	
4137	Operability issues with ICE affecting patient care and service effectiveness due to lack of results, and incorrect reporting.	15	↔	30/09/2025	Clinical Safety Risk	[06/08/2025] Reduction in ZUNK results due to changes within the system, however, still issues with the abnormal histology report which are being worked on by IT.
BAF Objective 2: People						
1697	Insufficient Permanent Workforce Capacity to Meet Patient Need (Overarching Risk).	20	↔	27/06/2025	Workforce Risk	
4136	Shortage of Therapeutic Radiographer and Support Workforce (Radiotherapy)	16	↔	31/10/2025	Workforce Risk	[20/08/2025] On-going problems recruiting Therapeutic Radiographers - band 5 post out to advert 4 times, band 6 dosimetrist post out to advert 4 times. Now all mutual aid ended demand has increased. Unable to staff two linacs (working on one 8-8). Working with recruitment.
2037	SACT Nursing Capacity on RGDU and Turner Ward (N&M Workforce Risk)	16	↔	30/04/2025	Workforce Risk	
3456	Single Site Specialist for Breast Radiotherapy	16	↓	30/08/2025	Workforce Risk	
3789	Lack of Capacity due to Inadequate Staffing Levels- Haematology (Workforce Risk)	15	↔	12/10/2025	Service/ Business Interruption Risk	[11/08/2025] We will be losing at least another 2 staff within the next 3 months and anticipate we will have issues recruiting experienced staff to replace them. this will leave the OOH rota with an unsustainable low number of participants for at least 3 to 6 months, possibly longer if we struggle to recruit suitable replacements.

BAF Objective 3: Financial Sustainability & Productivity						
2996	Financial Sustainability Risk Rating for 24/25 and 25/26	25	↔	28/09/2025	Financial Risk	
3867	Clinical Coding Retention and Recruitment	20	↔	01/10/2025	Financial Risk	[01/09/2025 16:11:47 Liz Procter] 1. No longer coding Maternity - this coding is not currently going to SUS - Impact mortality rating of the trust. 2. No longer coding SDEC, AMU under 1 day, etc - Impact: mortality rating of the trust. 3. The withdrawal of overtime - Impact: no longer able to meet the Flex and Freeze dates - Impact: direct impact on trust finance and activity recording.
3486	Failure to Deliver Strategies that Supports the Delivery of System Priorities on Finance and Workforce	20	↔	01/09/2025	Financial Risk	
BAF Objective 4: Estates						
1083	Inability to maintain/operate the estate in accordance with customer needs, NHS HTMs & Stat/Mand reqts within allotted funding	25	↔	26/09/2025	Financial Risk	
3684	Tower Block External Structural Condition (CD No 2)	25	↔	29/08/2025	Service/ Business Interruption Risk	
2801	Excessive Storage of Flammable Items in Corridors for Prolonged Periods	20	↔	31/10/2025	Health and Safety Risk	
1085	The Emergency Department Environment Is Not Fit for Purpose.	16	↔	16/01/2026	Clinical Safety Risk	
3783	Extension and Non Replacement of the Patient Transport Ambulance Fleet	16	↔	09/09/2025	Communication and Reputational Risk	

4124	Vulnerability of Buildings and Occupants to the Effect of an RTC	15	↔	30/09/2025	Health and Safety Risk	
BAF Objective 5: Operations and Performance Standards						
1815	Non-Compliance With the National Cancer Waiting Time Targets.	20	↔	31/10/2025	Performance Risk	[02/09/2025] 28d performance has deteriorated over the summer. Current performance for July is 70.1% - main causes are deterioration in Dermatology and performance in Urology and LGI remain poor. 31d standard still not being achieved due to ongoing R/T issues.
3493	Radiology Service Delivery and Performance (Overarching Radiology Risk)	16	↔	27/06/2025	Service/ Business Interruption Risk	
3249	Automated Dispensing System (Pharmacy)	16	↓	24/10/2025	Performance Risk	
3823	Patient safety capacity/ PSIRF - compliance	15	↔	01/10/2025	Service/Business Interruption Risk	
1070	Trust Patient Flow Pressures Resulting in Ambulance Handover Delays, Poor Levels of Care and Performance for 12hr & 4hr Standard	15	↔	30/09/2025	Performance Risk	
BAF Objective 6: Digital and Cyber Resilience						
1159	Current IT Systems and Infrastructure Will Not Meet Future Demands.	20	↔	31/07/2025	Information and Technology Risk	
3869	The Oncology Information System (OIS) - Mosaic end of life Support	16	↔	30/09/2025	Information and Technology Risk	
2920	Activity Dataset Non-Compliance for Community Setting	15	↔	31/08/2025	Information and Technology Risk	

3460	Compromise or Failure of Cloud Hosted IT Services or Systems	15	↔	14/11/2025	Information and Technology Risk	
3839	BAU Support of Systems NOT Replaced By Epic	15	↔	28/11/2025	Information and Technology Risk	
BAF Objective 8: Strategy & Transformation						
3774	Services that are "fragile" or have gone beyond fragility into "crisis" (Overarching Strategic Risk)	15	↔	05/09/2025	Strategy and Transformation Risk	



Torbay and South Devon
NHS Foundation Trust

Board of Directors

Information: Legal and Regulatory Updates

Date of meeting	Date report produced
24 September 2025	19 September 2025

Author(s)		Report approved by	
Name and title:	Sarah Fox Corporate Governance Manager	Name and title:	Emily Long Director of Corporate Governance and Trust Secretary
Phone:		Date:	19 September 2025
Email:			

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

N/a

Executive summary

The report provides the Board with information legal and regulatory updates published by NHS England over the past few months and which might be of interest to Board members. It is suggested this is reported to the Board on a more regular basis in the future.

June

- [NHS England » NHS Oversight Framework 2025/26](#)
- [NHS England » Quality impact assessment – framework and tool](#)
- [NHS England » The NHS Premises Assurance Model 2025](#)
- [National maternity investigation launched to drive improvements - GOV.UK](#)
- [Care for those with learning disabilities or autistic people - GOV.UK](#)

July

- [Health bosses won't be rewarded for failure under new regulations - GOV.UK](#)
- [NHS England » NHS publishes waiting list breakdowns to tackle health inequalities](#)

- [Independent review of the physician associate and anaesthesia associate roles: final report - GOV.UK](#)
- [NHS England » Your invitation to be involved in the National Neighbourhood Health Implementation Programme](#)
- [NHS England » Health inequalities and equality legal duties: A reference document for NHS commissioners and providers](#)
- [Review of patient safety across the health and care landscape - GOV.UK](#)
- [10 Year Health Plan for England: fit for the future - GOV.UK](#)
- [David Fuller inquiry - GOV.UK](#)
- [David Fuller inquiry: phase 2 report - GOV.UK](#)
- [Leading the NHS: proposals to regulate NHS managers - GOV.UK](#)

August - nil

September

- [NHS England » Martha's Rule rolled out to all acute hospitals](#)
- [NHS England » NHS oversight framework – NHS trust performance league tables process and results](#)
- [NHS England » Medium term planning](#)
- [Learning from Lives and Deaths – people with a learning disability and autistic people \(LeDeR\) | King's College London](#)
- [LeDeR - Action from learning reports](#)
- [NHS England » Getting the basics right for resident doctors: 10 Point Plan](#)
- [NHS England » Perinatal Quality Oversight Model](#)
- [NHS England » Enhanced therapeutic observation and care: developing a local policy](#)
- [Landmark NHS league tables launched to drive up standards - GOV.UK](#)

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
All	Satisfactory	n/a

Appendices

n/a

Committees that have previously discussed/agreed the report, and outcomes of that discussion

N/a

Key recommendations and actions requested

The Board are asked to note enclosed, which is provided for information; much of which has been presented in their weekly Board briefings.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

Good governance drives operational performance and accountability, ensuring we deliver a safe and quality service.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	
Quality of services provided	
Sustainable and efficient use of resources	

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	
Leadership and Governance	
Performance	All
People and Culture	
Strategy and Business Intelligence	
Finance	

Risk: Risk ID (as appropriate)

Risk	Risk ID
n/a	

External Standards affected by this report and associated risks

Best Practice

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance). There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.